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National Child Passenger Safety Week, February 8–14, 2004

National Child Passenger Safety Week is February 8–14, 2004. Activities will focus on the need to reduce motor-vehicle–related injuries and deaths among children by promoting age-appropriate interventions.

In 2002, a total of 1,543 children aged <15 years were killed and 227,000 were injured while riding in motor vehicles in the United States (1). Placing infants and children in age-appropriate restraints substantially reduces their risk for fatal and nonfatal injury (1,2).

Comprehensive approaches that use effective interventions simultaneously might be most successful at increasing child safety-seat use. These interventions include child safety-seat laws, communitywide information and enhanced enforcement campaigns, distribution/education programs, and incentive/education programs (2,3).

Additional information about Child Passenger Safety Week is available from the National Highway Traffic Safety Administration at <http://www.nhtsa.dot.gov> and from CDC at <http://www.cdc.gov/ncipc>. The World Health Organization has declared road safety as the theme for this year's World Health Day, April 7, 2004. Additional information about World Health Day is available at <http://www.who.int/world-health-day/2004/en>.

References

1. National Highway Traffic Safety Administration. Traffic safety facts 2002: children. Washington, DC: U.S. Department of Transportation, National Highway Traffic Safety Administration, National Center for Statistics and Analysis, 2003; publication no. DOT-HS-809-607.
2. Task Force on Community Preventive Services. Recommendations to reduce injuries to motor vehicle occupants. Increasing child safety seat use, increasing safety belt use, and reducing alcohol-impaired driving. *Am J Prev Med* 2001;21(suppl 4):16–22.
3. Zaza S, Sleet DA, Thompson RS, et al. Reviews of evidence regarding interventions to increase use of child safety seats. *Am J Prev Med* 2001;21(suppl 4):31–43.

Child Passenger Deaths Involving Drinking Drivers — United States, 1997–2002

Motor-vehicle crashes are the leading cause of death among children aged ≥ 1 year in the United States (1), and one in four crash-related deaths among child passengers aged ≤ 14 years involves alcohol use (2). To characterize the occurrence of child passenger deaths involving drinking drivers during 1997–2002, CDC analyzed data from the Fatality Analysis Reporting System (FARS) of the National Highway Traffic Safety Administration. This report summarizes the results of that analysis, which indicated that among the 2,355 children who died in alcohol-related crashes, 1,588 (68%) were riding with drinking drivers; the majority of these children were not restrained. To reduce the number of child fatalities in alcohol-related motor-vehicle crashes, effective interventions are needed to prevent alcohol-impaired driving and to increase use of child passenger restraints.

FARS is a census of fatal motor-vehicle crashes that occur on public roadways in the United States and result in the death of an occupant or nonoccupant (e.g., pedestrian or bicyclist) within 30 days of the crash. A fatal motor-vehicle crash was classified as alcohol related if either a driver or nonoccupant had a blood alcohol concentration (BAC) of ≥ 0.01 g/dL. When BACs were not available, they were imputed from driver and crash characteristics by using a two-stage estimation procedure (3). A drinking driver was defined as a driver with a

INSIDE

- 80 Trends in Intake of Energy and Macronutrients — United States, 1971–2000
- 82 Prevalence of No Leisure-Time Physical Activity — 35 States and the District of Columbia, 1988–2002
- 86 Notices to Readers

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measured or imputed BAC of ≥ 0.01 g/dL. Child passengers were defined as passengers aged ≤ 14 years.

During 1997–2002, a total of 9,622 child passengers died in motor-vehicle crashes; 2,335 (24%) were killed in crashes involving drinking drivers. Of the 2,061 alcohol-related crashes involving drinking drivers in which children were killed, 1,624 (79%) involved at least one driver with a BAC of ≥ 0.08 g/dL (in 31 states as of December 31, 2002, the legal BAC level for drivers aged ≥ 21 years is < 0.08 g/dL). Of these crashes, 1,238 (60%) occurred during 6 a.m.–9 p.m.

Of the 2,335 children who died in alcohol-related crashes, 1,588 (68%) were riding with drinking drivers (Table). The median BAC of the 1,409 drinking drivers who were transporting children was 0.13 g/dL (range: 0.01–0.65 g/dL). Of the 1,409 drinking drivers involved in these crashes, 956 (68%) survived.

For all child passenger deaths, including those not involving drinking drivers, child passenger restraint use decreased as both the child's age and BAC of the child's driver increased (Figure). Of 1,451 child passengers with known restraint information who died while riding with drinking drivers, 466 (32%) were restrained at the time of the crash.

Reported by: RA Shults, PhD, Div of Unintentional Injury Prevention, National Center for Injury Prevention and Control, CDC.

Editorial Note: The findings in this report indicate that during 1997–2002, approximately 390 children died annually in alcohol-related crashes in the United States. The majority of children who died while riding with drinking drivers were not restrained at the time of the crash. The majority of drivers in these crashes survived, suggesting that certain children killed in alcohol-related crashes might have survived had they been restrained properly. Strong enforcement of child safety-seat laws and passage of primary enforcement safety-belt laws (i.e., laws that allow police to stop and ticket a driver solely because an occupant is unbelted) in all states could further reduce child passenger deaths. Because 60% of alcohol-related crashes involving child passenger deaths occurred during 6 a.m.–9

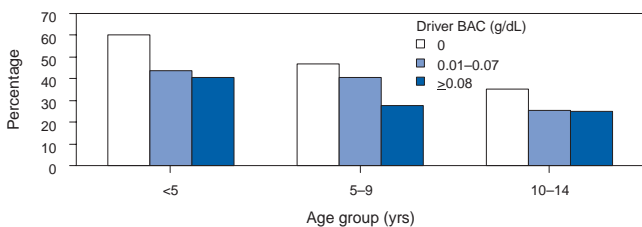
TABLE. Number and percentage of child passengers who died in motor-vehicle crashes involving drinking drivers, by blood alcohol concentration (BAC) and driver status — Fatality Analysis Reporting System, United States, 1997–2002

Driver BAC (g/dL)*	Transporting child		Not transporting child		Total
	No.	(%)	No.	(%)	
0.01–0.07	381	(24)	109	(15)	490
≥ 0.08 †	1,207	(76)	638	(85)	1,845
Total	1,588	(100)	747	(100)	2,335

* Highest driver BAC when multiple drinking drivers were involved in a fatal crash.

† The legal BAC level is < 0.08 g/dL in 31 states as of December 31, 2002.

FIGURE. Percentage of children restrained among those who died in motor-vehicle crashes*, by child's age group and blood alcohol concentration (BAC) of the driver of the vehicle in which the child was a passenger — United States, 1997–2002



* N = 8,839; does not include 734 children for whom restraint use was unknown and 49 children for whom driver information was unknown.

p.m., enforcement activities of child safety-seat and safety-belt laws (e.g., roadside checkpoints) are needed, especially during daylight hours. Drinking drivers have higher rates of severe crashes (4); for this reason, stricter enforcement of restraint laws might substantially reduce the number of deaths of children who are transported by these drivers.

The findings in this report are subject to at least three limitations. First, because BAC data are imputed for approximately 60% of FARS cases (3), the precision of the reported BACs is reduced. Second, for crashes in which a child's driver survived, driver alcohol use might have been underreported because alcohol testing is more complete among fatalities (5). Finally, information about restraint use is obtained from police crash reports, which might overreport restraint use (6).

To decrease alcohol-related crash fatalities among child passengers, communities should implement effective strategies to reduce alcohol-impaired driving, particularly among drivers who transport children. Effective policies that apply to the general driving population include sobriety checkpoints (7), lower legal BACs (e.g., <0.08 g/dL) (7), administrative license suspension (8), and mandatory substance-abuse assessment and treatment for persons convicted of driving under the influence of drugs or alcohol (9). Strategies to deter persons from drinking and driving with children might include lower legal BAC limits for drivers transporting children and child endangerment laws that apply to persons who drive while intoxicated with a child in the vehicle (2). Such laws have been enacted in 35 states (10); however, the effectiveness of these laws has not been evaluated.

Families and caregivers can reduce the risk to child passengers by adopting a "zero tolerance" policy regarding alcohol consumption when transporting children. When health-care providers advise caregivers about injury risks to children, they

should counsel against drinking and driving. Health-care providers treating adults can screen patients for alcohol-related problems and provide them with brief interventions or refer them to treatment, as needed. Additional information regarding effective community-based interventions to increase child safety-seat and safety-belt use and to reduce alcohol-impaired driving is available from the Task Force on Community Preventive Services at <http://www.thecommunityguide.org>. Information about alcohol-impaired driving and child passenger safety is available from the National Highway Traffic Safety Administration at <http://www.nhtsa.dot.gov>. Information about child endangerment laws is available from Mothers Against Drunk Driving at <http://www.madd.org>.

Acknowledgments

This report is based on contributions from T Lindsey, National Highway Traffic Safety Administration, Washington, DC. KP Quinlan, MD, Dept of Pediatrics, Univ of Chicago, Illinois.

References

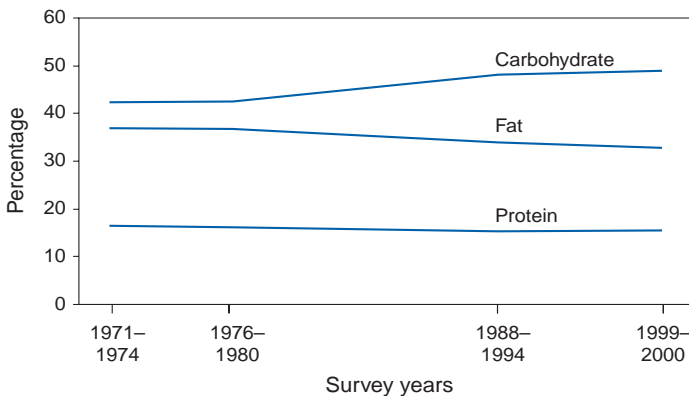
1. CDC. Ten leading causes of death, 2000. Atlanta, Georgia: U.S. Department of Health and Human Services, Public Health Service, CDC, 2002. Available at <http://webapp.cdc.gov/sasweb/ncipc/leadcaus10.html>.
2. Quinlan KP, Brewer RD, Sleet DA, Dellinger AM. Characteristics of child passenger deaths and injuries involving drinking drivers. *JAMA* 2000;283:2249–52.
3. National Highway Traffic Safety Administration. Transitioning to multiple imputation—a new method to impute missing blood alcohol concentration (BAC) values in FARS. Washington, DC: U.S. Department of Transportation, National Highway Traffic Safety Administration, National Center for Statistics and Analysis, 2002; publication no. DOT-HS-809-403.
4. Brewer RD, Morris PD, Cole TB, Watkins S, Patetta MJ, Popkin C. The risk of dying in alcohol-related automobile crashes among habitual drunk drivers. *N Engl J Med* 1994;331:513–7.
5. Ostrom M, Huelke DF, Waller PF, Eriksson A, Blow F. Some biases in the alcohol investigative process in traffic fatalities. *Accid Anal Prev* 1992;24:539–45.
6. National Highway Traffic Safety Administration. Police Accident Report Quality Assessment Project. Washington, DC: U.S. Dept of Transportation, National Highway Traffic Safety Administration, 1996; publication no. DOT-HS-808-487.
7. Shults RA, Elder RW, Sleet DA, et al. Reviews of evidence regarding interventions to reduce alcohol-impaired driving. *Am J Prev Med* 2001;21:66–88.
8. Zador PL, Lund AK, Fields M, Weinberg K. Fatal crash involvement and laws against alcohol-impaired driving. *J Public Health Policy* 1989;10:467–85.
9. Wells-Parker E, Bangert-Drowns R, McMillen R, Williams M. Final results from a meta-analysis of remedial interventions with drink/drive offenders. *Addiction* 1995;90:907–26.
10. Mothers Against Drunk Driving. Alcohol and child safety laws. Irving, Texas: Mothers Against Drunk Driving, 2004. Available at <http://www3.madd.org/laws>.

Trends in Intake of Energy and Macronutrients — United States, 1971–2000

During 1971–2000, the prevalence of obesity in the United States increased from 14.5% to 30.9% (1). Unhealthy diets and sedentary behaviors have been identified as the primary causes of deaths attributable to obesity (2). Evaluating trends in dietary intake is an important step in understanding the factors that contribute to the increase in obesity. To assess trends in intake of energy (i.e., kilocalories [kcal]), protein, carbohydrate, total fat, and saturated fat during 1971–2000, CDC analyzed data from four National Health and Nutrition Examination Surveys (NHANES): NHANES I (conducted during 1971–1974), NHANES II (1976–1980), NHANES III (1988–1994), and NHANES 1999–2000. This report summarizes the results of that analysis, which indicate that, during 1971–2000, mean energy intake in kcals increased, mean percentage of kcals from carbohydrate increased, and mean percentage of kcals from total fat and saturated fat decreased (Figures 1 and 2). An expert advisory committee appointed by the U.S. Department of Health and Human Services and the U.S. Department of Agriculture (USDA) is conducting a review of the *Dietary Guidelines for Americans* (3). Revised guidelines will be published in 2005.

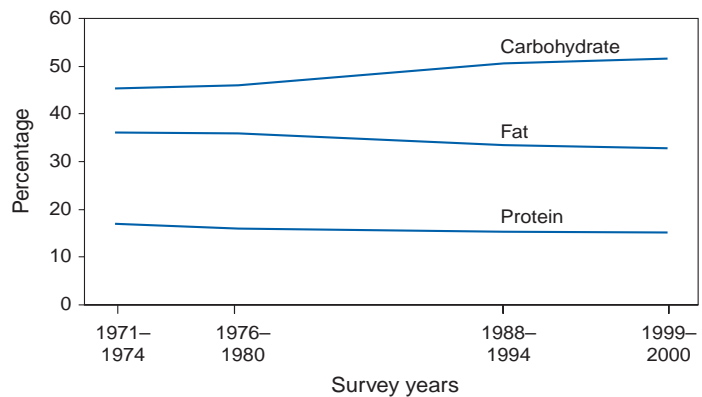
NHANES provides information on the health and nutritional status of the U.S. civilian, noninstitutionalized population by using a complex, multistage probability sample design. NHANES I sampled persons residing in the contiguous 48 states; subsequent surveys sampled all 50 states. Surveys consisted of a household interview followed by an examination at

FIGURE 1. Percentage of kilocalories from macronutrient intake among men aged 20–74 years*, by survey years — National Health and Nutrition Examination Surveys (NHANES), United States, 1971–2000



*Age adjusted by direct standardization to the 2000 U.S. Census population by using age groups 20–39, 40–59, and 60–74 years.

FIGURE 2. Percentage of kilocalories from macronutrient intake among women aged 20–74 years*, by survey years — National Health and Nutrition Examination Surveys (NHANES), United States, 1971–2000



*Age adjusted by direct standardization to the 2000 U.S. Census population by using age groups 20–39, 40–59, and 60–74 years.

a mobile examination center (MEC). All of the surveys included a dietary recall interview that was conducted at the MEC to obtain information on foods and beverages consumed during the preceding 24 hours. In this report, estimates of energy intake include kcals from alcoholic beverages; however, the percentage of kcals from alcohol is not presented separately. Age was recorded at the time of the household interview. The upper age limit was 74 years for NHANES I and NHANES II. No upper age limit was established for NHANES III and NHANES 1999–2000. To compare estimates across surveys, the analysis included only adults aged 20–74 years. Sample sizes ranged from 1,730 men and 2,003 women in NHANES 1999–2000 to 6,630 men and 7,537 women in NHANES III (Table).

Statistical analyses were conducted by using SAS version 8.2 and SUDAAN version 8.0.0, which used sample weights and design variables to produce national estimates. The recommended age categories used are based on the survey sample domains (4). Because of differences in the relative age distribution, estimates for persons aged 20–74 years were adjusted by direct standardization to the 2000 U.S. Census population by using the age groups 20–39, 40–59, and 60–74 years. Six persons who reported fasting (i.e., consuming 0 kcals) during the preceding 24 hours were excluded from these analyses.

During 1971–2000, a statistically significant increase in average energy intake occurred (Table). For men, average energy intake increased from 2,450 kcals to 2,618 kcals ($p < 0.01$), and for women, from 1,542 kcals to 1,877 kcals ($p < 0.01$). For men, the percentage of kcals from carbohydrate increased between 1971–1974 and 1999–2000, from 42.4% to 49.0% ($p < 0.01$), and for women, from 45.4% to 51.6%

TABLE. Mean energy and macronutrient intake* among adults aged 20–74 years†, by sex and age group — National Health and Nutrition Examination Surveys (NHANES), United States, 1971–2000

Sex and age group (yrs)	NHANES I 1971–1974		NHANES II 1976–1980		NHANES III 1988–1994		NHANES 1999–2000	
	Kcals	SE§	Kcals	SE	Kcals	SE	Kcals	SE
Energy intake								
Men, adjusted¶	2,450	28.8	2,439	25.9	2,666	25.4	2,618	29.6
20–39	2,784	37.5	2,753	40.8	2,965	38.2	2,828	59.1
40–59	2,303	37.2	2,315	36.5	2,568	38.0	2,590	55.8
60–74	1,918	40.5	1,906	17.4	2,105	28.2	2,123	66.2
Women, adjusted¶	1,542	14.8	1,522	13.3	1,798	13.6	1,877	23.5
20–39	1,652	16.4	1,643	18.0	1,958	25.7	2,028	40.8
40–59	1,510	20.6	1,473	21.3	1,736	19.5	1,828	35.4
60–74	1,325	21.4	1,322	12.9	1,522	22.6	1,596	40.8
% kcals from carbohydrate								
	%	SE	%	SE	%	SE	%	SE
Men, adjusted¶	42.4	0.21	42.6	0.20	48.2	0.39	49.0	0.40
20–39	42.2	0.25	43.1	0.28	48.1	0.46	50.0	0.57
40–59	41.6	0.39	41.5	0.32	47.8	0.53	47.5	0.62
60–74	44.8	0.36	44.1	0.31	49.7	0.45	49.7	0.64
Women, adjusted¶	45.4	0.24	46.0	0.19	50.6	0.30	51.6	0.38
20–39	45.8	0.28	46.0	0.25	50.6	0.41	52.6	0.59
40–59	44.4	0.36	45.0	0.31	50.0	0.43	50.9	0.61
60–74	46.8	0.46	48.6	0.29	52.5	0.39	51.1	0.78
% kcals from total fat								
Men, adjusted¶	36.9	0.20	36.8	0.19	33.9	0.29	32.8	0.42
20–39	37.0	0.27	36.2	0.26	34.0	0.34	32.1	0.50
40–59	36.9	0.39	37.3	0.24	34.2	0.41	33.4	0.62
60–74	36.4	0.38	36.9	0.23	32.9	0.38	33.0	0.50
Women, adjusted¶	36.1	0.14	36.0	0.17	33.4	0.24	32.8	0.34
20–39	36.3	0.20	36.0	0.22	33.6	0.31	32.3	0.47
40–59	36.3	0.26	36.5	0.27	34.0	0.35	33.1	0.63
60–74	34.9	0.29	34.7	0.26	31.6	0.32	33.3	0.60
% kcals from saturated fat								
Men, adjusted¶	13.5	0.11	13.2	0.08	11.3	0.10	10.9	0.16
20–39	13.6	0.14	13.1	0.13	11.5	0.14	10.8	0.22
40–59	13.5	0.19	13.5	0.10	11.3	0.16	11.1	0.23
60–74	13.3	0.20	13.1	0.10	10.9	0.14	10.7	0.22
Women, adjusted¶	13.0	0.11	12.5	0.08	11.2	0.10	11.0	0.14
20–39	13.0	0.12	12.6	0.11	11.4	0.15	10.9	0.18
40–59	13.1	0.16	12.7	0.12	11.3	0.14	11.1	0.25
60–74	12.4	0.13	11.8	0.11	10.4	0.16	10.9	0.25
% kcals from protein								
Men, adjusted¶	16.5	0.12	16.1	0.11	15.4	0.11	15.5	0.11
20–39	16.1	0.12	15.8	0.11	15.0	0.17	14.9	0.21
40–59	16.9	0.19	16.3	0.20	15.7	0.16	15.8	0.22
60–74	16.5	0.19	16.3	0.13	15.9	0.16	16.1	0.25
Women, adjusted¶	16.9	0.11	16.0	0.09	15.4	0.10	15.1	0.18
20–39	16.4	0.12	15.8	0.14	14.8	0.16	14.6	0.26
40–59	17.3	0.17	16.3	0.13	15.6	0.15	15.2	0.28
60–74	17.0	0.23	16.1	0.10	16.4	0.18	16.2	0.28

* Estimates of energy intake include kilocalories (kcals) from alcoholic beverages; however, percentage of kcals from alcohol is not presented separately.

† Sample sizes varied. NHANES I: 4,902 men, 7,984 women; NHANES II: 5,568 men, 6,227 women; NHANES III: 6,630 men, 7,537 women; and NHANES 1999–2000: 1,730 men, 2,003 women.

§ Standard error of the mean.

¶ Estimated means were adjusted by direct standardization to the 2000 U.S. Census population by using age groups 20–39, 40–59, and 60–74 years.

($p < 0.01$) (Table). The percentage of kcals from total fat decreased from 36.9% to 32.8% ($p < 0.01$) for men and from 36.1% to 32.8% ($p < 0.01$) for women. In addition, the percentage of kcals from saturated fat decreased from 13.5% to 10.9% ($p < 0.01$) for men and from 13.0% to 11.0% ($p < 0.01$) for women. A slight decrease was observed in the percentage

of kcals from protein, from 16.5% to 15.5% ($p < 0.01$) for men and from 16.9% to 15.1% ($p < 0.01$) for women.

The decrease in the percentage of kcals from fat during 1971–1991 is attributed to an increase in total kcals consumed; absolute fat intake in grams increased (5). USDA food consumption survey data from 1989–1991 and 1994–1996

indicated that the increased energy intake was caused primarily by higher carbohydrate intake (6). Data from NHANES for 1971–2000 indicate similar trends. The increase in energy intake is attributable primarily to an increase in carbohydrate intake, with a 62.4-gram increase among women ($p < 0.01$) and a 67.7-gram increase among men ($p < 0.01$). Total fat intake in grams increased among women by 6.5 g ($p < 0.01$) and decreased among men by 5.3 g ($p < 0.01$).

Reported by: JD Wright, MPH, J Kennedy-Stephenson, MS, CY Wang, PhD, MA McDowell, MPH, CL Johnson, MSPH, National Center for Health Statistics, CDC.

Editorial Note: The increase in caloric intake described in this report is consistent with previously reported trends in dietary intake in the United States (7). USDA survey data for 1977–1996 suggest that factors contributing to the increase in energy intake in the United States include consumption of food away from home; increased energy consumption from salty snacks, soft drinks, and pizza (8); and increased portion sizes (9).

The findings in this report are subject to at least two limitations. First, information on dietary intake is self-reported and subject to recall bias. Second, although the majority of the increase in average energy intake occurred between 1976–1980 and 1988–1994, changes in the 24-hour dietary recall interview method between these two periods might account for some of this difference. Beginning in 1988, dietary recalls were collected for weekend days as well as weekdays because food consumption differs on weekend days. The interview format was revised, and questions were added that might have allowed for collection of more complete dietary intake data.

The latest national dietary data available indicate that the previously reported increase in energy intake has continued, reflecting primarily increased carbohydrate intake. A focus on total energy intake and energy balance (i.e., the balance of energy intake with energy expenditure) is fundamental to preventing and reducing obesity in the United States. Continuing efforts to decrease saturated fat intake are important to reduce the risk for cardiovascular disease and should include assessment of fat intake in grams in addition to fat intake as a percentage of kcals. The energy- and macronutrient-intake trends described in this report should help guide the forthcoming revision of *Dietary Guidelines for Americans* and reviews of USDA's *Food Guide Pyramid* and the *Healthy People 2010* nutrition objectives.

References

1. Flegal KM, Carroll MD, Ogden CL, Johnson CL. Prevalence and trends in obesity among US adults, 1999–2000. *JAMA* 2002;288:1723–7.

2. U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. Rockville, Maryland: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General, 2001.
3. U.S. Department of Health and Human Services, U.S. Department of Agriculture. Development of the 2005 Dietary Guidelines for Americans, 6th ed. Available at <http://www.health.gov/dietaryguidelines/dga2005/default.htm>.
4. U.S. Department of Health and Human Services. NHANES 1999–2000 addendum to the NHANES III analytic guidelines. Available at <http://www.cdc.gov/nchs/data/nhanes/guidelines1.pdf>.
5. Ernst ND, Obarzanek E, Clark MB, Briefel RR, Brown CD, Donato K. Cardiovascular health risks related to overweight. *J Am Diet Assoc* 1997;97(suppl):S47–S51.
6. Chanmugam P, Guthrie JF, Cecilio S, Morton JF, Basiotis PP, Anand R. Did fat intake in the United States really decline between 1989–1991 and 1994–1996? *J Am Diet Assoc* 2003;103:867–72.
7. Federation of American Societies for Experimental Biology, Life Sciences Research Office. Third Report on Nutrition Monitoring in the United States (vol. 1). Washington, DC: U.S. Government Printing Office, 1995.
8. Nielsen SJ, Siega-Riz AM, Popkin BM. Trends in energy intake in U.S. between 1977 and 1996: similar shifts seen across age groups. *Obes Res* 2002;10:370–8.
9. Nielsen SJ, Popkin BM. Patterns and trends in food portion sizes, 1977–1998. *JAMA* 2003;289:450–3.

Prevalence of No Leisure-Time Physical Activity — 35 States and the District of Columbia, 1988–2002

Physical inactivity is associated with obesity and increased risk for chronic diseases (e.g., cardiovascular disease, certain cancers, and diabetes mellitus) and premature mortality (1). A national health objective for 2010 is to reduce the prevalence of no leisure-time physical activity to 20% (objective 22.1) (2). Women, older adults, and the majority of racial/ethnic minority populations have the greatest prevalence of leisure-time physical inactivity (2). To examine trends in no leisure-time physical activity and further characterize them by sex, age group, and racial/ethnic population, CDC analyzed 1988–2002 data from the Behavioral Risk Factor Surveillance System (BRFSS) for 35 states* and the District of Columbia (DC). This report summarizes the results of that analysis, which indicated that leisure-time physical inactivity decreased during 1988–2002, especially after 1996, with declining trends among men and women, the majority of age

*Alabama, Arizona, California, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, and Wisconsin.

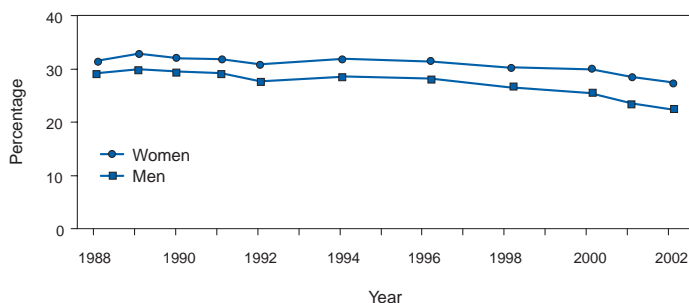
groups, and the majority of racial/ethnic populations. To promote further declines, state and local health departments and other organizations should adopt effective, evidence-based strategies to encourage more adults to be physically active in their leisure time.

BRFSS is a state-based, random-digit-dialed telephone survey of the U.S. civilian, noninstitutionalized population aged ≥ 18 years. Data on leisure-time physical inactivity were collected from 11 surveys (conducted in 1988, 1989, 1990, 1991, 1992, 1994, 1996, 1998, 2000, 2001, and 2002). During 1988–2002, annual sample sizes increased from 54,685 to 170,423 persons. No leisure-time physical activity was defined as a “no” response to the survey question, “During the past month, other than your regular job, did you participate in any physical activities or exercise such as running, calisthenics, golf, gardening, or walking for exercise?” Although this survey question has been used since 1986, the wording of the reference time frame of the survey question was changed to “past 30 days” in 2001 and back to “past month” in 2002, and the phrase “other than your regular job” was added in 2001. Prevalence estimates by sex, age, and race/ethnicity were weighted to represent the populations of states included in the study, and sex and race/ethnicity estimates were age-adjusted to the 2000 U.S. population. The annual median response rate among the 35 states and DC ranged from 68.8% in 1993 to 59.9% in 2002. SUDAAN was used to account for complex sampling.

Overall, the prevalence of no leisure-time physical activity peaked in 1989 at approximately 32% and was stable until 1996, after which it declined an average of 1% per year to 25% in 2002. By sex, the prevalence decreased from 29% to 22% among men and from 32% to 28% among women (Figure).

By age group, no leisure-time physical activity was least prevalent among adults aged 18–29 years. During 1988–2002, prevalences in this age group ranged from 18%–21% among men and 24%–27% among women (Table 1); however, comparing 1988 survey results with those from 2002, the prevalences for men and women in that age group were unchanged. Since 1996, the prevalence of no leisure-time physical activity declined among all age groups, especially among persons in older groups. During 1988–2002, the prevalence of no leisure-time physical activity among persons aged 50–59 years decreased from 38% to 23% among men and from 35% to 28% among women. Among women aged 60–69 years, the prevalence of leisure-time physical inactivity decreased from 37% to 31%, and among women aged ≥ 70 years, the prevalence decreased from 47% to 39%.

FIGURE. Prevalence of no leisure-time physical activity, by sex and survey year* — Behavioral Risk Factor Surveillance System, 35 states† and the District of Columbia, 1988–2002



* The survey question regarding no leisure-time physical activity was not asked in 1993, 1995, 1997, and 1999.

† Alabama, Arizona, California, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, and Wisconsin.

Among non-Hispanic whites, during 1988–2002, the prevalence of no leisure-time physical activity decreased from 28% to 19% among men and from 29% to 23% among women (Table 2). Among non-Hispanic blacks, the prevalence of no leisure-time physical activity decreased from 36% to 28% among men and from 47% to 36% among women. Among Hispanic men and women, prevalences for 1988 (37% and 40%, respectively) and 2002 (35% and 40%, respectively) were similar; yearly prevalences ranged from 34% to 42% among men and from 39% to 45% among women.

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Editorial Note: The findings in this report indicate that, in 2002, the overall prevalence of no leisure-time physical activity in 35 states and DC was at the lowest level in 15 years. During 1988–2002, the overall prevalence declined approximately seven percentage points from its peak in 1989, including five percentage points since 1996. An estimated 8.3 million fewer adults reported being inactive in 2002 than in 1996. The causes are unknown for the overall decline in no leisure-time physical activity since 1996; however, the decline followed issuance of new national guidelines on physical activity in 1995 and 1996 (1,3).

Findings through 1996 are consistent with a previous BRFSS trend analysis for 1990–1998 that indicated no change in prevalence (4), although prevalence during 1986–1990 declined (5). Analyses of National Health Interview Survey (NHIS) results show greater prevalence of no leisure-time physical activity than BRFSS and, since 1997, smaller declines

TABLE 1. Prevalence* of no leisure-time physical activity, by age group and sex — Behavioral Risk Factor Surveillance System, 35 states† and the District of Columbia, 1988–2002

Age group (yrs)	1988 % (95% CI) [§]	1989 % (95% CI)	1990 % (95% CI)	1991 % (95% CI)	1992 % (95% CI)	1994 % (95% CI)	1996 % (95% CI)	1998 % (95% CI)	2000 % (95% CI)	2001 % (95% CI)	2002 % (95% CI)
Male											
18–29	18.7 (±1.7)	19.3 (±1.6)	19.7 (±1.5)	19.2 (±1.5)	18.8 (±1.4)	19.5 (±1.6)	20.6 (±1.5)	17.8 (±1.3)	17.8 (±1.3)	18.2 (±1.5)	18.1 (±1.4)
30–39	25.2 (±1.9)	25.9 (±1.7)	26.1 (±1.6)	25.7 (±1.5)	25.1 (±1.4)	26.4 (±1.5)	25.0 (±1.4)	24.1 (±1.4)	24.2 (±1.4)	21.2 (±1.3)	20.2 (±1.3)
40–49	30.1 (±2.2)	31.9 (±2.3)	31.2 (±2.1)	31.2 (±2.0)	27.3 (±1.6)	28.2 (±1.6)	28.6 (±1.5)	26.7 (±1.4)	26.8 (±1.7)	24.3 (±1.4)	22.4 (±1.2)
50–59	38.4 (±3.0)	36.1 (±2.7)	36.7 (±2.6)	36.5 (±2.6)	33.6 (±2.1)	34.0 (±2.2)	34.2 (±2.0)	31.4 (±1.8)	29.1 (±1.7)	26.6 (±1.6)	23.0 (±1.4)
60–69	32.8 (±2.7)	36.1 (±2.7)	34.7 (±2.6)	35.2 (±2.4)	33.8 (±2.3)	35.6 (±2.3)	32.5 (±2.2)	32.2 (±2.1)	29.7 (±2.1)	26.3 (±1.9)	26.3 (±1.7)
≥70	40.6 (±3.2)	39.8 (±3.0)	37.4 (±2.8)	37.2 (±2.7)	35.3 (±2.4)	35.1 (±2.5)	36.0 (±2.2)	34.9 (±2.0)	31.3 (±2.2)	30.8 (±1.8)	29.7 (±1.7)
Total	29.3 (±0.9)	29.9 (±0.9)	29.6 (±0.9)	29.3 (±0.8)	27.6 (±0.7)	28.5 (±0.8)	28.1 (±0.7)	26.4 (±0.7)	25.4 (±0.7)	23.6 (±0.6)	22.3 (±0.6)
Female											
18–29	24.8 (±1.7)	26.6 (±1.6)	26.1 (±1.6)	26.2 (±1.5)	25.1 (±1.3)	24.8 (±1.5)	26.2 (±1.4)	24.7 (±1.3)	25.7 (±1.4)	25.0 (±1.2)	23.7 (±1.2)
30–39	27.2 (±1.6)	28.9 (±1.5)	27.6 (±1.4)	28.0 (±1.4)	27.1 (±1.2)	27.9 (±1.3)	28.4 (±1.2)	27.6 (±1.2)	28.9 (±1.2)	26.1 (±1.2)	24.9 (±1.1)
40–49	29.2 (±2.0)	31.8 (±2.1)	32.3 (±1.9)	30.0 (±1.8)	29.5 (±1.6)	31.2 (±1.5)	30.3 (±1.4)	29.1 (±1.3)	28.6 (±1.2)	27.1 (±1.2)	25.6 (±1.1)
50–59	35.0 (±2.6)	33.7 (±2.4)	33.1 (±2.4)	34.0 (±2.2)	31.7 (±1.9)	33.1 (±1.8)	32.6 (±1.7)	31.7 (±1.6)	29.9 (±1.5)	29.1 (±1.3)	27.5 (±1.2)
60–69	37.0 (±2.4)	37.6 (±2.3)	34.4 (±2.3)	34.5 (±2.0)	33.8 (±1.9)	37.4 (±2.0)	35.6 (±1.8)	34.3 (±1.8)	32.1 (±1.7)	30.8 (±1.6)	30.9 (±1.4)
≥70	47.3 (±2.3)	48.9 (±2.3)	47.6 (±2.1)	46.8 (±2.0)	46.3 (±1.8)	45.6 (±1.8)	43.2 (±1.6)	41.7 (±1.5)	39.6 (±1.6)	38.8 (±1.4)	39.2 (±1.4)
Total	31.6 (±0.8)	32.9 (±0.8)	32.0 (±0.8)	31.8 (±0.7)	30.8 (±0.7)	31.8 (±0.7)	31.4 (±0.6)	30.2 (±0.6)	29.9 (±0.6)	28.5 (±0.5)	27.5 (±0.5)
Total	30.5 (±0.6)	31.5 (±0.6)	30.9 (±0.6)	30.6 (±0.6)	29.3 (±0.5)	30.2 (±0.5)	29.9 (±0.5)	28.4 (±0.4)	27.8 (±0.4)	26.2 (±0.4)	25.1 (±0.4)

* Weighted by state population estimates.

† Alabama, Arizona, California, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, and Wisconsin.

§ Confidence interval.

(2%–3%) in multiple demographic groups (2). These variations might be due to differences in survey questions and sampling frames for the two surveillance systems. However, the majority of demographic groups measured by both BRFSS and NHIS have prevalences of no leisure-time activity greater than the 20% national health objective for 2010 (2).

Despite the recent decline in no leisure-time physical activity, the prevalence of overweight and obese persons has increased (6). This disparity might be explained, in part, by nationally representative data indicating an increase in the

caloric intake of the overall U.S. population (7). In addition, the declines in leisure-time physical inactivity might not have been accompanied by increases in physical activity sufficient to maintain or lose weight.

This report is subject to at least five limitations. First, BRFSS is a telephone survey; data are self-reported, subject to both recall and social desirability bias, and provided only by those with telephones. Second, the survey question was changed slightly in 2001 and again in 2002. Third, small sample sizes among certain racial/ethnic populations can result in wide

TABLE 2. Prevalence* of no leisure-time physical activity, by race/ethnicity and sex — Behavioral Risk Factor Surveillance System, 35 states† and the District of Columbia, 1988–2002

Race/Ethnicity	1988 % (95% CI) [§]	1989 % (95% CI)	1990 % (95% CI)	1991 % (95% CI)	1992 % (95% CI)	1994 % (95% CI)	1996 % (95% CI)	1998 % (95% CI)	2000 % (95% CI)	2001 % (95% CI)	2002 % (95% CI)
Male											
White, non-Hispanic	27.9 (±1.0)	28.4 (±1.0)	27.6 (±0.9)	27.2 (±0.8)	26.1 (±0.8)	26.8 (±0.8)	26.6 (±0.7)	24.7 (±0.7)	22.3 (±0.6)	20.5 (±0.6)	19.2 (±0.5)
Black, non-Hispanic	36.0 (±3.6)	38.0 (±3.3)	37.3 (±3.4)	38.7 (±3.1)	34.9 (±2.7)	35.2 (±2.7)	34.5 (±2.8)	27.7 (±2.4)	29.0 (±2.5)	29.3 (±2.3)	27.7 (±2.1)
Hispanic	37.0 (±5.4)	36.1 (±4.5)	37.8 (±4.1)	41.8 (±3.9)	33.9 (±3.5)	38.5 (±3.7)	37.2 (±3.3)	37.5 (±2.9)	39.0 (±3.3)	34.8 (±3.0)	35.2 (±2.9)
Asian/Pacific Islander	30.6 (±8.9)	28.8 (±9.0)	33.6 (±8.8)	22.7 (±5.9)	26.1 (±5.1)	25.1 (±4.8)	24.4 (±5.0)	26.0 (±5.6)	25.6 (±6.2)	25.2 (±5.4)	19.9 (±5.3)
AI/AN [¶]	34.1 (±10.3)	34.9 (±8.5)	48.1 (±10.8)	26.2 (±8.1)	24.4 (±7.9)	34.8 (±8.2)	24.3 (±6.8)	34.5 (±8.3)	29.7 (±5.5)	32.3 (±5.9)	26.3 (±4.5)
Other ^{**}	30.7 (±13.1)	30.4 (±13.3)	25.1 (±10.6)	28.1 (±12.2)	38.2 (±10.9)	35.9 (±8.5)	20.7 (±6.8)	19.6 (±6.5)	28.4 (±7.1)	27.1 (±5.5)	27.2 (±5.5)
Female											
White, non-Hispanic	29.0 (±0.9)	29.9 (±0.8)	28.8 (±0.8)	29.0 (±0.8)	27.8 (±0.7)	28.4 (±0.7)	28.2 (±0.6)	26.5 (±0.6)	25.8 (±0.6)	24.1 (±0.5)	23.2 (±0.5)
Black, non-Hispanic	46.5 (±3.0)	44.7 (±2.6)	45.6 (±2.5)	44.5 (±2.4)	43.2 (±2.3)	46.4 (±2.2)	43.0 (±2.0)	39.3 (±1.9)	38.2 (±1.9)	39.0 (±1.8)	36.0 (±1.7)
Hispanic	39.6 (±4.5)	43.4 (±4.3)	45.4 (±3.7)	39.1 (±3.4)	41.4 (±3.1)	45.3 (±3.1)	42.1 (±2.8)	44.5 (±2.5)	42.9 (±2.5)	42.8 (±2.4)	40.1 (±2.5)
Asian/Pacific Islander	40.4 (±7.9)	40.3 (±7.2)	38.7 (±6.9)	42.2 (±7.2)	37.5 (±5.9)	33.4 (±4.9)	31.0 (±5.6)	32.7 (±5.6)	34.2 (±5.7)	23.8 (±3.8)	28.0 (±4.5)
AI/AN	42.2 (±8.4)	38.0 (±9.2)	26.9 (±8.1)	40.2 (±8.8)	30.8 (±7.1)	36.2 (±7.4)	32.7 (±6.8)	31.5 (±6.2)	31.3 (±4.8)	34.1 (±5.3)	29.8 (±4.6)
Other	44.6 (±15.5)	29.5 (±13.4)	51.3 (±13.4)	34.3 (±11.2)	38.1 (±8.7)	29.8 (±7.9)	30.1 (±8.5)	28.0 (±7.9)	26.0 (±6.4)	33.8 (±5.9)	30.2 (±5.9)

* Weighted by state population estimates and age adjusted to the 2000 U.S. standard population, by groups aged 18–24 years, 25–34 years, 35–44 years, 45–64 years, and ≥65 years.

† Alabama, Arizona, California, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, West Virginia, and Wisconsin.

§ Confidence interval.

¶ American Indian/Alaska Native.

** Other race or multiracial.

data variability and imprecise trends in these populations. Fourth, declines in survey response rates can affect the generalizability of the reported behaviors; however, an analysis for bias in generalizability of the results suggests this did not occur (8). Finally, these data are limited by coverage- and nonresponse-related errors.

To promote their general health, adults are encouraged to meet or exceed recommendations of ≥30 minutes of moderate-intensity physical activity “most” days of the week (1,3). The majority of adults do not meet this recommendation (2,3,9).

Continued efforts are needed to decrease inactivity during leisure time and increase overall physical activity among all U.S. adults (2). State and local public health departments and

other organizations are encouraged to promote physical activity by using the following evidence-based strategies recommended by the Task Force on Community Preventive Services: 1) communitywide campaigns, 2) signs near elevators and escalators encouraging stair use, 3) individually adapted health-behavior change programs, 4) school physical education, 5) social support interventions in community settings, and 6) creation of, or enhanced access to, physical activity sites combined with informational outreach activities (10).

References

1. U.S. Department of Health and Human Services. Physical activity and health: a report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 1996.
2. U.S. Department of Health and Human Services. Data2010: the Healthy People 2010 database. Available at <http://wonder.cdc.gov/data2010>.

3. Pate RR, Pratt M, Blair SN, et al. Physical activity and public health: a recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine. *JAMA* 1995;273:402-7.
4. CDC. Physical activity trends—United States, 1990–1998. *MMWR* 2001;50:166-9.
5. Caspersen CJ, Merritt RK. Physical activity trends among 26 states, 1986–1990. *Med Sci Sport Exerc* 1995;27:713-20.
6. Mokdad AH, Ford ES, Bowman BA, et al. Prevalence of obesity, diabetes, and obesity-related health factors, 2001. *JAMA* 2003;289:76-9.
7. CDC. Trends in intake of energy and macronutrients — United States, 1971–2000. *MMWR* 2004;53:80-2.
8. CDC. Public health surveillance for behavioral risk factors in a changing environment: recommendations from the Behavioral Risk Factor Surveillance Team. *MMWR* 2003;52(No. RR-9).
9. CDC. Prevalence of physical activity, including lifestyle activities among adults—United States, 2000–2001. *MMWR* 2003;52:764-9.
10. CDC. Increasing physical activity: a report on recommendations of the Task Force on Community Preventive Services. *MMWR* 2001;50(No. RR-18).

Notice to Readers

National Black HIV/AIDS Awareness Day, February 7, 2004

The fourth annual National Black HIV/AIDS Awareness Day is February 7, 2004. The day is designed to raise awareness among blacks of human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS). The goal of this national event, which is supported by CDC and sponsored by a coalition of nongovernment organizations, is to mobilize blacks to become educated, get tested, and become involved in the fight against HIV/AIDS.

As of December 31, 2002, approximately 185,000 blacks in the United States had died of AIDS (1). AIDS is a leading cause of death among black women aged 25–44 years and among black men aged 25–54 years (2). Black men are nearly nine times more likely than white men to have AIDS, and black women are 23 times more likely than white women to have AIDS (1). In 2002, blacks were approximately 12% of the U.S. population but accounted for >50% of all new HIV diagnoses (1).

Testing and prevention remain key to stopping the spread of HIV, and being tested is an essential first step for persons to obtain treatment and take steps to protect their partners from infection. The new rapid HIV test, which gives preliminary results in approximately 20 minutes, is widely available. However, blacks are more likely than whites to test late in their illness, when life-extending antiretroviral treatments might no longer be as effective (3).

Additional information about HIV/AIDS is available from CDC, telephone 404-342-2437, and at <http://www.cdcnpin.org> and <http://www.cdc.gov/nchstp/od/nchstp.html>. Additional information about National Black HIV/AIDS Awareness Day is available at <http://www.blackaidsday.org>.

References

1. CDC. HIV/AIDS surveillance report: cases of HIV infection and AIDS in the United States, 2002. Available at <http://www.cdc.gov/hiv/stats/hasr1402.htm>.
2. CDC. National Center for Health Statistics. Deaths: leading causes for 2001. National Vital Statistics Report; vol. 52, no. 9. Hyattsville, Maryland: U.S. Department of Health and Human Services, CDC, National Center for Health Statistics, 2003.
3. CDC. Late versus early testing of HIV—16 sites, United States, 2000–2003. *MMWR* 2003;52:581-6.

Notice to Readers

National Center for Environmental Health and Public Health Training Network Satellite Broadcast and Webcast, February 10, 2004

CDC will present “Medical Response to Nuclear and Radiological Terrorism,” a live, interactive satellite broadcast and webcast on February 10, 2004, from 1 p.m. to 2 p.m. EST. The target audience for this program comprises emergency physicians, hospitalists (i.e., physicians whose practices emphasize providing care for hospitalized patients), nurse practitioners, physician assistants, nurses, and other clinical emergency department personnel.

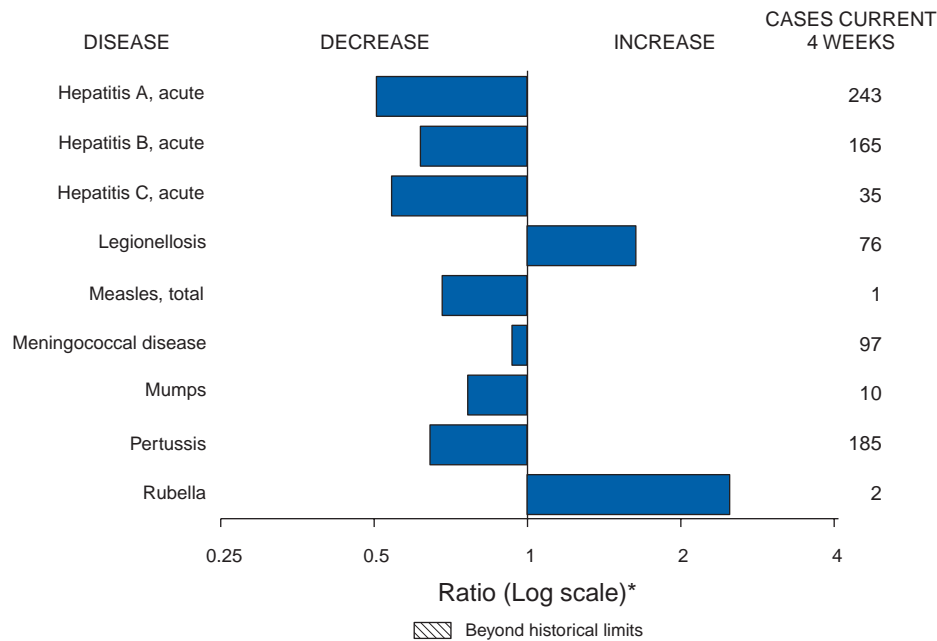
A terrorist attack involving radioactive materials could result in mass casualties, radiation-related illnesses, and contaminated persons. This broadcast will provide clinicians with the most current information on possible radiologic scenarios, basic information on radiation and protection for clinicians, medical management of victims of a radiologic incident, and decontamination and treatment of victims. After the presentation, participants may question panelists via a toll-free telephone, fax, or TTY lines.

Additional information about program content, registration, continuing education credit, and access is available at <http://www.phppo.cdc.gov/phtn/radiation-04/default.asp>. Information about registration also is available at CDC, telephone 800-418-7246 or e-mail, ce@cdc.gov.

Erratum: Vol. 53, No. 3

In the box on page 1, “40th Anniversary of the First Surgeon General’s Report on Smoking and Health,” an error occurred in the first sentence of the second paragraph. The sentence should read, “As a result of these and other efforts, during 1963–2002, per capita annual consumption of cigarettes among adults aged ≥ 18 years declined from 4,345 cigarettes to 1,979, the lowest figure recorded since 1941 (1,2).”

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals January 31, 2004, with historical data



* Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending January 31, 2004 (4th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	Hemolytic uremic syndrome, postdiarrheal [†]	2	7
Botulism:	-	-	HIV infection, pediatric [§]	-	22
foodborne	2	1	Measles, total	2 [¶]	-
infant	3	5	Mumps	13	15
other (wound & unspecified)	1	-	Plague	-	-
Brucellosis [†]	3	5	Poliomyelitis, paralytic	-	-
Chancroid	2	1	Psittacosis [†]	-	2
Cholera	-	-	Q fever [†]	2	5
Cyclosporiasis [†]	-	2	Rabies, human	-	-
Diphtheria	-	-	Rubella	2	-
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	-
human granulocytic (HGE) [†]	2	4	SARS-associated coronavirus disease [†] **	-	-
human monocytic (HME) [†]	1	3	Smallpox [†] ††	-	NA
human, other and unspecified	-	1	<i>Staphylococcus aureus</i> :	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA) [†] ††	-	1
California serogroup viral [†]	-	-	Vancomycin-resistant (VRSA) [†] ††	-	NA
eastern equine [†]	-	-	Streptococcal toxic-shock syndrome [†]	11	15
Powassan [†]	-	-	Tetanus	-	1
St. Louis [†]	-	-	Toxic-shock syndrome	6	2
western equine [†]	-	-	Trichinosis	1	-
Hansen disease (leprosy) [†]	3	6	Tularemia [†]	2	2
Hantavirus pulmonary syndrome [†]	-	3	Yellow fever	-	-

-: No reported cases.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

[†] Not notifiable in all states.

[§] Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update December 28, 2003.

[¶] Of two cases reported, one was indigenous, and one was imported from another country.

** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (notifiable as of July 2003).

†† Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 31, 2004, and January 25, 2003 (4th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2004§	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	-	3,016	42,993	55,542	92	225	118	123	2	-
NEW ENGLAND	-	64	1,820	2,066	-	-	5	8	-	-
Maine	-	-	50	138	N	N	2	-	-	-
N.H.	-	1	-	118	-	-	-	-	-	-
Vt.	-	-	71	68	-	-	2	1	-	-
Mass.	-	1	1,286	758	-	-	1	5	-	-
R.I.	-	5	361	202	-	-	-	1	-	-
Conn.	-	57	52	782	N	N	-	1	-	-
MID. ATLANTIC	-	905	5,582	6,978	-	-	15	15	1	-
Upstate N.Y.	-	51	791	603	N	N	5	2	-	-
N.Y. City	-	430	2,172	2,472	-	-	1	8	-	-
N.J.	-	72	585	1,268	-	-	-	1	-	-
Pa.	-	352	2,034	2,635	N	N	9	4	1	-
E.N. CENTRAL	-	278	5,975	10,661	-	1	21	25	-	-
Ohio	-	61	454	2,770	-	-	14	3	-	-
Ind.	-	42	1,064	1,345	N	N	1	-	-	-
Ill.	-	81	1,790	3,753	-	-	-	7	-	-
Mich.	-	89	2,184	1,505	-	1	6	4	-	-
Wis.	-	5	483	1,288	-	-	-	11	-	-
W.N. CENTRAL	-	36	2,033	3,182	-	-	8	7	-	-
Minn.	-	-	97	791	N	N	2	3	-	-
Iowa	-	13	-	195	N	N	1	2	-	-
Mo.	-	22	991	1,189	-	-	-	1	-	-
N. Dak.	-	-	57	42	N	N	-	-	-	-
S. Dak.	-	1	188	153	-	-	2	1	-	-
Nebr.†	-	-	229	234	-	-	-	-	-	-
Kans.	-	-	471	578	N	N	3	-	-	-
S. ATLANTIC	-	643	7,692	9,188	-	-	32	11	1	-
Del.	-	-	187	229	N	N	-	-	-	-
Md.	-	12	1,225	1,272	-	-	2	2	-	-
D.C.	-	157	202	253	-	-	-	-	-	-
Va.	-	137	992	947	-	-	1	-	-	-
W. Va.	-	-	213	178	N	N	-	-	-	-
N.C.	-	3	1,951	1,751	N	N	8	1	-	-
S.C.†	-	35	719	790	-	-	-	-	-	-
Ga.	-	155	185	1,336	-	-	8	7	-	-
Fla.	-	144	2,018	2,432	N	N	13	1	1	-
E.S. CENTRAL	-	17	3,189	3,787	N	N	8	8	-	-
Ky.	-	5	509	513	N	N	3	1	-	-
Tenn.	-	-	1,292	984	N	N	2	4	-	-
Ala.	-	12	973	1,156	-	-	2	3	-	-
Miss.	-	-	415	1,134	N	N	1	-	-	-
W.S. CENTRAL	-	572	8,151	7,253	-	-	5	3	-	-
Ark.	-	-	485	473	-	-	2	1	-	-
La.	-	-	2,865	1,034	N	N	-	-	-	-
Okla.	-	1	415	500	N	N	2	-	-	-
Tex.	-	571	4,386	5,246	-	-	1	2	-	-
MOUNTAIN	-	120	2,180	3,218	3	184	2	5	-	-
Mont.	-	6	26	128	N	N	-	-	-	-
Idaho	-	-	120	151	N	N	-	2	-	-
Wyo.	-	1	53	77	-	-	1	-	-	-
Colo.	-	22	132	882	N	N	1	2	-	-
N. Mex.	-	-	31	479	-	-	-	-	-	-
Ariz.	-	78	1,726	922	-	181	-	1	-	-
Utah	-	6	92	131	3	-	-	-	-	-
Nev.	-	7	-	448	-	3	-	-	-	-
PACIFIC	-	381	6,371	9,209	89	40	22	41	-	-
Wash.	-	31	1,157	950	N	N	-	-	-	-
Oreg.	-	35	-	270	-	-	1	2	-	-
Calif.	-	312	5,025	7,354	89	40	21	39	-	-
Alaska	-	3	178	222	-	-	-	-	-	-
Hawaii	-	-	11	413	-	-	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	50	22	N	N	N	N	-	-
V.I.	-	-	-	24	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update December 28, 2003.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending January 31, 2004, and January 25, 2003 (4th Week)*

Reporting area	<i>Escherichia coli</i> , Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped		Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003				
UNITED STATES	54	71	3	8	7	4	666	1,067	16,094	22,900
NEW ENGLAND	2	7	1	-	1	1	40	64	390	606
Maine	-	-	-	-	-	-	8	8	13	6
N.H.	-	-	-	-	-	-	-	3	-	10
Vt.	-	-	-	-	-	-	4	6	4	8
Mass.	-	3	-	-	1	1	28	46	282	225
R.I.	-	-	-	-	-	-	-	1	74	76
Conn.	2	4	1	-	-	-	-	-	17	281
MID. ATLANTIC	4	8	-	-	-	2	94	203	1,828	3,180
Upstate N.Y.	1	1	-	-	-	-	28	13	270	305
N.Y. City	-	1	-	-	-	-	4	99	736	1,044
N.J.	-	2	-	-	-	-	6	31	187	831
Pa.	3	4	-	-	-	2	56	60	635	1,000
E.N. CENTRAL	17	21	-	1	1	1	120	219	2,242	5,028
Ohio	9	4	-	-	1	1	68	70	234	1,572
Ind.	2	-	-	-	-	-	-	-	426	535
Ill.	1	4	-	-	-	-	11	69	655	1,758
Mich.	5	5	-	-	-	-	40	55	786	674
Wis.	-	8	-	1	-	-	1	25	141	489
W.N. CENTRAL	3	8	-	1	5	-	43	108	777	1,229
Minn.	2	2	-	1	-	-	13	6	33	249
Iowa	-	1	-	-	-	-	17	27	-	32
Mo.	-	2	-	-	-	-	-	48	468	657
N. Dak.	-	-	-	-	3	-	1	-	1	1
S. Dak.	-	-	-	-	-	-	2	2	20	5
Nebr.	-	3	-	-	-	-	3	10	76	55
Kans.	1	-	-	-	2	-	7	15	179	230
S. ATLANTIC	5	1	2	3	-	-	145	182	3,863	4,938
Del.	-	-	N	N	N	N	1	3	69	118
Md.	1	-	-	-	-	-	6	10	622	641
D.C.	-	-	-	-	-	-	2	-	130	212
Va.	-	1	-	-	-	-	8	7	374	522
W. Va.	-	-	-	-	-	-	1	-	74	62
N.C.	-	-	1	2	-	-	N	N	1,144	1,005
S.C.	-	-	-	-	-	-	-	1	363	479
Ga.	1	-	-	-	-	-	53	120	148	656
Fla.	3	-	1	1	-	-	74	41	939	1,243
E.S. CENTRAL	1	6	-	-	-	-	17	23	1,616	2,105
Ky.	-	-	-	-	-	-	N	N	218	260
Tenn.	-	4	-	-	-	-	9	12	557	566
Ala.	1	2	-	-	-	-	8	11	610	717
Miss.	-	-	-	-	-	-	-	-	231	562
W.S. CENTRAL	-	3	-	2	-	-	13	11	3,241	3,054
Ark.	-	1	-	-	-	-	9	8	232	313
La.	-	-	-	-	-	-	-	-	1,264	575
Okla.	-	-	-	-	-	-	4	3	209	223
Tex.	-	2	-	2	-	-	-	-	1,536	1,943
MOUNTAIN	5	4	-	1	-	-	47	80	668	779
Mont.	1	-	-	-	-	-	1	2	8	10
Idaho	1	1	-	-	-	-	17	12	3	7
Wyo.	-	-	-	-	-	-	-	2	3	5
Colo.	-	1	-	-	-	-	10	29	146	256
N. Mex.	-	-	-	1	-	-	-	4	4	83
Ariz.	1	1	N	N	N	N	-	15	492	272
Utah	2	1	-	-	-	-	19	5	12	14
Nev.	-	-	-	-	-	-	-	11	-	132
PACIFIC	17	13	-	-	-	-	147	177	1,469	1,981
Wash.	2	3	-	-	-	-	4	3	227	183
Oreg.	3	-	-	-	-	-	22	19	-	51
Calif.	9	10	-	-	-	-	117	138	1,211	1,625
Alaska	-	-	-	-	-	-	2	8	30	39
Hawaii	3	-	-	-	-	-	2	9	1	83
Guam	N	N	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	2	2	3
V.I.	-	-	-	-	-	-	-	-	-	5
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending January 31, 2004, and January 25, 2003 (4th Week)*

Reporting area	<i>Haemophilus influenzae</i> , invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years						A	
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		Cum. 2004	Cum. 2003
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003		
UNITED STATES	100	95	-	3	1	1	13	11	289	408
NEW ENGLAND	5	9	-	-	-	-	-	-	56	9
Maine	-	-	-	-	-	-	-	-	-	-
N.H.	-	1	-	-	-	-	-	-	-	-
Vt.	1	3	-	-	-	-	-	-	4	1
Mass.	-	3	-	-	-	-	-	-	47	5
R.I.	-	-	-	-	-	-	-	-	-	-
Conn.	4	2	-	-	-	-	-	-	5	3
MID. ATLANTIC	21	17	-	-	-	-	2	2	30	68
Upstate N.Y.	5	2	-	-	-	-	-	-	5	3
N.Y. City	2	5	-	-	-	-	1	2	1	32
N.J.	-	3	-	-	-	-	-	-	3	11
Pa.	14	7	-	-	-	-	1	-	21	22
E.N. CENTRAL	20	15	-	1	-	-	6	3	27	41
Ohio	13	2	-	-	-	-	3	1	4	6
Ind.	1	1	-	-	-	-	1	-	3	-
Ill.	-	8	-	-	-	-	-	2	5	16
Mich.	4	2	-	1	-	-	2	-	14	15
Wis.	2	2	-	-	-	-	-	-	1	4
W.N. CENTRAL	2	6	-	-	-	-	1	2	9	14
Minn.	-	1	-	-	-	-	-	-	-	-
Iowa	-	-	-	-	-	-	-	-	4	5
Mo.	-	5	-	-	-	-	-	2	-	4
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-
Nebr.	1	-	-	-	-	-	-	-	-	2
Kans.	1	-	-	-	-	-	1	-	5	3
S. ATLANTIC	34	13	-	-	-	-	1	-	69	127
Del.	-	-	-	-	-	-	-	-	-	1
Md.	12	6	-	-	-	-	-	-	11	17
D.C.	-	-	-	-	-	-	-	-	-	-
Va.	5	2	-	-	-	-	-	-	5	3
W. Va.	1	-	-	-	-	-	-	-	-	-
N.C.	1	-	-	-	-	-	-	-	5	2
S.C.	-	1	-	-	-	-	-	-	-	2
Ga.	7	4	-	-	-	-	1	-	26	66
Fla.	8	-	-	-	-	-	-	-	22	36
E.S. CENTRAL	8	7	-	-	-	-	1	1	6	9
Ky.	-	-	-	-	-	-	-	-	-	-
Tenn.	4	1	-	-	-	-	-	-	6	5
Ala.	4	6	-	-	-	-	1	1	-	3
Miss.	-	-	-	-	-	-	-	-	-	1
W.S. CENTRAL	2	6	-	-	-	1	-	-	8	34
Ark.	-	1	-	-	-	-	-	-	4	-
La.	-	2	-	-	-	-	-	-	-	5
Okla.	2	3	-	-	-	1	-	-	3	-
Tex.	-	-	-	-	-	-	-	-	1	29
MOUNTAIN	6	16	-	1	1	-	1	2	4	17
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	-	-	-	-	-	-	-	-	1	-
Wyo.	-	-	-	-	-	-	-	-	1	-
Colo.	1	3	-	-	-	-	-	-	1	1
N. Mex.	4	2	-	-	1	-	-	-	-	-
Ariz.	-	7	-	1	-	-	-	1	-	11
Utah	1	3	-	-	-	-	1	1	1	1
Nev.	-	1	-	-	-	-	-	-	-	4
PACIFIC	2	6	-	1	-	-	1	1	80	89
Wash.	1	-	-	-	-	-	1	-	2	1
Oreg.	1	3	-	-	-	-	-	1	3	6
Calif.	-	2	-	1	-	-	-	-	75	80
Alaska	-	-	-	-	-	-	-	-	-	1
Hawaii	-	1	-	-	-	-	-	-	-	1
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	-	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending January 31, 2004, and January 25, 2003 (4th Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C		Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003						
UNITED STATES	222	497	47	172	86	78	25	30	320	469
NEW ENGLAND	9	24	-	-	1	4	-	2	1	22
Maine	-	-	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	-	-	-	1	-	-
Vt.	1	1	-	-	-	1	-	-	-	2
Mass.	8	16	-	-	-	2	-	1	1	20
R.I.	-	-	-	-	-	-	-	-	-	-
Conn.	-	7	U	U	1	1	-	-	-	-
MID. ATLANTIC	16	75	9	6	14	20	3	10	269	373
Upstate N.Y.	3	-	1	-	3	3	1	1	102	79
N.Y. City	-	39	-	-	-	4	-	4	-	-
N.J.	3	18	-	-	1	1	1	1	9	79
Pa.	10	18	8	6	10	12	1	4	158	215
E.N. CENTRAL	17	41	7	13	31	23	4	3	11	12
Ohio	11	13	1	1	24	9	3	1	11	2
Ind.	-	-	-	-	-	-	-	-	-	1
Ill.	-	-	-	3	-	6	-	2	-	-
Mich.	6	18	6	9	7	8	-	-	-	-
Wis.	-	10	-	-	-	-	1	-	U	9
W.N. CENTRAL	2	30	-	11	1	2	-	2	4	2
Minn.	-	-	-	-	-	-	-	1	-	-
Iowa	-	1	-	-	-	1	-	-	2	1
Mo.	-	27	-	11	-	-	-	-	-	1
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	1	-	-	-	-	-
Nebr.	1	1	-	-	-	-	-	1	-	-
Kans.	1	1	-	-	-	1	-	-	2	-
S. ATLANTIC	100	168	22	7	21	10	8	4	28	37
Del.	-	-	-	-	1	-	N	N	-	8
Md.	8	5	2	2	3	5	2	1	19	22
D.C.	-	-	-	-	-	-	-	-	-	-
Va.	1	4	-	-	-	2	-	-	-	-
W. Va.	-	-	1	-	-	-	1	-	-	-
N.C.	11	12	1	1	3	2	2	1	5	5
S.C.	-	-	-	-	-	-	-	1	-	-
Ga.	40	132	4	2	-	1	2	1	-	-
Fla.	40	15	14	2	14	-	1	-	4	2
E. S. CENTRAL	14	24	3	7	1	1	1	2	-	5
Ky.	3	2	2	1	-	-	1	-	-	-
Tenn.	1	3	1	2	1	1	-	-	-	-
Ala.	2	9	-	-	-	-	-	2	-	-
Miss.	8	10	-	4	-	-	-	-	-	5
W.S. CENTRAL	4	46	2	119	-	11	-	1	-	8
Ark.	-	3	-	1	-	-	-	-	-	-
La.	4	8	2	13	-	-	-	-	-	-
Okla.	-	2	-	-	-	1	-	-	-	-
Tex.	-	33	-	105	-	10	-	1	-	8
MOUNTAIN	6	38	1	2	5	2	-	2	1	1
Mont.	-	1	-	-	-	-	-	1	-	-
Idaho	1	1	-	-	1	-	-	-	-	-
Wyo.	1	1	-	-	2	-	-	-	-	-
Colo.	2	4	-	2	-	-	-	-	-	-
N. Mex.	-	3	-	-	-	-	-	-	-	-
Ariz.	-	18	1	-	-	1	-	1	-	-
Utah	2	4	-	-	2	1	-	-	1	-
Nev.	-	6	-	-	-	-	-	-	-	1
PACIFIC	54	51	3	7	12	5	9	4	6	9
Wash.	4	1	-	-	1	-	1	-	-	-
Oreg.	9	10	1	1	N	N	3	-	-	2
Calif.	41	38	1	5	11	5	5	4	6	7
Alaska	-	-	-	-	-	-	-	-	-	-
Hawaii	-	2	1	1	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	3	-	-	-	-	-	-	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending January 31, 2004, and January 25, 2003 (4th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	51	57	130	108	356	365	168	269	47	19
NEW ENGLAND	4	3	3	5	152	70	11	31	3	-
Maine	-	1	-	-	-	-	1	-	-	-
N.H.	-	-	-	-	-	-	-	2	-	-
Vt.	-	-	-	-	3	14	1	2	-	-
Mass.	4	2	3	4	149	55	4	13	3	-
R.I.	-	-	-	-	-	-	-	-	-	-
Conn.	-	-	-	1	-	1	5	14	-	-
MID. ATLANTIC	3	10	17	12	86	36	18	56	2	3
Upstate N.Y.	-	1	5	1	57	9	18	17	-	-
N.Y. City	-	5	1	4	-	-	-	1	-	-
N.J.	-	2	-	2	-	6	-	12	-	2
Pa.	3	2	11	5	29	21	-	26	2	1
E.N. CENTRAL	5	9	21	20	52	33	1	1	1	1
Ohio	1	2	10	6	43	22	1	-	1	1
Ind.	-	-	2	3	-	-	-	-	-	-
Ill.	-	4	-	3	-	-	-	-	-	-
Mich.	2	2	8	4	8	2	-	1	-	-
Wis.	2	1	1	4	1	9	-	-	-	-
W.N. CENTRAL	4	4	6	9	8	12	21	39	-	1
Minn.	3	2	-	1	-	-	6	3	-	-
Iowa	-	2	2	2	4	1	6	3	-	1
Mo.	-	-	-	5	-	7	-	-	-	-
N. Dak.	-	-	-	-	-	-	4	5	-	-
S. Dak.	-	-	1	-	-	-	-	4	-	-
Nebr.	-	-	-	-	-	-	-	3	-	-
Kans.	1	-	3	1	4	4	5	21	-	-
S. ATLANTIC	27	8	28	9	17	35	94	122	38	14
Del.	-	-	-	3	1	-	-	-	-	-
Md.	9	5	3	2	6	9	11	24	3	5
D.C.	-	-	-	-	-	-	-	-	-	-
Va.	-	1	2	1	3	-	-	20	-	-
W. Va.	-	1	3	-	-	-	6	4	-	-
N.C.	1	-	3	3	-	12	40	27	34	9
S.C.	1	-	1	-	-	-	7	8	-	-
Ga.	2	1	4	-	-	13	30	35	1	-
Fla.	14	-	12	-	7	1	-	4	-	-
E.S. CENTRAL	1	1	5	7	6	6	5	8	2	-
Ky.	-	-	-	-	-	2	1	1	-	-
Tenn.	-	-	4	2	4	-	2	6	1	-
Ala.	1	1	1	2	1	4	2	1	-	-
Miss.	-	-	-	3	1	-	-	-	1	-
W.S. CENTRAL	1	8	9	16	-	-	6	3	-	-
Ark.	1	-	2	1	-	-	2	-	-	-
La.	-	1	3	4	-	-	-	-	-	-
Okla.	-	-	1	2	-	-	4	3	-	-
Tex.	-	7	3	9	-	-	-	-	-	-
MOUNTAIN	1	1	2	4	21	48	6	6	-	-
Mont.	-	-	-	-	3	-	-	1	-	-
Idaho	-	-	1	-	6	1	-	-	-	-
Wyo.	-	-	1	-	2	-	-	-	-	-
Colo.	-	1	-	-	8	22	-	-	-	-
N. Mex.	1	-	-	1	-	6	-	-	-	-
Ariz.	-	-	-	3	-	13	6	5	-	-
Utah	-	-	-	-	2	4	-	-	-	-
Nev.	-	-	-	-	-	2	-	-	-	-
PACIFIC	5	13	39	26	14	125	6	3	1	-
Wash.	-	2	-	2	2	-	-	-	-	-
Oreg.	-	4	7	5	12	10	-	-	-	-
Calif.	5	7	30	18	-	115	6	3	1	-
Alaska	-	-	-	-	-	-	-	-	-	-
Hawaii	-	-	2	1	-	-	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	1	-	-	1	1	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
 * Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending January 31, 2004, and January 25, 2003 (4th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		<i>Streptococcus pneumoniae</i> , invasive			
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Drug resistant, all ages		Age <5 years	
							Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	1,320	1,763	508	1,458	307	330	255	130	21	39
NEW ENGLAND	66	70	17	22	5	33	-	12	-	-
Maine	3	2	-	-	1	-	-	-	-	-
N.H.	-	2	-	-	-	1	-	-	N	N
Vt.	3	1	-	-	-	1	-	2	-	-
Mass.	46	53	14	18	4	17	N	N	N	N
R.I.	-	4	-	2	-	-	-	-	-	-
Conn.	14	8	3	2	-	14	-	10	U	U
MID. ATLANTIC	82	220	43	133	30	62	12	8	4	3
Upstate N.Y.	25	16	28	10	13	11	5	2	2	2
N.Y. City	3	73	-	38	-	10	U	U	U	U
N.J.	5	52	3	45	1	12	N	N	N	N
Pa.	49	79	12	40	16	29	7	6	2	1
E.N. CENTRAL	192	263	54	121	62	87	72	30	17	27
Ohio	72	88	19	21	28	19	64	30	14	19
Ind.	12	7	2	4	-	2	8	-	3	1
Ill.	49	94	16	64	-	33	-	-	-	-
Mich.	42	39	11	21	32	20	N	N	N	N
Wis.	17	35	6	11	2	13	N	N	-	7
W.N. CENTRAL	66	84	19	62	16	19	21	20	-	2
Minn.	13	16	2	1	-	-	-	-	-	1
Iowa	19	21	2	1	N	N	N	N	N	N
Mo.	-	29	-	32	-	9	-	-	-	-
N. Dak.	2	1	1	-	1	-	-	-	-	1
S. Dak.	5	4	1	2	3	3	-	-	-	-
Nebr.	6	3	1	20	-	4	-	-	N	N
Kans.	21	10	12	6	12	3	21	20	N	N
S. ATLANTIC	441	466	211	628	108	22	137	43	-	-
Del.	-	4	1	37	-	1	-	-	N	N
Md.	34	40	12	73	16	10	-	-	-	-
D.C.	-	-	4	-	-	-	-	-	-	-
Va.	24	15	6	11	4	1	N	N	N	N
W. Va.	1	-	-	-	1	-	4	-	-	-
N.C.	43	67	24	61	11	2	N	N	U	U
S.C.	9	3	9	3	1	1	9	7	N	N
Ga.	128	192	55	246	53	6	64	28	N	N
Fla.	202	145	100	197	22	1	60	8	N	N
E.S. CENTRAL	83	129	15	58	15	5	7	4	-	-
Ky.	7	15	1	9	5	1	3	-	N	N
Tenn.	18	38	3	8	10	4	4	4	N	N
Ala.	37	48	8	27	-	-	-	-	N	N
Miss.	21	28	3	14	-	-	-	-	-	-
W.S. CENTRAL	41	161	26	187	8	44	2	11	-	6
Ark.	20	14	3	1	-	-	1	-	-	-
La.	-	30	1	34	-	-	1	11	-	1
Okla.	16	5	16	24	3	3	N	N	-	2
Tex.	5	112	6	128	5	41	N	N	-	3
MOUNTAIN	84	101	30	61	14	42	4	2	-	1
Mont.	5	2	1	-	-	-	-	-	-	-
Idaho	22	8	-	-	1	3	N	N	N	N
Wyo.	2	1	1	1	2	-	2	-	-	-
Colo.	10	43	4	14	3	11	-	-	-	-
N. Mex.	13	9	11	20	6	8	2	2	-	-
Ariz.	21	19	12	22	-	19	-	-	N	N
Utah	11	8	1	2	2	1	-	-	-	1
Nev.	-	11	-	2	-	-	-	-	-	-
PACIFIC	265	269	93	186	49	16	-	-	-	-
Wash.	9	15	3	-	-	-	-	-	N	N
Oreg.	17	9	5	6	N	N	N	N	N	N
Calif.	211	221	79	176	35	7	N	N	N	N
Alaska	11	10	-	1	-	-	-	-	N	N
Hawaii	17	14	6	3	14	9	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	14	-	-	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending January 31, 2004, and January 25, 2003 (4th Week)*

Reporting area	Syphilis				Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Primary & secondary		Congenital		Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003						
UNITED STATES	336	496	11	42	308	397	6	12	757	1,294
NEW ENGLAND	8	7	-	-	4	10	-	-	89	303
Maine	-	-	-	-	-	-	-	-	5	199
N.H.	-	1	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	-	-	-	84	77
Mass.	4	4	-	-	3	1	-	-	-	27
R.I.	1	-	-	-	-	2	-	-	-	-
Conn.	3	2	-	-	1	7	-	-	-	-
MID. ATLANTIC	37	55	2	6	86	87	-	2	4	1
Upstate N.Y.	1	1	2	1	-	1	-	-	-	-
N.Y. City	26	27	-	1	86	59	-	1	-	-
N.J.	4	17	-	4	-	11	-	1	-	-
Pa.	6	10	-	-	-	16	-	-	4	1
E.N. CENTRAL	32	70	5	8	79	21	1	2	402	600
Ohio	12	12	-	1	8	5	1	-	63	91
Ind.	6	2	-	1	13	7	-	1	-	-
Ill.	3	31	-	5	54	9	-	-	-	-
Mich.	8	24	5	1	-	-	-	1	307	431
Wis.	3	1	-	-	4	-	-	-	32	78
W.N. CENTRAL	7	19	-	-	62	10	-	-	15	1
Minn.	-	6	-	-	8	2	-	-	-	-
Iowa	-	-	-	-	-	-	-	-	N	N
Mo.	7	8	-	-	-	1	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	7	1
S. Dak.	-	-	-	-	-	1	-	-	8	-
Nebr.	-	-	-	-	-	-	-	-	-	-
Kans.	-	5	-	-	54	6	-	-	-	-
S. ATLANTIC	99	115	1	9	2	95	-	2	151	234
Del.	1	-	-	-	-	-	-	-	-	-
Md.	21	19	-	2	-	2	-	2	-	-
D.C.	9	3	-	-	-	-	-	-	-	-
Va.	1	5	-	-	-	3	-	-	-	50
W. Va.	-	-	-	-	1	1	-	-	144	180
N.C.	7	14	-	-	-	2	-	-	-	-
S.C.	2	8	-	3	1	-	-	-	7	4
Ga.	5	15	-	3	-	24	-	-	-	-
Fla.	53	51	1	1	-	63	-	-	-	-
E. S. CENTRAL	19	28	1	-	11	12	-	-	-	-
Ky.	5	7	-	-	-	-	-	-	-	-
Tenn.	8	9	1	-	-	3	-	-	-	-
Ala.	5	12	-	-	11	9	-	-	-	-
Miss.	1	-	-	-	-	-	-	-	-	-
W.S. CENTRAL	70	55	2	4	6	97	-	-	-	148
Ark.	4	7	-	-	2	1	-	-	-	-
La.	14	8	-	-	-	-	-	-	-	2
Okla.	3	2	-	-	4	1	-	-	-	-
Tex.	49	38	2	4	-	95	-	-	-	146
MOUNTAIN	27	22	-	7	6	5	1	-	96	7
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	3	-	-	-	-	-	-	-	-	-
Wyo.	-	-	-	-	-	1	-	-	9	2
Colo.	-	5	-	1	1	2	-	-	22	-
N. Mex.	-	7	-	3	-	-	-	-	3	-
Ariz.	24	8	-	3	1	2	-	-	-	-
Utah	-	1	-	-	4	-	1	-	62	5
Nev.	-	1	-	-	-	-	-	-	-	-
PACIFIC	37	125	-	8	52	60	4	6	-	-
Wash.	8	3	-	-	16	9	-	-	-	-
Oreg.	-	4	-	-	2	4	-	1	-	-
Calif.	29	117	-	8	26	33	3	5	-	-
Alaska	-	-	-	-	2	3	-	-	-	-
Hawaii	-	1	-	-	6	11	1	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	2	4	-	-	-	-	-	-	-	15
V.I.	-	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending January 31, 2004 (4th Week)

Reporting Area	All causes, by age (years)							Reporting Area	All causes, by age (years)							P&I [†] Total
	All Ages	≥65	45-64	25-44	1-24	<1	P&I [†] Total		All Ages	≥65	45-64	25-44	1-24	<1	P&I [†] Total	
NEW ENGLAND	721	530	140	31	11	9	95	S. ATLANTIC	1,282	866	267	85	33	31	95	
Boston, Mass.	158	108	34	10	5	1	26	Atlanta, Ga.	207	140	48	12	6	1	11	
Bridgeport, Conn.	44	33	7	4	-	-	9	Baltimore, Md.	156	94	42	14	4	2	13	
Cambridge, Mass.	22	15	5	1	1	-	5	Charlotte, N.C.	107	69	26	6	4	2	12	
Fall River, Mass.	31	28	2	-	1	-	4	Jacksonville, Fla.	199	140	34	16	1	8	8	
Hartford, Conn.	59	39	17	-	1	2	9	Miami, Fla.	102	61	20	17	2	2	3	
Lowell, Mass.	27	23	4	-	-	-	2	Norfolk, Va.	51	29	14	5	3	-	2	
Lynn, Mass.	17	11	6	-	-	-	3	Richmond, Va.	51	36	10	3	1	1	6	
New Bedford, Mass.	38	35	2	1	-	-	5	Savannah, Ga.	85	56	16	5	4	4	10	
New Haven, Conn.	109	81	21	5	1	1	10	St. Petersburg, Fla.	95	66	20	1	1	7	5	
Providence, R.I.	77	57	15	2	-	3	9	Tampa, Fla.	207	159	33	6	5	4	19	
Somerville, Mass.	4	4	-	-	-	-	1	Washington, D.C.	U	U	U	U	U	U	U	
Springfield, Mass.	40	24	9	5	1	1	1	Wilmington, Del.	22	16	4	-	2	-	6	
Waterbury, Conn.	27	22	5	-	-	-	-	E.S. CENTRAL	1,110	772	229	68	21	20	104	
Worcester, Mass.	68	50	13	3	1	1	11	Birmingham, Ala.	211	129	54	17	5	6	23	
MID. ATLANTIC	1,883	1,303	398	115	40	26	148	Chattanooga, Tenn.	83	61	12	6	3	1	10	
Albany, N.Y.	52	38	9	4	-	1	8	Knoxville, Tenn.	130	94	30	4	1	1	2	
Allentown, Pa.	20	16	3	1	-	-	3	Lexington, Ky.	104	68	23	6	4	3	9	
Buffalo, N.Y.	83	60	17	3	2	1	16	Memphis, Tenn.	225	169	37	16	3	-	26	
Camden, N.J.	46	33	8	2	-	3	3	Mobile, Ala.	143	112	23	5	1	2	7	
Elizabeth, N.J.	20	11	6	2	1	-	-	Montgomery, Ala.	32	27	4	-	1	-	6	
Erie, Pa.	36	30	5	1	-	-	2	Nashville, Tenn.	182	112	46	14	3	7	21	
Jersey City, N.J.	27	18	5	3	-	1	-	W.S. CENTRAL	1,720	1,120	408	104	50	38	138	
New York City, N.Y.	775	540	164	41	19	10	52	Austin, Tex.	97	62	21	10	2	2	4	
Newark, N.J.	59	32	15	8	4	-	1	Baton Rouge, La.	48	35	10	3	-	-	2	
Paterson, N.J.	23	16	6	-	1	-	3	Corpus Christi, Tex.	65	41	17	1	3	3	5	
Philadelphia, Pa.	312	182	82	32	9	7	13	Dallas, Tex.	191	118	44	19	4	6	18	
Pittsburgh, Pa. [‡]	31	19	9	1	2	-	3	El Paso, Tex.	107	72	25	6	1	3	7	
Reading, Pa.	28	22	3	2	1	-	3	Ft. Worth, Tex.	152	96	39	9	5	3	10	
Rochester, N.Y.	148	118	25	4	-	1	17	Houston, Tex.	416	263	100	27	15	11	37	
Schenectady, N.Y.	28	24	1	3	-	-	4	Little Rock, Ark.	103	64	28	6	3	2	6	
Scranton, Pa.	32	27	4	1	-	-	2	New Orleans, La.	49	33	10	4	2	-	-	
Syracuse, N.Y.	86	63	21	1	-	1	9	San Antonio, Tex.	302	209	69	10	7	7	32	
Trenton, N.J.	23	14	5	3	-	1	3	Shreveport, La.	78	47	23	5	2	1	11	
Utica, N.Y.	22	16	5	1	-	-	1	Tulsa, Okla.	112	80	22	4	6	-	6	
Yonkers, N.Y.	32	24	5	2	1	-	5	MOUNTAIN	1,048	716	216	72	23	21	89	
E.N. CENTRAL	2,310	1,639	457	128	37	49	192	Albuquerque, N.M.	183	123	43	14	2	1	17	
Akron, Ohio	52	40	10	2	-	-	7	Boise, Idaho	45	29	11	4	-	1	1	
Canton, Ohio	37	28	4	3	1	1	11	Colo. Springs, Colo.	75	49	17	3	1	5	-	
Chicago, Ill.	357	221	84	34	9	9	21	Denver, Colo.	114	74	25	9	2	4	13	
Cincinnati, Ohio	99	75	16	2	2	4	11	Las Vegas, Nev.	269	183	59	13	9	5	24	
Cleveland, Ohio	320	236	65	9	6	4	20	Ogden, Utah	28	20	6	2	-	-	3	
Columbus, Ohio	233	159	51	17	3	3	16	Phoenix, Ariz.	U	U	U	U	U	U	U	
Dayton, Ohio	135	100	24	8	1	2	16	Pueblo, Colo.	19	15	4	-	-	-	2	
Detroit, Mich.	178	111	42	15	5	5	13	Salt Lake City, Utah	120	85	19	10	3	3	13	
Evansville, Ind.	59	46	12	1	-	-	6	Tucson, Ariz.	195	138	32	17	6	2	16	
Fort Wayne, Ind.	56	44	9	2	-	1	5	PACIFIC	2,853	2,028	536	171	74	43	325	
Gary, Ind.	20	6	8	4	2	-	-	Berkeley, Calif.	14	12	1	1	-	-	5	
Grand Rapids, Mich.	53	41	8	1	2	1	11	Fresno, Calif.	170	127	34	7	1	1	14	
Indianapolis, Ind.	185	130	41	7	-	7	19	Glendale, Calif.	37	27	8	-	1	1	8	
Lansing, Mich.	62	44	8	5	1	4	4	Honolulu, Hawaii	83	66	14	2	-	1	3	
Milwaukee, Wis.	109	81	21	5	1	1	10	Long Beach, Calif.	69	51	13	2	1	2	12	
Peoria, Ill.	54	41	7	3	-	3	10	Los Angeles, Calif.	1,164	777	240	90	37	20	116	
Rockford, Ill.	57	48	7	1	-	1	4	Pasadena, Calif.	U	U	U	U	U	U	U	
South Bend, Ind.	41	34	5	1	1	-	1	Portland, Ore.	250	194	34	13	5	4	26	
Toledo, Ohio	117	87	21	6	2	1	7	Sacramento, Calif.	247	176	44	15	10	2	37	
Youngstown, Ohio	86	67	14	2	1	2	-	San Diego, Calif.	220	153	43	13	7	3	32	
W.N. CENTRAL	608	438	114	28	10	18	66	San Francisco, Calif.	U	U	U	U	U	U	U	
Des Moines, Iowa	79	63	12	1	1	2	20	San Jose, Calif.	248	192	43	9	3	1	38	
Duluth, Minn.	41	33	6	1	-	1	2	Santa Cruz, Calif.	46	38	6	2	-	-	3	
Kansas City, Kans.	37	24	9	2	1	1	6	Seattle, Wash.	137	92	33	5	4	3	17	
Kansas City, Mo.	90	65	16	6	1	2	7	Spokane, Wash.	53	41	6	3	1	2	6	
Lincoln, Nebr.	34	28	5	1	-	-	2	Tacoma, Wash.	115	82	17	9	4	3	8	
Minneapolis, Minn.	85	59	16	4	1	5	7	TOTAL	13,535 [†]	9,412	2,765	802	299	255	1,252	
Omaha, Nebr.	80	56	16	3	2	3	12									
St. Louis, Mo.	U	U	U	U	U	U	U									
St. Paul, Minn.	74	49	15	7	2	1	6									
Wichita, Kans.	88	61	19	3	2	3	4									

U: Unavailable. -:No reported cases.

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

[†] Pneumonia and influenza.[‡] Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.[§] Total includes unknown ages.

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