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National Black HIV/AIDS Awareness and Information Day — February 7, 2005

National Black HIV/AIDS Awareness and Information Day is observed each year on February 7 to call attention to the disproportionate impact of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) on the black population in the United States. The event is sponsored by a coalition of nongovernment organizations, with support from CDC.

During 2000–2003, more than half of new HIV/AIDS diagnoses in 32 states were among blacks, although blacks represented only 13% of the population of those states. In 2003, black men had the highest rate of HIV/AIDS diagnoses of any racial/ethnic population, approximately seven times the rate among white men and twice the rate among black women (*1*). Black women are also severely impacted by HIV. During 2000–2003, approximately 69% of women who had HIV/AIDS diagnosed were black. In 2003, the rate of HIV/AIDS was 18 times greater among black women than among non-Hispanic white women (*1*).

CDC is working to reduce new HIV infections among blacks by developing interventions tailored to the cultural needs of this population. This combination of behavioral and biomedical approaches includes expanded access to voluntary HIV counseling and testing, behavioral interventions for at-risk and HIV-positive persons, and screening and treatment for sexually transmitted diseases, which can facilitate HIV transmission and acquisition. More information is available at http://www.cdc.gov/hiv.

Reference

1. CDC. Diagnoses of HIV/AIDS—32 states, 2000–2003. MMWR 2004;53:1106–10.

HIV Transmission Among Black Women — North Carolina, 2004

In 2003, women constituted 28% of human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) cases in the United States; approximately 69% of those cases were among non-Hispanic black women (*1*). Heterosexual transmission is now the most commonly reported mode of HIV transmission among women (*1*). In North Carolina, black women make up a growing proportion of newly reported HIV infections and, in 2003, the HIV-infection rate for black women in North Carolina was 14 times higher than that for white women (*2*). Despite this disparity, few epidemiologic studies have examined HIV transmission among black women in the United States, particularly those residing in southern states. In August 2004, the North Carolina Department of Health (NCDOH) invited CDC to assist in an epidemiologic investigation of HIV transmission among black women in North Carolina. This report summarizes the results of that investigation, which indicated that the majority of HIV-positive and HIV-negative sexually active black women in North Carolina reported HIV sexual risk behaviors. These findings underscore the need for enhanced HIV-prevention strategies in this population.

CDC and NCDOH reviewed public health surveillance data for 1998–2004 for newly reported HIV infections and HIV contact-tracing records of NC Disease Intervention Specialists (NCDIS). A case-control study was conducted to identify

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epidemiologic and behavioral differences between HIV-positive women (case-patients) and HIV-negative women (controls). Case-patients and controls were heterosexually active, non–injection-drug using black women aged 18–40 years who resided in regions with highest HIV morbidity (i.e., Raleigh, Durham, and Charlotte). Case-patients received an HIV diagnosis during January 2003–August 2004 and were recruited through NCDIS and medical clinics. Controls were recruited at HIV-testing sites during August–October 2004. Attempts were made to interview the HIV-positive male sex partners of case-patients to assess male partner risk factors. Face-to-face interviews were conducted with all participants to obtain epidemiologic and behavioral information, including sexual behaviors reported for the 12-month period preceding either the date of diagnosis for the case-patients and their partners or the date of interview for the controls. Participants were also asked to offer explanations for HIV risk behaviors among black women and to provide suggestions for strategies to reduce HIV transmission among black women in North Carolina. Univariate and multivariate analyses* were conducted by using statistical analysis software. Unless otherwise noted, all differences indicated in this report are statistically significant at $p \leq 0.05$.

During January 2003–August 2004, a total of 208 new HIV infections were reported among black women aged 18–40 years in Raleigh, Durham, and Charlotte. Of these, 97 (47%) patients were excluded, including 75 whose HIV was diagnosed before 2003 or in another state, 13 who could not be located, and nine who were deceased or too ill to be interviewed. Of the remaining 111 patients, 31 (28%) agreed to participate in the interview; 58 (52%) could not be located or did not respond to inquiries, and 22 (20%) refused participation. A total of 101 controls agreed to participate in the interview. Controls were recruited during HIV testing at health departments (87 controls), at an apartment complex (nine), at a pharmacy (three), and at a church (two). Of the 31 patients, 15 (48%) could identify an HIV-positive male who they suspected was the source of their HIV infection. Of these men, six (40%) agreed to be interviewed.

Patients and controls were demographically and behaviorally similar (Table). Similarities included their median age at first sexual intercourse, lifetime histories of any sexually transmitted disease (STD), reports of unprotected vaginal intercourse, and previous HIV testing. Although the majority of participants had either previously had an STD, been pregnant, or been tested for HIV, most felt they were unlikely or

* All variables with $p \leq 0.1$ in the univariate analysis were included in the multivariate model.

TABLE. Number and percentage of HIV-positive and HIV-negative black women, by selected characteristics — North Carolina, 2003–2004

Characteristic	HIV-positive women (n = 31) No.	(%)	HIV-negative women (n = 101) No.	(%)	p value
Mean (median; range) age (yrs)	28.8	(27.0; 18–42)	28.1	(27.0; 18–40)	0.64
Aged ≥25 yrs	21	(68)	61	(60)	0.46
Unmarried	28	(90)	85	(84)	0.40
≥High school diploma	22	(71)	81	(80)	0.28
Monthly income ≤$900	22	(71)	56	(56)	0.14
Unemployed	22	(71)	38	(38)	<0.01*
Received public assistance	24	(77)	52	(51)	0.01*
Mean no. (median; range) of pregnancies	2.9	(2.0; 0–10)	2.3	(2.0; 0–8)	0.23
Mean (median; range) age at first sexual intercourse	14.5	(14.0; 6–21)	15.5	(16.0; 5–22)	0.10
Lifetime sex partners					
≤5	8	(26)	48	(48)	referent
6–19	11	(35)	34	(34)	0.20
≥20	12	(39)	19	(19)	0.01*
Ever forced or frightened into sex	13	(42)	29	(29)	0.17
Likely/Very likely to discuss willingness to use condoms with their partner	28	(90)	96	(95)	0.34
Asked a man to use a condom all the time during sex	12	(39)	38	(38)	0.91
Type of sexual activity during preceding 12 months					
Unprotected vaginal sex	30	(97)	83	(83)	0.07
Unprotected oral sex	21	(68)	58	(57)	0.31
Unprotected anal sex	6	(19)	13	(13)	0.37
Sex during menses	9	(29)	24	(24)	0.55
Ever had a sexually transmitted disease (STD)					
Any STD	23	(74)	65	(64)	0.31
Herpes	9	(29)	6	(6)	<0.01*
Pelvic inflammatory disease†	6	(19)	6	(6)	0.03*
Gonorrhea	9	(29)	21	(21)	0.34
Chlamydia	9	(29)	40	(40)	0.29
Trichomonas	7	(23)	33	(33)	0.33
Syphilis	4	(13)	5	(5)	0.12
Hepatitis	2	(7)	2	(2)	0.22
Genital warts	3	(10)	7	(7)	0.61
Substance use during the preceding 12 months					
Alcohol	21	(68)	72	(71)	0.70
Marijuana	14	(45)	41	(41)	0.65
Cocaine/Crack	5	(16)	5	(5)	0.05*
Receipt of money, drugs, gifts, or shelter for sex	11	(36)	15	(15)	0.01*
History of male partner incarceration	25	(81)	60	(59)	0.04*
Suspicion of male partner activity	11	(37)	21	(21)	0.09
Ever had a previous HIV test	25	(81)	86	(88)	0.32
Believed they were unlikely/very unlikely to contract HIV	18	(58)	72	(71)	0.17
Likely/Very likely to discuss sexual/behavioral history issues with male sex partners					
No. of previous sex partners	10	(32)	66	(65)	<0.01*
No. of current sex partners	14	(45)	72	(71)	0.01*
HIV status	18	(58)	90	(89)	<0.01*
STD history	19	(61)	83	(82)	0.02*
Drug use history	18	(58)	86	(85)	<0.01*
Incarceration history	21	(68)	89	(88)	0.01*
Mean (median; range) no. of above issues discussed	3.2	(3.0; 0–6)	4.8	(5.0; 0–6)	<0.01*

* Statistically significant.
† Reported.

very unlikely to contract HIV. Seven (23%) patients learned they were HIV-positive during prenatal screening.

In the univariate analysis, several differences were identified among patients and controls (Table). Patients were significantly more likely than controls to be unemployed; have 20 or more lifetime sex partners; use crack/cocaine; and receive money, shelter, or drugs in exchange for sex. In the multivariate analysis, three statistically significant differences were identified. Women receiving public assistance (adjusted odds ratio [AOR] = 7.3; 95% confidence interval [CI] = 2.1–26.0) and who had a lifetime history of genital herpes infection (AOR = 10.6; CI = 2.4–47.2) were significantly more likely to be HIV-positive. However, women who discussed sexual and behavioral history with their male partners were less likely to be HIV-positive (AOR = 0.6; CI = 0.4–0.8).

According to NCDIS records, three of the six male partners who agreed to an interview had engaged in sex with another male, but only one admitted to this activity during the interview; none reported injecting drugs. Twenty-two (71%) of the HIV-positive women believed they were infected by a steady partner. Although only one third of the HIV-positive women characterized the relationship with their steady partner as mutually monogamous, the most common reason reported for not using condoms was that they trusted their partners.

The most common reasons reported by black women for engaging in behaviors that place them at risk for HIV infection were 1) financial dependence on male partners, 2) feeling invincible, 3) low self-esteem coupled with a need to feel loved by a male figure, and 4) alcohol and drug use. In addition, participant's proposed strategies for reducing HIV transmission among black women in North Carolina included 1) introducing HIV and STD educational activities in elementary and middle schools, 2) increasing condom availability and usage, and 3) integrating targeted HIV-education and -prevention messages into church and community activities, as well as into media and popular culture.

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Editorial Note: Findings from this investigation highlight several health concerns among black women that warrant ongoing public health attention. First, both HIV-positive and HIV-negative sexually active black women in North Carolina reported HIV risk behaviors. Second, within these women's hierarchy of needs, securing essential commodities (e.g., food or shelter) was of higher priority than protecting themselves from HIV infection. Third, despite the high prevalence of risk behaviors and previous HIV testing in this population, the majority of women perceived themselves to be at low risk for acquiring HIV infection. Finally, willingness to discuss condom use did not correlate with actual condom usage, as evidenced by the high prevalence of unprotected vaginal intercourse.

Results of the multivariate analysis provide insights into developing prevention strategies for black women. Although some HIV-positive women might have been receiving public assistance related to their HIV infection, the findings of higher rates of public assistance and exchanging drugs, money, or gifts for sex among HIV-positive women are consistent with previous studies, which suggested that economic disparities might contribute to the HIV epidemic among black women (*3,4*). A history of genital herpes was also strongly associated with HIV infection. This finding supports the need for intervention programs offering comprehensive diagnosis, treatment, and prevention services for HIV and other STDs (*5*). In addition, HIV-positive women were less likely to discuss HIV risk behaviors with their male sex partners. Encouraging women to discuss with their partners HIV status and other STD and drug-use history might provide them with information that leads to HIV risk reduction.

Because some study participants had been sexually active at a young age, targeted HIV-prevention messages might be more effective if introduced at younger ages and widely disseminated through various modalities, including families and those channels suggested by study participants. Furthermore, because many HIV-positive women were unaware of their HIV status until after presentation for prenatal care, integration of routine HIV testing and prevention messages in medical settings for sexually active persons might be beneficial.

The findings in this report are subject to at least five limitations. First, the low participation rates among patients might have introduced selection bias. Data comparing participants with nonparticipants were not available. Second, the results might not be applicable to all black women at risk for acquiring HIV infection, particularly those who are of higher socioeconomic status. Third, assessment of many of the complex sociocultural factors that likely influence HIV risk in this population was not possible. Fourth, causality could not be demonstrated in the association between HIV and a history of herpes, and the relationship between receipt of public assistance and HIV serostatus could not be clarified. Finally, because only a few HIV-positive male partners were interviewed in this investigation, describing the role of male partner risk in HIV transmission among black women in North Carolina was not possible.

a•ware: *adj*

(ə-'wâr) 1 : marked by comprehension, cognizance, and perception; see also *MMWR*.

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Findings from this investigation demonstrate the need for multiple approaches to reducing HIV infection among black women. CDC, in collaboration with state and local health departments and community-based organizations (CBOs), is disseminating effective HIV-prevention interventions that target sexually active black women (*6,7*). In addition, CDC's Advancing HIV Prevention strategy has introduced programs (e.g., HIV testing and sexual network demonstration projects) to improve HIV testing in at-risk populations (*8*). Whereas CBOs are funded to implement these programs throughout the United States, ensuring that such programs are accessible to black women living in disadvantaged areas of the urban and rural South is vital. In addition, more resources and prevention strategies are needed to help address underlying causes of HIV transmission in black women, such as poverty and partner risk behavior. Halting the spread of HIV among black women will require HIV-prevention strategies and programs that encourage delays in sexual activity, consistent condom use, mutually monogamous relationships, and improved partner communication. Furthermore, efforts are needed to introduce age-appropriate sex education before beginning of sexual activity, improve the availability of HIV and STD testing and treatment, and focus attention to the economic constraints that create challenges for disadvantaged black women to prioritize health issues such as HIV.

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Tobacco Use Among Students Aged 13–15 Years — Philippines, 2000 and 2003

Tobacco use is one of the major preventable causes of premature death and disease in the world. A disproportionate share of the global tobacco burden falls on developing countries, where an estimated 84% of the world's 1.3 billion current smokers live (*1*). The Global Youth Tobacco Survey (GYTS), part of the Global Tobacco Surveillance System (GTSS) initiated by the World Health Organization (WHO) and CDC, was developed to monitor youth tobacco use, attitudes about tobacco, and exposure to tobacco smoke, and has been completed by approximately 1.4 million students in 133 countries (*2*). A key goal of GTSS is for countries to conduct the GYTS every 4 years. This report presents findings from the GYTS conducted in the Philippines in 2000 and 2003, which revealed substantial declines in the proportions of students aged 13–15 years who currently smoked cigarettes, currently used other tobacco products, were likely to start smoking in the next year, or were exposed to secondhand smoke in public places. The findings also indicated an increase in the proportion of students who supported bans on smoking in public places, had learned about the dangers of tobacco use in school, and had seen antitobacco messages in media and advertising. Public health authorities in the Philippines should evaluate their current tobacco-control programs and enhance or expand them to further reduce youth smoking.

GYTS is a school-based survey that collects data from students aged 13–15 years by using a standardized methodology for constructing the sample frame, selecting participating schools and classes, and processing data. GYTS uses a two-stage, cluster-sample design that produces representative samples of students in grades associated with ages 13–15 years (*2*). In the Philippines, this age range is covered by the second, third, and fourth years of secondary school; the GYTS sampling frame included all secondary schools containing these grade levels. At the first sampling stage, the probability of selecting a school was proportional to the number of students enrolled in the specified grades. At the second stage, classes within the selected schools were randomly selected. All students attending school in the selected classes on the day the survey was administered were eligible to participate. In 2000, a total of 11,630 students completed the GYTS, and in 2003, a total of 7,478 completed the survey. The school response rate was 90.0% in 2000 and 99.3% in 2003; the student response rates were 88.7% and 85.4%, respectively; and the overall response rates (i.e., school rate multiplied by student rate) were 79.7% and 84.8%, respectively.

This analysis compared the 2000 and 2003 survey results by using several indicators of tobacco use. The indicators included lifetime cigarette smoking, age of initiation of cigarette smoking, current cigarette smoking, current use of other tobacco products, likelihood of never smokers to initiate smoking in the next year, exposure to secondhand smoke, tobacco education, exposure to tobacco images in media and advertising, cessation efforts, and access to tobacco. All differences noted are statistically significant ($p<0.05$) with nonoverlapping 95% confidence intervals.

In both years, approximately four in 10 students in the Philippines reported ever smoking cigarettes (i.e., even one or two puffs): 42.8% in 2000 and 41.9% in 2003 (Table 1). Adolescent boys were significantly more likely than adolescent girls to have ever smoked. Approximately one in eight students who had smoked cigarettes reported smoking their first cigarette before age 10 years: 12.9% in 2000 and 12.7% in 2003, with no significant difference between adolescent boys and girls.

Current tobacco use and likely initiation of smoking among never smokers declined significantly from 2000 to 2003. The percentage of students who reported being current cigarette smokers or currently using other tobacco products declined significantly. Among adolescent boys, the percentage of current smokers declined by approximately one third, from 32.6% in 2000 to 21.8% in 2003. Among adolescent girls, the decline was similar, from 12.9% in 2000 to 8.8% in 2003. Current use of other tobacco products declined by nearly half for both adolescent boys and adolescent girls, from 18.3% in 2000 to 10.9% in 2003 for adolescent boys and from 9.5% in 2000 to 5.7% in 2003 for adolescent girls. The percentage of students who had never smoked but were likely to initiate smoking in the next year also decreased by nearly half, from 26.5% in 2000 to 13.8% in 2003.

Changes in current tobacco use were mirrored by other results that indicated an increase in antismoking sentiment in the Philippines. Although the percentage of students who reported that their parents smoked did not change (approximately 56% in both 2000 and 2003), the percentage of students reporting exposure to secondhand smoke in public places declined from 74.6% in 2000 to 59.0% in 2003 (Table 2). In addition, support for bans on smoking in public places more than doubled, from 39.2% of students in 2000 to 88.7% in 2003, and the percentage of students who reported learning in school about the health hazards of tobacco use increased from 58.6% in 2000 to 68.0% in 2003. A greater percentage (90.3%) of students reported seeing an antitobacco message in the media in 2003 than in 2000 (83.4%).

The percentage of current smokers who were not refused purchase of tobacco products because of their age increased from 46.6% in 2000 to 62.8% in 2003. The percentage of students who reported being offered free cigarettes decreased from 17.6% in 2000 to 13.9% in 2003. In addition, a small but significant increase was observed in the percentage of students who reported seeing tobacco advertising on billboards (84.4% in 2000 versus 87.6% in 2003).

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Editorial Note: The findings in this report suggest that, from 2000 to 2003, tobacco use and exposure to secondhand smoke in public places declined significantly among students aged 13–15 years in the Philippines. In 2003, students were less likely to use tobacco currently, less likely to be exposed to secondhand smoke, more likely to support bans on smoking in public areas, and more likely to have learned in school and from the media about the health hazards of tobacco use. Finally, fewer students reported being offered free cigarettes in 2003 than in 2000.

During the same period, major changes in tobacco-control policies in the Philippines might have contributed to these changes. For example, before 1999, no restrictions on tobacco advertising and promotion were in effect, and few smoke-free policies existed. In addition, a lower level of taxation on tobacco products, few education efforts, and low enforcement

TABLE 1. Prevalence of tobacco use among students aged 13–15 years, by sex and year — Philippines, 2000 and 2003

	2000						2003					
	Total		Boys		Girls		Total		Boys		Girls	
Tobacco use	%	(95% CI*)	%	(CI)	%	(CI)	%	(CI)	%	(CI)	%	(CI)
Ever smoked cigarettes	**42.8**	**(±3.2)**	57.0	(±4.0)	32.0	(±2.9)	**41.9**	**(±3.2)**	54.2	(±3.9)	32.0	(±3.8)
First smoked cigarettes before age 10 years	**12.9**	**(±2.5)**	11.0	(±2.4)	15.4	(±3.1)	**12.7**	**(±2.0)**	12.3	(±2.6)	12.7	(±2.6)
Current cigarette smoker	**21.6**	**(±2.5)**	32.6	(±3.6)	12.9	(±1.7)	**15.0**	**(±2.9)**	21.8	(±4.5)	8.8	(±2.2)
Current user of other tobacco products	**13.6**	**(±1.2)**	18.3	(±1.6)	9.5	(±1.4)	**8.2**	**(±1.2)**	10.9	(±2.0)	5.7	(±1.0)
Never smokers likely to initiate smoking in the next year	**26.5**	**(±2.3)**	32.2	(±3.5)	23.7	(±2.5)	**13.8**	**(±1.7)**	14.4	(±2.5)	13.2	(±2.0)

* Confidence interval.

TABLE 2. Prevalence of factors influencing tobacco use among students aged 13–15 years, by sex and year — Philippines, 2000 and 2003

	2000						2003					
	Total		Boys		Girls		Total		Boys		Girls	
Factor	%	(95% CI*)	%	(CI)	%	(CI)	%	(CI)	%	(CI)	%	(CI)
Exposure to smoke												
One or more parents smoke	**56.3**	**(±1.6)**	55.0	(±2.1)	57.0	(±2.0)	**55.7**	**(±1.9)**	53.4	(±2.5)	57.2	(±2.4)
Best friend smokes	**10.6**	**(±1.7)**	15.1	(±2.2)	6.5	(±1.5)	**12.2**	**(±1.9)**	19.0	(±2.7)	6.7	(±1.7)
Exposed to smoke in public places	**74.6**	**(±1.8)**	74.5	(±2.0)	75.2	(±2.4)	**59.0**	**(±2.1)**	59.0	(±3.0)	58.9	(±2.9)
Supports ban on smoking in public places	**39.2**	**(±4.2)**	43.4	(±4.1)	36.8	(±4.6)	**88.7**	**(±1.6)**	87.0	(±2.1)	90.6	(±1.7)
School												
Taught dangers of smoking in school	**58.6**	**(±2.7)**	56.9	(±3.2)	61.2	(±3.2)	**68.0**	**(±2.8)**	66.7	(±3.7)	69.8	(±3.3)
Media/Advertising												
Saw antitobacco media message during the past 30 days	**83.4**	**(±1.9)**	81.1	(±2.2)	86.0	(±2.0)	**90.3**	**(±1.0)**	87.9	(±1.9)	92.2	(±0.9)
Saw pro-tobacco message on billboards during the past 30 days	**84.4**	**(±1.8)**	83.9	(±2.1)	85.6	(±2.1)	**87.6**	**(±1.3)**	86.3	(±2.0)	89.1	(±1.6)
Saw pro-tobacco message in newspapers or magazines during the past 30 days	**80.4**	**(±2.0)**	79.8	(±2.4)	81.7	(±2.3)	**81.7**	**(±1.6)**	81.5	(±2.3)	81.7	(±2.1)
Has an object that features the logo of a tobacco company	**17.8**	**(±1.4)**	22.2	(±2.1)	14.1	(±1.4)	**16.4**	**(±2.9)**	22.1	(±3.6)	11.7	(±2.6)
Cessation												
Wants to quit smoking	**84.8**	**(±3.0)**	85.1	(±3.1)	83.7	(±4.7)	**88.2**	**(±3.4)**	88.3	(±3.6)	87.9	(±7.5)
Dependent on tobacco (wants to have first cigarette <30 minutes after waking)	**7.2**	**(±1.6)**	7.2	(±1.7)	5.1	(±2.4)	**3.8**	**(±1.5)**	4.1	(±2.2)	1.9	(±2.1)
Access												
Not refused purchase when buying tobacco products from a store	**46.6**	**(±5.3)**	47.4	(±5.2)	43.9	(±9.1)	**62.8**	**(±7.4)**	60.2	(±8.7)	66.3	(±12.4)
Offered free cigarettes from a tobacco company representative	**17.6**	**(±1.3)**	22.7	(±1.8)	13.2	(±1.3)	**13.9**	**(±2.3)**	20.3	(±3.4)	8.6	(±1.8)

* Confidence interval.

of age restrictions for tobacco sales were observed. The Philippines Clear Air Act of 1999* identified cigarette smoke among the country's pollutants and instituted smoke-free indoor air laws. The national law still allows designated smoking areas in restaurants and other indoor areas, but some cities have declared all indoor areas completely smoke-free. The government is also seeking increased taxes on cigarettes. In 2003, the Youth Smoking Cessation Program† declared smoke-free campuses, improved training for students and teachers, and levied penalties for smoking. The Tobacco Regulatory Act of 2003§ seeks to increase public education measures, ban all tobacco advertisement, strengthen warning labels on tobacco products, and prohibit sales to minors. All of these smoke-free programs have received extensive national and local media coverage.

The findings in this report are subject to at least three limitations. First, because the sample surveyed was limited to youths attending school, it might not be representative of all adolescents aged 13–15 years in the Philippines. During school year 2002–03, the gross enrollment ratio in secondary schools was 65.7% (*3*). Second, these data apply only to youths who were in school on the day of the survey and who completed the survey. Despite this limitation, response rates were 89% in 2000 and 85% in 2003, suggesting that bias attributable to absence or nonresponse might be limited. Finally, data are based on the self reports of students, who might under- or over-report their use of tobacco. The extent of this bias cannot be determined from the Philippines data; however, responses to tobacco questions on surveys in the United States similar to GYTS have demonstrated good test-retest reliability (*4*).

The declines from 2000 to 2003 in cigarette smoking and other tobacco use among students in the Philippines were encouraging. However, other findings were of concern. In 2003, 13.8% of students who had never smoked indicated they would likely initiate smoking in the next year, with no difference between adolescent boys and adolescent girls. In addition, approximately eight in 10 students reported seeing pro-tobacco messages on billboards and in newspapers and magazines. Students who smoke also reported little difficulty purchasing cigarettes in stores. To reduce tobacco use among

* Republic Act No. 8749, enacted June 1999.
† Youth Smoking Prevention Program, Philippines Department of Education Order No. 33 series, enacted 2003.
§ Republic Act No. 9211, enacted July 2003.

adolescents in the Philippines, continued efforts are needed to monitor these behaviors and to develop, evaluate, and disseminate effective prevention strategies.

Systematic global surveillance of youth tobacco use is the essential first step in attempting to prevent the projected epidemic of death and disease that smoking will cause in the 21st century (*5*). The GYTS enhances the capacity of countries to evaluate their tobacco-prevention and -control programs. The more than 30% reduction in current tobacco use observed in the Philippines should encourage other countries that youth tobacco use can be reduced substantially during a short period.

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Progress Toward Poliomyelitis Eradication — Poliomyelitis Outbreak in Sudan, 2004

After the World Health Assembly of the World Health Organization (WHO) resolved in 1988 to eradicate poliomyelitis globally, the number of countries in which polio is endemic declined from 125 to six by 2003. However, in 2004, polio cases caused by wild poliovirus (WPV) originating from northern Nigeria were reported in 11 countries — Benin, Botswana, Cameroon, Guinea, Mali, Saudi Arabia, Burkina Faso, Central African Republic, Chad, Cote d'Ivoire, and Sudan — reestablishing transmission* in the latter five countries. Sudan, a member state of the WHO Eastern Mediterranean Region, initiated poliomyelitis eradication activities in the northern area of the country in 1994 and in the south in 1998. Since 1998, Sudan has made substantial progress in implementing polio eradication strategies, with no WPV reported from May 2001 through April 2004 (*1*). However, in May 2004, a WPV case was detected in West Darfur (*2*), and a polio outbreak is currently affecting 17 of the country's 26 states (*3*). This report describes the outbreak and response and provides an update on acute flaccid paralysis (AFP) surveillance and supplementary immunization activities (SIAs) in Sudan. The outbreak underscores the importance of continued SIAs in polio-free countries with low routine vaccination coverage, even in areas with moderate to low population density, as well as the need to ensure uniformly high-quality AFP surveillance.

Routine Vaccination

The Sudanese Ministry of Health reported that 74% of infants had received 3 doses of oral poliovirus vaccine (OPV3) in 2003, whereas WHO and the United Nations Children's Fund (UNICEF) estimated national OPV3 coverage in Sudan to be 50% for the same year. However, OPV3 coverage in conflict-affected southern Sudan is estimated to be substantially lower than national estimates.

Supplementary Immunization Activities

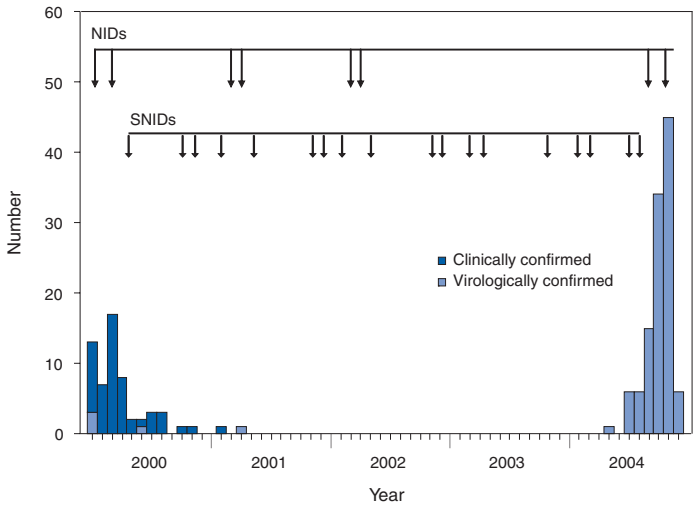
Sudan conducted two rounds of National Immunization Days (NIDs)† annually during 1998–2002; approximately 7 million children were vaccinated each round during 2001–2000 (*1*). After 2 years of conducting NIDs but detecting no new WPV cases, Sudan discontinued nationwide immunization campaigns; however, Sudan continued to conduct Subnational Immunization Days (SNIDs), resulting in vaccination of 68,000–3 million children per round during 2003 (three rounds) and the first half of 2004 (two rounds) (Figure 1).

After WVP type 1 (WPV1) was detected in May 2004 in West Darfur, statewide immunization activities were conducted in North, South, and West Darfur states in July and August 2004 (West Kordofan was also included in August 2004), resulting in vaccination of 1.0 million and 1.4 million children during those periods, respectively. In addition, two rounds of immunization activities were conducted in Bahr El Gazal states in August and September 2004, resulting in vaccination of approximately 500,000 children during each round. NID rounds conducted in October and November 2004 reached an estimated 7.6 million children. An additional round was conducted in December 2004 in parts of Upper Nile after the detection of a WPV1 case there in November. Although high coverage (95%) was reported for the 2004

* Country with continued transmission >6 months after importation.

† NIDs involve mass immunization campaigns over short periods (days to weeks) in which OPV is administered to all children in the target age group (usually those aged <5 years), regardless of previous vaccination history. These campaigns consist of at least two rounds, in which the consecutive dose(s) are administered approximately 4 weeks apart.

FIGURE 1. Clinically and virologically confirmed poliomyelitis cases and Nationwide Immunization Days (NIDs) and Subnational Immunization Days (SNIDs)*, by year — Sudan, 2000–2004



* Only SNIDs vaccinating >1 million children are shown; some SNIDs might have extended over a 4-week period.

rounds, certain areas of southern and western Sudan were not accessible because of conflict.

AFP Surveillance

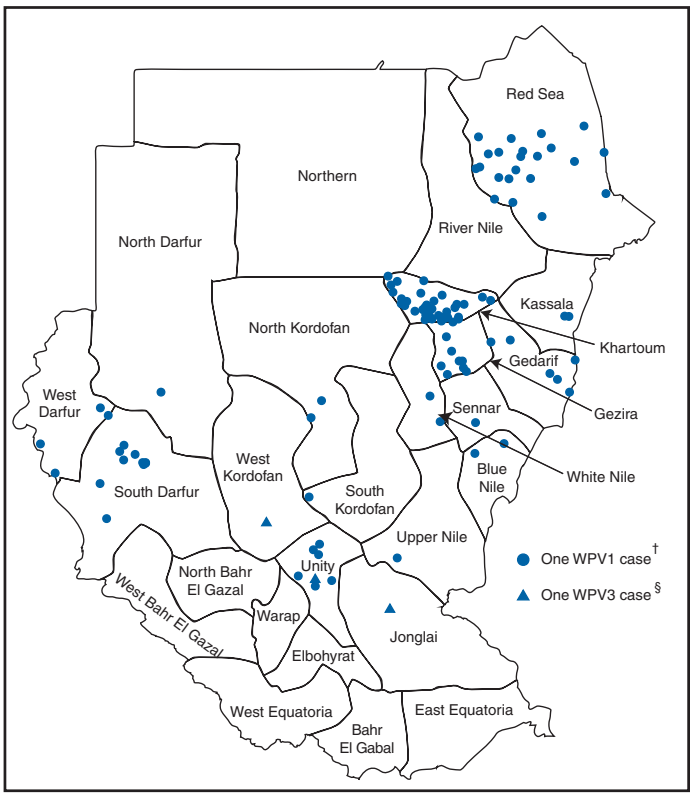
The key WHO-recommended indicators for monitoring AFP surveillance quality are the rate of AFP cases reported (target: ≥1.0 per 100,000 population aged <15 years) and the percentage of AFP cases for which adequate specimens[§] were collected (target: ≥80%). Both north-central and southern Sudan exceeded the targets for AFP surveillance quality in 2002 (AFP rate: 2.6; AFP cases for which adequate specimens were collected: 90%), although population denominators for southern Sudan are uncertain. Nationally, surveillance quality remained high through 2003 and 2004, although several states (six in 2003 and five in 2004) were below recommended levels for surveillance quality indicators.

WPV Incidence

The last WPV1 case detected in Sudan before the current outbreak was identified in April 2001 in Unity state, southern Sudan. The first case of the outbreak was detected in May 2004 in West Darfur, and the outbreak is currently affecting 17 of 26 states (109 WPV1 cases in 15 states and three WPV type 3 [WPV3] cases in three states) (Figure 2); both WPV1 and WPV3 were detected in one state (Unity). Although six

[§] Two stool specimens collected ≥24 hours apart within 14 days of paralysis onset and received in the laboratory in acceptable condition.

FIGURE 2. Distribution of cases confirmed with wild poliovirus types 1 (WPV1) and 3 (WPV3), by state — Sudan, May–December 2004*



* No cases had been detected during 2005 as of January 14.
† n = 109; cases are randomly distributed on this map within states.
§ n = three.

cases have been reported in six states since the second NID round in November 2004, the epidemic curve suggests a waning of the outbreak, after accounting for reporting and laboratory delays (Figure 1). As of January 14, the last case detected with WPV had a paralysis onset date of December 14.

The first WPV1 case in 2004 had a paralysis onset date of May 20 in West Darfur. Seven weeks later, two WPV1 cases were reported from South Darfur; 10 total cases have been reported from South Darfur as of January 14. By the end of 2004, major clusters of WPV1 cases were present in two additional states, Khartoum (41 cases) and Red Sea (22 cases). The first WPV1 case from Khartoum state had a paralysis onset date of August 31, 2004; the first case reported from Red Sea state had a paralysis onset date of October 20. Genetic sequencing results indicate that 70 (95%) of 74 WPV1 isolates sequenced were closely related to WPVs originating in northern Nigeria and Chad. Isolates from four WPV1 cases from Umbada and Karary localities of Khartoum state belong to a different genetic lineage with an undetermined geographic source.

Before the current outbreak, WPV3 was last detected in Sudan in River Nile state in 1999. The first WPV3 case in 2004 (West Kordofan) had a paralysis onset date of July 9. Subsequently, two additional cases were reported, one from Unity (July 29, 2004) and one from Jonglai (September 7, 2004). All 3 WPV3 isolates detected during 2004 belong to the same WPV3 genotype (East Africa), which includes the WPV3 case from River Nile in 1999, suggesting undetected WPV3 transmission.

Reported by: *World Health Organization (WHO) Sudan Office, Khartoum, Sudan. WHO Southern Sudan Liaison Office, Nairobi, Kenya. WHO Eastern Mediterranean Regional Office, Cairo, Egypt. Vaccines and Biologicals Dept, WHO, Geneva, Switzerland. Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program, CDC.*

Editorial Note: Despite Sudan's continued commitment to polio eradication, a large polio outbreak occurred in 2004, affecting 17 states. Although multiple SNIDs were conducted after NIDs ceased in 2002, the magnitude and spread of the outbreak indicates substantial gaps in population immunity. This poliovirus outbreak confirms the importance of continued SIAs for polio-free countries with low routine vaccination coverage, even in areas with moderate to low population density, such as those found in Sudan. It also underscores the need to ensure that surveillance quality is uniformly high throughout the country, especially in areas with continued armed conflict and difficult access; genetic sequencing suggests that WPV3 transmission in Sudan might have gone undetected for >36 months.

Despite the cessation of NIDS in 2002, the Sudanese Ministry of Health and national and international polio partners in Sudan responded rapidly to the outbreak. Large-scale subnational SIAs were planned and implemented in a timely manner in western Sudan under geographically and politically difficult conditions. Surveillance data indicating a possible waning of the outbreak suggests that the 2004 SIAs have had an impact on breaking chains of WPV transmission.

The global eradication initiative should increase efforts to stop transmission in Sudan to prevent further spread into neighboring countries. A SNID was conducted in January 2005 in all but four states in the south and will be followed by three NID rounds in February, March, and April. The peace agreement signed in January 2005 by the Sudanese government and the country's main southern rebel group might increase access to children living in conflict-affected areas in the south. Despite progress, the need remains to ensure safe access to vulnerable groups of children, especially in the western and southern parts of the country. Furthermore, the reintroduction of WPV in multiple western and central African countries and the outbreak in Sudan illustrate the continued risk of WPV importation and spread posed by areas where polio remains hyperendemic, such as northern Nigeria.

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Notice to Readers

National Parent Leadership Month — February 2005

February is National Parent Leadership Month, dedicated to recognizing the important role of parents in raising healthy families in their homes and communities. The event is sponsored by Parents Anonymous® Inc., which is supported by private and government agencies, including CDC. Throughout the month, events across the United States will present information on how parents and foster parents can become active leaders in promoting positive behaviors and preventing childhood injuries.

Each year in the United States, hundreds of thousands of children and adolescents are at high risk for injuries, some involving child abuse and neglect, that can lead to death or disability (*1*). During 2002, according to data collected from state child protective services agencies, an estimated 896,000 children were determined to have been abused (*2*). Children who experience maltreatment are at increased risk for adverse health effects and behaviors as adults, including smoking, alcoholism, drug abuse, physical inactivity, severe obesity, depression, suicide, multiple sex partners, and certain chronic diseases, such as heart disease and diabetes (*3*).

During National Parent Leadership Month, parents, community leaders, teachers, health-care providers, and others can become informed about effective strategies to prevent childhood abuse and neglect. These strategies include behavioral parent training and home visitation programs, which can reduce the rate of child maltreatment (*4,5*). Additional information about activities to prevent child maltreatment is available at http://www.cdc.gov/ncipc/factsheets/cmactivities.htm.

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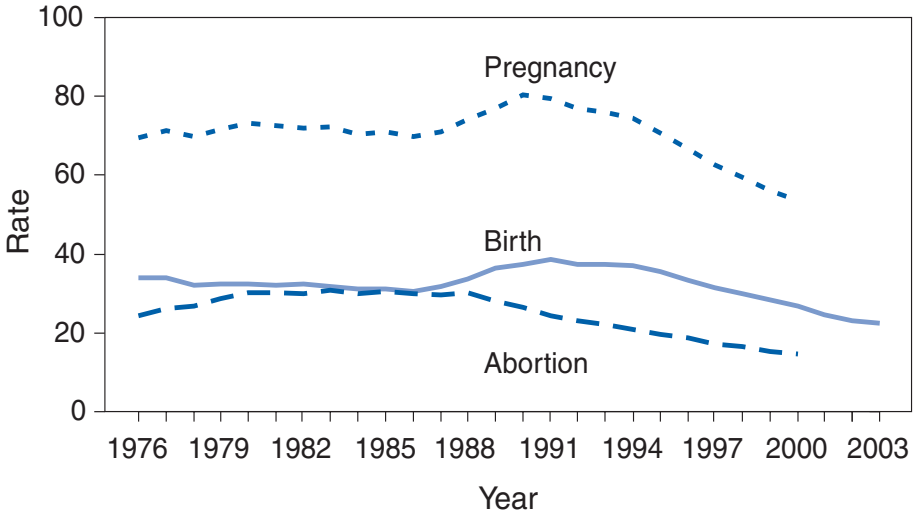
QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Pregnancy, Birth, and Abortion Rates* for Teenagers Aged 15–17 Years — United States, 1976–2003

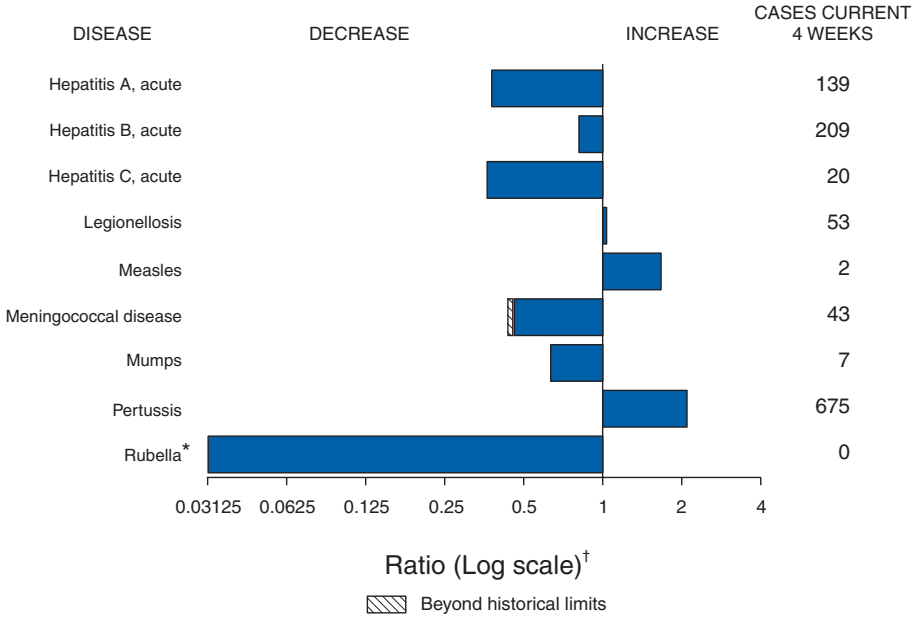


* Per 1,000 females.

Since 1990, pregnancy rates have declined substantially for teenagers aged 15–17 years. From 1990 to 2000, the pregnancy rate decreased 33%, from 80.3 per 1,000 females to 53.5, a record low. The birth rate declined 42%, from its peak at 38.6 in 1991 to 22.4 in 2003. The induced abortion rate peaked in 1983 at 30.7 and decreased by more than half to 14.5 by 2000.

SOURCES: Ventura SJ, Abma JC, Mosher WD, Henshaw S. Estimated pregnancy rates for the United States, 1990–2000: an update; and Hamilton BE, Martin JA, Sutton PD. Births: preliminary data for 2003. These reports and additional information are available at http://www.cdc.gov/nchs/births.htm.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals January 29, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending January 29, 2005 (4th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	3	3
Botulism:			HIV infection, pediatric†¶	26	22
foodborne	3	1	Influenza-associated pediatric mortality†**	4	—
infant	2	6	Measles	2††	2§§
other (wound & unspecified)	1	—	Mumps	15	17
Brucellosis	4	6	Plague	—	—
Chancroid	3	3	Poliomyelitis, paralytic	—	—
Cholera	—	1	Psittacosis†	—	—
Cyclosporiasis†	1	5	Q fever†	3	4
Diphtheria	—	—	Rabies, human	—	—
Domestic arboviral diseases			Rubella	—	2
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	—	—
California serogroup†§	—	—	SARS†**	—	—
eastern equine†§	—	—	Smallpox†	—	—
Powassan†§	—	—	*Staphylococcus aureus*:		
St. Louis†§	—	—	Vancomycin-intermediate (VISA)†	—	—
western equine†§	—	—	Vancomycin-resistant (VRSA)†	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	2	21
human granulocytic (HGE)†	2	5	Tetanus	—	1
human monocytic (HME)†	3	4	Toxic-shock syndrome	6	8
human, other and unspecified †	2	1	Trichinellosis¶¶	—	—
Hansen disease†	3	5	Tularemia†	—	1
Hantavirus pulmonary syndrome†	—	2	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of two cases reported, two were indigenous and none were imported from another country.
§§ Of two cases reported, one was indigenous and one was imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 29, 2005, and January 31, 2004 (4th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,759	2,511	45,108	63,738	262	120	83	195
NEW ENGLAND	85	50	2,144	2,451	—	—	1	12
Maine	3	1	192	140	N	N	—	4
N.H.	2	4	150	116	—	—	—	1
Vt.¶	—	7	69	77	—	—	1	2
Mass.	—	1	1,079	1,209	—	—	—	5
R.I.	14	16	250	361	—	—	—	—
Conn.	66	21	404	548	N	N	—	—
MID. ATLANTIC	292	459	5,729	7,154	—	—	12	29
Upstate N.Y.	39	24	713	791	N	N	2	5
N.Y. City	221	281	1,998	2,460	—	—	1	12
N.J.	31	98	726	1,441	N	N	1	2
Pa.	1	56	2,292	2,462	N	N	8	10
E.N. CENTRAL	274	307	4,758	10,859	—	—	16	47
Ohio	59	96	48	2,804	N	N	12	14
Ind.	37	53	1,501	1,189	N	N	—	1
Ill.	146	125	2,171	3,428	—	—	—	12
Mich.	26	15	489	2,184	—	—	2	8
Wis.	6	18	549	1,254	N	N	2	12
W.N. CENTRAL	78	60	947	4,222	—	1	8	12
Minn.	35	12	109	939	N	N	1	2
Iowa	9	5	—	536	N	N	1	1
Mo.	17	12	244	1,488	—	—	4	5
N. Dak.	—	5	60	103	N	N	—	—
S. Dak.	3	—	220	187	—	—	1	2
Nebr.¶	—	5	—	357	—	1	—	—
Kans.	14	21	314	612	N	N	1	2
S. ATLANTIC	1,093	715	10,549	11,392	—	—	23	39
Del.	—	12	233	187	N	N	—	—
Md.	80	10	1,177	1,260	—	—	3	2
D.C.	28	21	165	246	—	—	—	—
Va.¶	57	3	1,981	1,634	—	—	—	1
W. Va.	11	8	130	213	N	N	—	—
N.C.	119	1	1,813	1,951	N	N	4	8
S.C.¶	42	27	1,347	795	—	—	—	1
Ga.	231	192	981	2,655	—	—	8	14
Fla.	525	441	2,722	2,451	N	N	8	13
E.S. CENTRAL	141	98	3,459	3,957	—	—	4	11
Ky.	25	20	559	509	N	N	1	3
Tenn.¶	59	33	1,143	1,663	N	N	1	3
Ala.¶	54	26	182	1,007	—	—	2	4
Miss.	3	19	1,575	778	—	—	—	1
W.S. CENTRAL	331	383	6,715	9,123	—	—	—	7
Ark.	35	15	689	576	—	—	—	2
La.	39	28	572	2,864	—	—	—	—
Okla.	43	5	974	710	N	N	—	2
Tex.¶	214	335	4,480	4,973	N	N	—	3
MOUNTAIN	109	70	2,827	3,860	204	13	5	8
Mont.	—	—	8	25	N	N	—	—
Idaho¶	1	1	90	120	N	N	—	—
Wyo.	—	—	81	65	—	—	—	1
Colo.	12	1	439	879	N	N	1	6
N. Mex.	17	—	56	565	—	3	—	—
Ariz.	54	64	1,517	1,465	199	2	2	—
Utah	8	3	213	253	—	3	—	—
Nev.¶	17	1	423	488	5	5	2	1
PACIFIC	356	369	7,980	10,720	58	106	14	30
Wash.	28	22	1,271	1,155	N	N	—	—
Oreg.¶	32	16	594	551	—	—	1	3
Calif.	290	318	5,770	8,324	58	106	13	27
Alaska	5	—	214	190	—	—	—	—
Hawaii	1	13	131	500	—	—	—	—
Guam	—	—	—	96	—	—	—	—
P.R.	1	47	125	140	N	N	N	N
V.I.	3	—	—	45	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

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

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 29, 2005, and January 31, 2004 (4th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	45	78	3	11	11	8	708	1,039	16,930	23,812
NEW ENGLAND	3	3	—	3	2	—	54	73	426	556
Maine	—	—	—	—	—	—	5	10	9	19
N.H.	—	—	—	—	—	—	—	2	12	9
Vt.	—	—	—	—	—	—	4	4	3	4
Mass.	2	—	—	2	2	—	44	57	222	248
R.I.	—	—	—	—	—	—	—	—	34	74
Conn.	1	3	—	1	—	—	1	—	146	202
MID. ATLANTIC	3	8	—	—	—	1	128	223	1,844	2,436
Upstate N.Y.	1	1	—	—	—	—	31	32	312	270
N.Y. City	—	3	—	—	—	—	25	83	569	837
N.J.	—	—	—	—	—	1	25	29	268	509
Pa.	2	4	—	—	—	—	47	79	695	820
E.N. CENTRAL	10	21	1	4	3	1	73	185	1,850	4,672
Ohio	6	8	—	—	2	1	42	67	26	1,621
Ind.	—	3	—	—	—	—	N	N	640	483
Ill.	—	2	—	—	—	—	—	51	836	1,478
Mich.	3	5	—	—	1	—	21	45	168	786
Wis.	1	3	1	4	—	—	10	22	180	304
W.N. CENTRAL	8	9	—	2	1	5	49	78	312	1,470
Minn.	—	5	—	—	—	—	—	14	25	395
Iowa	4	—	—	—	—	—	18	17	—	87
Mo.	2	3	—	2	1	—	15	31	138	635
N. Dak.	—	—	—	—	—	3	—	1	1	8
S. Dak.	2	—	—	—	—	—	1	2	28	20
Nebr.	—	—	—	—	—	—	8	4	—	105
Kans.	—	1	—	—	—	2	7	9	120	220
S. ATLANTIC	9	5	—	1	5	1	124	156	5,608	5,505
Del.	—	—	N	N	N	N	—	1	56	69
Md.	3	1	—	—	—	—	13	7	554	637
D.C.	—	—	—	—	—	—	—	3	107	173
Va.	—	—	—	—	1	—	15	8	763	708
W. Va.	—	—	—	—	—	—	—	1	47	65
N.C.	—	—	—	—	4	1	N	N	1,593	1,144
S.C.	—	—	—	—	—	—	3	—	661	391
Ga.	2	1	—	—	—	—	41	64	539	1,206
Fla.	4	3	—	1	—	—	52	72	1,288	1,112
E.S. CENTRAL	2	2	—	—	—	—	16	21	1,252	1,947
Ky.	—	—	—	—	—	—	N	N	223	218
Tenn.	1	—	—	—	—	—	2	8	431	694
Ala.	1	1	—	—	—	—	14	13	99	618
Miss.	—	1	—	—	—	—	—	—	499	417
W.S. CENTRAL	1	5	—	—	—	—	9	17	2,963	3,654
Ark.	1	—	—	—	—	—	3	8	364	244
La.	—	—	—	—	—	—	—	5	350	1,266
Okla.	—	—	—	—	—	—	6	4	395	336
Tex.	—	5	—	—	—	—	N	N	1,854	1,808
MOUNTAIN	1	8	2	—	—	—	65	92	753	1,035
Mont.	—	1	—	—	—	—	4	1	1	8
Idaho	1	1	—	—	—	—	10	17	5	3
Wyo.	—	—	1	—	—	—	1	—	5	3
Colo.	—	1	1	—	—	—	22	48	162	276
N. Mex.	—	—	—	—	—	—	2	3	12	78
Ariz.	—	1	N	N	N	N	15	—	340	432
Utah	—	2	—	—	—	—	8	18	36	23
Nev.	—	2	—	—	—	—	3	5	192	212
PACIFIC	8	17	—	1	—	—	190	194	1,922	2,537
Wash.	2	2	—	—	—	—	6	4	233	229
Oreg.	—	2	—	1	—	—	15	34	92	65
Calif.	4	10	—	—	—	—	158	152	1,539	2,089
Alaska	1	—	—	—	—	—	3	2	33	35
Hawaii	1	3	—	—	—	—	8	2	25	119
Guam	N	N	—	—	—	—	—	—	—	19
P.R.	—	—	—	—	—	—	—	—	17	9
V.I.	—	—	—	—	—	—	—	—	—	14
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 29, 2005, and January 31, 2004 (4th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	115	173	—	1	3	3	10	23
NEW ENGLAND	5	16	—	—	—	—	2	—
Maine	—	—	—	—	—	—	—	—
N.H.	—	2	—	—	—	—	—	—
Vt.	4	1	—	—	—	—	2	—
Mass.	1	9	—	—	—	—	—	—
R.I.	—	—	—	—	—	—	—	—
Conn.	—	4	—	—	—	—	—	—
MID. ATLANTIC	27	37	—	—	—	—	2	6
Upstate N.Y.	8	6	—	—	—	—	—	—
N.Y. City	3	8	—	—	—	—	—	3
N.J.	5	8	—	—	—	—	—	1
Pa.	11	15	—	—	—	—	2	2
E.N. CENTRAL	21	38	—	—	—	1	2	10
Ohio	17	13	—	—	—	—	2	3
Ind.	1	1	—	—	—	—	—	1
Ill.	—	12	—	—	—	—	—	4
Mich.	3	4	—	—	—	1	—	1
Wis.	—	8	—	—	—	—	—	1
W.N. CENTRAL	5	6	—	—	—	—	1	1
Minn.	—	—	—	—	—	—	—	—
Iowa	—	—	—	—	—	—	—	—
Mo.	5	2	—	—	—	—	1	1
N. Dak.	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	—	4	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	—	—
S. ATLANTIC	37	39	—	—	1	—	1	2
Del.	—	—	—	—	—	—	—	—
Md.	8	14	—	—	1	—	1	—
D.C.	—	—	—	—	—	—	—	—
Va.	—	4	—	—	—	—	—	—
W. Va.	—	1	—	—	—	—	—	—
N.C.	11	1	—	—	—	—	—	—
S.C.	1	—	—	—	—	—	—	—
Ga.	8	11	—	—	—	—	—	2
Fla.	9	8	—	—	—	—	—	—
E.S. CENTRAL	4	9	—	—	—	—	—	1
Ky.	—	—	—	—	—	—	—	—
Tenn.	3	4	—	—	—	—	—	—
Ala.	1	5	—	—	—	—	—	1
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	4	5	—	—	—	—	1	—
Ark.	—	—	—	—	—	—	—	—
La.	2	3	—	—	—	—	1	—
Okla.	2	2	—	—	—	—	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	9	18	—	1	2	2	1	1
Mont.	—	—	—	—	—	—	—	—
Idaho	1	—	—	—	—	—	—	—
Wyo.	1	—	—	—	—	—	—	—
Colo.	—	8	—	—	—	—	—	—
N. Mex.	—	6	—	—	—	1	—	1
Ariz.	4	—	—	—	1	—	1	—
Utah	1	1	—	1	—	—	—	—
Nev.	2	3	—	—	1	1	—	—
PACIFIC	3	5	—	—	—	—	—	2
Wash.	—	1	—	—	—	—	—	1
Oreg.	1	2	—	—	—	—	—	—
Calif.	—	2	—	—	—	—	—	1
Alaska	1	—	—	—	—	—	—	—
Hawaii	1	—	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 29, 2005, and January 31, 2004 (4th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	190	445	285	367	29	71
NEW ENGLAND	36	66	12	23	—	—
Maine	—	—	—	—	—	—
N.H.	2	—	—	—	—	—
Vt.	—	3	—	1	—	—
Mass.	28	55	12	12	—	—
R.I.	—	—	—	—	—	—
Conn.	6	8	—	10	—	—
MID. ATLANTIC	15	60	62	59	—	12
Upstate N.Y.	3	3	4	1	—	1
N.Y. City	3	19	2	13	—	—
N.J.	—	13	46	28	—	—
Pa.	9	25	10	17	—	11
E.N. CENTRAL	16	50	18	21	8	5
Ohio	3	4	11	9	1	—
Ind.	4	7	—	—	—	—
Ill.	2	22	—	—	—	—
Mich.	5	14	7	9	7	5
Wis.	2	3	—	3	—	—
W.N. CENTRAL	5	12	9	23	3	6
Minn.	—	—	—	—	—	—
Iowa	1	3	—	1	—	—
Mo.	2	1	6	19	3	6
N. Dak.	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—
Nebr.	2	5	2	1	—	—
Kans.	—	3	1	2	—	—
S. ATLANTIC	31	83	102	116	11	15
Del.	—	—	—	—	—	—
Md.	3	11	11	12	5	2
D.C.	—	—	—	—	—	—
Va.	—	3	6	1	—	—
W. Va.	—	—	—	—	—	1
N.C.	1	5	12	11	1	1
S.C.	—	—	—	1	—	—
Ga.	12	43	35	54	—	2
Fla.	15	21	38	37	5	9
E.S. CENTRAL	1	15	11	25	1	6
Ky.	—	—	—	3	—	2
Tenn.	1	9	2	4	—	2
Ala.	—	2	8	5	1	—
Miss.	—	4	1	13	—	2
W.S. CENTRAL	4	64	1	17	—	22
Ark.	—	7	—	4	—	—
La.	3	1	1	11	—	16
Okla.	—	3	—	2	—	—
Tex.	1	53	—	—	—	6
MOUNTAIN	26	5	35	16	4	2
Mont.	2	—	—	—	—	—
Idaho	1	1	1	1	—	—
Wyo.	—	—	—	1	—	—
Colo.	2	2	1	3	—	—
N. Mex.	2	—	—	2	—	—
Ariz.	18	—	28	—	—	1
Utah	1	2	4	3	4	—
Nev.	—	—	1	6	—	1
PACIFIC	56	90	35	67	2	3
Wash.	1	2	1	4	—	—
Oreg.	4	7	3	15	1	1
Calif.	51	80	31	47	1	1
Alaska	—	—	—	—	—	—
Hawaii	—	1	—	1	—	1
Guam	—	—	—	—	—	—
P.R.	—	—	1	1	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 29, 2005, and January 31, 2004 (4th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	74	114	24	35	222	607	56	99
NEW ENGLAND	2	2	—	—	4	35	2	7
Maine	—	—	—	—	—	—	—	—
N.H.	—	—	—	—	4	—	—	—
Vt.	—	—	—	—	—	—	—	—
Mass.	2	1	—	—	—	35	2	7
R.I.	—	—	—	—	—	—	—	—
Conn.	—	1	—	—	—	—	—	—
MID. ATLANTIC	23	26	4	9	168	492	12	22
Upstate N.Y.	5	3	—	1	14	114	2	—
N.Y. City	—	—	—	1	—	—	4	14
N.J.	4	12	2	5	77	111	5	3
Pa.	14	11	2	2	77	267	1	5
E.N. CENTRAL	14	37	5	4	7	17	3	5
Ohio	9	24	2	3	6	3	1	—
Ind.	4	—	—	—	—	—	—	—
Ill.	—	6	—	—	—	—	—	1
Mich.	1	5	1	—	1	—	2	1
Wis.	—	2	2	1	U	14	—	3
W.N. CENTRAL	2	2	2	—	—	6	2	7
Minn.	—	—	—	—	—	—	—	3
Iowa	—	—	1	—	—	2	2	—
Mo.	2	1	—	—	—	4	—	3
N. Dak.	—	—	1	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—
Nebr.	—	—	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	—	1
S. ATLANTIC	16	17	5	7	37	43	11	33
Del.	—	—	N	N	—	3	—	—
Md.	6	4	1	2	27	30	4	10
D.C.	—	—	—	—	—	—	—	—
Va.	—	—	—	—	—	—	—	—
W. Va.	—	—	—	1	—	—	—	—
N.C.	2	3	2	2	4	5	1	1
S.C.	—	1	—	—	—	—	—	2
Ga.	1	—	—	1	—	2	3	7
Fla.	7	9	2	1	6	3	3	13
E.S. CENTRAL	—	3	—	2	2	—	3	3
Ky.	—	—	—	1	—	—	—	—
Tenn.	—	1	—	1	2	—	2	—
Ala.	—	2	—	—	—	—	1	2
Miss.	—	—	—	—	—	—	—	1
W.S. CENTRAL	—	9	1	1	—	7	—	12
Ark.	—	—	—	—	—	—	—	1
La.	—	1	1	—	—	—	—	2
Okla.	—	—	—	—	—	—	—	—
Tex.	—	8	—	1	—	7	—	9
MOUNTAIN	6	7	—	2	—	1	5	2
Mont.	—	—	—	—	—	—	—	—
Idaho	—	1	—	—	—	—	—	—
Wyo.	2	2	—	—	—	—	1	—
Colo.	—	1	—	1	—	—	1	—
N. Mex.	—	—	—	—	—	—	—	1
Ariz.	3	—	—	—	—	—	2	—
Utah	1	2	—	—	—	1	1	—
Nev.	—	1	—	1	—	—	—	1
PACIFIC	11	11	7	10	4	6	18	8
Wash.	—	1	1	1	—	—	—	—
Oreg.	N	N	—	4	—	2	1	—
Calif.	11	10	6	5	4	4	16	8
Alaska	—	—	—	—	—	—	1	—
Hawaii	—	—	—	—	N	N	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 29, 2005, and January 31, 2004 (4th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	64	156	7	14	3	5	—	—	54	137
NEW ENGLAND	11	4	—	—	—	—	—	—	11	4
Maine	1	1	—	—	—	—	—	—	1	1
N.H.	1	—	—	—	—	—	—	—	1	—
Vt.	3	—	—	—	—	—	—	—	3	—
Mass.	5	3	—	—	—	—	—	—	5	3
R.I.	—	—	—	—	—	—	—	—	—	—
Conn.	1	—	—	—	—	—	—	—	1	—
MID. ATLANTIC	8	25	2	8	1	2	—	—	5	15
Upstate N.Y.	3	6	—	2	1	—	—	—	2	4
N.Y. City	1	5	—	—	—	—	—	—	1	5
N.J.	2	3	—	—	—	—	—	—	2	3
Pa.	2	11	2	6	—	2	—	—	—	3
E.N. CENTRAL	5	16	2	5	1	—	—	—	2	11
Ohio	2	10	—	3	1	—	—	—	1	7
Ind.	1	2	—	—	—	—	—	—	1	2
Ill.	—	—	—	—	—	—	—	—	—	—
Mich.	2	2	2	2	—	—	—	—	—	—
Wis.	—	2	—	—	—	—	—	—	—	2
W.N. CENTRAL	6	7	1	—	—	1	—	—	5	6
Minn.	—	—	—	—	—	—	—	—	—	—
Iowa	1	1	—	—	—	1	—	—	1	—
Mo.	4	3	1	—	—	—	—	—	3	3
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—	—	1
Nebr.	—	1	—	—	—	—	—	—	—	1
Kans.	1	1	—	—	—	—	—	—	1	1
S. ATLANTIC	12	27	1	—	1	1	—	—	10	26
Del.	—	—	—	—	—	—	—	—	—	—
Md.	2	3	—	—	1	—	—	—	1	3
D.C.	—	—	—	—	—	—	—	—	—	—
Va.	—	2	—	—	—	—	—	—	—	2
W. Va.	—	3	—	—	—	—	—	—	—	3
N.C.	3	3	1	—	—	1	—	—	2	2
S.C.	1	—	—	—	—	—	—	—	1	—
Ga.	2	4	—	—	—	—	—	—	2	4
Fla.	4	12	—	—	—	—	—	—	4	12
E.S. CENTRAL	1	7	—	—	—	—	—	—	1	7
Ky.	—	—	—	—	—	—	—	—	—	—
Tenn.	1	4	—	—	—	—	—	—	1	4
Ala.	—	1	—	—	—	—	—	—	—	1
Miss.	—	2	—	—	—	—	—	—	—	2
W.S. CENTRAL	5	22	1	1	—	—	—	—	4	21
Ark.	1	3	—	—	—	—	—	—	1	3
La.	3	8	—	1	—	—	—	—	3	7
Okla.	1	1	1	—	—	—	—	—	—	1
Tex.	—	10	—	—	—	—	—	—	—	10
MOUNTAIN	3	5	—	—	—	1	—	—	3	4
Mont.	—	—	—	—	—	—	—	—	—	—
Idaho	—	1	—	—	—	—	—	—	—	1
Wyo.	—	1	—	—	—	—	—	—	—	1
Colo.	2	1	—	—	—	—	—	—	2	1
N. Mex.	—	—	—	—	—	—	—	—	—	—
Ariz.	1	—	—	—	—	—	—	—	1	—
Utah	—	—	—	—	—	—	—	—	—	—
Nev.	—	2	—	—	—	1	—	—	—	1
PACIFIC	13	43	—	—	—	—	—	—	13	43
Wash.	—	—	—	—	—	—	—	—	—	—
Oreg.	5	9	—	—	—	—	—	—	5	9
Calif.	8	32	—	—	—	—	—	—	8	32
Alaska	—	—	—	—	—	—	—	—	—	—
Hawaii	—	2	—	—	—	—	—	—	—	2
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 29, 2005, and January 31, 2004 (4th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	843	555	173	526	35	52	1,216	1,870	424	804
NEW ENGLAND	37	168	39	13	—	4	56	87	10	20
Maine	3	—	4	1	N	N	3	4	—	—
N.H.	—	1	2	1	—	—	2	2	1	1
Vt.	8	5	—	1	—	—	5	3	—	—
Mass.	26	158	23	5	—	4	35	64	9	15
R.I.	—	—	—	—	—	—	—	—	—	—
Conn.	—	4	10	5	—	—	11	14	—	4
MID. ATLANTIC	117	144	13	35	—	5	88	243	27	94
Upstate N.Y.	37	60	11	10	—	—	14	26	3	29
N.Y. City	—	11	2	1	—	2	20	76	14	30
N.J.	5	28	N	N	—	—	16	72	8	20
Pa.	75	45	—	24	—	3	38	69	2	15
E.N. CENTRAL	266	92	3	1	1	—	110	296	22	89
Ohio	217	43	1	1	1	—	58	70	7	19
Ind.	1	—	1	—	—	—	13	12	1	2
Ill.	—	1	1	—	—	—	—	115	—	46
Mich.	6	8	—	—	—	—	25	46	12	11
Wis.	42	40	—	—	—	—	14	53	2	11
W.N. CENTRAL	87	43	7	32	2	—	82	110	39	32
Minn.	22	—	2	6	—	—	10	23	1	5
Iowa	—	10	2	6	—	—	29	17	9	2
Mo.	29	29	3	1	2	—	28	36	17	8
N. Dak.	9	—	—	4	—	—	2	2	1	1
S. Dak.	1	—	—	6	—	—	2	5	5	1
Nebr.	19	—	—	—	—	—	7	7	5	1
Kans.	7	4	—	9	—	—	4	20	1	14
S. ATLANTIC	28	29	56	325	29	36	409	394	87	207
Del.	—	—	—	—	—	—	—	—	—	1
Md.	13	13	17	18	1	—	38	33	9	12
D.C.	—	3	—	—	—	—	—	—	—	4
Va.	—	5	6	25	—	—	10	23	1	6
W. Va.	—	—	1	6	—	—	—	1	—	—
N.C.	—	—	30	40	23	34	97	43	5	24
S.C.	7	1	—	7	—	2	11	9	—	9
Ga.	2	—	—	22	3	—	79	83	34	51
Fla.	6	7	2	207	2	—	174	202	38	100
E.S. CENTRAL	11	7	1	42	1	6	56	111	22	27
Ky.	3	1	—	1	—	—	5	6	2	1
Tenn.	1	4	—	36	1	2	12	29	8	10
Ala.	7	1	1	5	—	1	39	45	12	10
Miss.	—	1	—	—	—	3	—	31	—	6
W.S. CENTRAL	2	3	40	64	—	—	60	194	43	182
Ark.	1	2	6	2	—	—	16	18	6	3
La.	—	1	—	—	—	—	18	21	5	15
Okla.	—	—	3	5	—	—	15	17	24	19
Tex.	1	—	31	57	—	—	11	138	8	145
MOUNTAIN	249	43	10	7	2	—	117	133	48	51
Mont.	89	3	—	—	—	—	5	5	—	1
Idaho	11	6	—	—	—	—	4	22	—	—
Wyo.	5	2	—	—	—	—	4	2	—	1
Colo.	121	23	—	—	—	—	24	44	7	19
N. Mex.	1	6	—	—	—	—	5	19	4	18
Ariz.	9	—	10	7	—	—	54	17	31	6
Utah	11	2	—	—	2	—	7	11	2	1
Nev.	2	1	—	—	—	—	14	13	4	5
PACIFIC	46	26	4	7	—	1	238	302	126	102
Wash.	6	2	—	—	—	—	6	9	1	3
Oreg.	36	19	—	—	—	—	6	32	4	7
Calif.	—	5	4	7	—	1	201	225	118	85
Alaska	1	—	—	—	—	—	5	15	1	—
Hawaii	3	—	—	—	—	—	20	21	2	7
Guam	—	—	—	—	—	—	—	—	—	2
P.R.	—	—	6	1	N	N	2	9	—	—
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 29, 2005, and January 31, 2004 (4th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	270	428	142	256	35	54	281	513	7	42
NEW ENGLAND	13	25	—	—	4	7	17	8	—	—
Maine	1	1	N	N	—	—	—	—	—	—
N.H.	1	3	—	—	—	N	—	1	—	—
Vt.	1	—	—	—	—	—	—	—	—	—
Mass.	10	21	—	—	4	7	17	3	—	—
R.I.	—	—	—	—	—	—	—	1	—	—
Conn.	—	—	—	—	U	U	—	3	—	—
MID. ATLANTIC	54	65	15	16	4	5	28	64	1	7
Upstate N.Y.	25	14	2	5	1	2	1	—	1	1
N.Y. City	3	20	U	U	U	U	16	42	—	2
N.J.	6	12	N	N	1	—	9	12	—	3
Pa.	20	19	13	11	2	3	2	10	—	1
E.N. CENTRAL	25	106	32	78	11	18	9	49	—	8
Ohio	12	27	27	68	9	13	3	13	—	—
Ind.	1	—	5	10	2	3	3	5	—	1
Ill.	—	29	—	—	—	—	3	20	—	2
Mich.	12	38	—	N	—	N	—	8	—	5
Wis.	—	12	N	N	—	2	—	3	—	—
W.N. CENTRAL	14	22	3	1	3	3	3	12	—	—
Minn.	—	—	—	—	—	—	—	1	—	—
Iowa	N	N	N	N	—	N	—	1	—	—
Mo.	7	7	3	1	—	1	3	9	—	—
N. Dak.	1	1	—	—	1	—	—	—	—	—
S. Dak.	3	3	—	—	—	—	—	—	—	—
Nebr.	3	3	—	—	1	1	—	1	—	—
Kans.	—	8	N	N	1	1	—	—	—	—
S. ATLANTIC	69	78	68	119	8	6	103	119	—	7
Del.	—	—	—	—	—	N	—	1	—	—
Md.	27	15	—	—	8	5	20	23	—	2
D.C.	—	—	—	—	—	1	7	3	—	—
Va.	2	4	N	N	—	N	4	3	—	1
W. Va.	—	1	—	4	—	—	—	1	—	—
N.C.	9	11	N	N	U	U	20	7	—	—
S.C.	—	1	—	9	—	N	4	5	—	2
Ga.	12	24	15	41	—	N	—	18	—	—
Fla.	19	22	53	65	—	N	48	58	—	2
E.S. CENTRAL	5	23	6	12	—	—	24	26	2	2
Ky.	1	9	—	3	N	N	—	5	—	—
Tenn.	4	14	6	9	—	N	7	9	1	1
Ala.	—	—	—	—	—	N	16	7	1	1
Miss.	—	—	—	—	—	—	1	5	—	—
W.S. CENTRAL	6	33	8	9	2	7	53	79	3	13
Ark.	2	—	3	1	—	—	3	5	—	—
La.	—	1	5	8	1	2	6	14	—	—
Okla.	4	3	N	N	1	1	7	3	—	2
Tex.	—	29	N	N	—	4	37	57	3	11
MOUNTAIN	58	27	6	5	3	8	16	27	1	1
Mont.	—	—	—	—	—	—	—	—	—	—
Idaho	—	1	N	N	—	N	—	3	—	—
Wyo.	1	2	—	2	—	—	—	1	—	—
Colo.	22	10	N	N	3	8	—	4	—	—
N. Mex.	4	12	—	2	—	—	—	8	—	1
Ariz.	30	—	N	N	—	N	11	8	1	—
Utah	1	2	5	1	—	—	—	1	—	—
Nev.	—	—	1	—	—	—	5	2	—	—
PACIFIC	26	49	4	16	—	—	28	129	—	4
Wash.	N	N	N	N	N	N	4	8	—	—
Oreg.	N	N	N	N	—	N	—	3	—	—
Calif.	13	35	N	N	—	N	24	118	—	4
Alaska	—	—	—	—	—	N	—	—	—	—
Hawaii	13	14	4	16	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	3	10	—	—
V.I.	—	—	—	—	—	—	—	2	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

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

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending January 29, 2005, and January 31, 2004 (4th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	220	600	10	20	974	1,287	—	1	—
NEW ENGLAND	3	10	—	2	36	89	—	—	—
Maine	—	—	—	—	34	5	—	—	—
N.H.	1	—	—	—	—	—	—	—	—
Vt.	—	—	—	—	1	84	—	—	—
Mass.	2	3	—	2	1	—	—	—	—
R.I.	—	3	—	—	—	—	—	—	—
Conn.	—	4	—	—	—	—	—	—	—
MID. ATLANTIC	86	94	2	6	54	4	—	—	—
Upstate N.Y.	2	2	—	—	—	—	—	—	—
N.Y. City	53	81	—	2	—	—	—	—	—
N.J.	16	11	1	3	—	—	—	—	—
Pa.	15	—	1	1	54	4	—	—	—
E.N. CENTRAL	56	45	—	2	502	627	—	—	—
Ohio	13	8	—	1	106	199	—	—	—
Ind.	5	13	—	—	N	N	—	—	—
Ill.	33	19	—	—	—	—	—	—	—
Mich.	—	—	—	1	383	368	—	—	—
Wis.	5	5	—	—	13	60	—	—	—
W.N. CENTRAL	11	11	—	—	6	15	—	—	—
Minn.	2	8	—	—	—	—	—	—	—
Iowa	—	—	—	—	N	N	—	—	—
Mo.	8	2	—	—	—	—	—	—	—
N. Dak.	—	—	—	—	—	7	—	—	—
S. Dak.	—	—	—	—	6	8	—	—	—
Nebr.	1	—	—	—	—	—	—	—	—
Kans.	—	1	—	—	—	—	—	—	N
S. ATLANTIC	11	135	3	—	114	154	—	—	—
Del.	—	2	—	—	—	—	—	—	—
Md.	—	4	1	—	—	—	—	—	—
D.C.	—	—	—	—	—	2	—	—	—
Va.	—	—	—	—	—	—	—	—	—
W. Va.	4	1	—	—	111	144	—	—	N
N.C.	—	—	1	—	—	N	—	—	—
S.C.	7	1	—	—	3	8	—	—	—
Ga.	—	55	—	—	—	—	—	—	—
Fla.	—	72	1	—	—	—	—	—	—
E.S. CENTRAL	—	20	—	—	—	—	—	—	—
Ky.	—	—	—	—	N	N	—	—	—
Tenn.	—	7	—	—	—	—	—	—	—
Ala.	—	11	—	—	—	—	—	—	—
Miss.	—	2	—	—	—	—	—	—	—
W.S. CENTRAL	10	146	—	4	53	314	—	1	—
Ark.	5	2	—	—	—	—	—	1	—
La.	—	—	—	—	2	2	—	—	—
Okla.	5	4	—	—	—	—	—	—	—
Tex.	—	140	—	4	51	312	—	—	—
MOUNTAIN	3	10	—	2	209	84	—	—	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	10	9	—	—	—
Colo.	—	4	—	—	160	9	—	—	—
N. Mex.	—	1	—	—	4	6	—	—	—
Ariz.	2	1	—	—	—	—	—	—	—
Utah	1	4	—	1	35	60	—	—	—
Nev.	—	—	—	1	—	—	—	—	—
PACIFIC	40	129	5	4	—	—	—	—	—
Wash.	15	15	—	—	N	N	—	—	—
Oreg.	3	6	1	—	—	—	—	—	—
Calif.	9	101	3	3	—	—	—	—	—
Alaska	—	1	—	—	—	—	—	—	—
Hawaii	13	6	1	1	—	—	—	—	—
Guam	—	6	—	—	—	13	—	—	—
P.R.	—	—	—	—	4	27	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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

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

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

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending January 29, 2005 (4th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	533	407	98	15	7	6	76
Boston, Mass.	164	118	29	10	5	2	21
Bridgeport, Conn.	33	29	4	—	—	—	4
Cambridge, Mass.	29	24	5	—	—	—	7
Fall River, Mass.	42	36	5	1	—	—	9
Hartford, Conn.	52	38	12	1	—	1	8
Lowell, Mass.	29	20	9	—	—	—	6
Lynn, Mass.	9	5	3	1	—	—	2
New Bedford, Mass.	21	19	1	1	—	—	4
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	5	1	3	—	1	—	—
Springfield, Mass.	53	38	12	1	—	2	1
Waterbury, Conn.	39	33	6	—	—	—	6
Worcester, Mass.	57	46	9	—	1	1	8
MID. ATLANTIC	2,380	1,719	460	134	39	25	173
Albany, N.Y.	65	47	15	1	1	1	12
Allentown, Pa.	39	34	4	1	—	—	1
Buffalo, N.Y.	108	82	18	6	2	—	8
Camden, N.J.	U	U	U	U	U	U	U
Elizabeth, N.J.	31	22	7	2	—	—	8
Erie, Pa.	52	41	10	—	—	1	8
Jersey City, N.J.	46	31	12	2	—	1	—
New York City, N.Y.	1,106	810	203	66	18	6	67
Newark, N.J.	60	26	19	10	3	2	2
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	418	255	107	32	12	12	18
Pittsburgh, Pa.§	27	23	4	—	—	—	3
Reading, Pa.	27	20	6	—	1	—	3
Rochester, N.Y.	153	123	19	9	1	1	19
Schenectady, N.Y.	26	21	4	1	—	—	2
Scranton, Pa.	24	19	4	1	—	—	1
Syracuse, N.Y.	123	102	16	3	1	1	15
Trenton, N.J.	37	30	7	—	—	—	1
Utica, N.Y.	14	11	3	—	—	—	1
Yonkers, N.Y.	24	22	2	—	—	—	4
E.N. CENTRAL	2,331	1,557	541	137	47	48	186
Akron, Ohio	73	51	15	5	—	2	9
Canton, Ohio	44	33	10	—	—	1	4
Chicago, Ill.	374	243	93	25	9	3	26
Cincinnati, Ohio	90	54	21	6	2	7	8
Cleveland, Ohio	264	192	58	7	3	4	13
Columbus, Ohio	232	142	58	22	5	5	25
Dayton, Ohio	125	87	26	8	1	3	11
Detroit, Mich.	189	110	44	19	7	9	15
Evansville, Ind.	64	45	17	1	1	—	8
Fort Wayne, Ind.	61	37	19	2	3	—	5
Gary, Ind.	21	9	6	3	2	1	1
Grand Rapids, Mich.	81	62	11	5	—	3	10
Indianapolis, Ind.	204	133	58	9	3	1	7
Lansing, Mich.	63	49	13	1	—	—	8
Milwaukee, Wis.	143	83	39	12	5	4	13
Peoria, Ill.	56	38	13	2	2	1	9
Rockford, Ill.	59	52	4	1	1	1	5
South Bend, Ind.	45	37	6	—	1	1	3
Toledo, Ohio	143	100	30	9	2	2	6
Youngstown, Ohio	U	U	U	U	U	U	U
W.N. CENTRAL	488	322	120	23	11	12	35
Des Moines, Iowa	44	33	10	—	1	—	3
Duluth, Minn.	30	23	6	—	—	1	2
Kansas City, Kans.	5	3	1	—	1	—	—
Kansas City, Mo.	96	59	23	8	3	3	3
Lincoln, Nebr.	33	23	9	1	—	—	3
Minneapolis, Minn.	73	52	17	2	—	2	12
Omaha, Nebr.	U	U	U	U	U	U	U
St. Louis, Mo.	122	69	34	10	4	5	7
St. Paul, Minn.	71	52	15	2	2	—	5
Wichita, Kans.	14	8	5	—	—	1	—
S. ATLANTIC	1,289	814	313	97	34	31	96
Atlanta, Ga.	154	93	45	9	4	3	8
Baltimore, Md.	280	154	73	36	10	7	40
Charlotte, N.C.	117	73	27	8	1	8	10
Jacksonville, Fla.	U	U	U	U	U	U	U
Miami, Fla.	65	43	14	5	3	—	2
Norfolk, Va.	49	29	16	2	1	1	—
Richmond, Va.	65	42	17	3	3	—	2
Savannah, Ga.	85	51	27	4	2	1	5
St. Petersburg, Fla.	76	54	17	3	2	—	4
Tampa, Fla.	274	201	46	16	7	4	20
Washington, D.C.	100	59	25	8	1	7	3
Wilmington, Del.	24	15	6	3	—	—	2
E.S. CENTRAL	1,054	689	250	77	18	20	68
Birmingham, Ala.	219	151	50	10	1	7	16
Chattanooga, Tenn.	82	64	16	1	—	1	5
Knoxville, Tenn.	137	98	30	7	—	2	5
Lexington, Ky.	70	39	12	11	4	4	1
Memphis, Tenn.	179	109	50	15	3	2	14
Mobile, Ala.	138	89	29	14	2	4	7
Montgomery, Ala.	88	51	31	3	3	—	7
Nashville, Tenn.	141	88	32	16	5	—	13
W.S. CENTRAL	1,652	1,072	364	137	39	40	120
Austin, Tex.	98	61	21	12	1	3	10
Baton Rouge, La.	27	21	3	2	1	—	—
Corpus Christi, Tex.	57	37	12	6	—	2	3
Dallas, Tex.	232	136	58	21	8	9	18
El Paso, Tex.	135	107	15	8	1	4	9
Ft. Worth, Tex.	159	110	27	13	5	4	9
Houston, Tex.	426	244	125	40	8	9	36
Little Rock, Ark.	U	U	U	U	U	U	U
New Orleans, La.	63	36	15	12	—	—	—
San Antonio, Tex.	239	168	45	13	11	2	18
Shreveport, La.	55	38	12	2	1	2	5
Tulsa, Okla.	161	114	31	8	3	5	12
MOUNTAIN	963	645	219	57	24	16	75
Albuquerque, N.M.	144	101	30	11	1	1	12
Boise, Idaho	U	U	U	U	U	U	U
Colo. Springs, Colo.	72	53	9	4	5	1	3
Denver, Colo.	104	66	22	9	3	4	9
Las Vegas, Nev.	274	183	68	14	6	2	17
Ogden, Utah	29	19	7	1	2	—	2
Phoenix, Ariz.	182	116	42	12	5	6	9
Pueblo, Colo.	38	31	5	—	2	—	7
Salt Lake City, Utah	120	76	36	6	—	2	16
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	2,020	1,443	400	108	34	35	304
Berkeley, Calif.	16	15	—	1	—	—	3
Fresno, Calif.	172	114	44	10	2	2	13
Glendale, Calif.	U	U	U	U	U	U	U
Honolulu, Hawaii	59	48	8	2	1	—	1
Long Beach, Calif.	94	64	21	5	2	2	8
Los Angeles, Calif.	264	191	39	24	3	7	30
Pasadena, Calif.	103	76	17	5	2	3	12
Portland, Oreg.	165	122	29	9	2	3	17
Sacramento, Calif.	243	185	45	8	5	—	26
San Diego, Calif.	164	115	35	10	2	2	9
San Francisco, Calif.	133	87	32	8	2	4	133
San Jose, Calif.	248	179	53	8	5	3	21
Santa Cruz, Calif.	U	U	U	U	U	U	U
Seattle, Wash.	170	119	36	7	5	3	12
Spokane, Wash.	63	49	8	3	1	2	10
Tacoma, Wash.	126	79	33	8	2	4	9
TOTAL	12,710¶	8,668	2,765	785	253	233	1,133

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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