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The Great American Smokeout, November 17, 1994

Since 1977, the American Cancer Society (ACS) has sponsored the Great American Smokeout to foster community-based activities that encourage cigarette smokers to stop smoking for at least 24 hours. These activities include distributing materials to schools, hospitals, businesses, and other organizations that discourage tobacco use; encouraging restaurants and other businesses to be smoke-free for the day; and promoting media coverage of special events at the national and community level.

During the 1993 Great American Smokeout, an estimated 2.4 million (6%) smokers reported quitting, and 6.0 million (15%) reported reducing the number of cigarettes smoked on that day (*1*). In addition, approximately 1.6 million (4%) smokers quit smoking for 1–10 days after the Smokeout (*1*). Approximately 10.7 million packs of cigarettes were not smoked, resulting in an estimated $18.1 million not spent on cigarettes (*1–3*).

This year, the Great American Smokeout will be on Thursday, November 17. The goal of the Smokeout is to promote and encourage smoking cessation by helping smokers realize that if they can quit for 1 day, they can quit permanently. Information is available from local chapters of the ACS; for telephone numbers of these local chapters, telephone (800) 227-2345 or (404) 329-7576.

Reported by: American Cancer Society, Atlanta. Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

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Current Trends

Attitudes Toward Smoking Policies in Eight States — United States, 1993

Legislation regulating smoking has at least two functions: to protect nonsmokers from the adverse health effects of environmental tobacco smoke and to prevent young persons from smoking (*1*). To characterize public attitudes toward such legislation, the National Cancer Institute (NCI) and the American Cancer Society used the Behavioral Risk Factor Surveillance System (BRFSS) to survey persons in eight states* during July–August 1993 as part of the American Stop Smoking Intervention Study for Cancer Prevention (*2*). This report summarizes the survey findings.

BRFSS provides state-specific estimates of the prevalence of selected risk behaviors to be used for planning, implementing, and evaluating public health programs. Each month, state health departments use survey sampling and random-digit–dialing techniques (*3*) to conduct telephone interviews with adults aged ≥18 years. During July–August 1993, a total of 20 questions were added to BRFSS in the eight states to assess support for policies related to cigarette smoking (*4*). To estimate the state population prevalences (*5*), data were weighted to the age-, race-, and sex-specific population counts from the most current census (or intercensal estimate) in each state and for the respondent's probability of selection. SUDAAN (*6*) was used to calculate the 95% confidence intervals for the prevalence estimates. For this study, sample sizes ranged from 252 to 431 per state; state-specific response rates for completed interviews ranged from 63.6% to 93.3%. Current smokers were defined as persons who had smoked at least 100 cigarettes and who reported being a smoker at the time of the interview.

Environmental Tobacco Smoke

Respondents were given a list of public locations and asked whether, for each setting, smoking should be allowed in all areas (do not restrict), allowed in some areas (restrict), or not allowed at all (ban). Public opinion about whether to restrict or ban smoking varied across settings (Table 1): support was greater for banning smoking in fast-food restaurants (range: 42.5%–63.0%) and at indoor sporting events (55.4%–66.9%) than in sit-down restaurants (39.5%–50.6%) and indoor malls (33.4%–56.5%). Overall, smokers were less likely than nonsmokers to support banning smoking in the different locations.

Preventing Teenagers from Smoking

Respondents were given a list of five strategies that might prevent teenagers from smoking and asked whether they believed the strategies were not at all effective, somewhat effective, or very effective. Each of the strategies was believed to be effective (i.e., somewhat or very) by most respondents (Table 2): in particular, 65.3%–77.8% of respondents believed that banning all smoking inside and outside school property would be an effective strategy. Most respondents (79.1%–89.6%) favored a ban on smoking inside school buildings that applies to students, visitors, and teachers; 66.2%–85.1% of respondents favored a ban on the use of any tobacco product (includ-

*Louisiana, Missouri, New Jersey, Ohio, Oklahoma, South Carolina, Texas, and Washington.

TABLE 1. Percentage of persons* who favored restricting or banning† smoking in selected locations — eight states, United States, 1993

State	Sample size	Fast-food restaurant				Sit-down restaurant				Indoor malls				Indoor sporting events			
		Restrict		Ban		Restrict		Ban		Restrict		Ban		Restrict		Ban	
		%	(95% CI§)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Louisiana	275	47.9	(±6.3)	46.8	(±6.2)	49.1	(±6.3)	44.3	(±6.4)	47.2	(±6.3)	44.0	(±6.1)	34.3	(±5.3)	58.2	(±5.4)
Missouri	254	46.4	(±7.0)	49.0	(±6.9)	55.5	(±6.9)	39.5	(±6.8)	52.0	(±7.5)	39.4	(±7.2)	35.6	(±6.8)	57.8	(±6.6)
New Jersey	261	41.0	(±6.8)	51.0	(±7.0)	49.0	(±7.0)	44.8	(±7.0)	34.1	(±6.3)	46.9	(±7.1)	29.7	(±6.1)	56.4	(±6.9)
Ohio	258	46.8	(±6.9)	50.2	(±6.9)	55.1	(±6.9)	41.2	(±6.8)	56.2	(±6.8)	33.4	(±6.5)	33.6	(±6.4)	55.4	(±6.8)
Oklahoma	252	52.6	(±6.9)	42.5	(±7.0)	54.3	(±6.8)	42.3	(±6.8)	57.5	(±6.8)	35.5	(±7.1)	35.2	(±7.5)	60.8	(±7.7)
South Carolina	371	36.8	(±5.5)	56.8	(±5.6)	46.0	(±5.9)	50.0	(±5.8)	48.4	(±6.2)	45.6	(±6.3)	25.1	(±5.1)	66.9	(±5.2)
Texas	405	41.4	(±5.4)	50.5	(±6.0)	50.0	(±6.2)	45.8	(±5.8)	46.9	(±6.1)	45.3	(±6.0)	34.1	(±5.6)	57.0	(±6.3)
Washington	431	33.1	(±4.9)	63.0	(±5.0)	45.4	(±5.1)	50.6	(±5.1)	39.0	(±5.0)	56.5	(±5.1)	29.1	(±4.6)	66.8	(±4.8)

* Aged ≥18 years.
† Response categories included: allowed in all areas (do not restrict), allowed in some areas (restrict), not allowed at all (ban), don't know, and refused to answer.
§ Confidence interval.

TABLE 2. Percentage of persons* who believed that selected strategies would be somewhat or very effective† in keeping teenagers from smoking cigarettes — eight states, United States, 1993

State	Sample size	Ban smoking on school property		Ban all cigarette advertising		Strongly enforce laws		Ban all vending machines		Increase price of cigarettes	
		%	(95% CI§)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Louisiana	275	75.8	(±5.2)	71.9	(±6.1)	85.5	(±4.3)	76.0	(±5.6)	67.0	(±6.4)
Missouri	254	65.3	(±6.2)	54.3	(±7.0)	77.6	(±5.7)	69.3	(±6.2)	62.0	(±6.5)
New Jersey	261	76.4	(±6.2)	70.2	(±6.4)	77.1	(±5.8)	75.6	(±5.7)	62.5	(±6.6)
Ohio	258	72.1	(±6.2)	58.0	(±6.8)	78.8	(±5.9)	75.7	(±5.8)	59.0	(±6.8)
Oklahoma	252	77.8	(±6.2)	70.2	(±6.1)	80.9	(±5.4)	79.3	(±5.5)	55.4	(±6.7)
South Carolina	371	75.8	(±5.1)	60.6	(±5.4)	78.8	(±4.9)	72.9	(±5.4)	58.3	(±5.6)
Texas	405	73.6	(±4.8)	64.9	(±5.9)	77.4	(±4.9)	73.3	(±5.5)	63.0	(±5.8)
Washington	431	72.0	(±4.6)	71.0	(±4.8)	84.3	(±3.7)	78.7	(±4.4)	67.7	(±4.8)

* Aged ≥18 years.
† Response categories included: not at all effective, somewhat effective, very effective, don't know, and refused to answer.
§ Confidence interval.

Smoking Policies — Continued

ing cigarettes, cigars, pipes, and chewing tobacco) at school-sponsored events (e.g., football games and field trips).

Banning all cigarette advertising was considered to be an effective strategy in reducing smoking among teenagers by 54.3%–71.9% of respondents (Table 2). In addition, 49.8%–66.5% of respondents believed that tobacco advertising influences persons to buy tobacco products. The proportion of respondents who supported a ban on advertising tobacco products at sports stadiums and arenas ranged from 67.7% to 78.2%, and the proportion who supported a ban on advertising tobacco products on billboards ranged from 62.6% to 77.2%.

High proportions of respondents believed in the effectiveness of selected measures to limit teenager's access to tobacco products, including stronger enforcement of laws prohibiting the sale of cigarettes to minors (77.1% to 85.5%), banning all cigarette vending machines (69.3% to 79.3%), and increasing the price of a pack of cigarettes (55.4% to 67.7%) (Table 2). Most respondents (54.1% to 68.8%) favored increasing the tax on a pack of cigarettes $1 per pack; however, many (47.9% to 66.1%) believed that such an increase would be unfair to cigarette smokers. Belief in the effectiveness of teenage access restrictions was high among both smokers (41.8% to 79.3%) and nonsmokers (60.2% to 88.4%).

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Editorial Note: The findings in this report are consistent with previous studies that have documented public support for regulating tobacco use in public places (*2*). For example, in 1987, 72% of adults in seven Minnesota communities favored prohibiting smoking in public buildings (*7*). In 1989, findings from a survey conducted for the NCI Community Intervention Trial for Smoking Cessation (COMMIT) (*8*) indicated that among persons in 10 communities, 62%–100% supported restricting or banning smoking in selected locations. Most favored restricting smoking in five locations (bars, restaurants, bowling alleys, private worksites, and government buildings) and banning it in three other locations (indoor sports arenas, hospitals, and doctors' offices).

These findings also confirm increasing support for banning smoking in restaurants (*9*). For example, 16.2% to 32.3% of respondents in the COMMIT study (*8*) favored banning smoking in restaurants, compared with 39.5% to 63.0% of BRFSS respondents. In addition, the BRFSS findings distinguish between fast-food and sit-down restaurants. Support for banning smoking in fast-food restaurants was stronger than support for banning smoking in sit-down restaurants, possibly because of the perception that fast-food restaurants tend to cater to and be frequented by children and adolescents (*2*).

Previous studies (*2*) have documented high levels of support for measures to prevent teenagers from smoking (*7,10*). The BRFSS findings indicate widespread belief in the effectiveness of such measures and suggest broad support for banning the use of any tobacco product at school-sponsored events. Finally, the BRFSS findings indicate support for recommendations issued by the Institute of Medicine (*2*), which include the need to 1) adopt and enforce tobacco-free policies in all public locations,

Smoking Policies — Continued

especially those that cater to and are frequented by children and youths; 2) adopt tobacco-free policies that apply to persons attending events sponsored by organizations involved with youths; 3) restrict the advertising and promotion of tobacco products; and 4) increase the excise tax on cigarettes.

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Health Objectives for the Nation

Cigarette Smoking Among Women of Reproductive Age — United States, 1987–1992

Women who smoke cigarettes are at increased risk for lung cancer, chronic obstructive pulmonary disease, and complications of oral contraceptive use. During pregnancy, cigarette smoking increases the risks for a low birthweight infant and infant mortality. A national health objective for the year 2000 is to reduce cigarette smoking among women of reproductive age (i.e., 18–44 years) to a prevalence of no more than 12% (objective 3.4h) (*1*). This goal is substantially lower than the estimated baseline prevalence of 29% measured by CDC's 1987 National Health Interview Survey (NHIS). To characterize recent trends in cigarette smoking and monitor progress toward the year 2000 objective, data from the NHIS for 1987 through 1992 were analyzed for women aged 18–44 years.

The NHIS is an ongoing household survey conducted annually among a nationally representative sample (n=120,000) of the civilian, noninstitutionalized U.S. population. Information about tobacco use was collected through personal interviews with an adult (aged ≥18 years) randomly selected from each surveyed household (n=40,000).* Each year during 1987–1992, the sample sizes for the target study group that was

*Health-topic supplements: Cancer Control and Epidemiology, 1987; Occupational Health, 1988; Diabetes Risk Factors, 1989; Health Promotion and Disease Prevention, 1990 and 1991; and Cancer Control, 1992.

Cigarette Smoking — Continued

TABLE 1. Prevalence of current smoking* among women aged 18–44 years — United States, National Health Interview Survey,† 1987–1992

	1987 (n=13,809)		1988 (n=13,746)		1989 (n=6,502)		1990 (n=12,954)		1991 (n=13,439)		1992 (n=3,717)	
Characteristic	**%**	**(95% CI§)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**
Race (Age group [yrs])												
White												
18–24	27.8	(±2.2)	27.5	(±2.1)	26.0	(±3.0)	25.4	(±2.2)	25.2	(±2.1)	27.2	(±4.2)
25–34	31.8	(±1.5)	31.0	(±1.5)	30.9	(±2.3)	28.5	(±1.5)	28.4	(±1.5)	30.0	(±3.0)
35–44	29.2	(±1.5)	28.3	(±1.5)	26.2	(±2.3)	25.0	(±1.5)	26.8	(±1.5)	27.9	(±2.8)
Total	**30.0**	**(±1.0)**	**29.2**	**(±1.0)**	**28.1**	**(±1.5)**	**26.5**	**(±1.0)**	**27.1**	**(±1.0)**	**28.6**	**(±1.9)**
Black												
18–24	20.4	(±4.4)	21.8	(±4.1)	18.0	(±5.5)	10.0	(±2.8)	11.9	(±3.2)	5.9	(±4.2)
25–34	35.8	(±3.4)	37.2	(±3.6)	28.8	(±4.8)	29.1	(±3.3)	32.5	(±3.6)	29.0	(±6.9)
35–44	35.3	(±4.3)	27.6	(±3.8)	31.4	(±5.3)	25.5	(±3.6)	35.5	(±4.0)	27.9	(±7.3)
Total	**31.2**	**(±2.5)**	**30.0**	**(±2.3)**	**26.6**	**(±3.3)**	**22.8**	**(±2.1)**	**28.1**	**(±2.4)**	**22.6**	**(±4.1)**
Ethnicity												
Hispanic	20.0	(±2.7)	20.4	(±2.5)	21.9	(±4.1)	16.9	(±2.6)	16.5	(±2.1)	18.9	(±4.2)
Non-Hispanic	30.6	(±1.0)	29.7	(±0.9)	28.1	(±1.4)	26.6	(±1.0)	27.9	(±1.0)	27.8	(±1.8)
Education (yrs)												
<12	46.5	(±2.7)	45.9	(±2.7)	42.7	(±3.9)	40.6	(±2.9)	40.5	(±2.7)	40.2	(±4.8)
12	33.7	(±1.4)	32.7	(±1.4)	31.2	(±2.1)	31.1	(±1.5)	32.0	(±1.5)	31.9	(±3.0)
13–15	24.7	(±1.6)	24.7	(±1.6)	25.9	(±2.5)	20.6	(±1.5)	22.8	(±1.7)	24.0	(±3.1)
≥16	14.2	(±1.5)	13.9	(±1.4)	12.0	(±2.0)	10.5	(±1.3)	12.0	(±1.4)	12.5	(±2.4)
Socioeconomic status¶												
At/Above poverty level	28.3	(±1.0)	27.2	(±0.9)	26.4	(±1.4)	23.6	(±0.9)	25.3	(±0.9)	24.7	(±1.9)
Below poverty level	37.0	(±3.1)	38.0	(±2.7)	34.9	(±3.9)	36.1	(±3.1)	32.7	(±3.0)	40.0	(±4.9)
Unknown	31.1	(±4.0)	31.9	(±4.2)	28.9	(±5.2)	30.4	(±3.8)	31.0	(±3.3)	24.7	(±5.6)
Total	**29.6**	**(±0.9)**	**28.8**	**(±0.9)**	**27.6**	**(±1.3)**	**25.6**	**(±0.9)**	**26.7**	**(±0.9)**	**26.9**	**(±1.7)**

*Smoked at least 100 cigarettes and currently smoking. This analysis excludes persons with unknown smoking status.

†Health topic supplements: Cancer Control and Epidemiology, 1987; Occupational Health, 1988; Diabetes Risk Factors, 1989; Health Promotion and Disease Prevention, 1990 and 1991; and Cancer Control, 1992.

§Confidence interval.

¶Poverty statistics are based on a definition originated by the Social Security Administration in 1964, subsequently modified by federal interagency committees in 1969 and 1980, and prescribed by the Office of Management and Budget as the standard to be used by federal agencies for statistical purposes.

asked tobacco-use questions (i.e., women aged 18–44 years) ranged from 3717 to 13,809. Respondents were asked if they ever smoked 100 cigarettes during their lifetimes and whether they currently smoked (*2*). Annual prevalence estimates and 95% confidence intervals (CIs) were calculated using SUDAAN (*3*). Data were weighted to provide national estimates.

During 1987–1992, the prevalence of cigarette smoking among reproductive-aged women in the United States declined 3.7%, from 29.6% in 1987 to 26.9% in 1992 (Table 1). The prevalence declined substantially from 1987 (29.6%) to 1990 (25.6%) but increased slightly from 1991 (26.7%) to 1992 (26.9%). In 1992, an estimated 14.3 million U.S. women aged 18–44 years were smokers.

Cigarette Smoking — Continued

Smoking prevalence was inversely related to level of education and was consistently highest among women with less than a high school education (Table 1). Among women with less than a high school education, smoking prevalence decreased from 46.5% in 1987 to 40.6% in 1990; in 1992, the rate (40.2%) remained unchanged. For women with 16 or more years of education, smoking prevalence declined from 14.2% in 1987 to 10.5% in 1990; however, in 1992, the rate increased to 12.5%.

During 1987–1992, smoking prevalence rates varied by race. During 1987–1990, race-specific declines in smoking prevalence occurred among both black and white women (Table 1). For black women, the rate declined from 31.2% in 1987 to 22.8% in 1990, but increased significantly to 28.1% in 1991 before declining to 22.6% in 1992. For white women, the rate declined from 30.0% in 1987 to 26.5% in 1990, then increased to 27.1% in 1991 and 28.6% in 1992.

Among women aged 18–24 years, smoking prevalence among black women declined dramatically during 1987–1992, from 21.8% to 5.9%. In comparison, among white women, the prevalence was unchanged, 27.8% and 27.2% in 1987 and 1992, respectively.

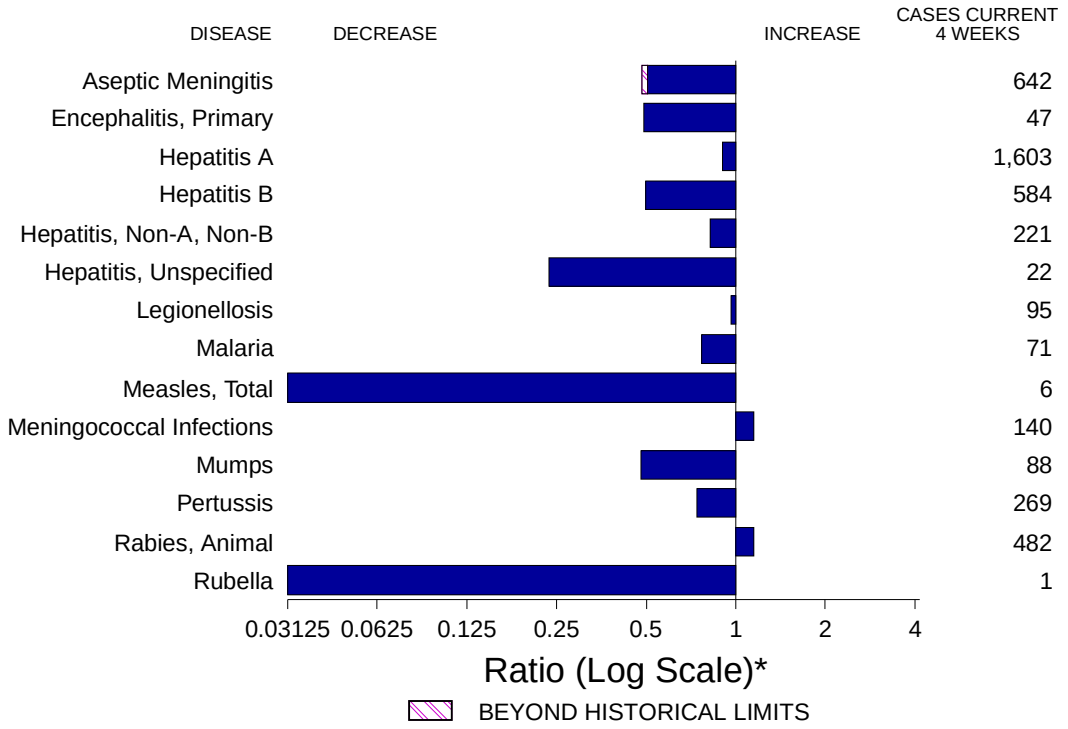
Reported by: Div of Health Interview Statistics, National Center for Health Statistics; Epidemiology Br, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: In 1965 (the first year the NHIS was used to monitor tobacco use), 33% of U.S. women were cigarette smokers (*4*). Since then, however, the health risks of cigarette smoking have been widely publicized, and the prevalence of cigarette smoking among women has declined gradually. During 1974–1985, smoking prevalence among women decreased at a rate of 0.3% per year, one third the rate for men (*5*). While smoking rates declined among women, death rates for lung cancer increased; in 1987, lung cancer surpassed breast cancer as the leading cause of cancer death among U.S. women. By 1990, 25.6% of women aged 18–44 years were current smokers.

Two important findings in this report regarding cigarette smoking by women during 1987–1992 are that 1) rates of cigarette smoking for young black women declined substantially during this period, and 2) after a 25-year decline, rates among women of other races and older women of reproductive age stopped declining in 1990. An important factor probably associated with the decline in smoking among younger black females was the decrease in rates of smoking reported by black female high school seniors during 1985–1989 (*6*). In addition, cigarette smoking has been suggested to have less functional value for black women (i.e., they may be less likely to use smoking for weight control or social acceptability) (*7*). However, reasons for the increase in smoking among black women aged 18–44 years in 1991 only have not been determined. At least two factors have been suggested to account for the reduction or termination of declines in cigarette smoking among women of reproductive age: first, tobacco companies used advertising campaigns (*8*) and other approaches to target women, and second, the increase in rates of smoking initiation by young adolescent females during the early 1970s resulted in a greater number of adult women smokers (*9*).

(Continued on page 797)

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending October 29, 1994, with historical data — United States



*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 — cases of specified notifiable diseases, United States, cumulative, week ending October 29, 1994 (43rd Week)

	Cum. 1994		Cum. 1994
AIDS*	61,173	Measles: imported	171
Anthrax	-	indigenous	683
Botulism: Foodborne	45	Plague	14
Infant	61	Poliomyelitis, Paralytic§	1
Other	7	Psittacosis	33
Brucellosis	71	Rabies, human	1
Cholera	27	Syphilis, primary & secondary	17,669
Congenital rubella syndrome	3	Syphilis, congenital, age < 1 year¶	1,123
Diphtheria	1	Tetanus	31
Encephalitis, post-infectious	92	Toxic shock syndrome	149
Gonorrhea	323,712	Trichinosis	30
Haemophilus influenzae (invasive disease)†	953	Tuberculosis	17,944
Hansen Disease	96	Tularemia	78
Leptospirosis	26	Typhoid fever	363
Lyme Disease	9,205	Typhus fever, tickborne (RMSF)	387

*Updated monthly to the Division of HIV/AIDS, National Center for Infectious Diseases; last update September 27, 1994.
†Of 907 cases of known age, 251 (28%) were reported among children less than 5 years of age.
§The remaining 5 suspected cases with onset in 1994 have not yet been confirmed. In 1993, 3 of 10 suspected cases were confirmed. Two of the confirmed cases of 1993 were vaccine-associated and one was classified as imported.
¶Total reported to the Division of Sexually Transmitted Diseases and HIV Prevention, National Center for Prevention Services, through second quarter 1994.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending October 29, 1994, and October 30, 1993 (43rd Week)

Reporting Area	AIDS*	Aseptic Meningitis	Encephalitis		Gonorrhea		Hepatitis (Viral), by type				Legionellosis	Lyme Disease
			Primary	Post-infectious			A	B	NA,NB	Unspecified		
	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1993	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994
UNITED STATES	61,173	6,559	544	92	323,712	328,166	18,689	9,507	3,595	353	1,310	9,205
NEW ENGLAND	2,251	251	16	4	7,221	6,315	243	264	114	15	70	2,309
Maine	71	28	3	-	77	70	23	11	-	-	5	17
N.H.	46	26	-	2	92	60	14	20	8	-	-	24
Vt.	29	27	2	-	31	22	8	-	-	-	-	13
Mass.	1,126	72	9	1	2,698	2,537	91	161	86	13	54	209
R.I.	202	98	2	1	390	354	21	7	20	2	11	372
Conn.	777	-	-	-	3,933	3,272	86	65	-	-	-	1,674
MID. ATLANTIC	18,266	751	47	16	36,841	38,062	1,388	1,181	386	9	221	5,622
Upstate N.Y.	1,722	353	27	2	8,590	8,069	452	313	188	5	55	3,430
N.Y. City	10,514	122	7	5	13,353	10,337	562	287	1	-	10	23
N.J.	4,205	-	-	-	4,164	4,356	235	301	166	-	38	1,156
Pa.	1,825	276	13	9	10,734	15,300	139	280	31	4	118	1,013
E.N. CENTRAL	4,776	1,227	138	22	61,206	69,125	1,852	928	256	8	390	108
Ohio	870	323	50	4	17,826	18,685	783	139	20	-	167	65
Ind.	479	174	10	1	7,247	7,068	307	158	9	-	101	14
Ill.	2,354	287	44	5	15,437	22,818	356	184	51	3	22	4
Mich.	780	436	30	12	15,214	14,995	251	329	173	5	71	25
Wis.	293	7	4	-	5,482	5,559	155	118	3	-	29	-
W.N. CENTRAL	1,244	347	23	6	17,367	17,644	953	544	78	10	83	233
Minn.	300	21	2	-	2,792	1,941	204	53	20	1	1	163
Iowa	88	105	1	1	1,306	1,259	56	24	9	9	29	15
Mo.	566	133	7	4	9,995	10,474	474	415	27	-	29	36
N. Dak.	22	12	3	-	18	44	5	-	-	-	4	-
S. Dak.	12	2	2	-	169	223	33	2	-	-	1	-
Nebr.	69	15	4	1	-	484	93	21	8	-	14	9
Kans.	187	59	4	-	3,087	3,219	88	29	14	-	5	10
S. ATLANTIC	14,441	1,257	131	27	89,614	83,932	1,189	1,974	539	41	304	699
Del.	213	34	1	-	1,624	1,262	16	5	1	-	26	70
Md.	2,356	215	20	4	14,643	13,546	172	351	29	12	79	274
D.C.	1,089	47	-	1	6,100	4,284	19	47	1	-	10	7
Va.	877	252	28	6	11,179	9,996	152	112	22	6	8	121
W. Va.	54	29	41	-	669	554	16	34	30	-	3	23
N.C.	931	204	40	1	23,551	20,765	114	237	52	-	24	76
S.C.	996	29	-	-	11,043	8,907	35	28	8	-	15	7
Ga.	1,688	47	1	-	1,058	4,660	24	524	172	-	95	100
Fla.	6,237	400	-	15	19,747	19,958	641	636	224	23	44	21
E.S. CENTRAL	1,606	438	34	3	39,128	37,870	518	965	794	2	63	38
Ky.	248	149	14	1	4,221	4,034	131	65	24	-	9	21
Tenn.	539	88	12	-	12,908	11,727	239	832	755	1	36	11
Ala.	468	154	6	1	12,792	13,458	85	68	15	1	13	6
Miss.	351	47	2	1	9,207	8,651	63	-	-	-	5	-
W.S. CENTRAL	5,837	728	44	2	40,062	36,708	2,731	1,272	509	68	38	109
Ark.	206	39	-	-	5,514	6,142	159	22	7	1	7	8
La.	995	31	7	-	10,165	10,011	133	145	150	1	13	1
Okla.	215	-	-	-	3,169	3,905	305	281	293	3	11	62
Tex.	4,421	658	37	2	21,214	16,650	2,134	824	59	63	7	38
MOUNTAIN	1,751	275	11	3	7,885	9,525	3,539	521	374	53	71	17
Mont.	19	7	-	-	76	67	19	21	12	-	14	-
Idaho	49	6	-	-	74	153	299	68	65	1	1	3
Wyo.	16	4	2	2	74	69	24	23	145	-	5	4
Colo.	658	105	2	-	2,650	3,165	478	88	58	14	15	-
N. Mex.	123	16	-	-	862	792	960	176	46	11	3	8
Ariz.	493	53	1	-	2,618	3,345	1,096	37	12	11	8	-
Utah	102	47	2	1	231	367	468	60	23	6	6	1
Nev.	291	37	4	-	1,300	1,567	195	48	13	10	19	1
PACIFIC	11,001	1,285	100	9	24,388	28,985	6,276	1,858	545	147	70	70
Wash.	730	-	-	-	2,460	3,157	292	60	56	2	7	-
Oreg.	486	-	-	-	570	987	634	74	17	1	-	-
Calif.	9,604	1,162	97	8	20,095	23,828	5,110	1,687	467	141	59	70
Alaska	34	17	3	-	730	523	186	11	-	-	-	-
Hawaii	147	106	-	1	533	490	54	26	5	3	4	-
Guam	1	16	-	-	179	83	42	6	1	12	3	-
P.R.	1,759	27	1	3	384	419	70	312	129	11	-	-
V.I.	39	-	-	-	25	79	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	28	40	7	-	-	-	-	-
C.N.M.I.	-	-	-	-	43	72	6	1	-	-	-	-

N: Not notifiable U: Unavailable C.N.M.I.: Commonwealth of Northern Mariana Islands

*Updated monthly to the Division of HIV/AIDS, National Center for Infectious Diseases; last update September 27, 1994.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending October 29, 1994, and October 30, 1993 (43rd Week)

Reporting Area	Malaria	Measles (Rubeola)					Menin-gococcal Infections	Mumps		Pertussis			Rubella		
		Indigenous		Imported*		Total									
	Cum. 1994	1994	Cum. 1994	1994	Cum. 1994	Cum. 1993	Cum. 1994	1994	Cum. 1994	1994	Cum. 1994	Cum. 1993	1994	Cum. 1994	Cum. 1993
UNITED STATES	877	1	683	-	171	291	2,166	20	1,165	93	2,849	5,220	1	211	169
NEW ENGLAND	68	-	15	-	14	63	112	-	19	6	314	661	-	128	2
Maine	6	-	1	-	4	1	19	-	3	-	18	15	-	-	1
N.H.	3	-	1	-	-	2	6	-	4	-	53	144	-	-	-
Vt.	3	-	2	-	1	31	2	-	-	-	40	85	-	-	-
Mass.	29	-	3	-	6	18	49	-	3	5	166	343	-	124	1
R.I.	8	-	4	-	3	2	-	-	2	-	5	7	-	2	-
Conn.	19	-	4	-	-	9	36	-	7	1	32	67	-	2	-
MID. ATLANTIC	170	-	166	-	23	27	222	3	91	10	496	793	-	9	58
Upstate N.Y.	42	-	12	-	3	7	80	-	25	-	199	290	-	6	16
N.Y. City	63	-	11	-	3	11	11	-	11	-	106	60	-	1	22
N.J.	38	-	139	-	14	9	52	-	6	-	10	77	-	2	15
Pa.	27	-	4	-	3	-	79	3	49	10	181	366	-	-	5
E.N. CENTRAL	93	-	58	-	44	31	345	3	198	3	357	1,313	-	11	8
Ohio	15	-	15	-	2	9	97	2	60	1	133	379	-	-	1
Ind.	14	-	-	-	1	1	61	-	7	2	55	121	-	-	3
Ill.	39	-	17	-	39	9	106	-	89	-	76	390	-	3	1
Mich.	23	-	23	-	2	6	49	1	38	-	43	97	-	8	2
Wis.	2	-	3	-	-	6	32	-	4	-	50	326	-	-	1
W.N. CENTRAL	40	-	126	-	44	3	151	-	60	37	183	472	-	2	1
Minn.	13	-	-	-	-	-	14	-	5	34	85	270	-	-	-
Iowa	5	-	6	-	1	-	18	-	15	-	18	35	-	-	-
Mo.	12	-	118	-	42	1	80	-	33	1	40	125	-	2	1
N. Dak.	1	-	-	-	-	-	1	-	5	-	4	5	-	-	-
S. Dak.	-	-	-	-	-	-	8	-	-	-	17	8	-	-	-
Nebr.	3	-	1	-	1	-	9	-	2	-	7	13	-	-	-
Kans.	6	-	1	-	-	2	21	-	-	2	12	16	-	-	-
S. ATLANTIC	198	1	59	-	8	28	370	2	162	2	254	525	-	11	6
Del.	3	-	-	-	-	-	5	-	-	-	3	9	-	-	-
Md.	97	-	2	-	2	4	35	-	53	1	72	117	-	-	2
D.C.	14	-	-	-	-	-	4	-	-	-	8	13	-	-	-
Va.	29	-	1	-	2	4	59	-	38	-	36	58	-	-	-
W. Va.	-	-	36	-	-	-	12	-	3	-	4	8	-	-	-
N.C.	11	-	2	-	1	-	44	-	35	-	58	124	-	-	-
S.C.	4	-	-	-	-	-	25	-	7	-	13	65	-	-	-
Ga.	20	-	2	-	-	-	65	-	8	-	22	50	-	2	-
Fla.	20	1	16	-	3	20	121	2	18	1	38	81	-	9	4
E.S. CENTRAL	31	-	28	-	-	1	127	-	20	-	119	268	-	-	-
Ky.	11	-	-	-	-	-	34	-	-	-	59	36	-	-	-
Tenn.	10	-	28	-	-	-	29	-	8	-	22	164	-	-	-
Ala.	9	-	-	-	-	1	64	-	5	-	31	58	-	-	-
Miss.	1	-	-	-	-	-	-	-	7	-	7	10	-	-	-
W.S. CENTRAL	40	-	10	-	7	10	267	3	226	1	180	136	-	13	17
Ark.	3	-	-	-	1	-	39	-	1	-	27	10	-	-	-
La.	8	-	-	-	1	1	32	2	27	-	10	12	-	-	1
Okla.	6	-	-	-	-	-	27	-	23	1	26	72	-	4	1
Tex.	23	-	10	-	5	9	169	1	175	-	117	42	-	9	15
MOUNTAIN	27	-	149	-	17	6	137	3	141	22	344	373	-	6	11
Mont.	-	-	-	-	-	-	6	-	-	-	8	8	-	-	-
Idaho	2	-	1	-	-	-	16	-	7	2	47	93	-	-	2
Wyo.	1	-	-	-	-	-	7	-	2	-	-	1	-	-	-
Colo.	12	-	16	-	3	3	28	-	3	12	122	151	-	-	2
N. Mex.	3	-	-	-	-	-	13	N	N	1	21	36	-	1	-
Ariz.	3	-	1	-	1	2	43	3	92	6	122	50	-	-	2
Utah	4	-	131	-	2	-	18	-	23	1	21	30	-	4	4
Nev.	2	-	-	-	11	1	6	-	13	-	3	4	-	1	1
PACIFIC	210	-	72	-	14	122	435	6	248	12	602	679	1	31	66
Wash.	10	-	-	-	-	-	30	-	7	-	29	62	-	-	-
Oreg.	11	-	-	-	1	4	80	N	N	-	38	63	-	2	-
Calif.	171	-	56	-	9	96	316	6	221	11	514	543	1	24	37
Alaska	2	-	16	-	-	2	2	-	3	-	2	5	-	1	1
Hawaii	16	-	-	-	4	20	7	-	17	1	19	6	-	4	28
Guam	3	U	211	U	-	2	1	U	4	U	2	-	U	1	-
P.R.	2	-	13	-	-	350	15	-	2	-	1	8	-	-	-
V.I.	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	1	-	2	2	-	-	-
C.N.M.I.	1	U	26	U	-	1	-	U	2	U	-	1	U	-	-

*For measles only, imported cases include both out-of-state and international importations.
N: Not notifiable U: Unavailable † International § Out-of-state

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending October 29, 1994, and October 30, 1993 (43rd Week)

Reporting Area	Syphilis (Primary & Secondary)		Toxic-Shock Syndrome	Tuberculosis		Tula-remia	Typhoid Fever	Typhus Fever (Tick-borne) (RMSF)	Rabies, Animal
	Cum. 1994	Cum. 1993	Cum. 1994	Cum. 1994	Cum. 1993	Cum. 1994	Cum. 1994	Cum. 1994	Cum. 1994
UNITED STATES	17,669	21,995	149	17,944	18,631	78	363	387	6,240
NEW ENGLAND	178	323	4	445	425	1	21	15	1,596
Maine	4	5	1	23	21	-	-	-	-
N.H.	3	24	-	15	15	-	-	-	167
Vt.	-	1	1	6	5	-	-	-	120
Mass.	77	114	2	245	232	1	17	7	604
R.I.	12	13	-	37	50	-	1	-	44
Conn.	82	166	-	119	102	-	3	8	661
MID. ATLANTIC	1,174	1,952	25	3,549	3,853	1	99	17	1,640
Upstate N.Y.	156	186	13	288	587	1	11	6	1,205
N.Y. City	515	944	-	2,163	2,235	-	66	1	-
N.J.	192	268	-	654	480	-	17	4	230
Pa.	311	554	12	444	551	-	5	6	205
E.N. CENTRAL	2,351	3,563	27	1,752	1,919	8	68	44	53
Ohio	977	962	6	284	264	1	7	27	4
Ind.	202	314	2	160	185	2	7	5	12
Ill.	656	1,350	9	881	1,012	3	42	10	17
Mich.	246	500	10	377	382	1	5	2	12
Wis.	270	437	-	50	76	1	7	-	8
W.N. CENTRAL	984	1,354	23	479	412	35	1	34	174
Minn.	43	54	1	111	50	1	-	-	13
Iowa	56	58	8	51	43	-	-	1	75
Mo.	832	1,124	6	207	216	22	1	16	17
N. Dak.	-	4	1	7	6	1	-	-	9
S. Dak.	1	2	-	22	12	2	-	13	29
Nebr.	-	10	2	18	21	2	-	1	-
Kans.	52	102	5	63	64	7	-	3	31
S. ATLANTIC	5,112	5,611	8	3,323	3,740	2	46	181	1,670
Del.	24	90	-	26	40	-	1	-	41
Md.	252	312	-	275	326	1	13	20	459
D.C.	189	276	-	100	140	-	1	-	2
Va.	657	542	1	255	377	-	8	17	353
W. Va.	9	12	-	67	62	-	-	2	64
N.C.	1,406	1,605	1	403	431	-	-	68	148
S.C.	703	823	-	298	335	-	-	17	150
Ga.	1,216	929	1	637	632	1	2	54	318
Fla.	656	1,022	5	1,262	1,397	-	21	3	135
E.S. CENTRAL	3,269	3,418	5	1,138	1,369	1	2	36	160
Ky.	178	295	2	261	310	1	1	8	18
Tenn.	870	975	2	324	434	-	1	22	34
Ala.	563	697	1	367	417	-	-	2	108
Miss.	1,658	1,451	-	186	208	-	-	4	-
W.S. CENTRAL	3,785	4,568	1	2,487	2,176	17	15	46	584
Ark.	400	472	-	224	158	16	-	8	25
La.	1,458	2,143	-	138	209	-	3	-	62
Okla.	111	243	1	224	131	1	3	31	33
Tex.	1,816	1,710	-	1,901	1,678	-	9	7	464
MOUNTAIN	198	211	7	409	462	9	9	14	127
Mont.	4	1	-	9	13	3	-	4	17
Idaho	1	-	1	11	12	-	-	-	3
Wyo.	1	7	-	8	4	-	-	2	19
Colo.	105	64	4	21	72	1	3	4	15
N. Mex.	18	24	-	54	59	1	1	2	6
Ariz.	33	91	-	188	192	-	1	1	43
Utah	8	9	2	41	25	2	2	-	15
Nev.	28	15	-	77	85	2	2	1	9
PACIFIC	618	995	49	4,362	4,275	4	102	-	236
Wash.	30	51	2	217	219	-	3	-	-
Oreg.	21	37	-	90	-	2	5	-	9
Calif.	561	893	43	3,792	3,795	1	89	-	197
Alaska	4	8	-	51	49	1	-	-	30
Hawaii	2	6	4	212	212	-	5	-	-
Guam	9	3	-	142	48	-	1	-	-
P.R.	257	435	-	137	165	-	-	-	55
V.I.	25	37	-	-	2	-	-	-	-
Amer. Samoa	1	-	-	4	4	-	1	-	-
C.N.M.I.	2	6	-	32	31	-	1	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending October 29, 1994 (43rd Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	524	378	81	41	12	12	36
Boston, Mass.	135	93	22	13	4	3	7
Bridgeport, Conn.	30	20	7	3	-	-	2
Cambridge, Mass.	32	24	7	-	-	1	1
Fall River, Mass.	37	33	1	3	-	-	1
Hartford, Conn.	24	12	5	2	2	3	-
Lowell, Mass.	22	18	3	1	-	-	1
Lynn, Mass.	25	22	2	-	1	-	1
New Bedford, Mass.	30	26	2	1	-	1	1
New Haven, Conn.	48	28	12	4	3	1	6
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	6	5	-	1	-	-	-
Springfield, Mass.	38	23	8	3	2	2	6
Waterbury, Conn.	21	17	3	1	-	-	1
Worcester, Mass.	76	57	9	9	-	1	9
MID. ATLANTIC	2,477	1,643	453	284	55	41	129
Albany, N.Y.	64	46	9	6	2	1	5
Allentown, Pa.	26	21	2	3	-	-	2
Buffalo, N.Y.	96	83	10	1	2	-	9
Camden, N.J.	31	18	10	2	-	1	2
Elizabeth, N.J.	14	14	-	-	-	-	-
Erie, Pa.§	45	34	6	3	2	-	1
Jersey City, N.J.	57	42	9	2	3	1	-
New York City, N.Y.	1,378	860	275	192	27	23	49
Newark, N.J.	52	21	11	15	3	2	1
Paterson, N.J.	U	U	U	U	U	U	U
Philadelphia, Pa.	300	198	52	32	10	8	24
Pittsburgh, Pa.§	61	39	13	7	-	2	5
Reading, Pa.	9	6	2	1	-	-	4
Rochester, N.Y.	106	76	24	4	2	-	6
Schenectady, N.Y.	18	14	3	-	1	-	-
Scranton, Pa.§	26	22	3	1	-	-	2
Syracuse, N.Y.	111	76	21	10	2	2	13
Trenton, N.J.	32	26	3	3	-	-	2
Utica, N.Y.	26	23	-	2	-	1	1
Yonkers, N.Y.	25	24	-	-	1	-	3
E.N. CENTRAL	2,063	1,274	415	201	115	58	108
Akron, Ohio	36	26	6	2	1	1	-
Canton, Ohio	44	33	10	-	1	-	5
Chicago, Ill.	406	168	90	76	65	7	11
Cincinnati, Ohio	81	46	19	9	3	4	4
Cleveland, Ohio	136	83	29	16	-	8	-
Columbus, Ohio	150	94	31	18	5	2	14
Dayton, Ohio	91	61	21	3	4	2	7
Detroit, Mich.	220	132	45	24	9	10	11
Evansville, Ind.	53	37	11	3	2	-	-
Fort Wayne, Ind.	53	35	10	3	3	2	2
Gary, Ind.	12	3	5	3	1	-	1
Grand Rapids, Mich.	77	60	10	4	1	2	8
Indianapolis, Ind.	205	131	45	15	8	6	11
Madison, Wis.	43	34	4	3	2	-	7
Milwaukee, Wis.	127	89	24	7	1	6	9
Peoria, Ill.	43	35	6	-	2	-	3
Rockford, Ill.	54	41	5	6	1	1	3
South Bend, Ind.	50	41	6	1	2	-	5
Toledo, Ohio	105	71	21	7	3	3	7
Youngstown, Ohio	77	54	17	1	1	4	-
W.N. CENTRAL	806	569	140	50	19	22	54
Des Moines, Iowa	85	65	16	-	1	3	6
Duluth, Minn.	33	23	10	-	-	-	-
Kansas City, Kans.	23	16	5	1	1	-	1
Kansas City, Mo.	117	73	21	7	4	6	7
Lincoln, Nebr.	28	21	5	2	-	-	3
Minneapolis, Minn.	181	133	24	12	6	6	18
Omaha, Nebr.	73	48	15	6	2	2	4
St. Louis, Mo.	123	82	20	15	3	3	5
St. Paul, Minn.	84	62	17	3	1	1	9
Wichita, Kans.	59	46	7	4	1	1	1
S. ATLANTIC	1,338	804	291	162	43	36	67
Atlanta, Ga.	174	100	44	25	3	2	3
Baltimore, Md.	258	143	53	49	10	3	23
Charlotte, N.C.	141	81	33	15	5	6	5
Jacksonville, Fla.	137	92	30	13	2	-	11
Miami, Fla.	75	31	24	13	5	2	-
Norfolk, Va.	56	45	7	3	1	-	4
Richmond, Va.	90	55	14	7	8	6	2
Savannah, Ga.	70	45	14	6	2	3	2
St. Petersburg, Fla.	45	34	4	3	2	2	2
Tampa, Fla.	148	96	31	12	2	6	15
Washington, D.C.	129	67	37	16	3	6	-
Wilmington, Del.	15	15	-	-	-	-	-
E.S. CENTRAL	766	509	147	70	16	24	50
Birmingham, Ala.	123	72	27	16	2	6	1
Chattanooga, Tenn.	79	57	11	5	1	5	4
Knoxville, Tenn.	75	54	15	5	-	1	4
Lexington, Ky.	68	50	11	5	1	1	9
Memphis, Tenn.	177	116	39	12	5	5	18
Mobile, Ala.	63	42	14	4	2	1	2
Montgomery, Ala.	43	26	9	5	1	2	2
Nashville, Tenn.	138	92	21	18	4	3	10
W.S. CENTRAL	1,469	923	285	157	61	40	77
Austin, Tex.	55	31	12	7	3	2	3
Baton Rouge, La.	56	39	7	6	3	1	5
Corpus Christi, Tex.	46	28	11	5	-	2	2
Dallas, Tex.	210	134	31	31	11	3	-
El Paso, Tex.	96	62	23	6	3	2	3
Ft. Worth, Tex.	104	69	21	7	3	4	3
Houston, Tex.	328	190	64	47	17	10	33
Little Rock, Ark.	62	37	13	7	3	2	5
New Orleans, La.	113	69	23	11	3	4	-
San Antonio, Tex.	222	140	44	18	13	7	12
Shreveport, La.	40	27	7	5	-	1	5
Tulsa, Okla.	137	97	29	7	2	2	6
MOUNTAIN	908	594	166	96	36	16	61
Albuquerque, N.M.	102	63	17	14	6	2	4
Colo. Springs, Colo.	47	31	9	6	-	1	4
Denver, Colo.	113	74	21	10	4	4	11
Las Vegas, Nev.	165	113	31	14	6	1	4
Ogden, Utah	27	20	6	1	-	-	4
Phoenix, Ariz.	193	122	35	23	10	3	19
Pueblo, Colo.	31	20	6	5	-	-	3
Salt Lake City, Utah	104	64	19	11	6	4	8
Tucson, Ariz.	126	87	22	12	4	1	4
PACIFIC	1,694	1,098	314	178	54	25	95
Berkeley, Calif.	17	6	7	2	1	1	1
Fresno, Calif.	93	55	22	8	4	3	3
Glendale, Calif.	25	19	4	2	-	-	1
Honolulu, Hawaii	73	49	12	7	4	1	5
Long Beach, Calif.	63	48	8	4	2	1	9
Los Angeles, Calif.	525	330	103	61	17	1	17
Pasadena, Calif.	29	20	5	2	-	2	1
Portland, Oreg.	158	103	24	21	6	4	7
Sacramento, Calif.	124	81	22	16	4	1	5
San Diego, Calif.	U	U	U	U	U	U	U
San Francisco, Calif.	132	74	31	12	3	1	10
San Jose, Calif.	152	109	29	9	4	1	19
Santa Cruz, Calif.	21	11	3	7	-	-	3
Seattle, Wash.	131	85	20	16	6	4	7
Spokane, Wash.	53	41	6	5	-	1	4
Tacoma, Wash.	98	67	18	6	3	4	3
TOTAL	12,045¶	7,792	2,292	1,239	411	274	677

*Mortality data in this table are voluntarily reported from 121 cities in the United States, most of which have populations of 100,000 or more. 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 these 3 Pennsylvania cities, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶Total includes unknown ages.

U: Unavailable.

Cigarette Smoking — Continued

Although the mean education level[†] of Hispanic women in this study was lower when compared with non-Hispanic women, the prevalence of cigarette smoking was significantly lower among Hispanic women, possibly reflecting the effect of potential cultural differences that decrease the social acceptability of smoking among Hispanic women. The findings in this report also indicate that, during 1987–1992, smoking rates were significantly higher for women living below the poverty level than those living at or above the poverty level. This inverse association between income and smoking prevalence also has been documented for men and reflects correlations with education level.

Comprehensive strategies to discourage tobacco use by women and to achieve the year 2000 national health objective should include four basic components: research, outreach, education, and advocacy. Research efforts should focus on the disparate race-specific trends in smoking by race and translation of successes in efforts to reduce smoking among other groups. Outreach should especially be directed toward providing interventions for the high proportion of women smokers with less than a high school education. Education campaigns that employ paid antismoking advertising have been implemented successfully in California and may be adapted for use in other locations in the United States (*10*). Examples of measures to strengthen advocacy of tobacco-control policies include increases in the excise taxes on tobacco products and enforcement of laws that restrict access to tobacco products by minors.

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[†]In this study, the mean number of years of education completed by Hispanic women was 11.3 years and for non-Hispanic women, 13.1 years.

Current Trends

Continuing Diabetes Care — Rhode Island, 1991

The annual economic impact of diabetes mellitus in the United States is an estimated $92 billion (*1*), primarily reflecting the treatment of both acute (e.g., diabetic ketoacidosis and hypoglycemic coma) and chronic (e.g., atherosclerotic cardiovascular disease, blindness, renal failure, neuropathy, and amputation of extremities) complications (*2*). The complications of diabetes may be prevented or delayed through intensive treatment (*3*) and through early detection and treatment of complications (*4,5*). To characterize continuing care of diabetes in Rhode Island in 1991, the Rhode Island Department of Health initiated a Diabetes Care Survey (DCS) in conjunction with its statewide Health Interview Survey (HIS) in 1990. This report summarizes the results of that survey.

Questions about the frequency of continuing diabetes care were based on standards published in 1989 that recommend persons using insulin visit a physician at least quarterly and persons not using insulin visit a physician at least semiannually. The standards also recommend examination by an "eye doctor" at least annually for persons aged 12–30 years with a diagnosis of diabetes of at least a 5-year duration and for all persons aged ≥30 years with diabetes (*4*). CDC has defined such examinations as "dilated eye examinations" (*5*).

The 1990 HIS used random-digit–dialing to survey 3118 households in Rhode Island; 2588 (83%) persons responded. One adult (aged ≥18 years) respondent in each household was asked about the sociodemographic characteristics, health status, and health-related behaviors of all household members. In 1991, 150 (71%) of 212 adult HIS respondents who reported having been told by a doctor that they had diabetes in 1990 were recontacted for the DCS and asked about health status and diabetes care.

Of the 150 respondents, 89% were aged ≥40 years, 52% were aged ≥65 years, and 54% were women. Forty-three percent had not graduated from high school, and 45% had family incomes at or less than 200% of the poverty level*. In approximately one third (34%), diabetes had been diagnosed within the preceding 5 years. Almost all (95%) received diabetes care from a physician. Almost half (48%) used oral hypoglycemic agents; 31% used insulin.

Of the 84 respondents with noninsulin-treated diabetes, nearly all (99%) had visited a health-care provider at least twice during the preceding year. Of the 54 respondents with insulin-treated diabetes, 61% had visited a provider four times during the preceding year. During the preceding year, 72% of the respondents who were eligible for a dilated eye examination had received one.

Respondents aged <40 years were less likely to have visited a health-care provider for regular diabetes care (53%) than were respondents aged 40–64 years (86%) or ≥65 years (95%) (Table 1). Men were less likely than woman to have had a dilated eye examination during the preceding year (60% versus 84%, respectively).

Reported by: D Goldman, MPH, J Fulton, PhD, D Perry, J Feldman, MD, Rhode Island Diabetes Control Program, Rhode Island Dept of Health. Epidemiology and Statistics Br, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

*Poverty statistics are based on a definition originated by the Social Security Administration in 1964, subsequently modified by federal interagency committees in 1969 and 1980, and prescribed by the Office of Management and Budget as the standard to be used by federal agencies for statistical purposes.

Continuing Diabetes Care — Continued

Editorial Note: The control of complications and costs of diabetes requires that persons with diabetes have access to continuing medical care for this disease. The findings in this report indicate that in Rhode Island, most persons with diabetes reported receiving dilated eye examinations in accordance with current recommendations. In comparison, other recent assessments indicate that during 1989, only 49% of adults with diagnosed diabetes in the United States had dilated eye examinations during the preceding year (*6*); in addition, during 1992, 33%–60% of patients with diabetes who were receiving care at three of the largest health maintenance organizations in the United States also had received yearly eye examinations (*7*).

Since 1979, efforts of the Rhode Island Diabetes Control Program have been directed toward reducing barriers to care and ensuring eye examinations for persons with diabetes; the program has especially focused on persons with low income and those with no health insurance. Components of the multifaceted campaign to ensure eye care for persons with diabetes include 1) distribution of information, including materials developed by the National Institutes of Health as a part of the National Eye Health Education Program, through sites (e.g., the offices of primary-care physicians and podiatrists, clinics, emergency rooms, hospitals, worksites, pharmacies, and Lions clubs) that promote annual eye examinations among persons with diabetes; 2) distribution of national standards for eye care by mail to all primary-care providers, through presentations to selected medical staff at all Rhode Island hospitals, and through publication of articles assessing and promoting diabetic eye care in Rhode Island; and 3) direct diabetes-care interventions through neighborhood health centers associated with the Providence Ambulatory Health Care Foundation.

The findings in this report also indicate that in Rhode Island, persons with insulin-treated diabetes visit health-care providers less frequently than is recommended; persons aged <40 years were least likely to visit providers at regular intervals. Possible reasons for lack of continuing care in this age group include lack of health insurance, self-perceived good health, and short duration of disease—and therefore, fewer complications (*5*).

The Rhode Island Diabetes Control Program and its Diabetes Professional Advisory Council have used these and other findings to develop a statewide diabetes control plan. These findings also may be used as a baseline for evaluating interventions. To facilitate this process, the advisory council has established a surveillance committee to develop an overall surveillance plan to be coordinated with the statewide diabetes control plan.

Although public health surveillance is integral to the control of infectious diseases, the role of state-based surveillance is less well established in the control of diabetes and other chronic conditions. The Rhode Island DCS is an innovative and useful tool for the surveillance of diabetes health-care patterns and practices and may serve as a model for other states with diabetes control programs.

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Continuing Diabetes Care — Continued

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Current Trends

National Notifiable Diseases Reporting — United States, 1994

CDC has recently published the *Summary of Notifiable Diseases, United States, 1993* (*1*). A notifiable disease is one for which regular, frequent, and timely information on individual cases is considered necessary for the prevention and control of the disease. As of January 1, 1994, a total of 49 infectious diseases were designated as notifiable at the national level (Table 1).

Reported by: Div of Surveillance and Epidemiology, Epidemiology Program Office, CDC.

Editorial Note: In 1878, Congress authorized the U.S. Public Health Service (PHS) to collect morbidity reports on cholera, smallpox, plague, and yellow fever from U.S. consuls overseas; this information was to be used for instituting quarantine measures to prevent the introduction and spread of these diseases into the United States. In 1879, a specific Congressional appropriation was made for the collection and publication of reports of these notifiable diseases. The authority for weekly reporting and publication was expanded by Congress in 1893 to include data from states and municipal authorities. To increase the uniformity of the data, Congress enacted a law in 1902 directing the Surgeon General to provide forms for the collection and compilation of data and for the publication of reports at the national level. In 1912, state and territorial health authorities—in conjunction with the PHS—recommended weekly telegraphic reporting of five infectious diseases and monthly reporting by letter of 10 additional diseases. The first annual summary of *The Notifiable Diseases* in 1912 included reports of 10 diseases from 19 states, the District of Columbia, and Hawaii. By 1928, all states, the District of Columbia, Hawaii, and Puerto Rico were participating in national reporting of nearly 30 specified conditions. At their meeting in 1950, the State and Territorial Health Officers authorized a conference of state epidemiologists for the purpose of determining what diseases should be reported to the PHS. CDC assumed responsibility for the collection and publication of data on nationally notifiable diseases in 1961.

Public health officials at state health departments and CDC continue to collaborate in determining which diseases should be nationally notifiable; during its annual meeting, the Council of State and Territorial Epidemiologists (CSTE) makes recommendations for additions and deletions to the national notifiable disease list on the

Notifiable Disease Reporting — Continued

TABLE 1. Infectious diseases designated as notifiable at the national level — United States, 1994

AIDS	Hepatitis, unspecified	Rocky Mountain spotted fever (Typhus fever, tickborne)
Amebiasis*	Legionellosis	
Anthrax	Leprosy (Hansen disease)	
Aseptic meningitis	Leptospirosis	Rubella
Botulism	Lyme disease	Salmonellosis*
Brucellosis	Lymphogranuloma venereum*	Shigellosis*
Chancroid*		Syphilis
Cholera	Malaria	Syphilis, congenital
Congenital rubella syndrome	Measles	Tetanus
Diphtheria	Meningococcal infection	Toxic shock syndrome
Encephalitis	Mumps	Trichinosis
Escherichia coli O157:H7*	Pertussis	Tuberculosis
Gonorrhea	Plague	Tularemia
Granuloma inguinale*	Poliomyelitis	Typhoid fever
Haemophilus influenzae	Psittacosis	Varicella (chickenpox)*†
Hepatitis A	Rabies, animal	Yellow fever*
Hepatitis B	Rabies, human	
Hepatitis, non-A, non-B	Rheumatic fever*	

*Reports of these diseases are not printed weekly in Table I or Table II of the *MMWR*.
†Although varicella is not officially a nationally notifiable disease, the Council of State and Territorial Epidemiologists encourage transmission of information about cases of varicella to CDC.

basis of CDC suggestions. However, reporting of nationally notifiable diseases to CDC by the states is voluntary. Reporting is mandated only at the state level. The list of diseases that are considered notifiable, therefore, varies by state. All states generally report the internationally quarantinable diseases (cholera, plague, and yellow fever) in compliance with the World Health Organization's International Health Regulations.

The list of nationally notifiable diseases is revised periodically. Diseases are added to the list as new pathogens emerge; diseases are deleted as their incidence declines. Of the 49 nationally notifiable infectious diseases reported to CDC in 1993, 41 were reported on a weekly basis, and eight were reported monthly. CSTE will review the principles of notifiable disease reporting in late fall of 1994.

Reference

1. CDC. Summary of notifiable diseases, United States, 1993. MMWR 1994;42(no. 53).

Erratum: Vol. 43, No. 19

In the report "Cigarette Smoking Among Adults—United States, 1992, and Changes in the Definition of Current Cigarette Smoking," the 95% confidence intervals (CIs) for the 1992 prevalence estimates published on pages 343 and 345 were incorrect. The following tables contain the corrected CIs and replace Table 1 (page 343) and Table 2 (page 345). In addition, the correct CI for daily smoking (page 342, fourth paragraph, second line) is ±0.7%, and the correct CI for some-day smoking (page 344, first paragraph, first line) is ±0.3%. The change in CIs affects one conclusion (page 344, second paragraph, fourth line, and page 344, fourth paragraph, second line): the increase in smoking among persons living below the poverty level is not statistically significant.

TABLE 1. Percentage of adults aged ≥18 years who were current cigarette smokers*, by sex, age group, race/ethnicity, level of education, and socioeconomic status — United States, National Health Interview Survey, 1991 and 1992†

Characteristic	1991 Original (HPDP§) (n=43,154)		1992 Original (CCS¶) (n=11,875)		1992 Interim (CCS) (n=11,865)		1992 Revised (CES**) (n=11,881)		1992 Combination (CCS/CES) (n=23,746)	
	%	(95% CI††)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Sex										
Men	28.1	(±0.8%)	28.0	(± 1.4%)	29.3	(± 1.5%)	28.0	(± 1.4%)	28.6	(±1.0%)
Women	23.5	(±0.6%)	23.5	(± 1.2%)	24.3	(± 1.2%)	24.8	(± 1.3%)	24.6	(±0.9%)
Age group (yrs)										
18–24	22.9	(±1.4%)	24.4	(± 3.0%)	25.8	(± 3.1%)	27.1	(± 2.8%)	26.4	(±2.2%)
25–44	30.4	(±0.7%)	29.7	(± 1.4%)	30.9	(± 1.4%)	30.6	(± 1.5%)	30.8	(±1.0%)
45–64	26.8	(±0.9%)	27.3	(± 1.8%)	28.2	(± 1.8%)	26.4	(± 1.8%)	27.3	(±1.3%)
≥65	13.3	(±0.8%)	13.3	(± 1.6%)	13.7	(± 1.6%)	14.2	(± 1.6%)	14.0	(±1.2%)
Race/Ethnicity§§										
White	26.0	(±0.6%)	26.2	(± 1.1%)	27.1	(± 1.1%)	27.3	(± 1.1%)	27.2	(±0.8%)
Black	29.4	(±1.6%)	27.0	(± 3.1%)	28.4	(æ 3.1%)	27.3	(± 2.7%)	27.8	(±2.0%)
Hispanic	20.1	(±1.7%)	20.4	(± 3.0%)	22.5	(± 3.1%)	18.7	(± 2.6%)	20.7	(±2.0%)
American Indian/ Alaskan Native¶¶	31.9	(±7.0%)	36.5	(±12.2%)	36.5	(±12.2%)	41.9	(±10.9%)	39.4	(±8.3%)
Asian/Pacific Islander	15.9	(±3.2%)	16.9	(± 5.9%)	17.9	(± 5.9%)	12.2	(± 4.5%)	15.2	(±3.9%)
Education level (yrs)										
<12	32.0	(±1.2%)	32.2	(± 2.1%)	33.4	(± 2.2%)	30.3	(± 2.1%)	31.8	(±1.5%)
12	29.9	(±0.8%)	29.8	(± 1.6%)	30.6	(± 1.6%)	31.4	(± 1.7%)	31.0	(±1.2%)
13–15	23.4	(±1.0%)	23.8	(± 1.8%)	24.8	(± 1.9%)	23.3	(± 1.9%)	24.1	(±1.3%)
≥16	13.6	(±0.8%)	13.4	(± 1.5%)	14.5	(± 1.5%)	16.5	(± 1.7%)	15.5	(±1.2%)
Socioeconomic status***										
At/Above poverty level	24.7	(±0.5%)	24.2	(± 1.0%)	25.2	(± 1.0%)	25.7	(± 1.0%)	25.4	(±0.7%)
Below poverty level	33.1	(±1.9%)	37.0	(± 3.3%)	38.4	(± 3.3%)	31.4	(± 3.2%)	34.9	(±2.6%)
Unknown	26.0	(±1.7%)	26.2	(± 3.0%)	27.0	(± 3.0%)	26.7	(± 3.2%)	26.9	(±2.3%)
Total	**25.6**	**(±0.5%)**	**25.6**	**(± 0.9%)**	**26.7**	**(± 0.9%)**	**26.3**	**(± 1.0%)**	**26.5**	**(±0.7%)**

* Persons who reported having smoked at least 100 cigarettes and who were currently smoking based on one of the following definitions: "Original" definition: Smoke now; "Interim" definition: Smoke now, or do not smoke now but on further questioning reported smoking some days; "Revised" definition: Smoke every day or some days now; "Combination" definition: Combined prevalence using the interim and revised prevalence estimates.
† Excludes 578 respondents in 1991 and 285 respondents in 1992 with unknown smoking status.
§ Health Promotion and Disease Prevention Supplement.
¶ Cancer Control Supplement.
** Cancer Epidemiology Supplement.
†† Confidence interval.
§§ Excludes 317 respondents in 1991 and 252 respondents in 1992 in unknown, multiple, and other race categories.
¶¶ Estimates should be interpreted with caution because of the small number of respondents.
*** Poverty statistics are based on definitions originated by the Social Security Administration in 1964, subsequently modified by federal interagency committees in 1969 and 1980, and prescribed by the Office of Management and Budget as the standard to be used by federal agencies for statistical purposes.

TABLE 2. Percentage of men and women aged ≥18 years who were current cigarette smokers*, by race/ethnicity, level of education, age group, and socioeconomic status — United States, National Health Interview Survey, 1991 and 1992†

	Men						Women					
	1991 Original (HPDP§) (n=18,050)		1992 Original (CCS¶) (n=5,000)		1992 Combined (CCS/CES**) (n=10,061)		1991 Original (HPDP) (n=25,104)		1992 Original (CCS) (n=6,875)		1992 Combined (CCS/CES) (n=13,685)	
Characteristic	**%**	**(95% CI††)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**	**%**	**(95% CI)**
Race/Ethnicity§§												
White	27.5	(±0.9%)	27.9	(± 1.7%)	28.6	(± 1.2%)	24.6	(± 0.7%)	24.6	(± 1.4%)	25.9	(± 1.1%)
Black	35.5	(±2.7%)	32.2	(± 4.7%)	32.3	(± 3.5%)	24.5	(± 1.9%)	22.9	(± 3.3%)	24.1	(± 2.2%)
Hispanic	25.2	(±3.0%)	22.2	(± 4.3%)	23.6	(± 3.0%)	15.5	(± 1.9%)	18.6	(± 3.6%)	18.0	(± 2.5%)
American Indian/ Alaskan Native¶¶	27.5	(±8.4%)	36.2	(±16.1%)	39.0	(±12.6%)	36.7	(±11.2%)	36.7	(±17.6%)	39.8	(±12.4%)
Asian/Pacific Islander	24.1	(±5.1%)	30.8	(±10.7%)	26.3	(± 6.8%)	7.1	(± 3.0%)	3.2	(± 2.5%)	4.0	(± 2.3%)
Education level (yrs)												
<12	37.4	(±1.9%)	37.8	(± 3.3%)	36.9	(± 2.3%)	27.4	(± 1.4%)	27.4	(± 2.6%)	27.5	(± 1.9%)
12	33.5	(±1.3%)	33.8	(± 2.5%)	34.4	(± 1.8%)	27.1	(± 1.0%)	26.6	(± 2.0%)	28.2	(± 1.5%)
13–15	25.1	(±1.6%)	24.8	(± 3.0%)	25.2	(± 2.1%)	22.0	(± 1.3%)	22.9	(± 2.4%)	23.1	(± 1.7%)
≥16	14.5	(±1.2%)	13.8	(± 2.2%)	16.2	(± 1.6%)	12.5	(± 1.1%)	13.0	(± 2.1%)	14.6	(± 1.6%)
Age group (yrs)												
18–24	23.5	(±2.2%)	26.0	(± 4.4%)	28.0	(± 3.1%)	22.4	(± 1.9%)	22.9	(± 3.8%)	24.9	(± 2.8%)
25–44	32.9	(±1.2%)	31.3	(± 2.2%)	32.8	(± 1.5%)	28.0	(± 1.0%)	28.0	(± 1.8%)	28.8	(± 1.4%)
45–64	29.3	(±1.5%)	30.1	(± 2.6%)	28.6	(± 1.9%)	24.6	(± 1.2%)	24.7	(± 2.4%)	26.1	(± 1.8%)
≥65	15.1	(±1.5%)	15.8	(± 2.7%)	16.1	(± 2.1%)	12.0	(± 1.0%)	11.6	(± 2.0%)	12.4	(± 1.3%)
Socioeconomic status***												
At/Above poverty level	26.8	(±0.8%)	26.2	(± 1.6%)	27.1	(± 1.0%)	22.7	(± 0.7%)	22.3	(± 1.3%)	23.8	(± 1.0%)
Below poverty level	39.3	(±3.1%)	42.5	(± 5.4%)	39.7	(± 3.9%)	29.3	(± 2.2%)	33.5	(± 3.6%)	31.7	(± 2.9%)
Unknown	31.0	(±3.0%)	33.1	(± 5.1%)	33.8	(± 3.7%)	22.4	(± 2.0%)	21.3	(± 3.4%)	22.1	(± 2.5%)
Total	**28.1**	**(±0.8%)**	**28.0**	**(± 1.4%)**	**28.6**	**(± 1.0%)**	**23.5**	**(± 0.6%)**	**23.5**	**(± 1.2%)**	**24.6**	**(± 0.9%)**

*Persons who reported having smoked at least 100 cigarettes and who were currently smoking based on one of the following definitions: "Original" definition: Smoke now; "Interim" definition: Smoke now, or do not smoke now but on further questioning reported smoking some days; "Revised" definition: Smoke every day or some days now; "Combination" definition: Combined prevalence using the interim and revised prevalence estimates.
†Excludes 578 respondents in 1991 and 285 respondents in 1992 with unknown smoking status.
§Health Promotion and Disease Prevention Supplement.
¶Cancer Control Supplement.
**Cancer Epidemiology Supplement.
††Confidence interval.
§§Excludes 317 respondents in 1991 and 252 respondents in 1992 with unknown, multiple, and other race categories.
¶¶Estimates should be interpreted with caution because of the small number of respondents.
***Poverty statistics are based on definitions originated by the Social Security Administration in 1964, subsequently modified by federal interagency committees in 1969 and 1980, and prescribed by the Office of Management and Budget as the standard to be used by federal agencies for statistical purposes.

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