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MORBIDITY AND MORTALITY WEEKLY REPORT

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World AIDS Day — December 1, 1994

"AIDS and the Family" is the theme selected by the World Health Organization Global Program on AIDS (WHO/GPA) for the seventh annual World AIDS Day, December 1, 1994. This theme focuses on the crucial role of families in responding to the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) pandemic. Families (defined by WHO/GPA as a group of persons linked by feelings of trust, mutual support, and a common destiny) can help reduce the risk for HIV infection among members and provide care for members who develop HIV infection or AIDS (1). An estimated 17 million persons worldwide have been infected with HIV since onset of the pandemic, and each day 6000 additional persons become infected (2). WHO/GPA estimates that by the year 2000, approximately 10 million children will have been orphaned because their parents died as the result of HIV infection (2).

Additional information about HIV infection, AIDS, and World AIDS Day is available from the CDC National AIDS Hotline (NAH) and the CDC National AIDS Clearinghouse (NAC). NAH provides information about HIV/AIDS, refers callers to services in their community, and places orders for HIV/AIDS publications; NAC provides educational materials and information on AIDS service organizations, funding sources, and drug trials. The telephone numbers for NAH are (800) 342-2437; Spanish, (800) 344-7432; or TTY/TDD, (800) 243-7889. The telephone number for NAC is (800) 458-5231 or (301) 217-0023.

Reported by: Global Program on AIDS, World Health Organization, Geneva. Office of the Associate Director (HIV/AIDS), Office of the Director, CDC.

References

1. Global Program on AIDS, World Health Organization. World AIDS Day Newsletter. Geneva: World Health Organization, Global Program on AIDS, 1994;(2):1.
2. Merson M. Global status of the HIV/AIDS epidemic and the response [Lecture]. Yokohama, Japan: Tenth Annual Conference on AIDS, August 8, 1994.

Current Trends

Update: Trends in AIDS Diagnosis and Reporting Under the Expanded Surveillance Definition for Adolescents and Adults — United States, 1993

The expansion of the surveillance case definition for acquired immunodeficiency syndrome (AIDS) in January 1993 (1) resulted in a large increase in reported AIDS cases. This increase has primarily reflected reports of human immunodeficiency virus (HIV)-infected persons in whom severe immunosuppression (CD4+ count <200 T-lymphocytes/ μ L or a CD4+ T-lymphocyte percentage of total lymphocytes of <14) had been diagnosed, which typically occurs before the onset of AIDS-defining opportunistic illnesses (AIDS-OIs, CDC clinical category C disease) (1,2). The inclusion of the CD4+ reporting criteria in AIDS surveillance has required an alteration in methods used to assess trends in AIDS incidence, previously based on the diagnosis of AIDS-OIs. This report first summarizes information about AIDS cases reported during 1993; then, to describe trends in AIDS incidence if the surveillance definition had not been expanded, this report uses estimates of eventual AIDS-OI diagnosis dates for persons who were reported with AIDS based only on the CD4+ criteria.*

Trends in AIDS by Date of Report

In 1993, a total of 105,990 AIDS cases were reported among adolescents and adults in the United States (2). Of 56,400 AIDS case reports based on any of the new reporting criteria (which include the CD4+ criteria, pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer), 50,800 (90%) were based on the CD4+ reporting criteria; cases meeting the CD4+ criteria represented 48% of the 105,990 total AIDS cases reported. The number of AIDS cases reported quarterly in 1993 ranged from 36,290 cases (first quarter) to 18,360 cases (fourth quarter) (Figure 1).

Trends in AIDS-OIs by Date of Diagnosis

Estimating AIDS incidence based on the 1993 definition in a manner consistent with the definition used in previous years requires estimating when persons who were reported using the CD4+ criteria would develop AIDS-OIs. The probability distribution of the duration from the occurrence of a specific CD4+ count to the onset of the first AIDS-OI among HIV-infected persons was estimated using data from the CDC-sponsored Adult/Adolescent Spectrum of Disease Project (4). The estimated median time until development of an AIDS-OI for these persons was 19 months. The estimated AIDS-OI incidence is the sum of the observed AIDS-OI incidence and the incidence based on estimated dates of diagnosis for persons reported with AIDS based only on the CD4+ criteria; both incidences were adjusted for reporting delays.

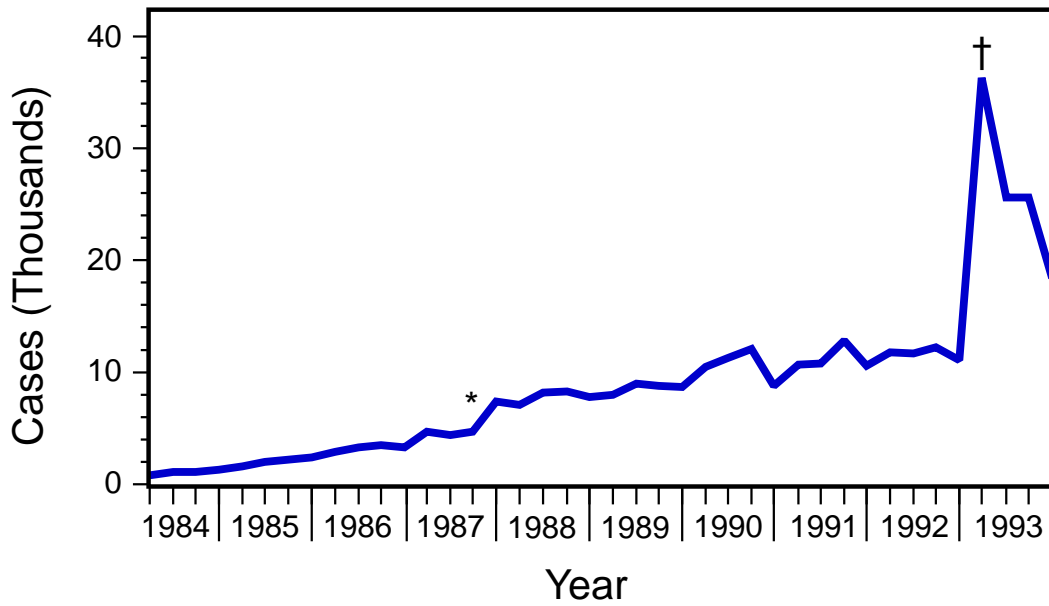
In 1993, the incidence of AIDS-OIs was estimated to have been 62,000 cases, approximately 15,000 cases each quarter (Figure 2).[†] The incidence in 1993 increased 3% compared with the estimated number of cases of AIDS-OIs (60,000) diagnosed in 1992. However, compared with 1992, the estimated number of AIDS-OIs diagnosed among homosexual/bisexual men (30,300) in 1993 decreased 1%; among persons

*Single copies of this report will be available until November 18, 1995, from the CDC National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; telephone (800) 458-5231.

[†]Estimates in this report are not adjusted for incomplete reporting of diagnosed AIDS cases.

AIDS — Continued

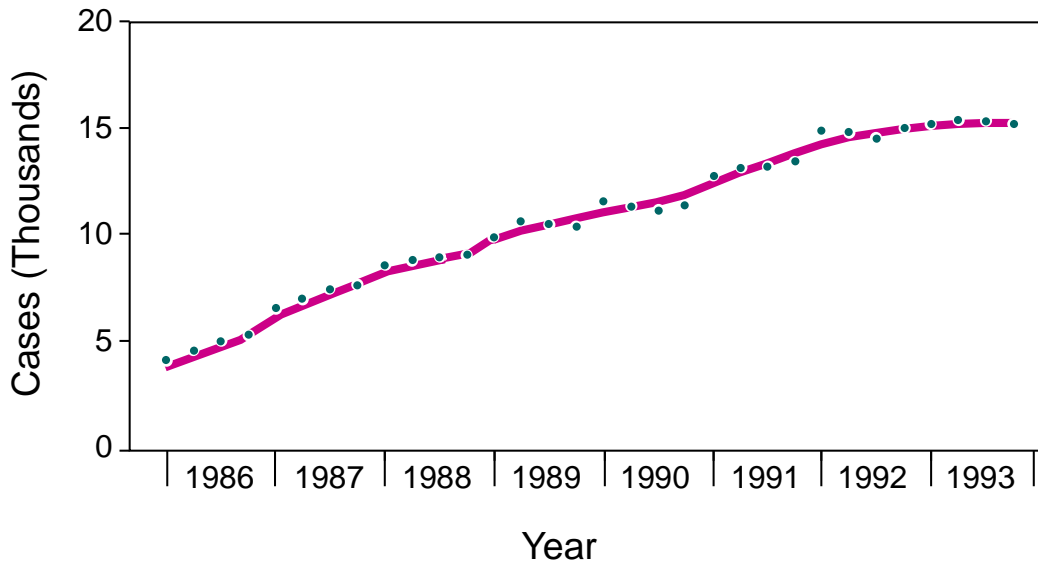
FIGURE 1. AIDS cases, by quarter year of report — United States, 1984–1993



*Case definition revised in October 1987 to include additional illnesses and to revise diagnostic criteria (3).

†Case definition revised in 1993 to include CD4+ criteria and three illnesses (pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer) (1).

FIGURE 2. Estimated AIDS-opportunistic illness incidence, adjusted for delays in reporting,* by quarter year of diagnosis — United States, 1986–1993†

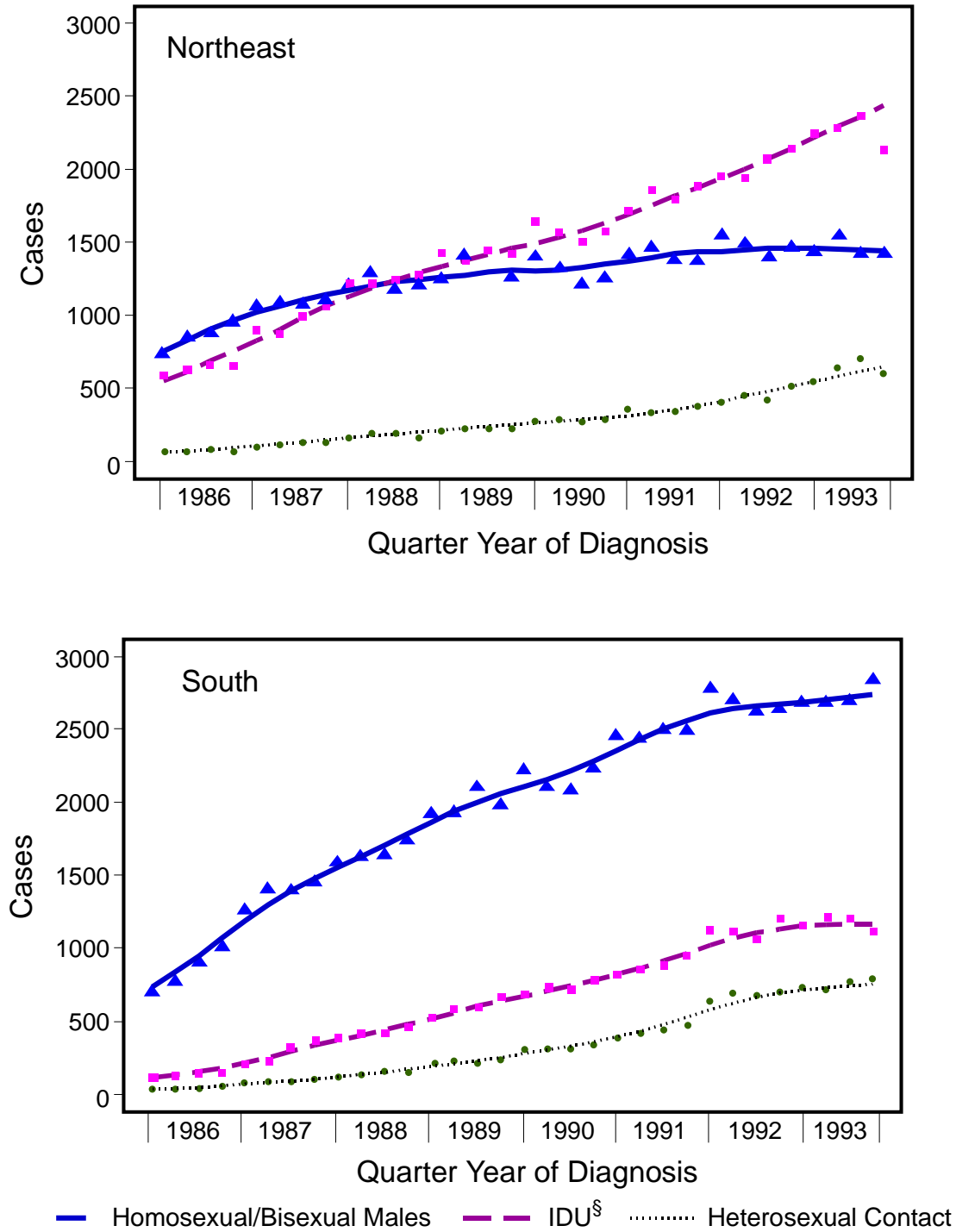


*Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

†Points represent quarterly incidence; line represents “smoothed” incidence (5).

AIDS — Continued

FIGURE 3. Estimated AIDS-opportunistic illness incidence, adjusted for reporting delays,* by region, transmission category, and quarter year of diagnosis — United States, 1986–1993†



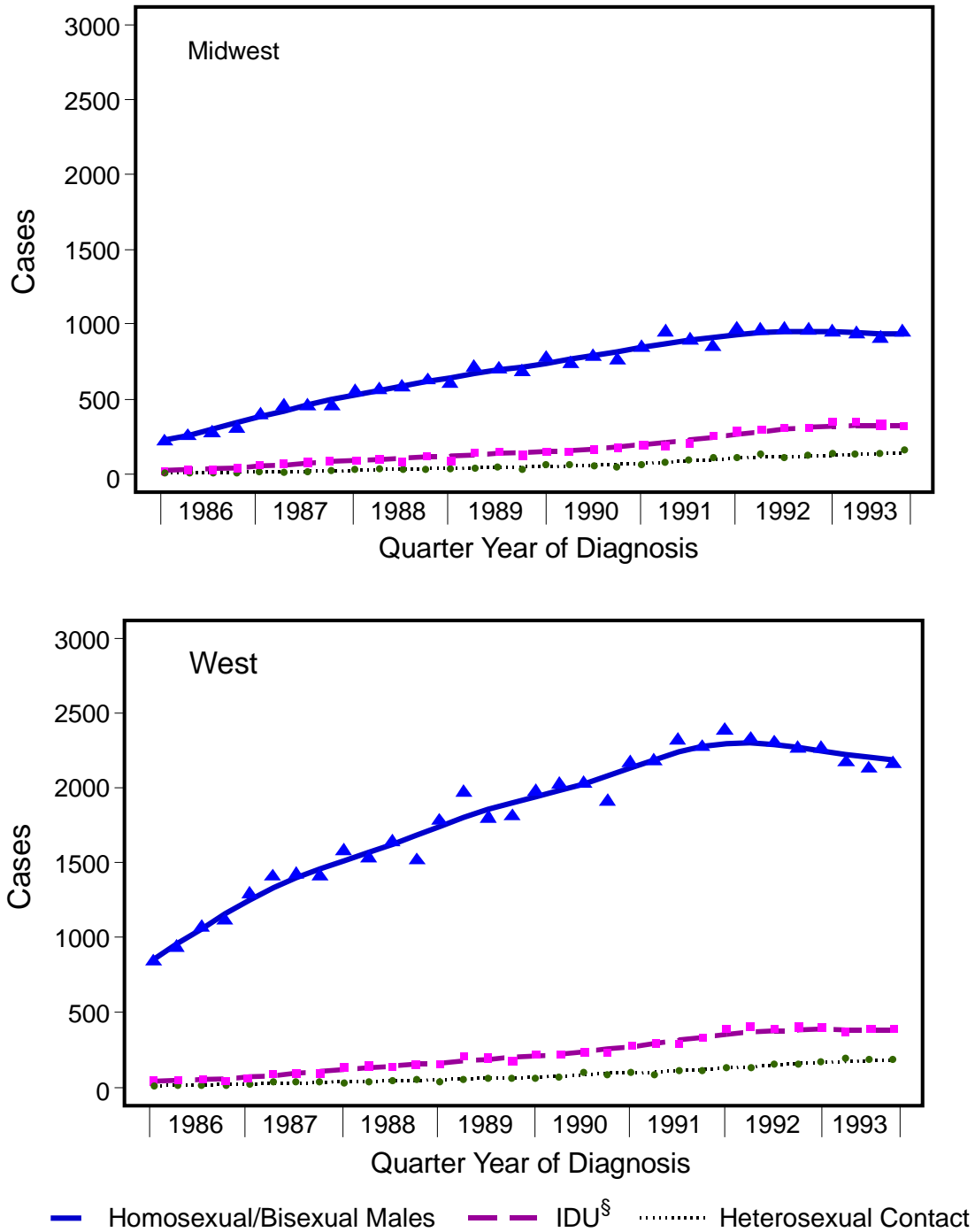
*Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.

†Points represent quarterly incidence; line represents "smoothed" incidence (5).

§Injecting-drug users.

AIDS — Continued

FIGURE 3. Estimated AIDS-opportunistic illness incidence, adjusted for reporting delays,* by region, transmission category, and quarter year of diagnosis — United States, 1986–1993† — Continued



* Estimates are not adjusted for incomplete reporting of diagnosed AIDS cases.
 † Points represent quarterly incidence; line represents “smoothed” incidence (5).
 § Injecting-drug users.

AIDS — Continued

who were injecting-drug users (IDUs) (17,800), it increased 8%, and among persons reported as infected through heterosexual contact (7500), it increased 23%.

The estimated incidence of AIDS-OIs varied substantially by geographic region (Figure 3). For example, compared with 1992, the estimated numbers of homosexual/bisexual men diagnosed with AIDS-OIs in 1993 were stable in the Northeast, South, and Midwest and decreased in the West. Among persons who were IDUs, the number of AIDS-OI cases increased in the Northeast, where most of these persons resided when diagnosed with AIDS, but were similar in 1992 and 1993 in the South and West. Although the number of estimated AIDS-OI cases associated with heterosexual transmission remained lower than cases among homosexual/bisexual men and persons who were IDUs, the incidence of cases associated with heterosexual transmission increased in all four regions. The increase in estimated AIDS-OI incidence from 1992 to 1993 associated with heterosexual transmission ranged from 11% (South) to 39% (Northeast).

The inclusion of HIV-infected persons with the three clinical conditions added to the surveillance definition in 1993 also may have contributed to the increased incidence of AIDS-OIs. These cases represented 4% of estimated AIDS-OIs diagnosed in 1992 and 8% of estimated AIDS-OIs diagnosed in 1993 (CDC, unpublished data, 1994). However, data are insufficient to estimate for persons with these clinical conditions the time until the development of an AIDS-OI included in the pre-1993 surveillance definition.

Reported by: Local, state, and territorial health depts. Div of HIV/AIDS, National Center for Infectious Diseases, CDC.

Editorial Note: Standard methods for examining AIDS surveillance data have been 1) by year of report, even though cases may be diagnosed in earlier years; and 2) by year of diagnosis, although adjustments have been necessary to account for delays in reporting. The analysis of AIDS surveillance data based on date of report provides information to immediately monitor the performance of surveillance efforts and enables rapid approximation of epidemiologic trends. Long-term trends in AIDS cases are reflected more closely by analyses based on year of diagnosis with adjustments for reporting delays. The expanded AIDS surveillance criteria have improved estimates of the number and characteristics of persons with severe HIV disease—particularly among populations most affected by the AIDS epidemic—and increased the usefulness of AIDS surveillance in describing HIV-related severe immunosuppression, morbidity, and mortality (2,6). However, the expansion also has complicated the interpretation of AIDS trends, a consequence that had been anticipated (7).

The increase in the number of reported AIDS cases in 1993 predominantly reflected the expansion of the surveillance criteria; the expansion has continued to affect reporting in 1994. During January–September 1994, a total of 63,101 AIDS cases were reported, compared with 36,333 and 88,075 cases reported during the same periods in 1992 and 1993, respectively. As the impact of the expanded case definition continues to diminish, the number of total cases for 1994 probably will be less than cases reported during 1993.

Estimates of the dates of eventual AIDS-OI diagnoses for persons reported with AIDS based only on the CD4+ criteria are necessary to more accurately track trends in AIDS incidence. At least two factors may affect these estimates. First, reporting of persons with AIDS based on the CD4+ criteria who die before the diagnosis of an AIDS-OI would result in overestimating AIDS-OI diagnoses. Second, the underreport-

AIDS — Continued

ing of concurrent AIDS-OIs diagnosed among persons reported based on the CD4+ criteria would result in an underestimate of the incidence of AIDS-OIs. However, analyses using preliminary estimates of unreported concurrent AIDS-OIs and probability of death before the development of AIDS-OIs indicate that correcting for these factors may increase the estimated incidence of AIDS-OIs in 1992 and 1993 by approximately 2% and 3%, respectively. These estimates also may be affected by the timeliness and completeness of AIDS case reporting. Studies are in progress to evaluate AIDS case reporting using the 1993 criteria. The results from these studies will help to refine future estimates of AIDS-OI incidence.

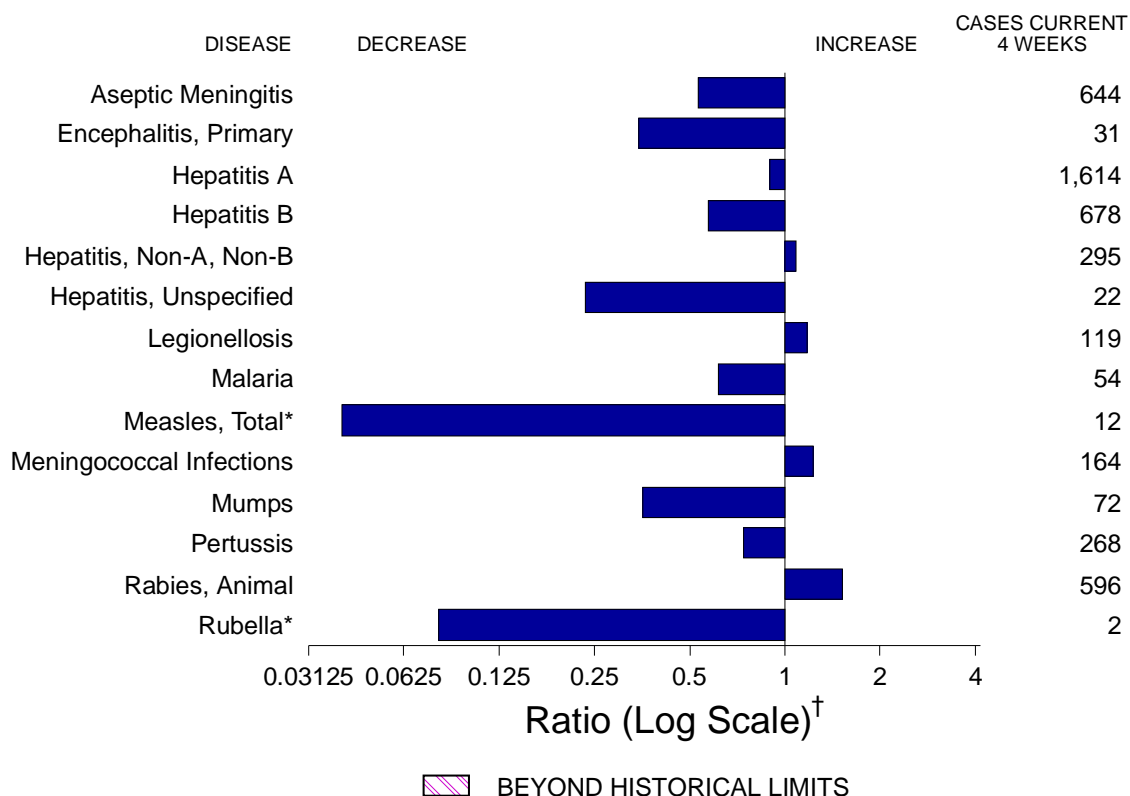
The changes in the incidence of AIDS-OIs reflect the evolution of the HIV epidemic in the United States. Overall, the epidemic of AIDS-OIs increased but at a slower rate than that in previous years. Among homosexual/bisexual men, AIDS-OI diagnoses have plateaued or decreased slightly. This reflects the rate of HIV transmission among homosexual/bisexual men, which peaked in the mid-1980s (7). However, male-to-male sexual transmission of HIV continues to occur, particularly among young men (8). The incidence of AIDS-OIs increased among persons who were IDUs and persons infected through heterosexual contact. As in previous years, AIDS-OI cases related to heterosexual transmission in 1993 showed the largest proportionate increases, disproportionately affected racial/ethnic minorities, and were closely related to the continued growth of the AIDS epidemic among persons who were IDUs (9).

The examination of regional AIDS trends reveals differences in the predominant modes of HIV transmission and their relative growth in recent years. Because of such variations, the use of AIDS surveillance to develop epidemiologic profiles at the local level is essential to target and develop appropriate HIV-prevention strategies. CDC is working with state, territorial, and local health departments, and community organizations to develop HIV-prevention planning programs based on local epidemiologic profiles.

References

1. CDC. 1993 Revised classification system for HIV infection and expanded surveillance case definition for AIDS among adolescents and adults. *MMWR* 1992;41(no. RR-17).
2. CDC. Update: impact of the expanded AIDS surveillance case definition for adolescents and adults on case reporting—United States, 1993. *MMWR* 1994;43:160-1,167-70.
3. CDC. Revision of the CDC surveillance case definition for acquired immunodeficiency syndrome. *MMWR* 1987;36(no. 1S).
4. Farizo KM, Buehler JW, Chamberland ME, et al. Spectrum of disease in persons with human immunodeficiency virus infection in the United States. *JAMA* 1992;267:1798-805.
5. Chambers JM, Cleveland WS, Kleiner B, Tukey PA. Graphical methods for data analysis. Belmont, California: Wadsworth International Group, 1983:91-104,121-3.
6. CDC. Assessment of laboratory reporting to supplement active AIDS surveillance—Colorado. *MMWR* 1993;42:749-52.
7. Rosenberg PS, Gail MH. Estimating HIV prevalence and projecting AIDS incidence in the United States: a model that accounts for therapy and changes in the surveillance definition for AIDS. *Statistics in Medicine* 1992;11:1633-55.
8. Lemp GF, Hirozawa AM, Givertz D, et al. Seroprevalence of HIV and risk behaviors among young homosexual and bisexual men: The San Francisco/Berkeley Young Men's Survey. *JAMA* 1994;272:449-54.
9. CDC. AIDS among racial/ethnic minorities—United States, 1993. *MMWR* 1994;43:644-7,653-5.

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending November 12, 1994, with historical data — United States



*The large apparent decreases in the number of reported cases of measles (total), and rubella reflect dramatic fluctuations in the historical baseline. (Ratio (log scale) for week 45 measles (total) and rubella are 0.03994 and 0.08043 respectively).

[†]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 November 12, 1994 (45th Week)

	Cum. 1994		Cum. 1994
AIDS*	66,921	Measles: imported	172
Anthrax	-	indigenous	692
Botulism: Foodborne	48	Plague	14
Infant	63	Poliomyelitis, Paralytic [§]	1
Other	7	Psittacosis	36
Brucellosis	78	Rabies, human	1
Cholera	29	Syphilis, primary & secondary	18,252
Congenital rubella syndrome	3	Syphilis, congenital, age < 1 year	1,123
Diphtheria	1	Tetanus	32
Encephalitis, post-infectious	96	Toxic shock syndrome	156
Gonorrhea	340,256	Trichinosis	32
<i>Haemophilus influenzae</i> (invasive disease) [†]	995	Tuberculosis	18,938
Hansen Disease	106	Tularemia	79
Leptospirosis	32	Typhoid fever	372
Lyme Disease	9,698	Typhus fever, tickborne (RMSF)	405

*Updated monthly to the Division of HIV/AIDS, National Center for Infectious Diseases; last update October 25, 1994.

[†]Of 948 cases of known age, 265 (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 first second 1994.

TABLE II. Cases of selected notifiable diseases, United States, weeks ending November 12, 1994, and November 13, 1993 (45th 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. 1993	Cum. 1994	Cum. 1994		
UNITED STATES	66,921	6,939	566	96	340,256	346,335	19,637	9,926	3,754	368	1,381	9,698
NEW ENGLAND	2,451	262	16	4	7,382	6,630	250	267	115	15	71	2,413
Maine	71	29	3	-	82	72	23	11	-	-	5	26
N.H.	52	27	-	2	95	62	14	21	8	-	-	26
Vt.	29	34	2	-	31	22	10	-	-	-	-	13
Mass.	1,245	73	9	1	2,832	2,676	93	162	87	13	55	221
R.I.	225	99	2	1	407	367	23	8	20	2	11	453
Conn.	829	-	-	-	3,935	3,431	87	65	-	-	-	1,674
MID. ATLANTIC	19,665	797	50	17	37,541	40,652	1,451	1,268	400	9	236	5,979
Upstate N.Y.	1,801	379	29	3	9,060	8,786	461	330	199	5	59	3,653
N.Y. City	11,313	127	7	5	13,353	10,703	591	322	1	-	10	26
N.J.	4,424	-	-	-	4,200	5,032	243	318	169	-	38	1,178
Pa.	2,127	291	14	9	10,928	16,131	156	298	31	4	129	1,122
E.N. CENTRAL	5,255	1,302	142	22	65,392	73,760	1,992	970	272	10	408	116
Ohio	940	339	50	4	18,985	19,418	849	141	21	-	179	69
Ind.	534	180	11	1	7,904	7,438	341	167	10	-	103	14
Ill.	2,584	311	46	5	16,655	25,521	380	198	57	3	24	8
Mich.	895	465	31	12	15,878	15,578	267	344	181	7	73	25
Wis.	302	7	4	-	5,970	5,805	155	120	3	-	29	-
W.N. CENTRAL	1,387	379	27	8	19,396	19,028	1,008	569	88	10	84	230
Minn.	341	21	2	-	2,896	2,093	212	55	20	1	1	165
Iowa	91	111	1	1	1,353	1,404	56	24	12	9	30	15
Mo.	624	138	7	4	10,743	11,551	490	433	29	-	32	36
N. Dak.	22	12	3	-	18	48	5	-	-	-	4	-
S. Dak.	15	2	3	-	172	229	34	2	-	-	1	-
Nebr.	77	33	5	3	1,060	484	118	27	12	-	10	2
Kans.	217	62	6	-	3,154	3,219	93	28	15	-	6	12
S. ATLANTIC	15,911	1,335	136	27	94,704	86,780	1,260	2,035	563	47	317	717
Del.	230	34	1	-	1,718	1,320	17	5	1	-	26	70
Md.	2,455	223	20	4	15,491	14,036	181	371	30	16	85	284
D.C.	1,226	50	-	1	6,208	4,431	23	51	1	-	10	7
Va.	986	273	29	6	11,736	10,204	164	114	25	7	8	122
W. Va.	64	32	45	-	713	577	18	39	36	-	4	23
N.C.	1,027	206	40	1	24,664	21,871	119	240	52	-	25	76
S.C.	1,042	30	-	-	11,575	9,233	36	30	9	-	15	7
Ga.	1,905	47	1	-	1,819	4,660	24	525	174	-	98	103
Fla.	6,976	440	-	15	20,780	20,448	678	660	235	24	46	25
E.S. CENTRAL	1,761	459	34	3	40,788	39,869	546	1,035	819	2	66	38
Ky.	273	159	14	1	4,487	4,262	133	66	26	-	9	21
Tenn.	599	97	12	-	13,318	12,284	258	893	777	1	39	11
Ala.	518	154	6	1	13,181	14,289	90	76	16	1	13	6
Miss.	371	49	2	1	9,802	9,034	65	-	-	-	5	-
W.S. CENTRAL	6,509	766	47	2	41,459	39,061	2,834	1,311	534	69	40	116
Ark.	226	47	-	-	5,666	6,564	172	24	7	2	9	8
La.	1,032	32	7	-	10,561	10,327	137	149	162	1	13	1
Okla.	234	-	-	-	3,259	4,062	329	285	304	3	11	67
Tex.	5,017	687	40	2	21,973	18,108	2,196	853	61	63	7	40
MOUNTAIN	1,980	302	11	4	8,268	9,977	3,727	550	396	57	85	19
Mont.	23	8	-	-	76	70	21	22	13	-	14	-
Idaho	50	6	-	-	76	158	320	69	67	1	2	3
Wyo.	16	4	2	2	76	73	28	23	157	-	6	5
Colo.	723	113	2	-	2,809	3,304	514	89	60	14	18	-
N. Mex.	190	18	-	-	925	862	992	182	46	11	3	8
Ariz.	526	63	1	1	2,775	3,503	1,106	44	12	11	14	-
Utah	122	49	2	1	231	385	531	70	26	6	7	2
Nev.	330	41	4	-	1,300	1,622	215	51	15	14	21	1
PACIFIC	12,002	1,337	103	9	25,326	30,578	6,569	1,921	567	149	74	70
Wash.	820	-	-	-	2,546	3,241	313	66	66	2	8	-
Oreg.	512	-	-	-	570	1,030	670	75	17	1	-	-
Calif.	10,475	1,194	100	8	20,914	25,262	5,342	1,742	479	143	62	70
Alaska	36	17	3	-	758	547	188	11	-	-	-	-
Hawaii	159	126	-	1	538	498	56	27	5	3	4	-
Guam	1	19	-	-	190	84	42	6	1	12	3	-
P.R.	1,929	30	1	3	396	450	77	327	148	11	-	-
V.I.	44	-	-	-	25	87	-	1	-	-	-	-
Amer. Samoa	-	-	-	-	31	40	7	-	-	-	-	-
C.N.M.I.	-	-	-	-	44	74	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 October 25, 1994.

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending November 12, 1994, and November 13, 1993 (45th Week)

Reporting Area	Measles (Rubeola)						Meningococcal Infections	Mumps		Pertussis			Rubella		
	Malaria	Indigenous		Imported*		Total		1994	Cum. 1994	1994	Cum. 1994	Cum. 1993	1994	Cum. 1994	Cum. 1993
		Cum. 1994	1994	Cum. 1994	1994										
UNITED STATES	912	7	692	1	172	293	2,284	14	1,207	41	2,999	5,461	1	212	174
NEW ENGLAND	74	-	14	-	14	63	117	-	19	-	324	671	-	128	2
Maine	6	-	1	-	4	1	19	-	3	-	18	15	-	-	1
N.H.	3	-	1	-	4	2	6	-	4	-	55	147	-	-	-
Vt.	3	-	2	-	1	31	3	-	-	-	40	88	-	-	-
Mass.	32	-	2	-	6	18	51	-	3	-	173	343	-	124	1
R.I.	8	-	4	-	3	2	-	-	2	-	6	7	-	2	-
Conn.	22	-	4	-	-	9	38	-	7	-	32	71	-	2	-
MID. ATLANTIC	179	-	167	-	23	29	233	1	95	16	546	820	1	10	59
Upstate N.Y.	44	-	13	-	3	7	82	1	27	16	215	301	1	7	17
N.Y. City	64	-	11	-	3	13	11	-	13	-	140	74	-	1	22
N.J.	43	-	139	-	14	9	52	-	6	-	10	79	-	2	15
Pa.	28	-	4	-	3	-	88	-	49	-	181	366	-	-	5
E.N. CENTRAL	96	-	58	-	44	31	365	1	210	1	374	1,366	-	11	8
Ohio	15	-	15	-	2	9	104	-	64	-	143	387	-	-	1
Ind.	14	-	-	-	1	1	68	-	7	-	56	133	-	-	3
Ill.	39	-	17	-	39	9	107	-	94	-	79	402	-	3	1
Mich.	26	-	23	-	2	6	52	1	41	1	46	105	-	8	2
Wis.	2	-	3	-	-	6	34	-	4	-	50	339	-	-	1
W.N. CENTRAL	42	-	126	-	44	3	165	-	61	2	189	509	-	2	1
Minn.	13	-	-	-	-	-	17	-	5	-	85	294	-	-	-
Iowa	5	-	6	-	1	-	18	-	16	1	19	36	-	-	-
Mo.	12	-	118	-	42	1	84	-	34	1	41	134	-	2	1
N. Dak.	1	-	-	-	-	-	1	-	5	-	4	5	-	-	-
S. Dak.	-	-	-	-	-	-	9	-	-	-	19	8	-	-	-
Nebr.	5	U	1	U	1	-	13	U	1	U	9	13	U	-	-
Kans.	6	-	1	-	-	2	23	-	-	-	12	19	-	-	-
S. ATLANTIC	205	6	66	-	8	28	393	4	174	3	285	563	-	11	6
Del.	3	-	-	-	-	-	5	-	-	-	3	9	-	-	-
Md.	98	-	2	-	2	4	39	1	58	-	74	120	-	-	2
D.C.	14	-	-	-	-	-	4	-	-	-	8	13	-	-	-
Va.	32	-	1	-	2	4	64	-	39	-	36	59	-	-	-
W. Va.	-	-	36	-	-	-	12	-	3	-	4	8	-	-	-
N.C.	11	-	2	-	1	-	48	-	36	1	79	151	-	-	-
S.C.	4	-	-	-	-	-	27	-	7	-	13	70	-	-	-
Ga.	22	-	3	-	-	-	68	-	8	-	25	50	-	2	-
Fla.	21	6	22	-	3	20	126	3	23	2	43	83	-	9	4
E.S. CENTRAL	31	-	28	-	-	1	135	1	21	2	121	269	-	-	1
Ky.	11	-	-	-	-	-	35	-	-	-	59	36	-	-	1
Tenn.	10	-	28	-	-	-	35	1	9	-	22	165	-	-	-
Ala.	9	-	-	-	-	1	65	-	5	2	33	58	-	-	-
Miss.	1	-	-	-	-	-	-	-	7	-	7	10	-	-	-
W.S. CENTRAL	41	1	11	1	8	10	285	1	229	4	184	138	-	13	17
Ark.	3	-	-	-	1	-	40	-	1	-	27	10	-	-	-
La.	8	-	-	-	1	1	34	-	27	-	10	12	-	-	1
Okla.	7	-	-	-	-	-	30	-	23	-	26	74	-	4	1
Tex.	23	1	11	1 [†]	6	9	181	1	178	4	121	42	-	9	15
MOUNTAIN	29	-	150	-	17	6	145	5	146	10	359	394	-	6	11
Mont.	-	-	-	-	-	-	6	-	-	-	8	9	-	-	-
Idaho	2	-	1	-	-	-	16	1	9	-	49	94	-	-	2
Wyo.	1	-	-	-	-	-	7	-	2	-	-	1	-	-	-
Colo.	13	-	16	-	3	3	29	-	3	1	123	160	-	-	2
N. Mex.	3	-	-	-	-	-	13	N	N	1	23	39	-	1	-
Ariz.	4	-	2	-	1	2	46	-	90	5	129	51	-	-	2
Utah	4	-	131	-	2	-	18	-	24	3	24	36	-	4	4
Nev.	2	-	-	-	11	1	10	4	17	-	3	4	-	1	1
PACIFIC	215	-	72	-	14	122	446	1	252	3	617	731	-	31	69
Wash.	11	-	-	-	-	-	30	-	7	1	32	68	-	-	-
Oreg.	12	-	-	-	1	4	84	N	N	-	38	89	-	2	-
Calif.	174	-	56	-	9	96	323	1	224	1	525	563	-	24	40
Alaska	2	-	16	-	-	2	2	-	4	-	1	5	-	1	1
Hawaii	16	-	-	-	4	20	7	-	17	1	21	6	-	4	28
Guam	4	U	211	U	-	3	1	U	6	U	2	-	U	1	-
P.R.	3	-	13	-	-	353	15	-	2	-	1	8	-	-	-
V.I.	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	1	-	2	2	-	-	-
C.N.M.I.	1	U	26	U	-	15	-	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 November 12, 1994, and November 13, 1993 (45th 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	18,252	23,045	156	18,938	19,505	79	372	405	6,544
NEW ENGLAND	185	328	4	428	451	1	21	15	1,666
Maine	4	7	1	27	22	-	-	-	-
N.H.	3	25	-	15	17	-	-	-	186
Vt.	-	1	1	6	5	-	-	-	125
Mass.	80	114	2	222	243	1	17	7	640
R.I.	13	14	-	37	52	-	1	-	44
Conn.	85	167	-	121	112	-	3	8	671
MID. ATLANTIC	1,186	2,042	26	3,801	4,155	1	100	17	1,676
Upstate N.Y.	161	209	13	448	604	1	11	6	1,221
N.Y. City	515	999	-	2,209	2,335	-	67	1	-
N.J.	192	268	-	682	653	-	17	4	238
Pa.	318	566	13	462	563	-	5	6	217
E.N. CENTRAL	2,454	3,739	30	1,846	2,017	8	69	45	55
Ohio	999	1,014	6	295	271	1	7	28	4
Ind.	228	323	2	168	197	2	7	5	13
Ill.	691	1,443	10	938	1,065	3	42	10	18
Mich.	256	508	12	394	406	1	6	2	12
Wis.	280	451	-	51	78	1	7	-	8
W.N. CENTRAL	1,024	1,441	24	501	432	36	1	35	183
Minn.	46	54	1	119	61	1	-	-	13
Iowa	56	60	8	53	47	-	-	1	76
Mo.	858	1,201	6	219	218	23	1	17	19
N. Dak.	-	4	1	8	6	1	-	-	9
S. Dak.	1	2	-	22	12	2	-	13	33
Nebr.	11	10	3	17	21	2	-	1	-
Kans.	52	110	5	63	67	7	-	3	33
S. ATLANTIC	5,276	5,796	8	3,539	3,907	2	46	192	1,771
Del.	24	90	-	26	41	-	1	-	41
Md.	264	328	-	293	337	1	13	22	474
D.C.	191	293	-	103	142	-	1	-	2
Va.	698	542	1	292	386	-	8	17	378
W. Va.	9	12	-	70	66	-	-	2	69
N.C.	1,461	1,670	1	423	459	-	-	76	154
S.C.	709	841	-	304	340	-	-	18	158
Ga.	1,247	969	1	654	660	1	2	54	336
Fla.	673	1,051	5	1,374	1,476	-	21	3	159
E.S. CENTRAL	3,422	3,560	5	1,196	1,420	1	2	40	200
Ky.	191	311	2	270	322	1	1	9	20
Tenn.	919	1,018	2	351	443	-	1	25	71
Ala.	563	731	1	377	433	-	-	2	109
Miss.	1,749	1,500	-	198	222	-	-	4	-
W.S. CENTRAL	3,882	4,833	1	2,606	2,236	17	15	47	611
Ark.	404	501	-	233	158	16	-	8	25
La.	1,503	2,250	-	138	220	-	3	-	63
Okla.	111	243	1	224	145	1	3	32	37
Tex.	1,864	1,839	-	2,011	1,713	-	9	7	486
MOUNTAIN	205	218	8	429	483	9	10	14	128
Mont.	4	1	-	9	13	3	-	4	18
Idaho	1	-	2	11	12	-	-	-	3
Wyo.	1	8	-	8	5	-	-	2	19
Colo.	110	69	4	21	72	1	3	4	15
N. Mex.	19	24	-	54	59	1	1	2	7
Ariz.	34	91	-	192	207	-	2	1	44
Utah	8	10	2	41	30	2	2	-	13
Nev.	28	15	-	93	85	2	2	1	9
PACIFIC	618	1,088	50	4,592	4,404	4	108	-	254
Wash.	30	54	3	224	229	-	3	-	-
Oreg.	21	37	-	90	-	2	5	-	12
Calif.	561	983	43	3,999	3,905	1	95	-	212
Alaska	4	8	-	56	52	1	-	-	30
Hawaii	2	6	4	223	218	-	5	-	-
Guam	10	3	-	153	61	-	1	-	-
P.R.	261	451	-	159	165	-	-	-	57
V.I.	25	39	-	-	2	-	-	-	-
Amer. Samoa	1	-	-	4	4	-	1	-	-
C.N.M.I.	2	7	-	33	38	-	1	-	-

U: Unavailable

TABLE III. Deaths in 121 U.S. cities,* week ending
November 12, 1994 (45th Week)

Reporting Area	All Causes, By Age (Years)						P&I [†] Total	Reporting Area	All Causes, By Age (Years)						P&I [†] Total
	All Ages	≥65	45-64	25-44	1-24	<1			All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	507	355	83	51	13	5	42	S. ATLANTIC	1,243	743	243	177	52	27	53
Boston, Mass.	150	93	33	18	6	-	15	Atlanta, Ga.	124	72	21	26	2	3	5
Bridgeport, Conn.	39	28	5	3	2	1	4	Baltimore, Md.	231	132	44	34	12	8	21
Cambridge, Mass.	24	17	4	3	-	-	5	Charlotte, N.C.	73	49	12	7	3	2	1
Fall River, Mass.	12	8	3	1	-	-	-	Jacksonville, Fla.	91	62	19	7	3	-	3
Hartford, Conn.	32	22	7	2	1	-	1	Miami, Fla.	103	54	18	21	7	3	-
Lowell, Mass.	24	18	4	2	-	-	2	Norfolk, Va.	53	28	10	10	3	2	2
Lynn, Mass.	16	8	3	4	-	1	1	Richmond, Va.	88	56	18	9	3	2	4
New Bedford, Mass.	18	15	2	1	-	-	2	Savannah, Ga.	40	23	12	5	-	-	2
New Haven, Conn.	45	31	3	8	2	1	3	St. Petersburg, Fla.	63	44	13	2	3	1	3
Providence, R.I.	34	29	3	1	-	1	2	Tampa, Fla.	168	121	25	17	3	2	9
Somerville, Mass.	3	3	-	-	-	-	-	Washington, D.C.	196	92	49	39	12	4	3
Springfield, Mass.	43	35	6	2	-	-	5	Wilmington, Del.	13	10	2	-	1	-	-
Waterbury, Conn.	16	11	4	-	1	-	-	E.S. CENTRAL	747	501	158	56	18	14	35
Worcester, Mass.	51	37	6	6	1	1	2	Birmingham, Ala.	130	85	23	17	1	4	2
MID. ATLANTIC	2,231	1,446	431	261	46	47	125	Chattanooga, Tenn.	59	37	17	3	1	1	2
Albany, N.Y.	56	38	10	3	5	-	4	Knoxville, Tenn.	52	35	7	6	3	1	3
Allentown, Pa.	23	17	2	4	-	-	1	Lexington, Ky.	75	55	16	3	-	1	6
Buffalo, N.Y.	77	70	3	1	-	3	14	Memphis, Tenn.	181	118	41	15	5	2	14
Camden, N.J.	23	17	3	2	-	1	-	Mobile, Ala.	64	45	13	2	2	2	3
Elizabeth, N.J.	U	U	U	U	U	U	U	Montgomery, Ala.	48	36	9	3	-	-	-
Erie, Pa.‡	47	43	2	2	-	-	5	Nashville, Tenn.	138	90	32	7	6	3	5
Jersey City, N.J.	54	25	12	12	1	4	3	W.S. CENTRAL	1,216	733	277	135	45	23	81
New York City, N.Y.	1,058	663	214	147	22	12	36	Austin, Tex.	61	41	10	8	1	1	5
Newark, N.J.	88	42	25	16	-	5	2	Baton Rouge, La.	43	26	12	1	3	1	1
Paterson, N.J.	19	10	6	2	-	1	1	Corpus Christi, Tex.	31	20	9	1	-	1	-
Philadelphia, Pa.	393	240	87	45	10	11	25	Dallas, Tex.	172	94	40	26	9	3	2
Pittsburgh, Pa.§	56	34	14	3	5	-	3	El Paso, Tex.	75	48	15	4	5	2	9
Reading, Pa.	13	8	3	1	-	1	1	Ft. Worth, Tex.	104	66	18	9	3	8	4
Rochester, N.Y.	110	81	13	10	2	4	9	Houston, Tex.	282	140	81	45	14	2	29
Schenectady, N.Y.	15	13	1	-	1	-	2	Little Rock, Ark.	48	29	13	6	-	-	3
Scranton, Pa.§	38	31	6	1	-	-	5	New Orleans, La.	123	81	21	13	2	4	-
Syracuse, N.Y.	85	67	14	4	-	-	10	San Antonio, Tex.	141	98	26	10	7	-	16
Trenton, N.J.	41	21	12	3	-	5	2	Shreveport, La.	42	28	7	7	-	-	6
Utica, N.Y.	11	10	-	1	-	-	-	Tulsa, Okla.	94	62	25	5	1	1	6
Yonkers, N.Y.	24	16	4	4	-	-	2	MOUNTAIN	800	529	142	66	36	27	55
E.N. CENTRAL	2,117	1,323	389	234	109	62	107	Albuquerque, N.M.	86	61	12	6	2	5	1
Akron, Ohio	51	38	10	3	-	-	-	Colo. Springs, Colo.	49	31	13	2	1	2	2
Canton, Ohio	32	25	5	1	1	-	6	Denver, Colo.	78	44	13	12	4	5	7
Chicago, Ill.	445	169	94	101	68	13	17	Las Vegas, Nev.	160	108	33	10	4	5	13
Cincinnati, Ohio	142	91	33	12	2	4	10	Ogden, Utah	20	13	3	-	2	2	-
Cleveland, Ohio	167	112	33	14	4	4	3	Phoenix, Ariz.	118	78	21	12	7	-	11
Columbus, Ohio	179	126	30	14	4	5	10	Pueblo, Colo.	25	21	1	2	1	-	4
Dayton, Ohio	82	57	14	7	4	-	4	Salt Lake City, Utah	116	71	18	15	7	5	7
Detroit, Mich.	221	126	44	33	6	12	4	Tucson, Ariz.	148	102	28	7	8	3	10
Evansville, Ind.	49	35	5	5	2	2	3	PACIFIC	1,404	933	254	139	32	24	100
Fort Wayne, Ind.	51	35	13	-	2	1	1	Berkeley, Calif.	11	9	1	1	-	-	1
Gary, Ind.	10	3	4	1	1	1	-	Fresno, Calif.	100	71	18	6	4	1	10
Grand Rapids, Mich.	64	55	3	3	1	2	10	Glendale, Calif.	23	20	-	2	1	-	1
Indianapolis, Ind.	162	108	30	15	6	3	11	Honolulu, Hawaii	46	33	7	5	-	1	2
Madison, Wis.	50	33	12	2	2	1	3	Long Beach, Calif.	69	43	10	12	3	1	9
Milwaukee, Wis.	124	98	14	5	2	5	6	Los Angeles, Calif.	357	223	73	40	12	5	10
Peoria, Ill.	36	23	10	-	1	2	4	Pasadena, Calif.	28	23	3	-	1	1	5
Rockford, Ill.	54	43	5	2	2	2	4	Portland, Oreg.	145	108	25	9	-	3	12
South Bend, Ind.	55	44	5	5	-	1	2	Sacramento, Calif.	U	U	U	U	U	U	U
Toledo, Ohio	95	68	17	6	-	4	8	San Diego, Calif.	120	72	25	17	3	3	12
Youngstown, Ohio	48	34	8	5	1	-	1	San Francisco, Calif.	114	56	23	14	1	2	7
W.N. CENTRAL	627	453	106	43	13	11	32	San Jose, Calif.	125	90	21	11	2	1	16
Des Moines, Iowa	34	25	5	3	1	-	4	Santa Cruz, Calif.	40	34	4	2	-	-	5
Duluth, Minn.	31	25	4	2	-	-	1	Seattle, Wash.	116	70	27	13	2	4	2
Kansas City, Kans.	8	8	-	-	-	-	-	Spokane, Wash.	48	34	8	4	2	-	3
Kansas City, Mo.	86	57	20	6	1	2	3	Tacoma, Wash.	62	47	9	3	1	2	5
Lincoln, Nebr.	27	17	10	-	-	-	-	TOTAL	10,892 [¶]	7,016	2,083	1,162	364	240	630
Minneapolis, Minn.	163	122	23	15	2	1	17								
Omaha, Nebr.	96	65	20	5	3	3	3								
St. Louis, Mo.	90	64	11	8	5	2	-								
St. Paul, Minn.	60	42	12	2	1	3	3								
Wichita, Kans.	32	28	1	2	-	-	1								

*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.

Current Trends

Pregnancies Complicated by Diabetes — North Dakota, 1980–1992

Women with established diabetes mellitus* (EDM) or gestational diabetes mellitus† (GDM) are at increased risk for maternal complications during pregnancy; infants born to women with diabetes also are at increased risk for adverse outcomes, including infant death, congenital malformation, birth injury, and hyaline membrane disease/respiratory distress syndrome (1). These health problems may be prevented in women with diabetes through improved glycemic control and through preconception and prenatal care (2,3). Population-based surveillance of EDM and GDM can assist in measuring the burden of diabetes during pregnancy and in identifying target groups for interventions (4). To determine the prevalence of pregnancies complicated by diabetes in North Dakota, the North Dakota State Department of Health and Consolidated Laboratories (NDSDH) studied birth certificate data for 1980–1992. This report summarizes the results of that assessment.

NDSDH compiled data from all North Dakota birth certificates for live infants. On birth certificates issued during 1980–1988, diabetes (specified as either EDM or GDM) was recorded as a line item under concurrent conditions affecting pregnancy on the *U.S. Standard Certificate of Live Birth*. In 1989, the *U.S. Standard Certificate of Live Birth* was revised to collect information about several medical risk factors, including diabetes. A check box on this revised certificate indicated whether the mother had concurrent diabetes but did not specify EDM or GDM. During 1989–1991, NDSDH contacted health-care providers to determine this information and enter it into the vital record. In 1992, North Dakota revised this standard certificate to include separate check boxes for EDM and GDM.

From 1980 through 1992, a total of 140,720 infants were born to women who were North Dakota residents. Of these pregnancies, 1433 (1.0%) were complicated by diabetes—324 (0.2%) by EDM and 1109 (0.8%) by GDM. The age-standardized prevalence of EDM was unchanged from 1980 (0.2%) to 1988 (0.2%) but increased in 1991 (0.3%) and 1992 (0.4%) (Figure 1). During the study period, the age-standardized prevalence of GDM increased substantially and in 1988 (0.9%) was approximately four times greater than that in 1980 (0.2%). Compared with 1980–1988, the prevalence of GDM further increased during 1989–1991 (1989 prevalence: 1.5%) and increased again in 1992 (1.7% prevalence).

Among women aged <30 years, the prevalence of pregnancy complicated by EDM increased from 0.2% in 1980 to 0.3% in 1992; among women aged ≥30 years, the prevalence increased from 0.4% in 1980 to 0.5% in 1992. The prevalence of GDM among women aged <30 years increased from 0.1% in 1980 to 1.5% in 1992; among women aged ≥30 years, the prevalence increased from 0.2% in 1980 to 2.8% in 1992.

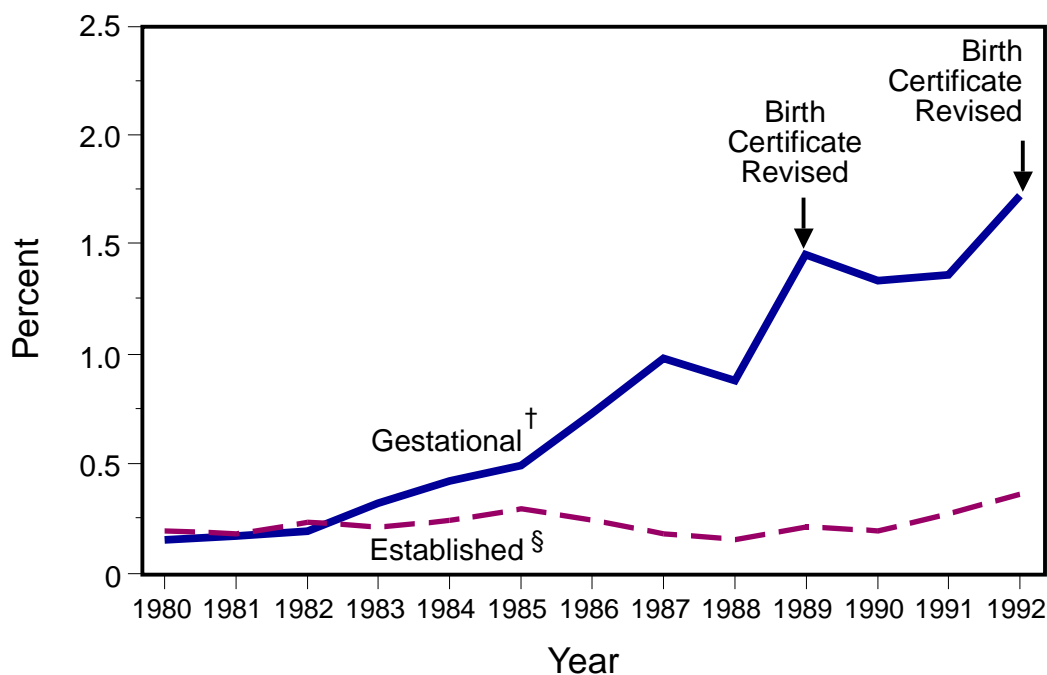
Reported by: DR Schaubert, MS, DA Mayer, LA Shireley, MPH, State Epidemiologist, Div of Disease Control, North Dakota State Dept of Health and Consolidated Laboratories. Epidemiology and Statistics Br, Div of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, CDC.

*Insulin-dependent or noninsulin-dependent diabetes mellitus diagnosed before pregnancy.

†Diabetes that develops or is first diagnosed during pregnancy.

Diabetes — Continued

FIGURE 1. Age-standardized* prevalence of diabetes during pregnancy — North Dakota, 1980–1992



* Directly standardized to the 1980 maternal age distribution.

† Diabetes that develops or is first diagnosed during pregnancy.

§ Insulin-dependent or noninsulin-dependent diabetes mellitus diagnosed before pregnancy.

Editorial Note: The findings in this report indicate increases in the proportion of pregnancies complicated by diabetes in North Dakota during 1980–1992 and, consistent with previous studies, a higher prevalence of diabetes-complicated pregnancies among older mothers (5). To increase preconception and nutritional counseling and appropriate prenatal care, the North Dakota Diabetes and Pregnancy Program is using the findings from this report to promote awareness among health-care providers about the increasing burden of diabetes-complicated pregnancies and to obtain health insurance reimbursement for pregnancy services for women with diabetes (4,6).

The secular increase in prevalence of diabetes-complicated pregnancies documented in North Dakota may have been associated with at least three factors. First, revisions of the *U.S. Standard Certificate of Live Birth* may have resulted in increased reporting of diabetes-complicated pregnancies, particularly the nearly nine-fold increase in GDM. Second, the increase may reflect increased awareness of GDM by health-care providers, especially during the 1980s when risk factors for this condition were described and screening recommendations published (7,8). Third, the increases in EDM and GDM since 1980 may reflect an increasing secular trend in some associated risk factors. For example, in the United States, the prevalence of obesity among women of reproductive age increased substantially during 1976–1991 (9).

Although hospital- or institution-based prevalence studies can provide useful information about EDM and GDM, they cannot provide population-based estimates that enable public health programs to target intervention efforts. As part of a comprehen-

Diabetes — Continued

sive program to reduce the burden of diabetes at both state and national levels, CDC has recommended the expanded use of data from the *U.S. Standard Certificate of Live Birth* to assess the prevalence of diabetes-complicated pregnancies. In addition, CDC has recommended the incorporation into birth certificates of separate check boxes for EDM and GDM (1).

References

1. CDC. Pregnancy complications and perinatal outcomes among women with diabetes—North Carolina, 1989–1990. *MMWR* 1993;42:847–51.
2. Rowe BR, Rowbotham CJ, Barnett AH. Pre-conception counselling, birthweight, and congenital abnormalities in established and gestational diabetic pregnancies. *Diabetes Res* 1987;6:33–5.
3. Willhoite MB, Bennert HW Jr, Palomaki GE, et al. The impact of preconception counselling on pregnancy outcomes. *Diabetes Care* 1993;16:450–5.
4. CDC. Public health guidelines for enhanced diabetes control through maternal- and child-health programs. *MMWR* 1986;35:201–8,213.
5. Barden TP, Knowles HC. Diagnosis of diabetes in pregnancy. *Clin Obstet Gynecol* 1981;3:447–52.
6. American Diabetes Association. Standards of medical care for patients with diabetes mellitus. *Diabetes* 1994;17:616–23.
7. Miller E, Hare JW, Cloherty JP, et al. Elevated maternal hemoglobin A_{1c} in early pregnancy and major congenital anomalies in infants of diabetic mothers. *N Engl J Med* 1981;304:1331–4.
8. Summary and recommendations of the Second International Workshop—Conference on Gestational Diabetes Mellitus. *Diabetes* 1985;34(suppl 2):123–6.
9. Kuczmarski RJ, Flegal KM, Campbell SM, Johnson CL. Increasing prevalence of overweight among US adults: the national health and nutritional examination surveys, 1960 to 1991. *JAMA* 1994;272:205–11.

*Health Objectives for the Nation***Selected Characteristics of Local Health Departments —
United States, 1992–1993**

A year 2000 national health objective is to increase to at least 90% the proportion of persons who are served by a local health department (LHD) that is effectively performing the core functions of public health (objective 8.14) (1). A framework for examining essential roles and services of LHDs is critical to developing a surveillance system to monitor progress toward this goal (2–4). To characterize the activities, staff, expenditures, and jurisdictions of LHDs in the United States, during 1992–1993 the National Association of County and City Health Officials (NACCHO), in collaboration with CDC, surveyed all LHDs. This report summarizes the services provided by LHDs by population of the jurisdiction, the expenditures and staff to support these services, and type of jurisdiction.

For this survey, an LHD was defined as “an administrative or service unit of local or state government concerned with health and carrying some responsibility for the health of a jurisdiction smaller than the state.” LHDs were identified from the 1990 NACCHO Profile database (5) through a review of NACCHO member mailing lists and inquiries to selected state health agencies. The questionnaire was mailed in November 1992 to LHDs in 49 states and the District of Columbia (Rhode Island had no LHDs

Local Health Departments — Continued

meeting the study definition). Three follow-up mailings and telephone calls were made to nonrespondents. Data collection ended in December 1993.

Overall, 2079 (72%) of the LHDs that met the study definition (n=2888) returned completed questionnaires. The estimated total population served by the responding LHDs was approximately 85% of the 1990 U.S. total (249 million); 1710 (82%) respondents served jurisdictions with populations less than 100,000, and 369 (18%) served jurisdictions with 100,000 or more.

Surveillance data. Data maintained by LHDs for surveillance activities included communicable diseases (82%), vital records (53%), drinking water supply (49%), chronic diseases (42%), recreational water quality (30%), behavioral risk factors (20%), injury (19%), and air quality (14%).

Program planning. Resources used by LHDs to guide program planning included *Healthy People 2000* by 70%, *Healthy Communities 2000 Model Standards* by 47%, the *Assessment Protocol for Excellence in Public Health* by 32%, and the *Planned Approach to Community Health* by 12%.

Agency services. The percentage of LHDs reporting activity in specific services generally increased in relation to the size of population served by the LHD. In addition to community prevention services (Table 1), substantial numbers of LHDs provided clinical prevention and health-care services (Table 2). Overall, 57% of LHDs reported they had conducted evaluations to determine whether a gap existed between available clinical prevention services and a need for these services in their jurisdictions. Of these LHDs, 83% reported the provision of clinical prevention service programs to address the gaps.

Personnel and budget. In general, LHD staff and annual expenditures increased in relation to the population served: for the 82% of LHDs serving less than 100,000 persons, the median number of full-time staff was nine, and the median annual expenditure was \$350,000. In comparison, for the 18% of LHDs serving 100,000 or more, the median number of full-time staff was 94, and the median annual expenditure was \$4.5 million.

Jurisdictional units. Geographic areas served by LHDs were single county (56%), multicounty districts (11%), city (7%), city/county units (13%), and town or township jurisdictions (11%).

Reported by: C Brown, N Rawding, D Custer, National Association of County and City Health Officials. Div of Public Health Systems, Public Health Practice Program Office, CDC.

Editorial Note: The findings from this survey of LHDs are being used to develop plans for a surveillance system for the year 2000 national health objective 8.14 and may be used as a baseline for evaluating potential changes in the role of LHDs associated with changes in the U.S. health-care system. For example, recent proposals have described the primary role for LHDs as the providers of surveillance, health planning, and community prevention programs; responsibilities for clinical prevention services and health-care services currently performed by LHDs potentially might be addressed through managed care or other health-care providers (2,4,6).

The findings in this survey are subject to at least two limitations. First, the results cannot be directly compared with the 1990 NACCHO Profile (5); because the set of respondents for this survey varied from the 1990 survey, temporal trends can be evaluated only by analyzing the subset of respondents that participated in both sur-

TABLE 1. Percentage distribution of selected community prevention services, by size of jurisdiction served — United States, 1992–1993

Community service	Size of jurisdiction served						Total		
	<100,000 Persons			≥100,000 Persons			Total (N=2079)*	Respondents†	
	Total* (n=1710)	No.	(%)	Total* (n=369)	No.	(%)		No.	(%)
Vaccinations	1707	1626	(95)	368	365	(99)	2075	1991	(96)
Tuberculosis services	1697	1420	(84)	367	348	(95)	2064	1768	(86)
High blood pressure	1704	1460	(86)	367	298	(81)	2071	1758	(85)
Sewage-disposal systems	1704	1231	(72)	367	310	(84)	2071	1541	(74)
Private water supply safety	1699	1232	(72)	368	294	(80)	2067	1526	(74)
Sexually transmitted diseases testing and counseling	1702	1119	(66)	368	347	(94)	2070	1466	(71)
HIV/AIDS testing and counseling	1705	1073	(63)	368	345	(94)	2073	1418	(68)
Family planning	1700	1106	(65)	365	296	(81)	2065	1402	(68)
Diabetes	1700	1033	(61)	363	214	(59)	2063	1247	(60)
Laboratory services	1698	941	(55)	364	305	(84)	2062	1246	(60)
School health	1693	1015	(60)	363	217	(60)	2056	1232	(60)
Environmental emergency response	1694	909	(54)	363	262	(72)	2057	1171	(57)
Vector control	1671	916	(55)	366	252	(69)	2037	1168	(57)
Cancer	1695	899	(53)	367	205	(56)	2062	1104	(54)

* Total number of local health departments responding to survey questions.

† Number and percentage of local health departments that directly provided a service or contracted to provide a service.

TABLE 2. Percentage distribution of selected clinical prevention and health-care services, by size of jurisdiction served — United States, 1992–1993

Service	Size of jurisdiction served						Total		
	<100,000 Persons			≥100,000 Persons			Total* (n=2079)	Respondents†	
	Total* (n=1710)	No.	(%)	Total* (n=369)	No.	(%)		No.	(%)
Clinical prevention services									
Well-child clinic	1695	1296	(77)	367	338	(92)	2062	1634	(79)
Women, infants, and children (WIC)	1695	1285	(76)	367	327	(89)	2062	1612	(78)
Early and periodic screening, diagnosis, and treatment for low-income children	1683	1155	(69)	359	310	(86)	2042	1465	(72)
Prenatal care	1701	1017	(60)	368	304	(83)	2069	1321	(64)
Health-care services									
Children with special health-care needs	1701	1069	(63)	363	270	(74)	2064	1339	(65)
Home health care	1700	946	(56)	362	162	(45)	2062	1108	(54)
Dental health	1691	659	(39)	366	247	(68)	2057	906	(44)
Geriatric care	1691	613	(36)	362	166	(46)	2053	779	(38)
Obstetric care	1691	465	(28)	366	210	(57)	2057	675	(33)
HIV/AIDS treatment	1694	490	(29)	367	179	(49)	2061	669	(33)
Primary care	1690	430	(25)	364	192	(53)	2054	622	(30)
School-based clinics	1692	393	(23)	363	114	(31)	2055	507	(25)
Substance abuse	1695	301	(18)	362	134	(37)	2057	435	(21)
Mental health facilities and services	1699	172	(10)	361	67	(19)	2060	239	(12)

* Total number of local health departments responding to survey questions.

† Number and percentage of local health departments that directly provided a service or contracted to provide a service.

Local Health Departments — Continued

veys. Second, no definitions or criteria were provided for reporting services, and the scope, quality, and quantity of services were not verified.

Subsequent analyses by NACCHO and CDC will examine the subset of respondents who participated in the surveys in both 1989 and 1992–1993. Related efforts include development of scientifically valid measures of the effectiveness of public health agencies (7,8). Before implementation of a national surveillance system for the year 2000 national health objective 8.14, methods must be developed to measure whether a community and its LHD are effectively performing the core functions of public health. Specifically, methods are needed to determine means for creating and maintaining a healthy community (3); assess the effectiveness of community-based prevention services, programs, and policies (9); measure the contribution to public health performance made by community providers and agencies other than LHDs; develop a community health “report card” (4); and compare the public health performance of different communities and their LHDs.

References

1. Public Health Service. Healthy people 2000: national health promotion and disease prevention objectives—full report, with commentary. Washington, DC: US Department of Health and Human Services, Public Health Service, 1991; DHHS publication no. (PHS)91-50212.
2. Rundall TG. The integration of public health and medicine. *Front Health Serv Manage* 1994; 10:3–24.
3. National Association of County Health Officials. Blueprint for a healthy community: a guide for local health departments. Washington, DC: National Association of County Health Officials, 1994.
4. Baker EL, Melton RJ, Stange PV, et al. Health reform and the health of the public: forging community health partnerships. *JAMA* 1994;272:1276–82.
5. CDC. Selected characteristics of local health departments—United States, 1989. *MMWR* 1990; 39:607–10.
6. Oberle MW, Baker EL, Magenheimer MJ. *Healthy People 2000* and community health planning. *Annu Rev Public Health* 1994;15:259–75.
7. Turnock BJ, Handler A, Hall W, Potsic S, Nalluri R, Vaughn EH. Local health department effectiveness in addressing the core functions of public health. *Public Health Rep* 1994;109:653–8.
8. Miller CA, Moore KS, Richards TB, McKaig C. A screening survey to assess local public health performance. *Public Health Rep* 1994;109:659–64.
9. Fielding J, Halfon N. Where is the health in health system reform? *JAMA* 1994;272:1292–6.

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David Satcher, M.D., Ph.D.

Deputy Director, Centers for Disease Control
and Prevention
Claire V. Broome, M.D.

Director, Epidemiology Program Office
Stephen B. Thacker, M.D., M.Sc.

Editor, *MMWR* Series

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Darlene D. Rumph-Person

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