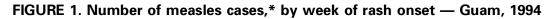


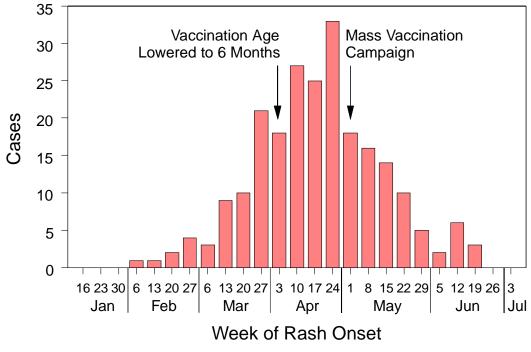


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Measles Outbreak — Guam, 1994

One of the largest outbreaks of measles in the United States and its territories since 1992 occurred in Guam during 1994. From February 8 through June 25, 1994, a total of 280 suspected, probable, or confirmed cases of measles were reported to the Guam Department of Public Health and Social Services (GDPH). Of these cases, 228 were considered confirmed, including 47 serologically confirmed cases (Figure 1). This report summarizes findings from the investigation of these 228 cases.





*n=228.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES / Public Health Service

Measles Outbreak — Continued

The index case occurred in an 8-month-old child who developed a rash on February 7, 1994. This case could not be epidemiologically linked to a previous measles outbreak in Guam (22 cases) that occurred during October 20–December 26, 1993; that outbreak was initiated by an imported case from the Republic of Palau. In addition, genetic sequencing of viral isolates indicated that viruses that had circulated in Palau and in Guam were different. The outbreak peaked in April, when 104 cases were reported.

The incidence of confirmed cases was 17 per 10,000 population. Patients ranged in age from 2 months to 57 years (median: 16 months), and 70% of cases occurred among preschool-aged children. The age-specific incidence was highest for children aged <1 year (318.0 per 10,000 population), and was higher for children aged 1–4 years (57.9) and 10–19 years (20.1) than for children aged 5–9 years (7.8) and persons aged \geq 20 years (4.8).

Of the 228 cases, 133 (58%) occurred among patients who were Chamorros (an ethnic group native to Guam), 45 (20%) occurred among persons from the Chuuk State of the Federated States of Micronesia (FSM), and 29 (13%) among Filipinos. The highest ethnicity-specific attack rate was among persons from FSM (91 per 10,000 population). The incidence among U.S. military personnel and dependents was three per 10,000 population.

Of the 138 (61%) patients aged \geq 12 months, measles vaccination history was known for 84 (61%). A history of receipt of at least one dose of measles-containing vaccine (MCV) was reported for 52 (62%) persons, and 14 (17%) had documentation of measles vaccination on or after their first birthday and at least 14 days before rash onset. Appropriate vaccination was documented for 7% of those aged 1–4 years and 25% of those aged 5–19 years. No cases were reported among persons who had received two doses of MCV.

Twenty-three (10%) patients were hospitalized, and three died (case-fatality rate=1.3%). The three fatal cases occurred among patients aged 9 months, 17 months, and 22 years who were immigrants or children of immigrants from the Chuuk State, FSM. The hospitalization rate was highest among children aged <6 months (four [22%] of 18).

Outbreak-control measures focused on vaccinating preschool-aged children and immigrants. Routine vaccination clinic hours were extended, and outreach clinics were provided in shopping centers, villages, and housing areas with large immigrant populations. On April 8, GDPH lowered the age for measles vaccination from 12 months to 6 months. In May, GDPH implemented a mass vaccination campaign and encouraged families to take all children aged 6 months–5 years to vaccination clinics for measles vaccination, regardless of previous vaccination history; children with documentation of two doses of MCV after age 12 months were not revaccinated. During March–June, approximately 12,000 doses of MCV were administered, 4000 of which were given to children aged <5 years. This was the first measles vaccination for 70% of the children who participated in the campaign. The campaign is estimated to have increased measles vaccination coverage among children aged <5 years to approximately 74%.

Other outbreak-control efforts included improving passive surveillance by providing outbreak information to health-care providers and active surveillance through periodic phone calls to the civilian hospital and private clinics, instituting triage and

Measles Outbreak — Continued

isolation for patients with rash illness in medical settings, exclusion of persons with cases from day care centers and schools and vaccination of their contacts, and disseminating public education messages about measles and measles vaccination.

Since June 25, when two cases imported from the Philippines were reported, no additional cases are known to have occurred.

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Editorial Note: The mass vaccination campaign in Guam appeared to be an effective strategy for controlling measles outbreaks among island populations. Although the campaign was initiated late in the course of the outbreak, the decline of the outbreak may have been accelerated by efforts to encourage all preschool-aged children to receive a dose of MCV, regardless of prior receipt of one dose of vaccine. Most of the preschool-aged children who participated in the campaign received their first dose of MCV during the campaign; among children who had already received a dose, the campaign also effectively lowered the age at which many children received a second dose of vaccine.*

Lowering the age for primary vaccination also was an important control strategy in Guam because the risk was highest among infants. Many of these infants lacked maternal antibody because they had been born to mothers who had received a maximum of one dose of measles vaccine and who had not had natural measles infection (e.g., children of immigrant mothers from islands where previous outbreaks occurred >20 years ago) (*1,2*). The Advisory Committee on Immunization Practices (ACIP) recommends that measles vaccine be administered at age 6 months if exposure of children aged <1 year is likely (*3*). Children vaccinated before age 12 months should be revaccinated after their first birthday and should be given another dose of MCV before entering school.

The outbreak in Guam was especially a consequence of the large number of unvaccinated, preschool-aged children. A retrospective survey in 1991 of the vaccination records of children entering school for the first time documented that only 55% of children on Guam had received a dose of MCV by age 2 years. Audits of records from public and private clinics in 1993 and 1994 indicated that coverage among 2-year-old children with one dose of MCV ranged from 53% to 90% depending on the site.

Reasons for higher morbidity and mortality in the Chuukese population than in other ethnic groups are unclear. Possible explanations include low levels of immunity because of low vaccination coverage levels; the lower likelihood of exposure to measles (the last outbreak in Chuuk was in 1968); limited access to health care; and large family size, resulting in increased exposure to measles.

Other factors associated with increased risk for measles importation and transmission on islands such as Guam include tourism and the high mobility of the local population. These factors underscore the importance of the need to achieve and maintain high vaccination coverage levels. Approaches to maintaining high vaccination

^{*}The second dose of measles vaccine is routinely recommended at entry to primary or secondary school but may be given at earlier ages provided it is administered at least 30 days after the first dose, and both doses are given after age 12 months.

Measles Outbreak — Continued

coverage levels among preschool-aged children should include establishing walk-in service to provide vaccinations on a routine basis, extending clinic hours, offering door-to-door vaccination in areas with hard-to-reach populations (e.g., immigrants), educating providers and parents about contraindications to vaccinations, and taking advantage of all opportunities to vaccinate children during health-care visits, as is recommended in the United States. Optimal levels of immunity may be achieved in school children through the establishment and enforcement of requirements for receipt of two doses of vaccine.

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Agricultural Auger-Related Injuries and Fatalities — Minnesota, 1992–1994

Agriculture remains one of the most hazardous industries in the United States: in 1992, approximately 37 fatalities occurred per 100,000 agricultural workers and an estimated 140,000 disabling injuries to farm workers (1). Recent surveillance for agricultural injuries and fatalities in Minnesota has helped characterize problems associated with the use of one type of implement—agricultural augers (large, corkscrew-like devices used to move dry materials [e.g., grains, animal feeds, and granular fertil-izers]). This report presents surveillance findings for auger-related injuries during 1992–1994, summarizes the investigations of four selected auger-related injuries that occurred in the state, and provides recommendations to prevent injuries to farmers who use these devices.

Since 1992, the Minnesota Department of Health has collected surveillance data about agricultural injuries and fatalities through three programs sponsored by CDC's National Institute for Occupational Safety and Health (NIOSH): the Fatality Assessment and Control Evaluation Program (FACE), which conducts on-site investigations of selected categories of occupational fatalities (e.g., falls and machinery-related and logging-related deaths); the Sentinel Event Notification System for Occupational Risks (SENSOR), which conducts surveillance for occupational amputation injuries; and the Occupational Health Nurses in Agricultural Communities Program (OHNAC), which identifies and investigates farm-related injuries and illnesses.* Case ascertainment employs a combination of surveillance methods, including reviews of medical re-

^{*}FACE, SENSOR, and OHNAC are cooperative agreements between NIOSH and various state health departments and are intended to develop models for state-based occupational health surveillance and intervention. FACE was developed to more accurately identify and evaluate work-related fatalities; 14 states currently have FACE programs. Fourteen states have been awarded SENSOR cooperative agreements to develop systems for surveillance of 12 occupational conditions. OHNAC is a national surveillance system that has placed public health nurses in 10 states. Surveillance data compiled by these programs ultimately are used to reduce work-related injury and illness.

Auger-Related Injuries — Continued

cords, articles from newspaper clipping services, death certificates, hospital records, and Minnesota Occupational Safety and Health Administration (M-OSHA) program records. In addition, the Minnesota Extension Service independently records agricultural injuries and deaths reported by extension agents and newspaper clipping services.

Surveillance for Auger-Related Injuries

During 1992–1994, augers were associated with two fatal and 25 nonfatal injuries in Minnesota. From 1993[†] through 1994, FACE received reports of two auger-related deaths, and SENSOR was notified of seven auger-related amputations. During 1992–1994, OHNAC was notified of 18 auger-related injuries, of which six (33%) were among children aged <18 years; three of these resulted in amputations.

During 1984–1994, the Minnesota Extension Service received reports of 14 augerrelated deaths, which were attributed to entanglement or crushing (eight) and electrocution (six). Although cases reported to OHNAC and SENSOR were not duplicated, duplication of fatalities reported to the Extension Service and to FACE could not be excluded.

Case Reports

Incident 1. On April 14, 1992, a 13-year-old boy was cleaning inside an oxygenlimiting silo while a sweep auger was in operation. The unguarded auger swept slowly around the silo floor, pivoting about a central axis. As the boy stepped over the moving equipment, the hem of his pants caught in the auger, and his leg was traumatically amputated below the knee as it became entangled. He required multiple surgical procedures and had been hospitalized for $2^{1}/_{2}$ months at the time of the OHNAC interview.

Incident 2. On January 16, 1993, a 70-year-old farm laborer was cleaning a grain auger that had been shut off, but the machine's electric power supply had not been disconnected (the controls for switching the auger on and off were located in a different building). The auger was inadvertently activated by a co-worker, and the laborer's left hand was traumatically amputated above the wrist. He was subsequently hospitalized and had not resumed work at the time of the SENSOR interview 2 months later.

Incident 3. On January 8, 1994, a 21-year-old farm laborer was using an auger to unload a silo. While attempting to step over the machine, he stepped on a metal shield that covered the bottom of the auger. The shield broke, and he fell into the auger, sustaining a traumatic below-the-knee amputation. He subsequently was hospitalized and had not resumed work at the time of the SENSOR interview 3 months later.

Incident 4. On June 22, 1994, a 46-year-old farmer died after becoming entangled in an unshielded auger system that was being used to move feed down the length of a feed bunk in a cattle feed lot. While the system was in operation, the farmer entered the feed bunk, and his leg became entangled when he either slipped or attempted to step over the auger. The electric motor driving the system stopped after the fuse blew. Although he freed himself from the auger and climbed out of the feed bunk, he died a short distance from the feed lot as a result of massive hemorrhage. This incident was unwitnessed, and data were compiled by FACE investigators based on a review of sheriff's reports and photographs of the incident site.

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[†]Both FACE and SENSOR in Minnesota were initiated in 1993.

Auger-Related Injuries — Continued

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Editorial Note: An agricultural auger consists of a continuous corkscrew blade attached to a long metal shaft and a round metal tube into which the blade is inserted. The metal tube contains the material as it is moved from the intake at one end of the auger to the discharge at the other end and protects the operator from contact with the rotating blade.[§] Augers vary in size, generally ranging from 4 to 15 inches in diameter and from several feet to 100 feet or more in length (2). An auger can be independent and movable or it can be integrated with another piece of machinery or a grain storage system (e.g., as a fixed component of a combine, grain dryer, grain wagon, storage bin system, or silo unloader). In addition, augers can be self-powered (by an electric motor or a gasoline- or diesel-fueled engine) or driven by power transferred from a second piece of equipment through a power take-off shaft (PTO) or a series of gears, chains, belts, and/or pulleys. Auger-related injuries result from 1) contact with the exposed auger blade; 2) entanglement in a belt drive or PTO conveying power to the blade; 3) electrocution when an auger contacts overhead power lines (e.g., while it is being moved or positioned in an upright configuration); or 4) contact with a spinning crank, which is used to position the auger (3).

Although auger-related injuries are preventable, they remain a public health concern among farmers. On a per-hour-of-use basis, augers are one of the most dangerous types of farming equipment (4); severe injuries have resulted from entanglement and electrocution (2). The occupational injury surveillance and investigation data from Minnesota underscore the risks augers pose for both disabling and fatal injuries among farmers. In particular, the Minnesota data emphasize the risk for traumatic amputation resulting from entanglement of extremeties.

NIOSH recommends the following precautions to substantially reduce the risks for hazards related to auger use:

- 1. Barriers (e.g., fences) should be used to prevent persons not involved in the operation of an auger from entering the area adjacent to the auger.
- 2. Children aged <18 years should not operate augers and should not enter the area near an auger.[¶]
- 3. Before starting an auger, the operator should ensure that all protective shields, as supplied by the manufacturer, are in place and in good condition. The federal OSHA standard for safety of farm equipment requires placement of guards on augers consistent with their designed use (5).
- 4. Before service or repair, power should be shut off and the auger power source "locked-out" and "tagged." (Locking out prevents power from being restored while maintenance is in progress, and tagging the switch indicates that power is disabled and the reason).

[§]An auger also may consist of only an exposed spiral corkscrew. A "sweep" auger, referred to in incident 1, is typically an exposed auger used to move material such as grain to a central discharge point inside a large storage structure. A sweep auger usually extends from the center of a round structure to its outside wall, is powered by a drive system that contacts the bin or silo wall, and slowly rotates (i.e., sweeps) around a pivot point at the center of the structure. The auger rests directly in the grain (or similar material), and the excess grain alongside the auger acts to confine the grain that is in contact with the auger.

Federal child labor laws prohibit employees aged <16 years from operating hazardous equipment (including agricultural augers). However, family members working on family farms are exempt from these provisions.

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Auger-Related Injuries — Continued

- 5. To prevent entanglement, persons wearing loose clothing or jewelry or persons with long, untied hair should not operate augers.
- 6. Workers should not step or jump on or over an auger while it is in operation.
- 7. Grain augers always should be lowered to a horizontal position before being moved from one location to another. Workers always should observe the presence and location of power lines before raising an auger into position.
- 8. Whenever possible, operators should ensure good footing while working around augers. Portable augers should be placed on dry, level ground or a gravel pad. Spilled grain should be removed between loads, after the equipment has been turned off.
- 9. Operators should never use their hands or feet to redirect the flow of grain or other materials into the auger.
- 10. All farm workers and auger operators should be educated about safe operating procedures and hazards associated with augers.
- 11. Augers should be clearly labeled as posing a hazard for entanglement and subsequent serious injury.

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State-Specific Changes in Physical Inactivity Among Persons Aged ≥65 Years — United States, 1987–1992

Regular physical activity can provide important health benefits, even when such activities are initiated later in life (1,2). Despite these benefits, most older persons in the United States have sedentary lifestyles (3). One of the national health objectives for the year 2000 is to reduce to 22% the proportion of adults aged \geq 65 years who engage in no leisure-time physical activity (objective 1.5a) (4). This report uses data from CDC's Behavioral Risk Factor Surveillance System (BRFSS) to summarize state-specific trends during 1987–1992 in the prevalence of physical inactivity during leisure time among persons aged \geq 65 years and projects state-specific prevalences for 1997.

The BRFSS is a population-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. population. Data were available for 83,858 persons aged ≥65 years residing in 49 states and the District of Columbia who participated in the BRFSS during 1987–1992. Of the 50 reporting areas, 32 states and the District of Columbia collected information about physical activity for the entire study period. Respondents were asked specific questions about physical activity, including the type, frequency, and duration of the two leisure-time physical activities in which they participated most frequently during the preceding month. Persons who reported

CASES CURRENT DISEASE DECREASE INCREASE 4 WEEKS Hepatitis A 1,577 Hepatitis B 545 Hepatitis, C/Non-A, Non-B 280 79 Legionellosis Malaria 110 Measles, Total* 4 Meningococcal Infections 89 Mumps 29 Pertussis 460 Rabies, Animal 429 Rubella 12 0.25 0.5 0.03125 0.0625 0.125 1 2 4 Ratio (Log Scale)[†]

FIGURE I. Notifiable disease reports, comparison of 4-week totals ending September 9, 1995, with historical data — United States

*The large apparent decrease in the number of reported cases of measles (total) reflects dramatic fluctuations in the historical baseline.

[†]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 September 9, 1995 (36th Week)

	Cum. 1995		Cum. 1995
Anthrax Brucellosis Cholera Congenital rubella syndrome Diphtheria <i>Haemophilus influenzae</i> * Hansen Disease Plague Poliomyelitis, Paralytic	64 11 4 829 89 6	Psittacosis Rabies, human Rocky Mountain Spotted Fever Syphilis, congenital, age <1 year [†] Tetanus Toxic shock syndrome Trichinosis Typhoid fever	48 1 375 132 19 127 24 207

*Of 809 cases of known age, 192 (24%) were reported among children less than 5 years of age. [†]Updated quarterly from reports to the Division of STD Prevention, National Center for Prevention Services. This total through first quarter 1995.

-: no reported cases

Beyond Historical Limits VV

		Jenner									
Reporting Area	AIDS*	Gonor	rhea	А		В		C/N/	A,NB	Legion	ellosis
Je S	Cum. 1995	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994
UNITED STATES	47,385	237,353	274,367	18,263	16,342	6,795	7,918	2,942	2,864	853	1,082
NEW ENGLAND	2,412	3,624	5,478	188	207	155	243	79	106	23	41
Maine N.H.	74 72	58 77	64 77	19 7	20 16	7 16	11 16	- 11	8	5 4	4
Vt. Mass.	23 1,014	39 1,951	21 2,152	4 78	6 82	1 57	6 145	1 63	7 71	- 11	- 25
R.I.	184	348	324	24	18	8	6	4	20	3	12
Conn. MID. ATLANTIC	1,045 12,777	1,151 22,975	2,840 30,968	56 1,068	65 1,164	66 825	59 1,035	- 272	- 338	N 123	N 167
Upstate N.Y.	1,634	3,846	7,397	268	410	274	277	153	161	33	38
N.Y. City N.J.	6,547 2,983	7,375 3,162	11,689 3,512	520 132	434 216	256 166	222 275	1 90	1 147	3 17	4 31
Pa.	1,613	8,592	8,370	148	104	129	261	28	29	70	94
E.N. CENTRAL Ohio	3,613 733	51,929 15,659	55,292 14,647	2,008 1,287	1,601 578	671 82	817 118	190 8	238 17	225 115	313 148
Ind.	383	5,727	6,066	118	263	165	148	5	8	53	34
III. Mich.	1,525 721	14,024 12,539	17,090 12,217	217 260	404 190	94 290	221 263	33 144	63 150	13 23	29 56
Wis.	251	3,980	5,272	126	166	40	67	-	-	21	46
W.N. CENTRAL Minn.	1,091 243	13,476 1,933	15,425 2,265	1,296 125	801 163	433 37	456 43	84 2	62 14	83 2	74 2
lowa	55	983	1,008	50	37	32	22	11	7	17	27
Mo. N. Dak.	476 5	7,734 20	8,521 28	935 23	390 4	311 4	340	48 7	15 1	43 4	23 4
S. Dak.	11 80	123 697	140 958	37 34	24 102	2 22	- 24	1 6	10	1 9	1 12
Nebr. Kans.	221	1,986	2,505	92	81	25	24	9	10	9 7	5
S. ATLANTIC	12,200	69,840	73,077	871	832	984	1,468	229	318	159	264
Del. Md.	220 1,635	1,502 7,471	1,323 12,907	7 154	19 116	2 179	11 236	1 3	1 17	2 25	31 58
D.C. Va.	738 965	3,121 7,422	5,028 9,178	17 142	16 118	15 81	36 89	10	20	4 15	5 5
W. Va.	77	471	545	17	11	40	29	41	23	3	3
N.C. S.C.	712 671	16,430 8,333	18,528 9,056	80 35	91 30	203 37	194 23	43 17	47 7	29 29	18 9
Ga.	1,628	10,893	Ū	55	25	63	505	15	165	23	95
Fla. E.S. CENTRAL	5,554 1,551	14,197 28,964	16,512 32,018	364 1,068	406 414	364 590	345 841	99 721	38 655	29 37	40 67
Ky.	197	3,377	3,437	30	119	45	61	15	21	7	8
Tenn. Ala.	638 411	9,343 11,637	10,295 10,849	863 63	170 68	468 77	725 55	704 2	621 13	21 6	33 11
Miss.	305	4,607	7,437	112	57	-	-	-	-	3	15
W.S. CENTRAL Ark.	4,178 186	22,444 2,080	32,318 4,735	2,586 343	2,128 143	1,142 36	813 20	496 4	212 6	11 1	33 6
La.	715	7,863	8,489	82	111	148	125	129	124	2	10
Okla. Tex.	196 3,081	1,496 11,005	3,482 15,612	662 1,499	208 1,666	376 582	95 573	323 40	42 40	3 5	11 6
MOUNTAIN	1,466	6,113	6,894	2,784	3,161	544	463	310	311	89	70
Mont. Idaho	16 37	47 91	66 61	75 229	17 242	19 61	17 65	11 40	6 63	4 2	14 1
Wyo.	10	38	55	86	20	16	19	129	107	7	3
Colo. N. Mex.	491 123	1,980 716	2,352 694	360 594	340 786	81 212	75 145	42 37	54 41	37 4	15 3
Ariz. Utah	392 98	2,334 131	2,251 186	819 510	1,242 349	82 48	48 54	29 8	14 13	7 13	8 6
Nev.	299	776	1,229	111	165	48 25	40	0 14	13	15	20
PACIFIC	8,097	17,988	22,897	6,394	6,034	1,451	1,782	561	624	103	53
Wash. Oreg.	667 285	1,771 212	2,044 716	551 1,361	775 670	128 60	164 100	147 29	187 26	18	10 -
Calif. Alaska	6,910 53	15,123 485	18,995 629	4,333 31	4,390 161	1,242 9	1,483 11	357 1	407	80	41
Hawaii	182	397	513	118	38	12	24	27	4	5	2
Guam	- 1 0E 1	51 251	87 244	2	18 45	1 522	4	-	-	1	1
P.R. V.I.	1,851 27	351 6	344 20	80	45 2	523 2	238 6	239	128 1	-	-
Amer. Samoa C.N.M.I.	-	18 23	21 34	5 15	8 5	-7	- 1	-	-	-	-
N: Not notifiable		navailable		urted cases					rthern Ma		

TABLE II. Cases of selected notifiable diseases, United States, weeks endingSeptember 9, 1995, and September 10, 1994 (36th Week)

N: Not notifiable U: Unavailable -: no reported cases C.N.M.I.: Commonwealth of Northern Mariana Islands *Updated monthly to the Division of HIV/AIDS Prevention, National Center for Prevention Services, last update August 31, 1995.

Measles (Rubeola) Meningococcal Lyme Mumps Indigenous Disease Malaria Imported* Total Infections **Reporting Area** Cum. 1995 Cum. 1995 Cum. 1994 Cum. 1995 Cum. Cum. Cum. Cum. Cum. Cum. Cum. Cum. UNITED STATES 5,345 2,156 1,968 8,253 1,033 NEW ENGLAND 1,395 2,011 Maine N.H. Vt. Mass. 27 7 R.I. -Conn. 1,534 MID. ATLANTIC 3,186 4,880 Upstate N.Y. 1,746 3,155 N.Y. City 173 72 3 4 1,020 N.J. -Pa. _ E.N. CENTRAL -Ohio --3 22 32 35 71 Ind. --III. --Mich. 9 -Wis. W.N. CENTRAL Minn. -lowa _ Mo. --N. Dak. --_ 7 S. Dak. --. 1 2 Nebr. 2 --Kans. S. ATLANTIC . Del. --Md. D.C. -Va. --W. Va. ---_ _ 7 N.C --. --S.C. --Ga. -_ 5 Fla. E.S. CENTRAL Ky. --Ténn. U _ U Ala. -Miss. -_ --_ _ W.S. CENTRAL --Ark. 3 1 6 --39 8 La. Okla. --Tex. -MOUNTAIN -Mont. Idaho Wyo. Colo. -N. Mex. Ň 7 2 -48 47 N 11 Ariz. Utah --Nev. 71 PACIFIC Wash. -Oreg. Ν Ν Calif Alaska 4 Hawaii -Guam U U З . P.R. 3 υ U V.I. Amer. Samoa C.N.M.I. υ υ

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks ending September 9, 1995, and September 10, 1994 (36th Week)

*For imported measles, cases include only those resulting from importation from other countries.

N: Not notifiable U: Unavailable -: no reported cases

							[
Reporting Area		Pertussis			Rubella		Sypl (Prima Secon	ary &	Tuberc	ulosis	Rab Ani	
	1995	Cum. 1995	Cum. 1994	1995	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994	Cum. 1995	Cum. 1994
UNITED STATES	86	2,418	2,584	1	114	205	10,303	14,791	13,278	15,141	4,867	5,228
NEW ENGLAND	7	312	266	-	34	128	120	158	341	331	1,106	1,296
Maine	2	24	9	-	1	-	2	4	12	8	22	-
N.H. Vt.	3 1	25 44	52 32	-	1	-	1	3	9 3	13 5	113 134	116 102
Mass.	-	205	149	-	7	124	43	66	190	174	335	485
R.I. Conn.	1	2 12	5 19	-	25	2 2	3 71	12 73	33 94	32 99	237 265	26 567
MID. ATLANTIC	9	196	406	-	11	6	572	981	2,753	3,114	943	1,365
Upstate N.Y.	9	107	172	-	4	5	43	127	317	382	379	1,001
N.Y. City	-	21	80	-	7	-	261	437	1,470	1,835	-	-
N.J. Pa.	-	5 63	12 142	-	-	1	120 148	151 266	522 444	527 370	257 307	203 161
	16	241		-		9						
E.N. CENTRAL Ohio	16 5	24 I 96	402 106	-	4	9	1,770 614	2,213 863	1,225 184	1,393 231	61 9	44 2
Ind.	1	15	47	-	-	-	176	175	56	122	10	12
III.	8	61	83	-	1	1	659	741	668	697	3	13
Mich. Wis.	2	57 12	39 127	-	3	8	197 124	203 231	269 48	302 41	32 7	10 7
W.N. CENTRAL	1	135	118		_	2	542	871	416	389	, 221	, 157
Minn.	-	43	51	-	-	-	28	33	94	95	8	14
lowa	1	7	8	-	-	-	34	43	48	40	88	67
Mo. N. Dak.	-	40 8	31 4	-	-	2	462	742 1	162 3	167 7	19 23	15 9
S. Dak.	-	10	4	-	-	-	-	1	3 15	17	23 49	9 25
Nebr.	-	7	7	-	-	-	9	11	17	16	5	-
Kans.	-	20	10	-	-	-	9	40	77	47	29	27
S. ATLANTIC	5	228	245	-	26	15	2,642	3,807	2,334	2,727	1,473	1,416
Del. Md.	-	9 18	2 57	-	-	-	10 137	21 202	12 241	28 226	74 265	42 390
D.C.	-	4	5	-	-	-	77	161	70	90	11	2
Va.	-	15	28	-	-	-	435	548	167	212	287	279
W. Va. N.C.	-	- 84	3 58	-	- 1	-	8 796	8 1,183	54 303	60 344	82 344	58 115
S.C.	2	20	12	-	1	-	412	560	222	252	97	132
Ga.	3	22	24	-	1	2	504	575	323	516	189	273
Fla.	-	56	56	-	23	13	263	549	942	999	124	125
E.S. CENTRAL	2	249	117	-	-	-	2,683	2,662	998	1,041	193	141
Ky. Tenn.	2 U	11 202	58 18	Ū	-	-	145 592	145 731	204 294	231 347	22 56	15 34
Ala.	-	34	29	-	-	-	460	467	283	285	108	88
Miss.	-	2	12	N	N	N	1,486	1,319	217	178	7	4
W.S. CENTRAL	10	208	105	-	7	12	1,367	3,211	1,708	1,917	527	467
Ark. La.	-	28 11	18 10	-	-	-	82 715	360 1,253	113 6	188 11	21 25	23 55
Okla.	1	24	22	_	-	4	54	114	146	178	31	25
Tex.	9	145	55	-	7	8	516	1,484	1,443	1,540	450	364
MOUNTAIN	12	365	355	-	4	4	189	199	410	377	111	112
Mont.	-	3	4	-	-	-	4	2	10	9	34	13
Idaho Wyo.	2	79 1	42	-	-	-	- 4	1	10 1	11 7	2 21	3 16
Colo.	-	34	173	-	-	-	87	101	22	47	-	9
N. Mex.	6	78	20	-	-	-	32	18	60	43	5	6
Ariz. Utah	4	147 18	95 19	-	3 1	- 3	30 4	39 10	209 19	146 29	34 9	48 10
Nev.	-	5	2	-	-	1	28	28	79	85	6	7
PACIFIC	24	484	570	1	28	29	418	689	3,093	3,852	232	230
Wash.	5	118	84	-	2	-	11	28	180	191	5	11
Oreg.	4 14	26 300	83 388	- 1	1 22	4 21	6 400	28 627	25	90 3 349	223	9 179
Calif. Alaska	- 14	- 300	388	-	- 22	21	400	627 3	2,726 47	3,349 48	223	31
Hawaii	1	40	15	-	3	4	-	3	115	174	-	-
Guam	U	-	2	U	-	1	3	3	33	62	-	-
P.R.	-	6	2		-	-	172	218	123	116	27	62
V.I.	U	-	- 1	U	-	-	2	23 1	- 3	- 4	-	-
Amer. Samoa	-	-		-			-				-	

TABLE II. (Cont'd.) Cases of selected notifiable diseases, United States, weeks endingSeptember 9, 1995, and September 10, 1994 (36th Week)

U: Unavailable -: no reported cases

	Å	All Cau	ses, Βγ	/ Age (Y	'ears)		P&I [†]			All Cau	ises, By	/ Age (Y	/ears)		P&I [†]
Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Total	Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND Boston, Mass. Bridgeport, Conn. Cambridge, Mass. Fall River, Mass. Hartford, Conn. Lowell, Mass. Lynn, Mass. New Bedford, Mass. New Haven, Conn. Providence, R.I. Somerville, Mass. Springfield, Mass. Waterbury, Conn.	558 183 29 20 16 59 16 14 30 44 4 42 33	370 102 19 12 15 36 11 23 21 28 21 28 1 33 24	112 48 7 6 1 16 2 1 4 11 4 5 6	49 19 2 2 5 4 2 - 4 3 - 3 2	14 8 - - 2 1 - - - 1 1	11 6 - - - 1 2 -	38 22 1 - - 1 - 1 4 - 4 3	S. ATLANTIC Atlanta, Ga. Baltimore, Md. Charlotte, N.C. Jacksonville, Fla. Miami, Fla. Norfolk, Va. Richmond, Va. Savannah, Ga. St. Petersburg, Fla. Tampa, Fla. Washington, D.C. Wilmington, Del.	137 164 11	713 67 900 103 80 70 26 40 34 25 91 82 5	29 37 24 26 8 25 15 5 34 40	151 17 24 16 13 19 4 8 8 4 6 27 5	43 3 9 2 3 3 3 3 3 3 2 11 1	27 1 4 6 3 - 2 1 1 1 4 4 4	62 1 19 2 8 2 4 - 8 3 12 3 -
Worcester, Mass. MID. ATLANTIC Albany, N.Y. Allentown, Pa. Buffalo, N.Y. Camden, N.J. Elizabeth, N.J. Erie, Pa.§ Jersey City, N.J. New York City, N.Y. Newark, N.J.	75	37 1,322 36 21 76 20 7 23 24 711 34	5 404 2 5 11 4 1 6 7 242 16	3 212 3 1 7 5 1 3 3 139 19	- 55 1 - 4 3 1 - 31 31 3	2 44 - 1 2 3 - 2 26 3	1 68 4 - 2 - 1 - 32 2	E.S. CENTRAL Birmingham, Ala. Chattanooga, Tenn. Knoxville, Tenn. Lexington, Ky. Memphis, Tenn. Mobile, Ala. Montgomery, Ala. Nashville, Tenn. W.S. CENTRAL Austin, Tex. Baton Rouge, La.	656 107 62 81 36 156 91 41 82 1,112 45 46	437 70 43 53 23 103 64 27 54 686 23 34	136 15 10 21 8 36 16 12 18 214 10 8	43 10 5 4 1 8 7 2 6 138 9 3	18 2 3 1 5 3 - 2 45 2	22 10 1 3 4 1 - 2 29 1 1	38 4 6 11 1 8 5 - 3 55 4
Paterson, N.J. Philadelphia, Pa. Pittsburgh, Pa.§ Reading, Pa. Rochester, N.Y. Schenectady, N.Y. Scranton, Pa.§ Syracuse, N.Y. Trenton, N.J. Utica, N.Y. Yonkers, N.Y.	24 200 50 11 99 26 27 28 22 24	17 133 35 10 68 16 19 21 17 18 16	1 46 9 1 23 2 6 4 10 4 4	2 17 - 8 - 1 - - 3	4 2 4 - 1 - - 1	2 2 - - 2 1 -	2 10 5 1 5 - 2 1 1 - -	Corpus Christi, Tex. Dallas, Tex. El Paso, Tex. Ft. Worth, Tex. Houston, Tex. Little Rock, Ark. New Orleans, La. San Antonio, Tex. Shreveport, La. Tulsa, Okla.	47 140 32 72 299 45 71 161 59 95	31 80 25 49 157 31 38 117 42 59	5 27 3 10 71 5 12 28 15 20	8 26 2 6 46 4 12 10 1	1426 13544 133	2 3 1 12 5 2 2	1 6 3 18 3 12 3 2
E.N. CENTRAL Akron, Ohio Canton, Ohio Chicago, III. Cincinnati, Ohio Cleveland, Ohio Columbus, Ohio Dayton, Ohio Detroit, Mich. Evansville, Ind. Fort Wayne, Ind.	1,812 54 31 423 75 120 127 108 174 43 39	1,181 42 25 249 35 85 80 82 104 36 32	360 9 3 101 12 20 29 19 43 5 3	160 2 1 47 6 10 7 5 15 2 1	34 1 7 3 4 1 6 - 1	53 1 16 1 2 7 1 6 - 2	120 2 38 11 12 7 4 3 1	MOUNTAIN Albuquerque, N.M. Colo. Springs, Colo Denver, Colo. Las Vegas, Nev. Ogden, Utah Phoenix, Ariz. Pueblo, Colo. Salt Lake City, Utah Tucson, Ariz.	65 131 22 133 22 86 100	423 50 27 40 78 14 72 19 54 69	143 11 15 37 30 2 20 14	74 6 8 7 14 3 17 1 8 10	22 3 2 1 2 8 3 3	15 - 1 3 1 - 5 - 1 4	41 3 6 3 7 3 7 4 6 2
Gary, Ind. Gary, Ind. Grand Rapids, Mich Indianapolis, Ind. Madison, Wis. Milwaukee, Wis. Peoria, III. Rockford, III. South Bend, Ind. Toledo, Ohio Youngstown, Ohio	17	9 44 88 U 78 23 30 28 69 42	3 2 11 35 U 21 2 9 7 19 10	- 6 6 18 U 13 2 8 2 7 2	2 3 U 2 1 - 1 2	2 3 2 U 4 - 3 1 3 -	- ' 313D 9 2 ' 5 6 3	PACIFIC Berkeley, Calif. Fresno, Calif. Glendale, Calif. Honolulu, Hawaii Long Beach, Calif. Los Angeles, Calif. Pasadena, Calif. Portland, Oreg. Sacramento, Calif. San Diego, Calif.	1,528 13 71 15 96 U 414 27 110 106 128	989 10 44 10 73 U 248 19 75 74 80	290 1 15 2 11 U 81 5 23 20 22	158 2 4 3 5 U 56 1 7 7 20	51 - 4 - 5 U 16 1 1 2 3 5	35 4 2 U 9 1 4 3 2	103 3 2 5 U 10 4 5 5 23
W.N. CENTRAL Des Moines, Iowa Duluth, Minn. Kansas City, Kans. Kansas City, Mo. Lincoln, Nebr. Minneapolis, Minn. Omaha, Nebr. St. Louis, Mo. St. Paul, Minn. Wichita, Kans.	673 17 15 47 110 26 152 77 99 47 83	466 14 12 33 64 20 111 53 68 33 58	99 1 3 6 15 4 20 15 13 5 17	62 1 6 10 2 16 3 13 8 3	21 1 8 5 3 2 1	15 - 1 3 - 3 3 1 4	34 116145565	San Francisco, Calif San Jose, Calif. Santa Cruz, Calif. Seattle, Wash. Spokane, Wash. Tacoma, Wash. TOTAL	f. 142 159 20 97 50 80 10,258	80 105 17 58 44 52 6,587	34 32 21 4 17 2,028	21 13 1 13 2 3 1,047	5 7 1 6 303	2 4 2 2 2 251	16 15 3 4 4 4 559

TABLE III. Deaths in 121 U.S. cities,* week ending September 9, 1995 (36th Week)

*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.
 ¹Pneumonia and influenza.
 ⁵Because 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.
 ¹Total includes unknown ages.
 U: Unavailable -: no reported cases

Physical Inactivity — Continued

engaging in no physical activity during leisure time were categorized as inactive. Confidence intervals and prevalence estimates were calculated using SUDAAN (5).

For the 33 reporting areas that participated in the BRFSS each year during 1987– 1992, the median prevalence of no reported leisure-time physical activity among persons aged \geq 65 years declined from 43.2% in 1987 to 38.5% in 1992. Consistent decreases (i.e., a decrease from the previous year in at least 4 years) occurred in three states (Maryland, New Mexico, and New York) and the District of Columbia; no state reported consistent increases (i.e., an increase over the previous year in at least 4 years) in physical inactivity (Table 1). The largest overall declines in prevalence of inactivity over the 6-year period were reported from Rhode Island (21.5%), Massachusetts (15.0%), Ohio (14.1%), New Mexico (12.7%) and Maryland (10.1%). The largest overall increases in prevalence were reported from Montana (7.2%), West Virginia (4.3%), Maine (3.9%), and Georgia (2.9%).

Two methods, a state-specific method and an aggregate method, were used to project the prevalence of physical inactivity in 1997. The analysis using the state-specific method was limited to data from the 33 reporting areas that collected physical activity information from 1987 through 1992. For each of these reporting areas, the 5-year change (i.e., the 1992 value minus the 1987 value) in the percentage of respondents participating in no leisure-time physical activity was added to that state's 1992 value to project the 1997 prevalence. The analysis using the aggregate method employed the median 5-year change in the prevalence of no leisure-time physical activity during 1987–1992 from the 33 areas reporting throughout the interval. The median 5-year change was then added to the 1992 prevalence for each of the 49 participating states and the District of Columbia to project the 1997 prevalence.

The projected median prevalence of no leisure-time physical activity for 1997 was 35.9% based on the state-specific method and 37.1% based on the aggregate method. Using the state-specific method, three states (Massachusetts, Rhode Island, and Minnesota) are projected in 1997 to meet the year 2000 objective to reduce physical inactivity. Using the aggregate method, the lowest projected prevalence is 24.8% for Washington, followed by 25.3% for Colorado.

Reported by the following BRFSS coordinators: J Durham, Alabama; P Owen, Alaska; B Bender, Arizona; J Senner, PhD, Arkansas; B Davis, PhD, California; M Leff, MSPH, Colorado; M Adams, MPH, Connecticut; F Breukelman, Delaware; C Mitchell, District of Columbia; D McTague, MS, Florida; E Pledger, MPA, Georgia; F Newfield, MPH, Hawaii; C Johnson, MPH, Idaho; B Steiner, MS, Illinois; N Costello, MPA, Indiana; P Busick, Iowa; M Perry, Kansas; K Bramblett, Kentucky; D Hargrove-Roberson, MSW, Louisiana: D Maines, Maine: A Weinstein, MA, Marvland: R Lederman, MPH, Massachusetts: H McGee, MPH, Michigan: N Salem, PhD, Minnesota: E Jones, MS, Mississippi; J Jackson-Thompson, PhD, Missouri; P Smith, Montana; S Huffman, Nebraska; E DeJan, Nevada; K Zaso, MPH, New Hampshire; G Boeselager, MS, New Jersey; P Jaramillo, MPA, New Mexico; C Maylahn, MPH, New York; G Lengerich, VMD, North Carolina; D Young, MS, North Dakota; E Capwell, PhD, Ohio; N Hann, MPH, Oklahoma; J Grant-Worley, MS, Oregon; L Mann, Pennsylvania; J Hesser, PhD, Rhode Island; J Ferguson, DrPH, South Carolina; B Miller, South Dakota; D Ridings, Tennessee; R Diamond, MPH, Texas; R Giles, Utah; R McIntyre, PhD, Vermont; S Carswell, MA, Virginia; K Holm, MPH, Washington; F King, West Virginia; E Cautley, MS, Wisconsin. Statistics Br, and Cardiovascular Health Studies Br, Div of Chronic Disease Control and Community Intervention, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The findings in this report indicate that in 19 (58%) of the 33 states for which complete data were available, the prevalence of physical inactivity among persons aged \geq 65 years declined moderately during 1987–1992. This analysis extends

		987*		1988 [†]		1989 [§]		990 [¶]		1991**		1992 ^{††}	Change in	Projected 1997 prevalence based on	Projected 1997 prevalence based on
State	%	(95% CI ⁺⁺⁺)	%	(95% CI)	%	(95% CI)		(95% CI)	_	(95% CI)	%	(95% CI)	prevalence 1987–1992 ^{§§}	state-specific method ^{¶¶}	aggregate method***
Alabama	42.7	(±7.1)	45.7	(± 6.7)	45.6	(±5.7)	43.6	(±5.1)	47.1	(± 5.7)	44.1	(± 5.3)	1.4	45.5	42.2
Alaska	NA ^{§§§}	(±/.1)	43.7 NA	(± 0.7)	43.0 NA	(±5.77	43.0 NA	(±5.1)	48.8	(± 12.9)	30.2	(± 12.5)	NA	43.5 NA	28.3
Arizona				(+ 6 2)	26.8	(+5.7)		(+E 2)		• •	30.2 34.4			35.9	
Arkansas	32.9	(±6.5)	28.3	(± 6.3)		(±5.7)	23.4	(±5.3)	31.0	(± 5.9)		(± 5.9)	1.5		32.5
California	NA	(+57)	NA 20.1	(+ E 2)	NA 21 E	(+C E)	NA	(+4.0)	48.9	(± 6.3)	NA	(+ 1 1)	NA 1 E	NA	NA 27.4
Colorado	27.8	(±5.7)	29.1	(± 5.3)	31.5	(±6.5)	30.0	(±4.9)	26.7	(± 4.3)	29.3	(± 4.1)	1.5	30.8	27.4
Connecticut	NA		NA	(+ 7 A)	NA	(+7.6)	30.4	(±6.3)	26.4	(± 5.3)	27.2	(± 6.1)	NA	NA	25.3
Delaware	NA		53.1	(± 7.4)	42.7	(±7.6)	36.8	(±5.9)	42.8	(± 5.9)	40.9	(± 5.5)	NA	NA	39.0
Delaware District	NA		NA		NA		39.3	(±6.1)	47.9	(± 6.9)	44.8	(± 6.1)	NA	NA	42.9
of Columbia	59.0	(±8.2)	71.2	(± 7.4)	63.8	(±6.1)	62.1	(±7.1)	56.6	(± 6.7)	50.2	(± 6.9)	- 8.8	41.4	48.3
Florida	39.1	(±6.1)	30.5	(± 4.9)	29.7	(±4.5)	39.1	(±4.5)	30.8	(± 4.5)	32.0	(± 3.7)	- 7.1	24.9	30.1
Georgia	49.6	(±6.9)	54.2	(±14.5)	53.6	(±7.1)	51.2	(±6.9)	53.9	(± 6.9)	52.5	(± 6.3)	2.9	55.4	50.6
Hawaii	31.5	(±7.6)	36.0	(± 6.9)	32.6	(±6.5)	29.0	(±6.3)	23.3	(± 5.3)	32.6	(± 6.9)	1.1	33.7	30.7
Idaho	32.9	(±5.1)	33.4	(± 5.1)	43.1	(±5.5)	40.8	(±5.7)	33.7	(± 4.9)	30.0	(± 5.1)	- 2.9	27.1	28.1
Illinois	44.5	(±5.9)	40.7	(± 5.9)	42.3	(±6.1)	44.6	(±6.3)	49.0	(± 5.5)	44.1	(± 4.9)	- 0.4	43.7	42.2
Indiana	40.4	(±5.3)	48.7	(± 5.1)	47.8	(±5.1)	35.7	(±4.9)	39.3	(± 4.9)	38.5	(±24.9)	- 1.9	36.6	36.6
lowa	NA		45.7	(± 7.8)	43.7	(±5.7)	46.4	(±5.9)	40.1	(± 5.5)	42.4	(± 5.1)	NA	NA	40.5
Kansas	NA		NA		NA		NA		NA		38.2	(± 6.1)	NA	NA	36.3
Kentucky	56.4	(±5.3)	54.9	(± 5.3)	54.3	(±5.7)	55.3	(±5.3)	56.0	(± 5.5)	56.5	(± 5.3)	0.1	56.6	54.6
Lousianna	NA		NA		NA		44.3	(±9.4)	45.5	(± 6.7)	48.7	(± 6.3)	NA	NA	46.8
Maine	42.4	(±6.7)	44.9	(± 6.3)	60.0	(±7.4)	53.1	(±7.4)	42.8	(± 6.7)	46.3	(± 6.9)	3.9	50.2	44.4
Maryland	52.0	(±8.6)	50.7	(± 7.3)	49.2	(±6.3)	43.5	(±6.7)	42.3	(± 6.5)	41.9	(± 5.5)	-10.1	31.8	40.0
Massachusetts	44.4	(±6.9)	48.5	(± 6.5)	47.3	(±7.1)	36.4	(±7.4)	39.9	(± 7.1)	29.4	(± 6.1)	-15.0	14.4	27.5
Michigan	NA		42.8	(± 8.4)	44.2	(±5.3)	46.6	(±5.1)	39.8	(± 5.1)	35.6	(± 4.7)	NA	NA	33.7
Minnesota	38.6	(±4.1)	37.2	(± 4.1)	44.5	(±4.1)	36.4	(±3.9)	36.7	(± 4.1)	29.6	(± 3.7)	- 9.0	20.6	27.7
Mississippi	NA		NA		NA		50.7	(±6.1)	55.3	(± 6.3)	62.5	(± 6.3)	NA	NA	60.6
Missouri	46.3	(±6.7)	45.5	(± 6.1)	45.5	(±6.7)	38.8	(±6.3)	47.8	(± 5.9)	44.0	(± 5.7)	- 2.3	41.7	42.1
Montana	28.3	(±5.5)	30.7	(± 5.9)	28.9	(±5.5)	33.1	(±6.3)	32.1	(± 6.1)	35.5	(± 6.5)	7.2	42.7	33.6
Nebraska	43.2	(±6.5)	47.0	(± 5.9)	48.6	(±5.7)	36.9	(±5.1)	40.6	(± 5.7)	39.2	(± 5.3)	- 4.0	35.2	37.3
Nevada	NA		NA		NA		NA		NA		37.3	(± 6.3)	NA	NA	35.4
New Hampshire	40.5	(±7.6)	42.2	(± 8.0)	35.5	(±6.9)	29.0	(±6.3)	35.5	(± 6.9)	32.0	(± 6.3)	- 8.5	23.5	30.1
New Jersey	NA		NA		NA		NA		45.6	(± 6.5)	45.1	(± 6.9)	NA	NA	43.2
New Mexico	51.7	(±7.6)	43.4	(± 8.2)	40.8	(±7.4)	37.2	(±7.6)	42.4	(± 8.8)	39.0	(± 7.1)	-12.7	26.3	37.1
New York	57.2	(±6.9)	53.7	(± 7.3)	48.1	(±7.3)	40.6	(±6.9)	49.8	(± 6.1)	47.4	(± 5.5)	- 9.8	37.6	45.5
North Carolina	45.4	(±5.5)	52.0	(± 5.7)	46.6	(±5.9)	50.8	(±5.5)	47.4	(± 5.5)	46.7	(± 5.1)	1.3	48.0	44.8

TABLE 1. Prevalence of leisure-time physical inactivity among persons aged ≥65 years, by state — United States, Behavioral हुर् Risk Factor Surveillance System, 1987–1992

September 15, 1995

* 0		(_0.07		(± 0.0)	1010	(±0.07	00.0	(±0.07		(± 0.07	00.0	(± 0.07		0017	00.7	
Wisconsin	34.5	(±6.5)	35.9	(± 6.5)	40.9	(±6.9)	36.0	(±6.5)	33.0	(± 6.3)	35.6	(± 5.9)	1.1	36.7	33.7	
West Virginia	48.7	(±5.5)	51.1	(± 5.3)	61.9	(±5.3)	55.3	(±4.5)	55.8	(± 4.5)	53.0	(± 4.7)	4.3	57.3	51.1	ed
Washington	27.8	(±6.5)	30.6	(± 6.3)	28.8	(±5.9)	27.9	(±5.1)	24.3	(± 4.9)	26.7	(± 4.3)	- 1.1	25.6	24.8	ũ
Virginia	NA		NA		53.7	(±8.6)	41.5	(±6.5)	39.0	(± 7.1)	40.9	(± 6.7)	NA	NA	39.0	tin
Vermont	NA		NA		NA		38.1	(±7.4)	45.8	(± 6.3)	40.3	(± 5.3)	NA	NA	38.4	nc
Utah	31.1	(±6.9)	32.7	(± 6.9)	33.0	(±5.5)	31.6	(±5.5)	30.4	(± 5.7)	32.3	(± 6.1)	1.2	33.5	30.4	Ĉ
Texas	36.7	(±7.6)	42.4	(± 7.8)	40.0	(±7.3)	38.0	(±6.3)	39.6	(± 7.1)	31.8	(± 5.3)	- 4.9	26.9	29.9	I
Tennessee	57.3	(±4.9)	57.4	(± 4.9)	57.3	(±4.7)	52.1	(±5.1)	50.0	(± 4.7)	53.9	(± 5.1)	- 3.4	50.5	52.0	
South Dakota	43.2	(±6.9)	39.6	(± 5.9)	42.1	(±5.3)	40.2	(±5.1)	37.0	(± 5.3)	38.1	(± 5.1)	- 5.1	33.0	36.2	rity
South Carolina	44.7	(±6.3)	46.2	(± 5.9)	58.7	(±6.1)	48.7	(±5.5)	52.1	(± 5.5)	46.9	(± 5.7)	2.2	49.1	45.0	36 tiv
Rhode Island	59.5	(±5.7)	57.8	(± 5.3)	58.7	(±5.5)	37.7	(±5.1)	39.3	(± 5.5)	38.0	(± 5.3)	-21.5	16.5	36.1	ac.
Pennsylvania	NA		NA		46.9	(±5.5)	40.1	(±4.7)	42.8	(± 5.1)	35.2	(± 4.7)	NA	NA	33.3	In No
Oregon	NA		NA		26.0	(±4.7)	28.8	(±3.7)	31.6	(± 3.7)	31.5	(± 3.7)	NA	NA	29.6	a
Oklahoma	NA		40.2	(±7.6)	53.9	(±6.5)	47.3	(±6.5)	49.0	(± 6.7)	43.9	(± 6.1)	NA	NA	42.0	રું 1 4
Ohio	60.1	(±5.9)	46.3	(± 6.5)	51.6	(±6.7)	46.3	(±6.1)	46.9	(± 6.7)	46.0	(± 6.1)	-14.1	31.9	44.1	ŝ
North Dakota	36.7	(±5.1)	36.7	(± 5.3)	42.8	(±5.5)	43.7	(±5.5)	42.2	(± 5.3)	37.7	(± 5.1)	1.0	38.7	35.8	Phy

Physical Inactivity — Continued

findings from a previous analysis of BRFSS data for 1986–1990 (6). However, based on analysis of the data for 1987–1992 by the state-specific and aggregate trends methods, the median prevalence in 1997 is projected to be approximately 36%–37%; if the decline continues at the projected rate, it will be insufficient to achieve the year 2000 objective.

Factors that may be associated with variations among the states in physical inactivity include differences in the age distribution of persons aged \geq 65 years, perceptions among both health-care providers and the public about the benefits and need for physical activity in older adults, variations in climate, and differences in communitylevel resources for physical activity (e.g., state funding of facilities and programs to promote physical activity). Community efforts have targeted barriers to participation in physical activity for older adults (e.g., lack of access to age-appropriate activities) by providing transportation to safe and accessible facilities, such as local malls to attend walking programs or to senior centers for low-impact stretching and exercise programs in conjunction with congregate meals.

The findings in this report are subject to at least three limitations. First, because BRFSS data are self-reported, activity levels cannot be validated; however, the categorization of only those persons who report no leisure-time activities as inactive probably reduced the degree of misclassification. Second, some respondents may have been active for other reasons (e.g., occupation or housework) but were misclassified as inactive. Third, the sensitivity of questions to ascertain leisure-time physical activity may vary in relation to the age of respondents.

The health benefits of regular physical activity for persons aged \geq 65 years include reducing the risks for coronary heart disease and noninsulin-dependent diabetes, preventing osteoporosis, promoting weight loss and weight maintenance, preserving functional capacity, and fostering psychologic well-being (1,2). In 1993, CDC and the American College of Sports Medicine recommended that all adults in the United States participate in \geq 30 minutes of moderate-intensity physical activity on most, if not all, days of the week (7). Persons who report no leisure-time physical activity are the target population with the greatest potential gain in health benefits as they increase their level of activity (8). Although increases in longevity are diminished compared with younger persons, older adults who begin to participate in regular physical activity can decrease their risks for death and disability and improve their quality of life (9).

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