MMWR™
Morbidity and Mortality Weekly Report
Weekly March 29, 2002 / Vol. 51 / No. 12

Progress Toward Global Eradication of Poliomyelitis, 2001

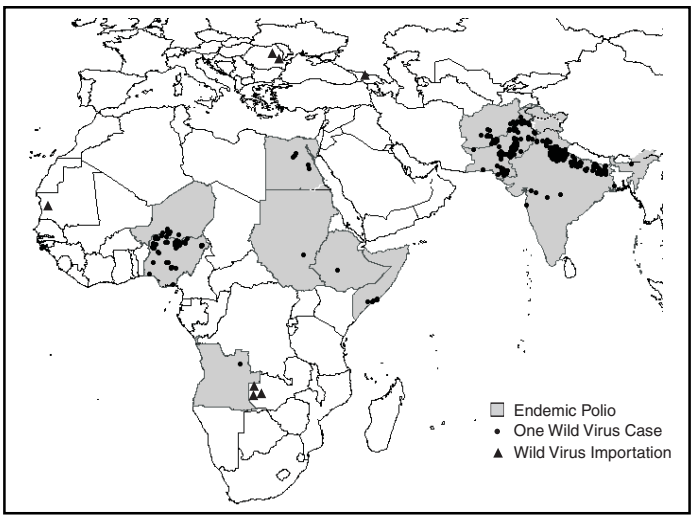
From the initiation of the global poliomyelitis eradication initiative in 1988 (*1*) through 2001, the number of countries where polio is endemic decreased from 125 to 10, and the number of reported polio cases decreased by >99% from an estimated 350,000 to <1,000. Wild type 2 poliovirus has not been detected worldwide since October 1999 (*2*). The American and Western Pacific Regions of the World Health Organization (WHO) have been certified free of indigenous wild poliovirus (*3,4*). Current challenges to global polio eradication efforts include ongoing intense transmission in northern India, continued importations of wild poliovirus into polio-free areas, and the detection of circulating vaccine-derived poliovirus (cVDPV). This report summarizes global progress in polio eradication during 2001 and the current status of the initiative.

Implementation of Polio Eradication Strategies

In 2000, reported global vaccination coverage with 3 doses of oral poliovirus vaccine (OPV3) among children aged <12 months was 82%. Routine coverage varies across WHO regions. The African Region (AFR) reported the lowest OPV3 coverage (55% in 2000). In most countries or areas where polio remained endemic in 2001 (Figure 1), OPV3 coverage in 2000 was <50%.

All countries where polio is endemic and many countries where polio was recently endemic continued to conduct supplemental immunization activities (SIAs) during 2001. Approximately 575 million children in 94 countries received an estimated 2 billion doses of OPV during 300 rounds of National Immunization Days* (NIDs), sub-NIDs, or mop-up activities†. All countries used house-to-house vaccination in part or all of the SIA target areas as the primary means to reach the highest possible coverage of children aged <5 years.

FIGURE 1. Location of laboratory-confirmed poliomyelitis in countries where polio is endemic, 2001



* Nationwide mass campaigns over a short period (days to weeks), in which 2 doses of OPV are administered to all children (usually aged <5 years), regardless of vaccination history, with an interval of 4–6 weeks between doses.

† Focal mass campaign in high-risk areas over a short period (days to weeks) in which 2 doses of OPV are administered during house-to-house visits to all children (usually aged <5 years), regardless of previous vaccination history, with an interval of 4–6 weeks between doses.

INSIDE

The *MMWR* series of publications is published by the Epidemiology Program Office, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION
Centers for Disease Control and Prevention. [Article Title]. MMWR 2002;51:[inclusive page numbers].

The quality of acute flaccid paralysis (AFP) surveillance to indicate reliably the presence or absence of wild poliovirus has improved (Table 1). All regions have reached the WHO-required annual nonpolio AFP detection rate of at least one per 100,000 persons aged <15 years (*5*). Progress in AFP reporting during 2000–2001 was notable in AFR, especially in Nigeria and Ethiopia. Similar progress was made in improving the reliability of virological surveillance through collection of adequate stool specimens. In 2001, all WHO regions except AFR reached the certification requirement of collecting two adequate stool specimens from at least 80% of AFP cases.

The WHO-accredited global network of 147 collaborating laboratories supports eradication strategies. Improvements in the efficiency and logistics of stool specimen handling and transport between collaborating laboratories in many countries enabled the network to reduce reporting delay between onset of paralysis and receipt of final laboratory results.

Impact on Poliovirus Transmission

In 2001, 537 confirmed polio cases (as of March 10, 2002) were reported; 473 (88%) were laboratory-confirmed (Table 1). In 2000, a total of 2,971 cases were reported, of which 719 (24%) were laboratory-confirmed. Because several AFP cases with onset of paralysis in 2001 are still pending final classification in all regions, the final number of confirmed cases for 2001 will be higher, but will probably remain below 1,000. Ten countries documented indigenous transmission of wild poliovirus during 2001, a decrease from 20 countries in 2000. Democratic Republic of Congo, Congo, Chad, Central African Republic, Benin, Ivory Coast, Ghana, Bangladesh, Nepal, and Iraq reported indigenous poliovirus transmission in 2000 but not in 2001.

Three densely populated countries (India, Pakistan, and Nigeria) represent major poliovirus reservoirs. Following a rapid decrease in the extent of wild virus transmission in India during 1997–2000 (*6*), wild poliovirus types 1 and 3 continued to be transmitted during 2001, mainly in the northern Indian states of Uttar Pradesh and Bihar. The number of laboratory-confirmed cases reported from India did not decrease from 2000 (265 cases) to 2001 (268 cases as of March 10, 2002). However, genetic analysis indicates that three poliovirus lineages circulated in India in 2001, compared with eight in 2000. The intensity and geographic extent of virus transmission in the Pakistan-Afghanistan epidemiological block also decreased from 2000 to 2001. In Pakistan, large population centers in Punjab and Sindh provinces became virus-free, and genetic evidence indicates decreasing virus

TABLE 1. Performance indicators for acute flaccid paralysis (AFP) surveillance — World Health Organization regions, 2000–2001*

Region/country†	No. reported AFP cases		Nonpolio AFP rate§		% AFP with adequate specimens¶		Confirmed** (clinical and virological)		Virus-confirmed cases	
	2000	2001	2000	2001	2000	2001	2000	2001	2000	2001
African	5,936	8,444	1.5	3.0	50%	71%	1863	113	160	63
Nigeria	979	1,931	0.7	3.8	36%	67%	638	51	28	51
Niger	93	229	1.2	4.4	37%	80%	33	6	2	6
Angola	213	149	1.6	2.4	55%	66%	115	1	55	1
Ethiopia	345	552	0.7	1.9	45%	47%	152	1	3	1
Eastern Mediterranean	3,253	3,852	1.4	1.9	70%	83%	505	140	287	140
Pakistan	1,152	1,562	1.5	2.3	71%	84%	199	116	199	116
Afghanistan	252	213	1.1	1.7	50%	74%	120	11	27	11
Egypt	275	257	1.3	1.2	90%	91%	4	5	4	5
Sudan	269	303	1.4	2.2	49%	74%	79	1	4	1
Somalia	161	129	2.2	4.1	50%	59%	96	7	46	7
South-East Asian	10,758	10,658	1.8	1.8	78%	83%	591	268	272	268
India	8,103	7,510	2.0	1.9	82%	83%	265	268	265	268
American	2,076	2,186	1.2	1.1	80%	89%	12	10††	0	0
European	1,645	1,818	1.1	1.2	80%	81%	0	3	0	2
Western Pacific	6,894	6,552	1.5	1.4	90%	88%	0	3††	0	0
Total	**30,562**	**33,510**	**1.6**	**1.6**	**75%**	**84%**	**2,971**	**537**	**719**	**473**

* Data as of March 10, 2002.
† Data presented only from countries with indigenous polio during 2001 and do not add to regional and global totals.
§ Per 100,000 children aged <15 years.
¶ Two stool specimens collected at an interval of at least 24 hours within 14 days of paralysis onset and adequately shipped to the laboratory.
** Decrease in total confirmed cases during 2000–2001 through switch from clinical to virological case classification criteria in most countries.
†† Vaccine-derived poliovirus.

biodiversity in remaining areas. However, multiple virus foci remained during 2001 in all provinces of Pakistan, with particularly intense transmission in the Northwest Frontier province. In Afghanistan during 2000–2001, virus transmission outside the two areas contiguous to Pakistan appears to have ceased. In 2000, endemic foci were found throughout Nigeria; however, during 2001, transmission became more localized in northern states of Nigeria and adjoining parts of Niger.

During 2001, three polio-free countries detected importations of wild poliovirus: Bulgaria (*7*), Georgia, and Zambia. The origin of a wild virus detected in Mauritania in 2001 is uncertain, but the virus probably was imported from areas where polio is endemic. Virus importations were detected rapidly and triggered immediate and appropriate large-scale surveillance and vaccination responses that prevented spread of the imported virus.

Polio cases attributed to cVDPV type 1 were found in Haiti and the Dominican Republic during 2000–2001 and in the Philippines during 2001 (*8*). The virus in both episodes showed >2% genetic sequence difference from the parent Sabin virus (VP1 region of genome) and probably circulated for >2 years before being detected. Public health investigations suggest that low vaccination coverage is allowing cVDPVs to circulate and revert to wild-type characteristics. Mass vaccination campaigns with OPV appear to have interrupted cVDPV circulation in Hispaniola and are underway in the Philippines. The global polio laboratory network established additional procedures to screen for cVDPV. Regional reference laboratories now routinely conduct intratypic differentiation of all poliovirus isolates using both antigenic and molecular tests. Isolates with discrepant results are referred for genetic sequencing studies. Retrospective analysis of approximately 2000 Sabin isolates from AFP cases detected during 1998–2000 has not revealed additional cVDPV.

Preparations for Posteradication Activities

When transmission of wild poliovirus is interrupted globally, wild poliovirus will remain only in diagnostic, research, and vaccine production laboratories. The goal of laboratory containment is to minimize the risk for inadvertent reintroduction of wild poliovirus from a laboratory into human circulation. The Global Plan of Action for Laboratory Containment of Wild Poliovirus (*9*) requires countries to identify all laboratories storing wild poliovirus or potentially infectious materials to ensure proper handling or disposal under appropriate biosafety conditions. This process has begun in 110 countries.

Planning for postcertification vaccination policy has three main objectives: 1) to develop contingency plans for reintroduction of poliovirus after certification, 2) to prevent cVDPVs from circulating and causing outbreaks, and 3) to broaden the knowledge base to support building a global consensus

about the safest and most effective strategy for eventually stopping oral polio vaccination. WHO, CDC, and other partners are coordinating a research agenda to address these issues systematically (*10*).

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Editorial Note: Acceleration of polio eradication activities during 2001 in countries where polio is endemic resulted in a reduction of both the extent of transmission and diversity of virus lineages. Eradication activities accelerated even in conflict-affected countries. During September 2001, a total of 35 million children received vaccine in Afghanistan and Pakistan, and unprecedented political commitment supporting national polio efforts was given in central and western Africa and India, with heads of state launching NIDs.

Several challenges remain in reaching the global polio eradication goal. The combination of large, dense populations, poor sanitation, and low routine vaccination coverage in Nigeria, Pakistan, and northern India might result in sustained transmission in these countries into 2003. Delays in interrupting transmission also could occur in less populated, conflict-affected countries if conflicts intensify or if access to children in these countries cannot be sustained. In areas where routine OPV coverage is low, interrupting wild poliovirus transmission requires high-quality, supplementary vaccination. National polio eradication efforts require both continued vigilance by the health sector alone and increased political commitment and multisector mobilization at all administrative levels.

The global eradication program has identified and defined the key risks to eradication in each country and is implementing country-specific response plans. Following the example of India, Technical Advisory Groups (TAGs) of experts have been formed for most countries where polio remains endemic, with support from the global polio partnership. TAGs regularly review each country's program status and advise on optimal strategy implementation. AFP surveillance systems have improved dramatically through placement of additional polio field staff. Expert groups exist in almost every country to improve the accuracy of final AFP case classification. Genetic sequencing data are used more systematically to identify main poliovirus circulation areas. The ability of SIAs to reach every child has improved through house-to-house vaccination with emphasis on social mobilization and information activities.

Interagency coordination committees (ICCs) at regional, national, and subnational levels facilitate coordination of partner and multisector support for the polio program and focus on fundraising at the regional level. ICCs created for polio eradication are being used increasingly to coordinate partner input to strengthen vaccination systems including routine vaccination services and vaccine-preventable disease surveillance. During 2000–2001, polio funds were used to purchase approximately 700 vehicles for vaccination and surveillance. An estimated 30% of the cold chain in sub-Saharan Africa has been refurbished through polio eradication funds. Approximately 80% of the nearly 2,000 health-care staff recruited with polio funds are involved in planning and implementing routine vaccination services.

Access to all children, continued political commitment, and assurance of uninterrupted funding will be necessary to interrupt wild poliovirus transmission in countries where polio remains endemic.

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Reporting of Laboratory-Confirmed Chlamydial Infection and Gonorrhea by Providers Affiliated with Three Large Managed Care Organizations — United States, 1995–1999

Surveillance for sexually transmitted diseases (STDs) depends on health departments receiving reports of positive STD test results from laboratories or of STD cases by clinicians (*1*). The completeness and timeliness of reporting can

affect prompt sex partner notification and outbreak detection. In 1998, approximately 70% of chlamydia cases and 55% of gonorrhea cases were reported by private clinicians, including many affiliated with managed care organizations (MCOs) (*2*). However, little is known about the completeness and timeliness of MCOs' STD case reporting practices. Three MCOs, three state health departments, and CDC evaluated reporting practices for chlamydial infection and gonorrhea by three large staff or group model* MCOs that used different reporting procedures. The findings indicate that state health departments were notified of 78%–98% of chlamydia cases and of 64%–80% of gonorrhea cases identified in these MCOs; the median interval between specimen collection and state health department receipt of a case report was ≤19 days. To improve surveillance quality, other MCOs, including network model† MCOs, which provide most STD care in the United States, should evaluate surveillance quality and identify interventions for improvement.

This study evaluated the chlamydia and/or gonorrhea reporting practices used during 1995–1999 by clinicians affiliated with three large MCOs: chlamydia and gonorrhea reporting at HealthPartners, a staff model HMO in Minnesota, and at Harvard Vanguard Medical Associates (HVMA), a large group practice in Massachusetts that was a staff model component of Harvard Pilgrim Health Care during the study period; and chlamydia reporting at Kaiser Permanente Foundation Health Plan of Colorado (KPCO), a group model HMO. In Minnesota and Massachusetts, clinicians and laboratories are required to report both chlamydia infection and gonorrhea, while in Colorado, only laboratories are required to report chlamydia infection (*3*).

Reporting procedures varied by MCO. In the case of HealthPartners, laboratories used a Minnesota Department of Health (MDH) form to report a positive STD test result to a patient's clinician, who was then responsible for contacting the patient, prescribing appropriate medication, noting prescribed treatments on the form, and mailing it to MDH. In the case of HVMA, laboratories transmitted a positive test result electronically to a patient's clinician and a single HVMA infection control specialist, who verified the treatment prescribed (*4*), mailed the test and treatment report to the Massachusetts Department of Public Health (MDPH), and notified the clinician that the case had been reported to MDPH. In the case of KPCO, laboratories filled out a positive STD test result reporting card provided by the Colorado Department of Public Health and Environment (CDPHE), mailed the card to CDPHE, and delivered the test result to a patient's clinician.

For this evaluation, each MCO created a database of positive tests for chlamydia infection and/or gonorrhea among MCO members. This database included all laboratory-confirmed cases of chlamydia infection and gonorrhea at HealthPartners during January 1997–December 1998 and at HVMA during January 1995–December 1997, and all laboratory-confirmed cases of chlamydia infection at KPCO during January–June 1999. These data were transferred confidentially to the respective state STD programs for case matching to determine whether laboratory-confirmed cases had been reported to state health departments.

Laboratory-confirmed cases of chlamydia infection and gonorrhea were matched to state STD registry databases in Minnesota and Massachusetts by patient name, date of birth, sex, specimen collection date, and disease pathogen, and in Colorado by patient name, date of birth, and date of positive test. Matched cases were defined as those for which all variables matched exactly. A case initially unmatched by these variables was reclassified as matched if the patient's address, phone number, or medical record number matched, and the initial mismatch was attributed to typographic error, transposition of first and last names, or a recent last name change. Completeness of reporting was defined as the proportion of cases in the MCO database classified as matched in the state registry database. Timeliness of reporting was defined for HealthPartners and HVMA as the time between specimen collection and entry of case report into the state registry database. Because CDPHE staffing shortages precluded data entry more than once every 6 months, timeliness was defined for KPCO as the time between the date a positive test was identified in the laboratory and the date of receipt by health department staff.

At HealthPartners (Minnesota), 654 (78%) of 841 chlamydia cases and 204 (80%) of 256 gonorrhea cases were matched. Case reports were entered into MDH's registry within a median of 19 days (mean: 33 days, range: 4–380 days) and a median of 17 days (mean: 30 days, range: 6–159 days) after chlamydia and gonorrhea specimen collection, respectively. At HVMA (Massachusetts), 800 (78%) of 1,032 chlamydia cases and 225 (64%) of 354 gonorrhea cases were matched. Case reports were entered into MDPH's registry within a median of 17 days (mean: 38 days, range: 1–268 days) and a median of 14 days (mean: 14 days, range: 1–189 days) after chlamydia and gonorrhea specimen collection, respectively. At KPCO (Colorado), 226 (98%) of 231 chlamydia cases were matched. Case reports were received by CDPHE within

* Physicians in a staff model HMO practice as salaried employees. Physicians in a group model HMO are members of a group that receives a monthly fee for every enrolled patient.

† Physicians in a network model HMO might be members of one group or two or more groups that contract to provide services for a monthly fee.

a median of 6 days (mean: 7 days, range: 1–25 days) after the date when a positive test was identified in the laboratory.

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Editorial Note: Several system-level factors might have contributed to the fairly high completeness of STD reporting at these MCOs: 1) a single, centralized reporting system handling reports from all MCO-affiliated laboratories; 2) MCOs' established relations with state STD programs; and 3) MCO Web site and newsletter communication to clinicians about trends in STD morbidity among members of two MCOs. The first two features are typical of staff or group model MCOs but rare in other MCO models (e.g., network model HMOs) that dominate the MCO market (*5*).

A higher proportion of chlamydia cases was reported by these three large staff or group model MCOs than by private clinicians in North Carolina (55%), the only state for which an evaluation of STD reporting in private health care settings has been published (*6*). However, the lower completeness of reporting found in that study might reflect chlamydia infection having become a reportable disease in North Carolina 5 years earlier. The average completeness of reporting at HealthPartners and HVMA for gonorrhea was similar to that in the North Carolina study (72%).

Although completeness of reporting was fairly high in these three MCOs, the median interval between test specimen collection or processing and receipt or entry of the report by the state health department ranged from 6–19 days. Delayed reporting might slow initiation of services for sex partners and detection of outbreaks, which might reduce the effectiveness of STD control measures (*7*). Such delays might be associated with the time taken to transfer specimens to laboratories, process specimens in the laboratories, verify treatment, and transmit reports to state health department using regular mail. Delays also might be associated with the time elapsed from the date of receipt to the date of manual entering or scanning of cases at health departments. In addition, manual entering and scanning of data at state health departments might result in mismatches in case information between MCO databases and state STD registry databases. To improve the completeness and timeliness of STD reporting, MCOs might consider collaborating with state health departments to use confidential electronic data transfer systems (*8*) to transfer STD test results to state health departments. MCOs might find implementing an electronic data transfer system for laboratory-based reporting from a small number of laboratories easier than for provider-based reporting from hundreds of affiliated providers. CDC, with the collaboration of state and local health departments, is implementing a National Electronic Disease Surveillance System (NEDSS) to better manage and enhance current surveillance systems and enable the public health community to respond more quickly to public health threats (*9*). When implemented, NEDSS will help state health departments receive electronic data.

The findings in this report are subject to at least three limitations. First, the completeness of reporting might have been underestimated slightly because some reports—those with suspected typographic errors in name, date, or disease type and those that were lost during mailing—could not be fully verified. Second, reporting of information that might improve matching (e.g., medical record number, address, or phone number) is not mandated by the three states evaluated and is commonly omitted from reports. Finally, the STD reporting practices in these three staff and group model MCOs might not be representative of other MCOs, especially network models that lack central laboratories, central electronic data transfer capacity, dedicated reporting staff, and regular communication to clinicians about STD rates of the MCO members. However, some features common to staff or group model MCOs that might facilitate STD reporting are readily introduced by other MCO models (e.g., Web site communication to clinicians about STD rates of MCO members).

MCOs that have centralized facilities, staffs, data systems, policies, and the capacity to reach large numbers of patients and clinicians are well positioned to make system-level interventions that will promote more complete and timely STD reporting.

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Oral Health Survey of Third Grade Students — New Hampshire, 2001

Dental caries is one of the most common chronic disease of childhood (*1*). Despite improvements in oral health in the United States, by late adolescence approximately 80% of children have a history of caries (*1*). To establish a baseline for monitoring oral disease trends in New Hampshire, the New Hampshire Department of Health and Human Services in cooperation with the New Hampshire Department of Education conducted a statewide assessment of the oral health status of third grade students attending public schools during the 2000–2001 academic year. This report summarizes the findings of the survey, which indicate that approximately one half of third grade students in New Hampshire have experienced dental decay. Increasing access to fluoridated water and dental sealants is needed to prevent childhood caries.

The survey was based on methodology outlined in the Basic Screening Surveys, a set of standardized, cross-sectional oral health surveys that can be used to collect data for monitoring the national health objectives for 2010 (*2*). Schools were selected with probability proportional to third grade enrollment size. One third grade class in each school was then selected randomly and all students in that class were eligible to participate. Of 273 public schools with 16,685 third grade students, 27 (9.9%) schools were selected. Only students with parental consent were eligible to participate. Each school decided whether consent was active or passive. For schools allowing active consent, parents wanting their child to participate in the screening were required to return a signed consent form. For schools requiring passive consent, all children were screened except those who returned a parental consent form requesting they not participate. Brief noninvasive dental screenings were conducted by five dental hygienists during February–April 2001; one hygienist conducted 85.9% of the screenings. Students (n=70) in five participating schools had been screened in school-based dental programs within 2 months of the start of the survey; data for these students were abstracted from existing records. Data were tabulated according to the percentage of children with dental caries experience, untreated decay, presence of sealants on permanent molars, and urgency of care. The need for early dental care was defined as having untreated dental caries without accompanying signs or symptoms, the presence of spontaneous bleeding of the gum, or suspicious white or red soft tissue areas. Urgent need for dental care included signs or symptoms consistent with pain, infection, swelling, or soft tissue ulceration of >2 weeks duration (*2*).

Of the 27 schools selected, 26 (96.3%) participated. The participating schools were located in 22 towns representing nine of the 10 counties in the state. Of the 507 eligible students, 410 (80.8%) were screened. The overall response rate was 77.9%. Almost all (98.8%) children screened were aged 8 or 9 years; 50.2% were female. Among children screened, 52.0% (95% confidence interval [CI]=45.5%–58.4%) had a history of dental caries, 21.7% (95% CI=14.3%–29.1%) had untreated decay, and 45.9% (95% CI=37.7%–54.0%) had a dental sealant on at least one permanent molar. Among children screened, 69.8% (95% CI=62.7%–76.8%) had no obvious dental problems, 25.1% (95% CI=19.1%–31.2%) required early care, and 5.1% (95% CI=3.0%–7.3%) required urgent care.

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Editorial Note: This survey provided New Hampshire health officials with the first statewide data to assess the oral health status of children. The survey was conducted quickly (i.e., 20 days) and inexpensively (i.e., screening budget=$5,000) by using the Basic Screening Surveys (*2*), limiting the sample size, and restricting the amount of data collected.

CDC, in collaboration with the Association of State and Territorial Dental Directors, developed the National Oral Health Surveillance System (NOHSS) to help public health programs monitor the burden of oral disease, the use of the oral health care delivery system, and the status of community water fluoridation on both a state and national level (*3*). NOHSS includes eight oral health surveillance indicators: four for adults (i.e., dental visits, teeth cleaning, tooth loss, and oral cancer), three for children (i.e., caries experience, untreated caries, and dental sealants) and one involving communities (i.e., fluoridation status). This survey provided New Hampshire data for the three indicators in the NOHSS that were specific to children.

The findings of this survey were consistent with a similar survey conducted in Maine in 1999. In the Maine survey

involving 1,297 third grade children, 20.4% had untreated decay, 44.7% had a history of decay, and 47.6% had sealants (*4*). The national health objectives for 2010 regarding oral health include decreasing the proportion of children aged 6–8 years with untreated decay to 21% (objective 21-2), decreasing the proportion of children aged 6–8 years with a history of caries to 42% (objective 21-1), and increasing the proportion of children aged 8 years with sealants to 50% (objective 21-8) (*5*).

The findings in this report are subject to at least three limitations. First, the survey was restricted to third grade students in public schools. In New Hampshire, 8% of third grade students attend private schools. Second, assessing the presence of interproximal caries, tooth-colored restorations, and clear sealants can be difficult in a noninvasive screening examination; therefore, the results might underestimate the prevalence of both untreated and treated decay and sealants (*6*). Third, the type of consent process selected by the schools might have resulted in selection bias. Of 298 eligible students, 273 (91.6%) participated in schools requiring passive consent compared with 137 (65.6%) of 209 eligible students in schools requiring active consent.

New Hampshire is approaching the 2010 national targets for two of three oral health objectives; however, only 43% of the state's residents on public water supply receive fluoridated water. Further progress in attaining the oral health objectives will require efforts to promote water fluoridation, expand sealant usage, and improve access to dental care for those without such services.

Acknowledgement

This report is based on data and logistical support contributed by I Coulon, T Tolman, Manchester Health Dept, Manchester; S Adams, Seacoast Healthy Grins, Portsmouth; G Barunas, Kiwanis School-based Dental Program, Laconia; K Rannie, MSc, New Hampshire Dept of Education.

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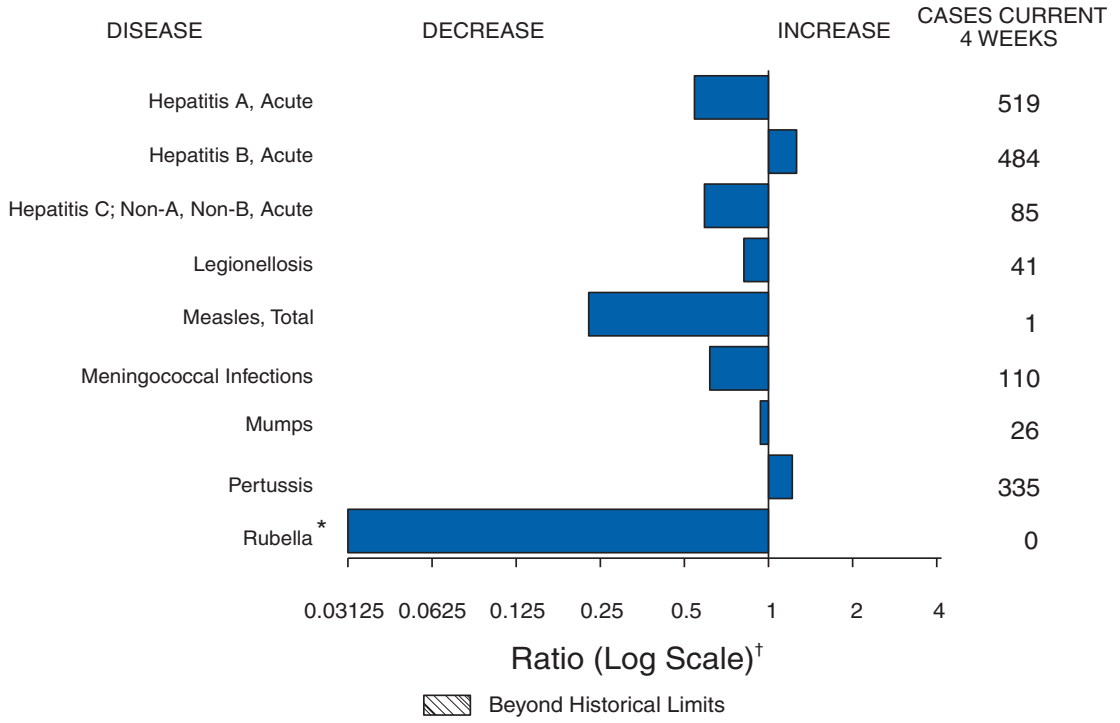
Erratum: Vol. 51, No. 11

In the article "Tuberculosis Outbreak on an American Indian Reservation—Montana, 2000–2001," an error occurred in the third sentence of the second paragraph on page 232. The sentence should read, "At the time of presentation, the index patient had a productive cough and a sputum smear that demonstrated acid-fast bacilli (AFB), *suggesting infectiousness*."

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending March 23, 2002, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 12 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending March 23, 2002 (12th Week)*

		Cum. 2002	Cum. 2001		Cum. 2002	Cum. 2001
Anthrax		-	-	Encephalitis: West Nile†	5	-
Botulism:	foodborne	5	5	Hansen disease (leprosy)†	14	23
	infant	11	23	Hantavirus pulmonary syndrome†	-	2
	other (wound & unspecified)	5	1	Hemolytic uremic syndrome, postdiarrheal†	21	19
Brucellosis†		17	17	HIV infection, pediatric†§	31	40
Chancroid		16	8	Plague	-	-
Cholera		1	-	Poliomyelitis, paralytic	-	-
Cyclosporiasis†		21	36	Psittacosis†	9	3
Diphtheria		-	-	Q fever†	5	1
Ehrlichiosis:	human granulocytic (HGE)†	10	21	Rabies, human	-	-
	human monocytic (HME)†	2	5	Streptococcal toxic-shock syndrome†	10	22
	other and unspecified	-	-	Tetanus	2	6
Encephalitis:	California serogroup viral†	6	1	Toxic-shock syndrome	26	39
	eastern equine†	-	-	Trichinosis	3	5
	Powassan†	-	-	Tularemia†	5	4
	St. Louis†	-	-	Yellow fever	-	-
	western equine†	-	-			

-:No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP). Last update February 24, 2002.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending March 23, 2002, and March 24, 2001 (12th Week)*

Reporting Area	AIDS		Chlamydia†		Cryptosporidiosis		*Escherichia coli* O157:H7		*Escherichia coli* Shiga Toxin Positive, Serogroup non-O157	
	Cum. 2002§	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	6,546	8,275	145,986	170,472	411	398	228	233	13	13
NEW ENGLAND	213	270	4,816	5,134	15	11	19	22	1	5
Maine	1	3	291	276	-	-	-	3	-	-
N.H.	4	12	359	274	3	-	1	3	-	2
Vt.	4	9	166	136	1	5	-	1	-	-
Mass.	137	191	2,460	2,022	2	2	10	14	1	1
R.I.	23	22	629	688	3	2	2	-	-	-
Conn.	44	33	911	1,738	6	2	6	1	-	2
MID. ATLANTIC	1,403	2,900	13,045	16,917	30	54	11	23	-	-
Upstate N.Y.	75	516	1,004	2,583	5	10	7	11	-	-
N.Y. City	874	1,722	6,506	6,752	18	25	-	1	-	-
N.J.	269	378	664	2,279	1	2	4	11	-	-
Pa.	185	284	4,871	5,303	6	17	N	N	-	-
E.N. CENTRAL	671	496	22,085	32,688	121	134	75	49	-	-
Ohio	156	69	3,184	8,894	37	25	13	17	-	-
Ind.	85	44	3,464	3,659	13	11	6	8	-	-
Ill.	333	230	5,904	9,877	15	12	18	10	-	-
Mich.	66	136	6,967	6,313	24	27	18	5	-	-
Wis.	31	17	2,566	3,945	32	59	20	9	-	-
W.N. CENTRAL	105	123	6,669	8,982	32	14	33	21	3	-
Minn.	20	27	1,820	1,949	10	-	10	8	3	-
Iowa	23	15	461	933	4	5	9	3	-	-
Mo.	36	38	1,963	3,108	10	6	10	4	-	-
N. Dak.	-	1	154	234	2	-	-	-	-	-
S. Dak.	1	-	491	428	3	-	1	1	-	-
Nebr.	12	18	314	854	-	3	-	-	-	-
Kans.	13	24	1,466	1,476	3	-	3	5	-	-
S. ATLANTIC	2,041	2,156	30,272	32,539	92	82	35	30	7	6
Del.	46	37	619	703	1	-	1	-	-	-
Md.	255	129	2,700	3,477	3	17	-	1	-	-
D.C.	87	166	774	782	1	3	-	-	-	-
Va.	160	196	3,622	3,909	1	5	3	6	-	1
W. Va.	13	10	518	521	1	-	-	1	-	-
N.C.	155	78	4,199	4,514	13	11	6	13	-	-
S.C.	148	193	2,923	4,202	1	1	-	1	-	-
Ga.	476	187	6,764	7,215	46	30	19	4	4	5
Fla.	701	1,160	8,153	7,216	25	15	6	4	3	-
E.S. CENTRAL	278	364	11,585	11,603	20	8	4	10	-	-
Ky.	31	51	1,904	2,018	1	-	1	1	-	-
Tenn.	133	136	3,669	3,553	6	2	3	4	-	-
Ala.	57	94	3,841	3,066	12	2	-	4	-	-
Miss.	57	83	2,171	2,966	1	4	-	1	-	-
W.S. CENTRAL	752	726	23,438	24,699	4	8	-	27	-	-
Ark.	35	45	1,365	1,967	2	2	-	-	-	-
La.	192	197	3,945	4,095	1	3	-	-	-	-
Okla.	35	35	2,086	2,271	1	1	-	5	-	-
Tex.	490	449	16,042	16,366	-	2	-	22	-	-
MOUNTAIN	208	277	8,799	9,806	28	25	19	14	1	1
Mont.	4	3	524	389	-	1	4	2	-	-
Idaho	4	5	557	419	9	3	1	2	-	-
Wyo.	1	-	200	196	1	-	-	-	1	-
Colo.	35	81	1,137	2,815	8	12	2	4	-	1
N. Mex.	7	18	1,315	1,437	2	6	2	-	-	-
Ariz.	92	81	2,433	3,071	4	1	4	5	-	-
Utah	13	21	1,333	270	2	2	3	-	-	-
Nev.	52	68	1,300	1,209	2	-	3	1	-	-
PACIFIC	875	963	25,277	28,104	69	62	32	37	1	1
Wash.	86	113	2,921	3,110	15	U	5	5	-	-
Oreg.	92	38	1,458	1,513	8	6	7	2	1	1
Calif.	686	798	19,355	21,899	46	56	19	26	-	-
Alaska	2	2	710	597	-	-	-	-	-	-
Hawaii	9	12	833	985	-	-	1	4	-	-
Guam	1	6	-	-	-	-	N	N	-	-
P.R.	166	196	-	1,043	-	-	-	-	-	-
V.I.	46	1	-	43	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	37	U	-	U	-	U	-	U

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

* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update March 3, 2002.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 23, 2002, and March 24, 2001 (12th Week)*

Reporting Area	*Escherichia coli* Shiga Toxin Positive, Not Serogrouped		Giardiasis	Gonorrhea		*Haemophilus influenzae*, Invasive			
						All Ages, All Serotypes		Age <5 Years Serotype B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1	3	2,385	64,003	78,452	350	393	2	6
NEW ENGLAND	-	-	267	1,442	1,404	29	11	-	1
Maine	-	-	35	16	38	1	-	-	-
N.H.	-	-	14	30	30	4	-	-	-
Vt.	-	-	22	25	19	2	-	-	-
Mass.	-	-	113	852	602	14	11	-	1
R.I.	-	-	18	210	169	-	-	-	-
Conn.	-	-	65	309	546	8	-	-	-
MID. ATLANTIC	-	-	367	5,534	8,040	40	61	1	-
Upstate N.Y.	-	-	74	499	1,528	12	11	1	-
N.Y. City	-	-	186	2,685	2,843	16	18	-	-
N.J.	-	-	-	423	1,034	9	26	-	-
Pa.	-	-	107	1,927	2,635	3	6	-	-
E.N. CENTRAL	1	2	513	11,033	16,423	47	63	-	1
Ohio	1	2	196	1,828	4,740	32	23	-	1
Ind.	-	-	-	1,529	1,594	6	6	-	-
Ill.	-	-	83	3,436	5,158	-	24	-	-
Mich.	-	-	165	3,453	3,522	5	3	-	-
Wis.	-	-	69	787	1,409	4	7	-	-
W.N. CENTRAL	-	-	262	2,959	3,735	12	10	-	-
Minn.	-	-	84	576	636	9	4	-	-
Iowa	-	-	58	134	229	1	-	-	-
Mo.	-	-	75	1,443	1,816	2	6	-	-
N. Dak.	-	-	3	10	8	-	-	-	-
S. Dak.	-	-	13	64	47	-	-	-	-
Nebr.	-	-	-	118	320	-	-	-	-
Kans.	-	-	29	614	679	-	-	-	-
S. ATLANTIC	-	-	425	18,033	20,456	105	129	-	1
Del.	-	-	10	389	377	-	-	-	-
Md.	-	-	21	1,493	1,999	25	31	-	-
D.C.	-	-	11	628	753	-	-	-	-
Va.	-	-	16	2,309	2,151	7	9	-	-
W. Va.	-	-	4	203	109	1	4	-	1
N.C.	-	-	-	3,271	3,774	10	17	-	-
S.C.	-	-	3	1,665	3,332	3	2	-	-
Ga.	-	-	117	3,643	3,942	36	35	-	-
Fla.	-	-	243	4,432	4,019	23	31	-	-
E.S. CENTRAL	-	1	66	6,570	7,476	17	19	1	-
Ky.	-	1	-	759	798	2	-	-	-
Tenn.	-	-	25	2,036	2,353	9	9	-	-
Ala.	-	-	41	2,465	2,493	5	9	1	-
Miss.	-	-	-	1,310	1,832	1	1	-	-
W.S. CENTRAL	-	-	14	10,621	12,209	18	9	-	-
Ark.	-	-	14	873	1,249	1	-	-	-
La.	-	-	-	2,533	2,851	-	2	-	-
Okla.	-	-	-	936	1,118	17	7	-	-
Tex.	-	-	-	6,279	6,991	-	-	-	-
MOUNTAIN	-	-	270	2,232	2,363	45	62	-	2
Mont.	-	-	14	32	20	-	-	-	-
Idaho	-	-	8	26	22	1	1	-	-
Wyo.	-	-	2	16	16	1	-	-	-
Colo.	-	-	98	766	774	11	11	-	-
N. Mex.	-	-	27	251	239	10	10	-	-
Ariz.	-	-	45	641	849	17	32	-	1
Utah	-	-	45	99	26	3	1	-	-
Nev.	-	-	31	401	417	2	7	-	1
PACIFIC	-	-	201	5,579	6,346	37	29	-	1
Wash.	-	-	50	653	705	-	1	-	-
Oreg.	-	-	104	208	271	24	3	-	-
Calif.	-	-	-	4,466	5,145	3	15	-	1
Alaska	-	-	19	136	68	1	1	-	-
Hawaii	-	-	28	116	157	9	9	-	-
Guam	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	263	-	-	-	-
V.I.	-	-	-	-	5	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	3	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 23, 2002, and March 24, 2001 (12th Week)*

Reporting Area	*Haemophilus influenzae*, Invasive, Age <5 Years, Non-Serotype B		*Haemophilus influenzae*, Invasive, Age <5 Years, Unknown Serotype		Hepatitis (Viral, Acute), By Type, A		B		C; Non-A, Non-B	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	58	74	3	6	1,801	2,921	1,221	1,591	310	1,199
NEW ENGLAND	5	4	-	-	83	97	33	28	4	18
Maine	-	-	-	-	3	1	1	1	-	-
N.H.	-	-	-	-	5	2	4	3	-	-
Vt.	-	-	-	-	-	2	2	1	4	5
Mass.	3	4	-	-	40	38	25	4	-	13
R.I.	-	-	-	-	4	4	1	6	-	-
Conn.	2	-	-	-	31	50	-	13	-	-
MID. ATLANTIC	5	11	-	-	157	306	231	336	76	583
Upstate N.Y.	1	-	-	-	15	41	11	20	1	8
N.Y. City	3	4	-	-	79	96	127	147	-	-
N.J.	1	3	-	-	13	124	49	113	73	559
Pa.	-	4	-	-	50	45	44	56	2	16
E.N. CENTRAL	5	13	-	-	209	685	181	148	26	74
Ohio	3	3	-	-	75	65	27	30	4	4
Ind.	1	1	-	-	13	13	4	3	-	-
Ill.	-	7	-	-	54	491	13	9	2	20
Mich.	1	-	-	-	51	95	137	106	20	50
Wis.	-	2	-	-	16	21	-	-	-	-
W.N. CENTRAL	1	1	2	1	83	118	45	47	98	284
Minn.	1	1	1	-	8	7	2	2	-	-
Iowa	-	-	-	-	24	9	5	5	1	-
Mo.	-	-	1	1	16	36	31	30	97	282
N. Dak.	-	-	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	2	1	-	1	-	-
Nebr.	-	-	-	-	-	17	-	5	-	1
Kans.	-	-	-	-	33	48	7	4	-	1
S. ATLANTIC	17	22	-	2	568	479	334	353	29	22
Del.	-	-	-	-	2	2	1	4	3	1
Md.	-	2	-	-	77	58	20	31	3	5
D.C.	-	-	-	-	22	12	3	3	-	-
Va.	2	4	-	-	11	35	26	27	-	-
W. Va.	-	-	-	-	5	1	6	3	-	-
N.C.	1	1	-	2	89	29	44	51	4	6
S.C.	1	-	-	-	13	13	9	1	3	2
Ga.	7	9	-	-	87	208	143	167	2	1
Fla.	6	6	-	-	262	121	82	66	14	7
E.S. CENTRAL	4	3	-	1	37	70	36	102	34	20
Ky.	-	-	-	-	14	9	9	15	1	1
Tenn.	2	1	-	-	-	32	-	36	10	14
Ala.	2	1	-	1	7	24	14	27	2	1
Miss.	-	1	-	-	16	5	13	24	21	4
W.S. CENTRAL	4	1	-	-	25	492	93	190	2	151
Ark.	-	-	-	-	11	16	26	21	-	1
La.	-	-	-	-	3	21	4	24	2	68
Okla.	4	1	-	-	10	42	1	22	-	1
Tex.	-	-	-	-	1	413	62	123	-	81
MOUNTAIN	10	8	1	1	163	211	91	126	17	18
Mont.	-	-	-	-	5	4	2	1	-	-
Idaho	-	-	-	-	-	23	-	4	-	1
Wyo.	-	-	-	-	3	1	6	-	4	2
Colo.	1	-	-	-	28	25	21	26	9	5
N. Mex.	4	4	-	1	4	7	10	38	-	6
Ariz.	4	4	-	-	89	107	37	42	-	1
Utah	-	-	-	-	14	16	6	4	-	-
Nev.	1	-	1	-	20	28	9	11	4	3
PACIFIC	7	11	-	1	476	463	177	261	24	29
Wash.	-	-	-	1	37	18	11	17	2	8
Oreg.	4	-	-	-	31	4	32	6	7	1
Calif.	2	10	-	-	403	430	132	230	15	20
Alaska	1	-	-	-	5	10	2	2	-	-
Hawaii	-	1	-	-	-	1	-	6	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	19	26	12	46	-	1
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	4	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 23, 2002, and March 24, 2001 (12th Week)*

Reporting Area	Legionellosis		Listeriosis		Lyme Disease		Malaria		Measles Total	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	126	179	74	92	519	955	200	266	1†	46§
NEW ENGLAND	5	5	9	8	33	161	13	22	-	4
Maine	-	-	2	-	-	-	1	1	-	-
N.H.	1	-	2	-	13	2	4	1	-	-
Vt.	-	2	-	-	1	1	-	-	-	1
Mass.	2	2	3	6	16	49	3	10	-	3
R.I.	-	-	-	-	3	-	-	-	-	-
Conn.	2	1	2	2	-	109	5	10	-	-
MID. ATLANTIC	12	38	8	15	351	641	32	65	-	3
Upstate N.Y.	-	7	3	3	191	161	4	7	-	2
N.Y. City	-	3	2	4	20	8	18	35	-	-
N.J.	1	6	-	6	25	117	6	16	-	-
Pa.	11	22	3	2	115	355	4	7	-	1
E.N. CENTRAL	49	54	12	13	13	27	23	46	-	7
Ohio	30	21	7	1	12	4	7	5	-	2
Ind.	3	4	-	1	1	-	1	8	-	2
Ill.	-	8	-	4	-	3	4	13	-	3
Mich.	14	13	3	5	-	-	9	13	-	-
Wis.	2	8	2	2	U	20	2	7	-	-
W.N. CENTRAL	5	11	2	2	9	12	17	6	-	3
Minn.	1	1	-	-	2	8	7	1	-	1
Iowa	-	2	-	-	3	1	2	1	-	-
Mo.	3	5	1	1	4	2	5	3	-	2
N. Dak.	-	-	1	-	-	-	-	-	-	-
S. Dak.	1	-	-	-	-	-	-	-	-	-
Nebr.	-	2	-	-	-	-	-	-	-	-
Kans.	-	1	-	1	-	1	3	1	-	-
S. ATLANTIC	30	23	11	9	79	76	75	58	1	3
Del.	3	-	-	-	5	5	1	1	-	-
Md.	4	6	1	1	41	60	16	20	-	3
D.C.	-	1	-	-	4	5	2	4	-	-
Va.	2	3	1	1	-	3	4	9	-	-
W. Va.	N	N	-	1	-	1	-	-	-	-
N.C.	3	2	1	-	9	2	6	1	-	-
S.C.	3	-	2	-	1	-	2	2	-	-
Ga.	3	2	3	2	-	-	33	10	-	-
Fla.	12	9	3	4	19	-	11	11	1	-
E.S. CENTRAL	5	16	5	4	2	2	3	8	-	-
Ky.	3	5	1	1	1	2	-	2	-	-
Tenn.	-	6	2	2	1	-	1	3	-	-
Ala.	2	3	2	1	-	-	1	3	-	-
Miss.	-	2	-	-	-	-	1	-	-	-
W.S. CENTRAL	-	3	3	9	2	21	2	3	-	1
Ark.	-	-	-	1	-	-	-	-	-	-
La.	-	2	-	-	1	1	2	1	-	-
Okla.	-	-	3	-	-	-	-	1	-	-
Tex.	-	1	-	8	1	20	-	1	-	1
MOUNTAIN	10	9	8	6	5	1	7	16	-	1
Mont.	1	-	-	-	-	-	-	1	-	-
Idaho	-	-	-	-	-	-	-	1	-	1
Wyo.	3	1	-	-	-	-	-	-	-	-
Colo.	3	3	2	1	2	-	2	9	-	-
N. Mex.	1	1	-	2	1	-	-	1	-	-
Ariz.	-	3	4	1	1	-	2	1	-	-
Utah	2	-	2	-	1	-	2	2	-	-
Nev.	-	1	-	2	-	1	1	1	-	-
PACIFIC	10	20	16	26	25	14	28	42	-	24
Wash.	-	5	1	1	-	1	1	1	-	15
Oreg.	N	N	1	3	1	1	-	2	-	2
Calif.	10	15	14	22	24	12	24	36	-	5
Alaska	-	-	-	-	-	-	1	1	-	-
Hawaii	-	-	-	-	N	N	2	2	-	2
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	2	-	-	N	N	-	-	-	-
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Of one case reported, zero were indigenous and one was imported from another country.
§ Of 46 cases reported, 27 were indigenous and 19 were imported from another country.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 23, 2002, and March 24, 2001 (12th Week)*

Reporting Area	Meningococcal Disease		Mumps		Pertussis		Rabies, Animal	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	383	834	64	39	939	1,261	774	1,245
NEW ENGLAND	33	46	4	-	166	151	142	107
Maine	2	-	-	-	3	-	10	15
N.H.	4	3	3	-	1	16	2	2
Vt.	3	4	-	-	28	22	28	23
Mass.	19	27	1	-	134	107	43	26
R.I.	2	-	-	-	-	-	4	11
Conn.	3	12	-	-	-	6	55	30
MID. ATLANTIC	25	100	7	2	32	89	44	78
Upstate N.Y.	2	24	1	1	16	58	23	-
N.Y. City	4	18	1	1	5	10	5	1
N.J.	6	38	1	-	-	-	-	26
Pa.	13	20	4	-	11	21	16	51
E.N. CENTRAL	55	96	8	5	167	150	2	8
Ohio	25	28	3	1	107	100	1	-
Ind.	11	1	-	-	12	5	1	1
Ill.	-	27	2	4	22	10	-	-
Mich.	13	25	3	-	18	16	-	3
Wis.	6	15	-	-	8	19	-	4
W.N. CENTRAL	38	45	6	1	121	39	65	72
Minn.	7	1	-	-	30	-	7	12
Iowa	5	11	-	-	43	7	7	13
Mo.	20	20	3	-	29	20	1	5
N. Dak.	-	2	-	-	-	-	-	11
S. Dak.	2	2	-	-	5	2	16	11
Nebr.	-	2	-	-	-	-	-	-
Kans.	4	7	3	1	14	10	34	20
S. ATLANTIC	77	142	9	4	79	53	391	430
Del.	3	-	-	-	1	-	3	-
Md.	1	18	1	2	9	10	38	74
D.C.	-	-	-	-	-	-	-	-
Va.	8	14	2	1	21	6	123	78
W. Va.	-	4	-	-	1	1	31	32
N.C.	11	36	1	-	11	19	120	121
S.C.	10	10	1	1	18	6	17	18
Ga.	10	25	2	-	9	7	59	68
Fla.	34	35	2	-	9	4	-	39
E.S. CENTRAL	19	49	4	-	34	26	29	113
Ky.	2	8	1	-	11	9	6	4
Tenn.	6	16	1	-	21	11	18	106
Ala.	9	19	1	-	2	3	5	3
Miss.	2	6	1	-	-	3	-	-
W.S. CENTRAL	17	178	4	3	92	31	23	304
Ark.	7	7	-	1	5	3	-	-
La.	3	34	-	2	-	1	-	2
Okla.	6	11	-	-	10	1	23	15
Tex.	1	126	4	-	77	26	-	287
MOUNTAIN	34	33	3	4	140	542	31	53
Mont.	1	-	-	-	2	3	-	5
Idaho	-	3	1	-	21	144	-	-
Wyo.	-	-	-	1	3	-	1	15
Colo.	11	12	-	1	76	121	-	-
N. Mex.	1	5	-	2	19	15	-	1
Ariz.	10	6	-	-	10	250	30	32
Utah	4	4	2	-	7	9	-	-
Nev.	7	3	-	-	2	-	-	-
PACIFIC	85	145	19	20	108	180	47	80
Wash.	14	22	-	-	66	20	-	-
Oreg.	17	4	N	N	14	3	-	-
Calif.	49	113	15	12	24	148	27	52
Alaska	2	1	-	1	2	-	20	28
Hawaii	3	5	4	7	2	9	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	1	1	-	-	-	1	16	24
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 23, 2002, and March 24, 2001 (12th Week)*

Reporting Area	Rocky Mountain Spotted Fever		Rubella				Salmonellosis	
			Rubella		Congenital Rubella			
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	61	18	-	3	1	-	4,885	5,588
NEW ENGLAND	-	-	-	-	-	-	281	360
Maine	-	-	-	-	-	-	42	14
N.H.	-	-	-	-	-	-	12	26
Vt.	-	-	-	-	-	-	13	18
Mass.	-	-	-	-	-	-	147	234
R.I.	-	-	-	-	-	-	5	18
Conn.	-	-	-	-	-	-	62	50
MID. ATLANTIC	4	1	-	2	-	-	409	873
Upstate N.Y.	-	-	-	1	-	-	60	139
N.Y. City	-	-	-	1	-	-	176	197
N.J.	-	-	-	-	-	-	57	320
Pa.	4	1	-	-	-	-	116	217
E.N. CENTRAL	3	2	-	1	-	-	853	767
Ohio	3	-	-	-	-	-	284	236
Ind.	-	1	-	-	-	-	50	50
Ill.	-	1	-	1	-	-	273	227
Mich.	-	-	-	-	-	-	158	132
Wis.	-	-	-	-	-	-	88	122
W.N. CENTRAL	8	3	-	-	-	-	401	313
Minn.	-	-	-	-	-	-	77	105
Iowa	-	-	-	-	-	-	59	45
Mo.	8	3	-	-	-	-	191	78
N. Dak.	-	-	-	-	-	-	5	1
S. Dak.	-	-	-	-	-	-	19	22
Nebr.	-	-	-	-	-	-	-	19
Kans.	-	-	-	-	-	-	50	43
S. ATLANTIC	43	8	-	-	-	-	1,364	1,275
Del.	-	-	-	-	-	-	9	15
Md.	4	2	-	-	-	-	96	129
D.C.	-	-	-	-	-	-	18	16
Va.	1	-	-	-	-	-	91	119
W. Va.	-	-	-	-	-	-	5	8
N.C.	28	5	-	-	-	-	218	218
S.C.	5	1	-	-	-	-	68	129
Ga.	4	-	-	-	-	-	375	362
Fla.	1	-	-	-	-	-	484	279
E.S. CENTRAL	3	3	-	-	-	-	286	300
Ky.	-	-	-	-	-	-	41	54
Tenn.	3	2	-	-	-	-	91	74
Ala.	-	1	-	-	-	-	98	114
Miss.	-	-	-	-	-	-	56	58
W.S. CENTRAL	-	-	-	-	-	-	111	595
Ark.	-	-	-	-	-	-	49	49
La.	-	-	-	-	-	-	7	130
Okla.	-	-	-	-	-	-	53	22
Tex.	-	-	-	-	-	-	2	394
MOUNTAIN	-	1	-	-	-	-	352	323
Mont.	-	-	-	-	-	-	7	9
Idaho	-	1	-	-	-	-	21	12
Wyo.	-	-	-	-	-	-	11	14
Colo.	-	-	-	-	-	-	103	90
N. Mex.	-	-	-	-	-	-	52	40
Ariz.	-	-	-	-	-	-	83	108
Utah	-	-	-	-	-	-	31	33
Nev.	-	-	-	-	-	-	44	17
PACIFIC	-	-	-	-	1	-	828	782
Wash.	-	-	-	-	-	-	35	68
Oreg.	-	-	-	-	-	-	59	12
Calif.	-	-	-	-	-	-	677	622
Alaska	-	-	-	-	-	-	14	9
Hawaii	-	-	-	-	1	-	43	71
Guam	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	35	171
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	2	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 23, 2002, and March 24, 2001 (12th Week)*

Reporting Area	Shigellosis		Streptococcal Disease, Invasive, Group A		*Streptococcus pneumoniae*, Drug Resistant, Invasive		*Streptococcus pneumoniae*, Invasive (<5 Years)	
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	2,495	2,854	857	1,033	597	854	57	43
NEW ENGLAND	52	41	45	38	1	3	15	2
Maine	2	1	10	6	-	-	-	-
N.H.	3	-	16	4	-	-	-	-
Vt.	-	-	1	5	1	3	15	1
Mass.	40	32	18	22	-	-	-	-
R.I.	-	-	-	1	-	-	-	1
Conn.	7	8	-	-	-	-	-	-
MID. ATLANTIC	99	361	83	182	7	42	2	29
Upstate N.Y.	11	93	22	62	7	41	2	29
N.Y. City	60	97	30	68	U	U	-	-
N.J.	6	106	22	46	-	-	-	-
Pa.	22	65	9	6	-	1	-	-
E.N. CENTRAL	345	426	130	244	30	54	12	11
Ohio	212	103	51	57	-	-	1	-
Ind.	14	63	6	-	30	54	8	11
Ill.	63	134	1	93	-	-	-	-
Mich.	38	81	72	77	-	-	3	-
Wis.	18	45	-	17	-	-	-	-
W.N. CENTRAL	217	302	64	62	129	13	8	1
Minn.	31	137	27	-	86	-	8	-
Iowa	24	43	-	-	-	-	-	-
Mo.	34	63	20	26	3	5	-	-
N. Dak.	-	9	-	2	-	1	-	1
S. Dak.	104	4	3	2	1	-	-	-
Nebr.	-	21	-	9	-	3	-	-
Kans.	24	25	14	23	39	4	-	-
S. ATLANTIC	1,020	413	189	210	362	599	20	-
Del.	3	3	-	1	3	-	-	-
Md.	95	23	19	15	-	-	-	-
D.C.	15	14	3	-	8	2	17	-
Va.	205	26	14	41	-	-	-	-
W. Va.	2	4	-	8	10	14	-	-
N.C.	64	94	48	32	-	-	-	-
S.C.	11	25	13	2	54	91	3	-
Ga.	427	99	52	77	103	232	-	-
Fla.	198	125	40	34	184	260	-	-
E.S. CENTRAL	195	200	34	26	46	95	-	-
Ky.	40	70	5	11	4	10	-	-
Tenn.	14	20	29	15	42	84	-	-
Ala.	77	37	-	-	-	1	-	-
Miss.	64	73	-	-	-	-	-	-
W.S. CENTRAL	86	516	12	118	5	33	-	-
Ark.	24	111	-	-	2	9	-	-
La.	7	56	-	-	3	24	-	-
Okla.	54	3	11	19	-	-	-	-
Tex.	1	346	1	99	-	-	-	-
MOUNTAIN	95	156	139	95	17	14	-	-
Mont.	-	-	-	-	-	-	-	-
Idaho	2	5	1	1	-	-	-	-
Wyo.	1	-	3	1	7	-	-	-
Colo.	27	30	78	53	-	-	-	-
N. Mex.	12	32	33	28	9	14	-	-
Ariz.	38	73	24	10	1	-	-	-
Utah	8	4	-	2	-	-	-	-
Nev.	7	12	-	-	-	-	-	-
PACIFIC	386	439	161	58	-	1	-	-
Wash.	15	43	26	-	-	-	-	-
Oreg.	29	4	-	-	-	-	-	-
Calif.	329	380	119	44	-	-	-	-
Alaska	1	1	-	-	-	-	-	-
Hawaii	12	11	16	14	-	1	-	-
Guam	-	-	-	-	-	-	-	-
P.R.	1	6	-	-	-	-	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	-	-	U	U
C.N.M.I.	-	U	-	U	-	-	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
*Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending March 23, 2002, and March 24, 2001 (12th Week)*

Reporting Area	Syphilis				Tuberculosis		Typhoid Fever	
	Primary & Secondary		Congenital†					
	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001	Cum. 2002	Cum. 2001
UNITED STATES	1,202	1,208	2	105	1,417	2,109	44	66
NEW ENGLAND	15	6	-	-	58	73	4	4
Maine	-	-	-	-	-	-	-	-
N.H.	-	-	-	-	3	6	-	-
Vt.	-	-	-	-	-	1	-	-
Mass.	10	3	-	-	23	38	3	4
R.I.	2	-	-	-	11	6	-	-
Conn.	3	3	-	-	21	22	1	-
MID. ATLANTIC	114	95	-	17	294	324	10	25
Upstate N.Y.	-	4	-	11	17	-	2	4
N.Y. City	69	57	-	-	223	177	5	2
N.J.	26	13	-	5	-	93	3	19
Pa.	19	21	-	1	54	54	-	-
E.N. CENTRAL	239	183	-	20	194	211	7	4
Ohio	37	16	-	1	35	39	3	1
Ind.	10	37	-	3	20	17	1	-
Ill.	53	66	-	14	96	107	-	1
Mich.	134	57	-	2	37	30	2	1
Wis.	5	7	-	-	6	18	1	1
W.N. CENTRAL	11	20	-	2	80	77	-	4
Minn.	3	11	-	-	43	41	-	-
Iowa	-	-	-	-	-	9	-	-
Mo.	3	5	-	1	30	16	-	4
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	5	1	-	-
Nebr.	3	-	-	-	-	10	-	-
Kans.	2	4	-	1	2	-	-	-
S. ATLANTIC	320	452	-	27	293	364	8	10
Del.	4	3	-	-	-	-	-	-
Md.	22	65	-	1	21	33	-	3
D.C.	14	8	-	1	-	17	-	-
Va.	8	37	-	-	14	44	-	1
W. Va.	-	-	-	-	6	7	-	-
N.C.	77	104	-	2	41	29	-	1
S.C.	29	62	-	8	27	37	-	-
Ga.	41	63	-	5	42	72	5	3
Fla.	125	110	-	10	142	125	3	2
E.S. CENTRAL	147	132	-	7	128	144	-	-
Ky.	15	11	-	-	21	17	-	-
Tenn.	57	73	-	4	58	42	-	-
Ala.	56	25	-	2	39	60	-	-
Miss.	19	23	-	1	10	25	-	-
W.S. CENTRAL	164	162	2	17	44	360	-	4
Ark.	6	12	-	2	19	27	-	-
La.	34	31	-	-	-	-	-	-
Okla.	14	19	-	1	25	11	-	-
Tex.	110	100	2	14	-	322	-	4
MOUNTAIN	51	42	-	4	40	87	3	2
Mont.	-	-	-	-	-	-	-	1
Idaho	1	-	-	-	-	4	-	-
Wyo.	-	-	-	-	1	-	-	-
Colo.	-	3	-	-	9	22	2	-
N. Mex.	9	4	-	-	7	10	-	-
Ariz.	38	28	-	4	16	27	-	-
Utah	3	6	-	-	5	5	1	-
Nev.	-	1	-	-	2	19	-	1
PACIFIC	141	116	-	11	286	469	12	13
Wash.	11	19	-	-	48	38	-	-
Oreg.	4	3	-	-	19	17	2	-
Calif.	125	91	-	11	172	369	10	12
Alaska	-	-	-	-	19	12	-	-
Hawaii	1	3	-	-	28	33	-	1
Guam	-	-	-	-	-	-	-	-
P.R.	-	77	-	4	-	11	-	-
V.I.	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	11	U	-	U

N: Not notifiable. U: Unavailable. - : No reported cases.
* Incidence data for reporting year 2001 and 2002 are provisional and cumulative (year-to-date).
† Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE III. Deaths in 122 U.S. cities,* week ending March 23, 2002 (12th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	585	428	102	35	13	7	73
Boston, Mass.	170	117	40	7	5	1	25
Bridgeport, Conn.	45	31	7	4	2	1	4
Cambridge, Mass.	18	15	2	-	-	1	2
Fall River, Mass.	37	32	4	1	-	-	9
Hartford, Conn.	42	27	9	3	2	1	1
Lowell, Mass.	28	21	3	4	-	-	5
Lynn, Mass.	8	6	2	-	-	-	2
New Bedford, Mass.	41	36	3	2	-	-	4
New Haven, Conn.	53	40	7	3	1	2	7
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	4	1	1	2	-	-	-
Springfield, Mass.	35	26	4	3	1	1	3
Waterbury, Conn.	34	24	9	1	-	-	2
Worcester, Mass.	70	52	11	5	2	-	9
MID. ATLANTIC	2,288	1,619	424	162	42	39	165
Albany, N.Y.	55	45	2	2	2	4	9
Allentown, Pa.	26	23	3	-	-	-	3
Buffalo, N.Y.	97	67	15	9	2	4	14
Camden, N.J.	41	28	6	2	3	2	4
Elizabeth, N.J.	24	13	8	2	1	-	1
Erie, Pa.	59	42	11	2	1	3	6
Jersey City, N.J.	U	U	U	U	U	U	U
New York City, N.Y.	1,191	835	231	92	19	12	51
Newark, N.J.	29	8	12	6	2	1	2
Paterson, N.J.	32	21	5	4	1	1	4
Philadelphia, Pa.	344	242	70	21	8	3	20
Pittsburgh, Pa.§	30	22	3	1	2	2	4
Reading, Pa.	17	15	2	-	-	-	5
Rochester, N.Y.	128	99	17	8	-	4	13
Schenectady, N.Y.	29	21	6	2	-	-	2
Scranton, Pa.	31	28	2	1	-	-	2
Syracuse, N.Y.	102	71	19	9	-	3	19
Trenton, N.J.	25	13	10	1	1	-	5
Utica, N.Y.	28	26	2	-	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,772	1,252	344	100	43	33	148
Akron, Ohio	66	46	12	5	3	-	8
Canton, Ohio	29	26	3	-	-	-	8
Chicago, Ill.	U	U	U	U	U	U	U
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	146	93	34	7	5	7	8
Columbus, Ohio	222	151	44	18	6	3	10
Dayton, Ohio	179	132	33	7	5	2	26
Detroit, Mich.	218	132	54	18	5	9	14
Evansville, Ind.	42	33	9	-	-	-	6
Fort Wayne, Ind.	67	58	5	4	-	-	9
Gary, Ind.	20	10	5	2	3	-	-
Grand Rapids, Mich.	74	45	15	7	6	1	14
Indianapolis, Ind.	217	149	48	15	-	5	20
Lansing, Mich.	51	34	12	2	3	-	2
Milwaukee, Wis.	132	93	29	5	3	2	7
Peoria, Ill.	66	49	12	1	2	2	4
Rockford, Ill.	49	40	4	2	1	2	2
South Bend, Ind.	U	U	U	U	U	U	U
Toledo, Ohio	127	102	19	5	1	-	3
Youngstown, Ohio	67	59	6	2	-	-	7
W.N. CENTRAL	747	543	123	40	21	19	65
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	26	21	4	-	-	1	2
Kansas City, Kans.	53	31	13	5	4	-	10
Kansas City, Mo.	102	74	13	5	3	6	9
Lincoln, Nebr.	90	82	4	1	2	1	11
Minneapolis, Minn.	71	52	11	4	2	2	8
Omaha, Nebr.	73	54	10	5	-	4	9
St. Louis, Mo.	137	88	37	6	4	2	-
St. Paul, Minn.	72	55	8	7	1	1	4
Wichita, Kans.	123	86	23	7	5	2	12
S. ATLANTIC	1,321	874	265	106	36	40	91
Atlanta, Ga.	198	121	39	20	7	11	8
Baltimore, Md.	231	141	53	23	6	8	21
Charlotte, N.C.	121	79	25	8	3	6	12
Jacksonville, Fla.	125	86	31	5	2	1	9
Miami, Fla.	119	83	22	9	2	3	10
Norfolk, Va.	53	33	15	3	2	-	-
Richmond, Va.	U	U	U	U	U	U	U
Savannah, Ga.	71	48	10	8	-	5	8
St. Petersburg, Fla.	94	73	9	6	6	-	8
Tampa, Fla.	190	137	31	14	4	4	11
Washington, D.C.	101	55	30	10	4	2	4
Wilmington, Del.	18	18	-	-	-	-	-
E.S. CENTRAL	1,017	683	211	72	27	21	94
Birmingham, Ala.	211	157	40	8	5	1	30
Chattanooga, Tenn.	88	70	13	1	2	2	6
Knoxville, Tenn.	120	72	27	15	3	-	8
Lexington, Ky.	87	58	17	4	4	4	13
Memphis, Tenn.	194	121	47	12	5	9	9
Mobile, Ala.	85	61	15	5	1	3	2
Montgomery, Ala.	38	30	3	4	1	-	11
Nashville, Tenn.	194	114	49	23	6	2	15
W.S. CENTRAL	1,615	1,126	304	114	46	25	134
Austin, Tex.	103	74	20	7	1	1	6
Baton Rouge, La.	51	36	9	4	1	1	1
Corpus Christi, Tex.	65	52	9	1	1	2	8
Dallas, Tex.	233	146	46	31	3	7	13
El Paso, Tex.	86	66	13	2	3	2	4
Ft. Worth, Tex.	184	135	33	12	4	-	13
Houston, Tex.	357	231	80	30	14	2	32
Little Rock, Ark.	U	U	U	U	U	U	U
New Orleans, La.	U	U	U	U	U	U	U
San Antonio, Tex.	258	175	49	14	14	6	22
Shreveport, La.	134	109	18	2	3	2	14
Tulsa, Okla.	144	102	27	11	2	2	21
MOUNTAIN	1,043	730	166	78	42	2	101
Albuquerque, N.M.	132	95	17	11	6	3	18
Boise, Idaho	41	30	6	3	2	-	5
Colo. Springs, Colo.	57	41	10	2	1	3	1
Denver, Colo.	124	77	24	9	5	9	18
Las Vegas, Nev.	292	201	55	26	6	4	28
Ogden, Utah	32	29	2	-	1	-	4
Phoenix, Ariz.	44	25	6	4	8	1	-
Pueblo, Colo.	38	29	6	2	-	1	3
Salt Lake City, Utah	123	79	22	12	6	4	15
Tucson, Ariz.	160	124	18	9	7	2	9
PACIFIC	1,736	1,238	333	98	30	37	191
Berkeley, Calif.	13	9	3	1	-	-	1
Fresno, Calif.	137	107	21	6	2	1	12
Glendale, Calif.	15	9	4	1	-	1	1
Honolulu, Hawaii	97	68	20	4	4	1	9
Long Beach, Calif.	64	40	15	5	1	3	11
Los Angeles, Calif.	298	199	64	23	6	6	19
Pasadena, Calif.	29	20	5	2	-	2	2
Portland, Oreg.	138	105	24	7	2	-	14
Sacramento, Calif.	199	139	38	13	4	5	37
San Diego, Calif.	163	115	33	12	2	1	20
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	216	163	34	7	4	8	30
Santa Cruz, Calif.	32	25	7	-	-	-	4
Seattle, Wash.	155	99	35	12	2	7	12
Spokane, Wash.	76	61	12	2	1	-	13
Tacoma, Wash.	104	79	18	3	2	2	6
TOTAL	12,124¶	8,493	2,272	805	300	248	1,062

U: Unavailable. -:No reported cases.

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

† Pneumonia and influenza.

§ Because of changes in reporting methods in this Pennsylvania city, these numbers are partial counts for the current week. Complete counts will be available in 4 to 6 weeks.

¶ Total includes unknown ages.

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