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World No Tobacco Day — May 31, 2004

“Up in Smoke: Tobacco’s Cost to the Family” is the U.S. theme of this year’s World No Tobacco Day, May 31. Tobacco use is responsible for nearly one in 10 adult deaths worldwide and five million deaths each year (1).

In the United States, on average, men and women who smoke have their lives cut short by 13.2 and 14.5 years, respectively (2). Each year, secondhand smoke is associated with thousands of new cases of asthma, bronchitis, and pneumonia among children and an increased risk for sudden infant death syndrome (2). The economic toll for smoking exceeds \$150 billion (i.e., \$3,400 per smoker) per year (3). In 1994, smoking-related Social Security Survivors Insurance payments cost the nation about \$1.4 billion (4). The poorest socioeconomic groups suffer the consequences of tobacco use the most (5), because of adverse health effects and having less money to spend on basic items such as food, education, and health care (6). Additional information is available at <http://www.who.int/tobacco/en>.

References

1. World Bank. Curbing the epidemic: governments and the economics of tobacco control, 1999. Available at <http://www1.worldbank.org/tobacco/reports.htm>.
2. U.S. Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 2004.
3. CDC. Annual smoking-attributable mortality, years of potential life lost, and economic costs—United States, 1995–1999. *MMWR* 2002;51:300–3.
4. Leistikow BN, Martin DC, Milano CE. Estimates of smoking-attributable deaths at ages 15–54, motherless or fatherless youths, and resulting social security costs in the United States in 1994. *Prev Med* 2000;30:353–60.
5. Jha P, Chaloupka F. Tobacco control in developing countries. Oxford, England: Oxford University Press, 2000.
6. De Beyer J, Lovelace C, Yurekli A. Poverty and tobacco. *Tob Control* 2001;10:210–1.

Cigarette Smoking Among Adults — United States, 2002

One of the national health objectives for 2010 is to reduce the prevalence of cigarette smoking among adults to $\leq 12\%$ (objective 27.1a) (1). To assess progress toward this objective, CDC analyzed self-reported data from the 2002 National Health Interview Survey (NHIS) sample adult core questionnaire. This report summarizes the results of that analysis, which indicated that, in 2002, approximately 22.5% of adults were current smokers. Although this prevalence is slightly lower than the 22.8% prevalence among U.S. adults in 2001 and substantially lower than the 24.1% prevalence in 1998, the rate of decline has not been at a sufficient pace to achieve the 2010 national health objective. During 1983–2002, adults with household incomes below the poverty level and those with less than some college education consistently had higher smoking prevalence. A comprehensive approach to smoking cessation that comprises educational, economic, clinical, and regulatory strategies and emphasizes reducing disparities is required to reduce further the prevalence of smoking (2).

The 2002 NHIS adult core questionnaire was administered by personal interview to a nationally representative sample ($n = 31,044$) of the U.S. civilian, noninstitutionalized population aged ≥ 18 years; the overall survey response rate was 74.3%. Respondents were asked, “Have you smoked at least 100 cigarettes in your entire life?” and “Do you now smoke cigarettes every day, some days, or not at all?” Ever smokers were defined as those who reported having smoked ≥ 100 cigarettes during their lifetimes. Current smokers were defined as

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those who reported both having smoked ≥ 100 cigarettes during their lifetimes and currently smoking every day or some days. Former smokers were defined as ever smokers who currently did not smoke. Data were adjusted for nonresponses and weighted to provide national estimates of cigarette smoking prevalence. Confidence intervals (CIs) were calculated by using SUDAAN to account for the multistage probability sample.

In 2002, an estimated 45.8 million adults (22.5%; 95% CI = ± 0.6) were current smokers; of these, an estimated 37.5 million (81.8%) smoked every day, and 8.3 million (18.2%) smoked some days. Among those who smoked every day, an estimated 15.4 million (41.2%; 95% CI = ± 1.5) reported that they had stopped smoking for ≥ 1 day during the preceding 12 months because they were trying to quit. In 2002, an estimated 46.0 million adults were former smokers, representing 50.1% (95% CI = ± 1.1) of adults who had ever smoked; 2002 was the first year that more than half of ever smokers were former smokers.

Cigarette smoking prevalence rates varied substantially across population subgroups (Table). The prevalence of smoking was higher among men (25.2%) than women (20.0%) and inversely related to age, from 28.5% for those aged 18–24 years to 9.3% for those aged ≥ 65 years. Among racial/ethnic groups, Asians (13.3%) and Hispanics (16.7%) had the lowest prevalence, and American Indians/Alaska Natives had the highest (40.8%). Current smoking prevalence also was higher among adults living below the poverty level* (32.9%) than among those at or above the poverty level (22.2%). During 1983–2002, the gap in smoking prevalence between those living below the poverty line and those living at or above it increased from 8.7 percentage points to 10.7 percentage points (Figure 1). In addition, the percentage of ever smokers who had quit was higher for persons at or above the poverty level than for those below the poverty line. As with current smoking prevalence, this gap was larger in 2002 than in 1983 (20.0 percentage points versus 18.7 percentage points).

Educational attainment has been associated consistently with adult smoking prevalence since 1983 (Figure 2). By education level, smoking prevalence was highest among adults who had earned a General Educational Development diploma (42.3%) and lowest among those with graduate degrees (7.2%). Women with undergraduate (10.5%) or graduate degrees (6.4%) and men with graduate degrees (7.8%) also had smoking prevalence rates below the overall U.S. 2010 objective. During 1983–2002, the largest decreases in smoking prevalence occurred among adults with a college degree

* Published 2000 poverty thresholds from the U.S. Bureau of the Census were used in these calculations.

TABLE. Percentage of persons aged ≥ 18 years who were current smokers*, by selected characteristics — National Health Interview Survey, United States, 2002

Characteristic	Men (n = 13,332)		Women (n = 17,374)		Total (n = 30,706)	
	%	(95% CI) [†]	%	(95% CI)	%	(95% CI)
Race/Ethnicity[§]						
White, non-Hispanic	25.5	(± 1.1)	21.8	(± 1.0)	23.6	(± 0.8)
Black, non-Hispanic	27.1	(± 2.4)	18.7	(± 1.8)	22.4	(± 1.6)
Hispanic	22.7	(± 2.2)	10.8	(± 1.3)	16.7	(± 1.2)
American Indian/Alaska Native [¶]	40.5	(± 13.9)	40.9	(± 12.8)	40.8	(± 9.8)
Asian ^{**}	19.0	(± 4.0)	6.5	(± 2.2)	13.3	(± 2.4)
Education^{††}						
0–12 yrs (no diploma)	32.0	(± 2.2)	23.8	(± 1.8)	27.6	(± 1.4)
<8 yrs	25.4	(± 3.2)	13.5	(± 2.2)	19.3	(± 2.0)
9–11 yrs	38.1	(± 3.7)	30.9	(± 2.9)	34.1	(± 2.1)
12 yrs (no diploma)	32.3	(± 6.8)	29.7	(± 6.1)	31.0	(± 4.4)
GED (diploma) ^{§§}	47.4	(± 5.6)	37.2	(± 5.0)	42.3	(± 3.7)
12 yrs (diploma)	29.8	(± 2.0)	22.1	(± 1.5)	25.6	(± 1.3)
Associate degree	24.1	(± 2.9)	19.6	(± 2.2)	21.5	(± 1.7)
Some college (no degree)	24.8	(± 2.2)	21.6	(± 1.6)	23.1	(± 1.4)
Undergraduate degree	13.6	(± 1.7)	10.5	(± 1.4)	12.1	(± 1.1)
Graduate degree	7.8	(± 1.6)	6.4	(± 1.5)	7.2	(± 1.1)
Age group (yrs)						
18–24	32.4	(± 2.8)	24.6	(± 2.5)	28.5	(± 2.0)
25–44	28.7	(± 1.4)	22.8	(± 1.3)	25.7	(± 1.0)
45–64	24.5	(± 1.4)	21.1	(± 1.2)	22.7	(± 0.9)
≥ 65	10.1	(± 1.4)	8.6	(± 1.1)	9.3	(± 0.8)
Poverty level^{¶¶}						
At or above	24.8	(± 1.1)	19.7	(± 0.9)	22.2	(± 0.7)
Below	36.9	(± 3.3)	30.1	(± 2.8)	32.9	(± 2.3)
Unknown	23.0	(± 1.8)	16.9	(± 1.3)	19.7	(± 1.1)
Total	25.2	(± 0.9)	20.0	(± 0.8)	22.5	(± 0.6)

* Persons who reported smoking ≥ 100 cigarettes during their lifetimes and who reported at the time of interview smoking every day or some days. Excludes 338 respondents whose smoking status was unknown.

[†] Confidence interval.

[§] Excludes 343 respondents of unknown, multiple, and other racial/ethnic categories.

[¶] Wide variances among estimates reflect small sample sizes.

^{**} Does not include native Hawaiians or other Pacific Islanders.

^{††} Persons aged ≥ 25 years. Excludes 369 persons with unknown years of education.

^{§§} General Educational Development.

^{¶¶} Published 2000 poverty thresholds from the U.S. Bureau of the Census were used in these calculations.

(10.0 percentage points) and those with some college education (9.3 percentage points); those with a high school diploma (6.6 percentage points) and those with less than a high school education (5.8 percentage points) showed the smallest decreases. During this period, the gap in smoking prevalence between adults who had graduated from college and those with less than a high school education increased from 14.0 percentage points in 1983 to 18.2 percentage points in 2002 (Figure 2). Similar patterns occurred in the percentage of ever smokers who had quit among different educational groups. The percentage of ever smokers who had quit was highest for those with college degrees, followed by persons with some college education. High school graduates and those with less than high school education had the lowest percentage of ever smokers who had quit. The gap between adults with a college degree and those with less than a high school education

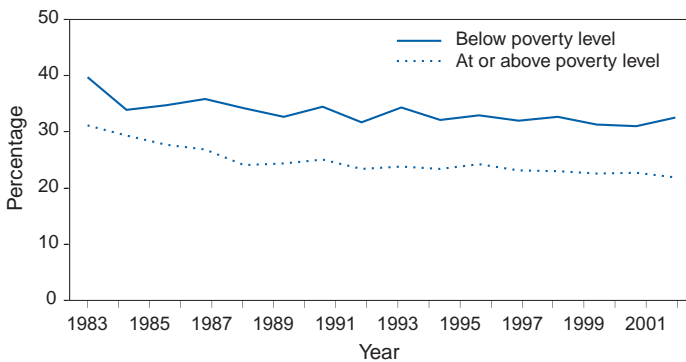
increased from 19.0 percentage points in 1983 to 25.9 percentage points in 2002.

Reported by: C Husten, MD, K Jackson, MSPH, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion; C Lee, PhD, EIS Officer, CDC.

Editorial Note: The findings in this report indicate that 1) the socioeconomic status of U.S. adults is inversely related to their likelihood of smoking and 2) during 1983–2002, the gap in smoking prevalence by socioeconomic status did not narrow and might have widened. These findings underscore the need for targeted interventions that can better reach persons of lower socioeconomic status.

Persons of low socioeconomic status have less access to health care than those of high socioeconomic status (3). Specific efforts to reduce socioeconomic disparities in smoking prevalence could include 1) offering comprehensive smoking

FIGURE 1. Trends in the percentage of current cigarette smoking among persons aged ≥ 18 years, by poverty level* and year — National Health Interview Survey, United States, 1983–2002

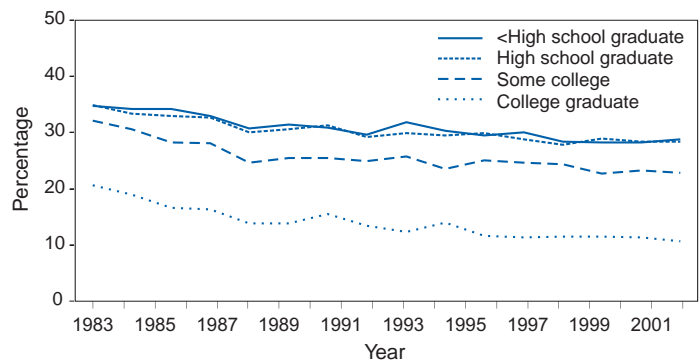


* Published 2000 poverty thresholds from the U.S. Bureau of the Census were used in these calculations.

cessation assistance through Medicaid and Medicare; 2) offering smoking cessation advice and counseling through clinics that care for the uninsured; 3) increasing support for smoking cessation at work places, particularly for low-income and blue-collar workers; 4) implementing telephone quitlines in all states; and 5) employing more media-based cessation campaigns (2,4,5). Expanding the scope of cessation coverage through Medicaid, Medicare, and private insurance and ensuring that persons without health insurance can obtain medical assistance to quit smoking is a key strategy to help low-income smokers quit (4). The lower rates of quitting among blue-collar workers can be partially explained by the lack of social support for quitting in their work environments (5). Encouraging all employers to implement programs and policies supporting smoking cessation can help reduce consistently observed disparities in smoking prevalence between blue- and white-collar workers (6). In addition, because tobacco use prevalence is associated with failing or dropping out of high school (7), school-based antismoking programs and policies should target younger students before they leave school (8,9). The U.S. Department of Health and Human Services recently announced a new initiative to increase access to telephone quitlines. Quitlines provide free counseling and have been shown to be effective in reaching low-income populations (10). Media campaigns also have been shown to reach low-income smokers and increase cessation (4,10).

The findings in this report are subject to at least two limitations. First, both the wording of NHIS cigarette smoking questions and NHIS data-collection procedures have changed since 1993. Because of these changes, trend analyses or comparisons of data from before 1993 with data collected since 1993 should be interpreted with caution. Second, because NHIS data for some population subgroups (e.g., American

FIGURE 2. Trends in the percentage of current cigarette smoking among persons aged ≥ 18 years, by education and year — National Health Interview Survey, United States, 1983–2002



Indians/Alaska Natives) are small, data for a single year might be unreliable. Combining data for several years can produce more accurate estimates for these subpopulations.

National health objectives for 2010 focus on eliminating health disparities among population subgroups (1). Closing the gap in smoking prevalence among persons of different socioeconomic strata will require comprehensive tobacco-control programs that discourage smoking initiation and promote smoking cessation among members of populations at high risk. Comprehensive tobacco-control programs at local, state, and national levels must ensure that their intervention efforts reach persons with inadequate resources and limited access to health care. Such efforts should address the needs of the uninsured (e.g., providing treatment through telephone quitlines and in community health centers), increase coverage for tobacco-use treatment under both public and private insurance, and improve workplace and social environments to better support smoking cessation, particularly for low-income and blue-collar workers.

References

1. U.S. Department of Health and Human Services. Healthy People 2010, 2nd ed. With Understanding and Improving Health and Objectives for Improving Health (2 vols.). Washington, DC: U.S. Department of Health and Human Services, 2000.
2. U.S. Department of Health and Human Services. Reducing tobacco use: a report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 2000.
3. Adler NE, Boyce WT, Chesney MA, Folkman S, Syme LS. Socioeconomic inequalities in health: no easy solution. *JAMA* 1993;269:3140–5.
4. CDC. Strategies for reducing exposure to environmental tobacco smoke, increasing tobacco-use cessation, and reducing initiation in communities and health-care systems: a report of recommendations of the Task Force on Community Preventive Services. *MMWR* 2000;49(No. RR-12).
5. Sorensen G, Barbeau E, Hunt MK, Emmons K. Reducing social disparities in tobacco use: a social-contextual model for reducing tobacco use among blue-collar workers. *Am J Public Health* 2004;94:230–9.
6. Nelson DE, Emont SL, Brackbill RM, et al. Cigarette smoking prevalence by occupation in the United States: a comparison between 1978 to 1980 and 1987 to 1990. *J Occup Med* 1994;36:516–25.

7. CDC. Youth risk behavior surveillance—National Alternative High School Youth Risk Behavior Survey, United States, 1998. In: CDC Surveillance Summaries (October 29). MMWR 1999;48(No. SS-7).
8. CDC. Best practices for comprehensive tobacco control programs. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 1999.
9. National Association of County and City Health Officials. Program and funding guidelines for comprehensive local tobacco control programs. Washington, DC: National Association of County and City Health Officials, 2000.
10. Haviland L, Thornton AH, Carothers S, et al. Giving infants a Great Start: launching a national smoking cessation program for pregnant women. *Nicotine and Tobacco Research* 2004;6:S181–8.

Immunization Registry Progress — United States, January–December 2002

Immunization registries are confidential, computerized information systems that collect vaccination data within a geographic area (1). By consolidating vaccination records from multiple health-care providers, generating reminder and recall notifications, and assessing clinic and vaccination coverage, registries serve as key tools to increase and sustain high vaccination coverage (2). One of the national health objectives for 2010 is to increase to 95% the proportion of children aged <6 years who participate (i.e., have two or more vaccinations recorded) in fully operational, population-based immunization registries (objective 14.26) (3). This report summarizes data from CDC's 2002 Immunization Registry Annual Report (2002 IRAR), a survey of registry activity among immunization programs in the 50 states and the District of Columbia (DC) that receive grant funding under section 317b of the Public Health Service Act. These data indicate that approximately 43% of children aged <6 years are enrolled in a registry; achieving the national health objective will require increased implementation of functional standards to improve data quality.

The 2002 IRAR, a self-administered questionnaire, was distributed to immunization program managers as part of the annual reporting requirement. Respondents were asked about the number of children aged <6 years with two or more vaccinations recorded in an immunization registry and progress toward implementing the 12 functional standards considered essential for immunization registry operation (4).

A total of 37 (72%) states* reported operating registries that target their entire geographic areas. Seven (14%) other states (California, Georgia, Indiana, Massachusetts, Maryland, Minnesota, and New York) reported operating registries that

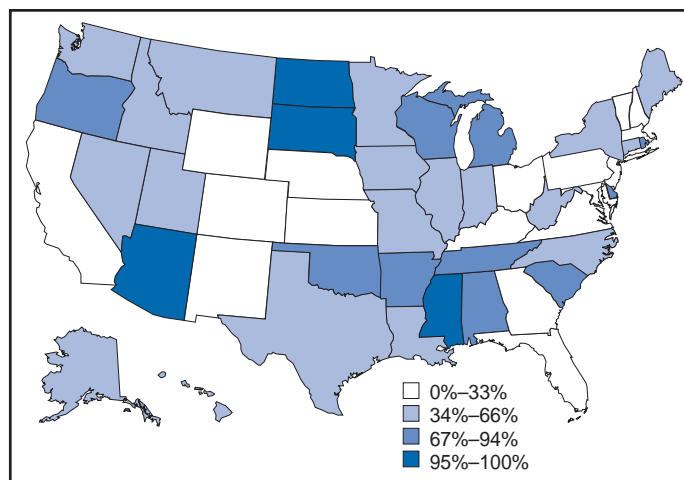
target only regions or counties within their geographic areas, and the remaining seven (14%) states (Colorado, Kansas, Kentucky, Nebraska, New Mexico, Vermont, and Wyoming) reported no regional registry activity but were planning or piloting a statewide system. Nationwide, approximately 43% of U.S. children aged <6 years had two or more vaccinations recorded in a grantee registry†. Four (8%) states (Arizona, Mississippi, North Dakota, and South Dakota) reported that ≥95% of children aged <6 years participated in an immunization registry (Figure). In the 44 states that operate registries regionally or statewide, an average of 75% of public vaccination providers and 31% of private providers submitted data to a registry during the last 6 months of 2002. Seven (16%) states (Arkansas, Connecticut, DC, Mississippi, North Dakota, Oregon, and South Dakota) reported that >75% of private vaccination providers submitted data to a registry.

All 51 immunization programs reported efforts to implement key elements of the 12 functional standards established for immunization registries (Table). Four (8%) states (Ohio, West Virginia, Wisconsin, and Wyoming) reported implementing all elements of the 12 functional standards. Seven (14%) other states (Alaska, Arkansas, Delaware, Idaho, Indiana, Louisiana, and Minnesota) implemented all elements of the functional standards except for exchanging data using the Health Level 7 (HL7) standard or establishing an immunization registry record within 6 weeks of birth.

Reported by: DL Bartlett, MPH, Immunization Svcs Div, National Immunization Program, CDC.

† Estimates of the number of children aged <6 years in the 50 states and DC are based on 2002 U.S. Census birth estimates.

FIGURE. Percentage of children aged <6 years with two or more vaccinations recorded in a Public Health Service Act § 317b immunization registry — United States, 2002



*For this report, DC is considered a state when summary data are presented.

TABLE. Number and percentage of 51 grantee immunization registries that implemented key elements of the 12 functional standards, by standard — United States, 2002

Functional standard	Registries meeting all key elements		Registries meeting at least two key elements	
	No.	(%)	No.	(%)
Electronically store data on all National Vaccine Advisory Committee–approved core data elements	32	(63)	47	(92)
Establish a registry record within 6 weeks of birth for each newborn child born in the catchment area	31	(61)	31	(61)
Enable access to vaccine information from the registry at the time of encounter	43	(84)	43	(84)
Receive and process information within 30 days of vaccine administration	41	(80)	41	(80)
Protect the confidentiality of medical information	27	(53)	36	(71)
Ensure the security of medical information	26	(51)	30	(59)
Exchange vaccination records by using Health Level 7 standards	11	(22)	11	(22)
Automatically determine the vaccination(s) needed when a person is seen for a scheduled vaccination	40	(78)	40	(78)
Automatically identify persons due or late for vaccinations to enable the production of reminder and recall notifications	37	(73)	37	(73)
Automatically produce vaccination coverage reports by providers, age groups, and geographic areas	34	(67)	39	(76)
Produce authorized vaccination records	41	(80)	41	(80)
Promote accuracy and completeness of registry data	42	(82)	42	(82)

Editorial Note: Immunization registries have made progress toward implementing the 12 immunization registry functional standards and enrolling more children and health-care providers in their systems. In 2002, only three functional standards (i.e., receive and process vaccination data within 30 days of vaccination, access information from the registry at the time of patient encounter, and produce reminder and recall notifications) reflected no increase in implementation at the state level, compared with six standards from the 2001 IRAR (5). In 2002, a total of 36 (71%) states included birth data in their registries, compared with 32 (63%) states in 2000 (6).

The findings in this report are subject to at least one limitation. Data from the 2002 IRAR are self-reported and might result in reporting bias, although site visits to certain immunization registries have shown high concordance with IRAR data (5).

Because 2002 IRAR data are self-reported by immunization program managers, efforts are under way to validate responses using data from the National Immunization Survey (NIS), a random-digit–dialed telephone survey of vaccine providers for children aged 19–35 months that estimates vaccination coverage for all 50 states and 28 urban areas (7,8). Although NIS focuses on a narrower age group, it can provide external validation to registry data and indicate areas for improving data quality. NIS also validates child participation in registries because it asks vaccine providers whether they submitted any child vaccination information to community or state immunization registries. In 2002, NIS data for 21,317 U.S. children, weighted to represent the U.S. population, indicated that 44% of children aged 19–35 months had their vaccination records reported to a community or state immunization registry, similar to the 43% reported in the 2002 IRAR for children aged <6 years.

NIS data also can be used to assess the completeness of registry data. Three months of 2002 NIS data were compared with data from four registries in three states and one city during the same period (9,10); the unweighted percentage of children with provider-verified NIS data who had two or more vaccinations logged in the registry ranged from 60% to 88% (9). In all cases, vaccination coverage estimates based on NIS provider-validated data were higher than registry-based data; approximately 40% of children had missing or incomplete registry information on doses of vaccine (10).

This level of data completeness indicates that registries need to improve data quality so that state and local health authorities can reliably calculate vaccination coverage and measure participation in immunization registries. Efforts are under way to develop additional tools to improve data quality; in 2002, CDC provided a tool to assess computer algorithms that prevent duplicate records in registry databases. For the 2002 IRAR, eight states and New York City reported performing this data quality test.

Registries also must improve functional and technical capacity to provide reliable evaluations and encourage data use by health-care providers and public health managers. In 2002, the National Immunization Program's Technical Working Group created Immunization Registry Certification guidelines for validating improvements to immunization registry functional standards and identifying registries with acceptable levels of technical capability. Additional information is available at <http://www.cdc.gov/nip/registry>; by telephone, 800-799-7062; or by e-mail, siisclear@cdc.gov.

References

1. National Vaccine Advisory Committee. Development of community and state-based immunization registries: report of the National Vaccine Advisory Committee (NVAC). Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, 1999. Available at <http://www.cdc.gov/nip/registry/nvac.htm>.

2. Linkins RW. Immunization registries: progress and challenges in reaching the 2010 national objective. *J Public Health Management Practice* 2001;7:67–74.
3. U.S. Department of Health and Human Services. *Healthy People 2010*, 2nd ed. With *Understanding and Improving Health and Objectives for Improving Health* (2 vols.). Washington, DC: U.S. Department of Health and Human Services, 2000.
4. CDC. Immunization registry minimum functional standards. Available at <http://www.cdc.gov/nip/registry/min-funct-stds2001.htm>.
5. CDC. Immunization registry progress—United States, 2002. *MMWR* 2002;51:760–2.
6. CDC. Immunization registry use and progress—United States, 2001. *MMWR* 2002;51:53–6.
7. Zell ER, Ezzati-Rice TM, Battaglia MP, Wright RA. National Immunization Survey: the methodology of an immunization surveillance system. *Public Health Rep* 2000;115:65–77.
8. Smith PJ, Battaglia MP, Huggins VJ, et al. Overview of the sampling design and statistical methods used in the National Immunization Survey. *Am J Prev Med* 2001;40:17–24.
9. Barker L. The National Immunization Survey/registry data comparison. Presented at the 2003 Immunization Registry Conference, Atlanta, Georgia, October 27–29, 2003.
10. Khare M, Piccinino L, Battaglia MP, Linkins R. Immunization registries as supplemental sources of data for improving vaccination coverage estimates in the U.S. Presented at the 2003 Immunization Registry Conference, Atlanta, Georgia, October 27–29, 2003.

Wild Poliovirus Importations — West and Central Africa, January 2003–March 2004

Since the 1988 World Health Assembly resolution to eradicate poliomyelitis (1), three World Health Organization (WHO) regions (Americas, European, and Western Pacific) have been certified polio-free, and the number of countries with endemic polio has decreased from 125 in 1988 to six in 2003 (Afghanistan, Egypt, India, Niger, Nigeria, and Pakistan). During January 2003–March 2004, importations of wild poliovirus (WPV) occurred in eight countries that were previously polio-free: five in the West African block* (Benin, Burkina Faso, Côte d'Ivoire, Ghana, and Togo) and three in the Central African block (Cameroon, Central African Republic, and Chad), resulting in 63 polio cases (2,3). This report summarizes the 1) investigation and response to these WPV importations and 2) progress toward polio eradication in West and Central Africa.

*The African regional office of WHO has divided its member states into four blocks (East, Central, South, and West) plus Angola, Democratic Republic of the Congo, Ethiopia, and Nigeria. The Central African countries are as follows: Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon, and Sao Tome and Principe. The West African countries are as follows: Algeria, Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Mauritania, Niger, Senegal, Sierra Leone, and Togo.

Routine and Supplementary Immunization

In 2002, reported routine coverage with 3 doses of oral poliovirus vaccine (OPV) varied from 13% to 93% for countries in West and Central Africa, excluding Ghana[†]. All West and Central African countries conducted supplementary immunization activities (SIAs) annually during 1999–2002. In 2002, all except Algeria conducted National Immunization Days (NIDs)[§], vaccinating approximately 30.6 million children aged <5 years with ≥ 2 doses of OPV.

Acute Flaccid Paralysis (AFP) Surveillance

AFP surveillance quality is evaluated by two key indicators: 1) annual reporting rate (target: nonpolio AFP rate of more than one case per 100,000 children aged <15 years) and 2) completeness of specimen collection (target: two adequate stool specimens from >80% of all persons with AFP). In 2002, these targets were met by all but six West and Central African countries (Algeria, Cape Verde, Chad, Equatorial Guinea, Gambia, and Sao Tome and Principe). In 2003, the number of countries not meeting the targets increased to eight (Algeria, Cameroon, Cape Verde, Chad, Ghana, Liberia, Niger, and Sao Tome and Principe).

WPV Importation and Spread

During January 2003–March 2004, a total of 63 cases of polio resulted from importation of WPV into the previously polio-free countries of West and Central Africa (Table). All imported viruses were type 1 and could be traced to common ancestral strains that circulate in endemic reservoirs shared by northern Nigeria and southern Niger (Figure). During this same period, Nigeria and Niger have reported 497 cases of infection with WPV type 1 or type 3, with cross-border transmission of both serotypes between the two countries. Of the 63 polio cases resulting from importation of WPV, 48 (76%) occurred during June–December 2003, coinciding with the peak transmission of indigenous WPV type 1 in Nigeria and Niger.

East of Nigeria, the first importation occurred in Chad in August 2003 from northeastern Nigeria, leading to an outbreak of 29 cases[¶]. The outbreak spread to the adjacent countries of Cameroon (two cases) and the Central African Republic (one case) during October–December. The continued circulation of virus after importation suggests that Chad

[†] Ghana reported 120% coverage.

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

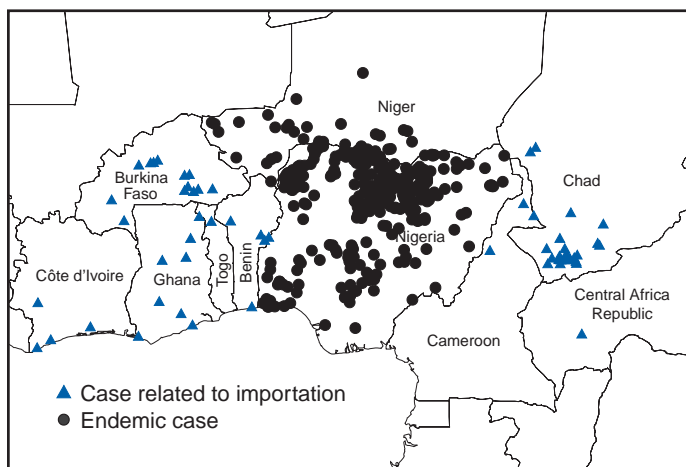
[¶] As of May 4, 2004.

TABLE. Number* and timeframe of wild poliovirus (WPV) cases related to importations in West and Central African countries, January 2003–March 2004

Country	Date of last WPV before importation	Date of WPV importation, during January 2003–March 2004	Polio-free period before importation (mos)	No. cases	
				2003	2004
Benin	March 4, 2000	November 4, 2003	44	2	3
Burkina Faso	1998†	July 20, 2003	>36	11	2
Cameroon	August 16, 1999	October 8, 2003	50	2	0
Central African Republic	July 26, 2000	December 16, 2003	41	1	0
Chad	June 30, 2000	August 2, 2003	37	25	4
Côte d'Ivoire	July 17, 2000	December 17, 2003	41	1	3
Ghana	October 16, 2000	February 5, 2003	28	8	0
Togo	January 1, 1999	July 22, 2003	55	1	0

* N = 63.

† WPV was imported previously into Burkina Faso in 2002; the most recent indigenous WPV was detected in 1998.

FIGURE. Endemic wild poliovirus (WPV) type 1 and type 3 in Nigeria and Niger and spread* of WPV type 1 to eight neighboring countries, January 2003–March 2004

* During 2001–2002, WPV spread from southern Niger to Burkina Faso, from where, in 2003, it later spread to Ghana, Togo, and Côte d'Ivoire. In 2003, genetically distinct WPV spread from northeastern Nigeria into Chad, and then into Cameroon and the Central African Republic. WPV from two areas in northern Nigeria was independently introduced into Benin during 2003–2004.

is at high risk for reestablishment of endemic poliovirus transmission.

West of Nigeria, three independent importations into Benin (five cases) occurred from different parts of Nigeria from late 2003 to early 2004. In addition, genetic sequencing data indicated that after a 2002 importation into Burkina Faso, in early 2003, WPV spread to Ghana. In 2003, closely related strains continued to circulate in Ghana (eight cases) and, during 2003–2004, in Burkina Faso (13 cases). The WPV strains isolated in Côte d'Ivoire (four cases) and Togo (one case) were linked genetically to the strains circulating in Burkina Faso and Ghana, indicating spread of poliovirus from Burkina Faso and possibly Ghana. These data suggest that independent

circulation of WPV might have been reestablished in Burkina Faso during 2003 and early 2004.

Among the 63 patients with WPV, 13% were aged <12 months, 21% were aged 12–23 months, 49% were aged 24–59 months, and 17% were aged >59 months. Of the 52 patients with known vaccination status, 16 (31%) had never received OPV, 26 (50%) had received 1–2 OPV doses, and 10 (19%) had received ≥ 3 OPV doses.

Response to WPV Importation

Investigations were initiated within 2 days of identifying the index patients in four of the eight countries (median: 4 days; range: 1–22 days). Clinical and epidemiologic information was verified, stool specimens were collected from immediate contacts, and the search for unreported AFP cases was intensified. Two of the eight index patients in the eight countries had traveled recently to a country with endemic polio, whereas the remaining six patients had no relevant travel history or immediate contact with persons who traveled to a country where polio is endemic. All index patients lived near commercial centers with substantial foreign trade with countries where polio is endemic.

All eight countries implemented SIAs in response to detection of imported WPV. The median duration from onset of paralysis to the start of SIAs was 12.5 weeks (range: 6–17 weeks). The magnitude of the response varied; four countries conducted NIDs, two countries conducted subnational immunization days** (SNIDs), and two countries conducted both SNIDs and NIDs. These campaigns provided approximately 21.7 million children aged <5 years with ≥ 2 doses of OPV.

Reported vaccination coverage exceeded 90% for all SIAs conducted; reported coverage at district level ranged from 48% to >100%. To determine the proportion of previously

** Campaigns similar to NIDs but confined to certain parts of the country.

unvaccinated children, caregivers were asked whether their children were receiving OPV for the first time during the campaign. The Central African Republic (4%) and Côte d'Ivoire (8%) were the only countries reporting that $\geq 4\%$ of children received their first dose of OPV during the most recent campaigns.

Four of the eight countries (Benin, Burkina Faso, Chad, and Ghana) detected WPV after at least two rounds of SIAs. The most recent WPV patient in Burkina Faso had onset in January 2004; two rounds of NIDs were then conducted in February and March 2004. The four WPV cases in Chad in 2004 were detected in provinces that had conducted at least two rounds of SNIDs in November and December 2003 and in January 2004; two rounds of NIDs were conducted in March and May 2004 after onset of these cases. The most recent WPV patient in Ghana had onset in September 2003 after two SNIDs in June and July 2003; since the most recent case, four rounds of NIDs were conducted (in October and December 2003 and February and March 2004).

Reported by: World Health Organization (WHO) Inter-Country Program Office, Abidjan, Côte d'Ivoire. WHO Inter-Country Program Office, Yaounde, Cameroon. Vaccine-Preventable Disease Unit, WHO Regional Office for Africa, Harare, Zimbabwe. Vaccines and Biologicals Dept; National, Regional, and Specialized Polio Reference Laboratories, Global Polio Laboratory Network; WHO, Geneva, Switzerland. Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program, CDC.

Editorial Note: During 1999–2000, West and Central African countries began intensifying and synchronizing NIDs, leading to a decrease in the number of countries with endemic WPV from 13 in 1999 to one in 2001 (4). During January 2003–March 2004, eight previously polio-free countries reported WPV importations from endemic poliovirus reservoirs shared by northern Nigeria and southern Niger, which were largely a result of suspension of immunization campaigns in certain northern states of Nigeria in August 2003 (3). Many of these countries had continued transmission after importation because of low routine vaccination coverage, increased intervals between SIAs, and possibly declining quality of SIAs. The importations and spread highlight the increased vulnerability of countries with low routine vaccination coverage that are no longer conducting SIAs.

Preparedness for response to WPV importation should be strengthened in West and Central African countries, which will continue to be at risk until WPV transmission in Nigeria and Niger is interrupted. According to WHO recommendations, $\geq 80\%$ of all outbreaks should be investigated within 48 hours of their notification. However, only four (50%) of the outbreaks during 2003–2004 were investigated within the recommended period. In addition, WHO recommends that

outbreak response vaccination occur within 4 weeks after confirmation of WPV; this was achieved in only one (13%) of the eight countries.

Four (50%) of the eight countries had continued transmission of WPV after completing two rounds of SIAs, indicating suboptimal quality of campaigns despite reported high coverage. The main challenges faced in implementing high-quality SIAs included 1) delayed provision of funds to support detailed planning aimed at vaccinating every eligible child, 2) gaps in supervision by national and subnational authorities, 3) lack of consistently effective social mobilization, and 4) inadequate commitment to conducting successful campaigns. The quality of SIAs has been improved in certain countries through enhanced political commitment and strengthened monitoring. In addition, experience was gained from the response to the importations during 2003–2004. This will lead to improved planning and more rapid implementation of high-quality SIAs during 2004–2005, an essential step to achieving eradication.

Ongoing transmission in Nigeria and Niger has set back the goal to interrupt poliovirus transmission in Africa by the end of 2004 (3). To restore gains made in polio eradication in West and Central Africa, WPV transmission must be interrupted in Nigeria and Niger. Until that time, neighboring countries must create a population immunity barrier by implementing high routine vaccination coverage and high-quality SIAs. In 2002, these steps proved successful in preventing importation of WPV into Bangladesh and Nepal during resurgence of polio in India. Surveillance standards also must be maintained to ensure rapid detection of any WPV importation, allowing for timely response and containment.

References

1. World Health Assembly. Global eradication of poliomyelitis by the year 2000: resolution of the 41st World Health Assembly. Geneva, Switzerland: World Health Organization, 1988 (WHA resolution no. 41.28).
2. Okwo-Bele JM, Lobanov A, Biellik RJ, et al. Overview of poliomyelitis in the Africa Region and current regional plan of action. *J Infect Dis* 1997;175(suppl 1):S10–S15.
3. CDC. Progress toward global poliomyelitis eradication—Nigeria, January 2003–March 2004. *MMWR* 2004;53:343–6.
4. World Health Organization. Global polio eradication initiative progress 2001. Geneva, Switzerland: World Health Organization, 2002.

Notice to Readers

Publication of Surgeon General's Report on Smoking and Health

The Surgeon General's report, *The Health Consequences of Smoking (1)*, was released on May 27, 2004. This report provides an update, evaluation, and synthesis of evidence on the health consequences of active smoking and examines cancer,

cardiovascular diseases, respiratory diseases, and adverse reproductive and other effects.

The four major conclusions of the report are 1) smoking harms nearly every organ of the body, causing many diseases and reducing the health of smokers in general; 2) quitting smoking has immediate as well as long-term benefits, reducing risks for diseases caused by smoking and improving health in general; 3) smoking cigarettes with lower machine-measured yields of tar and nicotine provides no clear benefit to health; and 4) the list of diseases caused by smoking has been expanded to include abdominal aortic aneurysm, acute myeloid leukemia, cataract, cervical cancer, kidney cancer, pancreatic cancer, pneumonia, periodontitis, and stomach cancer.

Additional information about the Surgeon General's report and a free copy of the executive summary are available from CDC's Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion at mailstop K-50, 4770 Buford Highway, N.E., Atlanta, Georgia 30341-3724 or by telephone, 770-488-5705 (press "3" for a publications specialist). Copies of the full report (stock no. 017-023-00211-2) can be purchased from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954; by toll-free telephone, 866-512-1800; or at <http://bookstore.gpo.gov>. The full report, executive summary, and the consumer-oriented publication, *The Health Consequences of Smoking — What It Means To You*, can also be downloaded from <http://www.cdc.gov/tobacco>.

Reference

1. U.S. Department of Health and Human Services. The health consequences of smoking: a report of the Surgeon General. Atlanta, Georgia: U.S. Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2004.

Notice to Readers

Buckle Up America! Week, May 24–31, 2004

Motor-vehicle crashes are a leading cause of death overall and the most common cause of death among children and young adults in the United States. During 2002, a total of

42,815 persons died in motor-vehicle crashes; of these, more than half were not wearing safety belts (1). Enactment and enforcement of safety-belt laws are the most effective means of reducing crash-related deaths and serious injuries, saving an estimated 14,000 lives in 2002.

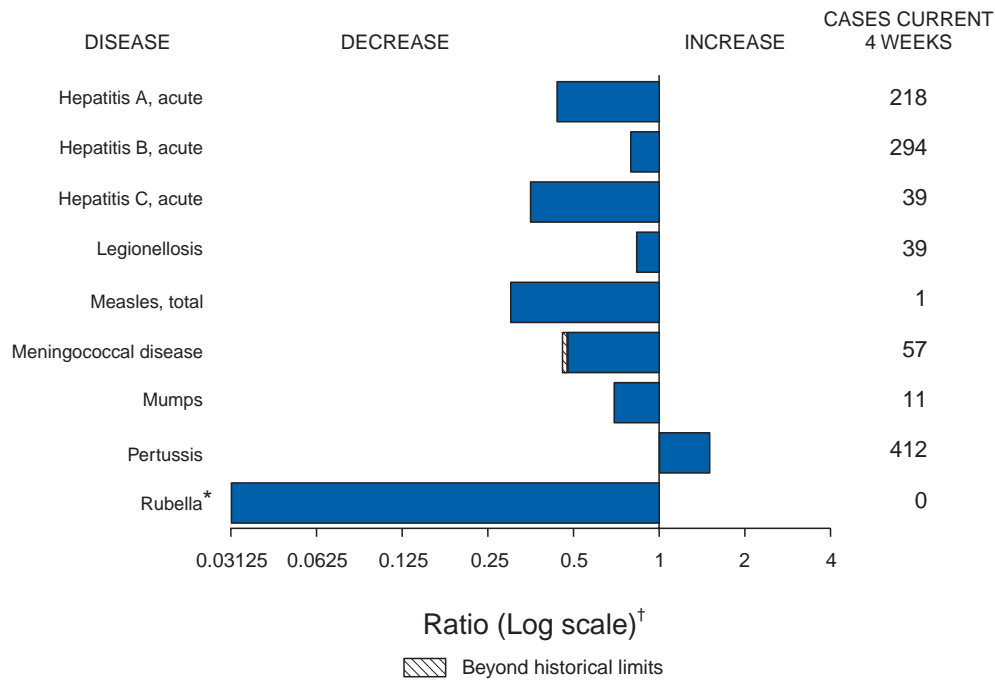
Age is a key predictor of safety-belt use. In 2002, prevalence of safety-seat or safety-belt restraint use was 99% for infants, 94% for toddlers, 83% for children aged 4–7 years, 82% among youths aged 8–15 years, and 69% among persons aged 16–24 years (2). The national rate of usage overall increased to 79% in 2003, an improvement of 4% since the preceding year (3). Greater safety-belt use has potential for saving lives, preventing injuries, and reducing economic costs associated with traffic crashes.

Buckle Up America! Week includes efforts to promote proper use of safety belts and child safety seats in the United States and move toward the National Highway Traffic Safety Administration's goal of 90% usage by 2005 (4) and the national health objective of 92% usage by 2010 (5). Safety-belt use is the most effective means of reducing fatal and non-fatal injuries in motor-vehicle crashes. Information about motor-vehicle injury prevention is available from CDC's National Center for Injury Prevention and Control at <http://www.cdc.gov/ncipc>. Information regarding Buckle Up America! Week activities is available at <http://www.buckleupamerica.org>.

References

1. National Highway Traffic Safety Administration. Traffic safety facts 2002: a compilation of motor vehicle crash data from the Fatality Analysis Reporting System and the General Estimates System. Washington, DC: U.S. Department of Transportation, 2004; publication no. DOT-HS-809-620. Available at <http://www-nrd.nhtsa.dot.gov/pdf/nrd-30/ncsa/tsfann/tsf2002final.pdf>.
2. National Highway Traffic Safety Administration. Traffic safety facts 2002: children. Washington, DC: U.S. Department of Transportation, 2004; publication no. DOT-HS-809-607.
3. National Highway Traffic Safety Administration. Safety belt use in 2003. Washington, DC: U.S. Department of Transportation, 2004; publication no. DOT-HS-809-646.
4. National Highway Traffic Safety Administration. Presidential initiative for increasing seat belt use nationwide: recommendations from the Secretary of Transportation. Washington, DC: U.S. Department of Transportation, 1997; publication no. DOT-HS-808-576.
5. U.S. Department of Health and Human Services. Healthy People 2010 (conference ed., 2 vols.). Washington, DC: U.S. Department of Health and Human Services, 2000.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals May 22, 2004, with historical data



* No rubella cases were reported for the current 4-week period yielding a ratio for week 20 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 May 22, 2004 (20th Week)*

	Cum. 2004	Cum. 2003		Cum. 2004	Cum. 2003
Anthrax	-	-	Hemolytic uremic syndrome, postdiarrheal [†]	25	42
Botulism:	-	-	HIV infection, pediatric ^{†§}	52	86
foodborne	6	6	Measles, total	9 [†]	22 ^{**}
infant	23	29	Mumps	65	81
other (wound & unspecified)	4	7	Plague	-	-
Brucellosis [†]	30	33	Poliomyelitis, paralytic	-	-
Chancroid	11	25	Psittacosis [†]	2	5
Cholera	2	1	Q fever [†]	12	27
Cyclosporiasis [†]	42	14	Rabies, human	1	-
Diphtheria	-	-	Rubella	10	4
Ehrlichiosis:	-	-	Rubella, congenital syndrome	-	1
human granulocytic (HGE) [†]	19	25	SARS-associated coronavirus disease ^{††}	-	5
human monocytic (HME) [†]	17	22	Smallpox ^{† §§}	-	NA
human, other and unspecified	-	5	<i>Staphylococcus aureus</i> :	-	-
Encephalitis/Meningitis:	-	-	Vancomycin-intermediate (VISA) ^{† §§}	4	NA
California serogroup viral [†]	1	-	Vancomycin-resistant (VRSA) ^{† §§}	-	1
eastern equine [†]	-	-	Streptococcal toxic-shock syndrome [†]	41	87
Powassan [†]	-	-	Tetanus	3	3
St. Louis [†]	1	1	Toxic-shock syndrome	44	57
western equine [†]	-	-	Trichinosis	4	-
Hansen disease (leprosy) [†]	27	31	Tularemia [†]	11	5
Hantavirus pulmonary syndrome [†]	4	6	Yellow fever	-	-

-: No reported cases.
 * Incidence data for reporting years 2003 and 2004 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. Last update March 26, 2004.
 ¶ Of nine cases reported, five were indigenous, and four were imported from another country.
 ** Of 22 cases reported, 16 were indigenous, and six were imported from another country.
 †† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (notifiable as of July 2003).
 §§ Not previously notifiable.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending May 22, 2004, and May 17, 2003 (20th Week)*

Reporting area	AIDS		Chlamydia†		Coccidiomycosis		Cryptosporidiosis		Encephalitis/Meningitis West Nile	
	Cum. 2004§	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	8,989	15,309	311,294	330,202	1,803	1,259	838	729	4	-
NEW ENGLAND	312	499	10,559	10,599	-	-	52	46	-	-
Maine	5	23	690	731	N	N	9	3	-	-
N.H.	11	12	593	599	-	-	14	7	-	-
Vt.	8	6	373	393	-	-	6	7	-	-
Mass.	84	226	5,350	3,998	-	-	16	22	-	-
R.I.	32	38	1,295	1,235	-	-	1	5	-	-
Conn.	172	194	2,258	3,643	N	N	6	2	-	-
MID. ATLANTIC	1,286	3,333	42,320	39,990	-	-	136	110	-	-
Upstate N.Y.	134	182	8,480	7,210	N	N	31	25	-	-
N.Y. City	380	1,627	11,794	13,551	-	-	29	42	-	-
N.J.	387	595	5,121	5,745	-	-	9	4	-	-
Pa.	385	929	16,925	13,484	N	N	67	39	-	-
E.N. CENTRAL	809	1,390	52,329	61,269	5	3	193	178	-	-
Ohio	231	228	11,628	16,742	-	-	53	23	-	-
Ind.	118	224	6,929	6,486	N	N	30	16	-	-
Ill.	279	595	13,584	19,034	-	-	13	30	-	-
Mich.	132	277	15,261	12,405	5	3	47	33	-	-
Wis.	49	66	4,927	6,602	-	-	50	76	-	-
W.N. CENTRAL	228	288	18,271	18,945	4	2	95	68	1	-
Minn.	48	56	3,358	4,181	N	N	40	34	-	-
Iowa	11	34	1,087	1,957	N	N	14	10	-	-
Mo.	107	139	7,473	6,912	3	1	17	6	1	-
N. Dak.	10	-	555	528	N	N	-	2	-	-
S. Dak.	-	6	944	922	-	-	10	12	-	-
Nebr.†	6	22	1,967	1,753	1	1	3	3	-	-
Kans.	46	31	2,887	2,692	N	N	11	1	-	-
S. ATLANTIC	3,515	4,482	58,393	61,143	-	1	169	98	2	-
Del.	42	80	1,141	2,392	N	N	-	1	-	-
Md.	343	411	7,346	6,274	-	1	9	8	-	-
D.C.	149	476	1,389	1,305	-	-	2	-	-	-
Va.	141	421	8,749	6,927	-	-	22	11	-	-
W. Va.	30	32	1,080	985	N	N	2	-	-	-
N.C.	243	504	10,639	9,092	N	N	31	12	-	-
S.C.†	205	311	6,579	5,139	-	-	7	2	2	-
Ga.	509	609	5,925	12,993	-	-	51	36	-	-
Fla.	1,853	1,638	15,545	16,036	N	N	45	28	-	-
E.S. CENTRAL	448	621	19,715	21,246	N	N	36	45	-	-
Ky.	42	67	2,121	3,197	N	N	9	9	-	-
Tenn.	189	269	8,594	7,362	N	N	12	13	-	-
Ala.	127	144	4,138	5,752	-	-	9	20	-	-
Miss.	90	141	4,862	4,935	N	N	6	3	-	-
W.S. CENTRAL	1,309	1,634	40,133	40,783	2	-	23	16	1	-
Ark.	43	47	2,951	2,751	1	-	8	2	-	-
La.	281	192	10,049	7,416	1	-	-	1	1	-
Okla.	37	74	3,832	3,947	N	N	7	3	-	-
Tex.	948	1,321	23,301	26,669	-	-	8	10	-	-
MOUNTAIN	259	586	15,849	19,840	1,161	855	42	34	-	-
Mont.	-	8	749	934	N	N	4	7	-	-
Idaho	2	10	1,191	953	N	N	4	6	-	-
Wyo.	2	4	425	397	-	-	2	1	-	-
Colo.	48	127	2,924	5,008	N	N	23	6	-	-
N. Mex.	20	42	2,298	2,827	9	2	1	1	-	-
Ariz.	109	274	5,660	6,027	1,118	835	6	2	-	-
Utah	19	29	845	1,376	12	3	1	8	-	-
Nev.	59	92	1,757	2,318	22	15	1	3	-	-
PACIFIC	823	2,476	53,725	56,387	629	397	92	134	-	-
Wash.	127	178	6,608	6,050	N	N	9	12	-	-
Oreg.	53	108	2,069	2,978	-	-	11	15	-	-
Calif.	604	2,148	42,863	43,829	629	397	71	107	-	-
Alaska	8	9	1,434	1,446	-	-	-	-	-	-
Hawaii	31	33	751	2,084	-	-	1	-	-	-
Guam	1	1	-	-	-	-	-	-	-	-
P.R.	143	437	594	824	N	N	N	N	-	-
V.I.	2	13	20	127	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	32	U	-	U	-	U	-	U

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

* Incidence data for reporting years 2003 and 2004 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 26, 2004.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 22, 2004, and May 17, 2003 (20th Week)*

Reporting area	<i>Escherichia coli</i> , Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped		Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003				
UNITED STATES	393	407	55	76	46	32	5,305	5,794	107,450	122,648
NEW ENGLAND	27	24	16	13	6	2	470	434	2,467	2,657
Maine	-	3	-	-	-	-	47	43	100	81
N.H.	4	6	2	1	-	-	13	19	51	47
Vt.	-	-	-	-	-	-	39	33	29	33
Mass.	10	6	2	5	6	2	253	213	1,245	995
R.I.	2	1	-	-	-	-	37	42	349	365
Conn.	11	8	12	7	-	-	81	84	693	1,136
MID. ATLANTIC	31	48	2	6	12	10	1,213	1,214	13,405	15,528
Upstate N.Y.	10	16	1	3	4	5	382	292	2,800	2,674
N.Y. City	4	3	-	-	-	-	372	460	3,761	5,128
N.J.	5	5	1	-	4	-	119	172	2,048	3,460
Pa.	12	24	-	3	4	5	340	290	4,796	4,266
E.N. CENTRAL	68	107	12	16	4	6	651	1,045	20,799	26,410
Ohio	19	24	1	9	4	6	271	304	5,541	8,592
Ind.	8	12	-	-	-	-	-	-	2,385	2,454
Ill.	14	20	-	1	-	-	84	315	5,661	8,140
Mich.	12	20	2	-	-	-	196	248	5,873	4,979
Wis.	15	31	9	6	-	-	100	178	1,339	2,245
W.N. CENTRAL	67	54	7	7	9	6	630	570	5,869	6,242
Minn.	25	20	3	6	2	-	205	190	1,205	1,014
Iowa	11	7	-	-	-	-	94	80	160	414
Mo.	10	17	4	1	2	-	175	170	2,984	3,185
N. Dak.	2	1	-	-	3	1	11	16	50	25
S. Dak.	2	2	-	-	-	-	19	17	100	64
Nebr.	8	4	-	-	-	-	53	49	392	578
Kans.	9	3	-	-	2	5	73	48	978	962
S. ATLANTIC	35	28	13	22	7	1	817	863	25,936	29,810
Del.	-	-	N	N	N	N	20	15	364	934
Md.	4	1	-	-	1	1	34	44	3,110	2,903
D.C.	1	1	-	-	-	-	25	14	950	938
Va.	1	8	6	1	-	-	138	98	3,517	3,234
W. Va.	1	1	-	-	-	-	12	10	323	323
N.C.	-	-	4	10	-	-	N	N	5,559	5,152
S.C.	1	-	-	-	-	-	17	45	3,003	2,994
Ga.	11	6	1	2	-	-	192	280	2,712	6,261
Fla.	16	11	2	9	6	-	379	357	6,398	7,071
E.S. CENTRAL	17	21	1	-	6	4	112	115	8,559	10,348
Ky.	8	8	1	-	4	4	N	N	897	1,335
Tenn.	3	9	-	-	2	-	52	51	3,049	3,039
Ala.	2	3	-	-	-	-	60	64	2,407	3,449
Miss.	4	1	-	-	-	-	-	-	2,206	2,525
W.S. CENTRAL	20	18	-	2	1	-	98	91	14,891	16,294
Ark.	4	2	-	-	-	-	44	49	1,382	1,438
La.	-	1	-	-	-	-	12	6	4,551	4,147
Okla.	4	2	-	-	-	-	42	36	1,647	1,525
Tex.	12	13	-	2	1	-	-	-	7,311	9,184
MOUNTAIN	63	42	3	8	1	3	454	454	3,737	4,153
Mont.	2	1	-	-	-	-	15	22	30	55
Idaho	12	12	1	4	-	-	64	58	34	30
Wyo.	-	1	-	-	-	-	5	6	22	19
Colo.	25	14	1	1	1	3	151	128	948	1,130
N. Mex.	4	1	-	3	-	-	21	18	267	466
Ariz.	7	9	N	N	N	N	72	80	1,598	1,585
Utah	8	3	-	-	-	-	91	97	102	138
Nev.	5	1	1	-	-	-	35	45	736	730
PACIFIC	65	65	1	2	-	-	860	1,008	11,787	11,206
Wash.	19	19	-	1	-	-	99	86	979	1,119
Oreg.	11	8	1	1	-	-	150	119	265	368
Calif.	29	37	-	-	-	-	554	735	10,133	9,111
Alaska	1	1	-	-	-	-	25	31	240	201
Hawaii	5	-	-	-	-	-	32	37	170	407
Guam	N	N	-	-	-	-	-	-	-	-
P.R.	-	1	-	-	-	-	8	43	57	92
V.I.	-	-	-	-	-	-	-	-	4	37
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	-	U	-	U	-	U	-	U	3	U

N: Not notifiable. U: Unavailable. - : No reported cases.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 22, 2004, and May 17, 2003 (20th Week)*

Reporting area	<i>Haemophilus influenzae</i> , invasive								Hepatitis (viral, acute), by type	
	All ages		Age <5 years						A	
	All serotypes		Serotype b		Non-serotype b		Unknown serotype		Cum.	Cum.
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	2004	2003
UNITED STATES	797	721	7	10	42	54	92	87	2,047	2,393
NEW ENGLAND	72	51	1	1	4	4	3	3	357	98
Maine	7	2	-	-	-	-	-	1	8	1
N.H.	12	5	-	-	2	-	-	-	7	6
Vt.	5	6	-	-	-	-	1	-	5	4
Mass.	30	25	1	1	-	4	2	1	302	50
R.I.	2	2	-	-	-	-	-	1	6	10
Conn.	16	11	-	-	2	-	-	-	29	27
MID. ATLANTIC	161	124	-	-	3	1	24	18	240	506
Upstate N.Y.	58	37	-	-	3	1	3	4	33	38
N.Y. City	32	22	-	-	-	-	7	5	80	187
N.J.	25	27	-	-	-	-	2	3	51	84
Pa.	46	38	-	-	-	-	12	6	76	197
E.N. CENTRAL	118	126	-	1	10	4	17	24	186	228
Ohio	58	34	-	-	2	-	10	7	22	37
Ind.	20	21	-	-	4	2	1	-	15	15
Ill.	19	52	-	-	-	-	5	14	69	75
Mich.	9	7	-	1	4	2	-	-	63	75
Wis.	12	12	-	-	-	-	1	3	17	26
W.N. CENTRAL	42	46	1	-	2	5	3	5	64	63
Minn.	14	18	-	-	2	5	-	-	10	14
Iowa	1	-	1	-	-	-	-	-	19	13
Mo.	14	18	-	-	-	-	2	5	19	19
N. Dak.	3	1	-	-	-	-	-	-	1	-
S. Dak.	-	1	-	-	-	-	-	-	2	-
Nebr.	5	-	-	-	-	-	-	-	7	4
Kans.	5	8	-	-	-	-	1	-	6	13
S. ATLANTIC	191	146	-	-	9	6	16	9	375	556
Del.	7	-	-	-	-	-	2	-	3	4
Md.	35	35	-	-	2	4	-	-	59	52
D.C.	-	-	-	-	-	-	-	-	3	17
Va.	17	15	-	-	-	-	1	3	33	35
W. Va.	8	3	-	-	-	-	3	-	2	6
N.C.	24	10	-	-	3	-	-	-	25	26
S.C.	2	2	-	-	-	-	-	-	13	22
Ga.	47	31	-	-	-	-	10	4	141	224
Fla.	51	50	-	-	4	2	-	2	96	170
E.S. CENTRAL	28	41	-	1	-	2	7	4	67	66
Ky.	-	3	-	-	-	1	-	-	9	11
Tenn.	19	22	-	-	-	1	5	3	40	35
Ala.	9	16	-	1	-	-	2	1	6	9
Miss.	-	-	-	-	-	-	-	-	12	11
W.S. CENTRAL	31	39	1	-	3	6	1	3	151	231
Ark.	1	4	-	-	-	1	-	-	32	12
La.	4	13	-	-	-	2	1	3	5	21
Okla.	25	22	-	-	3	3	-	-	16	4
Tex.	1	-	1	-	-	-	-	-	98	194
MOUNTAIN	120	87	2	5	11	13	17	11	200	156
Mont.	-	-	-	-	-	-	-	-	3	2
Idaho	4	1	-	-	-	-	2	1	10	7
Wyo.	-	-	-	-	-	-	-	-	1	1
Colo.	34	15	-	-	-	-	6	4	28	22
N. Mex.	20	12	-	-	3	3	3	1	5	8
Ariz.	46	48	-	5	7	6	1	3	125	87
Utah	9	7	2	-	-	2	3	2	23	12
Nev.	7	4	-	-	1	2	2	-	5	17
PACIFIC	34	61	2	2	-	13	4	10	407	489
Wash.	3	3	2	-	-	2	1	1	26	26
Oreg.	21	20	-	-	-	-	-	2	29	28
Calif.	3	33	-	2	-	11	2	7	342	427
Alaska	2	-	-	-	-	-	1	-	3	5
Hawaii	5	5	-	-	-	-	-	-	7	3
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	-	-	-	-	-	-	7	32
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 years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 22, 2004, and May 17, 2003 (20th Week)*

Reporting area	Hepatitis (viral, acute), by type				Legionellosis		Listeriosis		Lyme disease	
	B		C		Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003						
UNITED STATES	2,262	2,474	452	417	355	373	153	181	2,743	3,059
NEW ENGLAND	88	127	1	1	8	14	10	7	252	359
Maine	1	-	-	-	-	-	2	-	31	-
N.H.	20	5	-	-	-	2	1	2	13	5
Vt.	1	1	1	1	-	1	-	-	9	4
Mass.	63	93	-	-	3	6	2	3	91	188
R.I.	1	3	-	-	1	1	1	-	28	80
Conn.	2	25	U	U	4	4	4	2	80	82
MID. ATLANTIC	345	335	47	46	84	78	34	37	2,131	2,248
Upstate N.Y.	41	28	4	7	18	25	12	7	756	720
N.Y. City	34	115	-	-	3	8	3	10	-	3
N.J.	158	90	-	-	22	5	8	7	489	550
Pa.	112	102	43	39	41	40	11	13	886	975
E.N. CENTRAL	173	183	25	65	79	85	21	22	34	94
Ohio	61	57	2	4	39	35	9	3	28	11
Ind.	8	10	2	-	7	4	4	1	-	5
Ill.	-	-	2	11	2	13	-	7	-	2
Mich.	104	94	19	47	29	26	7	7	-	-
Wis.	-	22	-	3	2	7	1	4	6	76
W.N. CENTRAL	157	111	183	89	8	14	4	5	38	31
Minn.	12	13	1	1	-	2	2	2	12	17
Iowa	6	4	-	-	2	4	1	-	5	4
Mo.	122	74	182	87	4	5	1	1	16	7
N. Dak.	1	-	-	-	1	1	-	-	-	-
S. Dak.	-	1	-	-	1	-	-	-	-	-
Nebr.	9	12	-	1	-	1	-	2	2	1
Kans.	7	7	-	-	-	1	-	-	3	2
S. ATLANTIC	679	638	69	69	86	104	24	39	237	238
Del.	12	3	-	-	3	-	N	N	24	45
Md.	59	43	6	5	13	17	4	4	142	150
D.C.	12	1	1	-	1	1	-	-	2	3
Va.	75	40	10	1	7	6	3	4	10	10
W. Va.	2	7	8	1	2	-	1	1	1	-
N.C.	57	53	6	3	8	9	4	8	34	17
S.C.	37	60	1	17	1	4	-	2	1	1
Ga.	218	202	6	6	4	10	4	10	1	5
Fla.	207	229	31	36	47	57	8	10	22	7
E.S. CENTRAL	286	159	37	37	15	15	7	6	9	15
Ky.	21	34	12	7	4	3	2	-	5	2
Tenn.	69	53	11	7	9	7	4	1	2	6
Ala.	24	31	-	4	2	3	1	3	-	-
Miss.	172	41	14	19	-	2	-	2	2	7
W.S. CENTRAL	61	418	48	76	24	22	13	22	4	39
Ark.	17	38	-	3	-	-	-	-	-	-
La.	23	61	25	43	1	1	1	1	-	4
Okla.	16	18	2	-	2	2	-	1	-	-
Tex.	5	301	21	30	21	19	12	20	4	35
MOUNTAIN	193	222	20	12	25	19	6	11	8	3
Mont.	-	8	2	1	-	-	-	1	-	-
Idaho	6	2	-	1	1	2	1	-	2	1
Wyo.	3	9	-	-	4	1	-	-	1	-
Colo.	27	34	4	4	4	3	1	4	-	-
N. Mex.	5	17	3	-	-	2	-	2	-	-
Ariz.	101	112	2	3	5	6	-	4	1	-
Utah	20	14	1	-	9	3	-	-	4	1
Nev.	31	26	8	3	2	2	4	-	-	1
PACIFIC	280	281	22	22	26	22	34	32	30	32
Wash.	22	29	7	9	5	2	5	3	3	-
Oreg.	41	-	4	4	N	N	4	1	11	8
Calif.	202	243	9	8	21	20	25	28	16	23
Alaska	12	3	-	-	-	-	-	-	-	1
Hawaii	3	6	2	1	-	-	-	-	N	N
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	9	57	-	-	1	-	-	-	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 years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 22, 2004, and May 17, 2003 (20th Week)*

Reporting area	Malaria		Meningococcal disease		Pertussis		Rabies, animal		Rocky Mountain spotted fever	
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	356	363	639	793	3,072	2,474	1,407	2,657	182	119
NEW ENGLAND	29	8	29	38	665	251	182	172	9	-
Maine	2	1	7	5	-	2	18	14	-	-
N.H.	-	2	3	3	20	14	6	9	-	-
Vt.	1	-	1	-	30	27	6	10	-	-
Mass.	17	5	18	23	597	189	79	65	9	-
R.I.	2	-	-	2	9	4	10	22	-	-
Conn.	7	-	-	5	9	15	63	52	-	-
MID. ATLANTIC	74	86	81	90	811	231	152	318	16	11
Upstate N.Y.	13	17	19	14	613	88	119	114	1	-
N.Y. City	29	45	14	21	-	27	4	2	2	4
N.J.	16	10	19	12	72	39	-	62	5	4
Pa.	16	14	29	43	126	77	29	140	8	3
E.N. CENTRAL	23	39	91	124	370	174	10	16	10	4
Ohio	8	6	37	32	163	87	5	5	6	2
Ind.	-	-	10	19	23	24	2	2	1	-
Ill.	2	18	9	36	-	-	2	1	-	1
Mich.	8	12	29	22	36	17	1	8	3	1
Wis.	5	3	6	15	148	46	-	-	-	-
W.N. CENTRAL	22	14	37	57	164	113	174	250	7	4
Minn.	9	8	9	13	40	33	18	11	-	-
Iowa	1	2	9	10	21	33	21	28	-	1
Mo.	3	1	9	24	80	24	6	2	7	3
N. Dak.	2	-	1	-	6	2	23	24	-	-
S. Dak.	1	-	1	1	7	2	10	51	-	-
Nebr.	1	-	1	5	-	1	53	48	-	-
Kans.	5	3	7	4	10	18	43	86	-	-
S. ATLANTIC	106	92	116	143	171	169	668	1,078	91	88
Del.	2	-	1	8	3	1	9	18	-	-
Md.	26	24	6	12	36	20	50	147	7	15
D.C.	5	5	4	1	1	-	-	-	-	-
Va.	10	7	7	9	46	33	176	205	-	1
W. Va.	-	2	3	1	2	3	27	28	-	-
N.C.	5	6	18	16	33	62	249	280	78	47
S.C.	5	1	10	11	17	8	56	67	2	8
Ga.	12	18	6	18	8	17	99	145	1	13
Fla.	41	29	61	67	25	25	2	188	3	4
E.S. CENTRAL	12	9	26	33	40	47	52	81	27	10
Ky.	1	1	3	3	7	11	11	11	-	-
Tenn.	2	4	9	8	21	22	17	61	15	6
Ala.	7	2	6	10	6	9	21	8	4	-
Miss.	2	2	8	12	6	5	3	1	8	4
W.S. CENTRAL	32	43	58	104	120	141	74	634	16	1
Ark.	2	3	12	9	7	8	23	25	-	-
La.	2	2	14	30	2	4	-	-	3	-
Okla.	1	2	3	8	13	14	51	100	13	-
Tex.	27	36	29	57	98	115	-	509	-	1
MOUNTAIN	14	11	33	37	387	424	38	35	2	1
Mont.	-	-	1	2	11	-	5	5	-	-
Idaho	1	1	4	2	17	9	-	1	1	-
Wyo.	-	-	2	2	3	119	-	-	-	1
Colo.	6	8	14	7	209	159	4	1	1	-
N. Mex.	1	-	4	4	46	22	-	2	-	-
Ariz.	1	1	5	16	65	75	29	25	-	-
Utah	3	1	3	-	27	30	-	1	-	-
Nev.	2	-	-	4	9	10	-	-	-	-
PACIFIC	44	61	168	167	344	924	57	73	4	-
Wash.	2	8	17	15	171	152	-	-	-	-
Oreg.	8	5	36	29	125	130	-	1	2	-
Calif.	33	46	110	114	35	639	49	67	2	-
Alaska	-	-	1	2	8	-	8	5	-	-
Hawaii	1	2	4	7	5	3	-	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	-	-	2	5	1	-	17	25	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 years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 22, 2004, and May 17, 2003 (20th Week)*

Reporting area	Salmonellosis		Shigellosis		Streptococcal disease, invasive, group A		<i>Streptococcus pneumoniae</i> , invasive			
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Drug resistant, all ages		Age <5 years	
							Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
UNITED STATES	9,244	10,210	3,583	7,813	2,057	2,922	1,099	1,118	214	262
NEW ENGLAND	456	509	84	107	97	284	13	48	4	1
Maine	29	32	1	4	3	14	1	-	-	-
N.H.	27	35	3	3	11	15	-	-	N	N
Vt.	18	15	2	3	4	14	6	5	1	1
Mass.	243	298	53	70	63	130	N	N	N	N
R.I.	32	25	4	3	16	4	6	-	3	-
Conn.	107	104	21	24	-	107	-	43	U	U
MID. ATLANTIC	1,235	1,299	435	709	327	502	81	64	51	45
Upstate N.Y.	312	264	195	120	113	183	38	29	37	32
N.Y. City	331	382	123	150	43	71	U	U	U	U
N.J.	202	211	68	157	58	105	N	N	N	N
Pa.	390	442	49	282	113	143	43	35	14	13
E.N. CENTRAL	1,278	1,452	265	634	371	733	253	235	70	98
Ohio	342	409	67	99	131	158	192	155	47	52
Ind.	132	152	47	44	44	63	61	80	16	18
Ill.	321	477	87	354	35	205	-	-	-	-
Mich.	252	210	34	87	149	209	N	N	N	N
Wis.	231	204	30	50	12	98	N	N	7	28
W.N. CENTRAL	669	563	136	256	161	184	112	93	21	20
Minn.	167	154	17	34	73	87	-	-	18	17
Iowa	135	114	29	20	N	N	N	N	N	N
Mo.	184	145	50	105	39	39	5	6	3	1
N. Dak.	13	13	1	3	6	8	-	3	-	2
S. Dak.	23	25	6	8	8	14	1	-	-	-
Nebr.	47	49	7	58	8	19	-	-	N	N
Kans.	100	63	26	28	27	17	106	84	N	N
S. ATLANTIC	2,039	2,343	1,013	2,459	414	450	504	538	5	5
Del.	15	27	3	120	2	5	3	1	N	N
Md.	189	241	42	210	94	132	-	4	-	-
D.C.	14	12	20	24	4	4	3	-	3	-
Va.	234	235	32	105	38	45	N	N	N	N
W. Va.	46	23	-	-	12	19	55	28	2	5
N.C.	247	350	129	273	56	36	N	N	U	U
S.C.	125	129	143	130	28	16	41	80	N	N
Ga.	289	325	206	521	79	96	109	138	N	N
Fla.	880	1,001	438	1,076	101	97	293	287	N	N
E.S. CENTRAL	517	609	206	392	104	92	62	76	-	-
Ky.	99	108	31	46	36	22	17	6	N	N
Tenn.	148	205	84	135	68	70	45	70	N	N
Ala.	153	166	68	132	-	-	-	-	N	N
Miss.	117	130	23	79	-	-	-	-	-	-
W.S. CENTRAL	712	1,063	710	2,058	112	143	28	47	53	61
Ark.	102	109	19	26	5	3	5	17	5	4
La.	79	179	65	186	1	1	23	30	7	13
Okla.	95	82	166	274	31	42	N	N	24	26
Tex.	436	693	460	1,572	75	97	N	N	17	18
MOUNTAIN	776	670	275	329	279	247	15	15	10	32
Mont.	52	36	3	2	-	1	-	-	-	-
Idaho	56	70	5	8	4	11	N	N	N	N
Wyo.	20	32	1	1	5	-	4	2	-	-
Colo.	186	181	59	52	87	71	-	-	8	30
N. Mex.	68	58	38	68	42	64	5	13	-	-
Ariz.	253	177	134	165	117	95	-	-	N	N
Utah	77	64	16	17	23	4	4	-	2	2
Nev.	64	52	19	16	1	1	2	-	-	-
PACIFIC	1,562	1,702	459	869	192	287	31	2	-	-
Wash.	135	182	29	77	24	26	-	-	N	N
Oreg.	111	152	19	31	N	N	N	N	N	N
Calif.	1,171	1,267	393	746	134	217	N	N	N	N
Alaska	32	34	3	4	-	-	-	-	N	N
Hawaii	113	67	15	11	34	44	31	2	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	40	241	1	4	N	N	N	N	N	N
V.I.	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	3	U	-	U	-	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending May 22, 2004, and May 17, 2003 (20th Week)*

Reporting area	Syphilis				Tuberculosis		Typhoid fever		Varicella (Chickenpox)	
	Primary & secondary		Congenital		Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003
	Cum. 2004	Cum. 2003	Cum. 2004	Cum. 2003						
UNITED STATES	2,561	2,699	84	184	2,982	4,445	88	118	7,090	7,410
NEW ENGLAND	57	75	1	-	102	132	8	9	356	1,663
Maine	-	3	-	-	-	4	-	-	43	490
N.H.	1	9	-	-	6	6	-	-	-	-
Vt.	-	-	-	-	-	3	-	-	313	367
Mass.	42	51	-	-	76	62	8	4	-	85
R.I.	6	4	-	-	10	17	-	2	-	2
Conn.	8	8	1	-	10	40	-	3	-	719
MID. ATLANTIC	369	305	10	31	708	778	20	21	28	9
Upstate N.Y.	34	8	1	2	79	86	2	3	-	-
N.Y. City	168	168	6	19	369	420	5	11	-	-
N.J.	70	66	3	10	146	141	9	6	-	-
Pa.	97	63	-	-	114	131	4	1	28	9
E.N. CENTRAL	289	367	27	35	359	363	4	15	3,063	2,789
Ohio	92	82	1	2	64	58	1	-	867	625
Ind.	21	16	7	6	19	47	-	4	-	-
Ill.	90	140	1	11	180	176	-	5	-	-
Mich.	78	119	18	16	72	61	2	6	2,084	1,734
Wis.	8	10	-	-	24	21	1	-	112	430
W.N. CENTRAL	50	77	-	3	135	171	2	2	109	20
Minn.	7	22	-	-	57	63	1	1	-	-
Iowa	2	6	-	-	13	10	-	1	N	N
Mo.	24	27	-	3	31	52	1	-	2	-
N. Dak.	-	-	-	-	3	-	-	-	67	20
S. Dak.	-	-	-	-	4	9	-	-	40	-
Nebr.	4	2	-	-	6	7	-	-	-	-
Kans.	13	20	-	-	21	30	-	-	-	-
S. ATLANTIC	699	703	11	37	631	774	16	25	1,117	1,082
Del.	2	8	-	-	-	-	-	-	4	8
Md.	136	106	2	6	81	78	2	7	-	-
D.C.	30	15	-	-	-	-	-	-	17	7
Va.	25	32	1	1	74	78	2	10	317	265
W. Va.	2	1	-	-	10	7	-	-	620	701
N.C.	54	64	1	9	71	79	2	4	-	-
S.C.	44	46	-	4	68	53	-	-	159	101
Ga.	115	174	-	7	11	192	8	2	-	-
Fla.	291	257	7	10	316	287	2	2	-	-
E. S. CENTRAL	133	131	4	7	176	258	4	2	2	-
Ky.	22	20	-	1	29	42	2	-	-	-
Tenn.	53	52	1	1	46	83	2	1	-	-
Ala.	47	49	2	4	68	99	-	1	-	-
Miss.	11	10	1	1	33	34	-	-	2	-
W.S. CENTRAL	405	315	16	26	177	712	6	5	1,058	1,694
Ark.	16	13	-	1	52	41	-	-	-	-
La.	83	41	-	-	-	-	-	-	5	8
Okla.	9	19	2	-	50	49	-	-	-	-
Tex.	297	242	14	25	75	622	6	5	1,053	1,686
MOUNTAIN	138	116	12	19	132	122	6	4	1,357	153
Mont.	-	-	-	-	-	-	-	-	-	-
Idaho	10	4	-	-	-	1	-	-	-	-
Wyo.	1	-	-	-	1	2	-	-	16	21
Colo.	8	15	-	3	36	36	3	3	1,039	-
N. Mex.	25	22	1	5	-	6	-	-	29	-
Ariz.	84	69	11	11	80	59	1	1	-	2
Utah	3	1	-	-	15	9	1	-	273	130
Nev.	7	5	-	-	-	9	1	-	-	-
PACIFIC	421	610	3	26	562	1,135	22	35	-	-
Wash.	32	26	-	-	77	91	1	2	-	-
Oreg.	9	16	-	-	28	34	1	1	-	-
Calif.	378	562	3	26	406	948	15	32	-	-
Alaska	-	-	-	-	9	23	-	-	-	-
Hawaii	2	6	-	-	42	39	5	-	-	-
Guam	-	-	-	-	-	-	-	-	-	-
P.R.	45	73	-	8	14	33	-	-	98	246
V.I.	-	1	-	-	-	-	-	-	-	-
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	-	U	10	U	-	U	-	U

N: Not notifiable. U: Unavailable. -: No reported cases.

* Incidence data for reporting years 2003 and 2004 are provisional and cumulative (year-to-date).

TABLE III. Deaths in 122 U.S. cities,* week ending May 22, 2004 (20th Week)

Reporting Area	All causes, by age (years)							P&I† Total	Reporting Area	All causes, by age (years)							P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	All Ages			≥65	45-64	25-44	1-24	<1			
NEW ENGLAND	478	332	91	31	10	14	28	S. ATLANTIC	1,316	818	329	110	33	26	57		
Boston, Mass.	116	75	20	10	6	5	-	Atlanta, Ga.	132	72	46	10	4	-	2		
Bridgeport, Conn.	33	25	6	2	-	-	1	Baltimore, Md.	179	94	51	24	8	2	14		
Cambridge, Mass.	21	16	5	-	-	-	3	Charlotte, N.C.	90	58	22	6	3	1	9		
Fall River, Mass.	19	18	1	-	-	-	5	Jacksonville, Fla.	131	72	37	16	4	2	1		
Hartford, Conn.	66	42	11	8	2	3	5	Miami, Fla.	170	111	42	10	3	4	6		
Lowell, Mass.	26	21	4	1	-	-	2	Norfolk, Va.	45	26	10	4	1	4	1		
Lynn, Mass.	4	2	1	1	-	-	1	Richmond, Va.	65	44	13	4	2	2	3		
New Bedford, Mass.	25	18	5	2	-	-	1	Savannah, Ga.	59	43	13	1	1	1	2		
New Haven, Conn.	U	U	U	U	U	U	U	St. Petersburg, Fla.	61	48	7	5	1	-	6		
Providence, R.I.	54	37	12	2	1	2	-	Tampa, Fla.	170	123	29	15	-	3	10		
Somerville, Mass.	2	1	1	-	-	-	-	Washington, D.C.	199	116	55	15	6	7	2		
Springfield, Mass.	31	19	10	1	-	1	3	Wilmington, Del.	15	11	4	-	-	-	1		
Waterbury, Conn.	23	18	2	2	1	-	2	E.S. CENTRAL	723	460	184	51	19	9	53		
Worcester, Mass.	58	40	13	2	-	3	5	Birmingham, Ala.	198	122	53	14	6	3	21		
MID. ATLANTIC	2,046	1,400	434	129	39	42	111	Chattanooga, Tenn.	58	42	11	3	1	1	2		
Albany, N.Y.	52	40	7	1	2	2	4	Knoxville, Tenn.	110	68	31	7	2	2	-		
Allentown, Pa.	19	16	3	-	-	-	1	Lexington, Ky.	70	44	18	7	1	-	6		
Buffalo, N.Y.	87	66	13	4	2	2	4	Memphis, Tenn.	U	U	U	U	U	U	U		
Camden, N.J.	23	14	5	1	1	2	1	Mobile, Ala.	87	62	19	4	1	1	5		
Elizabeth, N.J.	13	9	2	2	-	-	-	Montgomery, Ala.	38	22	9	5	1	1	4		
Erie, Pa.	30	26	2	2	-	-	1	Nashville, Tenn.	162	100	43	11	7	1	15		
Jersey City, N.J.	48	34	12	1	1	-	-	W.S. CENTRAL	1,482	951	352	110	30	39	79		
New York City, N.Y.	1,022	702	223	64	16	15	53	Austin, Tex.	85	50	27	6	1	1	4		
Newark, N.J.	52	22	20	5	2	3	6	Baton Rouge, La.	17	10	4	3	-	-	-		
Paterson, N.J.	22	13	5	2	-	2	-	Corpus Christi, Tex.	62	40	12	6	2	2	6		
Philadelphia, Pa.	331	197	88	29	9	8	19	Dallas, Tex.	237	139	65	21	2	10	13		
Pittsburgh, Pa.‡	28	18	4	3	2	1	-	El Paso, Tex.	70	52	15	2	-	1	4		
Reading, Pa.	28	19	5	4	-	-	1	Ft. Worth, Tex.	140	86	29	13	7	5	11		
Rochester, N.Y.	115	87	19	3	1	5	8	Houston, Tex.	367	223	95	30	6	13	20		
Schenectady, N.Y.	21	16	3	2	-	-	1	Little Rock, Ark.	72	39	25	1	4	3	1		
Scranton, Pa.	25	18	3	2	1	1	-	New Orleans, La.	41	25	14	2	-	-	-		
Syracuse, N.Y.	75	63	9	-	2	1	5	San Antonio, Tex.	223	164	36	16	4	3	15		
Trenton, N.J.	18	13	2	3	-	-	2	Shreveport, La.	36	26	6	3	1	-	2		
Utica, N.Y.	23	18	5	-	-	-	3	Tulsa, Okla.	132	97	24	7	3	1	3		
Yonkers, N.Y.	14	9	4	1	-	-	2	MOUNTAIN	973	676	212	53	19	11	68		
E.N. CENTRAL	2,132	1,430	475	137	45	45	150	Albuquerque, N.M.	142	97	35	5	3	2	7		
Akron, Ohio	58	41	9	2	5	1	4	Boise, Idaho	34	25	5	1	3	-	8		
Canton, Ohio	32	24	6	1	1	-	4	Colorado Springs, Colo.	54	35	12	5	1	1	2		
Chicago, Ill.	342	209	84	29	10	10	15	Denver, Colo.	97	71	17	8	-	1	10		
Cincinnati, Ohio	86	55	20	2	6	3	6	Las Vegas, Nev.	248	161	62	20	3	2	14		
Cleveland, Ohio	277	187	67	14	3	6	13	Ogden, Utah	26	21	3	-	1	1	2		
Columbus, Ohio	208	139	50	12	2	5	23	Phoenix, Ariz.	87	56	23	2	4	-	4		
Dayton, Ohio	107	76	23	7	1	-	10	Pueblo, Colo.	33	23	7	3	-	-	2		
Detroit, Mich.	159	85	58	9	4	3	17	Salt Lake City, Utah	101	76	17	5	2	1	10		
Evansville, Ind.	53	39	8	5	1	-	6	Tucson, Ariz.	151	111	31	4	2	3	9		
Fort Wayne, Ind.	69	45	19	3	2	-	3	PACIFIC	1,690	1,202	311	102	51	23	163		
Gary, Ind.	13	3	7	3	-	-	1	Berkeley, Calif.	17	11	4	2	-	-	1		
Grand Rapids, Mich.	37	26	8	1	-	2	6	Fresno, Calif.	104	72	21	2	5	4	5		
Indianapolis, Ind.	198	141	31	19	2	5	10	Glendale, Calif.	16	11	4	-	1	-	7		
Lansing, Mich.	47	35	7	4	-	1	2	Honolulu, Hawaii	85	66	15	2	1	1	8		
Milwaukee, Wis.	114	85	22	5	2	-	10	Long Beach, Calif.	61	44	11	4	2	-	3		
Peoria, Ill.	57	42	8	4	1	2	4	Los Angeles, Calif.	260	187	41	24	8	-	38		
Rockford, Ill.	65	46	12	4	2	1	8	Pasadena, Calif.	32	26	4	1	1	-	5		
South Bend, Ind.	46	28	11	5	-	2	2	Portland, Oreg.	121	75	31	5	5	5	6		
Toledo, Ohio	92	70	16	3	2	1	3	Sacramento, Calif.	192	129	40	11	9	3	19		
Youngstown, Ohio	72	54	9	5	1	3	3	San Diego, Calif.	163	122	24	10	5	1	12		
W.N. CENTRAL	580	388	125	35	15	17	41	San Francisco, Calif.	144	102	25	13	1	3	15		
Des Moines, Iowa	115	74	28	7	1	5	7	San Jose, Calif.	229	178	33	7	9	2	24		
Duluth, Minn.	35	30	4	1	-	-	2	Santa Cruz, Calif.	26	15	8	2	1	-	2		
Kansas City, Kans.	18	8	8	1	1	-	3	Seattle, Wash.	87	61	19	5	2	-	6		
Kansas City, Mo.	75	51	18	4	2	-	3	Spokane, Wash.	53	37	8	5	-	3	4		
Lincoln, Nebr.	25	20	5	-	-	-	2	Tacoma, Wash.	100	66	23	9	1	1	8		
Minneapolis, Minn.	65	39	13	6	2	5	7	TOTAL	11,420 [¶]	7,657	2,513	758	261	226	750		
Omaha, Nebr.	86	60	16	6	3	1	10										
St. Louis, Mo.	U	U	U	U	U	U	U										
St. Paul, Minn.	58	46	8	1	2	1	4										
Wichita, Kans.	103	60	25	9	4	5	3										

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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