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Great American Smokeout — November 16, 2006

Since 1977, the American Cancer Society has sponsored the Great American Smokeout on the third Thursday in November to encourage smokers to quit. Approximately 45.1 million (20.9%) U.S. adults were current smokers in 2005 (*1*). Smokers can improve their chances of quitting by using proven cessation aids such as physician assistance, medications approved by the Food and Drug Administration, and behavioral counseling, including telephone quitlines (*2*). All 50 states, the District of Columbia, and certain U.S. territories now have quitlines, which can be reached by telephone: 800-QUIT-NOW (800-784-8669).

Other interventions that increase cessation include increasing the price of tobacco products, implementing sustained media campaigns, and reducing out-of-pocket treatment costs (*3*). Growing evidence indicates that, in addition to protecting nonsmokers from exposure to secondhand smoke, smoke-free workplace policies and smoke-free home rules help smokers quit (*4*). Comprehensive approaches are most effective in prompting smokers to make quit attempts and helping them to succeed (*3*).

Information on the Great American Smokeout is available at http://www.cancer.org/docroot/ped/ped_10_4.asp or by telephone: 800-227-2345. Information on how to quit smoking is available at www.smokefree.gov.

References

1. CDC. Tobacco use among adults—United States, 2005. MMWR 2006;55:1145–8.
2. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence: clinical practice guidelines. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2000. AHQR publication 00-0032.
3. Task Force on Community Preventive Services. The guide to community preventive services: what works to promote health? New York, NY: Oxford University Press; 2005.
4. CDC. The health consequences of involuntary exposure to tobacco smoke: a report of the Surgeon General. Atlanta, GA: CDC; 2006.

State Medicaid Coverage for Tobacco-Dependence Treatments — United States, 2005

In 2005, approximately 41 million persons in the United States had health insurance coverage through Medicaid, a federally and state-funded health-care program, managed at the state level, for persons with limited incomes (*1*). An estimated 29% of adult Medicaid recipients were current smokers in 2004 (*2*). The 2000 Public Health Service (PHS) clinical practice guideline recommends that insurance coverage be provided for tobacco-dependence treatments, including both medication (i.e., bupropion hydrochloride or nicotine patch, gum, inhaler, or nasal spray) and counseling (i.e., individual, group, or telephone) (*3*). A national health objective for 2010 is to increase insurance coverage of evidence-based treatments for tobacco dependence among all 51 Medicaid programs (objective 27-8) (*4*). The type of coverage for tobacco-dependence treatments offered by Medicaid has been reported since 1998, and most recently for 2003, from state surveys conducted by the Center for Health and Public Policy Studies at the University of California, Berkeley (*5,6*). All states and the District of Columbia (collectively referred to as states in this report) were resurveyed in 2005 regarding types of coverage and limitations in coverage since 1994. This report summarizes the results of that survey, which indicated that as of De-

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cember 31, 2005, 1) 38 state Medicaid programs covered some tobacco-dependence treatment (i.e., counseling or medication) for all Medicaid recipients; 2) four states offered coverage only for pregnant women; 3) one state (Oregon) offered coverage for all medication and counseling treatments recommended by the 2000 PHS guideline; and 4) seven states (including Oregon) covered all recommended medications and at least one form of counseling. If the 2010 national health objective is to be achieved, states should offer or increase Medicaid coverage for treatment of tobacco dependence (*4*).

In 2005, state Medicaid program directors were asked to identify the staff member who was most knowledgeable about tobacco-dependence treatment coverage and programs; a survey was faxed to the identified staff member in each state. Additional follow-up was conducted by telephone, e-mail, and fax; the response rate was 100%. The survey included 24 questions about coverage of tobacco-dependence treatments, the year coverage was first offered, treatments offered only to pregnant women, and any program requirements related to patient copayments or other limitations related to tobacco-dependence treatments. So that survey responses could be validated, all state Medicaid programs were asked to submit a written copy of coverage policies for tobacco-dependence treatments or other documentation. Of 42 states reporting Medicaid coverage in 2005, a total of 41 (98%) provided some supporting documentation: 16 (38%) provided detailed treatment documentation matching survey responses, 14 (33%) provided partial treatment information (i.e., documentation for medication but not counseling), eight (19%) provided general treatment information (i.e., documentation that addressed coverage for tobacco-dependence treatments but did not specify which type), and three (7%) provided documentation conflicting with survey responses that were later followed up for inclusion in this report.

In 2005, a total of 38 (75%) state Medicaid programs reported offering coverage for at least one form of tobacco-dependence treatment (i.e., medication or counseling) for all Medicaid beneficiaries (Table 1). Four additional states reported that they covered at least one form of tobacco-dependence treatment but only for pregnant women. Of the 38 states that offered at least one form of coverage to all Medicaid beneficiaries in 2005, all covered some type of medication treatment, including generic bupropion hydrochloride or

TABLE 1. State Medicaid program coverage of tobacco-dependence treatments,* by type of coverage and year coverage began — United States, 2005†

Area	Year any coverage began§	Medication coverage					Counseling coverage		
		Gum	Patch	Nasal spray	Inhaler	Zyban®/bupropion hydrochloride¶	Group	Individual	Telephone
Arizona	1997	—	—	—	—	Yes**	—	Yes (P)††	—
Arkansas	1999	Yes §§	Yes §§	—	—	Yes	—	Yes §§	—
California	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—¶¶
Colorado	1996	Yes	Yes	Yes	Yes	Yes	Yes (P)	Yes (P)	—
Delaware	1996	Yes	Yes	Yes	Yes	Yes	—	—	—
District of Columbia	1996	Yes	Yes	Yes	—	Yes	—	—	—
Florida	1997	Yes	Yes	—	—	Yes	Yes	Yes	—
Hawaii	1999	Yes**	Yes**	Yes**	Yes**	Yes**	—	—	—
Illinois	2000	Yes	Yes	Yes	Yes	Yes	—	—	—
Indiana	1999	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—
Iowa	Unknown*** (P)	—	—	—	—	—	—	Yes (P)	
Kansas	1999	—	Yes	—	—	Yes	—	—	—
Kentucky	2001 (P)	—	—	—	—	—	Yes (P)	Yes (P)	—
Louisiana	1990	Yes	Yes	Yes	Yes	Yes	—	—	—
Maine	1996	Yes	Yes	Yes	Yes	—	—	Yes	—
Maryland	1996	—	Yes	Yes	Yes	Yes	—	Yes (P)†††	—
Massachusetts	Unknown*** (P)	—	—	—	—	—	—	Yes (P)	—
Michigan	1997	Yes	Yes	—	—	Yes	—	—	—
Minnesota	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—
Mississippi	2001	Yes	Yes	Yes	Yes	Yes	Yes (P)	Yes (P)	—
Montana	1996	Yes	Yes	Yes	Yes	Yes	—	—	—
Nevada	1996	Yes	Yes	Yes	Yes	Yes	—	—	—
New Hampshire	1996	Yes	Yes	Yes	Yes	Yes	Yes (P)	Yes (P)	—
New Jersey	1996	—	—	—	—	Yes	—	—	—
New Mexico	1996	Yes	Yes	Yes	Yes	Yes	Yes (P)	Yes (P)	—
New York	1999	Yes	Yes	Yes	Yes	Yes	Yes	—	—
North Carolina	1996	Yes§§§	Yes§§§	Yes	Yes	Yes	—	—	—
North Dakota	1996	Yes	Yes	—	—	Yes	Yes§§	Yes	—
Ohio	1998	Yes	Yes	—	Yes	Yes	—	—	—
Oklahoma	1999	Yes	Yes	Yes	Yes	Yes	—	—	—
Oregon	1998	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pennsylvania	2002	Yes	Yes	Yes	Yes	Yes	Yes	Yes	—
Rhode Island	1994	Yes§§§	Yes§§§	Yes§§§	Yes§§§	—	Yes	Yes	—
South Carolina	1995	Yes§§	Yes§§	Yes§§	Yes§§	Yes§§	Yes (P)†††	Yes (P)†††	—
South Dakota	2001	—	—	—	—	Yes	—	—	—
Texas	1996	Yes	Yes	Yes	Yes	Yes	—	—	—
Utah	2001	Yes§§	Yes	Yes (P)	Yes (P)	Yes	Yes (P)	Yes (P)	Yes
Vermont	1999	Yes	Yes	Yes	Yes	Yes	—	—	—
Virginia	1996	—	—	Yes	Yes	Yes	Yes (P)	Yes (P)	—
Washington	2002 (P)	—	—	—	—	Yes (P)	—	Yes (P)	—
West Virginia	2000	Yes	Yes	Yes	Yes	Yes	—	Yes	Yes
Wisconsin	1996	—	—	Yes	Yes	Yes	Yes§§§†††	Yes†††	—
All Medicaid	—	31	33	28	28	36	10	12	3
Pregnant only	—	0	0	1	1	1	8	13	0
Total (N = 42)	**—**	**31**	**33**	**29**	**29**	**37**	**18**	**25**	**3**
Added since 2003	—	5	4	2	2	1	3	2	0
Dropped since 2003	—	1	1	1	2	1	1	1	1

* On the basis of response to the question, "Does your state Medicaid program cover any of the following tobacco-dependence treatments?" Each state also was asked to provide documentation regarding the year each covered treatment was first offered.
† N = 42. In 2005, a total of nine states with Medicaid programs (Alabama, Alaska, Connecticut, Georgia, Idaho, Missouri, Nebraska, Tennessee, and Wyoming) covered none of the tobacco-dependence treatments recommended in the 2000 Public Health Service clinical practice guideline (*3*).
§ Year any coverage began might differ from that listed in previous reports because earlier coverage might have existed for Wellbutrin® (chemically comparable to Zyban but approved for treatment of depression). Although providers might have used Wellbutrin to treat smokers, only generic bupropion and Zyban are approved by the Food and Drug Administration for smoking-cessation treatment. Years of initiation coverage were changed to reflect this. However, the survey did not collect data on when coverage began for generic bupropion specifically for smoking cessation.
¶ For smoking cessation only. Three states (Georgia, Maine, and Wyoming) covered bupropion hydrochloride but not Zyban. These data are not included because coverage might not be specifically for smoking cessation.
** If medically necessary.
†† P = Medicaid coverage exclusively for pregnant women.
§§ Treatment added in 2004.
¶¶ Some managed care plans might provide proactive telephone counseling.
*** State does not have any documentation or knowledge regarding the year coverage began.
††† Counseling indicated is not specific to tobacco-cessation counseling.
§§§ Treatment added in 2005.

Zyban®* (36 states), nicotine nasal sprays (28 states), nicotine inhalers (28 states), nicotine patches (33 states), and nicotine gum (31 states). During 2003–2005, two states (Rhode Island and South Carolina) added medication coverage, and three others (Arkansas, North Carolina, and Utah) expanded existing medication coverage. Some decreases in coverage also occurred; New Jersey eliminated seven previously covered tobacco-dependence treatments, and two states (Maine and Maryland) eliminated one form of medication coverage.

In 2005, a total of 14 states offered some form of tobacco-cessation counseling services for their entire Medicaid population (Table 1), and 12 additional states offered counseling services only for pregnant women. During 2003–2005, one state (Arkansas) added coverage for counseling of all Medicaid beneficiaries, one state (New Mexico) added coverage for counseling of pregnant women, and two states (North Dakota and Wisconsin) expanded existing counseling coverage.

Among the 38 state Medicaid programs covering any medication treatment for all Medicaid beneficiaries, 25 (66%) required some form of patient cost sharing (range: $0.50 to $5.00 per prescription) (Table 2). States were least likely to require copayments for nicotine gum (55%) and most likely to require copayments for nicotine nasal spray (71%). The median copayment among Medicaid programs was similar for all tobacco-dependence treatments, ranging from $2.50 to $3.00. Similarly, the median weeks of treatment covered (12 weeks) did not vary by type of medication, and little variation was observed in the median number of treatment courses covered per year (1–1.5 courses). In addition, certain states reported that they put no limits on coverage for these medications. States were least likely to offer unlimited coverage for the nicotine-replacement patch (27%), which is available over the counter, and most likely to offer unlimited coverage for Zyban (39%), which is available only with a prescription. Data collected on limitations in coverage indicate that for nicotine-replacement–therapy products that are available over the counter that were assessed by this study (i.e., patch and gum), all but one state require a prescription.

Almost one fourth of Medicaid programs that cover tobacco-dependence treatments indicated that medication coverage depended on enrollment in a behavior-modification program or participation in smoking-cessation counseling. Of the nine states that required behavioral counseling as a condition of covering medication, four covered the required counseling. In addition, approximately one third reported that their Medicaid program paid for one smoking-cessation medication at a time. Furthermore, one third of states covering medication indicated that tobacco-dependence treatments counted toward a general prescription limit.

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Editorial Note: Despite publication of tobacco-use treatment guidelines in 1996 and updates in 2000 documenting that use of nicotine-replacement therapy, the nonnicotine medication Zyban, or counseling all can double cessation rates (*3*), coverage of tobacco-dependence treatments by Medicaid remains low and is increasing slowly. In 2005, one state, Oregon, covered all medications approved by FDA and all

*The drug bupropion hydrochloride is sold in its generic form and under the brand names Wellbutrin® (with an indication for depression) and Zyban (with an indication for smoking cessation). Although generic bupropion, Wellbutrin, and Zyban contain the same active ingredient (bupropion hydrochloride), only generic bupropion and Zyban are approved by the Food and Drug Administration (FDA) specifically for smoking-cessation treatment. Therefore, although some state Medicaid programs cover Wellbutrin for smoking cessation, only coverage of generic bupropion and Zyban for smoking cessation are discussed in this report.

TABLE 2. State Medicaid program limitations in coverage for tobacco-dependence medications, by type of medication and characteristic of program — United States, 2005

Characteristic of state Medicaid program	Medication coverage									
	Gum		Patch		Nasal spray		Inhaler		Zyban®*	
No. of states with coverage†	31		33		28		28		36	
No. of states that require copay	17		19		20		19		24	
Median copay (range)	$3.00	($0.50–$5.00)	$3.00	($0.50–$5.00)	$2.50	($1.00–$3.00)	$2.75	($1.00–$3.00)	$3.00	($1.00–$3.00)
Median weeks of treatment per course (range)	12	(6–12)	12	(3–16)	12	(1–24)	12	(12–24)	12	(4–12)
Median courses per year (range)	1	(1–2)	1	(1–2)	1	(1–2)	1.5	(1–2)	1	(1–2)
No. of states requiring prescription	30		32		28		28		36	
No. of states requiring prior authorization	8		7		9		10		6	
No. of states with unlimited use	9		9		10		9		14	

*Data were not calculated for generic bupropion hydrochloride.
†Of 38 states offering some type of tobacco-cessation treatment (i.e., counseling or medication).

three forms of counseling recommended by PHS clinical practice guideline. Nine states offered no Medicaid coverage for tobacco-dependence treatments, and four states offered coverage for at least one treatment option (i.e., medication or counseling) but only to pregnant women.

The number of state Medicaid programs offering any medication coverage increased by one during 2003–2005, and the number of states that expanded coverage of medications also increased by one during the same period. Coverage for counseling increased by two states, and expansion of counseling coverage increased by two states. However, 66% of states that offered coverage required patients to share the cost of treatment. In addition, almost one fourth of state Medicaid programs that cover tobacco-dependence treatments indicated that medication coverage was dependent on enrollment in a behavior-modification program or participation in smoking-cessation counseling, another barrier to using treatment (particularly because counseling was covered by only 44% of these states). Previous studies also have indicated that most programs that offer tobacco-dependence treatment benefits do not inform their beneficiaries of those benefits (*7*), creating additional barriers to successful smoking cessation.

Because decreasing the cost of effective treatments increases smoking cessation (*8*), cost barriers for smokers should be reduced. In a study that assessed the impact and cost-effectiveness of recommended preventive services, smoking-cessation treatment was among the top-ranked clinical preventive services (with childhood immunization and discussing aspirin chemoprophylaxis for adults at risk for cardiovascular disease) (*9*); these three treatments were determined to save health-care costs. Because the adverse health effects of smoking result in 14% of Medicaid costs (*10*), implementation of tobacco-dependence treatments should be a priority.

The findings in this report are subject to at least two limitations. First, although all but one state provided some supporting documentation, only 38% provided complete documentation of the treatments covered. This lack of confirmatory documentation increases the likelihood of reporting errors. Second, these results might differ from other ratings of coverage because of differing interpretations of unwritten policies.

Because smoking prevalence among Medicaid recipients is approximately 39% greater than the prevalence in the overall U.S. adult population (*2*), Medicaid recipients are disproportionately affected by tobacco-related diseases and disabilities. Substantial measures to improve coverage will be needed to achieve the national health objective for 2010 of reducing the prevalence of smoking to 12% among persons aged ≥18 years (objective 27-1a) (*4*). To help states implement evidence-based tobacco-dependence treatment and to improve Medicaid service contracts, CDC collaborated with George Washington University (Washington, DC) to develop sample specifications for the purchase of tobacco-use prevention and cessation services (information available at http://www.gwumc.edu/sphhs/healthpolicy/chsrp/newsps/tobacco). As a result, Medicaid programs are encouraged to cover all PHS-recommended treatments, cover two courses of treatment per year, eliminate or minimize copayments, and promote tobacco-dependence coverage benefits to Medicaid recipients to reduce the adverse health effects in this population.

References

1. Kaiser Family Foundation's State Health Facts Online: Compiled by the Health Management Associates from state Medicaid enrollment reports, for the Kaiser Commission on Medicaid and the Uninsured. Available at http://www.statehealthfacts.kff.org.
2. Lethbridge-Cejku M, Rose D, Vickerie J. Summary health statistics for U.S. adults: National Health Interview Survey, 2004. National Center for Health Statistics. Vital Health Stat 10;2006.
3. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence: clinical practice guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2000.
4. US 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: US Department of Health and Human Services, 2000.
5. Schauffler HH, Barker DC, Orleans CT. Medicaid coverage for tobacco-dependence treatments. Health Aff 2001;20:298–303.
6. Halpin HA, Bellows NM, McMenamin SB. Medicaid coverage for tobacco-dependence treatments. Health Aff 2006:25:550–6.
7. CDC. State Medicaid coverage for tobacco-dependence treatments—United States, 1994–2002. MMWR 2004;53:54–7.
8. Hopkins DP, Briss PA, Ricard CJ, et al. Reviews of evidence regarding interventions to reduce tobacco use and exposure to environmental tobacco smoke. Am J Prev Med 2001;20(Suppl 2):S16–66.
9. Maciosek MV, Coffield AB, Edwards NM, et al. Priorities among effective clinical preventive services: results of a systematic review and analysis. Am J Prev Med 2006;31:52–61.
10. Miller LS, Zhang X, Novotny T, et al. State estimates of Medicaid expenditures attributable to cigarette smoking, fiscal year 1993. Public Health Rep 1998;113:140–51.

Outbreak of Polio in Adults — Namibia, 2006

After 10 years with no detected wild poliovirus (WPV) transmission in Namibia, an outbreak of poliomyelitis cases occurred in 2006. The outbreak was traced to importation from neighboring Angola of WPV type 1 (WPV1) that originated in India. As of October 2, 2006, a total of 19 cases of polio, with paralysis onset between early May and June 26, had been confirmed by isolation of WPV1 from stool specimens, primarily from young adult males; six of the patients died. This report describes outbreak investigation and response activities and provides an update on routine and supplemental immunization activities (SIAs)* and acute flaccid paralysis (AFP) surveillance in Namibia.

Outbreak Investigation and Response

On May 8, 2006, a man aged 39 years from the Hardap region, approximately 400 km southeast of the capital city of Windhoek, was admitted to a Windhoek hospital after onset of AFP 2 days earlier. On June 5, the Regional Reference Poliovirus Laboratory at the National Institute of Communicable Diseases in South Africa reported isolation of WPV1 in the patient's stool specimens. AFP surveillance was intensified, and as of October 2, 2006, a total of 306 AFP cases had been reported for the year (Figure 1).

Of the 306 AFP cases, 19 cases were confirmed as polio through WPV1 isolation, with the most recent onset of paralysis occurring on June 26. Of the other 287 AFP cases, 201 were classified as nonpolio AFP, and the National Polio Expert Committee classified seven cases as polio compatible. Another 66 AFP cases, with inadequate† stool specimens, all virus-negative, are pending classification, including some that subsequently might be classified as polio compatible; 13 additional cases are pending laboratory results and subsequent classification. In addition to the single case reported from the Hardap region, WPV-confirmed cases were reported from two densely populated areas: 1) informal settlements (i.e., areas with temporary substandard housing, poor sanitation, and crowding) in the Katutura vicinity of Windhoek in the Khomas region (14 WPV cases), and 2) three adjacent regions bordering Angola: Ohangwena and Omusati, with one case each, and Oshana, with two cases (Figure 2).

Compared with patients with nonpolio AFP, the WPV patients more often reported having contact with persons from Angola during the 3 months preceding paralysis onset (Fisher's exact test, p = 0.007). All WPV-confirmed cases occurred in persons aged >14 years (range: 14–51 years), with 14 (74%) of 19 confirmed cases in persons aged 15–29 years. Seventeen (89%) of the 19 patients were male. Six patients with confirmed WPV died (case-fatality ratio [CFR]: 32%); four of the six who died had respiratory symptoms requiring ventilator support, and at least one other patient developed respiratory difficulty shortly before death.

In response to the outbreak of WPV cases, the Namibia Ministry of Health and Social Services (MoHSS) activated the National Health Emergency Management Committee to coordinate activities. Three nationwide SIAs were held during June 21–23, July 18–20, and August 22–24, 2006, using both house-to-house and fixed-post vaccine delivery strategies. Because most patients were adults, the first two SIAs targeted the entire population of Namibia (i.e., adults and children of all ages); the third round targeted only children aged <5 years. Monovalent oral poliovirus vaccine type 1 (mOPV1) was administered during the first two SIAs; trivalent OPV (tOPV) was administered during the third SIA, along with measles vaccine and distribution of vitamin A supplements.

Based on the number of vaccine doses administered and current population estimates, close to 100% of the target populations were reached during all three SIAs. Postcampaign monitoring conducted in nine of the 13 regions determined vaccination coverage of >95%. The second and third SIAs were conducted after onset of the last reported confirmed case of polio, which occurred on June 26, 5 days after the first nationwide SIA (Figure 1).

Previous Outbreaks in Namibia

Namibia reported no polio cases from 1990 until May 1993, when an outbreak of 53 WPV1 cases (27 virologically confirmed and 26 clinically compatible) occurred. Seventy-nine percent of patients in the 1993 outbreak were aged <5 years. A smaller WPV1 outbreak with 27 cases occurred in the northern regions of Namibia during 1994–1995 (*1*). Both outbreaks were linked by genetic sequencing to WPV imported from Angola. The most recent reported WPV case before 2006 occurred in September 1995.

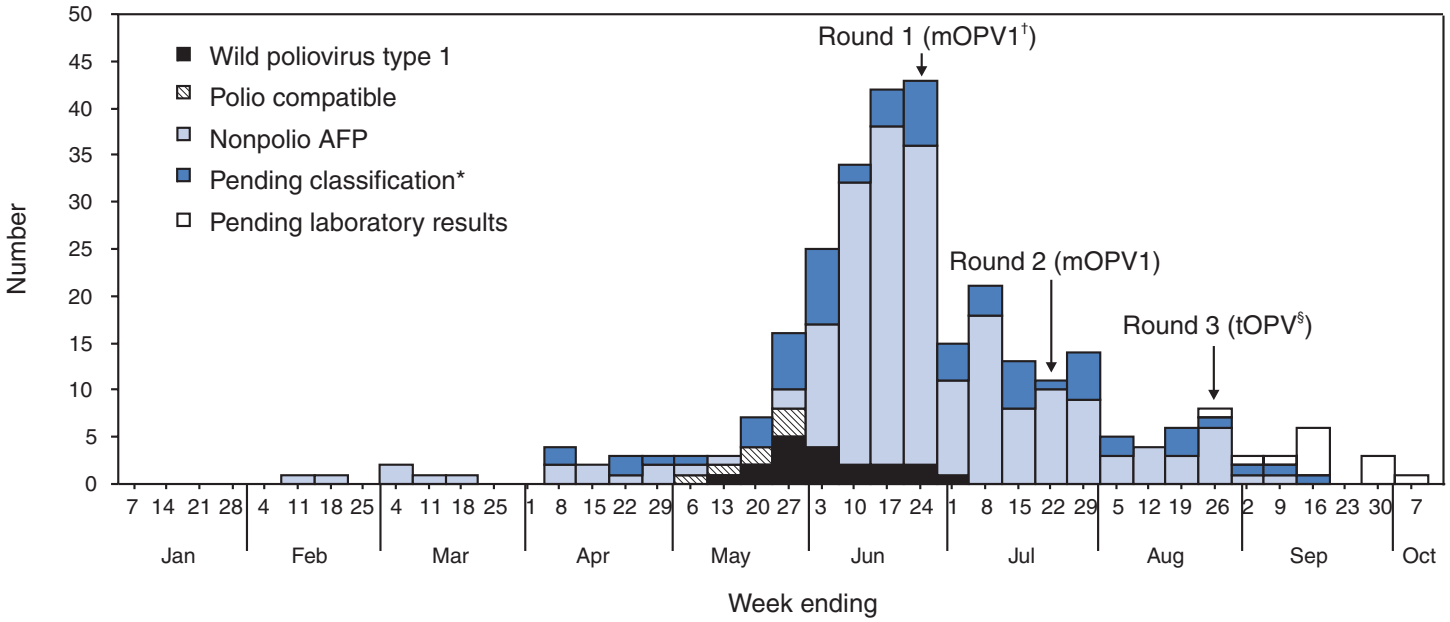
Immunization Activities

The Namibian Expanded Program on Immunization (EPI) was established in June 1990, the year Namibia gained independence from South Africa. Public health services,

* Nationwide mass campaigns during a short period in which 2 doses of oral poliovirus vaccine are administered to all persons in the target age group, regardless of vaccination history, with an interval of 4–6 weeks between doses.

† AFP cases with inadequate stool specimens are those that lack the following: two stool specimens collected at least 24 hours apart within 14 days of paralysis onset and shipped to the laboratory in good condition. Adequate stool specimens meet these criteria.

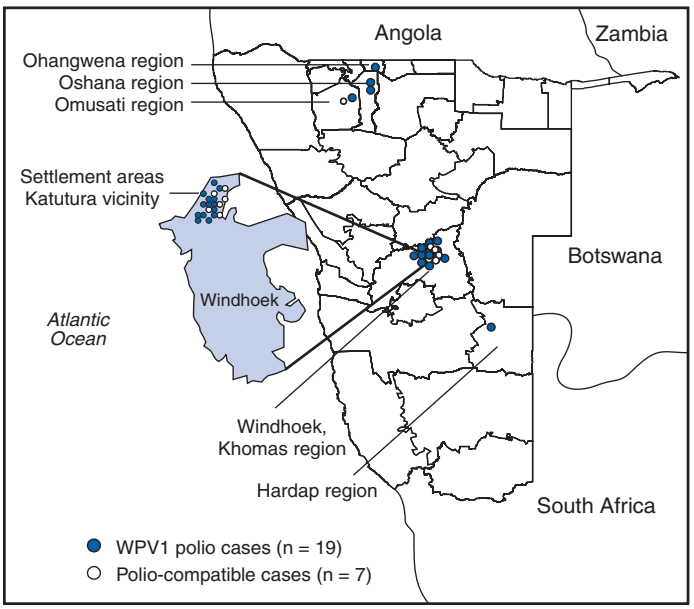
FIGURE 1. Acute flaccid paralysis (AFP) cases (N = 306), by week of onset — Namibia, January 1–October 2, 2006



* Pending classification by the National Polio Expert Committee. Cases pending classification include those with no stool specimens or inadequate stool specimens and might be classified as polio-compatible or nonpolio AFP after committee review. No poliovirus was isolated from inadequate stool specimens.
† Monovalent oral poliovirus vaccine type 1.
§ Trivalent oral poliovirus vaccine.

including immunization, had been severely disrupted by conflict during 1966–1989. Immunization services improved after 1990, with survey estimates for infant coverage with 3 doses of oral poliovirus vaccine (OPV3), increasing from 37% in 1989 to 76% in 2000 (Table). However, during 1989–2000, coverage estimates varied among regions (*2,7,8*); for example, OPV3 coverage varied by region from 48% to 78% in 1992 (*7*). Since 2000, annual national estimates of coverage with OPV3 have ranged from 64% to 83% (Table), with continued variation among regions. OPV3 coverage exceeded 80% in 20 (61%) of 33 districts in 2004 and 10 (30%) of 33 districts in 2005. In addition to routine immunization, annual SIAs have been held since 1996, targeting children aged <5 years.

FIGURE 2. Wild poliovirus type 1 (WPV1) cases and polio-compatible cases — Namibia, May 1–October 2, 2006



AFP Surveillance

Although most AFP cases are nonpolio (i.e., resulting from causes other than poliomyelitis), meeting goals for AFP surveillance helps to ensure that the surveillance system is sensitive enough to detect poliomyelitis cases should they occur. AFP surveillance is evaluated by two key indicators: sensitivity of reporting (target: nonpolio AFP rate of ≥1.0 case per 100,000 children aged <15 years[§]) and completeness of specimen collection (target: two adequate stool specimens collected from ≥80% of all AFP cases). During 2001–2005, national nonpolio AFP rates in Namibia exceeded ≥1.0 case per 100,000 persons aged <15 years (2.6 in 2004 and 2.0 in 2005). With the increase in AFP reporting during the outbreak, AFP rates in 2006 have exceeded 2.0 cases in all regions. Nationally,

§ In 2006, this indicator was changed to two cases per 100,000 children aged <15 years.

TABLE. Estimated vaccination coverage with 3 doses of live, attenuated oral poliovirus vaccine among children aged ≤12 months, by source of estimate — Namibia 1989–2006

Source	1989	1990	1991	1992	1993–1999	2000	2001	2002	2003	2004	2005
World Health Organization (WHO)/UNICEF* (%)	40	54	70	87	72–79	80	64	78	83	81	81
Demographic and Health Survey† (%)	37	38	55	65	—	76	—	—	—	—	—

* WHO/UNICEF estimate, based on country reports to WHO or UNICEF.
† Namibia Demographic and Health Survey (conducted in 1992 and 2000). Coverage estimates for 1989–1991 are based on data collected during the 1992 survey, shifted by year to match birth cohorts (*7,8*).

adequate stool specimens were obtained from >80% of persons with AFP during 2003–2005. However, adequate stool collection during January 1–October 2, 2006, was 67%, and exceeded 80% in only four of Namibia's 13 regions.

Genetic sequencing determined that the WPV1 in the Namibia outbreak belongs to the same cluster as the virus detected in 2005 in both Angola and the Democratic Republic of Congo, which had been imported into Angola from India. Sequencing indicated that this outbreak virus had been circulating for up to 2 years in the southwest subregion of Africa before detection in 2005. Consistent with recent undetected circulation and ongoing surveillance gaps, Angola reported 10 WPV1 cases in 2005 but none in 2006 until reporting a case with onset June 27, 2006. The genetic sequence relationships among the Namibian isolates indicate that spread of the virus occurred from a single-source importation.

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Editorial Note: This 2006 outbreak underscores the ongoing threat of WPV importations into polio-free areas, the ability of WPV to spread to susceptible populations of any age, and the need for polio-free countries to maintain high levels of preparedness for the timely detection of and response to importations. In this outbreak, virus importation from Angola was indicated by sequencing data, the frequency of cross-border contacts between population groups from Namibia and Angola, and the higher frequency of contact with Angolan residents by patients with confirmed WPV infection compared with patients with nonpolio AFP.

The Namibia outbreak illustrates that populations of any age with low immunity against poliovirus are at risk. This outbreak primarily affected young adults born before 1990, an age group consisting of persons who either had not been vaccinated for polio or had been vaccinated incompletely. For the most part, this group also would not have been covered by EPI SIAs conducted four times a year during 1990–1995 and targeted to children aged <5 years. Increasing vaccination coverage among children aged <5 years in the early 1990s would have reduced transmission of WPV, decreasing opportunities for older, unvaccinated persons to acquire natural immunity, a factor possibly contributing to the high attack rate in older age groups. Previous polio outbreaks among adults included a large outbreak (138 paralytic cases, 69 confirmed WPV1 cases) in Albania in 1996, with an attack rate of 10 per 100,000 persons among adults aged 19–25 years who had been vaccinated with OPV that might have been stored without refrigeration for prolonged periods (*3*). Outbreaks affecting adults also have occurred among religious groups with low vaccination acceptance (*4*).

The CFR was 32% in this outbreak involving young adults. High CFRs in young adults during polio outbreaks have been reported previously. In an outbreak in Cape Verde in 2000, the CFR was 57% among persons aged >15 years (*5*). In the 1996 outbreak in Albania, the CFR was highest (18%) among persons aged 19–25 years (*3*). In the 2006 outbreak in Namibia, at least five of the six patients who died had respiratory symptoms, and four required ventilator support, suggesting that bulbar paralysis might have contributed to the high CFR.

During 2004 and 2005, AFP surveillance systems in Namibia and Angola, at the national level, surpassed the key indicators for sensitivity of reporting and completeness of specimen collection. However, WPV circulation in the southwest African subregion escaped detection for approximately 2 years, suggesting considerable AFP surveillance quality gaps at the subnational level. During the 2006 outbreak, only four of Namibia's 13 regions have met the 80% stool adequacy standard. Surveillance training targeting district and regional MoHSS staff members was held in July, August, and September 2006. Maintaining sensitive surveillance and stool adequacy levels in Namibia and surrounding countries is critical to rapid detection of WPV virus circulation.

WHO's Advisory Committee on Polio Eradication recommends that any polio-free country that detects imported WPV conduct at least three large-scale, house-to-house SIAs using type-specific mOPV, initiating the first within 28 days of confirmation, and continuing with at least two additional SIAs after the last virus is detected (*6*). Namibia followed these recommendations, conducting the first SIA round, which targeted the entire population, within 3 weeks of laboratory confirmation of the first WPV-confirmed case and 46 days after the first onset of paralysis. The last known WPV-confirmed case occurred less than a week after the first SIA, with no WPV-confirmed cases reported since then, although the 66 cases with inadequate stool specimen collection pending review and classification by the National Polio Expert Committee are of concern. Additional SIA rounds in Namibia will be necessary if more WPV cases are detected.

The risk for continuing WPV spread from Angola south to Namibia or north to the Democratic Republic of Congo remains high until circulation in Angola is interrupted. SIAs in Angola are planned for November 16–18, 2006. The increase in the number of WPV cases reported from endemic countries (particularly Nigeria and India) in 2006 underscores the continuing threat of importations from polio-endemic countries and the necessity for full implementation of outbreak response recommendations (*6*) by all polio-free countries until poliovirus transmission is interrupted globally.

Acknowledgment

The findings in this report were based, in part, on data provided by the Namibia Ministry of Health and Social Services.

References

1. Biellik RJ, Allies T, Woodfill CJ, Lobanov A. Polio outbreaks in Namibia, 1993–1995: lessons learned. J Infect Dis 1997;175(Suppl 1):S30–6.
2. van Niekerk AB, Vries JB, Baard J, Schoub BD, Chezzi C, Blackburn NK. Outbreak of paralytic poliomyelitis in Namibia. Lancet 1994;344:661–4.
3. Prevots DR, Ciofi degli Atti ML, Sallabanda A, et al. Outbreak of paralytic poliomyelitis in Albania, 1996: high attack rate among adults and apparent interruption of transmission following nationwide mass vaccination. Clin Infect Dis 1998;26:419–25.
4. Expanded programme on immunization: poliomyelitis outbreak—Netherlands. Wkly Epidemiol Rec 1992;67:341–4.
5. CDC. Outbreak of poliomyelitis—Cape Verde, 2000. MMWR 2000;49:1070.
6. World Health Organization. Advisory committee on polio eradication—standing recommendations for responding to circulating polioviruses in polio-free areas. Wkly Epidemiol Rec 2005;80:330–1.
7. Katjiuanjo P, Titus S, Zauana M, Boerma T. Namibia demographic and health survey, 1992. Windhoek, Namibia, and Calverton, MD: Ministry of Health and Social Services and Macro International; 1993.
8. Ministry of Health and Social Services. Namibia demographic and health survey 2000. Windhoek, Namibia: Ministry of Health and Social Services; 2003.

Diagnosed Diabetes Among American Indians and Alaska Natives Aged <35 Years — United States, 1994–2004

Diabetes disproportionately affects American Indians/Alaska Natives (AI/ANs) (*1,2*), and the prevalence of diabetes is increasing among young persons in certain AI/AN populations (*3*). To examine trends in the prevalence of diagnosed diabetes among AI/ANs aged <35 years, CDC analyzed patient data collected by the Indian Health Service (IHS) during 1994–2004. This report summarizes the results of that analysis, which indicated that the age-adjusted prevalence of diagnosed diabetes increased from 8.5 to 17.1 per 1,000 population among AI/ANs aged <35 years who use IHS health-care services. Because young persons with diabetes have more years of disease and greater risk for costly and disabling complications early in life (*4*), diabetes prevention programs targeting younger age groups have become increasingly important in AI/AN communities.

IHS provides health-care services at its facilities and through tribal and urban Indian health programs; IHS also purchases services through contractual agreements with private providers (*5*). Approximately 60% of the nearly 3 million AI/ANs residing in the United States live in IHS health-care delivery areas (*5*). Diabetes cases among AI/ANs aged <35 years were identified using *International Classification of Diseases, Ninth Revision, Clinical Modification* diagnostic codes 250.0–250.9 from the IHS computerized system for ambulatory patient care for 1994–2004. The ambulatory patient-care database includes unduplicated case reports from patients who visited IHS service units one or more times during each of the years studied. Ambulatory patient-care data were analyzed from 118 of 158 service units; 40 service units (serving approximately 6% of the IHS user population) were excluded because their reported data were incomplete. Prevalence was calculated using the AI/AN population aged <35 years that received IHS health-care services at least once during the preceding 3 years. These overall population data and the number of persons aged <35 years identified in the IHS database as persons with diagnosed diabetes were used to estimate the age-specific prevalence of diagnosed diabetes among AI/ANs in four age groups: <15, 15–19, 20–24, and 25–34 years. Prevalence was age adjusted by the direct method, on the basis of the 2000 U.S. standard population, and average annual percentage changes (APCs) were modeled using regression analysis (*6*).

Results of the analysis indicated that the number of AI/ANs aged <35 years with diabetes diagnosed through IHS health-care services more than doubled from 6,001 in 1994 to 12,313 in 2004. During 1994–2004, prevalence of diagnosed diabetes among AI/ANs aged <35 years increased from an age-adjusted 8.5% per 1,000 to 17.1% per 1,000, increasing by an average of 7.7% per year (Table). Prevalence of diagnosed diabetes increased with age and, in 2004, ranged from 2.2 per 1,000 population among AI/ANs aged <15 years to 46.8 per 1,000 population among those aged 25–34 years. In 2004, the age-adjusted prevalence of diagnosed diabetes was 20.2 per 1,000 among AI/AN females and 13.7 among males (Table).

During 1994–2004, prevalence of diagnosed diabetes was greater among females than males in all age groups; prevalence also increased steadily for both sexes and in all age groups, with the exception of males aged 25–34 years (Figure). Among males in this age group, prevalence increased significantly ($p<0.05$) by an average of 5.6% per year during 1994–1997 and by 15.0% per year during 1997–2000, but did not change significantly during 2000–2004 (Table). Among all age groups, females aged 25–34 years had the greatest APC (9.1%).

TABLE. Prevalence* and annual percentage change (APC) of diagnosed diabetes among American Indians and Alaska Natives aged <35 years, by sex and age group — United States, 1994–2004

Age group (yrs)	Rate		Trend	
	1994	2004	APC	(95% CI†)
Both sexes				
<15	1.3	2.2	4.7	(2.1–7.4)
15–19	4.4	7.4	5.9	(4.5–7.3)
20–24	8.7	15.3	5.5	(4.0–7.0)
25–34	22.1	46.8	8.5	(6.9–10.1)
<35	7.5	14.9	7.4	(6.1–8.7)
<35§	8.5	17.1	7.7	(6.2–9.2)
Female				
<15	1.4	2.5	4.9	(2.4–7.4)
15–19	5.6	9.2	5.5	(3.8–7.4)
20–24	9.6	19.4	6.7	(4.8–8.5)
25–34	23.6	54.5	9.1	(7.5–10.8)
<35	8.5	18.2	7.9	(6.5–9.4)
<35§	9.3	20.2	8.3	(6.7–9.9)
Male				
<15	1.2	1.9	4.5	(1.6–7.5)
15–19	3.2	5.5	6.5	(5.2–7.8)
20–24	7.6	10.7	3.7	(2.6–4.8)
25–34	20.4	38.1	7.6¶	(5.8–9.5)
<35	6.5	11.4	6.6	(5.3–7.9)
<35§	7.7	13.7	6.9**	(5.3–8.5)

* Per 1,000 population in age group.
† Confidence interval.
§ Age adjusted to the 2000 U.S. standard population.
¶ APCs varied widely for intervals during the period: 5.6% ($p<0.05$) during 1994–1997, 15.0% ($p<0.05$) during 1997–2000, and 1.2% ($p = 0.19$) during 2000–2004.
** APCs varied widely for intervals during the period: 4.9% ($p<0.05$) during 1994–1997, 13.3% ($p<0.05$) during 1997–2000, and 1.5% ($p = 0.10$) during 2000–2004.

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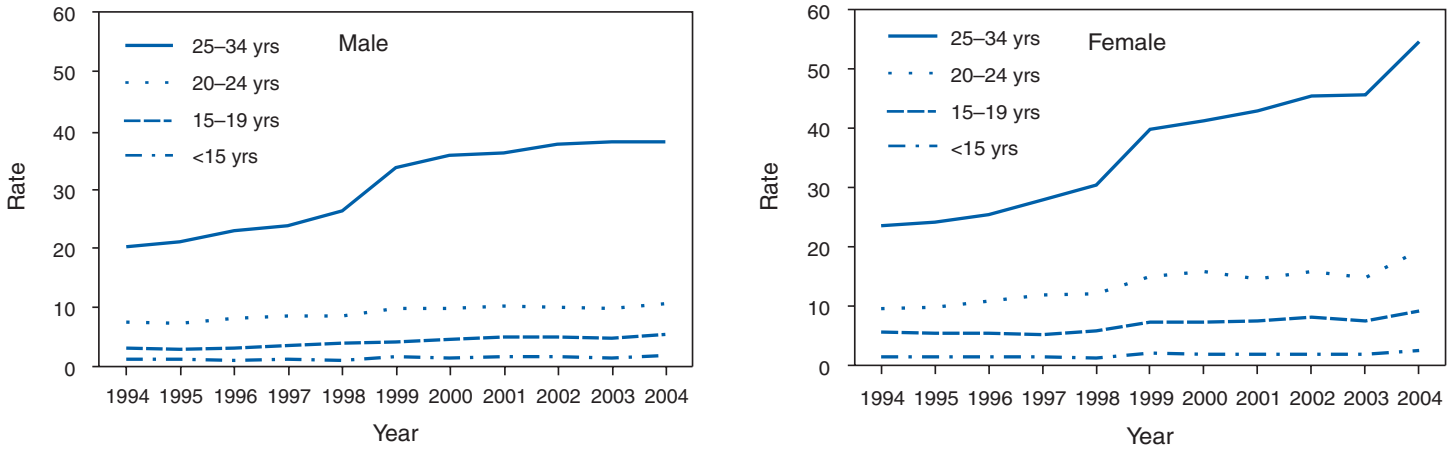
Editorial Note: The findings in this report indicate that, during 1994–2004, the prevalence of diagnosed diabetes doubled among AI/ANs aged <35 years in the IHS health-care delivery system. This increase in diagnosed diabetes might be the result of increased incidence of diabetes (*3*), increased screening for diabetes, or a combination of both. Screening for diabetes increased in AI/AN communities after implementation in 1997 of the Special Diabetes Program for Indians (SDPI) (*7*). In partnership and consultation with tribal leadership, IHS provided SDPI grants to create and enhance approximately 400 new diabetes prevention and treatment programs in AI/AN communities in the 35 states that contain the 12 IHS administrative areas.

If the increase in diagnosed diabetes described in this report represents an increase in the actual total prevalence (i.e., diagnosed plus undiagnosed) of diabetes among AI/ANs aged <35 years, that would be of particular concern. Earlier onset of diabetes increases the lifetime duration of disease and thus the risk for costly and disabling complications (*4*). The large increase among young females also is of concern because diabetes is a major cause of congenital anomalies, malformations, and perinatal death in the offspring of young women with diabetes (*4*). Furthermore, the children of mothers with diabetes during pregnancy might be at increased risk for having diabetes themselves (*3*). The greater prevalence of diagnosed diabetes among AI/AN females might have resulted from a greater number of health-care visits (e.g., for prenatal care) compared with males (*5*). Increasing rates of diabetes detected during pregnancy screening (*8*) might explain why the greatest APC was among females aged 25–34 years. Why the prevalence of diagnosed diabetes among males aged 25–34 years remained level during 2000–2004 is unknown.

The findings in this study are subject to at least five limitations. First, the data underestimate the actual prevalence of diabetes because they do not include information on persons with undiagnosed diabetes. Second, outpatient visits for diabetes screening might have been miscoded as diabetes visits, resulting in overestimates of the prevalence of diagnosed diabetes if the screening results were negative. Third, lack of clinical data did not enable distinguishing between type 1 and type 2 diabetes. However, previous studies have determined that, among AI/ANs, diabetes is predominantly type 2 (*3,4*). Fourth, approximately 6% of persons using IHS health-care

FIGURE. Prevalence* of diagnosed diabetes among American Indians and Alaska Natives aged <35 years, by sex and age group — United States, 1994–2004



* Per 1,000 population in age group.

services were excluded from this analysis because of incomplete data. Finally, data on diabetes prevalence were not collected for the 40% of the AI/AN population who do not use IHS or tribally operated health-care facilities (*5*). However, despite these limitations, previous research has indicated that IHS data are sufficiently consistent over time to estimate trends (*2*).

Randomized controlled trials such as the Diabetes Prevention Program (DPP) have determined that lifestyle interventions to reduce weight and increase physical activity can prevent or delay diabetes among adults at risk (*9*). In 2004, as part of the SDPI, IHS awarded 36 diabetes-prevention demonstration projects to translate DPP findings at the local level. In 2006, in collaboration with IHS, the American Association of Indian Physicians, and other partners, the National Diabetes Education Program (NDEP) distributed the "Move It! And Reduce Your Risk for Diabetes" kit to schools to help increase physical activity among young AI/ANs (available at http://www.ndep.nih.gov/diabetes/aian/moveit.htm). NDEP is a program sponsored by CDC and the National Institutes of Health to promote diabetes prevention and also control strategies for improving the treatment and outcomes of persons with diabetes.

In collaboration with IHS, CDC established the Native Diabetes Wellness Program (formerly the National Diabetes Prevention Center) to identify and share culturally relevant and appropriate interventions. One activity of this program was development and dissemination of The Eagle Books series for children, which focuses on physical activity, eating healthy foods, and learning about health and diabetes prevention (available by telephone, 800-CDC-INFO, or e-mail, cdc-info@cdc.gov). Information regarding a related CDC exhibit is available at http://www.cdc.gov/gcc/exhibit/exhibitions_changing.htm.

References

1. CDC. Diabetes prevalence among American Indians and Alaska Natives and the overall population—United States, 1994–2002. MMWR 2003;52:702–4.
2. Valway S, Freeman W, Kaufman S, Welty T, Helgerson SD, Gohdes D. Prevalence of diagnosed diabetes among American Indians and Alaska Natives, 1987. Estimates from a national outpatient database. Diabetes Care 1993;16:271–6.
3. Dabelea D, Hanson RL, Bennett PH, Roumain J, Knowler WC, Pettitt DJ. Increasing prevalence of type II diabetes in American Indian children. Diabetologia 1998;41:904–10.
4. Harris MI. Chapter 1: summary. In: Harris MI, Cowie CC, Stern MP, Boyko EJ, Reiber GE, Bennett PH, eds. Diabetes in America. 2nd ed. Washington, DC: US Department of Health and Human Services, Public Health Service, National Institutes of Health (DHHS publication no. NIH 95-1468); 1995:1–13.
5. Indian Health Service. Trends in Indian health, 2000–2001. Rockville, MD: US Department of Health and Human Services, 2000:3–9. Available at: http://www.ihs.gov/nonmedicalprograms/IHS_stats/trends00.asp.
6. Kim HJ, Fay MP, Feuer EJ, Midthune DN. Permutation tests for joinpoint regression with application to cancer rates. Stat Med 2000;19:335–51.
7. Indian Health Service. Special diabetes program for Indians: interim report to Congress. Available at http://www.ihs.gov/medicalprograms/diabetes/resources/r_rtc2004index.asp.
8. Moum KR, Holzman GS, Harwell TS, et al. Increasing rate of diabetes in pregnancy among American Indian and white mothers in Montana and North Dakota, 1989–2000. Matern Child Health J 2004;8:71–6.
9. Knowler WC, Barrett-Connor E, Fowler SE, Diabetes Prevention Program Research Group, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med 2002;346:393–403.

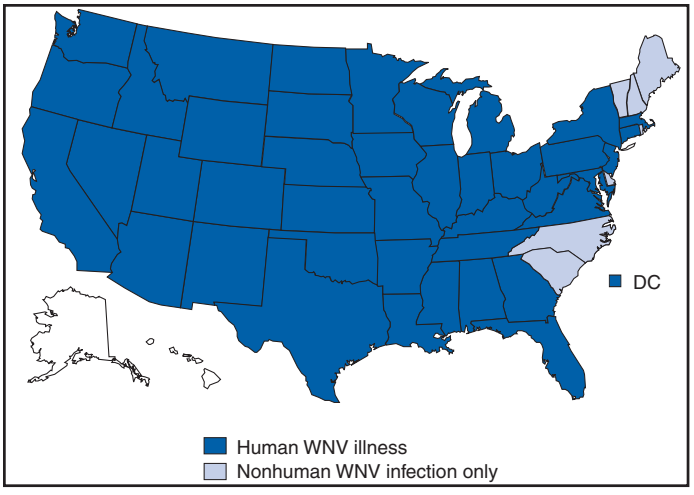
West Nile Virus Activity — United States, January 1–November 7, 2006

This report summarizes West Nile virus (WNV) surveillance data reported to CDC through ArboNET as of 3 a.m. Mountain Standard Time, November 7, 2006. A total of 41 states and the District of Columbia had reported 3,830 cases of human WNV illness to CDC (Figure, Table).

A total of 2,093 (55%) cases for which such data were available occurred in males; median age of patients was 51 years (range: 3 months–99 years). Dates of illness onset ranged from January 6 to October 22; a total of 119 cases were fatal.

A total of 306 presumptive West Nile viremic blood donors (PVDs) have been reported to ArboNET during 2006. Of these, 42 were reported from Nebraska; 33 from Texas; 26 from Colorado; 24 from Utah; 20 from Louisiana; 15 from California; 13 each from Arizona and Oklahoma; 12 from South Dakota; 11 each from Kansas and North Dakota; 10 each from Iowa, Mississippi, and Wisconsin; seven each from Indiana and Ohio; six from Idaho; five each from Minnesota and Virginia; four each from Kentucky, Missouri, and Montana; three each from Illinois and Nevada; two from Michigan; and one each from Arkansas, Maryland, New York, Oregon, Pennsylvania, and Wyoming. Of the 306 PVDs, three persons (median age: 73 years [range: 26–74 years]) subsequently had neuroinvasive illness, two persons (median age: 45 years [range: 41–49 years]) subsequently had other illness, and 65 persons (median age: 47 years [range: 17–71 years]) subsequently had West Nile fever.

FIGURE. Areas reporting West Nile virus (WNV) activity — United States, 2006*



* As of November 7, 2006.

TABLE. Number of human cases of West Nile virus (WNV) illness, by state — United States, 2006*

State	Neuroinvasive disease†	West Nile fever§	Other clinical/ unspecified¶	Total reported to CDC**	Deaths
Alabama	7	0	0	**7**	0
Arizona	45	53	33	**131**	6
Arkansas	21	5	0	**26**	0
California	76	179	11	**266**	6
Colorado	60	250	0	**310**	4
Connecticut	7	2	0	**9**	1
District of Columbia	0	1	0	**1**	0
Florida	3	0	0	**3**	0
Georgia	2	5	1	**8**	1
Idaho	108	710	6	**824**	11
Illinois	114	70	24	**208**	9
Indiana	26	7	42	**75**	3
Iowa	21	12	1	**34**	0
Kansas	16	12	0	**28**	3
Kentucky	5	1	0	**6**	1
Louisiana	87	77	0	**164**	0
Maryland	7	1	2	**10**	0
Massachusetts	2	1	0	**3**	0
Michigan	41	2	5	**48**	4
Minnesota	30	35	0	**65**	3
Mississippi	81	88	0	**169**	10
Missouri	47	12	1	**60**	3
Montana	12	21	1	**34**	0
Nebraska	41	176	0	**217**	1
Nevada	34	75	14	**123**	1
New Jersey	2	2	1	**5**	0
New Mexico	3	5	0	**8**	0
New York	8	4	0	**12**	2
North Dakota	20	117	0	**137**	1
Ohio	35	11	0	**46**	4
Oklahoma	26	17	3	**46**	5
Oregon	4	42	8	**54**	0
Pennsylvania	8	1	0	**9**	2
South Dakota	38	75	0	**113**	3
Tennessee	15	2	0	**17**	1
Texas	205	100	0	**305**	26
Utah	55	101	0	**156**	5
Virginia	0	0	4	**4**	0
Washington	0	3	0	**3**	0
West Virginia	1	0	0	**1**	0
Wisconsin	11	9	0	**20**	1
Wyoming	15	40	10	**65**	2
Total	**1,339**	**2,324**	**167**	**3,830**	**119**

* As of November 7, 2006.
† Cases with neurologic manifestations (i.e., West Nile meningitis, West Nile encephalitis, and West Nile myelitis).
§ Cases with no evidence of neuroinvasion.
¶ Illnesses for which sufficient clinical information was not provided.
** Total number of human cases of WNV illness reported to ArboNET by state and local health departments.

In addition, 3,214 dead corvids and 745 other dead birds with WNV infection have been reported in 42 states and New York City during 2006. WNV infections have been reported in horses in 34 states, in one squirrel in Kansas, and in two unidentified animal species in North Carolina and Wyoming.

WNV seroconversions have been reported in 846 sentinel chicken flocks in 12 states (Arizona, Arkansas, California, Florida, Iowa, Montana, Nevada, North Carolina, North Dakota, Pennsylvania, Utah, and Virginia). A total of 10,759 WNV-positive mosquito pools have been reported from 38 states, the District of Columbia, and New York City.

Additional information regarding national WNV activity is available from CDC at http://www.cdc.gov/ncidod/dvbid/westnile/index.htm and at http://westnilemaps.usgs.gov.

Notice to Readers

Public Health Informatics Fellowship Application Deadline

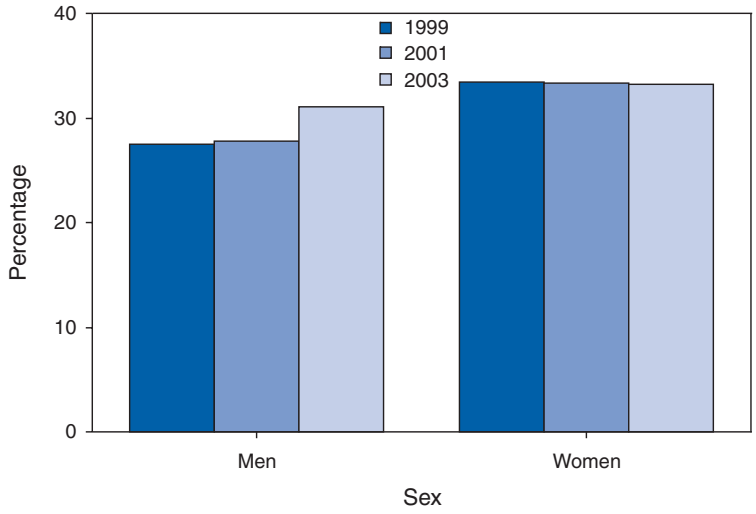
CDC offers a 2-year postgraduate fellowship in public health informatics, the systematic application of information technology to public health practice, research, and learning. Fellows receive training in both informatics and public health, are assigned to teams involved in research and development of CDC information systems, and are given the opportunity to lead one or more major projects during their fellowships.

Deadline to apply for the fellowship period beginning July 2007 is December 15, 2006. Applications are available at https://www.orau.gov/cdc/phip/login.asp. Additional information regarding the Public Health Informatics Fellowship Program is available by telephone, 404-498-6129, or e-mail, phitpepo@cdc.gov and bmcdonnell@cdc.gov.

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Prevalence of Obesity* Among Adults Aged ≥20 Years, by Sex — National Health and Nutrition Examination Survey (NHANES), United States, 1999–2000 Through 2003–2004



* Defined as having a body mass index (weight [kg]/height [m^2]) ≥30.

From 1999–2000 through 2003–2004, the prevalence of obesity among men increased significantly from 27.5% to 31.1%. During the same period, no significant change occurred among women, 33.2% of whom were obese in 2003–2004. Additional information regarding NHANES is available at http://www.cdc.gov/nchs/nhanes.htm.

SOURCE: Ogden CL, Carroll MD, Curtin LR, McDowell MA, Tabak CJ, Flegal KM. Prevalence of overweight and obesity in the United States, 1999–2004. JAMA 2006;295:1549–55.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending November 4, 2006 (44th Week)*

Disease	Current week	Cum 2006	5-year weekly average†	Total cases reported for previous years 2005	2004	2003	2002	2001	States reporting cases during current week (No.)
Anthrax	—	1	1	—	—	—	2	23	
Botulism:									
foodborne	—	8	0	19	16	20	28	39	
infant	—	69	1	90	87	76	69	97	
other (wound & unspecified)	1	46	1	33	30	33	21	19	CA (1)
Brucellosis	—	90	3	122	114	104	125	136	
Chancroid	2	26	1	17	30	54	67	38	NC (2)
Cholera	—	6	0	8	5	2	2	3	
Cyclosporiasis§	—	104	1	734	171	75	156	147	
Diphtheria	—	—	0	—	—	1	1	2	
Domestic arboviral diseases§,¶:									
California serogroup	—	45	2	80	112	108	164	128	
eastern equine	—	6	0	21	6	14	10	9	
Powassan	—	1	—	1	1	—	1	N	
St. Louis	—	5	0	13	12	41	28	79	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	6	319	8	790	537	362	511	261	NY (6)
human monocytic	3	321	6	522	338	321	216	142	OH (1), GA (1), AR (1)
human (other & unspecified)	2	137	1	122	59	44	23	6	MO (1), TN (1)
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	9	0	9	19	32	34	—	
nonserotype b	—	70	3	135	135	117	144	—	
unknown serotype	—	171	2	217	177	227	153	—	
Hansen disease§	1	62	2	88	105	95	96	79	CA (1)
Hantavirus pulmonary syndrome§	—	26	0	29	24	26	19	8	
Hemolytic uremic syndrome, postdiarrheal§	3	214	4	221	200	178	216	202	FL (2), CA (1)
Hepatitis C viral, acute	5	637	29	771	713	1,102	1,835	3,976	NY (1), MO (1), FL (1), TN (1), OK (1)
HIV infection, pediatric (age <13 yrs)§,††	—	52	7	380	436	504	420	543	
Influenza-associated pediatric mortality§,§§	—	40	0	45	—	N	N	N	
Listeriosis	10	601	16	892	753	696	665	613	NY (1), IN (1), MD (1), NC (1), FL (1), CA (5)
Measles	—¶¶	44	1	66	37	56	44	116	
Meningococcal disease, invasive***:									
A, C, Y, & W-135	2	184	3	297	—	—	—	—	WV (1), FL (1)
serogroup B	2	112	2	157	—	—	—	—	MO (1), WA (1)
other serogroup	—	15	1	27	—	—	—	—	
Mumps	15	5,964	6	314	258	231	270	266	NY (2), KS (3), NC (7), FL (1), AZ (2)
Plague	—	15	0	8	3	1	2	2	
Poliomyelitis, paralytic	—	—	—	1	—	—	—	—	
Psittacosis§	—	18	1	19	12	12	18	25	
Q fever§	2	129	1	139	70	71	61	26	FL (1), CA (1)
Rabies, human	—	1	0	2	7	2	3	1	
Rubella	—	8	0	11	10	7	18	23	
Rubella, congenital syndrome	—	1	—	1	—	1	1	3	
SARS-CoV§,†††	—	—	—	—	—	8	N	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	—	82	2	129	132	161	118	77	
Streptococcus pneumoniae,§									
invasive disease (age <5 yrs)	15	916	16	1,257	1,162	845	513	498	NY (4), PA (1), OH (2), KS (1), AR (1), OK (3), ID (1), CO (1), AZ (1)
Syphilis, congenital (age <1 yr)	—	230	8	361	353	413	412	441	
Tetanus	—	18	0	27	34	20	25	37	
Toxic-shock syndrome (other than streptococcal)§	2	81	2	96	95	133	109	127	AR (1), AZ (1)
Trichinellosis	—	11	0	19	5	6	14	22	
Tularemia§	1	76	2	154	134	129	90	129	CA (1)
Typhoid fever	5	235	6	324	322	356	321	368	PA (1), WA (1), CA (3)
Vancomycin-intermediate *Staphylococcus aureus*§	—	2	0	2	—	N	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	0	3	1	N	N	N	
Yellow fever	—	—	—	—	—	—	1	—	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.

* Incidence data for reporting year 2006 are provisional, whereas data for 2001, 2002, 2003, 2004, and 2005 are finalized.

† Calculated by summing the incidence counts for the current week, the two weeks preceding the current week, and the two weeks following the current week, for a total of 5 preceding years. Additional information is available at http://www.cdc.gov/epo/dphsi/phs/files/5yearweeklyaverage.pdf.

§ Not notifiable in all states.

¶ Includes both neuroinvasive and non-neuroinvasive. Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (ArboNET Surveillance).

** Data for *H. influenzae* (all ages, all serotypes) are available in Table II.

†† Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (proposed). Implementation of HIV reporting influences the number of cases reported. Pediatric HIV data will not be updated monthly for the remainder of this year due to upgrading of the national HIV/AIDS surveillance data management system. Data for HIV/AIDS are available in Table IV quarterly.

§§ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases (proposed).

¶¶ No measles cases were reported for the current week.

*** Data for meningococcal disease (all serogroups and unknown serogroups) are available in Table II.

††† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed).

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 4, 2006, and November 5, 2005 (44th Week)*

Reporting area	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	10,427	19,268	35,170	808,079	812,703	138	149	1,643	6,829	3,717	71	72	594	4,341	6,673
New England	516	638	1,550	28,137	26,961	—	0	0	—	—	—	4	35	256	319
Connecticut	244	178	1,214	8,213	7,824	N	0	0	N	N	—	0	32	32	75
Maine§	—	43	67	1,874	1,900	N	0	0	N	N	—	0	4	34	27
Massachusetts	234	296	618	12,927	12,005	—	0	0	—	—	—	1	14	88	138
New Hampshire	9	38	65	1,658	1,576	—	0	0	—	—	—	1	5	42	34
Rhode Island	27	63	107	2,549	2,836	—	0	0	—	—	—	0	6	14	11
Vermont§	2	19	43	916	820	N	0	0	N	N	—	0	5	46	34
Mid. Atlantic	1,078	2,411	3,696	101,838	100,748	—	0	0	—	—	6	11	444	489	2,803
New Jersey	—	369	497	14,815	16,394	N	0	0	N	N	—	0	2	10	56
New York (Upstate)	518	499	1,727	20,571	20,136	N	0	0	N	N	5	3	441	150	2,362
New York City	—	728	1,567	32,020	32,804	N	0	0	N	N	—	2	7	87	138
Pennsylvania	560	764	1,104	34,432	31,414	N	0	0	N	N	1	4	16	242	247
E.N. Central	1,109	3,140	12,578	132,931	137,446	—	1	3	40	11	6	16	103	1,090	1,516
Illinois	679	970	1,694	44,051	42,939	—	0	0	—	—	—	2	18	137	149
Indiana	274	392	510	16,461	17,106	N	0	0	N	N	1	1	18	85	76
Michigan	—	663	9,888	29,054	22,947	—	0	3	34	11	—	2	7	116	99
Ohio	56	657	1,430	26,603	37,137	—	0	2	6	—	5	5	33	321	727
Wisconsin	100	394	531	16,762	17,317	N	0	0	N	N	—	5	53	431	465
W.N. Central	647	1,160	1,456	49,724	50,121	—	0	12	1	4	18	11	75	758	569
Iowa	152	159	225	7,019	6,197	N	0	0	N	N	—	1	28	162	117
Kansas	145	152	269	6,090	6,239	N	0	0	N	N	1	1	8	76	33
Minnesota	1	229	347	9,398	10,487	—	0	12	—	3	14	2	22	200	124
Missouri	294	439	610	19,355	19,136	—	0	1	1	1	1	2	18	159	240
Nebraska§	—	92	176	4,208	4,353	N	0	1	N	N	2	1	16	84	25
North Dakota	22	34	58	1,431	1,390	N	0	0	N	N	—	0	4	9	1
South Dakota	33	51	116	2,223	2,319	N	0	0	N	N	—	1	7	68	29
S. Atlantic	2,518	3,663	4,935	156,108	149,822	—	0	1	3	2	31	14	65	963	638
Delaware	83	68	92	3,052	2,892	N	0	0	N	N	—	0	3	13	6
District of Columbia	63	52	138	2,250	3,225	—	0	0	—	—	—	0	3	13	13
Florida	672	954	1,155	41,392	36,650	N	0	0	N	N	21	6	32	462	293
Georgia	3	630	2,142	26,338	26,777	—	0	0	—	—	9	3	16	204	126
Maryland§	217	328	468	14,756	15,702	—	0	1	3	2	—	0	3	15	29
North Carolina	745	593	1,772	28,716	26,804	N	0	0	N	N	1	1	11	86	77
South Carolina§	379	314	1,452	16,540	15,764	N	0	0	N	N	—	1	13	119	20
Virginia§	356	430	840	20,470	19,736	N	0	0	N	N	—	1	6	42	61
West Virginia	—	58	226	2,594	2,272	N	0	0	N	N	—	0	3	9	13
E.S. Central	769	1,401	1,947	61,790	59,270	—	0	0	—	—	—	3	12	151	192
Alabama§	87	405	756	17,584	13,691	N	0	0	N	N	—	1	10	65	22
Kentucky	195	148	402	6,844	7,534	N	0	0	N	N	—	1	8	34	130
Mississippi	—	374	802	15,655	18,152	—	0	0	—	—	—	0	3	15	2
Tennessee§	487	516	608	21,707	19,893	N	0	0	N	N	—	0	5	37	38
W.S. Central	1,346	2,201	3,605	93,905	93,977	—	0	1	1	—	2	3	35	236	212
Arkansas	227	155	335	7,036	7,401	—	0	0	—	—	—	0	2	19	5
Louisiana	21	261	608	11,665	14,465	—	0	1	1	N	—	0	9	52	78
Oklahoma	349	221	2,159	10,541	9,970	N	0	0	N	N	—	1	4	35	40
Texas§	749	1,478	1,904	64,663	62,141	N	0	0	N	N	2	2	26	130	89
Mountain	615	1,045	1,839	43,197	52,998	83	112	452	4,750	2,428	8	3	39	331	123
Arizona	347	378	881	16,182	18,010	83	108	448	4,634	2,337	2	0	3	24	9
Colorado	116	147	482	5,108	12,922	N	0	0	N	N	1	1	7	62	44
Idaho§	—	50	191	2,333	2,265	N	0	0	N	N	2	0	5	33	14
Montana§	49	43	195	2,154	1,977	N	0	0	N	N	—	0	26	124	16
Nevada§	—	85	432	3,920	5,986	—	1	4	52	54	—	0	1	9	11
New Mexico§	—	179	339	8,126	7,051	—	0	3	13	17	—	0	5	20	15
Utah	103	94	173	4,237	3,819	—	1	3	49	17	—	0	3	16	11
Wyoming	—	27	54	1,137	968	—	0	2	2	3	3	0	11	43	3
Pacific	1,829	3,316	5,079	140,449	141,360	55	41	1,179	2,034	1,272	—	2	52	67	301
Alaska	—	82	152	3,469	3,626	—	0	0	—	—	—	0	1	4	3
California	1,171	2,578	4,231	110,177	109,655	55	41	1,179	2,034	1,272	—	0	14	—	176
Hawaii	—	101	135	4,382	4,695	N	0	0	N	N	—	0	1	4	1
Oregon§	309	165	315	7,519	7,568	N	0	0	N	N	—	1	6	59	65
Washington	349	340	604	14,902	15,816	N	0	0	N	N	—	0	38	—	56
American Samoa	U	0	46	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	17	27	—	717	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	67	161	2,945	3,498	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	—	5	16	178	196	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Chlamydia refers to genital infections caused by *Chlamydia trachomatis*.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 4, 2006, and November 5, 2005 (44th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	247	318	1,029	14,284	16,491	3,688	6,527	14,136	281,215	279,525	29	40	142	1,728	1,900
New England	9	24	75	1,048	1,472	104	109	288	4,752	4,809	—	2	19	132	145
Connecticut	—	0	37	253	310	53	42	241	1,941	2,020	—	0	9	42	43
Maine†	6	2	13	151	184	—	2	8	110	117	—	0	4	17	8
Massachusetts	—	9	18	357	656	37	47	86	2,063	2,105	—	1	7	52	70
New Hampshire	—	0	9	25	54	2	4	9	166	145	—	0	2	8	8
Rhode Island	—	1	25	100	105	12	9	19	414	372	—	0	7	4	7
Vermont†	3	3	12	162	163	—	1	4	58	50	—	0	2	9	9
Mid. Atlantic	41	61	254	2,743	2,963	274	647	1,014	27,184	28,884	9	8	30	363	366
New Jersey	—	8	13	297	391	—	102	151	4,178	4,843	—	1	4	45	78
New York (Upstate)	30	24	227	1,031	1,035	91	123	455	5,311	5,830	7	2	27	122	101
New York City	1	15	29	742	776	—	172	382	8,047	8,815	—	1	6	71	68
Pennsylvania	10	15	31	673	761	183	213	399	9,648	9,396	2	3	8	125	119
E.N. Central	15	48	86	2,080	2,905	409	1,279	7,047	54,210	55,937	9	5	14	238	323
Illinois	—	9	21	358	672	220	377	710	16,793	16,951	—	1	6	47	109
Indiana	N	0	0	N	N	122	162	243	7,358	6,873	6	1	11	72	55
Michigan	—	12	25	554	695	—	262	5,880	12,215	9,469	—	0	3	19	22
Ohio	15	16	32	706	691	17	313	648	12,123	17,717	3	2	6	73	97
Wisconsin	—	10	40	462	847	50	136	172	5,721	4,927	—	0	4	27	40
W.N. Central	20	29	260	1,531	1,959	196	367	436	15,775	15,912	1	2	15	133	95
Iowa	2	5	15	247	244	35	35	62	1,545	1,363	—	0	1	1	—
Kansas	3	3	11	171	183	36	43	124	1,703	2,192	—	0	3	14	13
Minnesota	2	1	238	481	853	3	62	105	2,455	2,951	—	0	9	71	38
Missouri	9	9	32	452	449	114	190	251	8,547	8,030	—	1	6	32	30
Nebraska†	2	2	9	100	110	—	23	56	1,101	985	1	0	2	8	12
North Dakota	2	0	7	17	14	2	3	7	101	92	—	0	3	7	2
South Dakota	—	1	7	63	106	6	6	15	323	299	—	0	0	—	—
S. Atlantic	48	49	106	2,214	2,358	1,270	1,573	2,334	70,061	65,883	9	10	26	452	450
Delaware	—	1	4	35	49	35	27	44	1,263	752	—	0	1	1	—
District of Columbia	—	1	5	55	47	44	35	61	1,443	1,789	2	0	1	7	8
Florida	24	19	44	950	833	308	445	552	19,549	16,905	5	3	9	146	113
Georgia	18	10	44	481	633	—	309	1,014	13,372	12,542	2	2	12	85	95
Maryland†	4	3	11	179	182	97	127	186	5,514	5,915	—	1	5	59	63
North Carolina	N	0	0	N	N	540	298	766	14,925	12,997	—	0	9	49	69
South Carolina†	2	1	7	89	97	164	138	704	7,497	7,242	—	0	3	29	32
Virginia†	—	9	50	399	476	82	134	288	5,695	7,140	—	1	8	57	45
West Virginia	—	0	6	26	41	—	18	42	803	601	—	0	4	19	25
E.S. Central	5	8	41	427	363	365	562	866	25,073	23,751	1	2	7	89	103
Alabama†	1	5	29	232	170	48	184	310	8,086	7,770	—	0	5	21	17
Kentucky	N	0	0	N	N	90	55	132	2,480	2,624	—	0	1	4	12
Mississippi	—	0	0	—	—	—	147	436	6,197	6,031	—	0	1	3	—
Tennessee†	4	4	12	195	193	227	193	237	8,310	7,326	1	1	4	61	74
W.S. Central	6	6	31	258	288	592	921	1,430	40,711	38,209	—	1	15	60	99
Arkansas	4	2	8	116	75	97	81	142	3,642	3,862	—	0	2	7	7
Louisiana	—	0	5	28	57	31	160	354	7,195	7,958	—	0	3	10	33
Oklahoma	2	2	24	114	156	148	79	764	3,921	3,928	—	1	14	41	52
Texas†	N	0	0	N	N	316	568	915	25,953	22,461	—	0	2	2	7
Mountain	32	30	66	1,418	1,327	114	220	552	9,739	11,393	—	4	8	166	193
Arizona	3	3	36	137	128	80	93	201	4,029	4,130	—	1	7	77	95
Colorado	12	9	33	472	462	10	42	90	1,814	2,717	—	1	4	43	39
Idaho†	2	3	12	157	136	—	3	15	139	95	—	0	1	4	5
Montana†	—	2	11	90	63	2	3	20	166	132	—	0	0	—	—
Nevada†	1	2	8	84	97	—	25	194	1,288	2,351	—	0	1	1	14
New Mexico†	—	1	6	56	80	—	31	65	1,477	1,308	—	0	4	22	23
Utah	13	7	19	390	338	22	17	25	724	594	—	0	4	16	9
Wyoming	1	1	4	32	23	—	2	6	102	66	—	0	1	3	8
Pacific	71	57	202	2,565	2,856	364	796	963	33,710	34,747	—	2	15	95	126
Alaska	—	1	17	90	97	—	11	24	478	501	—	0	2	9	26
California	63	41	105	1,809	2,030	273	653	830	27,760	28,924	—	0	9	22	52
Hawaii	—	1	3	39	57	—	18	29	759	870	—	0	1	15	8
Oregon†	—	7	14	322	366	39	28	49	1,144	1,312	—	1	6	47	40
Washington	8	6	90	305	306	52	75	142	3,569	3,140	—	0	4	2	—
American Samoa	U	0	0	U	U	U	0	2	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	11	—	2	15	—	79	—	0	1	—	12
Puerto Rico	—	1	12	68	234	—	4	16	188	309	—	0	1	1	4
U.S. Virgin Islands	—	0	0	—	—	—	0	5	30	45	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 4, 2006, and November 5, 2005 (44th Week)*

Reporting area	Hepatitis (viral, acute), by type: A — Current week	A — Previous 52 weeks Med	A — Previous 52 weeks Max	A — Cum 2006	A — Cum 2005	B — Current week	B — Previous 52 weeks Med	B — Previous 52 weeks Max	B — Cum 2006	B — Cum 2005	Legionellosis — Current week	Legionellosis — Previous 52 weeks Med	Legionellosis — Previous 52 weeks Max	Legionellosis — Cum 2006	Legionellosis — Cum 2005
United States	43	64	245	2,739	3,603	46	84	597	3,416	4,426	36	46	127	2,010	1,849
New England	1	3	20	152	417	—	2	8	82	133	1	2	12	109	134
Connecticut	1	1	2	37	46	—	0	3	27	42	1	0	9	45	25
Maine†	—	0	2	6	4	—	0	2	17	12	—	0	2	8	7
Massachusetts	—	1	6	51	269	—	0	5	14	45	—	0	4	27	63
New Hampshire	—	0	16	37	78	—	0	2	13	26	—	0	1	1	9
Rhode Island	—	0	4	12	14	—	0	4	9	3	—	0	10	21	21
Vermont†	—	0	2	9	6	—	0	1	2	5	—	0	2	7	9
Mid. Atlantic	3	6	16	308	577	6	8	55	350	562	19	14	47	755	647
New Jersey	—	2	7	65	130	—	2	8	83	203	—	1	10	83	109
New York (Upstate)	1	1	14	81	85	2	1	43	52	50	10	5	30	286	163
New York City	—	2	10	106	272	—	2	5	74	118	—	2	12	114	106
Pennsylvania	2	1	5	56	90	4	3	9	141	191	9	5	18	272	269
E.N. Central	1	6	11	251	320	—	8	24	337	492	3	9	24	389	377
Illinois	—	1	4	50	115	—	1	7	59	143	—	0	4	21	50
Indiana	—	0	5	28	18	—	0	17	47	33	—	0	3	27	27
Michigan	—	2	8	92	98	—	3	6	113	158	—	2	8	109	102
Ohio	1	0	4	48	47	—	2	10	110	115	3	4	19	197	166
Wisconsin	—	1	3	33	42	—	0	2	8	43	—	0	5	35	32
W.N. Central	2	2	30	116	78	2	4	22	141	232	1	1	15	68	79
Iowa	—	0	2	8	19	—	0	3	14	25	—	0	3	10	6
Kansas	—	0	5	26	15	—	0	2	10	26	—	0	2	5	3
Minnesota	—	0	29	16	3	—	0	13	23	29	1	0	11	23	16
Missouri	2	1	3	41	30	—	2	7	75	122	—	0	3	18	27
Nebraska†	—	0	3	17	11	2	0	2	18	23	—	0	2	8	4
North Dakota	—	0	2	—	—	—	0	0	—	—	—	0	1	—	2
South Dakota	—	0	3	8	—	—	0	1	1	7	—	0	1	4	21
S. Atlantic	13	10	29	478	630	14	23	66	991	1,196	5	9	19	371	347
Delaware	—	0	2	10	5	—	1	4	40	27	—	0	2	10	16
District of Columbia	—	0	2	7	4	—	0	2	7	10	4	0	5	27	10
Florida	5	4	13	187	250	12	8	19	358	407	1	3	9	141	97
Georgia	—	1	7	54	114	2	3	7	140	180	—	0	4	17	32
Maryland†	—	1	6	55	64	—	3	10	135	134	—	1	7	76	99
North Carolina	8	0	20	84	78	—	0	23	142	150	—	0	5	31	25
South Carolina†	—	0	3	23	36	—	2	7	71	133	—	0	1	4	13
Virginia†	—	1	11	52	75	—	1	18	52	120	—	1	7	52	38
West Virginia	—	0	3	6	4	—	0	18	46	35	—	0	3	13	17
E.S. Central	—	2	8	108	224	4	6	15	270	318	1	2	9	83	74
Alabama†	—	0	3	13	42	—	1	8	80	78	—	0	2	10	13
Kentucky	—	0	5	31	24	—	1	5	61	61	—	0	4	32	25
Mississippi	—	0	1	7	18	—	0	2	13	45	—	0	1	1	3
Tennessee†	—	1	5	57	140	4	2	8	116	134	1	1	7	40	33
W.S. Central	—	3	77	149	410	1	14	315	618	534	—	0	32	43	40
Arkansas	—	0	9	37	17	—	1	3	41	60	—	0	3	3	6
Louisiana	—	0	4	18	59	—	0	4	28	64	—	0	2	4	1
Oklahoma	—	0	2	6	4	1	0	17	58	39	—	0	3	1	7
Texas†	—	2	73	88	330	—	11	295	491	371	—	0	26	35	26
Mountain	3	5	17	231	287	1	4	39	150	467	2	2	8	114	88
Arizona	3	2	16	141	160	—	1	23	35	298	1	1	5	38	22
Colorado	—	1	4	33	36	—	1	5	30	52	1	0	2	22	19
Idaho†	—	0	2	9	21	—	0	2	10	15	—	0	3	11	4
Montana†	—	0	3	9	8	—	0	7	—	3	—	0	1	5	5
Nevada†	—	0	2	11	20	—	1	5	30	46	—	0	2	8	19
New Mexico†	—	0	3	12	22	—	0	2	18	18	—	0	1	5	3
Utah	—	0	2	13	19	1	0	5	27	33	—	0	6	25	12
Wyoming	—	0	1	3	1	—	0	1	—	2	—	0	0	—	4
Pacific	20	18	163	946	660	18	10	61	477	492	4	1	9	78	63
Alaska	—	0	0	—	4	—	0	3	9	7	—	0	1	—	—
California	18	15	162	853	552	16	7	41	361	330	4	1	9	78	60
Hawaii	1	0	2	10	22	—	0	1	6	7	—	0	0	—	3
Oregon†	—	0	5	39	40	—	1	5	57	90	N	0	0	N	N
Washington	1	1	13	44	42	2	0	18	44	58	—	0	0	—	—
American Samoa	U	0	0	U	1	U	0	0	U	—	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	2	—	0	0	—	18	—	0	0	—	—
Puerto Rico	—	0	5	23	59	—	1	8	25	46	—	0	1	1	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 4, 2006, and November 5, 2005 (44th Week)*

Reporting area	Lyme disease					Malaria				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	331	235	2,153	14,850	19,365	23	25	125	1,079	1,198
New England	62	30	780	2,480	3,483	—	1	11	45	65
Connecticut	31	13	753	1,613	709	—	0	3	11	16
Maine†	—	1	34	220	235	—	0	1	4	5
Massachusetts	—	1	30	33	2,242	—	0	3	19	36
New Hampshire	1	5	80	495	212	—	0	3	9	5
Rhode Island	30	0	5	31	37	—	0	8	1	2
Vermont†	—	1	14	88	48	—	0	1	1	1
Mid. Atlantic	131	142	1,176	8,488	11,114	2	5	13	233	316
New Jersey	—	21	171	1,789	3,224	—	1	3	28	71
New York (Upstate)	115	64	1,150	3,622	3,516	2	1	11	41	43
New York City	—	0	18	108	370	—	2	9	125	170
Pennsylvania	16	39	233	2,969	4,004	—	1	4	39	32
E.N. Central	—	10	146	1,318	1,665	—	2	7	104	130
Illinois	—	0	2	—	123	—	1	4	42	69
Indiana	—	0	3	17	30	—	0	3	9	5
Michigan	—	1	6	48	50	—	0	2	16	21
Ohio	—	1	5	38	52	—	0	3	27	24
Wisconsin	—	9	141	1,215	1,410	—	0	3	10	11
W.N. Central	119	6	169	709	827	12	0	32	47	44
Iowa	—	0	8	79	91	—	0	1	2	8
Kansas	—	0	2	4	3	—	0	2	7	6
Minnesota	119	4	167	606	714	12	0	30	26	11
Missouri	—	0	2	10	14	—	0	1	6	16
Nebraska†	—	0	1	9	3	—	0	1	4	3
North Dakota	—	0	3	—	—	—	0	1	1	—
South Dakota	—	0	1	1	2	—	0	1	1	—
S. Atlantic	11	27	110	1,568	2,044	3	7	16	284	262
Delaware	—	8	28	428	601	—	0	1	5	3
District of Columbia	5	0	7	55	8	—	0	2	3	8
Florida	—	1	5	38	38	2	1	6	55	45
Georgia	1	0	1	5	6	—	1	6	73	47
Maryland†	5	14	67	754	1,093	1	1	5	61	90
North Carolina	—	0	4	27	44	—	0	8	28	30
South Carolina†	—	0	2	18	19	—	0	2	9	8
Virginia†	—	3	25	231	219	—	1	9	48	28
West Virginia	—	0	44	12	16	—	0	2	2	3
E.S. Central	—	0	3	24	32	—	0	3	20	28
Alabama†	—	0	1	7	3	—	0	2	9	5
Kentucky	—	0	2	7	5	—	0	1	3	10
Mississippi	—	0	0	—	—	—	0	1	3	—
Tennessee†	—	0	2	10	24	—	0	2	5	13
W.S. Central	—	0	3	17	73	—	2	31	78	111
Arkansas	—	0	1	—	4	—	0	1	2	6
Louisiana	—	0	0	—	3	—	0	1	4	4
Oklahoma	—	0	0	—	—	—	0	2	7	9
Texas†	—	0	3	17	66	—	1	29	65	92
Mountain	—	0	4	28	21	1	1	9	62	49
Arizona	—	0	2	7	8	—	0	9	22	10
Colorado	—	0	1	5	—	—	0	1	12	24
Idaho†	—	0	2	5	2	—	0	1	1	—
Montana†	—	0	0	—	—	—	0	1	2	—
Nevada†	—	0	1	2	3	1	0	1	4	3
New Mexico†	—	0	1	2	3	—	0	1	4	3
Utah	—	0	1	6	2	—	0	2	17	7
Wyoming	—	0	1	1	3	—	0	0	—	2
Pacific	8	4	16	218	106	5	4	13	206	193
Alaska	—	0	1	3	4	—	0	4	23	5
California	8	3	15	202	74	3	4	10	138	144
Hawaii	N	0	0	N	N	—	0	2	4	16
Oregon†	—	0	2	10	19	—	0	1	9	12
Washington	—	0	3	3	9	2	0	5	32	16
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	N	0	0	N	N	—	0	0	—	4
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 4, 2006, and November 5, 2005 (44th Week)*

Reporting area	Meningococcal disease, invasive: All serogroups: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005	Meningococcal disease, invasive: Serogroup unknown: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005	Pertussis: Current week	Previous 52 weeks: Med	Previous 52 weeks: Max	Cum 2006	Cum 2005
United States	9	20	85	900	1,033	5	13	58	589	636	129	258	2,877	10,813	19,456
New England	—	1	3	39	64	—	0	2	26	22	1	27	83	998	1,215
Connecticut	—	0	2	9	12	—	0	2	2	1	—	1	5	37	59
Maine†	—	0	1	5	2	—	0	1	3	2	—	1	11	70	47
Massachusetts	—	0	2	15	30	—	0	2	15	5	—	18	43	594	923
New Hampshire	—	0	2	6	12	—	0	2	6	12	1	2	36	150	76
Rhode Island	—	0	1	2	3	—	0	0	—	—	—	0	17	49	31
Vermont†	—	0	1	2	5	—	0	0	—	2	—	1	14	98	79
Mid. Atlantic	1	3	13	138	133	1	2	11	107	103	35	34	137	1,559	1,144
New Jersey	—	0	2	16	31	—	0	2	16	31	—	3	13	176	162
New York (Upstate)	—	0	7	31	34	—	0	5	4	12	27	15	123	724	442
New York City	—	1	4	53	23	—	1	4	53	23	—	1	8	64	93
Pennsylvania	1	0	5	38	45	1	0	5	34	37	8	12	26	595	447
E.N. Central	—	2	11	101	135	—	1	6	70	109	23	38	133	1,573	3,336
Illinois	—	0	4	18	30	—	0	4	18	30	—	6	26	231	800
Indiana	—	0	5	20	18	—	0	1	7	8	16	4	75	209	282
Michigan	—	0	3	19	30	—	0	1	8	18	—	8	35	471	267
Ohio	—	1	5	41	36	—	1	4	34	32	7	13	30	511	994
Wisconsin	—	0	2	3	21	—	0	2	3	21	—	4	29	151	993
W.N. Central	2	1	4	54	70	1	0	3	18	29	6	24	552	1,028	3,267
Iowa	—	0	2	17	15	—	0	1	6	1	—	6	40	221	911
Kansas	—	0	1	2	9	—	0	1	2	9	3	6	25	266	405
Minnesota	1	0	2	13	13	1	0	1	4	5	—	0	485	161	966
Missouri	1	0	2	14	25	—	0	1	2	11	2	6	42	256	427
Nebraska†	—	0	2	5	5	—	0	1	3	3	1	2	9	78	253
North Dakota	—	0	1	1	—	—	0	1	1	—	—	0	25	26	131
South Dakota	—	0	1	2	3	—	0	0	—	—	—	0	4	20	174
S. Atlantic	4	3	14	159	191	2	2	7	65	83	32	20	46	867	1,241
Delaware	—	0	1	4	4	—	0	1	4	4	—	0	1	3	15
District of Columbia	—	0	1	1	5	—	0	1	1	4	—	0	3	6	7
Florida	3	1	6	63	72	2	0	5	23	29	5	4	9	189	184
Georgia	—	0	2	14	15	—	0	2	14	15	—	0	2	17	44
Maryland†	—	0	2	12	21	—	0	1	2	4	1	3	9	107	178
North Carolina	—	0	11	24	28	—	0	3	7	6	16	0	22	171	98
South Carolina†	—	0	2	18	13	—	0	2	8	8	2	3	13	151	369
Virginia†	—	0	4	15	27	—	0	3	6	11	8	1	27	180	302
West Virginia	1	0	2	8	6	—	0	0	—	2	—	0	9	43	44
E.S. Central	—	1	4	35	51	—	1	4	27	40	2	7	27	322	455
Alabama†	—	0	1	6	5	—	0	1	4	3	—	1	18	92	75
Kentucky	—	0	2	8	17	—	0	2	8	17	—	1	5	54	137
Mississippi	—	0	1	3	5	—	0	1	3	5	—	1	4	38	52
Tennessee†	—	0	2	18	24	—	0	2	12	15	2	2	10	138	191
W.S. Central	—	1	23	52	98	—	0	6	23	24	—	16	360	607	2,034
Arkansas	—	0	3	9	14	—	0	2	6	3	—	1	21	62	272
Louisiana	—	0	2	6	29	—	0	1	3	6	—	0	3	13	46
Oklahoma	—	0	4	8	14	—	0	0	—	2	—	0	124	18	1
Texas†	—	1	16	29	41	—	0	4	14	13	—	13	215	514	1,715
Mountain	—	1	5	60	82	—	0	4	29	23	25	57	230	2,218	3,525
Arizona	—	0	3	17	31	—	0	3	17	10	4	8	177	426	858
Colorado	—	0	2	19	17	—	0	1	2	—	5	14	40	664	1,150
Idaho†	—	0	1	3	6	—	0	1	2	5	1	2	8	81	188
Montana†	—	0	1	4	—	—	0	1	2	—	—	2	9	98	567
Nevada†	—	0	1	3	12	—	0	0	—	2	—	0	9	54	48
New Mexico†	—	0	1	5	5	—	0	1	2	4	—	2	6	65	164
Utah	—	0	1	5	11	—	0	0	—	2	13	14	39	758	502
Wyoming	—	0	2	4	—	—	0	2	4	—	2	1	8	72	48
Pacific	2	5	29	262	209	1	5	25	224	203	5	35	1,334	1,641	3,239
Alaska	—	0	1	2	3	—	0	1	2	3	—	1	15	63	128
California	1	3	14	163	133	1	3	14	163	133	—	24	1,136	1,140	1,584
Hawaii	—	0	1	7	11	—	0	1	7	6	—	1	4	70	154
Oregon†	—	1	7	60	43	—	1	4	41	43	—	2	8	94	609
Washington	1	0	25	30	19	—	0	11	11	18	5	6	195	274	764
American Samoa	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	1	—	0	0	—	1	—	0	0	—	2
Puerto Rico	—	0	1	4	7	—	0	1	4	7	—	0	1	2	6
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 4, 2006, and November 5, 2005 (44th Week)*

Reporting area	Rabies, animal					Rocky Mountain spotted fever					Salmonellosis				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	36	120	223	5,194	5,183	12	39	246	1,816	1,521	696	799	2,291	35,004	37,603
New England	12	11	26	583	626	—	0	2	2	8	8	27	440	1,644	1,907
Connecticut	8	3	14	182	180	—	0	0	—	—	—	0	432	432	422
Maine†	—	2	8	96	53	N	0	0	N	N	—	2	10	99	149
Massachusetts	—	4	17	178	304	—	0	1	1	6	—	17	53	782	1,009
New Hampshire	2	0	5	46	12	—	0	1	1	1	4	3	25	184	152
Rhode Island	—	0	4	23	25	—	0	2	—	1	—	1	17	83	90
Vermont†	2	1	5	58	52	—	0	0	—	—	4	1	6	64	85
Mid. Atlantic	7	24	60	1,177	866	—	1	5	65	91	54	83	272	4,323	4,485
New Jersey	N	0	0	N	N	—	0	1	7	27	—	14	45	741	874
New York (Upstate)	7	11	24	483	483	—	0	2	4	1	34	22	233	1,096	1,071
New York City	—	0	5	27	26	—	0	3	16	7	—	23	47	1,054	1,060
Pennsylvania	—	14	42	667	357	—	1	3	38	56	20	29	67	1,432	1,480
E.N. Central	—	2	18	151	166	1	0	6	35	40	27	100	187	4,336	4,990
Illinois	—	0	7	46	50	—	0	1	3	11	—	24	51	991	1,636
Indiana	—	0	2	11	11	—	0	1	5	—	6	15	67	755	546
Michigan	—	1	5	43	35	—	0	1	2	6	—	17	32	812	807
Ohio	—	0	9	51	70	1	0	4	24	21	21	22	56	1,084	1,167
Wisconsin	N	0	0	N	N	—	0	1	1	2	—	16	27	694	834
W.N. Central	—	5	20	266	296	—	2	15	196	147	38	43	107	2,246	2,260
Iowa	—	1	7	56	—	—	0	1	5	7	—	8	21	371	374
Kansas	—	1	5	71	73	—	0	1	4	5	3	7	16	317	323
Minnesota	—	1	6	38	65	—	0	2	4	2	9	11	60	619	490
Missouri	—	1	6	64	68	—	2	10	159	121	17	14	35	649	704
Nebraska†	—	0	0	—	—	—	0	5	24	7	4	3	8	155	195
North Dakota	—	0	7	16	29	—	0	1	—	—	5	0	46	27	36
South Dakota	—	0	4	21	61	—	0	0	—	5	—	3	7	108	138
S. Atlantic	13	36	168	1,856	1,857	7	20	94	1,019	789	320	208	450	9,499	10,799
Delaware	—	0	0	—	—	—	0	3	18	7	—	2	9	134	113
District of Columbia	—	0	0	—	—	—	0	1	1	2	2	1	7	54	52
Florida	—	0	152	152	201	1	0	3	19	13	176	95	214	4,029	4,375
Georgia	—	2	54	189	233	5	0	4	40	85	57	27	101	1,460	1,720
Maryland†	—	7	13	300	339	1	1	6	62	65	10	12	29	599	715
North Carolina	12	9	22	449	416	—	17	87	755	443	70	34	130	1,436	1,436
South Carolina†	—	3	11	149	192	—	0	5	31	66	5	19	51	848	1,241
Virginia†	—	11	27	523	424	—	2	13	90	101	—	20	57	820	991
West Virginia	1	1	13	94	52	—	0	2	3	7	—	2	19	119	156
E.S. Central	—	4	16	222	137	1	6	30	330	266	25	52	149	2,583	2,609
Alabama†	—	1	8	76	73	—	1	10	105	69	8	16	71	888	627
Kentucky	—	0	4	27	16	—	0	1	4	3	5	8	23	380	435
Mississippi	—	0	2	4	5	—	0	1	2	15	—	12	42	660	815
Tennessee†	—	2	9	115	43	1	4	21	219	179	12	14	31	655	732
W.S. Central	—	13	34	555	790	3	1	161	112	151	22	81	922	3,301	3,759
Arkansas	—	0	4	26	33	3	0	10	49	109	7	15	47	812	654
Louisiana	—	0	0	—	—	—	0	1	4	6	—	11	40	573	816
Oklahoma	—	1	9	58	69	—	0	154	35	7	15	8	48	440	355
Texas†	—	10	29	471	688	—	0	4	24	29	—	32	839	1,476	1,934
Mountain	2	3	27	192	247	—	1	6	50	27	37	53	87	2,207	2,038
Arizona	—	2	10	125	158	—	0	6	12	13	17	17	67	743	565
Colorado	—	0	1	—	18	—	0	1	2	4	6	12	30	542	506
Idaho†	—	0	25	25	—	—	0	3	13	3	4	3	9	154	125
Montana†	—	0	2	13	15	—	0	2	2	1	—	3	16	110	93
Nevada†	—	0	1	2	14	—	0	0	—	—	3	3	20	171	169
New Mexico†	—	0	2	8	10	—	0	2	8	4	—	4	15	201	224
Utah	—	0	1	11	15	—	0	2	6	—	6	5	15	245	279
Wyoming	2	0	2	8	17	—	0	1	7	2	1	1	4	41	77
Pacific	2	4	10	192	198	—	0	1	7	2	165	109	426	4,865	4,756
Alaska	—	0	4	15	1	—	0	0	—	—	—	1	7	66	49
California	2	3	9	157	190	—	0	1	5	—	135	86	292	3,809	3,635
Hawaii	—	0	0	—	—	—	0	0	—	—	—	5	10	207	257
Oregon†	—	0	4	20	7	—	0	1	2	2	—	7	16	343	359
Washington	U	0	0	U	U	N	0	0	N	N	30	8	124	440	456
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	7
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—	—	2	3	—	34
Puerto Rico	—	1	6	68	59	N	0	0	N	N	—	5	35	199	554
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 4, 2006, and November 5, 2005 (44th Week)*

Reporting area	Shiga toxin-producing *E. coli* (STEC)†					Shigellosis					Streptococcal disease, invasive, group A				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max				Med	Max		
United States	42	56	297	2,674	2,837	287	248	1,013	10,824	12,885	34	90	283	4,126	3,873
New England	—	3	68	230	197	—	3	65	216	285	1	4	15	182	252
Connecticut	—	0	67	67	52	—	0	59	59	50	U	0	3	U	89
Maine§	—	0	8	31	28	—	0	2	3	13	—	0	2	17	13
Massachusetts	—	1	9	82	79	—	2	11	128	173	—	2	6	101	114
New Hampshire	—	0	3	24	15	—	0	4	7	13	—	0	9	44	17
Rhode Island	—	0	2	8	7	—	0	6	13	20	—	0	3	7	9
Vermont§	—	0	2	2	16	—	0	2	6	16	1	0	2	13	10
Mid. Atlantic	2	4	107	179	321	2	16	72	729	1,105	3	18	43	789	768
New Jersey	—	0	3	3	68	—	4	34	236	278	—	3	8	123	161
New York (Upstate)	—	0	103	12	123	2	4	60	201	236	2	4	32	265	215
New York City	—	0	4	31	16	—	5	12	218	366	—	3	8	133	150
Pennsylvania	—	0	4	6	114	—	1	6	74	225	1	6	13	268	242
E.N. Central	4	10	55	542	565	23	20	37	863	999	1	14	43	702	793
Illinois	—	1	7	64	125	—	7	18	307	341	—	3	11	144	265
Indiana	1	1	8	76	61	11	2	18	132	149	—	2	11	100	90
Michigan	—	1	7	78	81	—	3	8	127	211	—	3	12	193	187
Ohio	3	3	18	158	150	12	3	14	166	94	1	4	19	214	168
Wisconsin	—	2	40	166	148	—	3	9	131	204	—	1	4	51	83
W.N. Central	2	9	32	465	480	25	36	77	1,442	1,412	5	5	57	296	239
Iowa	—	2	8	115	93	—	2	10	93	86	N	0	0	N	N
Kansas	—	0	4	21	49	—	3	20	127	201	2	1	5	52	35
Minnesota	2	3	27	210	159	6	2	23	186	80	—	0	52	136	90
Missouri	2	1	10	81	89	9	11	69	594	852	—	1	5	62	61
Nebraska§	—	1	8	55	53	1	2	14	117	112	2	0	4	27	22
North Dakota	—	0	15	—	7	9	0	18	101	4	1	0	5	11	10
South Dakota	—	0	5	40	30	—	5	22	224	77	—	0	3	8	21
S. Atlantic	3	7	39	394	365	129	57	138	2,621	2,020	16	22	43	990	789
Delaware	—	0	2	7	9	—	0	2	8	11	—	0	2	10	6
District of Columbia	—	0	1	2	1	—	0	2	15	12	1	0	2	15	9
Florida	2	2	29	81	82	77	27	75	1,291	976	5	6	16	256	208
Georgia	—	1	5	75	47	46	17	57	904	550	7	5	11	196	169
Maryland§	1	1	8	78	69	6	2	10	110	86	2	4	12	175	154
North Carolina	4	2	7	100	58	—	1	21	139	179	—	0	26	145	111
South Carolina§	1	0	2	8	11	—	1	9	72	92	1	1	6	54	31
Virginia§	—	0	8	—	85	—	1	9	78	113	—	2	11	113	79
West Virginia	—	0	5	12	3	—	0	2	4	1	—	0	6	26	22
E.S. Central	6	3	21	208	164	9	13	48	663	1,083	1	3	11	171	152
Alabama§	—	0	5	38	28	—	3	29	241	203	N	0	0	N	N
Kentucky	2	1	12	87	71	7	4	15	211	280	—	0	5	34	30
Mississippi	—	0	0	—	8	—	1	8	72	83	—	0	0	—	—
Tennessee§	—	0	4	24	57	2	3	12	139	517	1	3	9	137	122
W.S. Central	1	1	52	68	94	13	35	596	1,382	3,121	1	7	58	321	273
Arkansas	1	0	7	33	11	9	1	7	102	56	—	0	5	25	18
Louisiana	—	0	1	—	20	—	1	25	116	126	—	0	1	7	5
Oklahoma	—	0	17	35	25	4	3	286	117	577	—	2	14	90	99
Texas§	1	1	44	91	38	—	28	308	1,047	2,362	1	4	43	199	151
Mountain	14	5	16	274	272	45	23	86	1,210	793	5	11	78	576	512
Arizona	13	2	8	109	26	22	13	35	627	417	2	6	57	299	218
Colorado	1	1	8	92	71	8	3	16	206	142	3	3	8	124	154
Idaho§	1	1	7	72	45	—	0	3	14	17	—	0	2	8	3
Montana§	—	0	1	—	15	—	0	10	27	5	—	0	0	—	—
Nevada§	—	0	5	22	20	5	1	20	103	53	—	0	3	13	9
New Mexico§	—	0	1	4	24	—	2	15	143	115	—	1	7	66	70
Utah	3	1	14	111	63	2	1	6	71	39	—	1	7	62	54
Wyoming	—	0	3	18	8	8	0	3	19	5	—	0	1	4	4
Pacific	10	7	50	314	379	41	38	148	1,698	2,067	1	2	9	99	95
Alaska	—	0	1	—	9	—	0	2	9	11	—	0	0	—	—
California	2	4	18	194	125	37	31	104	1,403	1,791	—	0	0	—	—
Hawaii	1	0	2	14	11	—	1	4	42	31	1	2	9	99	95
Oregon§	—	2	13	107	148	—	1	31	112	117	N	0	0	N	N
Washington	7	1	32	106	86	4	2	43	132	117	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	7	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	3	—	16	—	0	0	—	—
Puerto Rico	—	0	0	—	2	—	0	2	12	8	N	0	0	N	N
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

C.N.M.I.: Commonwealth of Northern Mariana Islands.
U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Includes *E. coli* O157:H7; Shiga toxin positive, serogroup non-0157; and Shiga toxin positive, not serogrouped.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 4, 2006, and November 5, 2005 (44th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease Drug resistant, all ages					Syphilis, primary and secondary					Varicella (chickenpox)				
	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005	Current week	Previous 52 weeks Med	Previous 52 weeks Max	Cum 2006	Cum 2005
United States	34	52	334	2,138	2,176	106	174	334	7,585	7,168	562	811	3,204	34,370	24,072
New England	—	1	24	31	192	2	4	17	173	176	11	36	144	1,251	4,459
Connecticut	U	0	7	U	77	1	0	11	37	38	U	0	58	U	1,363
Maine†	—	0	2	8	N	—	0	2	8	1	—	4	20	151	263
Massachusetts	—	0	6	—	86	1	3	6	106	104	—	0	54	94	1,976
New Hampshire	—	0	0	—	—	—	0	2	11	13	5	6	47	418	271
Rhode Island	—	0	11	10	18	—	0	2	9	19	—	0	0	—	—
Vermont†	—	0	2	13	11	—	0	1	2	1	6	12	50	588	586
Mid. Atlantic	4	3	15	142	179	6	21	35	931	881	77	103	183	4,062	4,049
New Jersey	N	0	0	N	N	—	3	7	139	115	—	0	0	—	—
New York (Upstate)	3	1	10	53	69	3	3	14	130	67	—	0	0	—	—
New York City	U	0	0	U	U	—	10	23	438	533	—	0	0	—	—
Pennsylvania	1	2	9	89	110	3	5	12	224	166	77	103	183	4,062	4,049
E.N. Central	17	11	41	488	542	4	18	38	738	783	165	237	587	12,063	5,024
Illinois	—	0	3	15	29	2	8	23	343	438	—	2	7	68	86
Indiana	12	2	21	137	166	—	1	4	75	55	—	0	475	475	251
Michigan	—	0	4	17	38	—	2	19	102	71	—	95	174	3,544	3,050
Ohio	5	6	32	319	309	1	4	8	163	188	165	112	420	7,332	1,267
Wisconsin	N	0	0	N	N	1	1	4	55	31	—	13	52	644	370
W.N. Central	—	1	191	97	37	6	5	11	217	221	39	27	98	1,451	424
Iowa	N	0	0	N	N	2	0	2	16	8	N	0	0	N	N
Kansas	N	0	0	N	N	1	0	3	21	17	3	3	24	278	—
Minnesota	—	0	191	60	—	—	0	3	21	63	—	0	0	—	—
Missouri	—	1	3	36	30	3	3	8	143	127	35	20	82	1,070	282
Nebraska†	—	0	0	—	2	—	0	1	3	4	—	0	0	—	—
North Dakota	—	0	1	—	2	—	0	1	1	1	1	0	25	45	31
South Dakota	—	0	1	1	3	—	0	3	12	1	—	1	12	58	111
S. Atlantic	10	26	53	1,109	896	34	42	186	1,802	1,754	34	85	860	3,654	1,981
Delaware	—	0	2	—	1	—	0	2	16	10	1	1	5	61	28
District of Columbia	1	0	3	26	13	3	2	9	110	96	6	0	5	40	34
Florida	3	13	36	613	482	10	15	23	629	599	—	0	0	—	—
Georgia	6	8	29	372	295	1	7	147	311	383	—	0	0	—	—
Maryland†	—	0	0	—	—	3	5	19	249	259	—	0	4	7	—
North Carolina	N	0	0	N	N	10	5	17	258	219	—	0	0	—	—
South Carolina†	—	0	0	—	—	2	1	6	60	69	5	15	53	875	509
Virginia†	N	0	0	N	N	5	3	17	164	116	—	30	812	1,394	486
West Virginia	—	1	14	98	105	—	0	1	5	3	22	27	70	1,277	924
E.S. Central	1	3	13	161	150	6	14	25	632	406	8	1	70	112	205
Alabama†	N	0	0	N	N	3	5	19	280	134	8	1	70	110	205
Kentucky	1	0	5	31	26	1	1	8	61	44	N	0	0	N	N
Mississippi	—	0	0	—	1	—	1	7	60	43	—	0	1	2	—
Tennessee†	—	3	13	130	123	2	5	13	231	185	N	0	0	N	N
W.S. Central	—	0	5	19	104	44	28	52	1,358	1,056	171	186	1,757	9,466	5,694
Arkansas	—	0	3	12	12	4	1	5	64	45	47	9	110	734	17
Louisiana	—	0	4	7	92	17	4	27	248	227	—	0	8	48	115
Oklahoma	N	0	0	N	N	—	1	6	63	31	—	0	0	—	—
Texas†	N	0	0	N	N	23	22	36	983	753	124	170	1,647	8,684	5,562
Mountain	2	2	8	91	76	1	8	25	344	362	57	55	138	2,311	2,236
Arizona	N	0	0	N	N	1	3	16	154	150	—	0	0	—	—
Colorado	N	0	0	N	N	—	1	3	35	41	14	31	76	1,219	1,554
Idaho†	N	0	0	N	N	—	0	1	2	20	—	0	0	—	—
Montana†	—	0	1	—	—	—	0	1	1	5	—	0	2	2	—
Nevada†	—	0	3	12	30	—	1	12	85	91	—	0	3	7	2
New Mexico†	—	0	1	1	—	—	1	5	58	47	3	3	34	315	185
Utah	1	0	8	36	23	—	0	2	9	8	40	12	55	716	443
Wyoming	1	1	4	42	23	—	0	0	—	—	—	0	11	52	52
Pacific	—	0	0	—	—	3	34	51	1,390	1,529	—	0	0	—	—
Alaska	—	0	0	—	—	—	0	4	9	6	—	0	0	—	—
California	N	0	0	N	N	2	29	41	1,196	1,356	—	0	0	—	—
Hawaii	—	0	0	—	—	—	0	2	15	9	N	0	0	N	N
Oregon†	N	0	0	N	N	1	0	3	16	32	N	0	0	N	N
Washington	N	0	0	N	N	—	3	10	154	126	N	0	0	N	N
American Samoa	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	—	0	0	—	—	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	3	—	4	12	—	409
Puerto Rico	N	0	0	N	N	—	1	10	86	192	—	7	47	299	592
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending November 4, 2006, and November 5, 2005 (44th Week)*

Reporting area	West Nile virus disease†									
	Neuroinvasive					Non-neuroinvasive				
	Current week	Previous 52 weeks		Cum 2006	Cum 2005	Current week	Previous 52 weeks		Cum 2006	Cum 2005
		Med	Max				Med	Max		
United States	—	1	170	1,337	1,298	—	1	378	2,324	1,677
New England	—	0	3	9	9	—	0	2	3	4
Connecticut	—	0	3	7	4	—	0	1	2	2
Maine§	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	2	4	—	0	1	1	2
New Hampshire	—	0	0	—	—	—	0	0	—	—
Rhode Island	—	0	0	—	1	—	0	0	—	—
Vermont§	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	—	0	6	18	47	—	0	3	7	22
New Jersey	—	0	2	2	3	—	0	1	2	3
New York (Upstate)	—	0	0	—	19	—	0	0	—	5
New York City	—	0	4	8	11	—	0	2	4	3
Pennsylvania	—	0	2	8	14	—	0	1	1	11
E.N. Central	—	0	41	227	258	—	0	22	99	156
Illinois	—	0	21	114	136	—	0	19	70	115
Indiana	—	0	7	26	11	—	0	2	7	12
Michigan	—	0	9	41	54	—	0	1	2	8
Ohio	—	0	11	35	46	—	0	3	11	15
Wisconsin	—	0	2	11	11	—	0	2	9	6
W.N. Central	—	0	34	213	169	—	0	76	439	463
Iowa	—	0	3	21	14	—	0	4	12	23
Kansas	—	0	3	16	17	—	0	3	12	N
Minnesota	—	0	6	30	18	—	0	7	35	27
Missouri	—	0	13	47	17	—	0	2	12	13
Nebraska§	—	0	8	41	55	—	0	35	176	133
North Dakota	—	0	5	20	12	—	0	28	117	74
South Dakota	—	0	7	38	36	—	0	22	75	193
S. Atlantic	—	0	2	13	34	—	0	4	7	28
Delaware	—	0	0	—	1	—	0	0	—	1
District of Columbia	—	0	0	—	3	—	0	1	1	2
Florida	—	0	1	3	10	—	0	0	—	11
Georgia	—	0	1	2	9	—	0	3	5	10
Maryland§	—	0	2	7	4	—	0	1	1	1
North Carolina	—	0	0	—	2	—	0	0	—	2
South Carolina§	—	0	0	—	5	—	0	0	—	—
Virginia§	—	0	0	—	—	—	0	0	—	1
West Virginia	—	0	1	1	—	N	0	0	N	N
E.S. Central	—	0	15	106	64	—	0	15	91	38
Alabama§	—	0	2	7	6	—	0	0	—	4
Kentucky	—	0	1	3	5	—	0	1	1	—
Mississippi	—	0	10	81	39	—	0	15	88	31
Tennessee§	—	0	4	15	14	—	0	2	2	3
W.S. Central	—	1	59	339	268	—	0	26	199	148
Arkansas	—	0	4	21	13	—	0	2	5	15
Louisiana	—	0	14	87	112	—	0	9	77	54
Oklahoma	—	0	6	26	17	—	0	4	17	13
Texas§	—	0	38	205	126	—	0	15	100	66
Mountain	—	0	60	332	144	—	0	220	1,255	238
Arizona	—	0	9	45	51	—	0	12	53	59
Colorado	—	0	10	60	21	—	0	48	250	85
Idaho§	—	0	29	108	3	—	0	149	710	10
Montana§	—	0	3	12	8	—	0	7	21	17
Nevada§	—	0	9	34	14	—	0	13	75	17
New Mexico§	—	0	1	3	20	—	0	1	5	13
Utah	—	0	8	55	21	—	0	17	101	31
Wyoming	—	0	7	15	6	—	0	8	40	6
Pacific	—	0	15	80	305	—	0	45	224	580
Alaska	—	0	0	—	—	—	0	0	—	—
California	—	0	15	76	304	—	0	33	179	574
Hawaii	—	0	0	—	—	—	0	0	—	—
Oregon§	—	0	2	4	1	—	0	12	42	6
Washington	—	0	0	—	—	—	0	2	3	—
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	0	0	U	U	U	0	0	U	U
Guam	—	0	0	—	—	—	0	0	—	—
Puerto Rico	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	—	0	0	—	—	—	0	0	—	—

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U: Unavailable. —: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts. Med: Median. Max: Maximum.
* Incidence data for reporting year 2006 is provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (proposed) (ArboNET Surveillance).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending November 4, 2006 (44th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	504	366	80	25	15	17	30
Boston, MA	131	89	22	6	7	7	4
Bridgeport, CT	33	26	5	1	—	1	5
Cambridge, MA	20	18	1	—	—	—	2
Fall River, MA	19	15	1	2	—	1	—
Hartford, CT	47	30	12	1	3	1	4
Lowell, MA	23	18	2	3	—	—	—
Lynn, MA	14	8	6	—	—	—	1
New Bedford, MA	27	19	6	2	—	—	4
New Haven, CT	U	U	U	U	U	U	U
Providence, RI	60	48	4	5	—	3	3
Somerville, MA	5	3	2	—	—	—	—
Springfield, MA	32	23	4	1	2	2	1
Waterbury, CT	25	20	4	1	—	—	4
Worcester, MA	68	49	11	3	3	2	2
Mid. Atlantic	2,198	1,511	479	125	42	37	130
Albany, NY	55	36	17	2	—	—	—
Allentown, PA	29	24	4	—	—	1	2
Buffalo, NY	87	54	28	2	3	—	12
Camden, NJ	45	28	13	2	1	1	2
Elizabeth, NJ	14	8	5	1	—	—	1
Erie, PA	57	39	15	1	—	2	5
Jersey City, NJ	38	20	13	3	1	1	6
New York City, NY	1,116	777	231	66	22	16	54
Newark, NJ	28	11	7	3	3	4	2
Paterson, NJ	24	14	4	3	1	2	1
Philadelphia, PA	324	217	67	31	7	2	17
Pittsburgh, PA§	23	17	5	1	—	—	1
Reading, PA	27	21	4	1	—	1	4
Rochester, NY	135	94	35	4	1	1	11
Schenectady, NY	26	21	3	1	—	1	2
Scranton, PA	27	21	5	1	—	—	1
Syracuse, NY	83	60	13	2	3	5	8
Trenton, NJ	26	20	6	—	—	—	—
Utica, NY	13	9	3	1	—	—	—
Yonkers, NY	21	20	1	—	—	—	1
E.N. Central	1,994	1,312	450	138	49	45	123
Akron, OH	36	23	10	1	—	2	—
Canton, OH	45	33	8	4	—	—	3
Chicago, IL	357	190	105	37	16	9	19
Cincinnati, OH	54	35	14	2	3	—	11
Cleveland, OH	244	186	41	9	4	4	9
Columbus, OH	193	122	39	17	7	8	17
Dayton, OH	129	98	16	11	2	2	8
Detroit, MI	151	87	46	13	4	1	8
Evansville, IN	46	38	4	4	—	—	5
Fort Wayne, IN	73	55	14	3	1	—	6
Gary, IN	20	12	6	—	2	—	—
Grand Rapids, MI	46	34	9	—	—	3	5
Indianapolis, IN	199	112	58	14	8	7	11
Lansing, MI	34	24	10	—	—	—	—
Milwaukee, WI	97	62	22	6	2	5	7
Peoria, IL	52	32	15	3	—	2	1
Rockford, IL	50	39	4	6	—	1	4
South Bend, IN	26	20	6	—	—	—	3
Toledo, OH	91	67	17	6	—	1	4
Youngstown, OH	51	43	6	2	—	—	2
W.N. Central	562	391	121	27	11	12	30
Des Moines, IA	U	U	U	U	U	U	U
Duluth, MN	24	18	6	—	—	—	—
Kansas City, KS	33	23	7	1	—	2	1
Kansas City, MO	102	66	25	7	2	2	5
Lincoln, NE	53	38	12	2	1	—	3
Minneapolis, MN	54	35	14	2	1	2	6
Omaha, NE	69	58	8	1	1	1	2
St. Louis, MO	84	47	21	9	3	4	3
St. Paul, MN	67	47	16	3	1	—	5
Wichita, KS	76	59	12	2	2	1	5
S. Atlantic	1,178	716	292	98	39	32	57
Atlanta, GA	152	99	31	12	6	4	5
Baltimore, MD	182	102	55	13	6	6	14
Charlotte, NC	116	70	26	12	4	4	9
Jacksonville, FL	145	88	38	11	6	2	7
Miami, FL	84	46	23	10	3	2	3
Norfolk, VA	55	40	5	5	3	2	4
Richmond, VA	50	31	12	3	3	1	1
Savannah, GA	59	39	14	5	—	1	5
St. Petersburg, FL	53	33	12	3	1	4	2
Tampa, FL	188	119	48	15	3	3	6
Washington, D.C.	86	44	25	9	4	3	—
Wilmington, DE	8	5	3	—	—	—	1
E.S. Central	840	546	204	51	19	20	63
Birmingham, AL	188	129	38	12	6	3	12
Chattanooga, TN	64	38	20	3	2	1	3
Knoxville, TN	106	71	23	6	2	4	4
Lexington, KY	69	41	16	7	2	3	5
Memphis, TN	162	105	47	5	2	3	21
Mobile, AL	49	30	11	2	1	5	4
Montgomery, AL	51	31	14	3	3	—	3
Nashville, TN	151	101	35	13	1	1	11
W.S. Central	1,390	892	326	105	42	25	78
Austin, TX	69	48	15	5	—	1	8
Baton Rouge, LA	48	26	15	5	1	1	1
Corpus Christi, TX	60	37	12	7	2	2	6
Dallas, TX	181	105	53	13	4	6	5
El Paso, TX	55	38	12	3	1	1	5
Fort Worth, TX	109	79	25	2	1	2	9
Houston, TX	362	212	88	35	19	8	19
Little Rock, AR	60	37	16	5	1	1	2
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	234	163	41	21	7	2	11
Shreveport, LA	69	47	15	1	6	—	4
Tulsa, OK	143	100	34	8	—	1	8
Mountain	1,066	695	224	90	39	17	44
Albuquerque, NM	140	85	37	11	6	1	9
Boise, ID	49	34	7	2	2	4	1
Colorado Springs, CO	68	48	13	7	—	—	1
Denver, CO	75	51	11	5	5	3	2
Las Vegas, NV	254	159	64	21	9	1	8
Ogden, UT	31	22	6	2	—	1	1
Phoenix, AZ	197	126	32	25	8	5	8
Pueblo, CO	26	23	1	2	—	—	3
Salt Lake City, UT	106	61	31	9	5	—	7
Tucson, AZ	120	86	22	6	4	2	4
Pacific	1,460	996	329	92	22	21	119
Berkeley, CA	17	15	2	—	—	—	4
Fresno, CA	159	98	45	13	1	2	5
Glendale, CA	—	—	—	—	—	—	—
Honolulu, HI	84	60	12	7	3	2	12
Long Beach, CA	49	27	13	5	3	1	6
Los Angeles, CA	64	32	21	5	6	—	3
Pasadena, CA	21	16	3	1	—	1	2
Portland, OR	110	78	25	6	—	1	11
Sacramento, CA	212	143	46	12	6	5	20
San Diego, CA	164	112	36	12	1	3	16
San Francisco, CA	115	76	32	7	—	—	15
San Jose, CA	139	104	24	8	1	2	4
Santa Cruz, CA	32	23	7	2	—	—	—
Seattle, WA	123	87	27	6	1	2	8
Spokane, WA	67	47	14	5	—	1	5
Tacoma, WA	104	78	22	3	—	1	8
Total	11,192**	7,425	2,505	751	278	226	674

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.

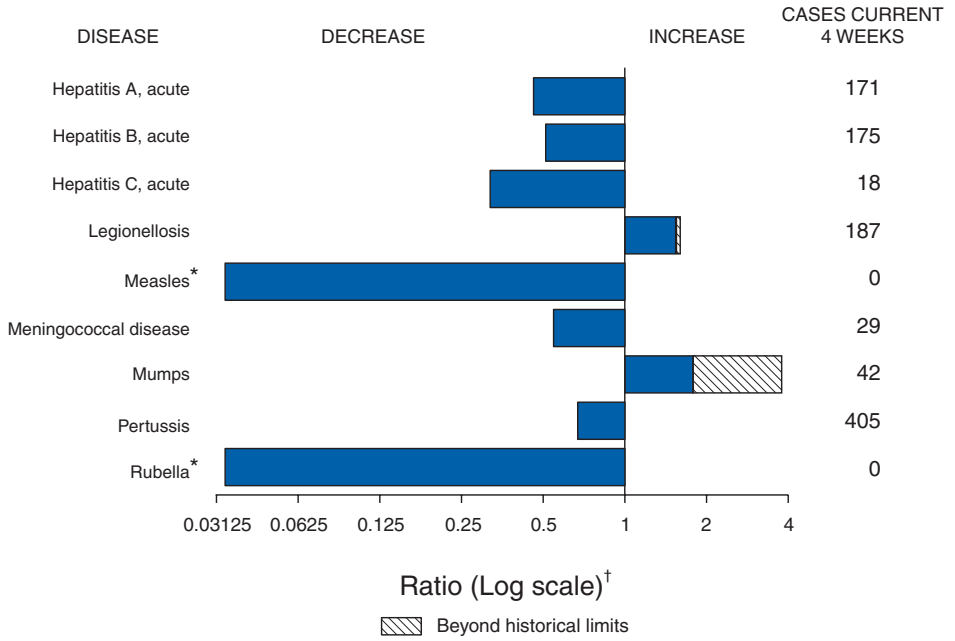
† Pneumonia and influenza.

§ 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.

¶ Because of Hurricane Katrina, weekly reporting of deaths has been temporarily disrupted.

** Total includes unknown ages.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals November 4, 2006, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 44 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.

Notifiable Disease Data Team and 122 Cities Mortality Data

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Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Data are compiled in the National Center for Public Health Informatics, Division of Integrated Surveillance Systems and Services. Address all inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop E-90, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333 or to *www.mmwrq@cdc.gov*.

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