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Hepatitis Awareness Month — May 2007

May 2007 marks the 12th anniversary of Hepatitis Awareness Month. This issue of *MMWR* highlights public health measures to vaccinate and protect children from hepatitis B virus (HBV) infection in China and to monitor the characteristics of persons with chronic hepatitis B in San Francisco, California.

Worldwide, 370 million persons have chronic HBV infection, and 500,000–700,000 persons die annually from HBV-related liver disease; approximately 75% of HBV infections occur in Asia (World Health Organization, unpublished data, 2006). In the United States, approximately half of the 1 million persons with chronic HBV infection are Asians/Pacific Islanders, most of whom became infected with HBV before arriving in the United States, including many who remain unaware of their infection (*1*). The HBV-related death rate among Asians/Pacific Islanders is seven times greater than the rate among whites (CDC, unpublished data, 2007).

Persons with chronic HBV infection are at risk for premature death from liver cirrhosis and cancer. Hepatitis B vaccination of infants worldwide will protect successive generations from chronic HBV infection and associated liver disease. Persons already infected with HBV can benefit from HBV screening, care, and treatment to protect their health and prevent transmission to others.

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Progress in Hepatitis B Prevention Through Universal Infant Vaccination — China, 1997–2006

Hepatitis B virus (HBV) infection is a leading cause of illness and death in China. Approximately 60% of the population has a history of HBV infection, and 9.8% of persons in China are chronically infected with HBV and at risk for premature death from liver disease (*1*). Each year, an estimated 263,000 persons in China die from HBV-related liver cancer or cirrhosis, accounting for 37%–50% of HBV-related deaths worldwide (*2*). Because most HBV infections occur during infancy or early childhood, when HBV infection is most likely to become chronic, vaccination of infants beginning at birth is the key strategy for preventing chronic HBV infection. This report describes China's progress in increasing coverage among infants with hepatitis B vaccine (HepB) and timely administration of the HepB birth dose (i.e., within 24 hours of birth). Infant vaccination coverage with both the timely birth dose and the complete vaccine series was substantially higher among children born during 2003 than among those born during 1997; timely birth-dose coverage increased from 29.1% to 75.8%, and HepB series completion increased from 70.7% to 89.8%. Furthermore, in economically disadvantaged

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populations in western and middle provinces* targeted by the China-Global Alliance for Vaccines and Immunization (China-GAVI) project, reported coverage with timely HepB birth dose increased from 64% in 2004 to 81% in 2006, and coverage with the complete HepB series increased from 52% in 2001 to 92% in 2006. China has established a goal to reduce chronic HBV infection among children aged <5 years to <1% by 2010 (*3*). Achieving this goal will require continued commitment to increasing vaccination coverage in impoverished regions and ensuring that infants born at home are vaccinated within 24 hours of birth.

Hepatitis B Immunization Program

HepB was first recommended for routine vaccination of infants in China in 1992, with the first dose to be administered within 24 hours of birth and subsequent doses at ages 1 and 6 months. However, because of high vaccine prices and user fees charged to parents by local health departments for vaccine purchase and administration, until 2002, infant vaccination occurred primarily in large cities of the wealthier eastern provinces.† Beginning in 2002, infant hepatitis B vaccination was added to China's National Immunization Programme. Also in 2002, the China Ministry of Health began a project with the GAVI Alliance§ (formerly known as the Global Alliance for Vaccines and Immunisation) to ensure HepB availability in China's poorest provinces and counties. The 5-year China-GAVI project provides free HepB, targeting approximately 5.6 million children born each year in 12 western provinces and in government-designated poor counties in 10 middle provinces, covering approximately 36% of China's child population. In 2005, a new vaccination regulation abolished all charges and user fees for all nationally recommended vaccines, including hepatitis B; the vaccine is now free to all children in China.

To estimate national 3-dose HepB coverage and timely (i.e., within 24 hours of birth) HepB birth-dose coverage and to describe the effects of province and location of birth (e.g., home versus hospital) on vaccination coverage levels, data from two national vaccination coverage surveys conducted by the China Ministry of Health in 1999 and 2004 were reviewed. In both 1999 and 2004, parents were interviewed

* China-GAVI–funded western provinces: Chongqing, Gansu, Guangxi, Guizhou, Neimenggu (Inner Mongolia), Ningxia, Qinghai, Shaanxi, Sichuan, Tibet, Yunnan, and Xinjiang; middle provinces with GAVI funding in government-designated poor counties: Anhui, Hainan, Hebei, Heilongjiang, Henan, Hubei, Hunan, Jiangxi, Jilin, and Shanxi.

† Eastern provinces: Beijing, Fujian, Guangdong, Jiangsu, Liaoning, Shandong, Shanghai, Tianjin, and Zhejiang.

§ Additional information regarding the GAVI Alliance is available at http://www.gavialliance.org.

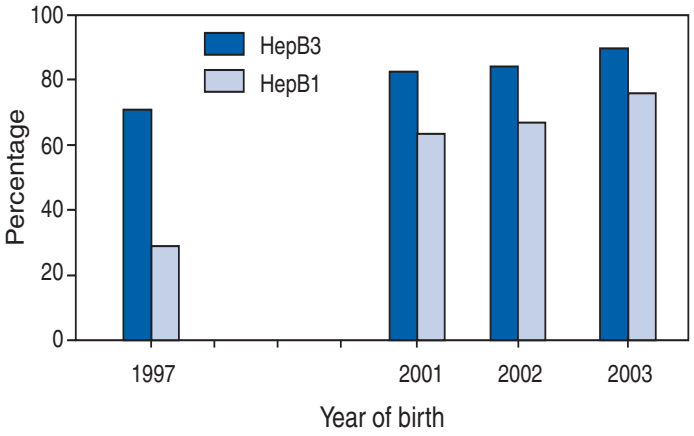
in house-to-house surveys regarding the vaccination status of eligible children born during the study periods. Sampling of households in each province was conducted using the probability proportional to size (PPS) method. In the 1999 survey, counties in each province were divided into four economic strata, and PPS sampling was conducted within each strata. In 2,173 counties in 31 provinces, parents of 25,878 children born during 1997 were interviewed (*4*). In the 2004 survey, 273 counties were selected randomly from all counties throughout the country, including at least three counties in each province, and PPS sampling was conducted in each county; parents of 171,188 children born during 2001–2003 were interviewed (*5*). For both surveys, 3-dose HepB and timely HepB birth-dose coverage were measured by dividing the number of children receiving 3-dose HepB and timely HepB birth dose, respectively, by the number of children surveyed, taking into account the PPS sampling design.

To examine in more detail the impact of the China-GAVI project, routine immunization-reporting–system data from 2001 through 2006 for China-GAVI–funded provinces were reviewed. In this national reporting system, the numbers of children targeted for and receiving each dose of routinely recommended vaccines are compiled by each immunization clinic and reported monthly to provincial and national immunization programs. For this analysis, 3-dose HepB and timely HepB birth-dose coverage in China-GAVI–funded provinces were measured by comparing the ratio of the number of children receiving doses of HepB to the number of children targeted to receive doses of diphtheria, tetanus, pertussis (DTP) vaccine, because the latter represents the most accurate local estimate of the number of children requiring routine childhood vaccination. Timely HepB birth-dose coverage could only be analyzed from 2004 through 2006 since reporting of HepB birth-dose timing was not required by the China Ministry of Health until 2004. A mathematical model was used to calculate hepatitis B disease burden before inception of the vaccination program and to estimate the number of deaths prevented through vaccination (*1,2*).

National Vaccination Coverage Survey

Comparison of the two national vaccination coverage surveys indicated that estimated 3-dose HepB coverage increased substantially overall, from 70.7% among children born in 1997 to 89.8% among children born in 2003 (Figure 1). Timely HepB birth-dose coverage also increased, from 29.1% among children born in 1997 to 75.8% among children born in 2003 (Figure 1). During 1997–2003, estimated national 3-dose DTP coverage remained level (93%). The difference between 3-dose HepB coverage and 3-dose DTP coverage was reduced from 20% in 1997 to 3% in 2003.

FIGURE 1. Estimated infant vaccination coverage with 3 doses of hepatitis B vaccine (HepB3) and timely* administration of the HepB birth dose (HepB1), by year of birth — China, 1997 and 2001–2003



SOURCE: China Ministry of Health national vaccination coverage surveys, 1999 and 2004.
* Within 24 hours of birth.

In the 2004 survey, estimated coverage was substantially lower in western provinces (68.0% for 3 doses of HepB and 49.5% for timely birth dose) than in middle provinces (91.8% for 3 doses of HepB and 72.7% for timely birth dose) or eastern provinces (94.1% for 3 doses of HepB and 81.9% for timely birth dose) (Figure 2).

Timely birth-dose coverage among infants born at home during 2001–2003 was less than half that of those born in hospitals. Among children born in 2004, timely birth-dose coverage for infants born in township hospitals was only two thirds that of those born in county, provincial, or national hospitals.

China-GAVI Project

For the period 2003–2006, 3-dose HepB coverage and timely HepB birth-dose coverage increased in the 12 western provinces and in the counties in 10 middle provinces supported by the China-GAVI project. In 2006, the ratios of 3-dose HepB/3-dose DTP coverage and timely HepB birth dose/first-dose DTP coverage were 92% and 81%, respectively (Figure 3). During 2003–2006, approximately 15.4 million children in China-GAVI project counties received the 3-dose HepB series, preventing an estimated 1.47 million chronic HBV infections in children and 265,000 future deaths attributable to chronic HBV infection.

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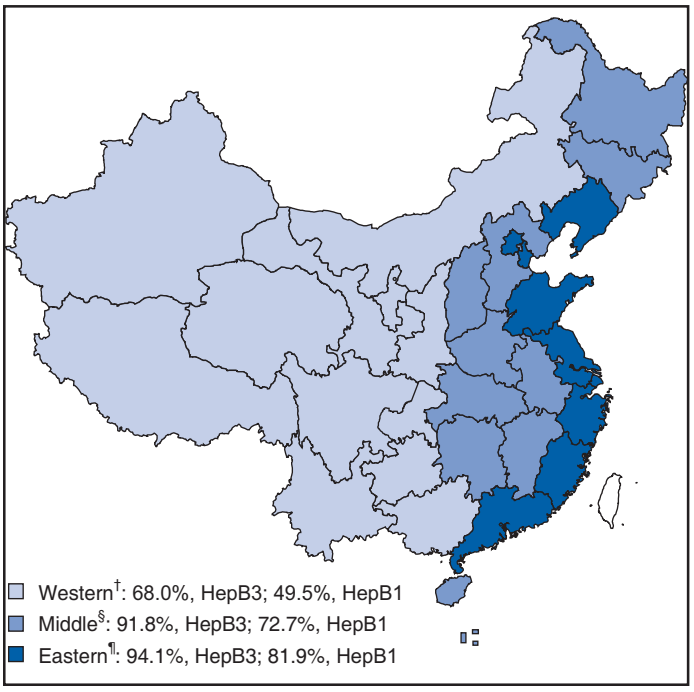
FIGURE 2. Estimated infant vaccination coverage with 3 doses of hepatitis B vaccine (HepB3) and timely* administration of the HepB birth dose (HepB1), by region — China, 2001–2003



SOURCE: China Ministry of Health national vaccination coverage survey, 2004.
* Within 24 hours of birth.
† China-GAVI–funded western provinces: Chongqing, Gansu, Guangxi, Guizhou, Neimenggu (Inner Mongolia), Ningxia, Qinghai, Shaanxi, Sichuan, Tibet, Yunnan, and Xinjiang. (GAVI was formerly known as Global Alliance for Vaccines and Immunisation.)
§ Middle provinces with GAVI funding in government-designated poor counties: Anhui, Hainan, Hebei, Heilongjiang, Henan, Hubei, Hunan, Jiangxi, Jilin, and Shanxi.
¶ Eastern provinces: Beijing, Fujian, Guangdong, Jiangsu, Liaoning, Shandong, Shanghai, Tianjin, and Zhejiang.

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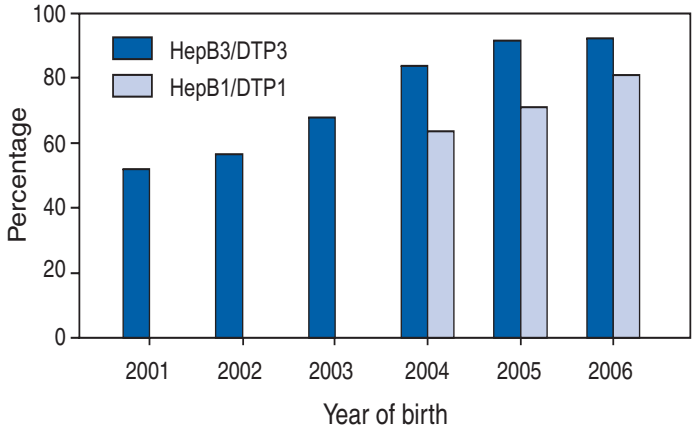
Editorial Note: China has made substantial progress in implementing universal, timely hepatitis B vaccination for infants and in reducing disparities in coverage between the poorest and wealthiest parts of the country. The support from the China-GAVI project has improved vaccination coverage and helped prevent chronic HBV infection in children. During 2003–2006, approximately 15 million children in China-GAVI–funded provinces and approximately 42 million children nationwide received HepB.

Since 2002, implementation of universal infant hepatitis B vaccination in China has focused particularly on improving timely administration of the birth dose. Approaches used to increase timely birth-dose coverage have included 1) increasing the percentage of births that occur in hospitals; 2) improving vaccine availability in hospitals and township health facilities; 3) building collaboration among delivery services (i.e., maternal and child health programs and obstetrics) and between vaccination services (i.e., immunization programs and pediatrics) in hospitals and township health centers; 4) increasing the awareness of the importance of timely birth-dose administration among providers and parents; 5) intensifying training, supervision, and monitoring of county, township, and village health workers; and 6) providing subsidies to village doctors to provide vaccines.

Disparities in vaccination coverage continue to exist by region and by location of birth. Despite the China-GAVI activities, during 1997–2006, children from eastern provinces had substantially higher coverage than those from middle or western provinces, as did children born in hospitals versus those born at home. Income levels continue to be highest in China's eastern provinces and lowest in the western provinces; residents in eastern provinces generally have greater access to and ability to pay for health care, including hospital care for childbirth. Children born in hospitals generally have better

FIGURE 3. Estimated infant vaccination coverage with 3 doses of hepatitis B vaccine (HepB3)/3 doses of DTP* vaccine (DTP3) and timely† administration of the HepB birth dose (HepB1)/ first dose of DTP vaccine (DTP1), by year of birth — China-GAVI§–funded provinces and counties,¶ China, 2001–2006



SOURCE: Routine Immunization Reporting System, China Center for Disease Control and Prevention.
* Diphtheria, tetanus, pertussis.
† Within 24 hours of birth.
§ Formerly known as Global Alliance for Vaccines and Immunisation.
¶ China-GAVI–funded western provinces: Chongqing, Gansu, Guangxi, Guizhou, Neimenggu (Inner Mongolia), Ningxia, Qinghai, Shaanxi, Sichuan, Tibet, Yunnan, and Xinjiang; middle provinces with GAVI funding in government-designated poor counties: Anhui, Hainan, Hebei, Heilongjiang, Henan, Hubei, Hunan, Jiangxi, Jilin, and Shanxi.

access to immunization services and can be vaccinated more easily within 24 hours of birth. In western China, children are more likely to live in remote, mountainous areas and have less access to hospital delivery and immunization services. The China Ministry of Health is implementing programs to increase births in hospitals nationwide by expanding and improving obstetric care in health-care facilities throughout China and providing incentives to give birth in hospitals.

Prevention of chronic HBV infection in China is integral to global initiatives to reduce the burden of HBV infection. In 1992, the World Health Assembly passed resolution 45.17, which called for all World Health Organization (WHO) member states to integrate cost-effective new vaccines, including HepB, into national immunization programs where feasible. The same year, WHO recommended that HepB be included in routine vaccination schedules for all children in all countries (*6*). During 2000–2006, the GAVI Alliance has provided support for HepB introduction to 51 less developed member states (i.e., countries with less than [U.S.] $1,000 per capita gross national income), and these countries have made substantial progress in introducing HepB into their vaccination schedules (*7*). As of 2005, a total of 154 (80%) of 192 WHO member states reported having integrated HepB into their routine infant vaccination schedules; global coverage with 3-dose HepB had increased from 32% in 2001 to 55% in 2005, with 2005 coverage varying by WHO region (South-East Asia: 27%; Africa: 39%; Eastern Mediterranean: 74%: Europe: 76%; Americas: 85%; Western Pacific: 87%) (*8*). The advances in hepatitis B vaccination have led countries and WHO regions to set goals for the elimination of HBV transmission. The WHO Western Pacific Region has committed to reducing chronic HBV infection in children aged <5 years to <2% by 2012.

The findings in this report are subject to at least two limitations. First, the design of the national surveys conducted in 1999 and 2004 differed in how counties were stratified before PPS sampling, which might limit comparability of the two surveys. Second, for the analyses using data from the routine immunization reporting system, the precise number of children requiring vaccination at local levels is not known because some children might not be registered; hence, the use of children targeted to receive DTP vaccine as a surrogate for total number of children might result in overestimation of reported vaccination coverage.

Despite China's progress in increasing hepatitis B vaccination coverage and timely administration of the birth dose, challenges remain to reaching the national goal of <1% chronic HBV infection among children aged <5 years by 2010. Achieving this goal will require increasing 3-dose HepB coverage to the same level as 3-dose DTP coverage and increasing timely HepB birth-dose coverage to 90% in all provinces. The greatest challenge is to increase administration of the birth dose among children born at home. Three provinces (Guizhou, Tibet, and Yunnan) and 42% of China-GAVI project counties still have timely birth-dose coverage levels of <75% and are most in need of targeted interventions. Although most hospitals now are achieving >95% timely birth-dose coverage for infants born in hospitals, strategies are needed to ensure that false contraindications to vaccination, including low birth weight and unstable medical condition at birth (*9*), do not delay administration of the birth dose. Innovative measures also are needed to reach infants born at home, particularly through linking prenatal care and birthing-care providers with immunization program staff at township and village levels. With these improvements, China can reduce substantially the burden of hepatitis B.

Acknowledgments

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Characteristics of Persons with Chronic Hepatitis B — San Francisco, California, 2006

Chronic hepatitis B is the most common cause of cirrhosis and liver cancer worldwide. Approximately 45% of the world's population lives in regions where chronic hepatitis B virus (HBV) infection is endemic, including most of Asia and the Pacific Islands, Africa, and the Middle East (*1*). Nearly one fourth of the population of San Francisco was born in Asia and the Pacific Islands.* In 2006, the San Francisco Department of Public Health (SFDPH) received reports consistent with probable chronic HBV infection for 2,238 persons. To characterize persons with reported confirmed chronic HBV infection in San Francisco in 2006, SFDPH collected additional data on a subset of 567 cases reported to the SFDPH chronic hepatitis B registry. Eighty-four percent of the persons were Asians/Pacific Islanders (A/PIs), 80% of whom were foreign born. Fewer than half had been referred to a gastroenterologist/hepatologist for evaluation at the time of reporting. Persons with chronic HBV infection can benefit from medical care by providers with expertise in viral hepatitis. In addition, close contacts of infected persons should be screened and offered vaccination if found to be susceptible to HBV infection. Culturally appropriate counseling for and follow-up of persons with chronic HBV infection and their contacts could help reduce the transmission of HBV infection.

Hepatitis B surface antigen (HBsAg), hepatitis B e antigen (HBeAg), HBV DNA, and immunoglobulin M antibody to hepatitis B core antigen (IgM anti-HBc) are detectable during acute HBV infection. The presence of HBsAg, HBeAg, or HBV DNA for more than 6 months is evidence of chronic infection. The California Code of Regulations† requires laboratories to report all positive test results for HBsAg to local health departments. Health-care providers also are required to report cases of acute and chronic hepatitis B. Reporting requirements for both laboratories and providers include supplying the name, age, sex, and contact information of persons with positive tests and the contact information for the associated health-care provider, although not all reports contain this information. SFDPH has maintained a registry of persons with positive HBsAg test results reported to SFDPH since 1984; the registry contains HBsAg test results for approximately 25,700 persons. Based on the standard case definitions approved by state epidemiologists for 2007, a confirmed case of chronic HBV infection is defined as an infection in a person who tests HBsAg positive, HBV DNA positive, or HBeAg positive two times at least 6 months apart.§ A probable case is defined as an infection in a person with a single HBsAg-positive, HBV-DNA-positive, or HBeAg-positive laboratory result with either a negative IgM anti-HBc or no IgM anti-HBc test reported.

To further characterize persons with known chronic HBV infection, in January 2006, SFDPH began requesting data from health-care providers on persons who met the case definition for confirmed HBV infection for whom a second positive HBsAg result was reported to SFDPH during 2006. SFDPH formed an advisory panel of clinicians from public, private, and academic settings, who provided input into the development of the supplemental data collection form and endorsed the activity in a letter mailed by SFDPH to local health-care providers. SFDPH faxed supplemental data forms to the providers who had ordered the most recent positive HBsAg test, requesting information on patient race/ethnicity, primary language, reasons for HBsAg testing, risk factors for HBV infection, referral for specialist care, and treatment history. Providers used information obtained from a chart review or during patient visits to complete the form. Providers who did not respond were sent faxes two more times and then contacted by telephone one time.

During 2006, SFDPH received reports of 2,238 persons with test results consistent with probable chronic HBV infection; all were reported by laboratories. Of these, 1,156 (52%) were male, and 1,090 (49%) were aged 30–49 years (Table 1). Among the 714 women of childbearing age (i.e., aged 12–45 years) for whom a positive HBsAg test result was reported to SFDPH, 170 (24%) were pregnant when follow-up was conducted by the perinatal hepatitis B coordinator.

Of the 2,238 positive HBsAg reports received by the registry in 2006, a total of 1,162 (52%) met the case definition for confirmed chronic HBV infection. Of these, 736 had available health-care provider contact information. Supplemental data forms were faxed to these providers; 567 forms were returned to SFDPH with at least partial information. Of persons for whom place of birth was reported, 84% were foreign born (Table 2); of persons for whom both race/ethnicity and place of birth were reported, 80% were foreign-born A/PIs. Cantonese Chinese was reported to be the primary language of 52% of persons. Reasons for HBsAg testing included screening (43%), follow-up of a history of hepatitis B (41%), or evaluation of abnormal liver enzymes (9%). The most frequently reported risk for HBV infection was birth in an

* US Census Bureau. American factfinder. Available at http://factfinder.census.gov.

† California Code of Regulations. 17 CCR §2500. Reportable diseases and conditions. Available at http://www.dhs.ca.gov/ps/dcdc/disb/pdf/Title%2017%20lab%20reportable%20conditions.pdf.

§ CDC. National notifiable diseases surveillance system. Chronic hepatitis B virus. Available at http://www.cdc.gov/epo/dphsi/casedef/hepatitisbcurrent.htm.

TABLE 1. Number and percentage of persons with probable chronic hepatitis B virus (HBV) infection,* by sex and age group — San Francisco, California, 2006

Characteristic	No.	(%)
Sex (n = 2,215)		
Female	1,059	(47.8)
Male	1,156	(52.2)
Age group (yrs) (n = 2,232)		
<30	544	(24.4)
30–49	1,090	(48.8)
≥50	598	(26.8)

* A person with a single positive hepatitis B surface antigen result with either a negative immunoglobulin M antibody to hepatitis B core antigen (IgM anti-HBc) or no IgM anti-HBc test reported. N = 2,238.

HBV-endemic region (74%); male-to-male sexual contact accounted for 12% (Table 2). A total of 21% of persons were reported to have been treated for chronic HBV infection, and 32% were reported to have been referred to a gastroenterologist/hepatologist at the time of reporting.

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Editorial Note: The findings in this report suggest that, in 2006, nearly 85% of persons with confirmed chronic HBV infection in San Francisco were A/PIs, 80% of whom were born outside the United States. These persons likely acquired their infections in their countries of origin, countries where HBV infection is endemic and infections usually are acquired at birth or during early childhood. Of persons who acquire chronic HBV infection when they are aged <5 years, an estimated 15%–40% will eventually have chronic liver disease, including cirrhosis and liver cancer (*2*). Treatment for chronic hepatitis B is increasingly effective and can prevent or slow the development of these sequelae (*2*). However, fewer than one third of persons with chronic HBV infection in San Francisco in 2006 had been referred to a specialist for evaluation or undergone treatment at the time of reporting.

Persons from countries where HBV infection is endemic might be unaware of their increased risk for hepatitis-B–related liver disease (*3,4*). Hepatitis B screening programs in A/PI communities in the United States can be an effective means of identifying persons with chronic HBV infection and encouraging them to seek medical care (*5–7*).

Health departments and large health systems can use electronic disease registries to characterize and provide services for persons with chronic HBV infection and their close contacts. Persons with chronic HBV infection should receive referrals for appropriate medical care, which can include treatment for HBV infection. Their close contacts should undergo screening for HBV infection and, if found to be susceptible, should receive hepatitis B vaccination. Registries also can provide local population-based data on the epidemiology of chronic HBV infection.

TABLE 2. Number and percentage of persons with confirmed chronic hepatitis B virus (HBV) infection* and a completed supplemental data form (N = 567), by selected characteristics — San Francisco, California, 2006

Characteristic	No.	(%)
Sex (n = 561)		
Female	311	(55.4)
Male	250	(44.6)
Age group (yrs) (n = 567)		
<30	76	(13.4)
30–49	301	(53.1)
≥50	190	(33.5)
Race/Ethnicity (n = 498)		
American Indian/Alaska Native	1	(0.2)
Asian/Pacific Islander	419	(84.1)
Black, non-Hispanic	15	(3.0)
Hispanic†	8	(1.6)
White, non-Hispanic	51	(10.2)
Other	4	(0.8)
Primary language (n = 470)		
Cantonese Chinese	245	(52.1)
English	171	(36.4)
Mandarin Chinese	19	(4.0)
Other	35	(7.5)
Foreign born (n = 388)	324	(83.5)
Risk factors for HBV infection (n = 423)		
Born in a country where HBV is endemic	313	(74.0)
Male-to-male sexual contact	52	(12.3)

* A person who tests positive for hepatitis B surface antigen two times at least 6 months apart.
† Might be of any race.

At least five factors are critical to ensuring that registry data are representative and complete. First, legally mandated laboratory reporting of test results is essential for complete ascertainment of cases. Second, electronic information systems are needed to promote efficiency, allowing the registry to receive data securely, account for duplicate case reports, and merge data from multiple reporting sources. Third, collaboration with laboratories is needed so that health departments can obtain additional patient demographic information and clinician contact information through laboratory reports. Fourth, communication with and timely feedback of surveillance data to clinicians are needed to increase cooperation with health departments that are requesting supplemental information on cases. Finally, because the majority of infected persons and their contacts might not speak English as their primary language, multilingual staff and culturally appropriate health education materials are needed to support these activities.

The findings in this report are subject to at least three limitations. First, the results are limited to persons who received medical care, who were tested for chronic HBV infection, and whose laboratory results or diagnoses were reported to SFPDH.

Therefore, these findings do not represent the actual number of persons with chronic HBV infection in San Francisco, especially among those who do not have regular access to medical care. Second, persons included in the analysis of confirmed cases were limited to those for whom provider contact information was available. Although the California Code of Regulations mandates reporting of provider name and contact information for all notifiable diseases and conditions, this information is not reported frequently. Finally, the findings are based on data collected from persons with confirmed chronic HBV infection. Because the case definition for confirmed cases requires additional laboratory testing, the 567 persons described in this analysis might represent a subset of patients with greater access to care or those who were more likely to have undergone follow-up and treatment.

During 2007, local organizations in San Francisco are planning low-cost, community-based HBV screening and vaccination activities targeted to A/PIs and educational outreach to promote awareness of HBV screening, prevention, and treatment guidelines (http://www.sfhepbfree.org). SFDPH plans to provide persons newly reported to the registry with information on how to reduce the risk for transmission to others and the need for medical monitoring. SFDPH also will explore different approaches to identifying persons who are household and sex contacts of infected persons to inform them of their potential exposure to HBV, to recommend testing and vaccination, and to better understand the barriers to obtaining HBV preventive services.

With proper resources, chronic hepatitis B registries can help health departments characterize the burden of chronic HBV infection. Such registries also enable health departments and health-care providers to link HBV-infected persons and their contacts with recommended prevention and care services.

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CDC's 60th Anniversary

Director's Perspective — William L. Roper, M.D., M.P.H., 1990–1993

The years 1990–1993 saw tremendous change in public health. CDC expanded its effectiveness and capacity by building key partnerships with academia, public health agencies, and the private sector. The explosion of telecommunications greatly enhanced CDC's ability to communicate the results of studies and recommendations directly with the public, which increased the visibility of the agency and the public health community. The agency's priorities were clear: strengthening the public health infrastructure, improving the health of children, and making prevention a practical reality in the nation's health system.

As the 21st century approached, CDC faced challenges more complex than could have been foreseen by the public health visionaries who first spoke of the need for a "center of excellence" devoted to communicable diseases. Overarching these priorities was a new strategic planning process at CDC that served to articulate the vision and mission of the agency and to establish strategies for accomplishing these goals.

The need for a stronger public health system was described in numerous scientific reports by the Institute of Medicine (IOM) (*1*–*4*). In 1990, the U.S. Department of Health and Human Services issued a national framework for addressing these concerns in *Healthy People 2000: The National Health Promotion and Disease Prevention Objectives* (*5*). CDC provided national leadership for development of these objectives and served as the lead or co-lead agency for 12 of the 22 *Healthy People* priority areas.

Using strategic planning processes derived from leading management experts (*6*) against the backdrop of the *Healthy*

In commemoration of CDC's 60th Anniversary, MMWR *is departing from its usual report format. This is the fourth in a series of occasional commentaries by directors of CDC. The directors were invited to give their personal perspectives on the key public health achievements and challenges that occurred during their tenures.*

People goals, CDC's vision for the world emerged as "Healthy People in a Healthy World." Later, this statement was refined to add "Through Prevention," adding greater emphasis to CDC's role as the nation's prevention agency. CDC's mission statement also was articulated: to promote health and quality of life by preventing and controlling disease, injury, and disability.

In crafting CDC's design for the future, five cross-cutting strategies emerged:

- Partnerships: strengthen relationships with public health partners while building new partnerships with community, national, and international organizations.
- Reinventing government: encourage integration and coordination of prevention programs.
- Health communications and social marketing: use consumer research to craft and strategically deliver health messages.
- Effectiveness: evaluate the efficacy, effectiveness, and cost-effectiveness of preventive services and public health programs.
- Workforce diversity: build a diverse workforce that reflects the populations that CDC serves.

The vision, mission, and strategy developed in the early 1990s laid the foundation for CDC's work. Key activities focused on the public health infrastructure, improving children's health in the United States and around the world, and the broader prevention agenda.

Strengthening the Public Health Infrastructure

In 1988, the IOM report *The Future of Public Health* had sounded the alarm that the public health infrastructure was inadequate to protect the nation's health and that dire consequences would result if the nation did not attend to infrastructure and leadership needs (*1*). CDC understood these needs and the associated challenges and quickly worked to shore up public health. The solutions developed and put in place invariably focused on empowering communities, community leaders, and community processes (*7*). The solutions also made use of the latest technological advances to reach out across the nation to build a human, information, and organizational infrastructure.

Distance-based learning. In the early 1990s, only 11% of public health departments surveyed reported having a trained epidemiologist or statistician on their staffs. At the same time, obtaining training for employees was becoming increasingly difficult because of budget cuts. As a result, distance-based learning became a priority and a focus for educational efforts developed and funded by CDC. The Public Health Training Network (PHTN) was developed by CDC and launched in 1993 (*8*), using a broad range of media (e.g., satellite, Internet, CD-ROM, and print) to reach the widest possible audience. To date, PHTN has provided training to approximately 5 million health professionals and, in some circumstances, has created and disseminated training products in less than 48 hours (e.g., in response to public health emergencies such as the multicountry outbreak of severe acute respiratory syndrome [SARS] in 2003).

Public Health Leadership Institute. A key point in the 1988 IOM report was that the public health field soon would have a significant lack of experienced leadership. In 1991, CDC established the National Public Health Leadership Institute, designed to strengthen the leadership competencies of senior public health officials and build interorganizational teams that could go back to their communities and take actions that would lead to improvements in health. Now, more than a decade later, the institute continues to prepare public health professionals to grow in leadership positions and to move public health forward as the challenges and opportunities become increasingly complex.

Information Network for Public Health Officials (INPHO) and Health Alert Network (HAN). Before the Internet became a household word, CDC created INPHO to give local and state public health officials access to what was then called "the information superhighway." As concerns regarding public health preparedness increased in later years, INPHO was expanded to include HAN, a computer-based network providing rapid and timely emergent health information to local and state public health agencies across the country.

National Profile of Local Public Health Departments and Essential Services of Public Health. CDC needed to know more about the organizational characteristics of public health, particularly the local health department, a cornerstone of the public health infrastructure. To that end, CDC created the National Profile of Local Public Health Departments, in partnership with the National Association of County & City Health Officials. In addition, the 10 Essential Services of Public Health were defined as a guide to building capacity in public health agencies. This delineation formed the basis for creation of the National Public Health Performance Standards, a national tool for assessing and building organizational infrastructure in the United States and globally (*9*).

Improving the Health of Children

Vaccine financing. Today, the life-saving and health-preserving impact of immunizations exceeds almost all other public health interventions, both in terms of effectiveness and

cost-effectiveness. However, in the early 1990s, costs were a significant barrier to obtaining recommended vaccines for persons who were uninsured or underinsured (*10*). The necessity for achieving high vaccination coverage rates was made especially clear through a resurgence of measles in 1989 (*11*), which involved more than 55,000 cases and 123 deaths, with preschoolers disproportionately affected (*10*). In 1993, the challenge of addressing vaccine financing led to the Childhood Immunization Initiative, which set a goal of 90% vaccination coverage for preschool children and addressed vaccine financing to make this possible (*11*).

Many solutions were considered and supported by various perspectives, but the compromise approach involved passage in 1993 of the Vaccines for Children (VFC) Act, which ensures that children who are uninsured or on Medicaid, who are American Indians/Alaska Natives, or who are underinsured and seen in Federally Qualified Health Centers, all have a right to receive free of charge any vaccines recommended by the Advisory Committee on Immunization Practices. The innovation of this entitlement was provision of vaccines directly to clinical-care providers, who then administer them to children as needed, permitting children to remain in their primary medical homes without requiring referrals and without loss of continuity of care. This collaboration between public health and the private sector created a large network of VFC providers and within 3 years led to >75% vaccination coverage. Today, more than 40% of vaccinations for children are provided through VFC (*10*), and vaccination rates are at record or near-record highs. Measles vaccinations for preschoolers exceed 90%, and racial and ethnic disparities in vaccination have been reduced dramatically (*12*).

Polio eradication. In 1988, CDC had joined forces with the World Health Organization (WHO), UNICEF, and Rotary International to spearhead the Global Polio Eradication Initiative. Despite elimination from the Americas in 1991, polio remained at high rates in many countries in Asia and Africa. CDC's commitment to global eradication intensified in the early 1990s, when CDC began assigning epidemiologists to the Pan American Health Organization and WHO to help in the polio battle. These dedicated CDC workers traveled around the world helping other countries develop and implement plans of action to eradicate polio. At the same time, CDC began hosting global polio eradication meetings. With the technical aid of CDC's immunization, laboratory, and epidemiology experts, as well as substantial financial contributions, the number of children with paralytic polio has been reduced worldwide from 350,000 in 1988 to approximately 2,000 in 2006.*

*Additional information available at http://www.polioeradication.org/casecount.asp.

Recommending folic acid to reduce neural tube defects. Neural tube defects (NTDs) are major birth defects that occur when the neural tube, from which the brain and spinal cord develop, does not form correctly. Because these defects occur very early in pregnancy, often before a woman even is aware that she is pregnant, identifying early preventive approaches was essential. Rigorous research conducted in the late 1980s demonstrated that if women at risk for becoming pregnant took a daily dose of folic acid (vitamin B9), the number of cases of NTDs could be reduced by 50%–70%. In 1992, the U.S. Public Health Service (USPHS) recommended that all women of childbearing age in the United States who are capable of becoming pregnant consume 0.4 mg of folic acid per day to reduce their risk for having a pregnancy affected with spina bifida or other NTDs (*13*). At the time, the recommendation listed three potential approaches to achieving this goal: 1) improvement of dietary habits, 2) fortification of the U.S. food supply, and 3) use of dietary supplements. The USPHS recommendation had both a national and an international impact. In the United States, the recommendation led directly to efforts by the Food and Drug Administration (FDA) to fortify cereal grain products, which became mandatory in 1998. Internationally, the recommendation has influenced more than 40 countries to adopt folic acid fortification of wheat flour for the prevention of NTDs.

Making Prevention a Practical Reality

The idea that prevention underscored the work of CDC was key to all of the efforts described. One reflection of this was the 1992 change of CDC's name to Centers for Disease Control and Prevention. This important symbolic change was reflected in the practical efforts of CDC.

In 1992, the National Center for Injury Prevention and Control was established, giving focus and energy to understanding and preventing both unintentional and intentional injuries. Injuries were and continue to be a leading cause of death. A cornerstone of this work was to prevent violence among young persons by scientifically determining the factors that put persons at risk for violence, disseminating information about violence-prevention programs, and evaluating potential violence-prevention interventions.

Preventing mortality from breast and cervical cancer. The 1990 Breast and Cervical Cancer Mortality Prevention Act authorized CDC to fund states for breast and cervical cancer follow-up. Through this program, CDC directed $23 million to help eight states develop comprehensive programs for the early detection of breast and cervical cancer, primarily in low-income minority women. In 1992, the program was expanded to 12 states, and by 1997, all states were funded. In addition

to outreach and screening of low-income, uninsured women, program activities included provider and public education, surveillance of screening outcomes, and quality assurance (in collaboration with FDA) (*14*). Since 1991, the program has served more than 2.9 million women, provided more than 6.9 million screening examinations, and diagnosed more than 29,000 breast cancers, 94,000 precursor cervical lesions, and 1,800 cervical cancers (*14*).

Expanding efforts to stop HIV/AIDS. CDC continued its leadership role in activities aimed at preventing human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). Recognizing that the disease affected certain vulnerable populations disproportionately, CDC funded prevention programs directed toward minorities and initiated a program to evaluate these activities to make sure they were effective. In 1991, CDC also identified a sharp increase in cases of tuberculosis that were related to HIV infection and AIDS; in that same year, CDC reported that the number of reported AIDS cases in the United States had reached 200,000. Recognizing that prevention activities were needed at the community level, CDC funded five HIV/AIDS demonstration projects that extended prevention efforts to community sites and elicited the help of community residents and peer groups to motivate behavior change. The following year, the HIV classification system was revised, with an expanded AIDS surveillance case definition. In 1992, CDC also launched Business Responds to AIDS, a program designed to help large and small businesses and labor groups to meet the challenges of HIV infection and AIDS on the job and in the community.

Managing the effects of tobacco use. In 1990, the Surgeon General's report on smoking made clear the substantial benefits not only of preventing tobacco use altogether but also of quitting smoking (*15*). These benefits included decreased risks for lung and other cancers, heart attack, stroke, and chronic lung disease. To act upon the recommendations in the report and move forward quickly on mediating the effects of tobacco use, funding for the National Tobacco Prevention and Control Program was established to build capacity in all state health departments. In coordination with the National Cancer Institute, the CDC program moved tobacco-control strategies beyond the individual-based medical model into a broader and more effective public health approach, emphasizing environmental and policy change. The Office on Smoking and Health was integrated fully into the Atlanta-based offices of CDC, with expanded staffing and programs located within the National Center for Chronic Disease Prevention and Health Promotion.

Enhancing the role of health communication. The agency's commitment to prevention, the arrival of videoconferencing and e-mail, and a backdrop of 24-hour news cycles led CDC to identify health communications as a core strategy to achieve its mission (Figure). An intense review of health communications science led first to the development of partnerships with the private sector and then, in 1993, to establishment of the Office of Health Communications.

Prevention effectiveness program. If prevention was to be a practical reality, CDC needed to develop methods for assessing and establishing the effectiveness of prevention activities. New scientific skills were added to the CDC toolkit, including economic and policy analysis, which opened the door for the rapidly expanded use of other scientific modalities, such as social sciences and law. The commitment to prevention effectiveness led to products such as the influential *Guide to Community Preventive Services* (*16*) and the *MMWR* report *A Framework for Assessing the Effectiveness of Disease and Injury Prevention* (*17*).

CDC Foundation. As public health threats continued to grow in number and complexity and the agency continued to have success in crossing public- and private-sector lines to address them, the benefit of establishing a new entity to assist CDC in forging partnerships became evident. In 1992, Congress passed legislation that authorized creation of an independent, nonprofit foundation to support CDC, and an organizing committee met 1 year later. Today, the CDC Foundation (http://www.cdcfoundation.org) has facilitated development of a diverse portfolio that includes the Management Academy for Public Health, an Emergency Preparedness and Response Fund, as well as the Knight Public Health Journalism Fellowship, which provides public health training for working journalists.

FIGURE. In 1991, Bill Roper (third from left) marks the 30th anniversary of *MMWR* at CDC (pictured also, from left to right, are Minnie Johnson, Steve Thacker, and Elliott Churchill)

Photo/CDC (reprinted from the March 1991 issue of *Dateline: CDC*)

Stronger Role for Public Health

Overall, efforts at CDC during 1990–1993 were focused on strengthening the role of public health in the nation's health system and emphasizing the value of prevention as the essential path to good health. By strengthening relationships with public health partners, building new partnerships with the private sector, and increasing the diversity of CDC's workforce, CDC became better equipped to fulfill its role as the nation's prevention agency.

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Notice to Readers

Public Health Information Network Conference, August 27–29, 2007

The fifth annual Public Health Information Network (PHIN) Conference will be held August 27–29, 2007, in Atlanta, Georgia, at the Omni Hotel at CNN Center. The theme for this year's conference is Harmonizing Public Health Voices in National Health Information Technology (IT).

Sponsored by CDC and the National Association of County & City Health Officials, the conference will feature workshops on knowledge management and standards implementation; training on informatics by the American Medical Informatics Association; opportunities for networking with informatics professionals from local, state, national, and international levels; and opportunities to provide input to CDC on how to implement the PHIN initiative in the context of the larger national Health IT Initiative. The goals of this year's conference are 1) to accelerate the development of a community that facilitates innovation and collaboration in public health informatics and the national Health IT Initiative and 2) to improve the ability of public health stakeholders to advance CDC's PHIN initiative and the national Health IT Initiative.

The call for abstracts, conference registration, and hotel registration are available online at the conference website: http://wwwlink.cdc.gov/phinconference. The deadline for abstract submission is midnight, May 18, 2007. The deadline for online registration is August 6, 2007.

Notice to Readers

Update on Supply of Vaccines Containing Varicella-Zoster Virus

In February 2007, CDC received notice from Merck & Co., Inc., that because of lower than expected amounts of varicella-zoster virus (VZV) in its recently manufactured bulk vaccine, Merck was prioritizing production of varicella (Varivax®) and zoster vaccines (Zostavax®) over production of MMR-V vaccine (ProQuad®) (*1*).

In May 2007, CDC received further notice from Merck that current projections of orders indicate ProQuad will be unavailable beginning in July 2007, although timing will depend on market demand. This might cause extended back orders for the next few months. After depletion of the existing supply, ProQuad is not expected to be available for the remainder of 2007. Merck is requesting that customers begin transitioning from ProQuad to M-M-R II® and Varivax at their earliest convenience.

Merck expects to continue to meet demands for Varivax and M-M-R II to fully implement the recommended immunization schedule. This will allow for continued use of varicella vaccine for all age groups, including the routine 2-dose schedule for children aged 12–15 months and 4–6 years, catch-up vaccination with the second dose for children or adolescents who received only 1 dose, and vaccination with 2 doses for other children, adolescents, and adults without evidence of immunity (*2–4*). For zoster vaccine, the supply of Zostavax is expected to be adequate for routine vaccination of adults aged ≥60 years (*5*).

Questions regarding the supply of these Merck products should be addressed to Merck's National Service Center at 800-637-2590. Updates on vaccine shortages and delays are available from CDC at http://www.cdc.gov/nip/news/shortages/default.htm.

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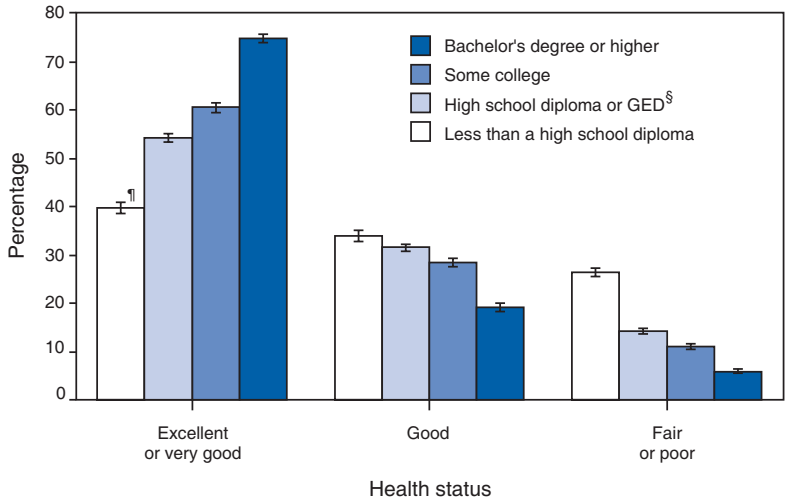
QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Respondent-Assessed Health Status* Among Persons Aged ≥25 Years, by Education Level — National Health Interview Survey, United States, 2005†



* Health status data were obtained by asking respondents to assess their own health and that of family members living in the same household as excellent, very good, good, fair, or poor. Data are reported only for family members aged ≥25 years.
† Estimates are based on household interviews of a sample of the U.S. civilian, noninstitutionalized population. Denominators for each category exclude persons for whom data were missing. Estimates are age adjusted to the 2000 U.S. standard population using four age groups: 25–44 years, 45–64 years, 65–74 years, and ≥75 years.
§ General Educational Development high school equivalency diploma.
¶ 95% confidence interval.

The percentage of adults aged ≥25 years whose health was reported as excellent or very good increased with education level. Persons with a bachelor's degree or higher (74.9%) were nearly twice as likely to be reported having excellent or very good health than persons with less than a high school diploma (39.8%). Persons with less than a high school diploma were most likely to be reported having fair or poor health.

SOURCE: National Health Interview Survey, 2005. Available at http://www.cdc.gov/nchs/nhis.htm. Additional information available at http://www.cdc.gov/nchs/data/series/sr_10/sr10_233.pdf.

TABLE I. Provisional cases of infrequently reported notifiable diseases (<1,000 cases reported during the preceding year) — United States, week ending May 5, 2007 (18th Week)*

Disease	Current week	Cum 2007	5-year weekly average†	Total cases reported for previous years 2006	2005	2004	2003	2002	States reporting cases during current week (No.)
Anthrax	—	—	—	1	—	—	—	2	
Botulism:									
foodborne	—	—	0	19	19	16	20	28	
infant	—	18	1	96	85	87	76	69	
other (wound & unspecified)	—	4	0	45	31	30	33	21	
Brucellosis	4	39	3	117	120	114	104	125	NC (2), FL (2)
Chancroid	—	9	1	34	17	30	54	67	
Cholera	—	—	0	7	8	5	2	2	
Cyclosporiasis§	2	19	15	135	543	171	75	156	NY (1), IN (1)
Diphtheria	—	—	—	—	—	—	1	1	
Domestic arboviral diseases§,¶:									
California serogroup	—	—	0	63	80	112	108	164	
eastern equine	—	—	—	7	21	6	14	10	
Powassan	—	—	—	1	1	1	—	1	
St. Louis	—	—	0	9	13	12	41	28	
western equine	—	—	—	—	—	—	—	—	
Ehrlichiosis§:									
human granulocytic	1	16	4	619	786	537	362	511	NY (1)
human monocytic	4	37	3	501	506	338	321	216	NC (2), FL (2)
human (other & unspecified)	—	13	1	237	112	59	44	23	
Haemophilus influenzae,**									
invasive disease (age <5 yrs):									
serotype b	—	4	0	13	9	19	32	34	
nonserotype b	2	31	3	130	135	135	117	144	NC (2)
unknown serotype	5	95	4	224	217	177	227	153	PA (2), MD (1), FL (1), OR (1)
Hansen disease§	—	17	1	62	87	105	95	96	
Hantavirus pulmonary syndrome§	—	2	1	37	26	24	26	19	
Hemolytic uremic syndrome, postdiarrheal§	2	36	3	268	221	200	178	216	CT (1), CA (1)
Hepatitis C viral, acute	4	200	21	820	652	713	1,102	1,835	MO (1), TX (1), CO (1), CA (1)
HIV infection, pediatric (age <13 yrs)††	—	—	4	52	380	436	504	420	
Influenza-associated pediatric mortality§,§§	3	56	0	41	45	—	N	N	CA (2), NM (1)
Listeriosis	8	156	10	831	896	753	696	665	NY (1), PA (2), IN (1), MO (1), DE (1), FL (1), CA (1)
Measles¶¶	—	6	1	52	66	37	56	44	
Meningococcal disease, invasive***:									
A, C, Y, & W-135	2	84	5	260	297	—	—	—	IN (1), OK (1)
serogroup B	1	35	2	163	156	—	—	—	FL (1)
other serogroup	—	7	0	28	27	—	—	—	
unknown serogroup	6	256	15	674	765	—	—	—	NYC (1), OH (2), AL (1), WA (1), CA (1)
Mumps	9	325	120	6,567	314	258	231	270	NY (1), OH (1), KS (1), MD (1), FL (1), WA (4)
Novel influenza A virus infections	—	—	—	N	N	N	N	N	
Plague	—	—	0	17	8	3	1	2	
Poliomyelitis, paralytic	—	—	—	—	1	—	—	—	
Poliovirus infection, nonparalytic§	—	—	—	N	N	N	N	N	
Psittacosis§	—	3	0	20	16	12	12	18	
Q fever§	4	51	2	172	136	70	71	61	MI (1), MO (2), FL (1)
Rabies, human	—	—	—	3	2	7	2	3	
Rubella†††	—	8	0	9	11	10	7	18	
Rubella, congenital syndrome	—	—	—	1	1	—	1	1	
SARS-CoV§,§§§	—	—	—	—	—	—	8	N	
Smallpox§	—	—	—	—	—	—	—	—	
Streptococcal toxic-shock syndrome§	2	25	4	123	129	132	161	118	OH (1), IN (1)
Syphilis, congenital (age <1 yr)	—	54	8	340	329	353	413	412	
Tetanus	—	3	1	34	27	34	20	25	
Toxic-shock syndrome (staphylococcal)§	1	24	2	95	90	95	133	109	AL (1)
Trichinellosis	—	1	0	13	16	5	6	14	
Tularemia	—	3	1	89	154	134	129	90	
Typhoid fever	4	84	6	315	324	322	356	321	MN (2), MD (1), CA (1)
Vancomycin-intermediate *Staphylococcus aureus*§	—	3	—	6	2	—	N	N	
Vancomycin-resistant *Staphylococcus aureus*§	—	—	—	1	3	1	N	N	
Vibriosis (non-cholera *Vibrio* species infections)§	6	45	—	N	N	N	N	N	NY (1), FL (3), CA (2)
Yellow fever	—	—	—	—	—	—	—	1	

—: No reported cases. N: Not notifiable. Cum: Cumulative year-to-date counts.
* Incidence data for reporting years 2006 and 2007 are provisional, whereas data for 2002, 2003, 2004, and 2005 are finalized.
† Calculated by summing the incidence counts for the current week, the 2 weeks preceding the current week, and the 2 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. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.
¶ 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 (ArboNET Surveillance). Data for West Nile virus are available in Table II.
** 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. Implementation of HIV reporting influences the number of cases reported. Updates of pediatric HIV data have been temporarily suspended until upgrading of the national HIV/AIDS surveillance data management system is completed. Data for HIV/AIDS, when available, are displayed in Table IV, which appears quarterly.
§§ Updated weekly from reports to the Influenza Division, National Center for Immunization and Respiratory Diseases. A total of 57 cases were reported for the 2006–07 flu season.
¶¶ No measles cases were reported for the current week.
*** Data for meningococcal disease (all serogroups) are available in Table II.
††† No rubella cases were reported for the current week.
§§§ Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2007, and May 6, 2006 (18th Week)*

Reporting area	Chlamydia†					Coccidioidomycosis					Cryptosporidiosis				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	11,755	19,886	23,844	320,483	346,801	85	151	649	2,748	2,944	21	69	302	788	880
New England	495	671	1,150	11,142	10,667	—	0	0	—	—	—	3	22	36	74
Connecticut	62	198	616	2,665	2,567	N	0	0	N	N	—	0	10	10	38
Maine§	36	47	74	870	728	—	0	0	—	—	—	0	6	7	9
Massachusetts	296	302	604	5,494	5,130	—	0	0	—	—	—	0	14	—	22
New Hampshire	22	38	69	655	639	—	0	0	—	—	—	1	5	8	3
Rhode Island§	79	63	108	1,169	1,161	—	0	0	—	—	—	0	5	5	—
Vermont§	—	20	45	289	442	N	0	0	N	N	—	1	4	6	2
Mid. Atlantic	1,855	2,583	4,164	46,820	42,512	—	0	0	—	—	1	11	33	93	145
New Jersey	—	382	541	5,132	6,715	N	0	0	N	N	—	0	1	—	9
New York (Upstate)	556	509	2,745	8,544	7,583	N	0	0	N	N	1	3	13	34	31
New York City	815	753	1,526	15,045	14,522	N	0	0	N	N	—	2	12	16	35
Pennsylvania	484	819	1,264	18,099	13,692	N	0	0	N	N	—	4	18	43	70
E.N. Central	1,579	3,221	6,123	56,071	59,192	—	1	3	10	15	5	15	110	183	195
Illinois	618	997	1,263	15,187	19,109	—	0	0	—	—	—	2	22	17	24
Indiana	—	376	641	6,874	7,241	—	0	0	—	—	—	1	18	15	12
Michigan	412	765	1,225	12,558	9,930	—	1	3	8	11	1	2	10	43	32
Ohio	439	643	3,646	15,222	15,387	—	0	2	2	4	4	5	33	64	70
Wisconsin	110	376	528	6,230	7,525	N	0	0	N	N	—	4	53	44	57
W.N. Central	475	1,192	1,445	17,096	21,359	—	0	54	3	—	8	12	77	122	134
Iowa	113	160	239	2,883	2,973	N	0	0	N	N	—	2	28	21	12
Kansas	180	149	266	2,832	2,809	N	0	0	N	N	5	1	8	18	18
Minnesota	—	241	314	3,117	4,561	—	0	54	—	—	—	2	25	31	55
Missouri	—	440	628	5,220	7,671	—	0	1	3	—	2	2	21	24	26
Nebraska§	141	104	180	1,772	1,756	N	0	0	N	N	—	1	16	6	10
North Dakota	—	28	64	418	671	N	0	0	N	N	—	0	1	1	1
South Dakota	41	50	84	854	918	N	0	0	N	N	1	1	7	21	12
S. Atlantic	2,592	3,595	6,740	50,155	66,250	—	0	1	1	2	4	17	68	213	204
Delaware	94	69	111	1,229	1,247	N	0	0	N	N	—	0	3	2	—
District of Columbia	96	73	161	1,841	1,033	—	0	0	—	—	—	0	2	3	5
Florida	—	932	1,187	3,300	16,328	N	0	0	N	N	3	8	32	103	87
Georgia	—	700	3,648	7,608	11,666	N	0	0	N	N	—	5	12	52	59
Maryland§	348	339	779	6,064	6,166	—	0	1	1	2	1	0	2	10	6
North Carolina	1,033	624	1,772	10,436	12,883	—	0	0	—	—	—	1	11	13	25
South Carolina§	470	402	2,105	10,184	7,776	N	0	0	N	N	—	1	14	13	7
Virginia§	510	473	685	8,655	8,122	N	0	0	N	N	—	1	5	15	13
West Virginia	41	54	80	838	1,029	N	0	0	N	N	—	0	3	2	2
E.S. Central	889	1,489	2,095	27,026	26,539	—	0	0	—	—	1	3	14	42	28
Alabama§	22	419	539	6,366	8,609	N	0	0	N	N	—	0	11	12	8
Kentucky	206	126	691	2,618	3,502	N	0	0	N	N	1	1	3	16	10
Mississippi	178	410	959	7,970	5,697	N	0	0	N	N	—	0	8	8	2
Tennessee§	483	530	703	10,072	8,731	N	0	0	N	N	—	1	5	6	8
W.S. Central	1,560	2,175	3,027	37,659	38,728	—	0	1	—	—	—	5	45	32	43
Arkansas§	205	162	337	3,049	2,822	N	0	0	N	N	—	0	2	2	5
Louisiana	—	315	610	5,125	5,986	—	0	1	—	—	—	1	9	14	—
Oklahoma	243	264	472	4,472	3,662	N	0	0	N	N	—	0	4	11	11
Texas§	1,112	1,429	1,910	25,013	26,258	N	0	0	N	N	—	2	36	5	27
Mountain	266	1,245	2,018	16,738	22,124	71	100	296	1,905	2,139	1	4	40	45	33
Arizona	23	479	993	6,410	6,691	71	98	296	1,868	2,078	1	0	4	12	4
Colorado	59	306	416	2,481	5,403	N	0	0	N	N	—	1	7	11	9
Idaho§	—	6	253	74	1,169	N	0	0	N	N	—	0	5	3	3
Montana§	5	52	144	878	819	N	0	0	N	N	—	0	26	4	5
Nevada§	—	107	397	2,234	2,139	—	1	3	12	27	—	0	2	2	3
New Mexico§	—	179	324	2,591	3,635	—	0	3	6	6	—	0	5	8	4
Utah	153	96	200	1,635	1,756	—	1	4	19	26	—	0	3	1	5
Wyoming§	26	29	54	435	512	—	0	0	—	2	—	0	11	4	—
Pacific	2,044	3,371	4,070	57,776	59,430	14	53	299	829	788	1	1	5	22	24
Alaska	80	87	157	1,426	1,435	N	0	0	N	N	—	0	1	—	1
California	1,366	2,663	3,262	45,176	46,277	14	53	299	829	788	—	0	0	—	—
Hawaii	—	107	130	1,652	2,019	N	0	0	N	N	—	0	1	—	—
Oregon§	191	160	394	3,248	3,365	N	0	0	N	N	1	1	4	22	23
Washington	407	348	621	6,274	6,334	N	0	0	N	N	—	0	0	—	—
American Samoa	U	0	46	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	147	114	235	2,505	1,706	N	0	0	N	N	N	0	0	N	N
U.S. Virgin Islands	U	4	9	U	U	U	0	0	U	U	U	0	0	U	U

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 years 2006 and 2007 are provisional. Data for HIV/AIDS, AIDS, and TB, when available, are displayed in Table IV, which appears quarterly.
† 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 May 5, 2007, and May 6, 2006 (18th Week)*

Reporting area	Giardiasis					Gonorrhea					*Haemophilus influenzae*, invasive All ages, all serotypes†				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	132	314	1,029	4,255	5,060	3,430	6,806	8,664	102,371	117,117	31	44	144	814	812
New England	10	18	45	178	364	82	110	211	1,798	1,821	—	2	12	26	45
Connecticut	—	5	25	70	94	13	43	153	597	650	—	0	6	17	8
Maine§	2	4	14	48	26	7	2	8	30	44	—	0	4	5	5
Massachusetts	—	0	18	—	167	55	47	96	926	854	—	0	7	—	25
New Hampshire	—	0	9	2	2	1	3	8	53	85	—	0	3	3	2
Rhode Island§	8	0	17	21	27	6	10	19	174	167	—	0	3	1	2
Vermont§	—	3	12	37	48	—	1	5	18	21	—	0	2	—	3
Mid. Atlantic	28	66	123	773	1,029	492	679	1,519	12,328	11,334	2	10	26	186	172
New Jersey	—	7	17	36	159	—	102	156	1,483	1,848	—	1	5	17	31
New York (Upstate)	17	25	101	289	304	140	121	1,035	2,088	2,030	—	3	14	53	42
New York City	3	17	33	256	327	140	177	376	3,312	3,575	—	2	6	37	36
Pennsylvania	8	14	35	192	239	212	240	414	5,445	3,881	2	3	10	79	63
E.N. Central	15	43	97	612	851	471	1,292	2,498	22,330	23,344	3	6	14	88	135
Illinois	—	9	27	103	191	183	356	485	5,307	7,018	—	1	5	11	38
Indiana	N	0	0	N	N	—	154	290	2,796	3,128	1	1	10	17	22
Michigan	2	13	38	201	235	97	307	880	5,356	3,747	—	0	5	11	18
Ohio	13	15	32	224	258	151	315	1,557	6,687	6,975	2	2	6	48	31
Wisconsin	—	9	27	84	167	40	133	181	2,184	2,476	—	1	4	1	26
W.N. Central	6	23	539	287	503	114	385	515	5,217	6,412	—	3	23	47	39
Iowa	1	5	16	60	80	18	40	63	651	609	—	0	1	—	—
Kansas	1	3	11	39	53	43	43	87	805	787	—	0	2	4	8
Minnesota	—	0	514	12	165	—	66	87	841	1,054	—	1	17	18	15
Missouri	1	9	28	127	142	—	195	269	2,354	3,387	—	1	5	19	13
Nebraska§	2	2	9	26	29	50	26	48	447	421	—	0	2	5	3
North Dakota	—	0	4	4	5	—	2	6	22	40	—	0	2	1	—
South Dakota	1	1	6	19	29	3	6	15	97	114	—	0	0	—	—
S. Atlantic	22	52	98	790	730	846	1,578	3,085	19,641	28,090	19	11	28	229	205
Delaware	1	0	4	9	8	26	28	44	489	506	—	0	3	5	1
District of Columbia	—	1	7	17	20	38	36	63	783	643	—	0	2	2	1
Florida	19	24	44	381	300	—	438	549	1,564	7,547	5	3	8	72	69
Georgia	—	12	26	162	173	—	348	1,928	3,159	5,282	—	2	6	53	47
Maryland§	2	4	12	71	49	92	114	202	1,968	2,342	3	2	5	41	29
North Carolina	—	0	0	—	—	354	317	676	5,227	5,809	9	0	8	27	15
South Carolina§	—	2	8	20	33	204	168	1,026	4,163	3,512	2	1	4	21	17
Virginia§	—	9	28	120	141	124	121	238	2,061	2,178	—	0	7	1	17
West Virginia	—	0	21	10	6	8	18	44	227	271	—	0	6	7	9
E.S. Central	4	8	34	130	121	306	578	878	9,705	10,445	1	2	9	43	52
Alabama§	3	3	22	57	58	4	191	271	2,559	3,951	—	0	3	8	11
Kentucky	N	0	0	N	N	61	48	268	906	1,203	—	0	1	2	4
Mississippi	N	0	0	N	N	66	158	434	2,828	2,099	—	0	1	—	4
Tennessee§	1	5	12	73	63	175	194	240	3,412	3,192	1	1	6	33	33
W.S. Central	1	7	26	97	47	539	949	1,483	15,334	16,424	2	2	27	43	31
Arkansas§	—	3	13	44	21	96	80	142	1,445	1,573	—	0	2	3	2
Louisiana	—	1	6	22	—	—	193	366	3,087	3,502	—	0	3	4	1
Oklahoma	1	2	13	31	26	78	103	237	1,806	1,250	1	1	25	33	26
Texas§	N	0	0	N	N	365	556	931	8,996	10,099	1	0	2	3	2
Mountain	16	30	69	406	453	61	263	455	3,281	4,743	2	4	14	112	96
Arizona	—	3	11	57	41	1	104	220	1,318	1,672	1	2	9	52	36
Colorado	8	9	26	128	155	42	70	93	683	1,246	—	1	4	21	29
Idaho§	2	3	12	37	50	—	1	20	6	71	—	0	1	4	3
Montana§	—	2	11	26	23	—	3	20	32	49	—	0	0	—	—
Nevada§	—	2	9	27	34	—	28	135	534	742	—	0	2	5	6
New Mexico§	—	1	6	28	20	—	30	65	443	591	—	0	3	13	13
Utah	6	6	27	91	124	18	16	28	243	315	1	0	3	16	9
Wyoming§	—	1	4	12	6	—	2	5	22	57	—	0	1	1	—
Pacific	30	60	147	982	962	519	765	938	12,737	14,504	2	2	8	40	37
Alaska	1	1	17	20	13	8	10	27	147	191	—	0	2	4	3
California	19	43	71	690	717	431	638	807	10,768	12,020	—	0	6	—	10
Hawaii	—	1	4	22	21	—	14	26	198	376	—	0	1	2	7
Oregon§	5	9	14	139	131	22	26	46	379	472	2	1	6	34	16
Washington	5	8	68	111	80	58	75	142	1,245	1,445	—	0	2	—	1
American Samoa	U	0	0	U	U	U	0	2	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	1	5	19	50	32	2	5	16	121	121	—	0	2	1	—
U.S. Virgin Islands	U	0	0	U	U	U	0	3	U	U	U	0	0	U	U

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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 years 2006 and 2007 are provisional.
† Data for *H. influenzae* (age <5 yrs for serotype b, nonserotype b, and unknown serotype) are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2007, and May 6, 2006 (18th Week)*

Reporting area	Hepatitis (viral, acute), by type† A: Current week	A: Previous 52 weeks Med	A: Previous 52 weeks Max	A: Cum 2007	A: Cum 2006	B: Current week	B: Previous 52 weeks Med	B: Previous 52 weeks Max	B: Cum 2007	B: Cum 2006	Legionellosis: Current week	Legionellosis: Previous 52 weeks Med	Legionellosis: Previous 52 weeks Max	Legionellosis: Cum 2007	Legionellosis: Cum 2006
United States	23	54	120	827	1,318	28	79	309	1,224	1,402	10	49	107	436	437
New England	—	1	19	11	72	1	2	5	21	47	—	2	13	9	18
Connecticut	—	0	3	4	13	—	0	5	10	21	—	0	9	3	3
Maine§	—	0	2	1	4	—	0	2	1	8	—	0	2	—	2
Massachusetts	—	0	1	—	47	—	0	1	—	14	—	0	4	—	10
New Hampshire	—	0	15	3	2	1	0	2	4	—	—	0	2	—	2
Rhode Island§	—	0	2	3	2	—	0	4	5	3	—	0	6	5	—
Vermont§	—	0	2	—	4	—	0	1	1	1	—	0	2	1	1
Mid. Atlantic	3	7	19	108	106	2	9	19	143	178	5	15	53	117	125
New Jersey	—	2	4	21	34	—	2	6	30	54	—	2	11	12	16
New York (Upstate)	2	2	12	29	18	2	1	14	28	24	2	5	30	38	41
New York City	—	2	11	41	37	—	2	6	27	37	—	2	20	16	18
Pennsylvania	1	1	4	17	17	—	3	7	58	63	3	5	19	51	50
E.N. Central	2	6	13	74	105	7	8	19	134	157	—	10	30	86	87
Illinois	—	1	4	18	22	—	1	5	17	57	—	1	11	—	15
Indiana	—	0	7	5	7	2	0	17	13	10	—	1	5	5	3
Michigan	1	2	8	27	36	—	2	8	42	51	—	3	10	32	19
Ohio	1	1	4	24	29	5	3	10	57	36	—	4	19	45	36
Wisconsin	—	0	4	—	11	—	0	3	5	3	—	0	3	4	14
W.N. Central	2	2	17	46	45	—	2	14	46	49	—	1	16	14	13
Iowa	1	0	1	7	4	—	0	3	9	8	—	0	3	2	1
Kansas	1	0	1	1	16	—	0	2	4	6	—	0	3	—	1
Minnesota	—	0	17	24	2	—	0	13	4	3	—	0	11	2	—
Missouri	—	1	3	8	12	—	1	5	24	29	—	0	2	8	8
Nebraska§	—	0	2	4	6	—	0	3	3	2	—	0	2	1	2
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
South Dakota	—	0	2	2	5	—	0	1	2	1	—	0	1	1	1
S. Atlantic	5	9	27	155	186	11	23	53	337	400	1	9	24	110	105
Delaware	—	0	2	1	6	—	0	4	6	15	—	0	2	1	1
District of Columbia	—	0	5	14	2	—	0	2	1	4	—	0	5	—	4
Florida	3	3	13	57	66	9	7	14	120	144	1	3	9	52	51
Georgia	—	1	5	16	16	—	3	8	39	58	—	1	5	11	2
Maryland§	2	1	7	24	27	1	2	8	31	59	—	2	8	22	17
North Carolina	—	0	11	7	40	—	1	16	52	67	—	0	5	9	13
South Carolina§	—	0	3	4	7	—	2	5	26	23	—	0	2	5	3
Virginia§	—	1	5	30	21	1	2	5	43	13	—	1	5	7	13
West Virginia	—	0	3	2	1	—	0	23	19	17	—	0	4	3	1
E.S. Central	—	2	7	22	45	1	6	20	80	123	1	2	9	21	15
Alabama§	—	0	2	3	2	—	2	10	25	33	—	0	2	1	3
Kentucky	—	0	2	4	21	—	1	3	2	31	—	1	6	9	3
Mississippi	—	0	4	4	3	—	0	7	7	14	—	0	2	—	1
Tennessee§	—	1	5	11	19	1	3	7	46	45	1	1	7	11	8
W.S. Central	1	6	18	62	114	—	19	151	214	219	—	1	12	22	8
Arkansas§	—	0	2	4	27	—	1	4	7	20	—	0	1	1	1
Louisiana	—	0	4	8	3	—	1	5	17	7	—	0	2	1	—
Oklahoma	—	0	3	3	3	—	1	37	11	1	—	0	6	—	1
Texas§	1	5	15	47	81	—	15	108	179	191	—	1	12	20	6
Mountain	2	5	16	109	112	2	3	9	74	53	2	2	8	28	30
Arizona	2	4	15	92	66	—	0	5	33	2	1	1	4	10	10
Colorado	—	1	3	7	17	2	0	4	10	15	—	0	2	5	5
Idaho§	—	0	2	1	4	—	0	2	4	6	—	0	3	1	4
Montana§	—	0	3	1	2	—	0	0	—	—	—	0	1	1	—
Nevada§	—	0	2	5	6	—	1	5	13	14	—	0	2	2	4
New Mexico§	—	0	2	1	8	—	0	2	5	8	—	0	2	2	1
Utah	—	0	2	2	8	—	0	4	9	8	1	0	2	5	6
Wyoming§	—	0	1	—	1	—	0	1	—	—	—	0	1	2	—
Pacific	8	15	38	240	533	4	11	38	175	176	1	1	11	29	36
Alaska	—	0	1	1	1	—	0	3	3	1	—	0	1	—	—
California	6	12	36	218	495	3	8	26	132	138	1	1	11	23	36
Hawaii	—	0	2	2	6	—	0	1	—	2	—	0	0	—	—
Oregon§	—	1	3	9	15	—	2	5	28	25	—	0	1	1	—
Washington	2	0	4	10	16	1	1	12	12	10	—	0	2	5	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	1	1	10	16	17	—	1	9	14	10	—	0	1	—	1
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

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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 years 2006 and 2007 are provisional.
† Data for acute hepatitis C, viral are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2007, and May 6, 2006 (18th Week)*

Reporting area	Lyme disease					Malaria					Meningococcal disease, invasive† All serogroups				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	86	253	1,029	1,844	2,064	5	24	49	236	376	9	19	39	382	503
New England	9	22	255	90	120	—	0	6	4	10	—	1	3	8	15
Connecticut	4	9	227	25	52	—	0	3	—	1	—	0	2	3	4
Maine§	3	2	39	18	29	—	0	1	3	2	—	0	3	2	2
Massachusetts	—	0	3	—	26	—	0	3	—	6	—	0	1	—	9
New Hampshire	2	5	97	39	6	—	0	3	1	—	—	0	2	—	—
Rhode Island§	—	0	93	—	1	—	0	1	—	—	—	0	1	1	—
Vermont§	—	1	15	8	6	—	0	0	—	1	—	0	1	2	—
Mid. Atlantic	62	147	571	931	1,412	—	5	18	55	100	1	2	8	44	83
New Jersey	—	26	190	102	354	—	1	7	—	28	—	0	2	1	8
New York (Upstate)	55	52	392	287	583	—	1	7	15	8	—	1	4	11	14
New York City	—	2	24	6	18	—	2	9	34	53	1	1	4	12	31
Pennsylvania	7	45	237	536	457	—	1	4	6	11	—	0	5	20	30
E.N. Central	—	9	158	21	135	—	3	10	32	45	3	2	8	56	69
Illinois	—	0	1	2	—	—	1	6	10	17	—	0	2	13	17
Indiana	—	0	3	1	3	—	0	2	1	5	1	0	4	14	8
Michigan	—	1	5	6	3	—	0	2	7	6	—	0	3	12	13
Ohio	—	0	5	3	12	—	0	2	8	12	2	1	4	14	19
Wisconsin	—	7	154	9	117	—	0	3	6	5	—	0	2	3	12
W.N. Central	—	5	188	48	55	4	1	13	18	19	—	1	5	28	28
Iowa	—	1	8	6	14	—	0	1	2	1	—	0	3	7	8
Kansas	—	0	2	3	1	—	0	2	—	—	—	0	1	1	1
Minnesota	—	2	188	32	39	4	0	12	11	14	—	0	3	8	4
Missouri	—	0	3	7	—	—	0	1	2	2	—	0	3	9	9
Nebraska§	—	0	2	—	1	—	0	1	2	—	—	0	1	1	5
North Dakota	—	0	0	—	—	—	0	0	—	1	—	0	1	1	1
South Dakota	—	0	1	—	—	—	0	1	1	1	—	0	1	1	—
S. Atlantic	8	44	135	689	303	1	5	15	54	97	1	3	9	53	85
Delaware	4	9	28	139	109	—	0	1	2	2	—	0	1	—	2
District of Columbia	—	0	7	3	7	—	0	2	2	—	—	0	1	—	—
Florida	1	0	3	11	7	—	1	4	14	16	1	1	7	23	35
Georgia	—	0	1	—	1	—	1	6	4	33	—	0	3	6	9
Maryland§	2	21	105	434	164	—	1	4	17	15	—	0	2	13	5
North Carolina	—	0	4	6	8	1	0	4	5	10	—	0	6	4	14
South Carolina§	—	0	2	4	1	—	0	2	—	4	—	0	2	5	9
Virginia§	1	7	36	88	6	—	1	4	9	16	—	0	2	2	10
West Virginia	—	0	14	4	—	—	0	1	1	1	—	0	2	—	1
E.S. Central	—	0	4	9	2	—	0	3	10	8	1	1	4	21	18
Alabama§	—	0	3	1	1	—	0	2	1	3	1	0	2	5	4
Kentucky	—	0	2	—	—	—	0	1	1	1	—	0	1	1	5
Mississippi	—	0	1	—	—	—	0	1	1	2	—	0	4	4	3
Tennessee§	—	0	3	8	1	—	0	2	7	2	—	0	2	11	6
W.S. Central	—	1	6	10	2	—	2	7	13	18	1	1	13	39	32
Arkansas§	—	0	0	—	—	—	0	2	—	—	—	0	2	5	5
Louisiana	—	0	1	2	—	—	0	2	11	1	—	0	4	11	5
Oklahoma	—	0	0	—	—	—	0	3	1	2	1	0	4	10	6
Texas§	—	1	6	8	2	—	1	6	1	15	—	0	9	13	16
Mountain	—	0	4	5	3	—	1	6	11	21	—	1	4	32	32
Arizona	—	0	2	—	3	—	0	3	4	6	—	0	3	10	9
Colorado	—	0	0	—	—	—	0	2	4	6	—	0	2	8	11
Idaho§	—	0	2	1	—	—	0	1	—	—	—	0	1	2	1
Montana§	—	0	1	1	—	—	0	1	1	1	—	0	1	1	1
Nevada§	—	0	1	3	—	—	0	1	—	—	—	0	1	3	3
New Mexico§	—	0	1	—	—	—	0	1	—	1	—	0	1	1	1
Utah	—	0	1	—	—	—	0	2	2	7	—	0	2	6	4
Wyoming§	—	0	1	—	—	—	0	0	—	—	—	0	2	1	2
Pacific	7	3	17	41	32	—	4	14	39	58	2	5	12	101	141
Alaska	—	0	1	2	—	—	0	4	2	6	—	0	1	1	2
California	7	3	14	39	32	—	3	6	29	45	1	3	10	72	93
Hawaii	N	0	0	N	N	—	0	2	—	—	—	0	2	2	4
Oregon§	—	0	1	—	—	—	0	3	7	4	—	0	3	12	23
Washington	—	0	3	—	—	—	0	11	1	3	1	0	5	14	19
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	—	—
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	—	—
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	N	0	0	N	N	—	0	1	1	—	—	0	1	4	3
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	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 years 2006 and 2007 are provisional.
† Data for meningococcal disease, invasive caused by serogroups A, C, Y, & W-135; serogroup B; other serogroup; and unknown serogroup are available in Table I.
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2007, and May 6, 2006 (18th Week)*

Reporting area	Pertussis					Rabies, animal					Rocky Mountain spotted fever				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	90	241	980	2,142	4,763	48	93	174	1,121	1,786	15	29	114	185	345
New England	1	16	54	76	516	9	11	25	154	196	—	0	8	—	1
Connecticut	—	2	10	15	24	5	4	14	52	42	—	0	0	—	—
Maine†	—	2	15	32	23	1	2	8	27	28	N	0	0	N	N
Massachusetts	—	0	22	—	356	—	0	7	—	102	—	0	1	—	1
New Hampshire	1	2	28	13	45	1	1	5	12	—	—	0	1	—	—
Rhode Island†	—	0	30	—	21	1	0	3	13	5	—	0	8	—	—
Vermont†	—	1	14	16	47	1	2	10	50	19	—	0	0	—	—
Mid. Atlantic	10	32	159	405	582	—	16	57	121	247	—	2	7	14	22
New Jersey	—	4	12	46	128	—	0	0	—	—	—	0	2	—	6
New York (Upstate)	6	20	150	244	204	—	0	0	—	—	—	0	2	—	—
New York City	—	0	6	—	—	—	1	5	24	2	—	0	3	4	3
Pennsylvania	4	9	22	115	250	—	15	56	97	245	—	1	4	10	13
E.N. Central	16	39	79	501	716	13	2	18	21	13	—	1	6	6	5
Illinois	—	9	23	59	182	—	0	7	3	2	—	0	4	1	2
Indiana	—	3	37	11	57	1	0	2	1	1	—	0	1	1	1
Michigan	2	10	39	104	139	—	0	5	4	10	—	0	1	1	—
Ohio	14	12	56	276	242	12	0	9	13	—	—	0	4	3	2
Wisconsin	—	3	10	51	96	—	0	0	—	—	—	0	1	—	—
W.N. Central	5	17	140	151	559	3	5	20	61	74	1	3	13	26	14
Iowa	—	4	16	43	145	—	1	7	7	10	—	0	1	—	—
Kansas	2	3	14	58	122	1	2	6	39	28	—	0	1	—	—
Minnesota	—	0	120	—	72	1	0	6	4	8	—	0	2	—	1
Missouri	2	4	10	24	148	1	1	6	4	7	1	3	12	26	13
Nebraska†	1	1	4	8	60	—	0	0	—	—	—	0	5	—	—
North Dakota	—	0	9	4	4	—	0	7	6	2	—	0	0	—	—
South Dakota	—	0	4	14	8	—	0	3	1	19	—	0	0	—	—
S. Atlantic	22	17	163	318	351	19	38	62	622	797	13	11	67	100	261
Delaware	—	0	1	2	2	—	0	0	—	—	—	0	3	4	4
District of Columbia	—	0	2	2	3	—	0	0	—	—	—	0	1	1	—
Florida	1	4	18	94	77	—	0	19	42	176	—	0	4	5	6
Georgia	—	0	3	—	8	—	4	16	36	81	—	0	5	2	5
Maryland†	1	2	7	43	64	—	6	12	93	134	—	1	6	14	9
North Carolina	18	0	112	109	70	8	11	21	157	117	12	4	61	58	228
South Carolina†	2	3	11	29	51	—	3	11	35	43	—	1	5	6	3
Virginia†	—	2	19	33	72	11	12	31	235	216	1	2	12	9	6
West Virginia	—	0	19	6	4	—	2	8	24	30	—	0	2	1	—
E.S. Central	1	6	24	73	91	—	4	13	28	76	1	5	27	38	29
Alabama†	—	1	17	21	23	—	1	8	—	25	—	1	9	6	7
Kentucky	—	0	5	1	14	—	0	4	7	5	—	0	1	1	—
Mississippi	—	0	8	8	11	—	0	1	—	3	—	0	1	—	—
Tennessee†	1	3	11	43	43	—	2	7	21	43	1	4	22	31	22
W.S. Central	—	16	147	94	210	—	2	34	27	283	—	1	28	—	6
Arkansas†	—	1	13	3	18	—	0	5	9	11	—	0	10	—	4
Louisiana	—	0	2	6	6	—	0	0	—	—	—	0	1	—	—
Oklahoma	—	0	9	1	2	—	1	9	18	20	—	0	18	—	1
Texas†	—	14	134	84	184	—	0	29	—	252	—	0	6	—	1
Mountain	31	34	75	430	1,125	1	2	28	26	45	—	0	4	1	6
Arizona	12	6	31	108	215	—	1	10	24	38	—	0	2	—	2
Colorado	6	7	20	108	431	—	0	0	—	—	—	0	1	—	1
Idaho†	1	1	7	16	27	—	0	24	—	—	—	0	3	1	—
Montana†	—	1	8	14	43	—	0	2	—	3	—	0	2	—	—
Nevada†	—	0	9	3	24	—	0	1	—	—	—	0	0	—	—
New Mexico†	—	2	8	13	31	—	0	2	—	4	—	0	2	—	2
Utah	12	10	50	156	327	—	0	1	1	—	—	0	0	—	—
Wyoming†	—	1	8	12	27	1	0	2	1	—	—	0	1	—	1
Pacific	4	31	229	94	613	3	4	12	61	55	—	0	1	—	1
Alaska	1	1	8	9	28	—	0	6	26	11	N	0	0	N	N
California	—	22	226	—	351	3	3	11	35	43	—	0	1	—	—
Hawaii	—	0	7	7	49	N	0	0	N	N	N	0	0	N	N
Oregon†	1	1	9	33	52	—	0	4	—	1	—	0	1	—	1
Washington	2	4	46	45	133	—	0	0	—	—	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	N	—	—	N	N
Puerto Rico	—	0	1	—	—	1	1	6	18	33	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

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 years 2006 and 2007 are 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 May 5, 2007, and May 6, 2006 (18th Week)*

Reporting area	Salmonellosis					Shiga toxin-producing *E. coli* (STEC)†					Shigellosis				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	354	832	1,337	8,771	9,580	35	75	178	636	655	175	259	526	3,500	3,119
New England	6	17	84	186	844	—	2	16	26	99	2	2	14	26	133
Connecticut	—	0	83	83	503	—	0	7	7	75	—	0	9	9	67
Maine§	1	2	14	30	24	—	0	8	11	3	—	0	5	12	—
Massachusetts	—	0	53	—	279	—	0	9	—	17	—	0	11	—	61
New Hampshire	3	4	26	31	11	—	0	4	4	1	1	0	2	3	—
Rhode Island§	1	2	15	26	19	—	0	2	1	1	—	0	3	1	4
Vermont§	1	1	6	16	8	—	0	4	3	2	1	0	2	1	1
Mid. Atlantic	41	99	194	1,176	1,166	2	8	62	74	79	1	13	48	144	273
New Jersey	—	19	50	54	230	—	1	16	1	22	—	3	34	13	81
New York (Upstate)	26	28	93	381	238	2	3	14	33	26	—	3	43	34	79
New York City	2	24	50	306	320	—	1	4	6	8	—	5	14	74	81
Pennsylvania	13	30	67	435	378	—	3	47	34	23	1	1	6	23	32
E.N. Central	46	104	199	1,162	1,367	7	9	61	82	103	11	24	72	192	325
Illinois	—	27	61	277	394	—	1	7	9	17	—	10	50	29	111
Indiana	24	15	55	169	144	4	1	8	9	11	2	2	17	22	42
Michigan	9	18	35	205	232	—	1	6	14	22	1	2	5	11	74
Ohio	13	23	56	317	336	3	3	18	38	26	8	4	14	87	52
Wisconsin	—	17	32	194	261	—	2	41	12	27	—	4	14	43	46
W.N. Central	40	46	109	697	636	9	11	45	93	91	64	43	84	745	270
Iowa	1	8	26	101	111	—	2	38	15	17	—	2	14	20	11
Kansas	4	7	16	108	95	—	0	4	6	2	—	2	11	12	28
Minnesota	22	12	60	175	145	9	3	26	40	34	4	5	24	91	24
Missouri	7	15	35	220	179	—	3	13	18	26	60	14	72	598	151
Nebraska§	5	3	9	39	60	—	1	11	14	9	—	1	14	7	26
North Dakota	1	0	5	9	6	—	0	0	—	—	—	0	18	4	4
South Dakota	—	3	11	45	40	—	0	5	—	3	—	6	24	13	26
S. Atlantic	83	226	395	2,561	2,253	3	13	32	158	110	56	71	143	1,223	747
Delaware	—	2	10	27	25	—	0	3	4	1	—	0	2	4	—
District of Columbia	—	1	4	8	19	—	0	1	—	—	—	0	5	4	3
Florida	48	95	176	1,105	1,017	1	2	8	47	19	54	36	76	811	326
Georgia	—	34	66	408	325	—	1	7	16	20	—	24	54	318	267
Maryland§	6	14	32	182	99	—	3	9	28	9	—	1	10	23	17
North Carolina	18	29	130	395	394	2	2	11	25	26	—	1	14	19	65
South Carolina§	10	19	55	205	163	—	0	3	4	3	2	0	10	21	52
Virginia§	1	20	58	195	187	—	3	11	33	32	—	2	9	22	17
West Virginia	—	1	31	36	24	—	0	5	1	—	—	0	2	1	—
E.S. Central	19	53	138	580	508	1	4	21	29	46	7	12	80	265	204
Alabama§	8	10	70	147	147	1	0	5	6	4	3	4	66	95	38
Kentucky	7	9	23	132	103	—	1	12	9	12	1	2	15	30	110
Mississippi	—	12	85	85	108	—	0	0	—	—	—	1	71	71	26
Tennessee§	4	17	32	216	150	—	2	9	14	30	3	3	14	69	30
W.S. Central	13	84	186	358	792	—	3	52	31	30	16	38	192	350	406
Arkansas§	5	14	45	105	242	—	0	7	5	2	2	2	10	38	28
Louisiana	—	17	42	120	79	—	0	1	—	—	—	3	24	68	8
Oklahoma	8	9	40	97	68	—	0	17	8	3	3	2	9	19	28
Texas§	—	46	107	36	403	—	2	48	18	25	11	31	174	225	342
Mountain	36	52	88	680	649	7	8	36	73	68	6	25	86	211	240
Arizona	7	18	45	258	185	7	1	12	32	17	5	11	34	110	122
Colorado	16	11	30	159	186	—	1	8	9	18	1	3	15	31	36
Idaho§	—	3	9	37	42	—	1	8	4	11	—	0	3	4	6
Montana§	—	2	10	30	34	—	0	0	—	—	—	0	13	9	1
Nevada§	—	4	20	47	45	—	0	5	4	10	—	1	20	11	24
New Mexico§	—	5	15	50	59	—	1	5	11	5	—	2	15	28	34
Utah	12	4	14	77	78	—	2	14	13	6	—	1	4	6	14
Wyoming§	1	1	4	22	20	—	0	3	—	1	—	0	19	12	3
Pacific	70	116	306	1,371	1,365	6	5	24	70	29	12	33	94	344	521
Alaska	1	1	5	23	30	N	0	0	N	N	—	0	2	6	4
California	43	89	218	1,053	1,016	6	0	5	42	N	7	28	81	272	397
Hawaii	—	4	16	63	75	—	0	3	3	4	—	1	3	12	13
Oregon§	1	7	17	77	129	—	1	9	10	17	—	1	6	16	57
Washington	25	11	83	155	115	—	3	22	15	8	5	2	13	38	50
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	N	—	—	N	N	—	—	—	—	—
Puerto Rico	15	14	65	151	87	—	0	0	—	—	—	0	6	5	3
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

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 years 2006 and 2007 are provisional.
† Includes *E. coli* O157:H7; Shiga toxin-positive, serogroup non-O157; 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 May 5, 2007, and May 6, 2006 (18th Week)*

Reporting area	Streptococcal disease, invasive, group A					*Streptococcus pneumoniae*, invasive disease† Age <5 years				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max		
United States	69	88	220	1,840	2,327	25	26	99	541	497
New England	4	3	21	59	124	—	1	7	10	42
Connecticut	—	1	17	22	45	—	0	6	—	17
Maine§	1	0	2	8	8	—	0	2	—	—
Massachusetts	—	0	5	—	61	—	0	4	—	25
New Hampshire	3	0	9	18	3	—	0	4	6	—
Rhode Island§	—	0	6	—	4	—	0	3	3	—
Vermont§	—	0	2	11	3	—	0	1	1	—
Mid. Atlantic	12	17	39	372	467	2	3	20	48	74
New Jersey	—	2	6	28	83	—	0	4	—	25
New York (Upstate)	8	5	26	140	143	2	2	14	48	49
New York City	—	3	9	79	88	—	0	3	—	—
Pennsylvania	4	6	11	125	153	N	0	0	N	N
E.N. Central	9	15	31	313	516	7	6	14	88	144
Illinois	—	4	11	71	164	—	1	6	9	34
Indiana	1	2	12	46	54	2	0	10	10	20
Michigan	2	3	10	80	109	1	1	5	36	37
Ohio	6	4	14	114	129	4	1	7	31	30
Wisconsin	—	1	6	2	60	—	0	2	2	23
W.N. Central	19	5	32	161	169	4	2	10	49	37
Iowa	—	0	0	—	—	—	0	0	—	—
Kansas	1	0	3	22	34	—	0	3	3	9
Minnesota	16	0	29	76	78	3	1	6	29	14
Missouri	—	2	6	42	30	1	0	3	13	8
Nebraska§	1	0	2	8	16	—	0	2	3	4
North Dakota	—	0	2	9	6	—	0	1	1	2
South Dakota	1	0	2	4	5	—	0	0	—	—
S. Atlantic	13	19	42	442	452	5	2	11	106	22
Delaware	1	0	2	2	5	—	0	0	—	—
District of Columbia	—	0	2	4	5	—	0	1	—	—
Florida	6	5	16	107	109	2	0	5	28	—
Georgia	—	4	11	94	117	—	0	5	31	—
Maryland§	4	4	10	81	61	3	1	6	33	17
North Carolina	—	0	26	51	61	—	0	0	—	—
South Carolina§	1	1	5	37	35	—	0	3	9	—
Virginia§	1	2	10	57	51	—	0	1	3	—
West Virginia	—	0	6	9	8	—	0	3	2	5
E.S. Central	5	4	11	78	98	3	0	6	35	6
Alabama§	N	0	0	N	N	N	0	0	N	N
Kentucky	1	0	4	18	27	—	0	0	—	—
Mississippi	N	0	0	N	N	—	0	2	2	6
Tennessee§	4	3	7	60	71	3	0	6	33	—
W.S. Central	3	6	61	124	172	—	4	39	101	74
Arkansas§	1	0	2	12	15	—	0	2	7	12
Louisiana	—	0	2	4	2	—	0	4	24	2
Oklahoma	2	2	5	40	53	—	1	12	22	16
Texas§	—	3	56	68	102	—	2	24	48	44
Mountain	3	11	42	249	295	3	4	12	91	95
Arizona	—	5	34	101	152	—	2	7	54	57
Colorado	3	2	9	70	51	3	1	4	22	22
Idaho§	—	0	1	6	5	—	0	1	2	1
Montana§	N	0	0	N	N	N	0	0	N	N
Nevada§	—	0	1	1	1	—	0	1	1	—
New Mexico§	—	1	6	20	59	—	0	4	12	15
Utah	—	1	7	48	25	—	0	0	—	—
Wyoming§	—	0	1	3	2	—	0	0	—	—
Pacific	1	3	9	42	34	1	0	4	13	3
Alaska	1	0	2	10	N	1	0	2	11	—
California	N	0	0	N	N	N	0	0	N	N
Hawaii	—	2	9	32	34	—	0	2	2	3
Oregon§	N	0	0	N	N	N	0	0	N	N
Washington	N	0	0	N	N	N	0	0	N	N
American Samoa	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	N	—	—	N	N
Puerto Rico	—	0	0	—	—	N	0	0	N	N
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U

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 years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease, in children aged <5 years, caused by *S. pneumoniae*, which is susceptible or for which susceptibility testing is not available (NNDSS event code 11717).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2007, and May 6, 2006 (18th Week)*

Reporting area	*Streptococcus pneumoniae*, invasive disease, drug resistant†										Syphilis, primary and secondary				
	All ages					Age <5 years									
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	29	43	242	990	1,149	7	7	32	149	148	79	182	297	2,707	3,046
New England	1	1	7	24	70	1	0	2	4	2	2	4	13	70	65
Connecticut	—	0	3	—	56	—	0	0	—	—	—	0	10	9	15
Maine§	—	0	2	5	3	—	0	1	1	1	—	0	1	1	3
Massachusetts	—	0	0	—	—	—	0	0	—	—	2	2	7	43	35
New Hampshire	—	0	0	—	—	—	0	0	—	—	—	0	2	7	5
Rhode Island§	—	0	4	8	3	—	0	1	1	—	—	0	5	9	5
Vermont§	1	0	2	11	8	1	0	1	2	1	—	0	1	1	2
Mid. Atlantic	3	3	7	67	64	—	0	5	16	10	15	24	44	532	381
New Jersey	—	0	0	—	—	—	0	0	—	—	—	3	8	57	66
New York (Upstate)	1	1	5	22	17	—	0	4	7	4	—	3	14	41	53
New York City	—	0	0	—	—	—	0	0	—	—	15	15	35	357	178
Pennsylvania	2	2	6	45	47	—	0	2	9	6	—	5	12	77	84
E.N. Central	14	10	40	258	248	1	1	7	30	42	9	15	32	182	307
Illinois	—	0	2	3	9	—	0	1	1	3	—	6	13	35	170
Indiana	8	2	30	59	56	—	0	5	5	12	—	2	5	15	26
Michigan	1	0	3	1	9	—	0	1	—	1	2	2	10	41	32
Ohio	5	5	38	195	174	1	1	5	24	26	4	4	9	71	66
Wisconsin	N	0	0	N	N	—	0	0	—	—	3	1	4	20	13
W.N. Central	1	1	124	42	19	—	0	15	5	1	—	5	14	52	86
Iowa	—	0	0	—	—	—	0	0	—	—	—	0	3	2	7
Kansas	—	0	1	4	—	—	0	0	—	—	—	0	3	8	9
Minnesota	—	0	123	—	—	—	0	15	—	—	—	1	5	21	20
Missouri	1	1	6	32	19	—	0	2	3	1	—	3	9	21	48
Nebraska§	—	0	1	2	—	—	0	0	—	—	—	0	2	—	2
North Dakota	—	0	0	—	—	—	0	0	—	—	—	0	1	—	—
South Dakota	—	0	3	4	—	—	0	1	2	—	—	0	3	—	—
S. Atlantic	8	21	54	455	604	3	3	8	70	52	30	42	175	477	656
Delaware	—	0	1	3	—	—	0	1	1	—	—	0	3	3	10
District of Columbia	—	0	2	4	17	—	0	0	—	2	1	2	11	51	39
Florida	8	11	29	264	281	3	2	8	63	49	—	13	23	68	247
Georgia	—	6	17	157	267	—	0	1	—	1	—	6	144	20	65
Maryland§	—	0	1	1	—	—	0	0	—	—	7	5	15	109	113
North Carolina	—	0	0	—	—	—	0	0	—	—	15	5	23	122	107
South Carolina§	—	0	0	—	—	—	0	0	—	—	2	1	5	31	27
Virginia§	N	0	0	N	N	—	0	0	—	—	5	4	17	71	47
West Virginia	—	1	17	26	39	—	0	1	6	—	—	0	2	2	1
E.S. Central	1	3	8	64	86	2	0	3	13	16	2	14	29	256	207
Alabama§	N	0	0	N	N	—	0	0	—	—	—	5	17	82	94
Kentucky	—	0	2	12	23	—	0	1	1	3	—	1	7	29	30
Mississippi	—	0	0	—	—	—	0	0	—	—	2	2	10	45	21
Tennessee§	1	2	8	52	63	2	0	3	12	13	—	6	12	100	62
W.S. Central	1	1	7	56	9	—	0	2	5	3	17	29	56	505	489
Arkansas§	—	0	3	1	4	—	0	0	—	2	—	1	7	37	34
Louisiana	—	1	3	22	5	—	0	1	2	1	8	6	30	109	68
Oklahoma	1	0	6	33	—	—	0	2	3	—	—	1	5	27	27
Texas§	—	0	0	—	—	—	0	0	—	—	9	21	31	332	360
Mountain	—	1	5	24	49	—	0	5	6	22	—	8	27	87	153
Arizona	—	0	0	—	—	—	0	0	—	—	—	3	16	29	65
Colorado	—	0	0	—	—	—	0	0	—	—	—	1	5	9	26
Idaho§	N	0	0	N	N	—	0	0	—	—	—	0	1	1	2
Montana§	—	0	0	—	—	—	0	0	—	—	—	0	1	1	1
Nevada§	—	0	3	13	12	—	0	2	3	—	—	1	12	19	32
New Mexico§	—	0	0	—	—	—	0	0	—	—	—	1	5	24	23
Utah	—	0	5	8	21	—	0	4	2	16	—	0	2	3	4
Wyoming§	—	0	3	3	16	—	0	2	1	6	—	0	1	1	—
Pacific	—	0	0	—	—	—	0	0	—	—	4	37	55	546	702
Alaska	—	0	0	—	—	—	0	0	—	—	—	0	2	4	5
California	N	0	0	N	N	—	0	0	—	—	4	34	52	494	613
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	1	1	9
Oregon§	N	0	0	N	N	—	0	0	—	—	—	0	6	5	5
Washington	N	0	0	N	N	—	0	0	—	—	—	2	11	42	70
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	N	—	—	N	N	—	—	—	—	—	—	—	—	—	—
Puerto Rico	N	0	0	N	N	—	0	0	—	—	1	2	11	43	53
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

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 years 2006 and 2007 are provisional.
† Includes cases of invasive pneumococcal disease caused by drug-resistant *S. pneumoniae* (DRSP) (NNDSS event code 11720).
§ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending May 5, 2007, and May 6, 2006 (18th Week)*

Reporting area	Varicella (chickenpox)					West Nile virus disease†									
						Neuroinvasive					Non-neuroinvasive§				
	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006	Current week	Previous 52 weeks		Cum 2007	Cum 2006
		Med	Max				Med	Max				Med	Max		
United States	659	786	1,543	16,103	20,500	—	0	178	—	9	—	1	399	—	3
New England	25	39	121	273	1,279	—	0	3	—	—	—	0	2	—	—
Connecticut	—	13	76	—	739	—	0	3	—	—	—	0	1	—	—
Maine¶	—	1	17	—	115	—	0	0	—	—	—	0	0	—	—
Massachusetts	—	0	1	—	92	—	0	1	—	—	—	0	1	—	—
New Hampshire	4	6	43	95	35	—	0	0	—	—	—	0	0	—	—
Rhode Island¶	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Vermont¶	21	10	66	178	298	—	0	0	—	—	—	0	0	—	—
Mid. Atlantic	97	104	193	2,056	2,279	—	0	11	—	—	—	0	4	—	—
New Jersey	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
New York (Upstate)	N	0	0	N	N	—	0	5	—	—	—	0	1	—	—
New York City	—	0	0	—	—	—	0	4	—	—	—	0	2	—	—
Pennsylvania	97	104	193	2,056	2,279	—	0	2	—	—	—	0	1	—	—
E.N. Central	257	228	568	4,840	7,651	—	0	43	—	—	—	0	33	—	—
Illinois	—	1	10	54	45	—	0	23	—	—	—	0	23	—	—
Indiana	—	0	0	—	—	—	0	7	—	—	—	0	12	—	—
Michigan	48	90	258	1,870	2,227	—	0	11	—	—	—	0	2	—	—
Ohio	209	122	449	2,499	4,777	—	0	11	—	—	—	0	3	—	—
Wisconsin	—	16	57	417	602	—	0	2	—	—	—	0	2	—	—
W.N. Central	47	30	136	929	980	—	0	36	—	—	—	0	79	—	—
Iowa	N	0	0	N	N	—	0	3	—	—	—	0	4	—	—
Kansas	21	8	52	368	176	—	0	3	—	—	—	0	3	—	—
Minnesota	—	0	0	—	—	—	0	6	—	—	—	0	7	—	—
Missouri	26	15	78	435	756	—	0	14	—	—	—	0	2	—	—
Nebraska¶	N	0	0	N	N	—	0	9	—	—	—	0	38	—	—
North Dakota	—	0	60	84	18	—	0	5	—	—	—	0	28	—	—
South Dakota	—	1	15	42	30	—	0	7	—	—	—	0	22	—	—
S. Atlantic	45	85	211	1,813	2,052	—	0	2	—	—	—	0	7	—	—
Delaware	—	1	6	12	39	—	0	0	—	—	—	0	0	—	—
District of Columbia	—	0	5	—	14	—	0	0	—	—	—	0	1	—	—
Florida	33	0	43	517	N	—	0	1	—	—	—	0	0	—	—
Georgia	N	0	0	N	N	—	0	1	—	—	—	0	4	—	—
Maryland¶	N	0	0	N	N	—	0	2	—	—	—	0	2	—	—
North Carolina	—	0	0	—	—	—	0	1	—	—	—	0	0	—	—
South Carolina¶	7	22	72	530	581	—	0	1	—	—	—	0	0	—	—
Virginia¶	4	22	177	248	644	—	0	0	—	—	—	0	2	—	—
West Virginia	1	25	52	506	774	—	0	1	—	—	—	0	0	—	—
E.S. Central	16	5	43	152	34	—	0	15	—	3	—	0	16	—	—
Alabama¶	16	5	43	150	34	—	0	2	—	—	—	0	0	—	—
Kentucky	N	0	0	N	N	—	0	2	—	—	—	0	1	—	—
Mississippi	—	0	2	2	—	—	0	10	—	3	—	0	16	—	—
Tennessee¶	N	0	0	N	N	—	0	4	—	—	—	0	2	—	—
W.S. Central	137	200	966	4,808	4,750	—	0	58	—	4	—	0	26	—	2
Arkansas¶	—	9	92	171	383	—	0	4	—	—	—	0	2	—	—
Louisiana	1	1	11	46	39	—	0	13	—	—	—	0	9	—	1
Oklahoma	—	0	0	—	—	—	0	6	—	—	—	0	4	—	—
Texas¶	136	172	873	4,591	4,328	—	0	38	—	4	—	0	16	—	1
Mountain	35	54	108	1,212	1,475	—	0	61	—	2	—	1	228	—	1
Arizona	—	0	0	—	—	—	0	9	—	—	—	0	15	—	—
Colorado	22	21	51	439	757	—	0	10	—	2	—	0	51	—	1
Idaho¶	N	0	0	N	N	—	0	30	—	—	—	0	157	—	—
Montana¶	—	0	26	167	N	—	0	3	—	—	—	0	8	—	—
Nevada¶	—	0	3	—	5	—	0	9	—	—	—	0	16	—	—
New Mexico¶	—	4	19	159	271	—	0	1	—	—	—	0	1	—	—
Utah	13	18	65	434	430	—	0	8	—	—	—	0	17	—	—
Wyoming¶	—	0	11	13	12	—	0	7	—	—	—	0	10	—	—
Pacific	—	0	9	20	—	—	0	15	—	—	—	0	51	—	—
Alaska	—	0	9	20	N	—	0	0	—	—	—	0	0	—	—
California	—	0	0	—	N	—	0	15	—	—	—	0	37	—	—
Hawaii	—	0	0	—	—	—	0	0	—	—	—	0	0	—	—
Oregon¶	N	0	0	N	N	—	0	2	—	—	—	0	14	—	—
Washington	N	0	0	N	N	—	0	0	—	—	—	0	2	—	—
American Samoa	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U
C.N.M.I.	U	—	—	U	U	U	—	—	U	U	U	—	—	U	U
Guam	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Puerto Rico	20	12	24	207	205	—	0	0	—	—	—	0	0	—	—
U.S. Virgin Islands	U	0	0	U	U	U	0	0	U	U	U	0	0	U	U

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 years 2006 and 2007 are provisional.
† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Zoonotic, Vector-Borne, and Enteric Diseases (ArboNET Surveillance). Data for California serogroup, eastern equine, Powassan, St. Louis, and western equine diseases are available in Table I.
§ Not notifiable in all states. Data from states where the condition is not notifiable are excluded from this table, except in 2007 for the domestic arboviral diseases and influenza-associated pediatric mortality, and in 2003 for SARS-CoV. Reporting exceptions are available at http://www.cdc.gov/epo/dphsi/phs/infdis.htm.
¶ Contains data reported through the National Electronic Disease Surveillance System (NEDSS).

TABLE III. Deaths in 122 U.S. cities,* week ending May 5, 2007 (18th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
New England	582	420	102	32	11	17	56
Boston, MA	152	92	38	10	5	7	12
Bridgeport, CT	24	17	4	2	1	—	3
Cambridge, MA	21	19	1	1	—	—	4
Fall River, MA	20	19	1	—	—	—	4
Hartford, CT	60	44	11	1	1	3	8
Lowell, MA	24	15	6	2	1	—	4
Lynn, MA	10	9	—	1	—	—	1
New Bedford, MA	23	23	—	—	—	—	3
New Haven, CT	15	11	2	1	1	—	6
Providence, RI	64	46	12	2	—	4	2
Somerville, MA	3	3	—	—	—	—	—
Springfield, MA	47	29	10	6	—	2	4
Waterbury, CT	26	20	5	—	1	—	2
Worcester, MA	93	73	12	6	1	1	3
Mid. Atlantic	2,143	1,460	411	164	64	43	116
Albany, NY	44	26	13	1	2	2	1
Allentown, PA	14	11	3	—	—	—	—
Buffalo, NY	78	53	12	5	5	3	12
Camden, NJ	23	15	4	4	—	—	—
Elizabeth, NJ	13	10	—	2	1	—	2
Erie, PA	59	46	12	1	—	—	5
Jersey City, NJ	21	15	4	2	—	—	1
New York City, NY	1,110	788	222	67	24	8	51
Newark, NJ	61	21	16	9	1	14	4
Paterson, NJ	17	12	1	2	1	1	1
Philadelphia, PA	347	195	57	58	26	11	15
Pittsburgh, PA§	32	26	3	3	—	—	1
Reading, PA	27	19	6	—	1	1	3
Rochester, NY	126	92	21	8	2	3	11
Schenectady, NY	26	21	5	—	—	—	2
Scranton, PA	26	21	5	—	—	—	1
Syracuse, NY	58	43	14	—	1	—	3
Trenton, NJ	30	20	9	1	—	—	1
Utica, NY	19	16	2	1	—	—	2
Yonkers, NY	12	10	2	—	—	—	—
E.N. Central	2,058	1,370	438	143	63	43	163
Akron, OH	42	26	10	5	1	—	1
Canton, OH	34	27	5	—	1	1	3
Chicago, IL	349	191	87	47	23	1	35
Cincinnati, OH	92	57	18	7	6	4	15
Cleveland, OH	270	189	53	18	4	6	14
Columbus, OH	185	128	32	12	6	7	24
Dayton, OH	125	91	27	4	2	1	12
Detroit, MI	174	99	53	15	3	4	7
Evansville, IN	50	36	10	2	1	1	2
Fort Wayne, IN	59	44	12	3	—	—	4
Gary, IN	23	10	11	2	—	—	—
Grand Rapids, MI	52	34	12	—	2	4	8
Indianapolis, IN	193	126	46	9	9	3	13
Lansing, MI	46	35	9	—	—	2	2
Milwaukee, WI	73	53	15	2	—	3	3
Peoria, IL	52	46	4	2	—	—	6
Rockford, IL	34	22	5	4	2	—	2
South Bend, IN	36	30	4	2	—	—	—
Toledo, OH	117	81	21	8	1	6	6
Youngstown, OH	52	45	4	1	2	—	6
W.N. Central	648	441	140	39	13	15	39
Des Moines, IA	73	47	21	4	—	1	4
Duluth, MN	29	27	2	—	—	—	1
Kansas City, KS	14	7	4	2	1	—	2
Kansas City, MO	117	79	29	6	—	3	5
Lincoln, NE	44	35	7	2	—	—	6
Minneapolis, MN	60	38	13	5	2	2	4
Omaha, NE	74	55	13	3	1	2	7
St. Louis, MO	89	53	20	7	6	3	7
St. Paul, MN	64	48	9	4	2	1	1
Wichita, KS	84	52	22	6	1	3	2
S. Atlantic	1,229	770	288	97	46	28	72
Atlanta, GA	159	95	39	11	9	5	—
Baltimore, MD	193	111	54	20	5	3	17
Charlotte, NC	132	93	25	10	1	3	11
Jacksonville, FL	112	76	23	8	4	1	5
Miami, FL	100	65	19	10	4	2	8
Norfolk, VA	52	28	16	6	1	1	4
Richmond, VA	54	30	13	4	4	3	3
Savannah, GA	52	33	10	4	3	2	7
St. Petersburg, FL	58	39	11	4	2	2	4
Tampa, FL	190	125	41	14	8	2	9
Washington, D.C.	118	67	36	6	5	4	4
Wilmington, DE	9	8	1	—	—	—	—
E.S. Central	793	503	184	56	19	31	65
Birmingham, AL	175	114	41	7	5	8	13
Chattanooga, TN	73	54	17	1	—	1	4
Knoxville, TN	91	56	23	7	—	5	6
Lexington, KY	52	31	11	4	1	5	5
Memphis, TN	147	84	36	13	11	3	16
Mobile, AL	69	49	13	4	1	2	4
Montgomery, AL	38	26	8	4	—	—	3
Nashville, TN	148	89	35	16	1	7	14
W.S. Central	1,594	997	401	113	38	45	86
Austin, TX	106	63	21	14	5	3	11
Baton Rouge, LA	30	23	5	2	—	—	—
Corpus Christi, TX	64	43	17	2	—	2	3
Dallas, TX	187	107	48	15	9	8	14
El Paso, TX	135	94	26	11	3	1	6
Fort Worth, TX	121	86	28	2	1	4	6
Houston, TX	351	198	101	31	10	11	13
Little Rock, AR	69	44	18	5	—	2	3
New Orleans, LA¶	U	U	U	U	U	U	U
San Antonio, TX	293	195	72	14	7	5	18
Shreveport, LA	110	69	27	6	1	7	7
Tulsa, OK	128	75	38	11	2	2	5
Mountain	1,093	718	238	88	31	18	75
Albuquerque, NM	148	98	32	11	4	3	8
Boise, ID	44	33	7	2	1	1	4
Colorado Springs, CO	67	44	16	3	2	2	4
Denver, CO	99	62	22	8	2	5	9
Las Vegas, NV	257	164	71	20	2	—	16
Ogden, UT	36	25	6	2	3	—	1
Phoenix, AZ	181	103	35	26	12	5	9
Pueblo, CO	32	22	9	1	—	—	3
Salt Like City, UT	122	86	22	10	3	1	14
Tucson, AZ	107	81	18	5	2	1	7
Pacific	1,521	1,076	306	81	30	28	103
Berkeley, CA	15	8	6	—	—	1	2
Fresno, CA	176	132	30	8	6	—	14
Glendale, CA	U	U	U	U	U	U	U
Honolulu, HI	87	63	14	5	—	5	10
Long Beach, CA	86	58	17	7	3	1	4
Los Angeles, CA	U	U	U	U	U	U	U
Pasadena, CA	29	22	5	1	—	1	4
Portland, OR	124	90	26	4	2	2	9
Sacramento, CA	219	153	42	11	6	7	11
San Diego, CA	172	125	24	15	5	3	11
San Francisco, CA	120	76	34	7	2	1	12
San Jose, CA	176	128	38	5	1	4	10
Santa Cruz, CA	42	30	9	3	—	—	1
Seattle, WA	96	61	25	6	2	2	6
Spokane, WA	73	54	15	3	—	1	6
Tacoma, WA	106	76	21	6	3	—	3
Total	11,661**	7,755	2,508	813	315	268	775

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.

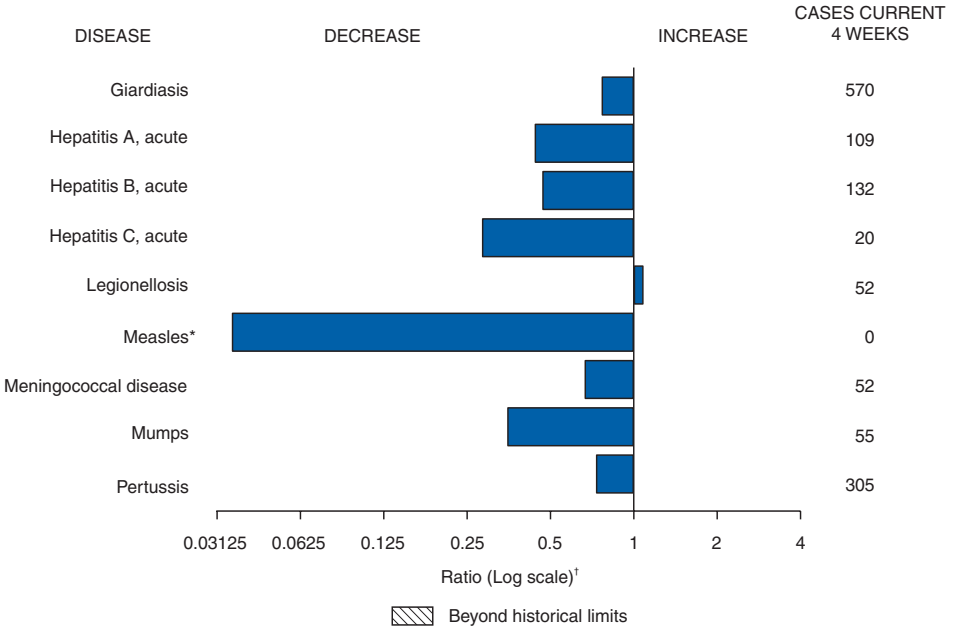
† Pneumonia and influenza.

§ 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 May 5, 2007, with historical data



* No measles cases were reported for the current 4-week period, yielding a ratio for week 18 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.

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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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