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Tobacco Use Among Middle and High School Students — United States, 1999

The prevalence of cigarette smoking nationwide among high school students increased during the 1990s (*1*); more than 80% of current adult tobacco users started smoking cigarettes before age 18 years (*2*). To determine the prevalence of cigarette, smokeless tobacco (i.e., chewing tobacco and snuff), cigar, pipe, bidi, and kretek use among middle school and high school students nationwide, the American Legacy Foundation, in collaboration with the CDC Foundation, conducted the National Youth Tobacco Survey (NYTS) during the fall of 1999. This report summarizes data from the NYTS on current use of tobacco products, which indicate that 12.8% of middle school students and 34.8% of high school students use any type of tobacco; that the low prevalence of current cigarette smoking observed among black high school students throughout the 1990s is not found among middle school students (*1*); and that the percentages of high school students who currently use bidis and kreteks (two new forms of tobacco in the United States) are almost as high as the proportion who use smokeless tobacco.

The school-based 1999 NYTS employed a three-stage cluster sample designed to produce a nationally representative sample of students in grades 6–12. The first-stage sampling frame contained 1306 primary sampling units (PSUs), each comprising a large county or a group of smaller adjacent counties. From the 1306 PSUs, 66 were selected from 16 strata formed on the basis of the degree of urbanization and the relative percentage of black and Hispanic students in the PSU. PSUs were selected with probability proportional to weighted school enrollment. At the second sampling stage, 145 schools from the 66 PSUs were selected with probability proportional to weighted school enrollment. To ensure separate analysis of black and Hispanic students, schools with substantial numbers of black and Hispanic students were sampled at higher rates than all other schools through a weighted measure of size. The third stage of sampling consisted of randomly selecting approximately five intact classes of a required subject (e.g., English or social studies) across grades 6–12 from each participating school. All students in the selected classes were eligible to participate. A weighting factor was applied to each student record to adjust for nonresponse and for the varying probabilities of selection, including those resulting from the oversampling of black and Hispanic students. Numbers of students in racial/ethnic groups other than black, white, and Hispanic were too small for meaningful analysis. The weights were

Tobacco Use — Continued

scaled so that the weighted count of students equaled the total sample size and the weighted proportions of students in each grade matched national population proportions. For the 1999 NYTS, 15,058 students in 131 schools completed questionnaires. The school response rate was 90%, and the student response rate was 93%, resulting in an overall response rate of 84%.

For the NYTS, students completed an anonymous, self-administered questionnaire that included questions about tobacco use, exposure to environmental tobacco smoke, minors' ability to purchase or otherwise obtain tobacco products, knowledge and attitudes about tobacco, and familiarity with pro- and anti-tobacco media messages. SUDAAN was used to compute 95% confidence intervals, which were used to determine differences between subgroups at the $p<0.05$ level. Differences between prevalence estimates were considered statistically significant if the 95% confidence intervals did not overlap. Current use of bidis, cigarettes, cigars, kreteks, pipes, and smokeless tobacco was defined as use on one or more of the 30 days preceding the survey. Any current tobacco use was defined as using any of these products on one or more of the 30 days preceding the survey.

Middle School Students

Among middle school (grades 6–8) students, the overall prevalence of any current tobacco use was 12.8% (Table 1). Cigarettes (9.2%) were the most prevalent type of tobacco used, followed by cigars (6.1%). Cigarette smoking rates were similar among boys and girls and among racial/ethnic groups. Boys were significantly more likely

TABLE 1. Percentage of students in middle school (grades 6–8) and high school (grades 9–12) currently* using tobacco products, by type of tobacco product, sex, and race/ethnicity — United States, National Youth Tobacco Survey, 1999

Type of tobacco product	Sex				Race/Ethnicity						Total	
	Male		Female		White		Black		Hispanic			
	%	(95% CI†)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Any use§												
Middle school	14.2	(± 2.2)	11.3	(± 2.2)	11.6	(± 2.3)	14.4	(± 2.7)	15.2	(± 5.2)	**12.8**	**(± 2.0)**
High school	38.1	(± 3.2)	31.4	(± 3.1)	39.4	(± 3.2)	24.0	(± 4.2)	30.7	(± 4.4)	**34.8**	**(± 2.7)**
Cigarette												
Middle school	9.6	(± 1.7)	8.8	(± 1.7)	8.8	(± 2.0)	9.0	(± 1.8)	11.0	(± 4.1)	**9.2**	**(± 1.6)**
High school	28.7	(± 2.8)	28.2	(± 3.3)	32.8	(± 3.1)	15.8	(± 3.8)	25.8	(± 4.7)	**28.4**	**(± 2.7)**
Smokeless												
Middle school	4.2	(± 1.3)	1.3	(± 0.5)	3.0	(± 1.1)	1.9	(± 0.9)	2.2	(± 0.9)	**2.7**	**(± 0.7)**
High school	11.6	(± 2.8)	1.5	(± 0.6)	8.7	(± 2.1)	2.4	(± 1.3)	3.6	(± 1.6)	**6.6**	**(± 1.6)**
Cigar												
Middle school	7.8	(± 1.3)	4.4	(± 1.3)	4.9	(± 1.0)	8.8	(± 2.3)	7.6	(± 2.9)	**6.1**	**(± 1.1)**
High school	20.3	(± 1.9)	10.2	(± 1.6)	16.0	(± 1.6)	14.8	(± 3.5)	13.4	(± 2.9)	**15.3**	**(± 1.4)**
Pipe												
Middle school	3.5	(± 0.8)	1.4	(± 0.6)	2.0	(± 0.6)	2.0	(± 0.9)	3.8	(± 1.7)	**2.4**	**(± 0.5)**
High school	4.2	(± 0.9)	1.4	(± 0.5)	2.6	(± 0.6)	1.8	(± 0.9)	3.8	(± 1.4)	**2.8**	**(± 0.5)**
Bidi												
Middle school	3.1	(± 0.8)	1.8	(± 0.6)	1.8	(± 0.5)	2.8	(± 1.3)	3.5	(± 1.6)	**2.4**	**(± 0.6)**
High school	6.1	(± 1.0)	3.8	(± 1.0)	4.4	(± 0.9)	5.8	(± 2.1)	5.6	(± 2.1)	**5.0**	**(± 0.8)**
Kretek												
Middle school	2.2	(± 0.6)	1.7	(± 0.7)	1.7	(± 0.7)	1.7	(± 0.8)	2.1	(± 0.6)	**1.9**	**(± 0.5)**
High school	6.2	(± 1.1)	5.3	(± 1.5)	6.5	(± 1.5)	2.8	(± 1.5)	5.5	(± 1.9)	**5.8**	**(± 1.2)**

* Used tobacco on one or more of the 30 days preceding the survey.
† Confidence interval.
§ Use of cigarettes, smokeless tobacco, cigars, pipes, bidis, or kreteks.

Tobacco Use — Continued

than girls to use smokeless tobacco (4.2% and 1.3%, respectively), smoke cigars (7.8% and 4.4%, respectively), and smoke tobacco in a pipe (3.5% and 1.4%, respectively). Black students were significantly more likely than white students to smoke cigars (8.8% and 4.9%, respectively).

High School Students

Among high school (grades 9–12) students, the overall prevalence of any current tobacco use was 34.8%. Cigarettes (28.4%) were the most prevalent type of tobacco used, followed by cigars (15.3%). Boys were significantly more likely than girls to use smokeless tobacco (11.6% and 1.5%, respectively), smoke cigars (20.3% and 10.2%, respectively), smoke tobacco in a pipe (4.2% and 1.4%, respectively), and smoke bidis (6.1% and 3.8%, respectively). White and Hispanic students were significantly more likely than black students to smoke cigarettes (32.8%, 25.8%, and 15.8%, respectively). White students were significantly more likely than black and Hispanic students to use smokeless tobacco (8.7%, 2.4%, and 3.6%, respectively).

Reported by: C Healton, DrPH, P Messeri, PhD, J Reynolds, MPH, C Wolfe, The American Legacy Foundation, Washington, DC. C Stokes, MEd, CDC Foundation, Atlanta, Georgia. J Ross, MS, K Flint, MA, W Robb, MS, Macro International Inc., Calverton, Maryland. M Farrelly, PhD, Research Triangle Institute, Research Triangle Park, North Carolina. Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: This report is the first to measure the prevalence of current tobacco use among a nationally representative sample of middle school students and the first to report the prevalence of current bidi and kretek use among a nationally representative sample of middle and high school students. Although previous national surveys have shown that cigarette smoking rates among black high school students have been increasing, black students still were smoking at much lower rates than other high school students (*1,3,4*). However, the findings in this report indicate that current cigarette smoking prevalence among middle school black students was similar to rates among white and Hispanic students and that current cigar use prevalence among middle school black students was significantly higher than among white students. Future surveys should evaluate whether the rate of increase in smoking rates among black students has accelerated and whether the difference in smoking rates between black and white high school students are disappearing. In addition, more research is needed to determine whether black youth are finding smoking appealing and socially acceptable.

Current use of novel tobacco products, such as bidis and kreteks, is an emerging public health problem among U.S. youth (*5*). Cigarettes remain the most widely used tobacco product by youth; however, recent trends underscore the importance of monitoring the rates at which youth adopt other tobacco products. The social and cultural factors related to differing patterns of tobacco product use across sex and racial/ethnic groups require additional study.

The 1999 NYTS estimates for high school students will be compared with those of the Monitoring The Future (MTF) study and the Youth Risk Behavior Survey (YRBS), the other national school-based surveys. Comparison of NYTS estimates with those of other national surveys must be interpreted with caution for several reasons. First, YRBS and MTF were conducted during spring 1999, and NYTS was conducted during September–October 1999, a different academic year. Within each grade, the fall school population is approximately 6 months younger than the spring school population.

Tobacco Use — Continued

This difference can be expected to lead to higher estimates of ever smoking in the spring surveys and may lead to higher estimates of current smoking. Second, the tobacco industry increased the wholesale price of tobacco products during 1999, but also provided substantial price discounts during the same period, making determination of the precise effect of retail prices on smoking rates difficult. However, preliminary per capita consumption estimates from the U.S. Department of Agriculture suggest cigarette consumption has decreased in 1999, suggesting that the prevalence among youth also may have decreased (*6*). Third, the NYTS is a single-topic survey (tobacco), and MTF and YRBS are multi-topic surveys. The effect of the number of topics surveyed on the resulting estimates is unknown. Finally, NYTS had a 90% school response rate, a higher reported school response rate than YRBS and MTF. Some schools that participated in the NYTS may not participate in YRBS or MTF.

The findings in this report are subject to at least two limitations. First, these data apply only to youth who attended middle or high school and are not representative of all persons in this age group. Few persons aged <16 years do not attend school and, in 1997, only 4% of 16-year-olds and 6% of 17-year-olds who had not completed high school were not enrolled in a high school program (*7*). The dropout rate for young adults aged 16–24 years varies greatly by race/ethnicity (7.6%, white; 13.4%, black; and 25.3%, Hispanic) (*7*). Second, "any current tobacco use" might be underestimated in this report because it does not include a measure of "roll-your-own" tobacco smoking.

To evaluate the potential impact of the expanding levels of tobacco prevention efforts nationwide and in the individual states, surveillance of trends in tobacco use among youth must be continued and expanded. YRBS has provided national and state-specific surveillance of tobacco use among high school students since 1991 (*8*). The NYTS and state-specific youth tobacco surveys are extending this surveillance effort to middle school students and across a wider range of evaluation variables, including knowledge and attitudes about tobacco, exposure to environmental tobacco smoke, familiarity with pro-smoking and antismoking media messages, and exposure to tobacco-use prevention curriculum in schools. CDC has prepared "Best Practices" guidelines to help states determine funding priorities and to plan and carry out effective comprehensive tobacco-use prevention and control programs (*9*). If current patterns of smoking behavior persist, an estimated 5 million U.S. persons who were aged ≤18 years in 1995 could die prematurely from smoking-related illnesses (*10*). Implementation of the "Best Practices" guidelines, along with nationwide prevention efforts, enforcement of the proposed Food and Drug Administration rules, increases in the excise tax on tobacco products, and increased availability of smoking cessation treatment options, could dramatically reduce these projected deaths.

References

1. CDC. Tobacco use among high school students—United States, 1997. MMWR 1998;47:229–33.
2. CDC. Preventing tobacco use among young people: report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services, Public Health Service, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1994.
3. CDC. Tobacco use among U.S. racial/ethnic minority groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: a report of the Surgeon General. Atlanta, Georgia: US Department of Health and Human Services,

Tobacco Use — Continued

CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1998.
4. University of Michigan. Monitoring the Future Survey. World-Wide Web site http://monitoringthefuture.org/data/99data.html#1999data_cigs. Accessed December 17, 1999.
5. CDC. Bidi use among urban youth—Massachusetts, March–April 1999. MMWR 1999;48: 796–9.
6. USDA. Cigarette production, exports, and domestic consumption down in 1999. World-Wide Web site http://usda.mannlib.cornell.edu/reports/erssor/specialty/tbs-bb/1999/tbs245s.asc. Accessed December 21, 1999.
7. National Center for Education Statistics. Dropout rates in the United States, 1997. Washington, DC: US Department of Education, 1999 (NCES 99-082).
8. CDC. Youth risk behavior survey—United States, 1997. MMWR 1998;47(no. SS-3).
9. CDC. Best practices for comprehensive tobacco control–August 1999. Atlanta, Georgia: US Department of Health and Human Services, CDC, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 1999.
10. CDC. Projected smoking-related deaths among youth—United States. MMWR 1996;45:971–4.

Update: Influenza Activity — United States, 1999–2000 Season

Influenza activity in the United States began to increase substantially during mid-December 1999, and as of January 15, 2000, laboratory-confirmed influenza infections have been reported from all nine surveillance regions. The predominant viruses isolated this season have been influenza type A(H3N2) viruses that have been circulating in the United States for the last two influenza seasons and are well-matched to this season's vaccine. This report summarizes influenza activity in the United States during October 3, 1999–January 15, 2000.*

During October 3–January 15, the highest percentage of patient visits to U.S. sentinel physicians for influenza-like illness (ILI)† was 6% during the week ending January 1 (week 52) (Figure 1). During that week, the percentage of patient visits for ILI was elevated above baseline levels (0–3%) in all nine regions. For the week ending January 15 (week 2), 4% of overall patient visits were for ILI.

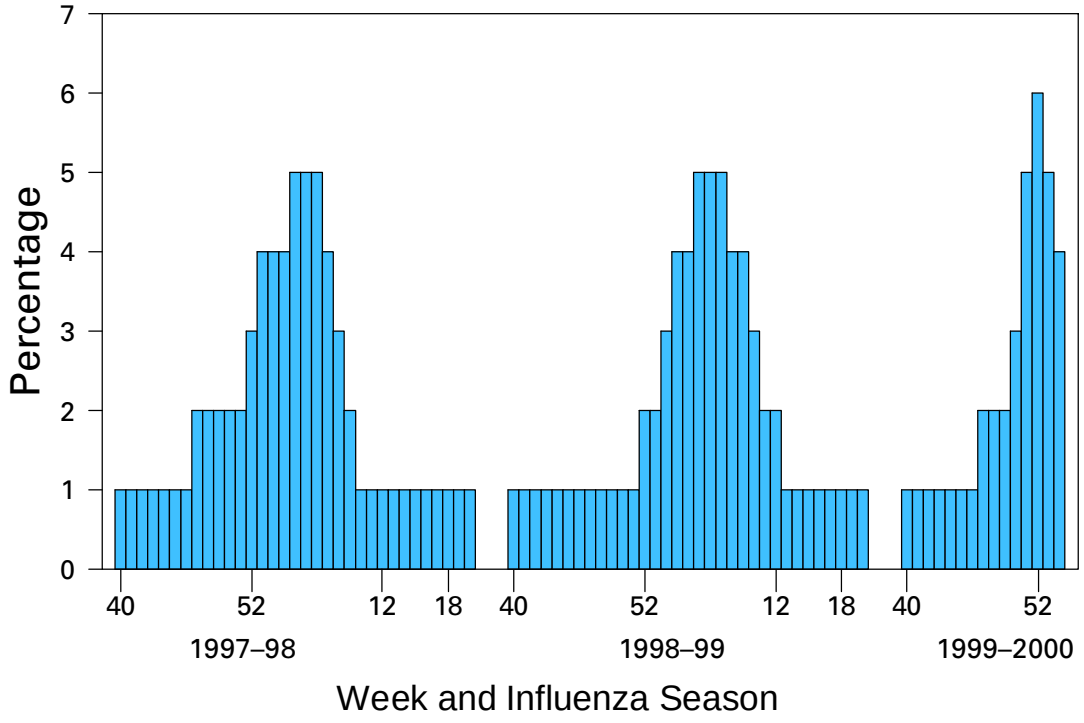
During October 3–January 15, the highest numbers of state and territorial epidemiologists reporting either widespread or regional influenza activity§ during any weeks were 42 during the week ending January 8 (week 1) and 43 during the week ending January 15 (week 2). For the week ending January 15, 31 states reported widespread activity, and 12 states reported regional activity. The highest percentage of deaths attributed to pneumonia and influenza (P&I) in the 122 Cities Mortality Reporting System was 10.5% during week 2. This was above the epidemic threshold¶ of 7.4% for that week and increased from 9.3% in week 1 (Figure 2).

Since the week ending October 3, the World Health Organization collaborating laboratories and the National Respiratory and Enteric Virus Surveillance System laboratories in the United States have tested 41,034 respiratory specimens for influenza

*The four components of the influenza surveillance system have been described (*1*).
†Defined as temperature ≥100 F (≥37.8 C) plus either cough or sore throat.
§Levels of activity are 1) *no activity*; 2) *sporadic*—sporadically occurring ILI or culture-confirmed influenza with no outbreaks detected; 3) *regional*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of <50% of the state's population; and 4) *widespread*—outbreaks of ILI or culture-confirmed influenza in counties with a combined population of ≥50% of the state's population.
¶The epidemic threshold is 1.645 standard deviations above the seasonal baseline. The expected seasonal baseline is projected using a robust regression procedure in which a periodic regression model is applied to observed percentages of deaths from P&I since 1983.

Influenza Activity — Continued

FIGURE 1. Percentage of patient visits to sentinel physicians for influenza-like illness,* by week of report — United States, 1997–98 and 1998–99 seasons (weeks 40–20) and 1999–2000 season (weeks 40–2)



*Defined as temperature ≥100 F (≥37.8 C) plus either cough or sore throat.

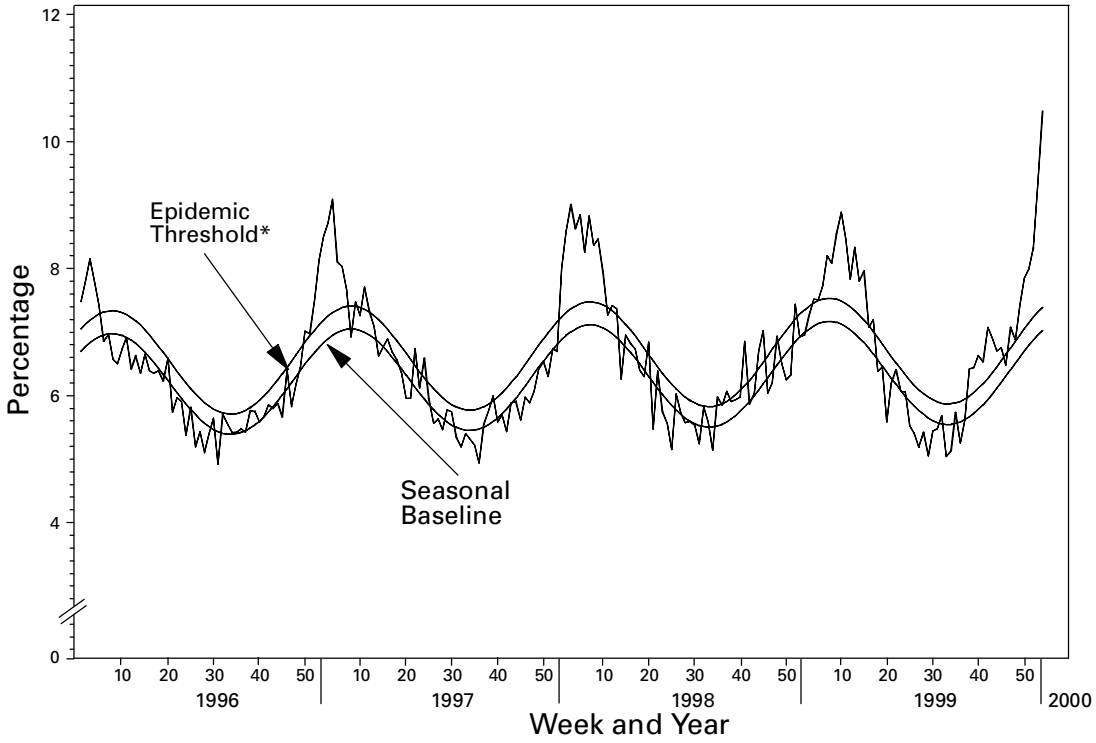
viruses; of these, 7361 (18%) tested positive. Of the positive specimens, 7338 (99.7%) were type A, and 23 (0.3%) were type B. For the week ending January 15, 21% of specimens tested for influenza viruses were positive, a decrease from the highest level of 33% during the week ending December 25. Of the 1665 influenza A isolates subtyped as of January 15, 1659 (99.6%) were H3N2 viruses, and six (0.4%) were H1N1 viruses.

CDC has characterized antigenically 246 influenza viruses received from U.S. laboratories since October 1. Of the 239 influenza A(H3N2) viruses tested, 214 (90%) were similar to the vaccine strain A/Sydney/05/97, and 25 (10%) showed somewhat reduced titers to ferret antisera produced against the A/Sydney/05/97 virus. All four of the U.S. influenza type B viruses antigenically characterized were similar to B/Beijing/184/93-like virus, which is represented in the current vaccine by the B/Yamanashi/166/98 virus. Of the three influenza A(H1N1) viruses antigenically characterized, two were similar to A/Beijing/262/95, the H1N1 component of the current vaccine, and one was related more closely to the antigenic variant A/New Caledonia/20/99. This is the third consecutive winter that the influenza A/Sydney/05/97-like (H3N2) viruses have been the predominant influenza viruses.

Reported by: Participating state and territorial epidemiologists and state public health laboratory directors. World Health Organization collaborating laboratories. National Enteric Virus Surveillance System Organization collaborating laboratories. Sentinel Physicians Influenza Surveillance System. Surveillance Systems Br, Div of Public Health Surveillance and Informatics, Epidemiology Program Office; Mortality Statistics Br, Div of Vital Statistics, National Center for

Influenza Activity — Continued

FIGURE 2. Percentage of mortality attributable to pneumonia and influenza (P&I) in 122 cities, by week of report — United States, 1996–2000



*The epidemic threshold is 1.645 standard deviations above the seasonal baseline. The expected seasonal baseline is projected using a robust regression procedure in which a periodic regression model is applied to observed percentages of deaths from P&I since 1983.

Health Statistics; WHO Collaborating Center for Reference and Research on Influenza, Respiratory and Enterovirus Br, and Influenza Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; and an EIS Officer, CDC.

Editorial Note: For the 1999–2000 season, influenza activity began to increase in mid-December, approximately 4 weeks earlier than in the 1997–98 season, and 7–8 weeks earlier than in the 1998–99 season. Influenza seasons are usually variable in onset, duration, timing of peak periods, and regional and overall health impact from year to year. As of January 15, 2000, the percentage of patient visits for ILI to sentinel physicians, the percentage of respiratory specimens testing positive for influenza, and the number of state and territorial epidemiologists reporting either widespread or regional influenza activity have been similar to the last two seasons. Recent declines in visits to sentinel physicians for ILI and in the percentage of respiratory specimens testing positive for influenza viruses suggest that influenza activity may have peaked nationally.

As of January 15, the percentage of mortality attributable to P&I in the 122 Cities Mortality Reporting System had not yet begun to decline, and the level of 10.5% was higher than any week during the last two A(H3N2) seasons. During the previous 3 years, P&I mortality levels have peaked between 8.8% and 9.1% of all deaths. This indicator of influenza activity typically lags behind other influenza surveillance indicators by approximately 2 weeks. Increased P&I mortality could be caused by several

Influenza Activity — Continued

factors, including high levels of influenza infection, deaths associated with other respiratory infections, and changes made this season to the case definition for reporting P&I deaths (*1*).

During winter months, other infectious pathogens such as respiratory syncytial virus (RSV), adenoviruses, parainfluenza viruses, rhinoviruses, coronavirus, mycoplasma, and bacterial infections also can cause respiratory illness. For example, national surveillance data indicate that RSV activity has been widespread this season (*2*); RSV activity peaks during the winter months (*3*).

Although viral culture of respiratory specimens obtained 1–4 days after illness onset remains the "gold standard" for confirming influenza virus infection, several commercial rapid diagnostic tests are available to test respiratory specimens for influenza. Such tests have reported sensitivities and specificities of 65%–87% and 93%–100%, respectively, and include tests that detect only influenza type A, or tests that detect both influenza type A and type B viruses, but do not distinguish between them (*4,5*). Rapid diagnostic tests use various clinical specimens and have not been compared in a controlled study.

Four prescription antiviral agents are approved for treating uncomplicated influenza. Amantadine and rimantadine are approved for treating influenza A, while the neuraminidase inhibitor drugs zanamivir and oseltamivir are approved to treat both influenza A and B (*6–8*). Amantadine and rimantadine also are approved for prophylaxis of influenza A, but neither zanamivir nor oseltamivir are approved for prophylactic use. On January 12, the Food and Drug Administration issued an advisory letter emphasizing that physicians should 1) always consider the possibility of primary or concomitant bacterial infection when making treatment decisions for patients with suspected influenza, and 2) use special caution if prescribing zanamivir to patients with underlying asthma or chronic obstructive pulmonary disease (*9*). All four antiviral agents can reduce the duration of influenza symptoms by approximately 1 day if treatment is started within 48 hours of symptom onset, but differ substantially in adverse effects, approved age-group use, and cost (*7–8,10*). CDC has issued a summary concerning the use of the neuraminidase inhibitors (*7*). None of the antiviral medications used to treat influenza are beneficial in treating other infectious diseases.

Despite the use of rapid diagnostic tests and availability of neuraminidase inhibitor drugs, influenza vaccination remains the most important measure to protect persons against influenza. At this time of year, influenza vaccine supplies are limited, but unvaccinated persons at high risk for complications from influenza (e.g., persons aged ≥65 years; adults and children who have chronic disorders of the pulmonary [including asthma] or cardiovascular system and chronic metabolic diseases [including diabetes]; and women in their second or third trimester of pregnancy) should consider vaccination if influenza vaccine is available in their area (*6*).

Influenza surveillance data collected by CDC are updated weekly from October through May. Summary reports are available through CDC's voice information system, telephone (888) 232-3228, fax (888) 232-3299 (request document number 361100), or through CDC's National Center for Infectious Diseases, Division of Viral and Rickettsial Diseases, Influenza Branch World-Wide Web site, http://www.cdc.gov/ncidod/diseases/flu/weekly.htm.

References

1. CDC. Influenza activity—United States, 1999–2000 season. MMWR 1999;48:1039–42.

Influenza Activity — Continued

2. CDC. National Respiratory and Enteric Virus Surveillance System—current trends. Available at http://www.cdc.gov/ncidod/dvrd/nrevss/trends.htm. Accessed January 2000.
3. CDC. Update: respiratory syncytial virus activity—United States, 1998–1999 season. MMWR 1999;48:1104–6,1115.
4. Leonardi GP, Leib H, Birkhead GS, et al. Comparison of rapid detection methods for influenza A virus and their value in health-care management of institutionalized geriatric patients. J Clin Microbiol 1994;32:70–4.
5. Anonymous. Rapid diagnostic tests for influenza. The Medical Letter 1999;41:121–2.
6. CDC. Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 1999;48(no. RR-4).
7. CDC. Neuraminidase inhibitors for treatment of influenza A and B infections. MMWR 1999; 48(no. RR-14).
8. Anonymous. Two neuraminidase inhibitors for treatment of influenza. The Medical Letter 1999;41:91–3.
9. Food and Drug Administration. Public health advisory letter: safe and appropriate use of influenza drugs. Rockville, Maryland: US Department of Health and Human Services, Food and Drug Administration, January 12, 2000. Available at http://www.fda.gov/cder/drug/advisory/influenza.htm.
10. Demicheli V, Jefferson T, Rivetti D, et al. Prevention and early treatment of influenza in healthy adults. Vaccine 2000;18:957–1030.

Progress Toward Poliomyelitis Eradication — Chad, 1996–1999

In 1988, the World Health Organization (WHO) resolved to eradicate poliomyelitis globally by December 31, 2000 (*1*). Polio eradication activities have been conducted in WHO's African Region (AFR) since 1996, and recently have been accelerated (*2*). In 1997, central African countries began conducting National Immunization Days (NIDs)* and established surveillance systems for acute flaccid paralysis (AFP). This report summarizes progress toward polio eradication and the establishment of AFP surveillance in Chad.

Routine Vaccination

Chad (population: 6.4 million) is a republic in central sub-Saharan Africa and is the fifth largest African country in area. After three decades of civil war, the damage to Chad's infrastructure affected the delivery of health-care services, including vaccination coverage. Most health-care providers practice in the capital, N'djamena, and few trained personnel are stationed in periurban and rural areas. Since 1990, reported routine infant vaccination coverage (e.g., three doses of oral poliovirus vaccine [OPV]) has been 10%–25%. This percentage is consistent with the continued reporting of clinically and virologically confirmed polio cases from the most populated areas of southern Chad (Figure 1).

Supplementary Vaccination Activities

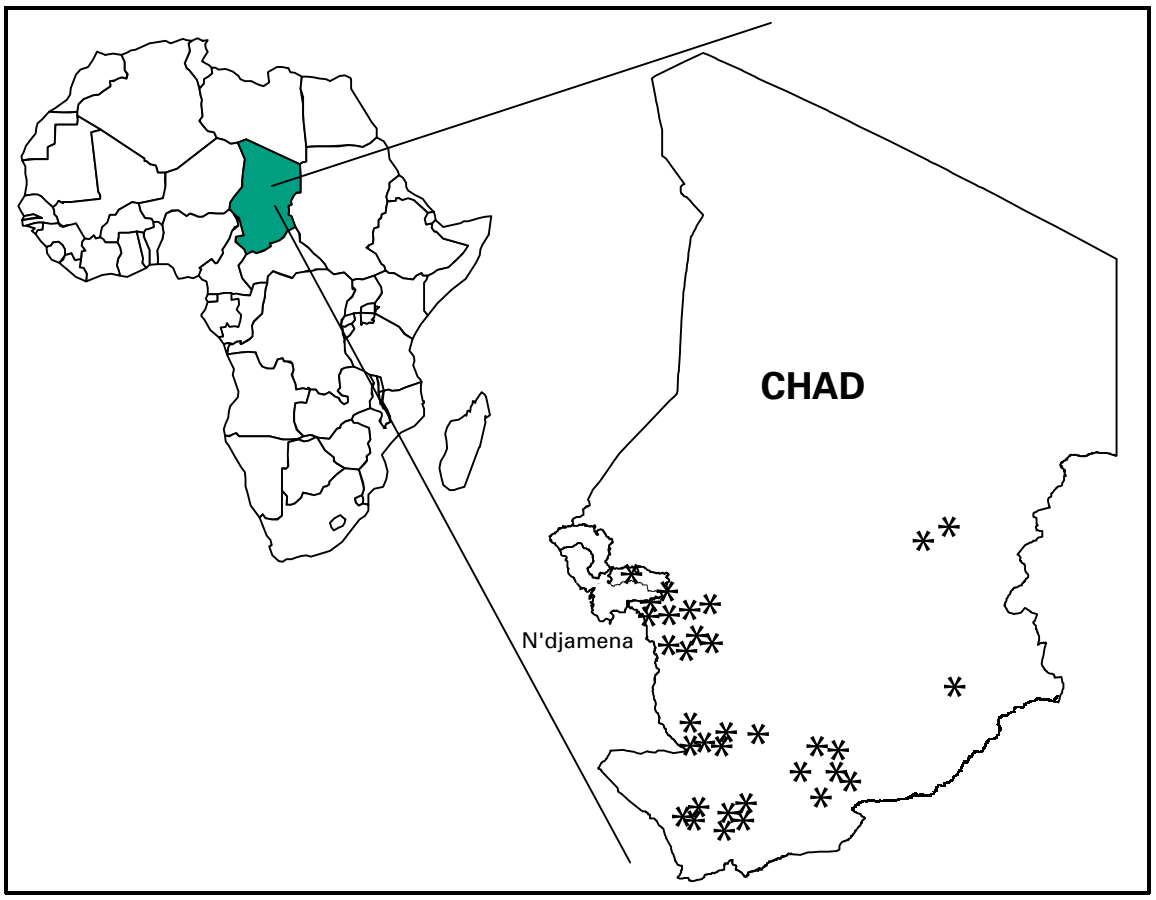
Chad implemented NIDs with OPV for the first time during February–March 1997, followed by two more rounds during February–March 1998 and November–December 1998. Approximately 800,000 (90%) children aged <5 years were vaccinated during each round. Vaccine vial monitors (VVMs)† were used to ensure that potent vaccine

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

†A heat-sensitive label that changes color if vaccine has been exposed to heat, which degrades the vial contents.

Poliomyelitis Eradication — Continued

FIGURE 1. Laboratory-confirmed cases of poliomyelitis — Chad, 1999*



* n=33.

was administered at each vaccination site. Two rounds of intensified, door-to-door NIDs were conducted in December 1999 and January 2000. Coverage data are not yet available.

AFP Surveillance

During 1995–1997, Chad collected information about clinically confirmed cases of paralytic polio through a passive surveillance system; 402, 331, and 326 clinically diagnosed polio cases in 1995, 1996, and 1997, respectively, were reported; however, reporting accuracy and completeness during this period are questionable because no standard case definition was used and few of the cases were investigated further (*3*).

In 1997, AFP and wild poliovirus surveillance began to include clinical and virologic case investigations; stool specimens were collected from four AFP cases. Despite shipment delays, the regional reference laboratory in Bangui confirmed wild poliovirus type 1 in one specimen. AFP case reporting and stool specimen collection increased in 1998; 14 AFP cases were identified and investigated from January to October 1998, confirming wild poliovirus type 1 in four cases (Table 1). Surveillance activities decreased in late 1998; no cases were reported from October 1998 to April 1999.

Poliomyelitis Eradication — Continued

In May 1999, the Ministry of Health (MOH) established the national service of integrated active surveillance to monitor AFP, measles, malaria, yellow fever, meningitis, and cholera. Five national surveillance officers began to train health-care personnel on active AFP surveillance in all provinces, and the first international team of three WHO/CDC Stop Transmission of Polio epidemiologists were sent to Chad.

In 1999, 182 AFP cases were reported; two stool specimens were collected from 133 of these cases. Forty-nine AFP cases were identified through retrospective record review, and these cases were subsequently confirmed as polio using the clinical classification system. As of December 1999, the Bangui regional reference laboratory reported final virus isolation and intratypic differentiation results for 85 of the 133 AFP cases for which two specimens were collected. Wild poliovirus was confirmed in 33 of 85 cases. Results have not been reported for 48 of the 133 cases for which two specimens were collected.

Two of the main indicators used to monitor AFP surveillance are the reported nonpolio AFP rate (*4*), which is used to assess the sensitivity of detection and accuracy of reporting suspected cases (target: a rate of >1 nonpolio AFP case per 100,000 children aged <15 years annually), and the proportion of AFP cases from which two specimens have been collected within 2 weeks of paralysis onset (target: two adequate stool specimens from >80% of AFP cases). In Chad in 1999, the nonpolio AFP rate was 1.49[§]. Two stool specimens within 2 weeks of paralysis onset were collected from 46% of reported AFP cases; specimen arrival at the laboratory within 3 days occurred in 11% of the cases, and 11% of the persons with cases received clinical follow-up examinations.

Reported by: Integrated Surveillance Unit and Expanded Program of Immunization, Ministry of Health, N'djamena, Republic of Chad; World Health Organization Country Office, N'djamena, Republic of Chad. World Health Organization Regional Office for Africa, Harare, Zimbabwe. Vaccines and Other Biologicals Dept, World Health Organization, Geneva, Switzerland. Robert Koch Institute, Berlin, Germany. Epidemiology and Surveillance Div and Vaccine Preventable Disease Eradication Div, National Immunization Program; and an EIS Officer, CDC.

[§]Nonpolio AFP rate is calculated using the 52 cases discarded as nonpolio through negative laboratory results.

TABLE 1. Reported cases of acute flaccid paralysis (AFP), confirmed poliomyelitis, confirmed wild virus, and nonpolio AFP rate — Chad, 1995–1999

Year	AFP cases reported	Confirmed polio cases	Wild virus confirmed	Nonpolio AFP rate*
1995	0	402[†]	—	—
1996	0	331[†]	—	—
1997	4	326[†]	1	0
1998	14	4[§]	4	0
1999	182	82[¶]	33	1.49

*Calculated as number of AFP cases not caused by polio per 100,000 population aged <15 years.
[†]Clinically confirmed.
[§]Confirmed through wild virus isolation.
[¶]Clinically and wild virus confirmed.

Source: World Health Organization (WHO) African Region Expanded Program of Immunization Plan of Action 1999, Ministry of Health, N'djamena, Chad, and WHO polio eradication update: available on the World-Wide Web at http://www-nt.who.int/vaccines/polio/case.asp. References to sites of non-CDC organizations on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of pages at these sites.

Poliomyelitis Eradication — Continued

Editorial Note: Chad connects western and central Africa where polio is endemic. Three decades of civil war have left Chad with a damaged health infrastructure, severe financial problems, and limited human resources. These factors and a large mobile population (e.g., nomads, migrant workers, and refugees) have led to low routine coverage with three doses of OPV and continued widespread transmission of wild poliovirus.

Chad's MOH is increasingly successful in implementing WHO's recommendations for supplemental OPV vaccination and intensified surveillance. Enhanced AFP and wild poliovirus surveillance has demonstrated that Chad is still a substantial reservoir for poliovirus transmission in Africa. Critical challenges to surveillance are lack of transportation and communication, inaccessibility of some regions during the rainy season (June to October), technical problems in conserving and transporting stool specimens, and population movements that make follow-up difficult. Improved surveillance will depend on better coordination among all levels of government and local nongovernmental organizations, and cooperation across international borders.

MOH priorities for 2000 are to implement high quality NIDs, particularly in the populated areas of southern Chad and among nomadic groups, and to maintain and improve the quality of AFP surveillance. Progress in these areas should enable Chad to reach the polio eradication goal.

References

1. World Health Assembly. Global eradication of poliomyelitis by the year 2000: resolution of the 41st World Health Assembly. Geneva, Switzerland: World Health Organization, 1988 (Resolution no. WHA 41.28).
2. CDC. Progress toward global poliomyelitis eradication—African Region, 1998–April 1999. MMWR 1999;48:513–8.
3. Ministry of Health. N'djamena, Republic of Chad: Plan of Action, National Service of Expanded Program of Immunization, December 1998;3–4.
4. World Health Organization. Field guide for supplementary activities aimed at achieving polio eradication, 1996 revision. Geneva, Switzerland: World Health Organization, 1997; appendix 11:78.

Public Health Dispatch

Outbreak of *Shigella sonnei* Infections Associated with Eating a Nationally Distributed Dip — California, Oregon, and Washington, January 2000

A multistate outbreak of *Shigella sonnei* infections with at least 30 culture-confirmed cases in California, Oregon, and Washington has been linked to eating a nationally distributed five-layer dip. Symptom onsets occurred during January 10–23, 2000; case-finding is ongoing. The implicated product is manufactured by Señor Felix's Mexican Foods* (Baldwin Park, California) and distributed under the brand names Señor Felix's 5-Layer Party Dip (sold in 16-ounce, 20-ounce, and 41-ounce containers), Delicioso 5-Layer Party Dip (33-ounce containers), and Trader Joe's 5-Layer Party Dip (20-ounce containers). The dip consists of layers of bean, salsa, guacamole, nacho cheese, and sour cream.

*Use of trade names and commercial sources is for identification only and does not constitute endorsement by CDC or the U.S. Department of Health and Human Services.

Shigella — *Continued*

On January 21, the company voluntarily recalled the products. The recall applies to all products prepared without preservatives and that have an expiration date of February 9 or earlier, and all products prepared with preservatives and that have an expiration date of March 4 or earlier. Consumers who have these products should avoid eating them and should return them to their place of purchase.

S. sonnei infection can cause abdominal cramps, fever, and bloody diarrhea. Symptoms usually develop 1–3 days after eating contaminated food. Many cases resolve without medical attention, but persons with severe infections may benefit from antibiotic treatment. General information on *Shigella* infection is available at http://www.cdc.gov/ncidod/dbmd/diseaseinfo/shigellosis_g.htm.

Reported by: Los Angeles County Health Dept, Los Angeles; San Diego County Health Dept, San Diego; California Dept of Health Svcs, Berkeley, California. Multnomah County Health Dept, Portland; Clackamas County Health Dept, Oregon City; Oregon Health Div, Portland, Oregon. Public Health–Seattle and King County, Seattle; Washington Dept of Health, Seattle, Washington. Foodborne and Diarrheal Diseases Br, Div of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC.

Notice to Readers

Update: Penicillin G Availability

In October 1999, the Food and Drug Administration (FDA) and CDC announced a shortage of penicillin G (potassium and sodium) for intravenous injection as a result of decreased production by a major manufacturer (*1*). In response to the shortage, FDA has identified a temporary alternate supplier of penicillin G sodium, Biochemie GmbH, Kundl, Austria, The company has supplied penicillin G to the United States since December 9, 1999. This product is distributed by Geneva Pharmaceuticals, Inc. (Broomfield, Colorado), and should be available through wholesale suppliers.

Because quantities are limited, Geneva Pharmaceuticals is operating under a drug shortage allocation program. For emergency allocations, contact Jenny Whitehouse, Customer Support Supervisor, Geneva Pharmaceuticals, telephone (303) 438-4399; fax (303) 727-4656; e-mail: jenny.whitehouse@gx.novartis.com). Another source of penicillin G potassium in frozen bags is Baxter Corporation (Deerfield, Illinois) at http://www.baxter.com*. If penicillin cannot be obtained, alternative treatment recommendations for some infections can be found at http://www.cdc.gov/nchstp/dstd/penicillinG.htm.

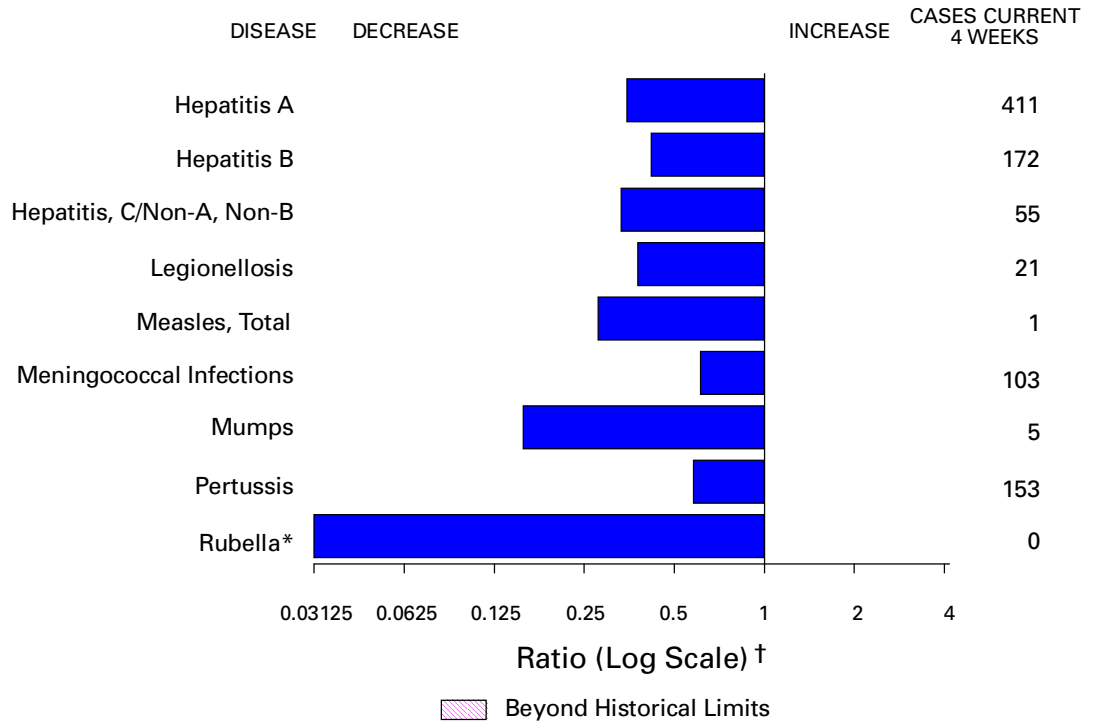
CDC requests case reports from physicians about patients with neurosyphilis or congenital syphilis who have been treated with an alternative regimen from September 1, 1999, to February 15, 2000. To report such persons, a form may be downloaded from http://www.cdc.gov/nchstp/dstd/PenGForm.htm, completed, and mailed to CDC's National Center for HIV, STD, and TB Prevention, Corporate Square Boulevard, Atlanta, GA 30329, or may be requested by telephone, (404) 639-8191.

Reference

1. CDC. Shortage of intravenous penicillin G—United States. MMWR 1999;48:974.

*References to sites of non-CDC organizations on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services.

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending January 22, 2000, with historical data — United States



*No rubella cases were reported for the current 4-week period, yielding a ratio for week 3 of zero (0).

† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary — provisional cases of selected notifiable diseases, United States, cumulative, week ending January 22, 2000 (3rd Week)

	Cum. 2000		Cum. 2000
Anthrax	-	HIV infection, pediatric*§	-
Brucellosis*	2	Plague	-
Cholera	-	Poliomyelitis, paralytic	-
Congenital rubella syndrome	-	Psittacosis*	-
Cyclosporiasis*	-	Rabies, human	-
Diphtheria	-	Rocky Mountain spotted fever (RMSF)	7
Encephalitis: California serogroup viral*	-	Streptococcal disease, invasive Group A	96
eastern equine*	-	Streptococcal toxic-shock syndrome*	2
St. Louis*	-	Syphilis, congenital¶	-
western equine*	-	Tetanus	-
Ehrlichiosis human granulocytic (HGE)*	-	Toxic-shock syndrome	4
human monocytic (HME)*	1	Trichinosis	-
Hansen Disease*	-	Typhoid fever	12
Hantavirus pulmonary syndrome*†	-	Yellow fever	-
Hemolytic uremic syndrome, post-diarrheal*	3		

-:no reported cases
*Not notifiable in all states.
† Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).
§ Updated monthly from reports to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP), last update December 26, 1999.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 22, 2000, and January 23, 1999 (3rd Week)

Reporting Area	AIDS		Chlamydia§		Cryptosporidiosis		*Escherichia coli* O157:H7*			
							NETSS		PHLIS	
	Cum. 2000†	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	-	1,726	12,729	38,109	25	60	32	57	13	45
NEW ENGLAND	-	124	833	1,143	2	2	7	7	3	7
Maine	-	-	67	7	1	-	-	1	-	-
N.H.	-	3	44	71	-	-	2	-	3	-
Vt.	-	-	31	22	1	1	-	-	-	-
Mass.	-	121	441	483	-	1	2	6	-	4
R.I.	-	-	-	119	-	-	-	-	-	-
Conn.	-	-	250	441	-	-	3	-	-	3
MID. ATLANTIC	-	401	415	4,021	1	6	-	1	-	-
Upstate N.Y.	-	18	N	N	1	-	-	1	-	-
N.Y. City	-	234	-	2,163	-	5	-	-	-	-
N.J.	-	76	41	677	-	-	-	-	-	-
Pa.	-	73	374	1,181	-	1	N	N	-	-
E.N. CENTRAL	-	45	2,859	5,972	5	12	4	17	-	6
Ohio	-	1	291	2,480	4	2	1	12	-	2
Ind.	-	-	229	586	-	-	-	2	-	2
Ill.	-	16	1,023	1,416	-	1	-	1	-	1
Mich.	-	22	702	773	1	1	3	2	-	-
Wis.	-	6	614	717	-	8	N	N	-	1
W.N. CENTRAL	-	21	508	1,861	1	2	5	9	7	7
Minn.	-	3	116	474	-	1	-	2	1	5
Iowa	-	4	29	29	-	-	1	3	-	1
Mo.	-	3	282	752	1	1	4	-	5	1
N. Dak.	-	-	-	43	-	-	-	-	-	-
S. Dak.	-	-	68	80	-	-	-	-	-	-
Nebr.	-	1	13	216	-	-	-	2	-	-
Kans.	-	10	-	267	-	-	-	2	1	-
S. ATLANTIC	-	486	2,084	8,287	-	2	2	5	-	7
Del.	-	-	138	144	-	-	-	-	-	-
Md.	-	79	120	782	-	1	-	1	-	-
D.C.	-	1	106	N	-	1	-	-	U	U
Va.	-	42	481	857	-	-	-	-	-	2
W. Va.	-	-	-	103	-	-	-	-	-	1
N.C.	-	66	1,041	1,235	-	-	2	2	-	2
S.C.	-	33	135	2,010	-	-	-	1	-	1
Ga.	-	2	63	1,637	-	-	-	-	U	U
Fla.	-	263	-	1,519	-	-	-	1	-	1
E.S. CENTRAL	-	80	462	1,936	-	-	1	7	-	3
Ky.	-	15	316	368	-	-	-	2	U	U
Tenn.	-	36	-	683	-	-	-	3	-	2
Ala.	-	29	146	652	-	-	-	1	-	1
Miss.	-	-	-	233	-	-	1	1	-	-
W.S. CENTRAL	-	517	1,499	4,829	-	2	2	-	1	3
Ark.	-	19	132	229	-	-	2	-	-	1
La.	-	14	-	1,094	-	-	-	-	1	1
Okla.	-	6	257	492	-	-	-	-	-	-
Tex.	-	478	1,110	3,014	-	2	-	-	-	1
MOUNTAIN	-	36	1,058	1,892	4	2	6	4	1	4
Mont.	-	-	-	-	-	-	4	-	-	-
Idaho	-	4	64	98	-	1	-	-	-	-
Wyo.	-	-	36	37	-	-	1	1	-	1
Colo.	-	26	196	357	-	-	-	2	1	1
N. Mex.	-	-	-	312	-	-	-	-	-	-
Ariz.	-	3	432	788	2	1	-	-	-	-
Utah	-	-	217	109	N	N	-	1	-	2
Nev.	-	3	113	191	-	-	1	-	-	-
PACIFIC	-	16	3,011	8,168	12	32	5	7	1	8
Wash.	-	2	677	596	N	N	-	-	1	2
Oreg.	-	-	145	221	-	2	-	3	-	3
Calif.	-	4	2,087	7,059	12	30	5	4	-	3
Alaska	-	-	102	104	-	-	-	-	-	-
Hawaii	-	10	-	188	-	-	-	-	-	-
Guam	-	-	-	29	-	-	N	N	U	U
P.R.	-	1	81	U	-	-	-	-	U	U
V.I.	-	-	-	U	-	U	-	U	U	U
Amer. Samoa	-	-	-	U	-	U	-	U	U	U
C.N.M.I.	-	-	-	U	-	U	-	U	U	U

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

*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

†Updated monthly from reports to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update December 26, 1999.

§Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP.

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending January 22, 2000, and January 23, 1999 (3rd Week)

Reporting Area	Gonorrhea		Hepatitis C/NA,NB		Legionellosis		Lyme Disease	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	6,570	20,594	60	166	16	37	15	203
NEW ENGLAND	250	411	-	1	2	2	7	22
Maine	2	1	-	-	2	-	-	-
N.H.	3	1	-	-	-	-	7	-
Vt.	1	3	-	-	-	1	-	-
Mass.	119	166	-	1	-	1	-	22
R.I.	-	31	-	-	-	-	-	-
Conn.	125	209	-	-	-	-	-	-
MID. ATLANTIC	328	2,316	-	3	-	10	3	123
Upstate N.Y.	55	102	-	-	-	-	2	5
N.Y. City	-	1,104	-	-	-	4	-	8
N.J.	11	510	-	-	-	2	-	46
Pa.	262	600	-	3	-	4	1	64
E.N. CENTRAL	1,615	3,179	20	97	5	15	-	7
Ohio	117	909	-	-	4	3	-	4
Ind.	168	356	-	-	-	1	-	-
Ill.	476	1,131	-	-	-	3	-	-
Mich.	485	409	20	39	1	6	-	-
Wis.	369	374	-	58	-	2	U	3
W.N. CENTRAL	197	1,018	6	14	1	-	-	2
Minn.	65	193	-	-	-	-	-	-
Iowa	12	13	-	-	-	-	-	-
Mo.	113	591	6	14	1	-	-	1
N. Dak.	-	3	-	-	-	-	-	-
S. Dak.	6	12	-	-	-	-	-	-
Nebr.	1	113	-	-	-	-	-	-
Kans.	-	93	-	-	-	-	-	1
S. ATLANTIC	2,017	6,453	3	5	3	2	3	34
Del.	76	90	-	-	-	1	-	2
Md.	69	1,051	-	3	2	-	2	28
D.C.	117	205	-	-	-	-	-	-
Va.	572	805	-	-	-	-	-	-
W. Va.	-	53	-	1	N	N	-	-
N.C.	1,010	1,151	3	1	1	1	1	4
S.C.	110	1,079	-	-	-	-	-	-
Ga.	63	829	-	-	-	-	-	-
Fla.	-	1,190	-	-	-	-	-	-
E.S. CENTRAL	309	1,742	11	6	-	1	-	3
Ky.	171	234	-	-	-	1	-	-
Tenn.	-	530	-	3	-	-	-	-
Ala.	138	674	3	1	-	-	-	3
Miss.	-	304	8	2	-	-	-	-
W.S. CENTRAL	836	3,005	-	-	-	-	-	-
Ark.	94	75	-	-	-	-	-	-
La.	-	1,001	-	-	-	-	-	-
Okla.	115	266	-	-	-	-	-	-
Tex.	627	1,663	-	-	-	-	-	-
MOUNTAIN	450	567	10	13	1	1	-	-
Mont.	-	-	-	-	-	-	-	-
Idaho	4	6	-	3	1	-	-	-
Wyo.	2	2	9	4	-	-	-	-
Colo.	227	75	-	1	-	-	-	-
N. Mex.	-	63	1	5	-	1	-	-
Ariz.	129	337	-	-	-	-	-	-
Utah	38	11	-	-	-	-	-	-
Nev.	50	73	-	-	-	-	-	-
PACIFIC	568	1,903	10	27	4	6	2	12
Wash.	130	112	1	-	-	-	-	-
Oreg.	5	44	2	-	N	N	-	-
Calif.	417	1,696	7	27	4	6	2	12
Alaska	16	18	-	-	-	-	-	-
Hawaii	-	33	-	-	-	-	N	N
Guam	-	5	-	-	-	-	-	-
P.R.	22	13	-	-	-	-	N	N
V.I.	-	U	-	U	-	U	-	U
Amer. Samoa	-	U	-	U	-	U	-	U
C.N.M.I.	-	U	-	U	-	U	-	U

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

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending January 22, 2000, and January 23, 1999 (3rd Week)

Reporting Area	Malaria		Rabies, Animal		Salmonellosis*			
					NETSS		PHLIS	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	20	71	127	196	648	1,199	145	1,490
NEW ENGLAND	-	2	17	36	42	75	3	84
Maine	-	-	3	2	4	7	-	4
N.H.	-	-	-	-	6	-	2	3
Vt.	-	-	2	7	-	3	-	5
Mass.	-	2	6	13	22	48	-	42
R.I.	-	-	-	4	-	2	1	10
Conn.	-	-	6	10	10	15	-	20
MID. ATLANTIC	2	20	32	34	18	192	3	177
Upstate N.Y.	1	2	29	15	8	20	3	49
N.Y. City	1	8	U	U	7	59	-	77
N.J.	-	9	3	14	-	76	-	50
Pa.	-	1	-	5	3	37	-	1
E.N. CENTRAL	1	7	-	-	62	227	27	216
Ohio	1	-	-	-	42	45	19	37
Ind.	-	-	-	-	-	-	-	14
Ill.	-	4	-	-	-	81	-	84
Mich.	-	1	-	-	20	56	3	58
Wis.	-	2	-	-	-	45	5	23
W.N. CENTRAL	-	1	5	29	24	44	24	89
Minn.	-	-	2	5	1	7	11	25
Iowa	-	-	2	5	4	5	-	11
Mo.	-	1	1	1	18	17	7	26
N. Dak.	-	-	-	3	-	-	1	3
S. Dak.	-	-	-	10	-	2	3	5
Nebr.	-	-	-	1	1	6	-	10
Kans.	-	-	-	4	-	7	2	9
S. ATLANTIC	5	8	57	51	98	173	27	272
Del.	-	-	-	3	1	5	-	6
Md.	3	3	4	9	23	43	7	33
D.C.	-	4	-	-	-	3	U	U
Va.	-	-	16	7	9	5	-	39
W. Va.	-	-	-	4	-	2	5	5
N.C.	2	-	21	19	54	64	-	72
S.C.	-	-	2	-	11	5	15	26
Ga.	-	-	-	-	-	14	-	70
Fla.	-	1	14	9	-	32	-	21
E.S. CENTRAL	-	-	-	2	36	98	-	62
Ky.	-	-	-	-	4	20	U	U
Tenn.	-	-	-	2	-	16	-	41
Ala.	-	-	-	-	28	26	-	19
Miss.	-	-	-	-	4	36	-	2
W.S. CENTRAL	-	2	-	5	7	29	7	171
Ark.	-	-	-	-	7	6	6	15
La.	-	1	-	-	-	1	-	32
Okla.	-	-	-	5	-	8	-	2
Tex.	-	1	-	-	-	14	1	122
MOUNTAIN	1	3	11	11	97	95	31	123
Mont.	-	1	5	1	3	1	-	-
Idaho	-	-	-	-	9	2	-	7
Wyo.	-	-	4	5	1	2	-	3
Colo.	1	-	-	1	4	31	10	33
N. Mex.	-	1	-	-	8	17	-	15
Ariz.	-	1	2	4	29	18	6	39
Utah	-	-	-	-	28	10	15	16
Nev.	-	-	-	-	15	14	-	10
PACIFIC	11	28	5	28	264	266	23	296
Wash.	-	1	-	-	1	-	2	30
Oreg.	1	1	-	-	10	11	19	26
Calif.	10	26	5	28	247	228	-	217
Alaska	-	-	-	-	6	5	2	2
Hawaii	-	-	-	-	-	22	-	21
Guam	-	-	-	-	-	4	U	U
P.R.	-	-	1	3	-	15	U	U
V.I.	-	U	-	U	-	U	U	U
Amer. Samoa	-	U	-	U	-	U	U	U
C.N.M.I.	-	U	-	U	-	U	U	U

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

*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending January 22, 2000, and January 23, 1999 (3rd Week)

Reporting Area	Shigellosis*				Syphilis (Primary & Secondary)		Tuberculosis	
	NETSS		PHLIS					
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999†
UNITED STATES	243	687	41	458	151	333	73	524
NEW ENGLAND	8	8	1	12	1	3	-	12
Maine	-	-	-	-	-	-	-	-
N.H.	1	1	-	3	-	-	-	-
Vt.	-	-	-	-	-	-	-	-
Mass.	7	6	-	7	1	2	-	4
R.I.	-	-	-	-	-	-	-	5
Conn.	-	1	1	2	-	1	-	3
MID. ATLANTIC	2	50	3	39	9	12	16	15
Upstate N.Y.	1	5	3	11	-	-	-	-
N.Y. City	1	13	-	17	6	5	10	9
N.J.	-	25	-	11	-	5	-	-
Pa.	-	7	-	-	3	2	6	6
E.N. CENTRAL	67	182	1	75	32	37	-	32
Ohio	10	72	-	7	3	5	-	16
Ind.	2	1	-	1	13	7	-	4
Ill.	-	63	-	60	10	21	-	12
Mich.	55	24	-	-	-	-	-	-
Wis.	-	22	1	7	6	4	-	-
W.N. CENTRAL	20	49	9	40	-	12	2	6
Minn.	4	4	5	9	-	-	1	5
Iowa	6	-	-	-	-	-	-	-
Mo.	10	36	4	28	-	11	1	1
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	-
Nebr.	-	5	-	2	-	1	-	-
Kans.	-	4	-	1	-	-	-	-
S. ATLANTIC	7	47	1	24	74	140	16	28
Del.	-	2	-	1	-	-	-	2
Md.	1	5	1	-	6	19	-	6
D.C.	-	2	U	U	33	8	-	2
Va.	1	-	-	-	12	11	-	-
W. Va.	-	-	-	-	-	1	-	3
N.C.	4	11	-	6	19	37	-	-
S.C.	1	10	-	3	4	12	16	14
Ga.	-	-	-	5	-	32	-	-
Fla.	-	17	-	9	-	20	-	1
E.S. CENTRAL	7	107	1	64	8	65	11	18
Ky.	1	9	U	U	1	6	-	4
Tenn.	-	79	1	57	-	29	4	-
Ala.	2	10	-	7	7	24	7	12
Miss.	4	9	-	-	-	6	-	2
W.S. CENTRAL	1	70	7	155	12	45	-	99
Ark.	1	6	-	4	1	1	-	-
La.	-	2	5	12	-	9	-	U
Okla.	-	25	1	-	5	10	-	2
Tex.	-	37	1	139	6	25	-	97
MOUNTAIN	46	37	11	33	9	5	3	8
Mont.	-	1	-	-	-	-	-	-
Idaho	2	2	-	-	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-
Colo.	2	8	7	12	1	-	-	U
N. Mex.	8	4	-	3	-	-	3	2
Ariz.	23	18	2	13	8	5	-	3
Utah	2	3	2	3	-	-	-	2
Nev.	9	1	-	2	-	-	-	1
PACIFIC	85	137	7	16	6	14	25	306
Wash.	2	1	2	8	2	-	9	4
Oreg.	4	2	5	3	-	1	-	6
Calif.	78	130	-	-	4	13	16	285
Alaska	1	-	-	-	-	-	-	2
Hawaii	-	4	-	5	-	-	-	9
Guam	-	1	U	U	-	-	-	-
P.R.	-	-	U	U	12	14	-	-
V.I.	-	U	U	U	-	U	-	U
Amer. Samoa	-	U	U	U	-	U	-	U
C.N.M.I.	-	U	U	U	-	U	-	U

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

*Individual cases may be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

†Cumulative reports of provisional tuberculosis cases for 1999 are unavailable ("U") for some areas using the Tuberculosis Information System (TIMS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending January 22, 2000, and January 23, 1999 (3rd Week)

Reporting Area	*H. influenzae*, invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
			A		B		Indigenous		Imported*		Total	
	Cum. 2000†	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	2000	Cum. 2000	2000	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	20	47	319	940	167	324	-	1	-	-	1	5
NEW ENGLAND	1	1	2	12	3	10	-	-	-	-	-	-
Maine	-	-	1	1	1	-	-	-	-	-	-	-
N.H.	-	-	1	1	1	-	-	-	-	-	-	-
Vt.	1	-	-	-	1	-	-	-	-	-	-	-
Mass.	-	1	-	7	-	5	U	-	U	-	-	-
R.I.	-	-	-	-	-	-	U	-	U	-	-	-
Conn.	-	-	-	3	-	5	-	-	-	-	-	-
MID. ATLANTIC	3	9	2	43	11	33	-	-	-	-	-	-
Upstate N.Y.	3	3	-	2	1	1	-	-	-	-	-	-
N.Y. City	-	5	2	30	10	10	-	-	-	-	-	-
N.J.	-	1	-	9	-	5	U	-	U	-	-	-
Pa.	-	-	-	2	-	17	-	-	-	-	-	-
E.N. CENTRAL	3	6	56	201	31	40	-	1	-	-	1	-
Ohio	2	6	25	35	6	6	-	-	-	-	-	-
Ind.	-	-	-	-	-	-	U	-	U	-	-	-
Ill.	-	-	-	-	-	-	-	-	-	-	-	-
Mich.	1	-	31	164	25	31	-	1	-	-	1	-
Wis.	-	-	-	2	-	3	-	-	-	-	-	-
W.N. CENTRAL	1	2	44	47	9	18	-	-	-	-	-	-
Minn.	-	-	-	-	-	-	-	-	-	-	-	-
Iowa	-	-	2	-	-	1	-	-	-	-	-	-
Mo.	1	1	42	41	9	13	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	U	-	U	-	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	-	-
Nebr.	-	-	-	4	-	4	-	-	-	-	-	-
Kans.	-	1	-	2	-	-	U	-	U	-	-	-
S. ATLANTIC	5	11	16	54	15	33	-	-	-	-	-	-
Del.	-	-	-	-	-	-	U	-	U	-	-	-
Md.	4	11	4	28	4	13	U	-	U	-	-	-
D.C.	-	-	-	4	-	-	-	-	-	-	-	-
Va.	-	-	-	1	-	1	-	-	-	-	-	-
W. Va.	-	-	-	-	-	-	U	-	U	-	-	-
N.C.	1	-	12	10	11	16	-	-	-	-	-	-
S.C.	-	-	-	-	-	2	U	-	U	-	-	-
Ga.	-	-	-	11	-	1	-	-	-	-	-	-
Fla.	-	-	-	-	-	-	-	-	-	-	-	-
E.S. CENTRAL	-	3	20	31	4	16	-	-	-	-	-	-
Ky.	-	1	-	4	-	2	-	-	-	-	-	-
Tenn.	-	2	-	4	-	3	-	-	-	-	-	-
Ala.	-	-	5	14	2	6	-	-	-	-	-	-
Miss.	-	-	15	9	2	5	-	-	-	-	-	-
W.S. CENTRAL	-	5	4	47	3	9	-	-	-	-	-	-
Ark.	-	-	4	3	3	2	-	-	-	-	-	-
La.	-	-	-	1	-	-	U	-	U	-	-	-
Okla.	-	4	-	14	-	3	U	-	U	-	-	-
Tex.	-	1	-	29	-	4	U	-	U	-	-	-
MOUNTAIN	5	3	33	54	9	25	-	-	-	-	-	-
Mont.	-	-	-	-	-	-	-	-	-	-	-	-
Idaho	1	-	-	1	-	3	-	-	-	-	-	-
Wyo.	-	1	-	1	-	-	-	-	-	-	-	-
Colo.	3	-	10	19	2	9	-	-	-	-	-	-
N. Mex.	-	2	6	3	6	6	-	-	-	-	-	-
Ariz.	-	-	9	17	-	1	-	-	-	-	-	-
Utah	1	-	3	7	-	-	-	-	-	-	-	-
Nev.	-	-	5	6	1	6	-	-	-	-	-	-
PACIFIC	2	7	142	451	82	140	-	-	-	-	-	5
Wash.	-	-	-	2	-	-	-	-	-	-	-	-
Oreg.	2	2	10	11	5	5	U	-	U	-	-	5
Calif.	-	4	132	437	76	134	-	-	-	-	-	-
Alaska	-	1	-	1	1	1	-	-	-	-	-	-
Hawaii	-	-	-	-	-	-	U	-	U	-	-	-
Guam	-	-	-	-	-	1	U	-	U	-	-	-
P.R.	-	-	-	1	-	6	-	-	-	-	-	-
V.I.	-	U	-	U	-	U	U	-	U	-	-	U
Amer. Samoa	-	U	-	U	-	U	U	-	U	-	-	U
C.N.M.I.	-	U	-	U	-	U	U	-	U	-	-	U

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

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

†Of 6 cases among children aged <5 years, serotype was reported for 1 and of those, 0 were type b.

TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending January 22, 2000, and January 23, 1999 (3rd Week)

Reporting Area	Meningococcal Disease		Mumps			Pertussis			Rubella		
	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999	2000	Cum. 2000	Cum. 1999
UNITED STATES	81	100	1	2	19	54	123	187	-	-	-
NEW ENGLAND	4	10	-	-	2	12	25	36	-	-	-
Maine	1	2	-	-	-	-	-	-	-	-	-
N.H.	-	1	-	-	-	7	8	-	-	-	-
Vt.	1	1	-	-	-	5	17	5	-	-	-
Mass.	1	6	U	-	2	U	-	31	U	-	-
R.I.	-	-	U	-	-	U	-	-	U	-	-
Conn.	1	-	-	-	-	-	-	-	-	-	-
MID. ATLANTIC	4	13	-	-	-	1	2	4	-	-	-
Upstate N.Y.	1	1	-	-	-	1	2	1	-	-	-
N.Y. City	2	5	-	-	-	-	-	2	-	-	-
N.J.	1	5	U	-	-	U	-	1	U	-	-
Pa.	-	2	-	-	-	-	-	-	-	-	-
E.N. CENTRAL	10	12	-	-	1	18	55	34	-	-	-
Ohio	4	9	-	-	-	18	54	30	-	-	-
Ind.	-	2	U	-	-	U	-	-	U	-	-
Ill.	-	-	-	-	1	-	-	1	-	-	-
Mich.	6	1	-	-	-	-	1	1	-	-	-
Wis.	-	-	-	-	-	-	-	2	-	-	-
W.N. CENTRAL	17	9	-	1	1	1	1	4	-	-	-
Minn.	-	-	-	-	-	-	-	-	-	-	-
Iowa	2	1	-	1	1	-	-	2	-	-	-
Mo.	15	6	-	-	-	1	1	-	-	-	-
N. Dak.	-	-	U	-	-	U	-	-	U	-	-
S. Dak.	-	-	-	-	-	-	-	-	-	-	-
Nebr.	-	1	-	-	-	-	-	-	-	-	-
Kans.	-	1	U	-	-	U	-	2	U	-	-
S. ATLANTIC	6	10	-	-	1	1	5	16	-	-	-
Del.	-	-	U	-	-	U	-	-	U	-	-
Md.	2	6	U	-	-	U	-	9	U	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-
Va.	-	-	-	-	-	1	1	-	-	-	-
W. Va.	-	-	U	-	-	U	-	-	U	-	-
N.C.	4	2	-	-	1	-	4	7	-	-	-
S.C.	-	2	U	-	-	U	-	-	U	-	-
Ga.	-	-	-	-	-	-	-	-	-	-	-
Fla.	-	-	-	-	-	-	-	-	-	-	-
E.S. CENTRAL	1	5	-	-	-	-	2	4	-	-	-
Ky.	-	-	-	-	-	-	-	-	-	-	-
Tenn.	-	1	-	-	-	-	-	1	-	-	-
Ala.	1	1	-	-	-	-	2	3	-	-	-
Miss.	-	3	-	-	-	-	-	-	-	-	-
W.S. CENTRAL	-	3	-	-	2	-	1	1	-	-	-
Ark.	-	1	-	-	-	-	1	-	-	-	-
La.	-	-	U	-	-	U	-	-	U	-	-
Okla.	-	1	U	-	-	U	-	-	U	-	-
Tex.	-	1	U	-	2	U	-	1	U	-	-
MOUNTAIN	3	13	-	-	1	20	28	34	-	-	-
Mont.	-	-	-	-	-	-	-	-	-	-	-
Idaho	1	2	-	-	-	-	-	14	-	-	-
Wyo.	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	4	-	-	-	17	17	8	-	-	-
N. Mex.	1	1	N	N	N	3	9	3	-	-	-
Ariz.	-	3	-	-	-	-	-	1	-	-	-
Utah	1	2	-	-	-	-	2	7	-	-	-
Nev.	-	1	-	-	1	-	-	1	-	-	-
PACIFIC	36	25	1	1	11	1	4	54	-	-	-
Wash.	3	2	-	-	-	1	1	1	-	-	-
Oreg.	5	6	N	N	N	U	3	1	U	-	-
Calif.	28	13	1	1	8	-	-	52	-	-	-
Alaska	-	2	-	-	-	-	-	-	-	-	-
Hawaii	-	2	U	-	3	U	-	-	U	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	-	-	-	-	-	-	-	-	-	-
V.I.	-	U	U	-	U	U	-	U	U	-	U
Amer. Samoa	-	U	U	-	U	U	-	U	U	-	U
C.N.M.I.	-	U	U	-	U	U	-	U	U	-	U

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

TABLE IV. Deaths in 122 U.S. cities,* week ending January 22, 2000 (3rd Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	664	499	94	47	12	12	92
Boston, Mass.	194	135	30	19	4	6	29
Bridgeport, Conn.	65	49	8	6	1	1	6
Cambridge, Mass.	U	U	U	U	U	U	U
Fall River, Mass.	42	37	4	1	-	-	14
Hartford, Conn.	37	28	7	-	1	1	5
Lowell, Mass.	38	29	8	1	-	-	4
Lynn, Mass.	18	14	2	2	-	-	4
New Bedford, Mass.	38	31	6	1	-	-	5
New Haven, Conn.	64	39	9	10	3	3	1
Providence, R.I.	U	U	U	U	U	U	U
Somerville, Mass.	7	6	-	1	-	-	1
Springfield, Mass.	43	35	5	1	1	1	7
Waterbury, Conn.	37	32	4	1	-	-	6
Worcester, Mass.	81	64	11	4	2	-	10
MID. ATLANTIC	2,391	1,674	489	156	42	30	165
Albany, N.Y.	58	42	8	4	3	1	3
Allentown, Pa.	U	U	U	U	U	U	U
Buffalo, N.Y.	56	44	9	2	-	1	12
Camden, N.J.	U	U	U	U	U	U	U
Elizabeth, N.J.	22	17	3	2	-	-	-
Erie, Pa.	57	47	9	1	-	-	5
Jersey City, N.J.	50	38	10	1	-	1	-
New York City, N.Y.	1,306	868	300	99	27	12	53
Newark, N.J.	60	38	14	5	1	2	9
Paterson, N.J.	33	18	8	3	-	4	-
Philadelphia, Pa.	267	175	61	22	7	2	15
Pittsburgh, Pa.§	102	78	18	3	-	3	14
Reading, Pa.	41	35	5	1	-	-	7
Rochester, N.Y.	169	131	25	9	2	2	18
Schenectady, N.Y.	U	U	U	U	U	U	U
Scranton, Pa.	34	29	3	1	1	-	5
Syracuse, N.Y.	99	84	11	1	1	2	18
Trenton, N.J.	10	7	2	1	-	-	4
Utica, N.Y.	27	23	3	1	-	-	2
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,513	1,774	489	161	46	41	270
Akron, Ohio	62	48	11	1	-	2	9
Canton, Ohio	38	31	5	1	1	-	5
Chicago, Ill.	410	270	86	35	12	5	42
Cincinnati, Ohio	102	72	18	9	-	3	8
Cleveland, Ohio	193	119	45	16	4	9	6
Columbus, Ohio	231	159	45	20	4	3	21
Dayton, Ohio	168	128	26	10	2	2	29
Detroit, Mich.	247	151	62	25	6	3	21
Evansville, Ind.	U	U	U	U	U	U	U
Fort Wayne, Ind.	88	66	15	5	2	-	10
Gary, Ind.	12	5	4	2	1	-	2
Grand Rapids, Mich.	66	49	3	8	4	2	11
Indianapolis, Ind.	266	182	63	10	4	7	28
Lansing, Mich.	61	45	11	2	1	2	9
Milwaukee, Wis.	165	131	30	4	-	-	20
Peoria, Ill.	62	51	10	-	1	-	10
Rockford, Ill.	79	65	9	4	-	1	19
South Bend, Ind.	49	42	7	-	-	-	6
Toledo, Ohio	121	98	12	5	4	2	9
Youngstown, Ohio	93	62	27	4	-	-	5
W.N. CENTRAL	810	612	122	44	12	20	97
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	23	21	2	-	-	-	2
Kansas City, Kans.	47	33	11	2	1	-	3
Kansas City, Mo.	159	103	29	16	5	6	15
Lincoln, Nebr.	51	44	4	2	-	1	15
Minneapolis, Minn.	209	165	27	10	2	5	23
Omaha, Nebr.	81	64	13	3	1	-	12
St. Louis, Mo.	84	60	13	5	1	5	-
St. Paul, Minn.	46	35	8	2	-	1	10
Wichita, Kans.	110	87	15	4	2	2	17
S. ATLANTIC	1,006	639	232	94	14	23	123
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	285	167	79	35	1	3	39
Charlotte, N.C.	136	91	26	11	3	5	25
Jacksonville, Fla.	158	109	32	10	3	1	19
Miami, Fla.	77	41	20	11	1	4	11
Norfolk, Va.	47	31	10	1	2	3	6
Richmond, Va.	87	54	21	6	1	5	6
Savannah, Ga.	87	64	14	7	2	-	11
St. Petersburg, Fla.	U	U	U	U	U	U	U
Tampa, Fla.	118	76	25	13	1	2	6
Washington, D.C.	U	U	U	U	U	U	U
Wilmington, Del.	11	6	5	-	-	-	-
E.S. CENTRAL	944	628	228	57	18	12	111
Birmingham, Ala.	221	147	53	14	4	3	22
Chattanooga, Tenn.	88	61	18	4	2	3	13
Knoxville, Tenn.	99	77	17	4	1	-	5
Lexington, Ky.	34	24	6	1	2	1	2
Memphis, Tenn.	214	129	63	14	5	2	35
Mobile, Ala.	82	55	21	4	2	-	6
Montgomery, Ala.	56	40	11	5	-	-	13
Nashville, Tenn.	150	95	39	11	2	3	15
W.S. CENTRAL	1,870	1,267	357	151	63	32	204
Austin, Tex.	127	92	26	5	2	2	19
Baton Rouge, La.	112	87	12	7	6	-	5
Corpus Christi, Tex.	109	71	20	12	4	2	20
Dallas, Tex.	239	145	49	32	12	1	17
El Paso, Tex.	118	91	16	7	2	2	16
Ft. Worth, Tex.	144	98	35	8	2	1	17
Houston, Tex.	318	188	67	36	18	9	28
Little Rock, Ark.	U	U	U	U	U	U	U
New Orleans, La.	69	35	18	8	4	4	-
San Antonio, Tex.	342	247	65	19	7	4	46
Shreveport, La.	94	60	23	8	1	2	11
Tulsa, Okla.	198	153	26	9	5	5	25
MOUNTAIN	1,081	779	188	71	27	16	118
Albuquerque, N.M.	116	75	21	12	7	1	11
Boise, Idaho	44	35	5	2	1	1	5
Colo. Springs, Colo.	60	47	9	3	1	-	7
Denver, Colo.	U	U	U	U	U	U	U
Las Vegas, Nev.	248	172	58	13	1	4	18
Ogden, Utah	37	23	9	2	2	1	7
Phoenix, Ariz.	224	156	38	17	8	5	26
Pueblo, Colo.	29	25	4	-	-	-	2
Salt Lake City, Utah	113	76	21	9	4	3	18
Tucson, Ariz.	210	170	23	13	3	1	24
PACIFIC	1,452	1,082	229	95	29	17	225
Berkeley, Calif.	25	16	6	-	-	3	4
Fresno, Calif.	157	123	24	7	3	-	40
Glendale, Calif.	17	14	2	1	-	-	-
Honolulu, Hawaii	49	39	5	3	-	2	5
Long Beach, Calif.	91	72	14	3	1	1	20
Los Angeles, Calif.	331	211	62	40	14	4	14
Pasadena, Calif.	30	22	6	1	1	-	9
Portland, Oreg.	108	85	15	8	-	-	14
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	248	191	37	18	1	1	54
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	175	144	17	6	5	3	33
Santa Cruz, Calif.	39	32	7	-	-	-	10
Seattle, Wash.	105	79	19	5	-	2	11
Spokane, Wash.	77	54	15	3	4	1	11
Tacoma, Wash.	U	U	U	U	U	U	U
TOTAL	12,731¶	8,954	2,428	876	263	203	1,405

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 or more. A death is reported by the place of its occurrence and by the week that the death certificate was filed. Fetal deaths are not included.

†Pneumonia and influenza.

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

¶Total includes unknown ages.

Contributors to the Production of the *MMWR* (Weekly)
Weekly Notifiable Disease Morbidity Data and 122 Cities Mortality Data

Samuel L. Groseclose, D.V.M., M.P.H.

State Support Team
Robert Fagan
Jose Aponte
Paul Gangarosa, M.P.H.
Gerald Jones
David Nitschke
Carol A. Worsham

CDC Operations Team
Carol M. Knowles
Deborah A. Adams
Willie J. Anderson
Patsy A. Hall
Kathryn Snavely
Sara Zywicki

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