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Great American Smokeout — November 16, 2000

In 1998, one fourth of U.S. adults smoked cigarettes; in 1999, one in 10 U.S. middle school students and nearly one in three U.S. high school students smoked cigarettes (*1,2*). Helping smokers quit by implementing science-based methods and comprehensive approaches outlined in *Reducing Tobacco Use: A Report of the Surgeon General* is critical to reducing deaths, illness, and disability attributable to smoking-related causes and to achieving the national health objective for 2010 of reducing adult and adolescent smoking prevalence by half (*3,4*). Consistent with the Surgeon General's report, evidence-based Public Health Service (PHS) guidelines (*5*) outline effective clinical interventions to help smokers quit.

The American Cancer Society (ACS) hosts the 24th annual Great American Smokeout, Thursday, November 16, to encourage smokers to quit tobacco use for at least 24 hours. Despite effective therapies to combat tobacco use, most smokers still try to quit without assistance (*6*). Without assistance, however, most smokers are not able to sustain a quit attempt.

Smokers should use the Great American Smokeout to obtain treatments from their physicians that help convert their quit attempt into successful long-term cessation. As part of the Great American Smokeout, ACS volunteers provide smoking-cessation and smoking-prevention activities at the local ACS offices. Health-care systems should use the Great American Smokeout to implement the PHS guidelines on treatment for tobacco use to ensure that all smokers receive appropriate treatment.

Additional information is available from ACS, telephone (800) 227-2345, World-Wide Web site http://www.cancer.org; or from CDC, telephone (800) 232-1311, World-Wide Web site http://www.cdc.gov/tobacco.

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State-Specific Prevalence of Current Cigarette Smoking Among Adults and the Proportion of Adults Who Work in a Smoke-Free Environment — United States, 1999

Tobacco use in the United States causes approximately 430,000 deaths each year, including an estimated 3000 deaths from lung cancer among nonsmokers exposed to environmental tobacco smoke (ETS) (*1*). In addition, an estimated 62,000 coronary heart disease deaths annually among nonsmokers exposed to ETS (*2*). The detrimental health effects of exposure to ETS are well documented and include, in addition to lung cancer and coronary heart disease among adults, low birthweight and sudden infant death syndrome from exposure during and after pregnancy and asthma, bronchitis, and pneumonia in children (*2*). This report summarizes the 1999 prevalence of current cigarette smoking among adults by state and the proportion of persons who work indoors and who report that their workplaces have smoke-free policies. The findings indicate that in 1999, adult smoking prevalence differed more than two-fold across states (13.9%–31.5%) and that the proportion of persons who reported that their workplace had an official smoke-free policy ranged from 61.3%–82.1%. As the respondents' level of education increased, they were more likely to report working under a smoke-free policy.

State- and sex-specific prevalences of current cigarette smoking among adults were obtained from the Behavioral Risk Factor Surveillance System (BRFSS), a state-based, random-digit–dialed telephone survey of the noninstitutionalized U.S. population, aged ≥18 years. The 1999 BRFSS was conducted in the 50 states, the District of Columbia (DC), and Puerto Rico (PR). To determine current cigarette smoking, respondents were asked, "Have you ever smoked at least 100 cigarettes in your entire life?" and "Do you now smoke cigarettes every day, some days, or not at all?" Current smokers were defined as those who reported having smoked ≥100 cigarettes during their lives and who currently smoked every day or some days. Because BRFSS data were state-specific, median values rather than a national average were reported. Estimates were weighted to the age, race, and sex distribution of each state's population, and 95% confidence intervals were calculated by using SUDAAN.

To assess workplace smoking policies, respondents who work indoors most of the time were asked: "Which of the following best describes your place of work's official smoking policy for indoor public or common areas, such as lobbies, rest rooms, and lunch rooms?" and "Which of the following best describes your place of work's official smoking policy for work areas?" Possible responses included "not allowed in any work (or public/common) areas," "allowed in some work (or public/common) areas," "allowed in all work (or public/common) areas," and "no official policy." A smoke-free policy was defined as a policy that did not permit smoking in the common, public, or work areas of the workplace. The percentage of respondents who reported smoke-free workplace policies was calculated and reported by state and by respondents' education level.

In 1999, the adult prevalence of current cigarette smoking differed more than twofold across the states (range: 13.9%–31.5%), with a median of 22.7% (Table 1). Current cigarette smoking prevalence was highest in Nevada (31.5%), Kentucky (29.7%), and Ohio (27.6%) and lowest in Utah (13.9%), Hawaii (18.6%), California (18.7%), Massachusetts (19.4%), and Minnesota (19.5%). Smoking prevalence in PR (13.7%) was lower than the overall prevalence in the 50 states. The median smoking prevalence among men was 24.2% (range: 16.6%–33.9%) and among women was 20.9% (range: 11.4%–30.3%).

Cigarette Smoking Among Adults — Continued

TABLE 1. Prevalence of current cigarette smoking* among adults, by state and sex — Behavioral Risk Factor Surveillance System, United States, 1999

State	Men		Women		Total	
	%	(95% CI†)	%	(95% CI)	%	(95% CI)
Alabama	26.1	(±3.3)	21.2	(±2.6)	**23.5**	**(±2.1)**
Alaska	25.3	(±3.5)	29.4	(±4.7)	**27.2**	**(±2.9)**
Arizona	23.6	(±4.4)	16.7	(±3.5)	**20.0**	**(±2.8)**
Arkansas	29.7	(±3.0)	25.0	(±2.2)	**27.2**	**(±1.8)**
California	22.0	(±2.1)	15.5	(±1.6)	**18.7**	**(±1.3)**
Colorado	22.8	(±3.2)	22.1	(±2.8)	**22.5**	**(±2.1)**
Connecticut	25.4	(±3.1)	20.4	(±2.9)	**22.8**	**(±2.2)**
Delaware	27.6	(±3.7)	23.5	(±3.3)	**25.4**	**(±2.5)**
District of Columbia	21.5	(±4.2)	19.8	(±3.3)	**20.6**	**(±2.6)**
Florida	22.3	(±2.2)	19.2	(±1.6)	**20.7**	**(±1.3)**
Georgia	28.3	(±3.5)	19.5	(±2.4)	**23.7**	**(±2.1)**
Hawaii	20.1	(±3.2)	17.0	(±2.9)	**18.6**	**(±2.2)**
Idaho	22.5	(±2.4)	20.6	(±1.8)	**21.5**	**(±1.4)**
Illinois	26.9	(±3.0)	21.8	(±2.1)	**24.2**	**(±1.8)**
Indiana	31.0	(±4.7)	23.3	(±3.7)	**27.0**	**(±3.0)**
Iowa	26.6	(±2.8)	20.7	(±2.0)	**23.5**	**(±1.7)**
Kansas	24.3	(±2.5)	18.1	(±1.7)	**21.1**	**(±1.5)**
Kentucky	33.9	(±2.5)	25.9	(±1.7)	**29.7**	**(±1.5)**
Louisiana	26.9	(±3.8)	20.7	(±3.0)	**23.6**	**(±2.4)**
Maine	27.7	(±4.2)	19.2	(±2.7)	**23.3**	**(±2.5)**
Maryland	22.2	(±2.6)	18.6	(±2.0)	**20.3**	**(±1.6)**
Massachusetts	19.5	(±2.2)	19.2	(±1.8)	**19.4**	**(±1.4)**
Michigan	26.6	(±3.0)	23.7	(±2.4)	**25.1**	**(±1.9)**
Minnesota	21.7	(±1.8)	17.3	(±1.5)	**19.5**	**(±1.2)**
Mississippi	27.4	(±3.5)	19.0	(±2.3)	**23.0**	**(±2.0)**
Missouri	30.6	(±3.0)	23.9	(±2.3)	**27.1**	**(±1.9)**
Montana	18.5	(±3.1)	21.9	(±2.9)	**20.2**	**(±2.1)**
Nebraska	27.5	(±3.0)	19.5	(±2.2)	**23.3**	**(±1.8)**
Nevada	32.8	(±4.2)	30.3	(±4.2)	**31.5**	**(±3.0)**
New Hampshire	21.7	(±4.2)	23.1	(±3.5)	**22.4**	**(±2.7)**
New Jersey	22.0	(±3.1)	19.4	(±2.3)	**20.7**	**(±1.9)**
New Mexico	24.1	(±2.4)	20.9	(±2.0)	**22.5**	**(±1.6)**
New York	22.8	(±2.9)	21.1	(±2.4)	**21.9**	**(±1.9)**
North Carolina	27.7	(±3.3)	23.0	(±2.7)	**25.2**	**(±2.1)**
North Dakota	23.4	(±3.1)	21.0	(±2.7)	**22.2**	**(±2.0)**
Ohio	29.3	(±4.3)	26.0	(±3.2)	**27.6**	**(±2.6)**
Oklahoma	26.7	(±3.0)	23.9	(±2.3)	**25.2**	**(±1.9)**
Oregon	22.9	(±3.3)	20.1	(±2.7)	**21.5**	**(±2.1)**
Pennsylvania	24.3	(±2.5)	22.2	(±2.0)	**23.2**	**(±1.6)**
Rhode Island	23.3	(±2.4)	21.6	(±1.9)	**22.4**	**(±1.5)**
South Carolina	28.4	(±2.8)	19.3	(±1.9)	**23.6**	**(±1.7)**
South Dakota	23.1	(±2.4)	21.9	(±1.8)	**22.5**	**(±1.5)**
Tennessee	25.7	(±2.9)	24.1	(±2.1)	**24.9**	**(±1.8)**
Texas	27.4	(±2.7)	17.7	(±1.6)	**22.4**	**(±1.6)**
Utah	16.6	(±2.6)	11.4	(±1.8)	**13.9**	**(±1.6)**
Vermont	22.9	(±2.7)	20.7	(±2.2)	**21.8**	**(±1.7)**
Virginia	21.3	(±2.7)	21.2	(±2.4)	**21.2**	**(±1.8)**
Washington	24.0	(±2.6)	20.8	(±2.2)	**22.4**	**(±1.7)**
West Virginia	30.2	(±3.2)	24.4	(±2.5)	**27.1**	**(±2.0)**
Wisconsin	23.0	(±3.0)	24.3	(±2.7)	**23.7**	**(±2.0)**
Wyoming	25.8	(±3.0)	22.0	(±2.6)	**23.9**	**(±2.0)**
Territory						
Puerto Rico	18.9	(±2.7)	9.1	(±1.5)	**13.7**	**(±1.5)**

* Persons aged ≥18 years who reported having smoked ≥100 cigarettes and who reported smoking every day or some days.
† Confidence interval.

Cigarette Smoking Among Adults — Continued

Current smoking prevalence was highest among men in Kentucky (33.9%) and women in Nevada (30.3%); Utah had the lowest current smoking prevalence among both men (16.6%) and women (11.4%).

Respondents in 17 states and DC were asked questions on the protection provided by official workplace nonsmoking policies (Table 2). Among respondents who primarily worked indoors (median: 75.2%), the proportion who reported an official workplace policy that addressed smoking in public, common, or work areas ranged from 87.1%–97.1% (median: 92.3%); the proportion who did not know the policies or refused to answer ranged from 0.1%–1.4% (median: 0.7%). The proportion of respondents who reported a smoke-free workplace policy ranged from 61.3% in Mississippi to 82.0% in DC (median: 73.0%). The proportion increased as the level of education increased: among high school graduates or less education, the range was 48.2%–82.4% (median: 63.2%); among those with some college education, the range was 60.7%–84.5% (median: 72.4%); and among college graduates or more education, the range was 68.9%–89.1% (median: 84.1%).

Reported by the following BRFSS coordinators: S Reese, MPH, Alabama; P Owen, Alaska; B Bender, MBA, Arizona; G Potts, MBA, Arkansas; B Davis, PhD, California; M Leff, MSPH, Colorado; M Adams, MPH, Connecticut; F Breukelman, Delaware; I Bullo, District of Columbia; S Hoecherl, Florida; L Martin, MS, Georgia; F Reyes-Salvail, MS, Hawaii; J Aydelotte, MA, Idaho; B Steiner, MS, Illinois; L Stemnock, Indiana; J Davila, Iowa; C Hunt, Kansas; T Sparks, Kentucky; B Bates, MSPH, Louisiana; D Maines, Maine; A Weinstein, MA, Maryland; D Brooks, MPH,

TABLE 2. Proportion of adults* who reported a smoke-free workplace,† by state and educational level§ — Behavioral Risk Factor Surveillance System, United States, 1999

State	High school or less		Some college		College graduate		Overall¶	
	%	(95% CI**)	%	(95% CI)	%	(95% CI)	%	(95% CI)
Colorado	59.5	(±7.0)	74.4	(±6.1)	83.3	(+4.6)	**72.1**	**(±3.4)**
Delaware	62.4	(±7.3)	77.2	(±6.5)	89.1	(±3.6)	**76.3**	**(±3.4)**
District of Columbia	82.4	(±7.0)	84.5	(±8.0)	82.7	(±4.6)	**82.0**	**(±3.4)**
Iowa	64.5	(±4.4)	72.8	(±4.5)	87.4	(±3.3)	**73.5**	**(±2.4)**
Mississippi	48.1	(±6.0)	66.2	(±6.7)	75.6	(±5.2)	**61.3**	**(±3.5)**
Montana	69.0	(±6.4)	71.7	(±7.8)	86.7	(±4.3)	**75.6**	**(±3.5)**
Nebraska	63.5	(±5.3)	79.1	(±4.7)	86.3	(±3.6)	**74.4**	**(±2.7)**
New Jersey	72.4	(±5.4)	76.4	(±6.2)	85.0	(±3.3)	**78.2**	**(±2.7)**
New York	72.4	(±5.5)	78.1	(±5.2)	78.5	(±4.3)	**75.7**	**(±2.8)**
North Carolina	62.5	(±5.3)	70.0	(±6.4)	88.4	(±3.7)	**72.0**	**(±3.1)**
North Dakota	64.8	(±6.6)	72.9	(±5.7)	84.6	(±4.6)	**73.9**	**(±3.2)**
Ohio	64.9	(±6.5)	77.8	(±7.2)	86.5	(±5.6)	**72.4**	**(±4.0)**
Oklahoma	57.5	(±5.2)	68.9	(±5.5)	68.9	(±5.0)	**64.1**	**(±3.1)**
Pennsylvania	63.8	(±4.2)	71.1	(±5.5)	82.8	(±3.4)	**69.7**	**(±2.5)**
South Carolina	60.8	(±4.5)	71.9	(±5.1)	80.8	(±3.8)	**67.8**	**(±2.6)**
West Virginia	62.9	(±5.1)	70.2	(±6.9)	88.7	(±4.0)	**73.5**	**(±3.1)**
Wisconsin	55.3	(±5.5)	60.7	(±6.0)	78.9	(±4.4)	**64.4**	**(±3.0)**
Wyoming	54.4	(±5.9)	71.1	(±5.0)	80.0	(±4.6)	**66.5**	**(±3.1)**

* Respondents who reported working indoors. Respondents who answered "don't know" or refused to answer either of the workplace smoking policy questions were excluded.

† A smoke-free workplace was defined as an indoor work environment that was reported as having an official policy that did not allow smoking in common, public, or work areas.

§ Analysis restricted to data on respondents aged ≥25 years.

¶ Analysis restricted to data on respondents aged ≥18 years.

** Confidence interval.

Cigarette Smoking Among Adults — Continued

Massachusetts; H McGee, MPH, Michigan; N Salem, PhD, Minnesota; D Johnson, MS, Mississippi; J Jackson-Thompson, PhD, Missouri; P Feigley, PhD, Montana; L Andelt, PhD, Nebraska; E DeJan, MPH, Nevada; L Powers, MA, New Hampshire; G Boeselager, MS, New Jersey; W Honey, MPH, New Mexico; C Baker, New York; Z Gizlice, PhD, North Carolina; L Shireley, MPH, North Dakota; P Pullen, Ohio; K Baker, MPH, Oklahoma; K Pickle, MPH, Oregon; L Mann, Pennsylvania; Y Cintron, MPH, Puerto Rico; J Hesser, PhD, Rhode Island; M Wu, MD, South Carolina; M Gildemaster, South Dakota; D Ridings, Tennessee; K Condon, MS, Texas; K Marti, Utah; C Roe, MS, Vermont; K Carswell, MPH, Virginia; K Wynkoop Simmons, PhD, Washington; F King, West Virginia; K Pearson, Wisconsin; M Futa, MA, Wyoming. Cardiovascular Health Br, Div of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion; Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

Editorial Note: The prevalence of smoking among adults leveled off in the 1990s following a steady decline since the mid-1960s (*3*), and a wide range of smoking prevalence persists among states. Both Utah and PR have achieved the national health objective for 2000 of reducing the prevalence of cigarette smoking in adults to ≤15% (*4*). BRFSS data on smoking in PR are being reported for the first time. PR's overall median prevalence of 13.7% was lower than the 26.9% prevalence among persons of Puerto Rican descent living in the United States (CDC, unpublished data, 2000). Additional research is needed to clarify whether the twofold difference can be attributed to factors related to acculturation among persons from PR residing the United States or to other factors specific to the population sampled in PR. The exclusion of 25% of households that do not have telephones in PR also could have contributed to the difference in prevalence estimates.

The proportion of respondents who reported that smoking was not permitted in either the public or work areas in the Current Population Survey (CPS) increased from 46.5% in 1992–1993 to 63.7% in 1995–1996 (*5*). The 1999 BRFSS findings suggest that the proportion of respondents who report a smoke-free environment continues to increase. In addition, the association between increasing level of education and working in a smoke-free workplace is consistent with findings from CPS (*5*). Findings from the 1992–1993 CPS also showed substantial differences in the proportion of workers who reported smoke-free policies among various occupational groups (*6*).

The findings in this report are subject to at least four limitations. First, smoking data are based on self-reports without biochemical verification. Second, previous studies have shown that persons with less than a high school education have higher rates of smoking (*7*); however, sample size considerations led to the combining of respondents with less than a high school education and high school graduates. Third, respondents' definitions of "official policy" may vary, and the validity of self-report of workplace policies is unknown. Fourth, PR's smoking prevalence was determined from a sample of households with telephones, which represents approximately 75% of the population (D. Zavala, MD, Puerto Rico Department of Health, personal communication, 2000).

Momentum to regulate public smoking began to increase in 1990 when the Environmental Protection Agency released its publication draft *Risk Assessment on Environmental Tobacco Smoke* (*ETS*), classifying ETS as a Group A carcinogen that can cause lung cancer in nonsmokers (*5*). Government and private business policies that limit smoking in public workplaces have become increasingly common and restrictive (*5*). In 1999, laws restricting smoking in government work sites were in effect in 43 states and DC: 11 prohibit smoking, and two require either no smoking or designated smoking areas with separate ventilation (*7*). Twenty-one states have laws restricting smoking in private work sites, but only one requires either no smoking or separate ventilation for smoking

Cigarette Smoking Among Adults — Continued

areas (*7*). During 1998–1999, 79% of work sites with ≥50 employees had formal policies that prohibited smoking or limited it to separately ventilated areas (*8*). Information on the prevalence of smoking policies in workplaces with <50 employees, where most U.S. adults work, is not readily available (*7*).

In addition to reducing smoking by adolescents and adults, public health initiatives should reduce exposure to ETS. Healthy People 2010 contains objectives related to reducing the proportion of nonsmokers exposed to environmental smoke, increasing the proportion of work sites with restrictive policies, and increasing the number of states with smoke-free indoor air laws (*8*). Policy approaches, including the voluntary adoption of work site restrictions, enactment of restrictive clean indoor air laws, and enforcement of restrictions are effective in reducing the number of persons exposed to ETS (*7*). Smoke-free workplace policies reduce exposure of nonsmokers to ETS and increase the likelihood that smokers in these settings will smoke fewer cigarettes or quit (*7*). Persistent disparities in exposure to ETS at the work place must be addressed (*8*). To meet the national ETS-related objectives for 2010, states need to implement comprehensive programs that protect nonsmokers from ETS and follow the recommendations in the CDC report *Best Practices for Comprehensive Tobacco Control Programs* and the 2000 Surgeon General's report on reducing tobacco use (*7,9*).

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Update: Outbreak of Rift Valley Fever — Saudi Arabia, August–November 2000

On September 10, 2000, the Ministry of Health (MOH), Kingdom of Saudi Arabia and subsequently, the MOH of Yemen began receiving reports of unexplained hemorrhagic fever in humans and associated animal deaths and abortions from the far western Saudi-Yemeni border region. These cases subsequently were confirmed as Rift Valley fever

Rift Valley Fever — Continued

(RVF), the first such cases on the Arabian peninsula (*1*). This report updates the findings of the ongoing investigation conducted by the Saudi Arabian MOH in collaboration with CDC and the National Institute of Virology, South Africa.

As of November 1 in Saudi Arabia, 516 persons with suspected severe RVF* requiring hospitalization have been reported from primary health-care centers and hospitals (Figure 1); 87 (17%) have died. Suspected cases have been identified through an elaborate pre-existing system of primary health-care centers that refer acutely ill persons to district hospitals for assessment of hepatitis and other criteria for admission as RVF case-patients. Of the 216 suspected severe case-patients with appropriate serum samples, 206 (95%) have been laboratory confirmed by either viral antigen or IgM antibody testing. Of the 516 case-patients, 407 (79%) were male; the median age was 46 years (range: 1–95 years); the youngest confirmed patient was aged 14 years; and 424 (82%) were Saudi citizens, 80 (16%) were Yemeni citizens, and 12 (2%) were of other nationalities. The largest number of cases have been reported from the southwestern province of Jazan (365 [77%]), and 122 (24%) cases have been reported from the contiguous Asir region. Except for one case-patient in Al Quenfadah, northwest of Jazan, all other case-patients had traveled recently to Jazan or Asir.

The mean duration from disease onset to hospitalization was 3.3 days (standard deviation [SD]= ±3.2 days), and the average time from disease onset to death among the 87 fatalities was 6.3 days (SD= ±5.3 days). Of 148 case-patients at King Fahad Central Hospital in Jazan, 57 (39%) with mild to moderate RVF disease had reversible acute renal failure, requiring only supportive care for 2–14 days; 27 (18%) with severe disease required hemodialysis.

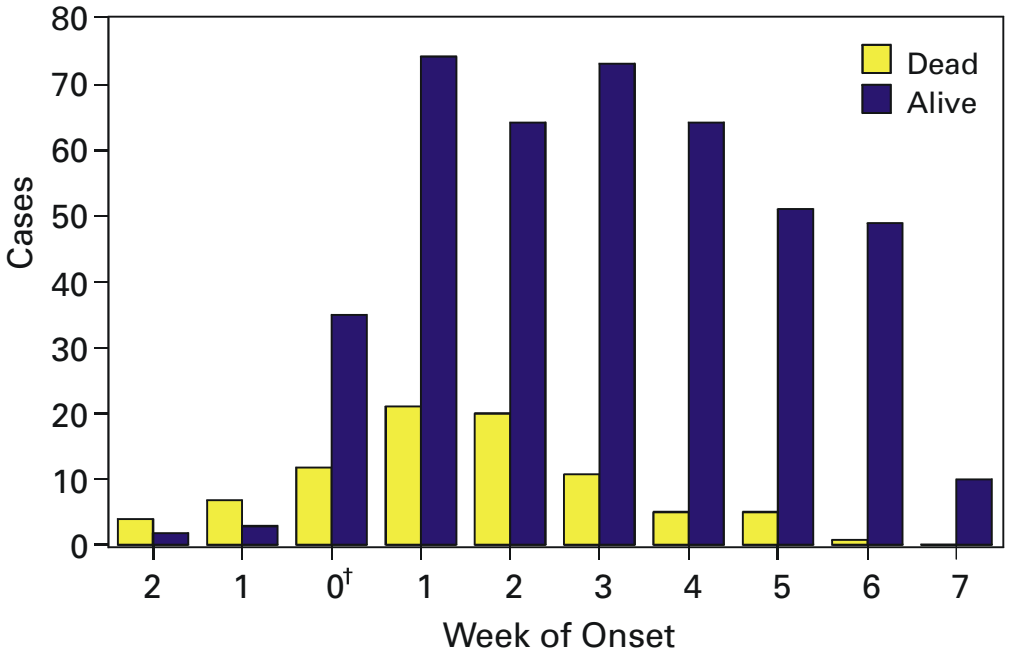
Based on preliminary data from the ongoing epidemiologic investigation, 125 (76%) of 165 case-patients reported close contact with animals, especially sheep and goats, and 91 (64%) of 143 case-patients reported a history of exposure to dead, and/or aborted animals. Nearly all persons reported having had mosquito bites and that the mosquitoes were present at their place of residence.

Entomologic studies found large numbers of two species of mosquitoes, *Culex tritaeniorrhynchus* and *Aedes caspius*, in the flood irrigation farming areas at the foot of the mountains and the foothills of Al Ardah district in Jazan, where the first and most human cases were reported. Preliminary laboratory studies have already yielded isolates of RVF virus from both of these species. Further laboratory identification of the collected mosquitoes suggests the presence of additional *Aedes* species; definitive

*Suspected severe RVF is defined as unexplained illness >48 hours in duration associated with threefold elevation in transaminases (alanine aminotransferase, aspartate aminotransferase, and gamma glutamyl transpeptidase) or clinical jaundice; or unexplained illness >48 hours in duration associated with abortion or bleeding manifestations (e.g., from puncture sites, ecchymosis, petechiae, purpura, epistaxis, gastrointestinal bleeding, or menorrhagia); or unexplained illness >48 hours in duration associated with neurologic manifestations (e.g., vertigo, confusion, disorientation, amnesia, lethargy, hallucination, meningismus, choreiform movements, ataxia, tremor, convulsions, hemiparesis, decerebrate posturing, locked-in syndrome, or coma); or unexplained illness >48 hours in duration associated with fever, diarrhea, nausea, vomiting, or abdominal pain and any one of the following laboratory values: 1) hemoglobin <8 gm/dL; 2) platelets <100,000 mm^3 (<10 x 10^{10}/L); 3) LDH 2 x upper limit of normal; 4) creatinine >150 mol/L; or 5) CPK 2 x upper limit of normal; or unexplained death with recent history of fever during the preceding 2 weeks; and if a specimen is available, evidence of RVF-specific antigen or IgM antibody. Specimens must be obtained at least 7 days after illness onset before they can be considered negative.

Rift Valley Fever — Continued

FIGURE 1. Number of suspected severe cases of Rift Valley fever (RVF),* by outcome and week of disease onset — Saudi Arabia, August 26–November 1, 2000



*Suspected severe RVF is defined as unexplained illness >48 hours in duration associated with threefold elevation in transaminases (alanine aminotransferase, aspartate aminotransferase, and gamma glutamyl transpeptidase) or clinical jaundice; or unexplained illness >48 hours in duration associated with abortion or bleeding manifestations (e.g., from puncture sites, ecchymosis, petechiae, purpura, epistaxis, gastrointestinal bleeding, or menorrhagia); or unexplained illness >48 hours in duration associated with neurologic manifestations (e.g., vertigo, confusion, disorientation, amnesia, lethargy, hallucination, meningismus, choreiform movements, ataxia, tremor, convulsions, hemiparesis, decerebrate posturing, locked-in syndrome, or coma); or unexplained illness >48 hours in duration associated with fever, diarrhea, nausea, vomiting, or abdominal pain and any one of the following laboratory values: 1) hemoglobin <8 gm/dL; 2) platelets <100,000 mm^3 (<10 x 10^{10}/L); 3) LDH 2 x upper limit of normal; 4) creatinine >150 mol/L; or 5) CPK 2 x upper limit of normal; or unexplained death with recent history of fever during the preceding 2 weeks; and if a specimen is available, evidence of RVF-specific antigen or IgM antibody. Specimens must be obtained at least 7 days after illness onset before they can be considered negative.

† Week 0 is September 9–15, during which RVF was first suspected and laboratory confirmed at CDC.

species typing is pending. A regional survey for RVF antibody prevalence in domestic ungulates, primarily goats and sheep, was conducted in Jazan and Asir provinces. RVF antibody prevalence ≥90% was found in Al Ardah district. RVF antibodies also were found among ungulates in other surveyed areas. A correlation was found between areas where human cases were reported and the same flood irrigation farming areas in the upper reaches of the wadis identified by the entomologists.

Reported by: H Arishi, MD, A Ageel, MD, M Abdu Rahman, MD, A Al Hazmi, MD, AR Arishi, MD, B Ayoola, MD, C Menon, MD, J Ashraf, MD, O Frogusin, MD, L Ochia, F Sawwan, M Al Hazmi, MD, Medical Svcs, King Fahad Central Hospital, Jazan; M Almaradni, MD, Medical Svcs, Al Ardah Hospital, Jazan; M Yasim Shah, MD, Medical Svcs, Samta General Hospital, Jazan;

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A As-Sharif, MS, M Al Sayed, Preventive Medicine, A Raheem Ageel, MSD, Regional Health Affairs, Jazan; A Shihry, MD, Al Khobar, Eastern Province; A Abudahish, PharmD, A Al Sharif, MD, Abha, Asir Province; I Al Hazmi, Al Quenfadah; An A Alrajhi, MD, King Faisal Specialist Hospital and Research Center, Riyadh; MA Al-Hedaithy, MD, College of Medicine, King Khalid Univ Hospital, Riyadh; A Fatani, MD, A Sahaly, MD, A Ghelani, MD, T Al Basam, MD, A Turkistani, DDS, AM Al Rabeah, N Al Hamdan, MD, Saudi Arabia Field Epidemiology Training Program, Riyadh; A Mishkas, MBBS, Infectious Diseases; MH Al Jeffri, MD, Parasitic and Infectious Diseases; YY Al Mazrou, MD, M MA Alamri, MM Al-Qahtani, MD, A Al Drees, Laboratories and Blood Banks, Riyadh; T Madani, MD, G Al Gasabi, MD, OA Shubokshi, MD, Ministry of Health, Saudi Arabia; M Al Khamees, DVM, D Al Mujalli, DVM, A Aziz Ibn Moamar, PhD, Ministry of Agriculture and Water, Riyadh, Saudi Arabia. World Health Organization, Geneva, Switzerland. P Jupp, PhD, A Kemp, MS, F Burt, PhD, R Swanepoel, PhD, Special Pathogens Unit, National Institute of Virology, Johannesburg, South Africa. Infectious Disease Pathology Activity, Special Pathogens Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; and an EIS Officer, CDC.

Editorial Note: RVF is a mosquito-borne zoonotic disease affecting domestic ungulates (especially goats and sheep) characterized by large epizootics during periods of heavy rainfall with associated outbreaks in humans. Most human infection is associated with an uncomplicated febrile illness or is inapparent. More severe complications include retinitis, hepatitis, renal failure, hemorrhagic fever, encephalitis, and death. This outbreak extends the geographic distribution of known infection outside of Africa and indicates this virus may be able to establish itself almost anywhere in the world based on the availability of potential permissive vectors and animal reservoirs.

Official reports from Yemen suggest ongoing transmission over a large area, compared with the outbreak in Saudi Arabia, which is more circumscribed and is now mainly focused in Asir province. However, the differing case definitions and surveillance methodologies preclude a direct comparison of the Saudi Arabian and Yemeni outbreaks. Nevertheless, these outbreaks demonstrate disease transmission in an approximately 600 km area, including the flood plains of the wadis extending from the Sarawat mountains to the Red Sea coastal plain and extending from the Hodediah governate in Yemen to the Al Quendafah health region in Saudi Arabia. Epidemiologic data suggest the simultaneous, extensive, and multicentric nature of the outbreaks rather than radiation of disease from a single focus in Saudi Arabia or Yemen.

Control and prevention measures are ongoing in these countries as are preparations for studies to better define risk factors for infection and severe disease, examine the risk for nosocomial infection, gauge the magnitude and scope of the outbreak, characterize viral sequences from isolates, test the efficacy of intravenous ribavirin, and determine the prevalence of infection among captured vector species. The abundance of *A. caspius* (a floodwater breeding aedine mosquito) breeding in the flooded agricultural fields suggests that this species can act as an interepidemic (reservoir) host for the virus and an epidemic vector when heavy rains promote mosquito population explosions; *C. tritaeniorrhynchus* is probably an epidemic vector. Continued surveillance will be necessary to determine if these infected "floodwater" *Aedes*, the major vector for persistence of the virus in Africa attributed to transovarial transmission, supports establishment of RVF on the Arabian Peninsula.

Reference

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Progress Toward Interrupting Indigenous Measles Transmission — Region of the Americas, January 1999–September 2000

In 1994, countries in the Region of the Americas set a goal of interrupting indigenous measles transmission by the end of 2000 (*1*). From 1990 to 1996, measles cases declined from approximately 250,000 to an all-time low of 2109 confirmed cases (*2*). However, a resurgence began in 1997, with 52,284 confirmed cases reported from Brazil (Figure 1) (*3*) and in 1998, with 14,330 confirmed cases reported from 16 (39%) of the 41 countries that report to the Pan American Health Organization (PAHO). This report summarizes the measles control strategies implemented in the region and measles incidence during 1999–2000 and indicates that the region has made important progress towards interrupting indigenous measles transmission and that achieving this goal is within reach.

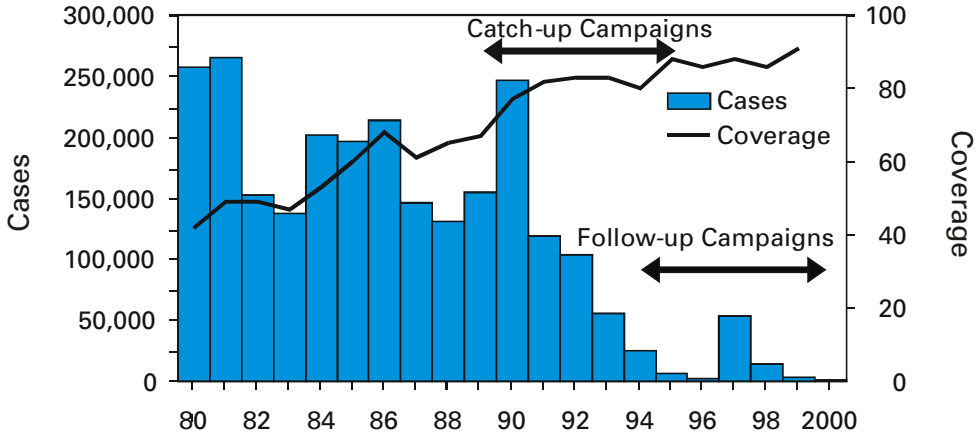
Measles Vaccination

PAHO recommends a three-part vaccination strategy for interrupting indigenous measles transmission: 1) a one-time nationwide "catch-up" campaign targeting all persons aged 1–14 years; 2) routine, "keep-up" vaccination among 1-year-olds; and 3) nationwide "follow-up" campaigns conducted every 4 years, targeting all children aged 1–4 years, regardless of previous measles vaccination status (*4*). Thirty-nine (95%) of 41 countries in the region conducted catch-up campaigns during 1989–1995 and conducted follow-up campaigns since 1994; routine keep-up coverage in the region increased from 80% in 1994 to 91% in 1999 (*2*).

Measles Cases

From January 1999 through September 16, 2000, 28 (68%) of 41 countries in the region reported no measles cases, including Cuba, the English-speaking Caribbean countries, and most of Central and South American countries. In 1999, 3091 confirmed cases were reported from 11 countries, 78% fewer cases than in 1998 and 94% fewer than in

FIGURE 1. Number of confirmed measles cases and percentage of routine infant measles vaccination coverage — Region of the Americas, 1980–2000*



* Data as of September 20, 2000.

Indigenous Measles Transmission — Continued

1997 (Table 1). In 1999, ongoing endemic transmission occurred in four countries (Bolivia [1441 cases], Brazil [797], Argentina [313], and the Dominican Republic [274]). In 1999 and 2000, Canada, Chile, Costa Rica, Mexico, Peru, Uruguay, and the United States reported measles importations; spread was limited by high vaccination coverage (*5*–*7*).

From January 1 through September 16, 880 confirmed measles cases were reported in the region, the lowest number recorded in any year during those weeks. Endemic transmission occurred in Argentina, Bolivia, Brazil, the Dominican Republic, and Haiti. Forty (<1%) of the approximately 12,000 reporting municipalities reported confirmed measles cases during this period.

Since December 1997, virus isolates were obtained from nine outbreaks in the region (including urine specimens from Argentina, Bolivia, Brazil, Chile, the Dominican Republic, Haiti, and Uruguay) and were analyzed by the measles laboratories of the CDC and Fundação Oswaldo Cruz in Brazil. All virus were genotype D6, which indicates its continued endemic circulation in the region.

Argentina. The 1997 measles epidemic in São Paulo, Brazil, spread to Argentina, where 10,667 confirmed cases were reported during 1997–1999. Of these, 10,229 (96%) occurred in 1998 and 313 (3%) in 1999. Cases decreased after a follow-up vaccination campaign was implemented in 1998, with 98% reported measles vaccination coverage among children aged 1–4 years. From January 1 through September 16, 2000, six confirmed cases were reported, a 99% decrease from 1999. These cases all occurred during February 21–March 13, 2000 in the central province of Córdoba, and all but one occurred among unvaccinated persons. Three cases occurred in young adults and two in healthcare workers.

Brazil. Following the 1997 epidemic, a national follow-up vaccination campaign was conducted (*3*). In 1999, 797 cases were reported compared with 2781 confirmed cases in 1998. From January 1 through September 16, 47 (1%) confirmed cases were reported. Of these, 15 (32%) were from an outbreak in the western Amazon region, possibly related to an outbreak in Bolivia, 27 (57%) were sporadic laboratory-confirmed cases from São Paulo, and six cases were sporadic cases from other States. In June 2000, a national follow-up vaccination campaign was conducted targeting children aged 1–11 years; reported nationwide coverage was 97%.

Bolivia. In 1999, 1441 confirmed measles cases were reported, an increase from the 1004 cases reported in 1998. A measles epidemic began in May 1998, spreading from Yacuiba on the Argentinean border to all regions. A follow-up vaccination campaign was conducted during November–December 1999, with reported national coverage of 98%. However, outbreaks continued during 2000, and house-to-house monitoring indicated that many areas had not achieved 95% coverage during the 1999 campaign. From January through September 16, 118 confirmed cases were reported; 110 were associated with five outbreaks affecting rural, unvaccinated children and young unvaccinated adults who had immigrated from rural areas. The largest outbreak (66 cases) occurred during March–June in a Mennonite community in Santa Cruz that objects to vaccination; this outbreak was identified after a measles outbreak was reported from a related community in Alberta, Canada, linked to travel to the Bolivia's Mennonite community (*8*). A nationwide, house-to-house vaccination campaign was initiated in September to administer all vaccines used in the routine infant vaccination schedule (diphtheria and tetanus toxoids and pertussis vaccine [DTP], measles, mumps, and rubella vaccine, and oral poliovirus vaccine).

Indigenous Measles Transmission — Continued

TABLE 1. Measles cases, by subregion, country, and year — Region of the Americas, 1997–2000*

Subregion/Country	1997	1998	1999	2000
Andean				
Bolivia	7	1,004	1,441	118
Colombia	67	61	37	0
Ecuador	0	0	0	0
Peru	95	10	12	1
Venezuela	27	4	0	0
Brazil				
Brazil	52,284	2,781	797	47
Central American				
Belize	0	0	0	0
Costa Rica	26	27	23	1
El Salvador	0	0	0	0
Guatemala	8	1	0	0
Honduras	5	0	0	0
Nicaragua	0	0	0	0
Panama	0	0	0	0
Caribbean				
Anguilla	0	0	0	0
Antigua and Barbuda	0	0	0	0
Bahamas	1	0	0	0
Barbados	0	0	0	0
Cayman Islands	0	0	0	0
Dominica	0	0	0	0
Grenada	0	0	0	0
French Guyana	0	0	0	0
Guyana	0	0	0	0
Jamaica	0	2	0	0
Monserrat	0	0	0	0
St. Christopher and Nevis	0	0	0	0
St. Lucia	0	0	0	0
St. Vincent and Grenadines	0	0	0	0
Suriname	0	0	0	0
Trinidad and Tobago	1	0	0	0
Turks and Caicos	0	0	0	0
British Virgin Islands	0	0	0	0
Latin Caribbean				
Cuba	0	0	0	0
Dominican Republic	1	14	274	162
Haiti	0	3	0	351
Mexico				
Mexico	0	0	0	28
North American				
Bermuda	0	0	0	0
Canada	579	12	29	100
United States	138	100	100	66
South American				
Argentina	125	10,229	313	6
Chile	58	6	31	0
Paraguay	143	70	0	0
Uruguay	2	6	34	0
Total	**53,683**	**14,330**	**3,091**	**880**

* Data as of September 16, 2000.

Indigenous Measles Transmission — Continued

Dominican Republic. In 1999, 274 confirmed measles cases were reported. From January 1 through September 16, 162 confirmed cases (18% of the region's total) were reported. Of these, 104 (64%) occurred among unvaccinated persons. The highest age-specific incidence rates were among infants aged <9 months (14 cases per 100,000), children aged 9 months–4 years (five), and adults aged 20–29 years (three per 100,000). Investigations of cases from 2000 indicated that outbreaks occurred in large cities among young factory workers where factories that attract workers from rural areas are located.

Haiti. No confirmed cases were reported in 1999. In 2000, an outbreak began in Artibonite; through September 16, 351 confirmed cases (40% of the region's total) have been reported, most from this area (241) and metropolitan Port au Prince (72). Attack rates were highest for children aged 12–23 months (1.5 per 10,000), aged 2–4 years (1.2 per 10,000), and aged 5–9 years (0.8 per 10,000). In June, house-to-house vaccination was initiated for all children aged 6 months–15 years.

Reported by: HS Izurieta, L Venczel, P Carrasco, G Tambini, C Castillo, M Landaverde, M Brana, CA de Quadros, Div of Vaccines and Immunizations, Pan American Health Organization, Washington DC. Z Garib, Ministry of Health, C Pedreira, Pan American Health Organization, Santo Domingo, Dominican Republic. R Quiroga, Ministry of Health, O Barrezueta, Pan American Health Organization, La Paz, Bolivia. AM Desormeaux, Ministry of Health, F Laender, J Dobbins, J André, Pan American Health Organization, Port au Prince, Haiti. E Luna, L Brondi, MC Quixadá, S Parise, C Segatto, Ministry of Health, R Prevots, Pan American Health Organization, Brasilia, Brazil. I Micelli, J Vilosio, Ministry of Health, V Dietz, Pan American Health Organization, Buenos Aires, Argentina. National Reference Center for Measles, Dept of Virology, Fundação Oswaldo Cruz, Rio de Janeiro, Brazil. Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Measles Br, Vaccine Preventable Disease Eradication Div, National Immunization Program, CDC.

Editorial Note: Countries in the Region of the Americas have made important progress in interrupting measles transmission. Countries have dedicated health-care personnel, resources, and political support to both vaccination programs and intensified disease surveillance. Countries that have adequately implemented all of the PAHO-recommended strategies have successfully interrupted measles transmission (*2,4*).

Effective measles control relies on achieving and sustaining a high level of vaccine-induced measles immunity. Although Haiti and the Dominican Republic have conducted nationwide vaccination campaigns, endemic transmission continues, mainly because measles coverage in the campaigns did not reach 95% (*9*). Reasons for suboptimal coverage included insufficient supervision and monitoring of house-to-house vaccination and delayed case investigations that prevented rapid assessment of the situation in areas with poor coverage. Sustaining a high level of vaccine-induced immunity to prevent spread of measles from importations is the most effective measles-control strategy.

PAHO recommends the appropriate and timely implementation of the following strategies to achieve, maintain, and monitor the interruption of endemic measles transmission in the region: 1) Obtaining ≥95% routine coverage with measles-containing vaccine in all municipalities. Countries should validate coverage regularly through house-to-house monitoring and/or comparing the number of measles vaccine doses administered to the number of first doses of DTP or the number of doses of Bacille Calmette-Guerin vaccine; 2) Performing follow-up campaigns at least every 4 years and achieving ≥95% vaccination coverage in all municipalities. Supervisors should verify the vaccination coverage daily during the campaign through house-to-house monitoring; 3) Vaccinating and monitoring coverage among groups at high risk for acquiring or transmitting the disease (i.e., health-care workers, migrant workers, groups philosophically opposed to vaccination,

Indigenous Measles Transmission — Continued

military recruits, and other young adults of rural origin); 4) Conducting reliable, routine surveillance for disease and actively validating data by looking for disease during all house-to-house vaccinations, regular visits to schools and health-care centers by each district's supervisor, including monthly visits to high-risk areas (those where coverage is low, that do not submit weekly reports, with limited access to health services, where tourism or immigration are high, or that have had cases during the preceding weeks); and 5) Investigating all outbreaks, including a) conducting household visits within 48 hours of identifying a suspected case and investigating all contacts and settings where case-patients were during both their exposure periods (7–18 days preceding rash onset) and their infectious periods (from the first respiratory symptoms until 4 days after rash onset); b) collecting blood and either throat or nasopharyngeal swabs or urine specimens at the first contact with the suspected case-patients, sending them to the country's measles reference laboratory within 5 days of taking them and analyzing the serum specimen, and reporting results within 4 days after the laboratory received the specimen; c) identifying the epidemiological links of confirmed cases and evaluating the risk factors involved in every outbreak; and d) verifying the absence of measles exportations/importations between countries within the region, including determining the viral genotypes to identify endemic or imported viruses.

References

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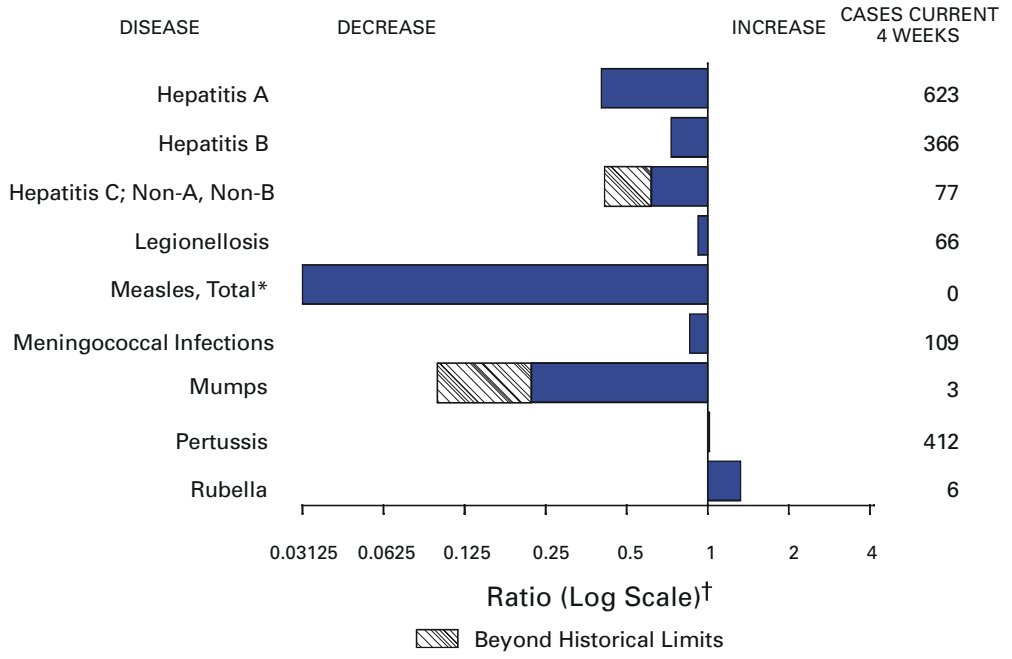
FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending October 28, 2000, with historical data



* No Measles cases were reported for the current 4-week period, yielding a ratio for week 43 of zero (0).

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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending October 28, 2000 (43rd Week)

	Cum. 2000		Cum. 2000
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	57	Psittacosis*	10
Cholera	2	Q fever*	18
Cyclosporiasis*	37	Rabies, human	1
Diphtheria	1	Rocky Mountain spotted fever (RMSF)	379
Ehrlichiosis: human granulocytic (HGE)*	144	Rubella, congenital syndrome	6
human monocytic (HME)*	86	Streptococcal disease, invasive, group A	2,347
Encephalitis: California serogroup viral*	94	Streptococcal toxic-shock syndrome*	64
eastern equine*	1	Syphilis, congenital¶	173
St. Louis*	3	Tetanus	20
western equine*	-	Toxic-shock syndrome	122
Hansen disease (leprosy)*	56	Trichinosis	14
Hantavirus pulmonary syndrome*†	27	Tularemia*	107
Hemolytic uremic syndrome, postdiarrheal*	158	Typhoid fever	274
HIV infection, pediatric*§	170	Yellow fever	-
Plague	6		

-: 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 September 24, 2000.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending October 28, 2000, and October 30, 1999 (43rd 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	30,346	37,258	534,214	542,759	2,196	2,241	3,841	3,140	2,688	2,410
NEW ENGLAND	1,599	1,884	17,229	17,551	97	161	350	369	337	340
Maine	27	68	1,187	824	20	24	26	34	26	-
N.H.	28	40	871	812	21	17	32	30	28	29
Vt.	22	15	438	396	26	34	32	32	33	20
Mass.	1,006	1,211	7,263	7,476	27	61	153	162	156	174
R.I.	78	90	2,104	1,920	3	4	18	26	16	26
Conn.	438	460	5,366	6,123	-	21	89	85	78	91
MID. ATLANTIC	6,780	9,653	46,213	54,947	152	481	350	283	231	112
Upstate N.Y.	692	1,147	N	N	105	135	255	218	56	-
N.Y. City	3,619	5,101	20,948	22,729	9	214	10	17	9	17
N.J.	1,336	1,732	7,016	10,213	9	39	85	48	106	57
Pa.	1,133	1,673	18,249	22,005	29	93	N	N	60	38
E.N. CENTRAL	2,871	2,534	87,508	91,041	704	572	859	872	490	466
Ohio	427	421	21,862	24,571	226	56	240	196	182	187
Ind.	286	282	10,515	10,069	57	35	120	82	71	61
Ill.	1,569	1,202	23,425	26,921	7	82	171	484	-	81
Mich.	437	502	20,603	18,309	86	43	125	110	98	76
Wis.	152	127	11,103	11,171	328	356	203	N	139	61
W.N. CENTRAL	681	839	29,573	30,950	334	180	612	474	461	506
Minn.	130	158	5,894	6,242	119	68	186	156	166	173
Iowa	70	70	3,901	3,615	73	52	175	102	76	74
Mo.	316	408	9,728	11,037	30	21	98	37	87	59
N. Dak.	2	6	577	756	15	16	15	16	18	16
S. Dak.	7	13	1,506	1,311	15	7	53	44	55	59
Nebr.	53	58	3,052	2,867	73	14	59	90	45	111
Kans.	103	126	4,915	5,122	9	2	26	29	14	14
S. ATLANTIC	8,394	10,213	106,251	115,349	409	330	321	281	251	171
Del.	156	146	2,370	2,280	5	-	1	6	1	3
Md.	1,060	1,240	11,190	10,833	10	17	28	35	1	4
D.C.	570	493	2,726	N	15	7	1	-	U	U
Va.	574	684	12,974	11,937	16	21	61	65	55	55
W. Va.	47	61	1,379	1,517	3	3	14	13	11	8
N.C.	529	691	18,505	18,471	21	21	77	61	64	51
S.C.	660	842	8,434	15,567	-	-	21	18	14	14
Ga.	983	1,466	21,447	28,255	148	121	37	28	36	1
Fla.	3,815	4,590	27,226	26,489	191	140	81	55	69	35
E.S. CENTRAL	1,533	1,661	40,707	38,327	42	29	118	125	92	97
Ky.	160	241	6,638	6,250	5	6	40	43	31	31
Tenn.	657	640	12,139	12,010	11	10	52	53	45	42
Ala.	397	418	12,878	10,416	15	10	9	21	7	20
Miss.	319	362	9,052	9,651	11	3	17	8	9	4
W.S. CENTRAL	3,049	3,803	82,145	76,840	86	78	168	121	205	136
Ark.	150	156	4,977	5,151	11	1	55	13	30	12
La.	510	743	15,261	13,643	10	23	9	13	44	13
Okla.	257	116	7,454	6,668	17	10	18	33	14	25
Tex.	2,132	2,788	54,453	51,378	48	44	86	62	117	86
MOUNTAIN	1,131	1,464	31,103	27,831	160	86	396	270	219	223
Mont.	12	11	1,154	1,287	10	10	30	24	-	-
Idaho	19	20	1,512	1,429	21	7	65	40	-	37
Wyo.	7	10	652	635	5	1	17	14	9	15
Colo.	258	271	8,390	5,513	67	11	151	107	97	86
N. Mex.	116	78	3,721	4,133	17	37	20	11	15	6
Ariz.	367	742	10,681	10,375	11	12	47	27	34	19
Utah	112	128	1,815	1,808	25	N	53	31	64	45
Nev.	240	204	3,178	2,651	4	8	13	16	-	15
PACIFIC	4,308	5,207	93,485	89,923	212	324	667	345	402	359
Wash.	394	303	10,396	9,728	N	N	196	136	173	165
Oreg.	113	185	4,002	4,999	16	88	148	66	110	68
Calif.	3,693	4,628	74,639	70,971	196	236	282	130	108	115
Alaska	15	13	2,011	1,568	-	-	27	1	1	1
Hawaii	93	78	2,437	2,657	-	-	14	12	10	10
Guam	15	11	-	393	-	-	N	N	U	U
P.R.	1,028	1,094	3,188	U	-	-	6	5	U	U
V.I.	27	35	U	U	U	U	U	U	U	U
Amer. Samoa	-	-	U	U	U	U	U	U	U	U
C.N.M.I.	-	-	U	U	U	U	U	U	U	U

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

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

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

§ Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update September 24, 2000.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending October 28, 2000, and October 30, 1999 (43rd Week)

Reporting Area	Gonorrhea		Hepatitis C; Non-A, Non-B		Legionellosis		Listeriosis	Lyme Disease	
	Cum. 2000[§]	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 2000	Cum. 1999
UNITED STATES	280,096	298,619	2,486	2,363	798	833	582	11,395	13,122
NEW ENGLAND	4,804	5,530	14	14	47	68	42	3,789	3,808
Maine	74	67	2	2	2	3	2	-	41
N.H.	86	93	-	-	2	8	2	59	18
Vt.	54	37	4	6	5	13	3	24	18
Mass.	1,960	2,072	3	3	13	25	23	973	712
R.I.	526	491	5	3	8	8	1	417	408
Conn.	2,104	2,770	-	-	17	11	11	2,316	2,611
MID. ATLANTIC	28,502	33,042	543	110	162	208	139	5,818	7,058
Upstate N.Y.	6,015	5,606	58	50	69	52	76	3,180	3,284
N.Y. City	9,061	10,363	-	-	-	40	26	18	131
N.J.	4,901	6,448	450	-	12	18	19	1,426	1,556
Pa.	8,525	10,625	35	60	81	98	18	1,194	2,087
E.N. CENTRAL	53,434	57,281	185	814	211	230	98	315	562
Ohio	13,171	15,118	11	3	100	65	49	82	41
Ind.	4,976	5,348	1	1	35	36	7	32	17
Ill.	15,914	19,047	14	43	9	29	11	11	17
Mich.	14,593	12,805	159	751	41	59	26	-	11
Wis.	4,780	4,963	-	16	26	41	5	190	476
W.N. CENTRAL	13,389	13,707	420	218	54	47	13	353	278
Minn.	2,329	2,365	5	10	7	9	5	267	168
Iowa	909	954	2	-	13	12	3	26	22
Mo.	6,450	6,739	398	205	24	16	4	39	61
N. Dak.	35	72	-	-	-	1	1	1	1
S. Dak.	254	157	-	-	2	3	-	-	-
Nebr.	1,184	1,228	6	3	4	6	-	4	11
Kans.	2,228	2,192	9	-	4	-	-	16	15
S. ATLANTIC	78,877	87,839	108	145	165	113	96	882	1,135
Del.	1,418	1,415	-	-	8	14	2	140	114
Md.	7,822	8,262	18	20	57	27	21	488	800
D.C.	2,211	3,100	3	1	5	3	-	5	4
Va.	8,682	7,965	3	10	31	28	7	133	109
W. Va.	451	482	14	17	N	N	3	26	16
N.C.	15,114	16,454	14	32	13	13	-	43	64
S.C.	10,582	12,046	2	22	4	8	9	7	4
Ga.	13,833	19,234	3	1	6	1	21	-	-
Fla.	18,764	18,881	51	42	41	19	33	40	24
E.S. CENTRAL	29,658	30,594	353	241	30	45	17	45	90
Ky.	2,942	2,821	31	17	17	17	3	11	17
Tenn.	9,731	9,632	83	91	10	22	10	28	50
Ala.	10,087	9,312	7	1	3	4	4	6	19
Miss.	6,898	8,829	232	132	-	2	-	-	4
W.S. CENTRAL	43,454	44,126	405	462	16	10	14	37	52
Ark.	2,689	2,784	9	26	-	1	1	4	4
La.	11,247	10,981	290	273	6	5	-	3	8
Okla.	3,303	3,292	8	15	3	3	6	-	7
Tex.	26,215	27,069	98	148	7	1	7	30	33
MOUNTAIN	8,511	8,064	284	161	40	40	29	29	13
Mont.	39	45	4	5	1	-	-	-	-
Idaho	69	71	3	7	5	2	-	3	3
Wyo.	41	25	210	45	2	-	1	9	3
Colo.	2,534	2,069	21	29	14	11	6	11	2
N. Mex.	827	819	13	28	1	1	2	-	1
Ariz.	3,562	3,757	18	33	8	6	12	-	-
Utah	177	181	2	6	9	14	4	3	2
Nev.	1,262	1,097	13	8	-	6	4	3	2
PACIFIC	19,467	18,436	174	198	73	72	134	127	126
Wash.	1,873	1,727	28	17	16	17	5	7	7
Oreg.	570	728	27	15	N	N	5	11	12
Calif.	16,427	15,351	117	166	57	53	121	107	107
Alaska	283	254	-	-	-	1	-	2	-
Hawaii	314	376	2	-	-	1	3	N	N
Guam	-	43	-	1	-	-	-	-	-
P.R.	547	279	1	-	1	-	-	N	N
V.I.	U	U	U	U	U	U	-	U	U
Amer. Samoa	U	U	U	U	U	U	-	U	U
C.N.M.I.	U	U	U	U	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 October 28, 2000, and October 30, 1999 (43rd 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	1,031	1,219	4,976	5,653	30,027	32,314	25,433	28,405
NEW ENGLAND	57	55	704	751	1,899	1,902	1,853	1,912
Maine	6	3	117	144	108	119	83	95
N.H.	1	2	21	44	123	118	122	118
Vt.	2	4	53	86	100	83	108	73
Mass.	22	19	228	186	1,069	1,015	1,022	1,031
R.I.	8	4	55	80	121	119	128	142
Conn.	18	23	230	211	378	448	390	453
MID. ATLANTIC	201	355	904	1,095	3,429	4,333	3,636	4,474
Upstate N.Y.	67	60	623	774	1,016	1,101	1,099	1,162
N.Y. City	75	207	U	U	789	1,254	723	1,291
N.J.	33	48	167	159	774	899	670	975
Pa.	26	40	114	162	850	1,079	1,144	1,046
E.N. CENTRAL	107	149	137	153	4,313	4,690	2,644	4,099
Ohio	18	18	48	33	1,257	1,126	1,022	939
Ind.	4	19	-	12	542	446	473	415
Ill.	46	68	21	10	1,198	1,420	1	1,374
Mich.	29	37	62	79	760	862	804	859
Wis.	10	7	6	19	556	836	344	512
W.N. CENTRAL	54	65	472	646	2,038	1,950	2,048	2,115
Minn.	27	33	78	92	472	507	572	634
Iowa	3	13	70	137	317	220	185	201
Mo.	8	13	49	29	598	625	779	767
N. Dak.	2	-	106	129	48	40	67	55
S. Dak.	1	-	80	163	85	85	93	108
Nebr.	7	1	2	4	195	172	91	144
Kans.	6	5	87	92	323	301	261	206
S. ATLANTIC	276	296	2,023	1,848	6,809	7,283	4,662	5,634
Del.	5	1	47	50	100	142	126	133
Md.	89	86	346	345	717	743	656	778
D.C.	15	17	-	-	55	68	U	U
Va.	47	62	486	483	849	1,118	753	917
W. Va.	4	2	103	96	144	147	130	138
N.C.	32	26	488	383	940	1,128	916	1,173
S.C.	2	15	142	129	641	547	482	436
Ga.	19	21	272	201	1,233	1,186	1,429	1,463
Fla.	63	66	139	161	2,130	2,204	170	596
E.S. CENTRAL	42	23	179	223	1,851	1,824	1,376	1,273
Ky.	17	7	19	33	326	346	220	235
Tenn.	11	8	91	80	535	495	644	519
Ala.	13	7	69	109	573	514	423	432
Miss.	1	1	-	1	417	469	89	87
W.S. CENTRAL	18	15	71	406	2,621	3,154	3,507	2,393
Ark.	3	3	20	14	618	572	508	201
La.	7	10	-	-	248	656	580	506
Okla.	8	2	51	82	344	395	233	304
Tex.	-	-	-	310	1,411	1,531	2,186	1,382
MOUNTAIN	43	40	224	193	2,415	2,570	1,831	2,264
Mont.	1	4	61	54	79	53	-	1
Idaho	3	3	9	-	103	94	-	93
Wyo.	-	1	47	42	55	60	37	56
Colo.	21	17	-	1	639	642	589	629
N. Mex.	-	2	19	9	201	335	167	263
Ariz.	7	6	70	71	667	762	622	705
Utah	5	4	10	8	436	451	416	468
Nev.	6	3	8	8	235	173	-	49
PACIFIC	233	221	262	338	4,652	4,608	3,876	4,241
Wash.	25	23	-	-	494	545	547	732
Oreg.	37	19	7	3	276	377	324	411
Calif.	165	166	233	328	3,625	3,340	2,783	2,820
Alaska	-	1	22	7	56	51	23	31
Hawaii	6	12	-	-	201	295	199	247
Guam	-	-	-	-	-	34	U	U
P.R.	4	-	67	68	466	490	U	U
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
* Individual cases can 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 October 28, 2000, and October 30, 1999 (43rd Week)

Reporting Area	Shigellosis* NETSS Cum. 2000	Shigellosis* NETSS Cum. 1999	Shigellosis* PHLIS Cum. 2000	Shigellosis* PHLIS Cum. 1999	Syphilis (Primary & Secondary) Cum. 2000	Syphilis (Primary & Secondary) Cum. 1999	Tuberculosis Cum. 2000	Tuberculosis Cum. 1999
UNITED STATES	16,612	13,593	8,834	8,222	4,967	5,584	10,232	12,815
NEW ENGLAND	336	741	328	707	67	52	342	354
Maine	10	5	12	-	1	-	12	16
N.H.	6	16	8	14	2	1	15	11
Vt.	4	6	-	4	-	3	4	2
Mass.	229	635	220	612	43	30	212	196
R.I.	26	23	28	18	4	2	27	35
Conn.	61	56	60	59	17	16	72	94
MID. ATLANTIC	1,733	900	1,110	632	221	247	1,877	2,153
Upstate N.Y.	637	241	180	65	13	17	239	267
N.Y. City	650	299	426	211	103	105	1,029	1,109
N.J.	270	210	313	197	42	59	446	445
Pa.	176	150	191	159	63	66	163	332
E.N. CENTRAL	3,321	2,567	934	1,381	959	1,021	1,044	1,364
Ohio	328	365	215	125	66	74	205	212
Ind.	1,358	259	133	96	311	364	80	112
Ill.	843	1,044	2	788	286	360	522	684
Mich.	588	378	532	311	255	185	167	270
Wis.	204	521	52	61	41	38	70	86
W.N. CENTRAL	1,980	1,011	1,612	676	53	113	389	430
Minn.	612	202	733	214	13	9	128	164
Iowa	455	50	217	44	10	9	32	39
Mo.	587	618	425	312	23	79	154	155
N. Dak.	16	3	49	2	-	-	2	6
S. Dak.	7	13	4	6	-	-	16	17
Nebr.	111	74	84	59	2	6	20	16
Kans.	192	51	100	39	5	10	37	33
S. ATLANTIC	2,564	2,061	1,001	463	1,655	1,804	2,098	2,566
Del.	21	13	20	8	8	8	-	25
Md.	186	138	103	47	246	318	203	222
D.C.	67	46	U	U	43	43	27	38
Va.	394	116	304	54	114	134	216	247
W. Va.	4	8	3	5	2	4	26	37
N.C.	316	185	242	79	410	416	248	382
S.C.	112	106	81	57	181	227	109	210
Ga.	223	199	162	77	316	363	468	512
Fla.	1,241	1,250	86	136	335	291	801	893
E.S. CENTRAL	910	1,037	454	613	749	968	756	866
Ky.	384	217	78	139	70	87	100	154
Tenn.	313	600	334	406	448	547	280	297
Ala.	69	102	36	58	107	186	255	254
Miss.	144	118	6	10	124	148	121	161
W.S. CENTRAL	1,833	2,231	2,348	976	686	877	870	1,649
Ark.	178	73	44	24	86	58	149	140
La.	134	177	146	105	187	259	74	180
Okla.	109	486	35	149	108	158	113	150
Tex.	1,412	1,495	2,123	698	305	402	534	1,179
MOUNTAIN	1,067	904	584	642	207	199	415	428
Mont.	7	7	-	-	-	1	14	10
Idaho	44	23	-	11	1	1	10	12
Wyo.	5	3	2	1	1	-	2	3
Colo.	229	165	156	129	11	2	66	59
N. Mex.	132	114	67	87	20	11	36	50
Ariz.	465	454	286	348	168	178	175	180
Utah	72	55	73	60	1	2	41	34
Nev.	113	83	-	6	5	4	71	80
PACIFIC	2,868	2,141	463	2,132	370	303	2,441	3,005
Wash.	403	99	339	98	55	63	203	215
Oreg.	155	75	94	70	6	6	25	89
Calif.	2,268	1,938	-	1,935	308	230	2,024	2,505
Alaska	8	3	3	3	-	1	82	47
Hawaii	34	26	27	26	1	3	107	149
Guam	-	15	U	U	-	-	-	56
P.R.	23	128	U	U	122	133	238	172
V.I.	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	U	U

N: Not notifiable. U: Unavailable. -: No reported cases.
*Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public Health Laboratory Information System (PHLIS).

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending October 28, 2000, and October 30, 1999 (43rd 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	961	987	9,956	13,548	5,520	5,732	-	53	-	18	71	85
NEW ENGLAND	82	79	299	283	84	130	-	2	-	4	6	11
Maine	1	5	19	11	5	1	-	-	-	-	-	-
N.H.	12	16	18	14	15	13	-	2	-	1	3	1
Vt.	6	5	9	18	6	4	-	-	-	3	3	-
Mass.	36	31	109	109	12	41	-	-	-	-	-	8
R.I.	4	5	22	16	18	32	-	-	-	-	-	-
Conn.	23	17	122	115	28	39	-	-	-	-	-	2
MID. ATLANTIC	150	170	955	1,013	739	729	-	14	-	5	19	5
Upstate N.Y.	81	68	192	227	116	155	-	9	-	-	9	2
N.Y. City	31	53	290	338	373	221	-	5	-	4	9	3
N.J.	29	44	154	131	57	114	-	-	-	-	-	-
Pa.	9	5	319	317	193	239	-	-	-	1	1	-
E.N. CENTRAL	131	164	1,166	2,521	583	614	-	8	-	-	8	3
Ohio	47	52	229	561	93	81	-	2	-	-	2	-
Ind.	26	21	90	92	41	35	-	-	-	-	-	2
Ill.	48	68	434	657	106	52	-	4	-	-	4	-
Mich.	7	17	400	1,144	342	418	-	2	-	-	2	1
Wis.	3	6	13	67	1	28	-	-	-	-	-	-
W.N. CENTRAL	60	61	663	694	494	248	-	2	-	1	3	1
Minn.	34	40	175	75	35	48	-	-	-	1	1	1
Iowa	1	2	64	121	31	36	-	2	-	-	2	-
Mo.	16	6	293	415	367	139	-	-	-	-	-	-
N. Dak.	1	1	3	2	2	-	-	-	-	-	-	-
S. Dak.	1	2	1	9	1	1	-	-	-	-	-	-
Nebr.	3	4	33	43	36	17	-	-	-	-	-	-
Kans.	4	6	94	29	22	7	-	-	-	-	-	-
S. ATLANTIC	259	208	1,267	1,563	1,074	936	-	3	-	-	3	15
Del.	-	-	-	2	-	1	-	-	-	-	-	-
Md.	73	53	194	262	102	129	-	-	-	-	-	-
D.C.	-	4	23	54	28	22	-	-	-	-	-	-
Va.	35	16	130	146	138	75	-	2	-	-	2	13
W. Va.	9	7	53	33	12	22	-	-	-	-	-	-
N.C.	21	31	123	134	208	201	-	-	-	-	-	-
S.C.	15	5	70	40	14	61	-	-	-	-	-	-
Ga.	59	55	244	417	181	139	-	-	-	-	-	-
Fla.	47	37	430	475	391	286	-	1	-	-	1	2
E.S. CENTRAL	42	53	327	339	368	402	-	-	-	-	-	2
Ky.	12	6	42	64	60	40	-	-	-	-	-	2
Tenn.	19	29	121	128	180	195	-	-	-	-	-	-
Ala.	10	15	52	50	47	79	-	-	-	-	-	-
Miss.	1	3	112	97	81	88	-	-	-	-	-	-
W.S. CENTRAL	56	55	1,557	2,648	631	994	-	-	-	-	-	12
Ark.	2	2	104	48	73	67	-	-	-	-	-	5
La.	11	12	56	196	87	157	-	-	-	-	-	-
Okla.	41	37	232	438	137	125	-	-	-	-	-	-
Tex.	2	4	1,165	1,966	334	645	-	-	-	-	-	7
MOUNTAIN	91	93	836	1,068	459	490	-	11	-	1	12	1
Mont.	1	3	7	17	7	17	-	-	-	-	-	-
Idaho	4	1	23	36	7	25	-	-	-	-	-	-
Wyo.	1	1	39	8	25	12	-	-	-	-	-	-
Colo.	15	13	175	199	87	85	-	1	-	1	2	-
N. Mex.	19	18	63	43	93	152	-	-	-	-	-	-
Ariz.	37	48	418	592	179	120	-	-	-	-	-	1
Utah	11	6	50	45	20	30	-	3	-	-	3	-
Nev.	3	3	61	128	41	49	-	7	-	-	7	-
PACIFIC	90	104	2,886	3,419	1,088	1,189	-	13	-	7	20	35
Wash.	5	5	245	282	97	58	-	2	-	1	3	5
Oreg.	26	35	165	215	98	94	-	-	-	-	-	12
Calif.	30	50	2,452	2,892	873	1,009	-	10	-	3	13	17
Alaska	6	6	11	10	9	15	-	1	-	-	1	-
Hawaii	23	8	13	20	11	13	-	-	-	3	3	1
Guam	-	-	-	1	-	2	U	-	U	-	-	1
P.R.	4	2	197	263	213	198	U	-	U	-	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	U	U	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 200 cases among children aged <5 years, serotype was reported for 84 and of those, 21 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending October 28, 2000, and October 30, 1999 (43rd 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	1,736	2,014	2	276	309	120	5,300	5,260	-	127	239
NEW ENGLAND	115	97	-	4	8	14	1,274	651	-	12	7
Maine	8	5	-	-	-	-	41	-	-	-	-
N.H.	11	12	-	-	1	-	102	81	-	2	-
Vt.	3	5	-	-	1	2	202	58	-	-	-
Mass.	67	56	-	1	4	10	871	456	-	8	7
R.I.	9	4	-	1	2	-	16	33	-	1	-
Conn.	17	15	-	2	-	2	42	23	-	1	-
MID. ATLANTIC	161	194	1	21	38	12	519	796	-	9	31
Upstate N.Y.	55	60	1	10	9	12	266	612	-	2	18
N.Y. City	33	52	-	4	11	-	44	48	-	7	6
N.J.	34	43	-	3	1	-	35	22	-	-	4
Pa.	39	39	-	4	17	-	174	114	-	-	3
E.N. CENTRAL	307	359	-	28	40	29	580	479	-	1	2
Ohio	78	121	-	7	14	25	290	184	-	-	-
Ind.	41	53	-	1	4	-	86	62	-	-	1
Ill.	72	96	-	6	10	-	64	84	-	1	1
Mich.	93	56	-	14	8	4	75	51	-	-	-
Wis.	23	33	-	-	4	-	65	98	-	-	-
W.N. CENTRAL	148	201	-	18	12	17	478	377	-	2	127
Minn.	20	47	-	-	1	2	287	188	-	-	5
Iowa	30	34	-	7	7	1	47	55	-	-	30
Mo.	77	76	-	4	1	8	67	67	-	1	2
N. Dak.	2	3	-	-	-	-	6	4	-	-	-
S. Dak.	5	11	-	-	-	3	7	5	-	-	-
Nebr.	7	10	-	4	-	3	28	6	-	1	90
Kans.	7	20	-	3	3	-	36	52	-	-	-
S. ATLANTIC	275	339	1	42	44	31	429	365	-	74	35
Del.	1	10	-	-	-	-	8	5	-	1	-
Md.	26	49	-	10	5	5	104	110	-	-	1
D.C.	-	3	-	-	2	-	3	-	-	-	-
Va.	37	45	-	9	10	7	97	29	-	-	-
W. Va.	12	7	-	-	-	-	1	3	-	-	-
N.C.	34	40	1	6	8	17	94	89	-	64	34
S.C.	21	42	-	10	4	-	27	15	-	7	-
Ga.	43	56	-	2	4	1	36	37	-	-	-
Fla.	101	87	-	5	11	1	59	77	-	2	-
E.S. CENTRAL	115	140	-	7	12	2	98	86	-	5	2
Ky.	24	27	-	1	-	-	49	26	-	1	-
Tenn.	50	58	-	2	-	2	30	36	-	1	-
Ala.	31	33	-	2	9	-	18	21	-	3	2
Miss.	10	22	-	2	3	-	1	3	-	-	-
W.S. CENTRAL	116	190	-	24	39	1	286	190	-	5	14
Ark.	13	31	-	2	-	1	32	24	-	-	5
La.	35	60	-	4	10	-	12	9	-	1	-
Okla.	26	28	-	-	1	-	19	33	-	-	1
Tex.	42	71	-	18	28	-	223	124	-	4	8
MOUNTAIN	122	124	-	20	24	7	667	653	-	2	16
Mont.	4	2	-	1	-	-	35	2	-	-	-
Idaho	7	9	-	-	1	-	57	138	-	-	-
Wyo.	-	4	-	2	-	-	6	2	-	-	-
Colo.	31	33	-	1	6	6	389	247	-	1	1
N. Mex.	8	14	-	1	N	1	80	103	-	-	-
Ariz.	62	41	-	4	8	-	70	97	-	1	13
Utah	7	14	-	5	4	-	18	56	-	-	1
Nev.	3	7	-	6	5	-	12	8	-	-	1
PACIFIC	377	370	-	112	92	7	969	1,663	-	17	5
Wash.	52	59	-	10	2	4	344	623	-	7	-
Oreg.	62	67	N	N	N	3	111	47	-	-	-
Calif.	247	231	-	81	75	-	465	951	-	10	5
Alaska	8	7	-	7	2	-	20	4	-	-	-
Hawaii	8	6	-	14	13	-	29	38	-	-	-
Guam	-	1	U	-	3	U	-	2	U	-	-
P.R.	9	11	U	-	-	U	5	22	U	-	-
V.I.	U	U	U	U	U	U	U	U	U	U	U
Amer. Samoa	U	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	U	U	U	U	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 October 28, 2000 (43rd Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	594	450	94	23	20	7	60
Boston, Mass.	179	125	36	5	10	3	15
Bridgeport, Conn.	23	20	2	1	-	-	1
Cambridge, Mass.	30	25	5	-	-	-	1
Fall River, Mass.	27	22	3	2	-	-	5
Hartford, Conn.	54	39	10	2	1	2	2
Lowell, Mass.	33	29	3	-	1	-	3
Lynn, Mass.	13	9	3	-	1	-	1
New Bedford, Mass.	17	15	2	-	-	-	2
New Haven, Conn.	34	25	5	2	1	1	4
Providence, R.I.	56	49	6	-	1	-	10
Somerville, Mass.	8	6	1	1	-	-	-
Springfield, Mass.	32	23	6	1	2	-	5
Waterbury, Conn.	29	22	3	2	2	-	4
Worcester, Mass.	59	41	9	7	1	1	7
MID. ATLANTIC	2,384	1,712	434	153	42	43	117
Albany, N.Y.	51	37	11	2	1	-	6
Allentown, Pa.	22	18	3	-	1	-	2
Buffalo, N.Y.	93	72	13	4	1	3	6
Camden, N.J.	28	20	6	2	-	-	1
Elizabeth, N.J.	26	21	4	1	-	-	-
Erie, Pa.§	55	48	5	1	1	-	3
Jersey City, N.J.	53	37	9	6	-	1	-
New York City, N.Y.	1,156	799	219	90	23	25	42
Newark, N.J.	U	U	U	U	U	U	U
Paterson, N.J.	13	8	2	3	-	-	-
Philadelphia, Pa.	400	272	82	28	9	9	18
Pittsburgh, Pa.§	60	40	12	5	-	3	4
Reading, Pa.	38	30	5	1	2	-	3
Rochester, N.Y.	153	125	22	4	1	1	9
Schenectady, N.Y.	26	21	5	-	-	-	2
Scranton, Pa.§	28	23	5	-	-	-	3
Syracuse, N.Y.	95	71	19	3	1	1	10
Trenton, N.J.	42	31	9	2	-	-	4
Utica, N.Y.	16	14	1	1	-	-	2
Yonkers, N.Y.	29	25	2	-	2	-	2
E.N. CENTRAL	2,138	1,486	378	164	57	51	147
Akron, Ohio	54	36	7	5	3	3	5
Canton, Ohio	41	32	6	2	-	1	5
Chicago, Ill.	395	259	79	36	12	7	44
Cincinnati, Ohio	89	72	6	7	2	2	4
Cleveland, Ohio	123	84	25	8	2	4	2
Columbus, Ohio	185	125	34	14	6	6	-
Dayton, Ohio	158	107	30	12	7	2	7
Detroit, Mich.	212	136	38	22	8	8	12
Evansville, Ind.	51	39	10	2	-	-	1
Fort Wayne, Ind.	66	48	12	4	1	1	5
Gary, Ind.	16	9	3	3	-	1	-
Grand Rapids, Mich.	79	60	6	6	3	4	12
Indianapolis, Ind.	207	134	42	17	8	6	9
Lansing, Mich.	32	17	9	5	1	-	4
Milwaukee, Wis.	138	98	24	12	3	1	16
Peoria, Ill.	47	39	7	1	-	-	3
Rockford, Ill.	51	39	10	1	-	1	4
South Bend, Ind.	47	38	8	1	-	-	3
Toledo, Ohio	90	66	17	5	-	2	7
Youngstown, Ohio	57	48	5	1	1	2	4
W.N. CENTRAL	792	586	135	45	15	11	70
Des Moines, Iowa	59	46	10	2	-	1	10
Duluth, Minn.	14	12	1	1	-	-	-
Kansas City, Kans.	38	25	7	1	4	1	6
Kansas City, Mo.	104	81	14	3	4	2	10
Lincoln, Nebr.	41	29	8	4	-	-	5
Minneapolis, Minn.	207	152	38	12	2	3	25
Omaha, Nebr.	63	48	12	3	-	-	9
St. Louis, Mo.	96	67	19	7	2	1	2
St. Paul, Minn.	105	83	14	4	1	3	-
Wichita, Kans.	65	43	12	8	2	-	3
S. ATLANTIC	1,270	793	300	116	37	23	83
Atlanta, Ga.	151	80	46	15	7	3	3
Baltimore, Md.	263	154	69	27	9	4	29
Charlotte, N.C.	106	65	24	11	2	4	12
Jacksonville, Fla.	144	92	34	8	6	4	5
Miami, Fla.	111	74	20	12	2	3	10
Norfolk, Va.	48	30	11	5	1	1	-
Richmond, Va.	76	46	17	7	5	-	3
Savannah, Ga.	59	38	16	3	-	2	6
St. Petersburg, Fla.	58	44	12	2	-	-	4
Tampa, Fla.	138	96	28	11	2	1	9
Washington, D.C.	101	59	23	15	3	1	2
Wilmington, Del.	15	15	-	-	-	-	-
E.S. CENTRAL	834	563	180	53	17	19	67
Birmingham, Ala.	203	144	42	8	3	4	19
Chattanooga, Tenn.	56	40	10	3	3	-	4
Knoxville, Tenn.	96	65	22	8	1	-	5
Lexington, Ky.	59	40	13	3	2	1	4
Memphis, Tenn.	179	120	44	9	1	5	16
Mobile, Ala.	84	51	19	7	2	5	4
Montgomery, Ala.	36	28	5	2	1	-	6
Nashville, Tenn.	121	75	25	13	4	4	9
W.S. CENTRAL	1,448	901	291	129	94	30	110
Austin, Tex.	62	45	8	3	3	3	6
Baton Rouge, La.	42	30	8	4	-	-	2
Corpus Christi, Tex.	42	33	3	3	-	3	6
Dallas, Tex.	188	116	45	17	8	2	12
El Paso, Tex.	67	53	10	1	1	1	2
Ft. Worth, Tex.	116	86	26	3	1	-	14
Houston, Tex.	419	222	81	50	59	7	34
Little Rock, Ark.	49	27	13	5	2	2	-
New Orleans, La.	47	18	4	7	13	3	13
San Antonio, Tex.	224	146	48	23	5	2	7
Shreveport, La.	55	39	10	4	2	-	-
Tulsa, Okla.	137	86	35	9	-	7	14
MOUNTAIN	1,005	670	195	73	46	19	52
Albuquerque, N.M.	129	86	25	13	4	1	7
Boise, Idaho	43	32	4	6	-	1	5
Colo. Springs, Colo.	42	29	5	2	3	3	-
Denver, Colo.	104	71	14	9	6	4	4
Las Vegas, Nev.	238	147	68	9	11	2	12
Ogden, Utah	30	21	6	2	1	-	3
Phoenix, Ariz.	152	97	32	11	7	4	6
Pueblo, Colo.	28	20	6	1	1	-	2
Salt Lake City, Utah	103	66	18	10	7	2	6
Tucson, Ariz.	136	101	17	10	6	2	7
PACIFIC	1,767	1,238	336	121	34	35	132
Berkeley, Calif.	12	9	2	-	-	1	1
Fresno, Calif.	113	86	17	7	1	2	14
Glendale, Calif.	19	18	1	-	-	-	-
Honolulu, Hawaii	55	33	17	5	-	-	6
Long Beach, Calif.	74	49	15	8	1	1	10
Los Angeles, Calif.	381	235	83	40	15	8	19
Pasadena, Calif.	16	11	4	-	-	1	1
Portland, Oreg.	133	105	22	4	1	1	6
Sacramento, Calif.	179	129	35	7	5	3	14
San Diego, Calif.	181	129	31	14	2	4	16
San Francisco, Calif.	128	82	29	11	2	4	11
San Jose, Calif.	183	139	29	8	2	5	11
Santa Cruz, Calif.	25	22	1	2	-	-	5
Seattle, Wash.	125	86	23	8	5	3	8
Spokane, Wash.	56	40	12	2	-	2	6
Tacoma, Wash.	87	65	15	5	-	-	4
TOTAL	12,232¶	8,399	2,343	877	362	238	838

U: Unavailable. -:No reported cases.

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

†Pneumonia and influenza.

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

¶Total includes unknown ages.

Notice to Readers

CDC Contract for Additional 9 Million Doses of Influenza Vaccine for the 2000–01 Season

CDC has contracted with Aventis-Pasteur, Inc. (Av-P) for the production of 9 million doses of influenza vaccine for the 2000–01 season. This additional production ensures that approximately the same quantity of influenza vaccine is available for the 2000–01 season as the previous year (*1,2*). The 9 million doses are not intended to substitute for vaccine that is already ordered and expected to be delivered.

For the 1999–2000 influenza season, approximately 77 million doses of influenza vaccine were distributed in the United States, of which 3 million doses were returned to the manufacturers. For the 2000–2001 influenza season, distribution of approximately 75 million doses is anticipated, including the 9 million doses contracted by CDC.

Av-P will give first priority to orders from providers who plan to vaccinate primarily high-risk persons. Applications for vaccine orders from health-care providers and programs should be sent directly to Av-P beginning November 3, 2000. Wholesale distributors can apply to purchase vaccine starting December 4, 2000, if doses remain available. Once an application has been received by Av-P, notification regarding order acceptance will be provided to the applicant before mid-December. Delivery of vaccine is anticipated to begin December 12, 2000, and end by early January 2001.

Additional information about the application process and vaccine availability is available through Av-P, telephone (800) 720-8972, or World-Wide Web, http://www.vaccineshoppe.com (click on Fluzone® Application Form link). Completed application forms can be faxed to (888) 889-7129. Orders for this vaccine will not be taken by telephone.

CDC's National Immunization Program (NIP) has developed an "Influenza Vaccine Availability" website that will provide information about the availability of influenza vaccine from manufacturers and wholesale distributors and will list state health departments that may have information about vaccine availability among local providers. This website will be updated weekly. The website can be accessed at http://www.cdc.gov/nip/flu-vac-supply. The updated ACIP recommendations for influenza vaccine for the 2000–01 season and other influenza-related information can be accessed at http://www.cdc.gov/ncidod/diseases/flu/fluvirus.htm. Additional information and assistance can be obtained by contacting NIP by e-mail, nipinfo@cdc.gov, or by telephone, (800) 232-2522.

References

1. CDC. Updated recommendations from the Advisory Committee on Immunization Practices in response to delays in supply of influenza vaccine for the 2000-01 season. MMWR 2000;49:888–92.
2. CDC. Delayed supply of influenza vaccine and adjunct ACIP influenza vaccine recommendations for the 2000–01 influenza season. MMWR 2000;49:619–22.

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