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WEEKLY REPORT

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World AIDS Day — December 1, 2000

"All Men—Make a Difference!" is the theme designated by the Joint United Nations Program on Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) for this year's World AIDS Day, December 1, 2000. This year's theme encourages men to increase their awareness of the risk for HIV infection for themselves, their sex partners, and their families and to use their influence to help stem the HIV/AIDS epidemic. In the United States, most persons living with HIV infection and AIDS are men. Some men's behavior often places their sex partners at risk for infection. In cultures where there is a substantial imbalance in men's and women's social power, focusing prevention efforts on men is an essential step toward reducing HIV transmission.

As of June 2000, AIDS was reported among 753,907 persons in the United States, and 438,795 of these persons have died; an estimated 311,701 persons were reported to be living with AIDS (*1*). Although deaths from AIDS began to decline in the United States in 1996, primarily because of the use of effective combination antiretroviral therapy, AIDS deaths and AIDS incidence trends began to level by 1999 (*2*). Since 1992, HIV incidence in the United States has been relatively stable; an estimated 40,000 new HIV infections are expected to occur each year. Prevalence of HIV infection (number of persons living with HIV and AIDS) at the end of 1998 ranged from 800,000–900,000. Among these persons, approximately one third do not know they are infected with HIV (*2*). In addition, approximately 4% of the U.S. population (approximately 4–5 million persons) engage in behaviors that put them at high risk for HIV infection (*3*).

Worldwide, 36.1 million adults are living with HIV/AIDS; of these, 5.3 million became infected in 2000 (*4*). Of the approximately 21.8 million persons who have died from AIDS, 3.0 million died in 2000. Of all persons living with HIV, 90.0% live in sub-Saharan Africa, southeast Asia, or Latin America (*4*).

Additional information about World AIDS Day and HIV infection and AIDS is available from CDC's National Prevention Information Network, telephone (800) 458-5231, and on the World-Wide Web, http://www.cdcnpin.org; CDC's National AIDS and STD hotline, telephone (800) 342-2437; and CDC's Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention World-Wide Web site, http://www.cdc.gov/hiv/dhap.htm.

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HIV-Related Knowledge and Stigma — United States, 2000

An essential component of efforts to prevent new human immunodeficiency virus (HIV) infections in the United States is the use of voluntary HIV counseling and testing by persons at risk for HIV, especially members of underserved populations (*1*). To increase the number of persons at risk for HIV who receive voluntary HIV counseling and testing services, barriers to these services must be identified and removed. The stigmatization of persons infected with HIV and the groups most affected by HIV, including men who have sex with men and illicit drug users, is a barrier to testing (*2,3*). Measuring public attitudes and knowledge about HIV transmission to determine the prevalence and the correlates of stigmatizing attitudes is important for guiding efforts to remove barriers to HIV prevention. This report describes the results of a national public opinion survey conducted through the Internet to measure indicators of HIV-related stigma and knowledge of HIV transmission. The findings indicate that most persons do not have stigmatizing views.

During August–September 2000, Research Triangle Institute conducted an Internet-based, household survey in a sample of 7493 adults aged ≥18 years. The sample was proportionately selected from a nationally representative panel of approximately 45,000 households. To establish the panel, a sample of U.S. households obtained through random-digit–dialed telephone sampling was offered Internet access and equipment in exchange for participation in weekly surveys. Surveys were conducted using a standard television set connected to the Internet, and responses were entered using a remote control. A module on HIV-related stigma and knowledge of transmission was included in a larger survey on health and aging. This analysis is based on 5641 respondents (75.3%) who answered the question on HIV stigma.

The survey included one question that was considered a proxy indicator for a stigmatizing attitude. Participants were identified who strongly agreed or agreed with the statement "People who got AIDS [acquired immunodeficiency syndrome] through sex or drug use have gotten what they deserve." Although this question addresses only one element of HIV/AIDS stigma, for this report, these answers were considered a "stigmatizing" response. Two questions concerned knowledge about HIV transmission. Persons who responded that it was very unlikely or impossible to become infected through sharing a glass or being coughed or sneezed on were considered informed; those who stated that it was very likely, somewhat likely, or somewhat unlikely were classified as misinformed. Percentage estimates were weighted to provide representative estimates, and confidence intervals (CIs) and p-values were computed using SUDAAN.

Among the 5641 respondents, 40.2% (95% CI=38.8%–41.6%) responded that HIV transmission could occur (i.e., it was very likely, somewhat likely, or somewhat unlikely) through sharing a glass, and 41.1% (CI=39.7%–42.5%) responded that it could occur from being coughed or sneezed on by an HIV-infected person. A total of 18.7% responded that persons who acquired AIDS through sex or drug use have gotten what they deserve. Stigmatizing responses were more common among men (21.5%), whites (20.8%), persons aged ≥55 years (30.0%), those with only a high school education (22.1%), those with an income <$30,000 (23.4%), and those in poorer health compared with others (23.6%) (Table 1). For both transmission questions, approximately 25% of those who were misinformed gave stigmatizing responses, compared with approximately 14% who were informed ($p<0.05$).

HIV-Related Knowledge — Continued

TABLE 1. Percentage of respondents who gave stigmatizing response*, by demographic characteristics and knowledge of modes of HIV transmission — United States, 2000

Characteristic	No.†	(%)	(95% CI§)
Sex			
Male	2631	(21.5)	(19.7%–23.2%)
Female	2779	(15.9)	(14.4%–17.4%)
Race/Ethnicity			
White, non-Hispanic	4146	(20.8)	(19.4%–22.1%)
Black, non-Hispanic	557	(7.0)	(4.7%– 9.4%)
Hispanic	498	(11.2)	(8.1%–14.3%)
Other¶	243	(27.9)	(21.7%–34.2%)
Age group (yrs)			
18–24	571	(15.5)	(12.1%–18.8%)
25–29	522	(11.4)	(8.4%–14.3%)
30–34	583	(13.0)	(10.0%–16.0%)
35–39	652	(15.6)	(12.5%–18.6%)
40–44	659	(13.8)	(10.9%–16.8%)
45–49	630	(17.3)	(14.0%–20.6%)
50–54	533	(15.6)	(12.2%–19.0%)
55–64	582	(21.9)	(18.2%–25.6%)
≥65	902	(35.2)	(31.7%–38.7%)
Education			
<High school	504	(23.4)	(19.2%–27.5%)
High school	1732	(21.7)	(19.5%–23.8%)
Some college	1906	(16.8)	(14.9%–18.7%)
Bachelor's degree	1000	(15.4)	(12.9%–17.9%)
Graduate degree	465	(17.7)	(13.9%–21.6%)
Income level			
<$20,000	598	(21.8)	(18.0%–25.5%)
$20,000–$29,999	570	(25.0)	(21.0%–29.0%)
$30,000–$39,999	777	(18.0)	(15.0%–21.0%)
$40,000–$49,999	713	(18.4)	(15.3%–21.6%)
$50,000–$74,999	1342	(16.6)	(14.4%–18.8%)
≥$75,000	834	(18.0)	(15.0%–20.9%)
Health status			
Excellent	1065	(17.5)	(15.0%–20.1%)
Very good	2093	(18.8)	(16.9%–20.6%)
Good	1777	(17.3)	(15.4%–19.3%)
Fair or poor	694	(23.6)	(20.0%–27.2%)
Region**			
Northeast	924	(18.1)	(15.4%–20.9%)
Midwest	1177	(19.9)	(17.3%–22.5%)
South	1836	(17.9)	(16.0%–19.9%)
West	1295	(19.0)	(16.6%–21.4%)
Transmission knowledge			
Sharing a drink			
Misinformed††	2269	(25.1)	(23.1%–27.1%)
Informed§§	3355	(14.4)	(13.0%–15.7%)
Cough or sneeze			
Misinformed	2307	(25.4)	(23.4%–27.4%)
Informed	3318	(14.0)	(12.6%–15.3%)
Total	**5641**	**(18.7)**	**(17.5%–19.8%)**

* Persons who strongly agreed or agreed with the statement, "People who get AIDS through sex or drug use have gotten what they deserve."

† Numbers differ because of item nonresponse. Chi-square tests indicated significant differences ($p<0.05$) among categories for each variable except region.

§ Confidence interval.

¶ Numbers for races/ethnicities other than black, white, and Hispanic were combined because, when analyzed separately, data were too small for meaningful analysis.

** *Northeast*=Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont; *Midwest*=Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin; *South*=Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia; *West*=Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming.

†† Transmission is very likely, somewhat likely, or somewhat unlikely.

§§ Transmission is very unlikely or impossible.

HIV-Related Knowledge — Continued

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Editorial Note: The findings in this report suggest that most U.S. adults do not hold stigmatizing views about persons with HIV infection or AIDS. However, a substantial minority gave a response that suggests they may have stigmatizing attitudes about persons with HIV. The smallest proportion of respondents who gave this response was black, the racial/ethnic group with the highest rates of AIDS in the United States. Significantly more of the respondents who were misinformed about HIV transmission gave a stigmatizing response, suggesting that increasing understanding about behaviors related to HIV transmission may result in lower levels of stigmatizing beliefs about infected persons. However, many other factors are probably related to stigma.

Early HIV diagnosis and entry into health care have both individual and societal benefits: improved health and productivity, reduced hospitalization costs, and decreased transmission from persons who do not know their HIV status (*1*). Because most HIV-infected persons probably will adopt safer sexual behaviors after the diagnosis of HIV infection (*4,5*), increasing the number of infected persons who know their serostatus is an important prevention goal. However, HIV-infected persons who fear being stigmatized are typically reluctant to acknowledge risk behaviors, avoid seeking prevention information, and may experience real or perceived barriers to prevention and other health-care services (*2,3*). Therefore, public health measures that encourage access to HIV testing by reducing stigma (e.g., social marketing campaigns targeted to high risk, stigmatized populations; sexuality and cultural sensitivity training for health-care providers; and anonymous testing opportunities) strengthen HIV-prevention efforts.

The findings in this report are subject to at least two limitations. First, the results are based on only one question about stigma, which comprises a range of attitudes, beliefs, and behaviors. Second, the survey did not include persons who do not own a telephone, persons in institutions, the transient or homeless, and those living on military installations. Despite these limitations, the sampling methods eliminated the main bias in earlier Internet samples (i.e., a lack of universal access to the Internet) while preserving the advantages of Internet surveys. In addition, the panel closely matched the overall U.S. population with respect to age, race/ethnicity, sex, education, and income.

Stigma includes prejudice and active discrimination directed toward persons either perceived to be or actually infected with HIV and the social groups and persons with whom they are associated (*3*). Overcoming stigma is an important step in persons seeking to know their HIV status. Measurements such as those conducted in this study help to direct and assess efforts to overcome these barriers.

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Outbreak of Rift Valley Fever — Yemen, August–October 2000

On September 17, 2000, the Ministry of Agriculture and Irrigation (MAI) and Ministry of Health (MOH) of Yemen received reports about the occurrence of disease compatible with Rift Valley fever (RVF) in El Zuhrah district of Hodeidah governorate. Reports of animal disease included abortions and deaths in young animals. Surveillance efforts by MOH and MAI documented widespread disease among humans and animals in the area of Wadi Mawr in El Zuhrah district, which is located on a coastal plain that extends from the southern tip of Yemen into the Jizan area of the Kingdom of Saudi Arabia (KSA). The Saudi Arabian Ministry of Health has described a simultaneous outbreak of RVF in the Jizan area in KSA (*1,2*). This report summarizes the investigation of the Yemen outbreak.

MAI and MOH responded to the epidemic by organizing a national effort to limit spread of disease, optimize management of affected persons, and track the course of the outbreak. The World Health Organization (WHO) provided technical assistance, including experts in virology, epidemiology, laboratory diagnostics, and entomology.

Disease in humans. Because most patients in the outbreak area do not seek health care in medical facilities, mobile surveillance teams traveled to villages to interview case-patients or animal owners about recent illness in the community. Initial case finding was focused among villages in Wadi Mawr and was expanded to include areas throughout the coastal plain. The WHO case definition for disease in humans was used (*3*). During August 7–November 7, 2000, 1087 suspected case-patients were identified, including 121 (11%) persons who died. The mean age of suspected case-patients was 32.2 years (range: 1 month–95 years). The clinical spectrum of disease was typical of that associated with RVF and includes patients with hemorrhagic disease, encephalitis, retinitis, and uncomplicated RVF. Of the 1087, 815 (75%) case-patients reported exposure to sick animals, handling an abortus, or slaughtering animals in the week before onset of illness. Of 490 case-patients with serologic testing, 136 (26%) had IgM-class antibody to RVF virus; 17 (3%) patients had weakly reactive serologic test results. Serologically confirmed disease transmission was detected in 15 districts throughout the coastal plain and adjacent mountains.

Disease in animals. To assess the extent of transmission in animals, cross-sectional surveys were conducted in late September in diverse areas throughout Yemen. These surveys detected a high prevalence of IgM-class antibody to RVF in numerous areas in the northern part of the coastal plain and adjacent mountains. Little evidence exists of RVF transmission south of Marawah. Since that time, transmission has been detected in animals and humans in areas to the south.

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Rift Valley Fever — Continued

Editorial Note: The outbreak described in this report coincides with an ongoing outbreak of RVF in KSA that together represent the first documented evidence of RVF virus transmission outside Africa. RNA sequencing of the virus from KSA indicates that it is similar to the RVF viruses isolated from East Africa in 1998 (*1*).

It is unclear whether there was a recent introduction of RVF virus into the Arabian peninsula or the emergence of an epidemic resulting from unique ecologic conditions. RVF virus may have been introduced into Yemen in 1998 and environmental factors may be promoting wide-scale disease occurrence.

Satellite images and aerial surveys reveal numerous areas throughout the coastal plain and adjacent mountains that would be conducive for transmission of RVF virus. The geographic distribution of disease hampered surveillance efforts and presents a challenge for disease-control efforts. Outbreak-control measures included vector-control (i.e., outdoor and indoor thermal fogging and larviciding and residual house spraying), restricting animal movement, preventing exposure to infected animals or abortuses through educational campaigns, and upgrading local hospitals to optimize treatment of infected patients. Entomologic studies are ongoing to evaluate and guide vector-control operations. Impregnated mosquito bed nets also have been distributed in the affected areas.

Despite intensive vector-control measures, transmission continues to occur in selected areas. The finding that most patients had direct contact with infected animals emphasizes the importance of health education to prevent transmission through this route. Cross-sectional surveys are ongoing to evaluate the severity of disease and to target and evaluate control efforts.

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Declines in Lung Cancer Rates — California, 1988–1997

Cigarette smoking is the leading cause of lung and bronchus cancer (*1*). During 1988–1997, per capita cigarette smoking in California declined more than twice as rapidly compared with the rest of the country (*2*). To characterize lung cancer incidence in California, data from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) program were compared with data from the population-based California Cancer Registry (CCR). This report summarizes the results of that analysis, which indicated that during 1988–1997, age-adjusted lung cancer incidence rates in California declined significantly compared with stable incidence rates for the combined SEER area of five states and three metropolitan areas.

SEER data used in the analysis were from Connecticut, Hawaii, Iowa, New Mexico, and Utah, and Atlanta, Georgia; Detroit, Michigan; and Seattle–Puget Sound, Washington (*3*). SEER registries in California were excluded from the SEER analysis and were included with the CCR data. CCR data were statewide; SEER data collected in California included Los Angeles and the San Francisco Bay area only. Data collection standards for SEER and CCR were similar. However, CCR had more data than the SEER California

Lung Cancer Rates — Continued

component; therefore, the combined CCR and SEER data provided a more reliable estimate of cancer rates than using the California SEER data alone.

Cancer incidence rates were age-adjusted by the direct method based on estimated 2000 U.S. population data (*3*). Annual lung and bronchus cancer (*International Classification of Diseases, for Oncology*, codes C340–C349) incidence rates per 100,000 population during 1988–1997 were reported among men, women, and both sexes combined for California and the eight SEER regions combined (Table 1). Two measures of change were reported. First, the estimated annual percentage change (EAPC) was calculated using the average percentage increase or decrease in cancer incidence rates per year during 1988–1997, and a regression line was fitted using the assumption that the natural logarithm of cancer rates changed at a constant rate during the 10-year period. Second, the total percentage change was the average of 1988 and 1989 data minus the average of 1996 and 1997 data divided by 1988 and 1989 data and multiplied by 100. Statistical significance was set at alpha=0.01 (Figure 1).

Non-California SEER data did not reveal a consistent pattern in the age-adjusted lung and bronchus cancer incidence rates during 1988–1997. EAPC of –0.4% per year was not significantly different from zero. Comparing the CCR incidence rates with non-California SEER incidence rates, the CCR lung and bronchus cancer incidence rates were slightly higher during 1988–1990 (Table 1). However, during 1991–1997, incidence rates in CCR declined from 68.0 per 100,000 to 60.1. During 1988–1997, overall lung and bronchus cancer CCR incidence rates decreased an average of 1.9% per year ($p<0.01$) (Figure 1). The CCR incidence rates decreased 14.0% during the 10-year period; the rates in non-California SEER regions decreased 2.7%.

The decline in incidence rates among men (all ages combined) in the CCR data was 1.5 times greater than the decline among men in the non-California SEER regions. Among men, lung and bronchus cancer incidence rates declined significantly during 1988–1997 in data from the CCR and the SEER regions; however, the decline was greater in CCR (EAPC=–2.9%; $p<0.01$) compared with non-California SEER regions (EAPC=–1.8%; $p<0.01$). Among women (all ages combined) in CCR, lung and bronchus cancer incidence rates declined 4.8% during 1988–1997 (EAPC=–0.6; $p<0.01$); incidence rates among women in non-California SEER regions increased 13.2% (EAPC=1.5; $p<0.01$).

TABLE 1. Age-adjusted lung and bronchus cancer incidence rates* — California Cancer Registry (CCR) and Surveillance, Epidemiology, and End Results (SEER) program (excluding California)†, 1988–1997

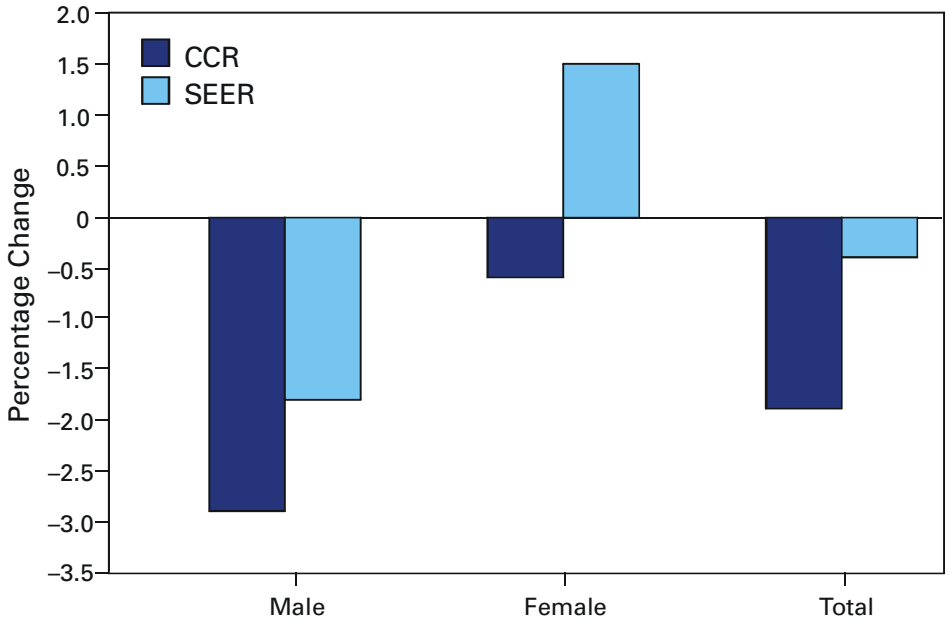
	CCR			SEER		
Year	Male	Female	Total	Male	Female	Total
1988	98.8	52.6	**71.9**	100.5	44.5	**67.7**
1989	96.4	52.0	**70.3**	98.4	44.8	**67.1**
1990	95.8	52.3	**70.2**	98.3	46.7	**68.0**
1991	91.2	51.5	**68.0**	99.0	48.8	**69.5**
1992	88.6	52.0	**67.3**	98.9	49.0	**69.7**
1993	85.6	51.8	**65.9**	95.6	48.8	**68.3**
1994	83.7	50.6	**64.4**	92.4	50.0	**67.6**
1995	83.2	50.8	**64.4**	89.9	50.0	**66.8**
1996	78.6	50.4	**62.2**	88.0	50.9	**66.5**
1997	74.9	49.1	**60.1**	84.9	50.1	**64.7**

* Per 100,000 population.

† Includes Connecticut, Hawaii, Iowa, New Mexico, and Utah, and Atlanta, Georgia; Detroit, Michigan; and Seattle–Puget Sound, Washington; August 1998.

Lung Cancer Rates — Continued

FIGURE 1. Estimated annual percentage change* in age-adjusted lung and bronchus cancer incidence rates — California Cancer Registry (CCR) and Surveillance, Epidemiology, and End Results (SEER) (excluding California)†, 1988–1997



*All changes significantly different from zero ($p<0.01$) except SEER total.
† Includes Connecticut, Hawaii, Iowa, New Mexico, and Utah, and Atlanta, Georgia; Detroit, Michigan; and Seattle–Puget Sound, Washington.

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Editorial Note: More than 80% of lung and bronchus cancer is caused by cigarette smoking, and former smokers have about half the risk for dying from lung cancer than do current smokers (*1*). Compared with current smokers, the risk for lung and bronchus cancer among former smokers declines as the duration of abstinence lengthens, with risk reduction becoming evident within 5 years of cessation (*1*). Reductions in the smoking rate in a state could reduce lung and bronchus cancer rates within 5 years of the decline in smoking rates (*1*).

The difference in the rate of decline in lung and bronchus cancer incidence rates between California and other U.S. regions may be related, in part, to the significant declines in smoking rates as a result of California tobacco control initiatives. The California Tobacco Control Program was created by Proposition 99 and was approved in 1988 (*2*). The program emphasized a comprehensive approach to tobacco control, prevention, and education and included strategies to change social norms related to tobacco use. The decrease in per capita cigarette consumption that began in 1990 has been

Lung Cancer Rates — Continued

attributed to the $0.25 increase in the excise tax in 1989 (*2*). During 1988–1996, California had a more rapid decline in per capita cigarette consumption compared with the rest of the country (*2,4*). This decline has been attributed primarily to a change in the social acceptability of smoking among California residents (*2,4*). However, smoking rates in California were declining more rapidly than the rest of the country since the late 1980s, before enactment of Proposition 99.

The findings in this study are subject to at least three limitations. First, the SEER cancer incidence rates are based on data from selected geographic areas and may not represent incidence rates nationally; SEER data in this analysis represent 9.5% of the U.S. population (excluding California). Second, although a constant rate of change over the study period is the standard assumption when using EAPC, this assumption has not been tested (*3*). Third, although decreased population smoking rates in California are probably responsible for reduced rates of lung and bronchus cancer, a cause-and-effort relation cannot be determined through population-based assessments.

Following the California model, aggressive and comprehensive tobacco-control programs have been implemented in other states, including Arizona, Florida, Maine, Massachusetts, and Oregon. Initial results from several states have shown substantial declines in per capita cigarette consumption and/or changes in the prevalence of adult or youth smoking rates (*4–8*). The results of this report suggest that a comprehensive tobacco prevention and education program also may reduce rates of lung and bronchus cancer.

On the basis of results from state programs, CDC published *Best Practices for Comprehensive Tobacco Control* (*9*). This document, along with the release of *Surgeon General's Report, Reducing Tobacco Use: A Report of the Surgeon General* (*10*), provides guidance to states in establishing successful and sustainable tobacco control programs.

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Public Health Dispatch

Outbreak of Poliomyelitis — Cape Verde, 2000

During August 16–October 17, 2000, 33 cases of acute flaccid paralysis (AFP), including seven (21%) deaths, were reported in Cape Verde, an archipelago of 10 islands west of Senegal and Mauritania. Preliminary laboratory results identified wild type 1 poliovirus among eight cases. The first patient was a child aged 2 years from the capital city of Praia; paralysis onset occurred August 16. The child had received one dose of the recommended three doses of oral poliovirus vaccine (OPV). Twenty-two cases were reported from the island of Santiago, seven from Sal, three from San Vincente, and one from Maio. The ages of the AFP patients ranged from 3 months–38 years; 11 (33%) were aged <5 years, 15 (46%) were 5–14 years, and seven (21%) were ≥15 years. No deaths were reported among patients aged <5 years. Three deaths (case fatality rate [CFR]: 20%) occurred among patients aged 5–14 years and four deaths occurred among patients aged ≥15 years (CFR: 57%). Of 33 cases with known vaccination status, 13 (39%) were fully vaccinated.

The estimated population of Cape Verde in 2000 was 437,500 (World Health Organization [WHO], unpublished data, 2000). Reported routine vaccination coverage with three doses of OPV has been <80% every year since 1995. The country has not conducted mass vaccination campaigns against poliomyelitis and has not established AFP surveillance. In response to the outbreak, a mass vaccination campaign was initiated October 16 with the goal of vaccinating every child aged 0–59 months with two OPV doses. Investigations by the Cape Verde Ministry of Health and WHO are under way to determine the circumstances associated with the outbreak, whether the outbreak has spread to other territories such as the neighboring countries of West Africa, and whether additional interventions will be required to control the outbreak, including a mass campaign targeting persons aged 5–14 years.

Travelers to Cape Verde and West Africa who are not vaccinated adequately must be considered at risk for polio. Recommendations for children in the United States include a four-dose vaccination series with inactivated poliovirus vaccine (IPV) at ages 2, 4, and 6–18 months, and 4–6 years. Unvaccinated adults should receive three doses of IPV, the first two doses at 4–8 week intervals and the third dose 6–12 months after the second. If three doses cannot be administered within the recommended intervals before protection is needed, alternative schedules are proposed (*1*). For incompletely vaccinated persons, additional IPV doses are recommended to complete a series. Booster IPV doses should be considered for persons who have completed a primary series of poliovirus vaccination and who may be traveling to areas where poliomyelitis is endemic.

Reported by: Ministry of Health, Country Office, Praia, Cape Verde; Intercountry Office for West Africa, Abidjan, Cote d'Ivoire; Intercountry Office for Southern Africa and Regional Office for Africa, Harare, Zimbabwe. Institute Pasteur, Dakar, Senegal. National Institute of Virology, Johannesburg, South Africa. Vaccines and Other Biologicals Dept, World Health Organization, Geneva, Switzerland. Div of Quarantine and Respiratory and Enteric Viruses Br, Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Vaccine Preventable Disease Eradication Div, National Immunization Program, CDC.

Reference

1. CDC. Poliomyelitis prevention in the United States: updated recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2000;49(no. RR-5).

Notice to Readers

Alcohol Involvement in Fatal Motor-Vehicle Crashes — United States, 1998–1999

The following table compares alcohol involvement in fatal motor-vehicle crashes by age group and blood alcohol concentration (BAC) levels for 1998 and 1999. A fatal crash is considered alcohol-related by the National Highway Traffic Safety Administration (NHTSA) if either a driver or nonoccupant (e.g., pedestrian) had a BAC of ≥0.01 g/dL in a police-reported traffic crash. Because BACs are not available for all persons in fatal crashes, NHTSA estimates the number of alcohol-related traffic fatalities on the basis of a discriminant analysis of information from all cases for which driver or nonoccupant BAC data are available (*1*).

From 1998 to 1999, the number of alcohol-related traffic fatalities decreased 1.5% (95% confidence interval [CI]=–3.6%–0.7%). For BACs ≥0.10 g/dL (the legal limit for intoxication in most states), fatalities decreased 1.4% (95% CI=–3.8%–1.1%), and for BACs of 0.01–0.09 g/dL, fatalities decreased 1.7% (95% CI=–2.9%–1.6%).

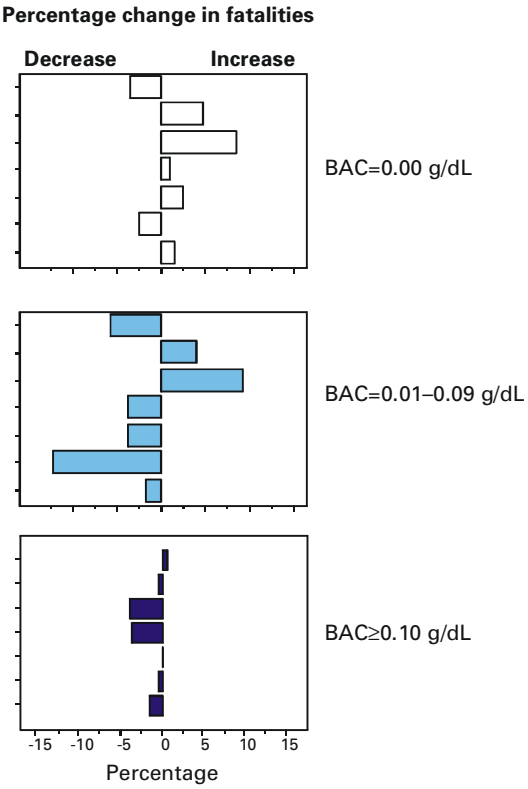
Reference

1. Klein TM. A method for estimating posterior BAC distributions for persons involved in fatal traffic accidents: final report. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, 1986; report no. DOT-HS-807-094.

Alcohol Involvement in Fatal Motor-Vehicle Crashes — Continued

Changes in the estimated number and percentage of traffic fatalities (including drivers, occupants, and nonoccupants), by age group* and highest blood alcohol concentration (BAC)† of drivers§ or nonoccupants in crashes — United States, January 1–December 31, 1998 compared with January 1–December 31, 1999

Age group (yrs)	No. fatalities 1998	1999
<15	2,034	1,962
15–20¶	3,953	4,136
21–24¶	1,639	1,777
25–34	3,182	3,214
35–64	8,371	8,578
>65	6,250	6,098
Total**	**25,481**	**25,825**
<15	191	180
15–20	650	676
21–24	417	455
25–34	676	651
35–64	1,203	1,158
>65	384	337
Total**	**3,526**	**3,466**
<15	330	332
15–20	1,568	1,563
21–24	1,721	1,652
25–34	3,065	2,956
35–64	5,121	5,126
>65	655	653
Total**	**12,494**	**12,321**



* Age of decedent was unknown for 91 traffic fatalities in 1998 and 109 in 1999. Decedents of unknown age were included in the calculations of the total number of fatalities by BAC level.

† BAC distributions are estimates for drivers and nonoccupants involved in fatal crashes. Fatalities include all occupants and nonoccupants who died within 30 days after a motor-vehicle crash on a public roadway.

§ Driver may or may not have been killed.

¶ Percentage change statistically significant at p=0.05.

** The number of fatalities for each BAC category is rounded to the nearest whole number.

Source: Fatality Analysis Reporting System, National Highway Traffic Safety Administration.

National Drunk and Drugged Driving Prevention Month — December 2000

December has been designated National Drunk and Drugged Driving Prevention Month by the National Drunk and Drugged Driving Prevention Month Coalition, a national public-private partnership devoted to preventing impaired driving crashes. During 1999, alcohol-related motor-vehicle crashes resulted in an estimated 15,786 deaths in the United States (National Highway Traffic Safety Administration [NHTSA], unpublished data, October 2000). On the basis of data provided by NHTSA and the U.S. Bureau of the Census, the rate of alcohol-related motor-vehicle deaths steadily declined from 8.9 to 5.8 per 100,000 persons during 1990–1999 (NHTSA, unpublished data, October 2000) (*1,2*). The 1999 rate nearly met the national health objective for 2000 of no more than 5.5 deaths per 100,000 persons (*3*). The *Healthy People 2010: Health Objectives for the Nation* has set a target for alcohol-related traffic fatalities of no more than 4.0 per 100,000 persons (*4*). Meeting the 2010 objective will require a further decrease of 31% in the rate of alcohol-related traffic fatalities.

The passage of the national 0.08% blood alcohol concentration standard for impaired driving (*5*) represents an important step toward reducing alcohol-related traffic fatalities. Other strategies include strict enforcement of impaired driving and minimum legal drinking age laws, sobriety checkpoints, and prompt suspension of licenses for persons arrested for driving while impaired (*6*).

Additional information about National Drunk and Drugged Driving Prevention Month is available from the National Commission Against Drunk Driving, 1900 L Street, NW, Suite 705, Washington, DC 20036; telephone, (202) 452-6004; or World-Wide Web site, http://www.3dmonth.org*.

References

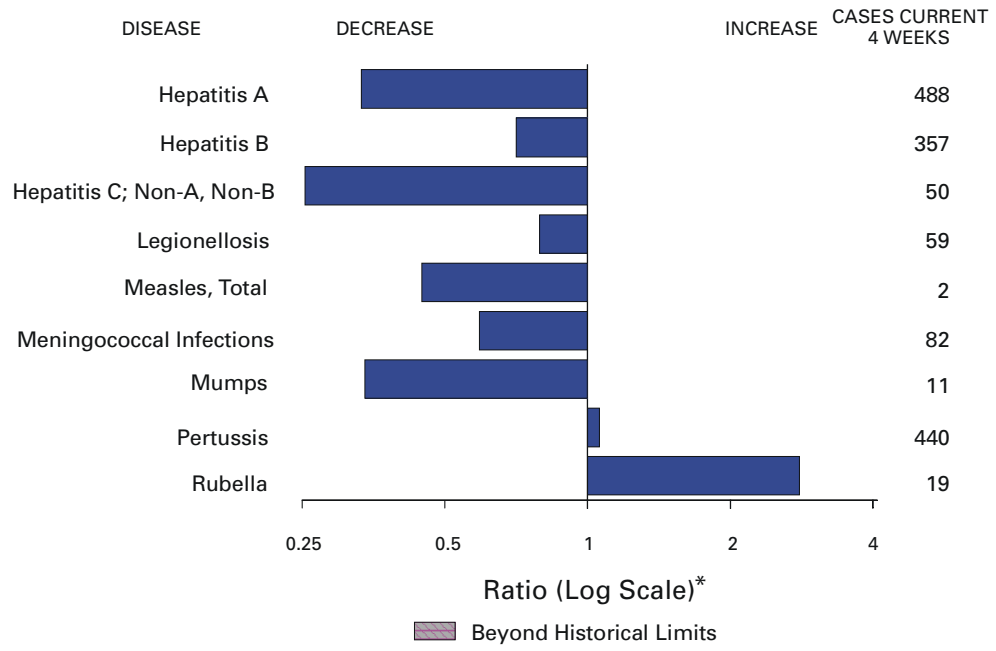
1. National Highway Traffic Safety Administration. Traffic safety facts 1998: a compilation of motor vehicle crash data for the Fatality Analysis Reporting System and the General Estimates System. Washington, DC: US Department of Transportation, National Highway Traffic Safety Administration, National Center for Statistics and Analysis, 1999; report no. DOT-HS-808-983.
2. Bureau of the Census, Economics and Statistics Administration, US Department of Commerce. IDB data access-display mode. Available at http://www.census.gov/population/www/estimates/popest.html. Accessed November 2000.
3. National Center for Health Statistics. Healthy people 2000 review, 1998–99. Hyattsville, Maryland: US Department of Health and Human Services, CDC, 1996.
4. US Department of Health and Human Services. Healthy people 2010 (conference ed, 2 vols). Washington, DC: US Department of Health and Human Services, January 2000.
5. Department of Transportation and Related Agencies Appropriations Act, 2001, Public Law no. 106-346 (October 23, 2000).
6. DeJong W, Hingson R. Strategies to reduce driving under the influence of alcohol. Annu Rev Public Health 1998;19:359–78.

*References to sites of non-CDC organizations on the World-Wide Web 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 found at these sites.

Erratum: Vol. 49, No. RR-13

In the *MMWR Recommendations and Reports,* "Use of Diphtheria Toxoid-Tetanus Toxoid-Acellular Pertussis Vaccine as a Five-Dose Series: Supplemental Recommendations of the Advisory Committee on Immunization Practices (ACIP)," the table on page 2 is incorrect regarding the pertussis antigens contained in ACEL-IMUNE.® ACEL-IMUNE contains *inactivated pertussis toxin, 3.2 µg; filamentous hemagglutinin, 34 µg; pertactin, 1.6 µg; and type 2 fimbriae, 0.8 µg*. All amounts are approximate.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending November 25, 2000, with historical data



* 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 November 25, 2000 (47th Week)

	Cum. 2000		Cum. 2000
Anthrax	-	Poliomyelitis, paralytic	-
Brucellosis*	58	Psittacosis*	10
Cholera	2	Q fever*	21
Cyclosporiasis*	38	Rabies, human	1
Diphtheria	2	Rocky Mountain spotted fever (RMSF)	397
Ehrlichiosis: human granulocytic (HGE)*	167	Rubella, congenital syndrome	6
human monocytic (HME)*	93	Streptococcal disease, invasive, group A	2,517
Encephalitis: California serogroup viral*	102	Streptococcal toxic-shock syndrome*	67
eastern equine*	2	Syphilis, congenital¶	175
St. Louis*	3	Tetanus	24
western equine*	-	Toxic-shock syndrome	120
Hansen disease (leprosy)*	58	Trichinosis	14
Hantavirus pulmonary syndrome*†	27	Tularemia*	108
Hemolytic uremic syndrome, postdiarrheal*	176	Typhoid fever	298
HIV infection, pediatric*§	190	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 October 29, 2000.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2000, and November 27, 1999 (47th 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	33,120	38,849	582,183	590,780	2,411	2,440	4,124	3,465	3,007	2,583
NEW ENGLAND	1,699	1,998	18,993	19,008	101	175	370	390	356	356
Maine	28	68	1,309	932	20	27	31	36	28	-
N.H.	29	46	909	887	22	17	36	34	35	33
Vt.	32	16	476	435	26	35	33	32	33	20
Mass.	1,061	1,318	7,923	8,065	30	68	158	171	162	183
R.I.	84	90	2,294	2,108	3	6	18	27	16	26
Conn.	465	460	6,082	6,581	-	22	94	90	82	94
MID. ATLANTIC	7,189	10,137	52,515	59,370	173	547	387	347	266	134
Upstate N.Y.	694	1,192	N	N	119	155	280	273	62	5
N.Y. City	3,765	5,371	22,457	24,465	11	233	10	17	11	17
N.J.	1,461	1,845	7,436	11,159	12	44	97	57	106	64
Pa.	1,269	1,729	22,622	23,746	31	115	N	N	87	48
E.N. CENTRAL	3,190	2,603	94,932	99,750	770	611	954	941	562	508
Ohio	489	437	23,019	26,575	254	63	259	233	209	214
Ind.	324	282	11,481	10,887	57	39	131	95	81	64
Ill.	1,597	1,202	25,538	29,389	7	87	182	493	14	85
Mich.	604	550	22,910	20,484	94	49	135	120	104	80
Wis.	176	132	11,984	12,415	358	373	247	N	154	65
W.N. CENTRAL	767	865	32,183	34,177	351	195	647	506	555	530
Minn.	153	159	6,644	6,821	132	74	198	165	177	181
Iowa	75	70	4,294	4,445	75	55	181	106	143	78
Mo.	349	410	10,486	12,149	29	25	106	43	96	64
N. Dak.	2	6	677	841	15	18	19	16	20	18
S. Dak.	7	13	1,647	1,395	15	7	55	45	58	62
Nebr.	65	58	3,260	3,090	76	14	62	101	45	112
Kans.	116	149	5,175	5,436	9	2	26	30	16	15
S. ATLANTIC	9,203	10,705	114,132	125,244	449	357	354	314	264	178
Del.	183	146	2,587	2,515	6	-	1	6	1	3
Md.	1,131	1,322	11,648	11,899	10	17	30	41	1	4
D.C.	695	493	2,920	N	18	7	1	1	U	U
Va.	598	752	14,053	12,953	17	27	71	71	60	57
W. Va.	56	61	1,442	1,648	3	3	15	14	13	9
N.C.	609	692	19,766	19,884	25	27	87	71	65	52
S.C.	703	899	8,746	17,021	-	-	21	19	14	14
Ga.	1,050	1,466	23,675	30,423	164	128	41	30	36	1
Fla.	4,178	4,874	29,295	28,901	206	148	87	61	74	38
E.S. CENTRAL	1,644	1,717	43,814	41,209	46	34	126	134	99	102
Ky.	169	242	7,248	6,714	6	7	43	47	31	34
Tenn.	706	671	13,313	12,854	11	10	53	55	45	43
Ala.	420	420	13,137	11,360	15	12	11	24	9	21
Miss.	349	384	10,116	10,281	14	5	19	8	14	4
W.S. CENTRAL	3,413	4,086	90,438	83,875	122	84	178	136	227	144
Ark.	159	185	5,204	5,503	13	2	57	15	38	14
La.	606	744	16,383	14,973	10	24	9	14	47	14
Okla.	291	125	8,208	7,362	17	10	19	37	17	28
Tex.	2,357	3,032	60,643	56,037	82	48	93	70	125	88
MOUNTAIN	1,232	1,512	33,200	29,995	171	93	413	315	272	239
Mont.	12	13	1,251	1,393	10	10	30	24	-	-
Idaho	19	20	1,682	1,607	23	8	70	64	35	43
Wyo.	9	11	720	710	5	1	17	15	9	16
Colo.	291	289	8,441	5,794	71	12	159	112	108	88
N. Mex.	126	79	4,237	4,447	21	41	23	12	16	6
Ariz.	403	743	11,539	11,269	11	12	49	32	37	23
Utah	117	128	2,035	1,935	26	N	52	35	67	48
Nev.	255	229	3,295	2,840	4	9	13	21	-	15
PACIFIC	4,783	5,226	101,976	98,152	228	344	695	382	406	392
Wash.	445	304	11,344	10,786	N	N	219	148	173	176
Oreg.	146	185	4,533	5,546	19	92	152	67	113	68
Calif.	4,072	4,631	81,250	77,222	209	252	281	153	108	136
Alaska	21	13	2,187	1,690	-	-	28	1	1	1
Hawaii	99	93	2,662	2,908	-	-	15	13	11	11
Guam	15	12	-	432	-	-	N	N	U	U
P.R.	1,134	1,174	3,432	U	-	-	6	6	U	U
V.I.	31	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 October 29, 2000.

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2000, and November 27, 1999 (47th 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	304,315	325,485	2,678	2,633	878	924	622	12,201	14,371
NEW ENGLAND	5,313	5,922	15	15	51	73	52	4,152	4,290
Maine	80	70	2	2	2	3	2	-	41
N.H.	93	101	-	-	3	8	4	59	22
Vt.	60	45	4	7	5	14	3	35	23
Mass.	2,155	2,229	4	3	16	26	26	1,098	757
R.I.	581	530	5	3	8	11	1	528	464
Conn.	2,344	2,947	-	-	17	11	16	2,432	2,983
MID. ATLANTIC	32,937	35,849	610	118	194	226	148	6,203	7,678
Upstate N.Y.	6,625	6,080	64	54	86	58	81	3,455	3,633
N.Y. City	9,825	11,084	-	-	-	43	27	40	133
N.J.	5,081	7,085	510	-	14	18	21	1,448	1,628
Pa.	11,406	11,600	36	64	94	107	19	1,260	2,284
E.N. CENTRAL	57,244	62,845	199	862	231	248	104	315	573
Ohio	13,928	16,413	12	3	107	73	52	82	43
Ind.	5,435	5,687	1	1	39	39	7	32	17
Ill.	17,084	20,839	16	47	9	30	11	11	17
Mich.	15,702	14,312	170	795	49	63	29	-	11
Wis.	5,095	5,594	-	16	27	43	5	190	485
W.N. CENTRAL	14,742	15,004	449	277	55	50	14	362	297
Minn.	2,617	2,567	5	10	7	9	5	267	185
Iowa	1,031	1,113	2	-	13	13	3	30	22
Mo.	7,138	7,490	426	263	24	17	5	42	63
N. Dak.	40	75	-	1	-	2	1	1	1
S. Dak.	260	170	-	-	2	3	-	-	-
Nebr.	1,287	1,295	6	3	4	6	-	4	11
Kans.	2,369	2,294	10	-	5	-	-	18	15
S. ATLANTIC	84,305	95,994	114	148	184	132	101	929	1,229
Del.	1,560	1,531	-	-	10	17	2	140	147
Md.	8,094	9,136	18	21	63	32	22	503	840
D.C.	2,485	3,353	3	1	6	4	-	10	4
Va.	9,297	8,805	3	10	32	32	8	140	114
W. Va.	465	518	14	17	N	N	4	31	17
N.C.	16,168	17,693	17	33	15	14	-	44	69
S.C.	10,737	13,402	3	22	6	11	9	13	6
Ga.	15,435	20,872	3	1	7	2	21	-	-
Fla.	20,064	20,684	53	43	45	20	35	48	32
E.S. CENTRAL	31,617	32,975	405	290	32	46	19	46	97
Ky.	3,189	3,046	34	21	18	18	3	11	17
Tenn.	10,592	10,352	89	111	10	22	12	28	56
Ala.	10,235	10,137	8	1	3	4	4	6	20
Miss.	7,601	9,440	274	157	1	2	-	1	4
W.S. CENTRAL	47,671	48,053	425	509	16	30	15	44	54
Ark.	2,855	2,999	9	27	-	1	1	4	4
La.	12,114	11,954	292	287	6	8	-	3	9
Okla.	3,667	3,632	9	15	3	3	6	1	7
Tex.	29,035	29,468	115	180	7	18	8	36	34
MOUNTAIN	9,091	8,699	293	195	44	45	35	29	16
Mont.	47	48	5	5	1	-	-	-	-
Idaho	83	79	3	7	5	2	-	2	3
Wyo.	45	28	211	64	2	-	1	9	3
Colo.	2,620	2,280	28	32	15	12	9	11	3
N. Mex.	953	883	13	32	1	1	2	-	1
Ariz.	3,830	3,990	18	41	8	7	14	-	2
Utah	208	204	2	6	12	17	4	3	2
Nev.	1,305	1,187	13	8	-	6	5	4	2
PACIFIC	21,395	20,144	168	219	71	74	134	121	137
Wash.	2,057	1,888	31	19	18	19	7	9	10
Oreg.	671	785	27	19	N	N	5	15	14
Calif.	18,014	16,791	108	181	53	53	119	95	113
Alaska	311	268	-	-	-	1	-	2	-
Hawaii	342	412	2	-	-	1	3	N	N
Guam	-	48	-	1	-	-	-	-	-
P.R.	598	301	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 November 25, 2000, and November 27, 1999 (47th 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	1,122	1,319	5,342	6,127	33,812	35,573	28,217	30,452
NEW ENGLAND	64	61	771	821	2,028	2,039	1,995	2,072
Maine	6	3	128	161	118	124	88	99
N.H.	1	2	21	45	134	130	131	130
Vt.	3	4	55	86	103	88	111	79
Mass.	27	22	256	205	1,149	1,097	1,116	1,121
R.I.	8	5	57	91	123	121	128	150
Conn.	19	25	254	233	401	479	421	493
MID. ATLANTIC	224	390	954	1,212	3,744	4,909	4,140	4,830
Upstate N.Y.	78	65	650	855	1,139	1,233	1,213	1,254
N.Y. City	80	230	4	U	887	1,360	834	1,406
N.J.	36	53	182	170	774	1,076	670	1,039
Pa.	30	42	118	187	944	1,240	1,423	1,131
E.N. CENTRAL	115	159	145	163	4,722	5,027	3,220	4,362
Ohio	21	18	50	35	1,406	1,210	1,329	1,002
Ind.	6	21	-	13	593	485	540	442
Ill.	46	71	22	10	1,313	1,502	129	1,458
Mich.	31	40	67	84	809	931	852	913
Wis.	11	9	6	21	601	899	370	547
W.N. CENTRAL	57	73	491	680	2,188	2,086	2,299	2,250
Minn.	27	41	84	103	495	536	613	667
Iowa	3	13	73	145	340	235	311	216
Mo.	11	13	50	29	664	691	834	824
N. Dak.	2	-	107	135	55	44	74	60
S. Dak.	1	-	87	169	92	90	100	114
Nebr.	7	1	2	4	205	178	94	156
Kans.	6	5	88	95	337	312	273	213
S. ATLANTIC	299	309	2,198	1,988	7,568	8,181	5,084	6,036
Del.	5	1	49	50	105	156	130	143
Md.	100	89	381	370	738	793	701	835
D.C.	16	18	-	-	61	72	U	U
Va.	49	68	531	533	929	1,172	839	964
W. Va.	4	2	108	103	156	162	141	147
N.C.	34	26	523	409	1,026	1,230	1,003	1,235
S.C.	2	15	146	132	701	608	512	486
Ga.	26	22	306	222	1,459	1,421	1,531	1,560
Fla.	63	68	154	169	2,393	2,567	227	666
E.S. CENTRAL	44	24	192	245	2,178	1,999	1,561	1,375
Ky.	18	7	20	35	356	382	240	269
Tenn.	11	8	97	89	587	531	679	556
Ala.	14	7	75	119	620	556	521	458
Miss.	1	2	-	2	615	530	121	92
W.S. CENTRAL	18	15	73	462	3,751	3,503	3,942	2,600
Ark.	3	3	20	14	673	624	587	233
La.	7	10	-	-	248	691	685	568
Okla.	8	2	53	88	369	424	265	332
Tex.	-	-	-	360	2,461	1,764	2,405	1,467
MOUNTAIN	50	42	235	207	2,619	2,778	2,064	2,391
Mont.	1	4	64	55	90	70	-	1
Idaho	3	3	9	5	113	119	97	97
Wyo.	-	1	50	43	59	66	44	57
Colo.	25	17	-	1	678	675	637	661
N. Mex.	-	3	20	9	221	350	182	279
Ariz.	9	6	73	78	755	832	673	748
Utah	6	4	10	8	466	478	431	499
Nev.	6	4	9	8	237	188	-	49
PACIFIC	251	246	283	349	5,014	5,051	3,912	4,536
Wash.	32	26	-	-	551	618	547	777
Oreg.	39	20	7	4	287	391	345	438
Calif.	169	187	253	338	3,905	3,678	2,783	3,028
Alaska	-	1	23	7	59	53	23	31
Hawaii	11	12	-	-	212	311	214	262
Guam	-	-	-	-	-	36	U	U
P.R.	4	-	76	68	511	566	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 November 25, 2000, and November 27, 1999 (47th 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	18,998	15,080	9,844	9,102	5,377	6,037	11,009	13,752
NEW ENGLAND	368	819	346	799	69	54	372	381
Maine	10	5	12	-	1	-	12	16
N.H.	6	17	8	16	2	1	17	13
Vt.	4	6	-	4	-	3	4	3
Mass.	256	703	233	688	44	32	225	208
R.I.	26	23	28	26	4	2	28	39
Conn.	66	65	65	65	18	16	86	102
MID. ATLANTIC	1,882	993	1,250	683	244	268	1,992	2,342
Upstate N.Y.	719	255	211	68	14	18	259	296
N.Y. City	684	329	466	222	110	118	1,078	1,210
N.J.	296	228	313	217	42	62	492	478
Pa.	183	181	260	176	78	70	163	358
E.N. CENTRAL	3,597	2,914	1,120	1,585	1,055	1,112	1,149	1,452
Ohio	380	395	291	134	68	86	205	234
Ind.	1,461	299	143	103	334	396	102	124
Ill.	918	1,193	76	888	315	382	584	716
Mich.	618	437	555	392	295	208	185	287
Wis.	220	590	55	68	43	40	73	91
W.N. CENTRAL	2,196	1,104	1,802	733	57	119	416	476
Minn.	679	213	797	233	13	9	128	177
Iowa	504	60	314	52	11	9	32	50
Mo.	621	667	439	330	25	85	179	164
N. Dak.	42	3	49	2	-	-	2	6
S. Dak.	7	18	4	10	-	-	16	17
Nebr.	128	78	84	61	2	6	22	16
Kans.	215	65	115	45	6	10	37	46
S. ATLANTIC	2,768	2,283	1,064	509	1,794	1,934	2,311	2,705
Del.	23	15	23	10	8	8	14	25
Md.	191	151	108	52	254	329	218	245
D.C.	74	51	U	U	47	43	29	50
Va.	432	124	331	62	121	144	247	268
W. Va.	10	8	7	5	2	5	28	37
N.C.	355	195	249	90	448	433	303	429
S.C.	129	115	83	61	201	243	109	218
Ga.	240	217	165	82	353	400	496	539
Fla.	1,314	1,407	98	147	360	329	867	894
E.S. CENTRAL	1,062	1,102	502	643	798	1,050	792	934
Ky.	456	228	108	145	78	96	110	164
Tenn.	335	622	339	429	480	590	280	329
Ala.	87	110	49	59	110	195	273	277
Miss.	184	142	6	10	130	169	129	164
W.S. CENTRAL	2,761	2,450	2,587	1,074	751	955	888	1,704
Ark.	195	73	52	26	89	75	157	155
La.	134	201	173	120	198	279	74	208
Okla.	118	507	42	154	118	169	123	162
Tex.	2,314	1,669	2,320	774	346	432	534	1,179
MOUNTAIN	1,215	1,049	701	717	220	220	444	464
Mont.	7	9	-	-	-	1	17	13
Idaho	44	25	25	12	1	1	11	12
Wyo.	5	3	3	1	1	-	4	3
Colo.	259	188	186	150	11	2	68	66
N. Mex.	157	127	99	98	21	11	36	55
Ariz.	551	547	311	386	180	199	196	190
Utah	76	60	77	64	1	2	41	37
Nev.	116	90	-	6	5	4	71	88
PACIFIC	3,149	2,366	472	2,359	389	325	2,645	3,294
Wash.	421	106	339	105	60	64	222	226
Oreg.	159	88	101	83	6	7	25	101
Calif.	2,525	2,140	-	2,136	322	250	2,191	2,750
Alaska	8	3	3	3	-	1	91	52
Hawaii	36	29	29	32	1	3	116	165
Guam	-	17	U	U	-	-	-	62
P.R.	29	131	U	U	147	137	238	178
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 November 25, 2000, and November 27, 1999 (47th 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	1,092	1,070	11,266	14,846	6,019	6,268	-	59	-	18	77	92
NEW ENGLAND	95	88	337	319	87	137	-	3	-	4	7	11
Maine	1	7	21	12	5	1	-	-	-	-	-	-
N.H.	12	17	18	17	16	16	-	2	-	1	3	1
Vt.	9	5	10	19	6	4	-	-	-	3	3	-
Mass.	36	36	119	129	12	42	-	1	-	-	1	8
R.I.	4	6	23	21	20	33	-	-	-	-	-	-
Conn.	33	17	146	121	28	41	-	-	-	-	-	2
MID. ATLANTIC	171	184	1,018	1,088	793	800	-	14	-	5	19	5
Upstate N.Y.	94	74	215	248	128	167	-	9	-	-	9	2
N.Y. City	36	55	334	363	402	240	-	5	-	4	9	3
N.J.	31	50	100	141	57	126	-	-	-	-	-	-
Pa.	10	5	369	336	206	267	-	-	-	1	1	-
E.N. CENTRAL	135	176	1,304	2,708	642	639	-	9	-	-	9	4
Ohio	49	55	248	607	97	84	-	2	-	-	2	-
Ind.	28	22	114	97	45	35	-	-	-	-	-	2
Ill.	48	73	487	751	110	52	-	4	-	-	4	1
Mich.	7	19	442	1,182	389	439	-	3	-	-	3	1
Wis.	3	7	13	71	1	29	-	-	-	-	-	-
W.N. CENTRAL	62	68	677	860	510	313	-	3	-	1	4	1
Minn.	35	43	177	94	36	49	-	-	-	1	1	1
Iowa	1	2	65	133	35	38	-	2	-	-	2	-
Mo.	16	10	299	527	374	190	-	-	-	-	-	-
N. Dak.	2	1	3	3	2	2	-	-	-	-	-	-
S. Dak.	1	2	2	9	1	1	-	-	-	-	-	-
Nebr.	3	4	33	48	41	20	-	-	-	-	-	-
Kans.	4	6	98	46	21	13	-	1	-	-	1	-
S. ATLANTIC	279	218	1,377	1,721	1,209	1,036	-	4	-	-	4	20
Del.	-	-	-	2	-	1	-	-	-	-	-	-
Md.	74	57	200	274	111	141	-	-	-	-	-	-
D.C.	-	5	24	56	29	25	-	-	-	-	-	-
Va.	37	18	146	165	152	87	-	2	-	-	2	18
W. Va.	9	7	53	39	15	22	-	-	-	-	-	-
N.C.	23	31	129	150	226	212	-	-	-	-	-	-
S.C.	15	5	76	43	21	63	-	-	-	-	-	-
Ga.	65	57	280	444	218	149	-	-	-	-	-	-
Fla.	56	38	469	548	437	336	-	2	-	-	2	2
E.S. CENTRAL	47	60	364	374	413	439	-	-	-	-	-	2
Ky.	12	7	45	64	65	45	-	-	-	-	-	2
Tenn.	22	34	130	146	200	206	-	-	-	-	-	-
Ala.	12	16	52	53	49	79	-	-	-	-	-	-
Miss.	1	3	137	111	99	109	-	-	-	-	-	-
W.S. CENTRAL	57	60	2,135	2,825	697	1,057	-	-	-	-	-	12
Ark.	2	2	108	62	75	77	-	-	-	-	-	5
La.	11	15	57	206	90	164	-	-	-	-	-	-
Okla.	42	39	248	469	151	139	-	-	-	-	-	-
Tex.	2	4	1,722	2,088	381	677	-	-	-	-	-	7
MOUNTAIN	111	102	922	1,171	502	529	-	12	-	1	13	2
Mont.	1	3	7	17	6	17	-	-	-	-	-	-
Idaho	4	1	31	42	6	28	-	-	-	-	-	-
Wyo.	1	1	39	8	25	13	-	-	-	-	-	-
Colo.	20	14	197	208	104	92	-	2	-	1	3	-
N. Mex.	23	18	68	47	105	167	-	-	-	-	-	-
Ariz.	47	52	451	652	189	128	-	-	-	-	-	1
Utah	11	9	59	58	24	33	-	3	-	-	3	-
Nev.	4	4	70	139	43	51	U	7	U	-	7	1
PACIFIC	135	114	3,132	3,780	1,166	1,318	-	14	-	7	21	35
Wash.	7	8	262	315	109	66	-	2	-	1	3	5
Oreg.	29	37	169	226	107	102	-	-	-	-	-	12
Calif.	32	52	2,677	3,203	929	1,119	-	11	-	3	14	17
Alaska	44	9	11	13	10	16	-	1	-	-	1	-
Hawaii	23	8	13	23	11	15	-	-	-	3	3	1
Guam	-	-	-	1	-	4	U	-	U	-	-	1
P.R.	4	2	206	312	225	224	-	-	-	-	-	-
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 231 cases among children aged <5 years, serotype was reported for 97 and of those, 23 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending November 25, 2000, and November 27, 1999 (47th 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	1,869	2,136	2	295	334	93	5,960	5,892	-	150	244
NEW ENGLAND	121	105	-	4	8	14	1,458	779	-	13	7
Maine	8	5	-	-	-	4	45	-	-	-	-
N.H.	12	12	-	-	1	-	116	91	-	2	-
Vt.	3	5	-	-	1	3	223	68	-	-	-
Mass.	71	60	-	1	4	7	1,012	556	-	9	7
R.I.	9	7	-	1	2	-	17	33	-	1	-
Conn.	18	16	-	2	-	-	45	31	-	1	-
MID. ATLANTIC	177	211	-	23	41	4	590	938	-	9	34
Upstate N.Y.	61	66	-	10	11	4	299	697	-	2	20
N.Y. City	34	53	-	4	12	-	51	56	-	7	7
N.J.	40	49	-	3	1	-	35	26	-	-	4
Pa.	42	43	-	6	17	-	205	159	-	-	3
E.N. CENTRAL	328	380	-	30	45	18	669	530	-	1	2
Ohio	86	126	-	7	18	-	312	195	-	-	-
Ind.	44	58	-	1	4	14	107	71	-	-	1
Ill.	72	101	-	6	11	4	78	90	-	1	1
Mich.	100	59	-	16	8	-	91	63	-	-	-
Wis.	26	36	-	-	4	-	81	111	-	-	-
W.N. CENTRAL	160	211	-	18	13	12	545	432	-	3	128
Minn.	20	47	-	-	1	11	328	188	-	1	5
Iowa	33	37	-	7	7	1	54	84	-	-	30
Mo.	85	82	-	4	1	-	79	71	-	1	2
N. Dak.	2	4	-	-	1	-	6	18	-	-	-
S. Dak.	5	11	-	-	-	-	7	6	-	-	-
Nebr.	7	10	-	4	-	-	32	9	-	1	90
Kans.	8	20	-	3	3	-	39	56	-	-	1
S. ATLANTIC	284	364	2	46	47	13	466	405	-	94	35
Del.	1	10	-	-	-	-	8	5	-	1	-
Md.	26	50	-	10	6	-	106	116	-	-	1
D.C.	-	4	-	-	2	-	3	1	-	-	-
Va.	38	50	1	10	10	-	106	50	-	-	-
W. Va.	12	8	-	-	-	-	1	3	-	-	-
N.C.	36	42	-	7	8	10	108	93	-	82	34
S.C.	21	43	1	11	4	1	32	17	-	9	-
Ga.	44	59	-	2	4	-	38	40	-	-	-
Fla.	106	98	-	6	13	2	64	80	-	2	-
E.S. CENTRAL	122	147	-	7	14	-	104	94	-	5	2
Ky.	26	30	-	1	-	-	53	30	-	1	-
Tenn.	52	60	-	2	-	-	31	40	-	1	-
Ala.	32	35	-	2	10	-	19	21	-	3	2
Miss.	12	22	-	2	4	-	1	3	-	-	-
W.S. CENTRAL	125	199	-	30	40	-	327	210	-	6	15
Ark.	13	33	-	5	-	-	34	24	-	-	5
La.	35	62	-	4	11	-	12	9	-	1	-
Okla.	26	33	-	-	1	-	40	40	-	-	1
Tex.	51	71	-	21	28	-	241	137	-	5	9
MOUNTAIN	150	129	-	21	26	13	734	730	-	2	16
Mont.	4	4	-	1	-	-	35	2	-	-	-
Idaho	7	10	-	-	3	-	59	144	-	-	-
Wyo.	1	4	-	2	-	-	6	2	-	-	-
Colo.	34	33	-	1	6	12	436	269	-	1	1
N. Mex.	11	14	-	1	N	-	82	137	-	-	-
Ariz.	83	41	-	4	8	1	80	109	-	1	13
Utah	7	15	-	6	4	-	24	57	-	-	1
Nev.	3	8	U	6	5	U	12	10	U	-	1
PACIFIC	402	390	-	116	100	19	1,067	1,774	-	17	5
Wash.	56	63	-	10	2	19	395	630	-	7	-
Oreg.	71	72	N	N	N	-	113	56	-	-	-
Calif.	259	242	-	85	82	-	506	1,036	-	10	5
Alaska	8	7	-	7	3	-	22	5	-	-	-
Hawaii	8	6	-	14	13	-	31	47	-	-	-
Guam	-	1	U	-	3	U	-	2	U	-	-
P.R.	9	12	-	-	-	-	12	23	-	-	-
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 November 25, 2000 (47th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	532	408	75	29	13	7	54
Boston, Mass.	134	104	17	4	5	4	15
Bridgeport, Conn.	26	21	4	-	-	1	2
Cambridge, Mass.	22	13	8	-	1	-	-
Fall River, Mass.	27	24	1	2	-	-	5
Hartford, Conn.	79	60	10	5	2	2	5
Lowell, Mass.	21	16	2	2	1	-	3
Lynn, Mass.	6	6	-	-	-	-	-
New Bedford, Mass.	22	18	3	1	-	-	1
New Haven, Conn.	38	26	9	3	-	-	3
Providence, R.I.	47	29	8	6	4	-	1
Somerville, Mass.	3	3	-	-	-	-	1
Springfield, Mass.	31	23	7	1	-	-	8
Waterbury, Conn.	25	23	1	1	-	-	1
Worcester, Mass.	51	42	5	4	-	-	9
MID. ATLANTIC	2,067	1,463	406	132	35	31	117
Albany, N.Y.	50	31	15	3	-	1	-
Allentown, Pa.	15	13	1	1	-	-	-
Buffalo, N.Y.	91	65	17	6	-	3	4
Camden, N.J.	16	12	3	-	-	1	-
Elizabeth, N.J.	18	16	1	1	-	-	-
Erie, Pa.§	36	32	2	2	-	-	2
Jersey City, N.J.	43	29	10	3	1	-	-
New York City, N.Y.	1,118	772	229	79	28	10	52
Newark, N.J.	36	16	14	4	1	1	2
Paterson, N.J.	16	10	4	1	-	1	1
Philadelphia, Pa.	266	191	53	14	-	8	19
Pittsburgh, Pa.§	57	36	10	5	2	4	6
Reading, Pa.	28	23	5	-	-	-	3
Rochester, N.Y.	122	98	15	6	2	1	10
Schenectady, N.Y.	39	33	3	3	-	-	4
Scranton, Pa.§	27	22	4	1	-	-	1
Syracuse, N.Y.	68	48	15	3	1	1	11
Trenton, N.J.	7	5	2	-	-	-	1
Utica, N.Y.	14	11	3	-	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	1,589	1,049	332	123	39	46	80
Akron, Ohio	33	19	11	3	-	-	1
Canton, Ohio	36	26	7	2	-	1	1
Chicago, Ill.	352	208	75	35	18	16	2
Cincinnati, Ohio	35	25	7	2	1	-	3
Cleveland, Ohio	121	79	23	13	4	2	6
Columbus, Ohio	195	139	41	9	1	5	11
Dayton, Ohio	74	53	9	6	5	1	2
Detroit, Mich.	147	79	43	16	5	4	16
Evansville, Ind.	22	18	1	3	-	-	-
Fort Wayne, Ind.	56	43	10	2	1	-	3
Gary, Ind.	14	6	3	3	-	2	-
Grand Rapids, Mich.	34	21	8	1	1	3	4
Indianapolis, Ind.	136	91	29	7	2	7	12
Lansing, Mich.	25	21	3	1	-	-	2
Milwaukee, Wis.	69	47	12	9	-	1	4
Peoria, Ill.	46	27	12	3	1	3	4
Rockford, Ill.	41	30	7	4	-	-	1
South Bend, Ind.	47	38	9	-	-	-	4
Toledo, Ohio	64	48	13	2	-	1	4
Youngstown, Ohio	42	31	9	2	-	-	-
W.N. CENTRAL	437	301	76	34	14	12	23
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	14	11	1	1	1	-	-
Kansas City, Kans.	27	16	6	3	2	-	3
Kansas City, Mo.	107	70	24	6	4	3	4
Lincoln, Nebr.	25	19	5	1	-	-	2
Minneapolis, Minn.	61	53	5	2	-	1	8
Omaha, Nebr.	66	44	10	8	1	3	2
St. Louis, Mo.	71	38	19	8	4	2	-
St. Paul, Minn.	U	U	U	U	U	U	U
Wichita, Kans.	66	50	6	5	2	3	4
S. ATLANTIC	871	542	196	93	28	12	53
Atlanta, Ga.	117	75	21	13	5	3	3
Baltimore, Md.	230	136	57	28	6	3	22
Charlotte, N.C.	81	54	20	5	1	1	5
Jacksonville, Fla.	79	48	23	4	2	2	6
Miami, Fla.	U	U	U	U	U	U	U
Norfolk, Va.	30	17	7	3	2	1	2
Richmond, Va.	21	12	5	3	1	-	1
Savannah, Ga.	U	U	U	U	U	U	U
St. Petersburg, Fla.	39	26	7	4	2	-	5
Tampa, Fla.	151	101	27	14	8	1	8
Washington, D.C.	100	58	29	11	1	1	1
Wilmington, Del.	23	15	-	8	-	-	-
E.S. CENTRAL	622	417	123	42	25	15	37
Birmingham, Ala.	99	69	18	6	3	3	5
Chattanooga, Tenn.	61	41	11	5	2	2	4
Knoxville, Tenn.	48	32	12	3	1	-	1
Lexington, Ky.	35	25	6	3	-	1	1
Memphis, Tenn.	200	131	41	15	10	3	11
Mobile, Ala.	53	33	9	2	6	3	4
Montgomery, Ala.	46	35	7	3	1	-	4
Nashville, Tenn.	80	51	19	5	2	3	7
W.S. CENTRAL	984	646	199	86	32	19	74
Austin, Tex.	57	41	13	1	1	1	4
Baton Rouge, La.	U	U	U	U	U	U	U
Corpus Christi, Tex.	33	26	3	2	1	1	8
Dallas, Tex.	118	63	25	22	1	7	9
El Paso, Tex.	67	51	12	3	1	-	-
Ft. Worth, Tex.	69	49	18	1	1	-	4
Houston, Tex.	288	173	63	38	12	2	20
Little Rock, Ark.	30	17	9	1	2	1	1
New Orleans, La.	52	28	12	-	9	1	13
San Antonio, Tex.	99	72	17	7	3	-	7
Shreveport, La.	95	70	15	7	-	3	7
Tulsa, Okla.	76	56	12	4	1	3	1
MOUNTAIN	850	574	175	66	19	16	49
Albuquerque, N.M.	70	46	15	6	3	-	3
Boise, Idaho	29	21	4	2	1	1	2
Colo. Springs, Colo.	30	18	8	2	1	1	2
Denver, Colo.	106	69	26	4	4	3	5
Las Vegas, Nev.	195	125	43	21	3	3	7
Ogden, Utah	27	24	2	1	-	-	-
Phoenix, Ariz.	151	97	32	15	3	4	8
Pueblo, Colo.	15	10	4	1	-	-	2
Salt Lake City, Utah	103	72	21	5	4	1	12
Tucson, Ariz.	124	92	20	9	-	3	8
PACIFIC	1,292	903	237	90	23	36	113
Berkeley, Calif.	9	6	2	1	-	-	3
Fresno, Calif.	91	65	17	5	2	2	6
Glendale, Calif.	30	24	4	1	-	1	4
Honolulu, Hawaii	73	56	10	3	1	3	3
Long Beach, Calif.	27	18	6	2	-	1	4
Los Angeles, Calif.	371	250	74	28	8	11	21
Pasadena, Calif.	27	19	4	1	-	3	6
Portland, Oreg.	83	65	10	3	3	2	7
Sacramento, Calif.	198	137	37	18	5	1	16
San Diego, Calif.	104	69	19	8	3	5	9
San Francisco, Calif.	95	69	14	8	-	3	17
San Jose, Calif.	U	U	U	U	U	U	U
Santa Cruz, Calif.	23	18	4	1	-	-	5
Seattle, Wash.	67	42	18	5	-	2	4
Spokane, Wash.	39	27	8	2	-	2	4
Tacoma, Wash.	55	38	10	4	1	-	4
TOTAL	9,244	¶6,303	1,819	695	228	194	600

U: Unavailable. -:No reported cases.

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

†Pneumonia and influenza.

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

¶Total includes unknown ages.

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