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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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MORBIDITY AND MORTALITY

WEEKLY REPORT

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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 Internetbased, household survey in a sample of 7493 adults aged \geq 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 (Cls) 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 \geq 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

Characteristic	No.⁺	(%)	(95% Cl⁵)	
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	(1/.3)	(14.0% - 20.6%)	
50-54	533	(15.6)	(12.2%-19.0%)	
55-64	582	(21.9)	(18.2%-25.6%)	
≥00 Education	902	(35.2)	(31.7%-38.7%)	
	504	(22 1)	(10.20/ 27.50/)	
High school	504 1732	(23.4)	(19.2/0-27.3/0) (19.5%-23.8%)	
Some college	1906	(21.7)	(13.5% - 25.6%) (14.9% - 18.7%)	
Bachelor's degree	1000	(15.4)	(14.370-10.770)	
Graduate degree	465	(17.7)	(12.5%-17.5%)	
Income level	400	(17.77	(10.070 21.070)	
<\$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**	004	(40.4)		
Northeast	924	(18.1)	(15.4% - 20.9%)	
Midwest	11//	(19.9)	(17.3% - 22.5%)	
South	1830	(17.9)	(16.0%-19.9%)	
Transmission knowledge	1295	(19.0)	(10.0%-21.4%)	
Sharing a drink				
Misinformed ^{††}	2269	(25.1)	(23 1%-27 1%)	
Informed ^{§§}	3355	(14.4)	(13.0%–15.7%)	
Cough or sneeze	0000	(17.7)	(10.070 10.770)	
Misinformed	2307	(25.4)	(23.4%-27.4%)	
Informed	3318	(14.0)	(12.6%–15.3%)	
Total	5641	(18.7)	(17.5%–19.8%)	

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

* 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 Merica, Omerger, Ukeh Michierter, and Wiscons, and West New Mexico, Oregon, Utah, Washington, and Wyoming. ¹¹ 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 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).

		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

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

* 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, Epidemiol-ogy, 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 \geq 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 \geq 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 \geq 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 \geq 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

 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 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 motorvehicle 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

- 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.
- 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.

		Cum. 2000		Cum. 2000
Anthrax		-	Poliomvelitis, paralytic	-
Brucellosis*		58	Psittacosis*	10
Cholera		2	O 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 diseas	e (leprosy)*	58	Trichinosis	14
Hantavirus pu	Imonary syndrome* [†]	27	Tularemia*	108
Hemolytic ure	mic syndrome, postdiarrheal*	176	Typhoid fever	298
HIV infection,	pediatric* [§]	190	Yellow fever	-
Plague		6		

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending November 25, 2000 (47th Week)

-: 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

[¶]Updated from reports to the Division of STD Prevention, NCHSTP.

								Escherichia	coli O157:H	7*
	All Cum.	DS Cum.	Chlan Cum.	nydia⁺ Cum.	Cryptosp Cum.	oridiosis Cum.	Cum.	Cum.	PH Cum.	LIS Cum.
Reporting Area	2000 [§]	1999	2000	1999	2000	1999	2000	1999 2.465	2000	1999
NITED STATES NEW ENGLAND Maine N.H. Vt. Vt. Mass. R.I. Conn.	1,699 28 29 32 1,061 84 465	1,998 68 46 1,318 90 460	582,183 18,993 1,309 909 476 7,923 2,294 6,082	590,780 19,008 932 887 435 8,065 2,108 6,581	2,411 101 20 22 26 30 3 3	2,440 175 27 17 35 68 6 22	4,124 370 31 36 33 158 18 94	3,465 390 36 34 32 171 27 90	3,007 356 28 35 33 162 16 82	2,583 356 33 20 183 26 94
MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	7,189 694 3,765 1,461 1,269	10,137 1,192 5,371 1,845 1,729	52,515 N 22,457 7,436 22,622	59,370 N 24,465 11,159 23,746	173 119 11 12 31	547 155 233 44 115	387 280 10 97 N	347 273 17 57 N	266 62 11 106 87	134 5 17 64 48
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	3,190 489 324 1,597 604 176	2,603 437 282 1,202 550 132	94,932 23,019 11,481 25,538 22,910 11,984	99,750 26,575 10,887 29,389 20,484 12,415	770 254 57 7 94 358	611 63 39 87 49 373	954 259 131 182 135 247	941 233 95 493 120 N	562 209 81 14 104 154	508 214 64 85 80 65
W.N. CENTRAL Minn. Iowa Mo. N. Dak. S. Dak. S. Dak. Nebr. Kans.	767 153 75 349 2 7 65 116	865 159 70 410 6 13 58 149	32,183 6,644 4,294 10,486 677 1,647 3,260 5,175	34,177 6,821 4,445 12,149 841 1,395 3,090 5,436	351 132 75 29 15 15 76 9	195 74 25 18 7 14 2	647 198 181 106 19 55 62 26	506 165 106 43 16 45 101 30	555 177 143 96 20 58 45 16	530 181 78 64 18 62 112 15
S. ATLANTIC Del. Md. D.C. Va. W. Va. N.C. S.C. Ga. Fla.	9,203 183 1,131 695 598 56 609 703 1,050 4,178	10,705 146 1,322 493 752 61 692 899 1,466 4,874	114,132 2,587 11,648 2,920 14,053 1,442 19,766 8,746 23,675 29,295	125,244 2,515 11,899 N 12,953 1,648 19,884 17,021 30,423 28,901	449 6 10 18 17 3 25 - 164 206	357 17 27 3 27 128 128 148	354 1 30 1 71 15 87 21 41 87	314 6 41 71 14 71 19 30 61	264 1 U 60 13 65 14 36 74	178 3 4 57 9 52 14 1 38
E.S. CENTRAL Ky. Tenn. Ala. Miss.	1,644 169 706 420 349	1,717 242 671 420 384	43,814 7,248 13,313 13,137 10,116	41,209 6,714 12,854 11,360 10,281	46 6 11 15 14	34 7 10 12 5	126 43 53 11 19	134 47 55 24 8	99 31 45 9 14	102 34 43 21 4
W.S. CENTRAL Ark. La. Okla. Tex.	3,413 159 606 291 2,357	4,086 185 744 125 3,032	90,438 5,204 16,383 8,208 60,643	83,875 5,503 14,973 7,362 56,037	122 13 10 17 82	84 2 24 10 48	178 57 9 19 93	136 15 14 37 70	227 38 47 17 125	144 14 14 28 88
MOUNTAIN Mont. Idaho Wyo. Colo. N. Mex. Ariz. Utah Nev.	1,232 12 19 291 126 403 117 255	1,512 13 20 11 289 79 743 128 229	33,200 1,251 1,682 720 8,441 4,237 11,539 2,035 3,295	29,995 1,393 1,607 710 5,794 4,447 11,269 1,935 2,840	171 10 23 5 71 21 11 26 4	93 10 8 1 12 41 12 N 9	413 30 70 17 159 23 49 52 13	315 24 64 15 112 12 32 35 21	272 35 9 108 16 37 67	239 - 43 16 88 6 23 48 15
PACIFIC Wash. Oreg. Calif. Alaska Hawaii	4,783 445 146 4,072 21 99	5,226 304 185 4,631 13 93	101,976 11,344 4,533 81,250 2,187 2,662	98,152 10,786 5,546 77,222 1,690 2,908	228 N 19 209 -	344 N 92 252	695 219 152 281 28 15	382 148 67 153 1 13	406 173 113 108 1 11	392 176 68 136 1 11
Guam P.R. V.I. Amer. Samoa C.N.M.I.	15 1,134 31 - -	12 1,174 35 - -	3,432 U U U	432 U U U U	- U U U	- U U U	N 6 U U U	N 6 U U U		

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2000, and November 27, 1999 (47th Week)

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.

	Gonor	rhea	Hepatit Non-A, I	tis C; Von-B	Legione	llosis	Listeriosis	Ly Dis	/me sease
Reporting Area	Cum. 2000§	Cum.	Cum.	Cum.	Cum. 2000	Cum.	Cum. 2000	Cum. 2000	Cum.
UNITED STATES	304,315	325,485	2,678	2,633	878	924	622	12,201	14,371
NEW ENGLAND Maine N.H. Vt. Mass. R.I. Conn.	5,313 80 93 60 2,155 581 2,344	5,922 70 101 45 2,229 530 2,947	15 2 - 4 5 -	15 2 - 7 3 3 -	51 2 3 5 16 8 17	73 3 14 26 11 11	52 2 4 3 26 1 16	4,152 59 35 1,098 528 2,432	4,290 41 22 23 757 464 2,983
MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	32,937 6,625 9,825 5,081 11,406	35,849 6,080 11,084 7,085 11,600	610 64 510 36	118 54 - - 64	194 86 - 14 94	226 58 43 18 107	148 81 27 21 19	6,203 3,455 40 1,448 1,260	7,678 3,633 133 1,628 2,284
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	57,244 13,928 5,435 17,084 15,702 5,095	62,845 16,413 5,687 20,839 14,312 5,594	199 12 16 170	862 3 47 795 16	231 107 39 9 49 27	248 73 39 30 63 43	104 52 7 11 29 5	315 82 32 11 190	573 43 17 17 11 485
W.N. CENTRAL Minn. Iowa Mo. N. Dak. S. Dak.	14,742 2,617 1,031 7,138 40 260 1 287	15,004 2,567 1,113 7,490 75 170 1 205	449 5 2 426 -	277 10 263 1 -	55 7 13 24 - 2	50 9 13 17 2 3	14 5 3 5 1	362 267 30 42 1	297 185 22 63 1
Kans.	2,369	2,295	10	-	4 5	- -	-	4 18	15
S. ATLANTIC Del. Md. D.C. Va. W. Va. N.C. S.C. Ga. Fla.	84,305 1,560 8,094 2,485 9,297 465 16,168 10,737 15,435 20,064	95,994 1,531 9,136 3,353 8,805 518 17,693 13,402 20,872 20,684	114 - 18 3 3 14 17 3 3 53	148 21 10 17 33 22 1 43	184 10 63 6 32 N 15 6 7 45	132 17 32 4 32 N 14 11 2 20	101 2 22 - 8 4 - 9 21 35	929 140 503 10 140 31 44 13 - 48	1,229 147 840 4 114 17 69 6 6 - 32
E.S. CENTRAL Ky. Tenn. Ala. Miss.	31,617 3,189 10,592 10,235 7,601	32,975 3,046 10,352 10,137 9,440	405 34 89 8 274	290 21 111 1 157	32 18 10 3 1	46 18 22 4 2	19 3 12 4	46 11 28 6 1	97 17 56 20 4
W.S. CENTRAL Ark. La. Okla. Tex.	47,671 2,855 12,114 3,667 29,035	48,053 2,999 11,954 3,632 29,468	425 9 292 9 115	509 27 287 15 180	16 - 6 3 7	30 1 8 3 18	15 1 - 6 8	44 4 3 1 36	54 4 9 7 34
MOUNTAIN Mont. Idaho Wyo. Colo. N. Mex. Ariz. Utah Nev.	9,091 47 83 45 2,620 953 3,830 208 1,305	8,699 48 79 28 2,280 883 3,990 204 1,187	293 5 3 211 28 13 18 2 13	195 5 7 64 32 32 41 6 8	44 1 5 15 1 8 12	45 - 2 - 12 1 7 17 6	35 - 1 9 2 14 4 5	29 - 2 9 11 - 3 4	16 - 3 3 1 2 2 2 2
PACIFIC Wash. Oreg. Calif. Alaska Hawaii	21,395 2,057 671 18,014 311 342	20,144 1,888 785 16,791 268 412	168 31 27 108 - 2	219 19 19 181 -	71 18 N 53 -	74 19 N 53 1 1	134 7 5 119 3	121 9 15 95 2 N	137 10 14 113 N
Guam P.R. V.I. Amer. Samoa C.N.M.I.	- 598 U U U	48 301 U U U	1 U U U	1 - U U U	- 1 U U U	- U U U	- - - -	N U U U	N U U U

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2000, and November 27, 1999 (47th Week)

N: Not notifiable.

U: Unavailable. -

- : No reported cases.

						Salmo	nellosis*	
	Mal	aria	Rabies	, Animal	NE	TSS	Pł	ILIS
Reporting Area	2000	Cum. 1999	2000	Cum. 1999	2000	Cum. 1999	2000	1999
UNITED STATES	1,122	1,319	5,342	6,127	33,812	35,573	28,217	30,452
NEW ENGLAND Maine N.H. Vt. Mass. R.I. Conn.	64 6 1 3 27 8 19	61 3 2 4 22 5 25	771 128 21 55 256 57 254	821 161 45 86 205 91 233	2,028 118 134 103 1,149 123 401	2,039 124 130 88 1,097 121 479	1,995 88 131 111 1,116 128 421	2,072 99 130 79 1,121 150 493
MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	224 78 80 36 30	390 65 230 53 42	954 650 4 182 118	1,212 855 U 170 187	3,744 1,139 887 774 944	4,909 1,233 1,360 1,076 1,240	4,140 1,213 834 670 1,423	4,830 1,254 1,406 1,039 1,131
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	115 21 6 46 31 11	159 18 21 71 40 9	145 50 - 22 67 6	163 35 13 10 84 21	4,722 1,406 593 1,313 809 601	5,027 1,210 485 1,502 931 899	3,220 1,329 540 129 852 370	4,362 1,002 442 1,458 913 547
W.N. CENTRAL Minn. Iowa Mo. N. Dak. S. Dak. S. Dak. Nebr. Kans.	57 27 3 11 2 1 7 6	73 41 13 13 - - 1 5	491 84 73 50 107 87 2 88	680 103 145 29 135 169 4 95	2,188 495 340 664 55 92 205 337	2,086 536 235 691 44 90 178 312	2,299 613 311 834 74 100 94 273	2,250 667 216 824 60 114 156 213
S. ATLANTIC Del. Md. D.C. Va. W. Va. N.C. S.C. Ga. Fla.	299 5 100 16 49 4 34 2 26 63	309 1 89 18 68 2 26 15 22 68	2,198 49 381 108 523 146 306 154	1,988 50 370 - 103 409 132 222 169	7,568 105 738 61 929 156 1,026 701 1,459 2,393	8,181 156 793 72 1,172 162 1,230 608 1,421 2,567	5,084 130 701 839 141 1,003 512 1,531 227	6,036 143 835 U 964 147 1,235 486 1,560 666
E.S. CENTRAL Ky. Tenn. Ala. Miss.	44 18 11 14 1	24 7 8 7 2	192 20 97 75	245 35 89 119 2	2,178 356 587 620 615	1,999 382 531 556 530	1,561 240 679 521 121	1,375 269 556 458 92
W.S. CENTRAL Ark. La. Okla. Tex.	18 3 7 8 -	15 3 10 2	73 20 53	462 14 - 88 360	3,751 673 248 369 2,461	3,503 624 691 424 1,764	3,942 587 685 265 2,405	2,600 233 568 332 1,467
MOUNTAIN Mont. Idaho Wyo. Colo. N. Mex. Ariz. Utah Nev.	50 1 3 - 25 - 9 6 6	42 4 3 1 17 3 6 4 4	235 64 9 50 - 20 73 10 9	207 55 43 1 9 78 8 8 8	2,619 90 113 59 678 221 755 466 237	2,778 70 119 66 675 350 832 478 188	2,064 97 44 637 182 673 431	2,391 1 97 57 661 279 748 499 49
PACIFIC Wash. Oreg. Calif. Alaska Hawaii	251 32 39 169 11	246 26 20 187 1 12	283 7 253 23	349 - 4 338 7 -	5,014 551 287 3,905 59 212	5,051 618 391 3,678 53 311	3,912 547 345 2,783 23 214	4,536 777 438 3,028 31 262
Guam P.R. V.I. Amer. Samoa C.N.M.I.	4 U U U	- - U U U	76 U U U	- 88 U U U	511 U U U	36 566 U U U	U U U U	U U U U

 TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending November 25, 2000, and November 27, 1999 (47th Week)

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).

		Shige	llosis*		Sy	philis		
	NET Cum	SS	P Cum	HLIS Cum	(Primary &	& Secondary)	Tube	rculosis
Reporting Area	2000	1999	2000	1999	2000	1999	2000	1999
UNITED STATES	18,998	15,080	9,844	9,102	5,377	6,037	11,009	13,752
NEW ENGLAND Maine N.H. Vt. Mass. R.I. Conn.	368 10 6 4 256 26 66	819 5 17 6 703 23 65	346 12 8 - 233 28 65	799 - 16 4 688 26 65	69 1 2 - 44 4 18	54 - 3 32 - 2 16	372 12 17 4 225 28 86	381 16 13 3 208 39 102
MID. ATLANTIC Upstate N.Y. N.Y. City N.J. Pa.	1,882 719 684 296 183	993 255 329 228 181	1,250 211 466 313 260	683 68 222 217 176	244 14 110 42 78	268 18 118 62 70	1,992 259 1,078 492 163	2,342 296 1,210 478 358
E.N. CENTRAL Ohio Ind. III. Mich. Wis.	3,597 380 1,461 918 618 220	2,914 395 299 1,193 437 590	1,120 291 143 76 555 55	1,585 134 103 888 392 68	1,055 68 334 315 295 43	1,112 86 396 382 208 40	1,149 205 102 584 185 73	1,452 234 124 716 287 91
W.N. CENTRAL Minn. Iowa Mo. N. Dak. S. Dak. S. Dak. Nebr. Kans.	2,196 679 504 621 42 7 128 215	1,104 213 60 667 3 18 78 65	1,802 797 314 439 49 4 84 115	733 233 52 330 2 10 61 45	57 13 11 25 - 2 6	119 9 85 - 6 10	416 128 32 179 2 16 22 37	476 177 50 164 6 17 16 46
S. ATLANTIC Del. Md. D.C. Va. W. Va. N.C. S.C. Ga. Fla.	2,768 23 191 74 432 10 355 129 240 1,314	2,283 15 151 124 8 195 115 217 1,407	1,064 23 108 U 331 7 249 83 165 98	509 10 52 U 62 5 90 61 82 147	1,794 8 254 47 121 2 448 201 353 360	1,934 8 329 43 144 5 433 243 400 329	2,311 14 218 29 247 28 303 109 496 867	2,705 25 245 50 268 37 429 218 539 894
E.S. CENTRAL Ky. Tenn. Ala. Miss.	1,062 456 335 87 184	1,102 228 622 110 142	502 108 339 49 6	643 145 429 59 10	798 78 480 110 130	1,050 96 590 195 169	792 110 280 273 129	934 164 329 277 164
W.S. CENTRAL Ark. La. Okla. Tex.	2,761 195 134 118 2,314	2,450 73 201 507 1,669	2,587 52 173 42 2,320	1,074 26 120 154 774	751 89 198 118 346	955 75 279 169 432	888 157 74 123 534	1,704 155 208 162 1,179
MOUNTAIN Mont. Idaho Wyo. Colo. N. Mex. Ariz. Utah Nev.	1,215 7 44 5 259 157 551 76 116	1,049 9 25 3 188 127 547 60 90	701 25 3 186 99 311 77	717 12 1 150 98 386 64 64 6	220 - 1 1 11 21 180 1 5	220 1 2 11 199 2 4	444 17 11 68 36 196 41 71	464 13 12 3 66 55 190 37 88
PACIFIC Wash. Oreg. Calif. Alaska Hawaii	3,149 421 159 2,525 8 36	2,366 106 88 2,140 3 29	472 339 101 3 29	2,359 105 83 2,136 3 32	389 60 6 322 1	325 64 7 250 1 3	2,645 222 25 2,191 91 116	3,294 226 101 2,750 52 165
Guam P.R. V.I. Amer. Samoa C.N.M.I.	29 U U U	17 131 U U U		U U U U	- 147 U U U	137 U U U	238 U U U	62 178 U U U

TABLE II. (Cont'o	Provisional cases of selected notifiable diseases, United State	es,
weeks ending	November 25, 2000, and November 27, 1999 (47th Week))

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).

	H. influ	uenzae,	H	epatitis (V	iral), By Ty	/pe			Meas	les (Rubec	ola)	
	Inva	sive	Α	-	В	-	Indige	nous	Impo	rted*	Tota	l
Reporting Area	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 N.H.	1 12	/ 17	21 18	12 17	5 16	1 16	-	2	-	- 1	- 3	- 1
Vt. Mass	9 36	5 36	10 119	19 129	6 12	4 42	-	- 1	-	3	3 1	- 8
R.I.	4	6	23	21	20	33	-	-	-	-	-	-
	33 171	194	140	1 0 9 9	20	41 900	-	-	-	-	- 10	2
Upstate N.Y.	94	74	215	248	128	167	-	9	-	-	9	2
N.Y. City N.J.	36 31	55 50	334 100	363 141	402 57	240 126	-	5	-	4	9	3
Pa.	10	5	369	336	206	267	-	-	-	1	1	-
E.N. CENTRAL	135 49	176 55	1,304 248	2,708 607	642 97	639 84	-	9	-	-	9	4
Ind.	28	22	114	97	45	35	-	-	-	-	-	2
III. Mich.	48 7	73 19	487 442	1,182	389	52 439	-	4 3	-	-	4	1
Wis.	3	7	13	71	1	29	-	-	-	-	-	-
W.N. CENTRAL Minn.	62 35	68 43	677 177	860 94	510 36	313 49	-	3	-	1 1	4 1	1 1
lowa	1	2	65	133	35	38	-	2	-	-	2	-
N. Dak.	2	1	299	527	2	190	-	-	-	-	-	-
S. Dak. Nebr.	1 3	2 4	2 33	9 48	1 41	1 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
Md.	74	57	200	274	111	141	-	-	-	-	-	-
Va.	37	5 18	24 146	56 165	29 152	25 87	-	2	-	-	2	- 18
W.Va. N.C.	9 23	7 31	53 129	39 150	15 226	22 212	-	-	-	-	-	-
S.C.	15	5	76	43	21	63	-	-	-	-	-	-
Fla.	56	57 38	469	444 548	437	336	-	2	-	-	2	2
E.S. CENTRAL	47	60	364	374	413	439	-	-	-	-	-	2
Ky. Tenn.	12 22	7 34	45 130	64 146	65 200	45 206	-	-	-	-	-	2
Ala. Miss	12 1	16 3	52 137	53 111	49 99	79 109	-	-	-	-	-	-
W.S. CENTRAL	57	60	2,135	2.825	697	1.057	-	-	-	-	-	12
Ark.	2	2	108	62	75	77	-	-	-	-	-	5
Okla.	42	39	248	469	151	139	-	-	-	-	-	-
lex.	2	4	1,722	2,088	381	677	-	-	-	-	-	7
MOUNTAIN Mont.	111	102 3	922 7	1,171 17	502 6	529 17	-	12	-	1	13	2
Idaho Wyo	4	1	31 39	42	6 25	28 13	-	-	-	-	-	-
Colo.	20	14	197	208	104	92	-	2	-	1	3	-
N. Mex. Ariz.	23 47	18 52	68 451	47 652	105	167	-	-	-	-	-	- 1
Utah Nev.	11 4	9 4	59 70	58 139	24 43	33 51	- U	3 7	- U	-	3 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
Calif.	32	52	2,677	3,203	929	1,119	-	11	-	3	14	12
Alaska Hawaii	44 23	9 8	11 13	13 23	10 11	16 15	-	1 -	-	- 3	1 3	- 1
Guam	-	_	-	1	-	4	U	-	U	_	-	1
P.R. V.I.	4 U	2 U	206 U	312 U	225 U	224 U	- U	Ū	- U	- U	- U	- U
Amer. Samoa C.N.M.L	Ū	Ū	Ŭ	Ū	Ū	Ŭ	Ŭ	Ū	Ū	Ū	Ū	Ū

TABLE III. Provisional cases of selected notifiable diseases preventableby vaccination, United States, weeks ending November 25, 2000,
and November 27, 1999 (47th Week)

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.

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

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)

N: Not notifiable. U: Unavailable.

- : No reported cases.

		All Cau	ses, By	Age (Y	ears)		P&I⁺			All Cau	ses, By	Age (Y	ears)		P&I [†]
Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Total	Reporting Area	All Ages	≥65	45-64	25-44	1-24	<1	Total
NEW ENGLAND Boston, Mass. Bridgeport, Conn Cambridge, Mass Fall River, Mass. Hartford, Conn. Lowell, Mass. Lynn, Mass. New Bedford, Ma New Haven, Conn Providence, R.I. Somerville, Mass. Springfield, Mass Waterbury, Conn. Worcester, Mass.	532 134 26 27 79 21 6 ss. 22 25 . 38 . 47 . 31 . 31 . 25 51	408 104 21 13 24 60 16 6 18 26 29 3 3 23 23 23 42	75 17 4 8 1 10 2 - 3 9 8 - 7 1 5	29 4 - 25 2 5 2 - 1 3 6 - 1 1 4	13 5 1 2 1 - - 4 - - -	7 4 1 - - - - - - - - - - - - - -	54 152 - 553 - 131 1819	S. ATLANTIC Atlanta, Ga. Baltimore, Md. Charlotte, N.C. Jacksonville, Fla Miami, Fla. Norfolk, Va. Richmond, Va. Savannah, Ga. St. Petersburg, F Tampa, Fla. Washington, D.C. Wilmington, Del E.S. CENTRAL	871 117 230 81 . 79 . 0 30 21 . 30 . 10 . 100 . 23 . 622	542 75 136 54 48 U 17 12 U 26 101 58 51 54 17 54 54 54 54 54 54 54 54 54 54 54 54 54	196 21 57 20 23 U 7 5 U 7 29 - 123	93 13 28 5 4 U 3 3 U 4 14 11 8 42	28 5 6 1 2 U 2 1 U 2 8 1 - 25	12 3 3 1 2 U 1 - U 1 1 - 15 2	53 3 22 5 6 U 2 1 U 5 8 1 - 37 - 37 -
MID. ATLANTIC Albany, N.Y. Allentown, Pa. Buffalo, N.Y. Camden, N.J. Elizabeth, N.J. Erie, Pa.§	2,067 50 15 91 16 18 36	1,463 31 13 65 12 16 32	406 15 1 17 3 1 2	132 3 1 6 1 2	35 - - - - -	31 1 3 1 -	117 - 4 - 2	Birmingham, Ai Chattanooga, Te Knoxville, Tenn. Lexington, Ky. Memphis, Tenn. Mobile, Ala. Montgomery, A Nashville, Tenn.	a. 99 nn. 61 48 35 200 53 Ia. 46 80	69 41 32 25 131 33 35 51	18 11 12 6 41 9 7 19	6 5 3 3 5 2 3 5 5	3 2 1 - 10 6 1 2	3 2 - 1 3 3 - 3	5 4 1 11 4 7
Jersey City, N.J. New York City, N.Y Newark, N.J. Paterson, N.J. Philadelphia, Pa. Pittsburgh, Pa.§ Reading, Pa. Rochester, N.Y. Schenectady, N.Y. Scranton, Pa.§ Syracuse, N.Y. Trenton, N.J. Utica, N.Y. Yonkers, N.Y.	43 43 36 266 57 28 122 39 27 68 7 7 14 U	29 772 16 10 191 36 23 98 33 22 48 5 11 U	10 229 14 4 53 10 5 5 5 5 3 4 15 2 3 U	3 79 4 1 14 5 - 6 3 1 3 U	1 28 1 - 2 - 2 - 1 - 1 - U	- 10 1 8 4 - 1 - 1 - U	- 52 1 19 6 3 10 4 1 1 1 1 U	W.S. CENTRAL Austin, Tex. Baton Rouge, La Corpus Christi, T Dallas, Tex. El Paso, Tex. Ft. Worth, Tex. Houston, Tex. Little Rock, Ark. New Orleans, La San Antonio, Te Shreveport, La. Tulsa, Okla.	984 57 . U fex. 33 118 67 288 30 288 30 . 228 30 . 228 30 . 52 . 52 . 52 . 52 . 55 . 55 . 55 . 56 . 55 . 56 . 57 . 57 . 57 . 57 . 57 . 57 . 57 . 57	646 41 26 63 51 49 173 17 28 72 70 56	199 13 U 325 12 18 63 9 12 17 15 12	86 1 22 3 1 38 1 - 7 7 4	32 1 1 1 1 12 9 3 -	19 1 7 - 2 1 1 - 3 3	74 4 9 - 4 20 1 13 7 7 1
E.N. CENTRAL Akron, Ohio Canton, Ohio Chicago, III. Cincinnati, Ohio Columbus, Ohio Dayton, Ohio Detroit, Mich. Evansville, Ind. Gary, Ind. Grand Rapids, Mi Indianapolis, Ind. Lansing, Mich. Milwaukee, Wis.	1,589 33 36 352 35 121 195 74 147 25 56 14 ch. 34 136 25 69 69	1,049 19 208 25 79 139 53 79 18 43 6 21 91 21 21	332 11 75 75 7 23 41 9 43 10 3 8 29 3 12	123 3 35 2 13 9 6 16 3 2 3 1 7 1 9 2	39 - 18 1 4 1 5 5 - 1 - 1 2 -	46 16 25 14 - 23 7 12	80 1 1 2 3 6 11 2 6 - 3 - 4 12 2 4 4	MOUNTAIN Albuquerque, N Boise, Idaho Colo. Springs, C Denver, Colo. Las Vegas, Nev. Ogden, Utah Phoenix, Ariz. Pueblo, Colo. Salt Lake City, U Tucson, Ariz. PACIFIC Berkeley, Calif. Fresno, Calif. Glendale, Calif. Honolulu, Hawa	850 .M. 70 29 olo. 30 106 195 27 151 151 151 151 151 151 151 152 9 124 9 91 300 31 300 31 31 32 31 31 31 31 31 31 31 31 31 31 31 31 31	574 46 21 18 69 1255 24 97 10 72 92 903 6 65 24 903 65 24 56	175 15 4 8 26 43 2 32 4 21 20 237 27 27 4 10	66 6 2 4 21 1 5 9 90 1 5 1 3	19 3 1 4 3 - 4 - 23 - 2 1	16 - 1 3 - 4 - 1 3 - 1 3 6 - 2 1 3	49 3 2 5 7 - 8 2 12 8 113 3 6 4 3
Rockford, III. South Bend, Ind. Toledo, Ohio Youngstown, Ohi W.N. CENTRAL Des Moines, Iowa Duluth, Minn. Kansas City, Kans Kansas City, Kans Kansas City, Mo. Lincoln, Nebr. Minneapolis, Min Omaha, Nebr. St. Louis, Mo. St. Paul, Minn.	40 41 47 64 0 42 437 1 U 14 25 n. 61 66 71 06 66	2/ 30 38 48 31 301 11 16 70 19 53 44 38 U 50	12 7 9 13 9 76 U 1 6 24 5 5 10 19 U 6	3 4 2 2 34 U 1 3 6 1 2 8 8 U 5	14 - - - - - - - - - - - - - - - - - - -	3 - - 1 - 1 - - 3 - 1 3 2 U 3	4 4 4 23 U - 3 4 2 8 2 - U 4	Long Beach, Cal Los Angeles, Cal Pasadena, Calif. Portland, Oreg. Sacramento, Cal San Diego, Calif San Francisco, C San Jose, Calif. Santa Cruz, Calif Seattle, Wash. Spokane, Wash. Tacoma, Wash. TOTAL	if. 27 if. 371 27 83 iif. 198 - 104 alif. 95 4 5 5 9,244	18 250 19 65 137 69 0 0 18 42 27 38 16,303	6 74 4 10 37 19 14 U 4 18 8 10 1,819	2 28 1 3 18 8 U 1 5 2 4 695	8 3 5 3 U - 1 228	1 11 3 2 1 5 3 U - 2 2 - 194	4 21 6 7 16 9 17 U 5 4 4 4 4 600

TABLE IV. Deaths in 122 U.S. cities,* week ending November 25, 2000 (47th Week)

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.

Weekly Notifiable Disease Morbidity	Data and 122 Cities Mortality Data
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