CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

February 18, 2000 / Vol. 49 / No. 6

MMWR™
MORBIDITY AND MORTALITY
WEEKLY REPORT

Importation of Wild Poliovirus into Qinghai Province — China, 1999

Indigenous wild poliovirus was last isolated in China in 1994. On October 13, 1999, a case of acute flaccid paralysis (AFP) in a 16-month-old boy was reported to public health authorities in Xunhua Autonomous County, Haidong Prefecture, Qinghai Province, China. Following onset of paralysis on October 12, the boy was no longer able to stand or walk. Two stool samples, taken within 14 days of onset of paralysis, were analyzed in the Qinghai provincial laboratory and yielded poliovirus. The isolates were later differentiated as wild poliovirus type 1 at the National Poliovirus Laboratory in Beijing. Stool specimens from one of five children with whom the boy had contact yielded wild poliovirus type 1. This report describes this case of poliomyelitis and the public health response to the case in China.

The case occurred among the Sala, a group of approximately 80,000 persons who live mainly in Xunhua Autonomous County, Qinghai, or in neighboring Gansu province. Many Sala are traders, and Sala men travel widely within Qinghai and to nearby provinces, including Gansu, Sichuan, and Xinjiang, and to Tibet as far south as the border with Nepal. The Sala have trade contacts in India, Pakistan, and Central Asia. Neither the case-patient nor immediate family members are reported to have traveled outside Xunhua County during the 2 months before paralysis onset.

Despite intensive investigations, including retrospective record reviews in health-care facilities and active case searches in villages in selected areas, no additional polio cases or other evidence of continued poliovirus circulation was found. Since 1996, the quality of AFP surveillance in Qinghai has been excellent, with nonpolio AFP rates of >1.5 per 100,000 population and proportion of cases with two adequate stool specimens between 70%–90% annually. The provincial laboratory in Qinghai has shown proficiency in 1999 and received full accreditation within the World Health Organization polio laboratory network.

The Qinghai poliovirus strain is closely related (98%) to poliovirus isolates from central and northern India during 1998–1999, but unrelated to polioviruses that circulated in China until 1994. Despite the absence of a history of travel by the case-patient or his immediate family, evidence suggests that the virus was imported from a neighboring country, probably India, where polio is endemic. The extent of virus circulation following importation has not yet been determined (the paralytic case-to-infection ratio is typically 1:200 in a fully susceptible population). No evidence exists of continued circulation of poliovirus.

Importation of Wild Poliovirus into Qinghai Province — Continued

Before confirmation of the index case (but after onset of paralysis), provincewide supplementary vaccination with oral poliovirus vaccine, planned earlier in 1999 and targeting children aged 0–3 years, was carried out in late November in both Qinghai and Tibet. In response to confirmation of the index case, an initial local case-response vaccination round was conducted in Xunhua County in November. This was followed by round 1 of a larger, intense house-to-house mopping-up vaccination activity targeting children aged 0–9 years that was implemented in six of eight prefectures of Qinghai, beginning in early December. Round 2 in January 2000 also included house-to-house mopping-up vaccination targeting 7.1 million children in an even larger area, including Qinghai, Ningxia, most of Gansu, and parts of Tibet. These extensive mopping-up vaccination activities were in addition to the second round of subnational immunization days conducted January 5–6, 2000, in all provinces in high-risk areas to vaccinate children aged 0–3 years. All vaccination activities reported good coverage of the target population. Two additional large multiple-province vaccination rounds, targeting approximately 26 million children, are planned for March and April.

Since the case was identified, surveillance activities have been intensified through active case searches in health-care facilities and communities during mopping-up vaccination and retrospective review of hospital records. Special assessments of the quality of virologic surveillance were conducted, including specimen collection and handling procedures, and the quality of specimen processing at the provincial laboratory.

Reported by: Ministry of Health; World Health Organization, Beijing, China. Regional Office for the Western Pacific, World Health Organization, Manila, Philippines. Vaccines and Biologicals Dept, World Health Organization, Geneva, Switzerland. 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.

Editorial Note: Preliminary data from this investigation suggest that the polio case in Qinghai was caused by importation of wild poliovirus with limited circulation. No other cases have been detected despite high-quality AFP surveillance and extensive searches of hospital records, health-care facilities, and communities. Further intensive surveillance and vaccination activities, including active house-to-house searches for recent AFP cases, are being conducted.

The detection of this case in a sparsely populated rural area of China indicates that high-quality AFP surveillance continues to be maintained in China. The detection also highlights the need for all polio-free countries to remain vigilant to allow early detection of wild poliovirus imported from countries where polio is endemic and to institute rapid control measures.

Role of Victims' Services in Improving Intimate Partner Violence Screening by Trained Maternal and Child Health-Care Providers — Boston, Massachusetts, 1994–1995

From 1992 to 1996, approximately 1 million incidents of nonfatal intimate partner violence (IPV) occurred each year in the United States; 85% of victims were women (*1*). In 1989, pediatric research found a concurrence of victimization of mothers and their children and supported a recommendation that maternal and child health-care providers (HCPs) pursue training and advocate for increased access to services to promote the safety and well-being of mothers and their children (*2*). From 1992 to 1997, the Pediatric

Intimate Partner Violence Screening — Continued

Family Violence Awareness Project (PFVAP), a training project for maternal and child HCPs, promoted prevention of and intervention for IPV in Massachusetts (*3*). In 1994, PFVAP conducted a pilot evaluation in two urban community health centers to determine whether HCPs trained to conduct IPV assessment would increase their screening rates of women at risk for IPV if an on-site referral service for victims was available. This report summarizes the results of the pilot project, which indicate that IPV screening rates did not increase after implementing on-site victim services.

Screening rates were assessed for 14 HCPs at two community health centers (centers A and B) in a low-income, racially mixed, urban community in the Boston area. Because the two centers were dissimilar in patient demographics and other characteristics, one could not be compared with the other. Therefore, a phased intervention design was used; IPV screening was measured during two 10-week periods (phases 1 and 2). Phase 1 followed a 2-hour group training session to teach HCPs to implement a brief screening protocol* of female patients and mothers of pediatric patients aged 0–12 years during routine visits using a recommended screening schedule.† Phase 2 followed implementation of on-site victim services that offered weekly support groups separately for battered women and children using the identical protocol as in Phase 1. Between the end of phase 1 and the beginning of phase 2, there was a 3-month period.

To document screening in each phase, HCPs recorded during each visit with each female adult patient and each mother of a pediatric patient whether 1) the patient received IPV screening and who performed the screening; 2) any family members were present during the patient visit; and 3) a staff interpreter was present during the visit. Date of birth, race/ethnicity, marital status, date and type of visit, and diagnosis were gathered from the patients' files. A physician subsequently coded diagnoses into the following categories: routine health-care maintenance, prenatal care, acute/sick, chronic problem, injury, psychosocial, human immunodeficiency virus/sexually transmitted diseases (HIV/STD), and pain.

For both phases, an observed screening rate was calculated for each HCP and defined as the proportion of the HCPs' patients seen and screened by the HCP during that period. Although the PFVAP protocol recommended screening some patients (pregnant women and mothers of children aged <2 years) more than once a year, patients who were screened at least once during phase 1 were considered "previously screened" and were not included in calculating phase 2 screening rates.

The combined data from both health centers and both phases (after exclusions) (Table 1) comprised 14 HCPs, 642 patients, and 1352 patient visits. Each patient's final screening status (ever or never screened) was based on combined data from each phase and was evaluated relative to patient demographics and visit characteristics by two separate logistic regression models.

*Suggested questions were 1) "I ask all my patients, do you feel safe in your home?"; 2) "Is anyone hurting you, harassing you, or making you feel afraid?"; and 3) "At any time, has your partner ever pushed, hit, or kicked you?"

† The recommended schedule consisted of screening 1) adult and adolescent females during routine gynecologic, internal or family medicine, or pediatric visits annually; 2) mothers of pediatric patients aged 2–12 years annually; 3) mothers of pediatric patients aged 0–2 years twice annually; and 4) patients during prenatal-care visits once per trimester.

Intimate Partner Violence Screening — Continued

TABLE 1. Inclusion and exclusion criteria for health-care providers (HCPs) and patient visits for intimate partner violence (IPV) screening — Boston, Massachusetts, 1994–1995

Level	Inclusion criteria	Exclusion criteria
HCPs	Met with ≥26 patients during study period	Met with ≤25 patients during study period
Patient visits	Scheduled at least 1 day in advance	Visits by females aged 13–17 years*
	"Screening target"† present	Adult other than screening target in room with HCP§
		For phase 2: patients screened during phase 1

*Excluded because two possible screening targets (the mother or the adolescent female) could have been in the room with the HCP. HCPs' documentation of screening was unclear about whether mothers or adolescent females were interviewed for IPV risk.

† A woman aged ≥18 years or the female caretaker of a pediatric patient aged 0–12 years.

§ For the safety of patients and HCPs, HCPs were instructed not to screen for IPV risk if adults other than the screening target and a staff interpreter were in the room.

Source: Pediatric Family Violence Awareness Project Evaluation

Eleven (79%) of 14 HCPs did not demonstrate increased screening during phase 2, following on-site services implementation. Unadjusted combined screening rates for both health centers decreased significantly from phase 1 (33% patients screened) to phase 2 (23%) ($p<0.03$). For each phase, health center A had approximately twice the documented screening rate of health center B. On average, screening rates declined 7.4% (standard deviation [SD]=15.7 percentage points) at health center A and 14.1% (SD=17.5 percentage points) at health center B.

At both health centers, unadjusted individual HCP screening rates varied during both phases from 1.8% to 92.8% during phase 1 and from 0 to 94.9% during phase 2. The degree of change in HCP screening rates also varied widely. Individual HCP screening rates of decline ranged from 1.8 to 46.6 percentage points. For the three HCPs who demonstrated increases between phase 1 and phase 2, the increase ranged from 0.6 to 24.7 percentage points.

Analyses of visit, HCP, and patient characteristics controlled for health center and used combined rates from both phases to improve the stability of estimates. Several aspects of patient visits predicted the likelihood of screening. Patients were screened more often during routine visits ($p<0.01$). However, screening was 23 times more likely during adult medical visits ($p<0.01$) and 10 times more likely during gynecologic visits ($p<0.01$) than during pediatric visits. Diagnostic categories also were related significantly to screening status. Patients seeking treatment for pain were four times more likely to be screened ($p<0.03$). A combined variable of injury, HIV/STD, and psychosocial problems also was a significant predictor of screening ($p<0.04$). Of the patient characteristics examined, only unknown marital status was a significant predictor of screening status, with women of unknown marital status less likely ($p<0.01$) to be screened than married patients.

Reported by: L McKibben, MD, AC Hauf, Carney Hospital; A Must, PhD, Dept of Family Medicine and Community Health, Tufts Univ School of Medicine, Boston; EL Roberts, MSW, Women's

Intimate Partner Violence Screening — Continued

Health Unit, Bur of Family and Community Health, Massachusetts Dept of Public Health. Family and Intimate Violence Prevention Team, Div of Violence Prevention, National Center for Injury Prevention and Control, CDC.

Editorial Note: The results of this study suggest that the availability of on-site services for IPV victims alone may not be sufficient to overcome trained HCPs' perceptions of IPV as a problem for which they are ill-prepared to intervene (*4*). Systems approaches, such as continuous quality improvement in community health centers, may be more likely to sustain improved IPV screening rates through institutional policies linked to accountability (*5*). The impact of case mix on provider- and institutional-level IPV screening rates also requires more study. However, clinicians' adherence to the recommended practices to screen routinely all women at risk for IPV should be encouraged (*6,7*).

The findings in this report are subject to at least three limitations. First, because a convenience sample of community health centers was used, the results cannot be generalized to other community health centers or HCPs in the rest of Massachusetts or elsewhere. Second, the quasi-experimental design, which lacked a concurrent control, does not account for secular changes in screening behavior that may have occurred over the course of the study. Finally, phase 2 was delayed to involve the community health centers' administrative and clinical staff in the process of selecting IPV advocates and to address other administrative details of service development. Because data were not collected on the screening rates of HCPs immediately before phase 2, the effects of the on-site victims' services on individual HCPs cannot be determined fully.

Maternal and child HCPs see many battered women and their children in various settings, but rarely ask about family violence and IPV (*6–9*). Practitioners need additional training and support to assess and manage complex cases of family violence longitudinally (*10*). Further research to explore effective IPV interventions in health-care settings is needed.

References

1. Greenfield LA, Rand MR, Craven D, et al. Violence by intimates: analysis of data on crimes by current or former spouses, boyfriends, and girlfriends. Washington, DC: US Department of Justice, 1998. (Bureau of Justice Statistics factbook, publication no. NCJ-167237).
2. McKibben L, DeVos E, Newberger E. Victimization of mothers of abused children: a controlled study. Pediatrics 1989;84:531–5.
3. McKibben L, Roberts EL. The Pediatric Family Violence Awareness Project curriculum: a collaborative approach to family violence education. Workshop presented at the annual meeting of the Ambulatory Pediatric Association, Washington, DC, May 1996.
4. Sugg NK, Inui T. Primary care physicians' responses to domestic violence: opening Pandora's box. JAMA 1992;267:3157–60.
5. Berwick DM. Developing and testing changes in delivery of care. Ann Intern Med 1998;128:651–6.
6. Flitcraft AH, Hadley SM, Hendricks-Matthews MK, et al. Diagnostic and treatment guidelines on domestic violence. Chicago, Illinois: American Medical Association, 1992.
7. American Academy of Pediatrics. The role of the pediatrician in recognizing and intervening on behalf of abused women. Pediatrics 1998;101:1091–2.
8. Stark E, Flitcraft AH. Spouse abuse. In: Rosenberg ML, Fenley MA, eds. Violence in America: a public health approach. New York, New York: Oxford University Press, 1991.
9. Gazmararian JA, Lazorick S, Spitz AM, et al. Prevalence of violence against pregnant women. JAMA 1996;275:1915–20.
10. Saunders DG, Kindy P. Predictors of physician's responses to woman abuse: the role of gender, background, and brief training. J Gen Int Med 1993;8:606–9.

Information Needs and Uses of the Public Health Workforce — Washington, 1997–1998

Substantial efforts have been made to ensure that state and local public health agencies have the information technology and training needed for public health communications, information access, and data exchange (*1,2*). Numerous public health-related data and information resources are available on the World-Wide Web (e.g., MEDLINE, *MMWR*, CDC Prevention Guidelines Database, and *Emerging Infectious Diseases*); however, little systematic work has been done to understand the information needs of the public health workforce. To identify these needs and patterns of use and to set priorities for developing new online public health information resources, the University of Washington School of Public Health and Community Medicine (UW SPHCM) and the Washington State Department of Health (WSDoH) held structured and facilitated discussions with segments of the local public health workforce in Washington during 1997–1998. This report summarizes the results of those discussions, which indicate that different segments of the public health workforce have different information needs.

Five subgroups of the local public health workforce were selected for inclusion in the investigation on the basis of input from state and local public health leaders: 1) local health officers and public health agency directors, 2) environmental health directors, 3) directors of public health nursing, 4) health assessment coordinators and epidemiologists, and 5) a group comprising public health officials from small local health departments in which staff typically have responsibilities in multiple areas (e.g., nursing and disease investigation). Open-ended questions about information acquisition and use were developed in consultation with UW SPHCM faculty, WSDoH leaders, and staff from the Eastern and Western Washington Area Health Education Centers (AHECs). AHEC directors served as facilitators at each discussion.

Eight sessions were held from June 1997 through April 1998. A total of 70 persons participated; the smallest group had four and the largest had 14 participants. Persons in each group were from a cross section of local health jurisdictions representing metropolitan and rural areas, large and small agencies, and eastern and western Washington. The participants included 22 environmental health directors (in two sessions in different parts of the state), 10 public health nursing directors, 13 health assessment coordinators and epidemiologists (in two sessions in different parts of the state), four health officers/agency directors, and 21 staff members (mixed segments) from two small county health departments.

Seven information needs were identified by all four workforce segments (Table 1): 1) better tools and resources for contacting experts; 2) updates on pertinent legislative issues and events; 3) structured information ("metadata") characterizing the contents of data sets; 4) outcome measures and "best practice" resources; 5) better scheduling software and event calendars; 6) standard templates for frequently used applications; and 7) synthesized, knowledge-based information from external databases. Five needs were identified by more than one group and another 15 needs were identified by a single group (Table 1).

Interest in the use of information resources and technology also varied across groups (e.g., nursing directors expressed more interest in using videoconferencing technology than did other groups [Table 1]). Some groups expressed readiness to incorporate online resources (e.g., contact lists, statistical databases, and Web-accessible knowledge resources) into their work.

Information Needs and Uses of the Public Health Workforce — Continued

TABLE 1. Data and information resource needs of four local public health workforce segments — Washington, 1997–1998

Needs	Assessment coordinators and epidemiologists	Nursing directors	Environmental health directors	Health officers and agency directors
Access to academic/state experts	X	X	X	X
Administrative/budget data				X
Notification of continuing education opportunities			X	
Criminal justice data	X			
Disease incidence data (county/state/national)	X	X		
Disease/condition information*	X			
Geographically coded health-related data			X	
Health education information for the public			X	
Health education program information		X		
Health insurance billing data	X			
Vaccination guidelines		X		
Industrial effluent data			X	
Laboratory data (online)			X	
Laws and regulations (county/state)			X	X
Legislative issues updates	X	X	X	X
Local/small area data	X			
Metadata on data sets†	X	X	X	X
Outcome measurement resources	X	X	X	X
Group-specific electronic discussion lists	X		X	
Remote access to office systems and meetings		X		
Scheduling software/resources	X	X	X	X
Socioeconomic data	X			
Standard templates§	X	X	X	X
State agency data/resources/publications	X	X		
Synthesized, knowledge-based information¶	X	X	X	X
Treatment data**	X	X		
U.S. census data	X			

*Includes fact sheets, nursing protocols, treatment for contacts, epidemiologic summaries, and prevention guidelines.

†Include information on scope, coverage, location, how to access, and strengths and weaknesses of the data.

§E.g., reporting forms, surveys, assessment instruments, and management tools.

¶Include custom synthesized information and access to online bibliographic and factual databases (e.g., MEDLINE and CDC Prevention Guidelines Database).

**Include hospital-based and clinic-based ambulatory, emergency, and inpatient care.

Information Needs and Uses of the Public Health Workforce — Continued

Reported by: N Rambo, Health Sciences Library, Univ of Washington, Seattle, Washington, and Pacific Northwest Region, National Network of Libraries of Medicine; P Dunham, School of Public Health and Community Medicine, Univ of Washington, Seattle, Washington. Office of the Director, Public Health Practice Program Office, CDC.

Editorial Note: Public health practice spans numerous health, environmental, and social science disciplines; therefore, public health practitioners need access to diverse and complex information and data from multiple sources. Electronic access to peer-reviewed biomedical literature is available through MEDLINE (*3*); however, this resource meets only a portion of the public health practitioner's information needs (*4*). The variety in the types of information needed is matched by the diversity of the public health workforce itself that includes agency directors, environmental health scientists, epidemiologists and health assessment specialists, health educators, health officers, laboratorians, nurses, nutritionists, sanitarians, social workers, and outreach workers. Ideally, the development of online public health information resources should reflect this complexity and diversity.

Approximately one fourth of the information needs identified in this study was shared by all segments of the Washington public health workforce, but nearly half of the information needs was not shared by more than one segment. Also, readiness to incorporate the use of online information resources into public health practice varied across segments. In addition to diverse information needs, these findings may reflect differences in training, experience, and professional culture.

This study is subject to at least two limitations. First, these data are based on interviews with public health professionals in Washington only and may not represent the information needs in other states. Second, some public health workforce groups were not interviewed (e.g., health educators, nutritionists, social workers, and other outreach workers); therefore, the study probably underestimates the range and diversity of information needs among public health workers.

CDC's Information Network for Public Health Officials (*1*), the Health Alert Network (*2*), and the National Library of Medicine's Partnership in Information Access for Public Health Officials (*5*) are designed to strengthen the information infrastructure of state and local public health agencies. The success of these initiatives will depend not only on technology but also on the information content being delivered and used and on a workforce trained to use effectively these new tools and resources. Further research is needed to determine optimal development, structure, delivery, and marketing of public health information to specific public health workforce segments.

References

1. Baker EL, Friede AM, Moulton AD, Ross DA. A framework for integrated public health information and practice. Journal of Public Health Management Practice 1995;1:43–7.
2. Rotz LD, Koo D, O'Carroll PW, Kellogg RB, Sage MJ, Lillibridge SR. Bioterrorism preparedness: planning for the future. Journal of Public Health Management Practice 2000 (in press).
3. Lindberg DAB, Siegel ER, Rapp BA, Wallingford KT, Wilson SR. Use of MEDLINE by physicians for clinical problem solving. JAMA 1993;269:3124–9.
4. Friede A, Blum HL, McDonald M. Public health informatics: how information-age technology can strengthen public health. Annu Rev Public Health 1995;16:239–52.
5. Humphreys B, Ruffin A, Cahn M, Rambo N. Resources for strengthening the public health infrastructure: the National Library of Medicine and the National Network of Libraries of Medicine. Am J Public Health 1999;89:1633–6.

Notice to Readers

Satellite Broadcast on Genital Dermatology

The National Network of STD/HIV Prevention Training Centers will present "STD Grand Rounds: Genital Dermatology," a national satellite broadcast on Thursday, March 9, 2000, from 1 to 3 p.m. eastern standard time. This program is for clinicians at sites across the United States and will be available in English or Spanish. The program is produced by the New York State Centers for STD/HIV Prevention Training in collaboration with the STD/HIV Prevention Training Center of New England. The broadcast is jointly sponsored for continuing medical education credit by the University of Cincinnati and for continuing education unit credit by the Massachusetts Department of Public Health.

Information on attending at a prearranged site or an alternate site is available from the STD/HIV Prevention Training Center in each public health region: Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont), telephone (617) 983-6945; Region II (New Jersey, New York, Puerto Rico, and U.S. Virgin Islands), telephone (518) 474-1692; Region III (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia), telephone (410) 396-3876; Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee), telephone (205) 930-1154; Region V (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin), telephone (513) 558-3197; Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas), telephone (214) 819-1947; Region VII (Iowa, Kansas, Missouri, and Nebraska), telephone (314) 747-0294; Region VIII (Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming), telephone (303) 436-7226; Region IX (Arizona, California, Hawaii, Nevada, and the Pacific Islands), telephone (510) 883-6600; and Region X (Alaska, Idaho, Oregon, and Washington), telephone (206) 685-9850. Registration also is available through the World-Wide Web at http://www.stdptc.uc.edu.*

Sites must be registered for participants to receive the handouts and continuing education credit. Additional information is available by telephone, (888) 232-3299 (or for persons with hearing impairment, [877] 232-1010); enter document number 130035 when prompted.

*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.

Notice to Readers

Availability of Draft of Updated Guidelines for Evaluating Surveillance Systems

A surveillance system enables ongoing collection, analysis, and dissemination of data to prevent and control disease or injury. Because all surveillance systems should be assessed periodically for their purpose and usefulness, in 1988 CDC published *Guidelines for Evaluating Surveillance Systems* (*1*). Recent developments in the electronic exchange of health data, the establishment of data-collection standards, and interest in

Notices to Readers — Continued

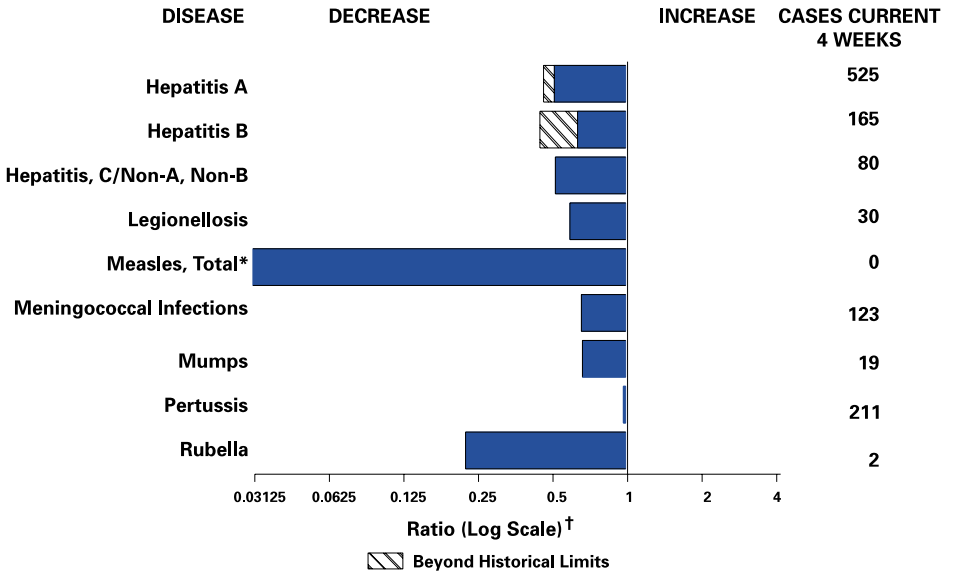
the integration of health information and surveillance systems have resulted in the need to update CDC's guidelines (*2*).

After researching and discussing various issues related to public health surveillance systems, the CDC Guidelines Working Group has composed a draft of *Updated Guidelines for Evaluating Surveillance Systems*. A copy of this draft is available on the World-Wide Web at http://www2.cdc.gov/revguide/index.htm (user name=community; password=guidelines) or by mailing a request for a copy to CDC Guidelines Working Group, Epidemiology Program Office, Mailstop K74, 4770 Buford Highway, Atlanta, GA 30341-3717. Comments about the draft of the updated guidelines should be submitted at the above Internet site or by mail by March 31, 2000.

References

1. CDC. Guidelines for evaluating surveillance systems. MMWR 1988;37(no. S-5).
2. CDC. Revising CDC's guidelines for evaluating surveillance systems. MMWR 1998;47:1083.

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending February 12, 2000, with historical data — United States



*No measles cases were reported for the current 4-week period, yielding a ratio for week 6 of zero (0).

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

TABLE I. Summary — provisional cases of selected notifiable diseases, United States, cumulative, week ending February 12, 2000 (6th Week)

		Cum. 2000		Cum. 2000
Anthrax		-	HIV infection, pediatric*§	9
Brucellosis*		3	Plague	1
Cholera		-	Poliomyelitis, paralytic	-
Congenital rubella syndrome		1	Psittacosis*	-
Cyclosporiasis*		2	Rabies, human	-
Diphtheria		-	Rocky Mountain spotted fever (RMSF)	19
Encephalitis:	California* serogroup viral	-	Streptococcal disease, invasive Group A	301
	eastern equine*	-	Streptococcal toxic-shock syndrome*	16
	St. Louis*	-	Syphilis, congenital¶	-
	western equine*	-	Tetanus	-
Ehrlichiosis	human granulocytic (HGE)*	4	Toxic-shock syndrome	13
	human monocytic (HME)*	1	Trichinosis	1
Hansen Disease*		3	Typhoid fever	26
Hantavirus pulmonary syndrome*†		-	Yellow fever	-
Hemolytic uremic syndrome, post-diarrheal*		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 January 30, 2000.
¶ Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2000, and February 13, 1999 (6th 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	2,750	3,075	39,345	74,212	93	113	135	121	55	95
NEW ENGLAND	289	156	2,316	2,282	2	5	14	22	12	25
Maine	3	3	135	57	1	1	1	1	-	-
N.H.	3	3	88	120	-	-	3	1	3	1
Vt.	1	-	64	42	1	1	1	-	1	-
Mass.	234	122	1,161	989	-	2	3	13	2	13
R.I.	6	9	-	258	-	-	-	-	-	-
Conn.	42	19	868	816	-	1	6	7	6	11
MID. ATLANTIC	795	486	438	8,524	9	21	20	6	-	2
Upstate N.Y.	21	18	N	N	4	7	20	3	-	-
N.Y. City	495	236	-	4,352	4	12	-	1	-	1
N.J.	194	158	64	1,389	-	-	-	2	-	1
Pa.	85	74	374	2,783	1	2	N	N	-	-
E.N. CENTRAL	143	177	8,574	12,363	10	27	14	26	4	16
Ohio	25	37	1,824	4,405	5	4	4	16	1	6
Ind.	26	25	1,324	1,194	3	2	1	4	1	3
Ill.	64	77	2,130	3,145	-	3	6	2	-	2
Mich.	19	22	2,329	2,146	2	2	3	4	1	2
Wis.	9	16	967	1,473	-	16	N	N	1	3
W.N. CENTRAL	49	114	1,862	4,398	2	7	30	23	20	14
Minn.	11	22	506	947	-	1	7	6	9	9
Iowa	7	4	101	167	-	-	3	5	1	2
Mo.	15	73	686	1,800	2	4	18	2	7	1
N. Dak.	-	-	-	99	-	-	-	2	-	1
S. Dak.	1	-	112	265	-	-	-	-	-	-
Nebr.	4	5	263	473	-	1	2	2	2	1
Kans.	11	10	194	647	-	1	-	6	1	-
S. ATLANTIC	588	845	8,229	16,929	11	7	16	12	9	7
Del.	15	13	338	316	-	-	-	-	-	-
Md.	92	81	639	1,695	1	2	5	1	1	-
D.C.	22	8	302	N	-	2	-	-	U	U
Va.	41	54	857	1,785	-	-	3	4	2	2
W. Va.	4	10	-	274	-	-	1	-	1	1
N.C.	27	68	2,111	2,504	2	1	4	2	-	2
S.C.	35	56	669	3,409	-	-	-	1	-	1
Ga.	97	110	661	3,364	3	1	1	1	3	U
Fla.	255	445	2,652	3,582	5	1	2	3	2	1
E.S. CENTRAL	140	155	3,951	3,990	3	2	5	12	1	4
Ky.	20	15	950	782	-	1	2	3	U	U
Tenn.	35	62	1,168	1,607	-	1	2	5	1	2
Ala.	50	30	1,102	1,363	3	-	1	2	-	1
Miss.	35	48	731	238	-	-	-	2	-	1
W.S. CENTRAL	276	530	3,235	9,450	4	4	4	1	4	6
Ark.	8	19	375	567	1	-	2	-	-	2
La.	45	26	-	784	-	-	-	-	3	1
Okla.	10	6	908	1,097	-	-	-	-	-	-
Tex.	213	479	1,952	7,002	3	4	2	1	1	3
MOUNTAIN	102	45	2,234	3,953	6	14	15	5	3	4
Mont.	1	-	-	114	-	-	5	-	-	-
Idaho	3	4	64	186	1	2	1	-	-	-
Wyo.	1	-	82	81	-	-	2	1	-	1
Colo.	34	26	432	781	-	-	4	2	1	1
N. Mex.	8	4	94	614	1	8	-	-	-	-
Ariz.	22	4	916	1,591	2	4	1	1	2	-
Utah	12	4	319	231	2	N	1	1	-	2
Nev.	21	3	327	355	-	-	1	-	-	-
PACIFIC	368	567	8,506	12,323	46	26	17	14	2	17
Wash.	48	28	1,516	1,436	N	N	1	-	1	5
Oreg.	11	15	374	615	1	3	3	8	1	6
Calif.	299	509	6,373	9,696	45	23	11	6	-	6
Alaska	-	5	243	210	-	-	-	-	-	-
Hawaii	10	10	-	366	-	-	2	-	-	-
Guam	-	1	-	50	-	-	N	N	U	U
P.R.	77	92	113	U	-	-	-	1	U	U
V.I.	-	-	-	U	-	U	-	U	U	U
Amer. Samoa	-	-	-	U	-	U	-	U	U	U
C.N.M.I.	-	-	-	U	-	U	-	U	U	U

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

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

† Updated monthly from reports to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update January 30, 2000.

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2000, and February 13, 1999 (6th Week)

Reporting Area	Gonorrhea		Hepatitis C/NA,NB		Legionellosis		Lyme Disease	
	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999	Cum. 2000	Cum. 1999
UNITED STATES	21,363	41,501	176	367	55	81	238	459
NEW ENGLAND	794	804	-	2	3	5	32	53
Maine	8	7	-	-	2	-	-	-
N.H.	9	9	-	-	-	1	11	-
Vt.	1	5	-	1	-	2	-	-
Mass.	344	317	-	1	1	1	21	52
R.I.	-	77	-	-	-	1	-	-
Conn.	432	389	-	-	-	-	-	1
MID. ATLANTIC	589	4,628	-	8	3	17	160	286
Upstate N.Y.	275	332	-	3	2	2	56	38
N.Y. City	-	2,048	-	-	-	4	1	12
N.J.	52	922	-	-	-	3	-	79
Pa.	262	1,326	-	5	1	8	103	157
E.N. CENTRAL	4,892	7,349	32	234	15	36	1	18
Ohio	999	1,963	-	-	11	12	1	7
Ind.	596	743	-	-	2	1	-	-
Ill.	1,077	2,362	2	4	-	6	-	1
Mich.	1,628	1,578	30	75	2	10	-	1
Wis.	592	703	-	155	-	7	U	9
W.N. CENTRAL	747	2,368	24	26	4	3	2	6
Minn.	205	351	-	-	1	-	1	-
Iowa	31	88	-	-	1	2	-	1
Mo.	324	1,413	24	24	2	1	1	2
N. Dak.	-	7	-	-	-	-	-	1
S. Dak.	8	24	-	-	-	-	-	-
Nebr.	91	221	-	1	-	-	-	-
Kans.	88	264	-	1	-	-	-	2
S. ATLANTIC	6,963	13,526	6	25	18	8	30	62
Del.	184	187	-	-	1	1	-	3
Md.	318	2,161	1	16	6	-	24	50
D.C.	312	975	-	-	-	-	-	1
Va.	971	1,504	-	2	2	2	-	-
W. Va.	-	90	-	1	N	N	1	-
N.C.	1,963	2,337	3	5	1	2	3	8
S.C.	574	1,744	-	1	2	1	-	-
Ga.	556	1,903	-	-	-	-	-	-
Fla.	2,085	2,625	2	-	6	2	2	-
E.S. CENTRAL	3,040	3,454	32	20	1	4	-	8
Ky.	426	460	3	2	-	2	-	-
Tenn.	1,001	1,344	8	14	-	2	-	2
Ala.	935	1,342	3	1	1	-	-	3
Miss.	678	308	18	3	-	-	-	3
W.S. CENTRAL	1,786	5,429	35	5	-	-	-	-
Ark.	242	294	-	-	-	-	-	-
La.	-	859	-	2	-	-	-	-
Okla.	456	597	-	1	-	-	-	-
Tex.	1,088	3,679	35	2	-	-	-	-
MOUNTAIN	899	1,180	23	30	4	4	1	1
Mont.	-	1	-	-	-	-	-	-
Idaho	4	10	-	3	1	-	-	-
Wyo.	5	3	13	15	-	-	-	-
Colo.	410	213	4	3	2	1	-	-
N. Mex.	18	134	3	6	-	1	-	1
Ariz.	285	634	3	2	-	-	1	-
Utah	48	23	-	1	1	2	-	-
Nev.	129	162	-	-	-	-	-	-
PACIFIC	1,653	2,763	24	17	7	4	12	25
Wash.	289	247	2	2	1	-	-	-
Oreg.	47	99	5	1	N	N	1	-
Calif.	1,288	2,303	17	14	6	4	11	25
Alaska	29	44	-	-	-	-	-	-
Hawaii	-	70	-	-	-	-	N	N
Guam	-	12	-	-	-	-	-	-
P.R.	28	35	-	-	-	-	N	N
V.I.	-	U	-	U	-	U	-	U
Amer. Samoa	-	U	-	U	-	U	-	U
C.N.M.I.	-	U	-	U	-	U	-	U

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2000, and February 13, 1999 (6th 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	1,170	1,466	265	842	464	787	530	1,191
NEW ENGLAND	31	32	12	35	6	9	11	23
Maine	2	-	-	-	-	-	-	-
N.H.	1	2	-	4	-	-	-	-
Vt.	-	1	-	1	-	1	-	-
Mass.	21	24	11	23	5	5	9	7
R.I.	2	3	-	3	-	-	2	9
Conn.	5	2	1	4	1	3	-	7
MID. ATLANTIC	28	107	29	69	9	30	65	145
Upstate N.Y.	13	22	3	16	-	2	-	6
N.Y. City	10	34	26	30	6	13	37	58
N.J.	-	33	-	23	-	9	22	45
Pa.	5	18	-	-	3	6	6	36
E.N. CENTRAL	200	329	42	121	107	107	33	115
Ohio	14	127	1	9	9	10	11	37
Ind.	18	11	5	4	50	28	2	9
Ill.	68	111	-	98	14	57	17	51
Mich.	96	36	34	-	23	7	-	15
Wis.	4	44	2	10	11	5	3	3
W.N. CENTRAL	57	76	31	66	6	30	23	27
Minn.	12	10	12	14	2	1	13	16
Iowa	12	-	7	1	-	-	-	-
Mo.	25	54	8	45	4	27	8	9
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	1
Nebr.	8	6	2	3	-	1	2	-
Kans.	-	6	2	3	-	1	-	1
S. ATLANTIC	97	147	15	38	176	322	83	118
Del.	-	4	-	1	1	1	-	2
Md.	10	11	2	2	23	57	-	19
D.C.	-	6	U	U	10	32	-	4
Va.	9	5	-	3	17	21	-	9
W. Va.	-	3	-	-	-	1	5	5
N.C.	8	38	4	9	60	72	9	29
S.C.	3	15	1	5	11	33	18	33
Ga.	5	8	3	8	12	63	24	16
Fla.	62	57	5	10	42	42	27	1
E.S. CENTRAL	44	205	19	122	77	144	31	71
Ky.	9	20	U	U	3	17	-	6
Tenn.	19	149	17	114	52	63	4	16
Ala.	5	22	-	8	14	44	27	42
Miss.	11	14	2	-	8	20	-	7
W.S. CENTRAL	84	211	63	299	42	94	11	234
Ark.	18	15	-	11	3	10	8	8
La.	-	11	10	18	-	4	-	U
Okla.	-	63	1	9	27	24	3	6
Tex.	66	122	52	261	12	56	-	220
MOUNTAIN	142	101	33	57	18	16	17	30
Mont.	-	1	-	-	-	-	-	-
Idaho	15	2	-	1	-	-	-	-
Wyo.	-	1	-	-	-	-	-	-
Colo.	16	19	7	17	2	-	1	U
N. Mex.	17	10	5	6	-	-	3	4
Ariz.	62	60	17	25	14	16	8	12
Utah	5	5	4	6	-	-	4	8
Nev.	27	3	-	2	2	-	1	6
PACIFIC	487	258	21	35	23	35	256	428
Wash.	57	4	2	18	4	1	21	12
Oreg.	65	7	19	9	-	1	-	10
Calif.	359	239	-	-	19	32	226	383
Alaska	2	-	-	-	-	-	1	6
Hawaii	4	8	-	8	-	1	8	17
Guam	-	2	U	U	-	-	-	-
P.R.	-	6	U	U	16	32	-	-
V.I.	-	U	U	U	-	U	-	U
Amer. Samoa	-	U	U	U	-	U	-	U
C.N.M.I.	-	U	U	U	-	U	-	U

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

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

TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending February 12, 2000, and February 13, 1999 (6th 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	1,170	1,466	265	842	464	787	530	1,191
NEW ENGLAND	31	32	12	35	6	9	11	23
Maine	2	-	-	-	-	-	-	-
N.H.	1	2	-	4	-	-	-	-
Vt.	-	1	-	1	-	1	-	-
Mass.	21	24	11	23	5	5	9	7
R.I.	2	3	-	3	-	-	2	9
Conn.	5	2	1	4	1	3	-	7
MID. ATLANTIC	28	107	29	69	9	30	65	145
Upstate N.Y.	13	22	3	16	-	2	-	6
N.Y. City	10	34	26	30	6	13	37	58
N.J.	-	33	-	23	-	9	22	45
Pa.	5	18	-	-	3	6	6	36
E.N. CENTRAL	200	329	42	121	107	107	33	115
Ohio	14	127	1	9	9	10	11	37
Ind.	18	11	5	4	50	28	2	9
Ill.	68	111	-	98	14	57	17	51
Mich.	96	36	34	-	23	7	-	15
Wis.	4	44	2	10	11	5	3	3
W.N. CENTRAL	57	76	31	66	6	30	23	27
Minn.	12	10	12	14	2	1	13	16
Iowa	12	-	7	1	-	-	-	-
Mo.	25	54	8	45	4	27	8	9
N. Dak.	-	-	-	-	-	-	-	-
S. Dak.	-	-	-	-	-	-	-	1
Nebr.	8	6	2	3	-	1	2	-
Kans.	-	6	2	3	-	1	-	1
S. ATLANTIC	97	147	15	38	176	322	83	118
Del.	-	4	-	1	1	1	-	2
Md.	10	11	2	2	23	57	-	19
D.C.	-	6	U	U	10	32	-	4
Va.	9	5	-	3	17	21	-	9
W. Va.	-	3	-	-	-	1	5	5
N.C.	8	38	4	9	60	72	9	29
S.C.	3	15	1	5	11	33	18	33
Ga.	5	8	3	8	12	63	24	16
Fla.	62	57	5	10	42	42	27	1
E.S. CENTRAL	44	205	19	122	77	144	31	71
Ky.	9	20	U	U	3	17	-	6
Tenn.	19	149	17	114	52	63	4	16
Ala.	5	22	-	8	14	44	27	42
Miss.	11	14	2	-	8	20	-	7
W.S. CENTRAL	84	211	63	299	42	94	11	234
Ark.	18	15	-	11	3	10	8	8
La.	-	11	10	18	-	4	-	U
Okla.	-	63	1	9	27	24	3	6
Tex.	66	122	52	261	12	56	-	220
MOUNTAIN	142	101	33	57	18	16	17	30
Mont.	-	1	-	-	-	-	-	-
Idaho	15	2	-	1	-	-	-	-
Wyo.	-	1	-	-	-	-	-	-
Colo.	16	19	7	17	2	-	1	U
N. Mex.	17	10	5	6	-	-	3	4
Ariz.	62	60	17	25	14	16	8	12
Utah	5	5	4	6	-	-	4	8
Nev.	27	3	-	2	2	-	1	6
PACIFIC	487	258	21	35	23	35	256	428
Wash.	57	4	2	18	4	1	21	12
Oreg.	65	7	19	9	-	1	-	10
Calif.	359	239	-	-	19	32	226	383
Alaska	2	-	-	-	-	-	1	6
Hawaii	4	8	-	8	-	1	8	17
Guam	-	2	U	U	-	-	-	-
P.R.	-	6	U	U	16	32	-	-
V.I.	-	U	U	U	-	U	-	U
Amer. Samoa	-	U	U	U	-	U	-	U
C.N.M.I.	-	U	U	U	-	U	-	U

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

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

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

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 12, 2000, and February 13, 1999 (6th 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	97	123	1,097	1,724	403	541	-	1	-	-	1	13
NEW ENGLAND	6	9	18	27	6	16	-	-	-	-	-	-
Maine	-	-	1	2	1	-	-	-	-	-	-	-
N.H.	1	1	4	2	3	2	-	-	-	-	-	-
Vt.	1	2	1	-	2	-	-	-	-	-	-	-
Mass.	4	6	3	10	-	6	-	-	-	-	-	-
R.I.	-	-	-	-	-	2	-	-	-	-	-	-
Conn.	-	-	9	13	-	6	-	-	-	-	-	-
MID. ATLANTIC	12	19	38	115	23	82	-	-	-	-	-	-
Upstate N.Y.	10	9	26	12	6	12	-	-	-	-	-	-
N.Y. City	-	6	12	47	17	23	-	-	-	-	-	-
N.J.	1	4	-	24	-	14	U	-	U	-	-	-
Pa.	1	-	-	32	-	33	-	-	-	-	-	-
E.N. CENTRAL	13	24	126	465	58	63	-	1	-	-	1	-
Ohio	8	11	52	77	13	14	-	-	-	-	-	-
Ind.	2	1	2	9	1	4	-	-	-	-	-	-
Ill.	2	12	10	93	-	-	-	-	-	-	-	-
Mich.	1	-	61	278	44	41	-	1	-	-	1	-
Wis.	-	-	1	8	-	4	-	-	-	-	-	-
W.N. CENTRAL	2	5	109	95	17	28	-	-	-	-	-	-
Minn.	-	-	12	-	-	-	-	-	-	-	-	-
Iowa	-	1	11	7	2	2	-	-	-	-	-	-
Mo.	1	2	80	73	14	18	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	U	-	U	-	-	-
S. Dak.	-	1	-	-	-	-	U	-	U	-	-	-
Nebr.	1	-	6	9	1	6	-	-	-	-	-	-
Kans.	-	1	-	6	-	2	U	-	U	-	-	-
S. ATLANTIC	35	23	98	131	65	75	-	-	-	-	-	-
Del.	-	-	-	-	-	-	-	-	-	-	-	-
Md.	17	17	18	49	17	32	-	-	-	-	-	-
D.C.	-	-	-	7	-	-	-	-	-	-	-	-
Va.	8	-	16	9	15	6	-	-	-	-	-	-
W. Va.	1	1	7	-	-	-	-	-	-	-	-	-
N.C.	3	2	20	19	11	26	-	-	-	-	-	-
S.C.	1	2	2	1	1	8	-	-	-	-	-	-
Ga.	4	1	4	46	-	3	-	-	-	-	-	-
Fla.	1	-	31	-	21	-	-	-	-	-	-	-
E.S. CENTRAL	3	10	51	54	31	44	-	-	-	-	-	-
Ky.	-	2	2	9	1	2	-	-	-	-	-	-
Tenn.	2	4	15	18	23	23	-	-	-	-	-	-
Ala.	1	3	8	18	2	11	-	-	-	-	-	-
Miss.	-	1	26	9	5	8	-	-	-	-	-	-
W.S. CENTRAL	-	6	133	172	6	44	-	-	-	-	-	2
Ark.	-	-	11	3	6	7	-	-	-	-	-	-
La.	-	-	-	1	-	1	U	-	U	-	-	-
Okla.	-	5	-	61	-	10	-	-	-	-	-	-
Tex.	-	1	122	107	-	26	-	-	-	-	-	2
MOUNTAIN	18	16	85	181	42	57	-	-	-	-	-	-
Mont.	-	1	1	1	1	-	-	-	-	-	-	-
Idaho	1	1	3	4	3	4	-	-	-	-	-	-
Wyo.	-	1	-	1	-	-	-	-	-	-	-	-
Colo.	5	1	26	40	11	13	-	-	-	-	-	-
N. Mex.	5	3	9	5	12	20	-	-	-	-	-	-
Ariz.	6	6	31	99	14	9	-	-	-	-	-	-
Utah	1	3	8	12	-	5	-	-	-	-	-	-
Nev.	-	-	7	19	1	6	-	-	-	-	-	-
PACIFIC	8	11	439	484	155	132	-	-	-	-	-	11
Wash.	2	-	3	8	1	1	-	-	-	-	-	2
Oreg.	2	3	27	22	13	7	-	-	-	-	-	8
Calif.	-	7	406	451	138	121	-	-	-	-	-	1
Alaska	1	1	3	2	2	2	-	-	-	-	-	-
Hawaii	3	-	-	1	1	1	-	-	-	-	-	-
Guam	-	-	-	2	-	1	U	-	U	-	-	-
P.R.	-	-	-	7	-	14	U	-	U	-	-	-
V.I.	-	U	-	U	-	U	U	-	U	-	-	U
Amer. Samoa	-	U	-	U	-	U	U	-	U	-	-	U
C.N.M.I.	-	U	-	U	-	U	U	-	U	-	-	U

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

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

†Of 26 cases among children aged <5 years, serotype was reported for 10 and of those, 2 were type b.

TABLE III. (Cont'd) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending February 12, 2000, and February 13, 1999 (6th 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	265	238	11	35	43	33	337	425	1	2	1
NEW ENGLAND	14	18	-	-	3	5	72	62	1	1	1
Maine	1	2	-	-	-	2	4	-	-	-	-
N.H.	-	2	-	-	1	-	20	3	1	1	-
Vt.	1	1	-	-	-	2	24	7	-	-	-
Mass.	7	13	-	-	2	-	23	52	-	-	1
R.I.	1	-	-	-	-	-	-	-	-	-	-
Conn.	4	-	-	-	-	1	1	-	-	-	-
MID. ATLANTIC	19	31	-	2	5	7	24	21	-	-	-
Upstate N.Y.	6	4	-	1	-	7	22	11	-	-	-
N.Y. City	4	13	-	-	2	-	-	7	-	-	-
N.J.	3	8	U	-	-	U	-	2	U	-	-
Pa.	6	6	-	1	3	-	2	1	-	-	-
E.N. CENTRAL	32	35	-	1	2	8	96	61	-	-	-
Ohio	9	15	-	-	1	6	89	41	-	-	-
Ind.	7	3	-	-	-	2	3	1	-	-	-
Ill.	4	13	-	-	1	-	1	6	-	-	-
Mich.	11	2	-	1	-	-	3	5	-	-	-
Wis.	1	2	-	-	-	-	-	8	-	-	-
W.N. CENTRAL	30	24	3	6	1	-	7	11	-	-	-
Minn.	1	-	-	-	-	-	3	-	-	-	-
Iowa	3	4	-	1	1	-	3	4	-	-	-
Mo.	26	12	1	1	-	-	1	1	-	-	-
N. Dak.	-	-	U	-	-	U	-	-	U	-	-
S. Dak.	-	3	U	-	-	U	-	1	U	-	-
Nebr.	-	1	2	4	-	-	-	-	-	-	-
Kans.	-	4	U	-	-	U	-	5	U	-	-
S. ATLANTIC	52	25	1	4	5	2	23	42	-	-	-
Del.	-	1	-	-	-	-	-	-	-	-	-
Md.	4	6	-	1	1	1	9	18	-	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-
Va.	9	2	-	-	-	-	1	6	-	-	-
W. Va.	1	1	-	-	-	-	-	-	-	-	-
N.C.	11	5	-	-	1	-	4	16	-	-	-
S.C.	6	6	1	3	2	1	9	2	-	-	-
Ga.	7	4	-	-	-	-	-	-	-	-	-
Fla.	14	-	-	-	1	-	-	-	-	-	-
E.S. CENTRAL	10	23	-	1	-	-	7	12	-	-	-
Ky.	2	3	-	-	-	-	3	3	-	-	-
Tenn.	3	8	-	-	-	-	1	4	-	-	-
Ala.	5	9	-	1	-	-	3	5	-	-	-
Miss.	-	3	-	-	-	-	-	-	-	-	-
W.S. CENTRAL	1	17	-	-	9	-	1	16	-	-	-
Ark.	1	3	-	-	-	-	1	2	-	-	-
La.	-	5	U	-	-	U	-	-	U	-	-
Okla.	-	6	-	-	1	-	-	2	-	-	-
Tex.	-	3	-	-	8	-	-	12	-	-	-
MOUNTAIN	14	28	-	2	3	9	95	91	-	1	-
Mont.	-	-	-	-	-	-	-	-	-	-	-
Idaho	2	4	-	-	-	2	15	44	-	-	-
Wyo.	-	1	-	-	-	-	-	1	-	-	-
Colo.	1	8	-	-	1	5	52	14	-	-	-
N. Mex.	2	4	N	N	N	1	16	7	-	-	-
Ariz.	6	7	-	-	-	-	8	9	-	-	-
Utah	3	3	-	-	1	-	3	15	-	1	-
Nev.	-	1	-	2	1	1	1	1	-	-	-
PACIFIC	93	37	7	19	15	2	12	109	-	-	-
Wash.	4	4	-	-	-	-	2	1	-	-	-
Oreg.	13	8	N	N	N	2	8	3	-	-	-
Calif.	75	18	7	19	11	-	-	100	-	-	-
Alaska	-	3	-	-	1	-	2	1	-	-	-
Hawaii	1	4	-	-	3	-	-	4	-	-	-
Guam	-	-	U	-	-	U	-	-	U	-	-
P.R.	-	-	U	-	-	U	-	-	U	-	-
V.I.	-	U	U	-	U	U	-	U	U	-	U
Amer. Samoa	-	U	U	-	U	U	-	U	U	-	U
C.N.M.I.	-	U	U	-	U	U	-	U	U	-	U

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

TABLE IV. Deaths in 122 U.S. cities,* week ending February 12, 2000 (6th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	≥65	45-64	25-44	1-24	<1	
NEW ENGLAND	622	473	105	29	4	11	77
Boston, Mass.	134	95	33	2	2	2	15
Bridgeport, Conn.	49	33	9	6	-	1	8
Cambridge, Mass.	25	21	4	-	-	-	4
Fall River, Mass.	33	32	1	-	-	-	4
Hartford, Conn.	U	U	U	U	U	U	U
Lowell, Mass.	31	22	7	2	-	-	3
Lynn, Mass.	17	14	2	1	-	-	2
New Bedford, Mass.	30	26	4	-	-	-	2
New Haven, Conn.	43	26	10	4	1	2	6
Providence, R.I.	74	59	9	5	1	-	4
Somerville, Mass.	7	5	2	-	-	-	-
Springfield, Mass.	69	52	12	3	-	2	8
Waterbury, Conn.	36	30	4	1	-	1	6
Worcester, Mass.	74	58	8	5	-	3	15
MID. ATLANTIC	2,779	1,970	523	176	54	56	186
Albany, N.Y.	49	33	12	1	1	2	3
Allentown, Pa.	U	U	U	U	U	U	U
Buffalo, N.Y.	190	148	28	9	-	5	21
Camden, N.J.	28	17	7	2	1	1	1
Elizabeth, N.J.	23	14	6	1	1	1	-
Erie, Pa.§	67	55	10	-	2	-	11
Jersey City, N.J.	60	44	10	3	1	2	-
New York City, N.Y.	1,344	925	265	101	29	24	42
Newark, N.J.	38	18	10	7	1	2	3
Paterson, N.J.	23	12	5	5	-	1	3
Philadelphia, Pa.	488	355	88	19	16	10	37
Pittsburgh, Pa.§	60	44	11	2	2	1	10
Reading, Pa.	38	27	6	4	-	1	2
Rochester, N.Y.	131	101	20	7	-	3	12
Schenectady, N.Y.	30	23	4	3	-	-	3
Scranton, Pa.§	38	28	9	1	-	-	-
Syracuse, N.Y.	82	65	12	5	-	-	19
Trenton, N.J.	51	30	13	5	-	3	11
Utica, N.Y.	39	31	7	1	-	-	8
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,329	1,645	418	163	41	62	256
Akron, Ohio	58	43	11	2	-	2	6
Canton, Ohio	52	40	9	2	-	1	8
Chicago, Ill.	438	267	93	45	9	24	47
Cincinnati, Ohio	122	88	20	7	5	2	14
Cleveland, Ohio	123	81	31	7	1	3	4
Columbus, Ohio	222	167	38	15	1	1	29
Dayton, Ohio	161	127	25	6	3	-	14
Detroit, Mich.	216	119	51	31	5	10	21
Evansville, Ind.	63	50	12	-	-	1	6
Fort Wayne, Ind.	94	69	17	5	1	2	10
Gary, Ind.	26	18	6	1	1	-	1
Grand Rapids, Mich.	57	42	4	5	3	3	12
Indianapolis, Ind.	159	115	26	7	5	6	25
Lansing, Mich.	55	42	8	3	1	1	2
Milwaukee, Wis.	118	88	18	9	2	1	14
Peoria, Ill.	53	44	7	1	-	1	2
Rockford, Ill.	64	46	10	6	1	1	10
South Bend, Ind.	46	39	4	2	1	-	6
Toledo, Ohio	129	98	20	6	2	3	21
Youngstown, Ohio	73	62	8	3	-	-	4
W.N. CENTRAL	1,116	797	196	69	32	22	141
Des Moines, Iowa	143	108	23	5	3	4	29
Duluth, Minn.	U	U	U	U	U	U	U
Kansas City, Kans.	50	34	7	6	2	1	4
Kansas City, Mo.	118	74	30	6	3	5	14
Lincoln, Nebr.	42	32	7	2	1	-	7
Minneapolis, Minn.	252	198	35	13	4	2	34
Omaha, Nebr.	100	76	16	7	1	-	18
St. Louis, Mo.	142	85	34	14	4	5	2
St. Paul, Minn.	109	85	14	4	4	2	13
Wichita, Kans.	160	105	30	12	10	3	20
S. ATLANTIC	1,239	813	246	105	45	29	114
Atlanta, Ga.	U	U	U	U	U	U	U
Baltimore, Md.	206	124	42	27	11	1	24
Charlotte, N.C.	105	76	22	2	3	2	13
Jacksonville, Fla.	153	91	37	18	5	2	19
Miami, Fla.	103	65	25	7	5	1	6
Norfolk, Va.	67	50	10	1	-	6	3
Richmond, Va.	82	57	13	7	1	4	8
Savannah, Ga.	68	50	10	3	2	3	11
St. Petersburg, Fla.	50	37	6	3	2	2	4
Tampa, Fla.	192	144	37	6	3	2	22
Washington, D.C.	190	116	39	16	13	6	4
Wilmington, Del.	23	3	5	15	-	-	-
E.S. CENTRAL	1,106	772	235	53	23	23	130
Birmingham, Ala.	214	162	39	6	5	2	29
Chattanooga, Tenn.	108	77	23	5	1	2	14
Knoxville, Tenn.	95	65	19	6	1	4	8
Lexington, Ky.	58	37	18	1	1	1	5
Memphis, Tenn.	262	165	64	17	7	9	32
Mobile, Ala.	141	99	31	5	5	1	14
Montgomery, Ala.	69	59	8	2	-	-	13
Nashville, Tenn.	159	108	33	11	3	4	15
W.S. CENTRAL	1,475	993	318	113	26	25	142
Austin, Tex.	85	62	16	6	-	1	4
Baton Rouge, La.	131	87	29	12	-	3	6
Corpus Christi, Tex.	54	40	10	3	-	1	7
Dallas, Tex.	U	U	U	U	U	U	U
El Paso, Tex.	50	36	11	1	1	1	6
Ft. Worth, Tex.	157	119	26	9	1	2	14
Houston, Tex.	389	245	92	39	10	3	45
Little Rock, Ark.	86	51	22	8	-	5	4
New Orleans, La.	80	48	18	7	4	3	2
San Antonio, Tex.	239	166	44	16	8	5	28
Shreveport, La.	55	35	18	1	1	-	8
Tulsa, Okla.	149	104	32	11	1	1	18
MOUNTAIN	1,055	743	206	72	19	14	92
Albuquerque, N.M.	121	86	25	7	-	2	9
Boise, Idaho	39	31	7	1	-	-	3
Colo. Springs, Colo.	51	40	8	2	1	-	3
Denver, Colo.	124	82	23	13	2	4	18
Las Vegas, Nev.	214	143	54	14	2	1	25
Ogden, Utah	28	24	4	-	-	-	4
Phoenix, Ariz.	174	119	34	13	5	3	11
Pueblo, Colo.	25	19	5	1	-	-	3
Salt Lake City, Utah	101	70	14	10	5	2	8
Tucson, Ariz.	178	129	32	11	4	2	8
PACIFIC	1,428	1,063	247	72	25	21	164
Berkeley, Calif.	9	6	2	1	-	-	1
Fresno, Calif.	136	93	33	7	2	1	19
Glendale, Calif.	18	12	4	2	-	-	-
Honolulu, Hawaii	76	61	10	1	2	2	7
Long Beach, Calif.	90	70	12	5	1	2	12
Los Angeles, Calif.	289	219	45	14	5	6	24
Pasadena, Calif.	18	13	5	-	-	-	6
Portland, Oreg.	115	83	20	9	3	-	15
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	177	124	30	14	5	4	19
San Francisco, Calif.	U	U	U	U	U	U	U
San Jose, Calif.	190	144	32	7	4	3	31
Santa Cruz, Calif.	23	20	3	-	-	-	2
Seattle, Wash.	143	107	28	6	-	2	16
Spokane, Wash.	56	43	8	2	2	1	5
Tacoma, Wash.	88	68	15	4	1	-	7
TOTAL	13,149¶	9,269	2,494	852	269	263	1,302

U: Unavailable -:no reported cases

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

†Pneumonia and influenza.

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

¶Total includes unknown ages.

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

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

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

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

The *Morbidity and Mortality Weekly Report (MMWR)* Series is prepared by the Centers for Disease Control and Prevention (CDC) and is available free of charge in electronic format and on a paid subscription basis for paper copy. To receive an electronic copy on Friday of each week, send an e-mail message to *listserv@listserv.cdc.gov*. The body content should read *SUBscribe mmwr-toc*. Electronic copy also is available from CDC's World-Wide Web server at *http://www.cdc.gov/* or from CDC's file transfer protocol server at *ftp.cdc.gov*. To subscribe for paper copy, contact Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402; telephone (202) 512-1800.

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to: Editor, *MMWR* Series, Mailstop C-08, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone (888) 232-3228.

☆U.S. Government Printing Office: 2000-533-206/08052 Region IV