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# Public Health Dispatch

MORBIDITY AND MORTALITY

WEEKLY REPORT

# Certification of Poliomyelitis Eradication — Western Pacific Region, October 2000

On October 29, 2000, the Regional Commission for the Certification of Poliomyelitis Eradication certified that the Western Pacific Region (WPR) of the World Health Organization (WHO) is free of indigenous wild poliovirus transmission. The last known case of indigenous poliovirus transmission occurred in Cambodia in March 1997 in a 15-month-old girl. WPR is the second of the six WHO regions to be certified as poliomyelitis-free; the first was the Region of the Americas in 1994 (1). WPR comprises 37 countries and territories\* (Figure 1) with an estimated 1.6 billion persons (27% of the world's population) (2).

The commission completed a 5-year review of programmatic data compiled by national certification committees to ensure that the absence of reported wild poliovirus isolation reflected interruption of indigenous transmission. The prerequisite for regional certification is the absence of indigenous wild poliovirus isolation for at least 3 years (3). Other criteria used to certify that countries and regions are polio-free include 1) high vaccination coverage rates in all countries and within all areas of a country; 2) sensitive surveillance for detecting all cases of acute flaccid paralysis (AFP) meeting standard performance indicators (e.g., the processing of all stool samples from AFP case-patients in WHO-accredited laboratories); 3) a plan of action to respond to imported cases of polio and poliovirus; and 4) political commitment by national governments to maintain polio eradication activities at current levels of intensity until at least 2005.

WPR is the first region to include the biocontainment of wild polioviruses in laboratories as part of the certification process. In its initial phase, this process entails conducting inventories of all stocks of wild poliovirus infectious materials and potentially infectious materials. Completion of this phase in WPR is expected in December 2001.

In 1988, the Global Poliomyelitis Eradication Initiative was established by the World Health Assembly and was coordinated by WHO, the United Nations Children's Fund (UNICEF), Rotary International, and CDC; it is the largest public health effort for disease eradication. National governments, private foundations, nongovernmental organizations,

<sup>\*</sup>American Samoa, Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, French Polynesia, Guam, Hong Kong/China, Japan, Kiribati, Republic of Korea, Lao People's Democratic Republic, Macao/China, Malaysia, Marshall Islands, Micronesia, Federated States of Mongolia, Nauru, New Caledonia, New Zealand, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Philippines, Pitcairn Islands, Samoa, Singapore, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Viet Nam, Wallis and Futuna Islands.



# FIGURE 1. Countries and territories\* certified free of wild poliovirus — Western Pacific Region, 2000

\* American Samoa, Australia, Brunei Darussalam, Cambodia, China, Cook Islands, Fiji, French Polynesia, Guam, Hong Kong/China, Japan, Kiribati, Republic of Korea, Lao People's Democratic Republic, Macao/China, Malaysia, Marshall Islands, Micronesia, Federated States of Mongolia, Nauru, New Caledonia, New Zealand, Niue, Northern Mariana Islands, Palau, Papua New Guinea, Philippines, Pitcairn Islands, Samoa, Singapore, Solomon Islands, Tokelau, Tonga, Tuvalu, Vanuatu, Viet Nam, Wallis and Futuna Islands.

corporations, and volunteers have collaborated to achieve eradication. In the European Region, no new indigenous polio cases have been detected since November 1998. Twenty countries in the three other WHO regions (Africa, Eastern Mediterranean, and South-East Asia) anticipate continued poliovirus transmission; global circulation of poliovirus may be interrupted by 2002 (4).

The occurrence of an imported case of polio in China in October 1999 (5) and the documented transmission of wild poliovirus in areas bordering WPR during 2000 (4) underscore that the continued circulation of poliovirus in the three WHO regions pose a risk for reintroduction to all polio-free countries. Polio-free countries should maintain high levels of polio vaccination coverage and sensitive surveillance for the prompt detection of any circulating poliovirus. To minimize the risk for poliovirus importation, supplementary vaccination campaigns will be required in high-risk areas, especially those bordering

# Poliomyelitis Eradication — Continued

countries where polio is endemic. During 2000, an outbreak of vaccine-associated polio was documented among populations with low poliovirus vaccine coverage in the Dominican Republic and Haiti (6). Global certification of polio eradication will be required before consideration of discontinuing polio vaccination.

Reported by: Western Pacific Regional Office, World Health Organization, Manila, Philippines. Vaccines and Other 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.

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# Progress in Development of Immunization Registries — United States, 2000

Immunization registries are confidential, population-based, computerized information systems that attempt to collect vaccination data about all children within a geographic area (1). Registries are an important tool to increase and sustain high vaccination coverage by consolidating vaccination records of children from multiple providers, generating reminder and recall vaccination notices for each child, and providing official vaccination forms and vaccination coverage assessments. One of the national health objectives for 2010 is to increase to 95% the proportion of children aged <6 years who participate in fully operational population-based immunization registries (objective 14.26) (2). To assess the status of immunization registry development, CDC analyzed selfreported data from 62 immunization grantees on the basis of data from the 2000 Immunization Registry Annual Report (IRAR). This report summarizes the results of this analysis, which indicate that approximately half of the grantees are operating populationbased immunization registries that target their entire catchment areas; however, approximately 75% of children aged <6 years still need to be included in an immunization registry to reach the national health objective.

The 2000 IRAR was a self-administered questionnaire distributed to immunization program managers or immunization registry managers that requested information on the enrollment status of a registry's target population and the implementation of 13 functional standards (Table 1) considered essential for immunization registry operation (*3*). Key elements for each of the 13 standards were defined by the Immunization Registry Technical Working Group (IRTWG) and are used to measure registry development. The 2000 IRAR also collected data on provider participation and other electronic information systems that shared data with the registry.

#### Immunization Registries — Continued

	Regi meet <u>key el</u>	stries ing all <u>ements</u>	Regis meeti <u>key e</u> l	stries ing ≥1 I <u>ments</u>
Functional standard	No.	(%)	No.	(%)
Electronically store data on all				
National Vaccine Advisory				
Committee-approved core data elements	21	(65.6)	32	(100.0)
Establish a registry record within 6 weeks				
of birth for each newborn child born				
in the catchment area	29	(90.6)	29	(90.6)
Enable access to vaccination information				
from the registry at the time of encounter	29	(90.6)	30	(93.8)
Receive and process vaccination information				
within 1 month of vaccine administration	28	(87.5)	32	(100.0)
Protect the confidentiality of medical information	6	(18.8)	28	(87.5)
Ensure the security of medical information	28	(87.5)	32	(100.0)
Recover lost data (disaster recovery)	26	(81.3)	32	(100.0)
Exchange vaccination records using				
Health Level 7 standards	4	(12.5)	8	(25.0)
Automatically determine the immunization(s) needed				
when a person presents for a scheduled vaccination	28	(87.5)	28	(87.5)
Automatically identify persons due/late for				
vaccinations to enable the production of				
reminder/recall notifications	25	(78.1)	30	(93.8)
Automatically produce vaccination coverage reports				
by providers, age groups, and geographic areas	24	(75.0)	29	(90.6)
Produce authorized immunization records	27	(84.4)	27	(84.4)
Consolidate all vaccination records from				
multiple providers, using deduplication and edit				
checking procedures to optimize accuracy				
and completeness	28	(87.5)	32	(100.0)

TABLE 1. Number and percentage of population-based immunization registriesthat implemented key elements of the 13 functional standards — United States,June 2000

In April 2000, CDC's 64 immunization grantees (50 states; the District of Columbia; Chicago, Illinois; Houston, Texas; New York, New York; Philadelphia, Pennsylvania; San Antonio, Texas; American Samoa; Guam; Marshall Islands; Micronesia; Northern Mariana Islands; Puerto Rico; Republic of Palau; and the U.S. Virgin Islands) were asked to complete the 2000 IRAR; 62 (97%) responded. Thirty-two (52%) of the 62 grantees (26 states, four cities, and two territories/commonwealths) reported operating population-based immunization registries that targeted their entire catchment areas. Of the remaining 30 (48%) grantees, seven operated population-based registries in regions or counties as demonstrations or pilot projects, and 23 were planning to develop population-based registries.

Data from 31 of the 32 grantees operating population-based registries indicated that approximately 46% of the estimated 10.4 million target children aged <6 years in these catchment areas had received at least two doses of vaccine. The two doses typically included one vaccine dose in addition to the dose of hepatitis B vaccine given at birth and recorded in a population-based registry's database (Figure 1). The 32 grantees also

#### Immunization Registries — Continued



FIGURE 1. Percentage of children aged <6 years with immunization history included in population-based immunization registries — United States, June 2000

\*Fourteen states and Puerto Rico.

<sup>†</sup> Eleven states and the District of Columbia; New York, New York; Philadelphia, Pennsylvania; San Antonio, Texas; and the Republic of Palau.

<sup>§</sup> Twenty-four states and Chicago, Illinois; Houston, Texas; American Samoa; Guam; Northern Mariana Islands; and the U.S. Virgin Islands.

reported that an average of 74% of public vaccination provider sites and 44% of private provider sites participated in a population-based registry during the 6 months preceding completion of the 2000 IRAR. All 32 grantees implemented at least one key element on nine of the 13 functional standards (Table 1). Six (19%) of the 32 grantees reported implementing at least one key element in each standard. However, none had implemented fully all key elements of the 13 functional standards.

Thirty-one of the 32 grantees reported electronic linkages (sending and/or receiving electronic data) between immunization registries and at least one other information system. Of these, 28 were linked electronically to their vital records department (Figure 2).

Reported by: Systems Development Br, Data Management Div, National Immunization Program, CDC.

**Editorial Note**: The findings in this report indicate that an estimated 21% of children aged <6 years have their immunization histories included in a population-based immunization registry. Four major issues may limit registry participation and development: protecting the privacy of persons and the confidentiality of registry information, ensuring provider participation, overcoming technical and operational challenges, and determining resources needed to develop and maintain immunization registries (*1*). To protect the privacy of patients, providers, and other participants of these systems, CDC developed privacy specifications and implementation guidelines in 2000 (*4*).

Ensuring provider participation in registries is critical to attaining complete and accurate electronic immunization records. By age 2 years, approximately 23% of children have seen more than one immunization provider (5). When most or all immunization providers in a registry's catchment area participate in a registry, scattered records can be consolidated and appropriate vaccination decisions can be made based on accurate and complete information. Data from San Bernardino, California, indicate that in 1999,

### Immunization Registries — Continued





\*Women, Infant, and Children Nutrition Program.

<sup>†</sup>Medicaid Management Information System.

<sup>§</sup> Early Periodic Screening, Diagnosis, and Treatment Program.

approximately 2000 children received at least one unneeded dose of vaccine because of incomplete immunization records (San Bernardino Department of Public Health, unpublished data, 2000). A national survey in 1997 indicated that an estimated \$26.5 million could have been saved by avoiding unneeded doses (6).

Because registry development initially was targeted at the public sector, the proportion of public vaccination provider sites participating in registries is considerably higher than that of private provider sites. Increasing private provider recruitment efforts will be critical as immunization services continue to shift to the private sector (7).

CDC and IRTWG are finalizing criteria to measure the progress being made toward achieving the national health objective for 2010 (2). Progress toward reaching these criteria will be evaluated through annual National Immunization Program on-site visits, and recommendations and feedback will be provided.

Although developing and operating immunization registries can be expensive (CDC, unpublished data, 2000), a fully operational population-based registry offsets many other costs by avoiding duplicate immunizations, limiting the cost of missed appointments through the use of reminder/recall notices, reducing vaccine waste, and reducing the staff time required to find and/or produce immunization records or certificates. Registries also can play an important role in assisting vaccine safety efforts and can be used for vaccine ordering, inventory control, and vaccine use monitoring.

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#### Immunization Registries — Continued

The findings in this report are subject to at least two limitations. First, because IRAR 2000 relied on self-reported information, some bias is expected. On-site verifications of these data are being conducted. Second, because only immunization grantees were surveyed, these data underestimate the degree of registry activity in the United States. Survey respondents reported an additional 22 population-based registries operating in local communities.

Additional information on immunization registries is available from CDC's immunization registry World-Wide Web site, http://www.cdc.gov/nip/registry; by telephone, (800) 799-7062; or e-mail, siisclear@cdc.gov.

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# Recommended Childhood Immunization Schedule — United States, 2001

Each year, CDC's Advisory Committee on Immunization Practices (ACIP) reviews the recommended childhood immunization schedule to ensure that it remains current with changes in manufacturers' vaccine formulations, revisions in recommendations for the use of licensed vaccines, and recommendations for newly licensed vaccines. This report presents the recommended childhood immunization schedule for 2001 (Figure 1) and documents the changes that have occurred since the January 2000 publication (4).

For 2001, ACIP, the American Academy of Family Physicians, and the American Academy of Pediatrics have added pneumococcal conjugate vaccine to the schedule (2) and have extended the recommendation for the use of hepatitis A vaccine to include persons through age 18 years in selected geographic areas and in certain high-risk groups (3). Detailed recommendations for using vaccines are available from the manufacturers' package inserts, ACIP statements on specific vaccines, and the 2000 Red Book (5). ACIP statements for each recommended childhood vaccine can be viewed, downloaded, and printed from CDC's National Immunization Program World-Wide Web site, http:// www.cdc.gov/nip/publications/ACIP-list.htm.

						Age						
Vaccine	Birth	1 0 m	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	24 mos	4–6 yrs	11–12 yrs	14–18 yrs
Hepatitis B <sup>†</sup>		Hep B #										
		He	p B #2			Hep	B #3				Hep B	
Diphtheria and tetanus toxoids and pertussis <sup>§</sup>			DTaP	DTaP	DTaP		DI	P		DTaP	Τd	
<i>H. influenzae</i> type b¶			Hib	Hib	Hib	Ē						
Inactivated Polio**			ΙΡΛ	IPV						Ν		
Pneumococcal <sup>††</sup> conjugate			PCV	PCV	PCV	PC						
Measles-mumps- rubella <sup>§§</sup>						MM	1R			MMR	MMR	
Varicella <sup>¶¶</sup>							Var				Var	
Hepatitis A***									Hep	A in s	elected	areas
Range of rec	commended	d ages for v	accination.									

FIGURE 1. Recommended childhood immunization schedule\* — United States, January-December 2001

Vaccines to be given if previously recommended doses were missed or were given earlier than the recommended minimum age. Recommended in selected states and/or regions.

Childhood Immunization Schedule — Continued

*** Hepatitis A vaccine (Hep A) is recommended for use in selected states and/or regions, and for certain high-risk groups. Information is available from local public
<sup>11</sup> Varicella vaccine (Var) is recommended at any visit on or after the first birthday for susceptible children, (i.e., those who lack a reliable history of chickenpox [as judged by a health-care provider) and who have not been immunized)]. Susceptible persons aged 213 vears should receive two doses given at least 4 weeks apart.
not received the second dose should complete the schedule no later than the routine visit to a health-care provider at age 11–12 years.
at least 4 weeks have elapsed since receipt of the first dose and that both doses are administered beginning at or after age 12 months. Those who previously have
months (2 ). <sup>55</sup> The second dose of measles, mumps, and rubella vaccine (MMR) is recommended routinely at age 4–6 years but may be administered during any visit, provided
<sup>11</sup> The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children age 2–23 months. It is also recommended for certain children age 24–59
circumstances (7).
at ages 2, + or princing a mess approved by the roug and brug region of the continue ages. ** An all inactivated poliovirus vaccine (IPV) schedule is recommended for routine children should receive four Ana schedure is the ana 7 morths and morths herween areas and herween areas dand forears. Oral nolinvirus vaccine should he used nolivin selected
products may induce a lower immune response to the Hib vaccine component. DTaP/Hib combination products should not be used for primary immunization in infants
<sup>1</sup> Three Haemophilus influenzae type b (Hib) conjugate vaccines are licensed for infant use. If Hib conjugate vaccine (PRP-OMP) (PedvaxHIB or ComVax [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. Because clinical studies in infants have demonstrated that using some combination
routine Td boosters are recommended every 10 years.
easts beam with the first of the last dose of diphthetia and tetamus toxidis and pertus is volued; to its recurit in earber at a set 1 = 7 years in a teast 5 years in a teast 5 years in a teast 5 years of the last dose of diphthetia and tetamus toxidis on pertus is volued; to Tai P, or diphthetia and tetamus toxidis (DT). Subsequent
<sup>1</sup> The fourth dose of diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) may be administered as early as age 12 months, provided 6 months have
been immunized against hepatitis. Eshould begin the series during any vsit, Providers should make apocial efforts to immunize children who were born in or whose
status is unknown should receive Hep B within 12 hours of birth. Maternal blood should be drawn at delivery to determine the mother's HBSAg status; if the HBSAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week). All children and adolescents (through age 18 years) who have not
12 hours of birth at separate sites. The second dose is recommended at age 1-2 months and the hind dose at age 6 months. <b>Intarts born to mothers whose HBsAg</b>
should be administered atteast. In morth after this toose. The tind does should be administered at least 4 months after in the stoce and a feast 4 months after 1 months after
<sup>1</sup> Infants born to hepatitis B surface antigen (HBsAg)-negative mothers should receive the first dose of hepatitis B vaccine (Hep B) by age 2 months. The second dose
recommendations
age in bears, additional vactines up be iterated and recommended ourning the year. Licensed combination vaccines may be used whenever any components of the combination vaccines may be used whenever any components of the combined providers explored and the vaccines interval experts of the combined providers explored and the vaccines of the components are not contrained and the vaccines of the components are not contrained and the vaccines of the components are not contrained are providers explored and the vaccines of the components are not contrained and the vaccines of the components are not contrained are providers explored and the vaccines of the components are not contrained are providers explored and the vaccines of the components are not contrained are providers explored and the vaccines of the components are not contrained are providers explored are providers explored and the vaccines of the components are not contrained are providers explored and the vaccines of the components are not contrained are providers explored are providers explored and the vaccines of the components are not contrained are providers explored and the vaccines of the components are not contrained are providers explored
* This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines as of November 1, 2000, for children through

Additional information about the immunization schedule is available on the National Immunization Program World-Wide Web site, http://www.cdc.gov/nip, or by telephone, (800)232-2522 (English) or (800)232-0233 (Spanish).

Childhood Immunization Schedule — Continued

# Childhood Immunization Schedule — Continued

# Pneumococcal Conjugate Vaccine

In February 2000, the Food and Drug Administration licensed a heptavalent pneumococcal polysaccharide-protein conjugate vaccine (PCV) (Prevnar<sup>TM</sup>,\* Wyeth Lederle Vaccines and Pediatrics, Philadelphia, Pennsylvania) for use among infants and young children. All children aged 2–23 months should receive four doses of PCV intramuscularly at ages 2, 4, 6, and 12–15 months. ACIP also recommends the vaccine for children aged 24–59 months who are at increased risk for pneumococcal disease (e.g., children with sickle cell hemoglobinopathies, human immunodeficiency virus infection, and other immunocompromising or chronic medical conditions). For these children, ACIP recommends two doses of PCV administered 2 months apart followed by one dose of a 23valent pneumococcal polysaccharide vaccine (PPV 23) administered two or more months after the second dose of PCV. ACIP also recommends that PCV be considered for all other children aged 24–59 months, with priority given to children aged 24–35 months, American Indian/Alaska Native and black children, and children who attend child-care centers. ACIP recommends one dose of PCV for children in these groups. Additional information on the use of PCV can be found in the ACIP statement (*2*).

# Hepatitis A Vaccination Recommendation

ACIP continues to recommend hepatitis A vaccine (Hep A) for routine use in some states and regions. For 2001, the recommendation has been extended to include adolescents through age 18 years and for persons in certain high-risk groups (i.e., persons traveling to countries where hepatitis A is moderately or highly endemic, men who have sex with men, users of injectable and noninjectable drugs, persons who have clotting-factor disorders, persons working with nonhuman primates, and persons with chronic liver disease). The hepatitis A vaccine label is shaded on the 2001 Immunization Schedule to indicate its use in selected states and regions, and for certain high-risk groups. Providers can contact their local public health authority for the current recommendations for hepatitis A vaccination in their community. Additional information on the use of Hep A can be found in the ACIP statement (*3*).

## Vaccine Information Statements

The National Childhood Vaccine Injury Act requires that all health-care providers give to parents or patients copies of Vaccine Information Statements before administering each dose of the vaccines listed in this schedule. Vaccine Information Statements, developed by CDC, can be obtained from state health departments and CDC's World-Wide Web site, http://www.cdc.gov/nip/publications/VIS. Instructions on use of the Vaccine Information Statements are available at http://www.cdc.gov/nip/publications/VIS/ vis-Instructions.pdf.

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



# FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals ending January 6, 2001, with historical data

- \* No rubella cases were reported for the current 4-week period yielding a ratio for week 1 of zero (0).
- <sup>†</sup> Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

#### TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending January 6, 2001 (1st Week)

		Cum. 2001		Cum. 2001
Anthrax Brucellosis* Cholera Cyclosporiasis Diphtheria	*		Poliomyelitis, paralytic Psittacosis* Qfever* Rabies, human Rocky Mountain spotted fever (RMSF)	
Ehrlichiosis: Encephalitis:	human granulocytic (HGE)* human monocytic (HME)* California serogroup viral* eastern equine* St. Louis* western equine*		Rubella, congenital syndrome Streptococcal disease, invasive, group A Streptococcal toxic-shock syndrome* Syphilis, congenital <sup>1</sup> Tetanus Toxic-shock syndrome	- 18 - - 3
Hansen diseas Hantavirus pu Hemolytic ure HIV infection, Plague	ie (leprosy)* Imonary syndrome*† mic syndrome, postdiarrheal* pediatric*§		Trichinosis Tularemia* Typhoid fever Yellow fever	- - 2 -

-: No reported cases.

\*Not notifiable in all states.

<sup>+</sup> Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases (NCID).

<sup>4</sup> 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 November 26, 2000. Updated from reports to the Division of STD Prevention, NCHSTP.

# TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending January 6, 2001, and January 8, 2000 (1st Week)

								Escherichia	<i>coli</i> 0157:H7	/*
	All	DS	Chlan	nydia⁺	Cryptos	poridiosis	NE	rss	PH	LIS
Reporting Area	Cum. 2001 <sup>§</sup>	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES			2,472	9,235	7	6	4	13	-	25
NEW ENGLAND	-	-	198	417	3	-	2	1	-	4
Maine	-	-	- 2	17 19	1	-	-	-	-	- 2
Vt.	-	-	8	9	2	-	-	-	-	-
Mass.	-	-	188	188	-	-	2	1	-	-
Conn.	-	-	-	138	-	-	-	-	-	2
MID. ATLANTIC	-	-	15	883	-	-	1	-	-	2
Upstate N.Y.	-	-	N	N 437	-	-	1	-	-	1
N.J.	-	-	15	167	-	-	-	-	-	-
Pa.	-	-	-	279	-	-	N	N	-	1
E.N. CENTRAL	-	-	539 94	1,705	-	2	-	4	-	2
Ind.	-	-	-	131	-	-	-	-	-	1
III. Mich	-	-	239 206	654	-	- 1	-	2	-	- 1
Wis.	-	-	-	357	-	1	-	Ň	-	-
W.N. CENTRAL	-	-	45	521	-	-	-	3	-	6
Minn. Iowa	-	-	-	152 7	-	-	-	-	-	3
Mo.	-	-	-	261	-	-	-	2	-	1
N. Dak. S. Dak.	-	-	- 27	10 24	-	-	-	-	-	-
Nebr.	-	-	18	55	-	-	-	-	-	1
	-	-	-	12	-	-	-	-	-	1
Del.	-	-	41	1,314	-	-	-	-	-	-
Md.	-	-	122	125	1	-	-	-		.ī.
Va.	-	-	-	167	-	-	-	-	-	1
W. Va.	-	-	- 251	30	-	-	-	-	-	-
S.C.	-	-	- 201	254		-	-	-	-	-
Ga. Fla	-	-	- 92	342 301	-	-	-	-	-	-
ES CENTRAL			220	194		1				
Ky.	-	-	- 220	98		-	-	-	-	-
Tenn. Ala	-	-	92	248 137	-	-	-	-	-	-
Miss.	-	-	128	1	-	-	-	-	-	-
W.S. CENTRAL	-	-	465	1,894	-	-	-	1	-	5
Ark.	-	-	- 315	72 432	-	-	-	-	-	1
Okla.	-	-	150	155	-	-	-	-	-	1
lex.	-	-	-	1,235	-	-	-	1	-	2
MOUNTAIN Mont.	-	-	68	591 4	-	2	-	-	-	3
Idaho	-	-	31	25	-	-	-	-	-	-
vvyo. Colo.	-	-	- 3	12	-	2	-	-	-	1
N. Mex.	-	-	-	71	-	-	-	-	-	-
Utah	-	-	- 34	257 72	-	N	-	-	-	-
Nev.	-	-	-	42	-	-	-	-	-	-
PACIFIC	-	-	410	1,426	2	1 N	1	4	-	2
Oreg.	-	-	204	190	-	-	- 1	-	-	-
Calif.	-	-	188	1,122	2	1	-	3	-	-
Hawaii	-	-	3	24 90	-	-	-	1	-	1
Guam	-	-	-	-	-	-	Ν	Ν	U	U
P.R.	-	-		U		ū	ū.		U	U
Amer. Samoa	-	-	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ
C.N.M.I.	-	-	U	U	<u> </u>	<u> </u>	<u> </u>	<u> </u>	U	U

N: Not notifiable. U: Unavailable. -: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands. \* Individual cases can be reported through both the National Electronic Telecommunications System for Surveillance (NETSS) and the Public

Health Laboratory Information System (PHLIS). Chlamydia refers to genital infections caused by *C. trachomatis*. Totals reported to the Division of STD Prevention, NCHSTP. Updated monthly from reports to the Division of HIV/AIDS Prevention — Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention. Last update November 26, 2000. ş

	Gono	rrhea	Hepatit Non-A, I	tis C; Non-B	Legione	llosis	Listeriosis	Ly Dise	me ease
Reporting Area	Cum. 2001 <sup>§</sup>	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	1,272	5,265	2	68	4	8	-	5	23
NEW ENGLAND Maine N.H.	65 - -	124 2	- - -	1 - -	- -	2 1 -	-	1 - -	1 - -
vt. Mass. R.I.	63	- 57 9	-	- 1 -	-	1	-	- 1 -	- - -
MID. ATLANTIC	- 11 4	360 8	-	7	-	-	-	-	14 -
N.Y. City N.J. Pa.	- 7	136 118 98	-	- 7 -	-	-	-	-	4 8 2
E.N. CENTRAL Ohio Ind	245 55	1,115 369 74	1 -	8	4	2 1	-	-	-
III. Mich. Wis.	123 67	503 169	- 1 -	2 6	-	- 1 -	-	- U	- - U
W.N. CENTRAL Minn.	5	258 70	1	11 -	-	-	-	-	-
No. N. Dak.	- - - 5	6 158 1	- 1 -	11	-	-	-	-	-
Nebr. Kans.	-	3 17 3	-	-	-	-	-	-	-
S. ATLANTIC Del. Md. D.C.	370 25 31 1	1,347 27 121 58		- - -	-	3 - 2 -		3 - 2 1	7 1 6 -
Va. W. Va. N.C.	- 249	212 10	-		N	N 1	-	-	-
S.C. Ga. Fla.	- 1 63	416 279 224	-	-	-	-	-	-	-
E.S. CENTRAL Ky. Tenn.	192 - 74	369 62 216	-	12 - -		-	-	-	-
Ala. Miss.	- 118 284	91 - 1 152	-	- 12 17	-	-	-	-	-
Ark. La. Okla.	204 206 78	40 355 69 688	-	6	-		-	-	-
MOUNTAIN Mont.	12	210	-	3	-	-	-	-	-
Idaho Wyo. Colo.	2	2 1 101	-	- 1 1	-	-	-	-	-
N. Mex. Ariz. Utah Nev	10	13 55 8 30	-	-	-	-	-	-	-
PACIFIC Wash.	88 43	330 32	-	9	-	-	-	1	1 -
Oreg. Calif. Alaska Hawaii	40 3 2	283 5 10	-	2 7 -	- - -	N - -	-	1 - N	1 - N
Guam P.R. V.I.	- - U	- - U	- - U	- - U	- - U	- - U	-	N U	N U
Amer. Samoa C.N.M.I.	Ū U	Ū U	Ū U	Ŭ U	Ŭ U	Ū U	-	Ŭ U	Ŭ U

# TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 6, 2001, and January 8, 2000 (1st Week)

N: Not notifiable.

-: No reported cases.

				-		Salmon	ellosis*	
	Mal	aria	Rabies	s, Animal	NE	TSS	PH	LIS
Reporting Area	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	5	16	16	50	94	387	-	455
NEW ENGLAND Maine N H	-	1 - -	5	5	17 2	15 3	-	26 - 1
Vt.	-	-	3	1	1	-	-	-
Mass. R.I.	-	1	2	3	14	11	-	17 1
Conn.	-	-	-	1	-	1	-	7
MID. ATLANTIC Upstate N.Y.	-	1 -	6	11 10	3 3	44	-	79 17 28
N.J. Pa.	-	- - 1	-	1	-	24 6	-	28 11 23
E.N. CENTRAL Ohio	1 1	2 1	-	-	13 11	73 19	-	32 14
III.	-	- 1	-	-	-	31	-	9
Mich. Wis.	-	-	-	-	2	12 11	-	4 5
W.N. CENTRAL Minn.	-	2	3	5 2	5	16 -	-	26 9
lowa Mo.	-	- 1	2	-	- 1	- 12	-	4
N. Dak.	-	-	-	-	-	-	-	1
Nebr.	-	-	-	-	1	1	-	1
Kans.	-	1	-	2	-	2	-	2
S. ATLANTIC Del.	1	3	-	19	14	34 1	-	83
Md. D.C.	1	3	-	4	5	15	Ū	12 U
Va.	-	-	-	4	-	-	-	9
N.C.	-	-	-	6	8	17	-	12
S.C. Ga.	-	-	-	-	-	-	-	8 33
Fla.	-	-	-	3	1	1	-	6
E.S. CENTRAL	-	-	-	-	9	30		16 1
Tenn.	-	-	-	-	1	-	-	8
Ala. Miss.	-	-	-	-	8	6 18	-	4 3
W.S. CENTRAL Ark	-	-	-	3	-	42	-	41 7
La.	-	-	-	-	-	3	-	10
Tex.	-	-	-	-	-	37	-	21
MOUNTAIN Mont.	-	-	1	3 1	8	32	-	38
Idaho	-	-	-	-	2	1	-	2
Colo.	-	-	-	-	1	14	-	- 7
N. Mex.	-	-	- 1	- 1	5	2	-	1 20
Utah Nev.	-	-	-	-	-	10 4	-	8
PACIFIC	3	7	1	4	25	101	-	114
Oreg.	- 1	- 1	-	-	- 1	5	-	13
Calif. Alaska Hawaii	2 - -	6 - -	1	4 - -	24	83 1 12	-	86 3 3
Guam	-	-	-	-	-	-	U	U
P.R. VI	ū		1	1	- 11	1	U	U
Amer. Samoa C.N.M.I.	Ŭ	UU	Ŭ	UU	ŰÜ	Ű	Ŭ U	Ŭ U

# TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 6, 2001, and January 8, 2000 (1st 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).

		Shigel	osis*		Sy	philis		
	NET	SS	Pł	ILIS	(Primary 8	Secondary)	Tube	rculosis
Reporting Area	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000
UNITED STATES	56	193	-	127	70	87	58	94
NEW ENGLAND	-	3	-	5	1	1	-	-
Maine N H	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	-	-	-
Mass. B I	-	1	-	4	1	1	-	-
Conn.	-	2	-	1	-	-	-	-
MID. ATLANTIC	5	18	-	21	-	3	-	1
Upstate N.Y. N.Y. Citv	5	- 7	-	4 12	-	- 1	-	- 1
N.J.	-	10	-	4	-	2	-	-
	-	1	-	10	-	-	-	-
Ohio	4	6	-	-	-	19	1	- Z
Ind.	-	2	-	-	- 2	5	-	- 2
Mich.	6	20	-	15	-	-	1	-
Wis.	-	2	-	1	-	-	-	-
W.N. CENTRAL	6	6	-	10 3	-	-	-	-
lowa	-	2	-	4	-	-	-	-
Mo. N. Dak.	5	4	-	2	-	-	-	-
S. Dak.	:	-	-	;	-	-	-	-
Nebr. Kans.	-	-	-	-	-	-	-	-
S. ATLANTIC	13	2	-	8	10	32	2	15
Del.	-	-	-	-	-	-	-	-
D.C.	1		Ū	Ū	-	-	2	1
Va. W Va	-	-	-	4	-	9	-	- 1
N.C.	10	1	-	-	8	5	-	-
Ga.	-	-	-	2	-	2	-	14
Fla.	-	1	-	2	1	6	-	-
E.S. CENTRAL	6	12	-	10	54	15	-	2
Ky. Tenn.	-	-	-	10	11	- 15	-	-
Ala. Miss	6	1	-	-	-	-	-	2
WISS.	-	10	-	-	40	- 10	-	-
Ark.	-		-	42	-	1	3	- 20
La. Okla	-	7	-	1	1	3	-	-
Tex.	-	37	-	40	-	4	-	26
MOUNTAIN	6	12	-	7	-	-	-	2
Mont. Idaho	-	- 1	-	- 1	-	-	-	-
Wyo.	-	-	-	-	-	-	-	-
N. Mex.	6	2	-	1	-	-	-	2
Ariz.	-	-	-	4	-	-	-	-
Nev.	-	5	-	-	-	-	-	-
PACIFIC	10	31	-	8	2	7	52	46
Wash. Oreg.	- 3	- 4	-	4	2	-	4	-
Calif.	7	25	-	-	-	7	48	45
Hawaii	-	2	-	- 1	-	-	-	- 1
Guam	-	-	U	U	-	-	-	-
P.R.	- U	- 11	U	U	4	3	ū	ū
Amer. Samoa	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ
<u>C.N.M.I.</u>	U	U	U	U	U	U	U	U

# TABLE II. (Cont'd) Provisional cases of selected notifiable diseases, United States, weeks ending January 6, 2001, and January 8, 2000 (1st 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).

	ienzae.	н	epatitis (Vi	iral), By Ty	pe			Meas	les (Rubed	ola)		
	Inva	sive	Α		B		Indige	nous	Impo	rted*	Tota	I
Reporting Area	Cum. 2001 <sup>†</sup>	Cum. 2000	Cum. 2001	Cum. 2000	Cum. 2001	Cum. 2000	2001	Cum. 2001	2001	Cum. 2001	Cum. 2001	Cum. 2000
UNITED STATES	5	21	21	216	14	94	-	-	-	-	-	1
NEW ENGLAND	1	3	1	4	1	2	-	-	-	-	-	-
Maine	-	-	-	-	-	-	-	-	-	-	-	-
Vt.	-	-	-	-	-	1	-	-	-	-	-	-
Mass.	1	3	-	1	1	-	-	-	-	-	-	-
Conn.	-	-	-	3	-	1	Ū	-	Ū	-	-	-
MID. ATLANTIC	-	2	-	7	-	14	-	-	-	-	-	-
Upstate N.Y.	-	1	-	Ē	-	-	-	-	-	-	-	-
N.J.	-	-	-	5 1	-	2	-	-	-	-	-	-
Pa.	-	-	-	1	-	6	-	-	-	-	-	-
E.N. CENTRAL	1	4	10	38	7	10	-	-	-	-	-	1
Uhio Ind.	-	2	- 1	10	2	2	-	-	-	-	-	-
III.	:	2	-	17	2	-	-	-	-	-	-	:
Wich. Wis.	-	-	9	9 2	5	8	-	-	-	-	-	-
W N CENTRAL			1	30	1	6	-	-	-	-	-	-
Minn.	-	-	-	-	-	-	-	-	-	-	-	-
lowa Mo.	-	-	-	- 27	-	- 6	-	-	-	-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-	-
S. Dak. Nebr.	-	-	- 1	-	1	-	-	-	-	-	-	-
Kans.	-	-	-	3	-	-	U	-	U	-	-	-
S. ATLANTIC	1	3	3	4	3	15	-	-	-	-	-	-
Del. Md	-	- 3	- 2	- 4	-	- 4	-	-	-	-	-	-
D.C.	-	-	ī	-	-	-	-	-	-	-	-	-
Va. W Va	-	-	-	-	-	-	ū	-	ū	-	-	-
N.C.	-	-	-	-	3	11	-	-	-	-	-	-
S.C. Ga	- 1	-	-	-	-	-	-	-	-	-	-	-
Fla.	-	-	-	-	-	-	-	-	-	-	-	-
E.S. CENTRAL	-	-	1	22	-	5	-	-	-	-	-	-
Ky. Tenn	-	-	- 1	-	-	-	U	-	U	-	-	-
Ala.	-	-	-	1	-	-	-	-	-	-	-	-
Miss.	-	-	-	21	-	5	-	-	-	-	-	-
W.S. CENTRAL	-	1	-	47	-	2	-	-	-	-	-	-
La.	-	1	-	2	-	2	-	-	-	-	-	-
Okla. Tex	-	-	-	- 45	-	-	ū	-	ū	-	-	-
	1	1	2	-0		-	0		0			
Mont.	-	-	-	-	-	-	Ū	-	Ū	-	-	-
Idaho Wyo	-	-	-	-	-	-	-	-	-	-	-	-
Colo.	-	-	2	2	-	3	-	-	-	-	-	-
N. Mex.	1	-	1	-	-	1	-	-	-	-	-	-
Utah	-	1	-	2	-	-	-	-	-	-	-	-
Nev.	-	-	-	1	-	-	-	-	-	-	-	-
PACIFIC	1	7	2	59	2	36	-	-	-	-	-	-
Oreg.	1	2	-	5	1	2	-	-	-	-	-	-
Calif.	-	2	2	53	1	34	-	-	-	-	-	-
Hawaii	-	2	-	1	-	-	-	-	-	-	-	-
Guam	-	-	-	-	-	-	U	-	U	-	-	-
P.R.	ū		ū	1	ū	ū			ū	Ū.	ū	ū
Amer. Samoa	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	Ŭ	ŭ	Ŭ	Ŭ
C.N.M.I.	U	U	U	U	U	U	U	U	U	U	U	U

# TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending January 6, 2001, and January 8, 2000 (1st Week)

N: Not notifiable. U: Unavailable. - : No reported cases. \*For imported measles, cases include only those resulting from importation from other countries. † Of 1 case among children aged <5 years, serotype was reported for 0 and 0 were type b.

	Mening Dis	gococcal ease		Mumps	-		Pertussis			Rubella	
Reporting Area	Cum. 2001	Cum. 2000	2001	Cum. 2001	Cum. 2000	2001	Cum.	Cum. 2000	2001	Cum. 2001	Cum. 2000
UNITED STATES	10	45	-	-	1	8	8	90	-	-	-
NEW ENGLAND Maine N H	1	1	-	-	-	5	5	28	-	-	-
Vt.	-	_	-	-	-	4	4	7	-	-	-
Mass. B I	1	-	-	-	-	1	1	21	-	-	-
Conn.	-	-	U	-	-	U	-	-	U	-	-
MID. ATLANTIC Upstate N.Y. N X City	1 1	4 - 1	-	-	-	-	-	4	-	-	-
N.J. Pa.	-	1 2	-	-	-	-	-	-	-	-	-
E.N. CENTRAL Ohio Ind	2 1	9 1	-	-	1 -	1 - -	1 - -	28 26	-	-	-
III.	-	4	-	-	-	-	-	1	-	-	-
Mich. Wis.	1	2	-	-	1	1	1	1	-	-	-
W.N. CENTRAL Minn.	-	6	-	-	-	1	1 -	-	-	-	-
lowa Mo	-	- 6	-	-	-		-		-	-	-
N. Dak.	-	-	-	-	-	-	-	-	-	-	-
S. Dak. Nebr	-	-	-	-	-	1	1		-	-	-
Kans.	-	-	U	-	-	U	-	-	U	-	-
S. ATLANTIC	3	3	-	-	-	-	-	5	-	-	-
Del. Md	- 2	- 2	-	-	-	-	-	- 2	-	-	-
D.C.	-	-	-	-	-	-	-	-	-	-	-
Va. W. Va.	-	-	Ū	-	-	Ū	-	-	Ū	-	-
N.C.	-	1	-	-	-	-	-	3	-	-	-
S.C. Ga.	- 1	-	-	-	-	-	-	-	-	-	-
Fla.	-	-	-	-	-	-	-	-	-	-	-
E.S. CENTRAL Ky. Topp	-	1 1	Ū	-	-	Ū	-	10 8	Ū	-	-
Ala.	-	_	-	-	-	-	-	2	-	-	-
Miss.	-	-	-	-	-	-	-	-	-	-	-
Ark.	-	-	-	-	-	-	-	-	-	-	-
La. Okla.	-	5	-	-	-	-	-	-	-	-	-
Tex.	-	1	U	-	-	U	-	-	U	-	-
MOUNTAIN Mont.	1 -	2	Ū	-	-	1 U	1 -	9	Ū	-	-
Idaho	1	1	-	-	-	1	1	-	-	-	-
Colo.	-	1	-	-	-	-	-	3	-	-	-
N. Mex. Ariz	-	-	-	-	N		-	4	-	-	-
Utah Nev.	-	-	-	-	-	-	-	2	-	-	-
PACIFIC Wash.	2	13	-	-	-	-	-	6	-	-	-
Oreg.	2	2	Ν	Ν	Ν	-	-	3	-	-	-
Alaska Hawaii	-	-	-	-	-	-	-	2 - 1	-	-	-
Guam P.R.	-	- 1	U	-	-	U	-	-	U	-	-
V.I. Amer. Samoa C.N.M.I.	U U U	U U U	U U U	U U U	U U U	U U U	U U U	U 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 January 6, 2001, and January 8, 2000 (1st Week)

N: Not notifiable.

U: Unavailable.

-: No reported cases.

		All Cau	ises, By	Age (Ye	ears)		P&I⁺			All Cau	ises, By	Age (Y	ears)		P&I <sup>†</sup>
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	601 213 36 13 21 U 23 13 55 45 50 0 6 57 45	420 133 29 12 17 U 16 9 35 37 U 5 5 37 0 5 35	103 43 4 1 3 U 2 2 9 7 U 1 3 5	44 18 2 - 1 U 3 2 1 3 U - 3 4	18 9 1 - - 2 U 2 - 2 U - - 2	16 10 - - - - - 1 U - - 1 U - 2	74 3 2 1 2 U 3 1 6 6 U 2 5 6	S. ATLANTIC Atlanta, Ga. Baltimore, Md. Charlotte, N.C. Jacksonville, Fla Miami, Fla. Norfolk, Va. Richmond, Va. Savannah, Ga. St. Petersburg, I Tampa, Fla. Washington, D.d. Wilmington, De	1,186 116 187 100 . 167 52 67 54 Fla. 72 171 C. 101 I. 13	815 67 131 77 125 53 32 42 43 58 122 55 10	232 31 38 31 31 17 10 14 9 5 27 29 3	87 12 9 7 3 4 7 1 5 17 8 -	25 2 1 3 1 3 2 1 - 1 4 7 -	27 43 33 4 31 31 2 -	76 318 6 15 6 1 6 5 1 14 1 4
Worcester, Mass. MID. ATLANTIC Albany, N.Y. Allentown, Pa. Buffalo, N.Y. Camden, N.J. Elizabeth, N.J. Erie, Pa.S	79 2,294 69 23 124 55 23 51	33 57 1,635 53 21 97 37 18 39	13 443 9 21 10 3 10	7 142 5 - 4 7 2 1	34 1 1 -	2 38 2 1 1 1	10 122 7 2 8 4 - 3	E.S. CENTRAL Birmingham, Al Chattanooga, Te Knoxville, Tenn. Lexington, Ky. Memphis, Tenn Mobile, Ala. Montgomery, A Nashville, Tenn.	847 a. 165 enn. 66 100 53 . 170 99 Ia. 50 144	585 125 49 73 34 119 66 27 92	174 29 12 19 15 35 20 12 32	53 10 3 7 1 10 8 4 10	16 2 2 3 1 3 5	19 1 1 3 4 5	82 20 6 7 3 18 6 8 14
New York City, N.J. New York City, 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.	Y. 1,201 21 275 68 20 163 32 163 32 55 23 30 U	45 835 U 176 516 122 23 U 46 18 27 U	265 U 8 57 4 3 22 8 U 6 4 3 U 6 4 3 U	4 69 U 27 6 1 11 1 U 2 1 - U	18 U 1 7 1 - 4 - U - U	13 U 8 6 4 U 1 - U	50 U 2 8 7 - 14 3 U 3 6 5 U	W.S. CENTRAL Austin, Tex. Baton Rouge, La Corpus Christi, 7 Dallas, Tex. El Paso, Tex. Ft. Worth, Tex. Houston, Tex. Little Rock, Ark. New Orleans, La San Antonio, Te Shreveport, Lousa, Okla.	1,355 101 A. 4 Tex. 40 218 94 131 276 74 x. 221 58 138	933 66 1 29 141 70 89 188 42 U 162 38 107	262 19 3 8 41 17 29 56 19 U 35 16 19	102 10 26 3 7 25 2 U 16 3 9	32 2 6 3 3 5 6 U 6 1	26 4 2 4 1 3 2 5 U 2 3	95 15 5 19 4 1 18 - U 18 4 11
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Gary, Ind. Grand Rapids, Mi Indianapolis, Ind. Lansing, Mich. Milwaukee, Wis. Peoria, III. Rockford, III. South Bend, Ind. Toledo, Ohio Youngstown, Ohi	20 214 214 75 134 53 65 75 97 0 70	10 12 54 139 57 97 38 51 56 70 54	10 5 8 44 11 23 10 9 17 15 11	3 3 16 2 10 - 3 - 3 4	1 11 3 2 1 - 2	- 5451 312 71	4 91261436511	PACIFIC Berkeley, Calif. Fresno, Calif. Glendale, Calif. Honolulu, Hawa Long Beach, Cal Los Angeles, Ca Pasadena, Calif. Portland, Oreg. Sacramento, Ca	1,166 18 62 U ii 60 if. 35 Iif. U 28 U U Iif. 172	842 10 44 U 45 22 U 22 U 22 U 111	214 7 12 U 13 10 U 4 U 47	75 1 4 U 1 1 U 0 6	21 2 U 1 U 7	13 - - - 2 U 2 U 2 U 1	123 2 7 U 2 6 U 2 U 17
W.N. CENTRAL Des Moines, Iowa Duluth, Minn. Kansas City, Kans Kansas City, Kans Lincoln, Nebr. Minneapolis, Min Omaha, Nebr. St. Louis, Mo. St. Paul, Minn. Wichita, Kans.	753 61 33 73 49 n. 134 83 83 113 93	546 50 23 24 52 40 103 52 63 79 60	124 5 4 3 14 6 21 14 13 24 20	48 4 2 2 5 1 7 7 5 7 8	24 - 3 2 1 1 8 2 2 5	11 2 1 - 1 2 2 - 1	45 9 2 4 4 2 9 8 - 3 4	San Diego, Čalif San Francisco, C San Jose, Calif. Santa Cruz, Cali Seattle, Wash. Spokane, Wash. Tacoma, Wash. TOTAL	. 143 Calif. 140 172 f. 30 128 . 66 112 10,841 <sup>1</sup>	101 104 128 25 82 57 91 7,629	18 18 30 5 26 9 15 2,062	17 11 11 17 6 690	4 5 - 2 - 2 33	2 2 3 - 1 - 224	18 22 20 5 7 6 9 812

### TABLE IV. Deaths in 122 U.S. cities,\* week ending January 6, 2001 (1st 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.

<sup>6</sup>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.

<sup>1</sup>Total includes unknown ages.

#### Vol. 50 / No. 1

#### MMWR

Childhood Immunization Schedule — Continued

- 4. CDC. Recommended childhood immunization schedule—United States, 2000. MMWR 2000;49:35-8,47.
- American Academy of Pediatrics. Active and passive immunization. In: Pickering LK, ed. 2000 Red book: report of the Committee on Infectious Diseases. 25th ed. Elk Grove Village, Illinois: American Academy of Pediatrics, 2000:1–81.

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