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MORBIDITY AND MORTALITY WEEKLY REPORT

Demographic Differences in Notifiable Infectious Disease Morbidity — United States, 1992–1994

Before the 1990s, National Notifiable Diseases Surveillance System (NNDSS) data consisted primarily of summary records that lacked demographic information for persons with reported diseases. By 1990, all 50 states were using CDC's National Electronic Telecommunications System for Surveillance (NETSS) to report individual case data that included demographic information (without personal identifiers) about most nationally notifiable diseases. These data are important for evaluating sex- specific differences in the occurrence of infectious diseases; monitoring infectious disease morbidity trends; determining the relative disease burdens among demographically diverse subpopulations in the United States; targeting prevention; and identifying priorities for research and control. This report describes and compares the numbers and rates of cases for the most frequently reported nationally notifiable infectious diseases, by sex and age of persons with reported illness, reported to CDC during 1992–1994. The findings indicate that for seven of the 10 most commonly reported notifiable diseases, the reported incidence is lower among women.

NNDSS data were evaluated for the 48 nationally notifiable infectious diseases* reported to CDC by state, territorial, and local health departments during 1992–1994 (*1*), the most recent years for which all notifiable disease data were available at the time of this analysis. Data for gonorrhea, primary/secondary syphilis, acquired immunodeficiency syndrome (AIDS), and tuberculosis (TB) were reported to CDC programs with disease-specific responsibility; other NNDSS data were derived from NETSS reports. Reports for persons for whom age or sex was unknown were not included in this analysis. Postcensal estimates from the Bureau of the Census were used to calculate age- specific and sex-specific rates (*2*). Children were defined as persons aged

*Acquired immunodeficiency syndrome; amebiasis; anthrax; aseptic meningitis; botulism; brucellosis; chancroid; cholera; congenital rubella syndrome; diphtheria; primary encephalitis; *Escherichia coli* O157:H7; gonorrhea; granuloma inguinale; *Haemophilus influenzae*; hepatitis A; hepatitis B; hepatitis, non-A, non-B; hepatitis, unspecified; legionellosis; leprosy; leptospirosis; Lyme disease; lymphogranuloma venereum; malaria; measles; meningococcal infection; mumps; pertussis; plague; poliomyelitis; psittacosis; rabies, animal; rabies, human; rheumatic fever; Rocky Mountain spotted fever; rubella; salmonellosis; shigellosis; syphilis; syphilis, congenital; tetanus; toxic-shock syndrome; trichinosis; tuberculosis; tularemia; typhoid fever; and yellow fever.

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<15 years; adolescents, persons aged 15–19 years; and adults, persons aged ≥20 years. Because AIDS cases were reported in a different format, persons with AIDS aged <13 years were defined as children and persons aged 13–19 years as adolescents. AIDS cases included in this analysis met the 1993 AIDS case definition for surveillance (*3*).

During 1992–1994, the 10 most frequently reported nationally notifiable infectious diseases for all ages and both sexes in the United States were, in descending order, gonorrhea, AIDS, salmonellosis, shigellosis, primary and secondary syphilis, TB, hepatitis A, hepatitis B, Lyme disease, and hepatitis C/non-A, non-B. The order remained the same when reports for persons for whom age and sex were unknown were included. Although the incidence of most diseases among children were similar for males and females (Table 1), the reported incidence of gonorrhea for females (29.8 cases per 100,000 population) was more than three times that for males (8.8). For children aged 10–14 years, the reported rate of gonorrhea for females (79.3) was more than four times that for males (19.4). For adolescents, the reported incidence of gonorrhea for females (878.0) was 1.4 times that for males (627.4) (Table 1). For adolescents, there were also sex-specific differences in the incidences of primary and secondary syphilis, hepatitis B, and shigellosis; for all of these diseases, rates for females were approximately twice those for males. For adults, rates were higher among males than females for seven of the 10 most commonly reported notifiable diseases (Table 1).

Reported by: Div of Public Health Surveillance and Informatics (proposed), Epidemiology Program Office, CDC.

Editorial Note: The findings in this analysis underscore the usefulness of reporting individual case data for evaluation of the differences in major causes of reported morbidity in the United States for both males and females of all ages. Although women use the health-care system more frequently than men (*4*), for seven of the 10 most commonly reported notifiable diseases the reported incidence is lower among women. Among the three broad age categories, the incidences for salmonellosis (28.2 cases per 100,000 population), shigellosis (25.9), and hepatitis A (13.5) were highest among children. Because hepatitis A virus infection in young children is often asymptomatic, the true incidence of this infectious disease among children may be substantially higher than that based on acute disease surveillance. Among adults, only for salmonellosis and shigellosis were the rates higher for women than for men.

Although most cases of salmonellosis are associated with consumption of contaminated foods of animal origin, some cases are related to environmental contamination (e.g., exposure to pet reptiles [*5*]). *Shigella* sp. and hepatitis A are transmitted primarily by the fecal-oral route and are possibly related to poor personal hygiene among persons of all ages and inadequate infection-control measures in the home and workplace. Educating family members and other adults who provide care for children about proper hygiene and infection-control measures can decrease transmission of infectious diseases in the home and other settings (e.g., day care centers) (*6*). Appropriate use of hepatitis A vaccine in communities with increased hepatitis A rates and among persons at increased risk for infection can prevent hepatitis A (*7*). To prevent and control foodborne diseases, food handlers (all persons involved in production, preparation, and delivery of food to consumers) should be targeted for education

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TABLE 1. Ten most commonly reported nationally notifiable infectious diseases among children, adolescents, and adults,* by sex — United States, 1992–1994†

	Females			Males		
Age group/ Rank	Disease	No. cases	Rate§	Disease	No. cases	Rate§
Children						
1	Gonorrhea¶	24,291	29.8	Salmonellosis	25,457	29.2
2	Salmonellosis	22,062	26.6	Shigellosis	22,272	25.6
3	Shigellosis	21,520	26.0	Hepatitis A	11,688	13.4
4	Hepatitis A	11,247	13.6	Gonorrhea¶	7,477	8.8
5	Pertussis	5,919	7.1	Pertussis	5,812	6.7
6	Congenital syphilis	4,367	5.3	Congenital syphilis	4,552	5.2
7	Lyme disease	2,633	3.2	Lyme disease	3,262	3.7
8	Tuberculosis	2,539	3.1	Tuberculosis	2,580	3.0
9	Meningococcal disease	1,774	2.1	Meningococcal disease	2,209	2.5
10	Mumps	1,412	1.7	Mumps	1,963	2.3
Adolescents						
1	Gonorrhea¶	218,018	878.0	Gonorrhea¶	164,079	627.4
2	Primary/Secondary syphilis	5,935	23.4	Primary/Secondary syphilis	3,067	11.4
3	Hepatitis A	2,639	10.4	Hepatitis A	3,019	11.3
4	Salmonellosis	2,280	9.0	Salmonellosis	2,531	9.5
5	Hepatitis B	1,812	7.2	Hepatitis B	1,011	3.8
6	Shigellosis	1,523	6.0	Tuberculosis	870	3.3
7	Tuberculosis	840	3.3	Shigellosis	865	3.2
8	Lyme disease	631	2.5	Lyme disease	717	2.7
9	Pertussis	476	1.9	AIDS¶	683	1.8
10	AIDS¶	425	1.2	Meningococcal disease	475	1.8
Adults						
1	Gonorrhea¶	344,433	122.0	Gonorrhea¶	531,384	205.2
2	AIDS	34,872	12.1	AIDS	187,211	71.0
3	Primary/Secondary syphilis	31,893	11.0	Tuberculosis	46,160	17.5
4	Salmonellosis	30,286	10.5	Primary/Secondary syphilis	39,504	15.0
5	Tuberculosis	23,184	8.1	Hepatitis A	25,729	9.8
6	Hepatitis A	18,258	6.3	Salmonellosis	24,943	9.5
7	Shigellosis	14,274	5.0	Hepatitis B	21,640	8.2
8	Hepatitis B	13,987	4.9	Lyme disease	10,152	3.9
9	Lyme disease	11,024	3.8	Hepatitis C/non-A, non-B	9,413	3.6
10	Hepatitis C/non-A, non-B	4,980	1.7	Shigellosis	8,054	3.1

*Children were defined as persons aged <15 years; adolescents, aged 15–19 years; and adults, aged ≥20 years. For AIDS cases, children were persons aged <13 years and adolescents were persons aged 13–19 years.
†Persons for whom age was not reported are excluded.
§Per 100,000 population.
¶Data from Georgia were excluded for 1993 because age was not reported and for 1994 because no cases were reported.

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about proper and frequent handwashing, safe storage and preparation of food, and the potential for serious implications (e.g., outbreaks) if food is mishandled (*5*).

Despite the high incidence of gonorrhea among adolescent and young adult females, surveillance data probably are underestimates because of underreporting. In addition, approximately 50% of gonococcal infections among females are asymptomatic, and other infected females may not seek treatment for the infection. Therefore, appropriate screening of sexually active adolescent and adult females for gonorrhea is important for accurate surveillance as well as for prevention and control of the disease, which if untreated, can result in serious complications (e.g., pelvic inflammatory disease, infertility, and ectopic pregnancy) (*8*). Hepatitis B also is sexually transmitted among adolescents and adults and is preventable by hepatitis B vaccine (*5*).

The data in this report include only the reported cases of those diseases designated as nationally notifiable. Factors affecting the representativeness of cases reported to NNDSS include underreporting; delays in reporting; misdiagnosis of disease; and differential patterns of disease detection, disease reporting, and health-care–seeking behavior. The completeness of reporting is strongly influenced by the interests, priorities, and professional and financial resources of national, state, and local officials responsible for disease control and public health surveillance (*9*). Although certain diseases are not considered nationally reportable, they may be leading causes of morbidity and mortality (e.g., pneumonia and influenza). For example, chlamydia was not included as a nationally notifiable disease until 1995, when it was the most frequently reported notifiable disease (*10*); more than 1 million cases of chlamydia were reported during 1992–1994.

Analysis of the data in this report by broad age groups may obscure important differences in rates by age for some diseases. For example, the age distribution of persons reported with cases of Lyme disease is bimodal, with the highest reported incidences among children aged 5–9 years and adults aged 45–69 years and substantially lower incidences among older adolescents and young adults.

Because notifiable diseases are underreported and represent only a subset of all infectious diseases, the findings in this report underscore the need for sustained efforts to improve the completeness and consistency of surveillance systems for monitoring the trends of notifiable infectious diseases. Improved understanding of the epidemiology of infectious diseases in subgroups of the U.S. population can assist public health agencies and others in strengthening measures to prevent, monitor, and control the incidence of infectious diseases.

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Prolonged Poliovirus Excretion in an Immunodeficient Person with Vaccine-Associated Paralytic Poliomyelitis

Recently completed molecular studies of poliovirus isolates suggest that viral replication of vaccine-related polioviruses may have persisted for as long as 7 years in a patient with vaccine-associated paralytic poliomyelitis (VAPP) in whom common variable immunodeficiency syndrome (CVID) previously had been diagnosed. This report summarizes the clinical and virologic data and discusses the possible implications of these new findings for the global polio eradication initiative, which include how and when to discontinue vaccination when polio has been eradicated.

The case-patient, a man born in 1964, had a history of multiple episodes of upper respiratory infections, otitis media, recurrent fever, chronic cough, sinusitis, and skin infections. At age 9 years, he was diagnosed with allergies to dogs, cats, food items, grass, and trees. At age 12 years, he was hospitalized because of lung infiltrates and maxillary sinusitis; CVID syndrome was diagnosed based on quantitative immune globulins of 42 mg/dL for IgG (normal: 639–1349 mg/dL), 3.8 mg/dL for IgA (normal: 70–132 mg/dL), and 4.5 mg/dL for IgM (normal: 56–352 mg/dL). He was placed on monthly therapy with fresh frozen plasma and maintained IgG levels of 62–330 mg/dL during 1975–1981. His vaccination history included three doses of inactivated poliovirus vaccine administered during 1964–1965 and four doses of trivalent oral poliovirus vaccine (OPV) administered during 1967–1974.

In July 1981, at age 16 years, he had fever (104 F [40 C]) and generalized weakness following an episode of diarrheal illness. Four days after onset of fever, he had onset of a stiff neck, diplopia, and generalized paralysis and required mechanical ventilation. Paralytic poliomyelitis was diagnosed. The clinical course included multiple hospital admissions for pneumonia and urinary tract infections. He was ventilator-dependent from 1981 until his death in October 1990.

Stool specimens were obtained from the patient at 11, 23, 48, 126, 159, and 200 days after onset of paralysis in July 1981. Poliovirus type 1 was isolated from each specimen. Initial characterization of isolates by RNase T_1 oligonucleotide fingerprinting was inconclusive. Nucleotide sequences encoding the major capsid protein VP1 were determined for each isolate. The first (day 11) isolate contained two subpopulations, equally divergent from the Sabin 1 vaccine strain (by 10% of VP1 nucleotides), and differing from each other by 6% of VP1 nucleotides. In contrast, each subpopulation differed from wild type 1 poliovirus isolates by 19%–24% of VP1 nucleotides. Polioviruses isolated from specimens obtained after day 11 were derived from only one subpopulation. VP1 sequences of these isolates revealed a stepwise divergence from the Sabin 1 sequence at a rate of about 1.1% per year. By assuming that the rate

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of sequence evolution was constant throughout the infection, the initial infection was estimated to have occurred at approximately the time of receipt of the last OPV dose in 1974.

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Editorial Note: Although the replication of poliovirus in immunocompetent persons is of limited duration (ranging from several days to 3 months) (*1*), poliovirus may replicate in immunodeficient persons for considerably longer periods (*2*). For example, vaccine-related poliovirus has been recovered from cerebrospinal fluid of a patient 1 year after vaccination and continually from stools of two patients for durations of 21 months and 31 months, respectively, after vaccination (*3*). In a patient with agammaglobulinemia, replication of vaccine virus persisted for at least 684 days (*4*).

The case described in this report is exceptional because it is the only known VAPP case in an immunodeficient person in which immunodeficiency had been diagnosed before onset of paralytic manifestations (*5*). In all other cases of VAPP among immunodeficient persons, the paralytic manifestations were the event that prompted consideration of the diagnosis of immunodeficiency. There is no evidence that this virus strain caused other cases of VAPP.

Because stool specimens were obtained only after onset of paralysis, the date the patient initially was infected with the vaccine-derived polioviruses cannot be determined. The extensive sequence differences of the isolates from the parental Sabin 1 strain suggest prolonged replication of the virus in one or more persons since administration of the original OPV dose. Because the two virus subpopulations infecting the patient were equally divergent from the Sabin 1 strain, it is likely that these viruses were derived from a single initiating OPV dose. Divergence of the two subpopulations occurred an estimated 2.5 years before onset of paralysis. The time of the initial infection estimated from VP1 evolution rate data is approximately when the patient received his last dose of OPV. Although the time for following the sequence evolution of the vaccine-derived virus was short (189 days), the rate of genomic evolution is similar to the rate determined for wild type 1 polioviruses circulating during a 10-year period (*6*). The apparent similarity in the rates of evolution of virus nucleotide sequences during replication in immunodeficient and normal persons is not unexpected, because under both conditions most (>90%) of the observed mutations do not alter virus proteins and would not be subject to immune selection. However, interpretation of the virologic data presented in this report is limited by the inability to directly determine the time of the initial infection and by the assumption that the rate of VP1 sequence evolution in immunodeficient persons is constant over several years.

The case described in this report was reviewed by an external group of experts convened by CDC in Atlanta on April 2, 1997, and during the meeting of the World Health Organization (WHO) Technical Consultative Group (TCG) on the Global Eradication of Poliomyelitis in Geneva, Switzerland, on April 28, 1997 (*7*). The conclusion that chronic poliovirus infection of immunodeficient persons is uncommon is based on the absence of any other reported case with a similar course during approximately 30 years of polio surveillance in the United States, including 32 cases of paralytic polio in immunocompromised persons studied since 1980 (*8,9*). However, both groups reaffirmed the need for specific research to determine 1) the extent of vaccine virus

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circulation in countries that rely solely on mass vaccination campaigns to deliver OPV and 2) the frequency and duration of vaccine virus shedding in immunocompromised persons, including persons infected with human immunodeficiency virus.

Based on an overall review of available data, the TCG concluded that the evidence is consistent with plans to discontinue polio vaccination after wild poliovirus has been eradicated. However, TCG also recommended that additional scientific studies should be conducted to assure that vaccine viruses will not continue to circulate and cause disease after vaccination has been stopped. A detailed strategy for discontinuing vaccination must be clearly defined to achieve the full benefits of polio eradication (*10*). WHO is sponsoring studies to determine how and when vaccination can be terminated.

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Adult Blood Lead Epidemiology and Surveillance — United States, First Quarter 1997, and Annual 1996

CDC's National Institute for Occupational Safety and Health Adult Blood Lead Epidemiology and Surveillance (ABLES) program monitors laboratory-reported elevated blood lead levels (BLLs) among adults in the United States. Data for New Mexico, Rhode Island, and Wyoming are included for the first time in this report, increasing the number of reporting states to 27 (Illinois discontinued reporting at the end of 1996). Twenty-five states reported surveillance data to the ABLES program in 1996.* This report presents ABLES data for the first quarter of 1997 compared with the

*Alabama, Arizona, California, Connecticut, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Washington, and Wisconsin.

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first quarter of 1996 and annual data for 1996 compared with 1995. The findings from 1995 and 1996 indicate a continuing decrease in the annual number of persons reported with elevated BLLs, although the number of reports in the first quarter of 1997 were higher than that for the same period in 1996.

First Quarter Reports, 1997

During January 1–March 31, 1997, the number of reports of BLLs ≥25 µg/dL increased by 11% over those reported for the same period in 1996 (Table 1).[†] This increase contrasts with the long-term decreasing trend noted in ABLES data (*2,3*) and among adults in the United States (*4*).

Annual Reports, 1996

Overall reports of BLLs ≥25 µg/dL decreased from 28,943 in 1995 to 25,894 in 1996 (Table 2); this represented an 11% decrease for the same 25 states reporting in each year.[§] The reported number of persons with BLLs ≥25 µg/dL decreased by 4% from 13,231 in 1995 to 12,672 in 1996, while the number of new cases was stable (6189 new cases in each year) (Table 2); the only category for which an increase occurred from 1995 to 1996 was the number of new cases with BLLs ≥50 µg/dL, the level designated

[†]To compare estimates for first quarter data for 1997 and 1996 for a constant roster of 28 states, first quarter 1997 data for New Mexico, Rhode Island, and Wyoming were added to the previously reported totals for the first quarter of 1996 (*1*), and estimates for first quarter 1996 data for Illinois, which discontinued reporting at the end of 1996, were included in the first quarter totals for 1997.

[§]To compare data for the same 25 states in both years, 1996 annual data for Minnesota and Ohio were added to previously published data for 23 states in 1995 (*1*). The 1995 data have been updated with corrected Pennsylvania data for reported persons and new cases.

TABLE 1. Number of reports of elevated blood lead levels (BLLs) among adults, number of adults with elevated BLLs, and percentage change in number of reports — 28 states,* first quarter, 1997

Reported BLL (µg/dL)	First quarter, 1997		No. reports, first quarter, 1996[¶]	% Change from first quarter, 1996 to 1997
	No. reports[†]	No. persons[§]		
25–39	5772	3998	5027	15%
40–49	1110	752	1177	– 6%
50–59	232	165	214	8%
≥60	113	74	104	9%
Total	**7227**	**4989**	**6522**	**11%**

*Reported by Alabama, Arizona, California, Connecticut, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Utah, Vermont, Washington, Wisconsin, and Wyoming. First quarter 1996 data for Illinois, which no longer reports, are included as an estimate for first quarter 1997 to allow comparison of data for a constant roster of 28 states.

[†]First quarter 1996 data were used as an estimate for Ohio because of problems in Ohio's 1997 first quarter report.

[§]Individual reports for persons are categorized according to the highest reported BLL for the person during the given quarter. The number of persons reported in Michigan is an estimate based on the number of reports received. First quarter 1996 data were used as an estimate for Ohio because of problems in Ohio's 1997 first quarter report.

[¶]First quarter 1997 data for New Mexico, Rhode Island, and Wyoming are included in addition to previously published 1996 totals (*1*) to compare data for the same 28 states.

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TABLE 2. Number of reports of elevated blood lead levels (BLLs) among adults, number of adults with elevated BLLs, and new cases* of elevated BLLS — 25 states,† 1995 and 1996

	1996				1995			
			New cases				New cases	
Highest BLL (μg/dL)	No. reports§	No. persons¶	No.	(%)	No reports§	No. persons¶	No.	(%)
25–39	20,335	9,884	4,900	(50)	21,754	9,888	4,705	(48)
40–49	4,228	2,037	855	(42)	5,629	2,560	1,078	(42)
50–59	847	492	244	(50)	1,061	527	235	(45)
≥60	484	259	190	(73)	499	256	171	(67)
Total	**25,894**	**12,672**	**6,189**	**(49)**	**28,943**	**13,231**	**6,189**	**(47)**

*A new case is defined as at least one report of a BLL ≥25 μg/dL in an adult appearing in state surveillance data during the current year who was not recorded in the immediately preceding year. In 1995, new cases were not reported for Illinois, Michigan, and South Carolina; data for those states were estimated based on proportions from the other states and the number of reports, persons, or unassigned new cases. Also in 1995, new cases for Alabama, New Hampshire, and Vermont were missing; 1994 data were used as an estimate. In 1996, new cases were not reported for Illinois, Michigan, New Hampshire, Pennsylvania, South Carolina, and Vermont; new cases for those states were estimated based on proportions from the other states and the number of reports, persons, or unassigned new cases.

†Alabama, Arizona, California, Connecticut, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Washington, and Wisconsin. To compare data for the same 25 states, Minnesota and Ohio data for 1996 were added to previously published 1995 data for 23 states (*1*). The 1995 data also have been updated with actual Pennsylvania data for reported persons and new cases, which replace the estimates previously used.

§In 1995, data for Alabama and Vermont were missing; 1994 data were used as estimates. In 1996, fourth quarter data for Illinois were missing; 1995 fourth quarter data were used as an estimate.

¶Individual reports are categorized according to the highest reported BLL for the person during the given year. In 1995, data for Alabama and Vermont were missing; 1994 data were used as an estimate. In 1995 and 1996, the number of persons was not reported by Michigan; the number of persons was estimated based on the proportions from the other states and the number of reports from Michigan. In 1996, fourth quarter data for Illinois were missing; 1995 fourth quarter data were used as an estimate.

by the Occupational Safety and Health Administration (OSHA) for medical removal from the workplace, which increased by 7% from 406 in 1995 to 434 in 1996. In comparison, from 1994 to 1995, the number of reports of BLLs ≥25 μg/dL decreased by 1%, the number of persons with BLLs ≥25 μg/dL increased by 8%, and the number of new cases decreased by 3%.

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Editorial Note: The data reported for 1996 suggest a continued decline in the overall number of detected cases of elevated BLLs among adults, which is consistent with the overall decline reported during 1993–1995 (*3*). Declines in the number of detected cases may reflect improved efforts of the various participating states, and lead-using industries within them, to identify lead-exposed workers and prevent new lead exposures. Alternatively, this decline may reflect diminished compliance with OSHA requirements for blood lead monitoring and/or a reduction in the size of the workforce in lead-using industries. Variation in nationwide reporting totals also may result from 1) changes in the roster of participating states, 2) changes in staffing and funding in state-based surveillance programs, and 3) state-specific differences in worker BLL testing by lead-using industries. The increase in reports for the first quarter of 1997 is an exception to this trend of decreasing reports. However, this increase may represent variation in quarterly reporting rather than changes in adult lead exposures; continued surveillance is required before this first quarter increase can be adequately interpreted.

The findings in this report document the continuing hazard of lead exposures as an occupational health problem in the United States. The ABLES program seeks to enhance surveillance for this preventable condition by expanding the number of participating states, reducing variability in reporting, and distinguishing between new and recurring elevated BLLs in adults. The effort, described below, by the Bureau of Epidemiology of the Pennsylvania Department of Health (PDH) to improve the adult BLL reporting capability for Pennsylvania is an example of surveillance enhancement fostered by the ABLES program.

During 1994–1995, Pennsylvania provided numbers of BLL reports ≥25 µg/dL, but did not report numbers of persons or new cases. Because Pennsylvania accounted for approximately 27% of all elevated BLLs reported, it was important to estimate the numbers of persons and new cases for Pennsylvania rather than omit this substantial portion of the data from the nationwide totals. Therefore, the estimated numbers of persons and new cases for Pennsylvania were based on the number of BLL reports from Pennsylvania and the proportions of persons and new cases to total BLL reports among the other ABLES states. These estimates, identified as such, were included in the yearly totals previously reported for the states in the ABLES program for 1994 and 1995 (*1*). With the assistance of the PDH's Bureau of Epidemiology, analysis of the database for Pennsylvania for 1994 and 1995 has determined the actual numbers of persons and new cases with BLLs ≥25 µg/dL: for 1994, a total of 2005 persons (compared with 2938 estimated previously) and 1089 new cases (compared with 1328); for

ABLES — Continued

1995, a total of 2897 persons (compared with 3481) and 1779 new cases (compared with 1562).¶ The following corrections in the *MMWR* ABLES nationwide totals reported previously for 1994 (*1*) and 1995 (*1*) result from the addition of these updated Pennsylvania data: in 1994, the nationwide number of persons with BLLs ≥25 µg/dL (reported as 12,137) should be 11,204, and the number of new cases (reported as 5619) should be 5380; in 1995, the total number of persons with BLLs ≥25 µg/dL (reported as 12,664) should be 12,080, and the number of new cases (reported as 4993) should be 5210.

References

1. CDC. Adult blood lead epidemiology and surveillance—United States, first quarter 1996, and annual 1995. MMWR 1996;45:628–31.
2. CDC. Adult blood lead epidemiology and surveillance—United States, fourth quarter, 1996. MMWR 1997;46:358–60,367.
3. CDC. Adult blood lead epidemiology and surveillance—United States, third quarter, 1996. MMWR 1997;46:105–7.
4. CDC. Update: blood lead levels—United States, 1991–1994. MMWR 1997;46:141–6.

¶The number of new cases for 1996 in this report (Table 2) still contains an estimate for Pennsylvania. Because of a change in computer databases, actual data for Pennsylvania will be provided for 1996 and for future years.

Characteristics of Community Report Cards — United States, 1996

Efforts to improve community health require methods to compile local health data, establish local priorities, and monitor health-related activities. Community health report cards (i.e., health assessments or health profiles) are central to these efforts. In 1995, the UCLA Center for Healthier Children, Families, and Communities initiated a 3-year project to enhance community health improvement efforts through the design and use of effective community report cards. During the first year of the project, the project examined the construction and application of report cards. This report summarizes the results of the first year, which indicate great diversity in the targets, processes, and formats of community report cards.

A total of 250 public health officials, national and state public health organizations, public and private organizations with an interest in community health improvement, and others at the national, regional, and state levels were sent letters requesting that they identify persons responsible for developing community health report cards. A total of 115 communities that were developing or had completed report cards were identified. A self-administered questionnaire was mailed to contacts in each of the 115 communities asking about 1) the report card development process, including community participation; 2) report card design and content; and 3) links between the report card and community health-improvement activities. Respondents also were asked to provide a copy of their most recent community health report card.

Of the 115 communities, 85 had ever produced a report card; 65 (76%) returned a questionnaire and a copy of their report card. Most questionnaires were completed by the coordinator or director of the community report card project.

Community Report Cards — Continued

Report cards were received from 30 states; 11 were received from California and six each from Connecticut and Florida. Fourteen (22%) were compiled from state-level data, eight (12%) from multicounty-, 28 (43%) from county-, and 14 (22%) from city- or town-level data; one report card covered four zip code areas. Thirty-five (54%) of the reports included only health-related indicators; 15 (23%) included data about crime, transportation, education, and environment. Fifteen (23%) focused on a specific issue or population subgroup (e.g., children or adolescents) rather than on the total population.

Of the 65 respondents, 49 (75%) reported their programs had initiated development of report cards in 1992 or later; 51 (79%) were planning to produce another report card, and 36 (55%) planned to produce report cards at minimal intervals of 1–2 years. Twenty-seven (42%) reported using a pre-existing format (e.g., APEX, PATCH, or Model Communities 2000) to guide in development of report cards. Most (57%) developed report cards based on the experience of others; of these, 30% developed report cards based on the experience of other states, and 24% used programs within the same state. Barriers to producing report cards included difficulty collecting data at the local level (32%) and lack of data (29%).

Forty-one (63%) collected some data from local residents. Of those report cards using primary data, 49% used a research firm or outside consultant and 32% used the local health department to collect data. Trend data was used in 74% of reports. The data were compared with other benchmarks (i.e., state or national) in 89% of the reports.

Respondents identified three major report card uses: identifying areas of need (31%), formulating public policy (32%), and providing an up-to-date database (26%). Forty (62%) respondents reported that the community report card was part of a wider community health improvement effort, and an additional 20% said they were planning to link their report card to health-improvement activities. Of those report cards that were part of a wider community health effort, 28 (70%) used indicators linked to specific health-improvement activities. Report cards were disseminated through newspaper reports (42 [65%]), a mailing to community organizations (43 [66%]), and presentation of reports to local organizations (41 [63%]) and to local government (36 [55%]).

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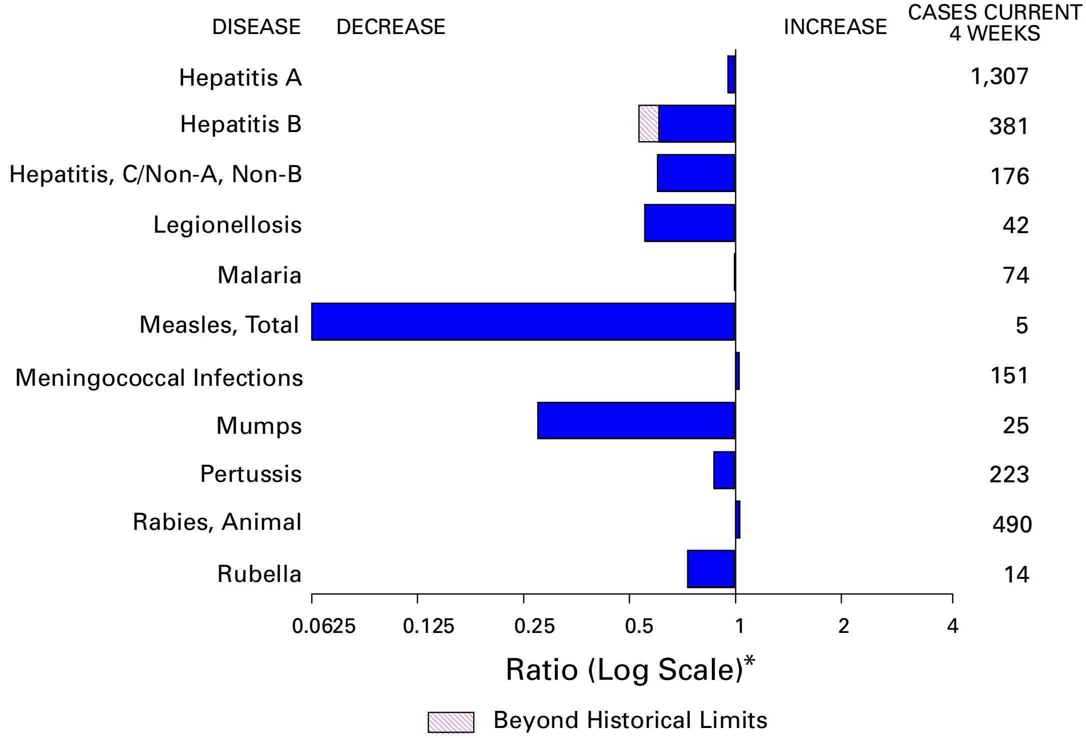
Editorial Note: The findings in this report document the diversity in approaches to producing community report cards. Report cards have been produced at the national level to assess performance of discrete components of the health system (e.g., Health Plan and Employer Data and Information Set [HEDIS]). However, their primary objective is monitoring the health outcomes of patients and the specific performance of organizations (e.g., managed-care organizations) rather than assessing the health status of communities. This project, through comprehensive analysis of existing report cards and in-depth case studies in selected communities, will identify the most effective approaches for communities to design and use report cards and to improve community health processes, activities, and outcomes.

CDC assists communities and states in collecting and analyzing health relevant data, establishing priorities, and developing effective action plans. This project is es-

(Continued on page 655)

FIGURE I. Selected notifiable disease reports, comparison of provisional 4-week totals ending July 12, 1997, with historical data — United States



*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 July 12, 1997 (28th Week)

	Cum. 1997		Cum. 1997
Anthrax	-	Plague	2
Brucellosis	31	Poliomyelitis, paralytic	-
Cholera	3	Psittacosis	21
Congenital rubella syndrome	2	Rabies, human	2
Cryptosporidiosis*	643	Rocky Mountain spotted fever (RMSF)	124
Diphtheria	5	Streptococcal disease, invasive Group A	888
Encephalitis: California*	4	Streptococcal toxic-shock syndrome*	22
eastern equine*	-	Syphilis, congenital¶	125
St. Louis*	1	Tetanus	23
western equine*	1	Toxic-shock syndrome	63
Hansen Disease	53	Trichinosis	3
Hantavirus pulmonary syndrome*†	7	Typhoid fever	142
Hemolytic uremic syndrome, post-diarrheal*	22	Yellow fever	-
HIV infection, pediatric*§	131		

-: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 to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention (NCHSTP), last update June 24, 1997.
¶Updated from reports to the Division of STD Prevention, NCHSTP.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending July 12, 1997, and July 13, 1996 (28th Week)

Reporting Area	AIDS		Chlamydia		*Escherichia coli* O157:H7		Gonorrhea		Hepatitis C/NA,NB	
					NETSS†	PHLIS§				
	Cum. 1997*	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1997	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996
UNITED STATES	30,463	34,369	217,409	213,016	765	338	136,957	157,349	1,615	1,913
NEW ENGLAND	1,277	1,475	8,796	8,612	71	29	2,958	3,340	32	51
Maine	28	22	501	U	8	-	29	24	-	-
N.H.	17	42	397	385	5	3	58	77	6	5
Vt.	23	10	207	235	4	1	26	33	-	15
Mass.	467	739	3,783	3,467	45	25	1,183	1,126	22	28
R.I.	85	94	1,069	1,079	1	-	243	278	4	3
Conn.	657	568	2,839	3,446	8	-	1,419	1,802	-	-
MID. ATLANTIC	9,745	9,522	29,982	35,597	46	13	17,640	21,975	178	160
Upstate N.Y.	1,645	1,163	N	N	29	4	2,799	3,823	138	127
N.Y. City	4,978	5,302	15,751	19,371	8	-	7,050	8,525	-	3
N.J.	1,973	1,869	4,573	6,864	9	7	3,214	4,285	-	-
Pa.	1,149	1,188	9,658	9,362	N	2	4,577	5,342	40	30
E.N. CENTRAL	2,041	2,762	30,983	45,989	134	41	19,254	29,969	301	276
Ohio	396	618	6,377	10,876	33	15	4,185	7,611	8	10
Ind.	361	389	4,673	5,007	27	10	3,129	3,336	9	7
Ill.	765	1,203	5,798	12,975	34	-	2,822	8,750	38	53
Mich.	386	401	9,672	11,421	40	6	7,202	7,726	246	206
Wis.	133	151	4,463	5,710	N	10	1,916	2,546	-	-
W.N. CENTRAL	565	811	12,044	16,375	136	65	5,737	7,610	85	52
Minn.	101	157	U	2,702	66	27	U	1,099	3	-
Iowa	70	57	2,406	1,980	20	9	663	504	19	25
Mo.	237	398	5,995	7,003	17	22	3,984	4,547	52	13
N. Dak.	7	9	434	508	5	3	32	14	2	-
S. Dak.	4	8	669	688	8	-	71	97	-	-
Nebr.	61	55	508	1,079	13	-	129	226	2	5
Kans.	85	127	2,032	2,415	7	4	858	1,123	7	9
S. ATLANTIC	7,504	8,521	46,873	27,500	86	39	45,466	50,858	161	98
Del.	144	165	U	1,148	3	3	616	762	-	-
Md.	950	1,022	3,790	U	7	3	6,981	5,224	10	1
D.C.	538	599	N	N	-	-	1,576	2,374	-	-
Va.	651	542	5,857	5,802	N	18	4,188	5,104	17	8
W. Va.	57	65	1,613	1,131	N	-	500	383	9	7
N.C.	428	466	9,891	U	22	12	9,457	9,888	30	29
S.C.	410	439	6,739	U	1	-	6,020	5,992	26	15
Ga.	965	1,279	6,323	6,923	25	-	7,106	11,652	U	-
Fla.	3,361	3,944	12,660	12,496	27	3	9,022	9,479	69	38
E.S. CENTRAL	1,022	1,132	17,381	15,926	50	7	17,370	16,808	189	351
Ky.	177	173	3,545	3,648	16	-	2,234	2,150	9	20
Tenn.	418	444	6,500	6,896	25	7	5,415	5,931	124	273
Ala.	237	323	4,345	4,387	6	-	6,163	6,911	6	2
Miss.	190	192	2,991	995	3	-	3,558	1,816	50	56
W.S. CENTRAL	3,187	3,354	28,882	11,115	28	5	18,067	10,515	195	187
Ark.	120	144	676	945	4	1	1,410	2,227	-	4
La.	545	834	4,627	3,725	4	3	4,301	3,973	118	110
Okla.	166	139	4,006	4,012	2	1	2,489	2,487	4	1
Tex.	2,356	2,237	19,573	2,433	18	-	9,867	1,828	73	72
MOUNTAIN	881	1,014	12,695	13,382	89	45	3,925	4,148	214	337
Mont.	22	14	477	659	5	-	20	14	12	10
Idaho	28	23	790	832	13	8	59	56	28	85
Wyo.	13	3	294	346	5	-	27	17	88	106
Colo.	210	298	1,896	1,023	33	16	1,091	954	24	31
N. Mex.	79	56	1,870	2,191	5	4	652	450	33	40
Ariz.	227	281	5,158	5,966	N	13	1,558	2,029	22	37
Utah	68	102	847	822	25	-	124	160	3	12
Nev.	234	237	1,363	1,543	3	4	394	468	4	16
PACIFIC	4,241	5,778	29,773	38,520	125	91	6,540	12,126	260	401
Wash.	380	380	4,748	5,308	25	22	1,001	1,151	17	35
Oreg.	162	279	2,086	2,976	38	40	323	448	4	6
Calif.	3,643	5,016	21,315	28,729	58	26	4,755	10,020	156	246
Alaska	22	14	769	563	4	-	214	240	-	2
Hawaii	34	89	855	944	N	3	247	267	83	112
Guam	2	4	31	225	N	-	3	39	-	6
P.R.	1,021	1,047	U	U	23	U	343	347	63	97
V.I.	52	14	N	N	N	U	-	-	-	-
Amer. Samoa	-	-	-	-	N	U	-	-	-	-
C.N.M.I.	1	-	N	N	N	U	16	11	2	-

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

*Updated monthly to the Division of HIV/AIDS Prevention–Surveillance and Epidemiology, National Center for HIV, STD, and TB Prevention, last update June 24, 1997.

†National Electronic Telecommunications System for Surveillance.

§Public Health Laboratory Information System.

TABLE II. (Cont'd.) Provisional cases of selected notifiable diseases, United States, weeks ending July 12, 1997, and July 13, 1996 (28th Week)

Reporting Area	Legionellosis		Lyme Disease		Malaria		Syphilis (Primary & Secondary)		Tuberculosis		Rabies, Animal
	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997
UNITED STATES	424	408	1,840	3,778	736	689	4,209	6,116	8,721	9,907	3,873
NEW ENGLAND	26	19	391	741	37	26	85	88	226	229	570
Maine	1	1	6	8	1	4	-	-	11	16	117
N.H.	3	-	7	14	1	1	-	1	9	8	23
Vt.	4	3	3	7	2	2	-	-	3	1	90
Mass.	8	9	84	39	15	8	41	40	132	100	124
R.I.	5	6	53	78	4	3	2	1	16	23	11
Conn.	5	N	238	595	14	8	42	46	55	81	205
MID. ATLANTIC	74	87	1,023	2,490	184	215	204	282	1,626	1,740	799
Upstate N.Y.	18	25	152	1,131	29	40	19	43	218	192	588
N.Y. City	2	4	17	141	101	121	41	90	841	910	-
N.J.	12	8	362	600	41	38	88	97	327	374	87
Pa.	42	50	492	618	13	16	56	52	240	264	124
E.N. CENTRAL	139	145	29	189	64	89	340	1,027	873	1,044	82
Ohio	70	49	23	12	10	8	107	389	168	156	60
Ind.	25	34	5	9	7	6	70	130	81	102	10
Ill.	5	19	1	6	22	44	34	284	424	567	4
Mich.	33	28	-	-	20	19	72	109	143	169	8
Wis.	6	15	U	162	5	12	57	115	57	50	-
W.N. CENTRAL	37	23	25	67	27	16	75	211	280	244	252
Minn.	1	2	20	9	10	4	U	25	73	63	26
Iowa	9	3	1	10	8	2	3	13	32	34	90
Mo.	10	5	2	28	4	7	50	150	116	89	11
N. Dak.	2	-	-	-	2	-	-	-	5	3	34
S. Dak.	2	2	-	-	-	-	-	-	7	13	32
Nebr.	9	9	1	-	1	-	1	8	12	13	1
Kans.	4	2	1	20	2	3	21	15	35	29	58
S. ATLANTIC	64	52	241	163	155	105	1,770	2,067	1,767	1,801	1,653
Del.	6	4	24	72	2	2	15	22	11	27	35
Md.	14	7	166	37	45	28	493	354	163	158	298
D.C.	3	3	7	1	9	5	50	84	57	73	3
Va.	12	12	11	10	34	19	145	237	165	149	330
W. Va.	N	N	1	7	-	2	3	2	29	29	48
N.C.	7	5	15	29	7	10	392	571	217	247	516
S.C.	2	4	1	2	9	7	218	227	183	197	83
Ga.	-	1	1	-	15	11	287	361	317	344	173
Fla.	20	15	15	5	34	21	167	209	625	577	167
E.S. CENTRAL	24	26	37	38	15	17	948	1,408	563	762	145
Ky.	2	2	4	13	3	3	85	76	97	127	19
Tenn.	16	12	18	12	4	7	407	458	154	268	83
Ala.	2	2	4	1	5	3	252	298	218	240	43
Miss.	4	10	11	12	3	4	204	576	94	127	-
W.S. CENTRAL	7	4	23	41	6	14	596	633	1,137	1,207	169
Ark.	-	1	4	15	2	-	66	152	118	107	25
La.	2	-	2	1	4	2	209	299	-	5	1
Okla.	2	3	5	3	-	-	60	108	97	89	66
Tex.	3	-	12	22	-	12	261	74	922	1,006	77
MOUNTAIN	26	26	9	4	41	29	84	73	291	348	67
Mont.	1	1	-	-	2	3	-	-	7	14	17
Idaho	2	-	2	-	-	-	-	1	7	5	-
Wyo.	1	3	2	3	3	2	-	2	2	3	18
Colo.	8	7	3	-	22	14	4	22	56	48	-
N. Mex.	1	1	-	-	5	1	8	4	16	52	4
Ariz.	7	7	1	-	4	3	62	38	146	129	26
Utah	5	2	-	1	2	4	3	2	11	34	-
Nev.	1	5	1	-	3	2	7	4	46	63	2
PACIFIC	27	26	62	45	207	178	107	327	1,958	2,532	136
Wash.	6	3	2	3	9	11	7	6	112	133	-
Oreg.	-	-	9	10	11	13	5	4	91	94	2
Calif.	20	22	51	31	182	148	93	316	1,616	2,157	115
Alaska	-	1	-	-	3	2	1	-	46	46	19
Hawaii	1	-	-	1	2	4	1	1	93	102	-
Guam	-	1	-	-	-	-	-	3	5	55	-
P.R.	-	-	-	-	3	-	124	131	88	105	32
V.I.	-	-	-	-	-	-	-	-	-	-	-
Amer. Samoa	-	-	-	-	-	-	-	-	-	-	-
C.N.M.I.	-	-	-	-	-	-	5	1	-	-	-

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

TABLE III. Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending July 12, 1997, and July 13, 1996 (28th Week)

Reporting Area	*H. influenzae,* invasive		Hepatitis (Viral), by type				Measles (Rubeola)					
			A		B		Indigenous		Imported[†]		Total	
	Cum. 1997*	Cum. 1996	Cum. 1997	Cum. 1996	Cum. 1997	Cum. 1996	1997	Cum. 1997	1997	Cum. 1997	Cum. 1997	Cum. 1996
UNITED STATES	617	637	14,151	14,439	4,468	5,052	1	50	2	23	73	299
NEW ENGLAND	34	17	330	168	79	105	-	9	-	1	10	11
Maine	3	-	41	12	7	2	-	-	-	-	-	-
N.H.	4	9	19	8	5	8	-	1	-	-	1	-
Vt.	3	-	7	4	2	8	-	-	-	-	-	1
Mass.	21	7	134	83	33	32	-	8	-	-	8	9
R.I.	2	1	65	7	9	6	-	-	-	-	-	-
Conn.	1	-	64	54	23	49	-	-	-	1	1	1
MID. ATLANTIC	71	133	1,048	978	632	806	-	12	-	4	16	24
Upstate N.Y.	13	35	154	218	123	190	-	2	-	3	5	4
N.Y. City	20	35	376	308	230	288	-	4	-	1	5	8
N.J.	28	35	180	215	132	166	-	1	-	-	1	1
Pa.	10	28	338	237	147	162	-	5	-	-	5	11
E.N. CENTRAL	102	107	1,435	1,312	478	586	-	5	-	3	8	16
Ohio	59	56	207	477	47	64	-	-	-	-	-	2
Ind.	10	7	161	168	53	80	-	-	-	-	-	-
Ill.	22	32	308	332	118	180	-	5	-	1	6	3
Mich.	10	7	673	224	243	207	-	-	-	2	2	2
Wis.	1	5	86	111	17	55	U	-	U	-	-	9
W.N. CENTRAL	30	24	1,075	1,130	243	253	-	9	-	2	11	16
Minn.	20	12	100	56	23	23	-	-	-	2	2	14
Iowa	3	3	186	212	29	29	-	-	-	-	-	-
Mo.	3	6	558	577	159	161	-	1	-	-	1	1
N. Dak.	-	-	10	28	2	-	-	-	-	-	-	-
S. Dak.	2	1	14	39	-	-	-	8	-	-	8	-
Nebr.	1	1	48	84	11	18	-	-	-	-	-	-
Kans.	1	1	159	134	19	22	-	-	-	-	-	1
S. ATLANTIC	120	113	902	578	671	661	1	2	2	5	7	5
Del.	-	1	16	6	4	4	-	-	-	-	-	1
Md.	47	38	145	106	102	84	-	-	-	1	1	-
D.C.	2	5	14	18	22	26	-	-	-	1	1	-
Va.	7	5	105	83	72	81	-	-	1	1	1	2
W. Va.	3	4	6	12	9	14	-	-	-	-	-	-
N.C.	17	18	108	73	134	188	-	-	-	1	1	-
S.C.	4	3	66	30	60	45	-	-	-	-	-	-
Ga.	21	28	190	41	57	7	-	-	-	-	-	1
Fla.	19	11	252	209	211	212	1	2	1	1	3	1
E.S. CENTRAL	34	18	344	811	367	440	-	-	-	-	-	-
Ky.	4	5	45	18	23	42	-	-	-	-	-	-
Tenn.	22	7	212	561	236	256	-	-	-	-	-	-
Ala.	8	5	52	103	40	30	-	-	-	-	-	-
Miss.	-	1	35	129	68	112	U	-	U	-	-	-
W.S. CENTRAL	31	29	2,905	2,764	556	599	-	3	-	1	4	12
Ark.	1	-	146	262	31	45	-	-	-	-	-	-
La.	6	3	118	83	81	61	-	-	-	-	-	-
Okla.	19	23	900	1,161	20	24	-	-	-	-	-	-
Tex.	5	3	1,741	1,258	424	469	-	3	-	1	4	12
MOUNTAIN	64	33	2,220	2,331	493	616	-	5	-	-	5	82
Mont.	-	-	52	68	5	6	-	-	-	-	-	-
Idaho	1	1	80	137	15	64	-	-	-	-	-	1
Wyo.	1	-	20	21	20	24	-	-	-	-	-	-
Colo.	9	7	247	211	99	66	-	-	-	-	-	6
N. Mex.	8	8	182	263	163	206	-	-	-	-	-	6
Ariz.	26	12	1,150	894	112	147	-	5	-	-	5	8
Utah	3	5	355	525	56	60	-	-	-	-	-	56
Nev.	16	-	134	212	23	43	U	-	U	-	-	5
PACIFIC	131	163	3,892	4,367	949	986	-	5	-	7	12	133
Wash.	2	2	295	300	43	57	-	-	-	-	-	37
Oreg.	22	22	209	569	61	64	-	-	-	-	-	7
Calif.	99	133	3,292	3,420	823	853	-	2	-	7	9	24
Alaska	2	4	23	28	14	4	-	-	-	-	-	63
Hawaii	6	2	73	50	8	8	-	3	-	-	3	2
Guam	-	-	-	6	1	-	U	-	U	-	-	-
P.R.	-	1	177	113	775	538	-	-	-	-	-	2
V.I.	-	-	-	24	-	21	U	-	U	-	-	-
Amer. Samoa	-	-	-	-	-	-	U	-	U	-	-	-
C.N.M.I.	5	10	1	1	21	5	U	1	U	-	1	-

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

*Of 133 cases among children aged <5 years, serotype was reported for 70 and of those, 27 were type b.

[†]For imported measles, cases include only those resulting from importation from other countries.

TABLE III. (Cont'd.) Provisional cases of selected notifiable diseases preventable by vaccination, United States, weeks ending July 12, 1997, and July 13, 1996 (28th Week)

	Meningococcal Disease		Mumps			Pertussis			Rubella		
Reporting Area	Cum. 1997	Cum. 1996	1997	Cum. 1997	Cum. 1996	1997	Cum. 1997	Cum. 1996	1997	Cum. 1997	Cum. 1996
UNITED STATES	2,045	1,977	3	330	394	71	2,598	2,025	-	65	138
NEW ENGLAND	127	81	-	7	1	4	533	437	-	-	24
Maine	13	9	-	-	-	-	6	15	-	-	-
N.H.	13	3	-	-	-	2	64	19	-	-	-
Vt.	2	3	-	-	-	1	174	10	-	-	2
Mass.	65	30	-	2	1	1	266	388	-	-	20
R.I.	9	8	-	4	-	-	12	-	-	-	-
Conn.	25	28	-	1	-	-	11	5	-	-	2
MID. ATLANTIC	178	219	-	30	55	-	174	132	-	3	7
Upstate N.Y.	45	54	-	6	16	-	53	68	-	1	3
N.Y. City	31	32	-	-	13	-	40	19	-	2	2
N.J.	42	48	-	-	2	-	5	7	-	-	2
Pa.	60	85	-	24	24	-	76	38	-	-	-
E.N. CENTRAL	295	281	1	35	87	2	191	266	-	4	3
Ohio	114	97	1	17	28	1	78	85	-	-	-
Ind.	34	40	-	4	5	-	30	19	-	-	-
Ill.	87	83	-	7	17	1	29	62	-	1	1
Mich.	36	29	-	7	36	-	31	23	-	-	2
Wis.	24	32	U	-	1	U	23	77	U	3	-
W.N. CENTRAL	151	151	-	12	6	6	155	81	-	-	-
Minn.	20	15	-	5	2	-	101	52	-	-	-
Iowa	34	32	-	6	-	2	18	3	-	-	-
Mo.	72	61	-	-	2	4	23	15	-	-	-
N. Dak.	1	3	-	-	2	-	2	1	-	-	-
S. Dak.	4	8	-	-	-	-	2	2	-	-	-
Nebr.	7	13	-	1	-	-	4	3	-	-	-
Kans.	13	19	-	-	-	-	5	5	-	-	-
S. ATLANTIC	366	309	-	46	56	18	259	199	-	33	29
Del.	5	2	-	-	-	-	-	13	-	-	-
Md.	35	36	-	4	18	-	79	68	-	-	-
D.C.	1	4	-	-	-	1	3	-	-	-	1
Va.	34	35	-	6	7	6	31	23	-	1	2
W. Va.	14	13	-	-	-	1	5	2	-	-	-
N.C.	66	52	-	7	11	-	68	34	-	22	15
S.C.	41	39	-	10	5	-	11	9	-	9	1
Ga.	69	90	-	4	2	-	7	13	-	-	-
Fla.	101	38	-	15	13	10	55	37	-	1	10
E.S. CENTRAL	157	138	-	16	16	4	59	151	-	-	2
Ky.	37	20	-	3	-	1	13	128	-	-	-
Tenn.	59	42	-	3	1	1	23	13	-	-	-
Ala.	45	40	-	6	3	2	15	5	-	-	2
Miss.	16	36	U	4	12	U	8	5	U	-	N
W.S. CENTRAL	202	225	-	34	30	2	64	70	-	4	7
Ark.	25	26	-	-	1	1	11	2	-	-	-
La.	40	42	-	11	11	1	12	5	-	-	1
Okla.	23	22	-	-	-	-	10	5	-	-	-
Tex.	114	135	-	23	18	-	31	58	-	4	6
MOUNTAIN	117	116	1	44	18	18	743	191	-	5	6
Mont.	8	5	-	-	-	-	9	7	-	-	-
Idaho	8	16	-	2	-	10	520	60	-	1	2
Wyo.	1	3	-	1	-	-	5	1	-	-	-
Colo.	33	19	-	3	3	5	150	44	-	-	2
N. Mex.	18	20	N	N	N	3	35	33	-	-	-
Ariz.	32	29	1	30	1	-	18	12	-	4	1
Utah	11	11	-	6	3	-	4	9	-	-	-
Nev.	6	13	U	2	11	U	2	25	U	-	1
PACIFIC	452	457	1	106	125	17	420	498	-	16	60
Wash.	55	59	1	13	17	15	207	205	-	3	12
Oreg.	92	82	-	-	-	-	18	33	-	-	1
Calif.	302	309	-	81	89	2	188	247	-	8	44
Alaska	1	5	-	2	2	-	1	1	-	-	-
Hawaii	2	2	-	10	17	-	6	12	-	5	3
Guam	-	4	U	1	4	U	-	-	U	-	-
P.R.	8	10	1	5	1	-	-	2	-	-	-
V.I.	-	-	U	-	1	U	-	-	U	-	-
Amer. Samoa	-	-	U	-	-	U	-	-	U	-	-
C.N.M.I.	-	-	U	4	-	U	-	-	U	-	-

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

TABLE IV. Deaths in 122 U.S. cities,* week ending July 12, 1997 (28th Week)

Reporting Area	All Causes, By Age (Years)						P&I† Total
	All Ages	>65	45-64	25-44	1-24	<1	
NEW ENGLAND	558	395	103	41	10	9	34
Boston, Mass.	149	90	41	12	3	3	9
Bridgeport, Conn.	36	27	6	2	-	1	2
Cambridge, Mass.	13	11	1	1	-	-	1
Fall River, Mass.	22	17	4	1	-	-	-
Hartford, Conn.	50	33	11	2	4	-	5
Lowell, Mass.	21	19	-	2	-	-	1
Lynn, Mass.	12	10	1	1	-	-	1
New Bedford, Mass.	20	17	1	1	1	-	-
New Haven, Conn.	37	27	5	4	1	-	3
Providence, R.I.	57	41	11	3	-	2	7
Somerville, Mass.	7	4	3	-	-	-	-
Springfield, Mass.	44	26	11	4	1	2	-
Waterbury, Conn.	30	23	2	5	-	-	-
Worcester, Mass.	60	50	6	3	-	1	5
MID. ATLANTIC	2,271	1,518	442	205	59	47	103
Albany, N.Y.	47	33	10	1	2	1	2
Allentown, Pa.	24	16	6	2	-	-	1
Buffalo, N.Y.	89	64	13	7	3	2	-
Camden, N.J.	41	20	7	2	8	4	4
Elizabeth, N.J.	19	11	6	1	1	-	-
Erie, Pa.	46	40	4	2	-	-	2
Jersey City, N.J.	16	11	3	1	-	1	1
New York City, N.Y.	1,263	847	251	123	26	16	53
Newark, N.J.	59	27	13	14	3	2	2
Paterson, N.J.	24	13	6	4	-	1	-
Philadelphia, Pa.	301	179	70	28	13	11	19
Pittsburgh, Pa.§	54	37	10	3	2	2	3
Reading, Pa.	11	8	1	2	-	-	1
Rochester, N.Y.	136	105	21	6	1	3	8
Schenectady, N.Y.	16	13	2	1	-	-	1
Scranton, Pa.	25	22	2	1	-	-	-
Syracuse, N.Y.	59	40	13	3	-	3	4
Trenton, N.J.	26	21	1	3	-	1	1
Utica, N.Y.	15	11	3	1	-	-	1
Yonkers, N.Y.	U	U	U	U	U	U	U
E.N. CENTRAL	2,007	1,350	391	153	56	56	105
Akron, Ohio	51	35	12	3	-	1	-
Canton, Ohio	55	40	11	3	-	1	2
Chicago, Ill.	375	236	81	34	12	11	33
Cincinnati, Ohio	U	U	U	U	U	U	U
Cleveland, Ohio	136	93	30	6	1	6	-
Columbus, Ohio	206	124	50	17	3	12	10
Dayton, Ohio	139	106	21	8	2	2	12
Detroit, Mich.	239	131	59	32	7	10	13
Evansville, Ind.	35	26	5	-	1	3	2
Fort Wayne, Ind.	44	36	3	4	1	-	3
Gary, Ind.	12	4	5	-	3	-	-
Grand Rapids, Mich.	58	42	11	2	2	1	4
Indianapolis, Ind.	195	128	37	19	5	6	9
Lansing, Mich.	57	34	14	3	6	-	1
Milwaukee, Wis.	126	91	22	10	2	1	5
Peoria, Ill.	43	37	3	2	-	1	5
Rockford, Ill.	49	38	6	2	2	1	2
South Bend, Ind.	42	34	5	1	2	-	-
Toledo, Ohio	71	57	8	3	3	-	1
Youngstown, Ohio	74	58	8	4	4	-	3
W.N. CENTRAL	644	443	106	50	27	13	40
Des Moines, Iowa	U	U	U	U	U	U	U
Duluth, Minn.	U	U	U	U	U	U	U
Kansas City, Kans.	43	27	8	5	2	1	2
Kansas City, Mo.	113	74	20	9	5	-	2
Lincoln, Nebr.	37	27	4	3	2	1	1
Minneapolis, Minn.	141	94	22	16	5	4	10
Omaha, Nebr.	71	54	13	1	1	2	4
St. Louis, Mo.	123	81	22	8	9	3	15
St. Paul, Minn.	65	47	14	2	1	1	3
Wichita, Kans.	51	39	3	6	2	1	3
S. ATLANTIC	1,218	772	267	106	46	27	60
Atlanta, Ga.	102	64	20	11	5	2	1
Baltimore, Md.	226	140	55	20	8	3	26
Charlotte, N.C.	102	58	32	6	2	4	4
Jacksonville, Fla.	128	87	24	10	2	5	3
Miami, Fla.	83	54	19	8	1	1	-
Norfolk, Va.	57	32	11	7	4	3	2
Richmond, Va.	83	56	15	6	4	2	7
Savannah, Ga.	42	31	5	5	-	1	6
St. Petersburg, Fla.	62	42	8	6	2	4	2
Tampa, Fla.	166	117	31	15	3	-	7
Washington, D.C.	143	78	36	12	15	2	2
Wilmington, Del.	24	13	11	-	-	-	-
E.S. CENTRAL	813	526	178	65	25	18	37
Birmingham, Ala.	128	88	30	6	2	1	8
Chattanooga, Tenn.	83	59	12	5	4	3	5
Knoxville, Tenn.	74	47	15	8	4	-	3
Lexington, Ky.	64	38	17	6	2	1	7
Memphis, Tenn.	186	118	49	11	6	2	9
Mobile, Ala.	105	69	18	14	2	2	2
Montgomery, Ala.	36	23	6	4	1	2	3
Nashville, Tenn.	137	84	31	11	4	7	-
W.S. CENTRAL	1,425	871	321	132	55	46	49
Austin, Tex.	80	53	17	7	1	2	6
Baton Rouge, La.	58	33	15	4	4	2	1
Corpus Christi, Tex.	42	26	10	3	3	-	1
Dallas, Tex.	217	117	51	26	7	16	1
El Paso, Tex.	86	57	13	9	6	1	4
Ft. Worth, Tex.	110	60	31	13	4	2	3
Houston, Tex.	349	224	84	23	12	6	21
Little Rock, Ark.	49	28	11	6	1	3	-
New Orleans, La.	91	51	21	13	5	1	-
San Antonio, Tex.	198	124	37	21	6	10	5
Shreveport, La.	37	25	9	2	-	1	2
Tulsa, Okla.	108	73	22	5	6	2	5
MOUNTAIN	947	612	181	87	32	26	57
Albuquerque, N.M.	121	71	29	12	8	1	1
Boise, Idaho	40	25	9	3	1	2	2
Colo. Springs, Colo.	56	38	13	1	3	1	1
Denver, Colo.	96	56	14	14	4	8	7
Las Vegas, Nev.	196	127	45	20	3	-	8
Ogden, Utah	28	24	1	1	-	1	3
Phoenix, Ariz.	187	114	33	23	5	5	20
Pueblo, Colo.	28	18	2	2	2	4	1
Salt Lake City, Utah	81	57	15	5	1	3	5
Tucson, Ariz.	114	82	20	6	5	1	9
PACIFIC	1,630	1,157	279	124	43	27	128
Berkeley, Calif.	23	19	3	-	-	1	3
Fresno, Calif.	95	51	24	12	5	3	10
Glendale, Calif.	25	20	2	2	-	1	1
Honolulu, Hawaii	61	47	7	6	1	-	7
Long Beach, Calif.	77	48	18	5	2	4	17
Los Angeles, Calif.	579	429	92	41	14	3	26
Pasadena, Calif.	26	21	3	-	-	2	4
Portland, Oreg.	86	61	16	6	3	-	4
Sacramento, Calif.	U	U	U	U	U	U	U
San Diego, Calif.	140	101	23	9	4	3	20
San Francisco, Calif.	125	83	25	15	1	1	10
San Jose, Calif.	121	86	20	10	2	3	11
Santa Cruz, Calif.	33	20	7	3	3	-	4
Seattle, Wash.	121	75	25	11	6	4	4
Spokane, Wash.	68	53	8	4	2	1	6
Tacoma, Wash.	50	43	6	-	-	1	1
TOTAL	11,513¶	7,644	2,268	963	353	269	613

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.

Community Report Cards — Continued

tablishing a baseline for developing and using these report cards at the local and state level. The preliminary findings suggest that some U.S. communities are using community report cards for developing public policy, establishing funding priorities, and developing programs with substantial community participation and support. During the second year of the project, eight report cards in communities with links to health-improvement activities and with broad community involvement will be analyzed to identify critical factors contributing to their effectiveness. During the third year, a technical-assistance manual will be produced to assist communities in designing report cards and in improving community health processes, activities, and outcomes.

Barriers for developing report cards include lack of data, constraints to obtaining reliable and valid local data, and the time required to develop report cards. User-friendly software and other design tools may assist communities in producing report cards in a timely manner using the best available data.

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