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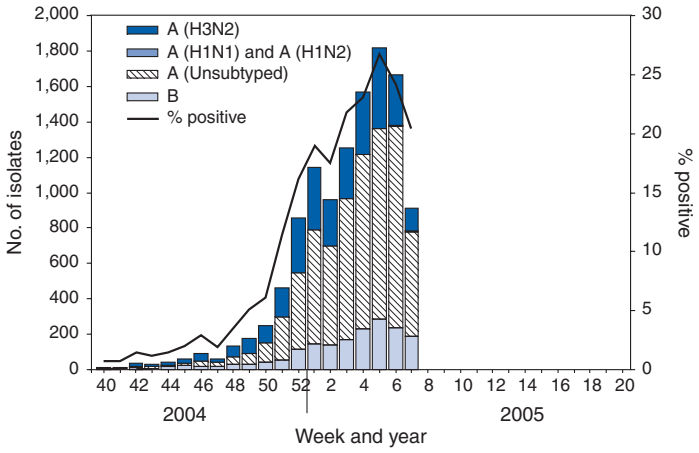
Update: Influenza Activity — United States, 2004–05 Season

Influenza activity has increased steadily in the United States since late December and, as of February 19, might not have peaked. Laboratory-confirmed influenza infections have been reported from all 50 states. This report summarizes influenza activity during October 3, 2004–February 19, 2005*.

Influenza Viral Surveillance and Characterization

During October 3–February 19, World Health Organization (WHO) and National Respiratory and Enteric Virus Surveillance System (NREVSS) collaborating laboratories in the United States tested 83,753 respiratory specimens for influenza viruses; 11,547 (13.8%) were positive. The weekly percentage of specimens that tested positive for influenza ranged from 0.7% to 26.7% (Figure 1) and first exceeded 10.0% during the week ending December 25 (week 51). During the 2001–02, 2002–03, and 2003–04 influenza seasons, peak percentages of specimens that tested positive for influenza ranged from 24.9% to 34.7% (CDC, unpublished data, 2004). During January 30–February 19, by region, the percentage of specimens that tested positive for influenza ranged from 8.9% in the Pacific region to 42.7% in the East North Central region†.

FIGURE 1. Number* and percentage of respiratory specimens testing positive for influenza reported by World Health Organization and National Respiratory and Enteric Virus Surveillance System collaborating laboratories, by week and year — United States, 2004–05 influenza season†



*N = 11,547.
†As of February 25, 2005, reporting is incomplete.

Of the 11,547 influenza viruses identified since October 3, a total of 9,773 (84.6%) were influenza A viruses, and 1,774 (15.4%) were influenza B viruses. Among the

*As of February 25, 2005, reporting is incomplete.
† Surveillance regions: *New England*: Connecticut, Maine, Massachusetts, New Hampshire, Vermont, and Rhode Island; *Mid-Atlantic*: New Jersey, New York City, Pennsylvania, and Upstate New York; *East North Central*: Illinois, Indiana, Michigan, Ohio, and Wisconsin; *West North Central*: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, and South Dakota; *South Atlantic*: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, and West Virginia; *East South Central*: Alabama, Kentucky, Mississippi, and Tennessee; *West South Central*: Arkansas, Louisiana, Oklahoma, and Texas; *Mountain*: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, and Wyoming; and *Pacific*: Alaska, California, Hawaii, Oregon, and Washington.

INSIDE

196 Interventions to Increase Influenza Vaccination of Health-Care Workers — California and Minnesota
199 Vaccination Coverage Among Callers to a State Influenza Hotline — Connecticut, 2004–05 Influenza Season
200 Progress in Reducing Measles Mortality — Worldwide, 1999–2003
203 Notice to Readers
203 QuickStats

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION

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influenza A viruses, 3,001 (30.7%) were subtyped; 2,990 (99.6%) were influenza A (H3N2), and 11 (0.4%) were influenza A (H1)[§]. In the Mid-Atlantic and New England regions, 95% and 94% of viruses reported were influenza type A, respectively. In the remaining seven surveillance regions, the proportion of influenza A viruses ranged from 60% in the Pacific region to 88% in the East South Central region.

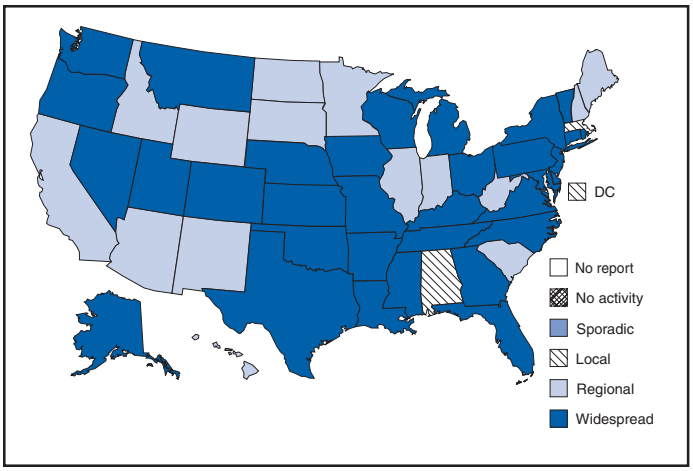
Using hemagglutination-inhibition tests with post-infection ferret serum, CDC has antigenically characterized 320 influenza viruses collected by U.S. laboratories since October 1, 2004. Of these, 228 (71.3%) were influenza A (H3N2) viruses, two (<1%) were influenza A (H1N1) viruses, and 90 (28.1%) were influenza B viruses. Of the 228 influenza A (H3N2) isolates, 125 (54.8%) were A/Fujian/411/2002-like (H3N2), the influenza A (H3N2) strain recommended for the 2004–05 influenza vaccine[¶], and 103 (45.2%) were antigenically similar to A/California/7/2004 (H3N2), a recently characterized drift variant of A/Fujian/411/2002-like (H3N2) viruses. Current influenza B viruses fall into one of two antigenically and genetically distinct lineages represented by B/Yamagata/16/88 and B/Victoria/2/87 viruses (*1*). Of the 90 influenza B viruses, 66 (73.3%) were similar to B/Shanghai/361/2002-like viruses (from the B/Yamagata/16/88 lineage), the influenza B strain recommended for the 2004–05 influenza vaccine, five (5.6%) had reduced titers to B/Shanghai/361/2002 using ferret antisera, and 19 (21.1%) belonged to the B/Victoria/2/87 lineage.

Influenza Activity Levels Reported by State and Territorial Epidemiologists

For the week ending February 19, 2005, a total of 33 states reported widespread influenza activity**; 15 states reported regional activity; and two states, New York City, and the District of Columbia reported local influenza activity (Figure 2). Since the week ending October 9, 2004, a total of 38 states and New York City have reported widespread influenza activity for at least 1 week.

§ Includes both the A (H1N1) and A (H1N2) influenza virus sybtypes.
¶ The A/Fujian/411/2002-like virus used by U.S. vaccine manufacturers was A/Wyoming/03/2003, an antigenically equivalent virus appropriate for vaccine production.
** Levels of activity are 1) *no activity*, 2) *sporadic*: small numbers of laboratory-confirmed influenza cases or a single influenza outbreak reported but no increase in cases of influenza-like illness (ILI), 3) *local*: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of a state, 4) *regional*: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least two but less than half the regions of a state, and 5) *widespread*: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of a state.

FIGURE 2. States in which estimated influenza activity levels have been reported by state and territorial epidemiologists, by level of activity* — United States, February 19, 2005



* Levels of activity are 1) *no activity*, 2) *sporadic*: small numbers of laboratory-confirmed influenza cases or a single influenza outbreak reported but no increase in cases of influenza-like illness (ILI), 3) *local*: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of a state, 4) *regional*: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least two but less than half the regions of a state, and 5) *widespread*: outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of a state.

Patient Visits for Influenza-Like Illness

During the weeks ending October 9–February 19, weekly percentages of patient visits for influenza-like illness (ILI)[††] reported by approximately 1,500 U.S. sentinel providers from all 50 states ranged from 1.0% to 5.7%. During the week ending February 19, a total of 5.7% of patient visits were for ILI. This was the sixth consecutive week that the percentage of visits for ILI exceeded the national baseline of 2.5%[§§]. During the 2001–02, 2002–03, and 2003–04 influenza seasons, national weekly peak percentages of patient visits for ILI ranged from 3.2% to 7.6% (CDC, unpublished data, 2004).

Pediatric Hospitalizations Associated with Laboratory-Confirmed Influenza Infection

The New Vaccine Surveillance Network (NVSN) provides population-based estimates of laboratory-confirmed influenza hospitalization rates for children aged <5 years residing in three cities (Cincinnati, Ohio; Nashville, Tennessee; and Rochester, New York). Children admitted to NVSN hospitals with fever or respiratory symptoms are prospectively enrolled, and respiratory samples are collected and tested by viral culture and reverse transcriptase-polymerase chain reaction (PCR). During October 3, 2004–February 5, 2005, the preliminary hospitalization rate was 2.0 per 10,000 children. During 2000–2004, the influenza (October to mid-May) hospitalization rates ranged from 3.7 per 10,000 children (2002–2003) to 12.0 (2003–2004).

The Emerging Infections Programs (EIP) conducts population-based surveillance for laboratory-confirmed influenza-related hospitalizations in persons aged <18 years in 11 metropolitan areas (San Francisco, California; Denver, Colorado; New Haven, Connecticut; Atlanta, Georgia; Baltimore, Maryland; Minneapolis/St. Paul, Minnesota; Albuquerque, New Mexico; Albany, New York; Rochester, New York; Portland, Oregon; and Nashville, Tennessee). Hospital laboratory and admission databases and infection-control logs are reviewed to identify children with a positive influenza test result (i.e., culture, direct or indirect fluorescent antibody assays, PCR, or a rapid test) from testing conducted as a part of their routine care. During October 1–February 5, the preliminary hospitalization rates for children aged 0–4 years and 5–17 years were 0.81 and 0.11 per 10,000, respectively (combined hospitalization rate: 0.35). The final 2003–04 influenza season EIP hospitalization rates were 7.8 per 10,000 children aged 0–4 years and 0.8 per 10,000 children aged 5–17 years.

Influenza-Associated Mortality Surveillance

During the week ending February 19, a total of 8.5% of deaths reported through the 122 Cities Mortality Reporting System were attributed to pneumonia and influenza (P&I), which is above the epidemic threshold of 8.2%[¶¶] for that week. The percentage of P&I deaths exceeded the epidemic threshold for 3 nonconsecutive weeks during October 3–February 19 but otherwise has remained below threshold.

In October 2004, pediatric deaths associated with laboratory-confirmed influenza infection became a nationally notifiable condition. As of February 19, nine states (California, Georgia, Maine, Massachusetts, Mississippi,

[††] Temperature of ≥100.0°F (≥37.8°C) and either cough or sore throat in the absence of a known cause.

[§§] The national baseline was calculated as the mean weighted percentage of visits for ILI during noninfluenza weeks, plus two standard deviations. Wide variability in regional data precludes calculating region-specific baselines; applying the national baseline to regional data is inappropriate.

[¶¶] The expected seasonal baseline proportion of P&I deaths reported by the 122 Cities Mortality Reporting System is projected by using a robust cyclical regression procedure in which a periodic regression model is applied to the observed percentage of deaths from P&I during the previous 5 years. The epidemic threshold is 1.645 standard deviations above the seasonal baseline.

New Jersey, Ohio, Pennsylvania, and Vermont) had reported nine pediatric deaths to CDC; all deaths occurred during January and February.

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Editorial Note: Influenza activity was low in the United States from October through mid-December but steadily increased during January and February and might not have peaked. In the United States, influenza activity typically peaks during December–March (*2*) and, in 16 of the preceding 27 seasons, has peaked during February or later. During the 2003–04 influenza season, 153 pediatric deaths associated with influenza infection were reported from 40 states, whereas only nine such deaths have been reported so far this season. However, numerous influenza outbreaks have been reported in long-term–care facilities and among school children, and the number of pediatric deaths associated with laboratory-confirmed influenza is expected to increase before the end of this season.

The viruses circulating this year include both influenza A and B viruses, but influenza A viruses have predominated, and most have been subtyped as influenza A (H3N2) viruses. Most of the influenza A (H3N2) viruses reported earlier in the season were antigenically similar to the influenza A (H3N2) component of the 2004–05 vaccine (A/Fujian/411/2002-like virus). However, since mid-January, an increasing proportion of influenza A (H3N2) viruses have been reported to be similar to A/California/7/2004, a recent reference strain that is related to A/Fujian/411/2002 but is antigenically distinguishable. Antibodies produced against A/Fujian/411/2002-like viruses cross-react with A/California7/2004-like viruses but at a lower level, and, because of this, effectiveness of the 2004–05 vaccine could be reduced against A/California/7/2004-like viruses.

Antiviral medications are useful for early treatment of influenza and as an adjunct to influenza vaccination for influenza prevention and control. They should be considered when treating persons with suspected influenza regardless of vaccination status during periods of community influenza activity. Influenza antiviral drugs differ in approved age groups, recommended dosages, routes of administration, adverse effects, development of antiviral resistance, and cost. When administered within 48 hours of symptom onset, antiviral treatment of influenza can reduce the duration of illness by approximately 1 day in healthy adults (*3*). Four prescription antiviral medications (amantadine, rimantadine, oseltamivir, and zanamivir) are approved for treatment of influenza A virus infections. Oseltamivir and zanamivir also are approved for treatment of influenza B virus infections. Antiviral chemoprophylaxis is approximately 70%–90% effective in preventing illness in healthy adults (*3*). Amantadine, rimantadine, and oseltamivir are approved for chemoprophylaxis of influenza A virus infections; only oseltamivir is approved for chemoprophylaxis of influenza B virus infections. Physicians should consult package inserts of antiviral drugs for information on approved age groups, dosing, and adverse effects.

Influenza surveillance reports for the United States are published weekly during October–May and are available at http://www.cdc.gov/flu/weekly or through the CDC voice (888-232-3228) and fax (888-232-3299, document number 361100) information systems.

Acknowledgments

The findings in this report are based, in part, on data contributed by participating state and territorial health departments and state public health laboratories, WHO collaborating laboratories, National Respiratory and Enteric Virus Surveillance System collaborating laboratories, the U.S. Influenza Sentinel Provider Surveillance System, the New Vaccine Surveillance Network, the Emerging Infections Program, and the 122 Cities Mortality Reporting System.

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Interventions to Increase Influenza Vaccination of Health-Care Workers — California and Minnesota

Vaccination of health-care workers (HCWs) has been shown to reduce influenza infection and absenteeism among HCWs (*1*), prevent mortality in their patients (*2*), and result in financial savings to sponsoring health institutions (*3*). However, influenza vaccination coverage among HCWs in the United States remains low (*4–6*); in 2003, coverage among HCWs was 40.1% (CDC, unpublished data, 2005). This report describes strategies implemented in three clinical settings that increased the proportion of HCWs who

received influenza vaccination. The results demonstrate the value of making influenza vaccination convenient and available at no cost to HCWs.

Educational Campaigns and Vaccine Days in Nursing Homes

In spring 2002, the California Department of Health Services, in collaboration with local health departments, conducted a knowledge, attitudes, and behaviors study of HCWs in 30 southern California nursing homes. This study determined that problems with vaccine access and misconceptions regarding influenza and the vaccine were associated with nonvaccination. The study results were used to develop two interventions: 1) educational campaigns that emphasized the seriousness of influenza and addressed employee misconceptions about influenza and the vaccine (through employee in-services, fact sheets distributed with employee paychecks, and informational handouts and posters); and 2) Vaccine Days offering influenza vaccination free of charge to all HCWs on designated days at the nursing home.

To evaluate the effectiveness of these interventions, the California Department of Health Services conducted a controlled study in 70 southern California nursing homes during the 2002–03 influenza season. Nursing homes were selected by convenience sample and represented approximately 14% of nursing homes in the areas from where they were selected. They were assigned to one of four groups: 1) group A (n = 25), which conducted no interventions; 2) group B (n = 15), which conducted an educational campaign; 3) group C (n = 15), which held Vaccine Days; and 4) group D (n = 15), which conducted both an educational campaign and held Vaccine Days.

Sixty-seven (95%) nursing homes completed the study, and 4,338 (61%) of the 7,123 HCWs returned postintervention vaccination questionnaires; response rates did not vary by study group but did range from 56% to 68% by nursing home. According to preliminary analysis, when compared with the 27% vaccination coverage in the control group (group A), Vaccine Days were effective in increasing coverage when implemented in combination with the educational campaign (group D) (53% coverage; adjusted odds ratio [AOR] = 3.54; 95% confidence interval [CI] = 2.17–5.72) and when implemented alone (group C) (45%; AOR = 2.28; CI = 1.30–3.98). However, an educational campaign alone (group B) did not significantly increase HCW vaccine coverage (34%; AOR = 1.31; CI = 0.76–2.25).

Mobile Vaccination Cart at a Veterans Affairs Medical Center

During the early 1980s, influenza vaccination rates among employees of the Minneapolis (Minnesota) Veterans Affairs Medical Center (VAMC) were less than 25%. In 1985, as part of a comprehensive effort to increase vaccination coverage among HCWs, VAMC initiated a Mobile Vaccination Cart Program. The program maximized both convenience and efficiency through advertising to employees, prescheduled vaccination times for employees in all wards and departments, streamlined documentation of vaccination, provision of free vaccination, and standing orders that authorized nurses to vaccinate VAMC employees.

The program is reviewed and endorsed each year by the VAMC Infection Control Committee. One employee-health nurse and two infection-control nurses set aside 2 weeks in mid-October to operate the mobile carts, which are stocked with vaccine in syringes, vaccine information statements, sharps disposal containers, alcohol hand rub, alcohol wipes, adhesive bandages, documentation forms, and injectable epinephrine with orders for administration in the event of an acute hypersensitivity reaction. Employees receive and are encouraged to read information about vaccination before the cart comes to their area. Inpatient wards are visited at the change of shift. Appointments are also made for other clinical areas (e.g., laboratory and radiology) and for departments with employees that might have direct patient contact (e.g., supply or housekeeping). These schedules are posted, and employees are encouraged to "go to the cart" if another time and location is more convenient than the scheduled time for their work area. In addition, employees can also be vaccinated at walk-in clinics for patients. A standardized, preprinted documentation form further streamlines record-keeping.

Since the program was introduced in 1985, influenza vaccination rates of VAMC HCWs increased steadily to 46% (1,475 of 3,177 employees) for the 1996–97 season and to 65% (1,950 of 3,008) for the 2003–04 season. The Mobile Vaccination Cart Program enables nurses to answer questions and educate employees about other strategies for preventing influenza transmission, such as proper hand hygiene. VAMC attributed the steady increase in coverage to the cumulative impact of ongoing education, communication, and access.

Vaccination Clinics, Peer Vaccination, and Incentives at Mayo Clinic

Yearly influenza vaccination of the approximately 25,000 employees at Mayo Clinic in Rochester, Minnesota, is a challenge. During the 1999–2000 influenza season, 53.6% of Mayo staff members received influenza vaccination. Since 2000, despite national vaccine shortages and delays, Mayo Clinic has conducted intensive influenza vaccination efforts among its employees by making vaccination increasingly convenient and by using gift incentives and peer advocacy.

During the 2000–01 influenza season, Mayo Clinic offered free vaccine to employees at large vaccination clinics in employee cafeterias and the employee health service center. Immediately after these clinics, a Peer Vaccination Program (PVP) enabling nurses to vaccinate coworkers at their worksites was offered to all inpatient units. The PVP eliminated the expense and logistical difficulty of establishing and staffing additional vaccination clinics and made vaccination more convenient for HCWs. Under this combination of programs, 42.2% of all Mayo employees were vaccinated during the 2000–01 season, despite barriers caused by vaccination shortage and delays. During the 2001–02 season, continued shortages and delays prevented many employees from receiving vaccination. As vaccine became available, employees in high-risk categories were vaccinated first, mini-clinics were offered throughout the Mayo campus at convenient locations, and 42.6% of all employees were ultimately vaccinated.

During the 2002–03 influenza season, an incentive program was added to the influenza clinics. Employees vaccinated at one of the main clinics could sign up for incentive gifts, such as movie tickets or health books, which were distributed through a drawing after the influenza clinics were held. In addition, electronic posters advertising the clinics were placed at all staff entrances, cafeterias, and elevator banks. Vaccination coverage for that season increased to 56.4%.

During the 2003–04 influenza season, Mayo Clinic placed additional emphasis on education and vaccine accessibility, resulting in vaccination of 76.5% of the 26,261 employees. As in previous years, vaccine was administered free of charge at influenza clinics held in employee cafeterias and offered through the PVP, and gift incentives were again provided. In December 2003, Mayo Clinic began offering vaccination at departmental grand rounds, further eliminating access and inconvenience barriers. Staff members were educated about the risk for influenza, the need for vaccination, and the safety and efficacy of the vaccine through newsletters, flyers, and poster presentations throughout the vaccination season. Furthermore, influenza vaccine "champions" (i.e., employee-health and infection-control staff members) promoted the importance of influenza vaccination by conducting grand rounds, sending notices to all employees by e-mail, attending meetings with nursing supervisors, staffing a telephone hotline, and answering questions at the vaccination clinics.

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Editorial Note: Influenza vaccination among U.S. HCWs increased from 10% in 1989 to 34% in 1997 (*4*) and only slowly increased to 40% in 2003. The interventions described in this report underscore the importance of making vaccination convenient and available at no cost to HCWs. The study of southern California nursing homes, the only controlled evaluation of efforts to influenza vaccination coverage among HCWs, suggests that publicity and educational messages about the importance of vaccination are only effective when combined with other approaches to increase coverage. The results of the interventions conducted by the Minneapolis VAMC and Mayo Clinic indicate that combining free vaccination with programs to increase vaccine accessibility by using either mobile carts or peer vaccination can overcome certain barriers to HCW influenza vaccination. These findings were supported by a recent cross-sectional evaluation of interventions for HCWs in neonatal and pediatric intensive-care units and hematology-oncology units (*7*) that demonstrated that use of mobile carts and educational materials were associated with higher vaccination rates. The Mayo Clinic intervention suggests that additional incentives might increase coverage further.

The results described in this report are consistent with other studies demonstrating that organizational change (e.g., separate clinics devoted to prevention), free vaccine, and gift incentives are particularly effective methods of increasing vaccination among adults (*8,9*). Interventions that were used to increase coverage among HCWs, including standing orders and reducing out-of-pocket costs, both in conjunction with education, are consistent with interventions strongly recommended by the Task Force on Community Preventive Services (*9*).

The findings in this report are subject to at least two limitations. First, ascertainment of vaccination status in the

southern California study was based on self-report, and only 61% of HCWs responded. Second, the VAMC and Mayo Clinic studies did not control for other factors that might have increased influenza vaccination; none of the studies were able to determine what proportion of HCWs had risk factors other than their status as HCWs that might have put them at increased risk for influenza and its complications. Nonetheless, each of the interventions described in this report resulted in vaccination rates exceeding national averages.

The influenza vaccine shortage during the 2004–05 season might have prevented health-care institutions from implementing aggressive campaigns for vaccination of HCWs. However, HCWs remain a high-priority group for vaccination (*5*). The National Foundation for Infectious Diseases has produced a call to action to improve rates of influenza vaccination in HCWs (*10*). The interventions described in this report suggest that making vaccination easily accessible at no cost to HCWs and designated peer vaccination champions are likely to increase vaccine coverage among HCWs.

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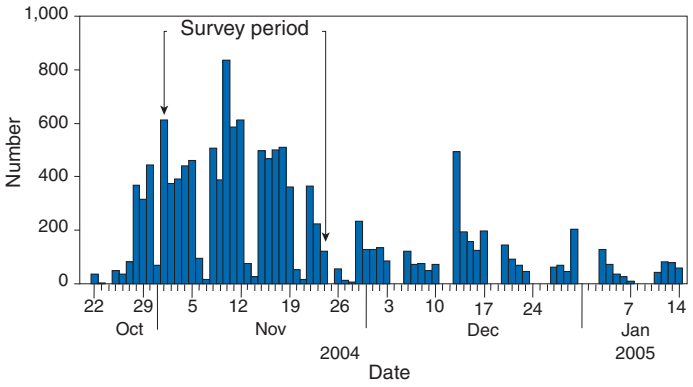
Brief Report

Vaccination Coverage Among Callers to a State Influenza Hotline — Connecticut, 2004–05 Influenza Season

In response to the influenza vaccine shortage in the United States (*1*), the Connecticut Department of Public Health (DPH) operated a telephone hotline during October 22, 2004–January 15, 2005. The purpose of the hotline was to address questions from the public regarding the availability of influenza vaccine, reduce the number of telephone inquiries to physicians and local health departments (LHDs), and advise callers regarding which groups were most at risk and in need of influenza vaccination. Caller information was collected and shared daily with LHDs, which were encouraged to follow up with callers as their resources allowed. This report summarizes results of a retrospective survey of callers to the DPH influenza vaccine hotline during November 2004. The results indicated that vaccination coverage varied by age group and that persons receiving follow-up calls from LHDs were more likely to receive vaccination. State health departments might consider a hotline as a method for educating the public regarding influenza vaccination and a follow-up system as a means to improve vaccination coverage, especially among those at greatest risk.

During December 9–17, DPH conducted a survey of persons who had called the state influenza hotline during November 1–24 to determine the proportion of persons vaccinated, identify barriers to vaccination, and obtain information on the usefulness of the influenza hotline. During the study period, 8,545 callers contacted the hotline, constituting 63% of all callers during October 22, 2004–January 15, 2005 (Figure). From the 8,545 names on the

FIGURE. Number of calls to the influenza vaccine hotline, by date and survey period — Connecticut, 2004–05 influenza season



hotline list, 400 were randomly selected and interviewed via telephone. Interviews were completed with 358 (89%). Of the 358 participants, 279 (78%) had called the hotline themselves; 79 had someone else call on their behalf.

Overall, 284 (79%; 95% confidence interval [CI] = 75%–83%) of the participants had received vaccination at the time of the survey. A total of 343 (97%; CI = 95%–98%) reported receiving vaccination during the preceding 2003–04 influenza season; status of four participants was unknown. Vaccination coverage during 2004–05 varied by age; coverage was 59% in persons aged <65 years and 84% in persons aged ≥65 years (p<0.0001). Vaccination coverage also varied by the population of the municipality of residence; coverage was 75% in persons who lived in municipalities with populations of <50,000, 84% in persons from municipalities with populations of 50,000–99,999, and 88% in persons from municipalities with populations of ≥100,000 (p<0.05). Coverage did not vary significantly by sex, race, or ethnicity.

Persons who reported receiving a follow-up call from their LHDs with information regarding local vaccine availability or scheduling of vaccination appointments were more likely to be vaccinated (94% versus 64%; p<0.001) than those who did not receive a follow-up call. Among those who received vaccine, 29% (CI = 24%–34%) were vaccinated by a private physician, hospital, or other private medical clinic; 56% (CI = 50%–62%) were vaccinated at a Visiting Nurses Association site, an LHD, or another public health clinic.

Among the 74 persons not vaccinated, the most common reasons for not receiving vaccine were as follows: 1) no vaccine available in the community (61%; CI = 49%–72%), 2) waiting to be contacted by an LHD (20%; CI = 12%–31%), 3) not in a group recommended for vaccination (12%; CI = 6%–22%), and 4) vaccination appointment scheduled for a future date (11%; CI = 5%–20%).

Among the 279 survey participants who called the hotline themselves, 252 of the 273 who responded to the question (92%; CI = 88%–95%) said they were satisfied with their call; no variation by vaccination status was observed. A total of 229 out of 268 (85%; CI = 81%–89%) said their questions were answered, 220 out of 271 (81%; CI = 75%–86%) said the influenza priority groups were explained, and 164 out of 271 (61%; CI = 60%–72%) said influenza prevention measures other than vaccination were discussed.

Vaccination coverage among the callers surveyed was greater than that reported previously for the general public in the United States during September–November 2004 (*2*). This disparity was likely an indication of greater motivation to receive influenza vaccine among callers to the Connecticut hotline, 97% of whom reported receiving vaccination during the 2003–04 season. Nonetheless, state and local health departments might consider reviewing the Connecticut hotline results as they plan how best to educate residents regarding influenza vaccination and how to maximize vaccination coverage among groups at greatest risk for influenza.

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Acknowledgment

The findings in this report are based, in part, on data collected by Connecticut Dept of Public Health workers who staffed the influenza vaccination hotline and who contributed to the design and implementation of the follow-up survey.

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Progress in Reducing Measles Mortality — Worldwide, 1999–2003

Measles remains an important cause of childhood mortality, especially in developing countries. In the joint *Strategic Plan for Measles Mortality Reduction, 2001–2005*, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) targeted 45 priority countries* with high measles burden for implementation of a comprehensive strategy for accelerated and sustained measles mortality reduction (*1*). Components of this strategy include achieving high routine vaccination coverage (≥90%) in every district and ensuring that all children receive a second opportunity for measles immunization. In May 2003, the World Health Assembly endorsed a resolution urging member countries to reduce deaths attributed to measles by half (compared with 1999 estimates) by the end of 2005 (*2*). This report updates progress toward this goal and summarizes recent recommendations on methods to estimate global measles mortality.

* Afghanistan, Angola, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Kenya, Lao People's Democratic Republic, Liberia, Madagascar, Mali, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Rwanda, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania, Viet Nam, and Zambia.

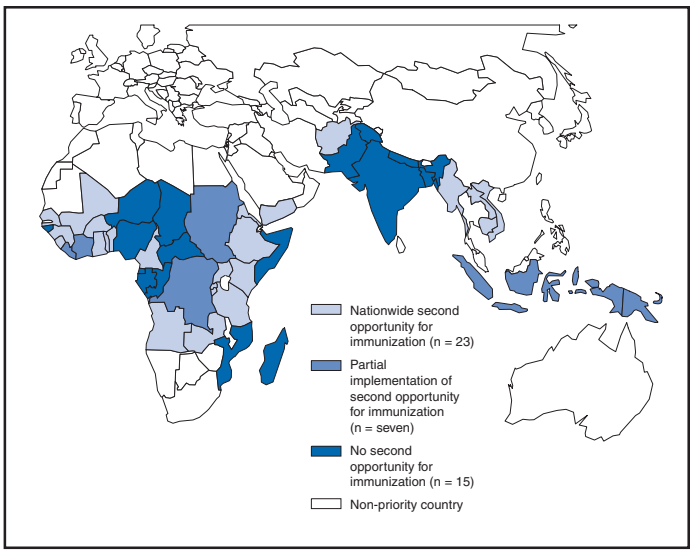
Vaccination Activities

By July of each year, all countries are requested to submit information on measles vaccination coverage from the previous year using the WHO/UNICEF Joint Reporting Form. Estimates of routine coverage with 1 dose of measles vaccine among children aged 1 year are based on review of coverage data from administrative records, surveys, national reports, and consultation with local and regional experts (*3*). Coverage achieved during nationwide supplementary immunization activities (SIAs) against measles are reported on the basis of tally sheets of the number of doses administered divided by the target population.

On the basis of WHO/UNICEF estimates, global routine measles vaccination coverage among children aged 1 year increased from 71% in 1999 to 77% in 2003. Coverage varied substantially by region (Table). Moreover, an increase was observed in the proportion of countries offering children a second opportunity for measles immunization. In 2003, a total of 164 (85%) countries offered children a second opportunity, compared with 150 (78%) countries in 2001.

During 2000–2003, approximately 197 million children received measles vaccination through "catch-up" and "follow-up" SIAs in 30 of the 45 priority countries (Figure 1). Of the 30 countries that conducted measles SIAs during this period, 23 (77%) were nationwide and 23 (77%) were in the African Region. Median reported coverage for these SIAs was 98% (range: 65%–99%).

FIGURE 1. Implementation of second opportunity for measles immunization in the 45 countries with highest measles mortality* — worldwide, 2000–2003



* Afghanistan, Angola, Bangladesh, Benin, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Guinea, Guinea-Bissau, India, Indonesia, Kenya, Lao People's Democratic Republic, Liberia, Madagascar, Mali, Mozambique, Myanmar, Nepal, Niger, Nigeria, Pakistan, Papua New Guinea, Rwanda, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania, Viet Nam, and Zambia.

Mortality Estimates

Because of limited disease surveillance and death registration in many countries with weak infrastructure and high measles burden, current routine reporting systems are inadequate for monitoring global measles mortality. Different modeling approaches have been used to estimate the global number of measles deaths (*4,5*). Published estimates from these approaches vary both in level and precision and have wide uncertainty bounds that overlap. A panel of six experts was convened in January 2005 to advise WHO on how best to monitor progress toward the 2005 measles mortality reduction goal. The panel noted strengths and weaknesses in various approaches to estimating measles mortality but endorsed the use of surveillance data (where they are reliable) and a natural history model (where surveillance data are unreliable) because the latter accounts for recent changes in vaccination coverage and is therefore better suited for monitoring trends. However, the panel recommended that uncertainty bounds around the point estimates be calculated to indicate the lack of precision.

On the basis of results from the natural history model, overall global measles mortality decreased 39%, from

TABLE. Routine measles vaccination coverage and estimated number of measles deaths, by geographical region — worldwide, 1999 and 2003

Geographical region	1999 Routine measles coverage (%)	1999 Estimated no. of deaths	1999 (Uncertainty bounds*)	2003 Routine measles coverage (%)	2003 Estimated no. of deaths	2003 (Uncertainty bounds)
Africa	55	519,000	(379,000–706,000)	65	282,000	(209,000–382,000)
South Asia	54	263,000	(203,000–354,000)	67	183,000	(129,000–252,000)
East Asia and Pacific	83	77,000	(54,000–114,000)	83	57,000	(40,000–85,000)
Other	91	14,000	(9,000–22,000)	92	8,000	(5,000–12,000)
Total	**71**	**873,000**	**(645,000–1,196,000)**	**77**	**530,000**	**(383,000–731,000)**

* Based on Monte Carlo simulations (*6*) that account for uncertainty in key input variables (i.e., vaccination coverage and case-fatality ratios).

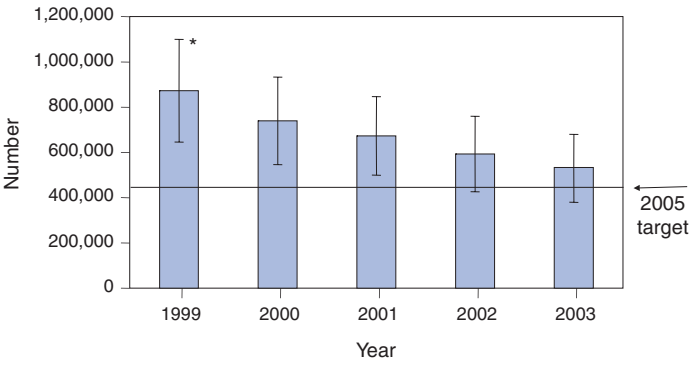
873,000 deaths (uncertainty bounds[†]: 645,000–1,196,000 deaths) in 1999 to 530,000 deaths (bounds: 383,000–731,000 deaths) in 2003 (Table; Figure 2). The largest reduction was in Africa, where estimated measles mortality decreased by 46% during this period.

Reported by: *Dept of Immunization, Vaccines, and Biologicals, World Health Organization, Geneva, Switzerland. United Nations Children's Fund, New York, New York. Global Immunization Div, National Immunization Program, CDC.*

Editorial Note: Improvements in routine measles vaccination coverage and implementation of measles SIAs in 30 of the 45 priority countries have substantially decreased the estimated number of global measles deaths. Although difficult to quantify, the widespread use of vitamin A through polio and measles SIAs and routine services has also likely contributed to the reduction of measles mortality. If progress continues at the rates achieved in recent years, the 2005 measles mortality reduction goal likely will be met. The mortality estimates based on the natural history model have been corroborated by surveillance data from countries that have fully implemented the recommended vaccination strategies; an analysis of the impact of intensified vaccination efforts in 19 African countries indicated that a 92% reduction in reported measles cases occurred and that only one country (Burkina Faso) experienced a large outbreak after the SIA (WHO, Regional Office for Africa, unpublished data, 2005). This outbreak was attributed to large-scale population migration as a result of civil unrest in neighboring Côte d'Ivoire.

[†] Based on Monte Carlo simulations (*6*) that account for uncertainty in key input variables (i.e., vaccination coverage and case-fatality ratios).

FIGURE 2. Estimated number of measles deaths — worldwide, by year, 1999–2003



* Uncertainty bounds based on Monte Carlo simulations (*6*) that account for uncertainty in key input variables (i.e., vaccination coverage and case-fatality ratios).

Both disease surveillance and mathematical models have been used to monitor progress toward the 2005 measles mortality reduction goal. The models are limited by their assumptions, overlapping and wide uncertainty bounds, and the lack of current information for key parameters, such as proportional cause-specific mortality or measles case-fatality ratios. As in polio-eradication programs, case-based surveillance with laboratory confirmation of suspected cases should be the "gold standard" for measuring program impact. Investments in strengthening disease surveillance and registration of cause-specific mortality are urgently needed in many developing countries. In the interim, while these health information systems are being developed, models remain useful for monitoring and directing program activities. More field studies of the natural history of measles, especially documenting the case-fatality in high-burden settings and the proportional mortality attributed to measles in similar settings, are needed to update model estimates.

A key factor contributing to progress in reducing measles mortality in Africa has been the support of the Africa Measles Initiative. This partnership, which was formed in 2001 and spearheaded by the American Red Cross, CDC, UNICEF, WHO, and the United Nations Foundation, has played a critical role in supporting African countries in their measles mortality reduction efforts. Since 2001, this partnership has mobilized $144 million, which has resulted in the vaccination of approximately 150 million African children against measles.

Major challenges remain in reaching the 2005 measles mortality reduction goal (*7*). First, measles mortality reduction activities need to be implemented in several large countries with high measles burden, such as Nigeria, India, and Pakistan. Second, to sustain the gains in reduced measles deaths in the 45 priority countries, enhanced efforts are needed to improve immunization systems to ensure that ≥90% of infants are vaccinated against measles before their first birthdays. Finally, the priority countries will need to continue to conduct follow-up SIAs every 3–4 years until their routine vaccination systems are capable of providing two opportunities for measles immunization to a very high proportion (i.e., ≥90%) of every birth cohort.

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Notice to Readers

Brain Injury Awareness Month — March 2005

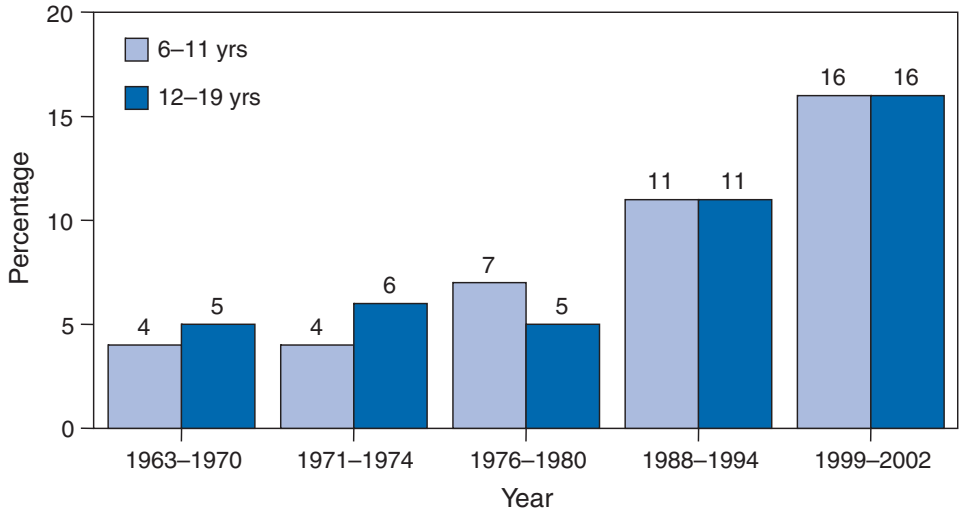
Brain Injury Awareness Month was developed to increase public awareness of brain injuries and their consequences. Previously, Brain Injury Awareness Month was held in October. However, starting this year, it will be observed in March and will coincide with Brain Injury Awareness Week (March 14–20, 2005).

Traumatic brain injury (TBI) often is called a silent epidemic because the problems that result from TBI

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Prevalence of Overweight* Among Children and Teenagers, by Age Group and Selected Period — United States, 1963–2002



* Children with body mass index (BMI) values at or above the 95th percentile of CDC sex-specific BMI growth charts for 2000 are categorized as overweight.

Overweight among children and teenagers more than tripled between the 1960s and 2002.

Source: National Health and Nutrition Examination Surveys. Additional information is available at http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overwght99.htm.

(e.g., impaired memory) are not immediately visible. Each year in the United States, at least 1.4 million persons sustain a TBI; of these persons, approximately 50,000 die, 235,000 are hospitalized, and 1.1 million are treated and released from emergency departments (*1*). Approximately 5.3 million U.S. residents have a long-term or lifelong need for help to perform activities of daily living as a result of a TBI (*2*).

In recognition of Brain Injury Awareness Month, the Brain Injury Association of America is offering educational kits about living with brain injury. The kits include posters, a fact sheet, and additional resources. Materials are available at http://www.biausa.org/Pages/biam2005.html. Additional information about brain injuries, including causes, symptoms, and prevention tips, is available at http://www.cdc.gov/tbi and at http://www.biausa.org.

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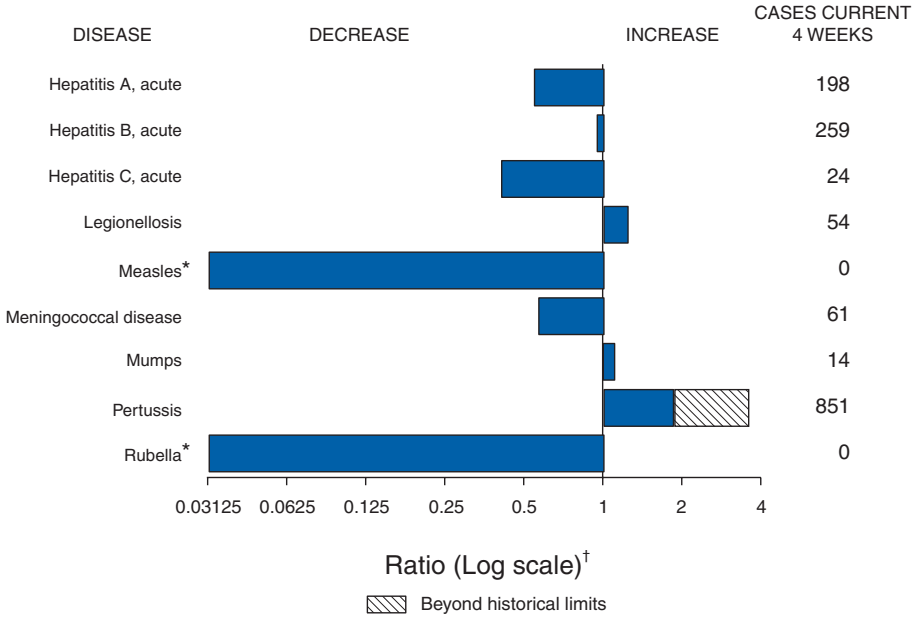
FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals February 26, 2005, with historical data



* No measles or rubella cases were reported for the current 4-week period yielding a ratio for week 8 of zero (0).
† Ratio of current 4-week total to mean of 15 4-week totals (from previous, comparable, and subsequent 4-week periods for the past 5 years). The point where the hatched area begins is based on the mean and two standard deviations of these 4-week totals.

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending February 26, 2005 (8th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal†	10	8
Botulism:			HIV infection, pediatric†¶	31	49
foodborne	3	1	Influenza-associated pediatric mortality†**	13	—
infant	6	12	Measles	4††	2§§
other (wound & unspecified)	3	—	Mumps	34	31
Brucellosis	14	11	Plague	—	—
Chancroid	5	7	Poliomyelitis, paralytic	—	—
Cholera	—	2	Psittacosis†	1	2
Cyclosporiasis†	2	12	Q fever†	5	8
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	2	6
(neuroinvasive & non-neuroinvasive):	—	—	Rubella, congenital syndrome	—	—
California serogroup† §	—	—	SARS†**	—	—
eastern equine† §	—	—	Smallpox†	—	—
Powassan† §	—	—	*Staphylococcus aureus*:		
St. Louis† §	—	—	Vancomycin-intermediate (VISA)†	—	—
western equine† §	—	—	Vancomycin-resistant (VRSA)†	—	—
Ehrlichiosis:	—	—	Streptococcal toxic-shock syndrome†	8	28
human granulocytic (HGE)†	8	9	Tetanus	2	1
human monocytic (HME)†	8	9	Toxic-shock syndrome	16	24
human, other and unspecified †	4	1	Trichinellosis¶¶	4	—
Hansen disease†	5	9	Tularemia†	1	4
Hantavirus pulmonary syndrome†	1	2	Yellow fever	—	—

—: No reported cases.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).
† Not notifiable in all states.
§ Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).
¶ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.
** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.
†† Of four cases reported, two were indigenous and two were imported from another country.
§§ Of two cases reported, none were indigenous and two were imported from another country.
¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending February 26, 2005, and February 28, 2004 (8th Week)*

Reporting area	AIDS		Chlamydia†		Coccidioidomycosis		Cryptosporidiosis	
	Cum. 2005§	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,989	5,431	112,588	133,330	630	731	219	415
NEW ENGLAND	133	180	3,962	4,699	—	—	11	25
Maine	3	5	343	287	N	N	1	5
N.H.	2	5	275	270	—	—	3	5
Vt.¶	—	7	151	187	—	—	2	3
Mass.	47	49	2,166	2,142	—	—	2	10
R.I.	14	22	517	646	—	—	—	—
Conn.	67	92	510	1,167	N	N	3	2
MID. ATLANTIC	447	626	13,610	15,962	—	—	38	69
Upstate N.Y.	39	78	2,486	2,604	N	N	12	10
N.Y. City	221	300	3,950	5,103	—	—	8	21
N.J.	87	186	1,602	2,684	N	N	1	5
Pa.	100	62	5,572	5,571	N	N	17	33
E.N. CENTRAL	275	614	14,260	25,564	—	—	33	96
Ohio	59	155	2,120	6,948	N	N	17	24
Ind.	37	83	3,039	2,856	N	N	2	10
Ill.	147	278	4,841	7,062	—	—	—	19
Mich.	26	61	2,561	6,040	—	—	5	18
Wis.	6	37	1,699	2,658	N	N	9	25
W.N. CENTRAL	85	176	6,133	8,713	—	1	30	36
Minn.	35	33	963	1,806	N	N	6	10
Iowa	16	9	643	1,103	N	N	7	5
Mo.	17	82	2,669	3,285	—	—	12	11
N. Dak.	—	8	165	231	N	N	—	—
S. Dak.	3	—	441	327	—	—	2	4
Nebr.¶	—	8	404	752	—	1	—	—
Kans.	14	36	848	1,209	N	N	3	6
S. ATLANTIC	1,108	1,966	23,946	23,878	—	—	52	81
Del.	—	29	474	447	N	N	—	—
Md.	82	193	2,391	2,856	—	—	5	6
D.C.	28	96	509	543	—	—	—	2
Va.	58	76	3,629	3,001	—	—	5	6
W. Va.	12	23	375	437	N	N	4	—
N.C.	127	173	5,892	3,294	N	N	8	14
S.C.¶	42	135	3,013	2,429	—	—	—	2
Ga.	231	324	1,398	5,137	—	—	14	35
Fla.	528	917	6,265	5,734	N	N	16	16
E.S. CENTRAL	141	266	7,882	8,051	—	1	6	23
Ky.	25	39	1,964	911	N	N	1	5
Tenn.¶	59	109	2,920	3,353	N	N	1	10
Ala.¶	54	75	350	2,110	—	—	3	6
Miss.	3	43	2,648	1,677	—	1	1	2
W.S. CENTRAL	331	788	15,809	16,683	—	—	6	20
Ark.	35	42	1,257	1,156	—	—	—	7
La.	39	147	1,034	3,922	—	—	—	—
Okla.	43	27	1,622	1,294	N	N	4	5
Tex.¶	214	572	11,896	10,311	N	N	2	8
MOUNTAIN	112	191	7,419	7,866	433	502	13	17
Mont.	—	—	325	26	N	N	—	—
Idaho¶	1	2	224	498	N	N	—	—
Wyo.	—	—	180	156	—	—	—	2
Colo.	12	28	1,545	1,761	N	N	4	10
N. Mex.	17	19	537	1,202	1	6	2	1
Ariz.	57	104	3,339	2,869	419	479	3	3
Utah	8	9	553	477	1	4	1	—
Nev.¶	17	29	716	877	12	13	3	1
PACIFIC	357	624	19,567	21,914	197	227	30	48
Wash.	28	63	2,830	2,558	N	N	—	—
Oreg.¶	32	17	1,293	1,181	—	—	1	5
Calif.	291	514	14,408	16,761	197	227	29	42
Alaska	5	5	504	475	—	—	—	—
Hawaii	1	25	532	939	—	—	—	1
Guam	1	—	—	160	—	—	—	—
P.R.	1	141	527	313	N	N	N	N
V.I.	3	2	—	78	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	2	U	—	U	—	U	—	U

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

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Chlamydia refers to genital infections caused by *C. trachomatis*.

§ Updated monthly from reports to the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention. Last update January 30, 2005.

¶ Contains data reported through National Electronic Disease Surveillance System (NEDSS).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 26, 2005, and February 28, 2004 (8th Week)*

Reporting area	*Escherichia coli*, Enterohemorrhagic (EHEC)						Giardiasis		Gonorrhea	
	O157:H7		Shiga toxin positive, serogroup non-O157		Shiga toxin positive, not serogrouped					
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	127	127	14	21	24	15	1,803	2,291	38,696	49,146
NEW ENGLAND	10	7	1	4	5	1	118	202	709	1,107
Maine	—	—	—	—	—	—	13	17	19	47
N.H.	—	1	—	—	—	—	5	5	22	18
Vt.	1	—	—	—	—	—	15	14	3	8
Mass.	3	2	—	3	5	1	84	103	414	465
R.I.	—	—	—	—	—	—	—	9	67	160
Conn.	6	4	1	1	—	—	1	54	184	409
MID. ATLANTIC	17	16	—	—	1	4	344	494	4,041	5,501
Upstate N.Y.	8	3	—	—	—	2	110	107	806	990
N.Y. City	1	5	—	—	—	—	79	183	1,076	1,725
N.J.	4	—	—	—	—	1	47	61	546	1,058
Pa.	4	8	—	—	1	1	108	143	1,613	1,728
E.N. CENTRAL	30	31	2	6	3	1	221	388	5,703	10,923
Ohio	15	11	—	—	2	1	88	120	1,059	3,744
Ind.	2	6	—	—	—	—	N	N	1,231	1,040
Ill.	2	4	1	—	—	—	11	136	2,023	3,090
Mich.	7	6	—	—	1	—	74	83	869	2,379
Wis.	4	4	1	6	—	—	48	49	521	670
W.N. CENTRAL	21	16	3	6	3	6	172	191	1,966	2,902
Minn.	3	9	—	2	—	—	46	54	296	696
Iowa	5	—	—	—	—	—	38	30	116	195
Mo.	8	3	2	4	1	1	40	76	1,104	1,335
N. Dak.	—	—	—	—	—	3	—	2	11	19
S. Dak.	2	—	—	—	—	—	9	4	53	29
Nebr.	2	1	1	—	1	—	20	10	106	192
Kans.	1	3	—	—	1	2	19	15	280	436
S. ATLANTIC	18	8	2	2	12	3	337	342	10,868	11,440
Del.	—	—	N	N	N	N	3	7	124	173
Md.	4	2	1	—	—	—	25	13	1,047	1,239
D.C.	—	—	—	—	—	—	4	12	330	364
Va.	—	—	—	1	2	—	71	42	1,370	1,335
W. Va.	—	—	—	—	—	—	4	1	113	128
N.C.	—	—	—	—	8	3	N	N	3,095	2,325
S.C.	—	—	—	—	—	—	7	2	1,347	1,296
Ga.	5	2	—	—	—	—	93	117	671	2,190
Fla.	9	4	1	1	2	—	130	148	2,771	2,390
E.S. CENTRAL	6	4	—	—	—	—	48	41	2,851	3,857
Ky.	—	1	—	—	—	—	N	N	585	414
Tenn.	3	1	—	—	—	—	19	16	1,106	1,296
Ala.	3	1	—	—	—	—	29	25	315	1,261
Miss.	—	1	—	—	—	—	—	—	845	886
W.S. CENTRAL	4	9	—	—	—	—	31	44	6,248	6,435
Ark.	1	—	—	—	—	—	13	21	670	541
La.	—	—	—	—	—	—	5	8	643	1,904
Okla.	1	3	—	—	—	—	13	15	770	602
Tex.	2	6	—	—	—	—	N	N	4,165	3,388
MOUNTAIN	6	15	6	2	—	—	150	217	1,653	1,871
Mont.	1	1	—	—	—	—	8	5	12	7
Idaho	1	2	4	—	—	—	19	31	12	11
Wyo.	—	—	1	—	—	—	1	1	8	7
Colo.	1	3	1	1	—	—	50	73	401	470
N. Mex.	—	1	—	—	—	—	7	7	100	149
Ariz.	2	2	N	N	N	N	36	42	709	811
Utah	1	2	—	—	—	—	23	40	94	50
Nev.	—	4	—	1	—	—	6	18	317	366
PACIFIC	15	21	—	1	—	—	382	372	4,657	5,110
Wash.	5	2	—	—	—	—	15	18	453	454
Oreg.	—	2	—	1	—	—	37	67	226	140
Calif.	7	14	—	—	—	—	309	272	3,800	4,211
Alaska	1	—	—	—	—	—	5	6	71	83
Hawaii	2	3	—	—	—	—	16	9	107	222
Guam	N	N	—	—	—	—	—	—	—	36
P.R.	—	—	—	—	—	—	4	3	52	25
V.I.	—	—	—	—	—	—	—	—	—	23
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 26, 2005, and February 28, 2004 (8th Week)*

Reporting area	*Haemophilus influenzae*, invasive							
	All ages		Age <5 years					
	All serotypes		Serotype b		Non-serotype b		Unknown serotype	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	307	367	—	3	13	19	21	42
NEW ENGLAND	15	41	—	1	1	3	2	—
Maine	1	3	—	—	—	—	—	—
N.H.	—	9	—	—	—	1	—	—
Vt.	4	3	—	—	—	—	2	—
Mass.	7	19	—	1	—	1	—	—
R.I.	—	1	—	—	—	—	—	—
Conn.	3	6	—	—	1	1	—	—
MID. ATLANTIC	65	73	—	—	—	1	6	10
Upstate N.Y.	16	23	—	—	—	1	1	1
N.Y. City	12	14	—	—	—	—	1	3
N.J.	11	13	—	—	—	—	1	2
Pa.	26	23	—	—	—	—	3	4
E.N. CENTRAL	41	76	—	—	—	6	2	14
Ohio	26	25	—	—	—	2	2	4
Ind.	7	8	—	—	—	3	—	1
Ill.	2	22	—	—	—	—	—	5
Mich.	6	7	—	—	—	1	—	3
Wis.	—	14	—	—	—	—	—	1
W.N. CENTRAL	18	15	—	1	1	1	2	2
Minn.	5	6	—	—	1	1	—	—
Iowa	—	1	—	1	—	—	—	—
Mo.	11	4	—	—	—	—	2	2
N. Dak.	—	—	—	—	—	—	—	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	1	4	—	—	—	—	—	—
Kans.	1	—	—	—	—	—	—	—
S. ATLANTIC	94	74	—	—	3	1	5	6
Del.	—	—	—	—	—	—	—	—
Md.	16	22	—	—	1	1	1	—
D.C.	—	—	—	—	—	—	—	—
Va.	4	7	—	—	—	—	—	—
W. Va.	—	4	—	—	—	—	—	2
N.C.	18	5	—	—	2	—	—	—
S.C.	2	—	—	—	—	—	—	—
Ga.	35	18	—	—	—	—	3	4
Fla.	19	18	—	—	—	—	1	—
E.S. CENTRAL	14	13	—	—	—	—	—	2
Ky.	—	—	—	—	—	—	—	—
Tenn.	13	6	—	—	—	—	—	1
Ala.	1	7	—	—	—	—	—	1
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	13	14	—	—	1	3	2	—
Ark.	—	—	—	—	—	—	—	—
La.	4	4	—	—	—	—	2	—
Okla.	9	10	—	—	1	3	—	—
Tex.	—	—	—	—	—	—	—	—
MOUNTAIN	37	50	—	1	7	4	1	6
Mont.	—	—	—	—	—	—	—	—
Idaho	1	2	—	—	—	—	—	1
Wyo.	1	—	—	—	—	—	—	—
Colo.	9	11	—	—	—	—	—	1
N. Mex.	5	13	—	—	2	1	—	3
Ariz.	17	20	—	—	3	2	1	1
Utah	1	1	—	1	—	—	—	—
Nev.	3	3	—	—	2	1	—	—
PACIFIC	10	11	—	—	—	—	1	2
Wash.	—	1	—	—	—	—	—	1
Oreg.	6	6	—	—	—	—	1	—
Calif.	2	3	—	—	—	—	—	1
Alaska	1	—	—	—	—	—	—	—
Hawaii	1	1	—	—	—	—	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 26, 2005, and February 28, 2004 (8th Week)*

Reporting area	Hepatitis (viral, acute), by type					
	A		B		C	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	523	982	701	835	69	145
NEW ENGLAND	74	160	40	56	—	2
Maine	—	4	—	—	—	—
N.H.	3	2	2	6	—	—
Vt.	—	3	—	1	—	1
Mass.	62	134	34	27	—	1
R.I.	—	—	—	—	—	—
Conn.	9	17	4	22	—	—
MID. ATLANTIC	60	129	129	138	9	24
Upstate N.Y.	10	10	10	5	1	—
N.Y. City	25	48	4	23	—	—
N.J.	8	28	85	62	—	—
Pa.	17	43	30	48	8	24
E.N. CENTRAL	38	91	48	58	15	9
Ohio	15	11	26	20	—	1
Ind.	7	11	1	2	—	—
Ill.	4	35	—	—	—	1
Mich.	10	26	21	27	15	7
Wis.	2	8	—	9	—	—
W.N. CENTRAL	14	19	25	52	5	15
Minn.	—	—	—	5	—	—
Iowa	3	5	1	1	—	—
Mo.	7	4	13	39	5	15
N. Dak.	—	—	—	1	—	—
S. Dak.	—	1	—	—	—	—
Nebr.	2	6	7	4	—	—
Kans.	2	3	4	2	—	—
S. ATLANTIC	98	179	260	247	20	28
Del.	—	2	—	2	—	—
Md.	7	36	26	21	6	2
D.C.	—	1	—	3	—	—
Va.	7	8	34	12	—	3
W. Va.	—	1	2	—	—	1
N.C.	21	8	32	24	4	1
S.C.	1	3	5	8	—	—
Ga.	30	75	70	91	—	5
Fla.	32	45	91	86	10	16
E.S. CENTRAL	24	26	29	60	7	15
Ky.	2	1	8	4	—	4
Tenn.	16	17	8	19	4	5
Ala.	3	2	12	12	2	—
Miss.	3	6	1	25	1	6
W.S. CENTRAL	16	143	19	36	1	36
Ark.	1	18	4	15	—	—
La.	4	6	3	17	1	23
Okla.	1	7	—	3	—	—
Tex.	10	112	12	1	—	13
MOUNTAIN	65	65	70	56	5	7
Mont.	4	—	—	—	—	—
Idaho	4	3	3	1	—	—
Wyo.	—	—	—	1	—	—
Colo.	7	3	5	7	—	—
N. Mex.	3	3	—	2	—	1
Ariz.	42	46	53	26	—	2
Utah	4	8	7	8	4	—
Nev.	1	2	2	11	1	4
PACIFIC	134	170	81	132	7	9
Wash.	11	8	5	9	1	—
Oreg.	7	14	12	24	2	3
Calif.	113	144	63	96	4	4
Alaska	1	1	—	2	—	—
Hawaii	2	3	1	1	—	2
Guam	—	—	—	—	—	—
P.R.	—	3	1	3	—	—
V.I.	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
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TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 26, 2005, and February 28, 2004 (8th Week)*

Reporting area	Legionellosis		Listeriosis		Lyme disease		Malaria	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	156	191	60	61	582	1,171	146	187
NEW ENGLAND	3	4	2	1	13	69	2	15
Maine	—	—	—	—	1	1	—	—
N.H.	—	—	1	—	7	—	—	—
Vt.	—	—	—	—	—	1	—	—
Mass.	3	3	—	—	5	60	2	11
R.I.	—	—	—	—	—	—	—	1
Conn.	—	1	1	1	—	7	—	3
MID. ATLANTIC	50	41	9	16	433	950	32	39
Upstate N.Y.	13	5	—	2	37	207	5	3
N.Y. City	—	—	1	2	—	—	11	20
N.J.	9	17	3	7	192	252	11	9
Pa.	28	19	5	5	204	491	5	7
E.N. CENTRAL	30	56	10	8	22	27	10	14
Ohio	17	27	4	3	20	5	2	3
Ind.	7	7	—	2	1	—	—	1
Ill.	—	11	—	—	—	—	1	2
Mich.	5	9	2	2	1	—	6	4
Wis.	1	2	4	1	U	22	1	4
W.N. CENTRAL	6	4	6	1	1	10	7	11
Minn.	—	—	1	—	—	3	1	5
Iowa	—	—	2	—	1	2	2	1
Mo.	5	3	2	1	—	5	3	3
N. Dak.	1	—	1	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—
Nebr.	—	—	—	—	—	—	—	—
Kans.	—	—	—	—	—	—	1	2
S. ATLANTIC	40	37	18	11	101	90	37	58
Del.	—	1	N	N	15	8	—	—
Md.	12	6	3	2	57	60	11	18
D.C.	—	2	—	—	1	1	—	3
Va.	3	3	1	—	2	—	4	4
W. Va.	1	—	—	1	—	—	1	—
N.C.	6	6	5	4	11	12	5	1
S.C.	—	1	—	—	2	1	—	2
Ga.	5	2	2	1	—	2	11	8
Fla.	13	16	7	3	13	6	5	22
E.S. CENTRAL	—	8	3	3	3	—	6	6
Ky.	—	2	—	1	—	—	1	1
Tenn.	—	3	1	2	3	—	4	—
Ala.	—	3	2	—	—	—	1	4
Miss.	—	—	—	—	—	—	—	1
W.S. CENTRAL	—	16	1	4	1	9	11	19
Ark.	—	—	—	—	—	—	1	1
La.	—	1	1	—	—	—	—	2
Okla.	—	1	—	—	—	—	—	1
Tex.	—	14	—	4	1	9	10	15
MOUNTAIN	11	11	—	4	—	3	10	5
Mont.	—	—	—	—	—	—	—	—
Idaho	—	1	—	—	—	—	—	—
Wyo.	2	2	—	—	—	1	1	—
Colo.	1	1	—	1	—	—	5	2
N. Mex.	1	—	—	—	—	—	—	1
Ariz.	3	2	—	—	—	1	2	—
Utah	2	4	—	—	—	1	2	1
Nev.	2	1	—	3	—	—	—	1
PACIFIC	16	14	11	13	8	13	31	20
Wash.	1	2	2	2	—	—	—	1
Oreg.	N	N	—	4	—	6	1	1
Calif.	15	12	9	7	7	7	29	18
Alaska	—	—	—	—	1	—	1	—
Hawaii	—	—	—	—	N	N	—	—
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	—	—
V.I.	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 26, 2005, and February 28, 2004 (8th Week)*

Reporting area	Meningococcal disease									
	All serogroups		Serogroup A, C, Y, and W-135		Serogroup B		Other serogroup		Serogroup unknown	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	166	295	14	21	9	8	—	—	143	266
NEW ENGLAND	17	10	—	—	—	—	—	—	17	10
Maine	1	2	—	—	—	—	—	—	1	2
N.H.	1	—	—	—	—	—	—	—	1	—
Vt.	3	1	—	—	—	—	—	—	3	1
Mass.	9	7	—	—	—	—	—	—	9	7
R.I.	—	—	—	—	—	—	—	—	—	—
Conn.	3	—	—	—	—	—	—	—	3	—
MID. ATLANTIC	26	46	7	14	2	3	—	—	17	29
Upstate N.Y.	6	13	1	3	1	1	—	—	4	9
N.Y. City	2	10	—	—	—	—	—	—	2	10
N.J.	9	5	—	—	—	—	—	—	9	5
Pa.	9	18	6	11	1	2	—	—	2	5
E.N. CENTRAL	12	30	4	5	2	2	—	—	6	23
Ohio	4	17	—	3	2	2	—	—	2	12
Ind.	2	5	—	—	—	—	—	—	2	5
Ill.	—	1	—	—	—	—	—	—	—	1
Mich.	4	2	4	2	—	—	—	—	—	—
Wis.	2	5	—	—	—	—	—	—	2	5
W.N. CENTRAL	11	9	1	—	—	1	—	—	10	8
Minn.	2	1	1	—	—	—	—	—	1	1
Iowa	2	1	—	—	—	1	—	—	2	—
Mo.	5	4	—	—	—	—	—	—	5	4
N. Dak.	—	—	—	—	—	—	—	—	—	—
S. Dak.	—	1	—	—	—	—	—	—	—	1
Nebr.	1	1	—	—	—	—	—	—	1	1
Kans.	1	1	—	—	—	—	—	—	1	1
S. ATLANTIC	29	52	1	1	2	1	—	—	26	50
Del.	—	1	—	—	—	—	—	—	—	1
Md.	3	4	—	—	1	—	—	—	2	4
D.C.	—	2	—	1	—	—	—	—	—	1
Va.	1	2	—	—	—	—	—	—	1	2
W. Va.	—	3	—	—	—	—	—	—	—	3
N.C.	4	5	1	—	1	1	—	—	2	4
S.C.	4	4	—	—	—	—	—	—	4	4
Ga.	6	5	—	—	—	—	—	—	6	5
Fla.	11	26	—	—	—	—	—	—	11	26
E.S. CENTRAL	6	14	—	—	—	—	—	—	6	14
Ky.	2	2	—	—	—	—	—	—	2	2
Tenn.	3	6	—	—	—	—	—	—	3	6
Ala.	—	2	—	—	—	—	—	—	—	2
Miss.	1	4	—	—	—	—	—	—	1	4
W.S. CENTRAL	13	34	1	1	1	—	—	—	11	33
Ark.	3	4	—	—	—	—	—	—	3	4
La.	6	10	—	1	1	—	—	—	5	9
Okla.	3	1	1	—	—	—	—	—	2	1
Tex.	1	19	—	—	—	—	—	—	1	19
MOUNTAIN	14	17	—	—	1	1	—	—	13	16
Mont.	—	1	—	—	—	—	—	—	—	1
Idaho	—	1	—	—	—	—	—	—	—	1
Wyo.	—	1	—	—	—	—	—	—	—	1
Colo.	6	6	—	—	—	—	—	—	6	6
N. Mex.	—	1	—	—	—	—	—	—	—	1
Ariz.	5	4	—	—	1	—	—	—	4	4
Utah	1	1	—	—	—	—	—	—	1	1
Nev.	2	2	—	—	—	1	—	—	2	1
PACIFIC	38	83	—	—	1	—	—	—	37	83
Wash.	7	2	—	—	1	—	—	—	6	2
Oreg.	8	18	—	—	—	—	—	—	8	18
Calif.	21	59	—	—	—	—	—	—	21	59
Alaska	—	1	—	—	—	—	—	—	—	1
Hawaii	2	3	—	—	—	—	—	—	2	3
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	—	—	—	—	—	—
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	—	—	—	—	—	—	—	—	—	—
C.N.M.I.	—	—	—	—	—	—	—	—	—	—

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 26, 2005, and February 28, 2004 (8th Week)*

Reporting area	Pertussis		Rabies, animal		Rocky Mountain spotted fever		Salmonellosis		Shigellosis	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	2,199	1,272	419	827	89	74	3,021	3,752	1,142	1,680
NEW ENGLAND	116	296	80	37	—	5	142	162	23	35
Maine	6	—	5	2	N	N	5	7	—	—
N.H.	—	6	2	4	—	—	8	5	2	2
Vt.	29	12	—	4	—	—	12	5	2	—
Mass.	81	269	59	16	—	5	88	108	17	26
R.I.	—	—	—	—	—	—	—	7	—	—
Conn.	—	9	14	11	—	—	29	30	2	7
MID. ATLANTIC	279	341	36	79	1	8	295	502	97	170
Upstate N.Y.	78	199	32	36	—	—	70	67	20	49
N.Y. City	5	20	4	1	—	3	73	173	47	56
N.J.	24	49	N	N	—	—	46	120	25	41
Pa.	172	73	—	42	1	5	106	142	5	24
E.N. CENTRAL	578	212	4	1	1	—	270	601	69	166
Ohio	386	82	2	1	1	—	104	143	11	35
Ind.	30	1	1	—	—	—	28	36	10	7
Ill.	2	2	1	—	—	—	17	213	4	80
Mich.	29	19	—	—	—	—	57	91	35	23
Wis.	131	108	—	—	—	—	64	118	9	21
W.N. CENTRAL	286	68	30	60	2	2	223	197	97	50
Minn.	92	6	11	7	—	—	45	43	4	11
Iowa	6	20	9	8	—	—	52	31	15	3
Mo.	79	35	4	2	2	2	64	59	53	15
N. Dak.	11	1	1	9	—	—	3	5	1	1
S. Dak.	1	—	1	10	—	—	20	9	6	1
Nebr.	43	—	—	11	—	—	18	19	14	3
Kans.	54	6	4	13	—	—	21	31	4	16
S. ATLANTIC	148	73	133	457	71	48	998	848	219	437
Del.	—	—	—	1	—	—	1	5	—	2
Md.	29	24	17	43	1	1	78	58	13	19
D.C.	—	4	—	—	—	—	2	4	—	9
Va.	27	13	46	58	—	—	91	91	13	14
W. Va.	3	—	2	9	—	—	8	5	—	—
N.C.	17	16	61	78	57	43	212	112	26	47
S.C.	50	2	4	11	2	2	45	47	5	42
Ga.	3	2	—	50	9	2	179	142	73	108
Fla.	19	12	3	207	2	—	382	384	89	196
E.S. CENTRAL	50	20	10	50	2	10	148	207	92	91
Ky.	9	2	—	2	—	—	23	23	6	7
Tenn.	21	12	—	36	2	3	55	54	53	43
Ala.	15	2	10	8	—	1	61	86	29	26
Miss.	5	4	—	4	—	6	9	44	4	15
W.S. CENTRAL	11	9	95	123	—	—	196	339	214	382
Ark.	1	6	7	5	—	—	35	30	12	10
La.	1	2	—	—	—	—	45	40	13	35
Okla.	—	1	10	9	—	—	31	35	62	60
Tex.	9	—	78	109	—	—	85	234	127	277
MOUNTAIN	560	120	26	13	10	—	222	297	82	143
Mont.	165	4	—	—	—	—	12	10	—	3
Idaho	25	13	—	—	—	—	11	28	—	—
Wyo.	5	2	1	—	—	—	6	4	—	1
Colo.	254	63	—	—	—	—	57	70	10	27
N. Mex.	12	12	—	—	—	—	15	26	8	26
Ariz.	47	9	25	13	8	—	88	115	44	66
Utah	49	16	—	—	2	—	17	26	5	8
Nev.	3	1	—	—	—	—	16	18	15	12
PACIFIC	171	133	5	7	2	1	527	599	249	206
Wash.	37	25	—	—	—	—	35	22	7	7
Oreg.	101	29	—	—	—	—	16	49	9	11
Calif.	18	76	5	7	2	1	431	466	228	178
Alaska	6	1	—	—	—	—	10	18	1	1
Hawaii	9	2	—	—	—	—	35	44	4	9
Guam	—	—	—	—	—	—	—	4	—	8
P.R.	—	—	11	11	N	N	9	25	—	1
V.I.	—	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

TABLE II. (*Continued*) Provisional cases of selected notifiable diseases, United States, weeks ending February 26, 2005, and February 28, 2004 (8th Week)*

Reporting area	Streptococcal disease, invasive, group A		*Streptococcus pneumoniae*, invasive disease				Syphilis			
			Drug resistant, all ages		Age <5 years		Primary & secondary		Congenital	
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004
UNITED STATES	692	855	361	449	91	120	832	1,073	23	77
NEW ENGLAND	24	45	—	1	10	13	32	17	—	—
Maine	1	1	N	N	—	—	1	—	—	—
N.H.	2	5	—	—	—	N	2	1	—	—
Vt.	3	—	—	—	—	—	—	—	—	—
Mass.	18	37	—	—	10	12	29	7	—	—
R.I.	—	2	—	1	—	1	—	1	—	—
Conn.	—	—	—	—	U	U	—	8	—	—
MID. ATLANTIC	124	140	39	27	19	10	100	141	4	13
Upstate N.Y.	47	39	10	9	9	4	10	3	2	1
N.Y. City	8	33	U	U	U	U	68	89	1	3
N.J.	22	30	N	N	2	—	14	26	—	8
Pa.	47	38	29	18	8	6	8	23	1	1
E.N. CENTRAL	88	192	69	110	25	32	71	108	1	17
Ohio	27	46	54	86	18	16	39	32	—	—
Ind.	15	11	15	24	3	5	6	8	—	5
Ill.	2	60	—	—	1	—	18	51	—	2
Mich.	40	57	—	N	—	N	5	14	—	10
Wis.	4	18	N	N	3	11	3	3	1	—
W.N. CENTRAL	25	62	9	2	8	11	25	32	—	—
Minn.	—	24	—	—	4	5	1	5	—	—
Iowa	N	N	N	N	—	N	—	1	—	—
Mo.	11	11	8	2	—	3	21	18	—	—
N. Dak.	1	3	—	—	1	—	—	—	—	—
S. Dak.	4	4	1	—	—	—	—	—	—	—
Nebr.	7	5	—	—	1	2	1	5	—	—
Kans.	2	15	N	N	2	1	2	3	—	—
S. ATLANTIC	168	152	172	221	10	10	248	271	4	11
Del.	—	—	—	1	—	N	2	1	—	—
Md.	54	40	—	—	9	7	54	44	1	3
D.C.	1	—	—	3	1	3	13	11	—	—
Va.	5	8	N	N	—	N	12	3	2	1
W. Va.	2	6	—	9	—	—	1	2	—	—
N.C.	15	17	N	N	U	U	44	27	—	—
S.C.	—	1	—	17	—	N	11	22	—	2
Ga.	37	41	63	74	—	N	5	42	—	1
Fla.	54	39	109	117	—	N	106	119	1	4
E.S. CENTRAL	17	43	27	30	—	—	51	59	3	2
Ky.	4	19	6	8	N	N	3	10	—	—
Tenn.	13	24	21	22	—	N	20	28	1	1
Ala.	—	—	—	—	—	N	25	13	2	1
Miss.	—	—	—	—	—	—	3	8	—	—
W.S. CENTRAL	28	74	20	18	10	31	155	165	9	20
Ark.	6	2	5	2	—	1	6	10	—	2
La.	3	1	15	16	4	7	12	29	—	—
Okla.	19	11	N	N	6	9	8	4	1	2
Tex.	—	60	N	N	—	14	129	122	8	16
MOUNTAIN	140	54	14	10	9	13	37	55	2	1
Mont.	—	—	—	—	—	—	—	—	—	—
Idaho	1	1	N	N	—	N	6	4	—	—
Wyo.	1	3	2	4	—	—	—	1	—	—
Colo.	58	20	N	N	8	12	—	10	—	—
N. Mex.	11	21	—	4	—	—	6	21	—	1
Ariz.	61	3	N	N	—	N	20	15	2	—
Utah	8	6	11	1	1	1	—	2	—	—
Nev.	—	—	1	1	—	—	5	2	—	—
PACIFIC	78	93	11	30	—	—	113	225	—	13
Wash.	N	N	N	N	N	N	17	12	—	—
Oreg.	N	N	N	N	—	N	1	9	—	—
Calif.	58	70	N	N	—	N	93	202	—	13
Alaska	—	—	—	—	—	N	—	—	—	—
Hawaii	20	23	11	30	—	—	2	2	—	—
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	N	N	N	N	—	N	17	20	3	—
V.I.	—	—	—	—	—	—	—	4	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	U	U
C.N.M.I.	—	U	—	U	—	U	—	U	—	U

N: Not notifiable. U: Unavailable. —: No reported cases. C.N.M.I.: Commonwealth of Northern Mariana Islands.
* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

Table II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending February 26, 2005, and February 28, 2004 (8th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
							Neuroinvasive		Non-neuroinvasive§
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	749	1,437	20	40	2,883	2,737	—	—	—
NEW ENGLAND	30	39	—	3	49	147	—	—	—
Maine	—	—	—	—	45	7	—	—	—
N.H.	1	—	—	—	—	—	—	—	—
Vt.	—	—	—	—	3	140	—	—	—
Mass.	24	21	—	3	1	—	—	—	—
R.I.	—	7	—	—	—	—	—	—	—
Conn.	5	11	—	—	—	—	—	—	—
MID. ATLANTIC	249	232	5	10	479	8	—	—	—
Upstate N.Y.	18	21	—	—	—	—	—	—	—
N.Y. City	151	150	—	5	—	—	—	—	—
N.J.	46	37	2	3	—	—	—	—	—
Pa.	34	24	3	2	479	8	—	—	—
E.N. CENTRAL	151	111	1	2	1,339	1,150	—	—	—
Ohio	21	20	—	1	193	287	—	—	—
Ind.	16	24	1	—	N	N	—	—	—
Ill.	91	48	—	—	2	—	—	—	—
Mich.	13	10	—	1	1,060	733	—	—	—
Wis.	10	9	—	—	84	130	—	—	—
W.N. CENTRAL	39	37	—	—	21	29	—	—	—
Minn.	16	14	—	—	—	—	—	—	—
Iowa	5	4	—	—	N	N	—	—	—
Mo.	12	11	—	—	1	—	—	—	—
N. Dak.	—	—	—	—	1	16	—	—	—
S. Dak.	—	—	—	—	19	13	—	—	—
Nebr.	1	2	—	—	—	—	—	—	—
Kans.	5	6	—	—	—	—	—	—	N
S. ATLANTIC	116	303	4	7	262	258	—	—	—
Del.	—	3	—	—	1	—	—	—	—
Md.	18	17	1	2	—	—	—	—	—
D.C.	12	4	—	—	—	4	—	—	—
Va.	—	13	—	1	27	20	—	—	—
W. Va.	6	4	—	—	221	213	—	—	N
N.C.	16	14	1	2	—	N	—	—	—
S.C.	20	15	—	—	13	21	—	—	—
Ga.	2	107	1	—	—	—	—	—	—
Fla.	42	126	1	2	—	—	—	—	—
E.S. CENTRAL	54	63	1	—	—	—	—	—	—
Ky.	18	5	1	—	N	N	—	—	—
Tenn.	36	22	—	—	—	—	—	—	—
Ala.	—	25	—	—	—	—	—	—	—
Miss.	—	11	—	—	—	—	—	—	—
W.S. CENTRAL	26	286	—	5	169	743	—	—	—
Ark.	11	12	—	—	—	—	—	—	—
La.	—	—	—	—	4	19	—	—	—
Okla.	15	17	—	—	—	—	—	—	—
Tex.	—	257	—	5	165	724	—	—	—
MOUNTAIN	13	40	1	3	564	402	—	—	—
Mont.	—	—	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	—	—	—	18	11	—	—	—
Colo.	—	10	—	—	399	260	—	—	—
N. Mex.	—	4	—	—	30	14	—	—	—
Ariz.	11	16	1	1	—	—	—	—	—
Utah	2	9	—	1	117	117	—	—	—
Nev.	—	1	—	1	—	—	—	—	—
PACIFIC	71	326	8	10	—	—	—	—	—
Wash.	30	37	—	1	N	N	—	—	—
Oreg.	12	10	1	—	—	—	—	—	—
Calif.	9	257	4	7	—	—	—	—	—
Alaska	2	3	—	—	—	—	—	—	—
Hawaii	18	19	3	2	—	—	—	—	—
Guam	—	12	—	—	—	15	—	—	—
P.R.	—	5	—	—	20	52	—	—	—
V.I.	—	—	—	—	—	—	—	—	—
Amer. Samoa	U	U	U	U	U	U	U	U	—
C.N.M.I.	—	U	—	U	—	U	—	U	—

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

* Incidence data for reporting years 2004 and 2005 are provisional and cumulative (year-to-date).

† Updated weekly from reports to the Division of Vector-Borne Infectious Diseases, National Center for Infectious Diseases (ArboNet Surveillance).

§ Not previously notifiable.

TABLE III. Deaths in 122 U.S. cities,* week ending February 26, 2005 (8th Week)

Reporting Area	All causes, by age (years)						P&I† Total
	All Ages	≥65	45–64	25–44	1–24	<1	
NEW ENGLAND	492	363	92	26	4	7	57
Boston, Mass.	126	93	23	8	1	1	18
Bridgeport, Conn.	28	16	10	1	1	—	4
Cambridge, Mass.	16	9	6	1	—	—	2
Fall River, Mass.	28	22	6	—	—	—	2
Hartford, Conn.	48	40	4	2	2	—	6
Lowell, Mass.	26	19	6	1	—	—	5
Lynn, Mass.	8	7	1	—	—	—	1
New Bedford, Mass.	23	15	5	3	—	—	4
New Haven, Conn.	U	U	U	U	U	U	U
Providence, R.I.	64	54	9	1	—	—	6
Somerville, Mass.	7	4	2	1	—	—	—
Springfield, Mass.	30	20	7	1	—	2	3
Waterbury, Conn.	28	19	8	—	—	1	1
Worcester, Mass.	60	45	5	7	—	3	5
MID. ATLANTIC	2,401	1,734	454	150	35	28	189
Albany, N.Y.	56	42	12	2	—	—	4
Allentown, Pa.	25	21	3	—	—	1	2
Buffalo, N.Y.	152	117	23	3	6	3	22
Camden, N.J.	29	16	5	6	2	—	2
Elizabeth, N.J.	18	11	4	3	—	—	3
Erie, Pa.	53	47	4	2	—	—	4
Jersey City, N.J.	31	25	4	2	—	—	—
New York City, N.Y.	1,187	863	225	74	15	10	78
Newark, N.J.	62	29	22	8	1	2	6
Paterson, N.J.	30	14	7	7	—	2	—
Philadelphia, Pa.	319	218	68	21	9	3	15
Pittsburgh, Pa.§	29	19	6	2	1	1	4
Reading, Pa.	37	25	8	1	—	3	4
Rochester, N.Y.	164	124	28	9	1	2	24
Schenectady, N.Y.	17	15	2	—	—	—	2
Scranton, Pa.	50	43	5	2	—	—	5
Syracuse, N.Y.	75	59	12	3	—	1	9
Trenton, N.J.	26	20	3	3	—	—	1
Utica, N.Y.	19	10	7	2	—	—	3
Yonkers, N.Y.	22	16	6	—	—	—	1
E.N. CENTRAL	2,239	1,556	475	127	40	40	206
Akron, Ohio	47	41	5	—	—	1	3
Canton, Ohio	44	36	4	3	—	1	12
Chicago, Ill.	405	259	98	40	4	3	33
Cincinnati, Ohio	100	66	20	5	4	5	7
Cleveland, Ohio	229	180	35	12	1	1	11
Columbus, Ohio	243	173	51	8	7	4	28
Dayton, Ohio	133	98	26	2	5	2	11
Detroit, Mich.	152	85	42	15	7	3	12
Evansville, Ind.	47	37	5	5	—	—	7
Fort Wayne, Ind.	76	53	16	4	2	1	11
Gary, Ind.	20	8	8	3	—	1	—
Grand Rapids, Mich.	60	39	11	4	3	3	4
Indianapolis, Ind.	202	131	53	8	3	7	20
Lansing, Mich.	54	37	15	1	—	1	3
Milwaukee, Wis.	134	92	34	6	1	1	20
Peoria, Ill.	61	45	12	2	—	2	3
Rockford, Ill.	56	40	11	3	1	1	7
South Bend, Ind.	46	35	4	4	1	2	4
Toledo, Ohio	80	58	21	—	1	—	8
Youngstown, Ohio	50	43	4	2	—	1	2
W.N. CENTRAL	546	402	99	25	9	11	67
Des Moines, Iowa	58	49	7	1	—	1	9
Duluth, Minn.	39	33	4	2	—	—	3
Kansas City, Kans.	4	1	1	—	1	1	—
Kansas City, Mo.	87	61	18	3	4	1	7
Lincoln, Nebr.	37	31	4	2	—	—	5
Minneapolis, Minn.	70	55	13	1	—	1	10
Omaha, Nebr.	107	72	22	10	1	2	16
St. Louis, Mo.	76	51	19	2	2	2	5
St. Paul, Minn.	58	47	6	3	1	1	10
Wichita, Kans.	10	2	5	1	—	2	2
S. ATLANTIC	1,302	853	311	93	22	23	81
Atlanta, Ga.	171	108	42	15	4	2	4
Baltimore, Md.	174	102	55	14	—	3	20
Charlotte, N.C.	120	86	23	10	1	—	11
Jacksonville, Fla.	121	80	31	5	1	4	7
Miami, Fla.	153	100	35	12	3	3	8
Norfolk, Va.	56	34	17	2	2	1	4
Richmond, Va.	66	40	13	8	4	1	7
Savannah, Ga.	66	40	20	5	—	1	6
St. Petersburg, Fla.	65	44	10	4	4	3	3
Tampa, Fla.	186	137	39	7	1	2	6
Washington, D.C.	100	63	24	9	2	2	1
Wilmington, Del.	24	19	2	2	—	1	4
E.S. CENTRAL	939	627	223	56	18	15	73
Birmingham, Ala.	146	95	34	10	3	4	18
Chattanooga, Tenn.	83	59	18	4	1	1	5
Knoxville, Tenn.	127	88	30	8	1	—	2
Lexington, Ky.	76	51	21	2	1	1	8
Memphis, Tenn.	170	117	33	12	3	5	12
Mobile, Ala.	139	88	38	10	2	1	8
Montgomery, Ala.	49	32	12	—	5	—	3
Nashville, Tenn.	149	97	37	10	2	3	17
W.S. CENTRAL	1,643	1,089	376	113	31	34	138
Austin, Tex.	77	51	16	6	1	3	13
Baton Rouge, La.	41	28	9	1	1	2	3
Corpus Christi, Tex.	60	44	8	5	2	1	4
Dallas, Tex.	228	136	58	24	6	4	21
El Paso, Tex.	91	69	15	5	1	1	12
Ft. Worth, Tex.	144	88	46	3	3	4	7
Houston, Tex.	401	256	97	30	9	9	21
Little Rock, Ark.	83	57	21	3	—	2	6
New Orleans, La.	39	27	12	—	—	—	—
San Antonio, Tex.	288	202	55	20	5	6	38
Shreveport, La.	56	36	13	5	1	1	3
Tulsa, Okla.	135	95	26	11	2	1	10
MOUNTAIN	1,069	746	182	63	25	25	102
Albuquerque, N.M.	177	127	31	15	1	3	14
Boise, Idaho	69	54	12	2	1	—	11
Colo. Springs, Colo.	81	61	12	5	2	1	3
Denver, Colo.	107	60	28	10	2	7	9
Las Vegas, Nev.	285	226	25	1	4	3	29
Ogden, Utah	37	30	4	2	—	1	3
Phoenix, Ariz.	166	96	38	12	12	7	20
Pueblo, Colo.	50	30	10	9	1	—	6
Salt Lake City, Utah	97	62	22	7	2	3	7
Tucson, Ariz.	U	U	U	U	U	U	U
PACIFIC	1,592	1,117	327	83	32	33	160
Berkeley, Calif.	17	11	3	1	—	2	1
Fresno, Calif.	56	36	13	7	—	—	6
Glendale, Calif.	17	14	2	1	—	—	1
Honolulu, Hawaii	79	62	15	1	—	1	7
Long Beach, Calif.	68	41	21	1	1	4	10
Los Angeles, Calif.	215	145	47	11	7	5	23
Pasadena, Calif.	23	17	3	—	1	2	1
Portland, Oreg.	71	53	12	4	2	—	7
Sacramento, Calif.	206	144	52	4	4	2	17
San Diego, Calif.	128	90	23	8	6	1	11
San Francisco, Calif.	190	112	51	17	4	6	24
San Jose, Calif.	171	136	23	9	1	2	24
Santa Cruz, Calif.	40	33	5	2	—	—	5
Seattle, Wash.	120	77	24	10	4	5	7
Spokane, Wash.	82	63	14	4	1	—	13
Tacoma, Wash.	109	83	19	3	1	3	3
TOTAL	12,223¶	8,487	2,539	736	216	216	1,073

U: Unavailable. —: No reported cases.

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

† Pneumonia and influenza.

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

¶ Total includes unknown ages.

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