



MMWRTM

Morbidity and Mortality Weekly Report

Weekly

July 8, 2005 / Vol. 54 / No. 26

State Smoking Restrictions for Private-Sector Worksites, Restaurants, and Bars — United States, 1998 and 2004

Secondhand smoke is a known carcinogen (1). Exposure to secondhand smoke causes approximately 35,000 heart disease deaths and 3,000 lung cancer deaths among nonsmokers in the United States every year (2). Implementing policies that establish smoke-free environments is the most effective approach to reducing secondhand smoke exposure among nonsmokers (1). Smoking restrictions and smoke-free policies can take the form of laws or regulations implemented at the state or local level or of voluntary policies implemented by private employers and businesses. Smoking restrictions limit smoking to certain areas within a venue; smoke-free policies ban smoking within the entire venue. One of the national health objectives for 2010 is to establish laws in all 50 states and the District of Columbia (DC) that prohibit or restrict smoking in public places and worksites. A related objective calls for all worksites to voluntarily implement policies that prohibit or restrict smoking. To assess progress toward meeting the first objective, CDC reviewed the status of state laws restricting smoking as of December 31, 2004, updating a 1999 study that reported on such laws as of December 31, 1998 (3). This report summarizes the changes in state smoking restrictions for private-sector worksites, restaurants, and bars that occurred during 1999–2004. The findings indicate an increase in the number and restrictiveness of state laws regulating smoking in private-sector worksites, restaurants, and bars from 1999 through 2004. At the end of 2004, however, 16 states still had no restrictions on smoking in any of the three settings considered. Although secondhand smoke exposure among U.S. nonsmokers has decreased sharply in recent years, a substantial portion of nonsmokers continue to be exposed to secondhand smoke (4).

The smoking restrictions in effect in each of the 50 states and DC* as of December 31, 1998, and December 31, 2004, were categorized into one of four levels for each of the three settings included in this study (Table). These settings were selected because worksites are a major source of secondhand smoke exposure for adult nonsmokers (1), and because workers in restaurants and bars are exposed to especially high levels of secondhand smoke (5). The four levels are as follows: 1) no restrictions, 2) designated smoking areas required or allowed, 3) no smoking allowed or designated smoking areas allowed if separately ventilated, and 4) no smoking allowed (i.e., 100% smoke-free). (These levels apply only to indoor areas of these settings.) These data were collected from CDC's State Tobacco Activities Tracking and Evaluation (STATE) System database, which contains tobacco-related epidemiologic and economic data and information on state tobacco-related legislation (6). The data used for this report are collected quarterly from an online database of state laws, analyzed by using a coding scheme and decision rules, and transferred into the STATE System database. The STATE System tracks state smoking restrictions in government worksites, private-sector worksites, restaurants, commercial and home-based child care centers, and other

*For this report, DC is included among the states.

INSIDE

- 653 Assessment of Local Health Department Smoking Policies — North Carolina, July–August 2003
- 655 Progress Toward Poliomyelitis Eradication — India, January 2004–May 2005
- 659 QuickStats
- 659 Notices to Readers

The *MMWR* series of publications is published by the Coordinating Center for Health Information and Service, Centers for Disease Control and Prevention (CDC), U.S. Department of Health and Human Services, Atlanta, GA 30333.

SUGGESTED CITATION

Centers for Disease Control and Prevention. [Article Title]. *MMWR* 2005;54:[inclusive page numbers].

Centers for Disease Control and Prevention

Julie L. Gerberding, MD, MPH
Director

Dixie E. Snider, MD, MPH
Chief Science Officer

Tanja Popovic, MD, PhD
(Acting) Associate Director for Science

Coordinating Center for Health Information and Service

Blake Caldwell, MD, MPH, and Edward J. Sondik, PhD
(Acting) Directors

National Center for Health Marketing*

Steven L. Solomon, MD
(Acting) Director

Division of Scientific Communications*

Maria S. Parker
(Acting) Director

Mary Lou Lindegren, MD
(Acting) Editor, MMWR Series

Suzanne M. Hewitt, MPA
Managing Editor, MMWR Series

Douglas W. Weatherwax
(Acting) Lead Technical Writer-Editor

Stephanie M. Neitzel
Jude C. Rutledge
Writers-Editors

Lynda G. Cupell
Malbea A. LaPete
Visual Information Specialists

Quang M. Doan, MBA
Erica R. Shaver
Information Technology Specialists

Notifiable Disease Morbidity and 122 Cities Mortality Data

Patsy A. Hall	Donna Edwards
Deborah A. Adams	Tambra McGee
Felicia J. Connor	Pearl C. Sharp
Rosaline Dhara	

* Proposed.

settings, including bars, shopping malls, grocery stores, enclosed arenas, public transportation, hospitals, prisons, and hotels and motels. Tobacco-control personnel in state health departments reviewed and commented on the coding of smoking restrictions in their states.

Laws enacted before December 31, 2004, but not effective until after that date are not reflected in this report. For example, Rhode Island enacted comprehensive smoke-free indoor air legislation in 2004 that did not take effect until 2005 and was therefore not included in this assessment. The report also does not reflect legislation enacted since the end of 2004. For example, during January 1–June 30, 2005, Georgia, Maine, Montana, North Dakota, Rhode Island, and Vermont enacted smoking restrictions.

During December 31, 1998–December 31, 2004, 10 states indicated changes in the level of their smoking restrictions for private-sector worksites, nine states indicated changes in the level of their smoking restrictions for restaurants, and five states indicated changes in the level of their smoking restrictions for bars, on the basis of the STATE System coding scheme. In every case, the restrictions became more stringent.

As of December 31, 1998, only one state (Maryland) banned smoking in private-sector worksites. As of December 31, 2004, six additional states (Delaware, Florida, Idaho, Massachusetts, New York, and South Dakota) had done so. In 1998, one state (California) required that private-sector worksites restrict smoking to separately ventilated employee break rooms. In 2004, two additional states (Connecticut and Oregon) had enacted smoking restrictions of this type. In 1998, 20 states required or allowed designated smoking areas in worksites. In 2004, 18 states had laws of this type in place, with two states moving from no smoking restrictions into this category and four states moving from this category into one of the more restrictive categories. In 1998, a total of 29 states had no smoking restrictions in place for private-sector worksites. In 2004, this number had decreased to 23 states.

In 1998, two states (Utah and Vermont) banned smoking in restaurants. During 1999–2004, six additional states (Delaware, Florida, Idaho, Maine, Massachusetts, and New York) did so. In 1998, one state (California) required that restaurants restrict smoking to separately ventilated employee break rooms. In 2004, one additional state (Connecticut) had enacted a smoking restriction of this type. In 1998, 27 states required or allowed designated smoking areas in restaurants; in 2004, 22 states had smoking restrictions of this type in place, with two states moving from no restrictions into this category and seven states moving from this category into one of the more restrictive categories. In 1998, 21 states had no smoking restrictions for restaurants. In 2004, this number had decreased to 19 states.

TABLE. State smoking restrictions* for private-sector worksites, restaurants, and bars, by state — United States, December 31, 1998, and December 31, 2004

State	Private-sector worksites		Restaurants		Bars	
	1998	2004	1998	2004	1998	2004
Alabama	None	Designated	None	None	None	None
Alaska	None	None	Designated	Designated	None	None
Arizona	None	None	None	None	None	None
Arkansas	None	None	None	None	None	None
California	Ventilated [†]	Ventilated [†]	Ventilated [†]	Ventilated [†]	Ventilated [†]	Ventilated [†]
Colorado	None	None	None	None	None	None
Connecticut	Designated	Ventilated [†]	Designated	Ventilated [†]	None	Ventilated [†]
Delaware	Designated	Smoke-free	Designated	Smoke-free	None	Smoke-free
District of Columbia	Designated	Designated	Designated	Designated	None	None
Florida	Designated	Smoke-free	Designated	Smoke-free	None	None
Georgia	None	None	None	None	None	None
Hawaii	None	None	Designated	Designated	None	None
Idaho	None	Smoke-free	Designated	Smoke-free	None	None
Illinois	Designated	Designated	Designated	Designated	None	None
Indiana	None	None	None	None	None	None
Iowa	Designated	Designated	Designated	Designated	None	None
Kansas	None	None	Designated	Designated	None	None
Kentucky	None	None	None	None	None	None
Louisiana	Designated	Designated	None	None	None	None
Maine	Designated	Designated	Designated	Smoke-free	None	Smoke-free
Maryland [§]	Smoke-free	Smoke-free	Designated	Designated	None	None
Massachusetts	None	Smoke-free	Designated	Smoke-free	None	Smoke-free
Michigan	None	None	Designated	Designated	None	None
Minnesota	Designated	Designated	Designated	Designated	None	None
Mississippi	None	None	None	None	None	None
Missouri	Designated	Designated	Designated	Designated	Designated	Designated
Montana	Designated	Designated	Designated	Designated	None	None
Nebraska	Designated	Designated	Designated	Designated	Designated	Designated
Nevada	None	None	Designated	Designated	None	None
New Hampshire	Designated	Designated	Designated	Designated	None	None
New Jersey	Designated	Designated	None	None	None	None
New Mexico	None	None	None	None	None	None
New York	Designated	Smoke-free	Designated	Smoke-free	None	Smoke-free
North Carolina	None	None	None	None	None	None
North Dakota	None	None	Designated	Designated	None	None
Ohio	None	None	None	None	None	None
Oklahoma [§]	None	Designated	None	Designated	None	None
Oregon	None	Ventilated [†]	Designated	Designated ^{†¶}	None	None
Pennsylvania	Designated	Designated	Designated	Designated	None	None
Rhode Island	Designated	Designated	Designated	Designated	None	None
South Carolina	None	None	None	None	None	None
South Dakota	None	Smoke-free	None	Designated	None	None
Tennessee	None	None	None	None	None	None
Texas	None	None	None	None	None	None
Utah	Designated	Designated	Smoke-free	Smoke-free	None	None
Vermont [§]	Designated	Designated	Smoke-free	Smoke-free	None	None
Virginia	None	None	Designated	Designated	None	None
Washington	None	None	None	None	None	None
West Virginia	None	None	None	None	None	None
Wisconsin	Designated	Designated	Designated	Designated	None	None
Wyoming	None	None	None	None	None	None

* None = no restrictions; designated = designated smoking areas required or allowed; ventilated = no smoking allowed or designated smoking areas allowed if separately ventilated; and smoke-free = no smoking allowed (i.e., 100% smoke-free).

[†] Restriction bans smoking in most settings, but exempts separately ventilated employee break rooms or lounges.

[§] Corrected from previous report (3). Maryland was previously listed as having no smoking restrictions for private-sector worksites; Oklahoma was previously listed as requiring or allowing designated smoking areas in restaurants; and Vermont was previously listed as requiring or allowing designated smoking areas in bars.

[¶] Restriction exempts restaurants and areas of restaurants that are posted as off-limits to minors.

In 1998, no states required bars to be smoke-free. During 1999–2004, four states (Delaware, Maine, Massachusetts, and New York) enacted laws that banned smoking in bars. In 1998, one state (California) required that bars restrict smoking to separately ventilated employee break rooms. In 2004, one additional state (Connecticut) had enacted a smoking restriction of this type. In 1998, two states required or allowed designated smoking areas in bars; this remained the case in 2004. In 1998, a total of 48 states had no smoking restrictions for bars. In 2004, this number had decreased to 43 states.

In 2004, three states (Delaware, Massachusetts, and New York) banned smoking in all three settings considered in this study, compared with no states in 1998. At the end of 2004, 16 states had no smoking restrictions in place in any of these three settings, compared with 19 states in 1998. Many other states had no restrictions, or restrictions that did not provide full protection, in some of these settings.

Reported by: *J Chriqui, PhD, J O'Connor, JD, MayaTech Corporation, Silver Spring, Maryland. S Babb, MPH, NA Blair, MPH, G Vaughn, A MacNeil, MPH, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.*

Editorial Note: The findings of this analysis indicate that the number and restrictiveness of state laws regulating smoking in private-sector worksites, restaurants, and bars increased from 1999 to 2004. This increase has provided U.S. nonsmokers with greater protection from exposure to secondhand smoke (1,3,10).

As of 1998–1999, 69.3% of U.S. workers reported that their workplace had an official policy that prohibited smoking in work areas and public or common areas, compared with 46.5% in 1993 (7). However, despite recent progress, many workers are still not protected by smoke-free workplace policies. Moreover, the proportion of workers covered by such policies during 1998–1999 varied by occupation, from 42.9% among food-preparation and food-service workers to 90.8% of primary-school teachers (7). The proportion of waiters (27.7%) and bartenders (12.9%) who reported being covered by smoke-free policies was lower than the proportion of food-preparation and -service workers overall (7). A previous study has indicated that food-service workers have a 50% greater risk for developing lung cancer than the general population, resulting in part from their higher level of occupational exposure to secondhand smoke (8). As a result of continuing gaps in policy coverage for many private-sector worksites, restaurants, and bars, a substantial portion of the U.S. nonsmoking population remains at risk for exposure to a known carcinogen in these settings, either as employees or customers.

In addition to protecting both workers and patrons from secondhand smoke exposure, smoke-free workplace policies also are associated with decreased cigarette consumption and

possibly with increased cessation rates among workers and members of the general public (1). Peer-reviewed studies relying on objective indicators such as sales tax revenue and employment levels have consistently found that smoking restrictions do not have a negative economic impact on restaurants and bars (9). Studies have also reported high levels of public support for and compliance with these laws (1,10).

The findings in this report are subject to at least four limitations. First, the STATE System only captures certain types of state smoking restrictions (primarily statutory laws and executive orders) and does not capture state administrative laws, such as regulations, or implementation guidelines. As a result, the manner in which a state smoking restriction is implemented in practice might differ from how it is coded in the STATE System. For example, this report does not reflect a regulation in the state of Washington that restricts smoking in private-sector worksites and an administrative rule in Utah that imposes restrictions on smoking in certain bars. The STATE System also does not capture the extent to which state smoking restrictions are actually enforced. Second, some state smoking restrictions apply only to private-sector worksites with more than a certain number of employees, to restaurants with more than a specified number of seats, or to bars of at least a certain size. In these cases, the state laws are coded according to the level of these restrictions, even though these restrictions do not apply to venues below the relevant size limit.[†] Third, because the STATE System only collects state-level data, it does not reflect local smoking restrictions that are in place in many states. Some states with no or minimal state smoking restrictions have strong local smoking restrictions in place in many communities (1). State legislative provisions that do not preempt communities from enacting more stringent local laws allow continued passage and enforcement of local smoking restrictions that can establish a greater level of protection of public health (3). Finally, this report does not address sources of secondhand smoke exposure other than private-sector worksites, restaurants, and bars. Homes are another important source of exposure, especially for children (1), who on average are exposed to higher levels of secondhand smoke than adults (4).

The importance of smoke-free indoor air laws and policies as a component of comprehensive tobacco-control interventions is reflected by their inclusion in national health objectives for 2010 and in CDC surveillance (1). Although population-based data indicate declining secondhand smoke

[†] Information on worksite and restaurant size exemptions is available at <http://www.cdc.gov/tobacco/statesystem>. The STATE System does not track information on bar size exemptions.

exposure in the workplace over time, this exposure remains a common public health hazard that is entirely preventable (1). Optimal protection of nonsmokers and smokers requires a smoke-free environment (1).

Acknowledgments

The findings in this report are based, in part, on contributions by L Lineberger, MayaTech Corporation, Silver Spring, Maryland. D Coleman, MPH, Northrop Grumman, Atlanta, Georgia. TF Pechacek, PhD, Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.

References

1. US Department of Health and Human Services. Reducing tobacco use: a report of the Surgeon General. Atlanta, GA: US Department of Health and Human Services; 2000.
2. CDC. Annual smoking-attributable mortality, years of potential life lost, and productivity losses—United States, 1997–2001. *MMWR* 2005;54:625–8.
3. CDC. State laws on tobacco control—United States, 1998. *MMWR* 1999;48(No. SS-3):21–62.
4. Wortley PM, Caraballo RS, Pederson LL, Pechacek TF. Exposure to secondhand smoke in the workplace: serum cotinine by occupation. *J Occup Environ Med* 2002;44:503–9.
5. US Department of Health and Human Services. Second national report on human exposure to environmental chemicals. Atlanta, GA: US Department of Health and Human Services; 2003. Available at <http://www.cdc.gov/exposurereport/2nd/pdf/tobaccosmoke.pdf>.
6. CDC. State Tobacco Activities Tracking and Evaluation (STATE) System. Available at <http://www.cdc.gov/tobacco/statesystem>.
7. Shopland DR, Anderson CM, Burns DM, Gerlach KK. Disparities in smoke-free workplace policies among food service workers. *J Occup Environ Med* 2004;46:347–56.
8. Siegel M. Involuntary smoking in the restaurant workplace: a review of employee exposure and health effects. *JAMA* 1993;270:490–3.
9. Scollo M, Lal A, Hyland A, Glantz S. Review of the quality of studies on the economic effects of smoke-free policies on the hospitality industry. *Tobacco Control* 2003;12:13–20.
10. New York City Department of Finance, New York City Department of Health and Mental Hygiene, New York City Department of Small Business Services, New York City Economic Development Corporation. The state of smoke-free New York City: a one-year review. New York, NY: New York City Department of Health and Mental Hygiene; 2004.

preempt more stringent local laws (8). North Carolina has such a preemptive state smoking law,* passed in 1993, which mandates that 20% of the space within state-controlled buildings be designated as smoking areas. Exemptions from the law included local health departments (LHDs), providing an opportunity for public health practitioners to enact more stringent policies. To assess smoking policy gains from this exemption, a research team from the University of North Carolina at Chapel Hill (UNC) surveyed LHD directors. Results of the survey indicated uncertainty regarding the state law, with 37% of LHD directors believing they were prohibited from enacting a 100% tobacco-free policy on LHD grounds† and 20% not knowing whether they were prohibited. The North Carolina Association of Local Health Directors used these findings to work with legislators in the North Carolina General Assembly to amend the state smoking law in 2005, specifying that the exemption applies to both LHD buildings and grounds.

North Carolina has 85 county or multicounty LHD directors, representing all 100 counties in the state. Of the 85 directors, a total of 76 (89.4%) agreed to participate in the study. During July–August 2003, the LHD directors responded to a telephone survey that included questions related to their knowledge and opinions regarding 1) the effects of exposure to secondhand smoke; 2) state legislation on smoking in public spaces; 3) tobacco-use policies, enforcement provisions, and availability of smoking-cessation support services at their LHDs; and 4) perceived LHD employee support for a 100% tobacco-free policy. LHD directors also were asked whether smoking was permitted in 13 traditional smoking sites§ in the buildings or on the grounds of their LHDs. To assess the accuracy of such self-reported data on tobacco-use policies, 15 written policies were obtained at random from the LHDs and compared with the responses of their 15 respective directors. The responses were determined to be 86% in agreement with the written policies. The survey received approval by the Biomedical Institutional Review Board of the UNC School of Medicine.

Assessment of Local Health Department Smoking Policies — North Carolina, July–August 2003

Secondhand smoke is a cause of disease in healthy nonsmokers (1–6), and an increasing number of states have adopted laws prohibiting smoking in private-sector worksites, restaurants, and bars (7). However, certain state governments have provisions in their state smoking restrictions that

*North Carolina General Statutes 143-595 to 143-601. Article 64. Smoking in public places (1993). Available at <http://www.ncga.state.nc.us/sessions/1993/bills/house/html/h957v5.html>.

† Defined as prohibiting the use of all tobacco products by anyone, at any time, at any place on LHD grounds, in LHD vehicles, or at LHD events or functions.

§ Indoor hallways and corridors; outdoor walkways and loading docks; waiting areas and lobbies; administrative and private offices; clinics and doctors' offices; cafeterias; break rooms and lounges; locker rooms; restrooms; LHD events and functions; outside entrances and exits; parking lots and structures; and LHD vehicles.

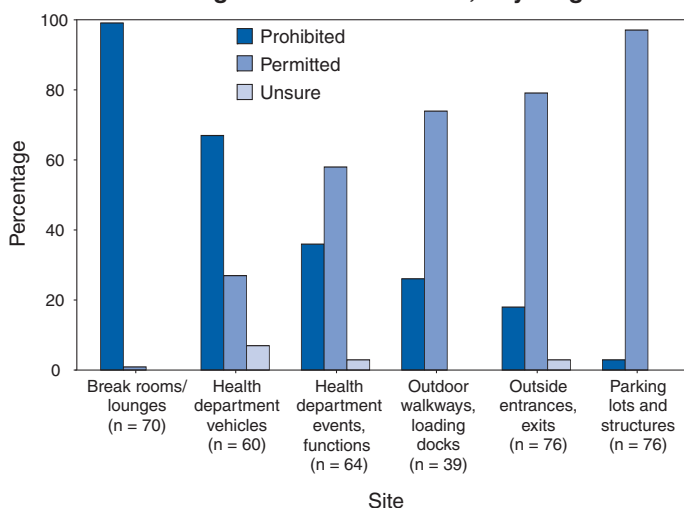
Among the 76 county or multicounty LHDs represented, the median number of employees was 85 (range: 15–600), the average number of buildings occupied was 3.2, and the median number of patients or visitors annually was 20,000 (range: 3,000–400,000). Among the 76 LHD directors, 53 (69.7%) were nonsmokers, 20 (26.3%) were former smokers, and three (3.9%) were current smokers.[‡] According to LHD director estimates, the mean percentage of current smokers among employees at the 76 LHDs was 10% (range: 1%–42%). Approximately 60% of LHD directors reported their departments did not routinely offer cessation services for employees who smoked.

High percentages of LHD directors agreed or strongly agreed that exposure to secondhand smoke can trigger asthma attacks (98.7%), cause lung cancer (97.4%) and lead to adverse short-term cardiovascular effects (84.3%). Official, written tobacco-use policies were in effect at 89.5% of the LHDs, whereas 10.5% operated with unofficial tobacco-use policies. Among 75 of the 76 LHDs, 33 (44.0%) had tobacco-use policies specific to the LHD, 33 (44.0%) operated under countywide policies, four (5.3%) operated under both LHD and countywide policies, and five (6.7%) operated under the federal Pro-Children Act of 1994.**

At 100% of the LHDs, smoking was prohibited in indoor hallways and corridors, waiting areas and lobbies, administrative and private offices, clinics and doctors' offices, cafeterias, locker rooms, and restrooms. One LHD reported having a 100% tobacco-free policy. However, among those LHD directors who answered the questions, 38 of 66 (57.6%) said smoking was permitted at LHD events and functions, 29 of 39 (74.4%) said smoking was permitted on outdoor walkways and loading docks, 60 of 76 (78.9%) said smoking was permitted outside all entrances and exits, and 74 of 76 (97.4%) said smoking was permitted in parking lots (Figure).

Among the LHD directors, 57 of 75 (76.0%) said they were very familiar or somewhat familiar with the preemptive provisions of North Carolina's state law on smoking in public places (9). However, 28 of 75 (37.3%) incorrectly believed the law prevented enactment and enforcement of a 100% tobacco-free policy on LHD grounds, and 15 (20.0%) said they did not know whether the law prohibited such a policy. Sixty-six of the 76 LHD directors (86.8%) believed the majority of their employees would support a 100% tobacco-free policy at their LHDs. Fifty-eight (76.3%) reported that

FIGURE. Local health department smoking policies*, by traditional smoking site — North Carolina, July–August 2003



* As reported by 76 local health directors.

† Two reported operating under the policy in effect at the host site.

no single person was officially responsible for enforcing their tobacco-use policy.

In May 2005, the North Carolina General Assembly, in response to data indicating uncertainty about exemptions and with leadership from the North Carolina Association of Local Health Directors, amended the section of the state's smoking law, enabling LHDs to implement more stringent policies. The new law specifies that the exemption applies to both LHD buildings and grounds, including areas within 50 feet of a building.^{††}

Reported by: AO Goldstein, MD, C Gray, MPH, AY Butzen, KM Ribisl, PhD, Dept of Family Medicine, School of Public Health, Univ of North Carolina at Chapel Hill.

Editorial Note: The findings described in this report indicate uncertainty among the majority of LHD directors in North Carolina regarding whether the state's 1993 smoking law prevented them from implementing a tobacco-free policy. The North Carolina Tobacco Control Program works to implement a comprehensive tobacco prevention and control program, of which smoke-free policies are a substantial component. Achieving tobacco-free policies in North Carolina LHDs will require leadership from LHD directors, policy approval from local boards of health, and support from LHD employees. Given that 86.8% of LHD directors reported that their employees would support 100% tobacco-free policies

[‡] Current smoker was defined as a person who uses pipes, cigars, or cigarettes. Nonsmoker was defined as a person who never uses pipes, cigars, or cigarettes. Former smoker was defined as a person who has used pipes, cigars, or cigarettes but not currently.

** Pro-Children Act of 1994. Pub. L. 103-227. 20 USC 6081-6084 (March 31, 1994).

^{††} North Carolina General Statute 143-599. An act to exempt from the law governing smoking restrictions local health departments and the buildings and grounds where they are located (2005). Available at <http://www.ncga.state.nc.us/sessions/2005/bills/house/html/h239v4.html>.

and given the known health benefits of such policies, policy gains might be possible. Implementation of such policies can reduce smoking and encourage cessation among LHD employees while protecting employees, patients, and visitors from exposure to secondhand smoke.

The findings in this report are subject to at least three limitations. First, the survey consisted of self-reported data and opinions of LHD directors regarding smoking policies; LHD directors might overestimate or underestimate the percentage of employees who smoke or employee support for tobacco-free policies. Second, although opinions of LHD directors are influential, LHD policies also are influenced by opinions from local boards of health, which might differ from those of directors. Finally, these data represent LHDs only in North Carolina. Other states already have tobacco-free policies in place at LHDs; however, such policies are not tracked.

If LHDs establish 100% tobacco-free policies, they will need to ensure enforcement. In the study described in this report, most directors reported that no single person was officially responsible for enforcement; new policies should include language and mechanisms to ensure prohibition of tobacco use in difficult-to-monitor locations such as in LHD vehicles, outside entrances, on loading docks, and at LHD events and functions. LHD employees who smoke also should be provided access to cessation-support services, which can substantially improve their odds of quitting smoking (9). In this study, LHD directors indicated their awareness of the adverse health effects of secondhand smoke. By implementing tobacco-free policies, they also can acknowledge the important role that LHD policies can play in modeling healthy behavior to the public and changes in social norms regarding the acceptability of smoking.

References

1. International Agency for Research on Cancer. IARC monographs on the evaluation of carcinogenic risks to humans: tobacco smoke and involuntary smoking [volume 83]. Lyon, France: IARC Working Group on the Evaluation of Carcinogenic Risks to Humans; 2004. Available at <http://www-cie.iarc.fr/htdocs/monographs/vol83/02-involuntary.html>.
2. National Toxicology Program. 9th report on carcinogens, 2000. Research Triangle Park, NC: US Department of Health and Human Services, National Institute of Environmental Health Services; 2000. Available at <http://ntp.niechs.nih.gov/ntp/roc/eleventh/profiles/176toba.pdf>.
3. California Environmental Protection Agency. Health effects of exposure to environmental tobacco smoke: smoking and tobacco control monograph No. 10. Bethesda, MD: National Cancer Institute, California Environmental Protection Agency; 1997. Available at http://cancercontrol.cancer.gov/tcrb/monographs/10/m10_complete.pdf.
4. Environmental Protection Agency. Respiratory health effects of passive smoking: lung cancer and other disorders. Washington, DC: Environmental Protection Agency; 1992.
5. Environmental Protection Agency. Setting the record straight: secondhand smoke is a preventable health risk. Washington, DC: Environmental Protection Agency; 1994. Available at <http://www.epa.gov/smokefree/pubs/strsfs.html>.
6. CDC. Exposure to environmental tobacco smoke and cotinine levels—fact sheet. Atlanta, GA: US Department of Health and Human Services, CDC; 2005. Available at http://www.cdc.gov/tobacco/research_data/environmental/factsheet_ets.htm.
7. CDC. State smoking restrictions for private-sector worksites, restaurants, and bars—United States, 1998 and 2004. *MMWR* 2005;54:649–53.
8. CDC. Preemptive state smoke-free indoor air laws—United States, 1999–2004. *MMWR* 2005;54:250–3.
9. Fiore MC, Bailey WC, Cohen SJ, et al. Treating tobacco use and dependence: clinical practice guideline. Rockville, MD: US Department of Health and Human Services, Public Health Service; 2000. AHRQ publication no. 00-0032.

Progress Toward Poliomyelitis Eradication — India, January 2004–May 2005

Since 1988, the global incidence of polio has decreased by more than 99%, and three World Health Organization (WHO) regions (Americas, Western Pacific, and European) have been certified as polio-free (1). India, the largest of the six countries where polio remains endemic, experienced a large polio outbreak (1,600 cases) in 2002 (2). Since then, the Government of India (GOI) has accelerated its polio eradication activities by increasing the number and quality of supplementary immunization activities (SIAs),* which reduced the number of reported cases to 225 in 2003, 134 in 2004, and 18 in 2005 (as of June 18) (3). During 2004 and early 2005, taking advantage of the geographic restriction of wild poliovirus (WPV) circulation, GOI and its partners launched several immunization and surveillance strategies to maximize the probability of eliminating poliovirus transmission in India. With continued high-quality interventions, interruption of WPV transmission in India by the end of 2005 appears feasible. This report summarizes progress toward polio elimination during January 2004–May 2005 toward that end.

Acute Flaccid Paralysis (AFP) Surveillance

Since 2000, India has exceeded the WHO-established AFP surveillance quality targets (i.e., a nonpolio AFP rate of ≥ 1 case per 100,000 population aged <15 years and adequate stool

* Mass campaigns conducted during a brief period (days to weeks) in which 1 dose of oral polio vaccine (OPV) is administered to all children aged <5 years, regardless of vaccination history. The geographic extent of campaigns (national versus subnational) is determined by analysis of surveillance data. OPV can be administered at fixed sites, by mobile teams during house-to-house visits, by mobile teams at transit points (e.g., train stations or markets), or through a combination of strategies, depending on local circumstances.

specimen collection[†] from $\geq 80\%$ of AFP cases). During 2004, the nonpolio AFP rate was ≥ 1 case per 100,000 in 29 of India's 35 states (representing more than 99% of India's population). Adequate stool specimen collection for $\geq 80\%$ of AFP cases was reported from 26 states, with adequate specimen collection at 70%–80% in the remaining nine states.

AFP surveillance in India is facilitated through a network of WHO surveillance medical officers (SMOs)[§] who assist national, state, and local health authorities. Since May 2004, SMOs have accelerated efforts to detect and investigate all AFP cases, resulting in increased nonpolio AFP rates nationally, particularly in the states of Bihar and Uttar Pradesh, where polio remains endemic. During January–May 2005, compared with the same period in 2004, approximately twice as many AFP cases were detected and investigated in India. Adequate stool specimen collection remained above 80% in Uttar Pradesh and increased from 77% to 83% in Bihar (Table).

Virologic testing of stool specimens from AFP patients is conducted at eight national laboratories, all of which are accredited by WHO as part of the Global Poliovirus Laboratory Network. These laboratories perform primary isolation of polioviruses. Two of the laboratories (Chennai and Lucknow) also serve as upgraded national laboratories performing intratypic differentiation (ITD); one laboratory, the Enterovirus Research Centre (ERC) (Mumbai), functions as one of seven Global Specialized Poliovirus Laboratories and performs genetic sequencing of all poliovirus isolates in India. The laboratories have sustained high levels of performance despite an increased workload (33,272 specimens from AFP cases tested in 2004, compared with 16,403 specimens in 2003). For 97% of specimens, results of primary virus isolation in 2004 were communicated to the program within 28 days of specimen receipt in the laboratory. The mean interval from receipt of primary culture results to receipt of ITD results was 8 days (range: 2–21 days).

WPV Incidence

India reported 134 polio cases with patient onset of paralysis in 2004, compared with 225 reported cases in 2003. Of the 134 cases, 127 (95%) had isolation of WPV type 1 (P1) and seven cases (5%) had isolation of WPV type 3 (P3). As of June 18, 2005, India had reported 18 polio cases with onset in 2005: eight from Bihar (most recent case with onset on May 8, Araria district), seven from Uttar Pradesh (most recent case with onset on April 19, Ferozabad district), and one each from the states of Delhi, Jharkhand, and Uttaranchal

(Figure 1). All 18 cases reported in 2005 were caused by P1; the most recent P3 case reported from India had onset in December 2004 in Rampur District, Uttar Pradesh.

All WPVs isolated in India are sequenced across the ~900-nucleotide interval encoding the major capsid protein (VP1) at ERC, and results are analyzed to determine the likely origin (by state and district) of the virus. The number of distinct genetic clusters[¶] of P1 decreased from 10 in 2003 to three in 2004 and two in 2005 (as of June 18). Only one P3 cluster was detected in 2004, with a single case in Bihar in January 2004; a distinct subcluster of lineages was detected in western Uttar Pradesh, including the most recent Indian P3 cases in December 2004.

Through weekly environmental sewage sampling in three urban wards of Mumbai, P1 was detected from late 2003 through most of 2004. During 2004, three P1 cases were reported from Mumbai and nearby districts, with onset on May 26 (Mumbai), July 10 (Thane district), and November 3 (Nasik district). As of June 18, no polio cases have been reported from Mumbai during 2005, but P1 was detected during April 2005 in environmental samples from two of the three sampled wards. Genetic sequencing of poliovirus isolates from sewage and cases in Mumbai and nearby districts indicate that all originated from Bihar or Uttar Pradesh.

Immunization Activities

Surveys indicate that routine vaccination coverage of infants with 3 doses of oral poliovirus vaccine (OPV), one of the four main polio eradication strategies, continues to be low in the remaining states where polio is endemic (Bihar: 21.1%; Uttar Pradesh: 41.4%). In April 2004, GOI, in partnership with WHO and UNICEF, initiated a strategic plan to strengthen routine childhood immunization in the polio-endemic districts of western Uttar Pradesh (Figure 2).

To sustain the impact of SIAs conducted in 2003, GOI conducted eight SIA rounds during 2004, including five nationwide rounds and three subnational rounds in states and districts in which WPV had been detected or that were at high risk for WPV circulation. During the first 5 months of 2005, four SIAs were conducted, including two national rounds and two subnational rounds in Mumbai and states with populations at high risk (Bihar, Delhi, Jharkhand, Uttaranchal, Uttar Pradesh, and West Bengal). During late 2004 and early 2005, additional personnel (from GOI, WHO, UNICEF, Rotary International, and the Child Survival Collaborations and Resources [CORE] group of private voluntary organizations)

[†]Two specimens collected ≥ 24 hours apart, both within 14 days of paralysis onset, and shipped on ice or frozen ice packs to a WHO-accredited laboratory.

[§]Includes eight regional coordinators, 21 subregional coordinators, and 265 district-level SMOs.

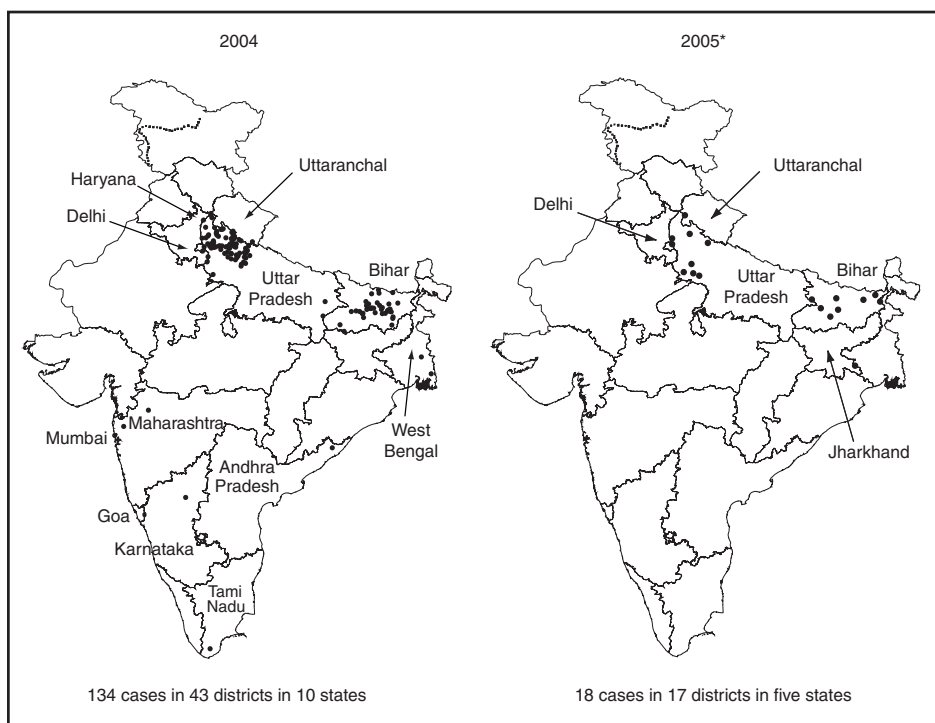
[¶]Isolates within a cluster share $\geq 95\%$ VP1 nucleotide sequence identity.

TABLE. Acute flaccid paralysis (AFP) surveillance data, by period — Uttar Pradesh and Bihar, India, January–May 2004 and January–May 2005*

Location	No. of AFP cases reported			Nonpolio AFP rate [†]			% of AFP cases with adequate specimen collection			No. of confirmed wild poliovirus cases		
	2004	Jan–May		2004	Jan–May		2004	Jan–May		2004	Jan–May	
		2004	2005		2004	2005		2004	2005		2004	2005
India	13,275	4,117	8,681	3.24	1.41	3.35	82	82	83	134	13	18
Uttar Pradesh	4,058	1,200	3,530	5.72	2.21	8.01	81	81	82	82	4	7
Bihar	2,189	572	1,548	6.15	2.05	6.97	78	77	83	39	4	8

* Year-to-date data reported to the World Health Organization as of June 19, 2004, for 2004 and as of June 18, 2005, for 2005.

[†] Per 100,000 population aged <15 years.

FIGURE 1. Laboratory-confirmed wild poliovirus cases — India, 2004 and 2005*

* As of June 18, 2005.

were deployed to assist in planning and implementing intensified SIAs in Bihar, Mumbai, and Uttar Pradesh. Increased emphasis was placed on developing communication and other strategies to target underserved population groups missed during previous SIAs. Mobile teams vaccinated children at major transit points (e.g., railway and bus stations) and on moving trains, resulting in vaccination of an additional 5 million children. External monitoring of the April 2005 SIA round indicated high coverage of populations in areas of high risk, with an estimated 5.6%, 3.6%, and 2.8% of children remaining unvaccinated in western Uttar Pradesh, Bihar, and Mumbai, respectively.

In December 2004, the India Expert Advisory Group recommended acceleration of the development and licensing of monovalent OPV type 1 (mOP1) for use in SIAs (4). One

dose of mOP1 elicits a stronger type 1–specific immune response, compared with 1 dose of trivalent OPV, for which the type 2 and 3 vaccine components interfere with the response to the type 1 component (5–7). In the absence of P2 (eliminated worldwide since 1999) and with P3 circulation in India localized and possibly eliminated, mOP1 is expected to optimize seroconversion among vaccine recipients.

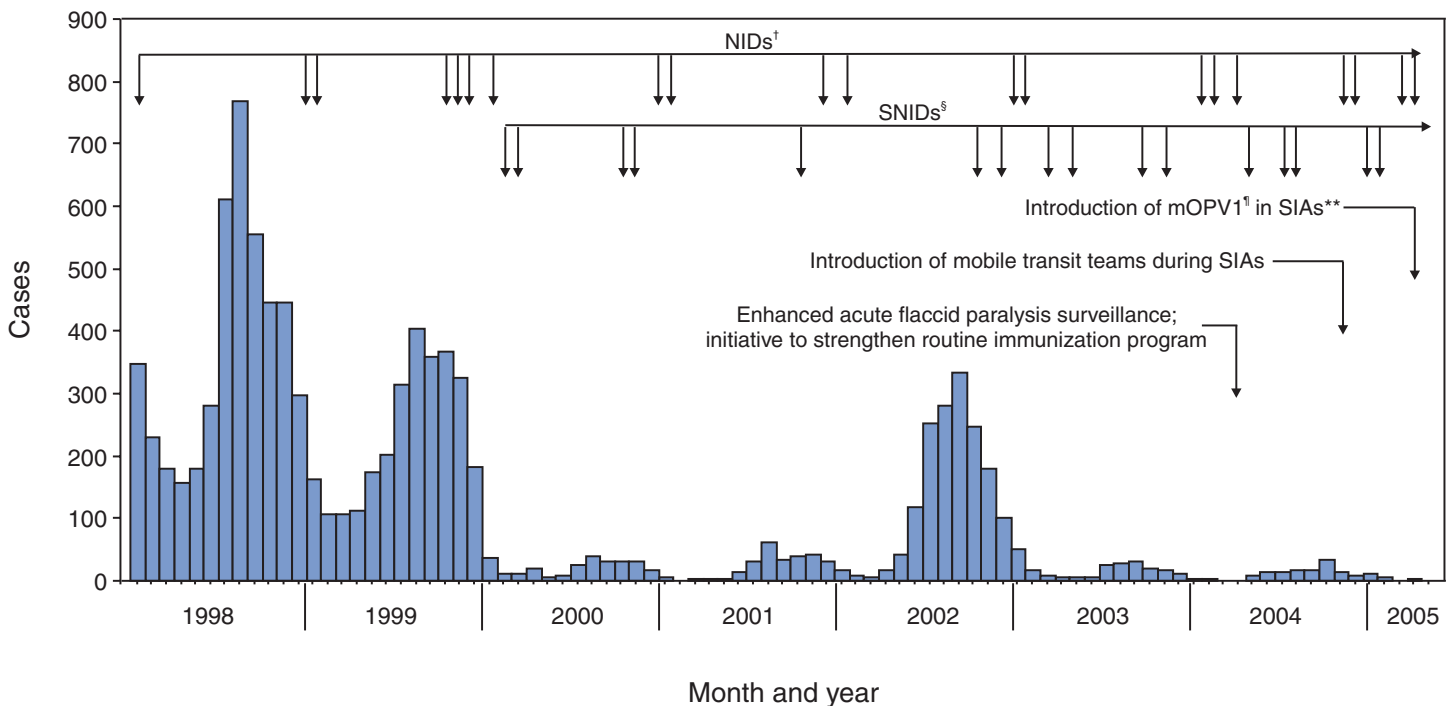
Through close cooperation among GOI, vaccine manufacturers, and partner agencies, mOP1 was developed, licensed, and used during the SIA rounds of April, May, and June 2005 in Bihar, Uttar Pradesh, Mumbai, Delhi, and certain districts of Uttaranchal. Trivalent OPV continues to be used in the routine childhood immunization program and in SIAs in states that are not at high risk for WPV circulation.

Reported by: Ministry of Health and Family Welfare, Government of India; National Polio Surveillance Project; Immunization and Vaccine Development Dept, WHO Regional Office for South-East Asia, New Delhi; Poliovirus Laboratory Network, Ahmedabad, Bangalore, Chennai, Coonoor, Kasauli, Kolkata, Lucknow, and Mumbai; UNICEF, New Delhi, India. Vaccines and Biologicals Dept, WHO, Geneva, Switzerland. Div of Viral and Rickettsial Diseases, National Center for Infectious Diseases; Global Immunization Div, National Immunization Program, CDC.

Editorial Note: The polio eradication program in India continues to improve, particularly in the states of Bihar and Uttar Pradesh, where poliovirus is endemic. The number of WPV cases declined from 225 in 2003 to 134 in 2004, the lowest incidence of polio in India since the polio eradication initiative began.

As of June 18, 2005, India reported 18 polio cases with paralysis onset dates during January–May 2005, compared with 13 cases reported for the same period in 2004. Despite this apparent increase, substantial evidence exists to indicate

FIGURE 2. Number of poliomyelitis cases, by month and year — India, January 1998–May 2005*



* As of June 18, 2005.

† National Immunization Days.

§ Subnational Immunization Days.

¶ Monovalent oral poliovirus vaccine type 1.

** Supplementary immunization activities.

continued restriction of WPV transmission. First, AFP surveillance sensitivity has improved substantially since mid-2004, particularly in Bihar and Uttar Pradesh. Second, genetic-sequencing data indicate that transmission is substantially restricted, with only two P1 genetic clusters circulating in 2005 (as of June 18). Third, P3 was last isolated in December 2004. Analysis of surveillance data through the remainder of 2005 will indicate whether P3 has been eliminated. Finally, the geographic distribution of P1 circulation has been less extensive during the first 5 months of 2005 compared with the same period in 2004, when cases were identified in the southern states of Karnataka and Tamil Nadu.

The polio laboratory network remains one of the strongest components of India's polio eradication program. The laboratories provided rapid results in 2004, even though more than twice as many specimens were tested that year as in 2003. Genetic data provided by ERC are being used to target efforts in the most critical areas. For example, during SIAs, vaccinators are now deployed along major train routes because genetic data and epidemiologic case investigations have identified routes of virus transmission across districts and states.

Throughout 2004 and the first 6 months of 2005, innovative strategies were used to increase the efficiency of SIAs. Through intensive cooperation among GOI and partner agencies, mOP1 was rapidly developed, licensed, and made available to the polio eradication program. Emphasis on community education that targets specific subpopulations and children in transit, as well as enhanced collaboration among all polio eradication partners, will help ensure that children in populations at highest risk are reached. Combining a more effective vaccine with improvements in its delivery increases the likelihood of interrupting WPV transmission.

The reduced number of polio cases, reduced genetic diversity and geographic spread of the virus, increased surveillance sensitivity, and improved SIA quality suggest that India will soon eliminate poliovirus. Success depends on the continued involvement of state and national governments, in collaboration with polio eradication partners.

References

1. CDC. Progress toward global eradication of poliomyelitis, 2002. *MMWR* 2002;52:366–9.
2. CDC. Progress toward poliomyelitis eradication—India, 2002. *MMWR* 2003;52:172–5.
3. CDC. Progress toward poliomyelitis eradication—India, 2003. *MMWR* 2004;53:238–41.

4. India Expert Advisory Group. Conclusions and recommendations: the Twelfth Meeting of the India Expert Advisory Group for Polio Eradication, New Delhi, India, 2–3 December 2004. New Delhi, India: National Polio Surveillance Project. Available at <http://www.npsindia.org/advisory.asp>.
5. John TJ, Devarajan LV, Balasubramanyan A. Immunization in India with trivalent and monovalent oral poliovirus vaccines of enhanced potency. *Bull World Health Organ* 1976;54:115–7.
6. Cáceres VM, Sutter RW. Sabin monovalent oral polio vaccines: review of past experiences and their potential use after polio eradication. *Clin Infect Dis* 2001;33:531–41.
7. Roberts L. Infectious disease. Polio eradication effort adds new weapon to its armory. *Science* 2005;307:190.

Notice to Readers

Epidemiology in Action Course

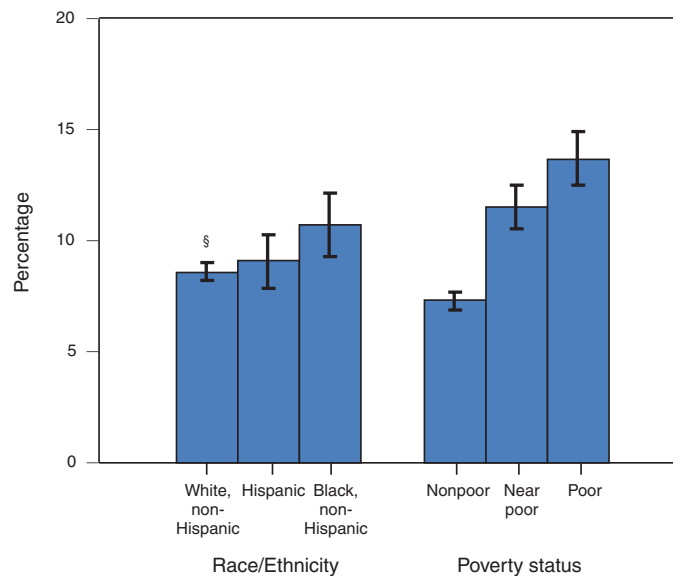
The Rollins School of Public Health at Emory University and CDC's Office of Workforce and Career Development will cosponsor the course, "Epidemiology in Action," October 31–November 11, 2005, at the Emory University campus. The course is designed for state and local public health professionals; tuition is charged.

The course emphasizes the practical application of epidemiology to public health problems and consists of lectures,

QuickStats

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Percentage* of Adults Who Reported Trouble Seeing, Even with Glasses or Contact Lenses, by Poverty Status† and Race/Ethnicity — United States, 2003



* Percentages are for the civilian, noninstitutionalized population and are age-adjusted to the 2000 U.S. standard population by using five age groups: 18–44 years, 45–54 years, 55–64 years, 65–74 years, and ≥75 years.

† Poor is defined as income <100% of the poverty threshold, near poor as 100%–199% of the poverty threshold, and nonpoor as ≥200% of the poverty threshold.

§ 95% confidence interval.

In 2003, poor adults aged ≥18 years were nearly twice as likely as nonpoor adults to report trouble seeing, even when wearing glasses or contact lenses. In addition, non-Hispanic black adults were more likely to report trouble seeing than non-Hispanic white adults.

Source: National Health Interview Survey, 2003. Available at <http://www.cdc.gov/nchs/nhis.htm>.

workshops, classroom exercises (including actual epidemiologic problems), and roundtable discussions. Topics include descriptive epidemiology and biostatistics, analytic epidemiology, epidemic investigations, public health surveillance, surveys and sampling, Epi Info (Windows version) training, and discussions of selected prevalent diseases.

Additional information and applications are available from Emory University, Department of Global Health, 1518 Clifton Road, N.E., Room 746, Atlanta, Georgia, 30322; telephone 404-727-3485; fax 404-727-4590; website <http://www.sph.emory.edu/epicourses>; e-mail pvaleri@sph.emory.edu.

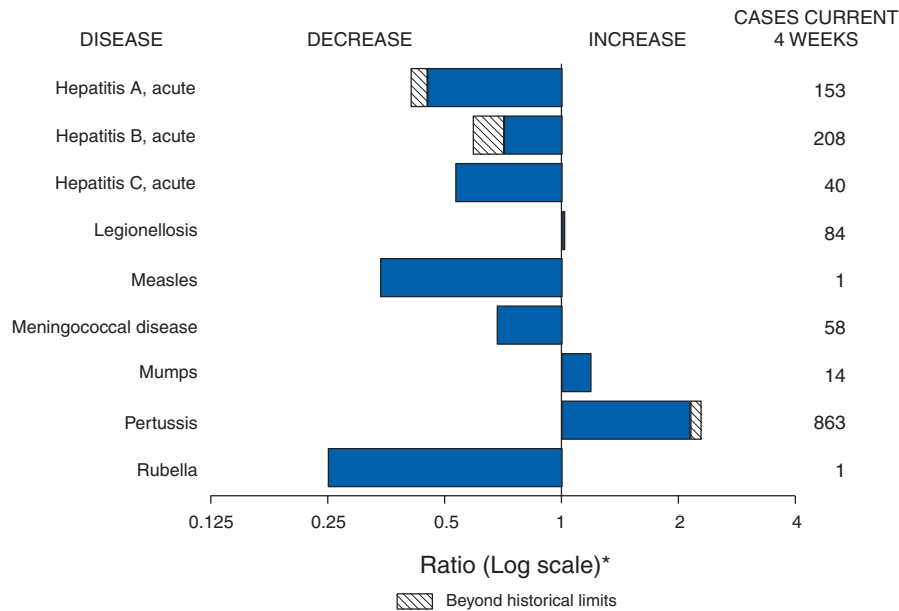
Notice to Readers

Enhanced CDC Public Health Image Library Available Online

The online CDC Public Health Image Library (PHIL) has been updated and enhanced with a new design and new functions; PHIL also has a new link to its website. PHIL contains approximately 7,000 free public health-related images, including high-resolution photographs, illustrations, and videos devoted to topics ranging from science, to public health, to CDC.

Most photos and illustrations are not copyrighted, although users should attribute CDC as the source where appropriate. Images are accessible by persons using both Windows and Macintosh operating systems. PHIL photos and illustrations are routinely used by health professionals, news media, and the general public to enhance news reports, health promotion brochures, manuscripts, classroom instruction, and presentations. PHIL is now available at <http://phil.cdc.gov/phil/home.asp>.

FIGURE I. Selected notifiable disease reports, United States, comparison of provisional 4-week totals July 2, 2005, with historical data



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

TABLE I. Summary of provisional cases of selected notifiable diseases, United States, cumulative, week ending July 2, 2005 (26th Week)*

Disease	Cum. 2005	Cum. 2004	Disease	Cum. 2005	Cum. 2004
Anthrax	—	—	Hemolytic uremic syndrome, postdiarrheal [†]	65	60
Botulism:			HIV infection, pediatric ^{†¶}	150	206
foodborne	5	6	Influenza-associated pediatric mortality ^{†**}	39	—
infant	29	38	Measles	21 ^{††}	19 ^{§§}
other (wound & unspecified)	11	5	Mumps	126	109
Brucellosis	46	47	Plague	2	—
Chancroid	12	24	Poliomyelitis, paralytic	—	—
Cholera	2	4	Psittacosis [†]	10	6
Cyclosporiosis [†]	563	108	Q fever [†]	50	34
Diphtheria	—	—	Rabies, human	1	—
Domestic arboviral diseases			Rubella	5	9
(neuroinvasive & non-neuroinvasive):			Rubella, congenital syndrome	1	—
California serogroup ^{†§}	—	18	SARS ^{†**}	—	—
eastern equine ^{†§}	—	—	Smallpox [†]	—	—
Powassan ^{†§}	—	1	<i>Staphylococcus aureus</i> :		
St. Louis ^{†§}	—	3	Vancomycin-intermediate (VISA) [†]	—	—
western equine ^{†§}	—	—	Vancomycin-resistant (VRSA) [†]	—	1
Ehrlichiosis:			Streptococcal toxic-shock syndrome [†]	79	89
human granulocytic (HGE) [†]	94	101	Tetanus	11	9
human monocytic (HME) [†]	68	69	Toxic-shock syndrome	51	45
human, other and unspecified [†]	18	12	Trichinellosis ^{¶¶}	7	—
Hansen disease [†]	36	50	Tularemia [†]	42	34
Hantavirus pulmonary syndrome [†]	8	8	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 May 29, 2005.

** Updated weekly from reports to the Division of Viral and Rickettsial Diseases, National Center for Infectious Diseases.

†† Of 21 cases reported, 13 were indigenous and eight were imported from another country.

§§ Of 19 cases reported, seven were indigenous and 12 were imported from another country.

¶¶ Formerly Trichinosis.

TABLE II. Provisional cases of selected notifiable diseases, United States, weeks ending July 2, 2005, and July 3, 2004 (26th 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	16,504	20,011	436,635	456,567	2,108	2,644	927	1,232
NEW ENGLAND	673	729	15,374	15,095	—	—	54	73
Maine	8	14	994	978	N	N	8	13
N.H.	10	26	882	825	—	—	7	16
Vt.¶	4	13	501	574	—	—	14	7
Mass.	331	234	7,174	6,648	—	—	18	26
R.I.	68	70	1,544	1,662	—	—	1	2
Conn.	252	372	4,279	4,408	N	N	6	9
MID. ATLANTIC	3,059	4,442	52,779	56,880	—	—	129	195
Upstate N.Y.	318	603	10,930	11,158	N	N	35	41
N.Y. City	1,725	2,328	17,997	17,683	—	—	31	60
N.J.	472	786	5,526	8,984	N	N	8	15
Pa.	544	725	18,326	19,055	N	N	55	79
E.N. CENTRAL	1,387	1,702	68,286	81,290	4	5	191	318
Ohio	209	229	19,187	20,879	N	N	71	71
Ind.	198	215	9,857	8,994	N	N	11	31
Ill.	664	846	19,605	23,253	—	—	12	49
Mich.	246	323	11,979	18,931	4	5	29	63
Wis.	70	89	7,658	9,233	N	N	68	104
W.N. CENTRAL	394	392	25,780	27,766	3	5	145	158
Minn.	104	92	4,067	5,857	3	N	42	57
Iowa	48	26	2,951	3,311	N	N	24	30
Mo.	163	169	11,145	10,115	—	3	55	23
N. Dak.	5	13	519	952	N	N	—	7
S. Dak.	9	6	1,377	1,208	—	—	12	20
Nebr.¶	18	21	2,545	2,603	—	2	1	9
Kans.	47	65	3,176	3,720	N	N	11	12
S. ATLANTIC	5,315	6,029	84,212	85,433	—	—	186	213
Del.	81	80	1,617	1,443	N	N	—	—
Md.	637	686	9,027	9,366	—	—	12	10
D.C.	407	355	1,872	1,796	—	—	2	4
Va.¶	273	330	9,713	10,789	—	—	14	24
W. Va.	30	30	1,294	1,389	N	N	4	3
N.C.	399	334	16,899	14,361	N	N	25	38
S.C.¶	287	375	9,964	9,001	—	—	7	11
Ga.	896	888	12,485	16,101	—	—	46	65
Fla.	2,305	2,951	21,341	21,187	N	N	76	58
E.S. CENTRAL	896	946	31,903	29,106	—	3	28	48
Ky.	118	106	4,941	2,769	N	N	10	16
Tenn.¶	369	386	10,978	11,196	N	N	6	13
Ala.¶	244	228	5,778	6,830	—	—	11	11
Miss.	165	226	10,206	8,311	—	3	1	8
W.S. CENTRAL	1,896	2,515	54,768	57,937	—	2	25	46
Ark.	71	125	4,361	4,107	—	1	1	8
La.	370	563	9,334	12,831	—	1	3	—
Okla.	113	87	5,224	5,546	N	N	13	11
Tex.¶	1,342	1,740	35,849	35,453	N	N	8	27
MOUNTAIN	643	717	25,939	25,580	1,378	1,611	59	55
Mont.	4	4	1,029	1,285	N	N	11	10
Idaho¶	7	11	1,112	1,433	N	N	4	5
Wyo.	1	6	558	533	2	—	2	2
Colo.	127	135	6,969	6,634	N	N	19	24
N. Mex.	60	106	1,945	4,375	3	12	2	3
Ariz.	258	278	9,428	7,072	1,340	1,558	6	8
Utah	33	31	1,919	1,752	2	8	7	2
Nev.¶	153	146	2,979	2,496	31	33	8	1
PACIFIC	2,241	2,539	77,594	77,480	723	1,018	110	126
Wash.	196	213	9,718	8,855	N	N	5	—
Oreg.¶	117	131	4,309	4,064	—	—	19	17
Calif.	1,865	2,135	59,415	59,820	723	1,018	86	107
Alaska	10	14	1,927	1,914	—	—	—	—
Hawaii	53	46	2,225	2,827	—	—	—	2
Guam	1	1	—	672	—	—	—	—
P.R.	335	208	2,089	1,902	N	N	N	N
V.I.	8	6	32	194	—	—	—	—
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 May 29, 2005.

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

TABLE II. (Continued) Provisional cases of selected notifiable diseases, United States, weeks ending July 2, 2005, and July 3, 2004 (26th Week)*

Reporting area	<i>Escherichia coli</i> , 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	661	778	92	120	76	65	7,109	8,022	145,952	158,196
NEW ENGLAND	51	56	25	29	8	7	648	744	2,945	3,514
Maine	9	2	5	—	—	—	77	66	61	130
N.H.	5	10	1	5	—	—	35	19	76	61
Vt.	6	6	1	—	—	—	74	61	26	44
Mass.	18	26	7	8	8	7	271	334	1,365	1,499
R.I.	2	5	—	1	—	—	40	54	242	428
Conn.	11	7	11	15	—	—	151	210	1,175	1,352
MID. ATLANTIC	79	100	6	17	8	14	1,364	1,767	15,051	18,131
Upstate N.Y.	36	42	5	6	3	6	476	546	3,073	3,657
N.Y. City	2	16	—	—	—	—	361	540	4,621	5,677
N.J.	14	17	—	4	—	4	171	232	2,066	3,384
Pa.	27	25	1	7	5	4	356	449	5,291	5,413
E.N. CENTRAL	121	161	8	21	4	8	1,053	1,200	27,168	33,489
Ohio	41	36	1	4	2	7	304	355	8,869	10,605
Ind.	21	17	—	—	—	—	N	N	3,864	3,097
Ill.	14	34	1	1	—	1	183	374	7,868	9,881
Mich.	27	35	—	4	2	—	319	281	4,539	7,601
Wis.	18	39	6	12	—	—	247	190	2,028	2,305
W.N. CENTRAL	101	138	19	17	10	14	853	889	8,244	8,194
Minn.	14	30	6	7	2	2	423	304	1,141	1,453
Iowa	26	41	—	—	—	—	97	121	643	592
Mo.	30	22	8	8	3	4	178	247	4,533	4,160
N. Dak.	1	4	—	—	—	5	1	13	29	64
S. Dak.	6	9	2	—	—	—	37	32	193	133
Nebr.	8	18	3	2	3	—	44	64	615	537
Kans.	16	14	—	—	2	3	73	108	1,090	1,255
S. ATLANTIC	87	68	12	11	35	10	1,037	1,260	35,325	37,874
Del.	—	1	N	N	N	N	16	25	394	461
Md.	16	17	2	2	—	2	74	46	3,335	3,967
D.C.	—	1	—	—	—	—	22	38	1,003	1,239
Va.	10	7	6	6	8	—	229	182	3,360	4,275
W. Va.	1	1	—	—	—	—	16	14	359	419
N.C.	—	—	—	—	19	6	N	N	7,877	7,617
S.C.	1	6	—	—	—	—	31	44	4,228	4,382
Ga.	13	15	2	1	—	—	234	405	5,411	6,864
Fla.	46	20	2	2	8	2	415	506	9,358	8,650
E.S. CENTRAL	37	46	—	3	5	8	171	176	11,938	12,559
Ky.	9	11	—	1	4	5	N	N	1,557	1,218
Tenn.	16	15	—	—	1	3	87	88	3,895	4,035
Ala.	11	12	—	—	—	—	84	88	3,368	3,986
Miss.	1	8	—	2	—	—	—	—	3,118	3,320
W.S. CENTRAL	22	41	3	2	3	4	112	129	21,659	21,781
Ark.	3	8	—	—	—	—	38	54	2,247	2,085
La.	3	2	3	—	2	—	17	22	5,033	5,822
Okla.	9	9	—	—	—	—	57	53	2,135	2,299
Tex.	7	22	—	2	1	4	N	N	12,244	11,575
MOUNTAIN	63	70	17	19	3	—	543	592	5,340	5,391
Mont.	4	3	—	—	—	—	22	19	56	48
Idaho	9	18	5	3	1	—	42	77	45	40
Wyo.	—	1	2	1	—	—	12	8	30	27
Colo.	15	18	1	1	1	—	202	197	1,407	1,562
N. Mex.	2	6	3	3	—	—	16	35	349	519
Ariz.	14	6	N	N	N	N	71	85	2,027	1,820
Utah	10	9	6	10	—	—	142	123	298	258
Nev.	9	9	—	1	1	—	36	48	1,128	1,117
PACIFIC	100	98	2	1	—	—	1,328	1,265	18,282	17,263
Wash.	25	30	—	—	—	—	120	124	1,780	1,340
Oreg.	25	12	2	1	—	—	117	192	760	537
Calif.	41	52	—	—	—	—	1,022	874	15,071	14,397
Alaska	6	1	—	—	—	—	36	32	263	312
Hawaii	3	3	—	—	—	—	33	43	408	677
Guam	N	N	—	—	—	—	—	2	—	109
P.R.	—	—	—	—	—	—	26	90	198	144
V.I.	—	—	—	—	—	—	—	—	2	64
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 July 2, 2005, and July 3, 2004 (26th Week)*

Reporting area	<i>Haemophilus influenzae</i> , 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	1,168	1,126	3	8	61	63	117	106
NEW ENGLAND	87	108	—	1	7	7	4	1
Maine	4	7	—	—	—	—	1	—
N.H.	4	13	—	—	—	2	—	—
Vt.	6	5	—	—	—	—	2	1
Mass.	38	54	—	1	2	2	1	—
R.I.	7	3	—	—	2	—	—	—
Conn.	28	26	—	—	3	3	—	—
MID. ATLANTIC	230	232	—	1	—	3	28	28
Upstate N.Y.	64	78	—	1	—	3	5	4
N.Y. City	42	49	—	—	—	—	9	9
N.J.	44	42	—	—	—	—	7	2
Pa.	80	63	—	—	—	—	7	13
E.N. CENTRAL	151	209	1	—	1	8	9	30
Ohio	80	66	—	—	—	2	7	10
Ind.	39	30	—	—	1	4	1	1
Ill.	13	67	—	—	—	—	1	15
Mich.	12	14	1	—	—	2	—	3
Wis.	7	32	—	—	—	—	—	1
W.N. CENTRAL	62	59	—	2	3	3	9	5
Minn.	21	27	—	1	3	3	—	—
Iowa	—	1	—	1	—	—	—	—
Mo.	30	20	—	—	—	—	7	4
N. Dak.	1	3	—	—	—	—	1	—
S. Dak.	—	—	—	—	—	—	—	—
Nebr.	5	2	—	—	—	—	1	—
Kans.	5	6	—	—	—	—	—	1
S. ATLANTIC	276	255	1	—	16	18	15	17
Del.	—	—	—	—	—	—	—	—
Md.	40	45	—	—	4	5	—	—
D.C.	—	2	—	—	—	—	—	1
Va.	26	21	—	—	—	—	—	1
W. Va.	15	10	—	—	1	3	3	—
N.C.	52	35	1	—	5	5	—	—
S.C.	10	7	—	—	—	—	1	1
Ga.	56	74	—	—	—	—	7	14
Fla.	77	61	—	—	6	5	4	—
E.S. CENTRAL	71	43	—	—	1	—	12	7
Ky.	6	3	—	—	1	—	1	—
Tenn.	49	29	—	—	—	—	7	5
Ala.	16	11	—	—	—	—	4	2
Miss.	—	—	—	—	—	—	—	—
W.S. CENTRAL	71	44	1	1	4	5	7	1
Ark.	4	1	—	—	—	—	1	—
La.	26	9	1	—	2	—	6	1
Okla.	41	33	—	—	2	5	—	—
Tex.	—	1	—	1	—	—	—	—
MOUNTAIN	161	123	—	3	16	14	26	12
Mont.	—	—	—	—	—	—	—	—
Idaho	3	5	—	—	—	—	1	2
Wyo.	3	—	—	—	—	—	1	—
Colo.	30	30	—	—	—	—	6	3
N. Mex.	13	25	—	—	4	4	1	4
Ariz.	88	44	—	—	10	6	9	1
Utah	11	9	—	2	—	1	6	1
Nev.	13	10	—	1	2	3	2	1
PACIFIC	59	53	—	—	13	5	7	5
Wash.	—	1	—	—	—	—	—	1
Oreg.	24	26	—	—	—	—	5	2
Calif.	26	17	—	—	13	5	1	1
Alaska	4	5	—	—	—	—	1	1
Hawaii	5	4	—	—	—	—	—	—
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 July 2, 2005, and July 3, 2004 (26th 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	1,811	2,873	2,753	2,884	386	354
NEW ENGLAND	248	413	149	186	7	7
Maine	1	8	8	1	—	—
N.H.	46	11	10	22	—	—
Vt.	3	7	2	2	7	1
Mass.	167	346	107	93	—	6
R.I.	5	10	1	3	—	—
Conn.	26	31	21	65	U	—
MID. ATLANTIC	293	352	574	378	51	65
Upstate N.Y.	50	41	46	37	12	3
N.Y. City	147	135	49	75	—	—
N.J.	47	80	371	103	—	—
Pa.	49	96	108	163	39	62
E.N. CENTRAL	175	231	186	269	67	41
Ohio	27	26	71	66	4	3
Ind.	22	24	15	16	15	3
Ill.	37	74	15	33	—	12
Mich.	75	83	85	130	48	23
Wis.	14	24	—	24	—	—
W.N. CENTRAL	57	81	186	178	25	6
Minn.	3	23	11	21	3	4
Iowa	17	25	64	11	—	—
Mo.	27	13	83	116	20	2
N. Dak.	—	1	—	2	1	—
S. Dak.	—	2	—	—	—	—
Nebr.	3	9	14	15	1	—
Kans.	7	8	14	13	—	—
S. ATLANTIC	263	519	719	930	128	90
Del.	1	5	34	25	59	4
Md.	27	66	89	81	17	2
D.C.	2	4	4	13	—	1
Va.	43	44	84	103	8	8
W. Va.	3	1	19	4	5	16
N.C.	38	34	86	91	9	6
S.C.	8	30	41	68	1	8
Ga.	45	194	95	279	4	7
Fla.	96	141	267	266	25	38
E.S. CENTRAL	117	89	182	237	44	38
Ky.	6	11	36	25	4	16
Tenn.	84	64	69	113	8	10
Ala.	14	6	40	39	8	2
Miss.	13	8	37	60	24	10
W.S. CENTRAL	105	389	180	137	18	56
Ark.	3	50	20	58	—	1
La.	35	20	27	28	8	3
Okla.	3	17	20	34	—	2
Tex.	64	302	113	17	10	50
MOUNTAIN	177	224	279	221	19	20
Mont.	7	4	3	1	—	2
Idaho	15	10	6	6	—	1
Wyo.	—	3	1	7	—	—
Colo.	20	22	24	23	9	4
N. Mex.	8	10	7	10	—	U
Ariz.	107	144	190	115	—	2
Utah	13	24	28	18	6	2
Nev.	7	7	20	41	4	9
PACIFIC	376	575	298	348	27	31
Wash.	22	31	37	26	7	9
Oreg.	26	40	46	58	9	9
Calif.	315	487	206	252	11	12
Alaska	3	3	6	8	—	—
Hawaii	10	14	3	4	—	1
Guam	—	1	—	10	—	8
P.R.	14	21	9	38	—	—
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.

* 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 July 2, 2005, and July 3, 2004 (26th 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	579	741	243	277	3,501	6,329	493	632
NEW ENGLAND	36	22	8	12	224	1,003	26	54
Maine	1	—	—	3	18	29	3	4
N.H.	4	—	1	1	31	49	3	—
Vt.	—	1	—	—	5	13	1	3
Mass.	22	14	4	3	112	633	17	32
R.I.	3	2	1	1	3	61	2	2
Conn.	6	5	2	4	55	218	—	13
MID. ATLANTIC	162	171	52	61	2,449	4,171	134	158
Upstate N.Y.	41	33	15	17	589	1,190	23	19
N.Y. City	18	20	9	10	—	137	61	78
N.J.	34	24	9	16	945	1,264	31	35
Pa.	69	94	19	18	915	1,580	19	26
E.N. CENTRAL	113	173	23	48	46	456	35	58
Ohio	57	81	10	16	30	22	11	13
Ind.	7	14	1	8	4	4	—	7
Ill.	12	23	—	9	—	47	9	18
Mich.	29	47	7	13	4	4	12	12
Wis.	8	8	5	2	8	379	3	8
W.N. CENTRAL	17	19	11	5	141	80	25	39
Minn.	1	1	2	1	112	39	11	18
Iowa	2	3	4	1	15	13	3	1
Mo.	9	10	2	2	12	20	10	10
N. Dak.	1	1	2	—	—	—	—	2
S. Dak.	2	1	—	—	—	—	—	1
Nebr.	—	1	—	1	—	6	—	2
Kans.	2	2	1	—	2	2	1	5
S. ATLANTIC	135	161	60	37	548	544	103	149
Del.	8	3	N	N	174	82	—	3
Md.	35	29	10	5	273	350	35	30
D.C.	2	7	—	—	3	2	3	8
Va.	12	14	5	5	40	26	11	12
W. Va.	5	3	2	1	3	2	1	—
N.C.	14	15	11	8	24	49	15	9
S.C.	2	6	1	1	7	5	3	7
Ga.	10	25	11	8	—	9	16	32
Fla.	47	59	20	9	24	19	19	48
E.S. CENTRAL	25	35	12	16	16	23	12	18
Ky.	7	9	1	4	1	11	3	1
Tenn.	10	14	6	7	15	9	6	3
Ala.	7	11	4	3	—	3	3	11
Miss.	1	1	1	2	—	—	—	3
W.S. CENTRAL	10	89	11	23	31	14	33	63
Ark.	1	—	—	2	2	2	2	6
La.	4	5	5	2	3	1	2	3
Okla.	2	2	—	—	—	—	2	2
Tex.	3	82	6	19	26	11	27	52
MOUNTAIN	49	40	3	12	3	5	26	22
Mont.	4	1	—	—	—	—	—	—
Idaho	1	4	—	1	1	2	—	1
Wyo.	3	4	—	—	—	2	1	—
Colo.	14	6	2	3	—	—	14	7
N. Mex.	1	1	—	—	—	—	—	1
Ariz.	14	10	—	—	—	1	5	5
Utah	5	11	—	1	2	—	4	5
Nev.	7	3	1	7	—	—	2	3
PACIFIC	32	31	63	63	43	33	99	71
Wash.	—	5	6	6	1	2	8	3
Oreg.	N	N	4	5	5	14	3	10
Calif.	32	26	53	51	36	17	80	55
Alaska	—	—	—	—	1	—	3	—
Hawaii	—	—	—	1	N	N	5	3
Guam	—	—	—	—	—	—	—	—
P.R.	—	—	—	—	N	N	1	—
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 July 2, 2005, and July 3, 2004 (26th 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	688	729	52	57	35	30	—	1	601	641
NEW ENGLAND	51	38	1	4	—	5	—	1	50	28
Maine	2	8	—	—	—	1	—	—	2	7
N.H.	8	3	—	—	—	—	—	—	8	3
Vt.	4	1	—	—	—	—	—	—	4	1
Mass.	25	22	—	4	—	4	—	—	25	14
R.I.	2	1	—	—	—	—	—	—	2	1
Conn.	10	3	1	—	—	—	—	1	9	2
MID. ATLANTIC	91	110	26	33	4	5	—	—	61	72
Upstate N.Y.	23	32	3	5	3	3	—	—	17	24
N.Y. City	12	19	—	—	—	—	—	—	12	19
N.J.	26	20	—	—	—	—	—	—	26	20
Pa.	30	39	23	28	1	2	—	—	6	9
E.N. CENTRAL	61	77	15	14	5	5	—	—	41	58
Ohio	28	41	—	3	5	4	—	—	23	34
Ind.	10	12	—	—	—	1	—	—	10	11
Ill.	3	1	—	—	—	—	—	—	3	1
Mich.	15	11	15	11	—	—	—	—	—	—
Wis.	5	12	—	—	—	—	—	—	5	12
W.N. CENTRAL	44	48	2	—	1	4	—	—	41	44
Minn.	6	14	1	—	—	—	—	—	5	14
Iowa	12	10	—	—	1	2	—	—	11	8
Mo.	15	14	1	—	—	1	—	—	14	13
N. Dak.	—	1	—	—	—	—	—	—	—	1
S. Dak.	2	2	—	—	—	1	—	—	2	1
Nebr.	3	2	—	—	—	—	—	—	3	2
Kans.	6	5	—	—	—	—	—	—	6	5
S. ATLANTIC	132	141	4	2	7	2	—	—	121	137
Del.	2	2	—	—	—	—	—	—	2	2
Md.	15	7	2	—	2	—	—	—	11	7
D.C.	—	5	—	2	—	—	—	—	—	3
Va.	16	9	—	—	—	—	—	—	16	9
W. Va.	5	4	1	—	—	—	—	—	4	4
N.C.	19	21	1	—	5	2	—	—	13	19
S.C.	11	13	—	—	—	—	—	—	11	13
Ga.	12	9	—	—	—	—	—	—	12	9
Fla.	52	71	—	—	—	—	—	—	52	71
E.S. CENTRAL	34	35	—	—	3	—	—	—	31	35
Ky.	11	4	—	—	3	—	—	—	8	4
Tenn.	15	11	—	—	—	—	—	—	15	11
Ala.	4	10	—	—	—	—	—	—	4	10
Miss.	4	10	—	—	—	—	—	—	4	10
W.S. CENTRAL	54	42	1	1	5	1	—	—	48	40
Ark.	9	10	—	—	—	—	—	—	9	10
La.	23	25	—	1	2	—	—	—	21	24
Okla.	12	4	1	—	3	1	—	—	8	3
Tex.	10	3	—	—	—	—	—	—	10	3
MOUNTAIN	59	41	2	1	5	4	—	—	52	36
Mont.	—	3	—	—	—	—	—	—	—	3
Idaho	1	4	—	—	—	—	—	—	1	4
Wyo.	—	3	—	—	—	—	—	—	—	3
Colo.	13	11	2	—	—	—	—	—	11	11
N. Mex.	1	6	—	1	—	3	—	—	1	2
Ariz.	32	6	—	—	2	—	—	—	30	6
Utah	7	3	—	—	2	—	—	—	5	3
Nev.	5	5	—	—	1	1	—	—	4	4
PACIFIC	162	197	1	2	5	4	—	—	156	191
Wash.	29	16	1	2	4	4	—	—	24	10
Oreg.	25	39	—	—	—	—	—	—	25	39
Calif.	99	135	—	—	—	—	—	—	99	135
Alaska	1	2	—	—	—	—	—	—	1	2
Hawaii	8	5	—	—	1	—	—	—	7	5
Guam	—	—	—	—	—	—	—	—	—	—
P.R.	4	9	—	—	—	—	—	—	4	9
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 July 2, 2005, and July 3, 2004 (26th 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	8,253	6,008	2,390	3,044	414	440	13,488	15,284	4,925	5,974
NEW ENGLAND	502	778	357	254	1	8	889	765	108	123
Maine	13	3	26	30	N	N	71	38	4	2
N.H.	25	25	7	10	—	—	78	48	4	5
Vt.	59	40	27	10	—	—	49	21	6	2
Mass.	374	669	210	103	—	7	474	457	64	78
R.I.	11	16	8	16	1	1	32	48	7	8
Conn.	20	25	79	85	—	—	185	153	23	28
MID. ATLANTIC	718	1,176	286	389	26	35	1,733	2,003	516	622
Upstate N.Y.	259	851	229	199	—	1	476	444	138	286
N.Y. City	44	77	14	9	1	12	389	576	200	182
N.J.	126	85	N	N	8	8	260	372	140	101
Pa.	289	163	43	181	17	14	608	611	38	53
E.N. CENTRAL	1,663	1,652	54	29	11	17	1,594	2,172	317	455
Ohio	663	217	25	9	8	6	509	504	36	79
Ind.	146	40	4	4	—	4	147	205	33	93
Ill.	190	328	15	9	1	6	274	720	55	173
Mich.	112	60	10	5	2	1	357	381	126	53
Wis.	552	1,007	—	2	—	—	307	362	67	57
W.N. CENTRAL	1,190	365	180	308	62	48	1,003	1,021	544	179
Minn.	337	72	37	25	—	—	254	246	31	24
Iowa	338	45	36	36	1	—	142	212	42	37
Mo.	223	195	31	13	58	42	330	275	393	76
N. Dak.	48	16	6	35	—	—	11	18	2	2
S. Dak.	1	11	27	63	2	—	63	45	16	6
Nebr.	113	5	—	67	—	6	73	64	30	7
Kans.	130	21	43	69	1	—	130	161	30	27
S. ATLANTIC	534	311	804	1,204	211	205	3,563	3,416	860	1,440
Del.	13	—	—	9	1	3	27	25	4	3
Md.	96	58	141	143	22	15	280	277	30	52
D.C.	4	6	—	—	—	—	20	18	8	21
Va.	91	81	280	228	9	7	364	357	43	54
W. Va.	28	5	20	32	3	1	59	68	—	—
N.C.	41	46	251	337	146	110	580	388	88	137
S.C.	161	50	5	79	6	22	161	274	35	268
Ga.	16	15	102	171	14	39	521	649	219	340
Fla.	84	50	5	205	10	8	1,551	1,360	433	565
E.S. CENTRAL	239	72	69	70	56	60	793	965	692	346
Ky.	65	11	7	12	—	—	142	145	114	36
Tenn.	115	39	21	23	44	33	280	267	379	160
Ala.	40	12	41	28	11	15	255	257	160	120
Miss.	19	10	—	7	1	12	116	296	39	30
W.S. CENTRAL	235	290	469	632	20	57	953	1,610	862	1,709
Ark.	132	20	19	27	12	26	291	205	30	28
La.	19	10	—	—	3	3	279	317	54	182
Okla.	—	17	53	72	5	27	154	143	382	255
Tex.	84	243	397	533	—	1	229	945	396	1,244
MOUNTAIN	2,047	534	105	60	22	7	888	970	286	366
Mont.	384	14	—	8	1	2	38	64	5	4
Idaho	66	18	—	—	1	1	53	70	2	6
Wyo.	19	3	12	—	1	1	21	22	—	1
Colo.	718	272	9	7	2	1	225	239	43	60
N. Mex.	62	75	—	2	—	1	62	105	31	67
Ariz.	566	107	81	43	13	1	287	289	161	189
Utah	205	35	—	—	4	—	132	101	19	18
Nev.	27	10	3	—	—	—	70	80	25	21
PACIFIC	1,125	830	66	98	5	3	2,072	2,362	740	734
Wash.	266	269	—	—	—	—	196	192	36	53
Oreg.	348	240	2	2	—	2	143	199	34	34
Calif.	431	301	63	85	5	1	1,577	1,756	650	618
Alaska	22	10	1	11	—	—	24	31	6	5
Hawaii	58	10	—	—	—	—	132	184	14	24
Guam	—	—	—	—	—	—	—	44	—	34
P.R.	1	—	32	28	N	N	86	169	1	12
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 July 2, 2005, and July 3, 2004 (26th 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	2,445	2,793	1,344	1,343	469	457	3,615	3,795	114	202
NEW ENGLAND	95	198	15	80	49	67	110	102	—	—
Maine	5	6	N	N	—	2	1	2	—	—
N.H.	8	15	—	—	3	N	6	3	—	—
Vt.	9	8	9	6	3	1	—	—	—	—
Mass.	66	90	—	22	43	39	80	60	—	—
R.I.	7	17	6	7	—	5	2	15	—	—
Conn.	—	62	U	45	U	20	21	22	—	—
MID. ATLANTIC	569	492	135	103	92	67	477	491	10	22
Upstate N.Y.	183	159	52	46	43	45	35	42	4	1
N.Y. City	98	76	U	U	17	U	310	294	5	9
N.J.	116	107	N	N	14	5	63	87	1	11
Pa.	172	150	83	57	18	17	69	68	—	1
E.N. CENTRAL	471	646	358	311	122	113	336	452	19	27
Ohio	124	156	233	225	53	55	108	121	2	1
Ind.	52	70	118	86	31	22	34	30	1	1
Ill.	100	178	7	—	34	1	148	177	5	3
Mich.	187	188	—	N	—	N	36	104	9	22
Wis.	8	54	N	N	4	35	10	20	2	—
W.N. CENTRAL	160	197	32	13	51	50	121	94	1	3
Minn.	60	96	—	—	29	31	30	16	—	1
Iowa	N	N	N	N	—	N	1	4	—	—
Mo.	47	42	27	10	5	8	75	53	1	1
N. Dak.	2	9	—	—	1	2	—	—	—	—
S. Dak.	16	8	3	3	—	—	—	—	—	—
Nebr.	12	14	2	—	6	5	3	5	—	—
Kans.	23	28	N	N	10	4	12	16	—	1
S. ATLANTIC	502	548	549	689	55	32	924	920	24	36
Del.	—	3	1	4	—	N	6	3	—	1
Md.	124	84	—	—	36	20	171	173	8	5
D.C.	6	5	14	5	2	4	60	30	—	1
Va.	44	42	N	N	—	N	50	49	3	1
W. Va.	12	16	73	75	17	8	2	3	—	—
N.C.	79	82	N	N	U	U	119	81	7	4
S.C.	11	46	—	77	—	N	30	63	1	9
Ga.	86	138	109	165	—	N	121	157	—	2
Fla.	140	132	352	363	—	N	365	361	5	13
E.S. CENTRAL	110	143	118	90	5	9	209	206	13	9
Ky.	23	45	21	20	N	N	17	24	—	1
Tenn.	87	98	97	68	—	N	92	71	9	1
Ala.	—	—	—	—	—	N	82	88	3	5
Miss.	—	—	—	2	5	9	18	23	1	2
W.S. CENTRAL	99	210	89	42	56	91	603	591	29	41
Ark.	10	8	12	6	13	7	28	23	—	3
La.	6	2	77	36	18	21	123	136	3	3
Okla.	69	42	N	N	16	27	21	17	1	2
Tex.	14	158	N	N	9	36	431	415	25	33
MOUNTAIN	386	311	48	14	33	28	184	198	14	27
Mont.	—	—	—	—	—	—	5	1	—	—
Idaho	1	5	N	N	—	N	18	13	1	2
Wyo.	2	6	20	5	—	—	—	1	—	—
Colo.	144	61	N	N	32	28	20	37	—	—
N. Mex.	23	68	—	N	—	—	23	52	1	2
Ariz.	167	146	N	N	—	N	69	80	12	23
Utah	48	24	27	7	1	—	4	3	—	—
Nev.	1	1	1	2	—	—	45	11	—	—
PACIFIC	53	48	—	1	6	—	651	741	4	37
Wash.	N	N	N	N	N	N	64	52	—	—
Oreg.	N	N	N	N	5	N	16	18	—	—
Calif.	—	—	N	N	N	N	565	668	4	37
Alaska	—	—	—	—	—	N	4	—	—	—
Hawaii	53	48	—	1	1	—	2	3	—	—
Guam	—	—	—	—	—	—	—	1	—	—
P.R.	N	N	N	N	—	N	102	72	6	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 July 2, 2005, and July 3, 2004 (26th Week)*

Reporting area	Tuberculosis		Typhoid fever		Varicella (chickenpox)		West Nile virus disease†		
	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Cum. 2005	Cum. 2004	Neuroinvasive		Non-neuroinvasive‡
							Cum. 2005	Cum. 2004	Cum. 2005
UNITED STATES	4,599	6,293	98	135	13,037	12,514	6	159	6
NEW ENGLAND	152	206	11	14	935	1,806	—	—	—
Maine	8	11	1	—	206	177	—	—	—
N.H.	4	7	—	—	159	—	—	—	—
Vt.	—	—	—	—	32	403	—	—	—
Mass.	103	118	7	12	538	49	—	—	—
R.I.	14	25	—	1	—	—	—	—	—
Conn.	23	45	3	1	U	1,177	—	—	—
MID. ATLANTIC	967	960	26	35	2,861	59	—	3	—
Upstate N.Y.	121	119	5	2	—	—	—	—	—
N.Y. City	500	493	6	13	—	—	—	2	—
N.J.	221	204	8	11	—	—	—	—	—
Pa.	125	144	7	9	2,861	59	—	1	—
E.N. CENTRAL	617	552	5	15	3,845	3,952	1	1	—
Ohio	129	98	—	3	867	995	—	—	—
Ind.	64	68	—	—	120	N	1	—	—
Ill.	283	244	1	7	24	1	—	—	—
Mich.	103	104	2	4	2,579	2,478	—	1	—
Wis.	38	38	2	1	255	478	—	—	—
W.N. CENTRAL	213	227	2	3	205	129	2	4	3
Minn.	88	82	2	2	—	—	—	—	—
Iowa	17	19	—	—	N	N	—	2	—
Mo.	59	65	—	1	131	2	1	1	—
N. Dak.	2	3	—	—	10	72	—	—	—
S. Dak.	6	5	—	—	64	55	1	—	3
Nebr.	13	16	—	—	—	—	—	—	—
Kans.	28	37	—	—	—	—	—	1	N
S. ATLANTIC	1,018	1,280	13	16	1,049	1,474	—	4	—
Del.	2	13	—	—	10	4	—	—	—
Md.	119	122	3	5	—	—	—	—	—
D.C.	28	4	—	—	18	18	—	—	—
Va.	130	102	3	3	209	343	—	—	—
W. Va.	12	12	—	—	635	826	—	—	N
N.C.	101	132	2	3	—	N	—	—	—
S.C.	100	104	—	—	177	283	—	—	—
Ga.	151	320	2	2	—	—	—	—	—
Fla.	375	471	3	3	—	—	—	4	—
E.S. CENTRAL	251	283	1	6	—	—	—	3	—
Ky.	52	51	1	2	N	N	—	—	—
Tenn.	106	100	—	4	—	—	—	—	—
Ala.	93	99	—	—	—	—	—	2	—
Miss.	—	33	—	—	—	—	—	1	—
W.S. CENTRAL	429	1,042	3	10	2,505	3,599	1	5	—
Ark.	49	63	—	—	—	—	—	1	—
La.	—	—	—	—	101	46	—	—	—
Okla.	70	79	—	—	—	—	—	—	—
Tex.	310	900	3	10	2,404	3,553	1	4	—
MOUNTAIN	158	261	3	6	1,637	1,495	1	118	2
Mont.	6	4	—	—	—	—	—	—	—
Idaho	—	—	—	—	—	—	—	—	—
Wyo.	—	1	—	—	43	22	—	—	—
Colo.	27	66	—	1	1,168	1,178	—	4	—
N. Mex.	8	19	—	—	97	U	1	—	1
Ariz.	104	106	1	2	—	—	—	113	1
Utah	13	20	1	1	329	295	—	—	—
Nev.	—	45	1	2	—	—	—	1	—
PACIFIC	794	1,482	34	30	—	—	1	21	1
Wash.	109	116	2	2	N	N	—	—	—
Oreg.	51	41	2	—	—	—	—	—	—
Calif.	564	1,257	24	22	—	—	1	21	1
Alaska	14	15	—	—	—	—	—	—	—
Hawaii	56	53	6	6	—	—	—	—	—
Guam	—	36	—	—	—	85	—	—	—
P.R.	—	49	—	—	106	247	—	—	—
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 July 2, 2005 (26th Week)

Reporting Area	All causes, by age (years)							P&I [†] Total	Reporting Area	All causes, by age (years)							P&I [†] Total
	All Ages	≥65	45-64	25-44	1-24	<1	All Ages			≥65	45-64	25-44	1-24	<1			
NEW ENGLAND	519	352	108	34	12	13	38	S. ATLANTIC	1,089	662	275	98	24	29	56		
Boston, Mass.	128	80	35	6	4	3	5	Atlanta, Ga.	132	79	39	7	2	5	1		
Bridgeport, Conn.	32	19	6	5	2	—	6	Baltimore, Md.	113	65	29	12	4	3	9		
Cambridge, Mass.	16	11	5	—	—	—	3	Charlotte, N.C.	102	63	21	15	—	3	9		
Fall River, Mass.	27	22	4	1	—	—	2	Jacksonville, Fla.	145	83	43	14	1	4	3		
Hartford, Conn.	63	42	13	5	1	2	5	Miami, Fla.	94	59	20	10	3	2	5		
Lowell, Mass.	25	19	5	1	—	—	—	Norfolk, Va.	44	28	5	4	3	4	3		
Lynn, Mass.	15	8	3	4	—	—	3	Richmond, Va.	50	27	16	3	1	3	5		
New Bedford, Mass.	37	29	7	—	—	1	6	Savannah, Ga.	67	37	24	2	3	1	1		
New Haven, Conn.	U	U	U	U	U	U	U	St. Petersburg, Fla.	64	43	15	5	—	1	3		
Providence, R.I.	59	36	14	3	3	3	—	Tampa, Fla.	153	107	29	12	3	2	12		
Somerville, Mass.	4	2	1	1	—	—	—	Washington, D.C.	99	55	26	12	4	1	3		
Springfield, Mass.	35	26	6	3	—	—	1	Wilmington, Del.	26	16	8	2	—	—	2		
Waterbury, Conn.	25	22	1	1	—	1	—	E.S. CENTRAL	830	555	194	42	20	19	58		
Worcester, Mass.	53	36	8	4	2	3	7	Birmingham, Ala.	153	109	27	8	4	5	18		
MID. ATLANTIC	1,937	1,312	426	121	39	35	103	Chattanooga, Tenn.	81	56	20	3	1	1	6		
Albany, N.Y.	47	29	15	1	—	2	3	Knoxville, Tenn.	98	53	30	7	5	3	4		
Allentown, Pa.	23	20	2	1	—	—	2	Lexington, Ky.	79	60	12	3	1	3	7		
Buffalo, N.Y.	68	39	21	4	4	—	2	Memphis, Tenn.	117	68	36	8	1	4	5		
Camden, N.J.	14	9	2	2	—	1	—	Mobile, Ala.	121	70	42	5	2	2	5		
Elizabeth, N.J.	14	11	2	1	—	—	1	Montgomery, Ala.	56	46	8	1	1	—	4		
Erie, Pa.	36	22	9	4	1	—	1	Nashville, Tenn.	125	93	19	7	5	1	9		
Jersey City, N.J.	39	24	14	—	1	—	—	W.S. CENTRAL	1,440	895	369	96	43	37	67		
New York City, N.Y.	1,012	692	222	59	16	19	53	Austin, Tex.	87	59	21	4	—	3	6		
Newark, N.J.	60	25	17	10	4	4	—	Baton Rouge, La.	44	28	15	—	—	1	—		
Paterson, N.J.	13	7	3	3	—	—	—	Corpus Christi, Tex.	U	U	U	U	U	U	U		
Philadelphia, Pa.	239	164	49	13	8	5	14	Dallas, Tex.	187	110	51	9	6	11	4		
Pittsburgh, Pa. [‡]	22	13	8	1	—	—	2	El Paso, Tex.	79	59	14	2	4	—	3		
Reading, Pa.	21	13	6	1	1	—	—	Ft. Worth, Tex.	126	74	37	5	3	7	2		
Rochester, N.Y.	126	85	29	10	1	1	15	Houston, Tex.	345	203	83	38	13	8	20		
Schenectady, N.Y.	25	19	5	1	—	—	1	Little Rock, Ark.	67	40	19	5	2	1	1		
Scranton, Pa.	30	22	4	4	—	—	2	New Orleans, La.	68	42	15	7	3	1	2		
Syracuse, N.Y.	87	71	11	2	2	1	6	San Antonio, Tex.	249	156	66	14	10	3	20		
Trenton, N.J.	28	21	4	3	—	—	1	Shreveport, La.	72	47	20	2	1	2	4		
Utica, N.Y.	13	9	1	1	1	1	—	Tulsa, Okla.	116	77	28	10	1	—	5		
Yonkers, N.Y.	20	17	2	—	—	1	—	MOUNTAIN	923	578	213	73	30	28	62		
E.N. CENTRAL	1,903	1,260	427	126	47	42	98	Albuquerque, N.M.	118	75	25	13	3	2	10		
Akron, Ohio	46	31	10	1	1	3	5	Boise, Idaho	42	27	14	—	—	1	1		
Canton, Ohio	34	28	5	1	—	—	1	Colo. Springs, Colo.	57	43	8	1	4	1	4		
Chicago, Ill.	245	156	56	20	4	8	17	Denver, Colo.	101	56	27	13	—	5	6		
Cincinnati, Ohio	81	51	20	6	4	—	7	Las Vegas, Nev.	282	174	69	25	8	6	15		
Cleveland, Ohio	220	153	48	12	5	2	3	Ogden, Utah	20	11	6	3	—	—	2		
Columbus, Ohio	175	108	43	16	4	4	9	Phoenix, Ariz.	173	93	41	16	11	11	11		
Dayton, Ohio	115	82	23	8	1	1	5	Pueblo, Colo.	36	29	5	—	2	—	5		
Detroit, Mich.	172	87	59	16	8	2	2	Salt Lake City, Utah	94	70	18	2	2	2	8		
Evansville, Ind.	58	44	10	1	3	—	1	Tucson, Ariz.	U	U	U	U	U	U	U		
Fort Wayne, Ind.	56	40	12	3	—	1	5	PACIFIC	1,663	1,126	378	97	41	21	133		
Gary, Ind.	20	11	7	1	1	—	1	Berkeley, Calif.	15	13	2	—	—	—	1		
Grand Rapids, Mich.	82	57	15	4	2	4	9	Fresno, Calif.	93	62	22	5	3	1	6		
Indianapolis, Ind.	193	120	40	16	7	10	10	Glendale, Calif.	18	17	1	—	—	—	2		
Lansing, Mich.	45	33	10	2	—	—	3	Honolulu, Hawaii	73	56	11	5	—	1	5		
Milwaukee, Wis.	86	59	19	6	1	1	3	Long Beach, Calif.	64	41	16	4	2	1	6		
Peoria, Ill.	35	22	9	3	1	—	4	Los Angeles, Calif.	328	218	76	20	12	2	46		
Rockford, Ill.	57	39	13	1	3	1	4	Pasadena, Calif.	17	15	2	—	—	—	2		
South Bend, Ind.	47	33	8	4	—	2	—	Portland, Oreg.	117	84	22	10	—	1	6		
Toledo, Ohio	84	63	14	3	2	2	3	Sacramento, Calif.	191	127	43	12	8	1	—		
Youngstown, Ohio	52	43	6	2	—	1	6	San Diego, Calif.	131	80	38	9	3	1	14		
W.N. CENTRAL	461	292	114	26	13	16	32	San Francisco, Calif.	125	82	32	11	—	—	11		
Des Moines, Iowa	37	22	8	6	—	1	3	San Jose, Calif.	173	116	41	6	3	7	12		
Duluth, Minn.	U	U	U	U	U	U	U	Santa Cruz, Calif.	37	30	6	—	1	—	2		
Kansas City, Kans.	29	16	7	5	1	—	1	Seattle, Wash.	128	76	32	10	5	5	5		
Kansas City, Mo.	100	66	21	5	4	4	10	Spokane, Wash.	63	40	19	3	1	—	10		
Lincoln, Nebr.	40	28	8	2	2	—	3	Tacoma, Wash.	90	69	15	2	3	1	5		
Minneapolis, Minn.	U	U	U	U	U	U	U	TOTAL	10,765 [§]	7,032	2,504	713	269	240	647		
Omaha, Nebr.	81	52	24	1	2	2	6										
St. Louis, Mo.	73	45	19	2	1	6	7										
St. Paul, Minn.	U	U	U	U	U	U	U										
Wichita, Kans.	101	63	27	5	3	3	2										

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.

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

Data in the weekly *MMWR* are provisional, based on weekly reports to CDC by state health departments. The reporting week concludes at close of business on Friday; compiled data on a national basis are officially released to the public on the following Friday. Address inquiries about the *MMWR* Series, including material to be considered for publication, to Editor, *MMWR* Series, Mailstop K-95, CDC, 1600 Clifton Rd., N.E., Atlanta, GA 30333; telephone 888-232-3228.

All material in the *MMWR* Series is in the public domain and may be used and reprinted without permission; citation as to source, however, is appreciated.

All *MMWR* references are available on the Internet at <http://www.cdc.gov/mmwr>. Use the search function to find specific articles.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

References to non-CDC sites on the Internet are provided as a service to *MMWR* readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in *MMWR* were current as of the date of publication.