Poliovirus — Continued

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

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

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

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

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

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

First Quarter Reports, 1997

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

Annual Reports, 1996

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Characteristics of Community Report Cards — United States, 1996

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

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

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

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MORBIDITY AND MORTALITY WEEKLY REPORT

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

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

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

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