

Appendix A: Profile Data Sources

AIDS Surveillance

Overview: AIDS is a reportable condition in all states and territories. AIDS cases have been reportable since the early 1980s and cases have been defined according to the CDC case definition. In Ohio, physicians are required to report diagnoses of AIDS. In addition, reporting laws were expanded in 2002 to include laboratory and physician reporting of CD4 T-lymphocyte cell counts of less than 200 or 14 percent. The AIDS surveillance system was established to monitor incidence of the disease and the demographic profile of the AIDS cases; describe the modes of HIV transmission among persons diagnosed with AIDS; guide the development and implementation of public health intervention and prevention programs; and to assist in the evaluation of the efficacy of public health interventions. AIDS surveillance data are also used to allocate resources for Part A and B of the RWHATMA.

State and local health departments actively solicit disease reports from health care providers and laboratories. Standardized case reports are used; these forms are used to collect socio-demographic information, mode of transmission, laboratory and clinical information, vital status and referrals for treatment services.

Population: All persons who meet the 1993 CDC AIDS Surveillance Case definition.

Strengths: Surveillance data is the only source of AIDS information that is available in all areas (states), these data reflect the impact of AIDS on a community and trends of the epidemic in a community. AIDS surveillance has been determined to be more than 85 percent complete. The data include all demographic groups (age, race/ethnicity, sex).

Limitations: Due to the long and variable period from infection to the development of AIDS, trends in AIDS surveillance do not represent recent HIV infections. Asymptomatic HIV-infected persons are also not represented by AIDS case data. In addition, incomplete HIV or CD4+ t-cell testing may interfere with the representativeness of reporting. Further, widespread use of HAART complicates the interpretation of AIDS case surveillance data and estimation of the HIV/AIDS epidemic in an area. Newly reported AIDS cases may reflect treatment failures or the failure of the health care system to halt progression of HIV infection to AIDS. AIDS cases represent late-stage HIV infections.

Behavioral Risk Factor Surveillance System

Overview: The BRFSS is a state-based, random digit-dialed telephone survey that monitors state-level prevalence of the major behavioral risks among adults associated with premature morbidity and mortality. Each month, a sample of households is contacted and one person in the household who is 18 years or older is randomly selected for an interview. Multiple attempts are made to contact the sampled household. A Spanish translation of the interview is available. Respondents to the BRFSS questionnaire are asked a variety of questions about their personal health behaviors and health experiences. Since 1994, the BRFSS questionnaire has asked questions related to HIV/AIDS of respondents aged 18 to 49 years. These questions include: perceived risk of getting an HIV infection; use of HIV testing; reasons for testing; if tested, the type of place where tested; receipt of post-HIV test counseling; attitudes toward condoms; and

attitudes about when to initiate HIV/AIDS education in school. As of 2001, respondents have been asked about their perception of the importance of HIV testing.

Population: All non-institutionalized adults, 18 years and older who reside in a household with a telephone.

Strengths: Data from the BRFSS survey are population-based; thus, estimates about testing attitudes and practices can be generalized to the adult population of a state. Information collected from the BRFSS survey may be useful for planning community-wide education programs.

Limitations: BRFSS data are self-reported; thus the information may be subject to recall bias. BRFSS respondents are contacted by telephone; thus the data are not representative of households without a telephone. In addition, BRFSS data are representative of the general, non-institutionalized adult population in an area, not just persons at highest risk for HIV/AIDS. The extent of HIV behavioral risk information collected by the BRFSS questionnaire is limited and inferences can be made only at the state level.

HIV Counseling, Testing and Referral Service

Overview: All states, territories and select cities receive funding to support HIV counseling, testing and referral programs as part of the HIV prevention cooperative agreements they have entered into with CDC. To monitor these programs, the CTR collects information to quantify and characterize counseling and testing services delivered at CDC-funded testing sites. Data captured include demographic, insurance, risk information, testing information (testing history, test result). Personal identifying information is not collected.

Population: All clients who receive confidential or anonymous HIV counseling and testing services at a counseling and testing site funded through a CDC cooperative agreement.

Strengths: Standardized data on clients who are tested for HIV are available at the local level. Data may offer insights into HIV infection rates in an area's high-risk population. CTR testing data may highlight the impact of a prevention program upon the populations being targeted.

Limitations: In most areas, the CTR collects test-based, rather than person-based, data and collects information only from persons who seek counseling and testing services at a CDC-funded site. Population estimation of HIV seroprevalence is not possible with CTR data because data are test-based. In test-based systems, it is not possible to distinguish individuals who have tested multiple times; however, a 'previous HIV test' variable is available on the client abstract form to quantify prior testing. Because the CTR system gathers data on HIV testing or program activities, changing testing patterns may reflect changing program priorities rather than testing patterns of individuals.

HIV Surveillance

Overview: CDC and other professional organizations have recommended reporting of HIV infections to local health authorities as an integral part of AIDS surveillance since HIV was identified and a test for HIV was licensed. As part of ongoing active HIV surveillance, health

departments educate providers on their reporting responsibilities, establish liaisons with laboratories conducting CD4+ lymphocyte cell analysis and EIA and Western Blot testing and follow up upon HIV cases of epidemiologic importance.

Ohio law requires physicians to report diagnoses of HIV infection, perinatal transmission to HIV and subsequent seroreversion. Laboratories are required to report lab finding indicating HIV infection. In addition, laboratories are required to report a CD4+ T lymphocyte count below 200 cells per microliter or a CD4+ T lymphocyte percentage of less than 14 when HIV infection has not been ruled out as the cause.

Population: All persons who test positive for HIV.

Strengths: HIV surveillance data represent more recent infection, compared with AIDS surveillance data. Based upon state evaluations, HIV infection reporting is estimated to be more than 85 percent complete for persons who have tested positive for HIV. HIV surveillance provides a minimum estimate of the number of persons known to be HIV infected and reported to the health department, may identify emerging patterns of transmission and can be used to detect trends in HIV infections among populations of particular interest (e.g. children, adolescents, women) that may not be evident from AIDS surveillance. HIV surveillance provides the basis for establishing and evaluating linkages to prevention and early intervention services and can be used to anticipate unmet needs for HIV care.

Limitations: HIV surveillance data may underestimate the level of recently infected persons because some infected persons either do not know they are infected or have not sought testing. Persons who have tested positive in an anonymous test site and have not sought medical care, where they would be confidentially tested, are not eligible to be reported to the surveillance system. HIV surveillance data represent infections in jurisdictions where reporting laws for HIV are in place. Reporting of behavioral risk information may not be complete.

National Household Survey of Drug Abuse

Overview: The NHSDA is an ongoing source of statistical information on the use of illicit drugs by the U.S. civilian population aged 12 or older. The survey collects data by administering questionnaires to a representative sample of the population through face-to-face, computer-assisted interviewing (CAI) method at their place of residence. Information captured by the NHSDA questionnaire includes use of cocaine; receipt of treatment for illicit drugs and need of treatment for illicit drugs during the past year; use of alcohol, tobacco or marijuana during the past month; and past month perceived risk of binge drinking, marijuana use or smoking during the past month.

The NHSDA employed a 50-state sampling design; for the eight states with the largest populations, the sampling design provides the sample large enough to support direct state estimates. Youths and young adults were over-sampled so that each state's sample was approximately equally distributed among three major age groups: 12-17 years, 18-25 years and 26 years or older.

Population: Noninstitutionalized, civilian U.S. population ages 12 years or older.

Strengths: National standardized survey of drug use behaviors among the general population. To increase the level of honest reporting, since 1999 information has been collected using a

combination of CAI methods to provide respondents with highly private and confidential means of responding to questions about substance use and other sensitive behaviors.

Limitations: NHSDA estimates represent behaviors in the general population; thus the survey may underestimate the level of substance use in the population at highest risk for HIV. Further, data from the NHSDA are self reported and are subject to recall bias and may under-report the level of a sensitive behavior.

Ohio Family Health Survey

Overview: The OFHS was originally conducted in 1998 by ODH to provide data on health issues in Ohio. In 2003, the Ohio Department of Job and Family Services (ODJFS) with participation from ODH and research partners including the Health Policy Institute of Ohio, the Cuyahoga County DJFS, the Center for Community Solutions, the Franklin County DJFS, assumed responsibility for conducting the survey.

Strengths: The survey was stratified to represent households in the 88 counties to obtain accurate county-level estimates of health issues. Random-digit telephone dialing algorithm was used to survey households. Census tracts with large minority populations were used to ensure survey coverage of under-represented minorities. In addition, commercially available lists of Hispanic and Asian surnames were used to gain additional minority respondents. The data were weighted based on the stratified sampling design and the oversample of minorities to generate estimates about the entire Ohio population.

Limitations: Participation in the survey and the willingness to provide information on an individual question may create unknown and unmeasurable response biases. Telephone surveys assume phone coverage is universal in the population of interest. However, in recent years there have been decreases in land-line coverage as many persons have switched to mobile telephones. This may exclude people from the sampling universe and could lead to under-represent low-income groups and minorities.

Ohio HIV/STD Surveillance Study

Overview: In 2011, The Ohio Department of Health (ODH) HIV/AIDS Surveillance Program retrospectively assessed all Ohio reports of syphilis, gonorrhea and HIV infections reported among persons 13 years of age and older during the 10 years between January 1, 2001 and December 31, 2010. All syphilis and gonococcal infections reported during the study period were exported out of the Ohio Disease Reporting System (ODRS) into a data set. Persons reported living with a diagnosis of HIV infection (PLWHA) as of June 30, 2011 during the 10-year study period were exported out of the Enhanced HIV/AIDS Reporting System (eHARS) into a separate data set. Each data set was standardized and de-duplicated, and probabilistic matching determined which individuals had multiple disease reports amongst the two data sets.

Population: All reported persons who test positive for HIV/AIDS, syphilis and/or gonorrhea.

Strengths: HIV infection reporting is estimated to be more than 85 percent complete for persons who have tested positive for HIV. HIV/AIDS surveillance provides a minimum estimate of the number of persons known to be HIV infected and reported to the health department, may

identify emerging patterns of transmission and can be used to detect trends in HIV infections among populations of particular interest. HIV/AIDS surveillance provides the basis for establishing and evaluating linkages to prevention and early intervention services and can be used to anticipate unmet needs for HIV care.

STD data are widely available at the state and local level and because of shorter incubation time periods between transmission and infection, STDs can serve as a marker for recent unsafe sexual behavior. In addition, certain STDs (i.e., ulcerative STDs) can facilitate transmission or acquisition of HIV infection.

Limitations: HIV/AIDS surveillance data may underestimate the level of recently infected persons because some infected persons either do not know they are infected or have not sought testing. Persons who have tested positive in an anonymous test site and have not sought medical care, where they would be confidentially tested, are not eligible to be reported to the surveillance system. HIV/AIDS surveillance data represent infections in jurisdictions where reporting laws for HIV infection are in place. Reporting of behavioral risk information may not be complete. Reporting of STDs from private-sector providers may be less complete. Although STD risk behaviors result from unsafe sexual behavior, they do not necessarily correlate with HIV risk.

Ohio Statewide HIV Prevention Strategic Plan to Reduce Incidence in Men who have Sex with Men

Overview: In 2009, through a supplemental grant from CDC, ODH's HIV/STD/AVH Prevention Program engaged the HIV prevention community who work with MSM in an intense strategic planning process. This strategic planning process included reviewing the mission and vision of the HIV/STD/AVH Prevention Program, the capacity and challenges of the MSM community, and the issues, behaviors and group norms of Ohio's MSM community. The primary intention of this strategic planning process is to utilize the information gained to reduce future incidence of HIV within the Ohio MSM community.

In partnership with MKM consulting, ASOs recruited focus group participants from among service consumers and stakeholders within the Ohio HIV/AIDS community. The ASO recruiting focus group participants included AIDS Resource Center, Dayton & Toledo; AIDS Task Force of Greater Cleveland; Akron Brother Circle; Community AIDS Network, Akron; Stop AIDS, Cincinnati; The Tobias Project, Columbus; and AIDS Coordinator for Rural Region, Portsmouth City Health Department.

To reach consumer participants, purposive sampling was employed. Purposive sampling is commonly employed as a means of getting answers to questions of practical interest. When used for organizational analysis or strategic planning, the goal is to collect data from representatives of the groups who need to be involved in resolving the issue or whose input is essential to the strategic plan. Data collection targeting specific locations frequented by MSM was employed in administering bar and online surveys in each of the Ohio regions. In addition, at least one focus group was held in each of the Ohio regions. The data collection was conducted from August 10 – September 23, 2009.

Population: MSM who attend bars that serve gay and bisexual men, have access to the internet or are networked to agency representatives, clients, programs or services.

Strengths: In most regions, some degree of homogeneous sampling was possible by convening groups with similar demographic characteristics such as race, age range, or HIV status within the local MSM community. Purposive sampling can be more efficient than random sampling in practical field circumstances because the random member of a community may not be as knowledgeable and observant as an expert informant. The use of purposive sampling supports rapid data collection. Results from the data collection will help to guide future strategic directions and provide valuable information on risk behaviors in a subpopulation of MSM at high risk for HIV infection.

Limitations: Interpretation of results is limited to the population under study. Subsets of MSM that may be under represented in the data include those without home computers, MSM who are not bar patrons, and MSM who do not identify with the MSM subgroup of gay men networked to agency representatives, clients, programs or services.

Pregnancy Risk Assessment Monitoring System

Overview: The Pregnancy Risk Assessment Monitoring System (PRAMS) is a population-based survey designed to examine maternal behaviors and experiences before, during and after a woman's pregnancy, and during the early infancy of her child. The Centers for Disease Control and Prevention initiated PRAMS in 1987 in an effort to reduce infant mortality and the incidence of low birth weight. PRAMS was implemented in Ohio in April of 1999.

Population: Women who have given birth to a live infant.

Strengths: PRAMS data are population-based, findings from data analyses can be generalized to the entire state's population of women having live births. Health planners have used PRAMS data to help understand maternal behaviors and experiences and their relationship with adverse pregnancy outcomes. These findings can be used to develop and assess public health programs and policies to improve maternal and infant health.

Limitations: PRAMS does not capture information about all women who become pregnant. Important differences may exist between women having live births and those whose pregnancies resulted in other outcomes. Furthermore, it is important to remember that most of the information from PRAMS is self-reported by the mother. Mothers are surveyed two to six months post partum about events occurring several months earlier and may inaccurately recall events.

Sexually Transmitted Disease Case Reporting

Overview: Surveillance activities are conducted to monitor the levels of syphilis, gonorrhea and chlamydia to establish prevention programs, develop and revise treatment guidelines and identify populations at risk for STDs. Case report forms include information on patient demographics, type of infection and source of report (private or public sector).

Population: All persons who are diagnosed with an infection that meets the CDC surveillance case definition for the infection and are reported to local health departments.

Strengths: STD surveillance data can serve as a surrogate marker for unsafe sexual practices and/or demonstrate the prevalence of changes in a specific behavior. STD data are widely available at the state and local level and because of shorter incubation time periods between transmission and infection, STDs can serve as a marker for recent unsafe sexual behavior. In addition, certain STDs (i.e., ulcerative STDs) can facilitate transmission or acquisition of HIV infection. Finally, changes in trends of STDs may indicate changes in community sexual norms (i.e., unprotected sex).

Limitations: STDs are reportable, but requirements for reporting vary across states. Reporting of STDs from private-sector providers may be less complete. Although STD risk behaviors result from unsafe sexual behavior, they do not necessarily correlate with HIV risk. Trends in chlamydia infections may reflect changes in reporting and screening practices rather than actual trends in disease.

U.S. Bureau of the Census

Overview: The Census Bureau collects and provides timely information about the people and economy of the United States. The Web site for the Census Bureau includes data on the demographic characteristics (e.g., age, race, Hispanic ethnicity, sex) of the population, family structure, educational attainment, income level, housing status and the percentage of persons living at or below the poverty level. Tables and maps of census data are available for all geographic areas to the block level. Summaries of the most requested data for states and counties are provided, as well as analytical reports on population change, race, age, family structure and apportionment. Links to other census-related sites are included.

Population: U.S. population.

Strengths: A wide range of online statistical data on the U.S. population are available in different formats (e.g., tables, maps). State- and county-specific information is easily accessible and links to other census Web sites are provided.

Limitations: Some files take longer to download.

Vital Records-Death Data

Overview: In the United States, state laws require death certificates to be completed for all deaths and federal law mandates national collection and publication of deaths. A standard certificate of death is used to record death information on each decedent.

Population: All deaths occurring within Ohio.

Strengths: Reporting of deaths is 100 percent complete. The data are widely available and can be used to determine the impact of deaths related to HIV infection in a service area. Standardized procedures are used throughout the nation to collect death certificate data.

Limitations: Deaths resulting from, or whose underlying cause was, HIV infection may be under reported on the death certificate. Clinical information related to HIV or AIDS may be missing. Death records are less timely than AIDS case reports.

Youth Risk Behavior Surveillance System

Overview: YRBSS was established to monitor six priority high-risk behaviors that contribute to leading causes of mortality, morbidity and social problems among youth and adults in the United States. YRBSS was developed to collect data that are comparable among national, state and local samples of youth. Using a self-administered questionnaire, YRBSS collects information on six categories of behaviors which includes sexual behaviors that contribute to unintended pregnancy, STDs and HIV. Questions are also asked about transmission to HIV prevention education materials, sexual activity (age of onset, number of partners, condom use, preceding drug or alcohol use), contraceptive use and pregnancy history.

Population: YRBSS is a representative sample of ninth through 12th grade students.

Strengths: YRBSS is a population-based survey that samples adolescents in public and private high schools. The YRBSS questionnaires are self-administered and anonymous inferences from YRBSS estimates can be drawn about behaviors and attitudes of young people in high school making the information useful for developing community-wide prevention programs aimed at adolescents. YRBSS uses a standardized questionnaire so comparisons can be made across participating states and the questionnaire is flexible so states can ask specific questions to meet their needs.

Limitations: The YRBSS projections rely on upon self-reported information; reporting of sensitive behavioral information may not be accurate (under-or over-reporting may occur). Because the YRBSS questionnaires are administered in high schools, the data are representative only of adolescents who are enrolled in school and cannot be generalized to all young people. Questions that ask about behaviors during the past year may be subject to recall bias; however, this bias may be minimal because of the young age of the respondents. In addition, the questionnaire does not ask about homosexual or bisexual behavior or experiences.

Appendix B: Glossary of Terms

Adjustments: Statistical calculations that allow the comparison of different groups (when the difference may affect what is being studied) as though they are alike. Differences in populations or subgroups make it difficult to make comparisons; adjustments remove the influence of a specific factor (e.g., age, sex, race or disease status) from the analysis.

AIDS (Acquired Immune Deficiency Syndrome): The condition that results from HIV infection and is marked by CD4 count below 200 cells/ μ L (or 14 percent) and/or the presence of opportunistic infections that do not affect persons with healthy immune systems.

Behavioral data: Data collected from studies of human behavior that are relevant to disease risk. Relevant behaviors for HIV risk may include sexual activity, substance use, sharing of drug paraphernalia, condom use or responses to primary and secondary prevention messages.

CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act): Now known as the Ryan White Treatment Modernization Act. The primary federal legislation created to address the needs for health and support services among persons living with HIV/AIDS and their families in the United States; enacted in 1990.

Case: A condition such as HIV infection (e.g., an HIV case) or AIDS (e.g., an AIDS case) diagnosed according to a standard case definition.

CDC: The Centers for Disease Control and Prevention (CDC), within the U.S. Department of Health and Human Services, is the lead federal agency for protecting the health and safety of the people of the United States. CDC accomplishes its mission through developing and applying disease prevention and control, environmental health and health promotion, and education activities designed to improve public health in the United States. The CDC provides majority of funding for HIV prevention and HIV surveillance activities in Ohio.

Community Planning Group: A group of persons who represent or have interests in a given community and who work in partnership with health departments to design local prevention plans to meet the needs of persons at risk for, or infected with, HIV.

Co-morbidity: The co-existence of a disease or illness and HIV infection in one person (e.g., an HIV-infected person who also has TB).

Confidentiality: The treatment of information that an individual or institution has disclosed in a relationship of trust, with the expectation that the information will not be divulged to others in ways that are inconsistent with the individual's or institution's understanding when the individual or institution provided the information. It encompasses access to and disclosure of information in accordance with requirements of state law or official policy. For HIV/AIDS surveillance data, confidentiality refers to the protection of private information collected by the HIV/AIDS surveillance system.

Eligible Metropolitan Area (EMA): A metropolitan statistical area that qualifies for Part A funding by reaching a certain threshold of AIDS cases. EMAs may cover one city, several cities or counties or more than one state.

Epidemiology: The study of the distribution and the determinants of health-related states or events in specified populations and the application of this study to the control of health problems.

Epidemiologic profile: A document that describes the HIV/AIDS epidemic in various populations and identifies characteristics both of HIV-infected and HIV-negative persons in defined geographic areas. It is composed of information gathered to describe the effect of HIV/AIDS on an area in terms of sociodemographic, geographic, behavioral and clinical characteristics. The epidemiologic profile serves as the scientific basis from which HIV prevention and care needs are identified and prioritized for a jurisdiction.

Estimate: In situations in which precise data are not available, an estimate may be made on the basis of available data and an understanding of how the data can be generalized to larger populations. In some instances, national or state data may be statistically adjusted to estimate local conditions. Good estimates are accompanied by statistical estimates of error (a confidence interval), which describes the limitations of the estimate.

Federal Poverty Level (FPL): Families and persons are classified as below poverty if their total family income or unrelated individual income was less than the poverty threshold specified for the applicable family size, age of householder and number of related children under 18 present.

HIV (Human Immunodeficiency Virus): The virus that causes AIDS. Persons with HIV in their immune system are referred to as HIV infected.

HIV Care Consortia: An association of public and private, nonprofit providers of health support services and community-based organizations that plans, develops and delivers services for people living with HIV. The CARE Act authorizes states to use Part B funds to establish consortia in “areas most affected by HIV disease.”

HIV primary medical care: Medical evaluation and clinical care that is consistent with U.S. Public Health Service guidelines for the treatment of HIV/AIDS.

HIV/AIDS surveillance: The systematic collection, analysis, interpretation, dissemination and evaluation of population-based information about persons with a diagnosis of HIV infection and persons with a diagnosis of AIDS.

Incidence: The number of new cases in a defined population during a specific period, often a year, which can be used to measure disease frequency. It is important to understand the difference between HIV incidence and reported HIV diagnoses. Because the results of anonymous tests are not included and therefore not all diagnoses of HIV infection are included, HIV surveillance data do not represent incident cases.

Incidence rate: The number of new cases in a specific area during a specific period among persons at risk in the same area and during the same period. Incidence rate provides a measure of the effect of illness relative to the size of the population. Incidence rate is calculated by dividing in the specified period by the population in which cases occurred. A multiplier is used to convert the resulting fraction to a number over a common denominator (often 100,000).

Interpretation: The explanation of the meaning of the data. For example, interpreting a trend in the number of HIV cases diagnosed during a five-year period enables a planning group to

assess whether the number of cases has increased or decreased. However, groups should use caution in interpreting trends that are based upon small increases or decreases.

Line graph: A type of figure used to display the changes in a particular variable over time. Values are recorded periodically as points on the graph and then connected as a line to show a trend.

Mean: The sum of individual values in a data set divided by the total number of values. The mean is what many people refer to as an average.

Median: The middle value in a data set. Typically, approximately half the values will be higher and half will be lower. The median is useful when a data set has unusually high or unusually low values, which can affect the mean. It is also useful where data are skewed, meaning most of the values are at one extreme or the other.

Men who have sex with men (MSM): Men who acknowledge having had sexual contact with another male regardless of how he identifies in terms of sexual orientation and regardless of any reported sexual contact with a female.

Morbidity: The presence of illness in the population.

Mortality: The total number of persons who have died from the disease of interest. Usually expressed as a rate, mortality (total number of deaths over the total population) measures the effect of the disease on the population as a whole.

Needs assessment: The process of gathering and analyzing information from a variety of sources to determine the current status and the unmet needs for HIV prevention or care among a defined population or in a geographic area.

No identified risk (NIR): Cases in which epidemiologic follow up has been conducted, sources of data have been reviewed – which may include an interview with the patient or provider – and no mode of transmission has been identified. Any case that continues to have no reported risk 12 or more months after the report date is considered NIR.

No reported risk (NRR): Cases in which risk information is absent from the initial case report because the information had not been reported by the reporting source, had not been sought or had not been found by the time the case was reported. Cases may remain NRR until epidemiologic follow up has been completed and potential risks (transmissions) have been identified. If risk has not been identified within one year of being reported as NRR, the case may be considered NIR.

Odds Ratio: The probability that an event will happen to the probability that it will not happen.

Percentage: A proportion of the whole, in which the whole is 100.

Prevalence: The total number of cases of a disease in persons not known to have died in a given population at a specific point in time. Prevalence does not indicate how long a person has had a disease and cannot be used to calculate rates of disease. It can provide an estimate of risk for a disease at a point in time. For HIV/AIDS surveillance, prevalence refers to living persons with HIV disease, regardless of time of infection or date of diagnosis. Note the

difference between prevalence of a condition in the population and the prevalence of cases, namely, that a case must be diagnosed according to a definition.

Proportion: A portion of a complete population or data set, usually expressed as a fraction or percentage of the population or data set.

Range: The largest and smallest values in a data set.

Rate: A measure of the frequency of an event or disease compared with the number of persons at risk for the event or disease.

Ratio: A way of showing the relative size of two numbers. The first number is divided by the other number to derive the ratio. The ratio may be expressed as a fraction (e.g. 2/3), or the two numbers may be separated by a colon (X:Y).

Reporting delay: The time between when a diagnosis of HIV infection or AIDS and the time the report is received by the health department.

Representative: A sample that is similar to the population from which it is drawn and thus can be used to draw conclusions about the population.

Sample: A group of people selected from a total population with the expectation that studying this group will provide important information about the total population.

Sociodemographic factors: Background information about the population of interest (e.g., age, sex, race, educational status, income, geographic location). These factors are often thought of as explanatory because they help make sense of the results of the analyses.

Socioeconomic status (SES). A measure of social and economic factors that helps to describe a person's standing in society (e.g. income levels, relationship to national poverty line, educational achievement, neighborhood of residence, home ownership).

Part A (CARE Act): Provides formula and supplemental grants to EMAs that are disproportionately affected by the HIV epidemic.

Part B (CARE Act): Provides formula grants to states, the District of Columbia, Puerto Rico and eligible U.S. territories to improve the quality, availability and organization of health care and support services for people living with HIV and their families.

Trend: A long-term movement or change in frequency, usually upward or downward; may be presented as a line graph.

Year of diagnosis: The year in which the diagnosis of HIV infection or AIDS was made.

Year of report: The year in which a person with a diagnosis of HIV infection or AIDS was reported to the health department.

Appendix C: Data Tables

Persons living in Ohio, by county, Census 2010

Persons Living in Ohio			Persons Living in Ohio		
County	No.	%	County	No.	%
Adams	28,550	0.2%	Logan	45,858	0.4%
Allen	106,331	0.9%	Lorain	301,356	2.6%
Ashland	53,139	0.5%	Lucas	441,815	3.8%
Ashtabula	101,497	0.9%	Madison	43,435	0.4%
Athens	64,757	0.6%	Mahoning	238,823	2.1%
Auglaize	45,949	0.4%	Marion	66,501	0.6%
Belmont	70,400	0.6%	Medina	172,332	1.5%
Brown	44,846	0.4%	Meigs	23,770	0.2%
Butler	368,130	3.2%	Mercer	40,814	0.4%
Carroll	28,836	0.2%	Miami	102,506	0.9%
Champaign	40,097	0.3%	Monroe	14,642	0.1%
Clark	138,333	1.2%	Montgomery	535,153	4.6%
Clermont	197,363	1.7%	Morgan	15,054	0.1%
Ciinton	42,040	0.4%	Morrow	34,827	0.3%
Columbiana	107,841	0.9%	Muskingum	86,074	0.7%
Coshocton	36,901	0.3%	Noble	14,645	0.1%
Crawford	43,784	0.4%	Ottawa	41,428	0.4%
Cuyahoga	1,280,122	11.1%	Paulding	19,614	0.2%
Darke	52,959	0.5%	Perry	36,058	0.3%
Defiance	39,037	0.3%	Pickaway	55,698	0.5%
Delaware	174,214	1.5%	Pike	28,709	0.2%
Erie	77,079	0.7%	Portage	161,419	1.4%
Fairfield	146,156	1.3%	Preble	42,270	0.4%
Fayette	29,030	0.3%	Putnam	34,499	0.3%
Franklin	1,163,414	10.1%	Richland	124,475	1.1%
Fulton	42,698	0.4%	Ross	78,064	0.7%
Gallia	30,934	0.3%	Sandusky	60,944	0.5%
Geauga	93,389	0.8%	Scioto	79,499	0.7%
Greene	161,573	1.4%	Seneca	56,745	0.5%
Guernsey	40,087	0.3%	Shelby	49,423	0.4%
Hamilton	802,374	7.0%	Stark	375,586	3.3%
Hancock	74,782	0.6%	Summit	541,781	4.7%
Hardin	32,058	0.3%	Trumbull	210,312	1.8%
Harrison	15,864	0.1%	Tuscarawas	92,582	0.8%
Henry	28,215	0.2%	Union	52,300	0.5%
Highland	43,589	0.4%	Van Wert	28,744	0.2%
Hocking	29,380	0.3%	Vinton	13,435	0.1%
Holmes	42,366	0.4%	Warren	212,693	1.8%
Huron	59,626	0.5%	Washington	61,778	0.5%
Jackson	33,225	0.3%	Wayne	114,520	1.0%
Jefferson	69,709	0.6%	Williams	37,642	0.3%
Knox	60,921	0.5%	Wood	125,488	1.1%
Lake	230,041	2.0%	Wyandot	22,615	0.2%
Lawrence	62,450	0.5%			
Licking	166,492	1.4%	Ohio	11,536,504	100.0%

Source: Summary File 1, U.S. Census Bureau, Census 2010

Persons living below poverty level in Ohio, by county, Census 2010

County	Population* Below Year 2010 Federal Poverty Level	% Below Federal Poverty Level	County	Population* Below Year 2010 Federal Poverty Level	% Below Federal Poverty Level
Adams	5949	21.4%	Logan	6399	14.0%
Allen	18751	18.8%	Lorain	42750	14.4%
Ashland	8781	16.7%	Lucas	84797	18.7%
Ashtabula	17245	17.5%	Madison	5280	14.2%
Athens	18756	34.7%	Mahoning	42135	18.3%
Auglaize	3874	8.5%	Marion	10361	17.3%
Belmont	10763	16.8%	Medina	11432	6.6%
Brown	5638	13.0%	Meigs	4510	20.0%
Butler	46350	13.2%	Mercer	3637	9.1%
Carroll	3810	13.5%	Miami	11591	11.6%
Champaign	3963	10.2%	Monroe	2304	16.6%
Clark	22130	16.3%	Montgomery	83595	16.2%
Clermont	20330	10.4%	Morgan	2760	19.6%
Clinton	4989	11.9%	Morrow	4388	12.8%
Columbiana	17056	16.4%	Muskingum	13811	16.8%
Coshocton	5142	14.6%	Noble	2147	18.4%
Crawford	6388	14.9%	Ottawa	4319	10.7%
Cuyahoga	235014	18.9%	Paulding	2048	10.9%
Darke	6058	11.9%	Perry	5979	17.1%
Defiance	4484	11.9%	Pickaway	7059	14.2%
Delaware	8433	5.1%	Pike	5880	21.6%
Erie	10981	14.6%	Portage	21367	14.3%
Fairfield	16569	11.8%	Preble	4190	10.3%
Fayette	5589	20.3%	Putnam	2557	7.5%
Franklin	207183	18.4%	Richland	17367	14.8%
Fulton	3806	9.1%	Ross	12740	18.3%
Gallia	6250	20.9%	Sandusky	7209	12.2%
Geauga	7789	7.9%	Scioto	16987	23.5%
Greene	18620	12.3%	Seneca	6775	12.5%
Guernsey	8090	20.5%	Shelby	5053	10.5%
Hamilton	126872	15.2%	Stark	54614	14.8%
Hancock	7910	11.0%	Summit	78762	14.8%
Hardin	4733	16.2%	Trumbull	32904	16.0%
Harrison	2643	17.7%	Tuscarawas	12647	14.1%
Henry	3038	10.8%	Union	3678	8.0%
Highland	6848	16.5%	Van Wert	2411	8.6%
Hocking	4703	16.8%	Vinton	2586	19.8%
Holmes	6154	15.0%	Warren	12051	5.9%
Huron	7349	12.4%	Washington	8204	13.9%
Jackson	7534	22.9%	Wayne	12435	11.2%
Jefferson	11524	17.6%	Williams	4418	12.1%
Knox	7383	13.2%	Wood	16031	13.5%
Lake	19274	8.2%	Wyandot	2176	9.9%
Lawrence	12168	19.6%			
Licking	18030	11.7%	Ohio	1699288	15.1%

*Population: All people except unrelated individuals under age 15 (such as foster children). Since the Current Population Survey asks income questions only to people age 15 and over, if a child under age 15 is not part of a family by birth, marriage, or adoption, we do not know their income and cannot determine whether or not they are poor. Those people are excluded from the totals so as not to affect the percentages.

Source: U.S. Census Bureau, Small Area Income and Poverty Estimates, <http://www.census.gov/did/www/saipe/data/index.html>

Estimates of uninsured adults (age 18 and older) by county of residence, Ohio 2008

County	Number of Persons Living Without Health Insurance	Percent of Persons Living Without Health Insurance	County	Number of Persons Living Without Health Insurance	Percent of Persons Living Without Health Insurance
Adams	8,146	47.4%	Logan	5,276	19.2%
Allen	12,321	18.9%	Lorain	29,597	15.9%
Ashland	5,063	15.8%	Lucas	54,184	19.5%
Ashtabula	11,645	18.9%	Madison	4,518	16.0%
Athens	9,018	18.8%	Mahoning	21,717	15.0%
Auglaize	3,267	12.0%	Marion	6,896	16.3%
Belmont	9,664	21.9%	Medina	11,129	10.5%
Brown	5,003	18.3%	Meigs	4,302	29.4%
Butler	28,897	12.4%	Mercer	2,065	8.7%
Carroll	3,845	22.1%	Miami	9,363	15.1%
Champaign	4,544	18.7%	Monroe	2,225	25.7%
Clark	16,737	20.1%	Montgomery	59,219	17.9%
Clermont	19,147	15.5%	Morgan	3,248	36.4%
Clinton	5,506	21.1%	Morrow	3,913	18.5%
Columbiana	17,015	25.6%	Muskingum	6,843	13.1%
Coshocton	4,340	19.7%	Noble	1,453	16.5%
Crawford	8,041	31.1%	Ottawa	3,944	15.8%
Cuyahoga	139,272	17.6%	Paulding	1,636	13.9%
Darke	6,564	21.3%	Perry	5,822	26.5%
Defiance	3,372	14.3%	Pickaway	4,140	11.7%
Delaware	8,147	7.6%	Pike	6,151	35.4%
Erie	8,300	17.8%	Portage	12,403	11.6%
Fairfield	9,147	10.2%	Preble	5,018	19.6%
Fayette	3,539	20.2%	Putnam	2,078	10.2%
Franklin	145,372	18.9%	Richland	13,868	18.2%
Fulton	1,927	7.5%	Ross	8,793	17.6%
Gallia	3,896	20.9%	Sandusky	5,367	14.6%
Geauga	5,851	10.7%	Scioto	13,402	27.3%
Greene	8,146	7.8%	Seneca	5,068	14.5%
Guernsey	6,637	27.6%	Shelby	2,631	8.9%
Hamilton	82,963	16.4%	Stark	35,208	15.4%
Hancock	7,948	17.1%	Summit	66,491	19.6%
Hardin	1,131	5.6%	Trumbull	18,043	14.2%
Harrison	3,167	33.3%	Tuscarawas	11,422	20.6%
Henry	1,862	11.1%	Union	4,734	14.3%
Highland	6,573	25.4%	Van Wert	2,770	16.4%
Hocking	3,219	18.0%	Vinton	2,639	32.1%
Holmes	6,202	26.9%	Warren	16,279	12.4%
Huron	10,189	28.4%	Washington	6,924	18.2%
Jackson	3,831	18.8%	Wayne	14,356	20.9%
Jefferson	8,365	19.5%	Williams	5,945	26.2%
Knox	6,032	16.2%	Wood	11,098	13.4%
Lake	20,171	14.2%	Wyandot	1,827	13.6%
Lawrence	8,988	23.6%			
Licking	13,323	12.9%	Ohio	1,220,337	17.0%

Source: Ohio Family Health Survey, Ohio Department of Job and Family Services, 2008. Available at <http://grc.osu.edu/ofhs/reports/index.cfm>

Percent of Ohio population on Medicaid, by county, state fiscal year 2009

County	Total Population		Medicaid Eligibles		County	Total Population		Medicaid Eligibles	
	No.	No.	%	No.		%	No.	%	
Adams	28,550	10,963	38.4%	Logan	45,858	9,859	21.5%		
Allen	106,331	23,924	22.5%	Lorain	301,356	56,655	18.8%		
Ashland	53,139	9,406	17.7%	Lucas	441,815	117,523	26.6%		
Ashtabula	101,497	27,709	27.3%	Madison	43,435	8,035	18.5%		
Athens	64,757	14,700	22.7%	Mahoning	238,823	58,273	24.4%		
Auglaize	45,949	6,892	15.0%	Marion	66,501	16,891	25.4%		
Belmont	70,400	16,755	23.8%	Medina	172,332	18,612	10.8%		
Brown	44,846	11,525	25.7%	Meigs	23,770	7,939	33.4%		
Butler	368,130	67,736	18.4%	Mercer	40,814	5,387	13.2%		
Carroll	28,836	6,978	24.2%	Miami	102,506	16,708	16.3%		
Champaign	40,097	8,501	21.2%	Monroe	14,642	4,114	28.1%		
Clark	138,333	36,105	26.1%	Montgomery	535,153	119,874	22.4%		
Clermont	197,363	35,328	17.9%	Morgan	15,054	4,757	31.6%		
Clinton	42,040	10,342	24.6%	Morrow	34,827	7,697	22.1%		
Columbiana	107,841	25,990	24.1%	Muskingum	86,074	25,994	30.2%		
Coshocton	36,901	9,631	26.1%	Noble	14,645	3,310	22.6%		
Crawford	43,784	11,778	26.9%	Ottawa	41,428	7,126	17.2%		
Cuyahoga	1,280,122	304,669	23.8%	Paulding	19,614	4,276	21.8%		
Darke	52,959	8,738	16.5%	Perry	36,058	11,863	32.9%		
Defiance	39,037	8,549	21.9%	Pickaway	55,698	11,919	21.4%		
Delaware	174,214	14,634	8.4%	Pike	28,709	11,742	40.9%		
Erie	77,079	15,030	19.5%	Portage	161,419	24,051	14.9%		
Fairfield	146,156	28,939	19.8%	Preble	42,270	8,200	19.4%		
Fayette	29,030	8,332	28.7%	Putnam	34,499	4,554	13.2%		
Franklin	1,163,414	264,095	22.7%	Richland	124,475	28,629	23.0%		
Fulton	42,698	7,558	17.7%	Ross	78,064	22,482	28.8%		
Gallia	30,934	10,270	33.2%	Sandusky	60,944	13,164	21.6%		
Geauga	93,389	7,191	7.7%	Scioto	79,499	28,222	35.5%		
Greene	161,573	23,913	14.8%	Seneca	56,745	12,654	22.3%		
Guernsey	40,087	12,547	31.3%	Shelby	49,423	9,292	18.8%		
Hamilton	802,374	154,056	19.2%	Stark	375,586	75,117	20.0%		
Hancock	74,782	12,339	16.5%	Summit	541,781	101,855	18.8%		
Hardin	32,058	6,604	20.6%	Trumbull	210,312	46,900	22.3%		
Harrison	15,864	4,521	28.5%	Tuscarawas	92,582	19,720	21.3%		
Henry	28,215	5,107	18.1%	Union	52,300	7,531	14.4%		
Highland	43,589	13,469	30.9%	Van Wert	28,744	5,663	19.7%		
Hocking	29,380	8,902	30.3%	Vinton	13,435	5,025	37.4%		
Holmes	42,366	4,957	11.7%	Warren	212,693	19,568	9.2%		
Huron	59,626	14,429	24.2%	Washington	61,778	13,097	21.2%		
Jackson	33,225	11,695	35.2%	Wayne	114,520	19,583	17.1%		
Jefferson	69,709	17,079	24.5%	Williams	37,642	8,018	21.3%		
Knox	60,921	12,611	20.7%	Wood	125,488	16,690	13.3%		
Lake	230,041	28,065	12.2%	Wyandot	22,615	4,319	19.1%		
Lawrence	62,450	20,671	33.1%						
Licking	166,492	33,631	20.2%	Ohio	11,536,504	2,419,754	21.0%		

Source: Ohio Medicaid DSS Members, FY 2009. U.S. Census Small Area Income and Poverty Estimates.

ODH Program Contact Information

Ryan White HIV Care Services Program

(614) 466-6374

<http://www.odh.ohio.gov/odhPrograms/hastpac/hivcare/aids1.aspx>

HIV Counseling, Testing and Referral Services (CTR) Program

(614) 466-1838

<http://www.odh.ohio.gov/odhPrograms/hastpac/hivstd/hivstd1.aspx>

HIV/STD Prevention Program

(614) 644-1838

<http://www.odh.ohio.gov/odhPrograms/hastpac/hivstd/hivstd1.aspx>

HIV/AIDS Surveillance Program

(614) 466-1388

Program: <http://www.odh.ohio.gov/odhPrograms/hastpac/hivsurv/surv1.aspx>

Data: <http://www.odh.ohio.gov/healthStats/disease/hivdata/hivcov.aspx>

STD Surveillance Program

(614) 466-1388

Program <http://www.odh.ohio.gov/odhPrograms/hastpac/stdsurv/stdsur1.aspx>

Data <http://www.odh.ohio.gov/healthStats/disease/std/std1.aspx>