

AIDS
Public
Information
Data Set

Data through December 2001

U.S. Department of Health and Human Services

Public Health Service
Centers for Disease Control and Prevention
National Center of HIV, STD, and TB Prevention
Division of HIV/AIDS Prevention

About this Data Set

The *AIDS Public Information Data Set* is computer software designed to run on an Microsoft Windows microcomputer, and contains information abstracted from acquired immunodeficiency syndrome (AIDS) cases reported in the United States. The data set is created each year by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention (CDC) and contains information extracted from CDC's national AIDS surveillance data base. Suggested citation: *Centers for Disease Control and Prevention. AIDS Public Information Data Set, December, 2001.*

In December 1995, the software was modified to add data from all metropolitan areas with 500,000 or more population, for metropolitan areas with 100,000 or more population from selected states, and for individual counties or health districts from selected states. To protect the confidentiality of the data, some information was removed from the data set. Month of death, survival time, central versus outlying portion of metropolitan areas, reporting delay adjustments for death dates, and information on individual AIDS-indicator conditions were removed from the data set. The December 1996 edition added information on patient vital status. The December 1998 edition added percentage calculation to each tabulation. Additional information is contained in the on-line help files.

The *AIDS Public Information Data Set* contains data in two formats. The first format consists of a rectangular data file of 16 variables extracted from CDC's national AIDS data base. One-way and two-way cross tabulations of any of these variables can be displayed on your computer screen. The second format consists of a series of state, metropolitan statistical area (MSA), and county/health district tables, containing information on 8 variables included in the rectangular data file plus a location variable. There is one set of tables for the entire United States, one set for each state, one set for each MSA, and one set for each county/health district. The rectangular data file, without the state or MSA tables, is also available as an ASCII data file.

To request a copy of this data set, contact the Statistics and Data Management Branch, Division of HIV/AIDS Prevention, Mailstop E-48, Centers for Disease Control and Prevention, Atlanta, GA, 30333, telephone (404) 639-2020. You can also download the software from the Internet by linking to <http://www.cdc.gov/hiv/software.htm>.

This manual describes the data set. It is divided into three sections and three appendices. On-line help screens provide additional information.

Section 1, *AIDS Surveillance in the United States*, describes the data collection process and the effect changes in this process may have on data analysis and interpretation. The section reviews the source of AIDS surveillance data and describes which patients are included in the CDC definition. It also discusses reporting delays and reporting completeness.

Section 2, *Data File Variables and Coding Schemes*, lists the variables included on the rectangular data file and describes each variable's coding scheme.

Section 3, *State, MSA, and County Tables*, describes the variables included on the state, MSA, and county/health district tables.

Appendix A: Installation, describes how to load and run this program on your computer. It also suggests computer hardware and software you can use to analyze the data.

Appendix B: Metropolitan Statistical Areas lists the MSAs included in the data set.

Appendix C: Health Districts lists the counties which comprise each health district included in the data set.

Assurance of Confidentiality

The data files on the enclosed CD contain information abstracted from acquired immunodeficiency syndrome (AIDS) case reports received from state and local health departments, who voluntarily report cases of AIDS to CDC. Case reports do not include patient or physician names or other personal identifiers. The data are protected under the Assurance of Confidentiality (Sections 306 and 308(d) of the Public Health Service Act, 42 U.S.C. 242k and 242m(d)), which prohibits disclosure of any information that could be used to directly or indirectly identify patients. The statistical data contained in the *AIDS Public Information Data Set* are being released for public use in accordance with the assurance and do not identify patients directly, nor do they contain information that can identify patients indirectly.

AIDS Surveillance in the United States

Background

In 1981, after early reports of *Pneumocystis carinii* pneumonia, Kaposi's sarcoma, and other opportunistic infections in young homosexual men in Los Angeles, New York, and San Francisco, the Centers for Disease Control and Prevention (CDC) began surveillance for a newly recognized constellation of diseases, now termed the acquired immunodeficiency syndrome (AIDS). CDC developed a surveillance case definition for this syndrome and initially received case reports directly from health care providers and state and local health departments. As the epidemic spread, state and local health departments assumed responsibility for AIDS surveillance, and by 1985 all states had regulations requiring physicians and other health care providers to report AIDS cases directly to the state or local health department. These health departments then share the reports with CDC, which produces the national AIDS surveillance data set.

The goals of AIDS surveillance have been to monitor both trends in AIDS cases and the scope of severe morbidity due to infection with the human immunodeficiency virus (HIV). AIDS surveillance data are used to allocate resources for patient care, target HIV prevention programs, and evaluate the impact of public health recommendations. Advances in the understanding of the epidemiology and manifestations of HIV infection and changing diagnostic practices, however, present multiple challenges to those analyzing and interpreting the AIDS surveillance data. The following are a few examples:

- ! A wide variety of persons are at risk for HIV, including men who have sex with men, injecting drug users, person who received a transfusion or who were tissue transplant recipients before March 1985, heterosexual partners of infected persons, children born to infected mothers, and persons with mucous membrane or percutaneous exposure to blood or body fluids of infected persons (e.g., health care workers). Because men who have sex with men comprise such a large proportion of the total number of AIDS cases, trends in this subgroup will overshadow those in other groups unless the data are examined separately. Analysis of data, without regard to specific subgroups, may conceal information or lead to misinterpretation of the data.

- ! The etiologic agent of AIDS, HIV, has been identified, and diagnostic tests for infection with this virus have been developed. As a result, the surveillance of AIDS, initially dependent on the presence of certain indicator diseases specific for the infection, was expanded in 1985, 1987, and 1993 to include additional conditions (some conditions may be less specific for HIV infection) in the presence of laboratory evidence for infection, and in 1993 to include HIV-infected persons with laboratory evidence of severe immunosuppression. The addition of these conditions to the AIDS case definition has affected trends in reported AIDS cases, as well as trends in reporting of AIDS-defining opportunistic conditions.

- ! Diagnostic practices have changed over time and vary geographically. AIDS is now a common diagnosis in many hospitals and clinics, and definitive diagnostic tests for manifestations of HIV infection (e.g., *Pneumocystis carinii* pneumonia or esophageal candidiasis) may not be done. HIV testing is not available for all patients and some patients choose not to be tested. Geographic variations in diagnostic practices and surveillance procedures, and changes over time could markedly affect trends in AIDS surveillance.

Source of AIDS Surveillance Data

CDC maintains national AIDS surveillance through receipt of AIDS case reports submitted by individual state and local health departments. Health departments report cases electronically through a CDC-developed microcomputer system. All 50 states, the District of Columbia, U.S. dependencies and possessions, and independent nations in free association with the United States (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, the Republic of Palau, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands, and the Federated States of Micronesia) report AIDS cases to CDC.

Although state and local health departments share AIDS surveillance data with CDC, the responsibility and authority for AIDS surveillance rests with the individual health departments. Like any reportable disease, the completeness of AIDS reporting reflects how actively health departments solicit case reports. Historically, disease surveillance systems have been categorized as passive or active, i.e., health departments may passively receive case reports from health care providers, depending on health care providers to know and comply with reporting requirements; or they may actively contact and interact with health care facilities or individual providers to stimulate disease reporting, sometimes directly assuming the primary responsibility of reporting cases from large or high-volume institutions.

CDC provides funding and technical assistance to health departments to actively stimulate AIDS case reporting and has encouraged them to take an active rather than passive approach to AIDS surveillance. Through surveillance cooperative agreements supported by CDC, health departments are encouraged to identify health care facilities that serve AIDS patients and work closely with these facilities to encourage reporting. They are also encouraged to send newsletters to health care providers and attend professional organization meetings, and to use other data sources to identify AIDS cases, including death certificates, laboratory reports, and tuberculosis and tumor registries. States vary in the structure and organization of their surveillance systems and, therefore, in the completeness of their case reporting (see below).

Case Definition

Before HIV was identified as the etiologic agent for AIDS, CDC defined a case of AIDS (for surveillance purposes) as a disease, at least moderately indicative of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance to the disease. Such diseases included *Pneumocystis carinii* pneumonia, Kaposi's sarcoma, and many other serious opportunistic infections (see *American Journal of Medicine*, March 1984, pages 493-500). With identification of HIV as the causative agent for AIDS and the availability of laboratory tests to detect HIV antibody, the case definition was expanded to reflect an increased understanding of HIV infection in 1985 (see CDC's *Morbidity and Mortality Weekly Report*, June 28, 1985, pages 373-375) and in 1987 (see *Morbidity and Mortality Weekly Report*, August 14, 1987, supplement, pages 3S-15S). These revisions applied to persons with laboratory evidence for HIV infection. Among diseases added in 1985 were disseminated histoplasmosis, chronic isosporiasis, and certain non-Hodgkin's lymphomas. Among those added in 1987 were extrapulmonary tuberculosis, HIV encephalopathy, and HIV wasting syndrome. In children, recurrent, serious bacterial infections were also added. In addition, the 1987 revision allowed certain indicator diseases to be diagnosed presumptively based on clinical presentation rather than "confirmed" by laboratory or diagnostic methods.

To be consistent with standards of medical care for HIV-infected persons and to more accurately reflect the number of persons with severe HIV-related immunosuppression who are at highest risk for HIV-related morbidity and most in need of close medical follow-up, the surveillance definition was expanded on January 1, 1993 (see CDC's *Morbidity and Mortality Weekly Report, Recommendations and Reports*, December 18, 1992). This expansion includes all HIV-infected adults and adolescents who have less than 200 CD4⁺ T-lymphocytes/ μ L or a CD4⁺ T-lymphocyte percent of total lymphocytes less than 14, or who have been diagnosed with pulmonary tuberculosis, invasive cervical cancer, or recurrent pneumonia. The addition of pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer in HIV-infected adults and adolescents to the 23 clinical conditions listed in the 1987 surveillance definition reflects their documented or potential importance in the HIV epidemic.

While the reported incidence of AIDS increased only 3 to 4 percent as a result of the 1985 revision, the 1987 revision greatly increased the numbers of reported cases. Roughly one fourth of all adults/adolescents who were both diagnosed and reported in the year following the 1987 revision were reported based only on the additional criteria included in the 1987 revision. Furthermore, the proportion of cases meeting only the revised criteria was higher in Hispanics and non-Hispanic blacks than in non-Hispanic whites, higher in heterosexual injecting drug users, and lower in men who have sex with men. The 1993 revision has had substantial impact on the number of reported cases. The immediate increase in case reporting was largely attributed to the addition of severe immunosuppression to the definition; a smaller impact was due to the addition of pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer, since many persons with these diseases also have a CD4⁺ T-lymphocyte count of less than 200 cells/ μ L. The early effects of expanded surveillance were greater than long-term effects because prevalent as well as incident cases

of immunosuppression were reported after implementation of the expanded surveillance case definition. In recent years, the effect on the number of reported cases has been smaller. Due to the large number of cases reported based on criteria in only the revised case definitions and to the inconsistent use of the revised case definitions in different populations, analyses of trends in AIDS cases must take these revisions into account.

Case report form

Separate case report forms are used for pediatric patients (patients less than 13 years of age at the time of diagnosis) and adult/adolescent patients (patients 13 years of age or older at the time of diagnosis). Although the forms are similar, the pediatric form includes behavioral risk information on the child's mother. These forms are completed by the health care provider or by the AIDS surveillance staff in the local or state health department. In addition, a laboratory report of an AIDS-defining condition sent to health departments may initiate a case report. In these cases, follow-up with the health care provider is required to obtain complete information.

Names are retained by the state or local health department and are converted to an alpha-numeric code called *soundex* for use by CDC. CDC does not receive names of persons with AIDS. Because more than one state may report an individual case, CDC screens reported cases by *soundex* code, date of birth, sex, and state of residence to cull presumed duplicate reports. States also cooperate in this process by reporting out-of-jurisdiction cases to the patient's state of residence.

The variables available on the AIDS data set are listed in the next section. However, a few deserve special comment.

- ! *Vital status.* Patients survive for a variable amount of time following the diagnosis of AIDS. Because death usually occurs after the initial report to CDC, case reports may not be updated to reflect the change in vital status. As a result, reporting of deaths among AIDS patients may be delayed or incomplete. However, states are required to perform periodic reviews of death certificates and state death registries to identify unreported cases, and to update vital status of known cases. In addition, 16 states participated in a special project to match their case registries to the National Death Index to assess the completeness of reporting and to identify deaths among cases that died out-of-jurisdiction.
- ! *Exposure category.* Some patients may have more than one mode of exposure to HIV. For surveillance purposes, AIDS cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure are listed in the category that appears first in the exposure hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They make up a separate exposure category.
- ! *AIDS definition category.* Patients may develop additional conditions indicative of AIDS after their initial AIDS diagnosis. The case report form may not be updated to reflect

additional conditions. Some persons reported as meeting only the immunologic criteria may have concurrent or prior opportunistic infections or conditions that are not included in the case report. Therefore, cases reported as meeting only the criteria added to the case definition in 1993 may include persons who meet the criteria in 1987 definition.

- ! *Date of diagnosis.* CDC collects dates of diagnosis for each AIDS-indicator disease, and, for patients with severe immunosuppression, the date of the CD4⁺ T-lymphocyte test. From this information, a single date of diagnosis is calculated for each patient; it is the earliest of these dates.

Delay in Reporting

The timeliness of AIDS case reporting to CDC is dependent on a number of factors, including the volume of cases reported from a state or locality, the cooperation of health care providers and medical institutions, the availability of staff to complete case report forms, and changes in the case definition. In many instances initial case reports are incomplete and require additional follow-up by state and local health department staff, including reviews of other record systems and contact with health care providers.

Based on estimates calculated using AIDS surveillance data reported between 1995 and 2000, about 50 percent of all cases were reported to CDC within 4 months of the date of diagnosis, but about 20 percent were reported more than 1 year after diagnosis. Delays vary widely among geographic, age, exposure, sex, and racial/ethnic categories. They are substantially longer for pediatric cases and shorter for AIDS cases previously reported with HIV infection, for example. Due to the reporting delay, the number of cases diagnosed during any period often exceeds the number reported during that period. This is particularly important in examining trends over time, since many cases in recent periods of time will not yet be reported.

To account for delays in the reporting of cases, the variable *adjwgt* is included in the data set. This variable may be used to weight each case on the data set and obtain adjusted case counts. For example, summing *adjwgt* for cases would estimate the number of cases diagnosed through the time period covered by the data set that will eventually be reported to CDC. To use this variable, select the adjustment weight option from the *Tools* menu. Once you turn the option on, all subsequent tabulations will be adjusted for reporting delay. The adjustment weight and resulting tabulations are not reliable for cases diagnosed during the most recent 6 to 9 months.

Effect of CD4 Reporting on AIDS Case Trends

As a result of the case definition change in 1993, trends in AIDS case counts showed an artifactual peak early in 1993, even after adjustment for reporting delay. To examine trends over time using a constant case definition, i.e., diagnoses of opportunistic illnesses that were included in the 1987 or

the 1993 case definition, CDC developed methods that estimated incidence of 1987 or 1993 definition opportunistic infections for cases that met only the 1993 immunologic (CD4⁺) criteria. These estimates showed that the number of diagnoses of AIDS-defining opportunistic infections increased during 1992 and 1993 by approximately 2 percent and 3 percent, respectively (see *Morbidity and Mortality Weekly Report*, November 18, 1994). The temporary distortion of the AIDS incidence curve caused by the 1993 expansion of the AIDS case definition had almost entirely waned by 1996.

Effect of Therapy on AIDS Incidence

Continuing the pattern first observed from 1995 to 1996, AIDS incidence decreased again from 1996 to 1997 and from 1997 to 1998. These decreases are mostly due to the effect of therapies for HIV infection and AIDS, which have altered the natural history of HIV infection and slowed progression to AIDS. AIDS incidence increasingly represents persons who were not diagnosed with HIV infection until they developed AIDS, persons who did not access treatment, or persons for whom treatment failed. Caution should be used when interpreting trends in AIDS incidence; the contribution of these effects to the AIDS incidence curve is currently being evaluated. See *Morbidity and Mortality Weekly Report*, September 19, 1997 and April 24, 1998.

Early Reporting Dates

Before 1990, CDC occasionally received reports on patients before they met the CDC AIDS case definition. If such patients were later diagnosed with AIDS, the diagnosis date on their record (when they first met the CDC definition) would be after the report date (when CDC first received information about the patient). Such records should be excluded from certain analyses, such as survival analysis and analysis of reporting delay. CDC's AIDS surveillance data base no longer receives reports on patients who do not meet the AIDS case definition.

Follow-up of Reported AIDS Cases

AIDS case records maintained at CDC contain all information reported to date from state and local health departments. As patients progress through their illness, additional conditions may be reported, or the patient's vital status may change. However, not all health departments have the resources to routinely follow-up patients for additional information. For this reason and because many patients move out of the reporting health department's jurisdiction, CDC records do not always contain all current information for each patient.

AIDS cases reports that do not include mode of HIV exposure information are routinely followed up by state and local health departments. As of December 1999, excluding cases which were not yet investigated, mode of exposure information has been identified for 78 percent of cases. Twenty-one percent of cases were closed with incomplete information because the patient died, declined interview, or was lost to follow-up; 1 percent of cases remained without a reported risk for HIV infection after complete investigation (see Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 1999;11(no.2):27). The demographic profile of persons who remain without risk information is more similar to that of other persons reported with AIDS than with the general U.S. population.

Evaluation of AIDS Surveillance

Cases of AIDS may not be reported to CDC for a variety of reasons. The diagnostic tests needed to confirm the diagnosis of certain AIDS-indicator conditions may not be performed, or physicians and hospital personnel may fail to report cases to the health department. Further, some patients with HIV disease may be ill or die from diseases or conditions not included in the current AIDS surveillance definition or from causes unrelated to their HIV infection.

Both CDC and state and local health departments have commissioned a variety of studies to evaluate the completeness of AIDS surveillance. Most evaluation projects have used alternate data resources if they are independent of routine case finding, such as death certificates, hospital discharge records, and laboratory records. Individual records from these alternate sources have then been matched against records in AIDS surveillance data bases. If an alternative source is found to be a productive source of case reports, it may be added to routine case finding methods. Evaluation projects have varied in size and scope (e.g., varying numbers of ICD-9 codes from death certificates or computerized discharge records), geographic area covered, detection of both inpatient and outpatient cases, and time frames. In general, evaluation studies suggest that reporting of AIDS cases is fairly complete; but, depending on the setting and evaluation method used, the level of reporting completeness may vary. High prevalence areas for AIDS appear to have more complete reporting than low prevalence areas. Following implementation of active case finding under the 1987 case definition, with funding support from CDC, completeness of case reporting increased in most areas and was estimated to be more than 85 percent complete (see *Journal of Acquired Immunodeficiency Syndrome*, 1992;5:257-64 and *American Journal of Public Health* 1992;82:1495-99).

Summary

Public health surveillance represents an ongoing and regular collection, analysis, interpretation, and application of health data for disease prevention and control. AIDS surveillance, like other national surveillance efforts, depends on health care providers and the state and local health departments and, thus, requires a balance between information needs versus practical limitations. AIDS surveillance in

the United States represents an unprecedented public health enterprise and has achieved an unusually high degree of completeness. In addition, surveillance has changed as understanding of AIDS and HIV infection have grown. Users of the public information data set should be familiar with the characteristics of public health surveillance in general as well as with the evolution of AIDS surveillance.

Data File Variables and Coding Schemes

The rectangular data file included in the *AIDS Public Information Data Set* contains one line of data for each AIDS case reported to CDC. Each line contains 35 columns. The columns contain 16 variables extracted from CDC's national AIDS data set.

Column	Variable	Description
1	<i>age</i>	Age group at diagnosis of the first AIDS-indicator opportunistic condition
2	<i>sexclass</i>	Sexual classification of patient
3	<i>race</i>	Race of patient
4	<i>categ</i>	Indicates which of the CDC AIDS case revisions the patient meets
5-10	<i>dxdate</i>	Month of diagnosis of first AIDS-indicator opportunistic condition
11-16	<i>repdate</i>	Date when CDC first received information about the case
17	<i>death</i>	Vital status of patient
18-19	<i>exposure</i>	Mode of exposure to HIV
20	<i>multrisk</i>	Indicates if patient had more than one risk of exposure to HIV
21	<i>birth</i>	Country of birth
22	<i>sexbi</i>	Sex with a bisexual man (women only)
23	<i>sexiv</i>	Sex with an injecting drug user
24	<i>sexother</i>	Sex with a person with hemophilia or with a transfusion recipient
25	<i>sexhiv</i>	Sex with a person known to be infected with HIV or to have AIDS, but whose mode of exposure is unknown
26-31	<i>adjwgt</i>	Reporting delay adjustment weight
32-35	<i>msa</i>	Region of residence at diagnosis of AIDS

Each of these variables is coded alpha-numerically. The codes used in the *AIDS Public Information Data Set* are described below.

Age (column 1)

This variable contains the patient's age when he or she was first diagnosed with an AIDS-indicator disease.

- 0 = Less than 1 year old
- 1 = 1 to 12 years old
- 2 = 13 to 19 years old
- 3 = 20 to 24 years old
- 4 = 25 to 29 years old
- 5 = 30 to 34 years old

- 6 = 35 to 39 years old
or age is missing
- 7 = 40 to 44 years old
- 8 = 45 to 49 years old
- 9 = 50 to 54 years old
- A = 55 to 59 years old
- B = 60 to 64 years old
- C = 65 years old or older

Sexclass (column 2)

Adult/adolescent males are classified according to their sexual orientation.

- 1 = Adult/adolescent male who has sex only with other men or sex is missing, or sexual orientation is missing
- 2 = Adult/adolescent male who has sex with both men and women
- 3 = Adult/adolescent heterosexual male or pediatric male
- 4 = Female (both adult/adolescent and pediatric)

Race (column 3)

- 1 = White (not Hispanic)
- 2 = Black (not Hispanic)
- 3 = Hispanic
- 4 = Asian/Pacific Islander
- 5 = American Indian/Alaskan Native
- 9 = Unknown

Categ (column 4)

This variable reflects changes made over time to the CDC surveillance definition for AIDS. Only cases meeting the current (1993) surveillance definition are included in this data set. *Categ* indicates whether the patient also met the pre-1985, 1985, or 1987 surveillance definition, and whether the diagnosis, if it meets the 1987 or 1993 definition, was definitive or presumptive. Cases that meet more than one of these surveillance definitions are classified into the category listed first. For more information about the 1993 definition, see *Morbidity and Mortality Weekly Report*, December 18, 1992, Recommendations and Reports.

- 1 = Case meets the pre-1985 surveillance definition
- 2 = Case meets the 1985 surveillance definition
- 3 = Case meets the 1987 surveillance definition and was diagnosed definitively
- 4 = Case meets the 1987 surveillance definition and was diagnosed presumptively
- 5 = Case meets the 1993 surveillance definition: pulmonary tuberculosis, recurrent pneumonia, and/or cervical cancer (definitive diagnosis)
- 6 = Case meets the 1993 surveillance definition: pulmonary tuberculosis and/or recurrent pneumonia (presumptive diagnosis)
- 7 = Case meets the 1993 surveillance definition, severe HIV-related immunosuppression

Dxdate (columns 5 through 10)

This variable contains the year and month in which the first AIDS-indicator condition was diagnosed. Columns 5 through 8 contain the year; columns 9 and 10 contain the month. Cases diagnosed before 1982 are coded as A198199.@ Cases whose month of diagnosis is unknown are coded as A99@ in the month portion of this variable.

Reptime (columns 11 through 16)

This variable contains the year and month in which CDC received the case report. Columns 11 through 14 contain the year; columns 15 and 16 contain the month. Cases reported during 1981 are coded as A198199.@

Death (column 17)

- 0 = CDC has not received a death notification for this case
- 1 = CDC has been notified that this patient died

Patients diagnosed during the 2 most recent years are coded as A0@ regardless of the patient's vital status. AIDS prevalence rates calculated for the most recent two-year period should be interpreted with caution. The rates calculated will be artificially high because all persons diagnosed in this period are coded with a vital status of A0@ (alive), even if a death has been reported to CDC for that person. This is to prevent inadvertent indirect identification of any record by linking a death date inferred from this data set to other publicly available data sets which contain death dates on individuals. For more information on trends in AIDS, see *Morbidity and Mortality Weekly Report*, September 19, 1997 and April 24, 1998.

Exposure (columns 18 and 19)

For surveillance purposes, AIDS cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure to HIV are classified in the exposure category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They make up a separate exposure category. Persons with multiple reported modes of exposure are indicated in the variable *multrisk*.

AMen who have sex with men cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). **AHeterosexual contact** cases are in persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., an injecting drug user).

Adults/adolescents born, or who had sex with someone born, in a country where heterosexual transmission was believed to be the predominant mode of HIV transmission (formerly classified as Pattern-II countries by the World Health Organization) are no longer classified as having heterosexually acquired AIDS. Similar to case reports for other persons who are reported without behavioral or transfusion risks for HIV, these reports are now classified (in the absence of other risk information which would classify them into another exposure category) as **Ano risk reported or identified** (see *Morbidity and Mortality Weekly Report*, March 11, 1994). Children whose mother was born, or whose mother had sex with someone born, in a Pattern-II country are now classified (in the absence of other risk information which would classify them into another exposure category) as **AMother with/at risk for HIV infection: has HIV infection, risk not specified**.

ARisk not reported or identified cases are in persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. Risk not reported or identified cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

Adult/adolescent exposure categories

- 1 = Men who have sex with men
- 2 = Injecting drug use
- 3 = Men who have sex with men and inject drugs
- 4 = Hemophilia/coagulation disorder
- 5 = Heterosexual contact with a person with, or at increases risk for, HIV infection
- 7 = Receipt of blood transfusion, blood components, or tissue
- 8 = Risk not reported or identified

Pediatric exposure categories

- 9 = Hemophilia/coagulation disorder
- 10 = Mother with, or at risk for, HIV infection
- 11 = Receipt of blood transfusion, blood components, or tissue
- 12 = Risk not reported or identified

Multrisk (column 20)

Multrisk is coded only for adult/adolescent patients (13 years old or older) and indicates if the patient has risk(s) of exposure to HIV other than the one indicated by *exposure*.

- 0 = Patient's only mode of exposure to HIV is that indicated by *exposure*
- 1 = Patient has additional risk(s) of exposure
- 2 = Patient's mode of exposure is not reported or identified

Birth (column 21)

- 1 = Patient was born in the United States or its dependencies and possessions, or place of birth was not specified
- 2 = Patient was born outside the United States

Heterosexual risk information (columns 22 through 25)

These variables (*sexbi*, *sexiv*, *sexother*, and *sexhiv*) contain additional exposure information for patients infected heterosexually. All 4 variables are coded as follows:

- 0 = no
- 1 = yes
- 9 = missing/unknown

The variable *sexbi* is coded only for women (for men, the variable contains a blank). All 4 variables contain #9@ (missing/unknown) for patients with hemophilia, regardless of whether the exposure information is in fact unknown. This restriction is necessary in order to comply with the Assurance of Confidentiality on page 5. Of the 4,596 AIDS cases reported through December 1995 among adults/adolescents with hemophilia, less than 4 percent also reported heterosexual contact with a person at increased risk for AIDS or HIV infection.

Adjwgt (columns 26 through 31)

This variable contains an adjustment weight which, when used as a weighting variable in a frequency tabulation, produces tabulations of AIDS cases that are adjusted for delays in case reporting (see page 11 for a discussion of delays in reporting). The weights are based on estimated reporting delay distributions that take into account exposure, geographic, and demographic variations in case reporting. The adjustment weights and the resulting tabulations are not reliable for cases diagnosed during the most recent 6 months. The *Tools* menu contains an adjusted weight option. If you select this option, all subsequent tabulations you request will be weighted accordingly.

MSA (columns 32 through 35)

Metropolitan area of residence at diagnosis of AIDS is identified for adult/adolescent patients residing in MSAs with 500,000 or more population, according to the latest available official U.S. Bureau of Census estimates. Each MSA is identified by a 4-digit code listed in Appendix B. For adult/adolescent patients residing in an MSA with less than 500,000 population, in a non-metropolitan area, or whose metropolitan area of residence is unknown, and for all pediatric patients, region of residence is identified. The regional codes are:

- 1 = Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
- 2 = Midwest: Indiana, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin
- 3 = South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia
- 4 = West: Alaska, Arizona, California, Colorado, Idaho, Hawaii, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming
- 5 = U.S. dependencies, possessions, and independent nations in free association with the United States: Guam, Puerto Rico, the U.S. Virgin Islands, and the U.S. Pacific Islands listed on page 8.

State, MSA, and County Tables

In addition to the rectangular data file discussed in section 2, the *AIDS Public Information Data Set* contains tabular data by state, metropolitan area, and county or health district. These tables consist of frequency tables and 2-way cross tabulations of 8 variables extracted from CDC's national AIDS surveillance data set. For counties or health districts, the data set contains only 1-way tables of 3 variables *age*, *race/ethnicity*, and *sex*). The data set contains one set of tables for the entire United States, one set for each state and for the District of Columbia, one set for each MSA, and one set for each county or health district. All MSAs with 500,00 or more population are included in the data set. Selected MSAs with populations between 100,000 and 500,000, and selected counties or health districts are included in the data set, based on the data release policies of the individual states.

Data from MSAs with populations between 100,000 and 500,000 are included from Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Iowa, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, and Wyoming.

Data from individual counties are included from Arkansas, Delaware, Georgia, Hawaii, Indiana, Louisiana, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, and Washington.

Data from health districts are included from Florida, Idaho, Kentucky, Mississippi, Montana, Nebraska, New Mexico, South Carolina, Tennessee, Virginia, and West Virginia.

See Appendix B for a list of MSAs. See Appendix C for a list of counties which comprise each health district.

The variables included in the state and MSA tables are:

Variable	Description
<i>age</i>	Age group at diagnosis of the first AIDS-indicator condition
<i>categ</i>	Indicates which of the CDC AIDS case revisions the patient meets
<i>dth_hyr</i>	Half-year of death for patients reported dead
<i>dx_hyr</i>	Half-year of diagnosis of first AIDS-indicator condition
<i>ent_hyr</i>	Half-year in which CDC first received information about the case
<i>exposure</i>	Mode of exposure to HIV
<i>race/ethnicity</i>	Race/ethnicity of patient
<i>sex</i>	Sex of patient

For counties and health districts, 1-way tables are available for the variables *age*, *race/ethnicity*, and *sex*. The values used for the variables are printed below.

Age

This variable contains the patient's age when he or she was first diagnosed with an AIDS-indicator condition. Ages printed in the documentation file are grouped as follows:

0 - 1
1 - 12
13 - 19
20 - 29
30 - 39
40 - 49
50 - 59
60 +

Categ

This variable reflects revisions made to the CDC surveillance definition for AIDS. Only cases meeting the current (1993) surveillance definition are included in the data set. *Categ* indicates whether the patient also meets the pre-1985, 1985, or 1987 surveillance definition, and whether the diagnosis, if it meets the 1987 or 1993 definition, was definitive or presumptive. Cases that meet more than one of these surveillance definitions are classified into the definition category listed first. For more information about the 1993 definition, see *Morbidity and Mortality Weekly Report, Recommendations and Reports*, December 18, 1992.

- 1 = Case meets the pre-1985 surveillance definition
- 2 = Case meets the 1985 surveillance definition
- 3 = Case meets the 1987 surveillance definition and was diagnosed definitively
- 4 = Case meets the 1987 surveillance definition and was diagnosed presumptively
- 5 = Case meets the 1993 surveillance definition: pulmonary tuberculosis, recurrent pneumonia, and/or cervical cancer (definitive diagnosis)
- 6 = Case meets the 1993 surveillance definition: pulmonary tuberculosis and/or recurrent pneumonia (presumptive diagnosis)
- 7 = Cases meets the 1993 surveillance definition: severe HIV-related immunosuppression

Dth_hyr

For patients whose death has been reported to CDC, this variable contains the half-year of death. The first four numbers indicate the year; the last two indicate the first or second half of that year. For example, the value "A198802" indicates that the patient died in the second half of 1988. Patients whose death has been reported to CDC, but whose date of death is unknown are coded as "A999999".

Dx_hyr

This variable contains the half-year in which the first AIDS-indicator condition was diagnosed. The first four numbers indicate the year; the last two indicate the first or second half of that year.

Ent_hyr

This variable contains the half-year in which CDC received the case report. The first four numbers indicate the year; the last two indicate the first or second half of that year.

Exposure

For surveillance purposes, AIDS cases are counted only once in a hierarchy of exposure categories. Persons with more than one reported mode of exposure to HIV are classified in the exposure category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They make up a separate exposure category.

AMen who have sex with men@cases include men who report sexual contact with other men (i.e., homosexual contact) and men who report sexual contact with both men and women (i.e., bisexual contact). **AHeterosexual contact@**cases are in persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., an injecting drug user).

Adults/adolescents born, or who had sex with someone born, in a country where heterosexual transmission was believed to be the predominant mode of HIV transmission (formerly classified as Pattern-II countries by the World Health Organization) are no longer classified as having heterosexually acquired AIDS. Similar to case reports for other persons who are reported without behavioral or transfusion risks for HIV, these reports are now classified (in the absence of other risk information which would classify them into another exposure category) as **Ano risk reported or identified@** (see *Morbidity and Mortality Weekly Report*, March 11, 1994). Children whose mother was born, or whose mother had sex with someone born, in a Pattern-II country are now classified (in the absence of other risk information which would classify them into another exposure category) as

AMother with/at risk for HIV infection: has HIV infection, risk not specified.@

RRisk not reported or identified@cases are in persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. Risk not reported or identified cases include persons who are currently under investigation by local health department officials; persons whose exposure history is incomplete because they died, declined to be interviewed, or were lost to follow-up; and persons who were interviewed or for whom other follow-up information was available and no exposure mode was identified. Persons who have an exposure mode identified at the time of follow-up are reclassified into the appropriate exposure category.

01 = Men who have sex with men

02 = Injecting drug use

03 = Men who have sex with men and inject drugs

04 = Adult/adolescent hemophilia/coagulation disorder

05 = Heterosexual contact with a person with, or at increased risk for, HIV infection

07 = Adult/adolescent receipt of blood transfusion, blood components, or tissue

08 = Adult/adolescent risk not reported or identified

09 = Pediatric hemophilia/coagulation disorder

10 = Mother with, or at risk for, HIV infection

11 = Pediatric receipt of blood transfusion, blood components, or tissue

12 = Pediatric risk not reported or identified

Race/ethnicity

1 = White (not Hispanic)

2 = Black (not Hispanic)

3 = Hispanic

4 = Asian/Pacific Islander

5 = American Indian/Alaskan Native

9 = Unknown

Sex

1 = Male

2 = Female

Small Cell Restriction

In accordance with CDC guidelines on protecting confidentiality and with an agreement made with state and local health departments for release of these data, entries whose value is 3 or less are not included in the tables. In addition, the *AIDS Public Information Data Set* software allows you to combine data from more than one state, MSA, or county/health district in either separate or aggregate form. If you select the aggregate option, each count may be off by an amount equal to 3 times the number of states/MSAs/counties aggregated. For example, if you select data from California, Washington State, and Oregon, each count may be off by as many as 9 cases (3 times the number of states, in this case 3).

Appendix A: Installation

In 1997, The *AIDS Public Information Data Set* was rewritten to be fully Windows compatible. While much of the original program design remained unchanged, many features were added, cursor and mouse controls were enhanced, and the installation procedure changed to reflect Windows conventions. Changes to the software are more fully described in the on-line help screens. The December 2001 edition contains the changes made in 1997. As with previous releases, the software allows you to display simple statistics without additional software such as SAS, SPSS, BMDP, or PRODAT. More complex analyses, however, require statistical software.

To transfer the data to another software package for analysis, you may wish to download only the ASCII version. You may also load the software and use the export option (under *File*) to extract the records and variables you wish to analyze. The export option will create an ASCII data file, which can then be processed by other software.

Loading the Software

The *AIDS Public Information Data Set* is available on CD, as part of the *CDC HIV/AIDS Information Guide*, or can be downloaded from CDC's web site. Installation instructions vary, depending on the medium you are using.

Minimum requirements for installation are:

- * Windows 95 or greater
- * 80486 CPU
- * 420 K of free RAM
- * 50Mb of free disk space

To install the software from CDC's web site

- 1) Download the self-extracting file (APIDS01.EXE) to desired directory (i.e., C:\AIDSPIDS).
- 2) Click on Start and Run. Using the Browse feature, locate and run APIDS01.EXE.

You may change the drive and directory to which the *AIDS Public Information Data Set* will be extracted.

If you want to be able to run the program from the Start Menu, be sure "Create program group(s): AIDS Public Information Data Set" is checked.

- 3) Click on Extract.

- 4) After the program has been extracted, double click on the AIDS Public Information Data Set icon to run it. The first time you run it, it will perform a setup/indexing process that will take up to a few minutes to complete.
- 5) In order to save disk space, the file APIDS01.EXE can be deleted.

To load the software from the CD, insert the disk into the reader. The software will automatically display the initial screen for the *CDC HIV/AIDS Information Guide*. To access the *AIDS Public Information Data Set*, first select menu item 7, **A**Software. Then select *AIDS Public Information Data Set*. Finally, select **A**Download APIDS01.EXE. This selection will initiate the software installation procedure described above. Simply proceed with steps 1 through 5, above.

Getting Help

The *AIDS Public Information Data Set* uses standard Windows interfaces, and can be mastered with minimum effort. On-line help screens describe how to use the program to display information. You can access help by pressing the **<F1>** key, by clicking the right (secondary) mouse button, or by selecting the *Help* menu. The information displayed will vary depending upon the last option you accessed. If you need additional information, contact the Statistics and Data Management Branch, Division of HIV/AIDS Prevention, telephone (404) 639-2020.

Displaying the Menus

Once you complete the installation procedure and run the program, you will see a screen with four options displayed on the upper-left corner: *File*, *Tools*, *Window*, and *Help*. Select *File* to display data from either the main data file or from the state, MSA, or county tables. A second screen will display so that you may select the variables you wish to tabulate. Select *Tools* to create indexes or set various options that control the display of data. Select *Window* to scroll through the tables you have created. Select *Help* to see further information on how to use this program.

Cursor Control

Cursor control uses a standard Windows interface. Select variables by double-clicking the left (primary) mouse button or the *Enter* key. An asterisk will display next to the fields you have selected. Menus and other options can also be selected by pressing the **<Alt>** key and typing the highlighted letter of that option.

Appendix B: Metropolitan Statistical Areas

Definitions for MSAs are issued by the Office of Management and Budget (OMB) to be used in presentation of statistics by agencies of the federal government. The metropolitan areas used on the *AIDS Public Information Data Set* are the MSAs for all areas except the 6 New England states. For these states, the New England County Metropolitan Areas (NECMA, also defined by OMB) are used. Metropolitan areas are named for a central city in the MSA or NECMA and may include several counties and cross state boundaries.

The AIDS Public Information Data Set contains data from all MSAs with 500,000 or more population, and from MSAs with 100,000 to 500,000 population from Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Iowa, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maryland, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, and Wyoming.

Code Metropolitan areas with 500,000 or more population

80	Akron, Ohio
160	Albany-Schenectady, N.Y.
200	Albuquerque, N.Mex.
240	Allentown, Pa.
440	Ann Arbor, Mich.
520	Atlanta, Ga.
640	Austin, Tex.
680	Bakersfield, Calif.
720	Baltimore, Md.
760	Baton Rouge, La.
875	Bergen-Passaic, N.J.
1000	Birmingham, Ala.
1123	Boston, Mass.
1280	Buffalo, N.Y.
1520	Charlotte, N.C.
1600	Chicago, Ill.
1640	Cincinnati, Ohio
1680	Cleveland, Ohio
1720	Colorado Springs, Colo.
1840	Columbus, Ohio
1920	Dallas, Tex.
2000	Dayton, Ohio
2020	Daytona Beach, Fla.

Code	Metropolitan areas with 500,000 or more population
2080	Denver, Colo.
2160	Detroit, Mich.
2320	El Paso, Tex.
2680	Fort Lauderdale, Fla.
2760	Fort Wayne, Ind.
2800	Fort Worth, Tex.
2840	Fresno, Calif.
2960	Gary, Ind.
3000	Grand Rapids, Mich.
3120	Greensboro, N.C.
3160	Greenville, S.C.
3240	Harrisburg, Pa.
3283	Hartford, Conn.
3320	Honolulu, Hawaii
3360	Houston, Tex.
3480	Indianapolis, Ind.
3600	Jacksonville, Fla.
3640	Jersey City, N.J.
3760	Kansas City, Mo.
3840	Knoxville, Tenn.
4120	Las Vegas, Nev.
4400	Little Rock, Ark.
4480	Los Angeles, Calif.
4520	Louisville, Ky.
4880	McAllen, Tex.
4920	Memphis, Tenn.
5000	Miami, Fla.
5015	Middlesex, N.J.
5080	Milwaukee, Wis.
5120	Minneapolis-Saint Paul, Minn.
5160	Mobile, Ala.
5190	Monmouth-Ocean City, N.J.
5360	Nashville, Tenn.
5380	Nassau-Suffolk, N.Y.
5483	New Haven, Conn.
5560	New Orleans, La.
5600	New York, N.Y.
5640	Newark, N.J.
5720	Norfolk, Va.
5775	Oakland, Calif.
5880	Oklahoma City, Okla.

Code	Metropolitan areas with 500,000 or more population
5920	Omaha, Nebr.
5945	Orange County, Calif.
5960	Orlando, Fla.
6160	Philadelphia, Pa.
6200	Phoenix, Ariz.
6280	Pittsburgh, Pa.
6440	Portland, Oreg.
6483	Providence, R.I.
6640	Raleigh-Durham, N.C.
6760	Richmond, Va.
6780	Riverside-San Bernardino, Calif.
6840	Rochester, N.Y.
6920	Sacramento, Calif.
7040	Saint Louis, Mo.
7160	Salt Lake City, Utah
7240	San Antonio, Tex.
7320	San Diego, Calif.
7360	San Francisco, Calif.
7400	San Jose, Calif.
7440	San Juan, P.R.
7510	Sarasota, Fla.
7560	Scranton, Pa.
7600	Seattle, Wash.
8003	Springfield, Mass.
8120	Stockton, Calif.
8160	Syracuse, N.Y.
8200	Tacoma, Wash.
8280	Tampa-Saint Petersburg, Fla.
8400	Toledo, Ohio
8520	Tucson, Ariz.
8560	Tulsa, Okla.
8735	Ventura, Calif.
8840	Washington, D.C.
8960	West Palm Beach, Fla.
9040	Wichita, Kans.
9160	Wilmington, Del.
9243	Worcester, Mass.
9320	Youngstown, Ohio

Code	Metropolitan areas with 100,000 to 500,000 population
40	Abilene, Tex.
120	Albany, Ga.
220	Alexandria, La.
280	Altoona, Pa.
320	Amarillo, Tex.
480	Asheville, N.C.
500	Athens, Ga.
560	Atlantic-Cape May, N.J.
600	Augusta, Ga.
733	Bangor, Maine
840	Beaumont, Tex.
860	Bellingham, Wash.
870	Benton Harbor, Mich
880	Billings, Mont.
920	Biloxi, Miss.
1020	Bloomington, Ind.
1040	Bloomington, Ill.
1080	Boise, Idaho
1125	Boulder, Colo.
1145	Brazoria, Tex.
1150	Bremerton, Wash.
1240	Brownsville, Tex.
1260	Bryan, Tex.
1320	Canton, Ohio
1360	Cedar Rapids, Iowa
1400	Champaign-Urbana, Ill.
1440	Charleston, S.C.
1480	Charleston, W.Va.
1540	Charlottesville, Va.
1560	Chattanooga, Tenn.
1660	Clarksville, Tenn.
1740	Columbia, Mo.
1760	Columbia, S.C.
1800	Columbus, Ga.
1880	Corpus Christi, Tex.
1900	Cumberland, Md.
1950	Danville, Va.
1960	Davenport, Iowa
2040	Decatur, Ill.
2120	Des Moines, Iowa
2190	Dover, Del.

Code Metropolitan areas with 100,000 to 500,000 population

2240	Duluth, Minn.
2330	Elkhart, Ind.
2360	Erie, Penn.
2400	Eugene, Oreg.
2440	Evansville, Ind.
2520	Fargo, N.D.
2560	Fayetteville, N.C.
2580	Fayetteville, Ark.
2640	Flint, Mich.
2655	Florence, S.C.
2670	Fort Collins, Colo.
2700	Fort Myers, Fla.
2710	Fort Pierce, Fla.
2720	Fort Smith, Ark.
2750	Fort Walton Beach, Fla.
2900	Gainesville, Fla.
2920	Galveston, Tex.
2980	Goldsboro, N.C.
2995	Grand Junction, Colo.
3060	Greeley, Colo.
3150	Greenville, N.C.
3180	Hagerstown, Md.
3200	Hamilton, Ohio
3285	Hattiesburg, Miss.
3290	Hickory, N.C.
3350	Houma, La.
3400	Huntington, W. Va.
3500	Iowa City, Iowa
3520	Jackson, Mich.
3560	Jackson, Miss.
3580	Jackson, Tenn.
3605	Jacksonville, N.C.
3660	Johnson City, Tenn.
3680	Johnstown, Pa.
3710	Joplin, Mo.
3720	Kalamozoo, Mich.
3740	Kankakee, Ill.
3810	Killeen, Tex.
3850	Kokomo, Ind.
3880	Lafayette, La.

Code Metropolitan areas with 100,000 to 500,000 population

3920	Lafayette, Ind.
3960	Lake Charles, La.
3980	Lakeland, Fla.
4000	Lancaster, Pa.
4040	Lansing, Mich.
4080	Laredo, Tex.
4100	Las Cruces, N.Mex.
4200	Lawton, Okla.
4243	Lewiston, Maine
4280	Lexington, Ky.
4320	Lima, Ohio
4360	Lincoln, Nebr.
4420	Longview, Tex.
4600	Lubbock, Tex.
4640	Lynchburg, Va.
4680	Macon, Ga.
4800	Mansfield, Ohio
4890	Medford, Oreg.
4900	Melbourne, Fla.
5200	Monroe, La.
5280	Muncie, Ind.
5330	Myrtle Beach, S.C.
5345	Naples, Fla.
5523	New London, Conn.
5660	Newburgh, N.Y.
5790	Ocala, Fla.
5800	Odessa, Tex.
5910	Olympia, Wash.
6015	Panama City, Fla.
6020	Parkersburg, W.Va.
6080	Pensacola, Fla.
6120	Peoria, Ill.
6403	Portland, Maine
6560	Pueblo, Colo.
6580	Punta Gorda, Fla.
6680	Reading, Pa.
6720	Reno, Nev.
6740	Richland, Wash.
6800	Roanoka, Va.
6820	Rochester, Minn.

Code	Metropolitan areas with 100,000 to 500,000 population
6880	Rockford, Ill.
6895	Rocky Mount, N.C.
6960	Saginaw, Mich.
6980	Saint Cloud, Minn.
7080	Salem, Oreg.
7200	San Angelo, Tex.
7490	Santa Fe, N.Mex.
7520	Savannah, Ga.
7610	Sharon, Pa.
7640	Sherman, Tex.
7680	Shreveport, La.
7720	Sioux City, Iowa
7800	South Bend, Ind.
7840	Spokane, Wash.
7880	Springfield, Ill.
7920	Springfield, Mo.
8050	State College, Pa.
8080	Steubenville, Ohio
8140	Sumter, S.C.
8240	Tallahassee, Fla.
8320	Terre Haute, Ind.
8360	Texarkana, Tex.
8440	Topeka, Kans.
8480	Trenton, N.J.
8640	Tyler, Tex.
8720	Vallejo, Calif.
8760	Vineland, N.J.
8800	Waco, Tex.
8920	Waterloo, Iowa
9000	Wheeling, W.Va.
9080	Wichita Falls, Tex.
9140	Williamsport, Pa.
9200	Wilmington, N.C.
9260	Yakima, Wash.
9280	York, Pa.

Appendix C: Health Districts

Listed below are the counties which comprise each health district included in the data set. The county name is preceded by its Federal Information Processing Standards (FIPS) code (see *Worldwide Geographic Location Codes*, available from the General Services Administration, telephone 202-219-0077).

Florida

Health District 1

	67	Lafayette
	75	Levy
33	Escambia	107 Putnam
91	Okaloosa	121 Suwannee
113	Santa Rosa	125 Union
131	Walton	

Health District 2

	3	Baker
5	Bay	19 Clay
13	Calhoun	31 Duval
37	Franklin	89 Nassau
39	Gadsden	109 Saint Johns
45	Gulf	
59	Holmes	
63	Jackson	
65	Jefferson	
73	Leon	
77	Liberty	
79	Madison	
123	Taylor	
129	Wakulla	
133	Washington	

Health District 3

1	Alachua
7	Bradford
23	Columbia
29	Dixie
41	Gilchrist
47	Hamilton

Health District 4

	3	Baker
	19	Clay
	31	Duval
	89	Nassau
	109	Saint Johns

Health District 5

101	Pasco
103	Pinellas

Health District 6

57	Hillsborough
81	Manatee

Health District 7

9	Brevard
95	Orange
97	Osceola
117	Seminole

Health District 8

15	Charlotte
21	Collier
27	De Soto
43	Glades
51	Hendry
71	Lee
115	Sarasota

Health District 9

99	Palm Beach
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Health District 10

11	Broward
----	---------

Health District 11

25	Dade
87	Monroe

Health District 12

35	Flagler
127	Volusia

Florida

Health District 13

- 17 Citrus
- 53 Hernando
- 69 Lake
- 83 Marion
- 119 Sumter

Health District 14

- 49 Hardee
- 55 Highlands
- 105 Polk

Health District 15

- 61 Indian River
- 85 Martin
- 93 Okeechobee
- 111 Saint Lucie

Idaho

Health District 1

9 Benewah
17 Bonner
21 Boundary
55 Kootenai
79 Shoshone

Health District 2

35 Clearwater
49 Idaho
57 Latah
61 Lewis
69 Nez Perce

Health District 3

3 Adams
27 Canyon
45 Gem
73 Owyhee
75 Payette
87 Washington

Health District 4

1 Ada
15 Boise
39 Elmore
85 Valley

Health District 5

13 Blaine
25 Camas
31 Cassia
47 Gooding
53 Jerome
63 Lincoln
67 Minidoka
83 Twin Falls

Health District 6

5 Bannock
7 Bear Lake
11 Bingham
23 Butte
29 Caribou
41 Fanklin
71 Oneida
77 Power

Health District 7

19 Bonneville
33 Clark
37 Custer
43 Fremont
51 Jefferson
59 Lemhi
65 Madison
81 Teton

Kentucky

Health District 1

7 Ballard
35 Calloway
39 Carlisle
75 Fulton
83 Graves
105 Hickman
145 McCracken
157 Marshall

Health District 2

33 Caldwell
47 Christian
55 Crittenden
107 Hopkins
139 Livingston
143 Lyon
177 Muhlenberg
219 Todd
221 Trigg

Health District 3

59 Daviess
91 Hancock
101 Henderson
149 McLean
183 Ohio
225 Union
233 Webster

Health District 4

3 Allen
9 Barren
31 Butler
61 Edmonson

99 Hart
141 Logan
169 Metcalfe
171 Monroe
213 Simpson
227 Warren

Health District 5

27 Breckinridge
85 Grayson
93 Hardin
123 Larue
155 Marion
163 Meade
179 Nelson
229 Washington

Health District 6

29 Bullitt
103 Henry
111 Jefferson
185 Oldham
211 Shelby
215 Spencer
223 Trimble

Health District 7

15 Boone
37 Campbell
41 Carroll
77 Gallatin
81 Grant
117 Kenton
187 Owen
191 Pendleton

Health District 8

23 Bracken
69 Fleming
135 Lewis
161 Mason
201 Robertson

Health District 9

11 Bath
165 Menifee
173 Montgomery
175 Morgan
205 Rowan

Health District 10

19 Boyd
43 Carter
63 Elliott
89 Greenup
127 Lawrence

Health District 11

71 Floyd
115 Johnson
153 Magoffin
159 Martin
195 Pike

Kentucky

Health District 12

25 Breathitt
119 Knott
129 Lee
131 Leslie
133 Letcher
189 Owsley
193 Perry
237 Wolfe

Health District 13

13 Bell
51 Clay
95 Harlan
109 Jackson
121 Knox
125 Laurel
203 Rockcastle
235 Whitley

Health District 14

1 Adair
45 Casey
53 Clinton
57 Cumberland
87 Green
147 McCreary
199 Pulaski
207 Russell
217 Taylor
231 Wayne

Health District 15

5 Anderson
17 Bourbon
21 Boyle
49 Clark
65 Estill
67 Fayette
73 Franklin
79 Garrard
97 Harrison
113 Jessamine
137 Lincoln
151 Madison
167 Mercer
181 Nicholas
197 Powell
209 Scott
239 Woodford

Mississippi

Health District 1

27 Coahoma
33 De Soto
43 Grenada
107 Panola
119 Quitman
135 Tallahatchie
137 Tate
143 Tunica
161 Yalobusha

Health District 2

3 Alcorn
9 Benton
57 Itawamba
71 Lafayette
81 Lee
93 Marshall
115 Pontotoc
117 Prentiss
139 Tippah
141 Tishomingo
145 Union

Health District 3

7 Attala
11 Bolivar
15 Carroll
51 Holmes
53 Humphreys
83 Leflore
97 Montgomery
133 Sunflower
151 Washington

Health District 4

13 Calhoun
17 Chickasaw
19 Choctaw
25 Clay
87 Loundes
95 Monroe
103 Noxubee
105 Oktibbeha
155 Webster
159 Winston

Health District 5

21 Claiborne
29 Copiah
49 Hinds
55 Issaquena
89 Madison
121 Rankin
125 Sharkey
127 Simpson
149 Warren
163 Yazoo

Health District 6

23 Clarke
61 Jasper
69 Kemper
75 Lauderdale
79 Leake
99 Neshoba
101 Newton
123 Scott
129 Smith

Health District 7

1 Adams
5 Amite
37 Franklin
63 Jefferson
77 Lawrence
85 Lincoln
113 Pike
147 Walthall
157 Wilkinson

Health District 8

31 Covington
35 Forrest
41 Greene
65 Jefferson Davis
67 Jones
73 Lamar
91 Marion
111 Perry
153 Wayne

Health District 9

39 George
45 Hancock
47 Harrison
59 Jackson
109 Pearl River
131 Stone

Montana

Health District 1

11 Carter
17 Custer
19 Daniels
21 Dawson
25 Fallon
33 Garfield
55 McCone
71 Phillips
75 Powder River
79 Prairie
83 Richland
85 Roosevelt
87 Rosebud
91 Sheridan
103 Treasure
105 Valley
109 Wibaux

Health District 2

5 Blaine
13 Cascade
15 Chouteau
35 Glacier
41 Hill
51 Liberty
73 Pondera
99 Teton
101 Toole

Health District 3

3 Big Horn
9 Carbon
27 Fergus
37 Golden Valley
45 Judith Basin
65 Musselshell
69 Petroleum
95 Stillwater
97 Sweet Grass
107 Wheatland
111 Yellowstone

Health District 4

1 Beaverhead
7 Broadwater
23 Deer Lodge
31 Gallatin
39 Granite
43 Jefferson
49 Lewis and Clark
57 Madison
59 Meagher
67 Park
77 Powell
93 Silver Bow

Health District 5

29 Flathead
47 Lake
53 Lincoln

Health District 6

61 Mineral
63 Missoula
81 Ravalli
89 Sanders

Nebraska

Health District 1

3 Antelope
11 Boone
15 Boyd
17 Brown
21 Burt
27 Cedar
31 Cherry
37 Colfac
39 Cuming
43 Dakota
51 Dixon
89 Holt
103 Keya Paha
107 Knox
119 Madison
125 Nance
139 Pierce
141 Platte
149 Rock
167 Stanton
173 Thurston
179 Wayne

Health District 2

53 Dodge
55 Douglas
153 Sarpy
177 Washington

Health District 3

23 Butler
25 Cass
59 Fillmore
67 Gage
95 Jefferson
97 Johnson

109 Lancaster
127 Nemaha
131 Otoe
133 Pawnee
143 Polk
147 Richardson
151 Saline
155 Saunders
159 Seward
169 Thayer
185 York

Health District 4

1 Adams
9 Blaine
19 Buffalo
35 Clay
41 Custer
61 Franklin
71 Garfield
77 Greeley
79 Hall
81 Hamilton
83 Harlan
93 Howard
99 Kearney
115 Loup
121 Merrick
129 Nuckolls
137 Phelps
163 Sherman
175 Valley
181 Webster
183 Wheeler

Health District 5

5 Arther
29 Chase
47 Dawson
57 Dundy
63 Frontier
65 Furnas
73 Gosper
75 Grant
85 Hayes
87 Hitchcock
91 Hooker
101 Keith
111 Lincoln
113 Logan
117 McPherson
135 Perkins
145 Red Willow
171 Thomas

Health District 6

7 Banner
13 Box Butte
33 Cheyenne
45 Dawes
49 Deuel
69 Garden
105 Kimball
123 Morrill
137 Scotts Bluff
161 Sheridan
165 Sioux

New Mexico

Health District 1

1 Bernalillo
6 Cibola
31 McKinley
43 Sandoval
45 San Juan
57 Torrance
61 Valencia

Health District 2

7 Colfax
21 Harding
28 Los Alamos
33 Mora
39 Rio Arriba
47 San Miguel
49 Santa Fe
55 Taos
59 Union

Health District 3

3 Catron
13 Dona Ana
17 Grant
23 Hidalgo
29 Luna
35 Otero
51 Sierra
53 Socorro

Health District 4

5 Chaves
9 Curry
11 De Baca
15 Eddy
19 Guadalupe
25 Lea
27 Lincoln
37 Quay
41 Roosevelt

South Carolina

Health District 1

7 Anderson
73 Oconee

Health District 2

45 Greenville
77 Pickens

Health District 3

21 Cherokee
83 Spartanburg
87 Union

Health District 4

23 Chester
57 Lancaster
91 York

Health District 5

1 Abbeville
37 Edgefield
47 Greenwood
59 Laurens
65 McCormick
81 Saluda

Health District 6

63 Lexington
71 Newberry

Health District 7

39 Fairfield
79 Richland

Health District 8

27 Clarendon
55 Kershaw
61 Lee
85 Sumter

Health District 9

25 Chesterfield
31 Darlington
69 Marlboro

Health District 10

3 Aiken
5 Allendale
11 Barnwell

Health District 11

9 Bamberg
17 Calhoun
75 Orangeburg

Health District 12

33 Dillon
41 Florence
67 Marion

Health District 13

43 Georgetown
51 Horry
89 Williamsburg

Health District 14

13 Beaufort
29 Colleton
49 Hampton
53 Jasper

Health District 15

15 Berkley
19 Charleston
35 Dorchester

Tennessee

Health District 1

5 Benton
17 Carroll
23 Chester
33 Crockett
39 Decatur
45 Dyer
47 Fayette
53 Gibson
69 Hardeman
71 Hardin
75 Haywood
77 Henderson
79 Henry
95 Lake
97 Lauderdale
109 McNairy
131 Obion
167 Tipton
183 Weakley

Health District 2

21 Cheatham
43 Dickson
83 Houston
85 Humphreys
125 Montgomery
147 Robertson
149 Rutherford
161 Stewart
165 Sumner
169 Trousdale
187 Williamson
189 Wilson

Health District 3

3 Bedford
31 Coffee
55 Giles
81 Hickman
99 Lawrence
101 Lewis
103 Lincoln
117 Marshall
119 Maury
127 Moore
135 Perry
181 Wayne

Health District 4

15 Cannon
27 Clay
35 Cumberland
41 Dekalb
49 Fentress
87 Jackson
111 Macon
133 Overton
137 Pickett
141 Putnam
159 Smith
175 Van Buren
177 Warren
185 White

Health District 5

7 Bledsoe
11 Bradley
51 Franklin
61 Grundy
107 McMinn
115 Marion
121 Meigs
139 Polk
143 Rhea
153 Sequatchie

Health District 6

1 Anderson
9 Blount
13 Campbell
25 Claiborne
29 Cocke
57 Grainger
63 Hamblen
89 Jefferson
105 Loudon
123 Monroe
129 Morgan
145 Roane
151 Scott
155 Seiver
173 Union

Tennessee

Health District 7

19 Carter
59 Greene
67 Hancock
73 Hawkins
91 Johnson
171 Unicoi
179 Washington

Health District 8

157 Shelby

Health District 9

113 Madison

Health District 10

37 Davidson

Health District 11

65 Hamilton

Health District 12

93 Knox

Health District 13

163 Sullivan

Virginia

Health District 1

3 Albemarle
 15 Augusta
 17 Bath
 33 Caroline
 43 Clarke
 47 Culpeper
 61 Fauquier
 65 Fluvanna
 69 Frederick
 79 Greene
 91 Highland
 99 King George
 109 Louisa
 113 Madison
 125 Nelson
 137 Orange
 139 Page
 157 Rappahannock
 163 Rockbridge
 165 Rockingham
 171 Shenandoah
 177 Spotsylvania
 179 Stafford
 187 Warren
 530 Buena Vista City
 540 Charlottesville City
 630 Fredericksburg City
 660 Harrisonburg City
 678 Lexington City
 790 Staunton City
 820 Waynesboro City
 840 Winchester City

Health District 2

13 Arlington
 59 Fairfax
 107 Loudoun
 153 Prince William

510 Alexandria City
 600 Fairfax City
 610 Falls Church City
 683 Manassas City
 685 Manassas Park City

Health District 3

5 Alleghany
 9 Amherst
 11 Appomattox
 19 Bedford
 21 Bland
 23 Botetourt
 27 Buchanan
 31 Campbell
 35 Carroll
 45 Craig
 51 Dickenson
 63 Floyd
 67 Franklin
 71 Giles
 77 Grayson
 89 Henry
 105 Lee
 121 Montgomery
 141 Patrick
 143 Pittsylvania
 155 Pulaski
 161 Roanoke
 167 Russell
 169 Scott
 173 Smyth
 185 Tazewell
 191 Washington
 195 Wise
 197 Wythe
 515 Bedford City
 520 Bristol City
 560 Clifton Forge City
 580 Covington City

590 Danville City
 640 Galax City
 680 Lynchburg City
 690 Martinsville City
 720 Norton Cith
 750 Radford Cith
 770 Roanoke City
 775 Salem City

Health District 4

7 Amelia
 25 Brunswick
 29 Buckingham
 36 Charles City
 37 Charlotte
 41 Chesterfield
 49 Cumberland
 53 Dinwiddie
 75 Goochland
 81 Greensville
 83 Halifax
 85 Hanover
 87 Henrico
 111 Lunenburg
 117 Mecklenburg
 127 New Kent
 135 Nottoway
 145 Powhatan
 147 Prince Edward
 149 Prince George
 181 Surry
 183 Sussex
 570 Colonial Heights City
 595 Emporia City
 670 Hopewell City
 730 Petersburg City
 760 Richmond City

Virginia

Health District 5

1	Accomack
57	Essex
73	Gloucester
93	Isle of Wight
95	James City
97	King and Queen
101	King William
103	Lancaster
115	Mathews
119	Middlesex
131	Northampton
133	Northumberland
159	Richmond
175	Southampton
193	Westmoreland
199	York
550	Chesapeake City
620	Franklin City
650	Hampton City
700	Newport News City
710	Norfolk City
735	Poquoson City
740	Portsmouth City
800	Suffolk City
810	Virginia Beach City
830	Williamsburg City

West Virginia

Health District 1

47 McDowell
55 Mercer
63 Monroe
81 Raleigh
89 Summers
109 Wyoming

Health District 2

11 Cabell
43 Lincoln
45 Logan
53 Mason
59 Mingo
99 Wayne

Health District 3

5 Boone
15 Clay
39 Kanawha
79 Putnam

Health District 4

7 Braxton
19 Fayette
25 Greenbrier
67 Nicholas
75 Pocahontas
101 Webster

Health District 5

13 Calhoun
35 Jackson
73 Pleasants
85 Ritchie
87 Roane
95 Tyler
105 Wirt
107 Wood

Health District 6

9 Brooke
29 Hancock
51 Marshall
69 Ohio
103 Wetzel

Health District 7

1 Barbour
17 Doddridge
21 Gilmer
33 Harrison
41 Lewis
49 Marion
61 Monongalia
77 Preston
83 Randolph
91 Taylor
93 Tucker
97 Upshur

Health District 8

3 Berkeley
23 Grant
27 Hampshire
31 Hardy
37 Jefferson
57 Mineral
65 Morgan
71 Pendleton