

West Virginia EPI-LOG



Division of Surveillance & Disease Control

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Statewide Disease Facts & Comparisons

New findings reveal youth attitudes and behaviors toward HIV/AIDS

The Henry J. Kaiser Family Foundation released their *National Survey of Teens on HIV/AIDS 2000 on December 1, 2000*. The survey was a nationally representative telephone survey of 1,512 teens ages 12-17. The findings indicate that teens are very concerned about the impact of the HIV/AIDS epidemic and are particularly concerned about the risk of infection for people their age and for themselves. Minority teens are even more likely to say they are concerned about becoming infected. The survey also shows that while teens know the basics about HIV, both the sexually active and non-sexually active feel they need more information. Few have been tested for HIV, and many would not know where to get tested. These facts are highly critical considering that HIV is a leading cause of death among young people. People under 25 are estimated to make up half of all new HIV infections in the United States. Young women and minority teens have been particularly hard hit. Teen girls account for 58% of new AIDS cases reported among young people ages 13-19. Although African American and Latino teens each represent about 15% of U.S. teens, they account for most of the new AIDS cases reported among teens. New cases diagnosed in West Virginia in 2000 follow the national trends: 16% under the age of 25, 3% in the 13-19 age group, and 30% in minority populations.

sonal concern with 34% indicating they were very concerned and 22% were somewhat concerned about becoming infected. Also, it was found that 60% of African American, 44% of Latino and 28% of white teens indicated they were very concerned. One in six teens say they know someone who has AIDS, has died from AIDS, or has tested positive for HIV. More than one in four African American teens and one in five Latino teens say they know someone as well.



Young people like these, participating in the West Virginia Peer Education Program, are making a difference in teen attitudes towards HIV and AIDS.

Teens indicated an awareness of the risks of unprotected vaginal intercourse, needle sharing, unprotected oral sex and having another STD. Teens had a

(See Teens & AIDS, page 6)

Teens Express High Levels of Personal Concern

The study indicates teens have a high level of per-

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 - Disease Surveillance Improves
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 - Year-End HIV/AIDS Statistics
 - New AIDS & STD Program Director

Study of WV disease surveillance encouraging, but improvement still possible

How good is communicable disease surveillance data in West Virginia? The answer is: Improving! This is thanks to the efforts of many within our surveillance system—provider office, hospital, lab, and local and state health department staff. Strong surveillance systems are a critical tool for addressing emerging, reemerging, or traditional communicable disease threats.

Project Objective: This study was designed to assess the impact of efforts to build local and state capacity for infectious disease surveillance. They include development of a regional epidemiologist system, improving state program staffing, enhancing state laboratory capacity, development of local health department standards for prevention and control of communicable diseases, local health department outreach to key reporting sources, and training initiatives. Funding for these activities comes from the Centers for Disease Control and Prevention through the Epidemiology and Laboratory Capacity Grant and from the WV State Legislature through the WV Transitions Project.

Methods: Data analyzed was from West Virginia's general communicable disease database (NETSS) and outbreak investigation data. Data did not include sexually transmitted disease data, rabies data, HIV/AIDS data or numerical total reports (i.e. influenza-like illnesses and chickenpox). For time trends, data from 1994 to 1999 was evaluated. For comparisons, 1996-97 data was compared to 1999 data. Year 2000 data was not included since it is not finalized until mid 2001. Five measures were examined: Timeliness of reporting (the interval from symptom onset date to NETSS entry date), completeness of selected variables, geographic distribution of reporting, changes in reporting rates (cases reported / 10^5 population) by region (adjusted for newly added reportable diseases, a true decline in LaCrosse encephalitis, and community outbreaks involving more than 10 cases), and outbreak detection and response. An underlying assumption, supported by a variety of state and national data, was that most diseases are under reported and that improvements in our capacity would initially lead to increased reports and better information for action.

Results and Discussion: Improvements in several arenas were identified.

Timeliness of Reporting: From 1994 to 1999 a marked improvement was noted in the timeliness of reporting for the 24 hour reportable diseases from a median of 67 days to 31 days. No significant change was seen in the timeliness of reporting for one week reportable diseases (median = 30 days). The measure examined reflects the overall timeliness of the system. Ideally, one

would examine the time for each step in the reporting system (symptom onset date to diagnosis date, diagnosis to local health department report, local report to state, and state report to CDC); however this information is not available electronically. While improvements in the timeliness of some reporting have been made, one month remains a relatively long period of time. The time from onset date to report should probably be reducible to 2 to 3 weeks allowing for an estimated week between symptom onset and diagnosis, 24 hours or up to one week for reporting (depending on the disease), and another week for the local health department to investigate, respond, and submit the report to the state health department. It should be noted that state staff are often aware of the case through consultation prior to the reports actual arrival and entry into NETSS.

Completeness of Selected Variables: Both demographic variables and variables key to public health follow up were examined.

Demographic variables: Case sex and race have always been relatively well reported (~99% and 90% respectively). Reporting of the case's date of birth has improved markedly, from 41% of reports having this information complete (1994) to 94% being complete (1999). Such demographic data is helpful in identifying subgroups or populations at higher risk of disease.

Follow-up Variables: Improvements in all three of the key case follow-up variables examined were seen. (see chart on page 3). Completion of information on the case's status as a food service worker increased to 85%, day care/long term care facility status to 76%, and onset date to 83%. This information is critical to evaluating the risk of spread to others and to directing case investigation and response.

Geographic Distribution of Reporting: Since even with excellent surveillance systems one wouldn't expect a high number of case reports from counties with very small populations, a cut off of 4 or more cases being reported was used for this measure. This measure suggests that at least some surveillance system is in place within the jurisdiction. In 1996, 34 counties covering 80% of our population reported 4 or more cases. By 1999, this had improved to 45 counties covering 95% of our population.

Changes in "Reporting Rates" (Total Cases Reported per 10^5 population) by Region: Given the assumption that diseases are under reported through WV's passive communicable disease surveillance system, higher overall "reporting rates" would reflect better case finding rather than

(next page)

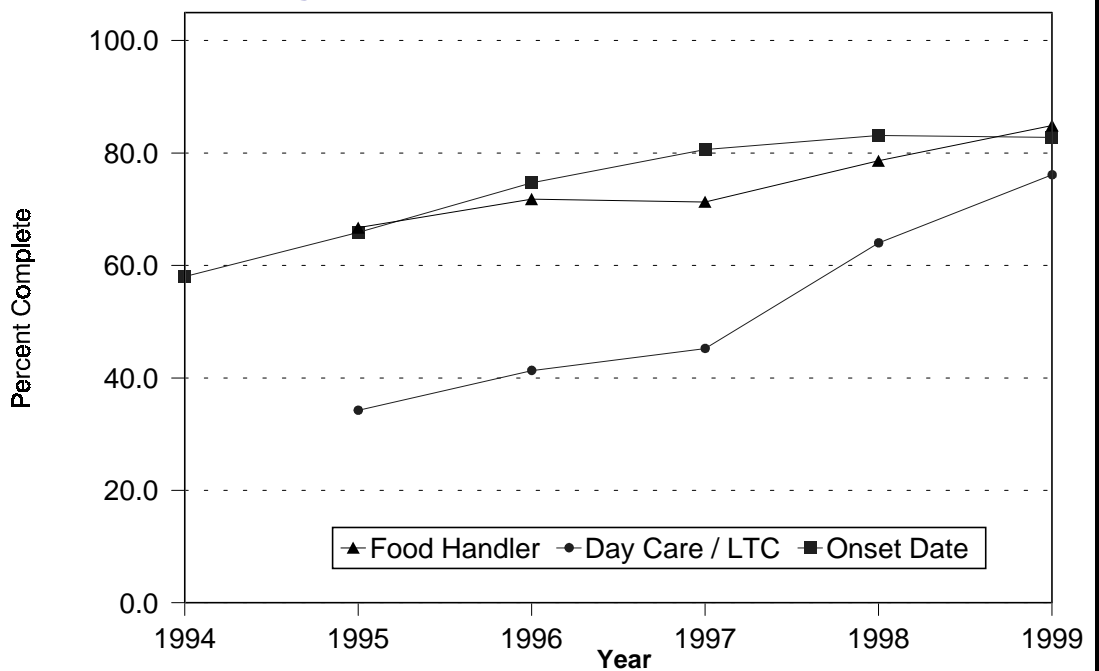
higher disease incidence. "Reporting rates" by region varied widely. Seven of nine regions showed improvements in reporting over time.

Outbreak Detection and Response:

As communities become more aware of public health's role in outbreak response, increasing numbers of outbreaks are reported to health departments. In addition, improving surveillance data identifies more outbreaks requiring investigation. There was a three-fold increase in reported WV outbreaks responded to by public health from 1996 to 1999.

Summary: Surveillance data is often called "Information for Action". It leads to such case-based public health activities as identification and prophylaxis of contacts, removal of an infectious source, or education to prevent disease spread. Surveillance data also supports critical population-based public health actions such as detecting outbreaks, evaluating program effectiveness, or developing disease prevention policies and programs. Significant improvements in WV communicable disease surveillance data have occurred over the past few years. These include improved timeliness of reporting for 24 hour reportable diseases; better reporting of variables including the case individual's date of birth, onset date, and day care, long term care, or food service activities; an improved geographic distribution of reporting; increased "reporting rates"; and improved outbreak detection and response. Only with the efforts of everyone reading this can we continue improving the information driving our policies and actions. In addition, a key component to preventing, detecting and responding to large population threats such as an outbreak, bioterrorist event, or flu pandemic is a strong day to day surveillance and response system in every county of the state. Make sure you do your part! ●

Completeness of Reporting: Case Follow-up Variables West Virginia Reportable Diseases, 1994 - 1999



Excludes Flu Activity, Chickenpox, Animal Rabies, and STDs

WV Immunization Program launches website

The West Virginia Immunization Program is continuing to meet the needs of its customers by publishing a web presence. Education plays a major role in the prevention and control of vaccine-preventable diseases among children, adolescents and adults in West Virginia. Therefore, a web site will help bring the program's goals to fruition.

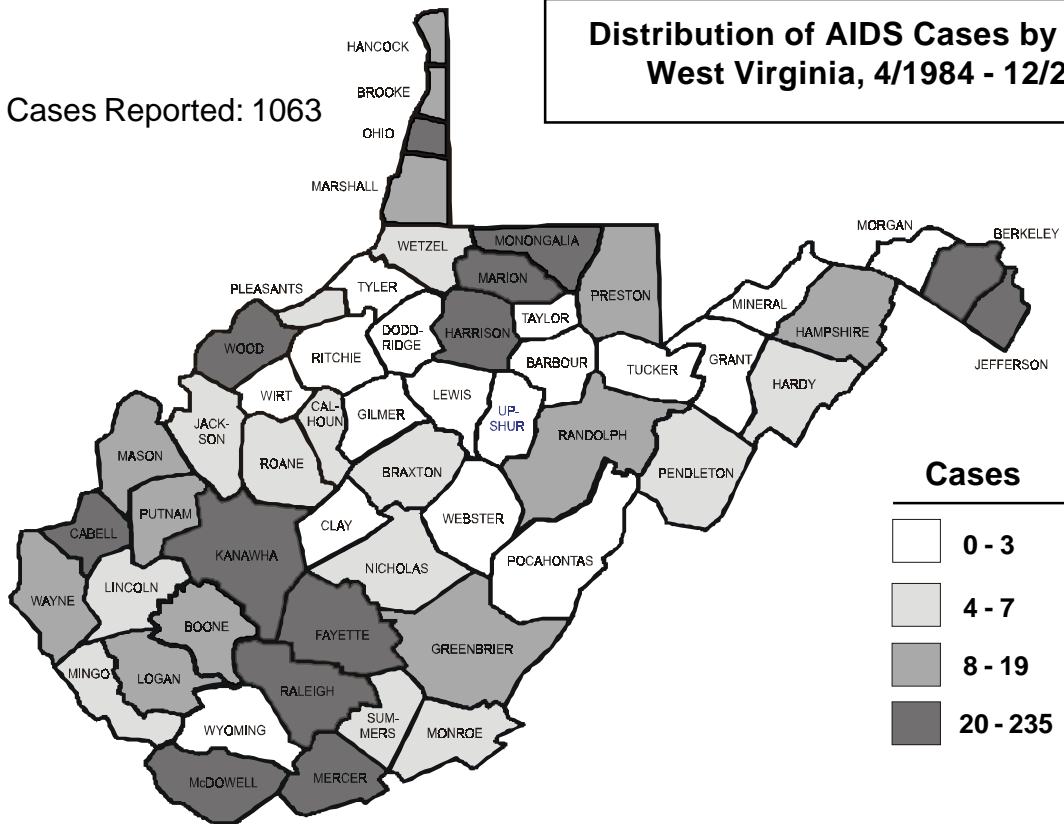
By accessing the web site, doctors and health departments can download commonly used forms, such as immunization schedules and vaccine information, at their convenience. Other on-line services include the Vaccine's For Children (VFC) Program, a health department locator, and a link for travelers to check their destination for current disease information. The general public can access information pertaining to diseases and vaccines and can check the community calendar to find out about immunization clinics in their area. In addition there are coloring pages for children featuring the immunization mascot, Hurdle the Turtle.

The web site also posts an online help service where visitors can chat directly to Immunization Staff.

The address for the web site is <http://www.wvdhhr.org/immunizations/home.htm> ●

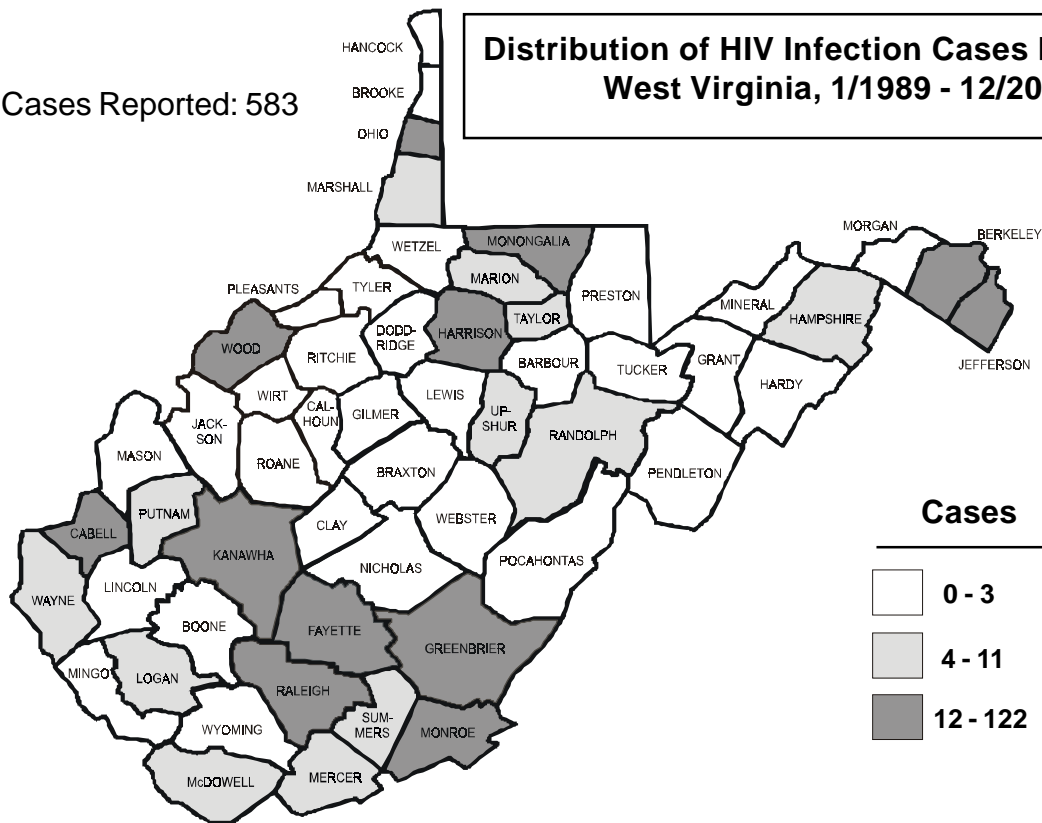
Total Cases Reported: 1063

**Distribution of AIDS Cases by County
West Virginia, 4/1984 - 12/2000**



Total Cases Reported: 583

**Distribution of HIV Infection Cases by County
West Virginia, 1/1989 - 12/2000**





West Virginia HIV Infection and AIDS Cases by Age Group, Gender, Race and Risk Behavior Cumulative through December 31, 2000*

Characteristic	AIDS		HIV		Total	
	#	%	#	%	#	%
Age Group						
Under 5	7	1	4	1	11	1
5-12	2	0	1	0	3	0
13-19	8	1	23	4	31	2
20-29	190	18	225	39	415	25
30-39	481	45	214	37	695	42
40-49	275	26	89	15	364	22
50 and Over	100	9	27	5	127	8
Gender						
Male	926	87	421	72	1347	82
Female	137	13	162	28	299	18
Race						
White	858	81	352	59	1210	74
Black	193	18	202	37	395	24
Other/Unknown	12	1	29	4	41	2
Risk Behavior						
Adult						
MSM	595	56	249	43	844	52
IDU	172	16	106	18	278	17
MSM/IDU	64	6	20	3	84	5
Coagulation Disorder	37	4	6	1	43	3
Heterosexual Contact	92	9	97	17	189	12
Transfusion/Transplant	34	3	5	1	39	2
No Identified Risk	6	1	7	1	13	1
Other^	54	5	88	15	142	9
Sutotal	1054	100	578	100	1632	100
Pediatric						
Coagulation Disorder	1	11	0	0	1	7
Mother HIV Positive	8	89	5	100	13	93
Sutotal	9	100	5	100	14	100
TOTAL CASES	1063	100	583	100	1646	100

MSM = Men having Sex With Men; IDU = Injecting Drug User

* AIDS data includes April 1984 through December 31, 2000, and HIV data includes January 1989 through December 31, 2000.

^ Other risk behavior includes cases reported with no risk identified that have been closed to follow-up.

New director named to state AIDS/STD program

The West Virginia Division of Surveillance & Disease Control is pleased to announce the selection of Dr. Faisal Khan as Director of the AIDS/STD Program.

A native of Pakistan, Dr. Khan received his postgraduate diploma in Public Health in 1997. He graduated in 1998 from the International Training Course for Epidemiology and Program Management organized jointly by the Centers for Disease Control and Prevention, the World Health Organization, and the International Union Against Tuberculosis and Lung Disease. Most recently he served as Epidemiologist for the West Virginia Medical Institute, Charleston.

Dr. Kahn replaces Robert Johnson, who took a new position in Richmond, Virginia, last year. ●

magazines. One interesting fact in the survey was the indication by seven out of ten older teens that they thought schools should provide them with condoms.

Few Teens Have Been Tested and Many Would Not Know Where to Go

The survey points out that while teens are generally aware of the risk behaviors, most have not been tested. Twenty seven percent of teens reporting to be sexually active have been tested, 16% of them say they have considered getting tested, while 57% report neither being tested nor considering it. The vast majority of teens report they do not know where to get tested. Other reasons voiced by teens include the belief that they need their parents' permission or they want to be tested where no one knows them, certainly an issue common in West Virginia. Of those tested the majority reported going to a general health clinic, while a third received the test at a private doctor's office. However, nearly a third who stated they had been tested may have been in error since they were under the impression that their HIV test was a part of a routine health exam. For purposes of the survey, sexually active was defined as having vaginal intercourse. The vast majority of teens suggested they did not consider oral sex to be sexually active and it is quite often initiated in Junior High/Middle School. ●

(Teens & AIDS, continued from page 1)

range of topics on which they wanted more information. These included how to protect themselves, where to get tested, what AIDS is and how it is spread, how to talk to a partner, how to talk to parents and the proper way to use condoms. The survey indicated teens had several sources of information. Schools, by far are the primary source followed by parents, the media and

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