

Introduction

HIV and AIDS surveillance is in a new era, because of treatment with protease inhibitors and new combination drug therapies. These treatments make it possible for HIV infection to remain asymptomatic. Therefore, the number of AIDS cases and AIDS related deaths have declined since 1996. As a result, the number of new AIDS diagnosis data alone are no longer an accurate tool for developing the HIV prevention plan's educational strategies.

People who are HIV positive, without any treatment, will consequently progress to AIDS. For some people, this progression may take a long time; up to ten years or more. Therefore, the aggregate data for AIDS cases may not be helpful enough for HIV education and prevention planning because, the data characterizes people who were infected up to ten years ago, which sometimes makes it difficult to collect accurate information about the individuals and their partners for surveillance purposes.

An active surveillance system is very important in understanding the epidemiology of a disease, its cause, transmission mode, and distribution of cases over time and geographical location. Active surveillance involves a variety of techniques to obtain cases, including but not limited to death certificate review, TB registry matches, and hospital records reviews. HIV and AIDS data are collected through passive surveillance and active surveillance. Passive surveillance refers to AIDS cases and HIV infections that are submitted to the West Virginia AIDS Program as required by West Virginia State Law. Surveillance nurses gather case reports through active surveillance from health care providers, hospitals, and laboratories. Additionally, active follow-up is conducted on each case reported passively to ensure accuracy and completeness.

Please forward any comments or questions regarding this report to:

Loretta Haddy, M.A., M.S.
Director
Division of Surveillance and Disease Control
350 Capitol Street, Room 125
Charleston, West Virginia 25301-3715
(304) 558-5358
(800) 423-1271
lorettahaddy@wvdhhr.org

OR Faisal Khan, M.D., D.P.H.
Director
West Virginia HIV/AIDS/STD Program
350 Capitol Street, Room 125
Charleston, West Virginia 25301-3715
(304) 558-2950
(800) 624-8244
faisalkhan@wvdhhr.org

Technical Notes

While reviewing this report, please keep in mind the following:

- Data available are limited to HIV infection and AIDS case reports that have been received by the West Virginia Division of Surveillance and Disease Control. It does not reflect HIV infections or AIDS cases that have gone undetected or that are not identifiable through active surveillance. Data are only as good as the completeness of reporting by providers.
- The HIV reported data are not as representative of the HIV population as are the AIDS reported data compared with the AIDS population. The Centers for Disease Control estimates that at least one-third of Americans infected with HIV are unaware of their infection because they have not been tested and are thus unreported.
- West Virginia data most often reflect the year a case was reported. Often when a case is reported to the Division of Surveillance and Disease Control, a surveillance staff nurse goes to the hospital or clinic to review the chart and may identify an AIDS-defining event which occurred at an earlier time, possibly even years earlier. The date of diagnosis is usually earlier than the date of the report.
- Individuals are included in either the HIV or AIDS data set, but not both. HIV infection cases later reported with AIDS are deleted from HIV infection tables and added to the AIDS tables.
- Percent columns in tables and charts may not add up to 100% due to rounding.
- HIV infection and AIDS cases are counted in the state of residence at the time of diagnosis. Therefore, West Virginia figures do not reflect cases diagnosed out of state before moving to West Virginia.
- In order to ensure confidentiality, persons of Hispanic, Asian, Pacific Islander, American Indian, or Alaskan Native ethnicities are collapsed into the “Other” category where race data are reviewed.

Explanation of No Identified Risk (NIR) Cases

Although 6 AIDS cases reported in this document have No Identified Risk (NIR), it must be explained that this does not support a concern for an unknown risk behavior. There have been 159 NIR's collected in West Virginia at initial reporting from 1984 to 2000. Of these 159, 105 were reclassified after surveillance follow-up and investigations. Of the remaining 54, 6 are still open and being investigated, and 46 were closed because no risk could be identified after interviews were declined or failed to uncover a mode of exposure, or cases were closed due to being lost to follow-up, or death. The lack of an identified risk may be explained by the CDC 1993 surveillance case definition change. For example, individuals who are HIV positive and found to have an initial CD4+ cell count test result <200 may be included as an AIDS case sooner in the course of disease than individuals diagnosed with opportunistic infections (OI). AIDS cases with OI's may have been receiving health care longer, thus allowing more time to counsel the patient and identify risk.

HIV NIR's for both males and females are higher than desired. A high percentage of NIR (16%, 95 cases) indicates that people with HIV infection are initially reluctant to reveal their risk behavior or do not know the HIV status of their high risk behavior partners. There were 140 HIV NIR's collected in West Virginia at initial reporting from 1989 to 2000. Of these 140, 84 were closed after follow-up and investigations, 51 were reclassified, and 5 are still open and being investigated.

The following categories are used regarding the status of NIR:

- OPEN, ACTIVE FOLLOW-UP: investigation is in progress.
- RECLASSIFIED: investigation is completed.
- MOVED OUT OF STATE: investigation unable to be completed because person with HIV/AIDS moved out of state.
- CLOSED, DEAD: investigation completed; no interview conducted due to death of the person with HIV/AIDS and no appropriate proxy to interview.
- CLOSED, DECLINED INTERVIEW: investigation completed; no interview conducted because person with HIV/AIDS or his/her physician declined interview.
- CLOSED, LOST TO FOLLOW-UP: investigation unable to be completed because person with HIV/AIDS was lost to follow-up.
- CLOSED, CDC RISK ASCERTAINMENT QUESTIONNAIRE COMPLETED and mailed to CDC.

Executive Conclusions

Detailed comments are included throughout this document specific to each table, figure, and map. The following statements are notable findings which should be considered by HIV community planning groups, community-based organizations, and other groups attempting to address issues surrounding HIV and AIDS in West Virginia.

- There was a decline (10%) in 2000 reported AIDS cases compared to the previous year. A possible reason for this decrease is that AIDS case surveillance is in a new era because of new treatment with anti-retrovirals, protease inhibitors, combination therapies, and increased prophylaxis for opportunistic infections.
- A notable change in the AIDS epidemic is that the number of AIDS cases in West Virginia is declining among all socio-demographic groups. We must be cautioned, however, to note that this may not be due to the decline in the epidemic but rather to the success of the new drug therapies.
- Comparing the time frames of 1984-90, with 1991-95 and 1996-00, the proportion of AIDS cases among females increased for IDU and heterosexual contact risk factors (28% to 35% to 37% for IDU and 33% to 44% to 46% for heterosexual, respectively).
- Cumulatively, females accounted for 13% of the reported AIDS, 27% of HIV infections, and 18% all reported HIV/AIDS cases, while accounts for 22% of PLWHA reported cases.
- The 20-29 age group comprised 18% of AIDS cases, 39% of the HIV infection cases, while 28% of PLWHA
- The 30-39 age group comprised 45% of AIDS, 37% of the HIV infection and 40% of PLWHA.
- Blacks in West Virginia are disproportionately affected by AIDS and HIV. Blacks account for 3% of the state's population, but comprised 18% of AIDS, 35% of HIV infection, and 28% of PLWHA reported cases.
- During 1989-00, HIV infection among males predominately occurred among MSM, IDU, and MSM/IDU (77%). HIV infection in females commonly occurred among persons with heterosexual contact (44%) and IDU (34%) risk behaviors.
- During 1984-00, IDU was more prevalent among blacks with AIDS (43%) than whites (11%) for AIDS, while IDU is the second largest percent of AIDS cases among females(37%) compare to 14% among males.
- During 1989-00, of males reporting MSM as risk behavior for HIV infection, 83% were white, 14% were black, while 72% of total HIV infection cases were reported among males