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CONF - 11/98
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FAX COVER SHEET

DATE: 8-26-98

TO: Sandra Thurman FAX #: 1-202-456-2439
Director - Office of National AIDS Policy

FROM: Patricia A. Young, R.N., B.S., CIC
STD/HIV Prevention Program
Iowa Department of Public Health
Phone #: (515) 242-5838
pyoung@idph.state.ia.us

FAX #: (515) 281-4570

RE: November conference

Pages (Including cover sheet) 2

If there is a problem with this transmission, call Pat at (515) 242-5838 or Shirley at (515) 281-6801.

NOTE:

Thank Sarah!



HIV/AIDS Prevention: A Rural Perspective

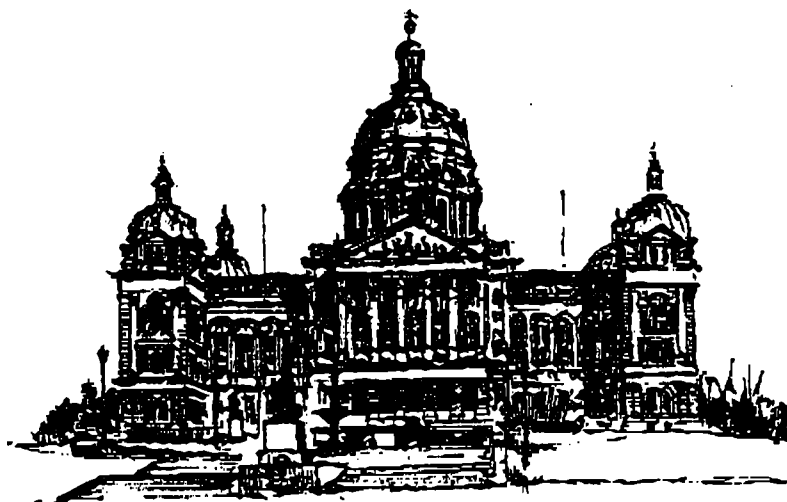
November 5 & 6, 1998

**Polk County Convention Complex
501 Grand Avenue
Des Moines, Iowa 50309**

Sponsors

**Iowa Department of Public Health
Iowa Department of Education
Polk County Health Department
In cooperation with
Centers for Disease Control & Prevention
Des Moines Area Community College**

***Putting
The
Pieces
Together***



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Attention: Sarah

RE: November conference # Pages (Including cover sheet) 4

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NOTE: Thanks Sarah!



TERRY E. BRANSTAD, GOVERNOR

DEPARTMENT OF PUBLIC HEALTH
CHRISTOPHER G. ATCHISON, DIRECTOR

August 26, 1998

Sandra Thurman
Director
Office of National AIDS Policy
736 Jackson Place NW
Washington, DC 20503

Dear Ms. Thurman:

The STD/HIV Prevention Program is holding their first HIV Prevention Conference on November 5 and 6, 1998 in Des Moines, Iowa. It is entitled "HIV/AIDS in Iowa: A Rural Perspective." This conference is being driven by the Community Planning Process and the Group. The purpose of the conference is to have presenters interpret current and emerging HIV prevention research findings and discuss their practical applications for working with various high risk populations. The Community Planning Group (CPG) wanted this to be a technology transfer conference.

The CPG and the conference planning group have met and discussed a number of potential speakers that might serve as an attraction to potential conference participants at our reception on November 5th, 1998. A number of committee members have heard you speak throughout the nation and were ever so impressed with your presentations and dedication to HIV prevention. The group consensus was that it would be an honor to have you present at our very first HIV Prevention Conference. As you might anticipate our conference focus this year will be from that of a rural perspective. Your participation in this conference would be greatly appreciated and your presence is certain to attract a diverse population from throughout the State of Iowa.

Thank you for your time and consideration.

Sincerely,

Patricia A. Young, R.N., B.S., C.I.C.

HIV Prevention Coordinator
STD/HIV Prevention Program

(515) 242-5838

FAX: 515-281-4570

pyoung@idph.state.ia.us

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Thursday November 5

8:00 – 9:00 a.m.

Registration and Continental Breakfast

9:00 - 9:30 a.m.

Welcome

Speaker: *Preston Daniels*

9:30 - 10:30 a.m. - Plenary

**The Changing Landscape of HIV/AIDS
Prevention: Effective Services and Emerging
Challenges.**

Keynote Speaker: *David Holtgrave*

10:30 - 10:45 a.m.

Break

10:45 - 12:00 noon

Session One – Concurrent Sessions

**A Road Map to HIV Prevention for the State
of Iowa: A review of Iowa's HIV Prevention
Plan**

Speakers: *Peter Cannice, David Packard and
Karen Robinson*

**"Walking the Walk" – Cultural Competency
in Action – Part I**

Speaker: *Frank Beadle de Paloma*

**STD: Update on Epidemiology,
Treatment, and Prevention**

Speaker: *Kevin Ault*

Iowans Living with HIV

New Technologies in Testing

Speaker: *Richard Steketee*

12:00 - 1:00 p.m.

Lunch

1:00 - 2:00 p.m. - Plenary

**Effective Work with Drug Users in the Era of
HIV: The Harm Reduction Model**

Speaker: *Edith Springer*

2:00 - 2:15 p.m.

Break

2:15 - 3:30 p.m.

Session Two – Concurrent Sessions

**Discussion of Application of Harm Reduction
in Working with the Injecting Drug User
Population**

Speaker: *Edith Springer*

**"Walking the Walk" – Cultural Competency
in Action – Part II**

Speaker: *Frank Beadle de Palma*

**HIV Prevention Social Marketing Part I:
Principles for Effective Programs**

Speaker: *Sean Bugg*

**Do You Hear What I Said? Tips for Client
Centered Counseling**

Speaker: *Lori Saxon Jordahl*

**Even in Iowa! Innovative HIV Prevention
Programs for Reaching Gay Men – Part I**

Speaker: *Peter Cannice and Christopher Taylor*

3:30 - 3:45 p.m.

Break

3:45 - 5:00 p.m.

Session Three – Concurrent Sessions

Collaborations and Coalition Building

Speaker: *Elisa Luna*

**Why I Don't Go to Funerals Anymore:
New HIV Treatment Guidelines**

Speaker: *Dr. Louis Karz*

**HIV Prevention Social Marketing From
Principles to Practice – Part II**

Speaker: *Sean Bugg*

**HIV Prevention for High Risk Youth:
Programs That Work**

Speaker: *Sara Peterson*

**Even in Iowa! Innovative HIV Prevention
Programs for Reaching Gay Men – Part II**

Speakers: *Peter Cannice and Christopher Taylor*

Friday November 6

8:00 – 8:30 a.m.

Continental Breakfast

8:30 - 9:30 a.m. - Plenary

HIV Prevention for Gay/Bisexual Men

Speaker: *Simon Rosser*

9:30 - 10:45 a.m.

Session Four – Concurrent Sessions

Reaching Gay Men: Programs That Work

Speakers: *Simon Rosser*

Evaluation – Part I

Speakers: *Christina Lopez and Emily Gantz*

Prevention Case Management

Speaker: *Amy DeGroff*

Challenges Faced in Establishing Peer Education Programs at Youth Detention Centers

Speaker: *Lynn Laws*

Viewing Prevention Literature

10:45 - 11:00 a.m.

Break

11:00 - 12:15 p.m.

Session Five – Concurrent Sessions

Being Balm in Gilead: The Role of the Church in HIV Prevention and Care

Speaker: *Reverend Bill McGill*

Evaluation – Part II

Speakers: *Christina Lopez and Emily Gantz*

HIV Prevention for Incarcerated Populations

Speaker: *John Miles*

Using Theory to Develop HIV Prevention Strategies for High Risk Youth – Part 1

Speaker: *Loretta Sweet Jemmott*

Legislative Survival Kit and Tricks of the Trade

Speaker: *Mark Schoeberl*

12:15 - 1:15 p.m.

Lunch

1:15 - 2:15 p.m.

HIV Prevention for Women - Plenary

Speaker: *Theresa Exner*

2:15 – 2:30 p.m.

Break

2:30 – 3:30 p.m.

Session Six – Concurrent Sessions

Women at Risk:

Programs That Work

Speaker: *Theresa Exner*

Evaluation – Part III

Speakers: *Christina Lopez and Emily Gantz*

HIV Surveillance & Partner Counseling and Referral Services:

New Laws/New Regulations

Speaker: *John Katz*

Implementing HIV Prevention Strategies for High Risk Youth – Part II

Speaker: *Loretta Sweet Jemmott*

National AIDS Hotline Classroom Demonstration

Speaker:

3:30 - 4:15 p.m.

Putting the Pieces Together: Reflections on the Iowa HIV/AIDS Prevention Conference - Plenary

Speaker: *David Holtgrave*

4:15 - 4:30 p.m.

Wrap-up and Evaluation

Speakers: *Patricia Young and Peter Cannice*

CHAPTER 2

Epidemiologic profile

Epidemiologic Profile

Introduction

The Iowa Department of Public Health (IDPH) has monitored Acquired Immunodeficiency Syndrome (AIDS) since 1983. An AIDS case, defined as an HIV-positive individual with one of 26 indicator diseases or a person who is HIV positive with a CD4 T-lymphocyte count below 200 or below 14 percent total lymphocytes, requires a named report by the health care provider. Effective July 1, 1998, Chapter 141 of the *Code of Iowa* states that named reporting of HIV infection to the IDPH by both the laboratory and the health care provider is required. Infection reporting by name in Iowa will improve the ability to track the epidemic, to provide the data needed to design targeted prevention-intervention programs and to fund appropriate services for those living with the disease. The IDPH contacts the patient to offer partner and spousal notification that facilitates access to medical care and to prevention services.

"In 1996, for the first time, deaths among persons with AIDS decreased substantially in the U.S. This decrease in AIDS deaths reflects both the leveling of AIDS opportunistic infection (OI) incidence and improved clinical survival among persons with AIDS. At the same time, there has been a substantial increase in AIDS prevalence. Prevalence is a function of both the rates of new infections and the duration of illness. The increase in AIDS prevalence reflects declines in AIDS deaths and stable AIDS incidence. The increased prevalence of AIDS indicates the need for medical and other services for persons with HIV infection and for prevention programs to reduce the number of persons becoming infected with HIV." (MMWR, Feb. 28, 1997)

The Centers for Disease Control and Prevention's (CDC) expansion of the AIDS surveillance case definition in 1993 resulted in a large increase in reported cases both nationally and in Iowa. This was followed by expected declines in numbers of AIDS cases reported each year from 1994 through 1996.

AIDS data are tabulated by the date of report to the IDPH unless otherwise stated and reflect reports received by 12/31/97. Modes of exposure used in this report include:

"Men who have sex with men" (MSM) include men who report sexual contact with other men and men who report sexual contact with both men and women.

"Injecting drug user" (IDU) is a person who injects nonprescription drugs.

"No identified risk" (NIR) is a person with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories.

"Heterosexual contact" is a person who reports specific heterosexual contact with a person with HIV/AIDS, or heterosexual contact with a person at increased risk for HIV infection such as an injecting drug user, hemophiliac, or bisexual male.

The source of data in this report is the Iowa Department of Public Health, STD/HIV Prevention

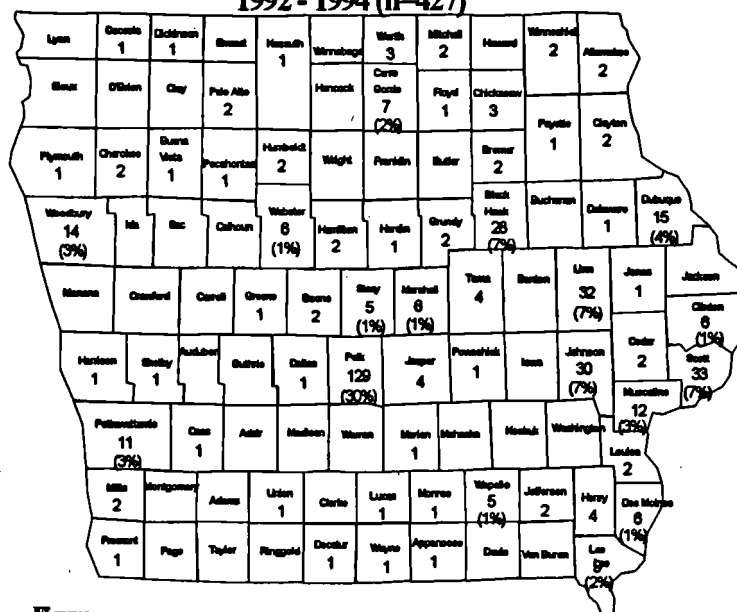
Program, unless otherwise noted.

AIDS has affected the entire state with 84 of Iowa's 99 counties having residents reported to IDPH as diagnosed with AIDS. Figure 1 shows AIDS cases reported between 1992 - 1994 by county of residence and Figure 2; between 1995 - 1997. The eight most populous counties (>50,000) account for 67 percent of the total AIDS cases reported in Iowa. These numbers reflect only the AIDS cases diagnosed while the individual resided in Iowa. They do not include out-of-state cases who resided elsewhere when diagnosed but later moved to Iowa or received care in Iowa. The numbers of cases do not indicate how many are living or dead or the movement of people within the state. The numbers also do not include cases of HIV infection, not yet diagnosed as AIDS. HIV prevalence in Iowa is estimated to be between 1,000 and 1,300 using a CDC method of estimation. HIV prevalence is the number of living HIV-infected persons, including those diagnosed with AIDS.

[illegible]

Figure 2

1992 - 1994 (n=427)



Figure

Iowa AIDS Cases Reported by Year

Year	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Cases	2	12	21	29	42	57	69	85	108	196	123	115	106	10

Table 1

AIDS Cases by Age at Diagnosis Iowa and U.S. 1981 – 1997

	Iowa 1995		Iowa 1996		Iowa 1997		Iowa Cumulative		US Cumulative	
	#	%	#	%	#	%	#	%	#	%
Under 5	0	0	0	0	1	1	7	1	6,343	
5-12	0	0	0	0	0	0	2	<1	1,743	
13-19	1	1	2	2	1	1	7	1	3,130	

20-29	17	15	17	16	12	11	208	19	111,368
30-39	49	43	44	42	59	55	490	46	290,093
40-49	27	23	32	30	23	21	245	23	162,176
Over 49	21	18	11	10	12	11	114	11	66,232
Total	115	100	106	100	108	100	1,073	100	641,086*

Table 2 Percent totals may not equal 100 due to rounding of numbers.

*Total includes person whose age at diagnosis is unknown.

Females have accounted for an increasing proportion of AIDS cases reported the last few years in Iowa, but this increase is not statistically significant. Nationally, 16 percent of the cumulative cases reported have been females compared to 9 percent in Iowa. (CDC, HIV/AIDS Surveillance Report, 1997)

Adult/Adolescent AIDS Cases by Sex

Iowa

1983 - 1997

	1992		1993		1994		1995		1996		1997		1983-1997	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Sex														
Male	96	91	177	92	112	93	103	90	89	85	95	89	961	91
Female	10	9	16	8	9	7	12	10	16	15	12	11	100	9

Table 3

Figure 3 illustrates the number of AIDS cases reported and the number of cases diagnosed each year. The contrast is a result of delay in reporting. AIDS cases should be reported to the IDPH at the time they are diagnosed. Case reports received in one year may be individuals diagnosed in previous years. For example, although 106 cases were reported in 1996, only 64 cases were diagnosed that year. The remaining 43 cases were diagnosed in previous years. The increase in numbers of diagnosed cases in 1992 and reported cases in 1993 is probably due to the expansion of case definition and not in reporting practices.

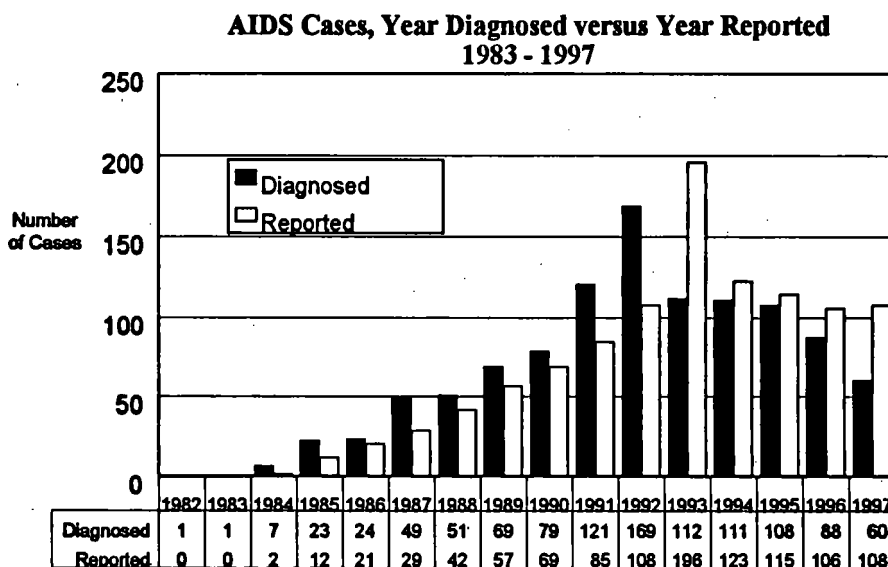


Figure 3

AIDS CASES AND DEATHS

Table 4 depicts the number of Iowa AIDS cases reported to the Iowa Department of Public Health and the number of persons with AIDS reported as having died. Nationally, in 1996, deaths among persons with AIDS decreased substantially for the first time. Despite this, HIV infection remained the leading cause of death among persons aged 25 - 44 years. (MMWR, Sept. 19, 1997)

In Iowa, HIV infection is not one of the five leading causes of death in any age group. However, in 1996, deaths related to HIV infection was the tenth leading cause of years of potential life lost before age 65, at 1,782 years. AIDS is therefore a cause of "early" mortality and should be a focus for prevention strategies. (IDPH, 1996 Vital Statistics)

**AIDS Cases and Deaths
Iowa and U.S.
1981 - 1997**

	Cases	Deaths	%
Iowa	1,073	605	56
U.S.	641,086	390,692	61

Table 4

Table 5 shows the mortality of Iowa AIDS cases. These AIDS cases, deaths, and case fatality rates are listed by year of diagnosis. Case fatality rates may be underestimated because of incomplete reporting of deaths. Reported deaths are not necessarily caused by HIV-related disease.

**Iowa AIDS Cases by Year Diagnosed and
Current Status as of January 31, 1998**

Year	1983*	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	19
Cases	2	7	23	24	49	51	69	79	121	169	111	111	109	
Deaths	2	6	20	24	47	46	60	62	91	103	60	44	20	
Case Fatality Rate	100	86	87	100	96	90	87	78	75	61	54	40	18	

Table 5 *Includes one case diagnosed and deceased before 1983.

**Preliminary data

“If the number of new HIV infections each year (HIV incidence) remains stable or increases, and deaths continue to decrease, there will be an increasing number of people living with HIV and AIDS. Additional resources will likely be needed for services, treatment, and care. . . . Prevention remains our best and most cost-effective approach for bringing the HIV/AIDS epidemic under control and saving lives.” (CDC Update, Feb., 1997)

EXPOSURE CATEGORY

For surveillance purposes, AIDS cases are counted only once in a hierarchy of exposure categories as listed in the tables below. These are mutually exclusive except for the MSM/IDU category. Heterosexual cases are persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (i.e., IDU). No identified risk (NIR) cases are persons with no reported history of exposure to HIV through any of the routes listed in the hierarchy of exposure categories. These include cases still under investigation or lost to follow-up. Recently reported AIDS cases are more likely to be reported as NIR and the proportional distributions will change over time as additional review is conducted and the exposure modes are re-classified.

Table 6 shows changes in exposure modes in five year intervals:

The proportion of cases reported among MSM has fluctuated from 68 to 71 to 60 percent.

The proportion of cases reported involving heterosexual exposure has increased from 0 to 7 to 11 percent.

The proportion of cases among injecting drug users has increased from 6 to 8 to 13 percent.

**Percent of Iowa Adult/Adolescent AIDS Cases by Exposure
Category by 5-Year Reporting Span**

	1983 - 1987	1988 - 1992	1993 - 1997
	%	%	%
MSM	68	71	60
IDU	6	8	13
MSM/IDU	14	5	5
Hemophilia	6	4	3
Heterosexual	0	7	11

	Transfusion	5		3		1	
	NIR/Other	0		1		7	
	Total	100		100		100	

Table 6

Table 7 shows the mode of exposure of reported Iowa cases for the last five years. There is a continued decline in proportion of cases among MSM. Nationally in 1997, 35 percent of cases reported were MSM, with a cumulative proportion of 49 percent. (CDC, HIV/AIDS Surveillance Report, 1997) Heterosexual exposure was 11 percent of Iowa cases in 1997 and 13 percent nationally. NIR cases accounted for 22 percent of cases in 1997 nationally, 21 percent in Iowa.

Adult/Adolescent AIDS Cases by Exposure Category

Iowa
1983 - 1997

Exposure Category	1993		1994		1995		1996		1997		1983-19	
	#	%	#	%	#	%	#	%	#	%	#	
MSM	119	62	84	69	65	57	62	59	55	51	683	
IDU	26	13	14	12	16	14	12	11	12	11	112	
MSM/IDU	12	6	5	4	8	7	4	4	3	3	59	
Hemophilia	10	5	8	7	1	<1	1	1	1	1	40	
Heterosexual	15	8	6	5	19	17	13	12	12	11	91	
Transfusion	2	1	1	1	3	3	0	0	2	2	23	
NIR/Other	9	5	3	2	3	3	13	12	22	21	53	
Total	193	100	121	100	115	100	105	100	107	100	1061	

Table 7 Percent totals may not equal 100 due to rounding of numbers.

IOWA AND U.S. EXPOSURES

**Adult/Adolescent AIDS Cases by Exposure Category
Iowa and U.S.
1981 - 1997**

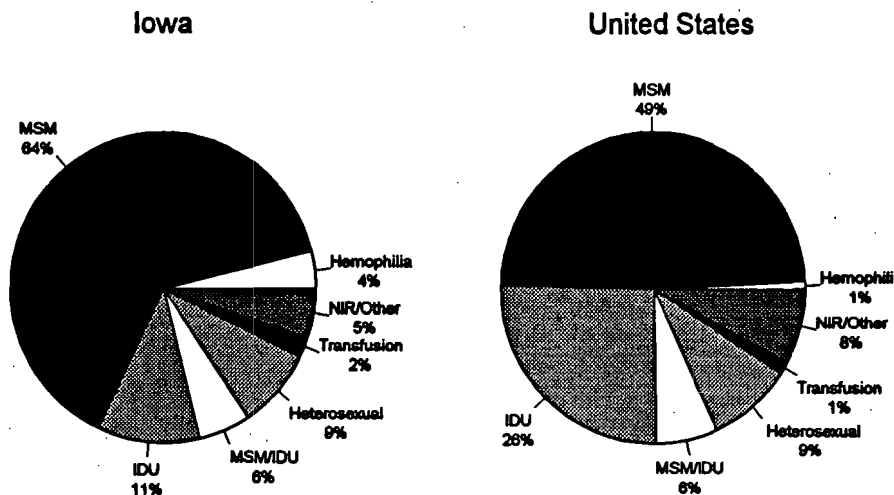


Figure 4

**Adult/Adolescent AIDS Cases by Exposure Category by Sex
Iowa and U.S.
1981 - 1997**

Exposure Category	Iowa				U.S.			
	Male		Female		Male		Female	
	#	%	#	%	#	%	#	%
MSM	683	71	—	—	309,247	58	—	—
Injecting Drug User	90	9	22	22	118,658	22	43,214	—
MSM/IDU	59	6	—	—	40,534	8	—	—
Hemophilia	39	4	1	1	4,483	1	206	—
Heterosexual	34	4	57	57	20,493	4	38,391	—
Transfusion	14	1	9	9	4,705	1	3,509	—
NIR/other	42	4	11	11	36,412	7	13,148	—
Total *	961	100	100	100	534,532	100	98,468	—

Table 8 *Excludes 1 U.S. case whose sex is unknown.

Percentage totals may not equal 100 due to rounding of numbers.

injecting drug use

Injecting drug use has been directly or indirectly involved with 207 (19%) of all Iowa AIDS cases. Of these cases, 83 percent are IDUs, while the remaining 17 percent are related to heterosexual exposure - sex partners of IDU, or to vertical transmission to a newborn.

AIDS Cases Associated With Injecting Drugs

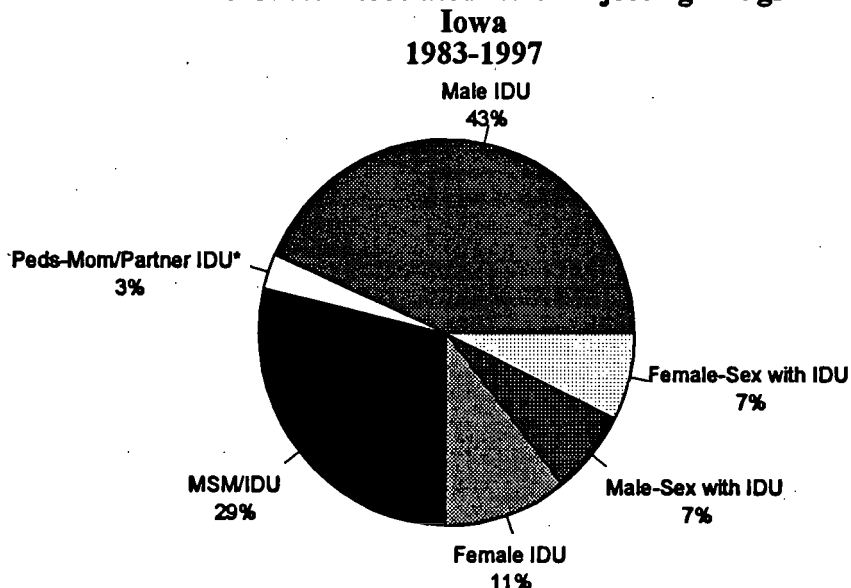


Figure 5 *Pediatric case with mom or mom's partner being IDU

Sexual contact with an IDU continues to be a factor in expanding the number of heterosexual cases. Gender does not appear to play a deciding role with heterosexual contact to IDU, which is equally distributed between females and males (50%).

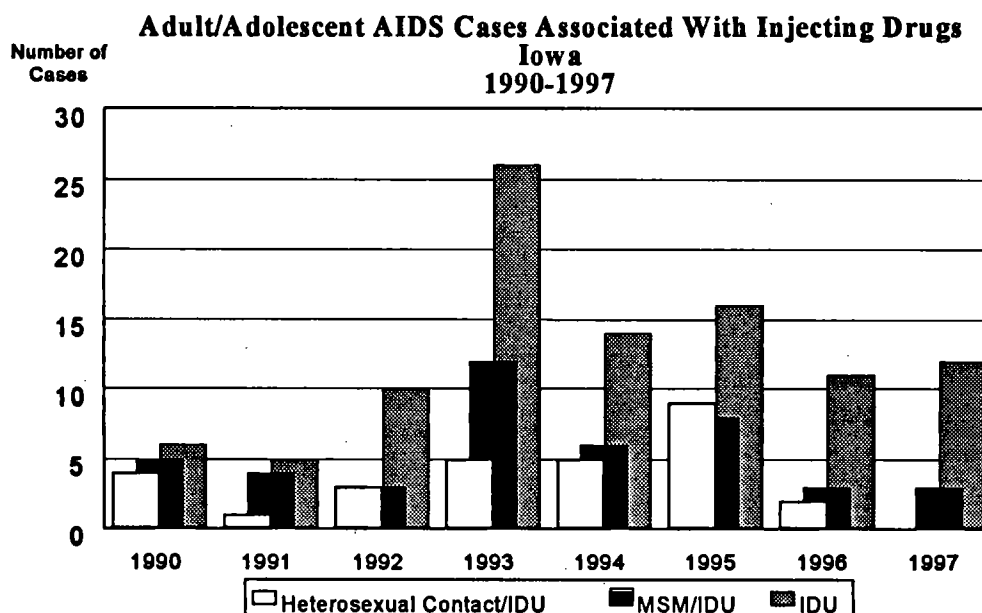


Figure 6

RACE/ETHNICITY

Nationally, the demographic characteristics of persons reported with AIDS reflect shifts in the population

at risk for HIV, notably the changing racial/ethnic profile. In 1997, the proportion of adults/adolescents reported with AIDS who are black non-Hispanic (45%) exceeded the proportion who are white non-Hispanic (33%). The 1997 reported AIDS incidence rate per 100,000 among black non-Hispanics (83.7) was eight times higher than among white non-Hispanics (10.4) and more than two times higher than among Hispanics (37.7). (CDC, HIV/AIDS Surveillance Report, 1997)

Findings indicate a decline in the rate of infection among white non-Hispanic men. This decline has contributed to the stabilization in infection overall. In the U.S., young minorities, particularly black non-Hispanics, are at an extremely high risk for HIV infections. Estimates of prevalence predict an average of one out of every 33 black non-Hispanic males aged 27-39 may have been infected as of January 1993. Black non-Hispanic females' chance of infection is estimated at one out of 98 for this same age group. An estimated one out of every 60 young Hispanic males and of one out of every 222 young Hispanic females may also be infected. In comparison, estimates in white, non-Hispanics were one in 139 males and one out of every 1,667 females. (Science, Nov. 1995)

The national shift in reported AIDS cases to the minority population is reflected in Iowa data. (Table 9) The proportion of AIDS cases reported in white non-Hispanics remained the majority (77%) in 1997. However, while numbers remain small, there is a statistically significant ($p < 0.05$) upward trend from 1992 to 1997 in the proportion of cases reported in black non-Hispanics.

Adult/Adolescent AIDS Cases by Race/Ethnicity
Iowa
1983 - 1997

Race	1992		1993		1994		1995		1996		1997		198
	#	%	#	%	#	%	#	%	#	%	#	%	#
White Non-Hispanic	92	87	171	88	102	84	94	82	86	81	82	77	927
Black Non-Hispanic	7	7	17	9	18	15	12	10	15	14	19	18	98
Hispanic	5	5	5	3	2	2	8	7	5	5	4	4	33
Asian/Pacific Islander	1	1	1	<1	0	0	0	0	0	0	2	2	4
Am. Indian/Alaskan Native	1	1	0	0	0	0	1	1	0	0	0	0	2
Total	106	100	194	100	122	100	115	100	106	100	107	100	1064

Table 9 Percent totals may not equal 100 due to rounding of numbers.

As is the case nationally, Iowa's minorities are disproportionately represented in the proportions of reported AIDS cases. (Figure 7) Black non-Hispanics constitute only 2 percent of the Iowa population, but 9 percent of all Iowa AIDS cases. The Hispanic population is 1 percent and Hispanic AIDS cases are 3 percent. In the U.S., white non-Hispanics constitute 80 percent of the total population and only 46 percent of total AIDS cases. Black non-Hispanics comprise 12 percent of the population and 36 percent of the AIDS cases. Hispanics are 9 percent of the U.S. population while 18 percent of the AIDS cases. (CDC, HIV/AIDS Surveillance Report, 1997)

AIDS Cases by Race/Ethnicity Compared to Total Population
Iowa

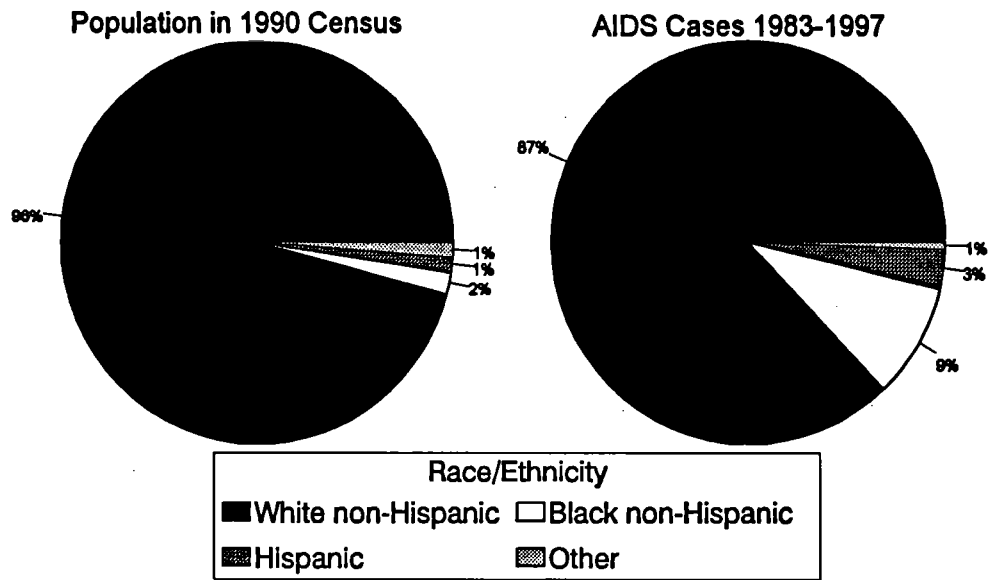
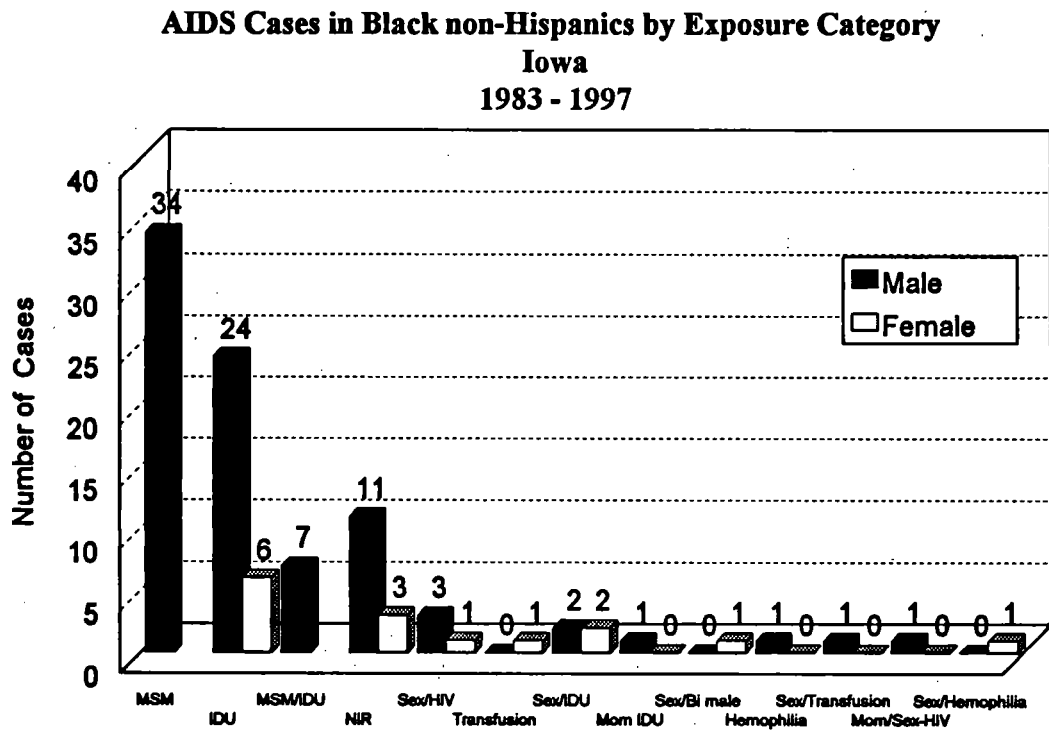
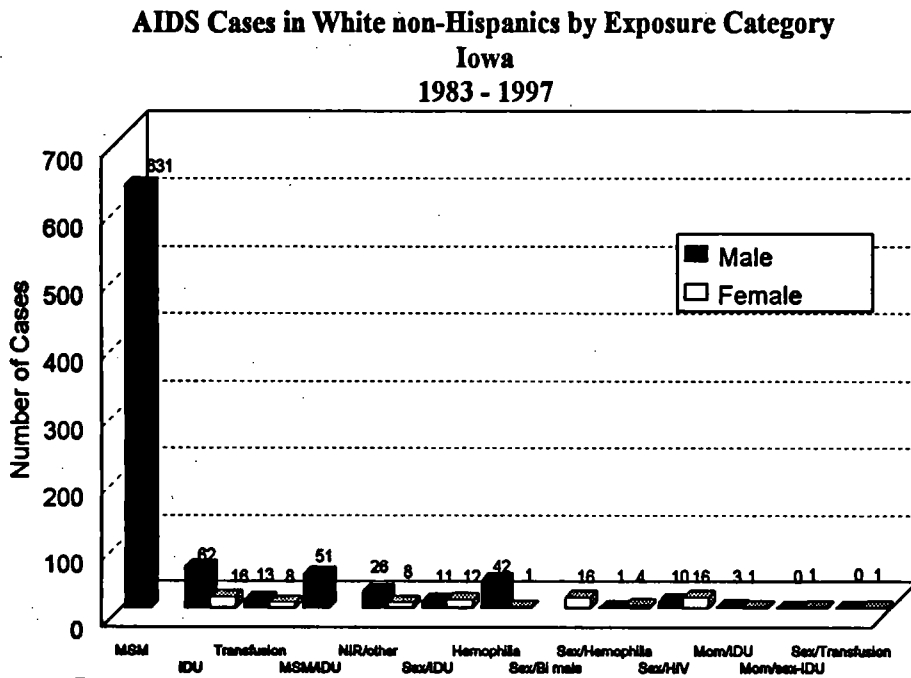


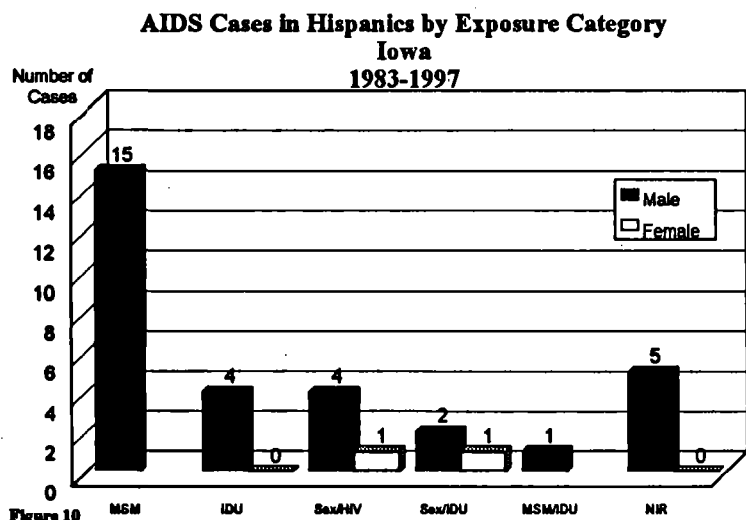
Figure 7

There have been 934 (87%) AIDS cases reported in Iowa's white non-Hispanic population. (Figure 8). The largest exposure category, MSM, constitutes 68 percent of the total. Injecting drug use is associated in some manner with 157 (17%) cases.



There have been 100 (9%) AIDS cases reported within the black non-Hispanic population through December 1997. Figure 9 displays the exposure categories for this population. There were 34 (34%) in the MSM category and 42 (42%) AIDS cases associated with injecting drug use in some manner.

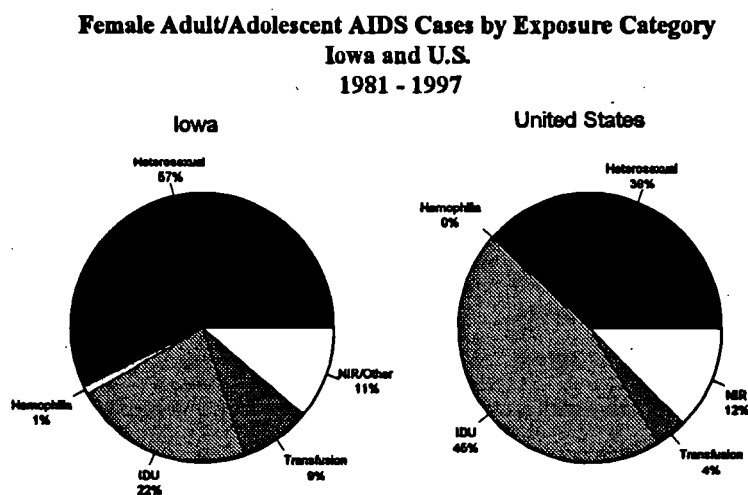
There have been 33 (3%) AIDS cases reported in the Hispanic population. (Figure 10) The MSM exposure category accounts for 15 (48%) of the cases. Injecting drug use is in some manner associated with eight (24%) of the Hispanic cases.



FEMALES and AIDS

There have been 98,468 (16%) cases of AIDS reported in adult/adolescent females in the US and 100 (9%) in Iowa. In 1996 and 1997, 20 and 22 percent respectively of adult/adolescent cases reported in the US were females. (CDC, HIV/AIDS Surveillance Report, 1997) In Iowa, 15 and 11 percent were females in 1996 and 1997 respectively.

When comparing exposure modes in Iowa and the U.S., injecting drug use plays a more prominent role nationally while the heterosexual and the transfusion categories are higher proportions among Iowa AIDS cases in females. (Figure 11)



The 100 cases in females represent 9 percent of all adult AIDS cases in Iowa. The heterosexual exposure

category comprises more than one-half of these cases (57%). (Figure 12) The next most prevalent exposure category is IDU (22%). When the heterosexual risk factor is isolated and separated further as indicated in Figure 12 with the bar at the right, three components become highlighted: females having sex with an HIV-infected male, females having sex with a bisexual male, and females having sex with an IDU. The cumulative proportion of females having sex with an HIV-positive male increased from 28 percent through 1996 to 33 percent through 1997.

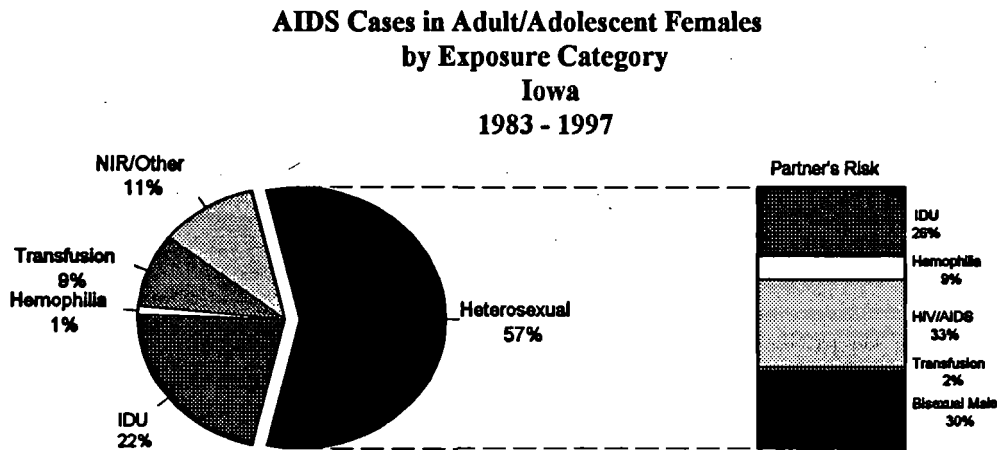


Figure 12

There have been 100 AIDS cases reported in adult/adolescent females in Iowa. Females of childbearing-age (20 - 39) account for 64 percent of these cases. Figure 13 illustrates the number of cases in each racial/ethnic group with reported cases and age at the time of diagnosis. White non-Hispanic females comprise 82 percent, black non-Hispanic females; 15 percent.

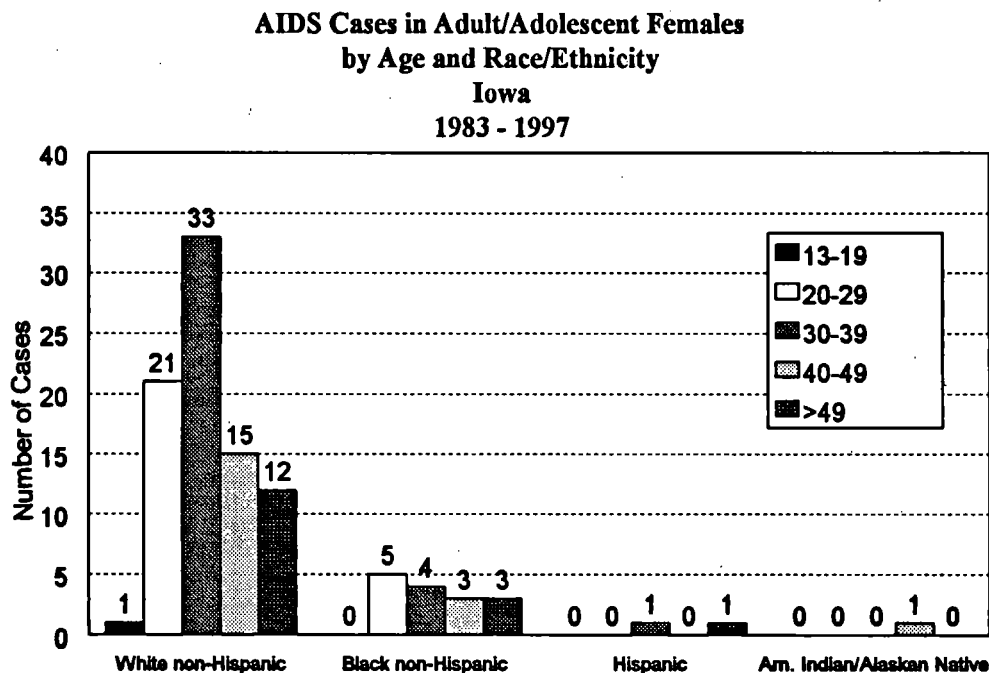


Figure 13

PEDIATRIC AIDS CASES

There have been nine pediatric AIDS cases (patients ≤ 12 years of age at time of diagnosis) reported in Iowa. Injecting drug use is associated with six of these cases. The discrepancy in total number of cases between the Iowa Pediatric AIDS Cases and the AIDS Cases with Pediatric Exposure is due to time differences between age at exposure and age of diagnosis. Pediatric exposure includes three additional persons who acquired HIV infection prior to the age of 13 but were not diagnosed with AIDS until after their 13th birthday. These three persons were considered adult AIDS cases because of age when diagnoses occurred, but fall in the pediatric definition when exposure was documented.

Pediatric AIDS Cases by Exposure Category

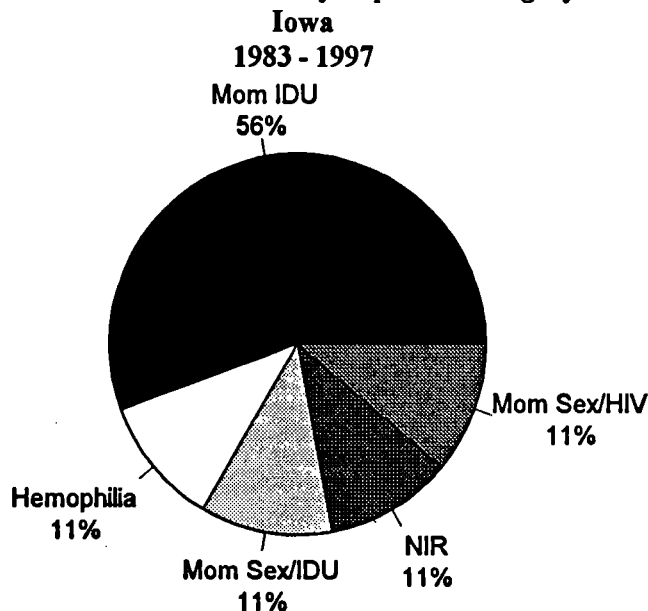


Figure 14

AIDS Cases with Pediatric Exposure

Iowa and U.S.

1981 - 1997

Exposure Category	Iowa		U.S.	
	#	%	#	%
Hemophilia	4	33	233	3
Mother at-risk/has AIDS/HIV	7	58	7,335	91
Transfusion with blood/blood product	0	0	374	5
NIR/other	1	8	144	2
Total	12	100	8,086	100

Table 10 Percent totals may not equal 100 due to rounding of numbers.

Guidelines to Prevent Misinterpretation of Data

Decisions about how to allocate limited resources for prevention activities depend, in part, on appropriate interpretation of epidemiologic data. The following guidelines are intended to facilitate proper interpretation of the tables and figures presented in this profile.

Understand what the figure is showing. Read the title of the table or figure, and look closely at the type of information presented on the vertical and horizontal axes. Is the number of cases being presented, or a percentage of the total cases? Pie graphs and stacked bar graphs show proportions—how much each part is of the whole. Side-by-side bar graph can show total numbers or percents. Examine how graphs are scaled. Does the number of cases increase by 5's, 10's, 100's or some other factor? What is the time period covered? Have any data been excluded from total counts?

Know the limitations of the data.

Strengths:

Relatively complete.

Covers all of Iowa.

Limitations:

New or emerging trends in HIV infection may not be apparent in AIDS case reports because of the five - ten year average time from HIV infection to the development of AIDS.

There are delays in the reporting of AIDS cases to IDPH. The tables and figures in this profile do not account for these reporting delays.

Represent only those individuals who are living in Iowa at the time of diagnosis. It excludes those individuals who are diagnosed and reported in another state and who subsequently move to or receive care in Iowa.

Comparison of pre-1993 AIDS case rates with rates of cases reported in or after 1993 is not valid! An analogy: Although you are not comparing apples with oranges, you are comparing red apples (pre-1993 definition AIDS cases) with a combination of green apples and red apples (1993 definition AIDS cases). Relative proportions of cases should not be substantially affected by the change in the case definition, whereas the same statement could not be made regarding numbers of cases.

Do not over-interpret small changes or differences. Comparing one year with another only shows a change and not a trend. Even if the change represented a substantial increase, how would it be interpreted? The change might be in the opposite direction (a substantial decrease) the following year. This is an especially important consideration in areas with low morbidity and unstable rates. For example, suppose that one AIDS case was diagnosed and reported among a particular risk group in 1992, and that two AIDS cases were diagnosed and reported within the same risk group in 1993. This change represents a 100% increase in AIDS cases from 1992. Although such a percentage change sounds alarming, an increase of one case is not.

Look for consistencies with other information sources. Do the numbers show patterns similar to

those from other studies or in other populations? Different findings should not be disregarded, but they should be examined carefully.

Use all information available for decision making, not just that information presented in an individual table or figure.

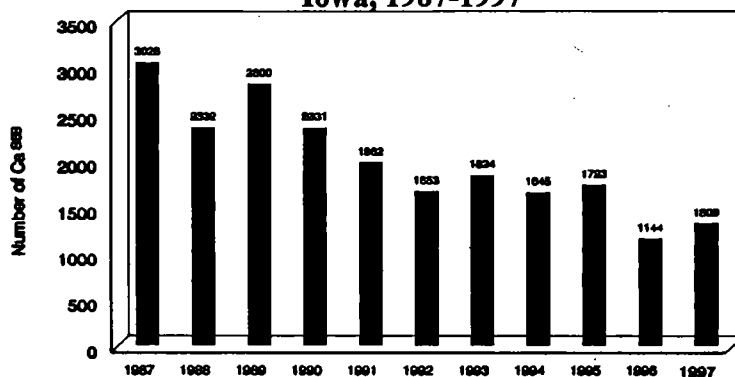
Sexually Transmitted Diseases (STD)

STD are among the most frequently reported infectious diseases and constitute a significant health problem in Iowa. White STD rates reflect unsafe sexual behavior, they do not necessarily correlate with HIV infection. National data suggest that syphilis rates, especially when related to the exchange of sex for drugs and crack cocaine use, may be more closely associated with HIV risk than gonorrhea or chlamydia.

In considering STD data, one should be aware of certain limitations. The quality of STD data are dependent upon the reporting provider and facility; laboratory confirmation is required; and the reported incidence of STDs may reflect the demographic characteristics of individuals seeking care at a particular facility or the practices of certain providers, and may not necessarily be representative of the characteristics of all infected individuals. Additionally, because of the nature of the specimen collection procedure, women are often tested for STDs as a routine part of a pelvic exam, while men are generally tested only if they have symptoms.

In 1997, 1,309 cases of gonorrhea were reported; 547 in males and 762 in females. The overall infection rate was 47.1 per 100,000 population. Rates were highest among ages 15-24. Of the cases reported in 1997, 597 (45.6 %) occurred in African Americans and 51 (.08%) occurred in Hispanics.

Reported Cases of Gonorrhea Yearly Comparison Iowa, 1987-1997



SOURCE: Iowa Department of Public Health, STD/HIV Prevention Program

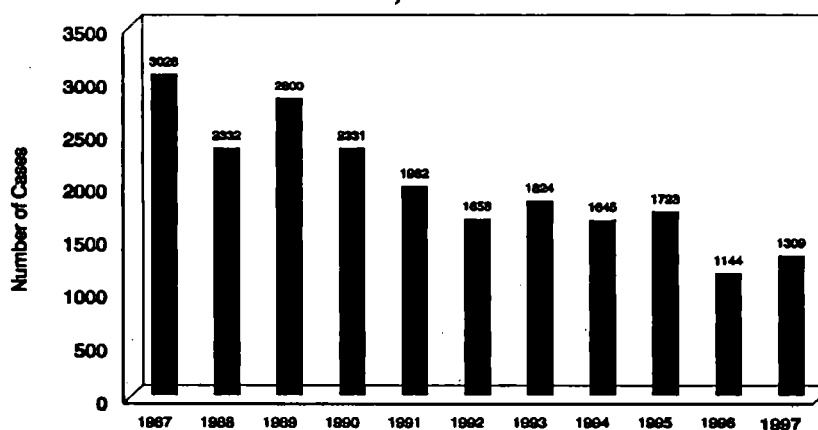
Reported Cases of Gonorrhea by Age, Race/Ethnicity, and Sex Iowa, 1997

[illegible]

10 - 14		8	1	9		1						3	1
15 - 19	20	185	79	107	7	9		1		2	5	32	109
20 - 24	30	132	114	74	16	5	3			5	7	25	170
25 - 29	29	43	71	31	4	2		1	2	1	11	15	117
30 - 34	17	9	41	14	4					1	5	5	67
35 - 39	11	18	30	8	3						1	3	46
40 - 44	8	6	8	2							2		18
45 - 54	5	1	5	2							5		17
55 - 64	1												1
65 & +	1												1
Unknown	1												1
Total	124	404	350	247	34	17	3	2	2	9	34	88	547

Boxes without values indicate 0

Reported Cases of Gonorrhea by Race and Sex Iowa, 1987-1997



SOURCE: Iowa Department of Public Health, STD/HIV Prevention Program

1997, 4906 cases of chlamydia were reported: (176.9 per 100,000). There were 3,739 cases reported in individuals ages 15-24 making this age group the highest rate 76.2%.

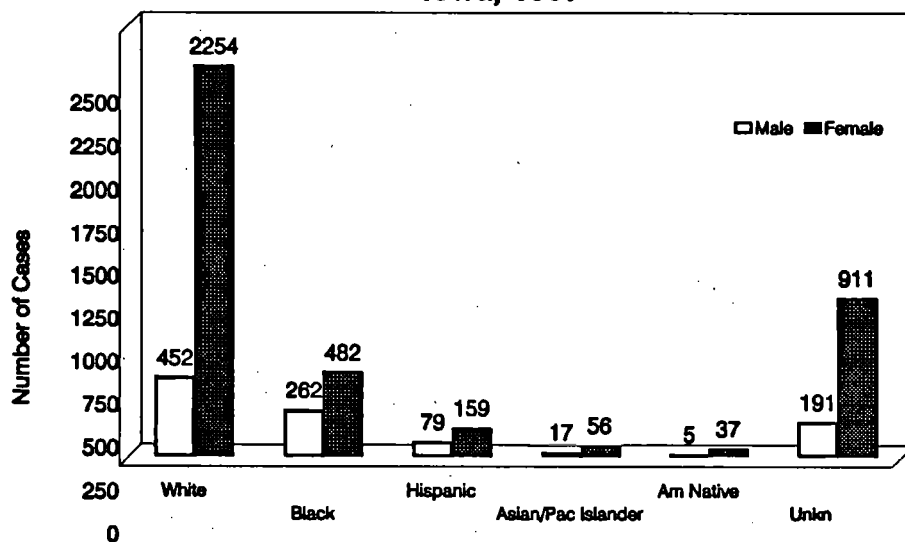
Reported Cases of Chlamydia by Age, Race/Ethnicity, and Sex Iowa, 1997

Age Groups (Years)	White Not Hispanic		Black Not Hispanic		Hispanic		Asian/Pacific Islander		American Native		Unknown		Total	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
00 - 04		10			1	2					1	3	2	
05 - 09														
10 - 14	2	53		20		4	2	2		2	1	22	5	
15 - 19	113	1015	98	231	11	50	2	14		15	44	374	268	
20 - 24	198	793	90	147	38	61	9	27	2	13	64	326	399	1
25 - 29	69	242	41	51	18	23	4	9	3	5	38	99	173	
30 - 34	32	66	17	17	4	13		2		1	19	33	72	
35 - 39	23	43	9	5	5	2				1	10	11	48	

40 - 44	8	14	4	2		2		1			2	11	14	
45 - 54	5	4	1		1	1		1			1	3	8	
55 - 64	1	1	1									1	2	
65 & +		3									1	2	1	
Unknown	3	11	1	3		1					10	27	14	
Total	452	2254	262	482	79	159	17	56	5	37	191	912	1006	3

Boxes without values indicate 0

Reported Cases of Chlamydia by Race and Sex Iowa, 1997

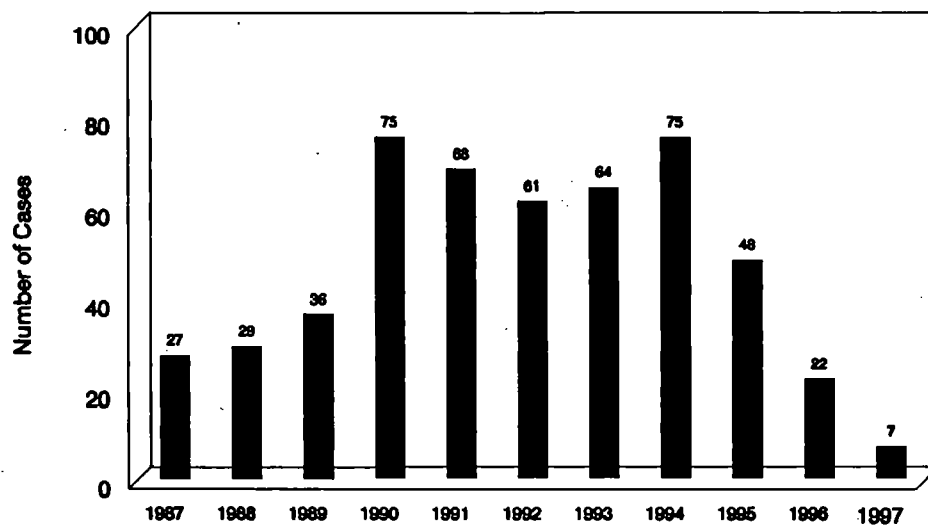


SOURCE: Iowa Department of Public Health, STD/HIV Prevention Program

own

Iowa is in a somewhat unique position for the elimination of all early syphilis. In 1997 there were 32 reported cases of early syphilis (seven primary and secondary and 25 early latent).

**Reported Cases of Primary and Secondary Syphilis
Yearly Comparison
Iowa, 1987 - 1997**



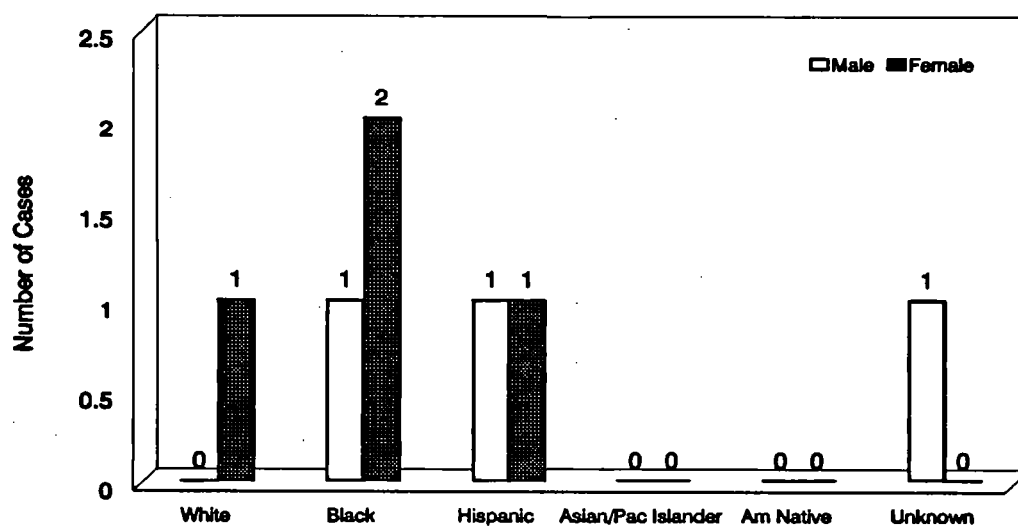
SOURCE: Iowa Department of Public Health, STD/HIV Prevention Program

Reported Cases of Primary & Secondary Syphilis by Age, Race/Ethnicity, and Sex Iowa, 1997

Age Groups (Years)	White Not Hispanic		Black Not Hispanic		Hispanic		Asian/Pacific Islander		American Native		Unknown		Total
	M	F	M	F	M	F	M	F	M	F	M	F	
00 - 04													
05 - 09													
10 - 14													
15 - 19		1				1							
20 - 24											1		1
25 - 29													
30 - 34			1	1	1								2
35 - 39				1									
40 - 44													
45 - 49													
50 - 54													
55 - 59													
60 & >													
Unknown													
Total	0	1	1	2	1	1	0	0	0	0	1	0	3

Boxes without values indicate 0

Reported Cases of Primary and Secondary Syphilis by Race and Sex Iowa, 1997



SOURCE: Iowa Department of Public Health, STD/HIV Prevention Program

Year	Number of Cases
1987	17
1988	28
1989	23
1990	59
1991	64
1992	62
1993	82
1994	90
1995	77
1996	42
1997	25

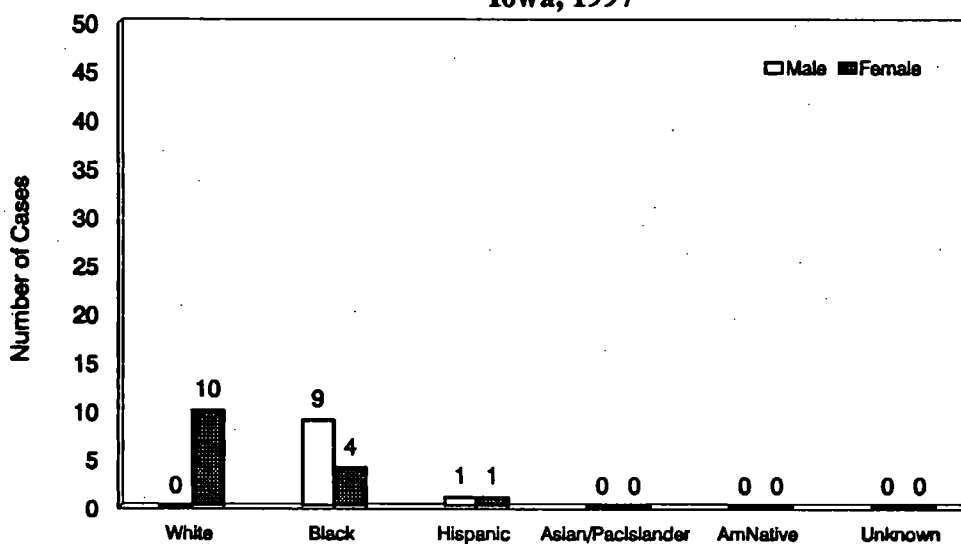
**Reported Cases of Early Latent Syphilis Cases by Age, Race/Ethnicity, and Sex
Iowa, 1997**

[illegible]

Total	0	10	9	4	1	1	0	0	0	0	0	0	10
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Boxes without values indicate 0

Reported Cases of Early Latent Syphilis by Race and Sex Iowa, 1997



SOURCE: Iowa Department of Public Health, STD/HIV Prevention Program

When will
you deny
again in /
Dr. Buckley
at his
commencement
here?