Kentucky HIV Prevention And Care Plan 2009

Prepared and Compiled by the
Kentucky HIV Planning and Advisory Council
in collaboration with the
Kentucky Department for Public Health
HIV/AIDS Branch

NOTE: The 2009 Prevention Plan is an update of the 2008 Plan. Updated areas include, KHPAC membership information; Population prioritization and Tool; Interventions, reference dates and some contact information. Beginning 2009, Kentucky will be going to the 5-year planning cycle. A brand new Comprehensive Care and Prevention Plan will be developed beginning 2009.

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KEY TO ABBREVIATIONS

AA	African Americans
AAMSM	African American Men who have Sex with Men
ADD	Area Development Districts
AED	Academy for Educational Development
AHEC/HETC	Area Health Education Center/Health Education Training Center
ASO	AIDS Service Organization
BFHC	Bluegrass Farmworker Health Center
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CLI	Community-Level Interventions
CRCS	Comprehensive Risk Counseling and Services
CTRPN	Counseling, Testing, Referral, and Partner Notification
DEBI	Diffusion of Effective Behavioral Interventions
DHAP-IRS	Division of HIV/AIDS Prevention-Intervention Research and Support
DIS	Disease Intervention Specialist
DL	Down-low
DPH	Department for Public Health
EW	Empowerment Workshop
FTE	Full Time Employee
HC/PI	Health Communications/Public Information
GLI	Group-level Interventions
GMOC	Gay Men of Color
HAR	Hispanics at Risk
HRH	High Risk Heterosexual
IDU	Injecting Drug User
ILI	Individual-level Interventions
KDE	Kentucky Department of Education
KHCIP	Kentucky Health Continuation Insurance Program
KHPAC	Kentucky HIV/AIDS Planning and Advisory Council
KIPWAC	Kentuckiana People With AIDS Coalition
KPOL	Key Peer Opinion Leader (MSM intervention)
LWA	Living With AIDS
MSM	Men who have Sex with Men
MSM/IDU	Men who have Sex with Men/Injecting Drug User
MSMOC	Men who have Sex with Men of Color
PCM	Prevention Case Management
PCRS	Partner Counseling and Referral Services
PLWHIV	Persons Living With HIV
PMI	Prevention Marketing Initiative
PS	Prevention Specialist
PSE	Public Sex Environment
PSI	Postponing Sexual Involvement
PWA	People With AIDS
RRW	Risk Reduction Workshop
RTR	Reducing the Risk
SISTA	Sisters Informing Sisters about Topics on AIDS
TA	Technical Assistance
WAR	Women at Risk
YAR	Youth at Risk

SECTION

1

KHPAC OVERVIEW

INTRODUCTION AND OVERVIEW OF THE COMMUNITY PLANNING PROCESS

The Kentucky Department for Public Health (DPH) initiated the community planning process in 1994 in response to the Centers for Disease Control and Prevention (CDC) Announcement #300. The state was divided into three regions for the purpose of Human Immunodeficiency Virus (HIV) prevention planning for the 1994 application for funding. The designation of regions was based on HIV and Acquired Immune Deficiency Syndrome (AIDS) case data in Kentucky, existing Area Development Districts (ADD), and HIV Ryan White Care consortia boundaries. In 1998 a single statewide HIV Prevention Community Planning Group was formed with representation from the existing regions. In 2005 the HIV Prevention Community Planning Group began the process of merging with the existing Governor's HIV/AIDS Advisory Council, with the addition of a care component to the planning process. This integrated group was named the Kentucky HIV/AIDS Planning and Advisory Council, (KHPAC) indicating the primary roles of planning and advising. In March of 2006, KHPAC had its inaugural meeting. KHPAC is administered by the Kentucky Department for Public Health, HIV/AIDS Branch. DPH and KHPAC work closely to ensure that HIV prevention, care planning and policy effectively identify the needs of the people of the Commonwealth of Kentucky.

The mission of KHPAC is to identify issues and develop public health policy recommendations to prevent further HIV/AIDS infections in Kentucky, and to serve populations currently infected.

KHPAC advises the Kentucky Cabinet for Health and Family Services (CHFS) on the formulation of HIV and AIDS policy. KHPAC monitors the responsiveness of CHFS, and ensure that recommendations are being considered and followed, as prescribed by the CDC's guidelines for HIV/AIDS Prevention community planning. KHPAC offers programmatic recommendations regarding Health Resources and Services Administration (HRSA) activities. Specifically, KHPAC advises regarding Ryan White Title II Services.

KHPAC JURISDICTION AND COMPOSITION

Kentucky is comprised of 120 counties. For HIV/AIDS planning the state is divided into three regions: North Central, Eastern and Western. The North Central region includes Jefferson and the six surrounding (mostly rural) counties. All seven counties in this region make up the North Central Area for Development District (ADD). According to the December 31, 2007 cumulative statistics, this region has 2209 (approximately 46%) of the State's total 4764 reported AIDS cases. Jefferson County is the most populated county in Kentucky and is the only urban county in the North Central region. The majority of the region's cases (2019 or 91%) are reported for Jefferson County (Louisville).

The Eastern Region includes the easternmost nine ADDs with a total of seventy-one counties. The two major urban centers of the Eastern Region are Lexington and the Northern Kentucky Area immediately south of Cincinnati, Ohio. The remaining counties are mostly rural. The region has 1561 (36%) of the State's December 31, 2007 cumulative AIDS cases reported. The majority of the regional cases are

reported for the Bluegrass ADD (916 or 19% of the state's cases) and the Northern Kentucky ADD (393 or 8% of the states cases). Fayette County (Lexington) accounts for 649 (38%) of the Bluegrass ADD's cases. The remaining ADDs reported AIDS cases ranging in number from 34 to 96.

The Western Region represents the western most five ADDs with a total of forty-two counties. Most of the Western Region is rural with small cities, with no major urban areas. The Western Region accounts for 828 (18%) of the state's December 31, 2005 cumulative AIDS cases reported. The five ADDs reported AIDS cases ranging in number from 137-189.

Current KHPAC membership consists of 28 members. KHPAC's full membership is 30 members. The Executive Committee which functions as the Membership Committee is in the process of reviewing applications to KHPAC. According to the mandates of KRS 214.640, KHPAC consists of 2 standing members, the Commissioner for Public Health and the Commissioner for Medicaid Services. In accordance with CDC, HRSA and KRS 214.640, KHPAC also consists of representatives from other state agencies that provide HIV/AIDS health care and/or education, physicians, representatives of community based organizations (CBO), experts in epidemiology, behavioral and social sciences, program evaluation and health planning; individuals living with HIV, and individuals who reflect the characteristics of the current and projected epidemic in Kentucky. Membership on KHPAC also ensures geographic representation. KHPAC geographic representation is outlined using 5 geographic regions; Western, North Central, Bluegrass, Northern and Eastern Kentucky. These delineations help to ensure that urban and rural areas are adequately represented.

The following is a regional list of agencies represented on KHPAC.

EASTERN REGION
Cumberland Valley District Health Department

BLUEGRASS

NORTHERN
Northern Kentucky Independent Health District

NORTH CENTRAL REGION
Sisters and Brothers Surviving AIDS (SABSA)
WINGS Clinic
Volunteers of America
Louisville-Metro Health Department

WESTERN REGION
Kentuckiana People With AIDS Coalition (KIPWAC)
Heartland CARES, Inc.
Kentucky HIV/AIDS Advocacy and Action Group
Matthew 25
Infectious Disease Associates

Table 1

Kentucky HIV/AIDS Planning and Advisory Council Characteristics
(as defined in the CDC Evaluation Guidance)

Age

< 19	19-24	25-34	34-44	45+	Total
0	Pending (0)	2	7	19	28

Gender

Male	Female	Transgender	Other	Total
16	11	1	0	28

Sexual Orientation

Heterosexual	Bisexual	Gay	Lesbian	Other	Unknown	No response	Total
13	0	11	1	1	2	0	28

Ethnicity

Hispanic/Latino	Non-Hispanic/Non-Latino	Total
1	27	28

Race

American Indian/Alaska Native	Black of African American	Native Hawaiian/ Pacific Islander	Asian	White	No response	Total
0	7	0	0	20	0	27

Geographic Distribution

Urban Metropolitan	Urban Non-Metro	Rural	Suburban	Other	Total
18	7	2	1	0	28

Expertise

Community Rep.	PLWHA or affected	Community Org.	Intervention Specialist/ Service Provider	HIV Care Provider	Medical Provider	Total
15	11	2	2	4	1	29[1]

Expertise Cont.

Behavioral or Social Scientist	Evaluation	Health Planner	Epidemiologist	Mental Health	Other	Total
2	2	1	1	1	2	10[1]

Representation of HIV Exposure category

MSM	MSM/IDU	IDU	HRH	Sex with transgender	Sex with transgender/IDU	No specific risk	Total
11	4	1	1	1	0	10	28[1]

Representation of other populations through personal life experience

Substance Use	Sex trade	STDs	Homelessness	Partners or family members of PLWHA	Corrections system	Total
13	2	1	1	2	4	18[1]

Agency representation

Faith Community	Non-minority CBO	Mental Health Services	Academic institution	Corrections	State/ Local Education Agencies	Total
2	8	1	0	1	1	13[1]

Agency representation Cont.

Community Rep.	Minority CBO	Health Department HIV/AIDS	Substance Abuse Services	Homeless Services	Research Center	Total
7	1	3	1	0	0	12[1]

Agency representation

HIV Care and Social Services	Business and Labor	Health Department: STD	Other Non-Profit	Other	Total
11	0	1	0	0	13[1]

HIV Status

Living with HIV/AIDS	Not living with HIV/AIDS	Unknown	No response	Total
11	17	0		28

1 – Total is unduplicated, but members may be counted in several categories

N.B. KHPAC Characteristics does not take into account the two standing members of KHPAC.

KHPAC MEMBERSHIP RECRUITMENT & ORIENTATION

KHPAC members are primarily recruited through personal referrals. The Executive Committee is responsible for reviewing applications, interviewing applicants and making membership recommendations to the full KHAPC body for approval. Once KHPAC approves individuals for membership, the applications are sent to the Governor's Office/designee for appointment.

KHPAC members underwent a two (2) day orientation and Technical Assistance at The Hyatt in Louisville, Kentucky from February 21 to 23, 2008. A community planning orientation was held in April 2008. New KHPAC members are provided with a Kentucky HIV/AIDS Planning and Advisory Council Handbook which includes KRS 214.640, the CDC HIV Prevention Community Planning Guidance, the HRSA Planning Body Duties, KHPAC by-laws and membership structures, a copy of the current HIV Prevention Plan and grant, a copy of the previous Year-End Report, an orientation guide to community planning, and other pertinent information necessary for the participation on KHPAC. Each new member is asked to attend an orientation conducted by the DPH HIV Health Policy Specialist and the Executive Committee, where they are also briefed on the current activities of KHPAC.

KHPAC members are placed into a 'Fellowship of Three', which consists of a former Advisory Council member, a former CPG member and a new member. These 'Fellowships of Three' provide a form of mentorship for all members during this first year of integration.

Each KHPAC Member is required to participate on one of the standing committees: Care and Prevention or Policy and Promotion. This year KHPAC met as a collective group so that all members could learn the various aspects of each component of KHPAC.

COLLABORATIONS AND AFFILIATIONS

INSTITUTIONAL AFFILIATIONS OF CO-CHAIRS

The 2009 State Co-chair for KHPAC is David Clark, Ryan White Grant Administrator for the Department for Public Health HIV/AIDS Branch. The Community Co-chair is Robert Stone. Robert is from Owensboro.

PROCESS FOR OBTAINING COMMUNITY INPUT BEYOND KHPAC MEMBERSHIP

If a particular demographic of HIV/AIDS community is not represented on KHPAC, input is obtained from individual interviews, invited representatives of organizations, focus groups, surveys, HIV Prevention Specialists (PSs) working with the affected communities, and input from the State MSM Initiatives, IDU Initiatives and Minority/High-Risk Heterosexual Initiatives Coordinators.

PROCESS FOR CONDUCTING BUSINESS & MEETINGS

KHPAC meets at least nine times per year. The length of meetings is dependant upon the agenda. Most KHPAC meetings are held between 9:30 a.m. and 4 p.m. KHPAC occasionally convenes bi-monthly. Regularly scheduled KHPAC meetings occur either in person or via tele/video-conferencing.

The assigned HIV Health Policy Specialist is the KHPAC Administrator and coordinates the activities of KHPAC to ensure that the mandates of KHPAC are carried out. The meetings are facilitated by the Administrator, as well as members of the Executive Committee. KHPAC members receive a summary meeting report of every meeting held, the results of evaluations which are completed by members after each meeting and any other information needed to prepare for the following meeting. These

evaluations are used to improve the planning and advising process, as well as to facilitate an annual evaluation. If a problem occurs that the group cannot rectify or if clarification of an issue is needed, technical assistance is sought from or through the DPH personnel.

All KHPAC members sign a Disclosure of Conflict of Interest form, a letter of commitment to KHPAC, and a statement of confidentiality.

Major tasks are accomplished at each KHPAC meeting. The products of the committees and reports are submitted to KHPAC where discussion, clarifications, questions and answers, and input are encouraged. Decisions are made by consensus, but if this is not possible a majority vote is taken. In Kentucky, all meetings by government or government supported groups are open to the public. Additionally, there are occasions when a group, organization, or individual are asked to attend the meeting to provide pertinent information to KHPAC.

KHPAC ACCESS TO INFORMATION & UPDATES

To ensure that KHPAC has access to any pertinent information or updates that pertain to HIV/AIDS in the Commonwealth of Kentucky or nationally, DPH provides KHPAC with updates on HIV prevention and community planning in the form of National Alliance of State and Territorial AIDS Directors (NASTAD) bulletins and newsletters, journal publications, CDC updates, and other publications.

HIV/AIDS Branch staff attend meeting KHPAC meetings (on a rotational basis) to ensure KHPAC members have access to their expertise, and to ensure the collaboration between KHPAC and DPH. HIV/AIDS Branch staff also participate in monitoring and evaluating the planning and advising process. The supplemental guidance for CDC Community Planning Groups dictates that "HIV Prevention Community Planning Group(s) should have access to current information related to HIV prevention from evaluation of programs and the behavioral and social sciences, especially as it relates to the at-risk population groups within a given community. Planning group members should also be routinely updated about relevant new findings of behavioral and social scientists." ("Supplemental Guidance on HIV Prevention Community Planning for Non-competing Continuation of Cooperative Agreements for HIV Prevention Projects", CDC, page 9).

SECTION

2a

2009 Priority Populations

WHAT ARE THE PRIORITY POPULATIONS FOR HIV PREVENTION?

ORDER OF PRIORITY POPULATIONS

At the June 24, 2008 KHPAC meeting the HIV/AIDS Semi-Annual Report was shared with the members to review epidemiological data. This was accompanied by a simulated priority setting exercise, the purpose was to provide KHPAC with an example on how to create a prioritization tool and set priorities. In addition the group reviewed the current prioritization tool.

On July 29, 2008 KHPAC prioritized populations. The Epidemiologist presented the Epidemiologic Profile, detailing the contents. Based on the Epidemiologic Profile and current anecdotal evidence, KHPAC members re-prioritized the target populations.

Per CDC's Advancing HIV Prevention Initiative, those living with HIV are prioritized as the highest target population. The major change in prioritization for 2008 was the reversal of the injecting drug use (IDU) and the high-risk heterosexual (HRH) populations. According to the epidemiology of HIV/AIDS in Kentucky, 14 % of cumulative adult AIDS cases were infected through injection drug use, while 16% were infected through heterosexual contact.

Prioritized Target Populations

1. HIV+
2. MSM
3. HRH
4. IDU
5. MSM/IDU
6. MARP

Explanation of the Prioritization Tool

Below are the current tools that Kentucky uses to prioritize populations. It is a two step process; labeled Step I and Step II respectively. The factors chosen for prioritization are fairly self-explanatory except for "Riskiness of Population Behavior." In this category, points were assigned relative to the most typical risk behavior in each target population. For populations that practice multiple risk behaviors, the highest risk behavior in which they participate was used. For instance, while MSM/IDU participate in injecting drugs, receptive anal intercourse, and insertive anal intercourse, the highest risk behavior is regarded to be injecting drug use, which is assigned 5 points. The assigned multiplier would then be multiplied by this number in order to generate the final score for the specific factor. Scores for each factor were added together to obtain the final point totals for each risk population. The final point totals are listed in within the table.

STEP I FACTORS FOR PRIORITIZING POPULATIONS - GRANT YEAR 2008							
FACTOR			**POPULATIONS**				
		Mult.	**MSM**	**MSM/IDU**	**IDU**	**Heterosexual**	**MARP**
AIDS Incidence (Number of New AIDS Cases Diagnosed in 2006)							
5 points	>40	**4**	5	1	3	5	0
4 points	31-40						
3 points	21-30		5x4 = **20**	1x4 = **4**	3x4 = **12**	5x4 = **20**	0x4 = **0**
2 points	11-20						
1 point	1-10		(N=98)	(N=7)	(N=24)	(N=48)	(N=0)
0 points	0						
AIDS Prevalence (Number of Living AIDS Cases as of 12/31/07)							
5 points	>400	**3**	5	2	4	5	1
4 points	301-400						
3 points	201-300		5x3 = **15**	2x3 = **6**	4x3 = **12**	5x3 = **15**	1x3 = **3**
2 points	101-200						
1 point	1-100		(N=1460)	(N=153)	(N=395)	(N=529)	(N=22)
0 points	0						
Percent HIV Seropositivity at Counseling and Testing Sites in 2006							
4 points	HIV seropositivity greater than or equal to 5%	**2**	4	3	1	1	1
3 points	HIV seropositivity greater than or equal to 2%						
2 points	HIV seropositivity greater than or equal to 1%		4x2 = **8**	3x2 = **6**	1x2 = **4**	1x3 = **1**	1x2 = **2**
1 point	HIV seropositivity greater than or equal to <1%		(5%)	(4%)	(<1%)	(<1%)	(<1%)
Riskiness of Population Behavior (Highest Risk Factor)							
5 points	Injecting Drug Use	**1**	4	5	5	3	3
4 points	Receptive Anal Intercourse						
3 points	Receptive Vaginal Intercourse		4x1 = **4**	5x1 = **5**	5x1 = **5**	3x1 = **3**	3x1 = **3**
2 points	Insertive Anal Intercourse						
1 point	Insertive Vaginal Intercourse						
TOTAL			47	21	33	39	8
RANK			**1**	**4**	**3**	**2**	**5**

MSM = Men Who Have Sex with Men

MSM/IDU = Men Who Have Sex with Men and are Injecting Drug Users

IDU = Injecting Drug Users

Heterosexual = Heterosexual Contact with a Person with HIV, an MSM, an MSM/IDU, or an IDU

MARP = Mothers at Risk for Perinatal HIV Transmission

STEP II

Ranking of Risk Population Categories Used in CDC's Evaluation Guidance						
Rank	**Raw Score**	**Population**	**Sub-population** **(Percents represent the proportion of living AIDS cases within each population as of 12/31/07)**		**Sub-Rank**	**CDC Definition of Population**
1	47	MSM	HIV + ♂ White >29	64%	**1.1**	Intervention will address the HIV prevention needs of men who report sexual contact with other men or with both men and women.
			HIV + ♂ Black/Hisp. >29	18%	**1.2**	
			HIV + ♂ White 13-29	11%	**1.3**	
			HIV + ♂ Black/Hisp. 13-29	6%	**1.4**	
			HIV – MSM	N/A	**1.5**	
2	39	Heterosexual Contact (with PWHIV, MSM, MSM/IDU, IDU)	HIV + ♀ Black/Hisp >29	24%	**2.1**	Intervention will address the HIV prevention needs of persons who report specific heterosexual contact with a person with, or at increased risk for, HIV infection (e.g., sex with an IDU, a bisexual male, or a person known to be HIV-positive or to have AIDS).
			HIV + ♀ White >29	20%	**2.2**	
			HIV + ♂ Black/Hisp. >29	17%	**2.3**	
			HIV + ♂ White >29	16%	**2.4**	
			HIV + ♀ Black/Hisp. 13-29	10%	**2.5**	
			HIV + ♀ White 13-29	6%	**2.5**	
			HIV + ♂ Black/Hisp. 13-29	4%	**2.6**	
			HIV + ♂ White 13-29	2%	**2.6**	
			HIV – Heterosexual	N/A	**2.7**	
3	33	IDU	HIV + ♂ Black/Hisp. >29	36%	**3.1**	Intervention will address the HIV prevention needs of people who are at risk for HIV infection through the use of equipment to inject drugs (e.g., syringes, needles, cookers, spoons, etc.).
			HIV + ♂ White >29	25%	**3.2**	
			HIV + ♀ Black/Hisp >29	13.4%	**3.3**	
			HIV + ♀ White >29	12.7%	**3.4**	
			HIV + ♂ Black/Hisp 13-29	5%	**3.5**	
			HIV + ♂ White 13-29	3%	**3.6**	
			HIV + ♀ White. 13-29	1.8%	**3.6**	
			HIV + ♀ Black/Hisp 13-29	1.5%	**3.7**	
			HIV – IDU	N/A	**3.8**	
4	21	MSM/IDU	HIV + ♂ White >29	54%	**4.1**	Intervention will address the HIV prevention needs of men who report both sexual contact with other men and
			HIV + ♂ Black/Hisp. >29	31%	**4.2**	

			HIV + ♂ White 13-29	12%	**4.3**	injection drug use.
			HIV + ♂ Black/Hisp. 13-29	2%	**4.4**	
			HIV – MSM/IDU	N/A	**4.5**	
5	8	Mother at Risk for Perinatal HIV Transmission	HIV + ♀ Black/Hisp. 13-29	N/A	**5.1**	Intervention will address the HIV prevention needs of women who have HIV or are at risk of becoming infected *and* who are pregnant and, thus, at risk of transmitting HIV to their infant.
			HIV + ♀ Black/Hisp. >29	N/A	**5.2**	
			HIV + ♀ White 13-29	N/A	**5.3**	
			HIV + ♀ White >29	N/A	**5.4**	
			HIV – Mother at Risk for Perinatal HIV Transmission	N/A	**5.5**	

KHPAC Recommendations for Interventions

Hand in hand with the population prioritization task, KHPAC must also give its recommendations to the Department for Public Health, HIV/AIDS Branch on interventions to be utilized for the corresponding populations. The department will support the interventions it has capacity to implement. Interventions fall into these six categories:

HIV+	**HRH**	**MSM/IDU**
Health Relationships	SISTA	Safety Counts
CRCS (PCM)	CRCS	Many Men, Many Voices
	Outreach	CRCS
MSM	CTS	Outreach
Many Men, Many Voices		CTS
POL	**IDU**	
CRCS	Safety Counts	
Outreach	CRCS	
Counseling and Testing (CTS)	Outreach	
	CTS	

SECTION

3

ASSESSMENT

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ASSESSMENT

1. Introduction: Prevention

The U.S. Centers for Disease Control and Prevention periodically require funded HIV prevention services providers to conduct a community services assessment. This report outlines the 2007 community services assessment for Kentucky. The needs assessment section draws upon a survey of 1,206 HIV- and HIV+ Kentuckians conducted in the summer of 2007. The resource inventory lists the current agencies providing prevention services in Kentucky. Finally, the gaps analysis examines where prevention services may be enhanced.

2. Needs Assessment

Survey
The 2007 Kentucky Needs Assessment Survey consists of 86 questions. HIV- individuals answer only the first 51 questions.

Principal Investigator
Jeff A. Jones, Ph.D., devised and analyzed the 2007 Kentucky Needs Assessment Survey in conjunction with the HIV Branch and participating service agencies. Dr. Jones conducted several prior HIV care assessments in Kentucky as well as administering several statewide adolescent health surveys for the CDC (Centers for Disease Control and Prevention). He is an Assistant Professor in the Department of Health Behavior at the University of Kentucky's College of Public Health.

Survey Methodology
Of the thirteen agencies participating in the joint survey of care and prevention clients, nine have prevention services. Because care clients at the four other sites also completed the prevention questions, their responses are included with the prevention sample responses. The sampling frame consists of the prevention clients at the nine participating care and prevention agencies. These sites were selected because they receive Federal funds for conducting care and prevention activities. Based on the client loads reported by each agency, Dr. Jones assigned a target sample of 1,000 prevention clients distributed between the nine agencies based on each agency's percentage of total prevention clients in the state. The agencies administered the survey to clients coming to the agency during late June and July 2007. The 86 question survey was anonymous and no names or identifying information were gathered on the survey. The participating agencies are:

- AVOL (AIDS Volunteers), Lexington*
- Barren River District Health Department, Bowling Green*
- Bluegrass Care Clinic, University of Kentucky, Lexington
- Cumberland Valley District Health Department, London
- Heartland CARES, Paducah*
- Lexington-Fayette County Health Department, Lexington*

- Louisville Metro Health Department, Louisville*
- Matthew 25, Henderson*
- Matthew 25, Bowling Green
- Northern Kentucky District Health Department, Fort Mitchell*
- Purchase District Health Department, Paducah*
- Volunteers of America, Louisville*
- WINGS Clinic, University of Louisville, Louisville

*Site has prevention services.

Sample, Responses, and Margins of Error

Site	Sample	Respondents	Response Rate	Margin of Error (+ or - at 95% confidence)
Cumberland Valley District HD	0	27	n/a	19
Bluegrass Care Clinic	0	125	n/a	9
Northern Kentucky District HD	22	65	298	12
WINGS Clinic	0	106	n/a	10
VOA	148	160	108	8
Matthew 25 Henderson	73	116	160	9
Matthew 25 Bowling Green	0	25	n/a	20
Heartland Cares	72	112	155	9
AVOL	73	16	22	25
Purchase District HD	55	47	86	14
Barren River District HD	13	10	75	31
Lexington-Fayette County HD	107	31	29	18
Louisville Metro HD	437	366	84	5
	1000	1206	121	3

The survey has an overall margin of error of +/- 3% at a 95% confidence interval and derives from the number of responses received on the survey. The margins of error for individual sites are also given. While the table above shows the margin of error for the entire survey or for individual sites, it would also be possible to compute this figure for each individual question based on the number of respondents answering the question.

Limitations

This survey has a number of limitations. Survey collection took place during a short one month period in mid-summer at various HIV care and prevention sites around the state. Some individuals who normally visit a site regularly may have been absent due to summer vacations and other summer activities. Furthermore, only individuals currently participating in prevention programs or care coordination completed the survey. As such, the prevention needs are not reflective of the state as a whole and have a bias towards urban, female, and African-American respondents.

Demographics
The following demographics compare HIV- and HIV+ respondents. These two groups are strikingly dissimilar in a number of ways.

The positive respondents are disproportionately non-Hispanic white males over the age of 40 living in urban areas. The HIV- respondents are still a male majority but with greater representation of women. The majority of negative respondents are also under the age of 40 and racial minorities. While almost half of the positive respondents are gay, four-fifths of the negative respondents are heterosexuals.

In terms of perception of residence, both groups feel they live in urban places, but the negative group is even more urban than the positive group. In another similarity, both groups have similar patterns of education attainment with about half of the individuals in both groups having a high school diploma or less.

Sex	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Male	397	54	308	71
Female	325	44	111	26
Male to female transsexual	7	1	13	3
Female to male transsexual	4	1	2	0
	733	100	434	100

Age	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Less than 18 years old	33	5	2	0
18 to 21	118	16	12	3
22 to 29	269	37	49	11
30 to 39	169	23	121	28
40 to 49	94	13	166	38
50 to 59	32	4	72	17
60 to 64	8	1	8	2
65 years or older	10	1	5	1
	733	100	435	100

Hispanic Ethnicity	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Yes	45	6	16	4
No	676	94	403	96
	721	100	419	100

Race	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
American Indian or Alaska Native	21	3	8	2
Asian	11	1	9	2
Black or African-American	315	43	114	26
Native Hawaiian or other Pacific Islander	6	1	4	1
White	340	47	283	66
Other	34	5	14	3
	727	100	432	100

According to the U.S. Census Bureau's current estimates, Kentucky's population consists of 89% non-Hispanic Whites and 7% African-Americans (Hispanic or non-Hispanic). The respondents are disproportionately minorities.

Sexual Orientation Identity	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Gay, lesbian, or homosexual	86	12	199	48
Bisexual	74	10	48	11
Heterosexual or straight	567	78	173	41
	727	100	420	100

Urban/Rural	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
City	528	74	277	64
Country	189	26	153	36
	717	100	430	100

Education	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Less than high school degree or GED	102	14	74	17
High school diploma or GED	258	36	126	30
Some college	201	28	145	34
College degree	117	17	50	12
Graduate or Professional degree	37	5	29	7
	715	100	424	100

Testing

All of the positive group should report on the 2007 Kentucky HIV/AIDS Needs Assessment Survey they have been tested at some point, but three percent marked they had not been. On the other hand, a quarter of HIV- respondents have not ever been tested for HIV. A fifth of the negative group has been tested but only returned for their results half the time or less. Fear of learning they are infected is the primary reason listed for not returning for test results in both groups.

Positive respondents are more likely to report they have been tested at a physician's office or hospital. This finding may reflect individuals who were first tested when they sought medical attention for an illness associated with their HIV disease.

Times Ever Tested for HIV	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
None	184	25	13	3
1	170	23	155	37
2	120	17	74	17
3	104	14	50	12
4	50	7	26	6
5 or more	101	14	105	25
Total	729	100	423	100

Times Tested Each Year	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
None	317	44	242	58
1	276	38	48	12
2	82	11	32	8
3	21	3	23	5
4	18	3	32	8
5 or more	15	2	36	9
Total	729	101	413	100

When Tested, How Often Returns for Results	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
I have never been tested	169	23	8	2
I never returned for my results	64	9	17	4
Sometimes	55	8	25	6
Half the time	22	3	11	3
Most of the time	41	6	33	8
Always	371	51	316	77
Total	722	100	410	100

Reasons For Not Returning for Results	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
I have never been tested	178	29	14	4
I always returned for my results	374	60	259	82
I was scared to find out my results	44	7	20	6
I was scared people would see me and talk bad about me	10	1	11	4
I did not think my results would be kept secret	5	1	4	1
I did not trust the people or had a past negative experience where I got tested	6	1	9	3
Another reason	7	1	0	0
Total	624	100	317	100

Why Do You Think Some People Don't Return for Their Results	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
They are scared that they might have HIV	559	80	274	71
They are scared that other people will find out about their HIV test	83	12	88	23
They don't trust doctors/healthcare workers	34	5	13	3
In the past, they had a bad time with doctors/healthcare workers	21	3	9	3
Total	697	100	384	100

Where Tested	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
I have never been tested	178	25	5	1
Health department	206	29	131	32
Physician's office	98	14	93	23
Hospital or clinic	149	21	2	33
Bar, street, or prevention event	22	3	9	2
Some place else	52	7	38	9
Total	705	99	278	100

Prevention Services Used	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Program on how to prevent HIV infection	341	47	237	56
Drug or alcohol abuse treatment program	247	34	134	32
Program for a specific group	118	17	83	20
Support group for partners, family, or friends of HIV+ Kentuckians	87	12	132	31
HIV testing center	301	43	269	64
HIV prevention specialist who tests for HIV outside of a clinic, office, or health department	196	28	120	29

Risks

Substance Used in Past Two Years	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Alcohol	493	70	282	68
Tobacco	430	61	294	71
Marijuana (recreational)	323	46	149	36
Pain pills not belonging to the client	177	25	102	24
Cocaine	129	18	71	17
Marijuana (health)	65	9	90	22
Ecstasy	103	15	35	8
Methamphetamines	79	11	34	8
Any illegal injected drug	43	6	28	7
Heroin	43	6	12	3

In a pattern similar to substance use among Kentucky youth and adults in general[1], alcohol, tobacco, and marijuana make up the most common substances used by respondents. Marijuana usage in the past two years for recreational purposes, however, is higher than in the general population as surveyed by the BRFSS. Prescription drug abuse is also higher.

It is interesting to note the self-reported prevalence of substance use is similar between positive and negative respondents in terms of alcohol, prescription drugs, cocaine, injectable drugs, and methamphetamines. Positive respondents, however, smoke more while negative respondents are more likely to use heroin, ecstasy, and recreational marijuana.

[1] Based on data from the Youth Risk Behavior Survey (YRBS) and Behavioral Risk Factor Surveillance Survey (BRFSS)

Sexual Behaviors in Past Two Years	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Unsafe oral sex	488	72	163	41
Multiple sex partners	625	88	323	78
Unsafe vaginal-penile intercourse	402	60	85	22
Unsafe anal sex	217	33	109	28
Have had sex with someone who was jailed	162	23	89	22
Celibate	82	12	93	22
Sex in exchange for drugs or money	78	13	39	10
Had sex with someone while jailed	27	5	19	5

Responses to questions about sexual behaviors are surprisingly similar between positive and negative individuals in terms of prostitution, having had sex while in jail, having had sex with someone formerly jailed, and barebacking (unsafe anal sex). On the other hand, negative respondents are far more likely to practice unsafe behaviors in terms of oral sex and unsafe vaginal-penile intercourse. Part of this difference is the greater percentage of the negative group reporting they are heterosexual. The negative group's higher incidence of unsafe behaviors may also be linked to being younger as well as less likely to report being celibate.

Information Sources

Where Do You Hear About HIV Prevention Services or Events?	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Care Coordinator	151	22	328	79
Physician/Clinic	300	43	297	75
HIV+ friend	163	24	171	43
HIV- friend	233	33	107	27
Internet	238	34	124	32
Media	359	51	160	41
Flyer or poster	291	42	174	44
Church, school, etc.	242	35	78	20
other	280	42	107	29

The negative and positive respondents have strikingly different sources in many cases for where they report getting information on HIV services and events. Negative respondents depend more on the media while positive individuals learn about services and events through their physician and care coordinator.

How To Improve Prevention Services	HIV Negative		HIV Positive	
	Frequency	Percentage	Frequency	Percentage
Pass out more free condoms (rubbers)	174	27	57	18
Use a mobile van to get to more places in the community	158	24	56	18
Put out flyers where people can get them	51	8	40	13
Send out TV and radio messages	128	20	70	21
Go to more community events	134	21	95	30
Total	645	100	318	100

COMMUNITY BASED ORGANIZATIONS PROVIDING HIV PREVENTION

Agencies funded in part with CDC Cooperative Agreement funds are indicated with the KHPAC logo:

American Red Cross (ARC) is located in nearly every county in Kentucky. The number of ARC employees range from one or two in the smaller communities to more than 300 in the Louisville Chapter. Budgets are also diverse, with smaller chapters having budgets of a few thousand dollars to in excess of a hundred thousand dollars in Lexington and Louisville. There is disparity in the provision of HI/AIDS services among counties, with smaller, more rural counties believing that there is "no problem" in their community (thus no reason for services) to the larger, more urban chapters offering quite a range of services. HIV/AIDS services include the distribution of brochures, AIDS 101 training, peer training for adolescents, African American AIDS 101 training, Hispanic AIDS 101 training, rural and church leader AIDS 101 training, prison personnel training, and a program specifically entitled "AIDS in the Workplace" which is designated for businesses and industries. (502) 589-4450

AIDS Services Center Coalition (ASCC) is a coalition of agencies whose primary goal is to direct the public to appropriate AIDS service agencies, literature distribution, and provide a HIV/AIDS resource directory. The agency has an extensive volunteer network. (502) 574-5490

House of Ruth provides social, emotional and financial support to people living with HIV/AIDS in the Louisville/Jefferson County area. (502) 587-5080

WINGS Clinic –The University of Louisville Research Foundation (ULRF) is a 501 (3) C private, non-profit foundation at the University of Louisville. WINGS provides quality HIV outpatient primary medical care and support services to the HIV infected population living in a 7county Kentucky region and Southern Indiana. Delivery of HIV medical care and services includes women, adolescents, and families. (502) 561-8844

Sisters and Brothers Surviving AIDS (SABSA) is a support group located in Louisville for all HIV positive people and their friends and family. SABSA provides education and emotional support specific to the needs of those living with HIV and more specifically to the needs of the African-American community. However, everyone is welcome regardless of gender, race, sexual orientation, creed, religion or ethnic background. (502) 231-3871

AIDS Interfaith Ministries (AIM) of Louisville provides support services to individuals living with HIV/AIDS and their families. (502) 574-6085

Matthew 25 AIDS Services, Inc. located in Henderson is a Ryan White CARE Act Part B, Part C and CDC Prevention PA04064 Grantee. They are a provider of primary health care to PWHIV and LWA, in Daviess, Henderson, Union and Webster counties. Services include medical case management and referral, a buddy program, literature, spiritual support and referral, financial assistance and referral, a speakers' bureau, support groups (positive, family and friends), transportation and prevention education for the community and medical professionals. Matthew 25 also distributes HOPWA funds and does counseling and testing for HIV (blood and oral testing). (270) 826-0200 www.matthew25clinic.org

AIDS Volunteers of Northern Kentucky (AVNK), located in Florence, KY was founded in 1990. AVNK seeks to understand and address the emotional, educational, social, spiritual and physical needs of the people in Northern Kentucky and surrounding communities who are living with HIV/AIDS, and the needs of their families, partners, friends and caregivers. AVNK strives to inform the general community about HIV/AIDS related issues for purposes of education, mobilization, prevention and advocacy. AVNK provides a number of services including three support groups, a monthly dinner/social, healing weekends, respite care, emergency financial assistance, memorial services, outreach to minority communities, World AIDS Day services and Healing Weekends. (859) 331-4719

AIDS Volunteers of Cincinnati (AVOC) located in Cincinnati, OH is a community-based organization that provides a wide variety of services to individuals diagnosed with HIV/AIDS and to the broader community, especially high-risk populations where HIV exposure is more likely. Although AVOC primarily serves Cincinnati and southwest Ohio, they offer many of their services to individuals and groups in Northern Kentucky. These services include community outreach, prevention and education presentations, street outreach to women in underserved communities, testing and counseling services, an informational and referral hotline and a speaker's bureau. (513) 421-AIDS (2437).

The I.N.D.Y (I'm Not Dead Yet) Project founded in 1994 serves Northern Kentucky. INDY is an organization dedicated to the enhancement of life for individuals affected by HIV and AIDS by providing social outlet in a variety of environments and frameworks with one basic goal in mind: having fun! Members and sponsors attend and host picnics, movie nights, dinners, camping trips, art events and parties. The group is dedicated to the proposition that through the joy of celebrating life there is hope and healing, and celebration is best engaged through groups of like minded individuals. (513) 343-9999.

University of Cincinnati Hospital, Holmes Clinic located in Cincinnati, Ohio is the Infectious Disease Center for the University of Cincinnati Hospital. Holmes Clinic provides medical services to individuals diagnosed with HIV/AIDS and is funded primarily through Ryan White Part C funds. Holmes Clinic provides these services to individuals from several states, and a significant percentage of individuals diagnosed with HIV/AIDS and living in Northern Kentucky use Holmes Clinic for their infectious disease care. In addition, Holmes Clinic conducts partner testing for patients of the clinic. (513) 584-6977

The University of Cincinnati Emergency Room also has a grant to conduct HIV testing and counseling services with patients who are seen through the Emergency Room. This program targets high-risk individuals who receive their primary medical care through the Emergency Room. If an individual is diagnosed, a referral is made to Holmes Clinic. (513) 584-5700

Bluegrass Care Clinic (BCC), located in Lexington is a Ryan White CARE Act Part C grantee. The BCC provides both clinical and support services for HIV/AIDS patients and their affected families in 63 counties through Central and Eastern Kentucky. The BCC staff is trained to provide harm reduction information and counseling regarding drug use, sexual activity and other high risk activities for HIV transmission and infection. In addition, the BCC also provides pre/post test counseling and testing. (859) 323-5544; Fax: (859) 257-2040; www.mc.uky.edu/bluegrasscareclinic.

Moveable Feast (MFL) is a nutritional support program, serving people living with HIV disease and their dependent children living in the Lexington/Fayette County area. Clients receive social

support and a hot, freshly cooked dinner five days a week. MFL can also serve as a referral source to other Area Service Organizations (ASOs) in the region. All services are completely free of charge. (859) 252-2867 www.feastlex.org.

Episcopal Diocese AIDS Ministry, located in Lexington, provides care and support through bi-annual social dinners. All meals and additional limited supportive services are provided free of charge. The Episcopal Diocese AIDS Ministry can also serve as a referral source/linkage for other ASOs in the region. Contact: Lisa – lisainky@adelphia.net.

The Salvation Army of Central Kentucky, located in Lexington, operates a free medical clinic. The medical clinic, operated by the University Kentucky's College of Medicine, provides exams and physical therapy, and HIV pre/post test counseling and testing. (859) 252-7706

Owensboro Area HIV/AIDS Task Force, Inc. is a non-profit CBO funded by donations. This agency serves its clients with emergency financial assistance, transitional housing, and acts as an advocate with property owners, utility companies, Social Security, HOPWA and other community service agencies. Volunteers also provide community outreach services with HIV prevention and risk reduction programs to targeted populations and various communities, medical professionals and local organizations. The Task Force dispenses printed risk reduction materials, condoms (male and female), dental dams, needle cleaning kits and crack pipe cleaning kits. The Task Force also goes into public sex environments (PSE) offering similar services, as well as HIV testing. Members of the Task Force are state certified pre and post-test counselors as well as certified to administer OraSure for HIV testing. Members are also certified to inspect potential housing for clients wishing to obtain HOPWA funding. The Task Force is a certified partner of the Balm in Gilead. A support group for PWHIV is in place. They act as a referral source to all the available assistance programs for clients. The Task Force has some HIV positive members who have made presentations at several high schools, a program describing the emotional, physical and financial stresses of being HIV positive. (270) 683-6018 www.owensboroaids.org

Heartland CARES, Inc., located in Paducah is a non-profit organization, serving people with HIV and AIDS in the Western Kentucky and Southern Illinois regions. The mission is to provide various components of care needed for persons living with HIV and AIDS regardless of ethnicity, gender, religious, beliefs, sexual orientation, or ability to pay, and to provide education and prevention to the general public to help stop the spread of HIV and STDs. Medical services are primarily supported through Ryan White Part C funding. The clinic also has numerous supporting services, which includes the Ryan White Part B Care Coordinator Program, HOPWA Grant Emergency Assistance, Supportive Housing Grant Assistance, SAMHSA-CSAT Grant, HOPWA SPNS and HOME Grant. Heartland CARES houses the Western Kentucky Prevention Team that is responsible for HIV/AIDS prevention in 42 Kentucky counties.
(270) 444-8183

Volunteers of America, Inc. (VOA) in Louisville provides HIV prevention education, focus groups, and risk reduction workshops to drug users, men, women, and youth at risk. The prevention services offered include pre-test and post-test counseling, factual information about reducing HIV risk factors associated with drug use and sexual behavior, alcoholism and drug abuse assessments, and referrals to HIV related and non-related resources as needed or by request. VOA also provides an AIDS Housing Integration Project, which offers technical assistance to shelters, housing providers, and housing developers to help establish and implement new housing programs for homeless and low-income persons with HIV/AIDS. VOA

also holds the HIV Services' contract, and provides case management services for PWHIV. This includes intake and assessment, goal setting, conflict resolution, crisis intervention, referral to community services, emergency financial assistance, linkage to rental and utility assistance, entry into support groups, mental health and substance abuse counseling. (502) 635-1361

The AIDS Project, located in Louisville, provides HIV prevention, education and testing services. Programs include staff led volunteer outreach teams that go to local bars, community fairs and special events. Services include condom distribution, counseling and testing, and referrals while practicing harm reduction techniques. (502) 608-0586

North Central AHEC/HETC: The mission of the North Central AHEC is to promote healthy communities through innovative partnerships. This is accomplished by providing educational support services to health professions students and health care providers, community health education and programs to encourage health professions as a career choice.

In order to address HIV prevention in Kentucky's growing Hispanic community, the Kentucky DPH has identified agencies providing other services to our Hispanic population and provided capacity building assistance to help these agencies provide HIV prevention activities including HIV antibody testing.

North Central AHEC/HETC collaborates with Area Health Education Centers across the state that recruit individuals from Hispanic communities, provide training, and utilize them to conduct HIV prevention activities in their communities. AHECs in Lexington (covering 5 counties) and Covington (covering 4 counties) currently conduct outreach in Hispanic communities, provide HIV testing, and conduct two community level intervention (Juntos and Promotores de Salud). A third AHEC in Louisville conducts similar activities with African-American communities.

North Central AHEC/HETC also collaborates with the Bluegrass Farmworker Health Center to provide additional outreach to migrant farm workers as well as testing.

The Lexington and Covington AHECs as well as the Bluegrass Farmworker Health Center have been extremely helpful in providing interpreters and assisting Hispanic clients receive services from other service providers who lack Spanish speaking employees.

Bluegrass Farmworker Health Center: Located in Lexington and Richmond, KY, the Bluegrass Farmworker Health Center (BFHC) serves a primarily migrant/ seasonal farmworker population among eight counties in Central Kentucky. The migrant health center's service area includes: Fayette, Scott, Bourbon, Clark, Madison, Garrard, Jessamine and Woodford counties. Spanish is the primary language of approximately 96% of the BFHC clients.

The BFHC strives to optimize clients' health outcomes by providing affordable, culturally appropriate primary and preventive health care in settings that embrace the Hispanic culture and language.

BFHC values: Client-centered care, client advocacy, excellent health care for clients, extensive client-centered referral and tracking system, optimal client outcomes, life long learning, fiscal responsibility, high degree of respect among staff members. The clinical and outreach staff is fluent in Spanish and English.

The BFHC counselors and educators work with farm workers on the work site and in residences as well as utilize referrals to the actual clinic for medical needs including HIV/AIDS and other related health and care issues.

Hazard Perry County Community Ministries is located in Hazard. Their purpose is to meet community needs through supportive services (outreach and case management), crisis aid, homeless shelter, transitional housing and childcare. (606) 436-0051

Harlan Countians for a Health Community located in Baxter, is a coalition of healthcare providers, consumers, and other interested agencies whose purpose is to improve healthcare in Harlan County. (606) 573-6115

Westlake Primary Care, located in Columbia, provides information and educational AIDS material, prevention kits with condoms, confidential testing and pre and post-test counseling. 270-384-4764

LESBIAN/GAY/BISEXUAL ORGANIZATIONS PROVIDING HIV PREVENTION SERVICES

Lesbian/Gay organizations: Include **GLSO**, **Lambda** on the University of Kentucky campus, **Pride Alliance** on the Eastern Kentucky University campus, **Common Ground** at the University of Louisville, **Diversity Coalition** at Western Kentucky University, **T-Unity** at Transylvania University, **Alliance** at Murray State University, **ACE League** at Berea College, and **Unity** at the Northern Kentucky University. All provide educational interventions and support for at-risk populations, referrals, condom distribution and advocacy services. The service area includes primarily students, but is available for the community. The number of clients is not known at this time. Fiscal resources include institution funding and contributions. Program referrals and linkages are with local agencies, CBOs, and Care Coordinators.

FAMILY PLANNING CLINICS PROVIDING HIV PREVENTION SERVICES

Family Planning Clinics are offered through Health Departments throughout the state. These clinics provide counseling and condom distribution. Total number of clients served is not available at this time. Fiscal and personnel resources include state and local monies and paid staff. Clients are women of childbearing age and sexually active men. Program referral and linkages include specialists as necessary, local Counseling and Testing sites, and CBOs.

Planned Parenthood has existed in Kentucky for more than 64 years. Planned Parenthood provides services in a large portion of Kentucky. The Louisville office has 16 employees and an operating budget of approximately $600,000. More than six thousand clients are seen annually in the Louisville office by doctors, nurses, medical assistants or nurse practitioners. Services include distribution of condoms and prevention brochures, programs on AIDS 101 and Safer Sex and peer education for teens and youth. Planned Parenthood contracts with local health departments to provide free and confidential HIV testing for women by appointment. In addition, health department staff in Lexington provides onsite HIV testing at Planned Parenthood on a walk-in basis one day each week. Males have been referred to other agencies in the past, but the agency is increasing its focus on young men. Most clients served are females under age 19 through 39.

YOUTH SERVICES PROGRAMS PROVIDING HIV PREVENTION SERVICES

Department for Human Services/Juvenile Detention Louisville provides formal presentations, video-based programs and peer counseling/peer presentation programs. Approximately 75-80 programs are done annually with services provided to approximately 75-80 youths. The organization reports 136 individuals employed who are designated education providers. The population served is approximately 50% white, 50% black, under age 23, and has equal distribution between males and females.

Morehead State University's Delta Sigma Theta Sorority provides HIV/AIDS Prevention materials to students on campus through community outreach efforts and presentation. Main target are individuals who come from rural areas of Kentucky.

University of Kentucky's Multicultural Center provides HIV/AIDS Prevention materials to students through community outreach as well as collaboration with AIDS Volunteers, Inc and Lexington Fayette County Health Department to provide testing.

STATE PROGRAMS PROVIDING HIV PREVENTION SERVICES

DPH Targeted HIV Prevention Program is funded with state money and began in 1992 as a means of ensuring that those populations at highest risk of HIV infection were being served. The health departments were asked to identify areas of need and individuals not receiving prevention interventions through CDC funded programs. The following five (5) local health departments, located throughout the state are eligible to receive funding under this program: Barren River District Health Department, Lexington-Fayette County Health Department, Louisville Metro Health Department, Northern Kentucky District Health Department, and Purchase Area District Health Department.

DPH Core Health Education Program provides basic HIV/AIDS information and materials through nearly every local health department in the state. Programs are provided to the general public, health care professionals, and to public and private schools.

Kentucky DPH Review/Approval of continuing education for health professionals mandated by state law: This program reviews and approves, rejects, or approves with recommendations, all courses that any individual, health care provider, health education provider, etc. wishes to provide Continuing Education Units to professionals. The program requires six content areas: epidemiology, transmission, medical treatment, legal, and appropriate attitudes and behaviors, to be included in each course offering.

DPH HIV Care Coordinator Program provides coordination of services for individuals living with HIV/AIDS. Prevention of transmission education, including safer sex and latex distribution is provided by the Care Coordinators.

Local Health Departments in each county provide on-site counseling and testing, condom distribution, and health care worker education. Off-site partner notification is also provided upon request or agreement from an infected person. Court ordered testing and court mandated risk reduction programs are provided. Many health departments (particularly those receiving Targeted HIV Prevention Program funds) employ health educators to provide street-outreach, one to one counseling, group and community outreach. Fiscal resources are federal, state and county funding. Counseling and testing is done by either social workers or nurses who have

completed a certification program provided by the State. Program referrals and linkages include the Care Coordinator Program and local resources where available.

Maternal Child Health provides a variety of programs and services that include RTR and condom distribution, literature/brochure distribution, and prenatal 076 Protocol through local health departments. The HIV/AIDS Prevention Program Coordinator, in collaboration with the Adult and Child Health Branch participated in the Association of Maternal and Child Health Programs (AMCHP) Action learning Lab in September 2004. This program is composed of various disciplines from areas in the state which come together to address perinatal HIV transmission in Kentucky. This team will focus on eliminating perinatal transmission through enhanced education of health care providers, general public and focus groups. This program consists of meetings that will run through 2006.

KENTUCKY GOVERNMENTAL DEPARTMENTS

Kentucky Department of Education (KDE): In 1990, the Kentucky Education Reform Act (KERA) was passed. KERA requires that local schools and districts determine the curricula used. The Program of Studies mandates the content to be taught at each grade level. Communicable diseases, communication strategies, peer pressure, decision-making, and abstinence are contained in the Program of Studies. KDE provides professional development and technical assistance on evidence-based curricula. Some of these programs are “Reducing the Risk” (RTR), “Making Proud Choices”, “Making A Difference” and “Postponing Sexual Involvement” (PSI). KDE, DPH HIV/AIDS Branch, Kentucky Parent Teacher Association, State Substance Abuse Program and other prevention providers co-sponsor training programs for peers and other individuals who provide prevention education to individuals in and out of school and individuals in alternative living settings such as faith-based organizations and juvenile justice facilities. The number of individuals served is not available at present.

KDE also finances and coordinates the Kentucky AIDS Prevention Education Technical Review Committee. This committee is responsible for reviewing a variety of educational materials including curricula, reference books, magazines, and videos.

Kentucky Department of Mental Health/Mental Retardation (Division of substance Abuse): Provides drug prevention education in schools throughout Kentucky. Also provides funding to treatment facilities.

CORRECTIONS/PUBLIC SAFETY PROVIDING HIV PREVENTION SERVICES

Jefferson County Corrections includes four county facilities housing offenders who have committed crimes. Their programs also include drug rehabilitation. Services include individual or group counseling, distribution of prevention brochures, free and confidential counseling services. The annual budget and number of employees are unknown at this time; however, their staff does include licensed counselors, physicians, and nurses. Client profile is 20% white, 80% African-American, 90% male, and 10% female. Ages among this population range from 18 to over 66.

Lexington-Fayette County Detention Center includes a recently built facility to house inmates. HIV counseling and testing is made available on site weekly, in close coordination with the Lexington-Fayette County Health Department

Life Line Recovery is a drug/alcohol rehabilitation program for incarcerated men in Louisville. Services include distribution of prevention brochures, group counseling, and educational programs in safer drug use, AIDS 101, and safer sex. Clients are over 18 and are equally divided between males and females, African-Americans, and whites. Size of budget and staff are unknown, but the staff sees an average of 50 men a month.

Federal Medical Center, Lexington provides medical treatment and educational programs to staff and inmates. The size of budget and personnel levels are unavailable at this time. Funding sources include government sources and inmate fund-raising activities. Program referrals and linkages include the University of Kentucky Medical Center, CBOs, and the ARC. The Lexington-Fayette County Health Department provides counseling and testing by request at the facility.

RELIGIOUS ORGANIZATIONS PROVIDING HIV PREVENTION/SERVICES

Religious Organizations known to actively support prevention efforts and support services in the Lexington community include the **Metropolitan Community Church**, **Integrity** (Episcopal), **Dignity** (Catholic), **More Light** (Presbyterian), AIDS-friendly parishes and **HIV/AIDS Ministry Team** (Catholic diocesan effort), and **Unitarian-Universalist Church**. Number of clients served is not available at this time, but their client base is their membership. There is much variety in funding sources, personnel resources and program referrals/linkages.

Gaps Analysis

The dedication of a number of key individuals has ensured that HIV prevention takes place with much more effectiveness and frequency than it would without the consistent and positive efforts these individuals put forward. That said, there are numerous serious gaps that remain that are of concern.

More effective implementation of the contracts has brought to the forefront increasingly accurate assessments of what is being completed effectively in Kentucky, given the limited amount of available funding and that some areas are less effective in practice than on paper. This assessment highlights the continued need for documented accountability and for more specific targeting of at-risk populations than has been required in the past. Recent and long-term epidemiological data support these recommendations.

The DPH will provide KHPAC with an annual report on the summary of interventions carried out for that year. With the legislative change in 2004, making it a law for HIV reporting by name. HIV data is not currently being released due to the recent implementation of name-based HIV reporting. The CDC has projected full implementation of the Program Evaluation Monitoring System (PEMS) for Fall 2006, which will provide more accurate intervention data.

A crucial gap in prevention efforts statewide are those targeted toward transgender communities. While anecdotal evidence indicates that transgender people do not comprise a large portion of those who are HIV+ in Kentucky at this time, the number of HIV+ transpeople statewide and nationally is increasing significantly. This conclusion is supported both by anecdotal evidence from Kentucky HIV care and service providers and by research being done throughout the U.S., and makes transgender-specific prevention efforts imperative. Given the difficulty many transpeople have in obtaining legitimate employment with reasonable compensation and health insurance coverage, the incidence of sex work for money and the use of non-prescribed/non-monitored hormones and silicone injected with shared needles increases this population's HIV risk dramatically. However, there are currently no CDC-promulgated DEBIs that address transgender identity and experience, and there is very little training available to educate HIV prevention professionals and care providers about them. This failure to recognize the unique aspects of trangender life creates significant barriers for those who do prevention outreach, but could be remedied in large part through the education of providers and the development of appropriate intervention strategies.

Another crucial gap in prevention efforts, is the lack of recognition of the indirect effect of substance use on the spread of HIV infection. The risk for HIV associated with substance use involves more than the sharing of IDU paraphernalia. Substance use (i.e., methamphetamine, alcohol, ecstasy, etc.) is, in fact, a major factor for the spread of HIV infection and other sexually transmitted diseases. Substance abusers are more likely to have lowered inhibitions and, often times engage in sexual relations with multiple partners. There are also those substance abusers who trade sex for drugs, and consequently may find it hard to place limitations on what they will and will not do. Drug use can reduce a person's commitment to use condoms and practice safer sex. Currently there are no prevention programs that target substance use apart from intravenous drug users.

EASTERN AND NORTHERN REGIONS

Due to staffing limitations and funding, HIV prevention outreach for all targeted populations in the Eastern region of Kentucky is still not enough to effectively cover the 72 counties this region covers. Travel in this region and the limited funding for such makes it difficult to effectively reach all areas of the Eastern region.

The DPH has tried to identify and provide capacity building to the Eastern Kentucky region, and has made an impact through local churches and countywide fairs, but there is still a need for increased outreach in the more rural areas of the region.

General STD awareness and HIV prevention is not provided adequately in the Lexington-Fayette Urban County public schools. There is no long-term project currently targeting youth under the age of 21 with HIV prevention education and risk reduction information.

The IDU population is still not being effectively reached, particularly outside of Lexington-Fayette County, where outreach to IDU is extremely difficult. Within Lexington-Fayette County, some collaborations have been made with local drug treatment centers, but there are still many centers and agencies which choose not to participate.

The transgender population is not included in the list of prioritized populations due to lack of data, nor are there any approved DEBIs for this population. This makes it difficult to perform outreach with this high-risk population, since their needs are unique and do not fit appropriately with those of any other prioritized population.

NORTH CENTRAL REGION

Prevention efforts in the Metro Louisville area should be better coordinated. Service providers should strive to avoid duplication of services/efforts. More collaborative efforts among all HIV service providers should be facilitated.

The loss of three-quarters of the regions minority Community Based Organizations (CBOs) has resulted in a significant gap in reaching communities of color. (There were only four minority CBOs serving the region's seven counties prior to this loss, though the region's HIV+ population is disproportionately comprised of people of color).

There is a major gap in reaching transgender communities, youth 25 and under and adults 50 and older.

High Risk Heterosexual (HRH) HIV cases are increasing, in part, due to (1) the lack of HIV testing before, during, and upon release from incarceration, (2) the exchange of sex for money or drugs, and (3) bisexual activity. There is a gap in targeted prevention efforts in these areas.

Prevention monies spent on the HIV+ population, the number 1 prioritized population, need to be focused on providing strategies for HIV+ individuals to live healthy lives, protecting the general public and the long term health of HIV+ individuals.

WESTERN REGION

The rate of HIV infection in Western Kentucky has shown that prevention efforts are in place but the need continues to grow. HIV+, MSM, HRH (primarily minority populations), IDU, MSM/IDU are those populations at greatest need in Western Kentucky.

Gaps in HIV education and prevention can be seen in the lack of consistent HIV education in high schools, the lack of prevention efforts in correctional facilities or the work place and the lack of HIV education for the general population. The rural setting and the large travel region (42 counties) of Western Kentucky complicates the efforts to provide widespread education and the reduction of stigmatization of the disease.

Other gaps identified in the Western region are the lack of consistent mental health services and substance abuse programs which outline the need to target non IDU drug users.

FUNDING AND ACCOUNTABILITY

The most important factor KHPAC has taken into consideration is that sizable efforts be taken with the limited amount of funding available to reach the most individuals at risk for contracting HIV with evidence-based harm reduction interventions. In the past, we have been unable to document that such interventions are occurring with any sustained approach. The evaluation of DEBI interventions (to be conducted at the end of 2006) which have targeted all at risk population will provide further information regarding the effectiveness of prevention interventions. The importance of the most cost-effective use of funding of the grant cannot be overemphasized.

It is crucial to prioritize interventions for HIV positive individuals. Programs utilizing HIV positive persons in the delivery of prevention services are lacking statewide. Lack of funding has seriously hampered the implementation of prevention case management for persons living with HIV. HIV + people across all risk categories are underserved. The best interventions for people living with HIV are peer education programs that use harm reduction.

An increased proportion of individuals reached through interventions have been designated to be HIV + within all target populations.

COUNSELING AND TESTING

A 2000-2001 evaluation of counseling and testing programs indicate that support staff at testing sites, at all levels, do not have adequate training in testing protocols, confidentiality, anonymity, client privacy and potentially awkward situations in a manner that promotes a successful program. Recommendations resulting from that evaluation and responses and goals to achieve those recommendations are listed below.

1. Site administrators and directors should raise HIV CTRPN to a higher priority, and should do so by hiring adequate numbers of staff, ensuring that anonymous and

confidential testing procedures are appropriately explained, and defining a clear policy which assesses client needs and protects confidentiality and anonymity.[2]

- This may be a reality in some areas of the state. The local health departments across Kentucky receive block grants from the State Health Department that are used to meet prioritized needs. Funds are allocated based on the highest prioritized need in that county. HIV may not rank very high in a given county and would receive less funding. David Raines will identify the health departments with the highest traffic related to STDs and the DPH will offer counseling and testing update and sensitivity training in these areas. Training can be offered but cannot be mandated.

2. Advertising and community outreach should be increased to raise awareness and utilization of HIV counseling and testing sites in Kentucky.

   - Press releases will be done four to five times a year highlighting prevention activities. The DPH has established a link on the DPH website to add prevention and CTS information. All Health Departments have access to the state training calendar (www.KY.TRAIN.org). The counseling and testing training has been approved by TRAIN for continuing education credits (CEUs). Tom Collins works very closely with Debbie Bohannon to make sure trainings are listed on the training website.

3. Counselors' training should be modified so that counselors receive training on HIV CTRPN goals, prevention and behavior change counseling including the discussion of risk factors and development of risk-reduction plans, discussion of homosexuality and more specifics of risk behaviors, and how to counsel an HIV positive client.
   - The HIV/AIDS Branch used the CDC sponsored curriculum 'Fundamental of HIV Prevention Counseling" as the foundation of the required training that all local health department nurses must complete before providing counseling and testing services. This curriculum addresses all the above mentioned subjects. Tom Collins completed the CDC course on the fundamentals of HIV counseling and testing in 2002. Beverly Mitchell completed the course in July 2005. Tom has trained numerous health department and CBO staff on counseling and testing and OraSure since he became certified in addition to the quarterly trainings conducted by David Raines. Update training will be offered to all counseling and testing sites, but the DPH cannot force staff to receive update training.

4. Continued counselor and site coordinator training should be required on a regular basis.

   - The DPH can offer training but it is not required by law, a change in legislation would have to take place for it to be mandatory.

5. Support staff should receive training on handling phone inquiries, the difference between anonymous and confidential testing, and ways of insuring privacy on the phone and at check-in.

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[2] Zimmerman R. et al. Evaluation of HIV Counseling, Testing, Referral, and Partner Notification Services of the Kentucky Department for Public Health. HIV Prevention Research Program, University of Kentucky, 2001.

- The DPH will research videos that are available on sensitivity training, and if needed, develop a video to use with recommendations that staff receive updated training every five years. The DPH will also offer the two day counseling and testing training to all new counselors.

6. A site coordinator should be designated for each HIV CTRPN program.

    - All nurses working at local health departments are required to receive counseling training. HIV testing in rural areas does not occur often at the health departments, as the nurses have numerous other responsibilities. With low numbers of clients coming in for testing in these areas, it is not possible to achieve this at this time with the staffing and funding that is available.

7. A regional coordinator should be appointed for each region.

    - As stated previously, this is not practical or possible in every region based on available resources and current responsibilities.

8. The state should consider consolidating HIV counseling and testing services so a smaller number of sites will have truly sufficient resources and staff to be adequately trained, more experienced, and comfortable on a regular basis with protocols and sensitive issues.

    - It is state mandated that every county in Kentucky will have a counseling and testing site at each local health department. It would require a regulation change to incorporate this. The latest recommendations from CDC are that all people be tested. It is not practical to require persons to travel a long distance to be tested if testing is not available in their area. This would create a barrier for testing. Rather than consolidate sites, the DPH will offer more update training to staff in rural areas.

9. An internal monitoring system should be developed. This would include regular feedback concerning the extent to which CDC protocol and guidelines are being met.

    - An objective listed under PCRS is to conduct regular site visits.

10. OraSure and OraQuick testing should become available statewide. Health departments and districts need to have funding available or should be encouraged to seek outside funding to provide OraSure and OraQuick testing kits and training.

OraSure is not the appropriate testing method in local health departments. OraSure testing was intended to be used in outreach settings to reach people that may not come to their local health department. We encourage blood draws to screen for other STDs in a clinical setting. OraQuick or another form of rapid testing could be used to increase the number of people actually learning their serostatus, but it may decrease testing for other STDs requiring a blood-draw.

CONTRACTS & EFFICACY OF INTERVENTIONS

Training was conducted in 2005 with Prevention Specialists on DEBI implementation. Prevention Coordinators conduct periodic site visits to ensure the core elements of DEBIs are being completed. A full evaluation of the effectiveness of DEBIs will be conducted at the end of 2007.

CULTURALLY SPECIFIC INTERVENTIONS

Culturally appropriate interventions in CDC defined risk populations are inappropriate for youth, rural communities, transgendered people and injecting drug users. Meaningful prevention efforts in rural areas and among youth remain largely non-existent. State law prohibits access to sterile injection equipment. Relying on education about cleaning syringes with bleach and the distribution of syringe cleaning kits gives a false sense of security to the IDU community and inadequately addresses the very real prevention needs.

There is a need for targeted funding for culturally specific outreach in storefront facilities, that is, facilities and settings removed from health departments and other government buildings. Such storefront settings, we believe, would facilitate community building in CDC defined at-risk individuals.

REDRAWING THE REGIONAL BOUNDARIES OF HIV PREVENTION CONTRACTS

Kentucky is divided into three geographic regions: Eastern, North Central and Western. We believe the sheer enormity in size of the Eastern and Western regions is a barrier for effective prevention work. The Eastern region consists of 72 counties; the Western region consists of 42 counties. We believe it is imperative that the DPH study the possibility of dividing the state into more than three regions. Creating smaller regions would entice smaller CBOs, especially in the rural regions of the state, to vie for and be awarded prevention contracts with the state.

CAPACITY BUILDING

The lack of funding to non-governmental contracted CBOs does not allow for capacity building. Efforts have been made to identify and fund potential new CBOs in underserved areas, however they do not exist.

SYNOPSIS

1. Capacity building needs to be encouraged and funded to non-government contracted CBOs for geographic underserved areas of the state and within areas currently dependent on CBOs unable or unwilling to embrace harm reduction strategies.

2. While the epidemic continues to extend throughout all geographic areas of the state, prevention funding does not allow for consistent outreach efforts, especially in rural areas.

3. The ability to test for HIV in the general population continues to improve. Complete HIV epidemiology does not exist due to recent legislation providing for named reporting. The number of AIDS cases reported remains statistically the same.

4. New generations of GLBT populations are informed on the issues; however continued education remains a priority.

5. Partners of individuals in risk groups, transgendered people and neo-nates at risk remains underserved.

6. High risk populations including incarcerated persons, Hispanics and persons in rural settings remain underserved or highly underserved. Racial disparity persists in access to services.

7. Access to sterile injection equipment remains limited due to state law.

8. While remaining committed to harm reduction, secondary prevention efforts in most cases remain insufficient.

9. Continued support for state conferences on HIV/AIDS and the African American and Hispanic Leadership conference is indicated.

11. Volunteers are not mobilized in significant numbers and community building is extremely limited.

12. The state and the recipients of HIV prevention contracts remain pro-active in seeking to resolve the gaps.

13. Collaboration between DPH and the Department for Education would assist in the inclusion of HIV education in individual school district curriculum.

CONCLUSION

Except for in a few metropolitan areas, prevention efforts across the state are hit and miss. A consistent, sustained plan which includes collaboration with other agencies, community development, and harm reduction interventions reaching individuals in CDC defined risk categories that can be fully documented is an ongoing challenge.

There is a lack of linkages between the HIV/AIDS Branch and other agencies that have HIV prevention resources, including the KY Department of Education, mental health programs, substance abuse programs, family services, correction facilities, and the STD and TB programs.

The lack of linkages between the HIV/AIDS Program and the Sexually Transmitted Disease (STD) Program adversely impacts prevention efforts statewide. The currently used Program Evaluation and Monitoring system (PEMS) will help identify information for the HIV/AIDS and STD programs. The Kentucky Department for Public Health will document linkages with other government agencies and where prevention efforts are lacking, they will make every effort to resolve those issues.

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1. Introduction: Care

The Health Resources and Services Administration administers the Ryan White CARE (Comprehensive AIDS Resources Emergency) Act and requires funded states to periodically conduct a needs assessment to better guide the allocation of care resources. The 2007 Kentucky Needs Assessment consists of several sections outlining the current status of HIV care and needs in the Commonwealth.

After consultations with the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC), the state Ryan White "Part B" grantee office participated in the 2007 Kentucky Statewide HIV/AIDS Needs Assessment. This process incorporated a single survey tool to assess statewide need regarding HIV/AIDS prevention and Care services. A single assessment process was developed for use by the states' HIV/AIDS prevention program (CDC), and Ryan White care services program (HRSA), and by the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) which is funded with federal CDC and HRSA funds. This needs assessment was accomplished through collaborations between the Kentucky Department for Public Health, Dr. Jeff Jones, and KHPAC.

Kentucky and HIV

In terms of population, Kentucky is the 25th largest state. Kentucky's population, however, has a comparatively low racial and ethnic diversity: almost 9 in every 10 Kentuckians are non-Hispanic Whites. While 7% of Kentucky's population is African-American, almost half of all African-American Kentuckians live in a single county: Jefferson County (Louisville). Making up almost a third of Kentuckians living with AIDS, African-Americans are also disproportionately affected by HIV. According to the 2000 U.S. Census, Kentucky's Hispanic and Asian-American populations are rapidly growing, but still account for less than 3% of the total population.

While many Kentuckians perceive of the state as largely rural, 56% of Kentuckians live in urban areas. In fact, half of all Kentuckians live in just fifteen counties[3]:

- Jefferson
- Fayette
- Kenton
- Hardin
- Warren
- Daviess
- Campbell
- Boone
- Christian
- Madison
- Pike
- McCracken
- Bullitt
- Pulaski
- Laurel

[3] 2000 U.S. Census

The five urban counties of Jefferson (Louisville), Fayette (Lexington) and northern Kentucky (Kenton, Campbell, and Boone Counties) define an urban "Golden Triangle" and are homes to almost two-thirds of all Kentuckians living with AIDS.[4] The other third of Kentuckians living with AIDS, however, are spread over 115 other counties extending from the Mississippi River to the Appalachian Mountains. For rural areas, providing care to a dispersed population where clinics and health services are often lacking or distant is a serious challenge. Urban areas face different challenges based on their large client loads.

In focus groups conducted in 2005 for Kentucky's *Statewide Coordinated Statement of Need*, clients and service agencies consistently listed greater funding for services as the key need in the state[5]. Therefore, the 2007 survey seeks additional service needs from respondents.

Principal Investigator

Jeff A. Jones, Ph.D., devised and analyzed the 2007 Kentucky Needs Assessment Survey in conjunction with the HIV Branch and participating service agencies. Dr. Jones conducted several prior HIV care assessments in Kentucky as well as administering several statewide adolescent health surveys for the CDC (Centers for Disease Control and Prevention). He is an Assistant Professor in the Department of Health Behavior at the University of Kentucky's College of Public Health.

Survey Methodology

Of the thirteen agencies participating in the joint survey of care and prevention clients, eight have care clients. The sampling frame consists of the care clients at the eight participating care service agencies. These sites were selected because they receive Federal funds for conducting care activities. Based on the client loads reported by each agency, Dr. Jones assigned a target sample of 1,000 care clients distributed between the eight agencies based on each agency's percentage of total care clients in the state. The agencies administered the survey to clients coming to the agency during late June and July 2007. The 86 question survey was anonymous and no names or identifying information were gathered on the survey. The participating agencies serving care clients are:

- Bluegrass Care Clinic, University of Kentucky, Lexington
- Cumberland Valley District Health Department, London
- Heartland CARES, Paducah
- Matthew 25, Henderson and Bowling Green
- Northern Kentucky District Health Department, Fort Mitchell
- Volunteers of America, Louisville
- WINGS Clinic, University of Louisville, Louisville

[4] *HIV/AIDS Semi-Annual Report*, December 2006

[5] Jones, Jeff. 2005. *Kentucky HIV/AIDS Statewide Coordinated Statement of Need*.

Sample, Responses, and Margins of Error

Site	Sample	Respondents	Response Rate	Margin of Error (+ or - at 95% confidence)
Cumberland Valley District Health Dept	37	27	73	19
Bluegrass Care Clinic	144	130	90	9
Northern Kentucky District Health Dept	63	38	60	16
WINGS Clinic	347	85	25	11
Volunteers of America	235	52	22	14
Matthew 25 Henderson	58	50	87	14
Matthew 25 Bowling Green	50	19	38	22
Heartland Cares	66	33	50	17
	1000	434	43	5

434[6] HIV+ clients responded to the survey to produce a response rate of 43% and a margin of error for the statewide sample of +/- 5 at a 95% confidence interval. In other words, the true figure for the percentages listed in the survey results is somewhere in a range +5 and -5 from the actual figure. Thus, 71% of respondents report they have used tobacco products in the past two years. The true percentage at this margin of error is therefore a percentage between 66% and 76%. The margins of error for individual sites are also given. While the table above shows the margin of error for the entire survey or for individual sites, it would also be possible to compute this figure for each individual question based on the number of respondents answering this question. The 434 HIV+ care clients also completed the questions on prevention services.

Limitations

This survey has a number of limitations. Survey collection took place during a short one month period in mid-summer at various HIV care and prevention sites around the state. Some individuals who normally visit a site regularly may have been absent due to summer vacations and other summer activities. Response rates at the WINGS Clinic and Volunteers of America, the two sites serving the greatest number of HIV+ clients, are also low. Only willing clients and prevention participants visiting a site were surveyed. HIV+ individuals utilizing private physicians, out-of-state facilities, or not in care were not surveyed.

Survey Demographics

The following tables describe the demographic characteristics of HIV+ respondents and are generalizable to Kentucky's HIV+ care population as a whole. These demographics show a considerably diverse group of Kentuckians.

The majority of respondents are non-Hispanic white males over the age of 40 whose HIV disease has not progressed to full blown AIDS. The majority perceive themselves as living in an urban area. Still, a quarter of respondents are female. Another quarter are African-American,

[6] Two additional HIV+ respondents from the Barren River District Health Department are included in the survey results. Why were these two respondents included? I thought barren river was only a prevention site in the sample. We wanted to look at services among HIV+ individuals receiving care at only the HRSA funded facilities.

and the age of a third of respondents is under 40. While a fifth of respondents have a college degree, one in six respondents have less than a high school diploma.

While gay/lesbian individuals account for almost half of respondents, a tenth identify as bisexual and two-fifths are heterosexual.

A fifth of men reporting they have had sex with another man in the past two years does not identify as gay. One in six men having sex with another man in the past two years identifies as bisexual.

One in every five respondents has known they are positive for less than three years. Fifty-five percent of respondents are HIV+ but do not have AIDS. A third of respondents were living outside of Kentucky when they learned they were infected with HIV.

Sex Breakdown of HIV+ Respondents

Sex	Frequency	Percentage
Male	308	71
Female	111	26
Male to female transsexual	13	3
Female to male transsexual	2	<1
	434	100

Age Breakdown of HIV+ Respondents

Age	Frequency	Percentage
Less than 18 years old	2	<1
18 to 21	12	3
22 to 29	49	11
30 to 39	121	28
40 to 49	166	38
50 to 59	72	17
60 to 64	8	2
65 years or older	5	1
	435	100

Hispanic Ethnicity Among HIV+ Respondents

Hispanic Ethnicity	Frequency	Percentage
Yes	16	4
No	403	96
	419	100

Race Breakdown for HIV+ Respondents[7]

Race	Frequency	Percentage
American Indian or Alaska Native	8	2
Asian	9	2
Black or African-American	114	26
Native Hawaiian or other Pacific Islander	4	1
White	283	66
Other	14	3
	432	100

Self-Reported Sexual Orientation Identity for HIV+ Respondents

Sexual Orientation Identity	Frequency	Percentage
Gay, lesbian, or homosexual	199	47
Bisexual	48	11
Heterosexual or straight	173	41
	420	100

Men Who Have Sex With Men Listed By Self-Reported Sexual Orientation Identity

MSM Sexual Behavior[8]	Frequency	Percentage
MSM -Gay Male	140	81
MSM -Bisexual	27	16
MSM - Heterosexual	6	3
	173	100

Time Since Diagnosis with HIV

Time Since Diagnosis with HIV	Frequency	Percentage
Less than a year	25	6
1 to 2 years	65	15
3 to 5 years	85	19
6 to 9 years	90	21
10 to 14 years	87	20
15 years or longer	84	19
	436	100

[7] Note: Hispanic respondents may be of any race. Hispanic and non-Hispanic individuals are included based on their self-reported race.
[8] Among male respondents reporting they have had sex with a man in the past two years

Time Since Diagnosis with AIDS

Time Since Diagnosis with AIDS[9]	Frequency	Percentage
I am HIV-	8	2
I don't know if I am HIV+ or HIV-	3	1
I am HIV+ but do not have AIDS	235	55
Less than a year	20	5
1 to 2 years	44	10
3 to 5 years	42	10
6 to 9 years	37	9
10 to 14 years	27	6
15 years or longer	13	3
	429	100

Self-Reported Perception of Residence as Urban or Rural Among HIV+ Respondents

Urban/Rural	Frequency	Percentage
City	277	64
Country	153	36
	430	100

Education Attainment of HIV+ Respondents

Education	Frequency	Percentage
Less than high school degree or GED	74	17
High school diploma or GED	126	29
Some college	145	34
College degree	55	13
Graduate or Professional degree	29	7
	429	100

Location at the Time of HIV Diagnosis

Living in Kentucky When Learned HIV+	Frequency	Percentage
Yes	276	66
No	145	34
	421	100

[9] Note: Eleven respondents report they are HIV- or do not know their status on this question but elsewhere report they are HIV+.

Decade When Respondents Learned of Their HIV Diagnosis

When Told HIV+	Frequency	Percentage
1980s	48	12
1990s	184	45
After 2000	174	43
	406	100

Various Survey Findings

The following findings from the 2007 Kentucky HIV/AIDS Needs Assessment reflect the responses from the 434 HIV+ individuals completing the survey.

The majority of HIV+ clients report they have smoked and consumed alcohol in the past two years. More than one in three clients report using marijuana recreationally. One in five also report using marijuana for medical purposes. Prescription drug abuse is also high with almost one in four clients saying they have taken pain pills not belonging to them. One in fourteen says they have injected an illegal drug in the past two years. While many care coordinators have long recognized the need for substance abuse counseling for a significant portion of their clients, these findings provide key data on the extent of substance abuse among clients.

HIV+ Respondents Reporting They Have Used the Following Substances in the Past Two Years

Substance Used in Past Two Years	Frequency	Percentage
Tobacco	**329**	**71**
Alcohol	**316**	**68**
Marijuana (recreational)	**167**	**36**
Pain pills not belonging to the client	**111**	**24**
Marijuana (health)	**102**	**22**
Cocaine	**79**	**17**
Ecstasy	**37**	**8**
Methamphetamines	**37**	**8**
Any illegal injected drug	**32**	**7**
Heroin	**14**	**3**

The majority of HIV+ respondents are sexually active: slightly less than four in five clients report having sex in the past two years. The minority of clients report unsafe sexual behaviors. However, almost half have had multiple sex partners. Two in every five clients also report having unprotected oral sex with another person in the past two years. More than a quarter of HIV+ clients report barebacking, or having unsafe anal sex. Just over one in five clients have had unsafe vaginal-penile intercourse, and a tenth have been involved in prostitution for money or drugs.

HIV+ Respondents Reporting They Have Practiced Any of the Following Sexual Behaviors in the Past Two Years

Sexual Behaviors in Past Two Years	Frequency	Percentage
Multiple sex partners	209	45
Unsafe oral sex	190	41
Unsafe anal sex	130	28
Have had sex with someone who was jailed	102	22
Celibate	102	22
Unsafe vaginal-penile intercourse	102	22
Sex in exchange for drugs or money	46	10
Had sex with someone while jailed	23	5

2. Epidemiologic Profile

See Appendix

3. Assessment of Service Needs Among Affected Population

Responses by HIV+ Respondents on Use, Need, and Unmet Needs of Various Services

	Get This Service and Need It (Frequency)	Get This Service and Need It (%)	Get This Service But Don't Think Need It (Frequency)	Get This Service But Don't Think Need It (%)	Need But Do Not Get (Frequency)	Need But Do Not Get (%)
Help with clothing	162	35	153	33	153	33
Help paying for health insurance	283	61	60	13	125	27
Dental services	302	65	46	10	116	25
Help with health care in home	144	31	213	46	111	24
Help paying for transportation	274	59	84	18	107	23
Mental health services	223	48	139	30	97	21
Hospice services	102	22	269	58	93	20
Help with food	288	62	84	18	93	20
Help with alcohol or drug problems	153	33	232	50	84	18
HIV information, counseling, and testing	316	68	102	22	51	11
Health care in a clinic or health office (other than a hospital)	390	84	28	6	42	9
Help getting medications	394	85	37	8	32	7
HIV Care Coordination	399	86	37	8	28	6
Case manager/Care coordinator	404	87	32	7	28	6

The above table displays responses by HIV+ clients regarding services. As would be expected, healthier individuals are unlikely to need hospice care currently. Likewise, individuals who do not have or do not perceive themselves as having a substance abuse problem list these services as unneeded. On the other hand, most clients list care coordination and clinic services as needed. In fact, eighty-two percent of respondents say they find out about new or current

HIV services from their care coordinator or doctor/clinic. A third of respondents also reports seeing or calling their care coordinator monthly. A quarter says they only contact their care coordinator on an as-needed basis. Seven percent report having no care coordinator. Another seven percent says they have a care coordinator but do not contact him/her.

Three out of every four respondents feels having multiple services "under one roof" would make accessing these services easier. One in four does not believe such an arrangement would affect their usage of services. No one views such an organization of services as making services harder to access.

Clients list assistance with clothing, health insurance, and dental services as the most commonly unmet needs they face.

Barriers

Almost a third of clients responding to the survey list transportation as a barrier to accessing local HIV services. Clients at Volunteers of America and Matthew 25 (Bowling Green) are the mostly likely to report lack of transportation as a problem. Cumberland Valley clients are the least likely to report transportation as a barrier. Volunteers of America clients also most frequently list the other issues as barriers.

Responses from HIV+ Respondents Reporting the Following Areas Serve as Barriers to Accessing Local HIV Care Services

Barriers to Using Local Services	Frequency	Percentage
Lack of transportation	144	31
Afraid will be seen or lack of privacy for records	111	24
Don't feel respected or safe	84	18
Fear staff will know client is using drugs	37	8

Respondents also report a high incidence of other health conditions concurrent with their HIV infection. Forty percent of clients report problems with blood pressure and high cholesterol. One in five has diabetes, cancer, and/or heart disease. Nineteen percent report having tuberculosis with most saying they are not being treated with medications for the condition.

Concurrent Health Conditions Listed By Clients	Has Condition and Taking Medications For It (Frequency)	Has Condition and Taking Medications For It (%)	Has Condition but NOT Taking Medications for It (Frequency)	Has Condition but NOT Taking Medications for It (%)	Not Diagnosed with This Condition (Frequency)	Not Diagnosed with This Condition (%)
High or low blood pressure	125	27	70	15	269	58
High cholesterol	97	21	74	16	288	62
Diabetes	51	11	51	11	362	78
Heart disease	42	9	60	13	362	78
Cancer	19	4	79	17	367	79
Tuberculosis (TB)	23	5	65	14	380	82

Respondents report a heavy reliance on government aid programs to pay for their HIV prescriptions. Only one in ten have private insurance coverage for their HIV medications. Three percent report paying out of pocket for their medications and/or having no insurance to assist in paying for their HIV medications.

Who Pays for Clients' HIV Medications	Frequency	Percentage
KDAP (Kentucky Drug Assistance Program)	241	52
Medicaid	65	14
Medicare Part D	46	10
private health insurance	46	10
don't know	32	7
KHICP (Kentucky Health Insurance Continuation Program)	14	3
out of pocket, no insurance	14	3
VA (Veterans Administration)	9	2

4. Resource Inventory

Current listing of clinics, care coordination sites, and other HIV services are to be attached to final report by HIV Branch staff.

Layers of Services

HIV/AIDS care services involve different agencies at the local, state, and federal levels. These different services can be thought of as layers:

- Layer 1: Prevention outreach and case management personnel working primarily at five agencies.
- Layer 2: Anonymous HIV counseling and testing services provided through health departments in all 120 Kentucky counties.
- Layer 3: Ryan White Title II Care Coordinator programs provided through six regional offices.
- Layer 4: Ryan White Title III clinics located at five sites in-state as well as a clinic in Cincinnati, Ohio, serving northern Kentucky residents.
- Layer 5: HOPWA programs that assist HIV+ people with housing.
- Layer 6: Different assistance services that vary greatly by region.

Ryan White Parts

For clients and agencies not intimately involved in HRSA funding through the Ryan White Act, the terminology and network of care services may be confusing. This situation became apparent during the focus groups when several individuals asked other participants what they meant by various "parts"[10]. Thus, for the reader we provide a brief overview:

The Ryan White CARE (Comprehensive AIDS Resource Emergency) Act was originally signed into law in 1990. It provides federal funding for HIV/AIDS care coordination, clinics, medications, and other services. Funding is channeled to particular types of services through Parts within the Act. In very general terms, here are the Parts and the areas they cover:

Part A: Provides funding to metropolitan areas with a large number of HIV infected residents. Kentucky does not have any Part A funded sites.

Part B: Provides funding for care coordinators and the Kentucky AIDS Drug Assistance Program (KADAP). The Care Coordination Program operates through six sites across Kentucky. Seventy-five percent of funds must be spent on core medical services.

Part C: Provides funding to medical clinics serving HIV+ patients. Kentucky currently has four such clinics that also operate several satellite offices. Dr. Hadad, an infectious disease physician in Glasgow, received a capacity building grant through HRSA. These grants often are the seed for a new clinic. Federal funding for new clinics, however, has become restricted and a fifth clinic has not yet emerged. Seventy-five percent of funds must be spent on core medical services.

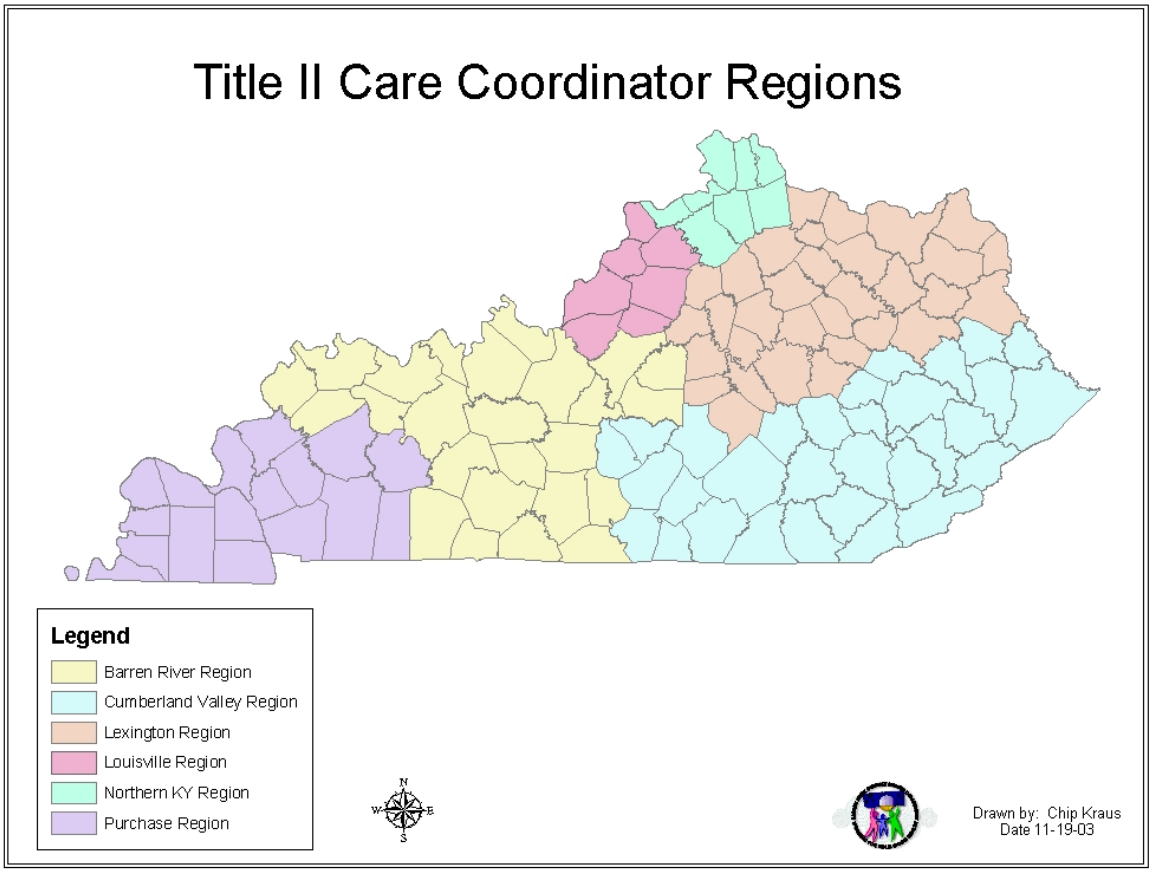
Part D: Provides funding for HIV services specifically for women and children. Kentucky has one such site in Louisville.

[10] Previously the Ryan White Care Act was divided into Titles I through 5 rather than Parts A through F.

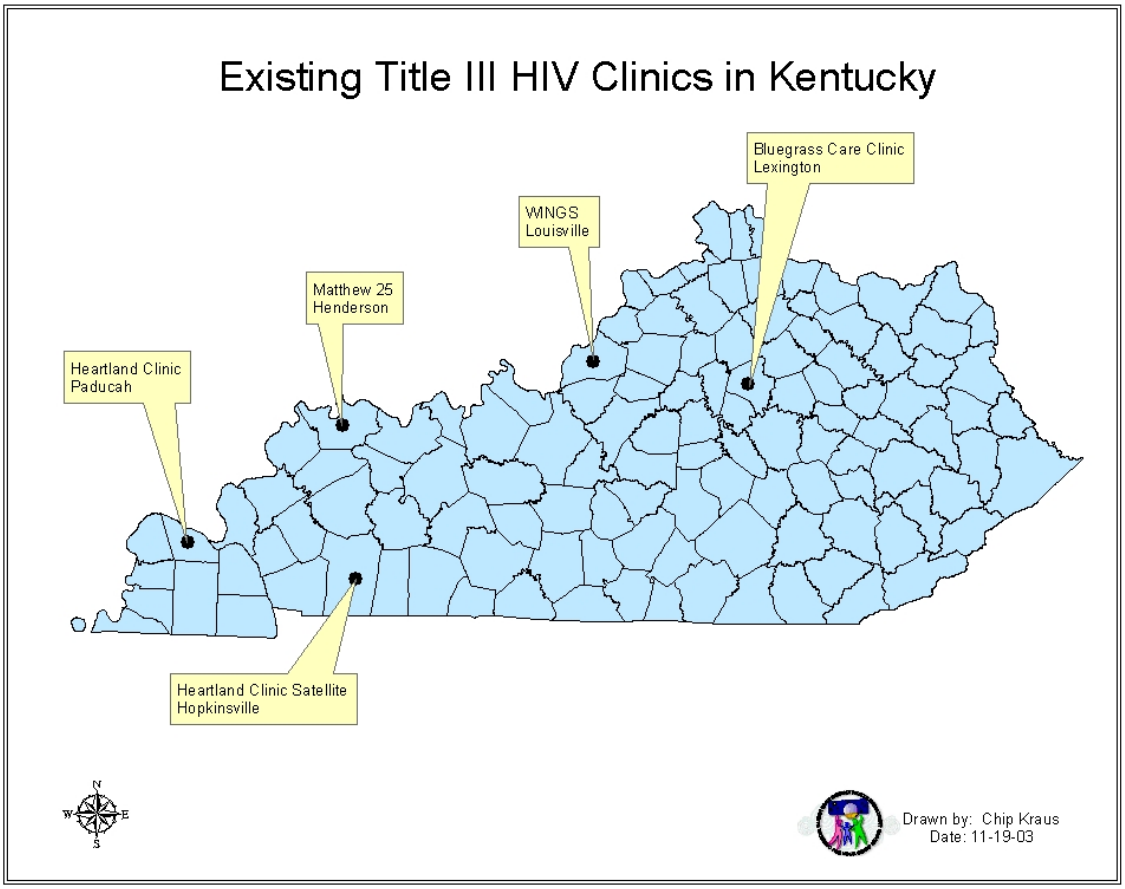
Part F: Comprises Special Projects of National Significance, AIDS Education & Training Centers, Dental Programs and Minority AIDS Initiative. Also requires HHS to develop Severity of Need Index by September 2008.

Prevention efforts, HIV testing, and post-test counseling are generally funded separately through federal channels such as grants from the U.S. Centers for Disease Control and Prevention. Kentucky HIV/AIDS care and prevention services are also supported by state, local, and private grant funds.

Map courtesy of Barren River Health District, Chip Kraus. Note: Title II is now Part B. There have been no changes to the Care Coordinator regions since this map was produced in 2003.



Courtesy of Barren River Health District, Chip Kraus. Note: Title III is now Part C. There have been no changes to the HIV clinics since this map was produced in 2003.



Core Services

The majority of Ryan White CARE funds are spent directly on health care for Ryan White clients. Under the new law, grantees receiving funds under Parts A, B, and C (formerly called Titles I, II and III) must spend at least 75 percent of funds on "core medical services."

The Administration and Congress wishes to ensure grantees target Federal funds to pay for essential medical care. That care includes

- outpatient and ambulatory health services;
- pharmaceutical assistance;
- substance abuse outpatient services;
- oral health;
- medical nutritional therapy;
- health insurance premium assistance;

- home health care;
- hospice services;
- mental health services;
- early intervention services; and
- medical case management, including treatment adherence services.

Remaining funds may be spent on support services, defined as services needed to achieve outcomes that affect the HIV-related clinical status of a person with HIV/AIDS. The law outlines support services as:

- outreach;
- medical transportation;
- language services;
- respite care for persons caring for individuals with HIV/AIDS; and
- referrals for health care and other support services.

5. Profile of Provider Capacity and Capability

Kentucky law limits the maximum caseload per care coordinator to 70. Currently the Kentucky Care Coordination Program employs 33 care coordinators and supervisors at six local sites. Four other staff members coordinate the program from Frankfort. Thus, the current maximum care coordination program is 2,310 clients. The latest *HIV/AIDS Semi-Annual Report* (12/31/2006) currently only reports cases of AIDS and does not HIV+ Kentuckians whose disease has not progressed to full blown AIDS. Since 1982 when the first case of AIDS was identified in Kentucky, 4,506 Kentuckians have been diagnosed with AIDS. As of 12/31/2006, 2,563 Kentuckians with AIDS were living in the state. Thus, even without factoring in HIV+ but without AIDS cases, the number of potential clients for the care coordination program exceeds maximum capacity by 253 clients.

2007 Care Coordination Program Directory:

Bluegrass Care Clinic, Lexington, 740 South Limestone, B265 or 1030 S. Broadway, Suite #5, 40536-0284

1. **Alice Thornton, Director……...(859)323-1694**
2. **Julie Mattern, Supervisor……..(859)323-6303**
3. **Sharon Brown……(859)323-1738**
4. **Donna Withrow……..(859)323-1815**
5. **Karen Ball……...(859)323-1780**
6. **Ann Dills……..(859)323-2349**
7. **Ken Wilson……..(859)323-1819**

Cumberland Valley District Health Department, London, PO Box 1269, 40743

1. **Pat Wagner, Supervisor……(606)864-3776 Ext. 121**
2. **Mary Lynn Philbeck……(606)864-3776 Ext. 113**
3. **Sherry Brumley……(606)864-3776 Ext. 125**

Heartland Cares, Paducah 3025 Clay Street, 42002

1. **Krista Wood, Director……..(270)444-8183 Ext. 103**
2. **Ann Ponder Simpson, Supervisor……...(270)444-8183 Ext. 105**
3. **Angie Polivick……(270)444-8183 Ext. 102**
4. **Nancy Wrye……...(270)444-8183 Ext. 117**
5. **Marissa Russell……..(270)444-8183 Ext. 113**

Matthew 25, Henderson & Bowling Green, 411 Letcher St. 42420

1. **Cyndee Burton, Director……(270)826-0200**
2. **Cookie Sutton, Supervisor……..(270)826-0200**
3. **Stacey Pruden (Henderson)……(270)826-0200**
4. **Carla Witlow (Bowling Green)……...(270)843-3331**

Northern Kentucky District Health Department, Ft. Mitchell 2388 Grandview Dr., 41017

1. **Cathy Kunkel-Mains, Supervisor……...(859)363-2082**
2. **Paul Trickel……...(859)363-2081**
3. **Amanda Beck……(859)363-2096**
4. **Barbara Laing……...(859)363-2089**

Volunteers of America, Louisville, 850 Barret Ave, Suite 302, 40204

1. **Tina Haley, Director……(502)574-0116**
2. **Richard Coomer, Clinical Coordinator……..(502)574-0119**
3. **Pat Bhattari……...(502)574-5494**
4. **Kathleen Hymer……(502)574-1060**
5. **Alex Durall……(502)574-0036**
6. **Brenda Maloney……(502)574-0115**
7. **Amy Jennings……(502)574-0117**
8. **Beth Harrison-Prado……(502)574-5492**
9. **Melanie Mattox……..(502)573-0121**
10. **Vacant……(502)574-5549**

State/Central Office Ryan White Staff

1. **David Clark, Grant Administrator……(502)564-6539 Ext. 3554**
2. **Merinda Brown, Health Ins. Administrator……..(502)564-6539 Ext. 3591**
3. **Vicki Johnson, KHCCP Administrator……..(502)564-6539 Ext. 3557**
4. **Trista Chapman, KADAP Administrator……..(866)510-0005**

6. Assessment of Unmet Need and Service Gaps

This final section summarizes the unmet needs of Kentuckians living with HIV and provides recommendations for closing service gaps. All statistics quoted in this section derive from the 2007 Kentucky HIV/AIDS Needs Assessment Survey.

- **Increased Funding:** Undoubtedly the greatest challenge to expanding services to fill service gaps consists of the perennial need for increased funding for HIV programs.

- **Increased Staffing:** The Care Coordination Program currently has insufficient staff to meet the needs of HIV+ Kentuckians and remain in compliance with Kentucky law mandating a maximum caseload of 70. Staffing needs should be reassessed upon official numbers of all HIV+ Kentuckians.

- **Prescription Coverage for Co-Morbidities:** Fifty-eight percent of respondents reports being 40 or older. More than forty percent also lists having a concurrent chronic condition such as high cholesterol or blood pressure problems. As with any aging population, treatment for chronic disease must also figure into a holistic approach to keeping an HIV infected person healthy.

- **Increasing "One Stop Shopping":** Respondents believe having more services at a single site makes it easier to use such services. HIV service agencies should attempt to expand coordination of multiple services at a central site.

- **Introduce Smoking Cessation Programs:** Respondents report tobacco use prevalence at a far greater level (71%) than both the national (20.0%) and Kentucky statewide (28.5%) prevalence. Reducing tobacco usage in this population would have clear preventative and health risk reduction benefits.

- **Continue Programming That Is Inclusive of Non-Gay-Identified MSM:** Almost one in every five men who report having sex with another man does not define himself as gay. Programming that is inclusive of bi and heterosexual identified MSM should be continued.

- **Expand Transportation, Clothing, and Dental Services:** Some sites offer dental services. Where possible, other sites should seek to extend dental services or referrals to clients. While difficult to solve, emphasis should be placed on improving transportation between clients and service sites. Similarly, the coordination of a clothing bank with local charities and retailers could help to meet this need identified by respondents.

SECTION

4

STRATEGIES

INTERVENTION TYPES USED IN CDC's EVALUATION GUIDANCE

The CDC, National Center for HIV, STD, & TB Prevention, DHAP-IRS provided a series of training sessions for health department staff on Evaluating CDC-Funded Health Department HIV Prevention Programs (commonly referred to as the "Evaluation Guidance") in February and March 2000. Kentucky sent three representatives to this training (the HIV/AIDS Branch Manager, the HIV Prevention Coordinator, and the former CPG State Co-Chair).

Upon return, the training on the Evaluation Guidance was provided to appropriate DPH personnel, the CPG, and the PSs. In compliance with the new Evaluation Guidance, the former CPG incorporated the use of CDC's intervention classifications.

A.	**Individual-level Interventions (ILI)**	Health education and risk-reduction counseling provided to one individual at a time. ILIs assist clients in making plans for individual behavior change and ongoing appraisals of their own behavior. These interventions also facilitate linkages to services in both clinic and community settings (e.g., substance abuse treatment settings) in support of behaviors and practices that prevent transmission of HIV, and they help clients make plans to obtain these services. **Note**: According to a strict categorization, outreach and prevention case management also are individual-level interventions. However, for the purposes of this reporting, ILI does not include outreach or prevention case management, which each constitute their own intervention categories.
B.	**Group-level Interventions (GLI)**	Health education and risk-reduction counseling (see above) that shifts the delivery of service from the individual to groups of varying sizes. GLIs use peer and non-peer models involving a wide range of skills, information, education, and support. **Note**: Many providers may consider general education activities to be group-level interventions. However, for the purposes of this reporting, GLI does *not* include "one-shot" educational presentations or lectures (that lack a skill component). Those types of activities should be included in the Health Communication/Public Information category.
C.	**Outreach**	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high-risk individuals in the clients' neighborhoods or other areas where clients' typically congregate. Outreach usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials. Includes peer opinion leader models.
D.	**Comprehensive Risk Counseling and Services (CRCS)**	Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.
E.	**Partner Counseling and Referral Services (PCRS)**	A systematic approach to notifying sex and needle-sharing partners of HIV-infected persons of their possible exposure to HIV so they can avoid infection or, if already infected, can prevent transmission to others. PCRS helps partners gain earlier access to individualized counseling, HIV testing, medical evaluation, treatment, and other prevention services.
F.	**Health Communications/ Public Information (HC/PI)**	The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk-reduction efforts, and/or inform persons at risk for infection how to obtain specific services. **Electronic Media:** Means by which information is electronically conveyed to large groups of people; includes radio, television, public service announcements, news broadcasts, infomercials, etc., which reach a large-scale (e.g., city-, region-, or statewide) audience. **Print Media:** These formats also reach a large-scale or nationwide audience; includes any printed material, such as newspapers, magazines, pamphlets, and "environmental media" such as billboards and transportation signage. **Hotline:** Telephone service (local or toll-free) offering up-to-date information and

		referral to local services, e.g., counseling/testing and support groups. **Clearinghouse:** Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations. **Presentations/Lectures:** These are information-only activities conducted in-group settings; often called "one-shot" education interventions.
G.	**Other Interventions**	Category to be used for those interventions funded with CDC Announcement 99004 funds that cannot be described by the definitions provided for the other six types of interventions. This category includes community-level interventions (CLI). CLI are interventions that seek to improve the risk conditions and behaviors in a community through a focus on the community as a whole, rather than by intervening with individuals or small groups. This is often done by attempting to alter social norms, policies, or characteristics of the environment. Examples of CLI include community mobilizations, social marketing campaigns, community-wide events, policy interventions, and structural interventions.

STRATEGIC OVERVIEW OF SELECTED INTERVENTIONS

POPULAR OPINION LEADERS

This intervention involves the identification of popular "opinion leaders" among the targeted community to serve as endorsers of the need for behavior change to their own circle of friends and acquaintances. This intervention involves conducting an extensive pre-intervention survey to bar patrons, training bar staff to identify "opinion leaders," recruitment and six week training of "opinion leaders," contracting with "opinion leaders" to educate and encourage their friends to practice safer sex, regularly scheduled contacts with "opinion leaders", and post-intervention survey for bar patrons.

MSM/POL is a Community Level Intervention (CLI) due to its' use of local bars and clubs of potential clientele. It is also labeled as an Individual Level Intervention (ILI) due to one on one personal contact with bar and club patrons. Even though there is an obvious barrier to targeting HIV positives in this forum, the opinion leader should concentrate on those that are thought to be involved in high-risk behavior.

NOTE: KHPAC recommended removing POL from the list of interventions for 2009.

A. POTENTIAL IMPACT OF STRATEGY TO PREVENT INFECTIONS: Rated as high, due to proactive nature of one-to-one communication and peer support from a friend talking to a friend approach.
B. COST EFFECTIVENESS OF STRATEGY: Initially high to moderately high cost due to expense of evaluation of surveys, payment of stipends to "opinion leaders", training expenses, and staff time to maintain contact. Cost decreases after evaluations of the first implementation occurs.
C. THEORETICAL BASIS OF STRATEGY: Diffusion of Innovation (Rogers, 1983; Kelly, et al., 1991). Social Cognitive Theory (Bandura, 1986). Theory of Reasoned Action (Fishbein & Middlestadt, 1989). Multi-component State Model (Prochaska et al., 1994).
D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS, AND PREFERENCES: High due to indigenous nature of intervention.
E. AVAILABILITY OF OTHER RELATED RESOURCES: DEBIs.

Diffusion of Effective Behavioral Interventions (DEBIs)

These interventions recognize that psychosocial factors are often triggers for engaging in unprotected behaviors. These multi-session workshops do not focus on "instructing" participants on the mechanics of safer sex. Instead, the focus is on providing a supportive setting for experiential learning (co-lead by a trained mental health professional, when possible, and the appropriate HIV prevention team member) designed to improve interpersonal relationship skills, increase self-esteem, remove social-isolation and cognitive-isolation,

increase coping skill for handling stress, and increase self-awareness of behaviors. These interventions recognize the need to bridge mental health services with HIV prevention efforts.

These interventions represent one of the longest periods of time that a client or at risk individual may be in a teachable platform designed solely to reach their population. This will open opportunities for the outreach team to instill a sense of responsibility among those that are positive. With the understanding that there is a limit to the long term effectiveness of the risk reduction approach, these interventions target HIV positives, their sex partner(s) and at risk associates. The intervention emphasis must be on Harm Reduction when participants choose to engage in risky sexual practices or judgment impairing activities.

DEBIs are group level interventions (GLI). DEBIs have been selected targeting five risk groups. They are: HIV+, MSM, IDU, MSM/IDU, and High-Risk Heterosexual. The number of workshops for each population will be determined by prioritized populations. The planning should also place the most emphasis on HIV positives, African-Americans and Hispanic. Even though the Transgender population is not specifically mentioned in the above populations, they remain an entity of all priority populations. A specific Transgender workshop should be included in the MSM/IDU and High-Risk Heterosexual workshop series. All workshop participants should be evaluated for enrolment in Comprehensive Risk Counseling and Services (CRCS) (formerly known as Prevention Case Management).

A. POTENTIAL IMPACT OF STRATEGY TO PREVENT NEW INFECTIONS: High. On going contacts with participants increase potential impact. Impact also increases when groups with disproportionate rates of infection are targeted or when the intervention targets HIV positive persons.
B. COST EFFECTIVENESS OF STRATEGY: Low to moderate. Cost associated with contracting with regional HIV prevention team worker (HIV+, MSM, MSM/IDU, IDU and Heterosexual).
C. THEORETICAL BASIS OF STRATEGY: Information-Motivation-Behavioral Skills Model (Fisher and Fisher, 1992). Theory of Gender and Power (DiClemente and Wingood, 1995).
D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS, AND PREFERENCES: High, issues are built in due to indigenous nature of intervention.
E. AVAILABILITY OF OTHER RELATED RESOURCES: "Key Peer Opinion Leader" intervention for MSM patronizing gay bars.

PUBLIC SEX ENVIRONMENTS (PSE) OUTREACH INTERVENTION

This intervention's primary purpose is to connect via one-to-one communications with individuals who may not be reached by more traditional interventions. The principle here is to meet people on their "turf." This intervention involves training individuals to safely go to PSEs in teams and provide information, support, and referrals. Extensive preparations are required for this intervention, including the consent and cooperation of various agencies, institutions, and local governments.

A. POTENTIAL IMPACT OF STRATEGY TO PREVENT NEW INFECTIONS: Moderately high due to connecting a low impact approach (brief public encounters) with very high prevalence target groups (Sex for trade/sale workers and non-gay identified MSMs).
B. COST EFFECTIVENESS OF STRATEGY: Moderate. Expense of training, traveling, tracking persons reached, and stipends.
C. THEORETICAL BASIS OF STRATEGY: Theory of Planned Behavior, (Ajzen, 1988).
D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS AND PREFERENCES: Clear understanding that workers are not to approach, but be approached and are not to condemn sexual behavior of target group. Workers are there to increase awareness of risks (HIV/AIDS, legal, physical, social, and family) and provide information, condoms, and referrals.
E. AVAILABILITY OF OTHER RELATED RESOURCES: N/A, many from target PSE group cannot be reached by other means.

COMMUNITY AWARENESS/MOBILIZATION INTERVENTION

This intervention (targeting (MSM, MSM/IDU, IDU, Heterosexual) recognizes the need to take into account the targeted community's culture, social, and behavioral norms in HIV prevention planning. This intervention involves contracting with an establishment, most likely a bar or community center, to provide a safe gathering place for the target population. Peer leaders from the target community will be identified, trained, and paid a stipend to serve as safer sex information "diffusion agents", to host the social event for their community and provide needed support, referrals, condoms and information. A core group will be maintained to continue the intervention activities and events.

A. POTENTIAL IMPACT OF STRATEGY TO PREVENT INFECTIONS: High due to proactive nature of one-to-one communication and peer support. Also high due to "grass root" creation of the intervention via direct input from targeted community.
B. COST EFFECTIVENESS OF STRATEGY: Moderate to high. Additional expense of renting facility, given current environment, a necessary expense.
C. THEORETICAL BASIS OF STRATEGY: Diffusion of Innovation, (Rogers, 1983; Kelly et al., 1991). Social Cognitive Theory, (Bandura, 1986). Theory of Reasoned Action, (Fishbein & Middlestadt, 1989). Multi-component Stage Model, (Prochaska et al., 1994). Multi-component Stage Model, (Prochaska et al., 1994).
D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS AND PREFERENCES: High, intervention is directly based on input from the targeted community.
E. AVAILABILITY OF OTHER RELATED RESOURCES: Empowerment workshops.

STREET OUTREACH

The Prevention Specialists providing outreach do one-to-one counseling, referrals, encourage and arrange counseling and testing, distribute bleach kits and latex condoms. All street outreach will include harm reduction information for IDU.

A. POTENTIAL IMPACT OF STRATEGY TO PREVENT NEW INFECTIONS: High due to connecting a low impact approach (brief public encounters) with very high prevalence target groups (IDUs and persons with a history of substance abuse/addiction, MSM,

MSM/IDU, and Heterosexual). Street outreach provides the most reliable gateway to prevention case management.

B. COST EFFECTIVENESS OF STRATEGY: Moderate, expense of funding for outreach workers.

C. THEORETICAL BASIS OF STRATEGY: Theory of Planned Behavior (Ajzen,1988).

D. RESPONSIVENESS TO TARGET POPULATION'S VALUES, NORMS AND PREFERENCES: Non-judgmental approach is essential to accessing difficult-to-reach populations. Increased contact contributes to awareness and effective referrals.

E. AVAILABILITY OF OTHER RELATED RESOURCES: N/A, many from the targeted populations cannot be reached by other means.

HIV+ CRCS

In order to maximize resources for Comprehensive Risk Counseling and Services (CRCS) for HIV+ individuals, the former CPG recommended in the 2002 plan, a pilot program to identify those individuals most likely to engage in unsafe behaviors. Development of the intervention at one (1) counseling and testing site, (preferably a high volume site), would involve a triage approach using markers to identify candidates for CRCS at the time of post-test counseling. (See “The Unsafe Behaviors of Persons Living With HIV/AIDS: An Empirical Approach to Developing New HIV Prevention Interventions Targeting HIV-Positive Persons, Rosser, Gobby & Carr, Journal of Sex Education and Therapy Vol. 24, no.1 & 2.)

Recent public information has been presented from numerous studies regarding the percentage of HIV positives that have failed numerous AIDS drug therapies, giving new credence to the necessity for proactive CRCS approach for HIV+ individuals.

Since 2002, CRCS has been expanded so that every Prevention Specialist carries a small case load within their target population. These individuals will either be HIV positive or determined to be high risk HIV negative. In addition, the CRCS for HIV positives pilot project has been expanded to all three regions with one full time CRCS Provider in the East and West region, and two in the North Central Region.

At all times PSs doing CRCS should keep a record of the level of development that the client has reached or the level at which the client elected to discontinue the program. The levels are known as the "Stage of Change Rating". They are:

Pre-contemplation
Contemplation
Preparation
Action
Maintenance

Prevention Specialists must be cautioned when being trained that their position involves management of the client only. When there are other needs that the client may have, the PS should direct the client to the proper Care Provider that is capable of administering the specific need of the client.

SECTION

4d

STRATEGIES

HIV TESTING AND PARTNER COUNSELING AND REFERRAL SERVICES (PCRS)

PCRS Goals, Objectives, Methods and Activities 2009 – Continued from 2008

Objective 1 - Throughout 2009, maintain an accessible network of HIV Counseling and Testing Sites (CTS), which provide quality service to clients.

Methods - At present, there are 209 CTS sponsored by the Kentucky Department for Public Health (DPH). Sites include local health departments and satellite clinics, community health centers, high schools, community based organizations, Planned Parenthood and hospitals that serve substance abusers. Non-invasive testing is also presently available at off-site facilities who provide services to populations most adversely affected by HIV/AIDS. Specimens at these sites are tested by the OraSure and OraQuick test kits. The intent of these off-site test centers is to encourage high-risk populations to learn their serostatus and to adopt safer sex and needle sharing practices. Clients who test positive are also provided with the knowledge that they need to quickly access health care. The OraSure and OraQuick sites are proving to be an effective way to provide counseling and testing services to men who have sex with men, injection drug users and other high-risk populations who are often reluctant to present to local health departments to receive health services. Funds sufficient for the testing of approximately 3000 OraSure/OraQuick clients are presently available.

In 2009, all 120 counties in Kentucky will have at least one public health clinic where persons may voluntarily present for HIV counseling and testing. All counselors at these sites will have been trained in a two-day course entitled HIV Counseling and Partner Notification conducted by certified trainers who are staff members of the Kentucky STD Program or the HIV Prevention Program. Clients who seek services at a CTS will usually have to call the site and make an appointment. Some sites, however, have sufficient staff to provide service on a walk-in basis. CTS will be urged to ensure that the delay between date of request and date of service receipt is kept to a minimum of two or three work days. Delays exceeding one week will be unacceptable. All clients will be advised that services can be provided on either a confidential or anonymous basis and given the right to decide which they prefer. Health department counselors will, however, stress to clients to seriously consider confidential testing because the confidentially tested HIV infected client who fails to return voluntarily for post-test counseling will be assigned for follow-up by a Disease Intervention Specialist (DIS) to ensure that post-test counseling is achieved, arrange for partner notification and referral for counseling and testing for HIV and other STDs, referral for other medical services including tuberculosis skin testing,

contraceptive and/or prenatal care, if needed or indicated, and referral to health care providers for further HIV/AIDS diagnostic testing including CD4 and viral load testing. HIV infected patients will be routinely provided with the name, address and telephone number of an AIDS Care Coordinator who can assist the patient with a variety of needs (medical, financial, social, housing, legal) if the client contacts the coordinator and requests help.

Local health departments have expanded HIV services to include patients assessed to be at-risk for HIV infection who attend family planning, prenatal, tuberculosis and sexually transmitted disease clinics. HIV counseling and testing at jails and juvenile detention centers has been undertaken by some health departments. Although most health departments do not provide prenatal services, those that do routinely offer HIV testing as part of their initial examination. Pregnant women served at these sites have the right to refuse HIV testing but very few actually do. Regardless of where a client receives HIV counseling and testing services in a DPH sponsored CTS, the following basic rules apply:

*Every client will receive face-to-face counseling from a counselor who has been trained in the HIV Counseling and Testing and Partner Notification course taught by a certified instructor.

*Clients have the right to refuse testing and, if tested, have the right to choose whether the test will be confidential or anonymous.

*All post-test counseling will be done face-to-face after the client has been properly identified as being the person tested. No post-test counseling or notification of a test result will be done by telephone or mail.

CTS operation brings with it the responsibility to assure that patients receive quality services delivered in a professional manner and setting by well-trained and competent staff. Service delivery at each CTS will be closely monitored and personal visits will be made by STD Program administrators and supervisors to a site when it is observed that deficiencies exist or if complaints are received from clients about the quality and/or sensitivity of service delivery at a site.

Evaluation - supervisors and administrators of the STD and HIV prevention programs will monitor all activities performed at each CTS. Specific outcome indicators that will be measured and reported in progress reports include:

1) Updated listing for all CTS,
2) New sites added during a quarter,
3) Number of new personnel trained in HIV Counseling and Testing and Partner Notification courses
4) Statewide and individual site reports of all CTS, including OraSure and OraQuick test sites, compiled from data collected from an optical scan HIV Counseling and Testing Form completed for every client receiving services. These data will also be collected in the PEMS data system.

Objective 2 - Throughout 2009, promote and assess the availability of comprehensive counseling and testing services by maintaining a level of health care providers (public, private, and military) who have received training in courses approved by the Kentucky Department for Public Health. Emphasis will be placed on expanding services to include additional agencies who serve clients who use and /or abuse narcotics.

Method - As courses are planned, area hospitals, drug treatment centers, university student health centers, and correctional facilities located near course sites will be offered the opportunity to have staff members attend. Facilities who have trained staff may remain an independent counseling and testing service or become an official Kentucky DPH CTS. Those who elect to be an official CTS must agree to pretest counsel all clients prior to testing, offer the client the option of being tested anonymously or confidentially, test only when the patient elects to be tested, attempt to post-test counsel all clients tested, and to set up or arrange an interview with a DIS and an infected patient so that partner notification can be done. They must also agree to use the optical scan form for collecting data and to submit them in a timely manner to the Kentucky STD Prevention Program for data compilation and review. Non public health facilities who elect to become a CTS must submit all specimens to the Division of Laboratory Services (DLS) for processing and properly identify specimens on an official DLS form for HIV specimen testing. DLS will process specimens free of charge.

Selected non-public health facilities trained in HIV counseling will be encouraged to become an official CTS but those who remain independent will have received the same training as counselors in a CTS. They will also have better understanding of patient care and services available through public health programs for infected patients who have limited or no access to health care

Evaluation - Progress toward achieving this objective will be measured as follows:

1) Documentation of new non-public health facilities added as an official CTS
2) Documentation as to the number of employees at new sites who were provided training.
3) Monthly, quarterly, semi annual, and annual reports from individual sites and a statewide basis showing the number of clients served ,demograhics of clients served, risk assessment of clients ,and test outcome.

Objective 3 - In 2009, maintain a test acceptance rate of at least 95% for all patients pre-test counseled in health department sponsored STD clinics.

Method - DIS and nurses serving patients with an STD or suspected exposure to an STD will emphasize to the patient that by virtue of being infected with an STD they are at increased risk of being infected with other STDs including HIV/AIDS infection. Patients will receive pre-test counseling for HIV and encouraged to be tested for HIV infection. Counselors in STD clinics will refer to the HIV test as the AIDS virus test because it is felt that many STD patients do not know that the HIV test is the test used to detect the virus that causes AIDS. STD patients will first be provided appropriate care for the STD infection they have and then referred to a counselor where they will receive basic information and educational materials about HIV and AIDS. They will then be offered and encouraged to be tested for HIV but assured that refusal to accept testing will not negatively impact or prevent their ability to receive health care services at the facility or any other clinic operated by a local health department. Patients who elect testing will be tested confidentially and advised that it will be necessary for them to return to the clinic in two weeks to learn their results and receive additional (post-test) counseling. In order to assure that a greater number of STD patients receive HIV/AIDS information, CTS services, when possible, will be provided while the patient is waiting to receive their STD examination.

Evaluation - Quarterly, semiannual and annual assessments will be made of the number of STD patients at public clinics provided HIV/AIDS information, pre-test counseling, testing and post-test counseling services. The specific documents used for data collection will be the HIV

Counseling and Testing Report (optical scan form) developed by the CDC and the PEMS form. These forms will be initiated on every STD patient approached and will enable us to accurately measure activity at each specific site as well as aggregate data on a state-wide basis. Data will be collected and tabulated by staff assigned to the STD Program.

Objective 4 - In 2009, confidentially or anonymously test at least 95% of CTS clients who receive pre-test counseling. Estimated number of pre-test counsels each year will be 19000 with 18000 tests performed.

Method - Brochures, handouts and pamphlets listing CTS locations will be distributed at public clinics statewide. Private, public and military care providers will be updated as to CTS locations by accessing information from the DPH Website and by periodic articles in EPI Notes and Reports, a DPH publication sent to over 8200 health care providers monthly. Newspapers and radio stations will be alerted about public awareness campaigns and asked to broadcast or print CTS locations in areas where awareness initiatives are being conducted. In order to achieve a high test acceptance rate, clients attending a CTS will have the option of receiving either confidential or anonymous services. Confidential services will be emphasized by counselors, as will procedures in place for the protection of privacy. During pre-test counseling the following will be stressed:

1) Educate the patient about HIV/AIDS infection including risk factors and modes of transmission.
2) Assess the patients' risk of infection.
3) Assist the patient with developing a plan to adopt safer sex/ needle use practices.
4) Explain what a negative, positive and indeterminate test result means and does not mean.
5) Let the patient decide whether to be tested. Care will be taken to ensure that the counselor neither talks a client into or out of being tested.
6) Emphasize to the patient the need to voluntarily return for his/her test result and post-test counseling and of the importance, if the test is positive, that all sex/needle sharing partners within the previous two years, and spousal partners within the previous ten years, be informed of possible exposure. All CTS services will be monitored to ensure that counseling is non-judgmental and sensitive to the needs of patients.

Evaluation - Data will be compiled and presented as part of quarterly, semiannual, and annual reports which will be sent to each CTS and which will be reviewed by the administrative staff of the Kentucky Sexually Transmitted Disease Program and HIV Prevention Program. These reports will also be forwarded to the CDC. Specific documents from which data will be compiled are:

1) The HIV Counseling and Testing Report Form initiated on every client served in a CTS. The form will provide information as to the clients age, sex, race, risk factors, reason for seeking services, county of residence, identification of the CTS site where service was sought, date of test and result if tested and date of post-test counseling if the client returns.
2) HIV CTS logs maintained at each CTS.
3) The Division for Laboratory Services Human Immunodeficiency Virus Serology (DLS form 197) completed on all persons tested in a CTS.

Objective 5 - In 2009 achieve at least a 70% return rate for post-test counseling for all persons tested (confidentially or anonymously) in a CTS and at least a 50% return rate for STD clinic patients.

Method - At the time of pretest counseling, counselors will emphasize to clients that there is nothing to be gained from testing and deciding not to return to learn their test result. Clients will be informed that the result, whether negative or positive, serves as a guide as to how to alter life styles and adapt safer sex and needle use practices. Clients tested by OraQuick procedure are virtually assured to receive post-test counseling because the test result will be available within 20 minutes of collection. To ensure a higher rate of return for post-test counseling when blood draws are performed, counselors will emphasize the following to clients:

1) Prior to testing, each client will be asked to verbally consent to return for post-test counseling.
2) Each client tested will be given a specific date and time to return for post-test counseling. The date and time will be entered on a piece of paper and the client will be asked to put the paper in a place where it will not be lost or easily forgotten.
3) Clients will be advised to call the site to ascertain that the test has returned and to reschedule another date if the result is not available. Clients will also be instructed to call the CTS to reschedule an appointment if they are unable to attend on the date scheduled.

In addition to the measures described above, STD patients will receive the following messages:

1) Confidential testing will be strongly advocated for STD patients but anonymous testing will remain available to patients who will not accept confidential HIV testing. STD patients seen at the Specialty Clinic, Louisville, and at the Lexington-Fayette County Health Department Annex will be advised that a counselor will be available to provide post- test counseling without delay.
2) Staff time and other resources permitting, high risk STD patients who accept confidential service and test negative but fail to return for post-test counseling, may be mailed a second appointment within three days of the missed appointment.
3) All patients testing positive who are confidentially tested in a CTS or STD clinic who fail to meet their scheduled post-test counseling date, will be assigned follow-up by a DIS within three days of the missed appointment.
4) Post-test counseling in the field will be done when possible, but only when the setting is one in which complete privacy is assured.

Evaluation - Achievement toward measuring whether 70% of all clients tested in a CTS and whether 50% of clients tested in STD clinics are post-test counseled will be assessed from data collected from the following documents:

1) HIV Counseling and Testing Report form and the PEMS data document. These optical scan forms will be completed on every client attending a CTS and on those approached in STD clinics. Monthly, quarterly semi-annual, and annual reports will be prepared and submitted to the state and the CDC.
2) HIV Counseling and Testing logs maintained at CTSs which include dates of pre and post-test counseling, test results if testing was done, and information as to whether the client was seen by a member of the STD or HIV prevention staff or by local health personnel.

Objective 6 - In 2009, increase the number of positive patients tested in a CTS who receive post-test counseling to at least 90%. (Baseline 84% in 2005)

Method - Many of the methods described in objective 5 to return clients for post-test counseling also apply to this objective. However, since targeted clients in this objective are HIV positive, they are of special concern because:

1) They are infectious.
2) They need appropriate risk reduction counseling.
3) They need to work closely with counselors to insure that sex/needle sharing partners and spouses are notified of exposure.
4) They need prompt medical, dental, social and human health services available through a CTS or through referral to other care providers.
5) They need to be referred to an AIDS Care Coordinator who can assist them in obtaining medical, financial and other services that are not provided by the CTS.

Patients tested confidentially, (who provide truthful information about their identity) present less problems because if they fail to return for post-test counseling their name, address and other locating information are available for follow-up by a DIS staff member. Unfortunately, those tested anonymously and who fail to return voluntarily cannot be followed. To ensure a higher rate of return for post-test counseling when anonymous or confidential testing is done with client assessed to be at high risk for HIV, counselors will:

1) Inform the client that they are high risk because of sexual/ needle sharing practices
2) Determine if the client has already developed signs and symptoms of HIV disease (weight loss, night sweats, fever, lymphadenopathy, diarrhea, white spots or unusual blemishes in the mouth, etc.) and if so, arrange for an immediate medical assessment by a physician.
3) Reemphasize to the client that they must return to learn their results and that a positive result indicates need for additional testing, medical evaluation and possible treatment with medicines that have proven to be very effective in delaying the on-set of AIDS and associated opportunistic infections.
4) Assure the client that there is nothing to fear about the counseling and testing service they received or will receive and resolve any concerns the client has which could result in a decision of not voluntarily returning for results.

Evaluation - Area supervisors and administrators of the Kentucky STD Program central office and administrators with the HIV Prevention Program off-site testing facilities will keep constant vigil on CTSs to ensure that every effort is being made to provide post-test counseling to clients testing positive for HIV. Counselors who have difficulty in returning patients for post-test counseling will be provided remedial training (audit and /or demonstration counseling sessions by a supervisor) to identify weaknesses in counseling techniques and to recommend and demonstrate methods that could possibly improve performance. Data collected from optical scan forms will be the basis for measuring objective achievement. Reports will be produced for each site on a regular basis and composite reports will be forwarded to the CDC on a semi-annual and annual basis.

Objective 7 - In 2009, improve the quality of services provided to clients by Kentucky DPH sponsored CTSs by conducting the following activities:

1) Conducting HIV Counseling and testing classes at various locales throughout the state on an as needed/indicated basis.
2) Continue the practice of providing each DIS assigned to the STD Program stationed in Louisville, Lexington, Bowling Green and Florence with at least two

audit/demonstration counseling sessions by a supervisor each quarter.

3) Improve the quality of counseling and testing services at all sites by developing half day workshops which address issues related to the proper scheduling of appointments, intake sensitivity issues, assessing risks factors and assisting clients with developing a risk reduction plan, assisting patients with referrals for needed services and improving ability to inform partners of exposure and need for counseling and testing.

Methods -The STD Program and HIV Prevention Program will work jointly on setting up courses at various locations throughout the state. The courses will be targeted at new employees of health departments and off-site test center employees who will be serving clients. Re-training will be offered to counselors who have not received up-dated training for three or more years.To encourage attendance, every effort will be made to keep the number of attendees to 15 or less and to select locations that are accessible to attendees without need of overnight travel and per-diem costs. Re-training will be directed to sites where review of optical scan forms suggests services are not being offered or poorly provided. Any verbal or written complaint received by the STD Program or HIV Prevention Program will be immediately investigated and remedial training will be provided when deemed necessary. Re-training will also be achieved by videotapes prepared by the HIV Program that deal with basic issues related to privacy, sensitivity and quality service delivery. DIS employed by the STD Program will be audited at least once quarterly, more often if needed, by their supervisor during a pre-test or post-test counseling session with a client. DIS will receive a written appraisal of their performance by the supervisor within 24 hours of the audit. The written appraisal will highlight portions of the session that were performed well and those in need of improvement. Remedial training will be provided if performance is substandard.

Evaluation - Quarterly, semi-annual and annual assessment will be made to determine the number of new counselors trained and the number who receive remedial training. The assessments will also include the number of video tapes reviewed for training and the number of personal visits made to sites by STD or AIDS staff to correct deficiencies and to address issues with sites from which complaints were received.

Objective 8 - In 2009, regularly assess the impact of HIV partner notification and other follow-up services for HIV positive individuals through activities performed by a DIS and through referral made by infected clients.

Method - At the time of post-test counseling, HIV infected clients will be advised of the crucial need to have all sexual partners within the previous two years and all marital partners within the previous ten years informed of possible exposure to HIV disease. HIV positive clients will be advised that informing of exposure can be done directly by the client or by a DIS. Those electing to self-refer will be cautioned that doing self referral may compromise their right to privacy because the contact may divulge the information to other people who have no legitimate right to know about their HIV status. The DIS or counselor will then explain that the only way to assure that complete confidentiality is maintained is to let the DIS take full responsibility for informing contacts with the absolute guarantee that their name, or any other information, will not be revealed. Patients who prefer to self-refer will be provided with information that will be helpful to them when attempting the referral. Role plays will be conducted pointing out specific questions and reactions which the client may encounter and how to best answer and respond in a manner that satisfies curiosity and doubt and at the same time motivates the contact to seek counseling and testing. DIS assistance will also be offered when the client is unable to complete the referral or encounters difficulty in communicating with the contact. When DIS assistance is

requested for partner notification, counselors will sensitively seek exposure history and locating and identifying information that will enable a DIS to complete the referral. Notification and referral attempts undertaken by a DIS will always be done in a manner which fully protects the infected client's identity and which avoids placing the contact in an awkward, compromising, or embarrassing position. Specific rules for notification include:

1) All referrals will be done face-to-face between the contact and the DIS.
2) No other person will be present when the referral is made except an interpreter if one is needed or a trainee who is accompanying the DIS.
3) Under no circumstance will a letter be mailed to or an appointment slip left at the residence of a contact which indicates exposure to HIV or AIDS
4) Telephone usage will be restricted to only informing a contact that it is important to meet them and discuss an urgent health matter. Under no circumstance will the telephone be used to inform the contact of exposure.
5) DIS will not go to a contact's place of employment to complete a referral unless the contact has agreed to meet the DIS and has assured that complete privacy can be maintained.

Evaluation - Area supervisors and STD Program management staff will monitor the performance of DIS as they conduct counseling sessions and perform field follow-up of HIV contacts. Semiannual and annual progress reports will be made available to the CDC, which will provide the following data and information:

- Total number of HIV infected clients who are post-test counseled.
- Total number of resident contacts named with sufficient information to initiate follow-up by a DIS.
- Total number of contacts residing outside of Kentucky with sufficient information to initiate follow-up.
- Total number of resident contacts located and informed of exposure and the number who elected to be tested for HIV.
- Total number of contacts located who were newly tested and found to be HIV positive, newly tested and found to be HIV negative, had previously tested positive for HIV, and the number who, after notification of exposure, refused to accept an HIV test.
- Total number of spousal notifications attempted and the results of those attempts.

SECTION

4e

STRATEGIES

OVERVIEW OF SPECIFIC TARGET GROUPS

MSM, Including AAMSM and MSMOC

The largest unmet issue in the area of MSMs and MSMOCs is the lack of community organizations and therefore the lack of "hands-on" community based efforts. Of the limited number of gay and lesbian organizations few are doing any HIV prevention or education besides providing brochures. The bulk of HIV prevention efforts for the gay community is provided by AIDS Service Organizations (ASO). There are also needs relating to MSMs who do not identify as "gay" who engage in high-risk activities such as sex with strangers. Gay youth are another area where little is being or can be done with the MSM community. There are limited interventions being conducted, especially with gay youth, which focus on the development or enhancement of skills to initiate or maintain safer sex practices and support maintenance of safer behaviors. Likewise, very few interventions that are directed at establishing or modifying community norms or values to promote behavior change exist outside those currently funded under the CDC Cooperative Agreement.

While there are numerous areas where services are not being provided for MSMs, there are areas where services are being provided. In the North Central region (Louisville) there may be duplication of efforts with regard to reaching gay and bisexual men through condom distribution and there is a great need to provide these products in an efficient, timely manner with better coordination among agencies. All county health departments provide anonymous and/or confidential counseling and testing, although there is a disparity in the quality of services among counties. Several health departments (Lexington-Fayette County, Jefferson County, and Northern Kentucky Independent Health Department) encourage testing for all populations and target MSMs specifically by posting information in adult bookstores, detention centers, and bars that are frequented by MSMs. On-site testing is also provided in all the gay bars in Lexington. Persons testing positive are referred to the Care Coordinator for their region. Many health departments, urban CBOs and other agencies are working together to improve infrastructure and to support HIV prevention/assessment.

IDU

As with other high-risk populations, there are few interventions targeting IDUs. A few local health departments distribute bleach kits and latex. All Health Departments provide anonymous and/or confidential testing. Individuals who test positive are referred to the Care Coordinator Program. Louisville, Lexington, and Paducah now provide CRCS for IDUs. There is a tremendous need for legislation that would decriminalize possession of sterile injection equipment and residue. This legislation would create a platform for harm reduction practices. This would additionally develop and promote social norms and values that

would offer support and decrease the stigma associated with substance abusers and IDUs. Several KHPAC members have independently lobbied for harm reduction legislation that would decriminalize efforts that are designed to reach IDUs. These measures began in the 2000 Legislature and have continued in subsequent legislative sessions without passage so far.

MSM/IDU

MSM/IDU are men who have sex with men and who also use intravenous drugs. While interventions have certainly targeted MSM and IDU, to date none have specifically targeted MSM who inject drugs. The issue relates to recognition of this community and finding MSM/IDU's that remain largely unrecognized in the North Central region. KHPAC recommends that the present emphasis should be on HIV positive MSM/IDUs and identifying candidates for CRCS. Interventions must also consider harm reduction techniques for this population. The continuing approach of prevention for positives for members of this community through CRCS may be the best approach for this population.

HETEROSEXUAL CONTACT with PWHIV, MSM, MSM/IDU, IDU

Kentucky has targeted African Americans, Hispanics, youth and women at risk for several years. Trends indicate that the HIV rates are on the rise in the heterosexual populations, particularly among women and youth. This risk group is often largely ignored in HIV prevention. Oftentimes, many African Americans, Hispanics, youth and women are at high risk of infection due to injecting drug use and/or their sexual interactions with IDU and MSM. However, interventions targeted towards heterosexuals as defined by CDC fail to address these relationships with MSM and IDU.

AFRICAN AMERICAN

There remain very few organizations that primarily serve the African-American population. The Louisville Jefferson County Minority AIDS Program that served this population exclusively with HIV prevention cancelled their contract in 2003. Many of the other organizations serving large numbers of African-Americans are tied to perceived societal "negatives", e.g., correctional facilities, drug treatment centers, homelessness, etc. This creates a void in the HIV prevention services to African-Americans and also allows for some dangerous myths and stereotyping. The impression is created that all African-Americans are drug abusers or criminals or that only African-Americans who are criminals or drug abusers are at risk for HIV. There is a great need for organizations based in the African American community to do work from an African-American perspective. Additionally, there remains a great need for services targeted to African-American youth and MSMOC.

All county health departments provide anonymous and/or confidential testing. There is a great deal of disparity in the quality of services offered among counties. Persons testing positive for HIV are referred to the Care Coordinator in their region. The distribution of latex condoms is done by local health departments, but many at risk individuals would not or do not feel comfortable coming to the health departments to obtain condoms. Efforts should be focused on developing additional sites where people of color feel free to obtain prevention supplies.
On a community level, there are few interventions for at-risk populations who seek to reduce risk behaviors by changing attitudes, norms and practices through health communications, community mobilization and community wide events. Intervention specific activities for African-Americans include Soul Fest events, Roots and Heritage Festival, Jubilee, Balm in Gilead, and the African American and Hispanic Leadership Conference on AIDS.

HISPANIC

Every county health department now has access to interpreters. The Lexington-Fayette County Health Department provides two interpreters and several volunteers. Matthew 25 and Heartland Cares each have one interpreter. There are still issues of distrust, as many of the Hispanic/Migrant worker population are "illegal".

From a former Hispanic CPG Member: "In the Hispanic community it is common, even for a married man with children, to go out and have sex with other men. They usually stay within their own community to seek out other men. Although it is known it is never talked about. I would say over 50% of married men go out on their wives with other men and alcohol and drugs does play a role. 75% to 80% of single Hispanic men will seek out some form of sex from other men. Hispanics have a macho problem and will seek MSM secretly within the Hispanic community. It is socially accepted but not talked about. Hispanic men would rather get a free blow job from a man than pay twenty dollars to a prostitute."

MOTHERS WITH/AT RISK OF HIV

As with other risk groups, there are too few interventions that target mothers with/ at risk of HIV. The local health departments provide CTRPN.

The greatest concern for this risk group is the identification and access to women who are IDUs, sex trade workers, and/or partners of MSMs, bisexual men, or other high risk or infected individuals. Another significant need is the provision of services at times that these at-risk women are able to access them. As with other at risk groups there is the need to provide interventions that target community norms or values that promote and support safer practices, communication skills and access to latex products and perinatal prophylaxes for infected women.

TRANSGENDER

The University of Kentucky Needs Assessment Report provides evidence of Transgendered and men on the DL also being un-reached. Additional anecdotal evidence from former CPG members underlines the need for pilot efforts to reach these populations.

From a Transgendered former CPG Member: "Men on the DL tend to want the illusion of the female, but because sometimes they choose to be penetrated and do not want this act to take place by another man, they go to transies. DL brothers should be included with the transies because they are the trade. A good term for people on the DL as well as transies could be Bridge Crossers, because they are living the life style of both worlds. Infection rates of transies are very high because most of them tend to make a living on the streets, because being accepted and hired on a normal job is not very easily achieved."

SECTION

4f

STRATEGIES

STRATEGIES COMMITTEE FINDINGS, RECOMMENDATIONS AND PRIORITIZATION

EVALUATION

KHPAC met over several meetings to prioritize interventions for the year 2008. Since the DEBI interventions first began in 2005, and an evaluation of the effectiveness of these DEBIs will be conducted at the end of 2006, KHPAC agreed to remain with the current DEBIs being implemented. In 2008 however, KHPAC decided to remove Popular Opinion Leader, (POL) as one of the interventions. DEBI trainings for Prevention Coordinators and Specialists were conducted from January to May of 2005. The first DEBI, Many Men Many Voices was implemented in April of 2005. All DEBIs were implemented by May of 2005.

The following report is guided by the HIV/AIDS epidemiology profile of Kentucky and the gaps analysis derived from the needs assessment. Accepted and proven evidence shows that all new HIV infections are a result of direct and indirect contact with an HIV positive individual. Therefore, in order to combat the spread of HIV, the concentrated effort of interventions must be directly aimed at those that are HIV positive and those most at risk of becoming infected with HIV.

KHPAC members chose to focus more on details of existing interventions and the introduction of new approaches than on a grading system using the prioritization tool. The committee decided the prioritized list from the 2008 Revised Prevention Plan would be used as a guide for the 2009 Plan. KHPAC believes it is important to spread the funding across the full range of interventions and pilot programs. The approach of funding every intervention and program to some extent may be the only way of evaluating as quickly as possible the practicality of any single project.

A large percentage of interventions are directed toward HIV positives. However, there is a limit to how much personal contact and guidance that the average client is willing to allow. There must be a concentrated effort among PSs to instill a sense of responsibility among those who are HIV positive.

Since there is an assumed limit on the effectiveness of risk reduction behaviors, KHPAC recommends that the focus of all interventions be based on harm reduction principles. When HIV positive or high-risk clients choose to engage in risky sexual, drug related, or judgment impairing activities, the principle of harm reduction allows clients to engage in these activities in a more responsible manner. The focus of this three-year planning cycle has been on expanding efforts in CRCS. A youth centered intervention continues to be a critical need. Youth are a major concern within the epidemic.

RECOMMENDATIONS

EASTERN AND NORTHERN REGION

Cultural and rural geographic barriers are the main deterrents to effective outreach in these regions of Kentucky. Recommendations are increased public media campaigns and increased PSE approaches that are now allowed during times of high activity. We believe a sector of the Hispanic population in this region can be reached through community mobilization. A higher concentration of CRCS specific to IDUs is also necessary in this region.

NORTH CENTRAL REGION

In Jefferson County, the groups that remain at highest risk with the greatest level of unmet need are biological and transgendered women. Prevention strategies, such as DEBIs should be designated to address these communities.

WESTERN REGION

Rural Western Kentucky continues to lack an effective number of CBOs. Capacity Building is needed immediately to serve this large area. Concentrated African American and Hispanic populations continue to be the most underserved and under represented. The most effective intervention seems to be with MSM PSs and PSE outreach as often as possible. Community Mobilization efforts are addressed for this region in this section under Community Mobilization requests. The time consuming travel of this geographic area is a great barrier. More cost effective interventions are being considered for this region.

CAPACITY BUILDING GUIDELINES

Capacity building efforts should be used to reach organizations that are interested in becoming contracted CBOs that will be addressing the concerns of emerging minority populations. It is assumed that in order to reach a specific population, a culturally sensitive CBO needs to be in place to first reach out to volunteers for assistance with this population and then to offer culturally inclusive Prevention Specialists, the needed contact with this population. The need for direct contact with capacity building efforts is seen in the Eastern and Western regions. The transgender and Hispanic communities are lacking interventions. Individuals should be recruited to work in their own communities, targeting all risk groups with special emphasis on transgendered and Hispanics, organizing outreach and peer-to-peer influence at a grass roots level.

COMMUNITY MOBILIZATION

Community Mobilization money needs to be made available for continuation of community awareness initiatives. These community mobilization events should address the needs of at risk communities. The successful local and statewide organizational efforts that need continued funding as well as new funding are:

a. Come Together Kentucky Conference
b. The African-American and Hispanic Leadership Conference
c. The Kentucky HIV/AIDS Conference
d. Owensboro/Henderson Dust Bowl

e. National Black HIV/AIDS Awareness Day
f. World AIDS Day
g. Pride Fair of Louisville
h. National HIV Testing Month
i. Latino/Hispanic HIV/AIDS Community Awareness Activities

OUTREACH TO HISPANIC POPULATIONS

While existing epidemiological data lacks reliable figures of transmission rates among members of Kentucky's exploding Hispanic population, anecdotal evidence suggests a pressing need for effective outreach. The existence of seasonal migrant workers and a less mobile, more stable Hispanic community working in year-round industries indicates a two-pronged approach.

The DPH has established a very good working relationship with the Area Health Education Centers in Kentucky and the Bluegrass Farmworker Clinic who provide services to the Hispanic and Latino communities.

MINORITY AND INDIGENOUS PREVENTION SPECIALISTS

The Prevention Plan must not overlook the need for culturally specific and indigenous CBO's and PSs (formerly CHOWs) contracted for their targeted at risk populations. For instance, CBOs that work with IDUs should be staffed with former IDUs or people with highly specific education and credentials relative to that community. This applies as well to MSM, MSM/IDU, MSMOC, HIV + etc.

Support should be given to CBOs or individuals qualified to address a gap in prevention efforts. Shortfalls in prevention should be addressed by using Capacity Building funds to increase the ability of CBOs to qualify as a contracting organization as well as recruit, hire and retain indigenous PSs specific to their targeted at risk populations.

OTHER RECOMMENDATIONS AND CONCERNS

NEEDLE EXCHANGE

The number one recommendation of KHPAC is, as in the past, needle exchange programs. Kentucky paraphernalia laws prohibit the possession, sale or distribution of injection equipment preempting any plans for needle exchange programs. The introduction of harm reduction principles for IDU's has been an incremental process and particularly difficult in agencies traditionally based on abstinence only substance abuse programs.

While no official endorsement of needle exchange program has been forthcoming from DPH, the commissioner did, in an interview with a Lexington television station, state his "belief" that such programs work. A lack of political will by Kentucky lawmakers to revise statutes to decriminalize activities related to needle exchange programs remains the largest single barrier to HIV prevention statewide. DPH should provide leadership in this area.

CTS EVALUATION

KHPAC recognizes the importance of Counseling and Testing Services in the prevention process. In 2001 the University of Kentucky evaluated sites through out the state. The UK evaluation cited numerous problems with the protocols used by the testing sites. The evaluation cited problems beginning with appointment information and continuing with pre-test and post-

test counseling of clients. A plan to address these recommendations is listed in the gap analysis section.

MSM/IDU

For 2009, MSM/IDU has been prioritized as the number five at-risk population in Kentucky. PS assignments were directed to regional needs, (1) MSM/IDU PS for Western Kentucky, (2) PS's for North Central and (1) for Eastern Kentucky. Continued training and adjusting of approaches to this community are a necessity if significant results are to be expected in this population. In spite of these efforts, this population continues to be underserved and IDU PSs continue to be disconnected with this population. MSM/IDU indigenous workers are desperately needed in this community.

YOUTH

It should be stressed that while Youth at Risk (YAR) is not prioritized as a separate target population, it is highly prioritized as a component of all target populations. KHPAC believes that interventions targeting young MSM/IDU, MSMOC, MSM and all risk groups are of major concern. It is a recognized problem, that with the longevity of this disease, a generation gap exists in planning proper intervention strategies. Initiatives to properly convey the realities of this disease to future generations must not only be creative to be effective, but must derive its design from the at risk group. CBOs and outreach workers must develop component programs with the input of at risk youth as an ongoing part of their prevention efforts.

STREET OUTREACH, PSE OUTREACH AND OFF-SITE TESTING

Previous recommendations have stressed the importance of street outreach, effective PSE outreach and off-site testing.

Using OraSure and OraQuick and other technologies to increase testing in all high-risk populations, contracts must require interventions to take place at the corresponding time of day or night when high-risk behaviors occur. Contracts must require training for PSs in effective outreach strategies, counseling and testing protocols, harm reduction training/utilization.

These combined activities will serve to reduce HIV, STD, TB, and Hepatitis transmission.

PROGRAM OVERSIGHT

Intervention oversight and implementation is directed in two different ways, either by state oversight delegated by statutes and contract language, or by independent contractor evaluation. We recommend that the daily intervention work report should list the number of daily hours worked and the hours of the day that the work took place. Without a comparison of the time of day that the work took place, there is no way to determine if the intervention is taking place at peak hours of activity. Comparing the two timelines will allow for more efficient scheduling and coordination between PSs and Initiative Coordinators.

With implementation of PEMS and the purchase of PEMS hardware, more accurate monitoring and evaluation data will be available to assist in the assessment of the effectiveness of specific interventions.

SURVEILLANCE AND REPORTING

HIV case reporting data has been available since December 2007. HIV data will assist in more clearly identifying emerging at risk populations.

PRIORITIZATION

KHPAC used the prioritized target populations (based on the December 31, 2007 semi-annual report) to assist in the prioritization of strategies for the 2009 grant year. The prioritization of interventions was finalized on July 29, 2008.

Prioritized Target Populations

1. HIV+
2. MSM
3. HRH
4. IDU
5. MSM/IDU
6. MARP

HIV+	**HRH**	**MSM/IDU**
Health Relationships	SISTA	Safety Counts
CRCS (PCM)	CRCS	Many Men, Many Voices
	Outreach	CRCS
MSM	CTS	Outreach
Many Men, Many Voices		CTS
POL	**IDU**	
CRCS	Safety Counts	
Outreach	CRCS	
Counseling and Testing (CTS)	Outreach	
	CTS	

There is no evaluation for Mothers with/or at Risk for HIV or General Population as defined risk categories by the CDC. This is because there are no prescribed interventions for Mothers with/or at Risk in Kentucky currently. While there are no specific interventions for General Populations, this is by design since most are not in high-risk categories. Most Community Mobilization public events and public information efforts also reach the general population.

SECTION

4g

STRATEGIES

PRIORITY STRATEGIES/INTERVENTIONS FOR DEFINED TARGET POPULATIONS

	Category	ILI	GLI	Outreach	CRCS	PCRS	HC/PI	Other
1	CRCS for HIV+	■			■			
2	Street Outreach for all Populations			■				
3	Healthy Relationships		■					
4	Community Mobilization						■	
5	Materials Distribution			■				
6	CTS-Ora-Sure/Ora-Quick	■						
7	CRCS for all populations	■			■			
8	SISTA		■					
9	Many Men Many Voices		■					
10	Safety Counts		■				■	

Condoms, lubricants and harm reduction supplies are to be included with each intervention.

SECTION

5

CONCLUSION

CONCLUSIONS AND RECOMMENDATIONS FOR PROGRAM COORDINATION

LINKAGE OF PRIMARY AND SECONDARY SERVICES

Many of the linkages are accomplished through referrals. The state maintains referral lists for prevention and care services. Some of the HIV PSs and health educators providing prevention interventions distribute pocket cards with referral sources and phone numbers for CTRPN and HIV Care Coordinators. Any individual who is targeted for prevention is encouraged to seek HIV testing, often through the use of OraSure or OraQuick. Individuals who seek testing are given information on sources of prevention and treatment. Individuals are also referred to substance abuse treatment, physicians, social services organizations, and AIDS Service Organizations (ASO). Individuals who test positive are referred to the Care Coordinator Program where coordination of many services occurs, and they are entered into HIV reporting. The services coordinated include travel, assistance with activities of daily living, physician referrals, drug and insurance assistance programs, legal aid services, etc. Many of the services provided to HIV positive individuals are funded through both state dollars and Ryan White CARE dollars and HOPWA.

THE LINKAGE OF PRIMARY AND SECONDARY SERVICES GOALS FOR 2009:

GOAL 1: Develop a comprehensive checklist of activities prescribed in this plan.

Objective 1: DPH to ensure that the goals and objectives of this plan are outlined in a time frame, and that all items are assigned to specific parties.

Objective 2: KHPAC will collaborate with DPH in monitoring all items on the checklist. Progress reports on this goal will be made semi-annually to KHPAC. This report should include a comparison of the year-end activities report to the application.

GOAL 2: Provide primary and secondary prevention services and/or referrals to all individuals who present for testing in Kentucky.

Objective 1: Ensure that all clients who test positive for HIV whether through PSs or CTSs receive HIV Care Coordinator Program referral, appropriate medical referrals, and social services referrals if indicated, as well as partner notification.

Objective 2: HIV positive and high-risk negative individuals are to be exclusively targeted for primary and secondary prevention activities.

Objective 3: Ensure that Care Coordinator clients who continue to practice high-risk behaviors are referred for CRCS and PS interventions. Develop a system to track these referrals.

Continued, Revised, or New Objective? Continued from 2008 Plan.

Activities:

1. The state should monitor and evaluate existing referral systems currently in place.
2. Continue to provide training for prevention specialists and other staff on referrals and existing resources.
3. Continue to provide training for Care Coordinators and other staff on referrals and existing prevention resources.

GOAL 4: Enhance linkages between HIV/AIDS Branch and TB Branch.

Objective 1: The DPH branch should ensure that clients who test positive for HIV are referred for TB assessment. Ensure that clients who test positive for TB are referred for HIV counseling and testing.

Continued, Revised, or New Objective? Continued from 2008 Plan

Activities:

1. Monitor and evaluate existing referral systems of TB and HIV testing programs currently in place.

2. Evaluate documentation of initial referrals and determine method of verifying client utilization of referrals to services.

LINKAGES WITH OTHER HIV PREVENTION RELATED ACTIVITIES

The HIV/AIDS epidemiological surveillance data, CTRPN data, and youth and adult behavioral survey results are utilized for development of the epidemiology profile. The CTRPN activities are addressed in this Comprehensive HIV Prevention Plan. Behavioral surveillance (both adult and youth) basic data and trend analysis data are utilized in planning interventions.

Coordination with STD, TB, Substance Abuse, Mental Health Services: Many referrals for HIV CTRPN occur through or at STD, specialty clinics and HIV CTS in local health departments. In addition, substance abuse clinics refer clients to various programs like CTRPN. Counseling and testing training is provided to individuals who perform these services. The PSs who target IDU and other substance abusers encourage individuals to get counseling and testing and treatment for drug abuse. Representatives of STD and CTRPN programs participate as advisors for KHPAC. Many PSs offer HIV OraSure testing in the field to targeted populations.

The Comprehensive School Health Program provides training to individuals on STDs, substance abuse, mental health, and HIV prevention. STD prevention and education and drug abuse prevention education is provided to the schools as dictated by local jurisdiction.

Coordination between public and nongovernmental programs: The DPH, local health departments, other government agencies, and private organizations work cooperatively in HIV

prevention through the community planning process and the delivery of interventions and services. (See 'Introduction and Overview of KHPAC Process' for additional information).

ASSISTANCE AND SUPPORT ACTIVITIES

Recommendations regarding epidemiologic and behavioral surveillance: Epidemiologic data needed to enhance assessment include more accurate assessment of the size of the at risk populations targeted and minority and migrant worker populations and assessment of their risk. Migration data of individuals to and from areas with establishments that cater to at risk populations is needed as well. Migration data on individuals who travel out of counties and the state for counseling and testing, diagnosis, and treatment is needed.

KHPAC also requested data on methamphetamine use as a risk factor for HIV, as well as a comparison of rural and urban data be included in the Epidemiological Profile.

EVALUATION OF PLANNING PROCESS

This year has been the first year of working as the newly integrated Kentucky HIV/AIDS Planning and Advisory Council. KHPAC undertook the completion of the final update of this 3 year Prevention plan, the provision of a Year-End Report for the Cabinet for Health and Family Services (CHFS), as well as receiving training on what is entailed in HRSA related planning activities. Each KHPAC meeting was evaluated and the summary of these evaluations are provided to KHPAC members to assist in monitoring the planning process. KHPAC will conduct a process evaluation survey by December 2008. KHPAC members report an overall sense of encouragement regarding the members of KHPAC working together to achieve the goals set out before them. PIR is ensured through recruitment and meeting facilitation. KHPAC members have worked hard together to learn the various components of KHPAC. Team building is emphasized to assist in recognizing and utilizing the similarities and differences among members.

KHPAC will work next year to integrate as many of the products as possible into cohesive documents, in order to fully integrate care, prevention and legislation and policy recommendations.

TECHNICAL ASSISTANCE ACTION PLAN FOR 2009 – 2010

NOTE: The 2009 Prevention Plan is update of the 2008 Plan. Updated areas include, KHPAC membership; Population prioritization and Tool, Interventions, reference dates and some contact information. Beginning 2009, Kentucky will be going to the 5-year planning cycle. A brand new Comprehensive Care and Prevention Plan will be developed beginning 2009.

Following the completion of this plan, KHPAC members will be meeting to determine the most effective tools/ technical assistance to be implemented to further support the integration of Care, Prevention and Legislation, as well as meet the expectations of CDC, HRSA and KRS 214.640. KHPAC will continue to collaborate with DPH. Specific product related technical assistance will be used throughout the year to ensure that KHPAC members have an in depth knowledge and the appropriate tools to conduct the work before them.

Appendices

December 31, 2007 Semi Annual Report:
Attached

2008 Prevention and Care Plan
http://chfs.ky.gov/NR/rdonlyres/83AE5D81-DE52-4C99-A11F-7D452FD172A4/0/2008FinalPreventionPlan.pdf

Kentucky UNBRIDLED SPIRIT

Volume 7, Number 2

HIV/AIDS Semi-Annual Report December 2007

Kentucky Cabinet for Health and Family Services
Department for Public Health
HIV/AIDS Branch

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR PUBLIC HEALTH

Steven L. Beshear
Governor

275 East Main Street, HS1GWA
Frankfort, KY 40621
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Janie Miller
Secretary

Dear Reader:

Enclosed you will find the December 2007 issue of the HIV/AIDS Semi-Annual Report for Kentucky. As of December 31, 2007, there have been 4,764 AIDS cases reported in Kentucky, of which 2,802 are presumed to be currently living with AIDS.

We are pleased to begin releasing data on HIV infections diagnosed since 2005 in Kentucky. There have been a total of 1,012 HIV infections diagnosed and reported between 2005 and 2007. The HIV/AIDS Surveillance Program is continuing to evaluate HIV cases previously reported under the old code-based identification system. Therefore, estimates of those living with HIV infection in Kentucky are not available. At this time, data presented on HIV infections is limited to a small section near the end of the report. Over time, we will continue to increase the amount of HIV data in the report. Please carefully read the information about the data source and technical notes on pages 2 and 3 for further information about interpreting the data presented.

The data presented in this report are available on our website at http://chfs.ky.gov/dph/epi/HIVAIDS/surveillance.htm. Only the December edition of the Semi-Annual Report will now be available in hard copy. However, you can now receive e-mail updates when new HIV/AIDS statistical reports are released online. For a subscription to receive these e-mails updates, please send a blank e-mail to the following address: subscribe-dph-semiannualreport@listserv.ky.gov.

Sincerely,

Karin Bosh, Ph.D.
HIV/AIDS Epidemiologist

HIV/AIDS Semi-Annual Report Production:

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Department for Public Health
Cabinet for Health and Family Services

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Data Source

The HIV/AIDS Semi-Annual Report presents data regarding AIDS cases diagnosed and reported to the Kentucky Department for Public Health HIV/AIDS Surveillance Program through December 31, 2007. In this edition, data regarding HIV cases diagnosed and reported between January 1, 2005 and December 31, 2007 will be presented. This represents the first release of HIV data since name-based HIV reporting was implemented in July 2004. The data only include those persons who have been confidentially tested and reported to the HIV/AIDS Surveillance Program. No adjustments are made to the data presented to account for undiagnosed, anonymously tested, or unreported cases.

HIV/AIDS Reporting Requirements

According to state regulation 902 KAR 2:020, Section 7, health professionals licensed under KRS chapters 311 through 314, health facilities licensed under KRS chapter 216B, and laboratories licensed under KRS chapter 333 are required to report HIV and AIDS cases to the Kentucky Department for Public Health or the Louisville Metro Department for Public Health and Wellness within five business days of diagnosis.

Cases residing in the Kentucky counties of Bullitt, Henry, Jefferson, Oldham, Shelby, Spencer, and Trimble counties are reported to the Surveillance Nurse Consultant at the Louisville Metro Department for Public Health and Wellness at 502-574-6575. All other cases are reported to the Kentucky Department for Public Health HIV/AIDS Surveillance Program at 866-510-0008. Case information from both sites is combined at the Kentucky Department for Public Health to produce this report. Additional case reporting information can be found on the Kentucky HIV/AIDS Branch website: http://chfs.ky.gov/dph/epi/HIVAIDS/surveillance.htm.

Key Terminology

Date of Report: The date HIV infection or AIDS diagnosis is reported to the Kentucky HIV/AIDS Surveillance Program.

Date of Diagnosis: The date HIV infection or AIDS is diagnosed.

HIV (Human Immunodeficiency Virus): A retrovirus that infects the helper T cells of the immune system, resulting in immunodeficiency. HIV is diagnosed by a positive confirmatory antibody test or positive/detectable viral detection test.

AIDS (Acquired Immunodeficiency Syndrome): Advanced stage of HIV infection characterized by severe immune deficiency. Diagnosed by the presence of at least one of 26 opportunistic illnesses or a CD4 laboratory test less than 200 cells/ml of blood or 14% of the total white blood cells (lymphocytes).

Transmission Category: Classification used to summarize the risk factor most likely responsible for disease transmission. Each case is only included in a single transmission category.

- **Men Who Have Sex With Men (MSM)**: Men who report having sexual contact with other men.
- **Injection Drug Use (IDU):** Individuals that report injecting nonprescription drugs.
- **MSM/IDU:** Men which report having sex with other men and also inject nonprescription drugs.
- **High-Risk Heterosexual Contact (HRH):**A person reporting heterosexual relations with an injection drug user, a bisexual male (females only), a person with hemophilia/coagulation disorder, or a person with documented HIV infection.
- **Hemophilia:** Individuals receiving clotting factor for hemophilia/coagulation disorder.
- **Blood Transfusion/Organ Transplant:** Individuals who received blood transfusions or organ transplants. Individuals with a transfusion date listed after March 1985 are considered cases of public health importance and are followed to verify the mode of transmission.
- **Perinatal:** Individuals born to a mother with HIV or a mother with an exposure history listed in the transmission category hierarchy.
- **Undetermined/No Identified Risk (NIR):** Individuals reporting no exposure history to HIV through any of the modes listed in the transmission category hierarchy.

Technical Notes

1. Reporting Delays- Delays exist between the time HIV infection is diagnosed and the time the infection is reported to the HIV/AIDS Surveillance Program. As a result of reporting delays, case numbers for the most recent years of diagnosis may not be complete and therefore the data from 2007 are considered provisional and will not be presented in the analysis of trends. The data presented in this report have not been adjusted for reporting delay.

2. Place of Residence- Data are presented based on the residence at the time HIV infection was diagnosed. Therefore, no data are available to determine the number of people who are currently living with HIV infection in Kentucky, but were originally diagnosed in another state. Data presented on living cases reflect those originally diagnosed in Kentucky that are still presumed to be living, regardless of their current residence.

3. Vital Status- Cases are presumed to be alive unless the HIV/AIDS Surveillance Program has received notification of death. Current vital status information for cases is ascertained through routine site visits with major reporting sites, reports of death from providers, reports of death from other states' surveillance programs, and routine matches with Kentucky death certificates.

4. Transmission Category- Despite possible existence of multiple methods through which HIV was transmitted, cases are assigned a single most likely transmission category based on a hierarchy developed by the Centers for Disease Control and Prevention (CDC). See the "Key Terminology" list on page 2 for a description of the transmission categories. A limitation of the dataset is the large number of cases reported with an undetermined transmission category. Currently, surveillance data is collected through hard copy case reports, telephone reports and chart reviews, which sometimes results in missing information. Enhanced surveillance activities have been implemented to attempt to resolve case reports with missing risk factor information.

5. Routine Interstate Duplicate Review (RIDR)- Case duplication between states can occur and has become more of an issue due to the mobility of our society. To help respond to potential duplication problems, the CDC initiated the Interstate Duplication Evaluation Project (IDEP), now called Routine Interstate Duplicate Review (RIDR), in 2004. RIDR compares patient records throughout the nation in order to identify duplicate cases. The states with duplicate cases contact one another to compare patient profiles in order to determine the state to which the case belongs, based on residence during the earliest date of diagnosis. Because of this process, the cumulative number of cases within Kentucky may change, but the process has increased the accuracy of Kentucky's data by reducing the chance that a case has been counted more than once nationally.

6. Small Numbers- Data release limitations are set to ensure that the information cannot be used to inadvertently identify an individual. When the population size for the smallest unit of analysis presented is less than 1,000 and the cell size is less than or equal to five, the specific number will not be released. Information on any geographic region lower than the county level will not be released. Rates will not be released when the numerator is less than 10 cases because of the low reliability of rates based on a small number of cases.

7. Difference between HIV Infection, HIV without AIDS, and concurrent diagnosis of HIV with AIDS- HIV infection includes all individuals diagnosed with the HIV virus regardless of the stage of disease progression. The data are presented based on the date of the first diagnosis reported to the HIV/AIDS Surveillance Program. HIV without AIDS includes individuals that were not diagnosed with AIDS during the same calendar month as the initial HIV diagnosis. Concurrent diagnosis with AIDS includes those newly diagnosed with HIV and AIDS during the same calendar month. See "Key Terminology" on page 2 for a description of how HIV and AIDS are diagnosed.

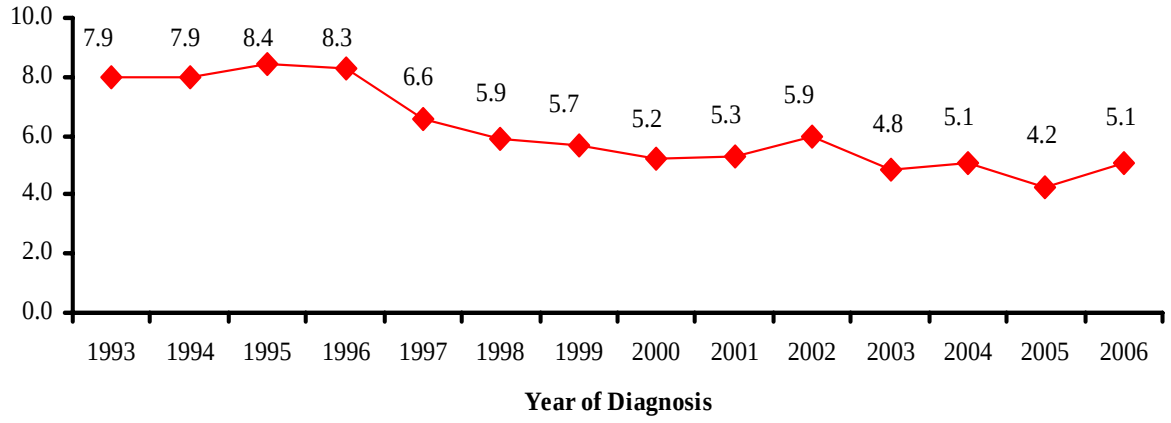
AIDS Cases in Kentucky

As of December 31, 2007, there have been a total of 4,764 AIDS cases reported in Kentucky to the Department for Public Health's HIV/AIDS Surveillance Program since 1982. Of these reported cases, 2,802 are still presumed to be living. In 2006, there were 215 new AIDS cases diagnosed. As of December 31, 2007, 201 new AIDS cases have been diagnosed and reported to the Kentucky HIV/AIDS Surveillance Program for 2007 (Table 1). The annual AIDS diagnosis rate among persons in Kentucky shows a trend by year of diagnosis (Figure 1). The annual AIDS diagnosis rate has remained fairly steady from 2000 to 2006, with slight fluctuations in 2002 and 2005.

Table 1. AIDS Cases by Year of Diagnosis

Year	Year of Diagnosis
1993	303
1994	306
1995	327
1996	324
1997	259
1998	236
1999	228
2000	212
2001	217
2002	243
2003	199
2004	210
2005	176
2006	215
2007	201

Figure 1. Annual AIDS Diagnosis Rates Among Persons Diagnosed in Kentucky, 1993-2006*



*Data are current as of December 31, 2007. However, data for 2007 are considered provisional due to reporting delays and are not presented in trend analysis.

Cumulative AIDS Statistics: Kentucky vs. The United States

Table 2. Kentucky AIDS Cases Cumulative through December 31, 2007

Characteristics	Total Cases	% of AIDS cases[1]
SEX		
Male (adult/adolescent)	4,006	84%
Female (adult/adolescent)	724	15%
Child (<13 yrs)	34	1%
TOTAL	4,764	100%
AGE AT DIAGNOSIS		
<13	34	1%
13-24	257	5%
25-44	3,497	73%
45-64	929	20%
65+	47	1%
TOTAL	4,764	100%
RACE/ETHNICITY		
White, Not Hispanic	3,096	65%
Black, Not Hispanic	1,490	31%
Hispanic	150	3%
Other/Undetermined	28	1%
TOTAL	4,764	100%
TRANSMISSION CATEGORY		
MSM[2]	2,612	55%
IDU[3]	643	13%
MSM/IDU	278	6%
Heterosexual	736	15%
Perinatal	29	1%
Other/Undetermined[4]	466	10%
TOTAL	4,764	101%

(1) Percentages may not always total 100% due to rounding
(2) MSM=Men Having Sex With Men
(3) IDU=Injection Drug Use
(4) Includes hemophilia, blood transfusion, and risk not reported or not identified.

Kentucky's distribution of AIDS cases by age at diagnosis (Table 2) closely parallels that of the U.S. distribution (Table 3). However, compared to U.S. data, the percentage of cases who are white is greater in Kentucky. This could be due to the greater percentage of white persons in Kentucky's general population compared to the U.S. population.

Table 3. Estimated United States AIDS Cases Cumulative through 2006[5]

Characteristics	Total Cases [6]	% of AIDS cases [1]
SEX		
Male (adult/adolescent)	783,786	80%
Female (adult/adolescent)	189,566	19%
Child (<13 yrs)	9,144	1%
TOTAL†	982,496	100%
AGE AT DIAGNOSIS		
<13	9,156	1%
13-24	42,929	4%
25-44	698,733	71%
45-64	216,607	22%
65+	15,074	2%
TOTAL†	982,499	100%
RACE/ETHNICITY		
White, Not Hispanic	394,024	40%
Black, Not Hispanic	409,982	42%
Hispanic	161,505	17%
Other	11,296	1%
TOTAL†	976,807	100%
TRANSMISSION CATEGORY		
MSM[2]	465,965	47%
IDU[3]	244,889	25%
MSM/IDU	68,516	7%
Heterosexual	173,493	18%
Perinatal	8,508	1%
Other/Undetermined	21,125	2%
TOTAL†	982,496	100%

(5) U.S. cases from Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States*, 2006: 18.
(6) These numbers do not represent actual cases, rather they are point estimates which have been adjusted for reporting delay and for redistribution of cases originally reported with unknown risk.
† Totals among subpopulations may be different because values were calculated independently.

In addition, a greater percentage of Kentucky AIDS cases report their primary mode of exposure to be men having sex with men (MSM) (55%) as compared to U.S. AIDS cases (47%).

Annual AIDS Diagnosis Rate per 100,000[1]
A Comparison of Kentucky to Other States, 2006

Table 4. Annual AIDS Diagnosis Rate by State

Rank	Area of Residence	Rate
1	District of Columbia	146.7
2	Maryland	29.0
3	New York	28.5
4	Florida	27.3
5	Louisiana	19.2
6	Georgia	17.1
7	South Carolina	16.3
8	Pennsylvania	15.2
9	North Carolina	13.9
10	Delaware	13.6
11	Texas	12.8
12	Mississippi	12.5
13	New Jersey	12.2
14	Connecticut	12.0
15	Nevada	11.8
16	Tennessee	11.3
17	California	10.9
18	Illinois	10.8
19	Rhode Island	10.4
20	Alabama	10.0
21	Arkansas	9.0
22	Arizona	8.7
23	Massachusetts	8.3
24	Missouri	8.0
25	Virginia	7.9
26	Oregon	7.6
27	Hawaii	7.2
28	Colorado	6.8
29	Ohio	6.7
30	Nebraska	6.7
31	Michigan	6.7
32	Washington	6.1
33	Oklahoma	5.7
34	Alaska	5.7
35	Indiana	5.5
36	Maine	5.1
37	**Kentucky**	**4.9**
38	New Mexico	4.8
39	Kansas	4.3
40	New Hampshire	4.2
41	Minnesota	4.1
42	Wisconsin	3.9
43	West Virginia	3.7
44	Vermont	2.9
45	Iowa	2.9
46	South Dakota	2.3
47	Utah	2.2
48	Idaho	1.8
49	Wyoming	1.6
50	North Dakota	0.9
51	Montana	0.7

(1) U.S. rates from Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report: HIV Infection and AIDS in the United States, 2006:18*

United States AIDS Diagnosis Rate: 12.7

Table 5. Cumulative and Living AIDS Cases By Area Development District (ADD) and County at Time of Diagnosis

ADD/County	Total AIDS Cases[1]	Living with AIDS
Barren River	**165**	**82**
Allen	11	7
Barren	24	8
Butler	1	1
Edmonson	3	3
Hart	6	4
Logan	18	10
Metcalfe	4	2
Monroe	9	5
Simpson	8	4
Warren	81	38
Big Sandy	**42**	**25**
Floyd	13	10
Johnson	6	2
Magoffin	2	1
Martin	3	3
Pike	18	9
Bluegrass	**916**	**585**
Anderson	9	3
Bourbon	11	6
Boyle	17	14
Clark	20	14
Estill	4	2
Fayette	649	410
Franklin	49	29
Garrard	5	4
Harrison	8	5
Jessamine	23	14
Lincoln	10	6
Madison	40	25
Mercer	16	10
Nicholas	1	1
Powell	6	4
Scott	28	22
Woodford	20	16

[1] Total cases both living and deceased

Note: Residence at diagnosis missing for 4 cases

ADD/County	Total AIDS Cases[1]	Living with AIDS
Buffalo Trace	**34**	**21**
Bracken	4	3
Fleming	5	3
Lewis	10	6
Mason	15	9
Robertson	0	0
Cumberland Valley	**96**	**60**
Bell	13	10
Clay	19	16
Harlan	11	6
Jackson	4	1
Knox	8	5
Laurel	20	12
Rockcastle	4	2
Whitley	17	8
FIVCO	**84**	**51**
Boyd	52	36
Carter	11	6
Elliott	3	2
Greenup	12	5
Lawrence	6	2
Gateway	**50**	**39**
Bath	4	3
Menifee	2	1
Montgomery	16	16
Morgan	18	10
Rowan	10	9
Green River	**158**	**98**
Daviess	81	51
Hancock	4	3
Henderson	40	28
McLean	3	1
Ohio	10	6
Union	15	7
Webster	5	2

Continued on page 8

Table 5. Cumulative and Living AIDS Cases By Area Development District (ADD) and County at Time of Diagnosis continued

ADD/County	Total AIDS Cases[1]	Living with AIDS
Kentucky River	**43**	**28**
Breathitt	4	4
Knott	1	0
Lee	5	4
Leslie	3	1
Letcher	16	10
Owsley	1	1
Perry	10	7
Wolfe	3	1
KIPDA/North Central	**2209**	**1248**
Bullitt	15	9
Henry	11	5
Jefferson	2019	1136
Oldham	128	75
Shelby	26	16
Spencer	4	2
Trimble	6	5
Lake Cumberland	**65**	**40**
Adair	3	2
Casey	2	0
Clinton	5	4
Cumberland	3	3
Green	2	0
McCreary	3	3
Pulaski	31	17
Russell	6	4
Taylor	5	3
Wayne	5	4
Lincoln Trail	**137**	**87**
Breckinridge	9	5
Grayson	10	6
Hardin	78	50
Larue	1	0
Marion	7	5
Meade	15	13
Nelson	14	6
Washington	3	2

ADD/County	Total AIDS Cases[1]	Living with AIDS
Northern Kentucky	**393**	**226**
Boone	55	34
Campbell	80	45
Carroll	6	4
Gallatin	2	1
Grant	14	7
Kenton	229	128
Owen	3	3
Pendleton	4	4
Pennyrile	**189**	**102**
Caldwell	13	8
Christian	72	44
Crittenden	3	3
Hopkins	30	10
Livingston	10	5
Lyon	14	5
Muhlenberg	22	9
Todd	18	12
Trigg	7	6
Purchase	**179**	**106**
Ballard	7	5
Calloway	21	12
Carlisle	1	0
Fulton	6	4
Graves	21	10
Hickman	3	2
Marshall	12	8
McCracken	108	65

[1] Total cases both living and deceased

Note: Residence at diagnosis missing for 4 cases

Table 6. AIDS Cases and Diagnosis Rates by Year of Diagnosis and Area Development District (ADD) of Residence at Time of Diagnosis

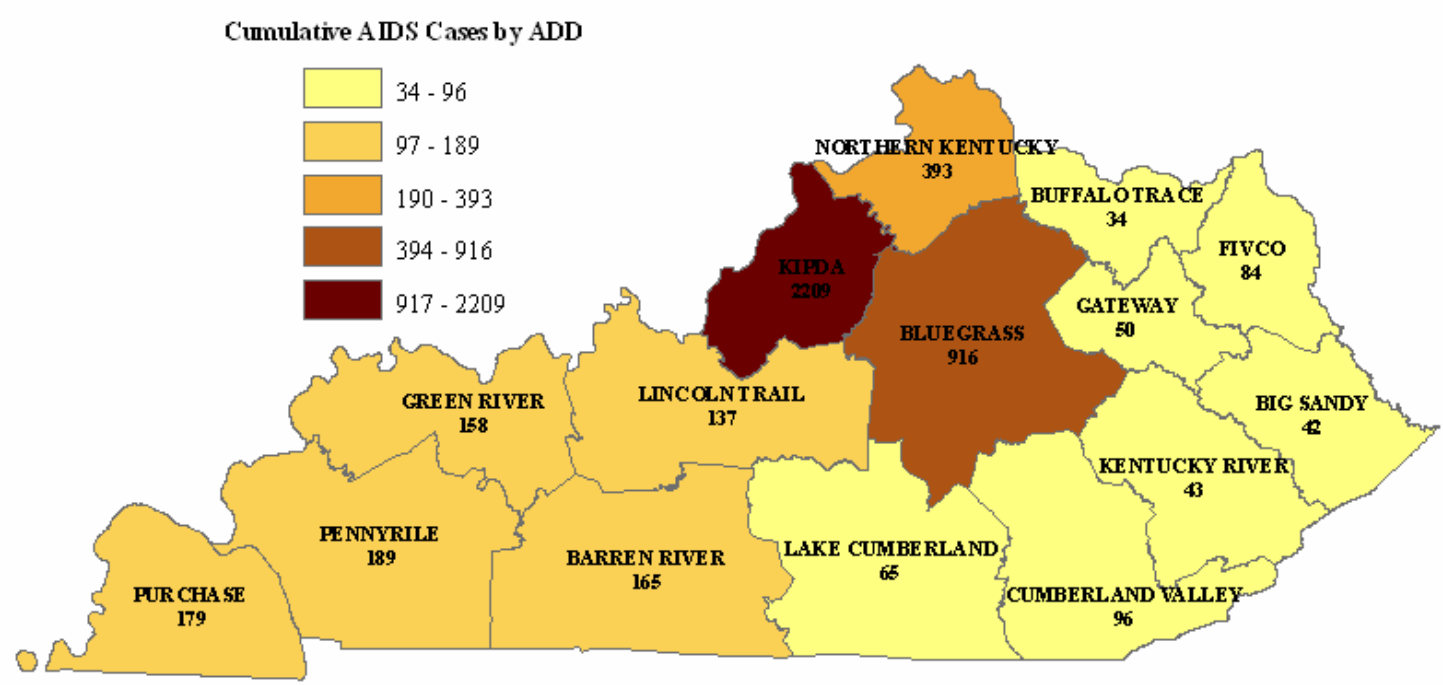
DISTRICT	CASES & RATES(1)	1982-2001	2002	2003	2004	2005	2006	2007	TOTAL CASES(2)	%
1. Purchase	Cases	127	7	12	9	4	11	9	179	4%
	Rate per 100,000			6.2			5.6			
2. Pennyrile	Cases	150	9	8	6	6	5	5	189	4%
	Rate per 100,000									
3. Green River	Cases	117	10	8	8	2	5	8	158	3%
	Rate per 100,000		4.8							
4. Barren River	Cases	116	9	6	11	8	9	6	165	3%
	Rate per 100,000				4.2					
5. Lincoln Trail	Cases	99	8	5	6	6	5	8	137	3%
	Rate per 100,000									
6. KIPDA/ North Central	Cases	1634	124	92	90	82	91	96	2209	46%
	Rate per 100,000		14.1	10.3	10.0	9.1	10.0			
7. Northern Kentucky	Cases	295	15	16	26	15	19	7	393	8%
	Rate per 100,000		3.7	3.9	6.3	3.6	4.5			
8. Buffalo Trace	Cases	23	2	1	1	5	0	2	34	1%
	Rate per 100,000									
9. Gateway	Cases	35	4	5	0	2	1	3	50	1%
	Rate per 100,000									
10. FIVCO	Cases	61	2	3	3	2	6	7	84	2%
	Rate per 100,000									
11. Big Sandy	Cases	32	1	3	1	1	0	4	42	1%
	Rate per 100,000									
12. Kentucky River	Cases	29	5	2	0	0	4	3	43	1%
	Rate per 100,000									
13. Cumberland Valley	Cases	72	5	2	4	5	3	5	96	2%
	Rate per 100,000									
14. Lake Cumberland	Cases	46	2	4	2	2	7	2	65	1%
	Rate per 100,000									
15. Bluegrass	Cases	683	40	31	43	36	47	36	916	19%
	Rate per 100,000		5.7	4.4	6.0	5.0	6.4			
TOTAL CASES		**3,519**	**243**	**198**	**210**	**176**	**213**	**201**	**4,760**	**100%**

(1) Rates are only listed for years of diagnosis 2002 - 2006. Data for 2007 are provisional due to reporting delay and are subject to change. Due to the small nubers of AIDS cases reported in some ADDs, please interpret the corresponding rates with caution. Rates are not published when cell size is less than 10.

(2) Total AIDS Cases both Living and Deceased; Total AIDS cases reported are 4,764—4 AIDS case with unknown residential information.

Cumulative AIDS Statistics by Area Development District (ADD)

Figure 2. Cumulative AIDS Cases by Area Development District (ADD) of Residence at Time of Diagnosis through December 31, 2007



The largest number of AIDS cases (n=2,209, 46%) were residing in the KIPDA ADD, which includes the city of Louisville, at the time of diagnosis (Figure 2). The Bluegrass ADD, which includes the city of Lexington, has the second largest number of AIDS cases (n=916, 19%) diagnosed in Kentucky, followed by the Northern Kentucky ADD with the third largest number of AIDS cases (n=393, 8%) diagnosed in Kentucky.

Adult/Adolescent AIDS Cases

Table 7. Adult/Adolescent[1] AIDS Cases by Year of Diagnosis

Characteristics	1982-01	%	2002	%	2003	%	2004	%	2005	%	2006	%	2007[2]	%	Total	%[3]
SEX																
Male	3026	87%	194	80%	151	76%	167	80%	139	79%	169	79%	160	80%	4006	85%
Female	466	13%	47	20%	47	24%	41	20%	36	21%	46	21%	41	20%	724	15%
TOTAL[3]	3492	100%	241	100%	198	100%	208	100%	175	100%	215	100%	201	100%	4730	100%
AGE AT DIAGNOSIS																
13-19	27	1%	1	0%	1	1%	1	0%	1	1%	0	0%	1	0%	32	1%
20-29	658	19%	34	14%	38	19%	33	16%	23	13%	32	15%	31	15%	849	18%
30-39	1623	46%	89	37%	61	31%	74	36%	63	36%	62	29%	70	35%	2042	43%
40-49	863	25%	75	31%	70	35%	79	38%	64	37%	76	35%	65	32%	1292	27%
>49	321	9%	42	17%	28	14%	21	10%	24	14%	45	21%	34	17%	515	11%
TOTAL[3]	3492	100%	241	100%	198	100%	208	100%	175	100%	215	100%	201	100%	4730	100%
RACE/ETHNICITY																
White, Not Hispanic	2384	68%	150	62%	111	56%	122	59%	99	57%	115	53%	101	50%	3082	65%
Black, Not Hispanic	1026	29%	77	32%	72	36%	70	34%	61	35%	82	38%	82	41%	1470	31%
Hispanic	72	2%	11	5%	9	5%	14	7%	13	7%	15	7%	16	8%	150	3%
Other	10	0%	3	1%	6	3%	2	1%	2	1%	3	1%	2	1%	28	1%
TOTAL[3]	3492	100%	241	100%	198	100%	208	100%	175	100%	215	100%	201	100%	4730	100%
TRANSMISSON CATEGORY																
MSM[4]	2041	58%	107	44%	92	46%	104	50%	89	51%	98	46%	81	40%	2612	55%
IDU[5]	474	14%	38	16%	35	18%	33	16%	16	9%	25	12%	22	11%	643	14%
MSM and IDU	223	6%	8	3%	12	6%	18	9%	4	2%	7	3%	6	3%	278	6%
Hemophilia/Blood Disorder	82	2%	1	0%	0	0%	1	0%	0	0%	0	0%	0	0%	84	2%
Heterosexual[6]	473	14%	52	22%	43	22%	37	18%	50	29%	44	20%	37	18%	736	16%
Transfusion/Transplant	36	1%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	36	1%
Undetermined[7]	163	5%	35	15%	16	8%	15	7%	16	9%	41	19%	55	27%	341	7%
TOTAL[3]	3492	100%	241	100%	198	100%	208	100%	175	100%	215	100%	201	100%	4730	100%

(1) Cases are classified as Adult/Adolescent if they are 13 years of age or older at time of diagnosis.
(2) Data for 2007 are provisional due to reporting delays.
(3) Percentages may not total 100% due to rounding.
(4) MSM = Men Having Sex With Men
(5) IDU = Injection Drug Use
(6) "Heterosexual" includes persons who have had heterosexual contact with a person with HIV or at risk for HIV.
(7) "Undetermined" refers to persons whose mode of exposure to HIV is unknown. This includes persons who are under investigation, deceased, lost to invesitgation, refused interview, and persons whose mode of exposure remains undetermined after investigation.

Adult/Adolescent AIDS Cases

Table 8. Cumulative Adult/Adolescent[1] AIDS Cases By Transmission Category, Race/Ethnicity, and Sex through December 31, 2007

	Transmission Category	White, Not Hispanic		Black, Not Hispanic		Hispanic		Other		TOTAL	
		No.	%	No.	%	No.	%	No.	%	No.	%[2]
MALE	MSM[3]	2020	74%	533	48%	48	41%	11	55%	2612	65%
	IDU[4]	189	7%	233	21%	29	25%	7	35%	458	11%
	MSM and IDU	180	7%	92	8%	6	5%	0	0%	278	7%
	Hemophilia/Coagulation Disorder	74	3%	8	1%	0	0%	0	0%	82	2%
	Heterosexual[5]	139	5%	141	13%	14	12%	1	5%	295	7%
	Transfusion/Transplant	18	1%	4	0%	0	0%	0	0%	22	1%
	Undetermined[6]	128	5%	109	10%	21	18%	1	5%	259	6%
	TOTAL	**2748**	**100%**	**1120**	**100%**	**118**	**100%**	**20**	**100%**	**4006**	**100%**
FEMALE	IDU[4]	82	25%	94	27%	8	25%	1	13%	185	26%
	Hemophilia/Coagulation Disorder	2	1%	0	0%	0	0%	0	0%	2	0%
	Heterosexual[5]	202	60%	211	60%	22	69%	6	75%	441	61%
	Transfusion/Transplant	11	3%	3	1%	0	0%	0	0%	14	2%
	Undetermined[6]	37	11%	42	12%	2	6%	1	13%	82	11%
	TOTAL	**334**	**100%**	**350**	**100%**	**32**	**100%**	**8**	**100%**	**724**	**100%**

(1) Cases are classified as Adult/Adolescent if they are 13 years of age or older at time of diagnosis.

(2) Percentages may not total to 100 due to rounding.

(3) MSM = Men Having Sex With Men

(4) IDU = Injection Drug Use

(5) "Heterosexual" includes persons who have had heterosexual contact with a person with HIV or at risk for HIV.

(6) "Undetermined" refers to persons whose mode of exposure to HIV is unknown. This includes persons who are under investigation, dead, lost to investigation, refused interview, and persons whose mode of exposure remain undetermined after investigation.

Pediatric AIDS Cases

Table 9. Cumulative Pediatric[1] AIDS Cases By Risk and Race/Ethnicity through December 31, 2007

Transmission Category	White, Not Hispanic		Black, Not Hispanic		Other		TOTAL	
	No.	%	No.	%	No.	%	No.	%[2]
Hemophilia/Coagulation Disorder	3	21%	1	5%	0	0%	4	12%
Perinatal	10	71%	19	95%	0	0%	29	85%
Transfusion	1	7%	0	0%	0	0%	1	3%
TOTAL	**14**	**100%**	**20**	**100%**	**0**	**0%**	**34**	**100%**

(1) Cases are classified as Pediatric if they are less than 13 years of age at time of diagnosis.
(2) Percentages may not total to 100 due to rounding.

Table 10. Pediatric[1] AIDS Cases by Year of Diagnosis

Transmission Category	1982-01	%	2002	%	2003	%	2004	%	2005	%	2006	%	2007[2]	%	Total	%[3]
Hemophilia/ Coagulation Disorder	4	14%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	4	12%
Perinatal	23	82%	2	100%	1	100%	2	100%	1	100%	0	0%	0	0%	29	85%
Transfusion/ Transplant	1	4%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	1	3%
Total	**28**	**100%**	**2**	**100%**	**1**	**100%**	**2**	**100%**	**1**	**100%**	**0**	**NA**	**0**	**NA**	**34**	**100%**

(1) Cases are classifed as Pediatric if they are less than 13 years of age at time of diagnosis.
(2) Data for 2007 are provisional due to reporting delays.
(3) Percentages may not total 100 due to rounding.

Overall, there have been 34 pediatric AIDS cases reported to the Kentucky HIV/AIDS surveillance program (Table 9 and Table 10). Twenty-eight of these cases (82%) were diagnosed prior to 2002. The majority of pediatric cases were reported due to perinatal transmission (n= 29, 85%), 4 were reported with their primary mode of exposure due to hemophilia or coagulation disorders, and 1 was reportedly due to transfusion or transplantation (Table 10). Since 1989 there have been no pediatric cases diagnosed which reported hemophilia or coagulation disorders as the mode of exposure. The only pediatric case to report transfusion or transplantation as the risk factor was diagnosed in 1988. There have been no pediatric cases due to perinatal transmission diagnosed since 2005.

Cumulative AIDS Cases

Table 11. Cumulative[1] AIDS Cases By Age at Diagnosis, Race/Ethnicity, and Sex through December 31, 2007

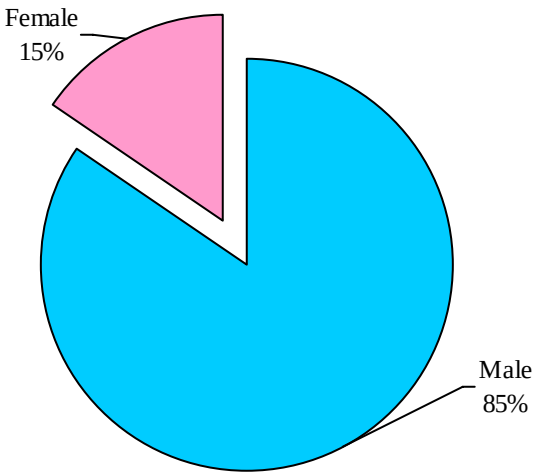
		White, Not Hispanic		Black, Not Hispanic		Hispanic		Other		TOTAL	
	Age Group	No.	%	No.	%	No.	%	No.	%	No.	%[2]
MALE	<13	7	≤1%	14	1%	0	0%	0	0%	21	1%
	13-19	17	1%	7	1%	2	2%	0	0%	26	1%
	20-29	455	17%	198	17%	37	31%	2	10%	692	17%
	30-39	1219	44%	462	41%	54	46%	9	45%	1744	43%
	40-49	753	27%	333	29%	17	14%	9	45%	1112	28%
	>49	304	11%	120	11%	8	7%	0	0%	432	11%
	TOTAL[2]	**2755**	**100%**	**1134**	**100%**	**118**	**100%**	**20**	**100%**	**4027**	**100%**
FEMALE	<13	7	2%	6	2%	0	0%	0	0%	13	2%
	13-19	4	1%	2	1%	0	0%	0	0%	6	1%
	20-29	72	21%	69	19%	13	41%	3	38%	157	21%
	30-39	136	40%	152	43%	8	25%	2	25%	298	40%
	40-49	79	23%	92	26%	7	22%	2	25%	180	24%
	>49	43	13%	35	10%	4	13%	1	13%	83	11%
	TOTAL[2]	**341**	**100%**	**356**	**100%**	**32**	**100%**	**8**	**100%**	**737**	**100%**

(1) Includes both Adult/Adolescent and Pediatric AIDS cases.

(2) Percentages may not total 100 due to rounding.

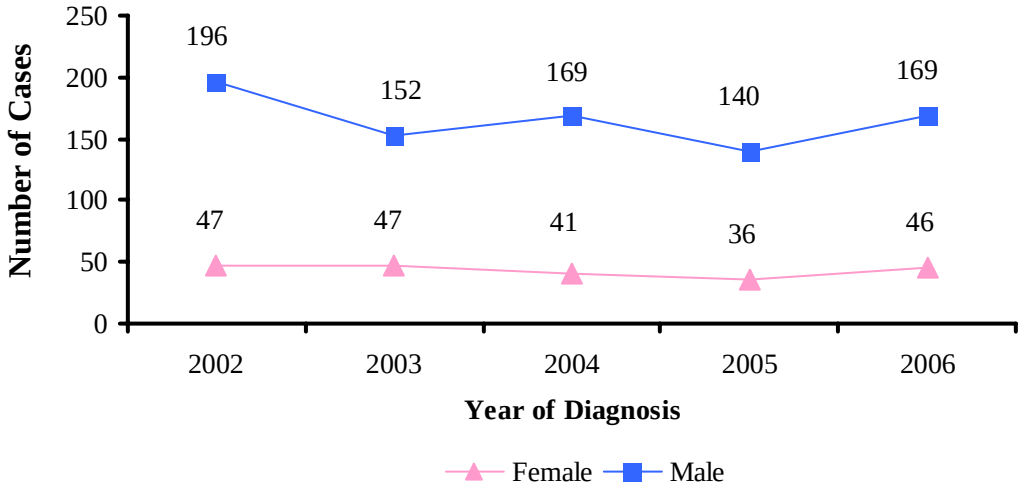
AIDS Cases in Kentucky by Sex

Figure 3. Percentage of Cumulative Kentucky AIDS Cases by Sex as of December 31, 2007



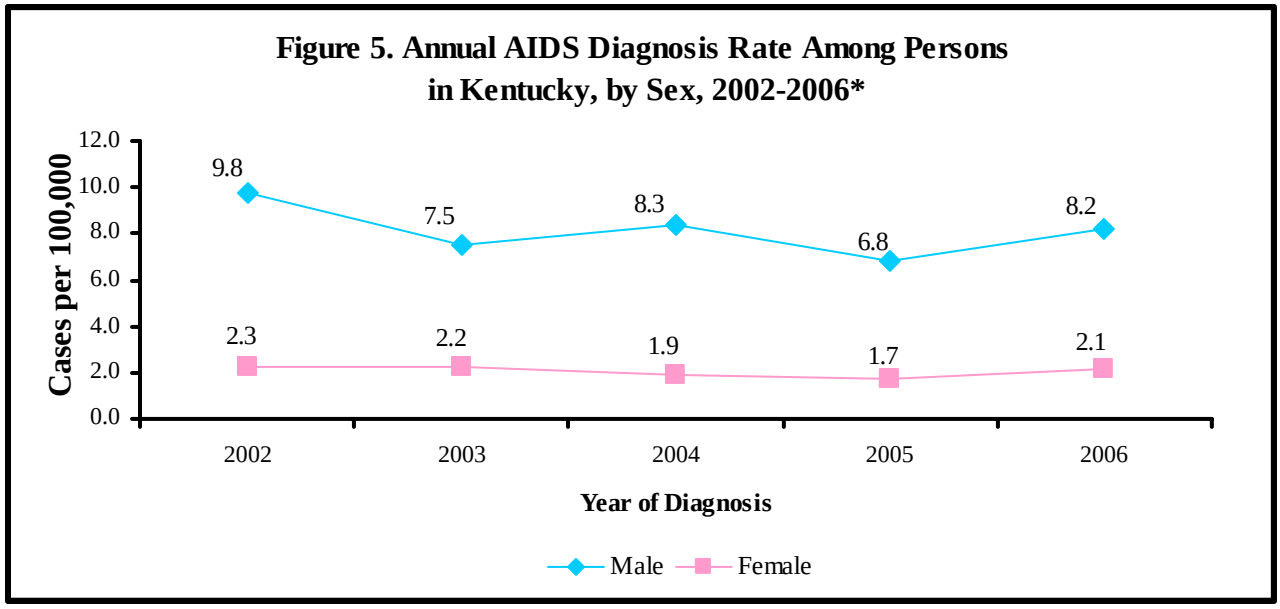
N=4,764

Figure 4. Kentucky AIDS Cases by Sex and Year of Diagnosis, 2002-2006*



*Data for 2007 are provisional due to reporting delays and are not used in trend analysis; all data are subject to change due to reporting delays.

AIDS Diagnosis Rates in Kentucky by Sex



*Data for 2007 are provisional due to reporting delays and are not used in trend analysis; all data are subject to change due to reporting delays.

Males represent the majority (85%) of total AIDS cases reported in Kentucky (Figure 3). On average from 2002 to 2006, the AIDS diagnosis rate among males has been approximately four times higher than for females (Figure 5). The number of male AIDS cases diagnosed and the diagnosis rate has fluctuated from 2002 to 2006 (Figure 4 and Figure 5). The female AIDS incidence rate has remained fairly steady from 2002 to 2006, with a slight decrease seen in 2004 and 2005. These trends will continue to be monitored as data become available.

AIDS Cases in Kentucky by Age at Diagnosis

Figure 6. Percentage of Cumulative Kentucky AIDS Cases by Age at Diagnosis as of December 31, 2007

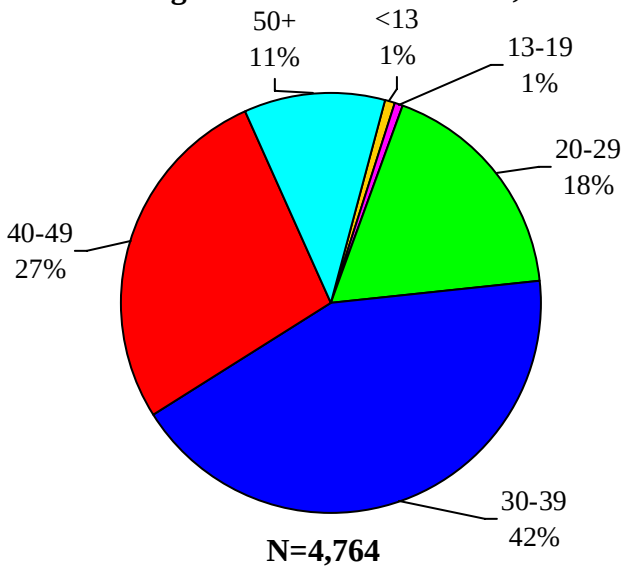
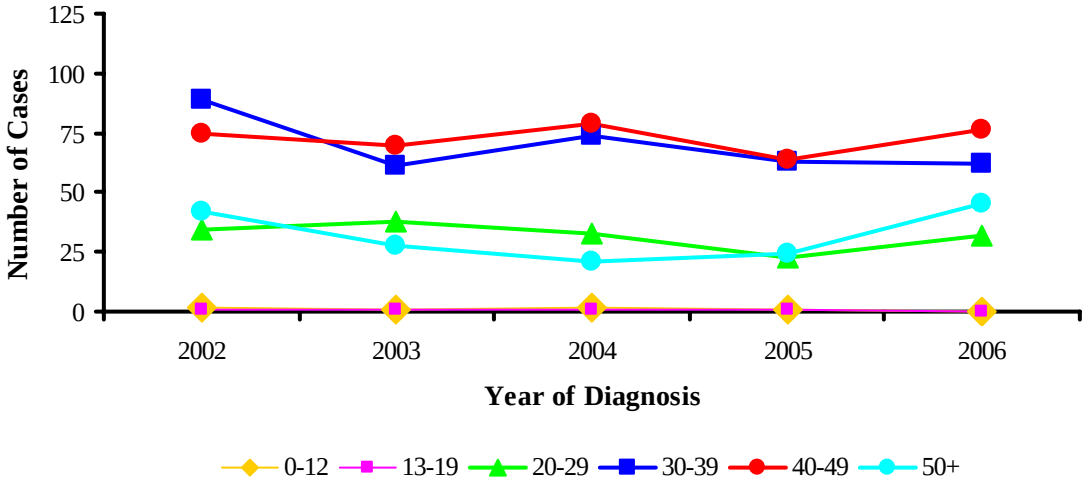
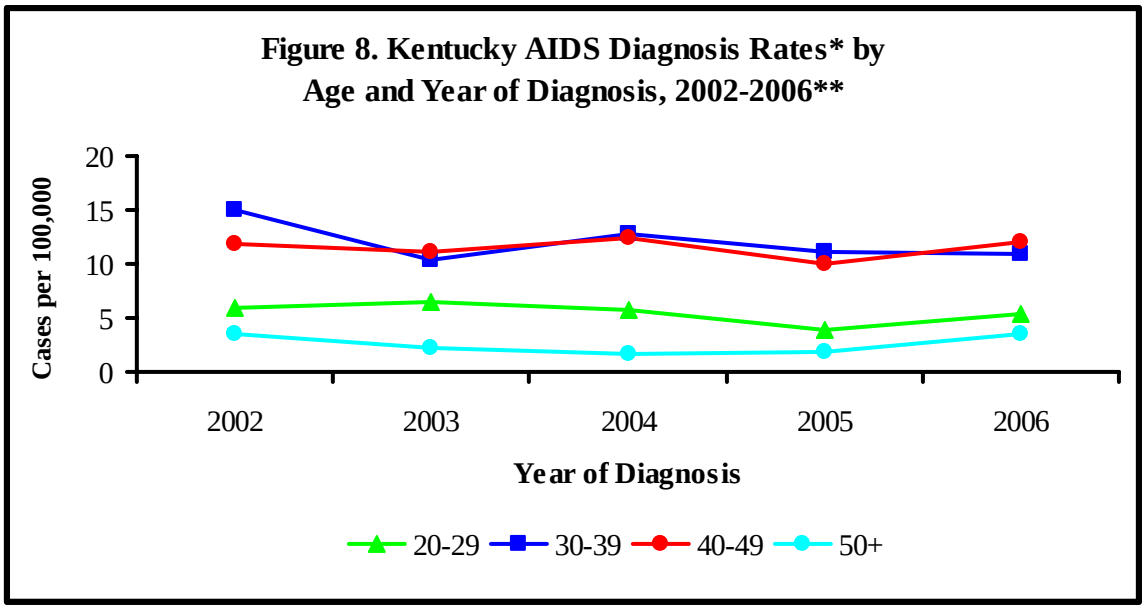


Figure 7. Annual AIDS Cases Among Persons in Kentucky by Age at Diagnosis, 2002-2006*



*Data for 2007 are provisional due to reporting delays and are not used in trend analysis; all data are subject to change due to reporting delays.

AIDS Cases in Kentucky by Age at Diagnosis



*Due to the small numbers of AIDS cases reported, rates are not presented for age groups 0-12 and 13-19 years old.
**Data for 2007 are provisional due to reporting delays and are not used in trend analysis; all data are subject to change due to reporting delays.

Cumulatively, the largest percentage of AIDS cases were diagnosed in their 30's (42%), followed by those in their 40's (27%) (Figure 6). The number of AIDS cases diagnosed in those less than 20 years of age has remained low from 2002 to 2006 (Figure 7). The AIDS diagnosis rate has been highest among those in their 30's and 40's from 2002 to 2006 (Figure 8). The slight increase in the diagnosis rates for all age categories from 2005 to 2006 may be due to increased surveillance activities initiated in 2006. The mean age for diagnosed AIDS cases has remained approximately 39 years old from 2002 to 2005, with an increase to 41 years of age in 2006 (Table 12). The highest age at diagnosis between 2002 and 2006 was 73 years of age, which occurred in 2006.

Table 12. Age at Reported AIDS Diagnosis, Kentucky 2002-2006

Year	Highest Age	Lowest Age	Mean Age
2002	68	1	39.7
2003	70	6	38.7
2004	69	<1	38.2
2005	67	10	39.7
2006	73	20	41.0

AIDS Cases in Kentucky by Transmission Category

Figure 9. Percentage of Cumulative Kentucky Adult/Adolescent AIDS Cases by Transmission Category through December 31, 2007

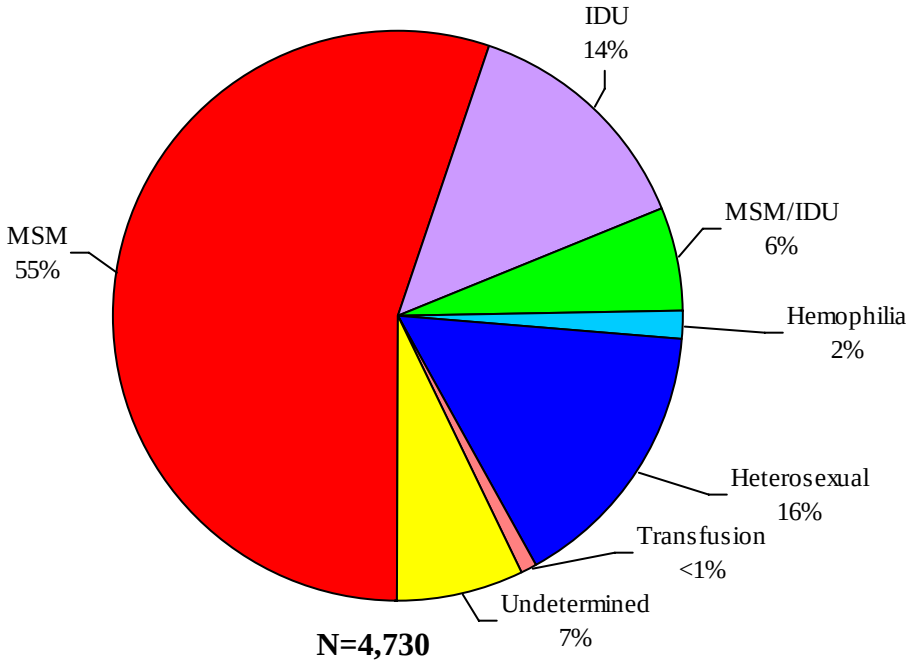


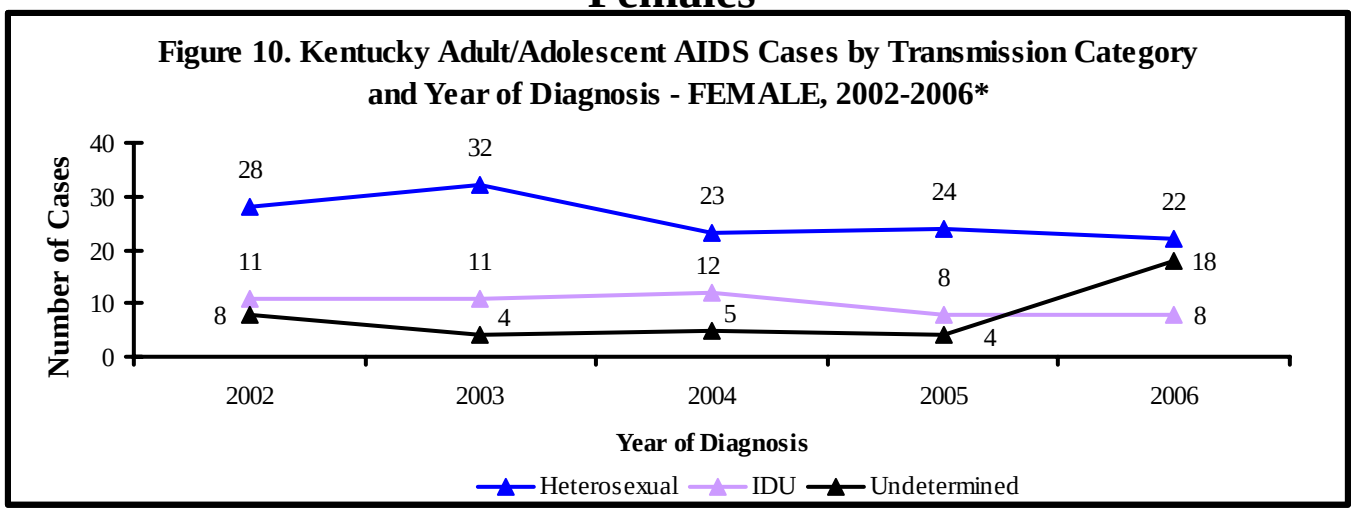
Table 13. Cumulative Kentucky Adult/Adolescent AIDS Cases by Transmission Category

Transmission Category	N
MSM	2612
IDU	643
MSM/IDU	278
Hemophilia	84
Heterosexual	736
Transfusion	36
Undetermined	341
Total	4730

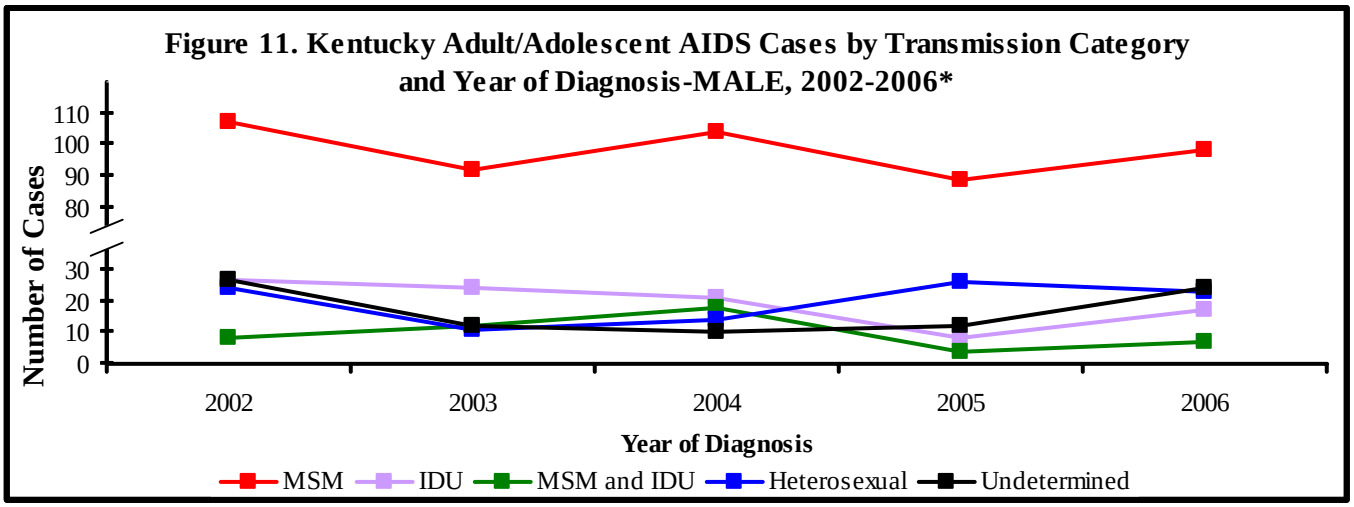
In Kentucky, 55% of cumulative adult/adolescent AIDS cases identified their primary transmission category as men who have sex with men (MSM), as shown in Figure 9. Fourteen percent of adult/adolescent AIDS cases reported their primary transmission category as injection drug use (IDU), and 16% reported heterosexual contact. Six percent of Kentucky adult/adolescent AIDS cases reported both MSM and IDU as the primary transmission category. Cumulative adult/adolescent AIDS case numbers for each mode of exposure are displayed in Table 13.

AIDS Cases in Kentucky by Transmission Category and Sex

Females



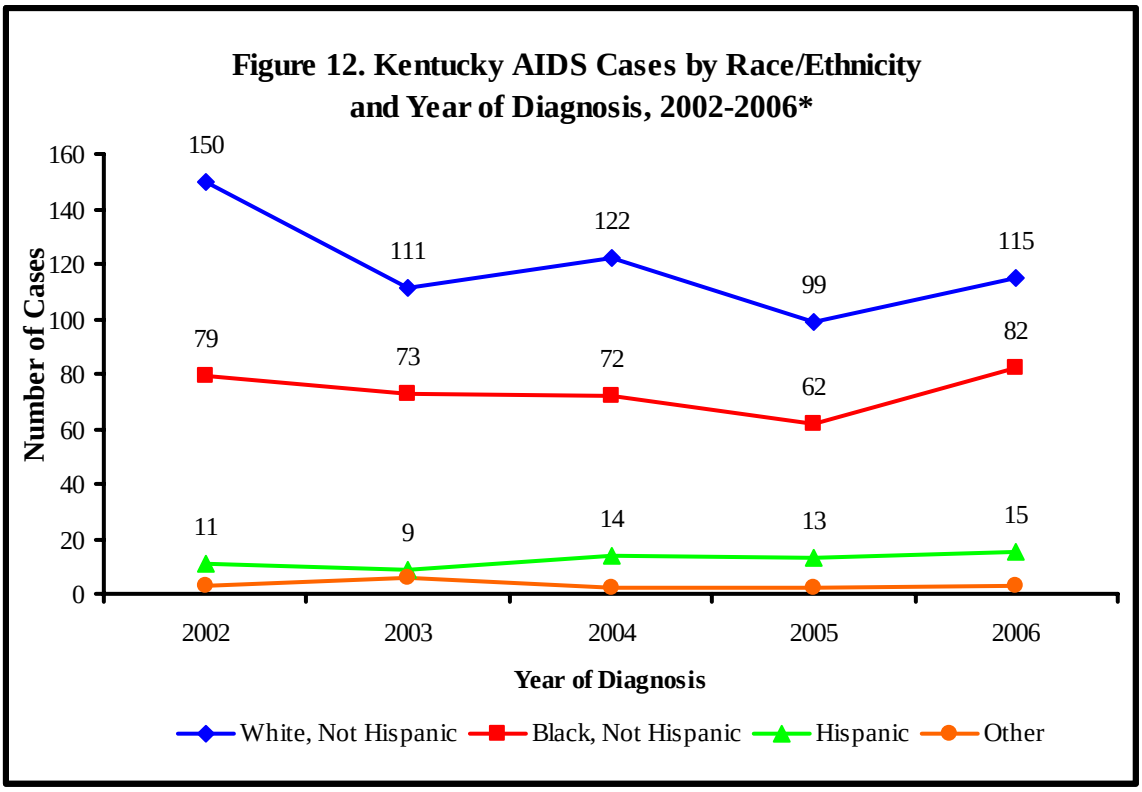
Males



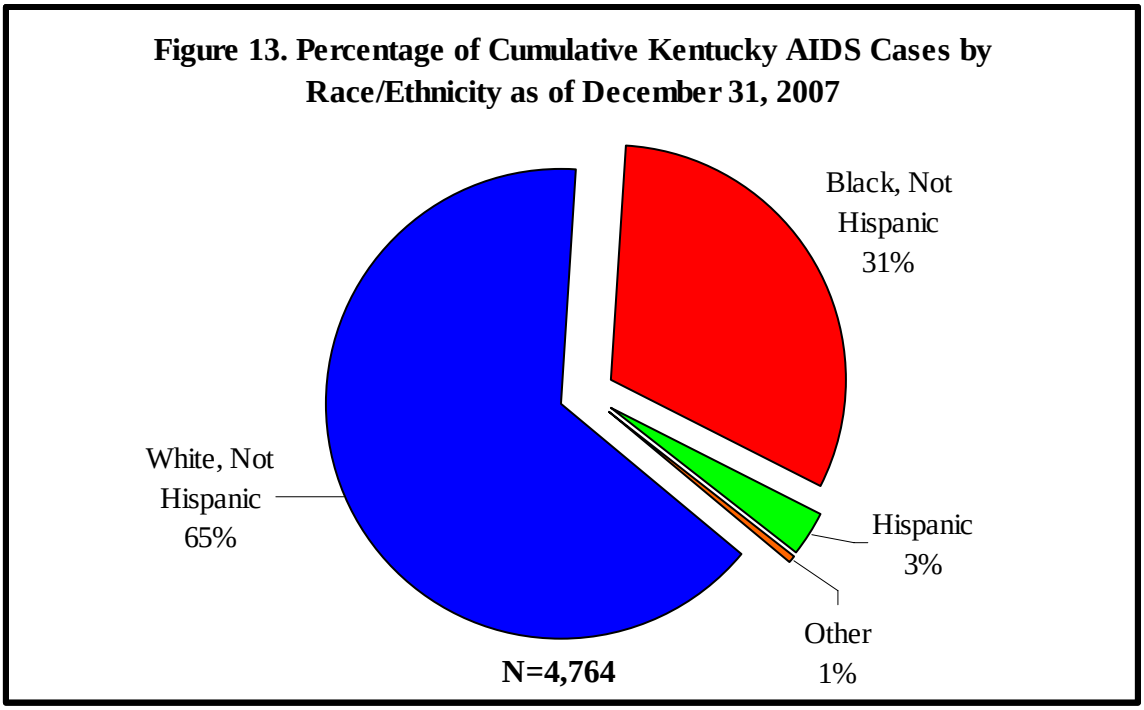
*Data for 2007 are provisional due to reporting delays and are not used in trend analysis; data are subject to change due to reporting delays.

Figure 10 and Figure 11 show female and male Kentucky adult/adolescent AIDS cases by transmission category and year of diagnosis. The number of cases among females reporting heterosexual contact as the mode of transmission decreased from 2003 to 2004, and remained fairly steady from 2004 to 2006 (Figure 10). Also, the number of female cases reporting IDU as their primary mode of transmission decreased from 2004 to 2005. In Figure 11 for adult/adolescent males, please note the break in the y-axis for the number of cases diagnosed. Among males, MSM's account for the largest number of cases diagnosed each year from 2002 to 2006. The number of males reporting IDU as their primary mode of transmission decreased from 2002 to 2005, and then increased in 2006. The number of cases among males attributed to heterosexual contact increased from 2003 to 2005. Among both females and males the number of cases with an undetermined transmission category increased in 2006.

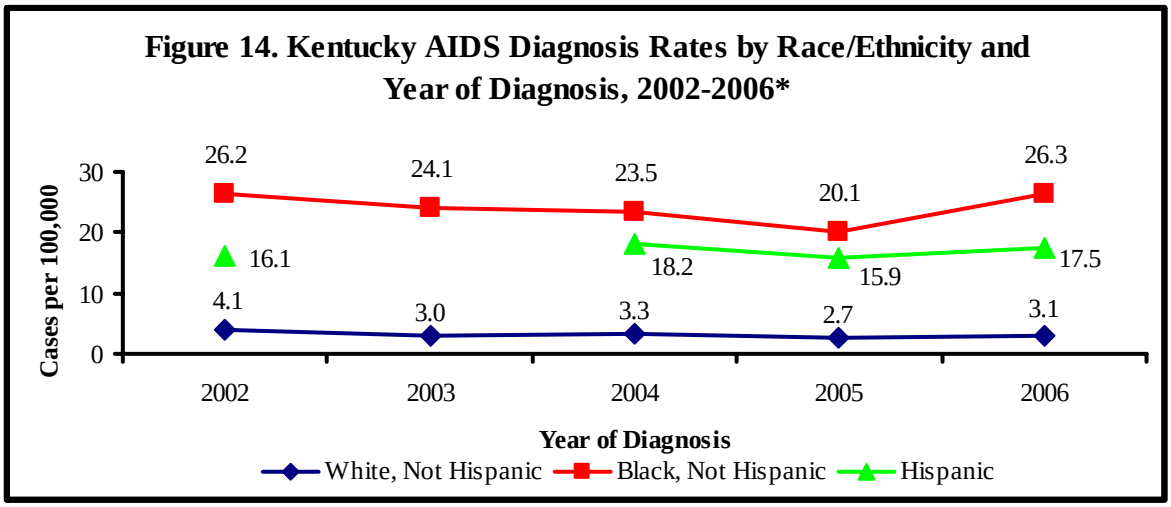
AIDS Cases in Kentucky by Race/Ethnicity



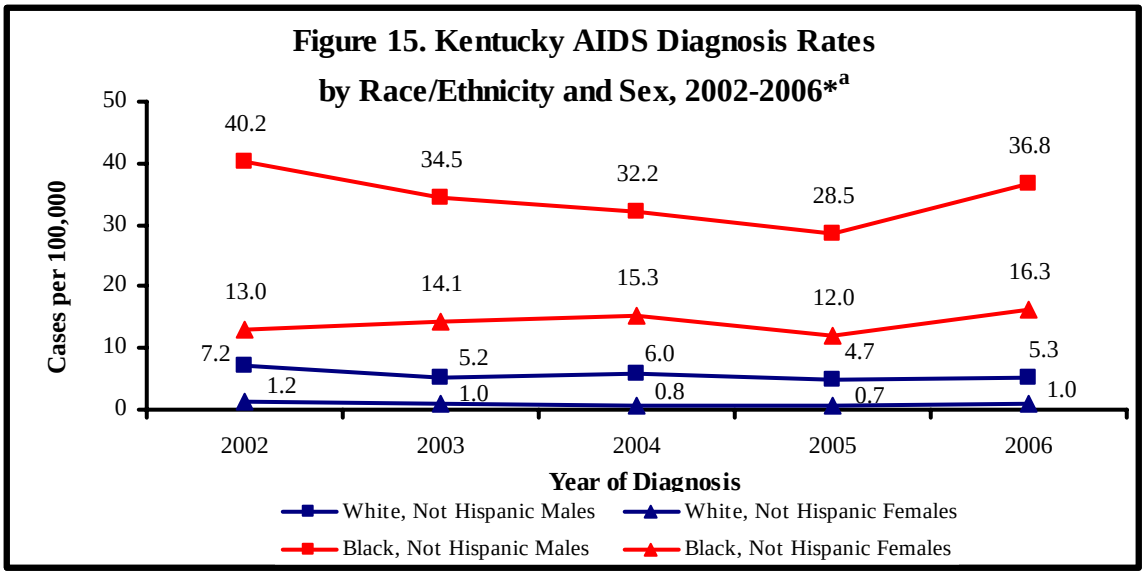
*Data for 2007 are provisional due to reporting delays and are not used in trend analysis; all data are subject to change due to reporting delays.



AIDS Diagnosis in Kentucky by Race/Ethnicity



*Data in 2007 are provisional due to reporting delays and are not used in trend analysis.
Note: The diagnosis rate for Hispanics in 2003 is not presented because the number of cases diagnosed was less than 10.



*Data in 2007 are provisional due to reporting delays and are not used in trend analysis.
[a] Rates for Hispanic cases by sex are not presented due to the small number of cases reported.

On average from 2002-2006, the AIDS diagnosis rate for blacks was approximately seven times higher than for whites, and five times higher for Hispanics than for whites in Kentucky (Figure 14). The diagnosis rate among black males has steadily decreased between 2002 and 2005 (Figure 15). The diagnosis rate among both black males and females increased from 2005 to 2006. This trend will continue to be monitored. The diagnosis rates among white males and females have remained fairly steady from 2002 to 2006 (Figure 15).

AIDS Mortality Rates in Kentucky

Table 14. Kentucky AIDS Deaths 2005 - All Ages

	White, Not Hispanic			Black, Not Hispanic			Hispanic			Total		
	Deaths	Rate*	Rank	Deaths	Rate*	Rank	Deaths	Rate*	Rank	Deaths	Rate*	Rank
Male	28	1.6	25th	21	13.9	10th	0			49	2.4	22nd
Female	7	0.4	30th	4	2.5	20th	1	2.9	15th**	12	0.6	30th
Total	35	0.9	29th	25	8.1	14th	1	1.2	17th	61	1.5	24th

Table 15. Kentucky AIDS Deaths 2005 - Age Group 25-44

	White, Not Hispanic			Black, Not Hispanic			Hispanics			Total		
	Deaths	Rate*	Rank	Deaths	Rate*	Rank	Deaths	Rate*	Rank	Deaths	Rate*	Rank
Male	14	2.7	8th	8	18.3	5th	0			22	3.8	8th
Female	5	1.0	12th	2	4.4	8th	1	8.4	2nd**	8	1.4	12th
Total	19	1.7	11th	10	11.2	5th	1	3.2	7th	30	2.6	10th

Data Source: Office of Vital Statistics, Kentucky Department for Public Health/Cabinet for Health & Family Services
* Rate per 100,000 population
**Tied with two other causes of death

In 2005, AIDS was the 24th leading cause of death for all Kentuckians (Table 14). AIDS was the 14th leading cause of death among blacks, 17th among Hispanics, and 29th among whites in Kentucky. For black males of any age in Kentucky, AIDS ranked as the 10th leading cause of death.

In 2005, among Kentuckians ages 25-44, AIDS was the 10th leading cause of death (Table 15). Among those ages 25-44, AIDS ranked as the 5th leading cause of death for black males, 8th among white males, 8th among black females, and 12th among white females. Among Hispanic females ages 25-44, AIDS tied as the 2nd leading cause of death with two other causes. In 2005, for blacks age 25-44 years, the AIDS death rate was approximately six times higher than the white AIDS death rate in this age group.

Overall, 41% of those reported with AIDS have died since the beginning of the epidemic in Kentucky (Table 16).

Table 16. Kentucky AIDS Cases[(1)]
Living and Deceased as of December 31, 2007

Diagnosis Year	Total Cases	Living	Deceased	Mortality[(1)]
1982	3	0	3	100%
1983	7	0	7	100%
1984	15	0	15	100%
1985	31	1	30	97%
1986	36	1	35	97%
1987	65	5	60	92%
1988	121	6	115	95%
1989	161	17	144	89%
1990	175	24	151	86%
1991	215	33	182	85%
1992	279	59	220	79%
1993	303	89	214	71%
1994	306	126	180	59%
1995	327	187	140	43%
1996	324	219	105	32%
1997	259	188	71	27%
1998	236	169	67	28%
1999	228	180	48	21%
2000	212	166	46	22%
2001	217	183	34	16%
2002	243	206	37	15%
2003	199	179	20	10%
2004	210	200	10	5%
2005	176	161	15	9%
2006	215	209	6	3%
2007	201	194	7	3%
TOTAL*	**4764**	**2802**	**1962**	**41%**

(1) The percentage of AIDS cases diagnosed in a year which are now deceased based on information received through December 31, 2007.

AIDS Case Fatality Rates

Table 17. Kentucky AIDS Case Fatality Rate Five Years Following AIDS Diagnosis

		Status 5 Years Following AIDS Diagnosis		
Diagnosis Year	**Total Cases**	**Living**	**Deceased**	**Case Fatality Rate (1)**
1982	3	0	3	100%
1983	7	1	6	86%
1984	15	1	14	93%
1985	31	3	28	90%
1986	36	4	32	89%
1987	65	10	55	85%
1988	121	12	109	90%
1989	161	33	128	80%
1990	175	30	145	83%
1991	215	47	168	78%
1992	279	78	201	72%
1993	303	116	187	62%
1994	306	156	150	49%
1995	327	213	114	35%
1996	324	250	74	23%
1997	259	206	53	20%
1998	236	177	59	25%
1999	228	186	42	18%
2000	212	166	46	22%
2001	217	183	34	16%
2002	243	207	36	15%
TOTAL	**3763**	**2079**	**1684**	**45%**

(1) Proportion of AIDS cases that died within 5 years of AIDS diagnosis.

Table 17 examines the proportion of individuals that died within five years of their AIDS diagnosis (i.e., case fatality rate). For example, of the 212 individuals that were diagnosed with AIDS in 2000, 46 (22%) died within five years of their diagnosis. Table 17 shows a decline in case fatality rates over time. This is likely due to an increased understanding of the virus, which has resulted in new medical monitoring techniques and improved treatment strategies, such as antiretroviral therapy.

HIV Infections Diagnosed in Kentucky

Notes to the Reader:

- Only cases first diagnosed in the first full year of confidential name-based HIV reporting (2005) or later are included in this section
- Trend data will not be presented at this time due to the limited number of years available for analysis.
- As with AIDS data, reporting delays also exist for the HIV data, especially in the most recent years.
- The data presented in this section on HIV Infections should **not** be compared directly to the cumulative AIDS data presented in the previous section because unlike the cumulative AIDS data, the HIV data only extends over a period of three years.

Table 18. Kentucky HIV Diagnoses, 2005-2007

	Total HIV Diagnoses	Without AIDS		Concurrent with AIDS Diagnosis	
Year of Diagnosis	**N**	**N**	**%**	**N**	**%**
2005	338	256	76%	82	24%
2006	347	260	75%	87	25%
2007	327	248	76%	79	24%
Total	**1012**	**764**	**75%**	**248**	**25%**

Between 2005 and 2007 there have been a total of 1,012 HIV infections reported in Kentucky (Table 18). Of these cases, 25% were concurrently diagnosed with AIDS during the same calendar month as the initial HIV diagnosis. The number of new HIV infections diagnosed between 2005 and 2007 and the proportion of concurrent diagnoses has remained fairly steady. The slightly lower number of HIV infections in 2007 is likely due to reporting delays.

Table 19 (page 26) examines the distribution of HIV infections among individuals diagnosed between 2005 and 2007 by sex, age at diagnosis, race/ethnicity, transmission category, and stage of disease progression at time of diagnosis. Among those diagnosed with HIV infection between 2005 and 2007, 80% were male. There were no differences in the distribution by sex between HIV without AIDS cases and cases concurrently diagnosed with HIV and AIDS. Eighty-three percent of all HIV infections diagnosed in this time period were among individuals 20-49 years of age. There were differences in the distribution of age at diagnosis between HIV without AIDS cases and cases concurrently diagnosed. For example, although individuals diagnosed between 40-49 years of age made up 26% of the cases diagnosed with HIV without AIDS, this age group represented 38% of all cases concurrently diagnosed with AIDS. In comparison, individuals diagnosed between 20-29 years of age represented 28% of the HIV without AIDS diagnoses, but only represented 14% of all cases concurrently diagnosed with AIDS. Whites represented 55% of all diagnosed HIV infections. Unlike other races, Hispanics made up a larger proportion (10%) of the concurrently diagnosed cases than their proportion (6%) among individuals diagnosed with HIV without AIDS. There are a large number of cases with an undetermined transmission category, which makes it difficult to interpret the distribution of cases.

HIV Diagnoses in Kentucky by Selected Characteristics, 2005-2007

Table 19. Kentucky HIV Diagnoses by Sex, Age at Diagnosis, Race/Ethnicity, and Tranmission Category, 2005-2007

	Total HIV Diagnoses		Without AIDS		Concurrent with AIDS Diagnosis	
Characteristics	**N**	**%(1)**	**N**	**%(1)**	**N**	**%(1)**
SEX						
Male	811	80%	615	80%	196	79%
Female	201	20%	149	20%	52	21%
AGE AT DIAGNOSIS						
<13	8	1%	7	1%	1	0%
13-19	45	4%	45	6%	0	0%
20-29	250	25%	216	28%	34	14%
30-39	292	29%	219	29%	73	29%
40-49	293	29%	198	26%	95	38%
>49	124	12%	79	10%	45	18%
RACE/ETHNICITY						
White, Not Hispanic	560	55%	430	56%	130	52%
Black, Not Hispanic	363	36%	274	36%	89	36%
Hispanic	64	6%	38	5%	26	10%
Other	19	2%	16	2%	3	1%
Unknown	6	1%	6	1%	0	0%
TRANSMISSON CATEGORY						
MSM(2)	473	47%	378	49%	95	38%
IDU(3)	72	7%	48	6%	24	10%
MSM and IDU	24	2%	18	2%	6	2%
Heterosexual(4)	176	17%	121	16%	55	22%
Perinatal	6	1%	5	1%	1	0%
Undetermined(5)	261	26%	194	25%	67	27%
TOTAL	**1012**	**100%**	**764**	**100%**	**248**	**100%**

(1) Percentages may not total to 100 due to rounding.

(2) MSM = Men Having Sex With Men

(3) IDU = Injection Drug Use

(4) "Heterosexual" includes persons who have had heterosexual contact with a person with HIV or at risk for HIV.

(5) "Undetermined" refers to persons whose mode of exposure to HIV is unknown. This includes persons who are under investigation, dead, lost to investigation, refused interview, and persons whose mode of exposure remain undetermined after investigation.

HIV Diagnoses in Kentucky by Selected Characteristics, 2005-2007

Table 20. Kentucky HIV Diagnoses by Sex, Age at Diagnosis, and Race/Ethnicity, 2005-2007

		White, Not Hispanic		Black, Not Hispanic		Hispanic		Other		Unknown		Total	
	Age Group	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
MALE	<13	2	0%	3	1%	0	0%	0	0%	0	0%	5	1%
	13-19	9	2%	23	9%	0	0%	2	14%	1	20%	35	4%
	20-29	101	21%	71	26%	18	37%	3	21%	0	0%	193	24%
	30-39	147	31%	62	23%	24	49%	4	29%	2	40%	239	29%
	40-49	163	34%	69	26%	5	10%	5	36%	1	20%	243	30%
	>49	51	11%	42	16%	2	4%	0	0%	1	20%	96	12%
	Total	**473**	**100%**	**270**	**100%**	**49**	**100%**	**14**	**100%**	**5**	**100%**	**811**	**100%**
FEMALE	<13	1	1%	2	2%	0	0%	0	0%	0	0%	3	1%
	13-19	5	6%	3	3%	0	0%	2	40%	0	0%	10	5%
	20-29	23	26%	25	27%	7	47%	1	20%	1	100%	57	28%
	30-39	24	28%	24	26%	5	33%	0	0%	0	0%	53	26%
	40-49	22	25%	25	27%	2	13%	1	20%	0	0%	50	25%
	>49	12	14%	14	15%	1	7%	1	20%	0	0%	28	14%
	Total	**87**	**100%**	**93**	**100%**	**15**	**100%**	**5**	**100%**	**1**	**100%**	**201**	**100%**

Table 20 examines the distribution of HIV infections among individuals diagnosed between 2005 and 2007 within race/ethnicity categories by sex and age at diagnosis. Caution should be taken when interpreting the data for the Other and Unknown race/ethnicity categories as the number of cases is small. There are differences in the distribution of age at HIV diagnosis among race/ethnicity categories and by sex. For example, a greater proportion of both Hispanic males and females were diagnosed between the ages of 20-29 and 30-39 compared to other race/ethnicity categories. Among Hispanics, the proportion of individuals diagnosed between the ages of 30-39 was greater among males (49%) compared to females (33%).

HIV Infections by Area Development District (ADD)

Figure 16. HIV Diagnoses by Area Development District (ADD) of Residence at Time of Diagnosis, 2005-2007

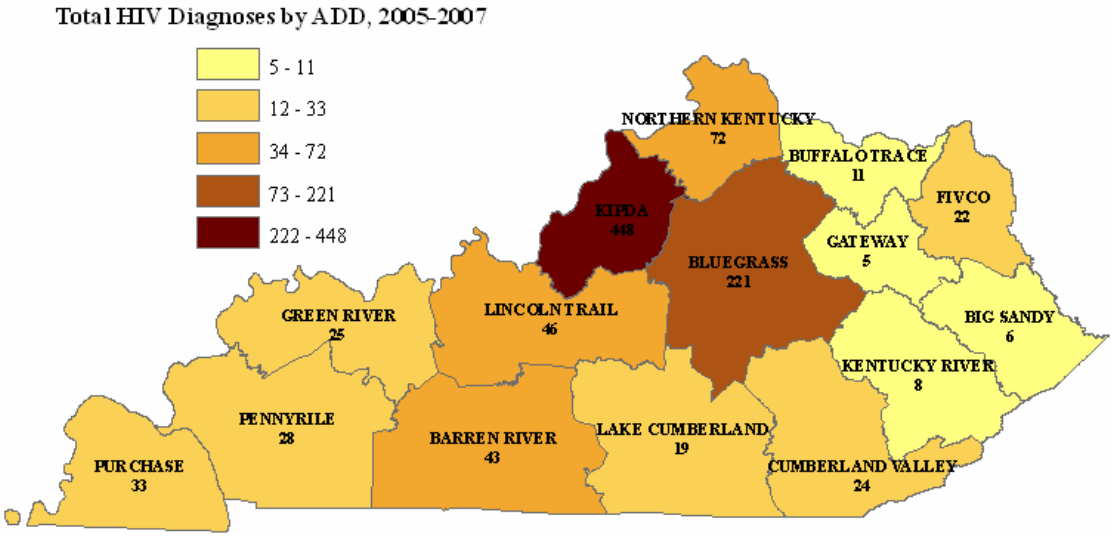


Figure 16 examines the total number of HIV infections diagnosed between 2005 and 2007 by ADD. The labels on the map represent the total number of HIV infections, regardless of disease progression status in each ADD. The largest number of cases (n=448, 44%) diagnosed in this three year period were residing in the KIPDA ADD, which includes the city of Louisville. The second largest number of cases (n=221, 22%) were residents of the Bluegrass ADD at the time of diagnosis. The smallest number of HIV infections diagnosed and reported during this three-year period occurred in the ADD's located in eastern Kentucky.

Figure 17. Percent of HIV Infections Reporting Concurrent Diagnoses with AIDS by Area Development District (ADD) of Residence at Time of Diagnosis, 2005-2007

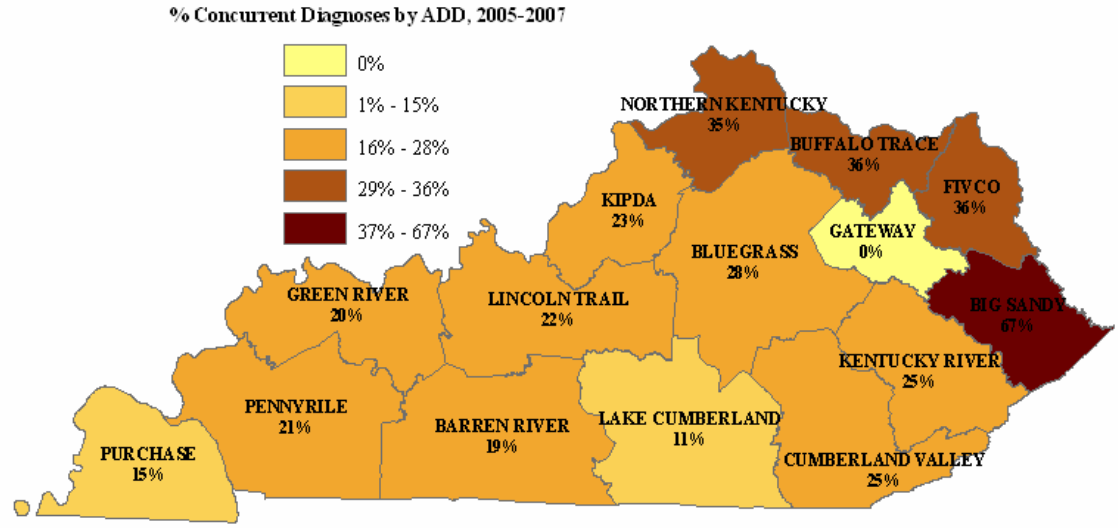


Figure 17 examines the variation by ADD in the proportion of cases within each ADD diagnosed concurrently with HIV and AIDS from 2005 to 2007. The proportion of HIV infections diagnosed concurrently with AIDS ranged from 0% to 67% among the ADDs. The greatest proportion of HIV infections diagnosed concurrently with AIDS (67%) occurred in the Big Sandy ADD in eastern Kentucky. However, there were only a total of six HIV infections diagnosed in this ADD. The ADDs in northern Kentucky also had comparatively higher percentages of concurrent diagnoses.

HIV Counseling and Testing Sites

Ora-Sure

The Ora-Sure test determines if HIV antibodies are present in oral mucosal transudate (OMT) that has been collected from the lower cheek and gum. *This is NOT a saliva test since the specimen collected is not saliva.* In order to collect a sample, a nylon pad is placed between the lower gum and cheek for two to five minutes. The pad is salt laden which sets up a concentration gradient causing fluids to be absorbed from cells in the linings of the cheeks and gums. Results are generally available in three to five days. If your agency is interested in becoming an Ora-Sure site, please contact Tom Collins at (502) 564-6539.

State Sponsored Ora-Sure Testing Sites*

All state sponsored testing sites offer **free** confidential or anonymous HIV testing. Testing hours and locations may vary. **Please contact the center to verify whether an appointment is needed or if walk-ins are acceptable.**

AIDS Volunteers of Lexington (AVOL)
263 North Limestone
Lexington, KY 40507
(859) 225-3000

Area Health Education Center-Covington
1030 Old State Road
Park Hills, KY 41011
(859) 442-1191

Area Health Education Center-Lexington
Black & Williams Neighborhood Center
498 Georgetown Street
Lexington, KY 40508
(859) 281-6086

Area Health Education Center-Louisville
Park Duvalle Community Health Center
3015 Wilson Avenue
Louisville, KY 40211
(502) 774-4401 ext 1260
(502) 776-5785

Barren River District Health Department
1109 State Street
Bowling Green, KY 42102
(270) 781-8039

Bluegrass Farm Worker Clinic (BFWC)
126 Cisco Road
Lexington, KY 40504
(859) 259-0717

Daviess County Health Department
1600 Breckenridge
Owensboro, KY 42302
(270) 686-7744

Heartland CARES
619 North 30th St
Paducah, KY 42001
(270) 444-8183

Kentucky Department for Public Health
275 East Main Street
Frankfort, Kentucky 40621
(502) 564-6539 or (800) 420-7431

Lexington-Fayette County Health Department
650 Newtown Pike
Lexington, KY 40508
(859) 288-2437

Louisville Metro Health Department
850 Barrett Avenue, Suite 301
Louisville, KY 40204
(502) 574-5600

*Please note that this list only includes those testing sites that are funded by the Kentucky Department for Public Health to administer Ora-Sure testing and **IS NOT** an all inclusive list of testing centers in the Commonwealth of Kentucky.

HIV Counseling and Testing Sites

State Sponsored Ora-Sure Testing Sites* continued

All state sponsored testing sites, offer **free** anonymous or confidential HIV testing. Testing hours and locations may vary. **Please contact the center to verify whether an appointment is needed or if walk-ins are acceptable.**

Matthew 25
411 Letcher Street
Henderson, KY 42420
(270) 826-0200

Northern Kentucky District Health Department
2388 Grandview Drive, Building A
Fort Mitchell, KY 41017
(859) 578-7660

Owensboro Task Force
224 South Ewing Road
Owensboro, KY 42301
(270) 683-6018

Purchase District Health Department
320 North 7th Street
Mayfield, KY 42066
(270) 247-1490

Volunteers of America—Louisville
850 Barrett Avenue, Suite 302
Louisville, KY 40204
(502) 574-5373

Western Kentucky Univ. Health Services
1906 College Heights Boulevard #8400
Bowling Green, KY 42101-1041
(270) 745-5033 or (270) 745-5653

WINGS Clinic
550 South Jackson Street
Louisville, KY 40292
(502) 561-8844

*Please note that this list only includes those testing sites that are funded by the Kentucky Department for Public Health to administer Ora-Sure testing and **IS NOT** an all inclusive list of testing centers in the Commonwealth of Kentucky.

HIV Counseling and Testing Sites

Ora-Quick

Ora-Quick tests are a type of screening performed on oral mucosal transudate (OMT) in which results are ready in 20 minutes. The oral fluid based rapid test received FDA approval on March 26, 2004. Several agencies working in association with the state HIV Prevention grant are currently using rapid testing. Other agencies are being encouraged to begin using rapid testing. If your agency is interested in becoming an Ora-Quick site, please contact Tom Collins at (502) 564-6539.

State Sponsored Ora-Quick Testing Sites*

All state sponsored testing sites, offer **free** anonymous or confidential HIV testing. Testing hours and locations may vary. **Please contact the center to verify whether an appointment is needed or if walk-ins are acceptable.**

Area Health Education Center-Louisville
Park Duvalle Comm. Health Center
3015 Wilson Avenue
Louisville, KY 40211
(502) 774-4401 ext 1260 or (502) 776-5785

Area Health Education Center-Covington
1030 Old State Road
Park Hills, KY 41011
(859) 442-1191

Area Health Education Center-Lexington
Black & Williams Neighborhood Center
498 Georgetown Street
Lexington, KY 40508
(859) 281-6086

AIDS Volunteers of Lexington (AVOL)
263 North Limestone
Lexington, KY 40507
(859) 225-3000

Bluegrass Farm Worker Clinic
126 Cisco Road
Lexington, KY 40504
(859) 259-0717

Heartland CARES
619 North 30th St
Paducah, KY 42001
(270) 444-8183

Kentucky Department for Public Health
275 East Main Street
Frankfort, Kentucky 40621
(502) 564-6539 or (800) 420-7431

Lexington-Fayette County Health Department
650 Newtown Pike
Lexington, KY 40508
(859) 288-2437

Louisville Metro Health Department
850 Barrett Avenue, Suite 301
Louisville, KY 40204
(502) 574-5600

Matthew 25
411 Letcher Street
Henderson, KY 42420
(270) 826-0200

Northern Kentucky District Health Dept.
2388 Grandview Drive, Building A
Fort Mitchell, KY 41017
(859) 578-7660

Planned Parenthood—Louisville
1025 S. Second Street
Louisville, KY 40203
(502) 584-2473

Planned Parenthood of the Bluegrass
508 West 2nd Street
Lexington, KY 40508
(859) 252-8494

Volunteers of America—Louisville
850 Barrett Avenue, Suite 302
Louisville, KY 40204
(502) 574-5373

*Please note that this list only includes those testing sites that are funded by the Kentucky Department for Public Health to administer Ora-Quick testing and **IS NOT** an all inclusive list of testing centers in the Commonwealth of Kentucky.