KENTUCKY
HIV/AIDS PLANNING AND ADVISORY COUNCIL
KHPAC

YEAR-END REPORT
SEPTEMBER 2008

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR PUBLIC HEALTH

ROBERT E. STONE
COMMUNITY CO-CHAIR

KENTUCKY HIV/AIDS
PLANNING AND ADVISORY COUNCIL
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STEPHAN ULRICH
STATE CO-CHAIR

August 29, 2008

Mr. Robert Sherman
Legislative Research Commission
Room 300, Capitol Building
700 Capitol Avenue
Frankfort, KY 40601

Dear Mr. Sherman:

Pursuant to KRS 214.640, the Kentucky HIV/AIDS Planning and Advisory Council, KHPAC submits to the General Assembly its Year-End Report, dated August 29, 2008. Thank you for your attention to this information.

Sincerely,

Robert E. Stone, Chairman
Kentucky HIV/AIDS Planning and
Advisory Council

Attachments:
2 Letters of Support
2008 KHPAC Year-End-Report

cc: Janie Miller, Secretary, Cabinet for Health and Family Services

Dee Ann Mansfield, Committee Staff Administrator
Interim Joint Committee on Health and Welfare

KENTUCKY PTA®
everychild. onevoice.®

ROSE BABIAK
President

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August 27, 2008

Bobby Sherman, Director
Legislative Research Commission
700 Capitol Avenue, Room 300
Frankfort, KY 40601

Mr. Sherman:

Kentucky PTA supports the Kentucky HIV/AIDS Planning and Advisory Council's (KHPAC) recommendation for comprehensive sexuality education. Comprehensive sexuality education is contained in the Kentucky PTA Legislative Platform which states: "Kentucky PTA promotes and supports legislation and funding for health, welfare, recreation and cultural arts services for children and youth including legislation designed to increase dissemination of information and services for voluntary family planning and education pertaining to sexually transmitted diseases and the prevention of teenage pregnancies and legislation that would authorize AIDS research, education programs and information dissemination.

Kentucky PTA believes that youth are capable of making responsible healthy decisions when given complete and accurate information. We are committed to giving youth opportunities which will help them develop into healthy adults who are positive contributors to society.

Sincerely,

Rose Babiak

Rose Babiak

Kentucky Teen Pregnancy Coalition
P. O. Box 12796
Lexington, KY 40583-2796

Bobby Sherman, Director
Legislative Research Commission
700 Capitol Avenue, Room 300
Frankfort, KY 40601

Mr. Sherman:

The Kentucky Teen Pregnancy Coalition (KTPC) supports the Kentucky HIV/AIDS Planning and Advisory Council's (KHPAC) recommendation for comprehensive sexuality education. Comprehensive sexuality education is one of the core values of KTPC and provides a complete message to our youth. Comprehensive sexuality education has demonstrated a positive impact on health behaviors.

Another core value of KTPC is that youth are capable of making responsible decisions about sexuality and pregnancy when given complete and accurate information, as well as support and age-appropriate skills. Research shows that comprehensive sexuality education can provide our youth with the skills needed to make healthy decisions.

We all want our youth to develop into healthy adults who contribute in positive ways to our society. By providing comprehensive sexuality education to our youth, we can help them meet this goal.

Sincerely,

Maria E. Locklear

Maria E. Locklear, President
Kentucky Teen Pregnancy Coalition

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Executive Summary

The 2008 Year-End Report of the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) summarizes KHPAC's actions throughout the last year and offers recommendations to the Cabinet for Health and Family Services (the Cabinet) and the Kentucky General Assembly to ensure better health for HIV positive Kentuckians. Despite successful past efforts, critical issues remain that require immediate and ongoing attention.

KHPAC IS RECOMMENDING LEGISLATIVE ACTION IN THE FOLLOWING AREAS:

Kentucky AIDS Drug Assistance Program
KHPAC recommends that the state increase its financial contribution to the Kentucky AIDS Drug Assistance Program (KADAP) by $1.4 million. With an average of 50 new individuals being added to KADAP each month; with decreasing federal funding of KADAP and with KADAP being responsible for Medicare "donut hole" payments, projections suggest that a waiting list could be re-instituted as early as the spring of 2009. The recommended $1.4 million increase would provide KADAP with the capacity to serve HIV+ individuals with access to lifesaving medications and avoid the imposition of a waiting list.

Comprehensive Sexuality Education
KHPAC recommends that comprehensive sexuality education be provided in all public middle and high schools in Kentucky. Comprehensive sexuality education would include developmentally appropriate, medically accurate information on the following topics: human development, relationships, decision-making, peer pressure, goal setting, conflict resolution, abstinence, contraception and disease prevention. This recommendation is consistent with Kentucky's current curriculum standards (704 KAR 3:303). KHPAC also recommends that a process be developed to ensure that all middle and high school students receive this education and that passive consent be adopted by all school districts. Comprehensive Sexuality Education would be offered to students in regular classrooms and special education classrooms.

Inmate Testing
KHPAC recommends amending KRS 197.055 to further define procedures for conducting voluntary HIV testing of inmates to include upon entry, and before an inmate's release from any unit or center of the Department of Corrections. Counseling regarding treatment options should be included in the provision of this service should an inmate test positive for the human immunodeficiency virus (HIV).

Drug Use and HIV Infection
To address drug use and HIV infection KHPAC is recommending that HIV prevention education be added to the curriculum of drug rehabilitation

organizations, and those facilities should provide opt-out routine HIV testing; the printing of materials to communicate information on HIV/AIDS be funded; and surveillance of HIV infection and AIDS to provide population-based data for research, evaluation, and prevention of HIV should receive state funding in the future (see Future Concerns below).

Building Partnership and Outreach

KHPAC recommends the creation of an Office of Minority Health within the Cabinet for Health and Family Services, Department of Public Health. KHPAC further recommends that the goal of this office be to reduce through the development of Partnerships and Outreach significant health disparities that exist for minority populations including HIV.

FUTURE CONCERNS:

Funding of HIV Surveillance Activities

Within KHPAC's 2007 Year-End Report we called for increased state funding of HIV surveillance activities. However because of some unexpected federal funding increases we are not forwarding that recommendation in our 2008 Report. However the federal funding is not indefinite so we are taking this opportunity to alert the Cabinet and the Legislature of the potential need for such funding. On July 10, 2008, the Centers for Disease Control**,** National Center for HIV, Viral Hepatitis, STDs and TB Prevention awarded the Kentucky Department for Public Health (DPH) $141,393 for HIV/AIDS surveillance activities. Given that federal funding is only authorized through 12/31/2012, it is imperative that a significant allocation of state funds be authorized in the future to support DPH's efforts to characterize the epidemic and gather resources for the fight against HIV in Kentucky.

Section I
LEGISLATIVE ACTION

A. Kentucky AIDS Drug Assistance Program Funding (KADAP)

Recommendation: Increase the State's financial contribution to the Kentucky AIDS Drug Assistance Program (KADAP) by $1.4 million. There is no longer a waiting list for KADAP, but with an average of 50 new individuals being added to KADAP each month and with KADAP being responsible for Medicare "donut hole" payments, projections suggest that a waiting list could be re-instituted as early as the spring of 2009.[1] The recommended $1.4 million state funding increase would provide KADAP with an increased capacity to serve HIV+ individuals with access to lifesaving medications.

Progress/Grade: (B+ & F) REGRESSION ON EARLIER GAINS. (continuing recommendation) – Recently, legislative action has been taken to increase State funding of KADAP. In 2004 an additional $90,000 in State funds was allocated to KADAP; doubling the amount of State funding that existed prior to that allocation. In 2005 legislative action allocated another $70,000 in State funding of KADAP; bringing the total annual State funding of KADAP to $250,000. KHPAC welcomed the legislature's support of these increases. However in fiscal year 2007, due to required budget cuts, $250,000 was redirected away from the KADAP budget by the Cabinet, and in the Cabinet's fiscal year 2008 budget no State funding was allocated to KADAP.

Background: KADAP makes available to eligible Kentuckians medications that are necessary to keep individuals in the work force, keep them from becoming more ill, and to help prevent other healthcare costs. KHPAC is aware that Kentucky has experienced some financial struggles in recent years, and despite this, legislative action has been taken to increase the State's annual contribution to KADAP. In fact, in 2006 the House Budget Review Committee recommended a $750,000 increase to KADAP. Although this was not approved, the Council appreciates the $70,000 funding increase authorized through H.B.1 of the 2006 Legislature. However as is indicated above the $250,000 previously allocated was redirected by the Cabinet in 2007 and was not included in the 2008 KADAP budget.

In a letter dated July 10, 2008, the Honorable United States Senator Mitchell McConnell, states, "AIDS Drugs Assistance Programs (ADAP) are state-based programs…"[2] Kentucky's ADAP budget for 2008 is $4,372,876 and no state funds are included in that budget. If as Senator McConnell states, ADAP's are state-based programs, where is Kentucky's financial commitment to this program and the Kentuckians who benefit from KADAP?

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[1] KADAP Fact Sheet, Cabinet for Health and Family Services, Department of Public Health, HIV/AIDS Branch; July 31, 2008. Appendix A.
[2] McConnell, Mitch, US Senator, letter to Mr. Timothy McAdoo, July 10, 2008. Appendix B.

For each additional $100,000 the State contributes to KADAP, approximately ten more Kentuckians will have access to life-saving medications that will enhance their health and quality of life. Increased State funding would likely reduce other costs to the State through decreased hospitalizations, decreased urgent care and decreased emergency care needs. KADAP clients, who remain healthy, are more able to work, pay taxes, and participate in the daily economy of our State.

In addition, Kentucky has seen cuts to its federal funding of KADAP over the past two years; a $227, 900 decrease in 2007 and a $22,231 decrease in 2008.[3]

Why this is still important: Individuals, who are diagnosed with HIV, must have access to treatment medications in order to maintain their health and be positive productive members of our community as family members, employees and in every imaginable spectrum of life.

For anyone without health insurance that provides a solid prescription plan, HIV medications remain unaffordable with an average monthly regiment costing $1,200. KADAP currently provides 1,211 Kentuckians with affordable access to HIV medications. Without KADAP most of these individuals would be unable to obtain their medications.

What needs to be done: KHPAC recommends the:

1. Reinstatement of the already allocated $250,000 in State funds to KADAP.
2. Allocation of an additional $1.4 million in State funds. The total allocation of $1.65 million in State funding would meet an identified unmet need for securing that Kentuckians already infected with HIV will continue to have access to necessary lifesaving medications.

[3] Ibib

B. Comprehensive Sexuality Education

Recommendation: Comprehensive sexuality education should be provided in all public middle and high schools in Kentucky. Comprehensive sexuality education would include science-based content and age appropriate and medically accurate information on the following topics: human development, relationships, decision-making, peer pressure, goal setting, conflict resolution, abstinence, contraception and disease prevention. This recommendation is consistent with Kentucky's current curriculum standards (704 KAR 3:303). KHPAC also recommends that a process be developed to ensure all middle and high school students receive this education and that passive consent be adopted by all school districts. If a parent wishes to opt a student out of any part of this instruction, the parent must provide written documentation of his/her wishes and provide a means of alternative education. This includes students in regular classrooms and special education classrooms.

Progress/Grade: (Poor) CURRENT GUIDELINES ARE NOT BEING ADMINISTERED WITHIN ALL KENTUCKY MIDDLE AND HIGH PUBLIC SCHOOLS. (new recommendation) - While current curriculum standards include comprehensive sexuality education, there is no evidence to show that all middle and high school students in Kentucky's public schools are receiving it. In fact, there is documentation to show that HIV prevention education is <u>not</u> being taught in all middle and high schools, even though law requires it. According to the 2008 School Health Education Profiles, only 89% of health education teachers in middle schools surveyed stated that they had tried to increase student knowledge on HIV prevention. Only 59% of middle and high schools are teaching all 11 topics related to HIV prevention recommended by the CDC. [4] HIV prevention education is needed because almost half (47.8%) of high schools students have had sexual intercourse (2007 National YRBS). According to the CDC, 15 to 24 year olds are 25% of the sexually active population but acquire nearly half of all new sexually transmitted infections.[5]

Background: Comprehensive sexuality education provides a complete message, and is effective in providing adolescents with information to make responsible decisions, as well as building knowledge, attitude, and skills.[6] Comprehensive sexuality education has shown positive impact on adolescent behaviors including increase use of contraception, decrease in onset of sexual activity, decrease in number of partners, decrease in frequency of sexual activity.[7] The majority of comprehensive programs had a positive effect.[8] Comprehensive programs work for both genders, for all major ethnic groups, for

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[4] 2008 School Health Education Profiles.
[5] (*http://www.cdc.gov/STD/STATS/adol.htm*)
[6] Healthy Teen Network
[7] Ibib
[8] Kirby, Emerging Answers (most cited source on research on sex ed)

sexually experienced and inexperienced teens, in different settings, and in different communities.[9]

Comprehensive sexuality education is effective at assisting young people to make healthy decisions about sex.[10] No abstinence-only-until-marriage program has been shown to help teens delay the initiation of sex or to protect themselves when they do initiate sex.[11] Young people who receive comprehensive sexuality education were significantly less likely to get pregnant compared to those who received no sexuality education.[12] In comparing abstinence-only programs with comprehensive sexuality education, comprehensive education was associated with a 50% lower risk of teen pregnancy.[13]

Sex education teachers believe that students should be taught about puberty, HIV and STI transmission, Peer pressure, implications of teen parenthood, abstinence, data, sexual abuse, and nonsexual ways to show affection.[14] More than 90% of teachers believe students should be taught about contraception but 25% are prohibited from doing so, and 20% of teachers believe that restrictions imposed on sexuality education are preventing them from meeting their students' needs.[15]

Supporters of comprehensive sexuality education include:

The American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American Medical Association
American Public Health Association
Institute of Medicine
Society for Adolescent Medicine
National Education Association
National Medical Association
National School Boards Association

Current curriculum standards

The Kentucky Department of Education includes HIV, STI, and teen pregnancy prevention in Program of Studies and Core Content. The Program of Studies for middle and high school states that students will

- Analyze personal decisions that impact an individual's emotional, sexual and reproductive health (e.g., abstinence)
- Explain basic structures and function of the reproductive system

[9] Ibib
[10] Advocates for Youth Effective Sex Education Fact Sheet
[11] Advocates for Youth Effective Sex Education Fact Sheet
[12] SIECUS – National Data
[13] Ibib
[14] Guttmacher, Facts in Brief, Sexuality Education
[15] Ibib

- Describe symptoms, causes, patterns of transmission, prevention and treatments of communicable diseases (colds, flu, mononucleosis, hepatitis, HIV/STD, tuberculosis)
- Explain how health is influenced by the interaction of body systems (e.g., reproductive, digestive, circulatory, skeletal, respiratory)

The Program of Studies outlines the minimum content standards required for all students. See 704 KAR 3:303, which incorporates the Program of Studies for Kentucky Schools Primary-12 (2006). For more information, see http://www.education.ky.gov/KDE/Instructional+Resources/Curriculum+Documents+and+Resources/Program+of+Studies/

Why this is still important: Kentucky teens are at-risk for HIV and other sexually transmitted infections. By age 17, 58.1% of Kentucky students will have had sexual intercourse. By age 18, this increases to 75.2 percent (2007 YRBS).

Ninety-four percent of adults and 93% of parents surveyed said that sexuality education should include contraception.[16] Ninety-three percent of Americans say that sexuality education should be taught in schools.[17] Parents (93%) whose children have taken sexuality education said that it was helpful.[18]

What needs to be done: All site-based decision making councils in Kentucky will be educated on the risk of HIV and other sexually transmitted infections to Kentucky youth. Also, all middle and high schools must develop a reporting process to ensure all students in Kentucky's public schools receive this education. Schools will report to the HIV Prevention Consultant at the Kentucky Department of Education. The HIV Prevention Consultant at the Kentucky Department of Education, in collaboration with the Division of Curriculum at the Kentucky Department of Education will provide technical assistance to schools on this process. The HIV Prevention Program is available to offer professional development and technical assistance to all Kentucky public schools.

Other References: Abstinence only vs Comprehensive Sexuality Education (Collins, Alagiri, and Summers 2002)

[16] Advocates for Youth Effective Sex Education Fact Sheet
[17] Sex Education in American (NPR)
[18] Ibib

C. HIV Testing of Inmates

Recommendation: Amend KRS 197.055 to further define procedures for conducting voluntary HIV testing of inmates to include upon entry, and before an inmate's release from any unit or center of the Department of Corrections. Counseling regarding treatment options should be included in the provision of this service if an inmate tests positive for the human immunodeficiency virus (HIV).

Grade: (C-) LIMITED MOVEMENT. (continuing recommendation) – KHPAC has made a similar recommendation for the past two years and legislative action has been introduced in the previous two legislative sessions. However no changes have been approved, and KHPAC learned this year that we overlooked existing Kentucky legislation, KRS 197.055, which already provides some guidance regarding HIV testing of inmates.

Background: HIV testing of inmates is an issue that was brought to the forefront of the 2007 Kentucky Legislative session in Senate Bill 201.[19] While KHPAC concurs with the need for inmate testing for HIV upon release, there are other critical issues that need to be considered when implementing an HIV testing protocol within correctional settings. KHPAC supports the development and implementation of a comprehensive HIV testing process for inmates that not only tests prior to release, but upon admission and as warranted by an inmates "known" engagement in risky behaviors. The later of these is already identified in KRS 197.055.
HIV rates are fourteen times higher in this [the correctional] population than the general U.S. population."[20] Consequently, HIV testing of inmates is a practical step for reducing the spread of HIV disease. KHPAC contends and research supports that HIV testing within correctional settings should be designed to educate individuals on effective ways to reduce the spread of HIV, and if an individual tests HIV positive, to help that person understand an HIV diagnosis, access treatment and medications, and reduce the risk of exposure to others.

Why this is still important: Four key factors speak to why this is a crucial topic for Kentucky today:

1. HIV infection rates in the United States are much higher in correctional settings than in the general public.
2. Individuals who know there status are more apt to takes steps to reduce the risk of exposure to others.
3. Early diagnosis, leads to treatment, which maintains health, which promotes an individuals ability to have a positive impact on our community

[19] 2007 Kentucky Senate Bill 201.
[20] Public Health & Corrections, "HIV Prevention Community Planning Groups and Correctional Institutions: A Collaboration for All." March, 2003.

4. Accurately documenting the rate of HIV infections in Kentucky could result in additional federal funding for addressing prevention and care needs within the state.

What needs to be done: Fortunately, the ground work for addressing this issue exists in KRS 197.055. KHPAC recommends that the following actions be taken to broaden the scope of 197.055 and thus, more comprehensively address this issue:

1. Amend KRS 197.055 as recommended in Appendix D.
2. Assure HIV testing of inmates is voluntary, meaning inmates have the option to “opt out” of testing, except when there is a risk of exposure to another individual.
3. Provide inmates diagnosed with HIV appropriate medical treatment and prompt access to treatment medications.
4. Collaboration between the Department of Corrections and the Cabinet for Health and Family Services is crucial to the success of inmate testing and care, and prevention of new infections within the prison population.

D. Drug Use and HIV Infection

Recommendation: KHPAC is adding poly-substance abuse to its list of recommendations for legislative action due to poly-substance abuse's wide-ranging impact on the transmission of HIV; from its impact on new infections, to the effectiveness of healthcare outcomes for those in treatment for HIV/AIDS and the ripple effect into other areas: from newly acquired STDs to related opportunistic infections and co-morbidity. As a result, KHPAC is recommending that HIV prevention education be added to the curriculum of drug rehabilitation organizations and that opt-out routine HIV testing be provided in all such facilities; fund printed materials to communicate information on HIV/AIDS; and fund surveillance of HIV infection and AIDS to provide population-based data for research, evaluation, and prevention of HIV.

Progress Grade: NEUTRAL PROGRESS (new recommendation)

Background: Drug abuse and addiction have been inextricably linked with HIV/AIDS since the beginning of the epidemic. While intravenous drug use is well known in this regard, less recognized is the role that drug abuse plays more generally in the spread of HIV— the virus that causes AIDS—by increasing the likelihood of high-risk sex with infected partners. This is because of the addictive and intoxicating effects of many drugs, which can alter judgment and inhibition and lead people to engage in impulsive and unsafe behaviors. Drug abuse and addiction can also worsen the progression of HIV and its consequences, especially in the brain.

Why this is important: Three key findings influence our approach, linking the interactions of drug abuse and HIV/AIDS in ways that extend far beyond injection drug use.

1. Drug abuse impairs judgment and good decision making, leaving people more prone to engage in HIV risk behaviors, including risky sexual behavior and non-adherence to HIV treatment.
2. Drug abuse adversely affects health and may exacerbate disease progression.
3. Finally and most important, because of these linkages, we must recognize that drug abuse treatment is HIV prevention.

What needs to be done? CDC employs a comprehensive approach to preventing further spread of HIV and AIDS. Strategies include monitoring the epidemic to target prevention and care activities, researching the effectiveness of prevention methods, funding local prevention efforts for high-risk communities, and fostering linkages with care and treatment programs.[21]

[21] http:www.cdc.gov/hiv

We recommend taking the following actions due to the impact that it can have in preventing the multifaceted problem of substance abuse, HIV infection, HIV care and the financial impact on the citizens and fiscal budgets of the Commonwealth:

1. Include HIV prevention education into the curriculum of drug rehabilitation organizations and provide opt-out routine HIV testing in all such facilities.
2. Fund printed materials to communicate scientific, statistical, programmatic, and technical information on HIV/AIDS to health care professionals, public health officials, prevention partners, federal government officials, and the general public.
3. Fund surveillance of HIV infection and AIDS in collaboration with state and local health departments to provide population-based data for research, evaluation, and prevention at the state and local levels (See Section II, Future Concerns on page 15).

Other References: http:www.cdc.gov/hiv

E. Developing Partnerships and Outreach

Recommendation: KHPAC recommends the creation of an Office of Minority Health within the Cabinet for Health and Family Services, Department of Public Health. KHPAC further recommends that the goal of this office be to reduce through the development of Partnerships and Outreach significant health disparities that exist for minority populations.

Grade: NEUTRAL PROGRESS (new recommendation)– KHPAC has not previously forwarded this recommendation, but given trends related to HIV disease and other chronic health conditions, KHPAC is offering this recommendation in an effort to address health disparities that exist for minority populations throughout Kentucky.

Background: Historically, health disparities for minority populations are clearly documented, and they have been the basis for many innovative and creative approaches to healthcare delivery systems. However these disparities still exist, and the rise in HIV disease within Kentucky's minority populations is evidence to this. The most recent census estimates indicate that about 8.8% of Kentucky residents are either African-American or Hispanic[22] however African-American and Hispanic persons represent 34% of cumulative AIDS cases in Kentucky as of December 31, 2007.[23] This represents a five times higher rate of infection with HIV than proportion of the state's population. Kentucky cannot ignore this disparity, and efforts must be made to reduce the impact of HIV on minority populations.

Why this is still important: Several key factors make this an important issue today:

1. Many minorities have less access to routine medical care and services,
2. Many minorities have an understandable fear and/or caution for existing health care systems in Kentucky.
3. Minorities are disproportionately infected with HIV disease and significant prevention and care services need to be implemented within these communities to reduce this crisis.

What needs to be done: KHPAC recommends the following actions:

1. Create an Office of Minority Health within the Cabinet for Health and Family Services
2. Empower the Office of Minority Health to engage minority communities and health care providers to develop and implement creative and innovative health care access systems for under-served minority populations.

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[22] http://quickfacts.census.gov/qfd/states/21/2128900.html, US Census Bureau.
[23] Kentucky Cabinet for Health and Family Services, Department of Public Health, HIV/AIDS Branch, "HIV/AIDS Semi-Annual Report December 2007, volume 7, number 2.

3. Direct the Office of Minority Health to develop and implement a state-wide media campaign aimed at minority populations that increases awareness of HIV prevention and care services, and results in increased services to minority populations.
4. Direct the Office of Minority Health to investigate other minority health disparities within Kentucky, and
5. Mandate that the Office of Minority Health to develop and implement creative and innovative health care initiatives for these issues.

Section II
FUTURE CONCERNS

A. State Funding for HIV Surveillance

On July 10, 2008, the Centers for Disease Control**,** National Center for HIV, Viral Hepatitis, STDs and TB Prevention awarded the Kentucky Department for Public Health (DPH) $141,393 for HIV/AIDS surveillance activities,[24] in addition to the $130,000 in federal funding Kentucky has received each year for the past decade for the same purpose. This increase was deemed essential in order for DPH to adequately conduct comprehensive HIV surveillance activities throughout the state.

Effective HIV surveillance efforts are crucial to addressing prevention, and care and services issues related to HIV disease. Recent Centers for Disease Control and Prevention studies indicate a significantly higher incidence of new HIV infections in the United States than previously indicated. [25] Consequently, the need for effective HIV surveillance efforts has not declined but, "significantly increased."

Given that there is no state funding for HIV/AIDS surveillance activities, federal funding has been and is crucial for these activities. However, federal funding cannot be expected annually in light of significant cuts in federal HIV/AIDS spending. Therefore, it is imperative that a significant allocation of state funds be authorized in the future to support DPH's efforts to characterize the epidemic in Kentucky, gather resources for the fight against HIV/AIDS, and maximize limited resources by directing assets to areas where they are likely to have the greatest impact. KHPAC continues to strongly support DPH's past and anticipated future requests for funding for statewide core HIV surveillance activities.

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[24] Department of Health and Human Services, Center for Disease Control and Prevention, Notice of Award, July 10, 2008.

[25] Estimation of HIV Incidence in the United States, Hall HI, Song R, Rhodes P, Prejean J, An Q, Lee LM< Karon J, Brookmeyer R, Kaplan EH, MeKenna MT, Janssen RS for the HIV Incidence Surveillance Group. Journal of the American Medical Association, August 6, 2008.

APPENDICES

APPENDIX A

KENTUCKY AIDS DRUG ASSISTANCE PROGRAM (KADAP)

Number of KADAP Clients Enrolled as of 07-31-08: 1211

Estimated start date for re-implementation of KADAP Waiting List: 04-01-09

Average number of new Kentuckians being added to KADAP monthly: 50
(Increase from 33 clients in 2007)

KADAP Total Federal Award by Year	KADAP State Award by Year
2008 - $4,372,876	2008 - $0
2007 - $4,637,372	2007 - $250,000 (Rescinded)
2006 - $4,857,637	2006 - $250,000
2005 - $5,178,691	2005 - $180,000
2004 - $4,640,297	2004 - $90,000

Explanation of Purchasing of Medications

KADAP contracts with the University of Kentucky, as the sole provider of medications through KADAP. This contract is awarded on an annual basis. Currently, KADAP pays 340 B pricing plus a dispensing fee. KADAP also covers the cost of shipping medications to clients – the program expends <1% of its total expenditures annually on shipping costs.

Other Cost Saving Mechanisms

The AIDS Drug Assistance Program (ADAP) Crisis Task Force, a national group, has worked with pharmaceutical companies to offer price relief to state ADAPs nationwide. As a result of negotiations with the Task Force, the following companies are offering special pricing/discounts/rebates to all ADAPs: Abbott, Agouron/Pfizer, Boehringer Ingelheim, Bristol-Myers Squibb, Gilead Sciences, GlaxoSmithKline, Merck, and Roche. The contents of each company's negotiation are strictly confidential but a substantial savings is anticipated and will help to serve additional clients. ****KADAP estimates that approximately $2.5M will be received in rebates for 2008.**

Eligibility Criteria

KADAP requires that all clients meet the following:

- Be a resident of Kentucky
- Have income at or below 300%FPL
- Have cash assets less than $10,000
- Be HIV+
- Have no other full third party payers (i.e., Medicaid, Veteran's Health Administration)
- All clients must maintain enrollment in the Kentucky HIV/AIDS Care Coordinator Program (KHCCP)

Persons who meet the above criteria qualify for KADAP, regardless of their disability and/or employment status. Those who qualify will have their names added to the waiting list in a first-come, first-served manner, once the Waiting List is re-established.

History of Federal KADAP Funding 2004 to 2008

Year	ADAP Earmark*	Supplemental	Carryover Funds	RW Title II Funds	Total	Base Award Increase
2008	$ 4,307,876	$ -	$ -	$ 65,000	$4,372,876	$ (22,231)
2007	$ 4,330,107	$	$ 307,235	$ -	$4,637,342	$ (227,900)
2006	$ 4,558,007	$ 227,356	$ -	$ 72,274	$ 4,857,637	$ 116,535
2005	$ 4,441,472	$ 465,945	$ 199,000	$ 72,274	$ 5,178,691	$ 354,731
2004	$ 4,086,741	$ 481,282	$ -	$ 72,274	$ 4,640,297	$ 155,971

APPENDIX B

MITCH McCONNELL
KENTUCKY

361-A RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510-1702
(202) 224-2541

United States Senate

REPUBLICAN LEADER

COMMITTEES:
AGRICULTURE
APPROPRIATIONS
RULES AND ADMINISTRATION

July 10, 2008

Mr. Timothy McAdoo
1012 Richwood Way
La Grange, Kentucky 40031-8930

Dear Mr. McAdoo:

Thank you for contacting me regarding improvements for the Medicare prescription drug benefit for people with HIV/AIDS. I appreciate your taking the time to share your thoughts with me, and I welcome the opportunity to respond.

Since the program began, more than 37 million Americans, or roughly seven out of eight eligible seniors, have enrolled in prescription drug coverage. The Department of Health and Human Services recently reported that the average senior enrolled in a plan will save $1,200 in drug expenses this year. Despite the dire predictions of the program's critics, the drug plans have cost 30 percent less than anticipated, and residents in every state can choose a plan that costs less than $20 per month. Most importantly, a recent independent survey of seniors found that 8 out of 10 Medicare beneficiaries were satisfied with the new benefit.

As you know, some of the new Medicare drug plans limit coverage once a certain dollar threshold has been reached. This is sometimes referred to as a "coverage gap" or "doughnut hole." Plans are not required to include a coverage gap and there are plans available to Kentuckians that do not.

AIDS Drugs Assistance Programs (ADAP) are state-based programs funded in part by Title II of the Ryan White CARE Act created in 1990 by the US Congress. ADAP provides medications to treat HIV disease or prevent related serious deterioration of health. Drugs provided and eligibility criteria are determined state by state with a focus on serving low-income individuals.

In your correspondence, you suggest that the Medicare Part D program should be improved so that ADAP expenditures could count towards True Out of Pocket (TrOOP) costs. Senator Jeff Bingaman introduced legislation, S. 1103, which would allow ADAP expenditures to count towards TrOOP. I appreciate your suggestions and assure you that I am closely following the implementation of this new benefit. As the Senate considers measures to improve access to these programs I will be certain to keep your views foremost in mind.

It may also interest you to know that the Senate Appropriations Committee, on which I serve, recently approved funding for the ADAP when it approved the Labor, Health and Human Services, and Education Appropriations bill for Fiscal Year 2009. This bill will provide nearly

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(270) 781-1673

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(859) 578-0188

771 CORPORATE DRIVE
SUITE 108
LEXINGTON, KY 40503
(859) 224-8286

300 SOUTH MAIN
SUITE 310
LONDON, KY 40741
(606) 864-2026

601 WEST BROADWAY
SUITE 630
LOUISVILLE, KY 40202
(502) 582-6304

PROFESSIONAL ARTS BUILDING
2320 BROADWAY
SUITE 100
PADUCAH, KY 42001
(270) 442-4554

$2.2 billion in funding for Ryan White AIDS Programs. Of this total, $800 million will fund ADAP, which is a $6 million increase from the previous year.

Again, thank you for sharing your thoughts with me. I hope you will continue to keep me informed of issues that are important to you.

Sincerely,

MITCH McCONNELL
UNITED STATES SENATOR

MM/la

APPENDIX C

SIECUS Releases Special Report on Abstinence-Only-Until-Marriage Programs in Kentucky

On July 29, the Sexuality Information and Education Council of the United States (SIECUS) released a special report on abstinence-only-until-marriage programs in Kentucky. The report provides an in-depth look at the funding for abstinence-only-until-marriage programs in Kentucky, the status of adolescent sexual health in the state, and Kentucky's current law and policy. In addition, the report found that a significant portion of state and federal funds are being directed towards crisis pregnancy centers (CPCs), and that some of the worst abstinence-only-until-marriage curricula are being used throughout Kentucky.

As abstinence-only-until-marriage funds have poured into Kentucky, youth in the state have faced increasingly poor health outcomes. The teen birth rate is nearly 20 percent higher than the national average (49.2 per 1,000 young women ages 15–19 compared to 41.1 in the same age group nationally).[i] In a single year the Centers for Disease Control and Prevention (CDC) reports Kentucky's rate rose nearly 7 percent. The nationwide teen birth rate increased by less than half that in the same year.[ii] HIV statistics in the state are also disturbing. The overall prevalence is low, but the disease disproportionately impacts some communities: African Americans make up only seven percent of the total population of Kentucky but nearly 34 percent of new HIV cases in the state, according to the CDC.[iii] Since 1997, the state of Kentucky, through the Cabinet for Health and Family Services and numerous community-based organizations, has received over $16.9 million in abstinence-only-until-marriage funding through the three funding streams. In Fiscal Year 2007 alone, over $3 million went into these programs in Kentucky.

In Kentucky, the state distributes abstinence-only-until-marriage funding to 16 local health departments – 11 of which use fear and shame based curricula. The state also provides Title V abstinence-only-until-marriage sub-grants to more CPCs than any other state. CPCs are anti-choice establishments that function to dissuade women with an unintended pregnancy from choosing abortion. These centers often pose as family planning/reproductive health clinics and claim to offer "abortion information and referrals."

In looking at the curricula used by these health departments, CPCs, and other community-based organizations, five central, and disturbing, themes emerged:

- advancing religious messages;
- relying on messages of fear and shame;
- fostering gender myths and stereotypes;
- promoting the questionable practice of virginity pledges; and
- providing misinformation.

One example of this is Marsha's Place (Pregnancy Resource Center of Henderson County), a Title V abstinence-only-until-marriage sub-grantee and CPC, which makes a clear effort to scare and shame students on its website. In the "Your Life" section, Marsha's Place lists reasons "why I will wait for sex," including: "to stop the need for lying," "to avoid bad memories," and "to avoid guilt and disappointment." The same section of the website offers different ways of "Saying 'NO'" including, "I don't give free samples—try Baskin Robbins," and "You see these dotted lines? If you touch anything between them, you do it at your own risk. My dad has a very large gun.[iv]

"The young people of Kentucky deserve evidence-based and comprehensive sex education," said William Smith, vice president for public policy at SIECUS. He continued, "The statistics around teen pregnancy and HIV make the case clear: we simply cannot wait any longer to provide the information and education Kentucky youth need to make fully informed decisions about their health."

APPENDIX D

197.055 Education program on AIDS -- Policies for inmates -- Testing program.

(1) The Department of Corrections, in conjunction with the Cabinet for Health and Family Services, shall establish introduce and maintain a mandatory introductory and continuing education program on human immunodeficiency virus and acquired immunodeficiency syndrome for all inmates. Programs shall be specifically designed for inmates while incarcerated and in preparation for release into the community. Consideration shall be given to cultural and other relevant differences among inmates in the development of educational materials and shall include emphasis on behavior and attitude change. The education program shall be continuously updated to reflect the latest medical information available.

(2) ~~If there is evidence that an inmate, while in the custody of the department, has engaged in behavior which places the inmate at a high risk of transmitting or contracting a human immunodeficiency disorder,~~ The department shall begin a testing program which is consistent with guidelines of the Centers for Disease Control and Prevention and recommendations of the correctional medical authority and shall target persons at entry into the state correctional system, who have been involved in or reasonably thought to have been involved in a high-risk behavior and upon release from the state correctional facility. For purposes of this subsection, "high-risk behavior" includes:

(a) Sexual contact with any person within the institution;

(b) The use of intravenous drugs;

(c) Tattooing; and

(d) Any other activity medically known to transmit the virus.

(3) Except as authorized in section (7) below inmates will be informed of their right to "opt out" or not get tested. Except as outlined in section (7) below, HIV testing will not be mandatory.

(4) The results of the tests shall become a part of that inmate's medical file, accessible only to persons designated by agency administrative regulations.

(5) The department shall establish policies consistent with guidelines of the Centers for Disease Control and recommendations of the correctional medical authority on the housing, physical contact, dining, recreation, and exercise hours or locations for inmates with immunodeficiency disorders as are medically indicated and consistent with the proper operation of its facilities.

(6) The department shall report to the General Assembly by July 1 each year as to the implementation of this program and the participation by inmates and staff.

(7) If an inmate is involved in a situation with ~~a department employee~~ another person which could result, according to the institution's physician, in the transmission of the human immunodeficiency virus infection, the inmate shall be tested.

(8) All testing procedures, disclosure, and payment shall be pursuant to KRS 438.250.

Effective: June 20, 2005

History: Amended 2005 Ky. Acts ch. 99, sec. 171, effective June 20, 2005. -- Amended 1998 Ky. Acts ch. 426, sec. 131, effective July 15, 1998. -- Amended 1994 Ky. Acts ch. 309, sec. 3, effective July 15, 1994. – Amended 1992 Ky. Acts ch. 211, sec. 47, effective July 14, 1992. -- Created 1990 Ky. Acts ch. 443, sec. 36, effective July 13, 1990.

Legislative Research Commission Note (11/19/91). No subsection (3) was contained in this statute as enacted in 1990 Acts ch. 443, sec. 36. Pursuant to KRS 7.136(1), the Reviser of Statutes has renumbered the subsections of this statute to correct this problem.

APPENDIX E

Census Quick Facts

People QuickFacts		Kentucky
Population, 2006 estimate		4,206,074
Population, percent change, April 1, 2000 to July 1, 2006		4.1%
Population, 2000		4,041,769
Persons under 5 years old, percent, 2000		6.6%
Persons under 18 years old, percent, 2000		24.6%
Persons 65 years old and over, percent, 2000		12.5%
Female persons, percent, 2000		51.1%
White persons, percent, 2000 (a)		90.1%
Black persons, percent, 2000 (a)		**7.3%**
American Indian and Alaska Native persons, percent, 2000 (a)		0.2%
Asian persons, percent, 2000 (a)		0.7%
Native Hawaiian and Other Pacific Islander, percent, 2000 (a)		Z
Persons reporting two or more races, percent, 2000		1.1%
Persons of Hispanic or Latino origin, percent, 2000 (b)		**1.5%**
Living in same house in 1995 and 2000, pct 5 yrs old & over		55.9%
Foreign born persons, percent, 2000		2.0%
Language other than English spoken at home, pct age 5+, 2000		3.9%
High school graduates, percent of persons age 25+, 2000		74.1%
Bachelor's degree or higher, pct of persons age 25+, 2000		17.1%
Mean travel time to work (minutes), workers age 16+, 2000		23.5
Housing units, 2000		1,750,927
Homeownership rate, 2000		70.8%
Median value of owner-occupied housing units, 2000		$86,700
Households, 2000		1,590,647
Persons per household, 2000		2.47
Median household income, 1999		$33,672
Per capita money income, 1999		$18,093
Persons below poverty, percent, 1999		15.8%
Wholesale trade sales, 2002 ($1000)		51,838,719
Retail sales, 2002 ($1000)		40,062,561
Retail sales per capita, 2002		$9,799
Accommodation and foodservices sales, 2002 ($1000)		4,908,331
Total number of firms, 2002		300,685
Black-owned firms, percent, 2002		2.5%
American Indian and Alaska Native owned firms, percent, 2002		0.4%
Asian-owned firms, percent, 2002		1.1%
Hispanic-owned firms, percent, 2002		0.7%
Native Hawaiian and Other Pacific Islander owned firms, percent, 2002		Z
Women-owned firms, percent, 2002		25.7%

Source: http://quickfacts.census.gov/qfd/states/21/2128900.html

APPENDIX F

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%).

APPENDIX G

Notice of Award

COOPERATIVE AGREEMENTS
Department of Health and Human Services
Centers for Disease Control
NATIONAL CENTER FOR HIV, VIRAL HEPATITIS, STDS AND TB PREVENTION

Issue Date: 07/10/2008

Grant Number: 1U62PS000998-01 REVISED

Principal Investigator(s):
KRAIG E HUMBAUGH, MD

Project Title: KENTUCKY HIV/AIDS SURVEILLANCE ACTIVITIES

KY CABINET FOR HLTH AND FAMILY
275 E. MAIN STREET HS2GWC
FRANKFORT, KY 40621

Budget Period: 01/01/2008 – 12/31/2008
Project Period: 01/01/2008 – 12/31/2012

Dear Business Official:

The Centers for Disease Control hereby revises this award to reflect an increase in the amount of $141,393 (see "Award Calculation" in Section I and "Terms and Conditions" in Section III) to KENTUCKY ST CABINET FOR HEALTH & FAMILY SERVICES in support of the above referenced project. This award is pursuant to the authority of 307,317K2 PHSA,42USC241,247BK2,PL108 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the "Terms and Conditions" is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact the individual(s) referenced in Section IV.

Sincerely yours,

Merlin J. Williams

Merlin Williams
Grants Management Officer
Centers for Disease Control

Additional information follows

SECTION I – AWARD DATA – 1U62PS000998-01 REVISED

Award Calculation (U.S. Dollars)

Salaries and Wages	$44,000
Fringe Benefits	$13,130
Personnel Costs (Subtotal)	$57,130
Supplies	$20,210
Travel Costs	$7,991
Other Costs	$13,010
Consortium/Contractual Cost	$208,306
Federal Direct Costs	$306,647
Approved Budget	$306,647
Federal Share	$306,647
TOTAL FEDERAL AWARD AMOUNT	$306,647
AMOUNT OF THIS ACTION (FEDERAL SHARE)	$141,393

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project.

02	$165,254
03	$165,254
04	$165,254
05	$165,254

Fiscal Information:

CFDA Number:	93.941
EIN:	1610600439B5
Document Number:	UPS000998A

IC	CAN	2008	2009	2010	2011	2012
PS	9212466	$138,867	$165,254	$165,254	$165,254	$165,254
PS	9213700	$38,432				
PS	9214061	$38,432				
PS	921Z0GQ	$3,969				
PS	921ZEHP	$86,947				

SUMMARY TOTALS FOR ALL YEARS		
YR	THIS AWARD	CUMULATIVE TOTALS
1	$306,647	$306,647
2	$165,254	$165,254
3	$165,254	$165,254
4	$165,254	$165,254
5	$165,254	$165,254

Recommended future year total cost support, subject to the availability of funds and satisfactory progress of the project

CDC Administrative Data:
PCC: N / **OC**: 4151

SECTION II – PAYMENT/HOTLINE INFORMATION – 1U62PS000998-01 REVISED

For payment information see Payment Information section in Additional Terms and Conditions.

INSPECTOR GENERAL: The HHS Office Inspector General (OIG) maintains a toll-free number (1-800-HHS-TIPS [1-800-447-8477]) for receiving information concerning fraud, waste or abuse under grants and cooperative agreements. Information also may be submitted by e-mail to hhstips@oig.hhs.gov or by mail to Office of the Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington DC 20201. Such

APPENDIX H

Press Release

New Technology Reveals Higher Number of New HIV Infections in the United States than Previously Known

The Centers for Disease Control and Prevention (CDC) announced today that an estimated 56,300 HIV infections occurred in the United States in 2006. That estimate differs from the agency′s previous estimate of 40,000 because CDC is now using a more precise method for estimating annual HIV incidence, which is the number of individuals who become newly infected with HIV in a given year. The new estimate is published today in a special HIV/AIDS issue of the Journal of the American Medical Association, released at the XVII International AIDS Conference in Mexico City.

"These data, which are based on new laboratory technology developed by CDC, provide the clearest picture to date of the U.S. HIV epidemic, and unfortunately we are far from winning the battle against this preventable disease," said CDC Director Dr. Julie Gerberding. "We as a nation have to come together to focus our efforts on expanding the prevention programs we know are effective."

The new estimate is derived from the first national surveillance system of its kind that is based on direct measurement of new HIV infections and builds on a new laboratory test (the BED HIV-1 Capture Enzyme Immunoassay) that can distinguish recent from long-standing HIV infections. CDC′s prior annual HIV incidence estimate was based on indirect and less precise methods available at the time.

A separate CDC historical trend analysis published as part of today′s study suggests that the number of new infections was likely never as low as the previous estimate of 40,000 and has been roughly stable overall since the late 1990s.

"It′s important to note that the new estimate does not represent an actual increase in the number of new infections, but reflects our ability to more precisely measure HIV incidence and secure a better understanding of the epidemic," said Kevin Fenton, M.D., director of CDC′s National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. "This new picture reveals that the HIV epidemic is and has been worse than previously known and underscores the challenges in confronting this disease."

Burden Greatest Among Gay and Bisexual Men of All Races and African Americans

CDC′s new surveillance system also provides more precise estimates than previously possible of new infections in specific populations. Results confirm that the impact of HIV remains greatest among gay and bisexual men of all races and among African American men and women. In 2006, men who have sex with men (MSM) accounted for 53 percent of those with new infections (28,700), heterosexuals for 31 percent (16,800), and injection drug users (IDU) for 12 percent (6,600). Infection rates among blacks were 7 times as high as whites (83.7/100,000 people versus 11.5/100,000) and almost 3 times as high as Hispanics (29.3/100,000 people), a group that was also disproportionately affected.

"Too many Americans continue to be affected by this disease," stressed Fenton. "These new findings emphasize the importance of reaching all HIV-infected individuals and those at risk with effective prevention programs."

Separate Trend Analysis Sheds New Light on History of U.S. Epidemic

In addition to the 2006 HIV incidence estimates, CDC conducted a separate, historical analysis that provides new insight into HIV incidence trends over time overall and for specific populations. Results confirm dramatic declines in the number of new HIV infections from a peak of about 130,000 in the mid-1980s to a low of roughly 50,000 annual infections in the early 1990s. However, findings also indicate that new infections increased in the late 1990s, but have remained roughly stable since that time (with estimates ranging between 55,000 and 58,500 during the three most recent time periods analyzed).

"Prevention can and does work when we apply what we know," said Richard Wolitski, Ph.D., acting director of CDC′s Division of HIV/AIDS Prevention. "While the level of HIV incidence is alarming, stability in recent years suggests that prevention efforts are having an impact. In this decade, more people are living with HIV and living longer than ever before due to advances in treatment. Even though this could mean more opportunities for transmission, the number of new infections has not increased overall. "

The analysis revealed some other encouraging signs of progress as well as significant challenges among specific groups. Findings indicated reductions in new infections among both injecting drug users and heterosexuals over time. Yet, the findings also indicate that HIV incidence has been steadily increasing among gay and bisexual men since the early 1990s, confirming a trend suggested by other data showing increases in risk behavior, sexually transmitted diseases and HIV diagnoses in this population throughout the past decade. The analysis also found that new infections among blacks are at a higher level than any other racial or ethnic group, though they have been roughly stable, with some fluctuation, since the early 1990s.

"These data confirm the critical need to revitalize prevention efforts for gay and bisexual men of all races and to build upon the growing momentum in the African American and Hispanic communities to confront HIV," said Wolitski. "We must all remember that we are dealing with one of the most insidious infectious diseases in history. Reducing this threat will require action from everyone individuals at risk, community leaders, government agencies and the private sector."

For more information on HIV prevention, visit www.cdc.gov/hiv
or http://www.aids.gov/.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION
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Kathleen O'Malley	At-Large

Members Ex-Offcio

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Elizabeth Johnson	Commissioner, Kentucky Department for Medicaid Services

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Sandy Kelly	DPH Reportable Disease section, Infectious Diseases Section
Paul Trickel	Northern KY Independent District Health Department
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Terry Carl	Kenton County Fiscal Court

Members from Community Based Organizations

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Aunsha Hall	AIDS Volunteers
Beth Harrison Prado	Volunteers of America
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