



New Mexico Comprehensive HIV Prevention Plan 2009 - 2011

**New Mexico HIV Prevention Community
Planning and Action Group (CPAG)**

and

**New Mexico Department of Health (NMDOH)
HIV Prevention Program**

June 2009

ACKNOWLEDGEMENTS

THANKS TO THE NEW MEXICO HIV PREVENTION COMMUNITY PLANNING AND ACTION GROUP (CPAG) AND OTHER VOLUNTEERS FROM ACROSS NEW MEXICO!

New Mexico has developed a series of comprehensive statewide HIV prevention plans that incorporate data and evidence to set priorities for the jurisdiction. These plans have each provided a thorough and complete picture of HIV prevention needs. This has only been possible due to the involvement in the planning process of a large and diverse group of committed individuals and partner organizations.

The New Mexico HIV Prevention Community Planning and Action Group (CPAG) has recruited this broad involvement and led planning efforts for the state. CPAG consistently has had 20 - 25 decision-making members, while 40 – 50 persons typically attend each statewide meeting. (See list and profile of CPAG decision-making members in Appendix 2.) This has been possible due to the inclusive and open leadership of CPAG. During the initial part of this planning cycle, through December 2008, CPAG was led by three statewide co-chairs: Justin Britton, Jerry Cheney and Martin Walker. Since the beginning of 2009, the group has been led by: Stella Martin, Community Co-Chair; Art Salazar, NMDOH Co-Chair; and Martin Walker, PLWH/A Co-Chair.

This plan would not be possible without the advocacy and input of the full CPAG, including decision-making members and ex-officio participants. A diverse group representing all regions of New Mexico also volunteered to serve as the “reading team” to edit the full draft of this plan: Kahlo Benavidez, Justin Britton, Melissa Charlie, Dave Daniels, Caroline Enos, Camille Johnson, Janet Lindsey, Stella Martin, Art Salazar, Martin Walker, Teresa Williams and Jeremy Yazzie.

During the planning cycle, CPAG built upon years of experience and expertise in HIV prevention planning. To develop this document, CPAG convened task forces and Regional Advisory Groups, held annual 3-day planning retreats, reviewed epidemiological data, gave input on statewide resources and gaps, and reviewed a number of planning models. While the CPAG made a number of difficult decisions in developing, adopting, and implementing prioritization models, it is a credit to the full membership that a consensus process was used effectively to make each decision.

THANKS TO STAFF AND CONSULTANTS

This plan was compiled, drafted and edited by Andrew A. Gans, MPH, HIV Prevention Program Manager with the New Mexico Department of Health (NMDOH). This was done by compiling information and expert input provided by a variety of NMDOH staff, CPAG members and other experts. Andrew also served as CPAG’s “planner” during this cycle, by providing expert support in developing the CPAG annual work plan, the “plan to plan” for creating this document, and other strategic planning support.

Staff of NMDOH’s HIV & Hepatitis Epidemiology Program developed the epidemiologic profile of HIV/AIDS in New Mexico. Under the leadership of Program Manager Lily Foster, the

team provided numerous epidemiologic presentations and trainings, distributed reports and data and provided consultative support to CPAG over the entire planning process. Thanks to Monica Brackney, Heidi Purcell and Kate Rooney for their extensive assistance.

Brent Herrera, Public Information Coordinator of the HIV Prevention Program, compiled the health and social indicators in Chapter 1 and developed content for the resource guide that serves as a companion document to this plan. He is also coordinating the planning process to create a targeted HIV prevention plan for a community heavily impacted by HIV in New Mexico, namely Hispanic Gay/Bisexual Men and Men Who Have Sex with Men (MSM).

Kathy Trujillo, Administrative Assistant with the HIV Prevention Program, provided staff support for CPAG during the entire process. Kathy maintained and distributed all CPAG records during this period, ensuring that key documents were available to participants as the planning process unfolded.

Patrick Foster of Hired Gun Design in Santa Fe provided graphic design and website development services for CPAG, under contract with the NMDOH HIV Prevention Program. Patrick developed the new CPAG style and logo, which is featured on the web site he created: www.nmcpag.org.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	1
TABLE OF CONTENTS	3
EXECUTIVE SUMMARY	5
What is a Comprehensive HIV Prevention Plan?	5
Overview of the HIV Prevention Plan	5
Chapters of the Plan	6
Chapter 1. Epidemiologic Profile of HIV/AIDS in New Mexico	6
Chapter 2. Overview of the New Mexico HIV Prevention Community Planning and Action Group (CPAG)	6
Chapter 3. Prioritized Target Populations	7
Chapter 4. Prioritized HIV Prevention Interventions	7
Chapter 5. Community Services Assessment	7
CHAPTER 1. EPIDEMIOLOGIC PROFILE OF HIV/AIDS IN NEW MEXICO	9
A. Profile of New Mexico and Its People	9
B. Profile of the HIV/AIDS Epidemic in New Mexico	9
Table 1. Epidemiologic Profile of HIV/AIDS Cases in New Mexico Through 2007	10
Mode of Exposure	11
Age at HIV/AIDS Diagnosis	11
Racial/Ethnic Groups	12
Trends in the HIV/AIDS Epidemic	12
C. Impact of HIV/AIDS in Each Region	14
Figure 1. Map of New Mexico Public Health Regions	14
Figure 2. Map of CPAG Regional Advisory Groups	15
D. Indicators of Health and Social Issues	16
CHAPTER 2. OVERVIEW OF THE NEW MEXICO HIV PREVENTION COMMUNITY PLANNING AND ACTION GROUP (CPAG)	22
A. Background and Structure of CPAG	22
B. CPAG Membership Guidelines	23
C. Profile of Current Membership and Strategies for Recruitment	24
D. HIV Prevention Planning Process	25
CHAPTER 3. PRIORITIZED TARGET POPULATIONS	27
A. Model for Prioritizing Target Populations	27
Target Population Groups	27
Inclusion of Transgender Persons	27
Prioritization Model and Factors	28
B. Prioritization of Major Target Populations	29
Table 2. CPAG Prioritization of Major Target Populations	30
C. Key Focus Areas and Trends in HIV/AIDS among Target Populations	31

Focus Areas and Trends for Persons Living with HIV/AIDS (PLWH/A)	33
Focus Areas and Trends for Men who Have Sex with Men (MSM)	36
Focus Areas and Trends for Injection Drug Users (IDU)	39
Focus Areas and Trends for Heterosexuals at Risk (HAR)	41
CHAPTER 4. PRIORITIZED HIV PREVENTION INTERVENTIONS	43
A. Background on Prioritization of Evidence-Based Interventions	43
B. Model for Prioritizing Interventions	43
C. Prioritized Interventions for Each Target Population	44
Table 3. Prioritized Interventions for Each Target Population	45
D. Additional Statewide Activities Prioritized by the CPAG	49
CHAPTER 5. COMMUNITY SERVICES ASSESSMENT	50
A. Overview of the Community Services Assessment	50
B. Resource Inventory of Statewide Programs and Resources	51
Figure 3. Overview of HIV Prevention Funding, Organizations and Activities	52
Harm Reduction	53
Statewide Resources for HIV Care	54
HIV Testing, Partner Services and Linkage to Care	55
C. Gaps Analysis – Top Gaps for Each Region and Statewide	56
D. Gaps Analysis by Region	57
Gaps Analysis for Region 1 – Northwest New Mexico	57
Gaps Analysis for Region 2 – Northeast New Mexico	58
Gaps Analysis for Region 3 – Bernalillo County, including Albuquerque	61
Gaps Analysis for Region 4 – Southeast New Mexico	64
Gaps Analysis for Region 5 – Southwest New Mexico	66
Gaps Analysis for Region 7 – American Indians/Alaskan Natives	68
APPENDICES	70
Appendix 1: Glossary of HIV Prevention Terminology	70
Appendix 2: CPAG Membership	74
Appendix 3: Plan to Plan	76
Appendix 4: CPAG Work Plan and Activities for 2007 – 2009 Planning Year	79
Appendix 5: Epidemiological Profile of HIV/AIDS by Region	84

EXECUTIVE SUMMARY

What is a Comprehensive HIV Prevention Plan?

The Federal Centers for Disease Control and Prevention (CDC) mandates that each State implement a community-based planning process that reviews local needs and sets priorities for HIV prevention activities across the jurisdiction. In New Mexico, this process has been implemented by the New Mexico HIV Prevention Community Planning and Action Group (CPAG), in collaboration with the New Mexico Department of Health (NMDOH) HIV Prevention Program. Planning efforts have determined the most effective means to prevent new HIV infection, including both the HIV prevention interventions to be implemented and the target populations to be served using Federal and State funds.

CPAG develops a new statewide comprehensive HIV prevention plan every 3 years. This plan is then updated with an annual supplement to reflect any new information about the epidemic or effective prevention strategies.

The *New Mexico Comprehensive HIV Prevention Plan 2005 – 2007* was completed and submitted to CDC in August 2005. Annual supplements to that document were completed in August 2006 and August 2007. Each of these documents is available online at the CPAG website:

www.nmcpag.org

Overview of the HIV Prevention Plan

This *New Mexico Comprehensive HIV Prevention Plan 2009 – 2011* is the result of an intensive planning process conducted by the CPAG from October 2007 through April 2009. This effort was directed by a “Plan-to-Plan” adopted by CPAG in December 2007 and revised throughout the process. (See copy of “Plan to Plan” in Appendix 3.)

This new plan includes a number of enhancements over previous statewide HIV prevention plans.

- The description of related indicators of health and social status is greatly expanded, as many factors contribute to the risk of HIV infection. (*Chapter 1D.*)
- CPAG conducted an in-depth analysis of seven key focus areas and trends for each of the identified major populations at risk of HIV infection. These were: 1) Internet and phone-line hookups, 2) Incarcerated populations, 3) Late diagnosis, 4) Increasing rates among Hispanics/Latinos, 5) Youth/young adult and older populations, 6) Border issues including migrant and transient populations, and 7) Women and perinatal cases. (*Chapter 3C.*)
- The model for prioritizing HIV prevention interventions and strategies was revised and expanded to have four priority categories. This incorporates the experience developed in recent years while implementing evidence-based models promoted by CDC, including those that are part of Diffusion of Evidence-Based Interventions (DEBIs). (*Chapter 4A and 4B.*)

Two key elements of the statewide HIV prevention plan are now separate documents.

1. ***New Mexico HIV/STD/Hepatitis Resource Guide:*** A listing of the many providers of HIV prevention and related services was included in the statewide HIV prevention plan each year

through 2005. However, service providers and their staff frequently change, so this information quickly became outdated. Starting in 2006, this section of the plan's Community Services Assessment (CSA) was made into a stand-alone resource guide. As of 2009, this guide will be available in two formats: a) as a stand-alone paper directory of services to be used to make referrals, and b) as a searchable page on the Internet (www.nmhivguide.org) that is accessible to the public and can be updated regularly.

2. ***HIV Prevention Plan for Hispanic Gay/Bisexual Men and Men who Have Sex with Men (MSM)***: The New Mexico Department of Health received a supplemental funding award from CDC in 2008 to conduct additional planning for gay/bisexual men and MSM. Given the increasing number of cases among Hispanic gay/bisexual men and MSM, CPAG decided to focus a new planning initiative on that population. The results of this effort are in a companion document to this plan entitled the *Hispanic Gay/Bisexual/MSM HIV Prevention Plan*.

Chapters of the Plan

The results of HIV prevention planning during 2007 – 2009 are summarized in the chapters of this document. Together they form a blueprint for effective HIV prevention efforts for the at-risk populations across New Mexico.

Chapter 1. Epidemiologic Profile of HIV/AIDS in New Mexico

Chapter 2. Overview of the New Mexico HIV Prevention Community Planning and Action Group (CPAG)

Chapter 3. Prioritized Target Populations

Chapter 4. Prioritized HIV Prevention Interventions

Chapter 5. Community Services Assessment

[Chapter 1. Epidemiologic Profile of HIV/AIDS in New Mexico](#)

An epidemiologic profile of the HIV/AIDS epidemic is provided in Chapter 1, to illustrate the wide range of factors that were incorporated into HIV prevention planning. This chapter includes a demographic overview of New Mexico and a description of key health and social indicators that may be facilitators of or barriers to HIV prevention. Since the CPAG has defined six Regional Advisory Groups (RAG) that collect local data to contribute to statewide planning, the description of the HIV/AIDS epidemic is provided both on a statewide basis and for each of these regions.

[Chapter 2. Overview of the New Mexico HIV Prevention Community Planning and Action Group \(CPAG\)](#)

The CPAG operates as a single statewide body that plans for HIV prevention needs across New Mexico. It is supported by six Regional Advisory Groups that each focus on the needs of a specific geographic area or demographic group. Regional input has been incorporated into this statewide plan, to ensure that it reflects differing needs and resources across all of the rural and urban areas of the State.

The CPAG may have up to 30 decision-making members, according to the group's bylaws, including both regional representatives and statewide at-large members. These individuals each

represent an affected community, rather than an organization. Members are called “decision makers” rather than voting members, since the group operates by consensus.

As described in Chapter 2 and Appendix 2, the 25 decision-making members of the CPAG as of March 2009 reflect the diversity of the State of New Mexico and the HIV/AIDS epidemic within this jurisdiction. Among the 25 members, 13 are male (52%), 10 are female (40%), and 2 are transgender (8%). Six members (24%) are persons living with HIV/AIDS.

Men who have sex with men and transgender persons (MSM-T), who account for the largest proportion of HIV/AIDS cases in New Mexico, are well represented. Almost half of members (11 persons or 44%) self-identify as MSM, MSM/IDU, gay, bisexual, and/or transgender. Two CPAG members represent injection drug users (IDU), while two others represent MSM/IDU. Four members self-identify as high-risk heterosexuals (HAR).

The ethnic/racial profile of CPAG members mirrors the overall State and HIV epidemic. Among the 25 decision makers, 8 are White (32%), 5 are Hispanic/Latino (20%), 5 are American Indian/Alaskan Native (20%), and 3 are African American (12%). Four CPAG members self-identify as being of two or more races, with these individuals reporting that they are White (2 persons), African American (2), Hispanic/Latino (2), American Indian (2) and Asian (1).

Chapter 3. Prioritized Target Populations

One of the core tasks of the CPAG is to identify and prioritize the target populations that are at greatest risk of HIV infection. In New Mexico, a data-driven model for this process was created to conform to the CDC requirement that limited resources be targeted in a fashion that has the greatest potential to reduce new HIV infection. Such prioritization also fits the CPAG vision: *The New Mexico CPAG is committed to eliminating HIV infection.*

The CPAG identified and prioritized six major target populations in 2003 during development of a five-year HIV prevention plan. This was done using CDC definitions of at-risk groups and a model that incorporated five weighted factors. This model and its supporting data were reviewed and updated several times in recent years, including during the 2007 – 2009 planning process, but the resulting rankings did not change.

Chapter 3 describes both the prioritization model and the target populations to be served across New Mexico.

Chapter 4. Prioritized HIV Prevention Interventions

One of the major tasks of the CPAG is to select and prioritize HIV prevention interventions that are determined to be the most effective and appropriate for the diverse populations at risk of HIV infection. During the planning process, the CPAG developed an enhanced prioritization model that incorporated CDC and NMDOH guidance regarding evidence-based interventions as well as shared CPAG values. This model and the resulting prioritization are described in Chapter 4.

Chapter 5. Community Services Assessment

The NMDOH HIV Prevention Program administers the majority of government resources allocated to provide HIV prevention and testing services in the State of New Mexico. The two major sources of funds are the CDC and the State of New Mexico general fund.

Funding is allocated for contracts with 12 community-based providers of HIV prevention education who serve all regions of the State. The HIV Prevention Program also supports a Disease Prevention Team (DPT) in each of the five NMDOH Public Health Regions to ensure that essential and core HIV prevention, testing and partner services (PS) activities are available in every part of New Mexico. A brief overview of current resources and programs is given in Chapter 5.

The Community Services Assessment (CSA) of an HIV prevention plan is comprised of three elements: 1) Resource Inventory, 2) Needs Assessment and 3) Gaps Analysis.

As noted previously, the *New Mexico HIV/STD/Hepatitis Resource Guide* is now a stand-alone document, available in hard copy and via the Internet at www.nmhivguide.org. This allows the guide to be updated more regularly than if it were included in this comprehensive plan.

Gaps in HIV prevention services are defined as identified needs which are not being met in one or more regions of the state. In other words, priorities identified in the needs assessment which are not currently part of the resource inventory are considered the statewide or regional gaps. Both statewide and regional gaps are described in Chapter 5.

Copies of this Comprehensive HIV Prevention Plan and prior statewide plans are available online at the CPAG website:

www.nmcpag.org

Questions about the plan can be directed to the NMDOH HIV Prevention Program or the CPAG statewide co-chairs. Contact information can be found on the CPAG website.

CHAPTER 1. EPIDEMIOLOGIC PROFILE OF HIV/AIDS IN NEW MEXICO

The unique profile of New Mexico requires HIV prevention planning to incorporate demographic and geographic factors in developing prevention strategies for the State. While a number of interventions are very effective in urban areas of New Mexico, many strategies are more costly or difficult to deliver in rural areas where there can be confidentiality concerns and a lack of venues for recruitment. Evidence-based models developed for major cities need to be adapted to be effective with at-risk groups in New Mexico. A good understanding of statewide, regional and local HIV data, populations and needs is essential to designing and delivering effective and culturally appropriate HIV prevention programs.

A. Profile of New Mexico and Its People

New Mexico is the fifth largest state in the Union, with an area of 121,598 square miles. Also known as the “Land of Enchantment”, the State includes areas of the Rocky Mountains, Rio Grande river valley, and high plateau, with 85% of the State above 4,000 feet in elevation.

With many rural and sparsely populated areas, New Mexico ranks 36th among the states in terms of population. According to 2008 census estimates, the State has a population of 1,984,356 persons. This reflects a 9% increase over the population in 2000.

The State’s four largest cities are Albuquerque, Las Cruces, Rio Rancho and Santa Fe. Albuquerque, Rio Rancho and the State capital of Santa Fe are located just northwest of the center of New Mexico. Las Cruces is located along the southern border near Texas and Mexico.

New Mexico boasts a diverse population and is a “majority-minority” state with less than 45% of its population made up of Whites. The State’s population is 44.1% Hispanic, 9.2% American Indian, 2.2% African American, 1.4% Asian/Pacific Islander, and 3.1% biracial or multi-racial. *(Note: Some Hispanic individuals identify as “Latino” or by country of origin. The term Hispanic is used in this chapter, as it is the federal category used for epidemiologic data collection.)*

Roughly 9.4% of New Mexico residents are foreign born. More than one third (36%) of all New Mexicans speak a language other than English at home, compared to 19.5% across the United States. More than one-quarter of residents (28.4%) report Spanish as their first language and 10.5% of New Mexicans report speaking English less than “very well”.

B. Profile of the HIV/AIDS Epidemic in New Mexico

The HIV/AIDS epidemic in New Mexico has evolved since the disease’s first appearance in 1981. A total of 5,464 cumulative cases of HIV/AIDS diagnosed by the end of 2007 have been reported to the NMDOH HIV/AIDS Epidemiology Program. To allow for reporting delays, this total includes all case reports received by June 2008.

Of the total cumulative cases, 4,041 (74%) had an AIDS diagnosis while 1,423 (26%) had HIV but were not diagnosed with AIDS. Roughly 21% of all cases are from out-of-state, meaning that they were diagnosed with HIV or AIDS in another jurisdiction but currently reside and receive services in New Mexico. Table 1 illustrates the epidemiologic profile of HIV/AIDS in New Mexico through 2007.

Table 1. Epidemiologic Profile of HIV/AIDS Cases in New Mexico Through 2007

Type of Case	Incident, 2007 ^a			Living ^b			Cumulative ^b	
	N	%	Rate ^c	N	%	Rate	N	%
HIV	93	62%	4.6	1324	38%	65.8	1423	26%
AIDS	57	38%	2.8	2156	62%	107.2	4041	74%
Sex								
Male	13			3065	88%	309.9	4905	90%
Female	0	87%	13.1	415	12%	40.6	559	10%
Race/Ethnicity								
White	20	13%	2.0	1727	50%	198.9	2853	52%
Hispanic	72	48%	8.2	1255	36%	143.8	1897	35%
American Indian/Alaska Native (AI/AN)	18	12%	8.9	249	7%	123.8	365	7%
African American	8	5%	19.8	226	6%	559.8	320	6%
Asian/Pacific Islander (Asian/PI)	3	2%	10.7	23	1%	81.7	29	1%
CPAG Region at Diagnosis^d								
Region 1, Northwest	25	17%	6.0	312	9%	74.4	492	9%
Region 2, Northeast	19	13%	6.3	527	15%	173.9	917	17%
Region 3, Bernalillo Co.	76	51%	12.1	1160	33%	184.7	2016	37%
Region 4, Southeast	7	5%	2.8	160	5%	63.3	278	5%
Region 5, Southwest	23	15%	5.6	415	12%	101.9	586	11%
Region 7, AI/AN	18	12%	8.9	249	7%	123.8	365	7%
Age at Diagnosis								
< 13	1	1%	0.3	15	0%	4.2	22	0%
13-19	7	5%	3.3	69	2%	33.0	74	1%
20-29	43	29%	15.0	818	24%	284.5	1153	21%
30-39	41	27%	17.0	1419	41%	586.9	2321	42%
40-49	27	18%	9.1	867	25%	292.8	1381	25%
50+	31	21%	5.0	292	8%	47.0	513	9%
Unknown	0	0%	-	0	-	-	0	-
Mode of Exposure								
Men who have sex with men (MSM)	82	55%	-	2118	61%	-	3382	62%
Injection drug users (IDU)	9	6%	-	349	10%	-	559	10%
MSM/IDU	5	3%	-	372	11%	-	610	11%
Heterosexual	12	8%	-	333	10%	-	421	8%
Other	0	0%	-	17	0%	-	58	1%
No Identified Risk (NIR)	41	27%	-	269	8%	-	402	7%
Pediatric	1	1%	-	22	1%	-	32	1%
TOTALS	150	100%	7.5	3480	100%	173.1	5464	100%

^a*Incidence reflects only cases diagnosed in New Mexico.*

^b*Living and cumulative reflects all cases diagnosed in New Mexico and out-of-state.*

^c*Rates per 100,000 based on Bureau of Business and Economic Research data for 2006.*

^d*Residence at time of HIV or AIDS diagnosis.*

*Source: HIV & Hepatitis Epidemiology Program, New Mexico Department of Health
Updated 10/9/08*

Men who have sex with men (MSM), including those who identify as gay or bisexual, continue to account for the majority of HIV/AIDS cases in New Mexico. Roughly 90% of all cases have been diagnosed among men and this proportion has remained fairly stable over time. New Mexico's large proportions of the population that are Hispanic and American Indian also influence the overall distribution of HIV/AIDS. These demographic issues are described in the following sections.

Mode of Exposure

Men who have sex with men (MSM), including MSM who also inject drugs (MSM/IDU), remain by far the largest transmission category in New Mexico. These populations account for 73% of cumulative cases and 72% of current living cases.

Injection drug users (IDU) account for 10% of cumulative HIV/AIDS cases and 10% of living cases. Despite the large number of active and former IDU in New Mexico, the state has remarkably fewer HIV/AIDS cases among IDU than in many parts of the country.

High-risk heterosexual contact (HAR) accounts for a minority of HIV/AIDS cases, but there is evidence that this is becoming an increasingly prominent risk factor. This mode of exposure accounts for only 8% of cumulative cases but a greater proportion of living cases (10%).

Vertical transmission from mother to child and HIV/AIDS among children is relatively rare in New Mexico. Only 22 cases of HIV/AIDS among persons aged less than 13 at diagnosis have been reported in New Mexico since the beginning of the epidemic. Of this total, 15 are living.

No identified risk (NIR) is being reported for an increasing number of cases. This is particularly an issue among women living with HIV/AIDS.

Age at HIV/AIDS Diagnosis

Most persons currently living with HIV/AIDS in New Mexico were in their 30's (41%), 40's (25%), or 20's (24%) when they first tested positive for HIV. Historically, diagnoses of HIV or AIDS have been most frequent among persons in their 30's. However, in recent years, there has been an increasing shift towards diagnosis of individuals while in their 20's who reflect a growing proportion of total cases. This likely reflects a combination of factors such as increased infection among persons in their teens and 20's, greater availability and utilization of HIV testing programs, and increased awareness of HIV. Also of note is that 21% of cases are in persons aged 50 and over.

Racial/Ethnic Groups

The CPAG has had a number of lively discussions about federally-defined categories used to define ethnic/racial demographics of persons living with HIV/AIDS. The group has a consensus opinion that current categories are limiting, and often don't reflect how individuals define themselves. While it is important to capture data that can show trends and impact of the HIV epidemic, it's difficult to do this without putting people in boxes with which they are not comfortable. For example, many people identify as being of a specific nationality first, while others may define themselves as members of more than one ethnic and/or racial group. CPAG members want to advocate for the diverse populations they serve, noting that community members should have the right to describe themselves. Prevention programs need to take these complexities into account, to reach individuals in an effective, comfortable, respectful and appropriate fashion.

The following demographic profile of the HIV/AIDS epidemic in New Mexico is based on the current federal categories of ethnic and racial groups.

Whites were overrepresented among HIV/AIDS cases in the early days of the HIV epidemic in New Mexico. However, their proportion has declined from 52% of cumulative cases to 50% of living cases.

Hispanics are slightly underrepresented among overall HIV/AIDS cases, though their proportion has grown from 35% of cumulative cases to 36% of living cases. However, recent data shows an alarming trend of increasing numbers and proportion of the impact of HIV/AIDS among Hispanics. With 72 incident cases in 2007, Hispanics accounted for 48% of new diagnoses in that year, which was almost 50% higher than the number of new diagnoses among Whites.

American Indians are also underrepresented among HIV/AIDS cases, accounting for 7% of cumulative and living cases.

African Americans are dramatically overrepresented among HIV/AIDS cases and account for 6% of both cumulative and living cases. This mirrors national trends. African Americans have the highest prevalence rate of persons living with HIV/AIDS at 559.8 cases per 100,000 population. This rate is 2.8 times the rate among Whites, 3.9 times the rate among Hispanics and 4.5 times the rate among American Indians.

Asian/Pacific Islanders account for < 1% of all cumulative and living HIV/AIDS cases.

Trends in the HIV/AIDS Epidemic

Epidemiological data on HIV/AIDS in New Mexico highlight two issues of significant concern and impact on HIV prevention and testing activities in the state.

- **Concurrent Diagnosis with HIV and AIDS:** Concurrent diagnoses of HIV and AIDS are cases in which individuals have an AIDS diagnosis at or within one year of being reported as having HIV infection. In other words, these persons are being tested and learning of their HIV status late in their disease, when HIV has already or soon will progress to the point of full-blown AIDS. This is of great concern, as these individuals overall have a worse prognosis in terms of the impact of HIV care. In addition, persons who are unaware of their HIV status for such a long time may be continuing to engage in behaviors that pose a risk of HIV transmission to others.

The proportion of concurrent diagnoses among all new HIV/AIDS case reports is high in New Mexico, and exceeds national figures. On cases reported through 2007, more than half (58%) were concurrently diagnosed with HIV and AIDS.

Rates of concurrent diagnoses are highest among Hispanics (66%), although they are also high among American Indians/Alaskan Natives (53%), Whites (50%) and African Americans (48%). By risk category, concurrent diagnoses are more frequent among heterosexuals at risk (HAR, 63%) and MSM (58%), with somewhat lower rates among IDU (48%) and MSM/IDU (44%). Persons who are foreign born are more likely (68%) to be concurrently diagnosed than persons born in the United States (53%).

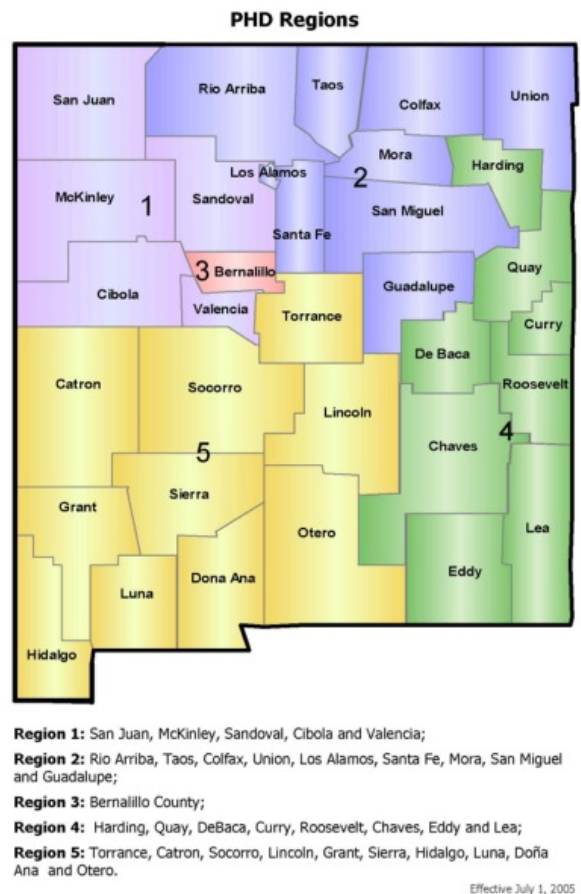
- ***Hepatitis C Co-Infection:*** Co-infection of persons with both HIV and hepatitis C (HCV) is becoming an increasing concern in New Mexico. Among living cases of HIV/AIDS reported through 2008, 17% are known to be co-infected with HCV, 35% do not have HCV, and HCV status is unknown for almost half (49%) of cases. The CDC estimates that as many as 25% of all persons living with HIV also are infected with HCV.

For persons co-infected with HIV and HCV, the most common risk factors are MSM (38%), IDU (30%), MSM/IDU (25%) and HAR (7%). When compared with the overall profile of the HIV epidemic in New Mexico, this is a much higher proportion of both IDU and MSM/IDU. When combined, these two categories account for more than half of all cases. This is understandable, given that sharing of injection equipment is one of the primary risks for HCV transmission.

C. Impact of HIV/AIDS in Each Region

The New Mexico Department of Health (NMDOH) has five Public Health Regions to serve all parts of the state. These are illustrated in the following figure.

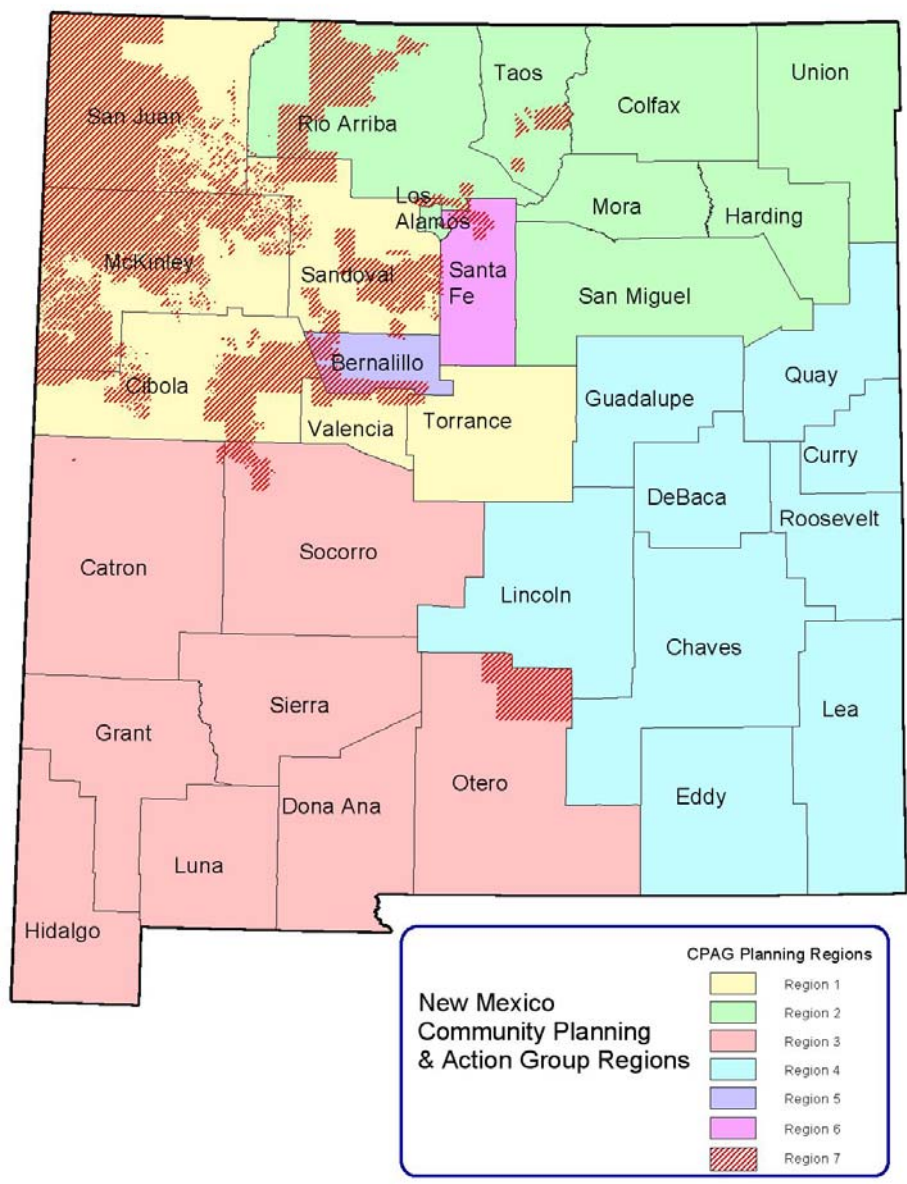
Figure 1. Map of New Mexico Public Health Regions



The CPAG has Regional Advisory Groups (RAG) that conduct HIV prevention planning and networking among providers in each of these five regions. To ensure that American Indians are represented and have a voice in planning that reflects their cultural traditions and specific prevention needs, there is also a “Region 7” Advisory Group that reflects tribes across all of New Mexico.

While the CPAG formerly had a distinct planning region for Santa Fe County, during 2007 this “Region 6” was merged into the larger “Region 2” covering all of northeastern New Mexico. The figure below shows the seven RAG that were in effect at the beginning of this planning process.

Figure 2. Map of CPAG Regional Advisory Groups



The following is an overview of the HIV/AIDS epidemic by CPAG planning region. A detailed chart with the epidemiological profile of each region is provided in Appendix 5. Data on living HIV/AIDS cases includes individuals diagnosed through 2007.

- CPAG Region 1:**
Northwestern New Mexico (including the cities of Farmington and Gallup)
 419,506 residents (21% of state total)
 312 living HIV/AIDS cases (12% of the statewide total)
 Rate of 74.4 cases per 100,000 population
- CPAG Region 2:**
Northeastern New Mexico (including the cities of Santa Fe, Española, Las Vegas, and Taos)
 303,127 residents (15% of state total)

527 living HIV/AIDS cases (20% of the statewide total)
Rate of 173.9 cases per 100,000 population

- **CPAG Region 3:**
Albuquerque/Bernalillo County
628,188 residents (31% of state total)
1,160 living HIV/AIDS cases (45% of the statewide total)
Rate of 184.7 cases per 100,000 population
- **CPAG Region 4:**
Southeastern New Mexico (including the cities of Carlsbad, Clovis, and Roswell)
252,654 residents (13% of state total)
160 living HIV/AIDS cases (6% of the statewide total)
Rate of 63.3 cases per 100,000 population
- **CPAG Region 5:**
Southwestern New Mexico (including the city of Las Cruces)
407,312 residents (20% of state total)
415 living HIV/AIDS cases (16% of the statewide total)
Rate of 101.9 cases per 100,000 population
- **CPAG Region 7:**
American Indians living in all areas
201,202 persons (10% of state total)
249 living HIV/AIDS cases (7% of the statewide total)
Rate of 123.8 cases per 100,000 population

The largest number of cases has been diagnosed among residents of Albuquerque and Bernalillo County, known as Region 3. This area accounts for 45% of living cases in New Mexico. Northeastern New Mexico (Region 2) also bears a disproportionate impact from the HIV epidemic. While Santa Fe County had the highest rates early in the HIV epidemic, Albuquerque/Bernalillo currently has the highest rate of living cases among any Public Health Region.

During 2007, Regions 1 (Northwest), 3 (Albuquerque/Bernalillo) and 5 (Southwest) accounted for a greater proportion of incident cases than their overall burden of cumulative HIV/AIDS cases. This may reflect that the epidemic is shifting towards these parts of the state. In contrast, while Region 2 (Northeast and Santa Fe) accounts for 17% of cumulative cases, only 6% of diagnoses in 2007 were from this region.

D. Indicators of Health and Social Issues

HIV prevention efforts must take into account a number of health and social issues, since these can be important co-factors that facilitate or hinder effective HIV prevention. Drug use (including alcohol), violence, and poverty certainly impact the ability of at-risk individuals to adopt and maintain safer behaviors that reduce their likelihood of being infected. In addition, the viral hepatitis and sexually transmitted disease (STD) epidemics have significant overlap and similar risk factors with the HIV epidemic.

A number of indicators illustrate the challenges faced by individuals in New Mexico that may contribute to at-risk behaviors or hinder participation in HIV prevention efforts.

Combined Social Health

- New Mexico ranks last among the 50 states for social health. The state's combined score of 26.8 out of a possible 100 points reflects poor results in 16 social indicators including infant mortality, child abuse, percent of children in poverty, teen drug abuse, high school completion, homicides, and alcohol related traffic deaths, according to the 2008 report by Vassar College's Institute for Innovation in Social Policy.

Source: <http://iisp.vassar.edu/>

Income and Poverty

- In 2005, 18.4% of New Mexico's population reported an income at or below the federal poverty level, compared to 13.3% nationwide.

Source:

http://ibis.health.state.nm.us/indicator/view_numbers/NMPopDemoPov.Year.NM_US.html

- New Mexico ranks 48th among all states for children under age 18 living in poverty. Almost one-quarter (23.8%) of New Mexico children live at or below the federal poverty compared to 17.8% nationwide. Figures are even higher (29%) for children under the age of 6.

Source: 1) Annie E. Casey Foundation, <http://www.kidscount.org/datacenter/>

2) The State of Health in New Mexico 2009,

[http://www.health.state.nm.us/epi/pdf/SoHiNM%202009%20\(12-21-08\).pdf](http://www.health.state.nm.us/epi/pdf/SoHiNM%202009%20(12-21-08).pdf)

Sexually Transmitted Diseases (STD)

- In 2006, the Chlamydia case rate (cases per 100,000 population) for New Mexico was 509.7 compared to the national rate of 347.8. During 2000 – 2006, New Mexico ranked in the top seven states for incidence of Chlamydia. Roughly one-third (37%) or 3,602 cases of Chlamydia in 2006 were among youth ages 20-24 years.
- From 2000 to 2006, the annual number of reported Gonorrhea cases increased from 1,136 to 1,732, an increase of 52.5%. In 2006, roughly one-quarter (27%) or 581 cases of Gonorrhea were among youth ages 20-24 years.
- From 2000 to 2006, the number of Primary and Secondary (P&S) Syphilis cases nationwide increased by 61.3%. In New Mexico, it increased by 271.4%. Syphilis disproportionately affects racial and ethnic minorities, with the highest disease burden in New Mexico occurring among American Indians.
- Source: *Infectious Diseases in New Mexico 2006 Annual Report. NMDOH STD Program.*

Drug Issues (including alcohol)

- Excessive alcohol consumption, including binge drinking, chronic heavy drinking, alcohol dependence and abuse, and alcohol-impaired driving contribute to a range of public health and public safety problems in New Mexico. Binge drinking (defined as drinking 5 or more drinks on an occasion for men, 4 or more drinks on an occasion for women) is a major risk factor for alcohol-related injury. Chronic heavy drinking (defined as drinking more than two drinks per day for men, and more than one drink per day for women) is associated with

alcoholism or alcohol dependence, and can cause or contribute to a number of diseases including liver disease.

- Binge drinking is the most commonly reported form of excessive drinking in New Mexico, reported by 14.4% of adults. By comparison, 5.1% of New Mexico adults report heavy drinking, 2.0% report impaired driving, and 1.8% report alcohol dependence (aka alcoholism).
Source: Woerle, S., Roeber, J., Landen, M. Prevalence of Alcohol Dependence among Excessive Drinkers in New Mexico. Alcoholism: Clinical and Experimental Research, 31(2): 293-298, 2007.
- Over the past 15 years, New Mexico's death rate for alcohol-related injury has consistently been among the worst in the nation, ranging from 1.4 to 1.8 times the national rate. In 2006 New Mexico's rate was 26.6 per 100,000 population.
- Over the past 15 years, New Mexico's death rate from alcohol-related chronic disease has consistently been first or second in the nation, and 1.5 to 2 times the national rate. While the national death rate from alcohol-related chronic diseases fell in the past decade, New Mexico's rate increased. In 2006 New Mexico's rate was 22.2 per 100,000 population.
Source: The State of Health in New Mexico 2009,
[http://www.health.state.nm.us/epi/pdf/SoHiNM%202009%20\(12-21-08\).pdf](http://www.health.state.nm.us/epi/pdf/SoHiNM%202009%20(12-21-08).pdf)
- Alcohol-related injury and chronic disease are the two principal causes of alcohol-related death. New Mexico's 2004 rate for alcohol related death per 100,000 population is 56% higher than the national rate (48.7 and 27.3 respectively). New Mexico's alcohol-related death rate has been the highest in the nation each year since 1997.
Source:
http://ibis.health.state.nm.us/indicator/view_numbers/AlcoholrelatedDth.Year.NM.US.html
- In 2005-2007, the alcohol-related death rate among American Indians in New Mexico was 87.2 per 100,000, compared to a rate of 51.2 for Hispanics and 37.5 among non-Hispanic Whites.
Source: 2008 NMDOH Racial and Ethnic Health Disparities Report Card
<http://www.health.state.nm.us/pdf/2008ReportCard.pdf>
- In 2007, among New Mexico high school students, binge drinkers were significantly more likely to report current sexual activity (56.2%) than non-binge drinkers (29.9%) and non-drinkers (18.9%).
- In 2007, New Mexico had the highest rate of early underage drinking (drinking before age 13) in the nation (30.7%), compared to the national rate of 23.8%.
Source: D Green et al. Alcohol Use and Related Behaviors, 2007, New Mexico YRRS, 2009
- In 2008, New Mexico had one of the highest drug-related death rates in the nation (20.8 per 100,000 population, compared to 11.2 per 100,000 nationally).
Source: 2008 NMDOH Racial and Ethnic Health Disparities Report Card,
<http://www.health.state.nm.us/pdf/2008ReportCard.pdf>
- Drug overdoses account for more than 80% of drug-related deaths.
Source: 2005 New Mexico State Epidemiology Profile

- The unintentional drug overdose death rate has increased from 5.6 per 100,000 population in 1990, to 15.5 per 100,000 in 2005, to 20.8 per 100,000 in 2008. In New Mexico, unintentional drug overdose rates are highest among Hispanic males (24.9 per 100,000 population) followed by non-Hispanic white males (11.8 per 100,000), non-Hispanic white females (5.2 per 100,000), Hispanic females (4.9 per 100,000), American Indian males (4.4 per 100,000) and American Indian females (1.4 per 100,000).
Source: Shah NG et al., "Unintentional drug overdose death trends in New Mexico, USA, 1990 – 2005: combinations of heroin, cocaine, prescription opioids and alcohol", Addiction, Volume 103, pp. 126-136
- In 2008, 750 individuals were enrolled in overdose prevention programs, which included the distribution of naloxone (Narcan) and 302 opioid overdose reversals were reported by program participants.
Source: 2008 NMDOH Harm Reduction Program Performance Report.

Injection Drug Use (IDU)

- According to the NMDOH Substance Abuse Epidemiology Unit, 1.7% of New Mexicans aged 18 years and older are injection drug users (IDU). This gives an estimate of roughly 25,400 active IDU in New Mexico.
- Rio Arriba County has the highest proportion (4.6%) of IDU in the state.
Source: NMDOH Substance Abuse Epidemiology Unit

Homicide and Suicide

- During 2005-2006, there were 1,127 violent death reported in New Mexico. Of these, 61.8% were suicide and 25.0% were homicide.
Source: December 2008; New Mexico Epidemiology Report Volume 2008, Number 10
<http://www.health.state.nm.us/epi/pdf/ER%20NVDRS%20120108.pdf>
- New Mexico has the 5th highest suicide rate among all states, with roughly twice the national rate (19.2 per 100,000 population) for all age groups. The suicide rate of 18.7 in New Mexico in 2003 was 80% higher than the national rate of 10.5 per 100,000 population for all age groups. In 2004, Whites and American Indians had almost equal suicide rates (19.0 and 18.9 respectively).
Source: March 10, 2006 SenGupta, Saumitra; New Mexico Epidemiology V 2006 (1)
- Among youth 15-24, New Mexico's suicide rate of 20.1 per 100,000 population during 2003-2005 was double the national rate of 10.0 per 100,000 population.
Source:
http://ibis.health.state.nm.us/indicator/view_numbers/SuicDeathYouth.Year.Nm_US.html

Youth

- From the 2003-2004 school year through the 2006-2007 school year, the overall New Mexico dropout rate has steadily increased from 3.3 to 4.4. There were 6,612 dropouts during the 2006-2007 school year. More than half (50.5%) of New Mexico dropouts in the 2006-2007 school year were Hispanic. One-quarter (26%) of 10th graders dropped out in the 2006-2007

school year. Grade 10 consistently has the highest dropout rate.

Source: *The 2006-2007 New Mexico Dropout Report*

- According to the 2005 New Mexico Youth Risk and Resiliency Survey (YRRS) there was a decrease from 2003 in the prevalence of several important substance abuse-related risk behaviors among all New Mexico high school students.
 - 1) Current alcohol use declined from 50.7% in 2003 to 43.2% in 2007.
 - 2) Binge drinking in the previous 30 days decreased from 35.4% in 2003 to 27.4% in 2007.
 - 3) Since 2003, New Mexico has seen a significant decrease in current use of cocaine (8.9% in 2003; 7.9% in 2005; 5.4% in 2007) and methamphetamine (7.3% in 2003; 4.6% in 2005; 4.4% in 2007).
 - 4) There has been no statistically significant change in current use of any other drug over the years.
- 3.6% of New Mexico high school students have ever injected an illegal drug (third highest among states using the YRBS study, after Wyoming and Kentucky.)

Source: <http://www.health.state.nm.us/epi/yrrs.html>

Behavioral Health

- According to the New Mexico 2006 Hospital Inpatient Discharge Data, “psychoses” were the most common mental health diagnoses among patients discharged from inpatient hospitals (96.1 per 10,000 population). “Episodic Mood Disorder” formerly known as “Affective Psychoses” was among the top 5 reasons for hospitalization for both females and males ages 18 and under, for males ages 19-44, and for males and females ages 45-64. Schizophrenia accounted for 15% of all “psychoses” discharges.
- The diagnosis rate of “alcohol dependence syndrome” formerly known as “alcoholism” was 2.6 times higher for males compared to females.
- Patients between the ages of 19-44 years had the highest discharge rates for both drug dependence (31.0 per 100,000) and nondependent abuse of drugs (48.1 per 10,000)
- Source (for all items in section): *2006 HIDD, New Mexico Health Policy Commission*, http://www.hpc.state.nm.us/documents/HIDD%20Report_2006.pdf

Domestic Violence

- In 2005, 1 in 4 adults in New Mexico were victims of domestic violence.
- There were 17,457 new clients served by 27 domestic violence service providers across the state. Available data shows that more than half (53%) were adults and 35% were children.
- On average, 1 in every 7 incidents of domestic violence reported by law enforcement involved a child witness.
- Source (for all items in section): *July 2008 Caponera, Betty, Ph.D., Domestic Violence in New Mexico 2007 Highlights. NMDOH Office of Injury Prevention*

Health Care Providers

- Many rural and border areas of New Mexico lack a comprehensive continuum of community-based, affordable primary care and behavioral health care.
- In 2003, New Mexico had fewer physicians than the national average per 100,000 population (217.0 vs. 278.0, respectively), ranking it 31st among the states. The physician to population ratio in counties that border Mexico was lower than the State's overall ratio (138.5 in border counties vs. 214.0 New Mexico).
- New Mexico has fewer Registered Nurses per 100,000 population than the national average (745.2 and 782.0 respectively), ranking it 49th among the states. In 2003, New Mexico had a higher rate of Certified Nurse Practitioner than the national rate (30.7 and 27.6, respectively).
- In 2003, New Mexico had fewer psychiatrists than the national average (9.5 and 14.2, respectively). Rates for psychologists in New Mexico and nationwide are similar (25.2 and 28.4, respectively).
- The number of Social Workers in New Mexico (106.0 per 100,000 population) in 2003 was higher than the national rate (35.6).
- *Sources (for all items in section):*
ftp://ftp.hrsa.gov/bhpr/workforce/border_reports/newmexico.pdf and
<http://hpc.state.nm.us/documents/GADS%20report%202007.pdf>

CHAPTER 2. OVERVIEW OF THE NEW MEXICO HIV PREVENTION COMMUNITY PLANNING AND ACTION GROUP (CPAG)

A. Background and Structure of CPAG

The Federal Centers for Disease Control and Prevention (CDC) mandates that each State implement a community-based planning process that reviews local needs and sets priorities for HIV prevention activities across the jurisdiction. In New Mexico, this process has been implemented by the New Mexico HIV Prevention Community Planning and Action Group (CPAG), in collaboration with the New Mexico Department of Health (NMDOH) HIV Prevention Program.

The mission of the CPAG is as follows.

The overall mission of the New Mexico HIV Prevention Community Planning and Action Group is to develop a comprehensive plan for HIV Prevention in the State of New Mexico. This process will promote health and prevent HIV and other diseases by facilitating collaboration among New Mexico's diverse communities and empowering its people through advocacy, respect, dignity, compassion, and social justice.

The CPAG developed a vision for its work during 2004. This statement illustrates the shared goals of this diverse body.

The New Mexico CPAG is committed to eliminating HIV infection.

The group also adopted a motto during 2007, based on the historic chant from HIV activist groups such as ACT-UP that “silence = death”.

Action = Life

Five core values of the group were identified, to ensure an open and inclusive approach to HIV prevention planning.

- *Respect diversity*
- *Support and care for all membership*
- *Commit to the process*
- *Accountability*
- *Catalyst*

The CPAG operates as a single statewide body that plans for HIV prevention needs. It is supported by six Regional Advisory Groups that each focus on the needs of a specific geographic area or demographic group (see map of regions in Figure 2). Each regional group convenes local meetings and solicits input from the communities it represents. Therefore, while the resulting plan is a statewide document with common priorities, regional detail is provided to illuminate the needs and resources that vary across New Mexico.

The CPAG has written bylaws that guide its operation. The current bylaws were initially adopted on July 1, 1999. Revisions have been made several times to reflect enhancements to the group's membership, structure or activities. The most recent amendments were approved in September 2007. The bylaws specify roles and responsibilities for the CPAG as a whole, its committees and task forces, and individual CPAG members.

All CPAG statewide, regional and committee meetings are open to the public. Individuals are invited and welcomed to attend and speak, regardless of whether they are decision-making members. This helps to promote discussion and encourage input from diverse communities.

B. CPAG Membership Guidelines

The CPAG makes ongoing efforts to ensure that its membership reflects the principles of Parity, Inclusion, and Representation (PIR) of the diverse populations of New Mexico and of the HIV/AIDS epidemic within the State. Various areas of interest and expertise are found among members who include affected populations, community leaders and advocates, epidemiologists, social scientists, school educators, community-based and government HIV prevention providers, HIV care providers, and NMDOH staff.

The CPAG may have up to 30 members, according to the group's bylaws, including both regional representatives and statewide at-large members. Each member represents an affected community, rather than an organization. Members are called "decision makers" rather than voting members, since the group operates by consensus.

These 30 membership seats include:

- 1) Three (3) statewide co-chairs;
- 2) Twelve (12) co-chairs of the six Regional Advisory Groups; and
- 3) Fifteen (15) at-large members.

While the CDC requires community planning groups to have co-chairs who represent both the community and the jurisdiction's health department, New Mexico has expanded upon this requirement to improve representation. The CPAG is led by a team of three co-chairs, representing: 1) Community, 2) Persons living with HIV/AIDS, and 3) the New Mexico Department of Health. The NMDOH co-chair is a staff person designated by the agency. The two other co-chair positions are nominated and approved by the CPAG membership.

Each of the six Regional Advisory Groups has two co-chairs who are CPAG decision-making members, reflecting 12 of the total seats. Among this group, NMDOH appoints four Disease Prevention Team (DPT) staff who serve as representatives of the NMDOH Public Health Regions. There are an additional 15 at-large members from all parts of New Mexico who add to the membership's overall diversity.

CPAG members are asked to make a commitment for a 2-year term. Terms begin upon appointment to the CPAG via consensus, which may be at any time during the planning year. Upon completion of their terms, decision making members may apply and be re-appointed through CPAG consensus to continue their memberships.

Regional Advisory Group co-chairs are nominated by each of these bodies through their own consensus process. Once nominated, the candidates are reviewed by the CPAG PIR Committee,

which makes recommendations to the entire decision-making membership for approval. They are then confirmed as CPAG decision-makers through consensus of the full body.

Prospective candidates for the CPAG's 15 at-large membership slots are recruited through an open process that ensures that PIR principles are achieved. The CPAG has a standing PIR committee that accepts nominations, assists candidates in completing membership applications (that cover expertise areas and demographic information), educates them about the CPAG process and role, and forwards nominations to the entire membership. New members are then approved by the entire CPAG through a consensus process.

C. Profile of Current Membership and Strategies for Recruitment

The CPAG has 25 decision-making members, as of March 2009. These individuals reflect the diversity of the State of New Mexico and the HIV/AIDS epidemic within this jurisdiction. The following demographic profile is based on self-reported information on membership applications and surveys.

- Members are diverse in gender and sexual orientation. Among the 25 members, 13 are male (52%), 10 are female (40%), and 2 are transgender (8%). Men who have sex with men and transgender persons (MSM-T), who account for the largest proportion of HIV/AIDS cases in New Mexico, are well represented. Almost half of members (11 persons or 44%) self-identify as MSM, MSM/IDU, gay, bisexual, and/or transgender. Two CPAG members represent injection drug users (IDU), while two others represent MSM/IDU. Four members self-identify as high-risk heterosexuals (HAR).
- The ethnic/racial profile of CPAG members mirrors the overall State and HIV epidemic. Among the 25 decision makers, 8 are White (32%), 5 are Hispanic/Latino (20%), 5 are American Indian/Alaskan Native (20%), and 3 are African American (12%). Four CPAG members self-identify as being of two or more races, with these individuals reporting that they are White (2 persons), African American (2), Hispanic/Latino (2), American Indian (2) and Asian (1).
- While the CPAG lacks any members under age 18, youth are represented by several members in their 20s.
- CPAG members live in all five NMDOH Public Health Regions and all six CPAG planning regions. There is a balance between persons from rural areas (8 persons or 32%) and persons who reside in urban areas such as Albuquerque, Santa Fe or Las Cruces (17 persons or 68%).
- Diverse professional disciplines and areas of expertise are represented both by CPAG decision-making members and ex-officio members. Ex-officio members are typically staff and consultants from NMDOH and other State agencies, such as the New Mexico Public Education Department. The following expertise areas are represented: Department of Health HIV/AIDS staff, Department of Health STD/STI staff, Department of Health hepatitis staff, Department of Health epidemiology staff, program evaluator, representatives of the substance abuse community, representatives of the mental health community, representatives of the education community, representatives of the State Corrections Department, staff from community-based HIV prevention agencies, staff from social services agencies including those who provide homeless services, community members affected by HIV/AIDS, AmeriCorps team members, volunteers, advocates and consumers.

- Six members (24%) have self-disclosed that they are living with HIV/AIDS. According to the CPAG bylaws, this figure includes at least one statewide co-chair position.
- While CPAG bylaws specify that decision-making members reflect the epidemic rather than represent their employer, current members work for a variety of types of agencies that help to bring broad expertise to CPAG. Among the 25 current members, 6 work for NMDOH and 9 work for a community-based HIV prevention agency.

The PIR committee reviews membership demographics and representation on an ongoing basis. Steps are taken to recruit additional members when gaps are found. The following are examples of strategies used to bring new members to the CPAG, with particular emphasis on underrepresented populations.

- The PIR committee gives a monthly report to the CPAG on any resignations and nominations. At this time, the committee identifies any ongoing areas where representation is needed.
- Each CPAG Regional Advisory Groups coordinates recruitment efforts with the PIR committee when there is a deficiency in membership from its region. This assists in having local contacts who know the community, local organizations, and community advocates.
- A community meeting was hosted by NMDOH, in collaboration with CPAG leadership, in Farmington during January 2008. This event worked to promote collaboration among local providers and recruit increased participation in CPAG's "Region 1" planning body. As a result of this initiative, Region 1 identified and elected new co-chairs, recruited participation and is now meeting regularly.

Statewide recruitment efforts over the past two years have focused on improving representation in three areas where there was only limited participation in CPAG: 1) Northwestern New Mexico (Region 1), 2) injection drug users (IDU) and MSM/IDU, and 3) transgender individuals. There was significant progress, with each of those groups now well represented among active decision-making membership.

D. HIV Prevention Planning Process

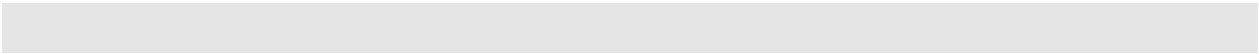
CPAG develops an annual Work Plan for each planning cycle, which normally begins in October of each year. Group process is used to identify the major tasks and activities for the coming year. At most monthly statewide meetings, the group reviews this Work Plan to identify progress on these tasks. The Work Plan for the 2007 – 2009 planning cycle was initiated in October 2007, adopted in January 2008 and finalized in March 2009. A copy is provided in Appendix 4.

Development of a statewide comprehensive plan every three years is a major undertaking for CPAG. Therefore, the group developed a "Plan to Plan" to describe the chapters and sections of this document, as well as the process and responsible parties for developing each component. This document was adopted by CPAG in December 2007. The final version is provided in Appendix 3.

The CPAG surveyed decision-making members during its March 2009 meeting to assess its HIV prevention planning process. The group elected to use a condensed, one-page survey tool that

reflects the eight major tasks for CPAG as directed by CDC's guidance for community planning. The survey was completed by all 25 active members.

The surveys had a total of 200 possible responses (8 questions completed by each of 25 members). Overall, there were 196 responses of "agree" (98%) with questions on whether the CPAG achieved its objectives during the planning cycle. Only one response was a "disagree", while the remaining 3 questions were either left blank or marked "don't know". This is an extraordinarily high rate of agreement, showing that most CPAG members felt that the planning process was effective and inclusive, while incorporating the expectations of CDC's guidance for community planning.



CHAPTER 3. PRIORITIZED TARGET POPULATIONS

A. Model for Prioritizing Target Populations

One of the core tasks of the CPAG is to identify and prioritize the target populations that are at greatest risk of HIV infection. In New Mexico, a data-driven model for this process was created to conform to the CDC requirement that limited resources be targeted in a fashion that has the greatest potential to reduce new HIV infection. Such prioritization also fits the vision statement developed by the CPAG: *The New Mexico CPAG is committed to eliminating HIV infection.*

The CPAG identified and prioritized six major target populations in 2003 during development of a five-year HIV prevention plan. This was done using CDC definitions of at-risk groups and a model that incorporated five weighted factors. This model and its supporting data were reviewed and updated in both 2004 and 2005, but the resulting rankings did not change.

During the current 2007 – 2009 planning cycle, CPAG determined that this prioritization model was still appropriate and effective for the jurisdiction. While data sources were updated again in this plan, the ranking of major target populations remained the same.

Target Population Groups

To begin the prioritization process, the CPAG defined six target population groups to be prioritized for HIV prevention. Based on guidance from the CDC, these groupings were defined in terms of risk behaviors known to transmit HIV, rather than on any other population characteristics. The categories were as follows.

- Persons living with HIV/AIDS (PLWH/A)
- Men who have sex with men and transgender individuals (MSM-T)
- Injection drug users (IDU)
- MSM-T who inject drugs (MSM-T/IDU)
- Heterosexuals at risk (HAR)
- General population

The CPAG reviewed these categories again in 2005 and considered eliminating “General population” as a target population group. However, to allow flexibility for future HIV awareness and prevention efforts, this category was retained. The CPAG noted that “General population” has a distinctly lower score and ranking, since the aim is to target limited resources to persons most at risk of HIV infection. Therefore, NMDOH may elect not to fund any HIV prevention efforts that serve “General Population”, rather than one of the other target populations.

Inclusion of Transgender Persons

The CPAG was concerned that transgender persons were not specifically noted as a priority population before the 2003 planning cycle. To ensure that this population was not invisible or ignored by HIV prevention efforts across the state, the category of men who have sex with men (MSM) was expanded in 2003 to be MSM-T. The intent was to be inclusive, rather than to imply that MSM and transgender persons have the same cultural background, risk factors for HIV, or needs for HIV prevention.

CPAG continues to learn that transgender individuals have unique needs related to HIV prevention. Some interventions that have been shown to be effective for MSM are not appropriate or responsive to transgender persons. For example, Navajo AIDS Network (NAN) learned that it was easier to adapt the SISTA intervention that was designed for HAR rather than the Many Men, Many Voices intervention designed for MSM when creating a program specifically for Navajo and other American Indian transgender individuals.

Based on these experiences, CPAG wishes to emphasize the need for targeted and specific HIV prevention for transgender persons. While they continue to be included in the “MSM-T” category in this plan, transgender clients should receive specific HIV prevention services designed for them, rather than just being given programs designed for gay/bisexual men and other MSM. Given the limited resources in terms of tested and evidence-based models for transgender communities, program development and adaptation efforts must involve community members and gatekeepers to ensure cultural appropriateness.

The CPAG formed a Transgender Task Force during its retreat in March – April 2009. This group will conduct a Community Services Assessment for this underserved population. This should help to inform the next planning cycle, which likely will defined transgender persons as a distinct priority group.

There is evidence that transgender persons have disproportionately high rates of HIV infection, and face a number of unique barriers in accessing appropriate health and social services. Nationally, one report found that 27.7% of transgender women had HIV infection (*Medical News Today*, November 27, 2008, www.medicalnewstoday.com/articles/131002.php). A number of reports and numerous anecdotes from clients show that transgender persons are more likely to be discriminated against in health care settings. Social stigma may also lead to higher rates of HIV risk co-factors and social indicators, such as homelessness, unemployment, rejection by family and/or friends, addiction, and engaging in “survival sex”.

Prioritization Model and Factors

The model for prioritizing major target population groups incorporated five weighted factors. These factors were reviewed by the CPAG in terms of their importance in measuring the HIV epidemic and their ability to respond to emerging HIV disease trends. Based on detailed discussion and consensus at a CPAG retreat held in May 2003, the following five factors and relative weights were adopted.

1. Size of the population group in New Mexico, relative to the general population
(Weight = 1)
2. Rates of sexually transmitted diseases (STD) and hepatitis C (HCV) within the population group
(Weight = 3)
3. Number of living HIV/AIDS cases
(Weight = 4)
4. HIV prevalence rate per 100,000 population
(Weight = 2)
5. Trends in HIV prevalence
(Weight = 3)

The weights were used to make certain factors more important. For example, a factor weighted as 4 was twice as important as a factor rated as 2. Therefore, the factor related to number of living HIV/AIDS cases (weight = 4) was considered most important within this model, while size of the population group in New Mexico (weight = 1) was the least important. A template was used to fill in the data found on each factor for each of the target population groups.

Data was collected for each factor and population group and then used to score each category. The scores were then multiplied by the weights to get the total for each population group. This process and the resulting prioritization rankings are described in the following narrative and illustrated in Table 2.

It should be noted that population estimates were developed by CPAG task forces to implement this model. Since census data and other reliable sources do not exist to provide an accurate count of MSM or IDU in New Mexico, expert testimony, survey data, and program information were used to create rough figures. Therefore, while the figures in Table 2 are likely accurate enough for this prioritization model, they should not be cited for other purposes that require reliable figures regarding these risk populations.

B. Prioritization of Major Target Populations

The CPAG implemented this prioritization model in 2003 to create a ranked list of major target populations. While the supporting data was updated and applied again in the 2004, 2005 and 2007 – 2009 planning cycles, the scores and rankings did not change. This likely reflects the fact that changes in the HIV/AIDS epidemic in New Mexico during this period were gradual, rather than significant new trends in risk factors.

The following is the prioritized and ranked list of major target populations adopted in 2003 that remain the targets for New Mexico in 2009 - 2011. The total scores for each category are shown below and the full calculations can be found in Table 2.

1. *Persons living with HIV/AIDS* – score of 47
2. *Men who have sex with men and transgender (MSM-T)* – score of 42
3. (tie) *Injection drug users (IDU)* – score of 39
3. (tie) *MSM-T who inject drugs (MSM-T/IDU)* – score of 39
4. *Heterosexuals at risk (HAR)* – score of 30
5. *General population* – score of 19

Under the CDC’s “Advancing HIV Prevention” initiative, there is a requirement that persons living with HIV/AIDS be the highest priority target population. The prioritization model used by the CPAG has ranked this population first each year based on the mathematical calculations, and is therefore in compliance with CDC requirements.

Table 2. CPAG Prioritization of Major Target Populations

FACTOR	WEIGHT	POPULATION GROUP					
		Men who have sex with men and transgender (MSM-T)	Injection drug users (IDU)	MSM-T/IDU	Heterosexuals at risk (HAR)	Persons living with HIV/AIDS	General population
Size of population	1	3 (37,000)	3 (25,400)	1 (1,000)	3 (40,000)	2 (3,480)	4 (1.9 million)
STD and HCV rates	3	3	4	4	4	3	2
Living HIV/AIDS cases	4	4 (2,118)	2 (349)	2 (372)	1 (333)	4 (3,480)	1 (269)
HIV/AIDS prevalence rate per 100,000 population	2	2.5 (5,724)	2 (1,374)	3 (37,200)	1 (833)	4 (100,000)	1 (14)
Prevalence trends	3	3	4	4	3	4	1
TOTAL SCORE		42	39	39	30	47	19
RANK		2	3	3	4	1	5

*Note: Numbers shown in (parentheses) in table are the total population figures for each category. Scores (on a 1-4 scale) are in **bold**.*

The following is a sample of how a score for a population group was determined, using the example of the “General Population” category.

Size of population: score of 4 times weight of 1 = 4

STD/HCV: score of 2 times weight of 3 = 6

HIV/AIDS cases: score of 1 times weight of 4 = 4

HIV/AIDS prevalence rate: score of 1 times weight of 2 = 2

Prevalence trends: score of 1 times weight of 3 = 3

Total: 4 + 6 + 4 + 2 + 3 = 19

C. Key Focus Areas and Trends in HIV/AIDS among Target Populations

During the 2007 – 2009 planning cycle, CPAG decided to augment the prioritization of target populations by conducting a more detailed review of a number of key areas. A list of seven key areas was developed during a brainstorming session in 2007. Each of these areas was a possible “trend” or “key focus” in New Mexico’s HIV epidemic because 1) it might lead to greater risk behavior, 2) it might be a population with increasing risk behaviors or HIV/AIDS rates, or 3) there were already some epidemiological data that were of note or caused concern.

CPAG has four “Population Task Force” committees that have been meeting on a regular basis for several years. Each of these committees examined the focus areas for their population. While there is not a Task Force for MSM/IDU, the findings from both the GLBT/MSM Task Force and the IDU Task Force would apply to that risk population.

- PLWH/A Task Force → examined focus areas for persons living with HIV/AIDS, including those unaware of their status, and their partners
- GLBT/MSM Task Force → examined focus areas for MSM-T and MSM-T/IDU
- IDU Task Force → examined focus areas for IDU and MSM-T/IDU
- HAR Task Force → examined focus areas for HAR

The seven key focus areas and trends that were examined are as follows.

1. Internet and phone-line hookups
2. Incarcerated populations
3. Late diagnosis
4. Increasing rates among Hispanics/Latinos
5. Youth/young adult and older sub-populations (revisit and expand upon planning from 2006 - 2007)
6. Border issues including migrant and transient populations
7. Women and perinatal cases – including female IDU and female HAR

This review built upon planning done in the 2006 – 2007 year, which focused just on youth/young adults (age 13-24 years) and older (age 50 years and over) sub-populations. Key findings from that work are included in the following narrative. The full details of that exploration can be found in the 2007 Supplement to the *New Mexico Comprehensive HIV Prevention Plan: 2005 – 2007*. Both the plan and supplement are available online at www.nmcpag.org.

The exploration of focus areas began with a presentation of available epidemiological data. This was provided by the NMDOH HIV & Hepatitis Epidemiology Program at the CPAG’s annual retreat in spring 2008. While this ensured that the review was data-driven as much as possible, this was supplemented by the expertise of Task Force members and anecdotal data, since only limited data is available on some of the focus issues.

The results of this exploration follow. For each population and focus area, the Task Forces answered 3 questions.

1. Key Concerns: This question highlighted the key sources of data or other evidence noting a concern about HIV rates or risk behaviors.
2. Emerging Trends: This question highlighted any new or emerging issues that have appeared or increased in recent years, or that had potential to be new issues. This included increasing rates of HIV, as well as other indicators such as risk co-factors.
3. Possible Strategies: This question highlighted HIV prevention interventions or other appropriate and effective strategies to address the concern.

The findings described in the following narrative are all important issues to consider when planning HIV prevention activities and responses. They are not ranked or in priority order. All seven focus areas are significant concerns.

Focus Areas and Trends for Persons Living with HIV/AIDS (PLWH/A)

1) Persons Engaging in Internet/Phone-Line Sex Hookups

- **Key Concerns:** Many persons living with HIV/AIDS fall into either the risk categories of MSM or HAR as well. Therefore, the key concerns listed in the following sections for these two populations apply to PLWH/A as well.
- **Emerging Trends:** There are some persons living with HIV who have newly diagnosed STD, with gonorrhea being the most common but also emerging syphilis cases, who describe having met partners via the Internet. Most of these cases have occurred in Albuquerque and Santa Fe. These are of particular concern as the presence of these STD can increase the risk of HIV transmission to partners and because it shows continuing unprotected sexual activity.
- **Possible Strategies:** Disease Prevention Team staff, particularly in the urban regions (Albuquerque and Santa Fe) should enhance and continue their collaboration with Health Management Alliance (HMA) agencies to ensure that they receive referrals for Partner Services (PS) for patients with new STD diagnoses. This will allow prevention programs to ensure that we are learning about possible exposures and tracking any new trends.

2) Incarcerated Populations

- **Key Concerns:** Interrupted HIV treatment for individuals when first incarcerated in state or county facilities or when released, limited access to testing, physical safety, no access to condoms or syringes, limited education and prevention programs.
- **Emerging Trends:** High percentage of late/concurrent diagnosis, perhaps due to reluctance to be tested for HIV or lack of available HIV testing.
- **Possible Strategies:** Release packets should be given to all inmates, with inclusion of condoms and lubricant, information on and referrals to Harm Reduction programs, and linkages to other services and resources. Condom access in jails and prisons has been challenging to resolve, but would be very beneficial for risk reduction, so there should be advocacy for condom distribution within all correctional facilities. Increase testing and education. Continue to enhance collaboration with State Corrections Department.

3) Persons Who Are Diagnosed Late in Their HIV Disease

- **Key Concerns:** Hispanics/Latinos have the highest percentage of late/concurrent diagnoses of any ethnic/racial group. Foreign-born persons with HIV are more likely to be late/concurrent diagnoses.
- **Emerging Trends:** Hispanics/Latinos have the highest rate of late/concurrent diagnoses, and also make up an increasing proportion of all diagnoses of HIV and AIDS.
- **Possible Strategies:** Increase targeted HIV testing and counseling that targets and reaches specific populations at risk. Social marketing can promote testing and learning one's status.

4) **Increased HIV Rates Among Hispanics/Latinos**

- **Key Concerns:** Hispanics/Latinos accounted for 47% of new cases; 89% of Hispanic/Latino cases were men.
- **Emerging Trends:** Hispanics/Latinos had the highest rate of late/concurrent diagnoses (66% of Hispanic/Latino PLWA had progressed to AIDS within 12 months of receiving their initial HIV diagnosis).
- **Possible Strategies:** Targeted and culturally appropriate testing, education and prevention programs in both English and Spanish that serve different at-risk sub-populations of Hispanics/Latinos across the state. Social marketing can promote education and testing.

5) **Younger and Older Sub-Populations**

- **Key Concerns:** The most common risk behavior for both younger and older populations is MSM (57%), followed by cases that have no identified risk (NIR, 17%). Older persons account for a larger proportion of total cases than comparable national rates.
- **Emerging Trends:** The majority of both younger (75%) and older (55%) HAR were women.
- **Possible Strategies:** Increase targeting testing and counseling. Better internet outreach. Social marketing. Age appropriate group-level interventions.

6) **Border Issues (including Migrant and Transient Populations)**

- **Key Concerns:** New Mexico is a border state, meaning there are a large number of new immigrants each year. Because many are migrant or transient, they may not get frequent, accurate or complete information and education about HIV, safer sex, and other important health issues. This is worsened by limited access to health care and health providers.
- **Emerging Trends:** It is challenging to track and reach these populations in a culturally specific fashion to overcome significant barriers to providing both education and HIV services and health care.
- **Possible Strategies:** Partnerships with existing Promotora and community health worker programs and services can help to access hidden, hard-to-reach and migrant groups. Community members, leaders and health workers can serve as liaisons for HIV prevention. Educational videos can also be helpful for low-literacy populations, especially if available in Spanish. Routine testing in medical care settings may also help to identify HIV cases.

7) **Women and Perinatal Cases**

- **Key Concerns:** There is limited data on new perinatal cases, as this fortunately remains fairly rare in New Mexico.
- **Emerging Trends:** The majority of both younger (75%) and older (55%) HAR were women. Most women diagnosed before pregnancy.

- **Possible Strategies:** Increase testing and counseling at women's clinics and OB/GYN providers. Social marketing.

Focus Areas and Trends for Men who Have Sex with Men (MSM)

1) Persons Engaging in Internet/Phone-Line Sex Hookups

- **Key Concerns:** Gay/bisexual men have a number of social factors that may promote risky practices such as bare-backing, PNP (party and play) and increased use of the internet for immediate sexual hookups. These issues include an accelerated sense of intimacy online, challenges of finding others with similar sexual preferences particularly in small communities, prevention burnout, social isolation and power differentials. Sero-sorting can be effective for risk reduction, but can also be mis-used. Limited awareness of and access to prevention and harm reduction messages, education, and services. Peer group social norms that HIV is no longer a serious health concern. Fatalism and “bug chasing”.
- **Emerging Trends:** Recent increase in syphilis infections through Internet sex hookups, continued increase in young GBT/MSM testing positive for HIV.
- **Possible Strategies:** Increased Internet outreach with linkages/referrals to prevention and harm reduction services, online interventions delivered to individuals, innovative online prevention group interventions such as an adapted and tailored Popular Opinion Leader (POL) intervention to impact community norms, online website resource/links library, prevention banner ads in appropriate GBT/MSM online networking sites with links to HIV, STD, viral hepatitis and gay health resources.

2) Incarcerated Populations

- **Key Concerns:** Increased risk for isolated non-identified and identified GBT/MSM while incarcerated. Limited access to and awareness of appropriate risk and population specific messages, education, and prevention services. Continued restricted access for prevention outreach workers in jail and prison environments. Power differentials and sexual violence.
- **Emerging Trends:** Continuation of incarcerated men testing positive for viral hepatitis, HIV and other STDs upon re-entry into the general community.
- **Possible Strategies:** Release packets should be given to all inmates, with inclusion of condoms and lubricant, information on and referrals to Harm Reduction programs, and linkages to other services and resources. Condom access in jails and prisons has been challenging to resolve, but would be very beneficial for risk reduction, so there should be advocacy for condom distribution within all correctional facilities. Increased jail and prison prevention outreach, increased cultural competency and sensitivity training for jail and prison staff, and outreach workers providing these prevention outreach services. Continued collaboration with DOH clinic within the Bernalillo County Metropolitan Detention Center (MDC). Work with select corrections personnel to address the problem of inmate to inmate (as well as guards to inmate) sexual and physical abuse.

3) Persons Who Are Diagnosed Late in Their HIV Disease

- **Key Concerns:** Stigma associated with AIDS and affected population in many communities and populations in the state. For other GBT/MSM concerns include continued disconnect with prevention messages and outreach efforts, lack of awareness

of/or access to appropriate population and culturally specific prevention messages and education. Continued spread of HIV due to individuals unaware of their HIV status. Prevention burnout. General population perception that HIV is no longer a serious health concern. Lack of media attention on HIV.

- **Emerging Trends:** Increases in late and concurrent HIV diagnosis.
- **Possible Strategies:** More culturally appropriate and specific message targeting these hard to reach individuals and communities. Using local television, radio, newspaper, Internet, and innovative forms of advertising targeting communities with high incidence of late diagnosis. These targeted social marketing campaigns should address the benefits of knowing your status, how knowledge and action can contribute to the health of communities, and decrease stigma that affects GBT/MSM and People Living with HIV/AIDS. Greater use of prevention messages in the general community. Routine testing, partner services (PS), primary health care provider education. Outreach in mixed (gay/straight venues) bars and clubs.

4) **Increased HIV Rates Among Hispanics/Latinos**

- **Key Concerns:** Continued disconnect with prevention messages and outreach efforts, lack of awareness of/or access to appropriate population and culturally specific prevention messages and education. Hispanic/Latino GBT/MSM are disproportionately affected by the continued spread of HIV due to individuals unaware of their HIV status. Cultural and social stigma faced by Hispanic/Latino GBT/MSM that acts as a barrier to education, prevention and HIV Counseling, Testing and Referral services. Prevention burnout. General population perception that HIV is no longer a serious health concern. Lack of media attention on HIV.
- **Emerging Trends:** Increases in late and concurrent HIV diagnosis among Hispanics/Latinos
- **Possible Strategies:** More culturally appropriate and specific messages targeting these hard to reach individuals and communities. Using local television, radio, newspaper, Internet, and innovative forms of advertising targeting individuals and communities with high incidence of late diagnosis. Messages in Spanish should include a focus on family. These targeted social marketing campaigns should address the benefits of knowing your status, how knowledge and action can contribute to the health of communities, and decrease stigma that affects Hispanic/Latino GBT/MSM and PLWH/A. Greater use of prevention messages in the general community. Outreach in mixed (gay/straight venues) bars and clubs.

5) **Younger and Older Sub-Populations**

- **Key Concerns:** Social isolation in the real world and online, combining PNP (party and play) with bare backing, sero-sorting, prevention burnout, power differentials between older and younger men, limited awareness of and access to prevention and harm reduction messages, education, and services. Peer group social norms that HIV is no longer a serious health concern. Fatalism and “bug chasing”. Young American Indians engaging in sex work on the streets in the Four Corners region and in the Albuquerque area.

- **Emerging Trends:** Increased HIV infections among younger and older GBT/MSM.
- **Possible Strategies:** Increased Internet Outreach with linkages/referrals to age appropriate prevention and harm reduction services, online interventions delivered to individuals, and online prevention group interventions such as an adapted and tailored Popular Opinion Leader (POL) intervention to impact community norms, innovative online prevention group interventions, online website resource/links library, prevention banner ads in appropriate GBT/MSM online networking sites that link to key health resources. Create cultural and specific age appropriate message targeting these hard to reach individuals and communities. Using local newspaper, Internet, and innovative forms of advertising targeting with age appropriate messages to breach peer group isolation. Age appropriate peer group safer sex educational forums. Outreach in mixed (gay/straight venues) coffee houses, bars and clubs.

6) **Border Issues (including Migrant and Transient Populations)**

- **Key Concerns:** Younger GBT/MSM from New Mexico traveling to El Paso for sex hookups at GBT/MSM venues. The availability of same sex sexual activity among GBT/MSM transient populations. This may include sex worker liaisons and GBT/MSM hookups in bars that aren't identified as specifically gay venues.
- **Emerging Trends:** Higher rates of HIV infection in Dona Ana County. Increase in migrant populations moving between Colorado and northern New Mexico for work.
- **Possible Strategies:** Increase dialog and collaborative efforts with HIV prevention programs in the El Paso area to increase collaborative outreach and prevention messages, and education programs at GBT/MSM venues and hookup locations across the New Mexico/Texas border and in Mexico. Special intervention need to be developed or tailored to target male sex workers.

7) **Women and Perinatal Cases**

- **Key Concerns:** Not applicable.
- **Emerging Trends:** Not applicable.
- **Possible Strategies:** Not applicable.

Focus Areas and Trends for Injection Drug Users (IDU)

1) Persons Engaging in Internet/Phone-Line Sex Hookups

- **Key Concerns:** Not applicable. Internet/Phone hookups are either gay/bisexual/MSM or heterosexual, so these issues are covered under these other two populations.
- **Emerging Trends:** Not applicable.
- **Possible Strategies:** Not applicable.

2) Incarcerated Populations

- **Key Concerns:** Injection drug use in prison almost always involves sharing due to lack of availability. Limited access to HIV and other testing while incarcerated.
- **Emerging Trends:** 54% of PLWHA who reported history of incarceration reported IDU. Incarceration for drug use always increasing, so more IDU in prison with no access to clean needles.
- **Possible Strategies:** Release packets should be given to all inmates, with inclusion of condoms and lubricant, information on and referrals to Harm Reduction programs, and linkages to other services and resources. Condom access in jails and prisons has been challenging to resolve, but would be very beneficial for risk reduction, so there should be advocacy for condom distribution within all correctional facilities.

Increase testing and Harm Reduction presence in county jails and state prisons, possibly using rapid testing. Increased partnership with State Corrections Department.

Advocate against the “War on Drugs” and instead approach addiction as a health issue and with a Harm Reduction approach. Advocate for Harm Reduction services and clean syringes in correctional facilities. Increase provider training on these issues for those in county and state correctional systems.

3) Persons Who Are Diagnosed Late in Their HIV Disease

- **Key Concerns:** People who are diagnosed late and unaware of their status may be more likely to engage in risks and transmit HIV and hepatitis C. Also, treatment is less effective when started later.
- **Emerging Trends:** IDU have a lower rate of late diagnosis than other risk populations, however the rate is still high at 48%.
- **Possible Strategies:** Make CTR available on a consistent basis along with other prevention interventions targeting IDU such as harm reduction. Continue adapting and offering DEBIs such as Community PROMISE and Popular Opinion Leader (POL) for IDU with CTR available as an option.

4) Increased HIV Rates Among Hispanics/Latinos

- **Key Concerns:** Generational drug use (from one generation of a family to the next). Prevention messages in English not reaching monolingual Spanish speakers and vice versa.

- **Emerging Trends:** Disparity between White and Hispanic/Latino PLWH/A, such as access to care and late diagnosis, growing across the board, including among IDU.
- **Possible Strategies:** Making sure prevention messages/interventions available in Spanish and culturally appropriate/specific. Continuing efforts to make sure rural Hispanic/Latino communities have harm reduction and syringe exchange available and accessible.

5) Younger and Older Sub-Populations

- **Key Concerns:** Methamphetamine use. Lack of access to syringe exchange for people under age 18. Lack of addiction treatment options. Need more hepatitis C treatment and support resources. Discomfort in IDU communities with traditional health care settings leads to less accessing of necessary healthcare.
- **Emerging Trends:** Increasing concerns about MRSA infection and wound botulism.
- **Possible Strategies:** Create links between hospitals (especially Emergency Departments) and rural clinics and HIV prevention and harm reduction providers (i.e. Department of Health and contract agencies) to encourage more non-judgmental care for IDU.

6) Border Issues (including Migrant and Transient Populations)

- **Key Concerns:** Monolingual Spanish speakers not reached as effectively with prevention messages. Migrant populations crossing back and forth along the US/Mexico border are less likely to be able to keep syringes on them.
- **Emerging Trends:** None.
- **Possible Strategies:** Making sure Spanish language prevention messages and exchange providers readily available.

7) Women and Perinatal Cases

- **Key Concerns:** Female IDU who are mothers sometimes wary of accessing exchange in Department of Health clinics that also provide WIC for fear of losing services or losing custody of their children. Power differentials in relationships sometimes results in their male IDU partners accessing services without them; there may be no opportunity for these female IDU to access testing and other prevention services.
- **Emerging Trends:** None.
- **Possible Strategies:** Making sure testing is readily available, especially at outreach sites where women are already (ex. ISD offices, children's clinics, etc). Making childcare or toys available during testing and interventions to make it easier for moms with young kids to access services.

Focus Areas and Trends for Heterosexuals at Risk (HAR)

1) Persons Engaging in Internet/Phone-Line Sex Hookups

- **Key Concerns:** No key concerns.
- **Emerging Trends:** There are some STD cases, particularly gonorrhea, who describe during partner services that they have met partners via the Internet; the number is small but emerging. These were primarily found in Albuquerque and with sites such as www.adultfriendfinder.com. So far there have not been any reported cases with HIV or syphilis who identified Internet contacts.
- **Possible Strategies:** Disease Prevention Team staff, particularly in the urban regions (Albuquerque and Santa Fe) should ask HAR with new STD diagnoses about any Internet contacts, to ensure that we are learning about possible exposures and tracking any new trends.

2) Incarcerated Populations

- **Key Concerns:** No key concerns.
- **Emerging Trends:** Release packets should be given to all inmates, with inclusion of condoms and lubricant, information on and referrals to Harm Reduction programs, and linkages to other services and resources. Condom access in jails and prisons has been challenging to resolve, but would be very beneficial for risk reduction, so there should be advocacy for condom distribution within all correctional facilities. Women in jail may have unprotected sex, either consensual, during conjugal visits, or during assault by guards or other inmates.
- **Possible Strategies:** Condom access in jails and prisons has been challenging, but could be very beneficial for risk reduction.

3) Persons Who Are Diagnosed Late in Their HIV Disease

- **Key Concerns:** The rate of late diagnoses among HAR (63%) is higher than the overall average among all populations.
- **Emerging Trends:** There is limited data on how this is changing.
- **Possible Strategies:** Routine HIV testing in a variety of medical settings may help to find these cases. This can be promoted through partnerships with WIC and Family Planning Programs, to increase HIV testing of women, particularly young women and those who are pregnant. Testing can also be done in homeless shelters, churches, community events, and social organizations. Social marketing can promote testing and learning one's status.

4) Increased HIV Rates Among Hispanics/Latinos

- **Key Concerns:** Hispanics/Latinos accounted for almost half (47%) of new cases among HAR and 11% of all Hispanics/Latinos with HIV/AIDS were HAR.
- **Emerging Trends:** Hispanic/Latina women may be exposed to HIV by their male partners who have MSM or IDU risk behaviors but do not self-identify with these populations. Hispanic/Latina women may have less power in relationships and inability

to control some risk behaviors, due to a variety of factors including culture, domestic violence and low socio-economic status (SES).

- **Possible Strategies:** A variety of DEBI models such as Voices/Voces and SISTA are tailored and culturally appropriate for this population.

5) **Younger and Older Sub-Populations**

- **Key Concerns:** Lack of information or inaccurate information about HIV. Media and educational sources have mixed or inconsistent information. Condom use is not a cultural norm, especially among older persons who may be resuming dating.
- **Emerging Trends:** Young persons may have misconceptions about the risk of various sexual activities such as oral, vaginal and anal sex; they may believe only vaginal intercourse is “sex” and therefore risky. Young girls and women may be at risk through violence or parties involving alcohol and other drugs. High rates of teen pregnancies illustrate that risk behaviors are occurring.
- **Possible Strategies:** Among younger HAR, condom use can be promoted with interventions such as Voices/Voces. It is important to build skills for condom and partner negotiation. Information and education can be promoted through youth-friendly health care providers including school-based health centers.

6) **Border Issues (including Migrant and Transient Populations)**

- **Key Concerns:** New Mexico is a border state, meaning there are a large number of new immigrants each year. Because many are migrant or transient, they may not get frequent, accurate or complete information and education about HIV, safer sex, and other important health issues. This is worsened by limited access to health care and health providers.
- **Emerging Trends:** It is challenging to track and reach these populations; therefore providing education and health care is difficult.
- **Possible Strategies:** Partnerships with existing Promotora and community health worker programs and services can help to access hidden, hard-to-reach and migrant groups. These individuals can be used as liaisons for HIV prevention. Educational videos can also be helpful, especially if available in Spanish. Routine testing may also help to identify HIV cases.

7) **Women and Perinatal Cases**

- **Key Concerns:** There is limited data on new perinatal cases, as this fortunately remains fairly rare in New Mexico. There was one new perinatal case diagnosed during 2007. This demonstrates that perinatal transmission is still a potential concern, even if it is not a high priority in New Mexico due to the low rate.
- **Emerging Trends:** HAR was the most common mode of exposure, accounting for 40% of new HIV/AIDS cases among women. In addition, the majority of those with no identified risk were likely to have been infected through heterosexual contact.
- **Possible Strategies:** Strategies used to reduce risk behaviors among women can impact potential perinatal transmission as well.

CHAPTER 4. PRIORITIZED HIV PREVENTION INTERVENTIONS

One of the major tasks of the CPAG is to select and prioritize HIV prevention interventions that are appropriate to the diverse populations and geographic areas of the State. During the most recent planning process, the CPAG developed a new prioritization strategy that incorporated CDC and NMDOH guidance, as well as shared CPAG values. The prioritization strategy and the resulting priorities are described in this chapter.

A. Background on Prioritization of Evidence-Based Interventions

CPAG reviewed its former model for prioritizing interventions that was used in planning during 2003 – 2007. Given that evidence-based interventions are now much more commonly used, including models that are part of the CDC’s Diffusion of Evidence-Based Interventions (DEBI) project, there was a need to expand and enhance this planning tool. However, there was also a desire to rank and show value placed on locally-developed effective programs.

Key components of CPAG’s mission and vision were the basis for developing the new prioritization model.

- As stated in the CPAG vision, the planning group shares a common mission with NMDOH of eliminating HIV transmission in the State of New Mexico. This can only be achieved by implementing interventions that decrease risky behaviors and promote safer behaviors among populations most at risk due to the existing HIV prevalence. HIV prevention strategies that can impact risky behaviors are valued more highly than HIV awareness efforts, “general education” programs or other non-targeted strategies. Therefore, one-shot presentations, HIV Speaker’s Bureaus, and health fairs are lower ranked.
- It is not a small task to get at-risk populations to adopt and maintain risk reduction techniques, especially given that HIV risk is due to very ingrained behaviors such as sexual activity and injection drug use. Therefore, it may take multiple contacts and multiple types of contacts before individuals develop the motivation, knowledge, attitude, beliefs, and skills needed to make such changes. For this reason, CPAG gives higher priority to more intensive interventions rather than brief or one-time prevention contacts.
- Interventions can be more effective if they incorporate behavioral theory, to ensure that they reach each group in a fashion that reflects their current beliefs and skills and builds on their strengths. Most effective “best practices” in HIV prevention incorporate one or more behavioral theories in their design.

B. Model for Prioritizing Interventions

An ad hoc group was formed in October 2007 to review the prioritization model from prior years, incorporate CPAG values, and proposed a new strategy for prioritizing interventions. A new model was proposed to the statewide CPAG in November 2007 and adopted at that time.

The model for prioritizing interventions categorizes all possible strategies into four distinct categories. **Priority #1: Evidence Based** is the highest ranked, while **Priority #4: Recruitment** is the lowest. The four groupings were defined as follows.

- **Priority #1: Evidence-Based:** Evidence-based models with data or evidence showing effectiveness at reducing risk.
- **Priority #2: Innovative:** Innovative models, including locally developed interventions and adaptations of DEBI models, created to fill a gap (i.e. a population for which there is no evidence-based model for reducing risk). These will be evaluated to determine their effectiveness.
- **Priority #3: Locally-Developed:** Locally developed models currently in use in New Mexico that are likely to have effectiveness in reducing risk, based on their conceptual or theoretical basis. These will be evaluated to determine their effectiveness.
- **Priority #4: Recruitment:** Strategies used either 1) to recruit high-risk populations to participate in effective programs, and/or 2) to access hard-to-reach, underserved high-risk populations.

The model also incorporated the following definitions.

- **Evidence-Based Model:** An HIV prevention strategy or program that has been demonstrated to be effective in reducing risk among participants. This includes, but is not limited to, Diffusion of Evidence-Based Interventions (DEBI) models from CDC.
- **Effectiveness in Reducing Risk:** Program data shows that participants demonstrate or report either
 - 1) changes in behaviors to reduce their risk of HIV via unprotected sexual intercourse or sharing of injection equipment, or
 - 2) changes in markers of behavior, namely knowledge, attitudes and skills.
- A given model might fall into multiple priorities for different sub-populations such as: age groups (i.e. teens), ethnic/racial groups, and/or rural vs. urban populations. If a model is only appropriate for a given sub-group, this population is described in the table in blue.
- Within each category, all interventions are of equal priority (i.e. the order listed does not imply importance).

C. Prioritized Interventions for Each Target Population

Each Population Task Force reviewed the prioritization model during December 2007 – April 2008 and applied it to potential interventions. The results were presented to the full CPAG for review and revision.

Revisions were made, such as to note that some strategies are important for all target populations. For example, “Integration of STD, Hepatitis and Harm Reduction services” was listed under **Priority #1: Evidence-Based** for all target populations.

The final prioritization was approved by the full CPAG at its statewide meeting on July 11, 2008. The following table illustrates the results of this process.

Table 3. Prioritized Interventions for Each Target Population

PRIORITY CATEGORY	DEFINITION	Priorities for PLWH/A	Priorities for MSM-T	Priorities for IDU	Priorities for HAR
PRIORITY #1: EVIDENCE BASED	<u>Evidence-based models with data or evidence showing effectiveness at reducing risk.</u>	<p>Healthy Relationships</p> <p>Together Learning Choices (TLC) <i>(for young persons age 13-29)</i></p> <p>Partner services (PS)</p> <p>Partnership for Health (PfH)</p> <p>Routine testing in primary and other medical care settings <i>(for case finding of those who don't know their status)</i></p> <p>HIV testing (CTR) <i>(for partners of PLWH/A and case finding of those who don't know their status)</i></p> <p>Integration of STD, Hepatitis and Harm Reduction services</p>	<p>Many Men, Many Voices (3MV)</p> <p>Popular Opinion Leader (POL)</p> <p>Mpowerment <i>(for MSM age 18-29)</i></p> <p>Street Smart <i>(for runaway and homeless youth)</i></p> <p>Community Promise</p> <p>Holistic Health Recovery Program (HHRP) <i>(for MSM-T/IDU)</i></p> <p>Safety Counts <i>(for MSM-T who are active IDU)</i></p> <p>Harm Reduction <i>(for MSM-T/IDU)</i></p> <p>HIV testing (CTR)</p> <p>RESPECT</p> <p>Integration of STD, Hepatitis and Harm Reduction services</p>	<p>Harm Reduction, including Interventions Delivered to Individuals (IDI) <i>(for IDU statewide this is highest priority need)</i></p> <p>Safety Counts <i>(for active IDU)</i></p> <p>Holistic Health Recovery Program (HHRP)</p> <p>Community PROMISE</p> <p>Acudetox</p> <p>HIV testing (CTR) (particularly linked with other interventions including Harm Reduction)</p> <p>RESPECT</p> <p>Integration of STD, Hepatitis and Harm Reduction services</p>	<p>Voices/Voces</p> <p>Safety Counts <i>(for active IDU)</i></p> <p>Street Smart <i>(for runaway and homeless youth)</i></p> <p>SISTA <i>(for African American and Hispanic/Latina women)</i></p> <p>Community Promise <i>(for HAR/IDU)</i></p> <p>Popular Opinion Leader (POL)</p> <p>HIV testing (CTR)</p> <p>RESPECT</p> <p>Integration of STD, Hepatitis and Harm Reduction services</p>

PRIORITY CATEGORY	DEFINITION	Priorities for PLWH/A	Priorities for MSM-T	Priorities for IDU	Priorities for HAR
<p>PRIORITY #2: INNOVATIVE</p>	<p><u>Innovative models, including locally developed interventions and adaptations of DEBI models, created to fill a gap</u> (i.e. a population for which there is no evidence-based model for reducing risk). These will be evaluated to determine their effectiveness.</p>	<p>Popular Opinion Leader (POL) Internet Partner Services (PS) Community Promise Many Men, Many Voices (3MV) <i>(for MSM-T)</i> Safety Counts <i>(for active IDU)</i> Next Step <i>(developed by Montrose and Thomas Street Clinics in Houston)</i> Do It Right Healthy Relationships adapted for specific sub-populations <i>(for American Indians, couples, etc.)</i></p>	<p>Popular Opinion Leader (POL) adapted to be delivered via the Internet Many Men, Many Voices (3MV) <i>(for American Indian MSM-T)</i> Mpowerment adapted to be delivered via the Internet Popular Opinion Leader (POL) <i>(for Transwomen)</i> SISTA/SISTAH <i>(for Transwomen, including American Indian)</i></p>	<p>Popular Opinion Leader (POL) SISTA <i>(for female IDU women, especially for communities with generational IDU)</i></p>	<p>Woman to Woman <i>(for Commercial Sex Workers) (developed by Planned Parenthood and Families and Youth, Inc.)</i> SISTA/SISTAH <i>(for American Indian women)</i></p>

PRIORITY CATEGORY	DEFINITION	Priorities for PLWH/A	Priorities for MSM-T	Priorities for IDU	Priorities for HAR
<p>PRIORITY #3: LOCALLY DEVELOPED</p>	<p><u>Locally developed models currently in use in New Mexico</u> that are likely to have effectiveness in reducing risk, based on their conceptual or theoretical basis. These will be evaluated to determine their effectiveness.</p>	<p>Positive Adventures <i>(developed by Santa Fe Mountain Center)</i></p> <p>Positive Living <i>(developed by Camino de Vida)</i></p> <p>Speaker's Bureau</p> <p>Support groups</p>	<p>Interventions Delivered to Individuals (IDI) including RESPECT, adapted to be delivered via the Internet</p> <p>Experiential Prevention Intervention <i>(developed by Santa Fe Mountain Center)</i></p> <p>Safer Sex Forums (i.e. Gay City)</p> <p>Safer Injection Workshops <i>(for MSM-T/IDU)</i></p> <p>Summer Gathering prevention and cultural awareness event <i>(developed by Navajo AIDS Network)</i></p>	<p>Strategic outreach, collaboration and integration of Harm Reduction with law enforcement</p> <p>Structural interventions, including training about Harm Reduction for emergency room doctors and dentists</p> <p>Project AWARE and WIP-ET <i>(peer education model for incarcerated women developed by New Mexico AIDS Services and Alianza)</i></p> <p>Safer Injection Workshops <i>(for MSM-T/IDU)</i></p>	<p>Project AWARE and WIP-ET <i>(peer education model for incarcerated women developed by New Mexico AIDS Services and Alianza)</i></p> <p><i>Multi-session peer education group intervention for women (developed by New Mexico AIDS Services)</i></p> <p>Cross-generational curriculum for American Indian women <i>(developed by RRP Consulting)</i></p>

PRIORITY CATEGORY	DEFINITION	Priorities for PLWH/A	Priorities for MSM-T	Priorities for IDU	Priorities for HAR
<p>PRIORITY #4: RECRUITMENT</p>	<p>Strategies used either 1) to <u>recruit high-risk populations to participate in effective programs, and/or 2) to access hard-to-reach, underserved high-risk populations.</u></p>	<p>Street and online outreach Social Marketing Internet sites with resource and referral information</p>	<p>Public Sex Environment (PSE) outreach linked with HIV testing (CTR) Online outreach linked with HIV testing (CTR) Social Marketing Internet sites with resource and referral information</p>	<p>Street outreach Use of incentives Internet sites with resource and referral information</p>	<p>Outreach Link with HIV testing (CTR) for referrals Use of incentives Public Service Announcements (PSAs) for recruitment Collaboration among community-based agencies Social Marketing Internet sites with resource and referral information</p>

D. Additional Statewide Activities Prioritized by the CPAG

During the prioritization of interventions, the CPAG discussed a range of supportive services that must be conducted to ensure that local HIV prevention interventions are successful. Many of these activities are conducted by NMDOH on a statewide basis, using a combination of Federal and State funds. While these activities may not directly prevent HIV infection, they are important to the service delivery system.

The following statewide priorities were identified during past planning cycles, and were retained as important activities to continue.

- *Statewide Priority:* Capacity Building
- *Statewide Priority:* Data Collection and Program Evaluation
- *Statewide Priority:* Quality Assurance
- *Statewide Priority:* STD Integration

The CPAG had extensive discussions about the value of social marketing and public information programs. However, the group noted that it is not the highest priority and therefore may not be funded each year. As dollars become available, the CPAG expressed an interest in collaborating with NMDOH in developing the aims and methods of any campaign. Social marketing should take into account the populations and sub-populations prioritized by the CPAG.

- *Statewide Priority:* Social Marketing/Public Information

CHAPTER 5. COMMUNITY SERVICES ASSESSMENT

A. Overview of the Community Services Assessment

The Community Services Assessment (CSA) of an HIV prevention plan is comprised of three elements.

- **Resource Inventory:** The resource inventory describes all HIV prevention and testing activities available in each region of New Mexico. Because many other types of services are essential to effective HIV prevention and/or needed referrals for prevention clients, a comprehensive inventory also includes activities for: HIV care, services and support; STD prevention, testing and treatment; hepatitis vaccination, testing and treatment; harm reduction, syringe exchange and overdose prevention; substance abuse prevention and treatment; and other core health and social services.

The Resource Inventory was a chapter of each comprehensive HIV prevention plan developed in New Mexico through 2006. However, these resources change and need to have their contact information revised and updated on an ongoing basis, while the plans are changed annually. Therefore, a stand-alone *New Mexico HIV/STD/Hepatitis Resource Guide* was developed for the first time in 2006.

The Resource Guide is currently being updated into an enhanced second edition, which will be complete in summer 2009 and serve as a companion document to this plan. This guide will be available in two formats: a) as a stand-alone paper directory of services to be used to make referrals, and b) as a searchable page on the Internet (www.nmhivguide.org) that is accessible to consumers and updated on a regular and ongoing basis.

A general overview of statewide programs and resources is described in the following section. This includes a description of HIV prevention and care, as well as related Harm Reduction Program services.

- **Needs Assessment:** A needs assessment describes the range of HIV prevention and related services that are needed for each prioritizing target population. The table of prioritized interventions in Chapter 4 serves as the summary of HIV prevention needs for New Mexico.
- **Gaps Analysis:** Gaps in HIV prevention services are defined as identified needs which are not available in one or more regions of the state. In other words, priorities identified in the needs assessment which are not currently part of the resource inventory are the statewide or regional gaps.

Each CPAG Regional Advisory Group reviewed the prioritized interventions and compared them with resources available in their area. The gaps for the region were defined as those priorities that would be appropriate to deliver in the region and needed by at-risk groups, but were not available at the time of this planning process.

A gaps analysis for each region is provided in the following section. In addition, each Regional Advisory Group identified the most important 4-6 gaps for their area. These “top gaps” are summarized in the first table.

B. Resource Inventory of Statewide Programs and Resources

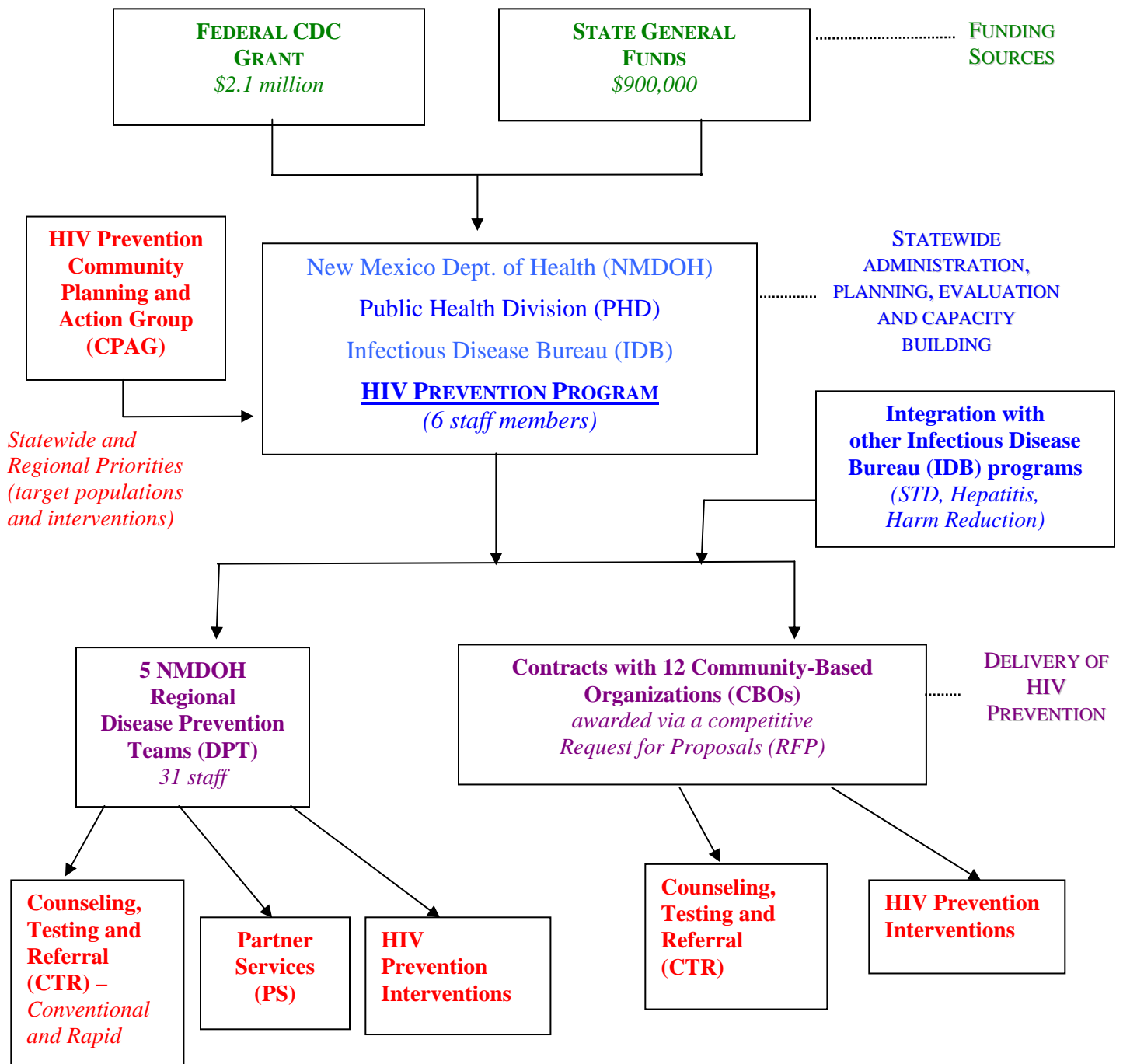
The NMDOH HIV Prevention Program administers the majority of government resources allocated to provide HIV prevention interventions, testing, partner services and other activities across the State of New Mexico. The two major sources of funds are the CDC and the State of New Mexico. The HIV Prevention Program currently administers roughly \$3 million annually, of which roughly \$2.1 million is from CDC and \$900,000 is from State of New Mexico General Funds.

The majority of resources are allocated for contracts with 12 community-based providers of HIV prevention education who serve all regions of the State. The HIV Prevention Program also supports a Disease Prevention Team (DPT) of state employees in each of the five NMDOH Public Health Regions to ensure that essential and core HIV prevention, testing and partner services (PS) activities are available in every part of New Mexico.

The following figure illustrates the major HIV prevention funding sources and organizations in the state. Funding is in green. The HIV Prevention Program, and its context within the State Department of Health, is shown in blue. Local providers are illustrated in purple, while their major activities are shown in red.

The CPAG plays a key role in setting priorities for target populations and HIV prevention strategies. This is illustrated in the figure in red. More detail about CPAG and its role were described previously in Chapter 2.

Figure 3. Overview of HIV Prevention Funding, Organizations and Activities



Harm Reduction

New Mexico has a well-established statewide Harm Reduction Program that offers a variety of prevention services. These services are an essential element of the overall effort to prevent HIV and hepatitis C infection in New Mexico, particularly among injection drug users (IDU) and their partners.

While harm reduction activities were coordinated by the HIV Prevention Program from their founding in February 1998 through June 2006, a separate Harm Reduction Program has been an independent unit of NMDOH since that time. All support for this program is exclusively from State of New Mexico general funds and no CDC dollars support this activity.

The Harm Reduction Program works to reduce drug-related harm while enhancing individual, family, and community wellness. This is done through the provision of linguistically appropriate and culturally competent services to IDU, such as syringe exchange at fixed, mobile and community sites. These services are provided by community-based organizations (CBO) and regional Public Health Offices (PHO). CBO and PHO also provide overdose prevention trainings for opiate users that include prescribing the opiate antagonist Naloxone (Narcan), which reverses the respiratory depression effect of an opiate overdose. The statewide Medical Cannabis Program is operated by the Harm Reduction Program as well. Acudetox activities are supported by both the Harm Reduction and HIV Prevention Programs.

Program goals include the following elements.

- To reduce the transmission of blood borne infections including hepatitis and HIV, and to limit the frequency of physical injury from injection drug use through syringe exchange services.
- To educate participants on ways to reduce the potential for harm associated with their substance use and other high-risk activities.
- To facilitate access to other health-related services including traditional preventive and primary medical care, as well as alternative healthcare resources.
- To act as a conduit for referring participants to substance use treatment, behavioral health, and other social services *when requested*.

The Harm Reduction Program serves a broad population with a variety of services, as illustrated by the following highlights.

- Since 1998, over 12 million syringes have been collected and disbursed.
- Since 1998, over 12,000 unique individuals have enrolled in the Syringe Exchange Program.
- From January 1 to September 31, 2008 there were approximately 2 million syringes collected and distributed
- Currently 12 contractors and 45 PHO are providing harm reduction services.
- Since 2001, 3,420 program participants have been trained in overdose prevention and the proper use of Naloxone. This includes over 1,000 individuals trained during the first 9 months of 2008.

- Since 2001, 996 individuals have had an opiate overdose reversed by Naloxone. Over half of these reversals took place in the first 9 months of 2008.
- The program has initiated a new collaborative effort to provide Buprenorphine opiate substitution therapy to persons recently released from correctional facilities. This effort in Albuquerque involves the Stanford Public Health Office and local harm reduction providers.

The proportion of all HIV/AIDS cases across New Mexico that are among injection drug users (IDU) has been declining. This may reflect and demonstrate the impact of the statewide syringe exchange program.

[Statewide Resources for HIV Care](#)

The NMDOH HIV Prevention Program has a close collaborative relationship with its parallel entity for HIV care, namely the AIDS Services Program. Both are part of the NMDOH Infectious Disease Bureau, as are the programs focusing on sexually transmitted diseases (STDs) and hepatitis. This structure ensures close communication and coordination. Given the CDC focus on prevention for persons living with HIV/AIDS expressed through its *Advancing HIV Prevention* initiative, these relationships are particularly important.

The AIDS Services Program manages Federal and State dollars for HIV care and support services within New Mexico, including funding from the Ryan White CARE Act. It contracts with five member agencies of the Health Management Alliance (HMA) to ensure that comprehensive HIV services are available across the state, including all five Public Health Regions.

- ***Northwestern New Mexico and Bernalillo County:***
New Mexico AIDS Services (NMAS), Albuquerque
- ***Northeastern New Mexico:***
Southwest C.A.R.E. Center, Santa Fe
- ***Southwestern New Mexico:***
Camino de Vida, Las Cruces
- ***Southeastern New Mexico:***
Alianza of New Mexico, Roswell
- ***American Indians:***
First Nations Community Healthsource, Albuquerque

Given that persons living with HIV/AIDS are the top ranked priority population by CPAG, there are a broad range of funded HIV prevention interventions for this population. The NMDOH HIV Prevention Program contracts directly with all five HMA member agencies to offer a range of HIV prevention strategies. This includes HIV testing (CTR), Comprehensive Risk Counseling and Services (CRCS), referrals to partner services (PS), the Healthy Relationships DEBI model and the Partnership for Health (PfH) DEBI model.

HIV care and services planning in New Mexico is conducted by the Governor's AIDS Policy Commission (GAPC). This group meets on a quarterly basis in Albuquerque, with all meetings open to the public. To ensure coordination between HIV prevention planning and HIV services

planning, several persons attend and/or serve as decision-making members of both the Commission and CPAG.

HIV Testing, Partner Services and Linkage to Care

A key goal of the HIV prevention program is to help identify persons living with HIV and link them to this network of care and support services. Most HIV prevention activities, including CTR and PS, contribute to this aim. Given the high rate of concurrent diagnoses of HIV and AIDS (see discussion of trends in Chapter 1B), it is currently a priority to ensure that efforts to provide testing and linkage are being enhanced and expanded.

A number of efforts to help persons seek testing and learn their HIV status are core elements of HIV prevention.

- **Targeted CTR:** Targeted HIV counseling, testing and referral (CTR) that recruits persons from at-risk groups into the 90+ test sites around the state.
- **Social Marketing:** Targeted social marketing efforts in two regions of the state to reach those persons who are most likely not to know their status and be concurrently diagnosed (including Hispanics in the Rio Grande Valley in central New Mexico.)
- **HIV Prevention Interventions:** HIV prevention interventions that help participants to consider HIV testing, disclosure issues or other ways to help themselves and their partners be aware of their status. Models designed for persons living with HIV, such as Healthy Relationships and Partnership for Health, can also help these persons to promote testing among their partners, family and friends.

The HIV Prevention Program is also working with primary care providers, and the five HMA agencies, to promote strategies within medical settings.

- **Routine Testing:** Routine HIV testing in primary care is being promoted through provider training and through pilot efforts to test specific patient populations routinely.
- **Partner Services:** Partner services is a very effective way to identify persons at risk of HIV and offer them testing. This strategy is being promoted among medical providers, particularly the HMA agencies that offer the majority of HIV care in the state.

C. Gaps Analysis – Top Gaps for Each Region and Statewide

REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 7
<ul style="list-style-type: none"> • Popular Opinion Leader (POL) for all populations • Mpowerment • Woman to Woman for transwomen • Collaboration and integration of Harm Reduction with Law Enforcement for IDU • Outreach to Public Sex Environments (PSE) 	<ul style="list-style-type: none"> • Increased targeted testing in rural areas, as well as promotion of routine testing • Increased prevention interventions in rural areas, including evidence-based interventions (EBIs) • Increased prevention services for pueblos including testing and EBIs • Interventions targeting at-risk homeless populations • Prevention and services for migrant populations 	<ul style="list-style-type: none"> • Expanded Harm Reduction and Syringe Exchange hours, especially on weekends • Adaptation and delivery in Spanish of VOICES/VOCES, Community PROMISE and Respect for HAR • Prevention and health education programs for MSM aged 30 and over • Incentives for retention of transgender gatekeepers to help facilitate prevention and outreach 	<ul style="list-style-type: none"> • Together Learning Choices (TLC) for young persons • Holistic Health Recovery Program (HHRP) • Community PROMISE for IDU and HAR • Acudetox • Internet Partner Services (PS) • Harm Reduction collaboration with law enforcement and hospitals for IDU 	<ul style="list-style-type: none"> • Many Men, Many Voices (3MV) for MSM-T • Mpowerment for young MSM-T • Safety Counts for IDU • RESPECT for IDU • Street Smart for HAR • iHEAL (adaptation of VOICES for incarcerated populations) 	<ul style="list-style-type: none"> • Popular Opinion Leader (POL) • Healthy Relationships • Safety Counts • SISTA, adapted for American Indian transgender and HAR • VOICES/VOCES • Recruiting at pow-wows and other community and cultural events
<p>STATEWIDE PRIORITY GAPS AND NEEDS FOR EXPANSION</p> <ul style="list-style-type: none"> • Increased access to mental health and substance abuse services for all populations • Enhanced integration of HIV prevention with sexually transmitted disease (STD), viral hepatitis, harm reduction and other infectious disease services 					

D. Gaps Analysis by Region

Gaps Analysis for Region 1 – Northwest New Mexico

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #1: EVIDENCE BASED	-- none --	Many Men, Many Voices (3MV) <i>(for young Latino men)</i> Popular Opinion Leader (POL) Mpowerment	-- none --	Voices/Voces, adapted to be culturally competent for American Indians Interventions for young Latino men
PRIORITY #2: INNOVATIVE	Popular Opinion Leader (POL) Internet Partner Services (IPN) Next Step <i>(developed by Montrose and Thomas Street Clinics in Houston)</i>	Popular Opinion Leader (POL), adapted to be delivered via the Internet Popular Opinion Leader (POL) <i>(adapted for transwomen)</i> SISTA <i>(adapted for transwomen, including American Indians)</i>	SISTA <i>(for female IDU, especially communities with inter-generational IDU)</i>	Woman to Woman <i>(for commercial sex workers) (developed by Planned Parenthood and Families and Youth, Inc.)</i>
PRIORITY #3: LOCALLY DEVELOPED	Community Inclusion Model	-- none --	Strategic outreach collaboration including integration of Harm Reduction with local law enforcement	Multi-session peer education group interventions for women <i>(adapted for other populations including American Indians) (developed by New Mexico AIDS Services)</i>
PRIORITY #4: RECRUITMENT	-- none --	Public Sex Environment (PSE) outreach linked with HIV testing (CTR)	-- none --	-- none --

Gaps Analysis for Region 2 – Northeast New Mexico

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
<p>PRIORITY #1: EVIDENCE BASED</p>	<p>Together Learning Choices (TLC) <i>(for young persons age 13-29)</i></p> <p>Routine testing in primary and other medical care settings, particularly in rural areas</p> <p>HIV testing (CTR), , particularly in rural areas</p>	<p>Many Men, Many Voices (3MV)</p> <p>Popular Opinion Leader (POL)</p> <p>Mpowerment <i>(for MSM age 18-29)</i></p> <p>Street Smart <i>(for runaway and homeless youth)</i></p> <p>Community Promise</p> <p>Holistic Health Recovery Program (HHRP) <i>(for MSM-T/IDU)</i></p> <p>Safety Counts <i>(for MSM-T who are active IDU)</i></p> <p>RESPECT</p>	<p>Safety Counts <i>(for active IDU)</i></p> <p>Holistic Health Recovery Program (HHRP)</p> <p>Community PROMISE</p> <p>RESPECT</p>	<p>Voices/Voces</p> <p>Safety Counts <i>(for active IDU)</i></p> <p>Street Smart <i>(for runaway and homeless youth)</i></p> <p>SISTA <i>(for African American and Hispanic/Latina women)</i></p> <p>Community Promise <i>(for HAR/IDU)</i></p> <p>Popular Opinion Leader (POL)</p> <p>HIV testing (CTR)</p> <p>RESPECT</p>

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #2: INNOVATIVE	<p>Popular Opinion Leader (POL)</p> <p>Internet Partner Services (PS)</p> <p>Community Promise</p> <p>Many Men, Many Voices (3MV) <i>(for MSM-T)</i></p> <p>Safety Counts <i>(for active IDU)</i></p> <p>Next Step <i>(developed by Montrose and Thomas Street Clinics in Houston)</i></p> <p>Do It Right</p> <p>Healthy Relationships adapted for specific sub-populations <i>(for American Indians, couples, etc.)</i></p>	<p>Popular Opinion Leader (POL) adapted to be delivered via the Internet</p> <p>Many Men, Many Voices (3MV) <i>(for American Indian MSM-T)</i></p> <p>Mpowerment adapted to be delivered via the Internet</p> <p>Popular Opinion Leader (POL) <i>(for Transwomen)</i></p> <p>SISTA/SISTAH <i>(for Transwomen, including American Indian)</i></p>	<p>Popular Opinion Leader (POL)</p> <p>SISTA <i>(for female IDU women, especially for communities with generational IDU)</i></p>	<p>Woman to Woman <i>(for Commercial Sex Workers) (developed by Planned Parenthood and Families and Youth, Inc.)</i></p> <p>SISTA/SISTAH <i>(for American Indian women)</i></p>
PRIORITY #3: LOCALLY DEVELOPED	<p>Positive Living <i>(developed by Camino de Vida)</i></p> <p>Speaker's Bureau</p>	<p>Interventions Delivered to Individuals (IDI) including RESPECT, adapted to be delivered via the Internet</p> <p>Safer Sex Forums (i.e. Gay City)</p>	<p>Project AWARE and WIP-ET <i>(peer education model for incarcerated women developed by New Mexico AIDS Services and Alianza)</i></p> <p>Safer Injection Workshops <i>(for MSM-T/IDU)</i></p>	<p>Project AWARE and WIP-ET <i>(peer education model for incarcerated women developed by New Mexico AIDS Services and Alianza)</i></p> <p><i>Multi-session peer education group intervention for women (developed by New Mexico AIDS Services)</i></p>

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #4: RECRUITMENT	-- none --	-- none --	Use of incentives	Use of incentives Public Service Announcements (PSAs) for recruitment

Gaps Analysis for Region 3 – Bernalillo County, including Albuquerque

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
<p>PRIORITY #1: EVIDENCE BASED</p>	<p>Community Promise Enhance Integration of STI, Hepatitis, and Harm Reduction Services</p>	<p>Community Promise <i>(for MSM and Transgender)</i> Respect Enhance Integration of STI, Hepatitis, and Harm Reduction Services</p>	<p>Community Promise Safety Counts expanded to more providers Expanded weekend syringe exchange hours. Respect Integrate Harm Reduction services in correctional and treatment facilities Increased NARCAN availability and training Enhance Integration of STI, Hepatitis, and Harm Reduction Services</p>	<p>Community Promise Respect Enhance Integration of STI, Hepatitis, and Harm Reduction Services</p>
<p>PRIORITY #2: INNOVATIVE</p>	<p>Healthy Relationships <i>(adapted in Spanish)</i></p>	<p>Community Promise <i>(adapted for the Internet)</i> Many Men, Many Voices (3MV) <i>(adapted in Spanish)</i></p>	<p>Safety Counts <i>(adapted in Spanish)</i> Community Promise <i>(adapted in Spanish)</i></p>	<p>Voices/Voces <i>(adapted in Spanish)</i> Community Promise <i>(adapted in Spanish)</i> Respect <i>(adapted in Spanish)</i></p>

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #3: LOCALLY DEVELOPED	<p>Next Step expanded to more providers</p> <p>Locally Developed Risk Reduction Workshop for Sero-discordant couples.</p> <p>Do It Right! expanded to more providers</p> <p>Increased access to Mental Health and Drug Treatment Services.</p>	<p>30+MSM Prevention and Health Education Programming</p> <p>Transgender Sex Worker Specific-Prevention and Health Education Outreach Programming.</p> <p>Collaborate with existing Detox/Treatment facilities to raise awareness of and sensitivity to GBT/MSM/IDU health concerns</p>	<p>Drop in Center for Harm Reduction with access to Healthcare, Prevention and Risk Reduction Education and Services for IDU, with shower and laundry facilities, collaboratively staffed by Harm Reduction providers</p> <p>Increased access to and availability of new and alternative treatment for addiction</p> <p>Increased Prevention and Harm Reduction education in correctional and treatment facilities</p>	<p>Increased Prevention and Harm Reduction education in correctional and treatment facilities</p> <p>More prevention and harm reduction education materials available in Spanish</p>

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #4: RECRUITMENT	Develop formalized peer education programs for gatekeepers and integrate into existing educational programming	Develop formalized peer education programs for gatekeepers and integrate into existing educational programming Expansion of Internet Outreach Interventions. Incentives for retention of transgender gatekeepers to help facilitate prevention workshops and outreach. Culturally appropriate prevention and harm reduction information for transgender persons	Develop formalized peer education programs for gatekeepers and integrate into existing educational programming (including correction facility staff) Organized contact and collaboration with other healthcare providers to raise awareness of and promote IDU services in Region 3 Promotional Brochure for other Healthcare Providers listing IDU services in Region 3	Develop formalized peer education programs for gatekeepers and integrate into existing educational programming (including correction facility staff) Expanded Social Marketing

Gaps Analysis for Region 4 – Southeast New Mexico

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #1: EVIDENCE BASED	<p>Healthy Relationships Together Learning Choices (TLC) <i>(for young persons age 13-29)</i> Partner services (PS) Partnership for Health (PFH) Routine testing in primary and other medical care settings <i>(for case finding of those who don't know their status)</i></p>	<p>Popular Opinion Leader (POL) Mpowerment <i>(for MSM age 18-29)</i> Street Smart <i>(for runaway and homeless youth)</i> Community Promise Safety Counts <i>(for MSM-T who are active IDU)</i></p>	<p>Harm Reduction, including Individual Level Interventions (ILI) <i>(for IDU statewide this is highest priority need)</i> Safety Counts <i>(for active IDU)</i> Holistic Health Recovery Program (HHRP) Community PROMISE Acudetox RESPECT</p>	<p>Street Smart <i>(for runaway and homeless youth)</i> SISTA <i>(for African American and Hispanic woman)</i> Community Promise <i>(for HAR/IDU)</i> Popular Opinion Leader (POL) RESPECT</p>
PRIORITY #2: INNOVATIVE	<p>Internet Partner Services (PS) Community Promise Next Step <i>(developed by Montrose and Thomas Street Clinics in Houston)</i> Do It Right Healthy Relationships adapted for specific sub-populations <i>(for American Indians, couples, etc.)</i></p>	<p>Popular Opinion Leader (POL) adapted to be delivered via the Internet Many Men, Many Voices (3MV) <i>(for American Indian MSM-T)</i> Mpowerment adapted to be delivered via the Internet Popular Opinion Leader (POL) <i>(for Transwomen)</i> SISTA/SISTAH <i>(for Transwomen, including American Indian)</i></p>	<p>Popular Opinion Leader (POL) SISTA <i>(for female IDU women, especially for communities with generational IDU)</i></p>	<p>Woman to Woman <i>(for Commercial Sex Workers) (developed by Planned Parenthood and Families and Youth, Inc.)</i> SISTA/SISTAH <i>(for American Indian women)</i></p>

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #3: LOCALLY DEVELOPED	Positive Adventures <i>(developed by Santa Fe Mountain Center)</i> Positive Living <i>(developed by Camino de Vida)</i> Speaker's Bureau Support groups	Individual Level Interventions (ILI) including RESPECT, adapted to be delivered via the Internet Experiential Prevention Intervention <i>(developed by Santa Fe Mountain Center)</i> Safer Sex Forums (i.e. Gay City) Safer Injection Workshops <i>(for MSM-T/IDU)</i> Summer Gathering prevention and cultural awareness event <i>(developed by Navajo AIDS Network)</i>	Strategic outreach, collaboration and integration of Harm Reduction with law enforcement Structural interventions, including training about Harm Reduction for emergency room doctors and dentists Project AWARE and WIP-ET <i>(peer education model for incarcerated women developed by New Mexico AIDS Services and Alianza)</i> Safer Injection Workshops <i>(for MSM-T/IDU)</i>	Project AWARE and WIP-ET <i>(peer education model for incarcerated women developed by New Mexico AIDS Services and Alianza)</i> Multi-session peer education group intervention for women <i>(developed by New Mexico AIDS Services)</i> Cross-generational curriculum for American Indian women <i>(developed by RRP Consulting)</i>
PRIORITY #4: RECRUITMENT	Street and online outreach Social Marketing Internet sites with resource and referral information Local Peer Supported outreach <i>(developed by Alianza)</i>	Public Sex Environment (PSE) outreach linked with HIV testing (CTR) Online outreach linked with HIV testing (CTR) Social Marketing Internet sites with resource and referral information	Street outreach Use of incentives Internet sites with resource and referral information	Outreach Link with HIV testing (CTR) for referrals Use of incentives Public Service Announcements (PSAs) for recruitment Collaboration among community-based agencies Internet sites with resource and referral information

Gaps Analysis for Region 5 – Southwest New Mexico

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #1: EVIDENCE BASED	Together Learning Choices (TLC)	Many Men, Many Voices (3MV) Mpowerment Street Smart Holistic Health Recovery Program (HHRP) Safety Counts	Safety Counts Holistic Health Recovery Program (HHRP) Community PROMISE RESPECT	Voices/ Voces (<i>for incarcerated population</i>) Safety Counts Street Smart SISTA Community PROMISE
PRIORITY #2: INNOVATIVE	Popular Opinion Leader (POL) Many Men, Many Voices (3MV) (<i>for Hispanics</i>)	Many Men, Many Voices (3MV) (<i>for Hispanics</i>) Mpowerment (<i>delivered via internet</i>)	SISTA (<i>for Hispanics</i>)	-- none --
PRIORITY #3: LOCALLY DEVELOPED	Speakers Bureau	Individual Level Interventions (ILI) delivered via the internet Experiential Prevention Intervention Safer sex forums Summer Gathering prevention and cultural awareness event	Strategic outreach collaboration and integration of Harm Reduction with law enforcement Structural interventions including training about Harm Reduction for emergency room doctors and dentists Acudetox	-- none --

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #4: RECRUITMENT	<p>Street and online outreach</p> <p>Social Marketing</p> <p>Internet sites with resource and referral information</p> <p>Use of incentives</p> <p>Public service announcements (PSAs) for recruitment</p> <p>Collaboration among community-based agencies</p>	<p>Public Sex Environment (PSE) outreach linked with HIV testing (CTR)</p> <p>Online outreach linked with HIV testing (CTR)</p> <p>Social Marketing</p> <p>Internet sites with resource and referral information</p> <p>Use of incentives</p> <p>Public service announcements (PSAs) for recruitment</p> <p>Collaboration among community-based agencies</p>	<p>Street outreach linked with HIV testing (CTR)</p> <p>Use of incentives</p> <p>Internet sites with resource ad referral information</p> <p>Social Marketing</p> <p>Public service announcements (PSAs) for recruitment</p> <p>Collaboration among community-based agencies</p>	<p>Street Outreach linked with HIV testing (CTR)</p> <p>Use of incentives</p> <p>Public service announcements (PSAs) for recruitment</p> <p>Collaboration among community-based agencies</p> <p>Social Marketing</p> <p>Internet sites with resource and referral information</p>

Gaps Analysis for Region 7 – American Indians/Alaskan Natives

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
<p>PRIORITY #1: EVIDENCE BASED</p>	<p>Healthy Relationships, adapted for Native Americans</p> <p>Partner Services</p> <p>Routine testing in medical programs, such as Indian Health Services and tribal clinics</p> <p>Integration of STD, Hepatitis and Harm Reduction Services</p>	<p>RESPECT</p> <p>Counseling, testing and referral (CTR)</p> <p>Integration of STD, Hepatitis and Harm Reduction Services</p>	<p>Harm Reduction</p> <p>Acudetox</p> <p>RESPECT</p> <p>Counseling, testing and referral (CTR)</p> <p>Integration of STD, Hepatitis and Harm Reduction Services</p>	<p>VOICES/VOCES</p> <p>RESPECT</p> <p>Counseling, testing and referral (CTR)</p> <p>Integration of STD, Hepatitis and Harm Reduction Services</p>
<p>PRIORITY #2: INNOVATIVE</p>	<p>-- none --</p>	<p>Popular Opinion Leader (POL) adaptation (<i>by Minnesota Indian Task Force</i>)</p> <p>SISTA, adapted for Native American transgender persons (<i>by Navajo AIDS Network - NAN</i>)</p> <p>Many Men, Many Voices (3MV) (<i>adapted by NAN</i>)</p>	<p>Safety Counts, adapted for Native Americans and to include emphasis on alcohol issues (<i>adapted by NNAPC</i>)</p>	<p>Popular Opinion Leader (POL) adaptation (<i>by Minnesota Indian Task Force</i>)</p> <p>SISTA, adapted for Native American women (<i>adapted by NAN</i>)</p> <p>Be Proud, Be Responsible (<i>by Sage Associates</i>)</p> <p>Native STAND (<i>adapted for youth by Albuquerque Area IHS</i>)</p>
<p>PRIORITY #3: LOCALLY DEVELOPED</p>	<p>-- none --</p>	<p>Summer Gathering prevention and cultural awareness event (<i>developed by NAN</i>)</p>	<p>-- none --</p>	<p>Cross-generational curriculum for American Indian women (<i>developed by RRP Consulting</i>)</p>

PRIORITY CATEGORY	Gaps for PLWH/A	Gaps for MSM-T	Gaps for IDU	Gaps for HAR
PRIORITY #4: RECRUITMENT	<p>Recruiting at pow-wows and other community and cultural events</p> <p>Linkage of HIV prevention interventions with outreach and CTR, to recruit clients</p>	<p>Recruiting at pow-wows and other community and cultural events</p> <p>Augmenting DEBI models with “HIV 101” information to ensure basic knowledge</p> <p>Linkage of HIV prevention interventions with outreach and CTR, to recruit clients</p>	<p>Recruiting at pow-wows and other community and cultural events</p> <p>Augmenting DEBI models with “HIV 101” information to ensure basic knowledge</p> <p>Linkage of HIV prevention interventions with outreach and CTR, to recruit clients</p>	<p>Recruiting at pow-wows and other community and cultural events</p> <p>Augmenting DEBI models with “HIV 101” information to ensure basic knowledge</p> <p>Linkage of HIV prevention interventions with outreach and CTR, to recruit clients</p>

APPENDICES

Appendix 1: Glossary of HIV Prevention Terminology

HIV PREVENTION TERMS AND ACRONYMS		
ACRONYM	CATEGORY	DEFINITION
3MV	Intervention	Many Men, Many Voices – a DEBI evidence-based intervention
AAIHB	Organization	Albuquerque Area Indian Health Board, Albuquerque
AED	Organization	The Academy for Educational Development (Technical Assistance provider)
AIDS	General	Acquired Immunodeficiency Syndrome
ART	General	Antiretroviral therapy
ASO	Organization	AIDS Service Organization
BHSD	Organization	Behavioral Health Services Division, New Mexico Human Services Department
C&T	Intervention	Counseling and testing (also CTR)
CAPS	Organization	Center for AIDS Prevention Studies, San Francisco
CBA	General	Capacity Building Assistance (training), from the CDC and its contractors
CBO	Organization	Community Based Organization
CDC	Organization	Federal Centers for Disease and Control and Prevention, Atlanta
CLI	Intervention	Community Level Intervention
COH	General	Circle of Harmony Conference
CPAG	General	HIV Prevention Community Planning and Action Group
CRCS	Intervention	Comprehensive Risk Counseling and Services, formerly known as PCM
CSA	General	Community Services Assessment (a section of the plan)
CSAP	Organization	Federal Center for Substance Abuse Prevention
CTR	Intervention	Counseling and testing (also C&T)
DEBI	Intervention	Diffusion of Effective Behavioral Interventions
DPS	General	Disease Prevention Specialist (staff of New Mexico Department of Health)
EIA/ELISA	General	Enzyme-linked immunoabsorbent assay (HIV antibody test that is sensitive for general screening)
FHPC	General	Fundamentals of HIV Prevention Counseling (manual for HIV test counseling)
FNCH	Organization	First Nations Community Healthsource, Albuquerque
FYI	Organization	Families and Youth Incorporated, Las Cruces

HIV PREVENTION TERMS AND ACRONYMS		
ACRONYM	CATEGORY	DEFINITION
GLBT	Population	Gay, Lesbian, Bisexual, Transgender
GMOC	Population	Gay men of color
HAART	General	Highly active anti-retroviral therapy
HAR	Population	Heterosexual(s) at Risk
HC/PI	Intervention	Health communications/public information
HCH	Organization	Healthcare for the Homeless, Albuquerque
HCV	General	Hepatitis C (also Hep C)
HE/RR	Intervention	Health Education or Risk Reduction
HEP C	General	Hepatitis C (also HCV)
HIPAA	General	Health Insurance Portability and Accountability Act (Federal law)
HIV	General	Human Immunodeficiency Virus
HMA	Organization	Health Maintenance Alliance
HPLS	General	HIV Prevention Leadership Summit (bi-annual national conference)
HPV	General	Human papilloma virus, genital warts
HR	Intervention	Harm Reduction
HR	Intervention	Healthy Relationships – a DEBI evidence-based intervention
HRSA	Organization	Federal Health Resources and Service Administration (funds HIV care services)
IDG	Intervention	Intervention delivered to groups, formerly known as Group Level Intervention (GLI)
IDI	Intervention	Intervention delivered to individuals, formerly known as Individual Level Intervention (ILI)
IDU	Population	Injection drug user
KFF	Organization	Kaiser Family Foundation (research and funding group)
LGBTIQ	Population	Lesbian, Gay, Bisexual, Transgender, Intersex, queer and/or questioning
MP	Intervention	Mpower/Mpowerment program
MSM	Population	Men/man who has sex with men (includes gay and non-gay identified men)
MSM-T	Population	Men/man who has sex with men (includes gay and non-gay identified men) and transgender persons
NA	General	Needs Assessment
NAN	Organization	Navajo AIDS Network, Gallup
NAPWA	Organization	National Association of People Living With AIDS
NASTAD	Organization	National Alliance of State and Territorial AIDS Directors

HIV PREVENTION TERMS AND ACRONYMS		
ACRONYM	CATEGORY	DEFINITION
NMAC	Organization	The National Minority AIDS Council
NMAS	Organization	New Mexico AIDS Services, Albuquerque and Farmington
NMDOH	Organization	New Mexico Department of Health
NMMLC	Organization	New Mexico Media Literacy Campaign
NNAAPC	Organization	National Native American AIDS Prevention Center, Denver
OMH	Organization	Federal Office of Minority Health
OMHRC	Organization	Federal Office of Minority Health Resource Center
OR	Intervention	Outreach
PCM	Intervention	Prevention case management, now known as CRCS
PCRS	Intervention	Partner Counseling and Referral Services, now known as PS
PED	Organization	New Mexico Public Education Department
PEMS	General	Program Evaluation Monitoring System (CDC electronic evaluation system)
PfH	Intervention	Partnership for Health – a DEBI evidence-based intervention
PI	General	Protease Inhibitor, a class of HIV drugs
PIR	General	Parity, Inclusion, and Representation
PLWA	Population	People/person living with AIDS
PLWHA	Population	People/person living with HIV/AIDS
POL	Intervention	Popular Opinion Leader – a DEBI evidence-based intervention
PROMISE	Intervention	Peers Reaching Out and Modeling Intervention Strategies – a DEBI evidence-based intervention, also known as Community PROMISE
PS	General	Partner Services (formerly known as PCRS)
PSA	Intervention	Public Service Announcement
PSE	General	Public Sex Environment(s)
RAPP	Intervention	Real AIDS Prevention Program – a DEBI evidence-based intervention
RFP	General	Request for Proposal
SAMHSA	Organization	Federal Substance Abuse and Mental Health Services Administration
SEP	Intervention	Syringe Exchange Program
SES	General	Socio-economic status
SFMC	Organization	Santa Fe Mountain Center, Santa Fe

HIV PREVENTION TERMS AND ACRONYMS		
ACRONYM	CATEGORY	DEFINITION
SHU	Organization	School Health Unit, New Mexico Public Education Department
SIPI	Organization	Southwestern Indian Polytechnic Institute
SISTA	Intervention	Sisters Informing Sisters on Topics about AIDS – a DEBI evidence-based intervention
STD	General	Sexually transmitted disease
SWCC	Organization	Southwest C.A.R.E. Center, Santa Fe
TA	Intervention	Technical Assistance
TLC	Intervention	Teens Linked to Care – an evidence-based intervention
TRANS	Population	Transgender
TSM/MST	Population	Transgenders who have sex with men/men who have sex with transgenders
VOICES/ VOCES	Intervention	Video Opportunities for Innovative Condom Education and Safer Sex – a DEBI evidence-based intervention
WB	General	Western Blot (HIV Antibody Test that is more specific and therefore used as a confirmatory test)
YDI	Organization	Youth Development, Inc., Albuquerque
YIPES/C	General	Youth Intervention and Prevention Education in Schools and Community
YMSM	Population	Young men who have sex with men

Appendix 2: CPAG Membership

The following table lists the 25 decision-making members of CPAG, as of March 2009.

DECISION-MAKING MEMBER	EMPLOYMENT/AFFILIATION (for informational purposes only)
Steven Belcher Albuquerque	Advocate/volunteer
Kahlo Benavidez Santa Fe	Santa Fe Mountain Center
Curtis Billie Albuquerque	New Mexico AIDS Services (NMAS)
Justin Britton Hope	Advocate/volunteer
Melissa Charlie Farmington	New Mexico Department of Health (NMDOH)
Benjamin W. Corsey III Pecos	AmeriCorps
Dave Daniels Las Cruces	New Mexico Department of Health (NMDOH)
Caroline Enos Albuquerque	American Red Cross (volunteer)
Tony Escudero Santa Fe	New Mexico Department of Health (NMDOH)
Yolanda J. Herrera Albuquerque	New Mexico Corrections Department
Camille Johnson Albuquerque	Advocate/volunteer
Bo Keppel Santa Fe	New Mexico Department of Health (NMDOH) AmeriCorps
Janet Lindsey Las Cruces	Families and Youth, Inc. (FYI)
Stella Martin Gallup	Navajo AIDS Network (NAN)
Will McLaughlin Roswell	Alianza of New Mexico
Stephani Patten Albuquerque	New Mexico Hepatitis C Alliance (NMHCA)
Wendell Robinson Albuquerque	Advocate/volunteer
Art Salazar Albuquerque	New Mexico Department of Health (NMDOH)

DECISION-MAKING MEMBER	EMPLOYMENT/AFFILIATION (for informational purposes only)
Jimmy Schrock Albuquerque	New Mexico AIDS Services (NMAS)
Kate Schneier Albuquerque	New Mexico AIDS Services (NMAS)
Mistina Smith Rio Rancho	African-American Health Services
Martin Walker Santa Fe	Santa Fe Mountain Center
Joby Wallace Albuquerque	New Mexico Department of Health (NMDOH)
Teresa Williams Roswell	New Mexico Department of Health (NMDOH)
Jeremy Yazzie Gallup	Navajo AIDS Network (NAN)

The following table illustrates the demographics of CPAG decision-making members, as of March 2009.

	Latino/ Latina	More Than One Race	Black or African American	American Indian or Alaska Native	Asian	Native Hawaiian or Pacific Islander	White	TOTAL
Male	2	4	1	2	0	0	4	13 (52%)
Female	3	0	2	2	0	0	3	10 (40%)
Transgender MTF	0	0	0	1	0	0	1	2 (8%)
Transgender FTM	0	0	0	0	0	0	0	0
MSM-T	1	3	1	2	0	0	2	9 (36%)
High Risk Heterosexual	2	0	0	1	0	0	1	4 (16%)
IDU	1	0	0	0	0	0	1	2 (8%)
MSM-T/IDU	0	0	0	1	0	0	1	2 (8%)
Living with HIV/AIDS	1	0	1	0	0	0	4	6 (24%)

Appendix 3: Plan to Plan

CHAPTER	KEY SECTIONS AND CONTENTS	PLAN TO PLAN
CHAPTER 1: Epidemiologic Profile	1a. Overview of HIV/AIDS in New Mexico and by Region	Prepared by NMDOH HIV & Hepatitis Epidemiology Program – by updating figures. One-page profiles/summaries for each CPAG region were updated and included as appendices. Draft of profile was presented to CPAG at statewide meeting on October 10, 2008.
	1b. Related Indicators and Health/Social Issues (i.e. STD rates, alcohol/drug use)	HIV Prevention Program staff collected and compiled data and indicators from other statewide plans and sources (i.e. YRBS survey, epi reports, STD-MIS data, IDU info from Nina Shah.) Brent Herrera presented to CPAG on August 8, 2008.
CHAPTER 2: Overview of CPAG	2a. Structure and Membership of CPAG	PIR Committee and staff summarized bylaws, structure, and current membership as of March 2009.
	2b. Annual Work Plan and CPAG Planning Activities during 2007-2008 Planning Year	CPAG reviewed and updated progress on work plan at statewide meetings through March 2009. Final version was included in plan.
	2c. Effectiveness of HIV Prevention Planning	CPAG member survey about planning attributes and member demographics was administered in March 2009. Results were summarized by HIV Prevention Program staff.
	3a. Model for Prioritizing Target Populations	Continue to use planning/prioritization model that was created by CPAG in 2003 and updated in 2005.

CHAPTER	KEY SECTIONS AND CONTENTS	PLAN TO PLAN
<p>CHAPTER 3: Prioritized Target Populations</p>	<p>3b. Prioritized Target Populations</p>	<p>Update data for each target population and insert into model to see if any priorities are revised. Sources for data included NMDOH HIV & Hepatitis Epidemiology Program, Harm Reduction Program and STD Program. HIV & Hepatitis Epidemiology Program presented updated HIV prevalence/incidence data and population estimates (particularly MSM and IDU) at statewide meeting on July 11, 2008 so that CPAG can update model.</p>
	<p>3c. Key Focus Areas and Trends in HIV/AIDS among Target Populations</p> <ol style="list-style-type: none"> 1) Internet and phone-line hookups 2) Incarcerated populations 3) Late diagnosis (with potential responses including routine testing, partner services, and provider education) 4) Increasing rates among Hispanics/Latinos 5) Youth/young adult and older sub-populations (revisit planning from 2006-07) 6) Border issues including migrant and transient populations 7) Women and perinatal cases – including female IDU and female HAR 	<p>NMDOH HIV & Hepatitis Epidemiology Program researched and reported on available data on these issues at the CPAG retreat in April 2008. Each CPAG Population Task Force examined data and discussed issues for these 7 areas, as applicable, during April – September 2008. Drafts from each task force presented and approved by CPAG in September 2008.</p> <p>Each Population Task Force answered these questions for each of the 7 focus areas:</p> <ol style="list-style-type: none"> 1. Are there any key concerns in terms of HIV prevention and risk behaviors, based on available data and/or anecdotal reports? If so, what are the top issues (2-3 bullets)? 2. Are there any emerging trends or new problems/issues, such as increasing HIV rates? If so, what are they? 3. What are some possible strategies in terms of HIV prevention interventions or activities to respond to these issues?
	<p>4a. Model for Prioritizing Interventions</p>	<p>Ad hoc group developed a new prioritization model, which was reviewed and adopted by CPAG in November 2007.</p>

CHAPTER	KEY SECTIONS AND CONTENTS	PLAN TO PLAN
CHAPTER 4: Prioritized Interventions	4b. Prioritized Interventions for Each Target Population	Each Population Task Force collected data needed to implement the prioritization model, review potential interventions and propose priorities for their sub-populations during February - April 2008 . These recommendations were reviewed and adopted by full CPAG on July 11, 2008.
CHAPTER 5: Community Services Assessment (CSA)	5a. Resource Inventory	The stand-alone statewide <i>HIV/STD/Hepatitis Resource Guide</i> is under development by the HIV Prevention Program and should be finished by June 2009 . This will substitute for this plan section. Both paper and searchable web versions will be available.
	5b. Needs Assessment and Gaps Analysis	This section cites the priorities described in Chapter 4. Each CPAG Regional Advisory Group (RAG) examined the list of priorities and determined what is available (aka resources) and what is missing (aka gaps) in their region. In addition to a list of gaps for each of the target populations, each identified the most important 4-6 overall gaps. These were completed and adopted in October 2008 and February 2009 .
	5c. Other Resources and Activities	HIV Prevention Program staff prepared narrative on statewide activities. This includes: 1) linkages and coordination with Harm Reduction, STD and viral hepatitis services, 2) training, technical assistance and capacity building, 3) data collection and evaluation activities, and 4) coordination with other planning bodies (Governor's AIDS Commission, Hepatitis C Alliance, etc.)

Appendix 4: CPAG Work Plan and Activities for 2007 – 2009 Planning Year

October 2007 – March 2009

Adopted January 11, 2008 – Updated and finalized March 13, 2009

TASK	RESPONSIBLE PARTY	TIMELINE	PROGRESS
GENERAL TASKS			
Develop regular meeting schedule for each Regional Advisory Group and Population Task Force, based on tasks needed to develop the <i>Comprehensive HIV Prevention Plan</i> .	CPAG Regional Advisory Groups and Population Task Forces.	Meetings occur from January to March 2009.	<i>Schedule set in November 2007 and updated monthly.</i>
Continue technical assistance (TA) on CPAG roles, processes and CDC guidance. Conduct regular orientations for new/continuing members and have an orientation packet available at all meetings. Additional training should focus on unique features of our CPAG, such as consensus process and committee structure.	CPAG co-chairs.	Orientations held in October, March and July each year.	<i>Orientations delivered in October 2007, March 2008, July 2008, October 2008 and March 2009.</i> <i>All orientation material is now available on www.nmcpag.org.</i>
Develop “hip” CPAG website (distinct from NMDOH site), to market CPAG group and recruit new members. Should include forms (i.e. PIR membership application), list of current members, and promotion/recruitment brochures/materials.	Camille Johnson and Justin Britton. Jerry will send electronic copies of bylaws and application forms to them for posting.	Ongoing.	<i>Justin created Myspace and Facebook pages in 2008. The main site, www.nmcpag.org, was completed in February 2009.</i>
Provide new information/research on HIV prevention and current activities in New Mexico via a periodic newsletter for CPAG and other interested persons.	Jerry Cheney will develop, with assistance of Lonnie Barraza and Caroline Enos. Future newsletters will emphasize local information and articles from CPAG members.	Ongoing.	<i>Newsletters distributed in November 2007 and at 2008 retreat. Jerry distributed a survey in February 2008.</i>

TASK	RESPONSIBLE PARTY	TIMELINE	PROGRESS
Provide training on epidemiology, focusing on topics identified by CPAG members such as how to pose questions and data requests and how to use data in grant proposals.	NMDOH HIV & Hepatitis Epidemiology Program.	January 2008.	<i>COMPLETE.</i>
Partner with other groups to provide support and education around legislative issues.	Drug Policy Alliance (DPA), Governor's AIDS Commission and other groups.	Ongoing, primarily during state legislative sessions (Jan – Feb 2008 and Jan – Mar 2009).	<i>COMPLETE.</i>
Partner with other organizations by having CPAG members attend and give reports: 1) New Mexico Hepatitis C Alliance 2) Governor's AIDS Policy Commission 3) Youth Intervention Prevention Education in Schools/Communities (YIPES/C)	1) Kory Montoya, Ben Corsey, Yolanda Herrera and Stephani Patten have served as Board members. 2) Andrew Gans, Lonnie Barraza, Kory Montoya, Martin Walker, Yolanda Herrera and Kahlo Benavidez have attended. 3) Lonnie Barraza facilitates. Peter Fishburn, Caroline Enos, Tony Escudero and Art Salazar attend.	Ongoing.	<i>At the annual meeting of the Hepatitis C Alliance in September 2008, they began to consider a proposal to merge and become a CPAG task force. The Alliance voted in February 2009 to collaborate in forming the CPAG Adult Hepatitis Task Force.</i>
Reinstate the public sex environment (PSE) committee to research and provide training on HIV prevention in settings such as the internet, commercial environments (i.e. bookstores and sex clubs) and sex parties. PSE outreach should link persons with testing, DEBI models and other services.	Martin Walker, Jimmy Schrock and Tony Escudero will serve on this committee. Tony and Martin will convene.	Ongoing.	<i>POSTPONED to future years, due to lack of resources.</i>

TASK	RESPONSIBLE PARTY	TIMELINE	PROGRESS
PARITY, INCLUSION AND REPRESENTATION (PIR)			
Recruit additional decision-making members to fill gaps in representation, including: 1) injection drug users (IDU) and MSM/IDU, 2) transgender persons, and 3) Region 1. Recruit IDU representation at quarterly Harm Reduction provider meetings and through program sites.	PIR Committee and IDU Task Force. Region 1 recruiting with help of diverse partners. Meeting in Farmington in January 2008 helped to recruit and find new co-chairs.	Ongoing.	<i>Kate Schneier and Martin Walker promoted CPAG at quarterly Harm Reduction provider meetings.</i> <i>Goals have been achieved in filling key gaps, including 2 co-chairs for Region 1, and new members who represent transgender and MSM/IDU.</i>
Make sure our parity, inclusion, and representation (PIR) reflects all affected and at-risk populations across the state.	PIR Committee.	Ongoing.	<i>COMPLETE. CPAG managed to fill key gaps during 2007 – 2009.</i>
Develop a brief brochure/pamphlet on CPAG that can be used to promote the group and recruit participants.	Martin Walker.	Complete by February 2008.	<i>COMPLETE. Brochure finalized and printed in November 2008.</i>
Retain youth members representing all areas of New Mexico.	PIR Committee, with support of full CPAG.	Ongoing.	<i>Good ongoing progress.</i>
Promote practice of bringing a colleague or friend to meetings. Remind of this practice when distributing agendas for statewide meeting.	CPAG members.	Ongoing.	<i>Ongoing.</i>
Recruit American Indians from around the state to participate in Region 7 and the statewide group. Include persons from Navajo Nation. Use Region 7 Orientation Packet to assist in promoting CPAG.	Region 7 Advisory Group and PIR Committee.	Ongoing.	<i>A number of new individuals have participated in Region 7 this year. Recruitment was aided by holding meetings in local communities, including Santo Domingo, Dulce and Nambe.</i>

TASK	RESPONSIBLE PARTY	TIMELINE	PROGRESS
Continue to thank CPAG members and their employers for participation. Consider developing a social event that offers recognition and/or incorporate into the annual retreat. A letter to employers/organizations will be created and sent.	Jerry Cheney, Caroline Enos and Teresa Williams.	Ongoing.	<i>Thank you certificate signed by all persons presented was given to church in May 2008. Letter to organizations was not completed.</i>
HIV PREVENTION LEADERSHIP SUMMIT (HPLS)			
Update guidelines for selection of CPAG members to attend HPLS and/or US Conference on AIDS (USCA).	Ad hoc committee convened by Justin Britton.	January 2008.	<i>COMPLETE.</i>
Submit abstracts to HPLS and USCA in a coordinated fashion from all regions of New Mexico to show our achievements, including syringe exchange.	CPAG members.	January 2008.	<i>COMPLETE. Region 4 team presented a poster at 2008 HPLS. Two presentations were made at 2008 USCA.</i>
Review applications from CPAG members and apply new selection criteria to pick delegation to attend HPLS and USCA.	Ad hoc committee.	February – March 2008.	<i>COMPLETE.</i>
Follow guidelines for HPLS attendance and reporting back to CPAG, with members expected to provide both verbal and written reports on the sessions they attend.	All HPLS and USCA attendees report.	July – September 2008 (HPLS) and October 2008 (USCA).	<i>COMPLETE Most of those who attended HPLS and/or USCA presented summaries to full CPAG.</i>

TASK	RESPONSIBLE PARTY	TIMELINE	PROGRESS
TRAINING			
<p>Provide trainings during CPAG statewide meetings on:</p> <ol style="list-style-type: none"> 1) Integration of HIV with STD and viral hepatitis services 2) Cultural issues for diverse Hispanic/Latino populations including New Mexicans and Mexicans 3) African American cultural issues 4) Transgender issues 5) Injection drug users 6) Agency report-backs on implementation of DEBI models 	<p>Provided or coordinated by:</p> <ol style="list-style-type: none"> 1) Jimmy Schrock 2) Tony, Carmelita 3) Mistina 4) Jerry 5) Bernie Lieving 6) Community providers <p>NAN will help with cultural competence trainings using National Minority AIDS Education and Training Center grant.</p>	<p>Report-backs on implementation of DEBIs are scheduled for statewide meetings all year. Other trainings ongoing.</p>	<p><i>Transgender training conducted by NAN in May 2008.</i></p> <p><i>DEBI reports happening monthly since January 2008 (Healthy Relationships in Jan, Safety Counts in Feb, Partnership for Health in April, Community PROMISE in May, Voices/Voces in July, Many Men/Many Voices in Aug)</i></p> <p><i>Need Harm Reduction, Hispanic/Latino, and African American trainings.</i></p>
<p>Provide ongoing training to CPAG members and HIV prevention providers, outside of CPAG.</p> <ol style="list-style-type: none"> 1) Public sex environments (PSE) work 2) Internet outreach 3) HIV/STD/Hepatitis update (“Quit Buggin’ Me”) 4) Group facilitation 	<ol style="list-style-type: none"> 1) PSE Committee. 2) NMAS staff, including Mpowerment team. 3-4) Jerry Cheney will coordinate. 	<p>Ongoing.</p>	<p><i>Group facilitation was held on March 12-13, 2008.</i></p> <p><i>Quit Buggin Me was held in July 2008 and March 2009.</i></p> <p><i>PSE training postponed to future years.</i></p>

Appendix 5: Epidemiological Profile of HIV/AIDS by Region

Epidemiological profiles of HIV/AIDS in each CPAG planning region follow.

Notes for each of the six profiles:

^a*Incidence reflects only cases diagnosed in New Mexico.*

^b*Living and cumulative reflects all cases diagnosed in New Mexico and out-of-state.*

^c*Rates per 100,000 based on Bureau of Business and Economic Research data for 2006.*

Source: *HIV & Hepatitis Epidemiology Program, New Mexico Department of Health*
<http://www.health.state.nm.us/epi/hiv-aids.html>

Updated 10/9/08

Epidemiologic Profile of HIV/AIDS Cases in New Mexico through 2007

Region 1: Northwest New Mexico

Type of Case	Incident, 2007 ^a			Living ^b			Cumulative ^b	
	N	%	Rate ^c	N	%	Rate	N	%
Type of Case								
HIV	20	80%	4.8	140	45%	33.4	150	30%
AIDS	5	20%	1.2	172	55%	41.0	342	70%
Sex								
Male	21	84%	10.2	263	84%	127.7	426	87%
Female	4	16%	1.9	49	16%	22.9	66	13%
Race/Ethnicity								
White	7	28%	4.6	123	39%	80.3	204	41%
Hispanic	7	28%	6.1	92	29%	80.3	141	29%
American Indian/Alaska Native (AI/AN)	11	44%	7.7	84	27%	58.5	21	4%
African American	0	0%	0.0	13	4%	267.1	125	25%
Asian/Pacific Islander (Asian/PI)	0	0%	0.0	0	0%	0.0	1	0%
Age at Diagnosis								
< 13	0	0%	0.0	0	0%	0.0	2	0%
13-19	1	4%	2.0	5	2%	10.2	7	1%
20-29	7	28%	11.5	76	24%	124.4	106	22%
30-39	5	20%	9.9	122	39%	240.4	194	39%
40-49	5	20%	7.9	84	27%	133.3	130	26%
50+	7	28%	6.1	25	8%	22.0	53	11%
Mode of Exposure								
Men who have sex with men (MSM)	11	44%	-	151	48%	-	243	49%
Injection drug users (IDU)	2	8%	-	50	16%	-	77	16%
MSM/IDU	0	0%	-	29	9%	-	49	10%
Heterosexual	2	8%	-	40	13%	-	51	10%
Other	0	0%	-	3	1%	-	13	3%
No Identified Risk (NIR)	10	40%	-	39	13%	-	56	11%
Pediatric	0	0%	-	0	0%	-	3	1%
TOTALS	25	100%	6.0	312	100%	74.4	492	100%

Epidemiologic Profile of HIV/AIDS Cases in New Mexico through 2007
Region 2: Northeast New Mexico, including Santa Fe

Type of Case	Incident, 2007 ^a			Living ^b			Cumulative ^b	
	N	%	Rate ^c	N	%	Rate	N	%
Type of Case								
HIV	10	53%	3.3	194	37%	64.0	209	23%
AIDS	9	47%	3.0	333	63%	109.9	708	77%
Sex								
Male	17	89%	11.4	476	90%	318.1	849	93%
Female	2	11%	1.3	51	10%	33.2	68	7%
Race/Ethnicity								
White	5	26%	4.2	291	55%	243.9	551	60%
Hispanic	12	63%	7.3	198	38%	120.4	310	34%
American Indian/Alaska Native (AI/AN)	1	5%	7.3	19	4%	138.9	30	3%
African American	0	0%	0.0	17	3%	754.5	23	3%
Asian/Pacific Islander (Asian/PI)	1	5%	28.8	2	0%	57.6	3	0%
Age at Diagnosis								
< 13	0	0%	0.0	0	0%	0.0	1	0%
13-19	0	0%	0.0	7	1%	24.2	8	1%
20-29	6	32%	16.2	91	17%	245.1	134	15%
30-39	9	47%	25.5	232	44%	656.5	404	44%
40-49	4	21%	8.4	151	29%	316.9	274	30%
50+	0	0%	0.0	46	9%	42.3	96	10%
Mode of Exposure								
Men who have sex with men (MSM)	12	63%	-	370	70%	-	667	73%
Injection drug users (IDU)	1	5%	-	34	6%	-	50	5%
MSM/IDU	2	11%	-	54	10%	-	93	10%
Heterosexual	1	5%	-	42	8%	-	54	6%
Other	1	5%	-	3	1%	-	10	1%
No Identified Risk (NIR)	2	11%	-	23	4%	-	40	4%
Pediatric	0	0%	-	1	0%	-	3	0%
TOTALS	19	100%	6.3	527	100%	173.9	917	100%

Epidemiologic Profile of HIV/AIDS Cases in New Mexico through 2007

Region 3: Bernalillo County, including Albuquerque

Type of Case	Incident, 2007 ^a			Living ^b			Cumulative ^b	
	N	%	Rate ^c	N	%	Rate	N	%
HIV	44	58%	7.0	471	41%	75.0	514	25%
AIDS	32	42%	5.1	689	59%	109.7	1502	75%
Sex								
Male	67	88%	21.8	1039	90%	338.7	1841	91%
Female	9	12%	2.8	121	10%	37.6	175	9%
Race/Ethnicity								
White	26	34%	9.0	543	47%	188.1	1014	50%
Hispanic	39	51%	13.5	489	42%	169.4	791	39%
American Indian/Alaska Native (AI/AN)	5	7%	1.8	52	4%	18.8	85	4%
African American	5	7%	16.6	68	6%	225.7	115	6%
Asian/Pacific Islander (Asian/PI)	1	1%	5.7	8	1%	45.5	11	1%
Age at Diagnosis								
< 13	0	0%	0.0	2	0%	1.8	4	0%
13-19	4	5%	6.7	26	2%	43.7	26	1%
20-29	24	32%	22.2	291	25%	268.7	447	22%
30-39	18	24%	30.2	441	38%	741.1	830	41%
40-49	13	17%	14.2	293	25%	320.2	510	25%
50+	17	22%	20.8	107	9%	130.8	199	10%
Mode of Exposure								
Men who have sex with men (MSM)	42	55%	-	764	66%	-	1320	65%
Injection drug users (IDU)	3	4%	-	89	8%	-	177	9%
MSM/IDU	3	4%	-	111	10%	-	227	11%
Heterosexual	6	8%	-	109	9%	-	140	7%
Other	0	0%	-	4	0%	-	13	1%
No Identified Risk (NIR)	22	29%	-	78	7%	-	132	7%
Pediatric	0	0%	-	5	0%	-	7	0%
TOTALS	76	100%	92.9	1160	100%	184.7	2016	100%

Epidemiologic Profile of HIV/AIDS Cases in New Mexico through 2007

Region 4: Southeast New Mexico

Type of Case	Incident, 2007 ^a			Living ^b			Cumulative ^b	
	N	%	Rate ^c	N	%	Rate	N	%
Type of Case								
HIV	4	57%	1.6	61	38%	24.1	69	25%
AIDS	3	43%	1.2	99	62%	39.2	209	75%
Sex								
Male	5	71%	4.0	125	78%	100.1	226	81%
Female	2	29%	1.6	35	22%	27.4	52	19%
Race/Ethnicity								
White	4	57%	3.0	78	49%	58.3	140	50%
Hispanic	2	29%	1.5	58	36%	43.4	103	37%
American Indian/Alaska Native (AI/AN)	0	0%	0.0	1	1%	1.0	2	1%
African American	1	14%	31.9	22	14%	701.8	31	11%
Asian/Pacific Islander (Asian/PI)	0	0%	0.0	1	1%	11.7	2	1%
Age at Diagnosis								
< 13	0	0%	0.0	1	1%	2.1	1	0%
13-19	0	0%	0.0	4	3%	14.5	5	2%
20-29	3	43%	8.2	36	23%	75.9	58	21%
30-39	1	14%	3.6	70	44%	254.4	118	42%
40-49	0	0%	0.0	37	23%	101.2	73	26%
50+	3	43%	10.8	12	8%	43.4	23	8%
Mode of Exposure								
Men who have sex with men (MSM)	3	43%	-	69	43%	-	123	44%
Injection drug users (IDU)	1	14%	-	33	21%	-	57	21%
MSM/IDU	0	0%	-	19	12%	-	34	12%
Heterosexual	1	14%	-	24	15%	-	33	12%
Other	0	0%	-	2	1%	-	7	3%
No Identified Risk (NIR)	2	29%	-	11	7%	-	22	8%
Pediatric	0	0%	-	2	1%	-	2	1%
TOTALS	7	100%	25.3	160	100%	63.3	278	100%

Epidemiologic Profile of HIV/AIDS Cases in New Mexico through 2007

Region 5: Southwest New Mexico

Type of Case	Incident, 2007 ^a			Living ^b			Cumulative ^b	
	N	%	Rate ^c	N	%	Rate	N	%
HIV	13	57%	3.2	181	44%	44.4	193	33%
AIDS	10	43%	2.5	234	56%	57.4	393	67%
Sex								
Male	20	87%	9.9	346	83%	171.5	500	85%
Female	3	13%	1.5	69	17%	33.6	86	15%
Race/Ethnicity								
White	7	30%	4.0	160	39%	92.5	241	41%
Hispanic	12	52%	6.9	221	53%	127.7	299	51%
American Indian/Alaska Native (AI/AN)	1	4%	0.5	5	1%	2.4	6	1%
African American	2	9%	18.6	26	6%	241.9	37	6%
Asian/Pacific Islander (Asian/PI)	1	4%	14.1	3	1%	42.2	3	1%
Age at Diagnosis								
< 13	1	4%	1.4	6	1%	8.3	6	1%
13-19	2	9%	4.5	17	4%	38.6	17	3%
20-29	3	13%	4.1	111	27%	181.3	137	23%
30-39	8	35%	18.2	157	38%	356.3	246	42%
40-49	5	22%	8.2	86	21%	140.5	116	20%
50+	4	17%	8.7	38	9%	82.2	64	11%
Mode of Exposure								
Men who have sex with men (MSM)	12	52%	-	190	46%	-	288	49%
Injection drug users (IDU)	2	9%	-	59	14%	-	82	14%
MSM/IDU	0	0%	-	37	9%	-	50	9%
Heterosexual	0	0%	-	44	11%	-	58	10%
Other	0	0%	-	2	0%	-	7	1%
No Identified Risk (NIR)	8	35%	-	77	19%	-	94	16%
Pediatric	1	4%	-	6	1%	-	7	1%
TOTALS	23	100%	5.6	415	100%	101.9	586	100%

Epidemiologic Profile of HIV/AIDS Cases in New Mexico through 2007

Region 7: American Indians/Alaskan Natives

	Incident, 2007 ^a			Living ^b			Cumulative ^b	
	N	%	Rate ^c	N	%	Rate	N	%
Type of Case								
HIV	13	72%	6.5	103	41%	51.2	110	30%
AIDS	5	28%	2.5	146	59%	72.6	255	70%
Sex								
Male	13	72%	13.5	194	78%	201.1	291	80%
Female	5	28%	4.8	55	22%	52.5	74	20%
Age at Diagnosis								
< 13	0	0%	0.0	1	0%	2.1	3	1%
13-19	2	11%	7.3	7	3%	25.4	9	2%
20-29	5	28%	14.9	72	29%	215.2	95	26%
30-39	5	28%	19.8	101	41%	400.3	157	43%
40-49	3	17%	11.1	48	19%	178.2	73	20%
50+	3	17%	7.4	20	8%	49.3	28	8%
Mode of Exposure								
Men who have sex with men (MSM)	6	33%	-	131	53%	-	191	52%
Injection drug users (IDU)	1	6%	-	25	10%	-	38	10%
MSM/IDU	1	6%	-	27	11%	-	40	11%
Heterosexual	1	6%	-	37	15%	-	49	13%
Other	0	0%	-	3	1%	-	6	2%
No Identified Risk (NIR)	9	50%	-	25	10%	-	38	10%
Pediatric	0	0%	-	1	0%	-	3	1%
TOTALS	18	100%	8.9	249	100%	123.8	365	100%