New Mexico Jurisdictional HIV Prevention Plan: 2012 – 2014
PRIORITIES

SHARED VALUES

These answer the question: How do we maintain the quality and impact of our HIV prevention work with less resources?

Shared Values all contribute to achieving our statewide HIV prevention goals, as stated in our grant applications to the Centers for Disease Control and Prevention (CDC).

Goal:

1) Reduce risk behaviors among populations impacted by HIV to reduce new HIV infection, AND

2) provide testing and other services that help persons with HIV to learn their status and be linked with care.

Shared value #1 – Statewide HIV Prevention: Maintain a statewide HIV prevention presence by ensuring that there is both a NMDOH Disease Prevention Team and a community-based HIV prevention program in each region. Continue close collaboration within each region to maximize scarce resources. This ensures that we have some minimum infrastructure in all areas that can be built upon with outside resources.

Shared value #2 – Core Services: Ensure funding of core services in each region, including targeted HIV counseling, testing and referral services (CTRS), partner services (PS), condom distribution and prevention for positives.

Shared value #3 – Use of State Funds: Use state general fund dollars (SGF) primarily to support innovative and effective local HIV prevention interventions and other behavioral interventions that are not defined as core services by CDC.

Shared value #4 – Harm Reduction: Maintain the state's model and innovative harm reduction services across New Mexico. Syringe Services Programs (SSP) are important to reduce new infections and the harm reduction philosophy should be incorporated into prevention activities for all risk populations.

Shared value #5 – Community Engagement: Ensure engagement of HIV infected individuals and communities affected by HIV into the planning, design and implementation of all HIV prevention activities.

Shared value #6 – Integration Across Infectious Diseases: Maintain close collaboration between all HIV prevention activities and integrated infectious disease services for hepatitis, sexually transmitted diseases (STD) and harm reduction to ensure a holistic approach to client needs.

PRIORITIZATION MODEL

This model has three tiered groups of priorities in ranked order.

<table>
<tr><th>Priority Tier</th><th>Interventions and Populations</th><th>Emphasis</th></tr>
<tr><td>Tier #1 - CORE:
Core services</td><td>• HIV Testing, including both a) targeted testing and counseling and b) routine testing in primary care settings.
• Comprehensive Prevention with Positives, including HIV Partner Services (PS).
• Condom Distribution.
• Non-occupational Post-Exposure Prophylaxis (nPEP)</td><td>CDC’s required core components under Category A of PS12-1201 grant, except for Policy Initiatives.</td></tr>
<tr><td>Tier #2 - HIGH:
Interventions for populations with high HIV incidence and rates</td><td>• Gay/bisexual men and other men who have sex with men (MSM).
• Injection drug users (IDU).
• Transgender persons.</td><td rowspan="2">Particular emphasis on the following sub-populations:
• Persons with multiple risk factors (i.e. MSM who are IDU).
• Incarcerated persons and those with a history of incarceration.
• Sex workers and persons who trade sex for money, drugs, or other incentives.
• Youth (up to and including age 24).
• Hispanic, African American and American Indian persons.</td></tr>
<tr><td>Tier #3 - MODERATE:
Interventions for populations with moderate incidence and rates</td><td>• Heterosexuals at risk.
• Social marketing, media and mobilization with a focus on promoting and recruiting to interventions in Tier #1 and #2.</td></tr>
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Within each Priority Tier, the following interventions are appropriate for the stated risk populations.

- Any **Diffusion of Evidence Based Interventions (DEBI) model** for that risk population, including in particular any culturally specific adaptations of DEBI models.
- **Locally developed interventions** with evidence of effectiveness in reducing HIV risk behaviors. Evidence is defined as any data showing increased or improved attitudes and skills, rather than just knowledge. This does not have to be published or peer-reviewed publications, but just data collected and analyzed by an organization.
- **Recruitment** to any prioritized intervention.
- **Integrated infectious disease outreach**, meaning community and detention-based services that incorporate HIV, STD, hepatitis and/or harm reduction services provided in a holistic fashion to respond to client needs and risks.

We recognize the increased effectiveness of all interventions and services when providers reflect the populations being served.

This model should take into account that interventions for IDU, particularly syringe services programs, are funded separately by the NMDOH Harm Reduction Program.

CPAG believes it is necessary and essential to fund required core activities to support the priorities listed above.

1. Jurisdictional HIV Prevention Planning
2. Capacity Building and Technical Assistance
3. Program Planning, Monitoring and Evaluation, and Quality Assurance