NMCPAG
NEW MEXICO COMMUNITY PLANNING & ACTION GROUP

New Mexico HIV Prevention Jurisdictional Plan

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

and

New Mexico Department of Health (NMDOH) HIV Prevention Program

September 2012

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I. Planning Overview and Process

A. Background and Structure of CPAG

The Federal Centers for Disease Control and Prevention (CDC) mandates that each State implement a data-driven HIV planning process. The revised HIV Planning Guidance that describes this process was released by CDC in July 2012. (Information is available at: http://www.cdc.gov/hiv/topics/funding/PS12-1201/index.htm.)

In New Mexico, HIV prevention planning has been conducted by the New Mexico HIV Prevention Community Planning and Action Group (CPAG) since 1995, 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 (RAG) that each focus on the needs of a specific geographic area or demographic group. Each RAG convenes local meetings and solicits input from the communities it represents.

The structure of the CPAG and its planning processes are described in greater detail in a companion document, the *New Mexico HIV Prevention Engagement Plan*, also completed in September 2012. That plan is available on the CPAG web site at: http://www.nmcpag.org/plans.html.

B. Plan to Plan

The New Mexico CPAG revised its planning timeline almost a decade ago to shift towards creating a single comprehensive HIV prevention plan for the jurisdiction every three years. To support this work, CPAG aimed to create annual supplements that updated key information about HIV prevention.

In collaboration with NMDOH, CPAG decided in October 2010 to implement its next planning cycle over an 18-month period from January 2011 through June 2012. To guide this work and specify some revisions to the structure of the plan, a "Plan to Plan" was developed. The revised version of this document from April 2011 follows as Table 1.

The Plan to Plan envisioned a single statewide plan, as had been produced in prior years. Given revised guidance from CDC in July 2012, this content was divided into three planning documents that support each other. All of these documents can be found online at: http://www.nmcpag.org/plans.html.

- ***Jurisdictional Plan:*** This document describes the needs assessment process, priority populations and their HIV-related health disparities and priorities for New Mexico.
- ***Engagement Plan:*** As noted above, this companion document describes the planning process that CPAG has undergone. It also includes plans and potential steps to bring additional perspectives into the planning process in the coming years.
- ***Comprehensive Program Plan:*** This third document contains goals and objectives for HIV prevention activities across the state, to be implemented by the NMDOH HIV Prevention Program using CDC and other funds. Therefore, goals and objectives are not included in this *Jurisdictional Plan.*

Because of this change in structure, several items described in the Plan to Plan are not found in this *Jurisdictional Plan* but rather are included in the two supporting documents, as noted above. In addition, while sections 3a and 3b proposed a model and process for prioritizing target populations, that task is no longer required by CDC and is not included in any of the plans.

Table 1. Plan to Plan

CHAPTER	KEY SECTIONS AND CONTENTS	PLAN TO PLAN	TIMELINE
CHAPTER 1: Epidemiologic Profile	**1a. Overview of HIV/AIDS in New Mexico and by Region**	Prepared by NMDOH HIV and Hepatitis Epidemiology Program – by updating figures. One-page profiles/summaries for each CPAG region will be updated and included as appendices.	Presentation at CPAG retreat in April 2011. Complete by August 2011 to present to CPAG.
	1b. Related Indicators and Health/Social Issues (i.e. STD rates, alcohol/drug use)	HIV Prevention Program staff will collect and compile data and indicators from other statewide plans and sources (i.e. YRRS survey, epi reports, PRISM data, IDU information from Harm Reduction Program.)	Complete by August 2011 to present to CPAG.
	1c. Health Disparities	Develop a new section on HIV/AIDS disparities and potential responses to them, similar to content in the National HIV/AIDS Strategy (NHAS).	NHAS Task Force develops by August 2011 to present to CPAG.
CHAPTER 2: Overview of CPAG	**2a. Structure and Membership of CPAG**	PIR Committee and HIV Prevention Program staff will summarize bylaws, CPAG structure, and current membership as of March 2012.	PIR and staff complete in March 2012.
	2b. Annual Work Plan and CPAG Planning Activities during 2011-2012 Planning Cycle	CPAG reviews and updates progress on work plan at statewide meetings. Final version included in plan.	CPAG reviews and updates during statewide meetings through May 2012.
	2c. Effectiveness of HIV Prevention Planning	CPAG member survey about planning attributes and member demographics. Results were summarized by HIV Prevention Program staff.	Conduct annual survey in March 2011 and March 2012.

CHAPTER	KEY SECTIONS AND CONTENTS	PLAN TO PLAN	TIMELINE
CHAPTER 3: Prioritized Target Populations	**3a. Model for Prioritizing Target Populations**	Review old planning model and update.	CPAG reviews model in June – July 2011 and adopts new prioritization model by September 2011.
	3b. Prioritized Target Populations	Update data for each target population and insert into model to see if any priorities are revised. Sources for data included NMDOH HIV and Hepatitis Epidemiology Program, Harm Reduction Program and STD Program.	CPAG implements new prioritization model by incorporating new data in October – November 2011.
	3c. Key Focus Areas and Trends in HIV/AIDS among Target Populations	Each Population Task Force answers these questions for each of the focus areas: 1) What are the key concerns in terms of HIV epidemiology and risk behaviors, based on available data and/or anecdotal information? Identify the top 3-5 issues. 2) Are there any emerging trends or new problems/issues, such as increasing HIV rates, new risk behaviors or new risk co-factors? If so, what are they? 3) What are the most effective HIV prevention interventions, programs and services to respond to the needs in this population?	CPAG develops new focus areas for reviewing trends during April – May 2011. Population Task Forces collect data and information to respond to trends during August – November 2011.

CHAPTER	KEY SECTIONS AND CONTENTS	PLAN TO PLAN	TIMELINE
CHAPTER 4: Prioritized Interventions	**4a. Goals and Objectives for the Jurisdiction**	Develop goals and objectives for HIV prevention in New Mexico, parallel to those in the National HIV/AIDS Strategy (NHAS).	NHAS Task Force, CPAG Co-Chairs and HIV Prevention Program staff will draft objectives during May – June 2011. These will be reviewed and adopted by CPAG by August 2011.
	4b. Model for Prioritizing Interventions	Review and revise existing prioritization model.	CPAG reviews and adopts new prioritization model in September – November 2011.
	4c. Prioritized Interventions for Each Target Population	Each Population Task Force collects data needed to implement the prioritization model, review potential interventions and propose priorities for their sub-populations.	Task Forces collect information and apply model during January – March 2012. CPAG reviews and adopts recommendations during April – May 2012.
CHAPTER 5: Community Services Assessment (CSA)	**5a. Resource Inventory**	The stand-alone statewide *HIV/STD/Hepatitis Resource Guide* has been online at www.nmhivguide.org since 2009. This will substitute for this plan section. Both paper and searchable web versions are available. Cite this resource in the plan.	Completed. HIV Prevention Program staff will continue to update resource guide during 2011 – 2012.

CHAPTER	KEY SECTIONS AND CONTENTS	PLAN TO PLAN	TIMELINE
	5b. Needs Assessment and Gaps Analysis	Each CPAG Regional Advisory Group (RAG) will examine the list of priorities in Chapter 4 and determine 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 RAG will identify the most important 4-6 overall gaps in their region.	Each Regional Advisory Group will review and identify gaps during March – May 2012.
	5c. Linkage to Care	Develop new narrative on strategies and activities related to 1) helping persons with HIV learn their status, and 2) helping persons with HIV link to care and support services. Follow and parallel content in the National HIV/AIDS Strategy (NHAS).	PLWH/A Task Force, CPAG Co-Chairs and HIV Prevention Program staff will draft section during August – November 2011. These will be reviewed and adopted by CPAG by January 2012.
	5d. Other Resources and Activities	HIV Prevention Program staff prepared narrative on statewide activities. This includes: 1) linkages and coordination with Harm Reduction, STD and Hepatitis services, 2) training, technical assistance and capacity building, 3) data collection and evaluation activities, and 4) coordination with other planning bodies (i.e. HIV Services Planning Council, Hepatitis C Alliance, etc.)	HIV Prevention Program staff will complete by March 2012.

C. Contribution to National HIV/AIDS Strategy and High Impact Prevention

This planning cycle coincided with several important shifts in HIV planning at the national level. This *Jurisdictional Plan* is designed to respond to these important efforts and better align New Mexico's work with them.

- ***National HIV/AIDS Strategy (NHAS)***
  http://www.cdc.gov/hiv/strategy/nhas/index.htm
  In October 2009, Albuquerque was one of 14 cities to host a community discussion to contribute to the development of this strategy. NHAS was released by the White House Office of National AIDS Policy (ONAP) in July 2010. Its three major goals are:
  1) reduce the number of people who become infected with HIV,
  2) increase access to care and optimizing health outcomes for people living with HIV, and
  3) reduce HIV-related health disparities.

- ***High Impact Prevention (HIP)***
  http://www.cdc.gov/hiv/strategy/hihp/index.htm
  Components of HIP include:
  - Effectiveness and cost
  - Feasibility of full-scale implementation
  - Coverage in the target populations
  - Interaction and targeting
  - Prioritization

- ***CDC's Funding Opportunity PS12-1201***
  This is the "flagship" funding stream from the CDC's Division of HIV/AIDS Prevention (DHAP) to state health departments. It contains a new funding formula that better aligns dollars with national HIV epidemiology, resulting in increased funds for cities but declining support for low-to-moderate HIV incidence states like New Mexico. In addition, 75% of funds must be directed to Required Core Components, which emphasize biomedical strategies such as prevention for persons living with HIV/AIDS, Partner Services (PS) and HIV Counseling, Testing and Referral Services (CTRS). Due to the diverse mix of activities funded through the NMDOH HIV Prevention Program, the state was already in alignment with this requirement, with 76.8% of activities funded in 2011 (prior to PS12-1201) fitting into the definition of Required Core Components.

The Plan to Plan proposed adding three key areas of discussion not included in prior statewide plans. This was done to align with the structure and goals of the National HIV/AIDS Strategy (NHAS).

- ***HIV-related Health Disparities*** *(Section 1c in Plan to Plan)*
  See *Section IV. Special Populations and Health Disparities* in this document
- ***Goals and Objectives for the Jurisdiction*** *(Section 4a in Plan to Plan)*
  See the *Comprehensive Program Plan.*
- ***Linkage to Care*** *(Section 5c in Plan to Plan)*
  NMDOH completed a Linkage to Care Protocol in December 2011. Development of new programs in this area is underway. Therefore, a discussion is not included here but will be provided in future plans. Some information is included in New Mexico's *Combined Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Services Plan*, completed by the NMDOH HIV Services Program in June 2012. That companion document is also available online at: http://www.nmcpag.org/plans.html.

While this planning was underway, the NMDOH HIV Prevention Program put all prevention contracts with community-based organizations to competitive bid via a Request for Proposals (RFP) in spring 2012. The aim of this RFP was to align HIV prevention programs more closely with the goals of NHAS, PS12-1201 and High Impact Prevention. Table 2 shows the progress made in terms of the mix of funded activities. It should be noted that this RFP process was completed prior to this *Jurisdictional Plan*; however, it did incorporate the priorities established by CPAG that are described in the following *Section V. Priorities for HIV Prevention.*

Table 2. Alignment of HIV Prevention Contracts with NHAS and High Impact Prevention

Service category	Prior to NHAS and PS12-1201 (funding for 2009-2012 cycle)	After NHAS and PS12-1201 (funding starting July 2012)
Targeted CTRS	10 agencies (91%) *(last has outside funding for CTRS)*	9 agencies (90%) *(last has outside funding for CTRS)*
Incentives for referrals to Partner Services (PS)	1 agency (9%)	4 agencies (40%)
Evidence-based prevention interventions for persons with HIV/AIDS	6 agencies (55%)	7 agencies (70%)
Evidence-based prevention interventions for gay/bisexual men and/or transgender persons	10 agencies (91%)	10 agencies (100%)
Total number of contract providers	11 agencies	10 agencies

In addition to efforts to restructure the statewide plan to align with NHAS, CPAG did specific planning around how New Mexico responds to the three major goals of NHAS. This was done through an Ad Hoc NHAS Planning Task Force, formed in fall 2010, and several brainstorming discussions with the entire CPAG.

The first result of these planning efforts was a description of strategies and activities currently being implemented in New Mexico that contribute to each of the three goals of the NHAS. This is illustrated in Table 3.

Table 3. Current Strategies That Contribute to NHAS Goals

	Strategies and activities <u>currently being implemented</u> in New Mexico that contribute to each goal
Goal 1: Reduce new HIV infections	• Prevention and education programs • Statewide syringe services programs (SSP) • Condom distribution, demonstration and safer sex kits • Conventional and rapid CTRS • Partner Services • Transgender-focused services • Integrated infectious disease services including collaborative multi-agency outreach • Targeted efforts • Developing curricula and adapting DEBIs • Social marketing • Community-level interventions at public events such as Gay Pride, Two-Seven African American HIV Awareness Day, National Latino AIDS Awareness Day (NLAAD) and World AIDS Day • Surveys such as BRFSS and YRRS • Health education requirement for high school graduation • Work with LGBT youth through programs such as N'MPower (based on Mpowerment model), Gay-Straight Alliance (GSA) network and Next Rainbow Generation (NRG) youth group in Las Cruces • Comprehensive risk counseling and services (CRCS) • Training, technical assistance (TA) and capacity-building assistance (CBA) for prevention workers • Statewide HIV prevention planning by CPAG • Using epidemiology data for planning and prioritization • Culturally-appropriate adaptations to all of the services listed • Non-occupational post-exposure prophylaxis (nPEP)

	Strategies and activities <u>currently being implemented</u> in New Mexico that contribute to each goal
Goal 2: Increase access to care and improve health outcomes for people living with HIV	• Access to care and medications through AIDS Drug Assistance Program (ADAP) and New Mexico Medical Insurance Pool (NMMIP) • Collaboration between community-based organizations (CBOs) and Infectious Disease Nurse Specialists (IDNS) • Literature and www.nmhivguide.org web site refer persons to care • Rural/frontier community adaptations and strategies • CRCS and case management • Planning efforts that have involvement of persons with HIV, such as CPAG and HIV Services Planning Council • Anonymous and confidential CTRS • Partner Services • nPEP • Support groups • SSP services can build relationships with clients and link them to care • Community advisory boards (CAB) of HIV service provider agencies • Collaboration of government, CBOs and communities • HIV provider training via University of New Mexico's (UNM) Extension for Community Healthcare Outcomes (ECHO) Model of telehealth case-based learning • Training of gatekeepers to provide peer education and support • Provider training by the New Mexico AIDS Education and Training Center (AETC) • System of HIV service providers (HSP), formerly the "HMAs" • Volunteer efforts • Advocacy by staff who are themselves from affected communities • Health fairs

	Strategies and activities <u>currently being implemented</u> in New Mexico that contribute to each goal
Goal 3: **Reduce HIV-related health disparities**	• Diversity of planning groups match epidemic, such as through efforts of PIR committee of CPAG • Culturally specific programs and local adaptations • CPAG population task forces and Region 7 Advisory Group • Cultural competence trainings for CPAG and providers, on ethnic/racial groups and LGBT issues • Events specifically designed to target and serve communities. - Two-Seven and Project SAVED - Supplement on Hispanic MSM - Es Mejor Saber - Transgender Task Force and summit - Circle of Harmony - NLAAD activities - Latino Advisory Council - Pasa La Voz - Gay Pride, with coordinated and collaborative statewide outreach • Harm Reduction activities beyond just syringe exchange, such as overdose prevention • Integration of hepatitis and STD services • Funding of ethnic/racially specific programs at various agencies - Navajo AIDS Network (NAN) - First Nations Community Healthsource (FNCH) - Planned Parenthood's Woman to Woman program - African American Health and Social Services (AAHSS) • Seeking outside funding to serve minority populations • ECHO eases access to care for rural/frontier and underserved populations • Programs in corrections such as NMPEP, ECHO, NMDOH Disease Prevention Teams (DPT), NMAS, PP

The additional finding from this planning was potential new strategies and activities that could be implemented in New Mexico to further each of these goals. Given that the long list of possible options would not be feasible to implement with current resources, CPAG prioritized the ideas related to each goal. The number next to each item is the number of "votes" gathered during a prioritization activity. This is illustrated in Table 4.

Table 4. Potential New Strategies to Contribute to NHAS Goals

	Potential <u>new strategies and activities</u> that could be implemented for each goal	
Goal 1: Reduce new HIV infections	14	Move away from abstinence-only to comprehensive sex education in middle and high schools
	10	More comprehensive prevention, education and support for gay/bisexual youth and transgender youth
	8	Look outside of CDC high-risk groups to focus on trends we're seeing such as youth, older, women, sex workers
	8	Invest more in mental health
	7	Emphasize that HIV can affect anyone to reduce stigma
	6	More youth involvement as peer educators to spread the word
	6	Universal testing at intake for incarceration
	6	Routine HIV testing becomes more universal in health care settings – with more involvement of HMOs and health care organizations
	6	LGBT wellness centers in regions, including Region 1 (Northwest)
	5	More prevention and CTRS in rural/frontier settings
	5	More internet outreach
	5	Standardized peer education for gatekeepers
	5	Safe places for homeless/street populations and sex workers
	5	More mobile SSP, such as a school bus
	5	Target younger folks with CTRS and prevention interventions that incorporate self-esteem and empowerment
	4	Campaign to promote women's self-determination over their bodies, especially for Native women
	3	Public Service Announcements (PSA) that target MSM
	3	More experiential education across prevention programs
	2	Have follow-up and outcome evaluation after populations participate in an intervention
	2	Identify high-risk groups such as MSM and IDU in corrections
	1	Conduct CTRS and social marketing in bars, such as with ads on Johnny Boards
	1	Supply of condoms available 24/7 for those on the street
	1	Check out models from other states to see what works
	1	Increase partnership with Epidemiology and Response Division (ERD) to get better numbers
	1	Create social consciousness around health including HIV and use holistic approaches
	0	Research psychology of HIV-infected persons to inform prevention

	Potential <u>new strategies and activities</u> that could be implemented for each goal	
Goal 2: Increase access to care and improve health outcomes for people living with HIV	15	Teach persons with HIV how to be proactive and advocate for their health
	14	Social marketing, including online, to increase awareness of services
	11	Support groups, including in rural/frontier areas
	10	Ensure access to care for incarcerated and on release
	9	Better linkages and more availability of mental health services
	8	Services for dually diagnosed with HIV and Hepatitis C (HCV) to remove barriers
	6	Navigation system for Natives with HIV to get services within and outside IHS
	6	Keep doctors we have and recruit good ones in rural/frontier areas, such as Region 4 (southeast), using tools like AETC and ECHO to provide training
	6	Treatment adherence promoted by getting donations for patients who can't afford their medications
	6	Look at strong programs nationwide such as Chicago House peer advocate model and Mosaica model
	5	Equal access to Ryan White services across the state
	5	Remember basics like transportation, healthy food and shelter to allow access
	4	Increase number of HIV Service Providers (HSP)
	3	Support national health care reform
	2	Ensure access to uninterrupted health insurance coverage
	2	Ensure access along border and for persons who are deported
	2	Change the name of New Mexico AIDS Services (NMAS) to avoid stigma
	1	Positives offer mutual support via the internet

	Potential <u>new strategies and activities</u> that could be implemented for each goal	
Goal 3: Reduce HIV-related health disparities	23	Train health care providers to be more competent and respectful regarding HIV, STD and homelessness, and be able to give better referrals to comfortable settings
	22	Social marketing campaigns with real budgets: - HIV anti-stigma campaign - LGBT anti-stigma campaign - Hispanic and African American culturally specific
	15	Educate other health and social service providers about our services
	13	Better data to be able to review outcomes such as community viral load, to see where NM is now in terms of disparities
	8	Programs and educational efforts that address treatment adherence
	8	Focus on human trafficking and sex workers
	7	Expand culturally specific programs for African Americans and Hispanics across the state
	7	Specific focus on pueblos to target and tailor programs
	6	Provide navigation and support for Native clients both within and outside IHS
	6	Look at disparities for homeless and use navigators

II. Needs Assessment and Community Input

HIV planning is intended to be a data-driven process to identify prevention needs, strategies and goals for the jurisdiction. Therefore, HIV planning starts with a process to gather information about the profile of needs for persons living with HIV/AIDS and persons at risk of infection. This includes several data sources. For this planning cycle, CPAG reviewed and compiled three key types of data.

- Epidemiologic profile of HIV/AIDS in New Mexico
- Needs assessment of persons living with HIV/AIDS
- Shared values for HIV prevention determined by CPAG

A. Epidemiologic Profile of HIV/AIDS in New Mexico

All diagnosed cases of HIV/AIDS are reportable in New Mexico to the HIV and Hepatitis Epidemiology Program, a unit of the NMDOH Epidemiology and Response Division (ERD). That program produces a number of reports for the public that summarize HIV/AIDS incidence and prevalence. Special reports are published periodically to describe trends in the epidemic, such as "no identified risk" (winter 2011), concurrent diagnoses (summer 2010) and opportunistic infections (winter 2009).

The most recent epidemiologic profile is the *HIV and AIDS Annual Surveillance Report: New Mexico 2011*. Because the stand-alone document is easily accessible, and data is regularly updated by the program, a summary of the profile is not repeated here. This complete document is available from the program and is posted on two Internet sites.

- HIV and Hepatitis Epidemiology Program page at: http://nmhealth.org/ERD/HealthData/hiv_aids.shtml
- CPAG web site at: http://www.nmcpag.org/plans.html.

During the 2011-2012 planning cycle, the HIV and Hepatitis Epidemiology Program did two presentations to statewide CPAG meetings about both HIV and hepatitis epidemiology. This included a repeat of the "Epi 101" talk on how to interpret data and request special analyses.

B. Needs Assessment and HIV Services Planning Process

HIV planning by CPAG emphasizes HIV prevention activities. In parallel, a new planning body was established in 2011 with an emphasis on HIV care and support services for people living with the disease. The first meeting of the New Mexico HIV Services Advisory Council was held on September 27, 2011. To ease participation for providers, consumers and advocates from around the state, all monthly meetings of this group took place via a televideo linkage provided by Project ECHO at the UNM in Albuquerque.

The HIV Services Advisory Council based its planning and prioritization tasks on a comprehensive statewide needs assessment of persons with HIV conducted via a sub-contract with UNM. The needs assessment team was led by faculty members Drs. John Oetzel and Magdalena Avila. Because this participatory research was so detailed and thorough, it was shared with CPAG to inform HIV prevention planning efforts. Methods to gather input in the first year included the following elements.

- Seven focus groups with 50 clients of HIV Service Provider (HSP) agencies around the state.
- 12 individual interviews of persons living with HIV.
- Surveys of 344 clients on: (a) where they get services and their satisfaction in general with services, (b) use and satisfaction with specific services; (c) barriers faced in seeking services; (d) their interaction with their providers; (e) medication adherence; (f) perception of social support and social undermining; (g) self-rated health and quality of life (including physical and mental health); (h) risk factors; and (i) demographics.
- Six focus groups with 53 providers who work at five of six HSP agencies.
- Written surveys of 47 providers.

The research continued for a second year to get more detailed information about unmet need and reasons that persons with HIV/AIDS might not be in care. The UNM team also asked for feedback on drafts of priorities and plans developed by the HIV Services Advisory Council. Methods included 10 focus groups and 10 individual interviews that reached a total of 80 participants. Of this group, 15 identified that they had unmet need at some point.

The full needs assessment process and findings are described in further detail in New Mexico's *Combined Statewide Coordinated Statement of Need (SCSN) and Comprehensive HIV Services Plan.* The result of the HIV Services Advisory Council's nine-month planning process, this document was released by the NMDOH HIV Services Program in June 2012. That companion document is also available online at: http://www.nmcpag.org/plans.html.

C. Shared Values

HIV planning by CPAG was directed by a set of Shared Values that were drafted by an Ad Hoc Planning Task Force and adopted by the full group in January 2012.

CPAG designed the Shared Values in the environment of NHAS, HIP and PS12-1201 to answer a key question: "How do we maintain the quality and impact of our HIV prevention work with fewer resources?"

CPAG determined that these six Shared Values would all contribute to achieving our statewide HIV prevention goals, as stated in our initial grant applications to the CDC under PS12-1201.

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. Monitor these activities to assure that they are provided effectively.

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.

III. HIV Services Continuum in New Mexico

A. Overview of Services Continuum

New Mexico boasts a coordinated system of HIV prevention, care and support services that are integrated with hepatitis, harm reduction and sexually transmitted disease (STD) services according to the principles of Program Collaboration and Service Integration (PCSI). Core services are available to residents of all areas of New Mexico based on a regional model.

The NMDOH Public Health Division has divided the state into five regions:

- Northwest (including the cities of Gallup and Farmington)
- Northeast (including the cities of Santa Fe, Taos and Las Vegas)
- Metro (including the metropolitan area around Albuquerque)
- Southeast (including the cities of Roswell, Carlsbad and Clovis)
- Southwest (including the city of Las Cruces)

Each region includes the following types of providers and services.

- ***Regional Disease Prevention Teams (DPT):***
  Operated by NMDOH, these teams are located in Public Health Offices. They provide core HIV prevention activities including CTRS and Partner Services. Integration is assured by the fact that this staff also has responsibilities in harm reduction, hepatitis and STD prevention. Each regional team includes a mix of Disease Prevention Program Managers, Supervisors, Disease Prevention Specialists and HIV Health Educators. Some regions also have state-funded Infectious Disease Nurse Specialists (IDNS) who support persons living with HIV and engage in linkage-to-care activities. HIV and STD Partner Services are fully integrated across New Mexico, as both are provided by the DPT and state statute requires that these activities be delivered solely by NMDOH.

- ***HIV Prevention Contractors:***
  There are ten community-based organizations around New Mexico with contracts to deliver evidence-based HIV prevention interventions and targeted CTRS. Each region has at least one provider. Within each region, these organizations work closely with their regional DPT to coordinate outreach, referrals, linkage-to-care and community level interventions and activities.

- ***HIV Services Providers (HSP):***
  HIV care and support services are integrated and coordinated by having "one stop" comprehensive HSP agencies in each region. Each provides case management and can enroll clients in Ryan White and other publicly funded HIV care and support services. Some provide HIV medical care directly, while others use contractual or referral agreements to assure these services. In addition to the four HSP agencies that are designed to cover five

geographic regions, First Nations Community Healthsource is an HSP in Albuquerque that focuses on American Indians/Alaskan Natives. All five HSP organizations also are HIV prevention contractors, ensuring successful efforts at prevention for positives and good coordination between prevention and care.

New Mexico boasts one of the first statewide Harm Reduction Programs in the nation. Supported entirely by State General Fund dollars, this program offers syringe exchange and education services and opioid overdose prevention using Narcan in all regions of the state, as well as acudetox services in some areas. Because of this resource, the NMDOH HIV Prevention Program has to focus fewer resources on HIV prevention activities for injection drug users (IDU).

B. Gaps in Services and Potential Scalability

New Mexico's current continuum of HIV prevention and care services assures that core activities take place in all regions. While dollars are limited, there is access to core functions such as CTRS, Partner Services, case management and harm reduction in all public health regions.

CPAG priorities allow a variety of activities that are currently not funded due to limited resources. These are some of the key gaps that are frequently highlighted.

- Additional targeted and outreach-based CTRS to reach the highest risk populations of MSM, transgender persons, IDU and HAR. These could include innovative recruitment methods such as social marketing, peer education and social network testing.
- While implementation of rapid testing using Unigold has expanded steadily across New Mexico over the past four years, additional training and resources could allow this to become the standard testing strategy. This is particularly important in rural/frontier areas and for risk groups who are less likely to return for the results of a conventional test.
- There are evidence-based DEBI and locally developed interventions for gay/bisexual men and other MSM in all regions; however, these costly and time-intensive interventions reach a limited number of persons. Additional resources would allow expansion.
- Harm Reduction programs around New Mexico would benefit from more efforts to provide risk reduction education to IDU, with models such as Safety Counts. Currently that intervention is only offered by one contractor in the entire state.

With the new funding model under CDC's funding opportunity PS12-1201, New Mexico is facing a stark and steady decline in resources for HIV prevention through 2016. The key effort will be to preserve core activities in each region of the state with dwindling resources. If new dollars were found, several of the above gaps could be overcome by scaling up the most effective interventions.

- Training additional NMDOH Public Health Offices and community-based partners to offer rapid HIV testing using Unigold.

- Expanding evidence-based HIV prevention interventions for gay/bisexual men and other MSM in the cities with the highest population. This would include Albuquerque, Santa Fe and Las Cruces. Given the small and hard-to-find populations in rural/frontier areas, the existing interventions reach a significant proportion of the population and would have limited opportunity to bring to a greater scale.
- Expanding evidence-based HIV prevention interventions for transgender persons. Currently these services are only available in two cities in the entire state.
- Expanding the Mpowerment model to reach additional populations. This might include creating such programs in Santa Fe and/or Las Cruces. In addition, the current N'MPower Program in Albuquerque only serves men aged 18-29, so it would be ideal to add a second parallel N'MPower for teens.
- Expanding the staffing and resources for STD Partner Services, which could reduce co-infection and the thereby the infectiousness of persons with HIV.
- Expanding Harm Reduction services to additional sites and populations.

IV. Special Populations and Health Disparities

One of the core tasks of HIV prevention planning from 1995 through 2011 was to identify and prioritize the target populations at greatest risk of HIV infection. With the new *HIV Planning Guidance* released by CDC in July 2012, the prioritization step is no longer a requirement. However, the CPAG continued to conduct a careful review of the behavioral risk groups most likely to be infected with HIV in New Mexico.

- Persons living with HIV/AIDS (PLWH/A)
- Gay/bisexual men and other men who have sex with men (MSM)
- Injection drug users (IDU)
- MSM who inject drugs (MSM/IDU)
- Heterosexuals at risk (HAR)

CPAG has had standing Population Task Forces to review the prevention needs of each of the above groups, except MSM/IDU, for over a decade. These groups continued their work in the 2011-2012 planning cycle. The prevention needs of MSM/IDU are reviewed by both the Gay/bisexual/MSM and IDU Task Forces, as this population fits into both and has dual risk behaviors and prevention needs.

Because transgender persons were not receiving enough focus as a key population for HIV prevention, the prior planning cycle redefined the "MSM" category to add transgender persons with a new grouping called "MSM-T". However, this did not account for the distinctly different risk behaviors, cultural norms and HIV prevention needs of transgender individuals. Therefore, CPAG determined in 2009 that planning for transgender populations should be done distinctly by a newly formed Transgender Task Force.

Several other populations do not receive adequate emphasis and resources in the current prevention continuum. Therefore, additional Population Task Forces were created in this planning cycle to review their needs.

- Sex workers
- Incarcerated persons and those with a history of incarceration

The CPAG established an Adult Viral Hepatitis Task Force in 2009 to achieve an even closer integration between HIV and adult viral hepatitis prevention, screening/testing and services across New Mexico. This group built upon prior planning efforts by other organizations, such as the New Mexico Hepatitis C Alliance, a 501(c)(3) non-profit organization with a long history of close collaboration with NMDOH.

In addition to the planning for viral hepatitis prevention and services, the integration has benefitted from other efforts by CPAG.

- CPAG has helped plan and supported events across New Mexico for hepatitis awareness day, such as National and International Hepatitis Awareness Days and Hepatitis Testing Days.
- During 2011-12, CPAG reviewed its bylaws and added language to specify that membership also include persons living with, advocating for and working on adult viral hepatitis.

Based on the above issues, CPAG determined that eight distinct Population Task Forces should review prevention needs during the 2011-2012 planning cycle. Each group responded to the same six planning questions in their comprehensive review. The results of this planning are shown in the following eight tables.

A. Persons living with HIV/AIDS (PLWH/A)

B. Gay/bisexual men and other men who have sex with men (MSM)

C. Injection drug users (IDU)

D. Heterosexuals at risk (HAR)

E. Transgender persons (TG)

F. Sex workers

G. Incarcerated persons and those with a history of incarceration

H. Adult viral hepatitis

Part of this review was designed to bring New Mexico further into alignment with the National HIV/AIDS Strategy (NHAS). Therefore, alignment with NHAS was a specific question for each group. In addition, this review also included extensive discussion of health disparities, which are one goal area of the NHAS.

A. Persons Living with HIV/AIDS (PLWH/A)

Planning question	In other words...	Information about this population
1. What are the key concerns in terms of HIV epidemiology and risk behaviors, based on available data and/or anecdotal information? Identify the top 3-5 issues.	What types of behaviors put this population at risk for HIV?	*See following reports for each population. PLWH/A fall into all of these groups.*
2. Are there any emerging trends or new problems/issues, such as increasing HIV rates, new risk behaviors or new risk co-factors? If so, what are they?	In what new ways is this population at risk for HIV?	*See following reports for each population. PLWH/A fall into all of these groups.*
3. What are the most effective HIV prevention interventions, programs and services to respond to the needs in this population?	What works to prevent new infection?	• Comprehensive Risk Counseling and Services (CRCS) • Healthy Relationships • Partner Services • Positive Adventures experiential adventure model created by Santa Fe Mountain Center • Partnership for Health (PfH) • Ask Screen Intervene (ASI) model for HIV and STD prevention • Peer-Led Models

Planning question	In other words...	Information about this population
4. What training needs regarding serving your population are there for CPAG, HIV prevention contractors, NMDOH or others?	How can the NMDOH best prepare you to engage the population?	• Mosaica Model • CRCS Training • Report about needs assessment and why clients leave care • Training about better documentation of linkage to care • CTRS • Healthy Relationships intervention training to maintain pool of trained staff • HIV and Mental Health • Linkage to care models • Peer-led Models.
5. What community level events should have HIV prevention presence? This can be existing events in the community or something new for CPAG to create.	How can we spread the message?	• Gay Pride and Rodeo • HIV/AIDS Advocacy Network (HAAN) Forums • Support Groups • NM-Consumer Advocacy Council (CAC) trainings and events • Circle of Harmony conference on HIV for American Indians/Alaskan Natives
6. How can we support goals of the National HIV/AIDS Strategy (NHAS) that are related to your population? What exists currently? What should be created?	What can the CPAG or a Population Task Force do to contribute to the NHAS?	• System development for better linkage to care after a positive test result • Client Handbook and brochure on service availability • Enhanced Partner Services • Targeted Testing • Continue expanding Rapid HIV Testing • Linkage to Care Protocol • Evidence based prevention for positives • Continued cross-training on Infectious Diseases (Quit Buggin' Me curriculum) • Peer-Led models

B. Gay/Bisexual Men and Other Men Who Have Sex with Men (MSM)

Planning question	In other words...	Information about this population
1. What are the key concerns in terms of HIV epidemiology and risk behaviors, based on available data and/or anecdotal information? Identify the top 3-5 issues.	What types of behaviors put this population at risk for HIV?	• Rise in syphilis rates among Hispanic MSM. Indicates higher rates of unprotected sex. • Of the 2,305 MSM tested in 2010, 1,770 (76.79%) reported sex without a condom. 45% of these did so with partners of unknown status. • Mental Health, self-esteem, stigma, and historical trauma.
2. Are there any emerging trends or new problems/issues, such as increasing HIV rates, new risk behaviors or new risk co-factors? If so, what are they?	In what new ways is this population at risk for HIV?	• Increasing use of Internet and mobile apps (i.e. Grindr) for hook ups. Making anonymous hookup easier and Partner Services more challenging. • Increasing social isolation from community information and support resources for gay men. • Increasing co-infections with HIV and Syphilis. • Increasing rates of HIV infections in both younger and older MSM. • Increased use of Facebook and Craigslist for hookups.
3. What are the most effective HIV prevention interventions, programs and services to respond to the needs in this population?	What works to prevent new infection?	• Targeted HIV testing. • Internet presence on popular MSM sites and mobile Apps. Including Partner Services awareness. • NMPower Program (Mpowerment model) • Many Men, Many Voices (3MV) intervention • Health Forums specific to gay men. • Collaboration with local Gay Straight Alliance and other Lesbian, Gay, Bisexual, Transgender, or Questioning (LGBTQ) organizations and support groups.

Planning question	In other words...	Information about this population
4. What training needs regarding serving your population are there for CPAG, HIV prevention contractors, NMDOH or others?	How can the NMDOH best prepare you to engage the population?	• Many Men Many Voices (3MV). • Cultural sensitivity training for providers. • Sex Positivity Training. • Public Sex Environment (PSE) Outreach Training. • Internet Intervention Training. • Personal Safety and Self Defense Training.
5. What community level events should have HIV prevention presence? This can be existing events in the community or something new for CPAG to create.	How can we spread the message?	• Gay Pride • Zia Regional Rodeo • HIV testing and outreach at local gay bars. • UNM LGBTQ center events. • Gay Straight Alliance events. • Web presence • Drag Shows
6. How can we support goals of the National HIV/AIDS Strategy (NHAS) that are related to your population? What exists currently? What should be created?	What can the CPAG or a Population Task Force do to contribute to the NHAS?	• Target MSM of color for testing. • Increase the numbers of all gay and bisexual men accessing HIV testing. • Create a Mentoring or Buddy program for those folks that had been in HIV services and dropped out of treatment or were lost to follow up that will help them re-enter services and help address the reasons why they were unable to stay in treatment.

C. Injection Drug Users (IDU)

Planning question	In other words...	Information about this population
1. What are the key concerns in terms of HIV epidemiology and risk behaviors, based on available data and/or anecdotal information? Identify the top 3-5 issues.	What types of behaviors put this population at risk for HIV?	• Sharing needles regardless of knowledge base • Access to services in rural/frontier areas • Participants attitudes about going to sites for supplies • Stigma • Proportion of reported HIV cases shown as No Identified Risk (NIR) that are IDU population and not wanting to out themselves
2. Are there any emerging trends or new problems/issues, such as increasing HIV rates, new risk behaviors or new risk co-factors? If so, what are they?	In what new ways is this population at risk for HIV?	• Older exchangers thinking of condoms in terms of preventing pregnancy, not HIV • Drug war in the south is causing people to reuse and share syringes along the border (strict check points, fear of being spotted as a user, etc.) • Increase of prescription drug use (synthetic opioids) among the younger generation- viewed as an easy gateway • Incarcerated IDU and sexual activity
3. What are the most effective HIV prevention interventions, programs and services to respond to the needs in this population?	What works to prevent new infection?	• Statewide Harm Reduction Program provides syringe exchange • Partner Services • Incarcerated Health Education for Addictive Lifestyles (iHEAL) curriculum for inmates, developed by NMDOH Southwest Region, based on VOICE/VOCES and incorporating HIV, hepatitis and harm reduction information • Popular Opinion Leader (POL)

Planning question	In other words...	Information about this population
4. What training needs regarding serving your population are there for CPAG, HIV prevention contractors, NMDOH or others?	How can the NMDOH best prepare you to engage the population?	• Harm Reduction Certification • Counseling, Testing and Referral Services Certification • iHEAL • Create Harm Reduction (HR)/SSP curriculum to educate secondary exchangers (based on a Popular Opinion Leader model) • Modify and rename a curriculum to create our own Evidence Based Intervention which combines Safety Counts, Street Smart, and POL
5. What community level events should have HIV prevention presence? This can be existing events in the community or something new for CPAG to create.	How can we spread the message?	• We have a presence at: - Local Health fairs - National HIV Testing Day - World AIDS Day - Two-Seven African American HIV Awareness Day - Gay Pride events • We could be present at: - Cinco de Mayo - Alien Festival (Roswell and Southeast Region) - Border Health Fairs (Southwest Region)
6. How can we support goals of the National HIV/AIDS Strategy (NHAS) that are related to your population? What exists currently? What should be created?	What can the CPAG or a Population Task Force do to contribute to the NHAS?	• Expand access to services - Expand SSP outreach areas, particularly in Southwest Region - Increased testing at outreach sites with Unigold - Syringe exchange via home visits in rural/frontier areas • Increase access to care: - Rapid referral to HIV services for positives - HIV service providers on outreach while testing with Unigold

D. Heterosexuals at Risk (HAR)

Planning question	In other words...	Information about this population
1. What are the key concerns in terms of HIV epidemiology and risk behaviors, based on available data and/or anecdotal information? Identify the top 3-5 issues.	What types of behaviors put this population at risk for HIV?	• HARs do not identify as "HAR". Doesn't know that their partners fit into a risk group, so it's hard to find and serve this group • Lack of data on HARs. Providers that report HIV cases need ways to capture data that assesses and identifies HAR partner risk so we can pull data • Lack of knowledge, resources, testing, and supplies, e.g. "clean works" for injection drug using (IDU) behaviors • Lack of condom negotiation skills • HAR criteria is limited
2. Are there any emerging trends or new problems/issues, such as increasing HIV rates, new risk behaviors or new risk co-factors? If so, what are they?	In what new ways is this population at risk for HIV?	• Sex workers, survivor sex • IDU (including prescription and over the counter drugs) • Prescription or over the counter drugs containing opiates, that are injected are more accessible • Increasing use of meth and heroin
3. What are the most effective HIV prevention interventions, programs and services to respond to the needs in this population?	What works to prevent new infection?	• Syringe Exchange services • CTRS • Addressing women's needs with active referrals • Effective Interventions - SISTA, Community Promise, Street Smart, Safety Counts, VOICES/VOCES • Focus on commercial sex workers and incarcerated women
4. What training needs regarding serving your population are there for CPAG, HIV prevention contractors, NMDOH or others?	How can the NMDOH best prepare you to engage the population?	• Access to local training on Evidence Based Interventions (EBI) and adaptations, as well as support for adaptations) • Sexually Transmitted Disease (STD) trainings • Domestic violence trainings • Syringe exchange trainings

Planning question	In other words...	Information about this population
5. What community level events should have HIV prevention presence? This can be existing events in the community or something new for CPAG to create.	How can we spread the message?	• HIV testing booth at the NM State Fair and Albuquerque Flea Market • Cultural sensitivity trainings • Message posters in bathroom stalls of clubs, bars, laundry mats, etc. • Include HAR in outreach at existing Gay Pride events • CTRS on outreach and at truck stops • Presence of HIV programs and handing out condoms during Fall Crawl, Spring Crawl and Summer Fest to reach university students and young people • Providing support and information to family planning programs and parenting classes
6. How can we support goals of the National HIV/AIDS Strategy (NHAS) that are related to your population? What exists currently? What should be created?	What can the CPAG or a Population Task Force do to contribute to the NHAS?	• Continue and/or expand an array of existing activities including: - CTRS - Street outreach - Testing at cultural events - Cultural adaptations to current effective EBI - Health Fairs - National testing day events - Gathering of Nations events

E. Transgender (TG) Persons

Planning question	In other words...	Information about this population
1. What are the key concerns in terms of HIV epidemiology and risk behaviors, based on available data and/or anecdotal information? Identify the top 3-5 issues.	What types of behaviors put this population at risk for HIV?	• Lack of Epidemiological data for the TG population both locally and nationally. • Survival Sex due to discrimination in both the housing and job markets • TG not clearly defined in risk groups and often just merged with gay/bisexual men and MSM, though there are distinctly different risk behaviors and prevention needs. CPAG just recently separating TG population as its own risk group
2. Are there any emerging trends or new problems/issues, such as increasing HIV rates, new risk behaviors or new risk co-factors? If so, what are they?	In what new ways is this population at risk for HIV?	• Just learning about emerging trends as we only have anecdotal evidence and starting to get info from other sources • Silicone use/needle sharing • The continued rise of survival sex in the TG populations.
3. What are the most effective HIV prevention interventions, programs and services to respond to the needs in this population?	What works to prevent new infection?	• Continued syringe exchange programs with targeted exchange sites for TG populations • Male-to-Female TG targeted CTRS • Evidence Based interventions adapted for TG population i.e. Nizhoni SISTA, Many Men Many Voices (3MV) • Utilize the term “gender variant” to be more inclusive.
4. What training needs regarding serving your population are there for CPAG, HIV prevention contractors, NMDOH or others?	How can the NMDOH best prepare you to engage the population?	• Cultural sensitivity training for HIV prevention and other providers such as TG 101, TG 201

Planning question	In other words...	Information about this population
5. What community level events should have HIV prevention presence? This can be existing events in the community or something new for CPAG to create.	How can we spread the message?	• TG info video • Prepare for the annual New Mexico TG summit • Gay Pride events throughout state • Transgender Resource Center of New Mexico (TGRCNM) support groups and outreach services • TG day of remembrance activities each year on Nov 17-20

6. How can we support goals of the National HIV/AIDS Strategy (NHAS) that are related to your population? What exists currently? What should be created?	What can the CPAG or a Population Task Force do to contribute to the NHAS?	• Target high risk TG population via CTRS
		• Continue CPAG TG Taskforce to identify needs, build collaboration and plan for services
		• Newly-formed New Mexico TG Coalition
		• Enhance self-esteem and cultural pride with adaptation for 3MV and SISTA
		• TGRCNM Youth Group
		• Santa Fe Mountain Center (SFMC) programs
		  ○ Trans Youth Camp
		  ○ Trans Leadership Camp

F. Sex Workers

Planning question	In other words...	Information about this population
1. What are the key concerns in terms of HIV epidemiology and risk behaviors, based on available data and/or anecdotal information? Identify the top 3-5 issues.	What types of behaviors put this population at risk for HIV?	• Stigma • Not using condoms because of fear • Engaging in unprotected sex with "Johns" due to getting paid more for not using condoms • Reluctance to get tested • Little information or data is available on male prostitutes in NM • Physical violence
2. Are there any emerging trends or new problems/issues, such as increasing HIV rates, new risk behaviors or new risk co-factors? If so, what are they?	In what new ways is this population at risk for HIV?	• Female condoms • Mental health • Sexually Transmitted Infections • Hepatitis • Drug abuse supporting the habit • Cross dressing stigma • Sexual abuse • Human trafficking • Kept escorts
3. What are the most effective HIV prevention interventions, programs and services to respond to the needs in this population?	What works to prevent new infection?	• Outreach to transgender population • Outreach to drug users • Annual Women's Health Fair in Albuquerque sponsored by New Mexico AIDS Services (NMAS) • Female condoms (slip on without client knowing) • "Cheeking" condoms

Planning question	In other words...	Information about this population
4. What training needs regarding serving your population are there for CPAG, HIV prevention contractors, NMDOH or others?	How can the NMDOH best prepare you to engage the population?	• Harm Reduction • Risk reduction strategies incorporated into prevention • Culturally sensitivity to Men who have Sex with other Men (MSM), Transgender (TG), or Heterosexuals At Risk populations • Support groups • Power dynamics discussion and training • Safety training
5. What community level events should have HIV prevention presence? This can be existing events in the community or something new for CPAG to create.	How can we spread the message?	• Women's Health Fair • Outreach events • Sex Workers Awareness Day • Gay Pride events
6. How can we support goals of the National HIV/AIDS Strategy (NHAS) that are related to your population? What exists currently? What should be created?	What can the CPAG or a Population Task Force do to contribute to the NHAS?	• Focus on TG and MSM minority sub-populations within the sex worker community

G. Incarcerated Persons

Planning question	In other words...	Information about this population
1. What are the key concerns in terms of HIV epidemiology and risk behaviors, based on available data and/or anecdotal information? Identify the top 3-5 issues.	What types of behaviors put this population at risk for HIV?	• Unprotected sex (consensual or non-consensual) • Sharing syringes and/ or works, tattooing equipment • In some areas, a new HIV diagnosed inmate must wait until release to receive medications • Stigma
2. Are there any emerging trends or new problems/issues, such as increasing HIV rates, new risk behaviors or new risk co-factors? If so, what are they?	In what new ways is this population at risk for HIV?	• Known cases of HIV in state facilities may be artificially low due to a prisoner opt-out of testing option • Risk of co-infection with Hepatitis C is greater • The overall social environment could pose a greater threat of illness to the infected individual
3. What are the most effective HIV prevention interventions, programs and services to respond to the needs in this population?	What works to prevent new infection?	• iHEAL curriculum for inmates, developed by NMDOH Southwest Region, based on VOICE/VOCES and incorporating HIV, hepatitis and harm reduction information • Inmate Peer Education Programs (NMPEP) of UNM's Project ECHO • Testing inmates 3 months from release • Evidence-based prevention interventions including DEBI models such as RESPECT, Women 2 Women (W2W, developed by UNM and Planned Parenthood) and SHIELD • Networking with wardens and other gatekeepers • Expanding reach of UNM's Project ECHO, including NMPEP project, state-wide • Rapid HIV testing • Health education with screenings and vaccinations

Planning question	In other words...	Information about this population
4. What training needs regarding serving your population are there for CPAG, HIV prevention contractors, NMDOH or others?	How can the NMDOH best prepare you to engage the population?	• Understanding the difference between correctional facilities (jails vs. prisons; county, state & federal) and their health governance (public, private, or combination) • Inform prison staff and inmates of linkage to care protocols for each correctional facility • Personalized risk reduction plans for inmates • Networking with Law Enforcement Against Prohibition for corrections staff presentations
5. What community level events should have HIV prevention presence? This can be existing events in the community or something new for CPAG to create.	How can we spread the message?	• We have a presence at: - National Night Out - National HIV Testing Day - World AIDS Day - World Hepatitis Day - Gay Pride events • We could be present at: - Cinco de Mayo - Alien Festival (Roswell and Southeast Region) - Border Health Fairs (Southwest Region)
6. How can we support goals of the National HIV/AIDS Strategy (NHAS) that are related to your population? What exists currently? What should be created?	What can the CPAG or a Population Task Force do to contribute to the NHAS?	• Increase access to services upon release: NMPEP, iHEAL, RESPECT, W2W, SHIELD • Normalize HIV testing upon release (Unigold!) • Syringe exchange • Increase access to care while incarcerated: • Equal access to care across NM • Uninterrupted access to care for positives

H. Adult Viral Hepatitis

Planning question	In other words...	Information about this population
1. What are the key concerns in terms of HIV epidemiology and risk behaviors, based on available data and/or anecdotal information? Identify the top 3-5 issues.	What types of behaviors put this population at risk for HIV?	• Limited or non-existent risk factor data for hepatitis mono-infection which makes it difficult to identify trends or relationships between the data. • Unclear if high rate of co-infections among the 40-50+ population is a result of late HIV diagnosis or limited/ineffective hepatitis testing efforts among younger HIV+ populations.
2. Are there any emerging trends or new problems/issues, such as increasing HIV rates, new risk behaviors or new risk co-factors? If so, what are they?	In what new ways is this population at risk for HIV?	• High rate of co-infection among HIV+ Men who have Sex with other Men (MSM) could indicate sexual transmission of Hepatitis C (HCV) • Injection Drug Use (IDU) including prescription and over the counter drugs
3. What are the most effective HIV prevention interventions, programs and services to respond to the needs in this population?	What works to prevent new infection?	• iHEAL Training • CTRS with integrated prevention messages • Harm Reduction/SSP services • It's Time Training • Hepatitis C Support Project (HCSP) Training • Increased HIV/hepatitis testing and vaccine provision during outreach • Targeted HIV/hepatitis testing among White, Hispanic, and American Indian/Alaskan Native populations
4. What training needs regarding serving your population are there for CPAG, HIV prevention contractors, NMDOH or others?	How can the NMDOH best prepare you to engage the population?	• Access and availability of : - iHEAL Training - HCSP Training - Phlebotomy training and staff to draw blood

Planning question	In other words...	Information about this population
5. What community level events should have HIV prevention presence? This can be existing events in the community or something new for CPAG to create.	How can we spread the message?	• PRIDE events • World Hepatitis Day events • Hepatitis Testing Day events • World AIDS Day events • Gay/Bisexual Men's Night at Stanford Public Health Office • National Latino HIV/AIDS Awareness Day (NLAAD) events • American Indian/Alaskan Native outreach events
6. How can we support goals of the National HIV/AIDS Strategy (NHAS) that are related to your population? What exists currently? What should be created?	What can the CPAG or a Population Task Force do to contribute to the NHAS?	• Collaborate with HIV & Hepatitis Epidemiology Program to utilize data to direct intervention programs • Yearly hepatitis and STD trainings to keep updated on new trends and technologies • Existence of CPAG Adult Viral Hepatitis TF and other hepatitis groups to ensure viral hepatitis representation • Support strategies to strengthen hepatitis surveillance programs

V. Priorities for HIV Prevention

CPAG developed a set of key priorities for HIV prevention that are designed to respond to the NHAS, HIP and funding under CDC funding opportunity PS12-1201. Given the new guidance from CDC, priorities are not stated in terms of priority populations and effective interventions for each population as in past plans. Instead, the prioritization model defines three tiers of prevention activities that incorporate both target populations and strategies to serve them.

This model has three tiered groups of priorities in ranked order. In addition, for the second and third tier of priorities, particular emphasis is noted for special populations. These reflect the groups with health disparities that were described previously in *Section IV. Special Populations and Health Disparities.*

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.

CPAG noted the increased effectiveness of all interventions and services when providers reflect the populations being served.

This model takes into account that interventions for IDU, particularly SSP, are funded separately by the NMDOH Harm Reduction Program.

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

- Jurisdictional HIV Prevention Planning
- Capacity Building and Technical Assistance
- Program Planning, Monitoring and Evaluation, and Quality Assurance

Table 5. Priorities for HIV Prevention in New Mexico

Priority Tier	Interventions and Populations	Emphasis
Tier #1 - CORE: Core services	• 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)	CDC's required core components under Category A of PS12-1201 grant, except for Policy Initiatives.
Tier #2 - HIGH: Interventions for populations with the highest HIV incidence and rates	• Gay/bisexual men and other men who have sex with men (MSM). • Injection drug users (IDU). • Transgender persons.	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/Alaskan Native persons.
Tier #3 - MODERATE: Interventions for populations with moderate incidence and rates	• Heterosexuals at risk. • Social marketing, media and mobilization with a focus on promoting and recruiting to interventions in Tier #1 and #2.	

Glossary of Common Acronyms

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
AAHSS	Organization	African American Health and Social Services
ADAP	General	AIDS Drug Assistance Program
AETC	Organization	AIDS Education and Training Center
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
CAB	Organization	Community advisory board, a group of consumers that works with a non-profit agency
CAC	Organization	New Mexico HIV Consumer Advocacy Council
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	New Mexico HIV Prevention Community Planning and Action Group
CRCS	Intervention	Comprehensive Risk Counseling and Services, formerly known as PCM
CSA	General	Community Services Assessment, a planning task
CSAP	Organization	Federal Center for Substance Abuse Prevention
CTRS	Intervention	HIV counseling, testing and referral services
DEBI	Intervention	Diffusion of Effective Behavioral Interventions, a compendium of model programs with evidence of effectiveness
DPS	General	Disease Prevention Specialist (staff of New Mexico Department of Health)
DPT	General	Disease Prevention Team, the regional HIV, STD, harm reduction and hepatitis providers of NMDOH

HIV PREVENTION TERMS AND ACRONYMS		
ACRONYM	**CATEGORY**	**DEFINITION**
ECHO	Organization	Extensions for Community Healthcare Outcomes Project of the University of New Mexico
EIA/ELISA	General	Enzyme-linked immunoabsorbent assay (HIV antibody test that is sensitive for general screening)
FHPC	General	Fundamentals of HIV Prevention Counseling (training for HIV test counseling)
FNCH	Organization	First Nations Community Healthsource, Albuquerque
FYI	Organization	Families and Youth Incorporated, Las Cruces
GLBT	Population	Gay, Lesbian, Bisexual, Transgender
GMOC	Population	Gay men of color
GSA	Organization	Gay-Straight Alliance, a school-based organization and statewide network
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 and Risk Reduction
HEP C	General	Hepatitis C (also HCV)
HIP	General	High Impact Prevention, a strategy from CDC
HIPAA	General	Health Insurance Portability and Accountability Act (Federal law)
HIV	General	Human Immunodeficiency Virus
HMA	Organization	Health Maintenance Alliance, formerly nickname of HIV Service Provider organizations
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)
HSP	Organization	HIV Service Provider organization
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)
IDNS	General	Infectious Disease Nurse Specialist, a position with the NMDOH

HIV PREVENTION TERMS AND ACRONYMS		
ACRONYM	**CATEGORY**	**DEFINITION**
IDU	Population	Injection drug user
iHEAL		Incarcerated Health Education for Addictive Lifestyles curriculum for inmates, developed by NMDOH
LGBTIQ	Population	Lesbian, Gay, Bisexual, Transgender, Intersex, queer and/or questioning
MP	Intervention	A program that uses the Mpowerment model
MSM	Population	Men/man who has sex with men (includes gay and non-gay identified men)
NA	General	Needs Assessment
NAN	Organization	Navajo AIDS Network, Gallup
NASTAD	Organization	National Alliance of State and Territorial AIDS Directors
NHAS	General	National HIV/AIDS Strategy, developed by the White House Office of National HIV/AIDS Policy
NLAAD	General	National Latino AIDS Awareness Day
NMAC	Organization	The National Minority AIDS Council
NMAS	Organization	New Mexico AIDS Services, Albuquerque and Farmington
NMDOH	Organization	New Mexico Department of Health
NMMIP	Organization	New Mexico Medical Insurance Pool, a high-risk pool operated by Blue Cross and Blue Shield
NNAAPC	Organization	National Native American AIDS Prevention Center, Denver
nPEP	General	Non-occupational post-exposure prophylaxis
OMH	Organization	Federal Office of Minority Health
OMHRC	Organization	Federal Office of Minority Health Resource Center
ONAP	Organization	Office of National AIDS Policy, at the White House
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, an evaluation database formerly used by CDC
PfH	Intervention	Partnership for Health – a DEBI evidence-based intervention
PIR	General	Parity, Inclusion, and Representation, the membership process for CPAG
PLWA	Population	People/person living with AIDS
PLWHA	Population	People/person living with HIV/AIDS

HIV PREVENTION TERMS AND ACRONYMS		
ACRONYM	**CATEGORY**	**DEFINITION**
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)
RAG	General	Regional Advisory Group, one of six advisory bodies to CPAG that cover local issues and needs
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
SCC	Organization	Southwest C.A.R.E. Center, Santa Fe
SES	General	Socio-economic status
SFMC	Organization	Santa Fe Mountain Center, Santa Fe
SIPI	Organization	Southwestern Indian Polytechnic Institute
SISTA	Intervention	Sisters Informing Sisters on Topics about AIDS – a DEBI evidence-based intervention
SSP	Intervention	Syringe Services Program, formerly known as SEP for Syringe Exchange Program
STD	General	Sexually transmitted disease, also known as STI for sexually transmitted infection
TA	Intervention	Technical Assistance
TG	Population	Transgender
TGRCNM	Organization	Transgender Resource Center of New Mexico, Albuquerque
TLC	Intervention	Teens Linked to Care – an evidence-based intervention
TSM/MST	Population	Transgender persons who have sex with men/men who have sex with transgender persons
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, a planning group convened by the Public Education Department

HIV PREVENTION TERMS AND ACRONYMS		
ACRONYM	**CATEGORY**	**DEFINITION**
YMSM	Population	Young men who have sex with men
YRRS	General	Youth Risk and Resiliency Survey of secondary school students, based on Youth Risk Behavior Survey (YRBS)