



The New Mexico
Integrated Epidemiologic Profile for
HIV/AIDS Prevention
and Care Planning

2006

**NEW MEXICO
DEPARTMENT OF HEALTH**

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EXECUTIVE SUMMARY

This epidemiologic profile describes the burden of human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) in New Mexico. The primary source of data is the New Mexico Department of Health's HIV & Hepatitis Epidemiology Program which is responsible for collecting data on all cases of HIV/AIDS in the state. Both HIV and AIDS are conditions reported by name; AIDS since 1981 and HIV since 1998.

This profile describes trends among cases of HIV/AIDS diagnosed through 2005 and, to account for reporting delays, reported by June 30, 2006. Other data sources are also used to describe which groups in New Mexico's population are most affected by HIV/AIDS. By examining changes over time, it also identifies trends of increasing risk in certain groups. This profile also contains statewide data on persons living with HIV/AIDS who are receiving care in New Mexico, including cases diagnosed in other states. This allows for an examination of potential needs and service gaps in the care system.

The key findings are as follows:

- As of June 30, 2005, a cumulative total of 3,709 cases of AIDS and 1,308 cases of HIV have been reported in New Mexico.
- Significant decreases in AIDS incidence and mortality have been observed since the introduction and use of new antiretroviral therapies in 1996. In 2005, New Mexico's incidence rate of HIV was 4.7 per 100,000 population and the incidence rate of AIDS was 6.6 per 100,000 population.
- While AIDS-related mortality has declined, prevalent cases of HIV/AIDS have increased steadily with the availability of highly active anti-retroviral therapy. At the end of 2005, 1,130 people were known to be living with HIV and 1,922 with AIDS.
- The number of newly diagnosed AIDS cases has remained relatively steady over the last 5 years, whereas cases of HIV have increased by 17%. In 2005, 127 new cases of AIDS and 90 new cases of HIV were diagnosed.
- The epidemic in New Mexico is still driven primarily by men who have sex with men (MSM), followed by injection drug users (IDU) and persons with the combination of these two risk factors (MSM/IDU). Heterosexual contact, particularly among women, is an emerging risk for HIV infection.
- Racial and ethnic minorities continue to be disproportionately affected by HIV/AIDS. The incidence of disease has risen dramatically in Hispanics and slowly in American Indians. The rate of disease is highest among African Americans, although this is a small population of the state.
- Late diagnoses of AIDS persist in New Mexico. Between 1998 and 2005, 57% of all new HIV infections diagnosed in New Mexico were concurrently diagnosed with AIDS.
- The majority of persons living with HIV/AIDS in New Mexico continue to use HIV related services in New Mexico. In 2005, only 25% of persons living with the disease failed to access medical care and/or treatment.

INTRODUCTION

New Mexico periodically develops an epidemiologic profile of its HIV/AIDS epidemic to aid in planning HIV prevention and care services across the state. This data provides a profile of those living with HIV/AIDS, including any emerging trends in HIV transmission, and is meant to guide available services to those populations at greatest risk for HIV infection.

This epidemiologic profile provides detailed information about the current HIV/AIDS epidemic in New Mexico. Data from HIV surveillance and multiple other sources were reviewed to create this comprehensive document that addresses the following key questions outlined by the Centers for Disease Control and Prevention (CDC):

1. What are the sociodemographic characteristics of the general population in New Mexico?
2. What is the scope of the HIV/AIDS epidemic in New Mexico?
3. What are the indicators of risk for HIV/AIDS in New Mexico?
4. What are the patterns of service utilization of HIV-infected persons in New Mexico?
5. What are the number and characteristics of HIV-infected persons who are not receiving primary medical care for HIV?

The profile is an essential resource of scientifically-based information for planning HIV/AIDS prevention and care activities throughout the state. The data presented serve to guide prevention interventions and service delivery efforts, to justify and obtain funding for the implementation of prevention and service programs, and to evaluate and improve HIV-related programs and policies in New Mexico.

Data Sources

Data were compiled from a variety of sources. The multiple perspectives provided by these resources help to create a complete profile of HIV/AIDS in New Mexico.

HIV/AIDS Surveillance

HIV/AIDS Core Surveillance

The New Mexico Department of Health (NMDOH) has been collecting confidential AIDS and HIV information since 1981 and 1998, respectively. All HIV and AIDS cases diagnosed or treated in New Mexico are reportable to the HIV & Hepatitis Epidemiology Program. Standardized case report forms are used to collect demographic information, mode of exposure, laboratory and clinical information, and vital status. All case information is entered into the HIV/AIDS Reporting System (HARS), a standardized database developed by the CDC and implemented in all reporting areas in the U.S. Since testing behavior and access to services can influence reporting, surveillance data may underestimate the number of persons recently infected with HIV.

Supplement to HIV/AIDS Surveillance (SHAS)

The CDC-funded SHAS project, completed in June 2004 in New Mexico, was a one-time cross-sectional interview project that collected self-reported behavioral information from individuals infected with HIV/AIDS who were enrolled for care. Data were collected on demographics, socioeconomics, illicit drug use, sexual behavior, diagnosis and treatment, and use of social services. Participants were recruited from the medical and care providers that are part of the Health Management Alliance (HMA). The HMA is a non-profit healthcare system that provides the majority of HIV medical care and case management in New Mexico.

Behavioral Surveys

Behavior Risk Factor Surveillance System (BRFSS)

BRFSS, another CDC supported activity, is a state-based random digit-dialed telephone survey of adults that monitors the prevalence of major behavioral risks associated with premature morbidity and mortality. New Mexico began participating in BRFSS in 1986; between 1997 and 2004, data were also collected about HIV/AIDS. Survey questions assessed knowledge and attitudes about HIV/AIDS, history of HIV testing, and behaviors associated with risk of HIV infection. Data from BRFSS are population based; therefore, estimates can be generalized to the adult population of New Mexico. However, because respondents are contacted by telephone, the data may not be representative of households that do not have telephones. Households which have only cell phones are excluded as well.

Youth Risk and Resiliency Survey (YRRS)

YRRS was developed in New Mexico as a tool to assess the behavioral risk and protective factors of high school students. It is implemented in the fall of odd-numbered years. Data from YRRS are comparable to CDC's Youth Risk Behavior Survey (YRBS) that is administered in many states to obtain data about school health issues. YRRS differs only in that the questions cover not only behavioral risk factors, to which YRBS is limited, but also resiliency ("protective") factors. Questions asked include those on illicit drug use and sexual activity. The survey relies upon self-report; therefore, sensitive behavioral information may be under- or over-reported. Since YRRS is administered in school, the data may not be representative of adolescents who are not enrolled in school.

Pregnancy Risk Assessment Monitoring System (PRAMS)

PRAMS is an ongoing, population-based risk factor surveillance system designed to identify and monitor selected self-reported maternal experiences and behaviors that occur before and during pregnancy. PRAMS surveys new mothers, within two to six months after delivery, about experiences, attitudes, and behaviors related to infant and maternal health. Data are regularly used to help plan and evaluate programs, inform policymakers, and educate healthcare providers and the public.

Prevention Data

Counseling and Testing Services (CTS)

The NMDOH HIV Prevention Program tracks confidential and anonymous testing outcomes reported by state funded HIV Counseling and Testing Services sites provided throughout New Mexico. CTS is provided at more than 100 sites across the state. Some of these providers also offer

services for sexually transmitted diseases (STD), family planning, prenatal, drug treatment, public health, community health, and HIV specific counseling and testing. Sites offer anonymous and confidential testing. Information is collected about the characteristics of clients receiving services, such as demographics, risk information, and testing information that may offer insights into HIV infection rates in high-risk populations.

Syringe Exchange Program (SEP)

The New Mexico Harm Reduction Act was passed in 1997 to legalize syringe exchange in the state. As a result, New Mexico has one of the largest number of contractors and local public health offices offering syringe exchange and prevention services in the nation. The SEP collects data on demographics, risk behaviors, and hepatitis infection from its participants. Since its inception, SEP has enrolled more than 9,000 participants, with about 4,000 active clients participating in syringe exchange, education, and other services. Over 6.5 million syringes having been exchanged.

Services Data

Ryan White CARE Act (RWCA)

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was enacted in 1990 by the federal government to improve the quality and availability of care for medically underserved individuals and families affected by HIV/AIDS. Providers are required to complete a CARE Act Data Report (CADR) which provides key information on all persons receiving assistance through any RWCA-funded programs. The CADR is an important tool for monitoring RWCA resources but cannot be generalized to all persons living with HIV/AIDS in New Mexico. Data are collected only from clients who know their HIV status, meet financial and insurance eligibility requirements, and who currently seek care and treatment services from RWCA providers. CADR data is maintained by the NMDOH HIV Services Program, which oversees service contracts with all providers in the state.

AIDS Drug Assistance Program (ADAP)

The NMDOH HIV Services Program manages the statewide ADAP which provides medications free of charge to persons living with HIV/AIDS who meet eligibility requirements. New Mexico's ADAP is supported by both RWCA Title II funds and state funds. More than 85 medications on the ADAP formulary are dispensed out of the NMDOH central pharmacy.

Vital Statistics Data

The Bureau of Vital Records and Health Statistics collects information on all births and deaths that occur in New Mexico. The HIV & Hepatitis Epidemiology Program ascertains vital status on reported cases by matching them with death certificates. The data can also be used to determine the number of deaths related to HIV/AIDS. However, deaths resulting from or whose underlying cause was HIV/AIDS may be underreported on a death certificate.

Population Data

U.S. Bureau of the Census

The U.S. Bureau of the Census prepares population estimates for states and counties between the decennial census years. This data includes demographic, economic and housing characteristics of the population (www.census.gov).

Bureau of Business and Economic Research (BBER)

BBER, located at the University of New Mexico, conducts economic and demographic research and analysis related to New Mexico. Analysis by BBER indicates that U.S. Bureau of the Census intercensal estimates of population data underestimate the New Mexico population. New Mexico population data presented here represent the BBER's revised estimates (www.unm.edu/~bber).

New Mexico State Data Center

The New Mexico State Data Center is coordinated by four agencies including BBER, the New Mexico State Library, and the New Mexico State University Department of Economics. The website presents business, economic, and community development data on New Mexico's communities and the 50 states (www.edd.state.nm.us/index.php?/data).

Infectious Disease Surveillance

Hepatitis C Virus (HCV)

Passive, laboratory-based surveillance for hepatitis C infection is also conducted by the HIV & Hepatitis Epidemiology Program. Laboratory test data from 1996 through 2005 reside in the Hepatitis C Surveillance Database, while data from 2006 onward are documented in the New Mexico Electronic Disease Surveillance System (NM-EDSS). HCV infection is a serious problem in HIV-infected persons as it may affect the progression and treatment of HIV.

Sexually Transmitted Disease (STD)

The STD Program monitors and provides case management of chlamydia, gonorrhea, and syphilis infection. Services include partner counseling, referral services, and treatment. Data are collected in the Sexually Transmitted Disease Management Information System (STD*MIS). STD data can serve as a surrogate marker of unsafe sexual practices and demonstrate the prevalence of changes in specific behaviors. Because of shorter incubation periods between exposure and infection, STD data can also serve as a marker of recent unsafe sexual behavior. Certain STDs can also facilitate the transmission or acquisition of HIV.

Tuberculosis (TB)

The TB/Refugee Program conducts statewide surveillance and case management of all cases of TB. Data are collected in the Tuberculosis Information Management System (TIMS). Persons with HIV/AIDS are at risk for complications and death due to TB infection.

Strengths & Limitations

When using these data to make planning decisions, it is important to consider the overall strengths and limitations of the data. Although the profile is comprehensive and draws from a number of data sources, there are many things that the profile cannot explain.

Although the HIV/AIDS surveillance system in New Mexico is extensive and population based, it is focused on data from people who have either been tested confidentially for HIV since 1998 or been diagnosed with AIDS since 1981. Consequently, HIV infections are under-detected and under-reported because only persons with HIV who choose to be tested confidentially are counted. Also, persons are tested at different times after infection, and many persons are not tested until HIV infection has progressed to AIDS. Thus, it is important to remember that the data in this report do not necessarily represent the characteristics of persons who have been recently infected with HIV, nor do they provide a true measure of HIV incidence.

Progression to AIDS may also differ among persons infected with HIV. Some individuals may rapidly progress in less than two years, but the majority progress over a five to ten year period. Thus, aggregate data about AIDS may have limited use for HIV prevention planning because they characterize persons who may have been infected up to ten years ago. The introduction of highly active anti-retroviral therapy (HAART) has further altered the natural history of HIV and delayed progression to AIDS, making AIDS data less useful each year for planning purposes.

Analyses of different data sets are presented to provide robust representations of particular subpopulations. However, demographic and geographic subpopulations are disproportionately sensitive to differences and changes in access to health care, HIV testing patterns, and specific prevention programs and services. All of these issues must be carefully considered when interpreting the data.

The most current analysis available is presented for each source of data; however, the most recent year of data differ from one source to another. More detailed analyses are available from certain sources. The information in this report is intended for statewide planning, but some regional data are presented. Regional data reflect where a person lived when diagnosed with HIV or AIDS, which may not be where the person currently resides or receives services. Detailed regional information is available upon request.

Methods

This profile was prepared by the HIV & Hepatitis Epidemiology Program in close collaboration with the HIV Prevention Program and HIV Services Program, all at NMDOH. All the sociodemographic data (except as otherwise noted), vital statistics, behavioral data, and other infectious disease data were either downloaded from a public Web site or obtained by special request.

The following statistical methods were used to measure the effect of the epidemic upon specific populations:

- Incidence rates were calculated for a 12-month period (January through December 2005) per 100,000 population. For these rates, denominators were derived from 2004 population estimates from BBER. The numerator is the number of reported cases that were diagnosed during the 12-month period.
- All HIV/AIDS data represent the number of cases diagnosed in that year without adjusting for reporting delay. Reporting delay refers to the time between diagnosis of a case and receipt of the report by NMDOH. To minimize reporting delays, surveillance information for 2005 was not tabulated until after June 30, 2006.
- Cases that have been diagnosed recently are more likely to be reported as having 'No Identified Risk' (NIR). At this time, the HIV & Hepatitis Epidemiology Program does not use imputation methods based on historical reporting to reclassify these cases missing risk information into one of the risk categories. Cases with missing risk information are continually investigated.

This epidemiologic profile includes data in many different forms. Readers should keep in mind the following:

1. Understand what the data represent – e.g. numbers of cases, rates, or percentages/ratios; HIV, AIDS, or HIV/AIDS.
2. Know the limitations of the data and their sources.
3. Don't over interpret small changes or differences particularly when the numbers themselves are small.
4. Do not sum data from different tables. Different methods may have been used to obtain various data sets; some data sets may overlap while others do not.

SECTION I: CORE EPIDEMIOLOGIC QUESTIONS

What are the sociodemographic characteristics of the general population in New Mexico?

Highlights

- In 2004, New Mexico ranked 36th in the nation for total population. New Mexico's population increased 6% since 2000.
- New Mexico is a "majority-minority" state in that a majority of New Mexico's population differs from the national majority population. New Mexico has the largest proportion of Hispanics of any state.
- New Mexico also has the 2nd highest proportion of American Indians. Nearly 10% of people in the state identify themselves as American Indian.
- New Mexico ranked 45th in 2004 for median household income at \$37,587, which is 84.5% of the national average.
- With 16.5% of its population living in poverty in 2004, New Mexico continues to have one of the highest poverty rates in the nation.

Demographics

Geography, Population Size and Distribution

New Mexico is a largely rural state covering a total land mass of 121,679 square miles, making it the 5th largest state. Between 2000 and 2004, New Mexico's population increased by 6% to 1,929,713. As of 2004, the state ranked 36th in the nation for total population. As a result, New Mexico has a population density of only 16 persons per square mile compared to the national population density of 84 persons per square mile. New Mexico is composed of 33 counties with populations ranging from a low of 790 persons (Harding County) to a high of 600,439 persons (Bernalillo County). Overall, the state has only three major metropolitan statistical areas which cover the Albuquerque, Las Cruces, and Santa Fe areas.

Sex, Race, and Age

The median age in New Mexico was 35.8 years for the year 2004, up from 35.6 in 2003. Table 1 shows the percentage distribution of the population by sex and age group. A slightly higher proportion of females than males in the population was over the age of 50. More than half of the population was under the age of 40. New Mexico's population was slightly younger than the overall U.S. During 2004, 29.1% of the population was under age 20 compared to 27.7% for the U.S.

Table 1. Distribution of the general population by sex and age, New Mexico, 2004

| | Males N = 948,335 | Females N = 981,378 | Total N = 1,929,713 |
|-----------|----------------------|------------------------|------------------------|
| Age Group | % | % | % |
| < 13 | 18.9 | 17.7 | 18.3 |
| 13-19 | 11.2 | 10.4 | 10.8 |
| 20-29 | 14.3 | 13.3 | 13.8 |
| 30-39 | 12.7 | 12.4 | 12.5 |
| 40-49 | 15.1 | 15.1 | 15.1 |
| 50+ | 27.7 | 31.0 | 29.4 |

Source: Bureau of Business and Economic Research at the University of New Mexico, 2004 population estimates, released 2006.

New Mexico is a “majority-minority” state in that a majority of New Mexico’s population differs from the national majority population. As shown in Table 2, Hispanics make up approximately the same proportion of the population as Whites. New Mexico also has the 2nd largest population of American Indians of any state in the nation, who comprise nearly 10% of its total population. New Mexico has a variety of American Indian tribes including 19 Pueblos, two Apache Nations, and the Navajo Nation. Each tribe is culturally unique and has a sovereign government.

Table 2. Distribution of the general population by sex and race/ethnicity, New Mexico, 2004

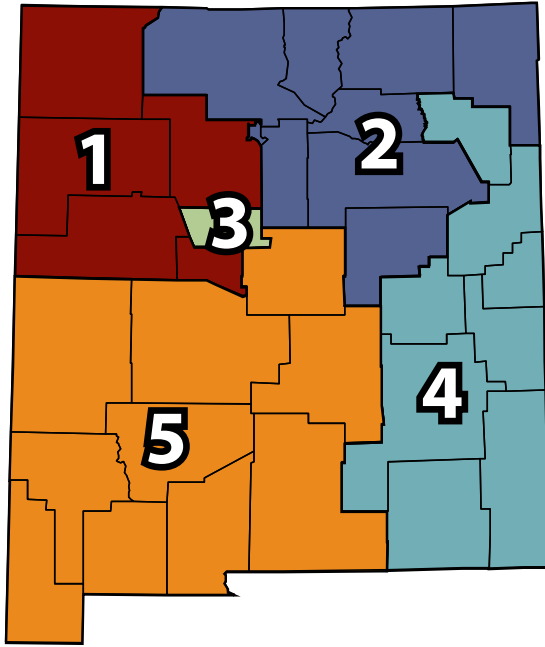
| | Males N = 948,335 | Females N = 981,378 | Total N = 1,929,713 |
|-------------------------------|----------------------|------------------------|------------------------|
| Race/Ethnicity | % | % | % |
| White | 43.1 | 43.7 | 43.5 |
| Hispanic | 43.7 | 42.8 | 43.2 |
| American Indian/Alaska Native | 9.7 | 10.2 | 9.9 |
| African American | 2.1 | 1.8 | 2.0 |
| Asian/Pacific Islander | 1.3 | 1.5 | 1.4 |

Source: Bureau of Business and Economic Research at the University of New Mexico, 2004, population estimates, released 2006.

Public Health Regions

NMDOH divides the state into five geographically distinct public health regions for the provision of services (Figure 1). Bernalillo County is a single-county public health region. The remaining four regions each cover roughly one-quarter or quadrant of the state and each consists of 5 to 10 counties.

Figure 1. Public Health Regions in New Mexico



The distribution of New Mexico’s population by race/ethnicity varies widely across the state. As shown in Table 3, Region 4 has the largest proportion of Whites while Region 2 has the largest proportion of Hispanics. Region 1, which includes part of the Navajo Nation, has the largest proportion of American Indians at 34%, or three times that seen across the state as a whole. African Americans reside primarily in Regions 3 and 4.

Table 3. Distribution of the general population by race/ethnicity and public health region, New Mexico, 2004

| | Region 1 N = 402,875 | Region 2 N = 291,896 | Region 3 N = 600,439 | Region 4 N = 247,561 | Region 5 N = 386,942 | Total N = 1,929,713 |
|-------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|---------------------------|
| Race/Ethnicity | % | % | % | % | % | % |
| White | 36.6 | 39.1 | 46.3 | 53.7 | 42.9 | 43.5 |
| Hispanic | 27.3 | 55.0 | 43.6 | 40.9 | 52.0 | 43.2 |
| American Indian/Alaska Native | 34.3 | 4.2 | 4.8 | 1.2 | 2.5 | 9.9 |
| African American | 1.1 | 0.6 | 2.8 | 3.3 | 1.6 | 2.0 |
| Asian/Pacific Islander | 0.8 | 1.1 | 2.4 | 1.0 | 0.9 | 1.4 |

Source: Bureau of Business and Economic Research at the University of New Mexico, 2004 population estimates, released 2006.

Socioeconomic Status

Poverty & Income

According to U.S. Census data for 2004, the median household income in New Mexico was \$37,587. This ranked New Mexico at 45th in the nation. During this same year, 16.5% of all New Mexicans were living in poverty; the national poverty rate was 12.7%. Children aged 18 years and under comprised nearly a third of all those living below the federal poverty level in New Mexico (Table 4); this ranked New Mexico 3rd in the nation. During 2004, the unemployment rate was 5.5% statewide, but has decreased to 5.0% in 2005 and continues to show signs of declining.

Table 4. Distribution of persons living in poverty by age group, New Mexico and United States, 2004.

| | New Mexico N = 1,929,713 | United States N = 290,286,350 |
|-----------------|-----------------------------|----------------------------------|
| Age Group | % | % |
| Children (0-18) | 31 | 23 |
| Adults (19-64) | 21 | 16 |
| Seniors (65+) | 15 | 13 |

Source: Kaiser Family Foundation, www.statehealthfacts.kff.org

Education

According to U.S. Census Data for 2000, 83% of New Mexico residents age 25 years and older attained a high school diploma or higher. A quarter of residents attained a bachelor's degree or higher. Level of education achieved differed according to public health region (Table 5). Regions 4 and 5 had the highest proportion of persons that achieved less than a 9th grade education as compared to the statewide percentage of 9.3%. Conversely, Regions 2 and 3 had the highest proportion of persons with bachelor's or graduate/professional degrees when compared to statewide percentages.

Table 5. Distribution of the general population 25 years and older, by public health region and level of educational attainment, New Mexico, 2000

| | Region 1 N = 216,919 | Region 2 N = 184,430 | Region 3 N = 358,680 | Region 4 N = 149,485 | Region 5 N = 225,287 | Total N = 1,134,801 |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|---------------------------|
| Level of Education | % | % | % | % | % | % |
| Less than 9 th grade | 9.2 | 7.9 | 6.0 | 11.9 | 13.8 | 9.3 |
| 9 th to 12 th grade, no diploma | 14.0 | 10.8 | 9.5 | 15.0 | 12.5 | 11.9 |
| High school diploma or GED | 30.3 | 23.8 | 24.8 | 29.1 | 26.6 | 26.6 |
| Some college, no degree | 23.7 | 21.2 | 23.5 | 23.3 | 22.4 | 22.9 |
| Associate degree | 6.5 | 5.7 | 5.7 | 6.0 | 5.7 | 5.9 |
| Bachelor's degree | 10.2 | 16.7 | 17.4 | 9.2 | 11.2 | 13.6 |
| Graduate or professional degree | 6.1 | 13.9 | 13.1 | 5.6 | 7.8 | 9.8 |

Source: U.S. Census Bureau, Census 2000 data and the New Mexico State Data Center

Health Insurance

According to the Kaiser Family Foundation in its 2004 population survey, 25% of New Mexico's non-elderly (aged 0-64 years) population were without health insurance and another 20% were on Medicaid (Table 6). The national percentage for persons without health insurance was only 18%. At 48%, New Mexico also had the lowest proportion in the nation of persons covered by employer insurance. As shown in Table 7, Hispanics made up 56% of all uninsured persons in New Mexico, as compared to 30% in the U.S.

Table 6. Distribution of adults and children by health insurance coverage, New Mexico, 2004

| | Males (19-64) N = 550,300 | Females (19-64) N = 576,530 | Children (0-18) N = 519,780 | Total (0-64) N = 1,646,610 |
|---------------------|------------------------------|--------------------------------|--------------------------------|-------------------------------|
| Source of Insurance | % ^a | % | % | % |
| Employer | 52 | 52 | 39 | 48 |
| Individual | 5 | 6 | 2 | 4 |
| Medicaid | 7 | 11 | 42 | 20 |
| Medicare | 4 | 4 | 2 | 4 |
| Uninsured | 31 | 27 | 15 | 25 |

Source: Kaiser Family Foundation, www.statehealthfacts.kff.org

^aDue to rounding, percentages may not total 100%.

Table 7. Distribution of non-elderly uninsured persons by race/ethnicity, New Mexico and United States, 2004

| | New Mexico N = 404,030 | United States N = 255,073,140 |
|------------------|---------------------------|----------------------------------|
| Race/Ethnicity | % | |
| White | 25 | 48 |
| Hispanic | 56 | 30 |
| African American | NSD ^a | 15 |
| Other | 17 | 7 |

Source: Kaiser Family Foundation, www.statehealthfacts.kff.org

^aNot sufficient data.

SECTION I: CORE EPIDEMIOLOGIC QUESTIONS

What is the scope of the HIV/AIDS epidemic in New Mexico?

Highlights

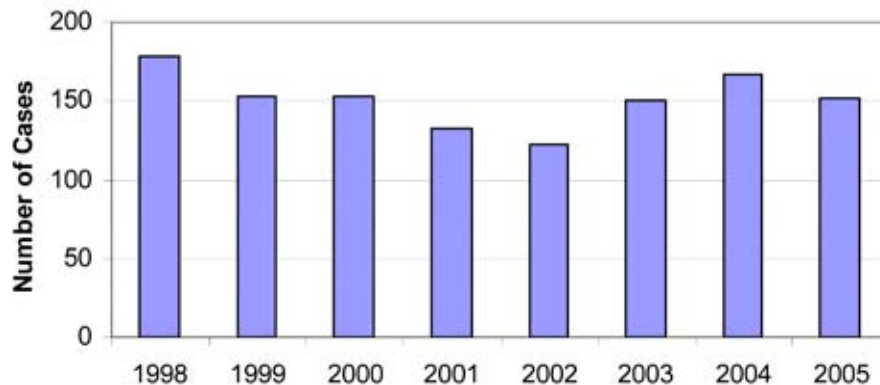
- The overall number of incident cases of HIV/AIDS in New Mexico has decreased from 1998 to 2005; from 1998-2002 there was a steady decline each year, followed by a significant increase through 2004, and a subsequent decrease in 2005.
- Data over the last five years indicate that Hispanics are newly diagnosed more often than any other racial/ethnic group.
- HIV incidence has been highest among persons aged 20-29 years, while AIDS incidence has been highest for persons aged 30-39 years.
- Men who have sex with men (MSM) continue to be the most heavily impacted risk group; however, heterosexual contact is an emerging risk factor for infection.
- In 2005, more than a third of all persons living with HIV/AIDS were diagnosed in Bernalillo County.
- The overall number of deaths among persons with HIV/AIDS has remained relatively stable over the last seven years.

Incidence

Overall Trends

Figure 2 illustrates the trend in incident cases of HIV/AIDS from 1998 to 2005. Overall, the number of cases of HIV/AIDS diagnosed each year decreased 15% from 1998 to 2005. The number of incident cases declined from 178 in 1998 to 122 cases in 2002, but began to increase through 2004. In 2005, the number of incident cases decreased again to 151.

Figure 2. Incidence of HIV/AIDS, New Mexico, 1998-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Sex

Table 8 compares HIV/AIDS diagnoses by sex in New Mexico during 2005, 2001-2005, and 1998-2005. In 2005, the rate of HIV/AIDS diagnoses among males was 13.4 per 100,000 population compared to 2.4 per 100,000 among females. During the past five years, males accounted for 85% of all diagnoses; this is consistent with data collected since 1998 when HIV reporting began in New Mexico.

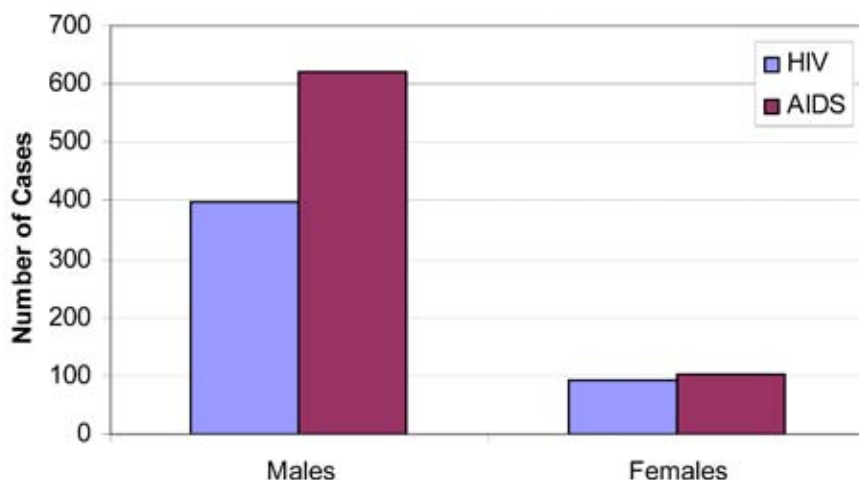
Figure 3 illustrates the incidence of HIV and AIDS from 2001 through 2005. During this five-year period, a total of 493 new cases of HIV were diagnosed; about 4 times more males (399) were diagnosed than females (94). In addition, a total of 725 new cases of AIDS were also diagnosed. About 6 times more males (620) were diagnosed with AIDS than females (104) during the last five years.

Table 8. HIV/AIDS diagnoses by sex, New Mexico, 1998-2005

| Sex | 2005 | | | 2001-2005 | | 1998-2005 | |
|--------|------|-----|------|-----------|-----|-----------|-----|
| | No. | % | Rate | No. | % | No. | % |
| Male | 127 | 84 | 13.4 | 611 | 85 | 1036 | 86 |
| Female | 24 | 16 | 2.4 | 111 | 15 | 170 | 14 |
| Total | 151 | 100 | 7.8 | 722 | 100 | 1206 | 100 |

Source: NMDOH, HIV & Hepatitis Epidemiology Program

Figure 3. HIV and AIDS diagnoses by sex, New Mexico, 2001-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Race/Ethnicity

Table 9 describes trends in HIV/AIDS diagnoses by race/ethnicity in 2005, 2001-2005, and 1998-2005. In 2005, African Americans were diagnosed with HIV/AIDS at a much higher rate (15.9 per 100,000) than other racial/ethnic groups, followed by Hispanics at a rate of 9.1. Whites and American Indians were diagnosed with HIV/AIDS at similar rates, 6.8 and 6.3 per 100,000, respectively.

In recent years, Hispanics have contributed an increasing proportion of newly diagnosed cases of HIV/AIDS; in 2005, they made up 50% of all new cases. During 2001-2005, Hispanics accounted for more HIV/AIDS diagnoses (47%) than Whites (38%). Since 1998, Hispanics have accounted for the largest proportion (46%) of all diagnoses compared with Whites (39%), American Indians (9%), African Americans (6%), and Asians/Pacific Islanders (< 1%). Hispanics comprise 43%, Whites 44%, American Indians 10%, African Americans 2%, and Asians/Pacific Islanders 1% of New Mexico's population.

Figure 4 illustrates the number of HIV and AIDS diagnoses during 2001-2005. During this time, there were a total of 493 new cases of HIV and 725 new cases of AIDS. Hispanics accounted for the largest number of both HIV (220) and AIDS (302) cases.

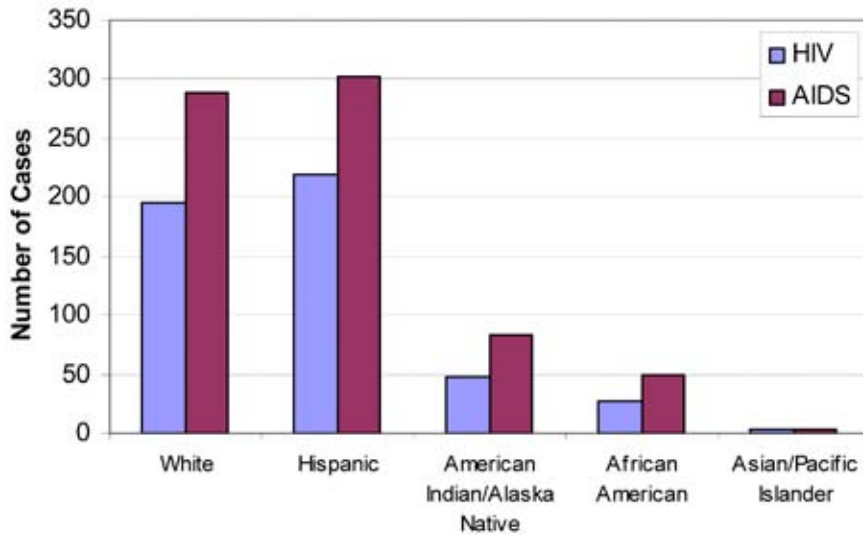
Table 9. HIV/AIDS diagnoses by race/ethnicity, New Mexico, 1998-2005

| Race/Ethnicity | 2005 | | | 2001-2005 | | 1998-2005 | |
|-----------------------------------|------|-----|-------------------|-----------|-----|-----------|-----|
| | No. | % | Rate ^a | No. | % | No. | % |
| White | 57 | 38 | 6.8 | 272 | 38 | 470 | 39 |
| Hispanic | 76 | 50 | 9.1 | 337 | 47 | 555 | 46 |
| American Indian/ Alaska Native | 12 | 8 | 6.3 | 70 | 10 | 104 | 9 |
| African American | 6 | 4 | 15.9 | 39 | 5 | 70 | 6 |
| Asian/Pacific Islander | 0 | 0 | 0 | 4 | < 1 | 7 | < 1 |
| Total | 151 | 100 | 7.8 | 722 | 100 | 1206 | 100 |

Source: NMDOH, HIV & Hepatitis Epidemiology Program

^aRates per 100,000 population.

Figure 4. HIV and AIDS diagnoses by race/ethnicity, New Mexico, 2001-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Age at Diagnosis

Table 10 describes incident cases of HIV/AIDS by age at diagnosis during 2005, 2001-2005, and 1998-2005. In 2005, persons aged 30-39 had the highest rate of HIV/AIDS diagnoses (18.2 per 100,000). During 2001-2005, persons aged 30-39 made up the largest proportion of cases (31%) followed by persons aged 20-29 (26%) and 40-49 (26%). The cumulative trend from 1998-2005 also shows that persons aged 30-39 had the largest percentage of cases by age group. For all three time periods, persons aged 50+ accounted for about 12-14% of all cases.

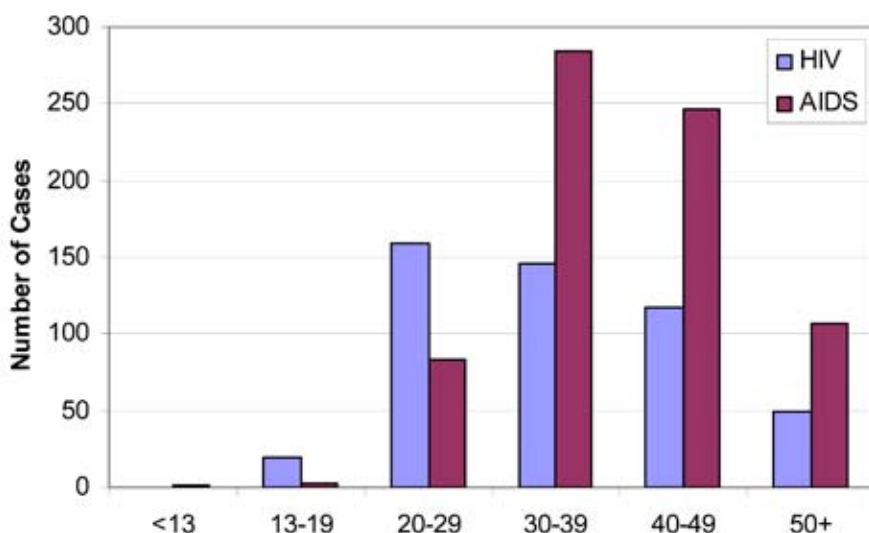
Figure 5 illustrates the five-year trend in HIV and AIDS diagnoses by age at diagnosis during 2001-2005. In all but two age groups there were more cases of AIDS than HIV. The largest number of AIDS cases were among those aged 30-39 (284) followed by those aged 40-49 (247) and those aged 50+ (107). In the younger age groups there were more cases of HIV than AIDS among persons aged 13-19 (20) and 20-29 (159).

Table 10. HIV/AIDS diagnoses by age at diagnosis, New Mexico, 1998-2005

| Age Group | 2005 | | | 2001-2005 | | 1998-2005 | |
|-----------|------|-----|------|-----------|-----|-----------|-----|
| | No. | % | Rate | No. | % | No. | % |
| < 13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 13-19 | 6 | 4 | 2.9 | 22 | 3 | 29 | 2 |
| 20-29 | 34 | 23 | 12.7 | 185 | 26 | 297 | 25 |
| 30-39 | 44 | 29 | 18.2 | 226 | 31 | 422 | 35 |
| 40-49 | 46 | 30 | 15.8 | 190 | 26 | 316 | 26 |
| 50+ | 21 | 14 | 3.7 | 99 | 14 | 142 | 12 |
| Total | 151 | 100 | 7.8 | 722 | 100 | 1206 | 100 |

Source: NMDOH, HIV & Hepatitis Epidemiology Program

Figure 5. HIV and AIDS diagnoses by age at diagnosis, New Mexico, 2001-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Risk Factor

Table 11 describes HIV/AIDS diagnoses from 1998 through 2005 by risk factor. For all time periods MSM continued to be the most important mode of exposure, accounting for over 50% of all cases. Heterosexual contact is emerging as an important risk factor for new diagnoses of HIV/AIDS; this accounted for 18% of all risk in 2005, 14% in 2001-2005, and 12% in 1998-2005. Sixteen percent of all new cases in 2005 had ‘No Identified Risk’ (NIR). The ascertainment of risk on such cases may take up to one year to resolve or may never be resolved.

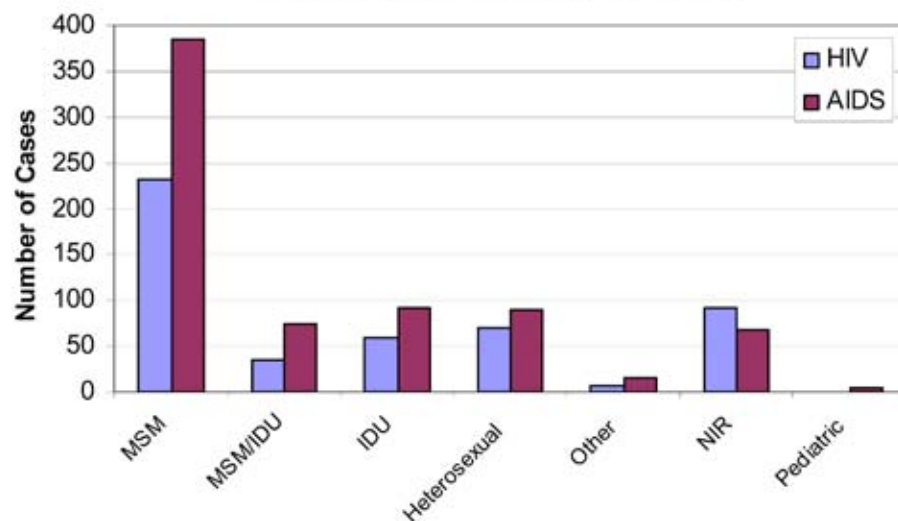
As shown in Figure 6, the vast majority of HIV (231) and AIDS (385) cases in New Mexico have been among MSM during 2001-2005. After MSM, heterosexual contact accounted for the next highest risk factor for HIV (70), while injection drug users (IDU) ranked as the second most common risk factor for AIDS (91). Given the time required to identify risk, more HIV cases than AIDS cases are classified as NIR.

Table 11. HIV/AIDS diagnoses by mode of exposure, New Mexico, 1998-2005

| Risk Group | 2005 | | | 2001-2005 | | 1998-2005 | |
|--------------|------|-----|------|-----------|-----|-----------|-----|
| | No. | % | Rate | No. | % | No. | % |
| MSM | 81 | 54 | - | 369 | 51 | 637 | 53 |
| IDU | 10 | 7 | - | 71 | 10 | 131 | 11 |
| MSM/IDU | 7 | 5 | - | 48 | 7 | 97 | 8 |
| Heterosexual | 28 | 18 | - | 100 | 14 | 148 | 12 |
| Other | 1 | 0 | - | 9 | 1 | 16 | 1 |
| Pediatric | 0 | 0 | - | 0 | 0 | 0 | 0 |
| NIR | 24 | 16 | - | 125 | 17 | 177 | 15 |
| Total | 151 | 100 | 7.8 | 722 | 100 | 1206 | 100 |

Source: NMDOH, HIV & Hepatitis Epidemiology Program

Figure 6. HIV and AIDS diagnoses by mode of exposure, New Mexico, 2001-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Prevalence

Table 12 compares incident HIV/AIDS cases and persons living with HIV/AIDS (PLWH/A) through the end of 2005. Males continued to account for almost equal proportions of both incident (84%) and living cases (88%). African Americans accounted for 1.9% of the population in New Mexico but 6% of all PLWH/A. As observed across the U.S., the incidence and prevalence rates for African Americans are very high relative to all other race/ethnicity groups. Although Hispanics had the next highest incidence rate in 2005, Whites continued to have the highest prevalence rate.

While persons aged 40-49 years had the largest proportion of incident HIV/AIDS cases in 2005, persons aged 30-39 years had the largest proportion of prevalent HIV/AIDS cases (42%) in 2005. New diagnoses in older age groups have most often been concurrent diagnoses of HIV and AIDS. Concurrent diagnoses in New Mexico are further discussed in this profile in HIV Testing Delays, under “Section 2: What are the patterns of service utilization of HIV-infected persons in New Mexico?”

Region 3, consisting of Bernalillo County, continued to have the majority of both incident and prevalent cases reported in New Mexico. More than one-third of all incident cases in 2005 and one-third of all PLWH/A were reported in Bernalillo County. Regions 2 (Northeast) and 5 (Southwest) had similar rates of incident cases of HIV/AIDS, 7.5 and 7.8 per 100,000, respectively. Although Region 2 has a smaller population, its prevalence rate (173.0 per 100,000) was nearly equal to that of Region 3 (174.5 per 100,000) where the majority of new cases were diagnosed. People diagnosed outside of New Mexico made up about one-fourth of all PLWH/A.

In 2005, MSM continued to make up the majority of incident and prevalent cases in New Mexico. However, the distribution of cases among the other modes of exposure have changed in frequency during the last few years. In 2005, the next largest risks for new diagnoses were heterosexual contact (18%), IDU (7%) and MSM/IDU (5%). This ranking is a reversal of the ranking of risks reported for PLWH/A, which has historically been IDU (11%), MSM/IDU (11%), followed by heterosexual contact (10%).

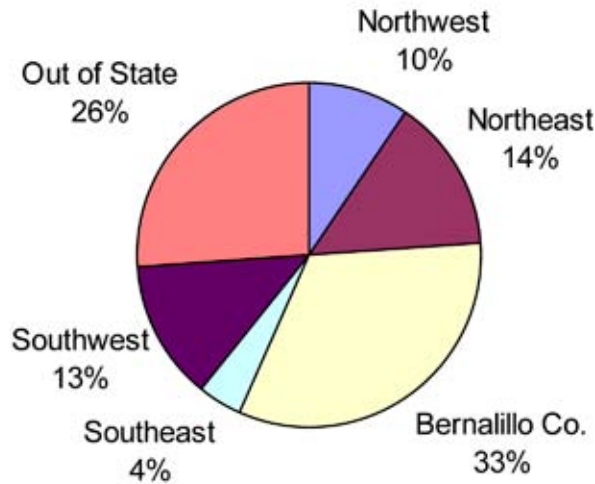
Table 12. Comparison of incident HIV/AIDS cases and persons living with HIV/AIDS, New Mexico, 2005

| Characteristic | 2005 | | | PLWH/A, 2005 | | |
|-----------------------------------|------------|------------|------------|--------------|------------|--------------|
| | No. | % | Rate | No. | % | Rate |
| Sex | | | | | | |
| Male | 127 | 84 | 13.4 | 2681 | 88 | 282.7 |
| Female | 24 | 16 | 2.4 | 371 | 12 | 37.8 |
| Race/Ethnicity | | | | | | |
| White | 57 | 38 | 6.8 | 1559 | 51 | 185.9 |
| Hispanic | 76 | 50 | 9.1 | 1075 | 35 | 128.8 |
| American Indian/ Alaska Native | 12 | 8 | 6.3 | 220 | 7 | 114.8 |
| African American | 6 | 4 | 15.9 | 184 | 6 | 487.5 |
| Asian/Pacific Islander | 0 | 0 | 0 | 14 | 1 | 51.6 |
| Age at Diagnosis | | | | | | |
| < 13 | 0 | 0 | 0 | 11 | 1 | 3.1 |
| 13-19 | 6 | 4 | 2.9 | 55 | 2 | 26.4 |
| 20-29 | 34 | 23 | 12.7 | 732 | 24 | 247.1 |
| 30-39 | 44 | 29 | 18.2 | 1288 | 42 | 533.1 |
| 40-49 | 46 | 30 | 15.8 | 742 | 24 | 254.8 |
| 50+ | 21 | 14 | 3.7 | 224 | 7 | 39.5 |
| Region | | | | | | |
| 1, Northwest | 25 | 16 | 6.2 | 286 | 9 | 71.0 |
| 2, Northeast | 22 | 15 | 7.5 | 505 | 17 | 173.0 |
| 3, Bernalillo Co. | 53 | 35 | 8.8 | 1048 | 34 | 174.5 |
| 4, Southeast | 8 | 5 | 3.2 | 149 | 5 | 60.2 |
| 5, Southwest | 30 | 20 | 7.8 | 375 | 12 | 96.9 |
| Out-of-State | 13 | 9 | - | 689 | 23 | - |
| Mode of Exposure | | | | | | |
| MSM | 81 | 54 | - | 1841 | 60 | - |
| IDU | 10 | 7 | - | 341 | 11 | - |
| MSM/IDU | 7 | 5 | - | 336 | 11 | - |
| Heterosexual | 28 | 18 | - | 289 | 10 | - |
| Other | 1 | 0 | - | 33 | 2 | - |
| Pediatric | 24 | 0 | - | 19 | < 1 | - |
| NIR | 0 | 16 | - | 193 | 6 | - |
| Total | 151 | 100 | 7.8 | 3052 | 100 | 158.2 |

Source: NMDOH, HIV & Hepatitis Epidemiology Program

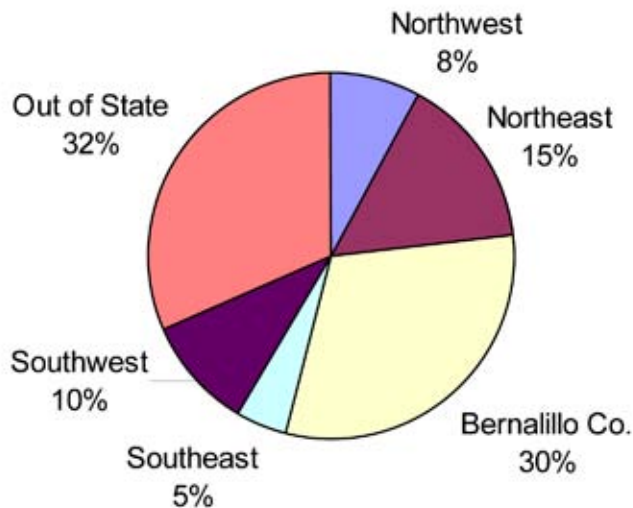
Figures 7 and 8 depict the burden of HIV and AIDS by region of residence at diagnosis. The majority of PLWH were located in Bernalillo County (33%), followed by persons diagnosed out-of-state (26%). In contrast, the majority of PLWA were persons diagnosed out-of-state (32%) compared to those diagnosed in Bernalillo County (30%). Persons diagnosed out-of-state may be residing in any part of New Mexico; the HIV & Hepatitis Epidemiology Program does not regularly track the current address of any person reported to NMDOH.

Figure 7. Persons living with HIV by region at diagnosis, New Mexico, 2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Figure 8. Persons living with AIDS by region at diagnosis, New Mexico, 2005

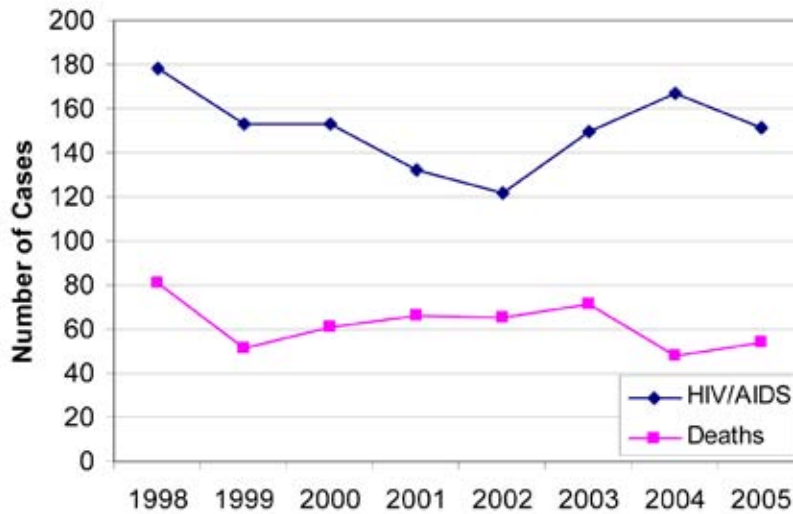


Source: NMDOH, HIV & Hepatitis Epidemiology Program

Mortality

Figure 9 shows the trend in HIV/AIDS-related deaths and the incidence of HIV/AIDS during 1998-2005. Since the introduction of highly active antiretroviral therapy (HAART) in 1996, the number of AIDS-related deaths in New Mexico has remained relatively stable. HAART has increased the time of progression to AIDS, decreased AIDS-related deaths and improved survival among persons with AIDS throughout the U.S. Since 1998, the number of all deaths from any cause in persons with HIV/AIDS has remained around 50 cases per year for a total of 495 deaths during this time period.

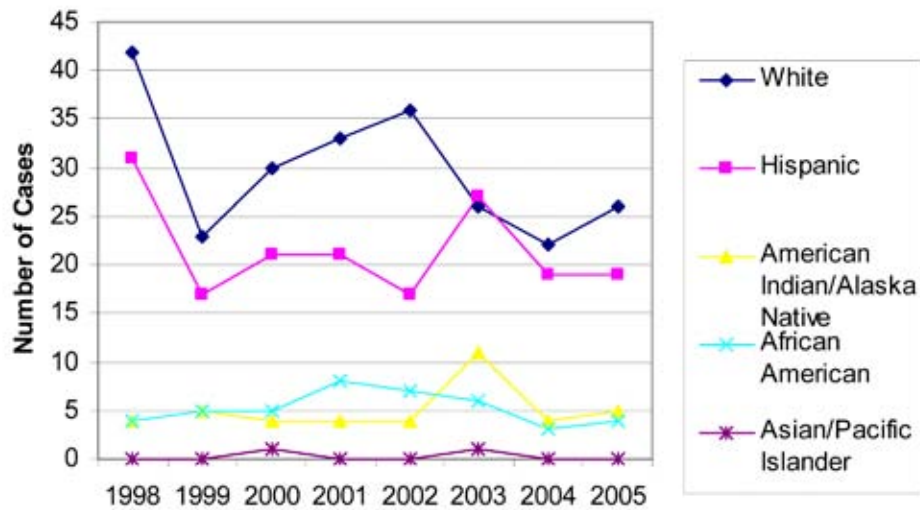
Figure 9. Trend in HIV/AIDS incidence and deaths, New Mexico, 1998-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Though numbers of deaths among persons with HIV/AIDS have remained stable, the number of deaths does differ by racial/ethnic group (Figure 10). From 1998-2005, the largest number of deaths have occurred among Whites (238), followed by Hispanics (172), American Indians (41), African Americans (42), and Asians/Pacific Islanders (2). These differences are further detailed in Table 13, which examines deaths prior to and after the implementation of HAART in 1996. There has been a noticeable decline in deaths among Whites since the introduction of HAART, but this is countered by increased deaths among other racial/ethnic groups living with HIV/AIDS. From 1981-1995 to 1996-2005, the proportion of deaths among Hispanics increased from 28% to 35%, in American Indians from 3% to 7%, and African Americans from 4% to 6%.

Figure 10. Trend in deaths among persons with HIV/AIDS by race/ethnicity, New Mexico, 1998-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

The number of deaths among persons with HIV/AIDS has also changed over time by age at diagnosis, region of diagnosis and reported mode of exposure (Table 13). During the time period after the introduction of HAART (1996-2005), deaths among persons aged 40-49 increased from 25% to 28%. This may, in part, be due to the relatively high rate of concurrent diagnoses of HIV and AIDS that occur in New Mexico. Late diagnoses ultimately increase the likelihood of complications from AIDS, including death. Regions 1 (Northwest) and 4 (Southeast) also experienced increases of 3-5% in deaths after HAART. Lastly, deaths among MSM decreased significantly prior to and after HAART (72% to 53%), while those among IDU increased (7% to 14%).

Table 13. Comparison of deaths among persons with HIV/AIDS and persons living with HIV/AIDS, New Mexico, 1981-2005

| Characteristic | Deaths, 1981-1995 | | Deaths, 1996-2005 | | PLWH/A, 2005 | |
|-----------------------------------|-------------------|------------|-------------------|------------|--------------|------------|
| | No. | % | No. | % | No. | % |
| Sex | | | | | | |
| Male | 1087 | 95 | 614 | 90 | 2681 | 88 |
| Female | 58 | 5 | 66 | 10 | 371 | 12 |
| Race/Ethnicity | | | | | | |
| White | 736 | 64 | 338 | 52 | 1559 | 51 |
| Hispanic | 325 | 28 | 239 | 35 | 1075 | 35 |
| American Indian/ Alaska Native | 40 | 3 | 51 | 7 | 220 | 7 |
| African American | 43 | 4 | 49 | 6 | 184 | 6 |
| Asian/Pacific Islander | 3 | < 1 | 3 | < 1 | 14 | 1 |
| Age at Diagnosis | | | | | | |
| < 13 | 4 | < 1 | 3 | < 1 | 11 | 1 |
| 13-19 | 3 | < 1 | 1 | 1 | 55 | 2 |
| 20-29 | 195 | 17 | 112 | 16 | 732 | 24 |
| 30-39 | 539 | 47 | 287 | 46 | 1288 | 42 |
| 40-49 | 288 | 25 | 183 | 28 | 742 | 24 |
| 50+ | 105 | 9 | 91 | 9 | 224 | 7 |
| Region | | | | | | |
| 1, Northwest | 82 | 7 | 70 | 10 | 286 | 9 |
| 2, Northeast | 269 | 23 | 88 | 13 | 505 | 17 |
| 3, Bernalillo Co. | 504 | 44 | 304 | 45 | 1048 | 34 |
| 4, Southeast | 55 | 5 | 69 | 10 | 149 | 5 |
| 5, Southwest | 91 | 8 | 52 | 8 | 375 | 12 |
| Out-of-State | 146 | 13 | 97 | 14 | 689 | 23 |
| Mode of Exposure | | | | | | |
| MSM | 824 | 72 | 362 | 53 | 1841 | 60 |
| IDU | 78 | 7 | 93 | 14 | 341 | 11 |
| MSM/IDU | 122 | 11 | 98 | 14 | 336 | 11 |
| Heterosexual | 32 | 3 | 39 | 6 | 289 | 9 |
| Other | 25 | 2 | 18 | 3 | 33 | 1 |
| Pediatric | 4 | < 1 | 4 | < 1 | 19 | < 1 |
| NIR | 62 | 5 | 66 | 10 | 193 | 6 |
| Total | 1147 | 100 | 680 | 100 | 3052 | 100 |

Source: NMDOH, HIV & Hepatitis Epidemiology Program

SECTION 1: CORE EPIDEMIOLOGIC QUESTIONS

What are the indicators of risk for HIV/AIDS in New Mexico?

Highlights

- During 2001-2004, more than a quarter of HIV-positive MSM and IDU who participated in behavioral surveys engaged in high risk activities; this included sharing needles and having a large number of male partners.
- At least 15% of all reported cases of HIV/AIDS were co-infected with hepatitis C.
- The majority (62%) of persons who tested positive for HIV with NMDOH Counseling & Testing Services did so primarily at STD clinics or during field visits by local public health staff.
- In the general population, 41% of persons reported ever having tested for HIV; persons aged 25-34 years were most likely to test.
- In 2003, surveys among high school students indicated that 49% had engaged in sexual intercourse; 10% had done so before age 13.
- Of those students who said they had engaged in sexual intercourse, only 28% reported using a condom the last time they had sex.
- In 2005, high numbers of chlamydia and syphilis cases ranked New Mexico at 4th and 14th in the nation, respectively.

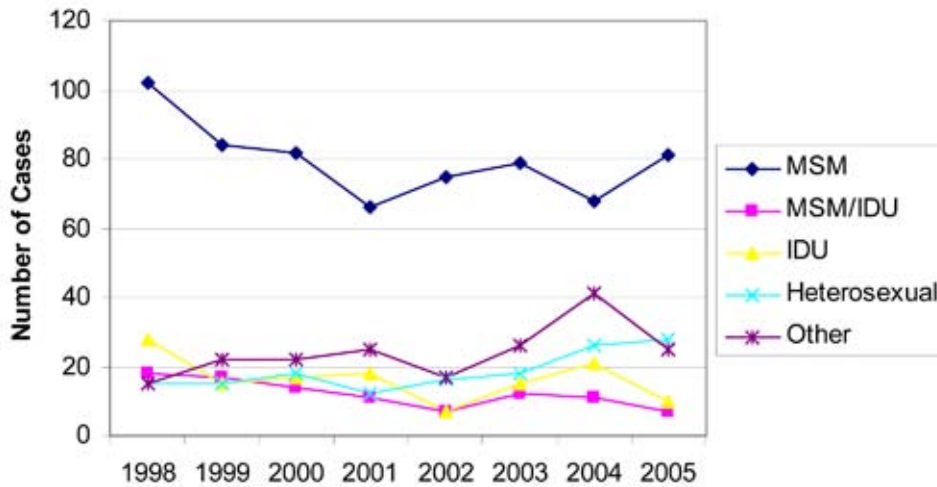
Risk Factors

Overall

Sexual intercourse is the primary mode of exposure for acquiring HIV/AIDS in New Mexico. Over 80% of persons have reported sexual contact as one possible mode of exposure to the virus. As shown in Figure 11, MSM have made up the largest number of newly diagnosed cases each year in New Mexico. Since 2001, there has been a slow increase in cases diagnosed among heterosexuals; however, through 2005 this mode of exposure made up only 9% of all cases living with HIV/AIDS in New Mexico (Figure 12).

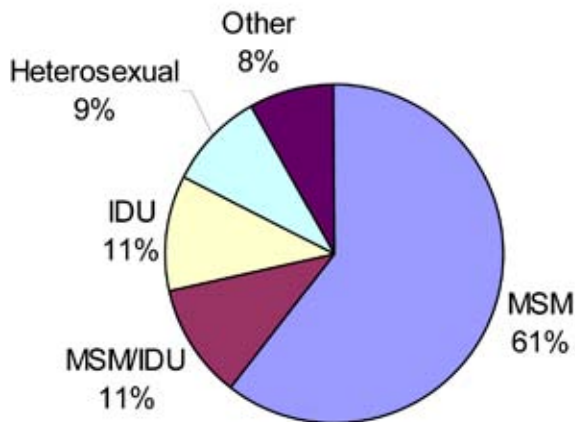
Other modes of exposure for HIV infection include IDU, MSM who also inject drugs (MSM/IDU), other, and pediatric. About 22% of HIV positive persons reported IDU or MSM/IDU as a possible mode of exposure to the virus. In Figures 11 and 12, the “Other” category includes pediatric transmission, needle stick injuries, blood transfusions and cases in which a risk factor has not been determined. Since the use of antiretroviral drugs and enhanced HIV screening in pregnant women, perinatal cases in the United States have been greatly reduced. Through the end of 2005, there have only been three new perinatal cases of HIV transmission documented in New Mexico since 1996. Given that blood donations have been screened for HIV since 1985, blood transfusion is also no longer a significant source of HIV transmission in the U.S.

Figure 11. Trend in HIV/AIDS incidence by mode of exposure, New Mexico, 1998-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Figure 12. Persons living with HIV/AIDS by mode of exposure, New Mexico, 2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

MSM

MSM represent the largest proportion of persons infected with HIV in New Mexico. Through 2005, MSM accounted for 61% of cases, and when combined with MSM/IDU, constituted nearly three-quarters of the total burden of HIV/AIDS. MSM made up 54% of newly diagnosed cases in 2005. Table 14 below compares the characteristics of MSM who are living with HIV/AIDS to the characteristics of MSM who were newly diagnosed with HIV/AIDS in 2005. The majority of new diagnoses in this group occurred among MSM in their 30's and 40's.

Table 14. Comparison of incident HIV/AIDS among MSM and MSM living with HIV/AIDS, New Mexico, 2005

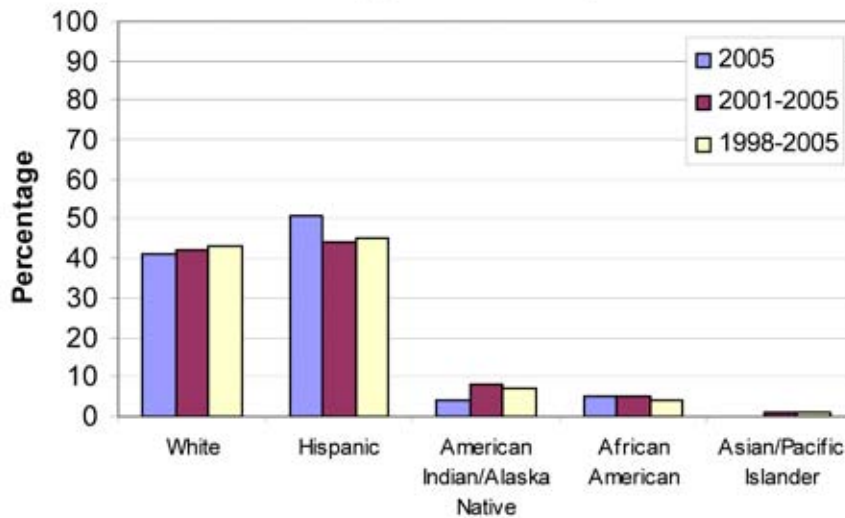
| Characteristic | 2005 | | PLWH/A, 2005 | |
|-------------------------------|-----------|----------------|--------------|------------|
| | No. | % ^a | No. | % |
| Race/Ethnicity | | | | |
| White | 33 | 41 | 1008 | 55 |
| Hispanic | 41 | 51 | 634 | 34 |
| American Indian/Alaska Native | 3 | 4 | 108 | 6 |
| African American | 4 | 5 | 85 | 5 |
| Asian/Pacific Islander | 0 | 0 | 6 | < 1 |
| Age at Diagnosis | | | | |
| < 13 | 0 | 0 | 0 | 0 |
| 13-19 | 3 | 4 | 23 | 1 |
| 20-29 | 16 | 20 | 418 | 23 |
| 30-39 | 26 | 32 | 835 | 45 |
| 40-49 | 24 | 30 | 446 | 24 |
| 50+ | 12 | 15 | 121 | 7 |
| Region | | | | |
| 1, Northwest | 12 | 15 | 136 | 7 |
| 2, Northeast | 12 | 15 | 359 | 19 |
| 3, Bernalillo Co. | 37 | 46 | 692 | 38 |
| 4, Southeast | 3 | 4 | 62 | 3 |
| 5, Southwest | 11 | 13 | 173 | 9 |
| Out-of State | 6 | 7 | 421 | 23 |
| Total | 81 | 100 | 1843 | 100 |

Source: NMDOH, HIV & Hepatitis Epidemiology Program

^aDue to rounding, percentages may not total to 100%.

Figure 13 shows the distribution of MSM by race/ethnicity during 2005, 2001-2005, and 1998-2005. The proportion of MSM among White HIV/AIDS cases remained stable over all time periods. During 2005, there was an increase in the proportion of new cases of HIV/AIDS in Hispanic MSM and a slight decrease in American Indian MSM.

Figure 13. HIV/AIDS cases among MSM by race/ethnicity, New Mexico, 1998-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

There are several factors that can increase or reduce the risk of HIV infection through sexual behavior. Among these factors are the use of barrier protection, specific types of sexual activities, and the number of sexual partners. The Supplement to HIV/AIDS Surveillance (SHAS) project provided insight into the behaviors that increase transmission from HIV positive persons. Among MSM who reported having sex with partners of unknown serostatus or who were known to be HIV negative, over 50% reported practicing unprotected sex with their partners. Table 15 details the responses of SHAS participants in New Mexico between 2001-2004 regarding number of lifetime male and female sexual partners among MSM participants. The majority of respondents claimed to have had over 20 male partners (67%), while a large proportion had over 100 (32%).

Counseling and Testing Services (CTS) data from 2005 revealed that 690 (14%) of persons seeking testing self-identified as either MSM or MSM/IDU. This group accounted for 21 (64%) of the total positive HIV tests for 2004. This data reinforces the significance of the MSM population among persons at risk for HIV/AIDS in New Mexico.

Table 15. Sexual partners of MSM participating in SHAS, New Mexico, 2001-2004

| | Number of Female Partners | | | | | | | Total |
|-------------|---------------------------|---------|---------|----------|----------|-----------|---------|-----------|
| | 0 | 1 to 5 | 6 to 10 | 11 to 20 | 21 to 50 | 51 to 100 | 100+ | |
| | N (%) | N (%) | N (%) | N (%) | N (%) | N (%) | N (%) | N (%) |
| MSM | 28 (30) | 41 (44) | 11 (12) | 4 (4) | 8 (9) | 0 (0) | 1 (1) | 93 (100) |
| MSM/ IDU | 7 (17) | 20 (49) | 2 (5) | 4 (10) | 3 (7) | 2 (5) | 3 (7) | 41 (100) |
| Total | 35 (26) | 61 (46) | 13 (10) | 8 (6) | 11 (8) | 2 (1) | 4 (3) | 134 (100) |
| | | | | | | | | |
| | Number of Male Partners | | | | | | | Total |
| | 0 | 1 to 5 | 6 to 10 | 11 to 20 | 20 to 39 | 40 to 100 | 100+ | |
| | N (%) | N (%) | N (%) | N (%) | N (%) | N (%) | N (%) | N (%) |
| MSM | 4 (4) | 13 (14) | 6 (6) | 7 (8) | 12 (13) | 21 (23) | 30 (32) | 93 (100) |
| MSM/ IDU | 1 (2) | 7 (17) | 2 (5) | 4 (10) | 2 (5) | 12 (29) | 13 (32) | 41 (100) |
| Total | 5 (4) | 20 (15) | 8 (6) | 11 (8) | 14 (10) | 33 (25) | 43 (32) | 134 (100) |

Source: NMDOH, HIV & Hepatitis Epidemiology Program, SHAS

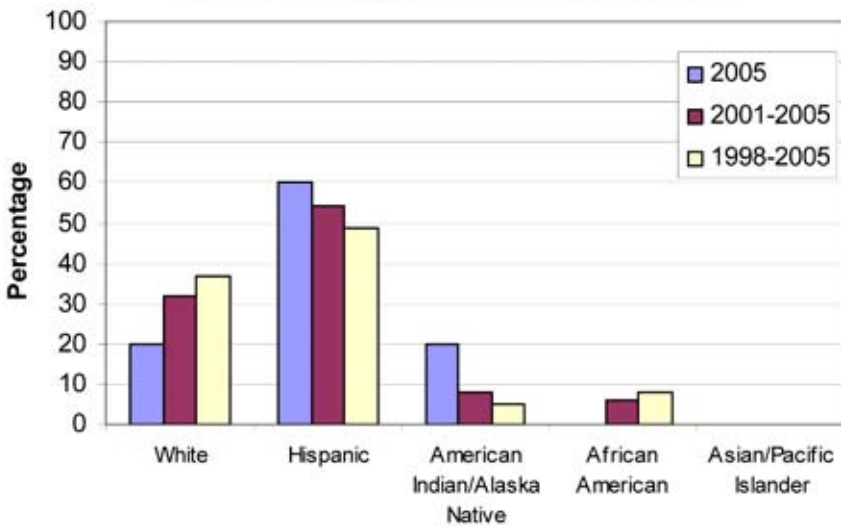
IDU

Approximately 11% of persons living with HIV/AIDS reported a history of injecting drugs. When MSM/IDU were included in this subgroup, injection drug use accounted for 22% of risk for HIV/AIDS. New cases of HIV among IDU have shown a slow overall decline since 1998.

Figure 14 describes cases among IDU by race/ethnicity for 2005, 2001-2005, and 1998-2005. There has been a steady decline in HIV/AIDS cases among White IDU during recent years, from 37% during 1998-2005 to only 20% in 2005. However, the proportion of HIV/AIDS cases among Hispanics and American Indians reporting injection drug use in 2005 reached highs of 60% and 20%, respectively.

SHAS participants who self-reported as IDU (26%) also reported a high rate of needle sharing behavior. Seventy percent of participants stated that they had shared needles and injection equipment with friends in their lifetime, and 50% reported they had shared with strangers. In some parts of New Mexico, injection drug use has been noted as a generational activity, with up to three generations in a household actively participating in injection drug use; 10% of SHAS participants reported sharing injection equipment with family members.

Figure 14. HIV/AIDS cases among IDU by race/ethnicity, New Mexico, 1998-2005

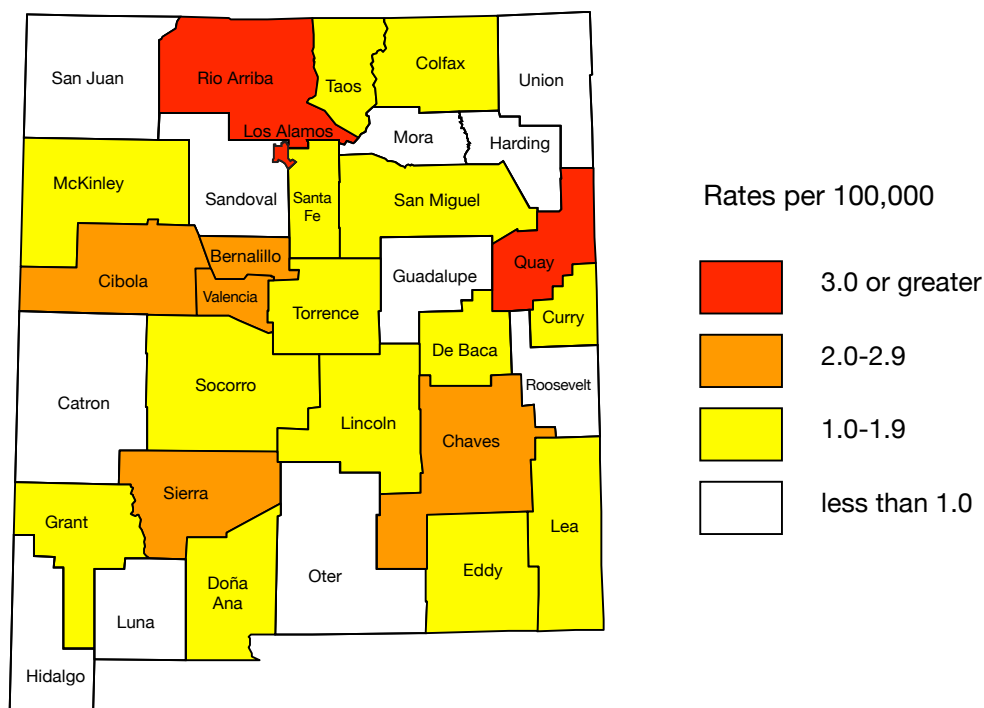


Source: NMDOH, HIV & Hepatitis Epidemiology Program

Among persons who accessed HIV testing services through CTS, 1,254 (25%) self-identified as IDU. Five of these IDUs tested positive for HIV. These positives represent 15% of all HIV positives identified in 2004, but less than 1% of all self-identified IDU. This indicates that CTS continues to capture persons at high risk for HIV and supports evidence of a low prevalence of HIV among IDU in New Mexico.

According to estimates by the NMDOH Substance Abuse Epidemiology Unit, there may be nearly 24,000 adult IDUs in New Mexico. The prevalence of injection drug use in New Mexico varies by county (Figure 15). Both Quay and Rio Arriba counties have the highest estimated rates at 3 per 100,000 population. The location of corrections facilities also plays a large role in the estimated prevalence of injection drug users in some areas, particularly in Cibola and Torrance counties.

Figure 15. Estimated rates of injection drug use, New Mexico, 2004



Source: NMDOH, Substance Abuse Epidemiology Unit

Over 9,000 IDU have been enrolled in the Syringe Exchange Program (SEP) through the end of 2005. Roughly 4,000 of these participants were active during 2005. Table 16 compares characteristics of SEP enrollees and PLWH/A who identify as IDU. A larger proportion of Hispanics (59%) participate in syringe exchange than is seen in the entire population of IDU living with HIV/AIDS (37%). Participants were more likely to be in their 40's or 50's and primarily resided in Region 3 at the time of enrollment. There are also fewer SEP enrollees in Regions 1 and 5. Regional differences in enrollment may reflect the distribution and prioritization of SEP resources.

Two seroprevalence studies have also documented positivity rates for infectious disease among IDU in New Mexico. Between 1994 and 1997, a study was conducted statewide that revealed that approximately 0.5% of IDU were infected with HIV¹. The study also found that 62% of IDU were infected with hepatitis B and 83% with hepatitis C. In 2005, a study was conducted in Doña Ana County among 100 IDU; only one HIV infection was identified².

¹ Samuel MC et al. Association between heroin use, needle sharing and tattoos received in prison with hepatitis B and C positivity among street-recruited injection drug users in New Mexico, USA. *Epidemiol Infect.* 2001;127:475-484.

² Foster LN. The Paso del Norte collaborative study: Infectious disease seroprevalence and risk behavior among injection drug users. *The New Mexico Epidemiology Report.* 2006;4.

Table 16. Comparison of SEP enrollees and IDU living with HIV/AIDS, New Mexico, 2005

| Characteristic | SEP Enrollees ^a | | PLWH/A ^b | |
|-------------------------------|----------------------------|----------------|---------------------|------------|
| | N | % ^c | N | % |
| Sex | | | | |
| Male | 6138 | 68 | 236 | 69 |
| Female | 2868 | 32 | 104 | 31 |
| Unknown | 20 | < 1 | 0 | 0 |
| Race/Ethnicity | | | | |
| White | 2750 | 30 | 159 | 47 |
| Hispanic | 5343 | 59 | 127 | 37 |
| American Indian/Alaska Native | 250 | 3 | 24 | 7 |
| African American | 205 | 2 | 30 | 9 |
| Asian/Pacific Islander | 16 | < 1 | 0 | 0 |
| Unknown | 462 | 5 | 0 | 0 |
| Age | | | | |
| < 20 | 6 | < 1 | 3 | 1 |
| 20-29 | 1343 | 15 | 84 | 25 |
| 30-39 | 2475 | 27 | 136 | 40 |
| 40-49 | 3165 | 35 | 100 | 29 |
| 50+ | 2027 | 22 | 17 | 5 |
| Unknown | 10 | < 1 | 0 | 0 |
| Region | | | | |
| 1, Northwest | 79 | 1 | 48 | 14 |
| 2, Northeast | 872 | 10 | 35 | 10 |
| 3, Bernalillo Co. | 5933 | 66 | 89 | 26 |
| 4, Southeast | 1262 | 14 | 32 | 9 |
| 5, Southwest | 713 | 8 | 58 | 17 |
| Out-of-state | - | - | 78 | 23 |
| Unknown | 167 | 2 | 0 | 0 |
| Total | 9026 | 100 | 340 | 100 |

Source: NMDOH, Syringe Exchange Program and HIV & Hepatitis Epidemiology Program

^aAge and Region at time of enrollment in SEP.

^bAge and Region at time of diagnosis of HIV/AIDS.

^cDue to rounding, percentages may not total to 100%.

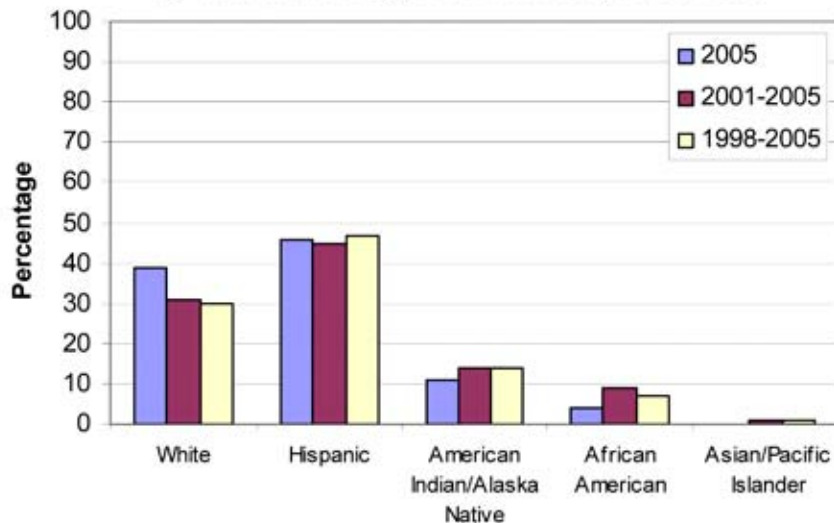
Heterosexual

Sexual activity among persons who identify as heterosexual still remains one of the less prevalent risk factors among persons with HIV in New Mexico. Recent analyses have identified a small increasing trend in heterosexuals diagnosed with HIV. In contrast, there has been a marked increase in HIV infection among heterosexuals, particularly African American females, in the U.S. and worldwide.

Of the HIV positive persons identified as heterosexual, two-thirds reported having had sexual contact with a known HIV-infected partner, but do not know the risk factor associated with their partner's infection. An additional 25% stated their partner was an IDU and the remaining 6% stated their partner was MSM.

Figure 16 illustrates HIV/AIDS among persons reporting heterosexual risk by race/ethnicity from 1998-2005. During 2005, persons reporting heterosexual contact as a risk factor for HIV were primarily Hispanic (46%) or White (39%); the proportion of cases occurring in these two racial/ethnic groups have increased both over the last 5 years and since 1998. However, American Indians and African Americans report the greatest proportion of heterosexual risk relative to the other risk categories.

Figure 16. HIV/AIDS cases among heterosexuals by race/ethnicity, New Mexico, 1998-2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Co-Infection

Hepatitis C

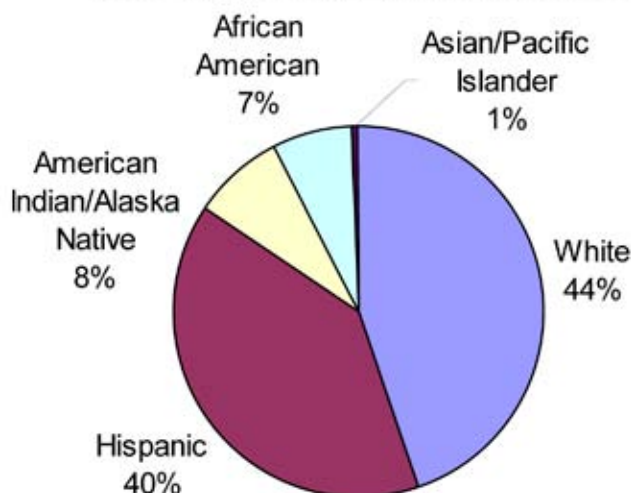
Co-infection with hepatitis C virus (HCV) can have serious consequences in persons living with HIV/AIDS. HIV causes more rapid progression of liver disease, while HCV may affect the treatment of HIV. Currently, the HIV & Hepatitis Epidemiology Program has identified co-infection status for

32% of PLWH/A; 485 (48%) of these were co-infected with HCV. Therefore, this implies that at least 15% of all persons reported with HIV were co-infected with HCV. Since data on hepatitis C has not been regularly collected with HIV surveillance data until 2003, this is likely an underestimate of the true burden of HCV and HIV co-infection.

As shown in Figure 17, persons living with HCV and HIV co-infection were primarily White or Hispanic. Though African Americans only made up 6% of the PLWH/A, this population had a larger burden of co-infection with HCV (7%). Injection drug use, as estimated by the IDU and MSM/IDU populations, contributed to more than half of all co-infections with HCV (Figure 18). MSM alone had more than one-third of the overall burden.

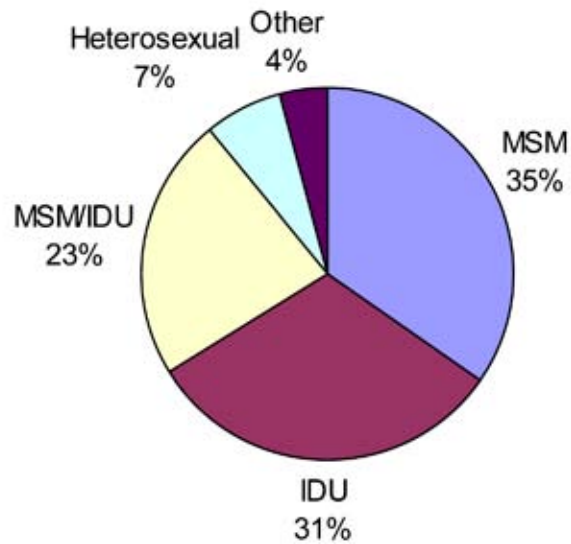
To update this information, the HIV & Hepatitis Epidemiology Program will be conducting a comprehensive matching project between the hepatitis C and HIV surveillance databases, with completion expected in early 2007.

Figure 17. Persons living with HIV/AIDS and HCV by race/ethnicity, New Mexico, 2005



Source: NMDOH, HIV & Hepatitis Epidemiology Program

Figure 18. Persons living with HIV/AIDS and HCV by mode of exposure, New Mexico, 2005

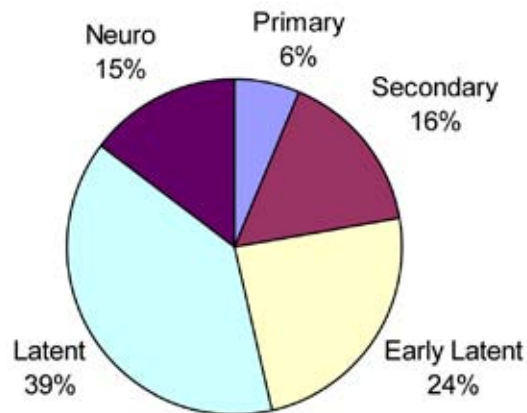


Source: NMDOH, HIV & Hepatitis Epidemiology Program

Syphilis

A number of studies have shown that syphilis facilitates the transmission of HIV. Syphilis and HIV share a primary mode of transmission, that of unprotected sexual contact. Syphilis sores directly facilitate infection with other blood borne diseases, particularly HIV, which tends to reside in the white blood cells that gather in sores and abrasions. In the past few years, New Mexico experienced increasing numbers of syphilis cases throughout the state. Between 1986 and 2005, a total of 105 persons were identified as having been infected with both HIV and syphilis during their lifetime. The stages of their syphilis infection are shown in Figure 19. Of these co-infected persons, 93% (98) were men. The most frequently identified exposure risk was MSM (70%). When MSM/IDU were included, MSM represented 87% of all co-infections.

Figure 19. Stage of syphilis infection among persons with HIV/AIDS, New Mexico, 1986-2004

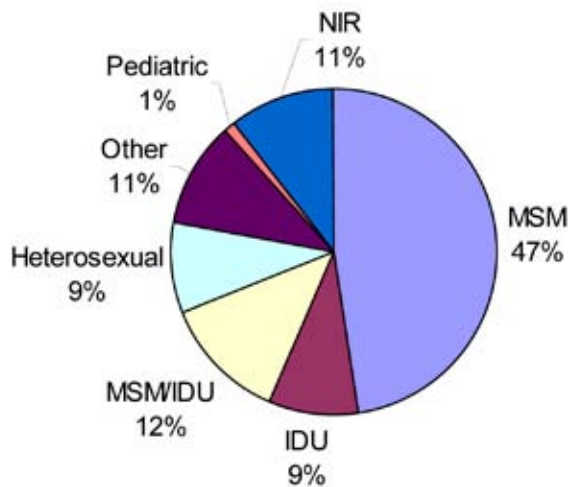


Source: NMDOH, STD Program and HIV & Hepatitis Epidemiology Program

Tuberculosis

Tuberculosis (TB) is a bacterial infection caused by the organism *Mycobacterium tuberculosis*. The disease can manifest in both a pulmonary and extra-pulmonary fashion in persons living with HIV/AIDS. In 2005, New Mexico reported a total of 39 active TB cases, or 2.0 per 100,000 population. This was below the national rate of 4.8 per 100,000 reported for the U.S. Since 1986, a total of 47 cases of pulmonary TB have been identified among persons with HIV/AIDS in New Mexico. Cases of co-infection have been found disproportionately among males (91%) and Hispanics (50%). MSM also had the largest overall burden of TB and HIV co-infection (Figure 20).

Figure 20. TB in persons with HIV/AIDS by mode of exposure, New Mexico, 1986-2004



Source: NMDOH, TB/Refugee Program and HIV & Hepatitis Epidemiology Program

General and Special Populations

Adults

The NMDOH HIV Prevention Program collects data on persons in the general population who have utilized HIV testing provided through CTS. From 2004 to 2005, the number of HIV tests conducted by CTS sites decreased by 36% from 7,906 in 2004 to 5090 in 2005. Fifty-four (0.6%) individuals tested positive for HIV. In 2005, 57% of persons tested were male. Most tests were performed in STD clinics, at field visits and sites specifically designated for HIV CTS, where the highest positivity rates were also found (Table 17).

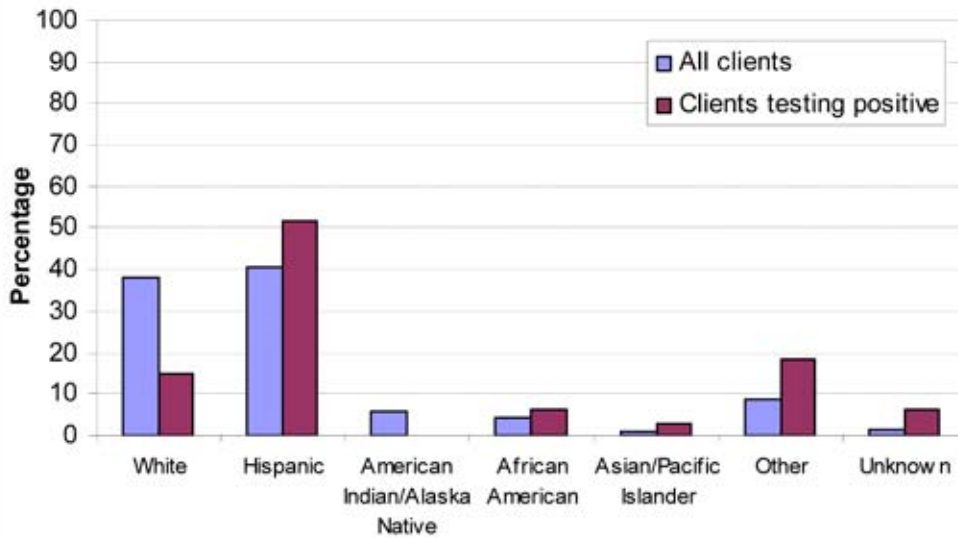
Table 17. CTS clients by testing site, New Mexico, 2005

| Testing Site | No. Tests | No. (%) Positive Tests | % of Total Tests N = 7,906 | % of Total Positive N = 54 |
|-----------------------------------|-----------|------------------------|-------------------------------|-------------------------------|
| STD Clinic | 2052 | 9 (.4%) | 40.3 | 27.3 |
| HIV CTS | 1365 | 14 (1%) | 26.8 | 42.4 |
| Field Visit | 827 | 6 (.7%) | 16.2 | 18.2 |
| Community or Public Health Clinic | 154 | 0 | 3.0 | 0.0 |
| Drug Treatment | 52 | 0 | 1.0 | 0.0 |
| Family Planning | 30 | 0 | 0.6 | 0.0 |
| Prenatal | 1 | 0 | 0.0 | 0.0 |
| Not Specified | 602 | 4 (.7%) | 11.8 | 12.1 |
| Total | 5090 | 33 | 100 | 100 |

Source: NMDOH, HIV Prevention Program

Preliminary U.S. data based on the 2005 National Health Interview Survey (NHIS) showed that 35% of adults 18 years or older have had at least one HIV test. African Americans were most likely to be tested (49%), followed by Hispanics (39%), and then Whites (33%). According to New Mexico's CTS 2005 data, clients were primarily White or Hispanic (Figure 21). Of those who tested positive, 15% were White, 52% Hispanic, and 6% African American.

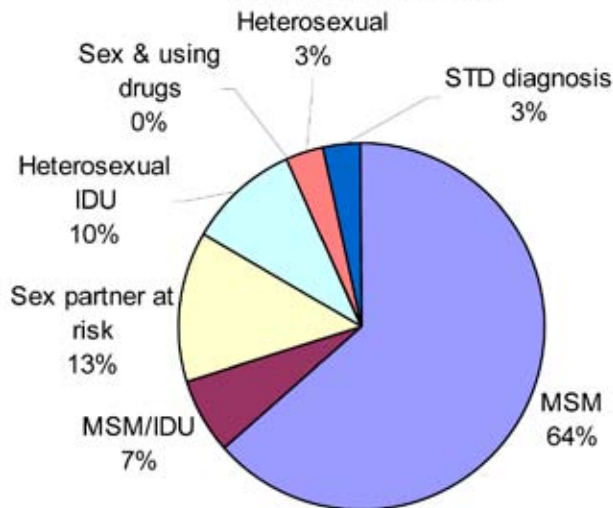
Figure 21. CTS clients and HIV positivity by race/ethnicity, New Mexico, 2004



Source: NMDOH, HIV Prevention Program

The majority of CTS clients who tested positive for HIV in 2005 reported MSM as their exposure risk (Figure 22). Another 6% reported MSM/IDU and 12% stated that their sexual partner was at risk for HIV. Three percent also reported heterosexual/IDU as their risk.

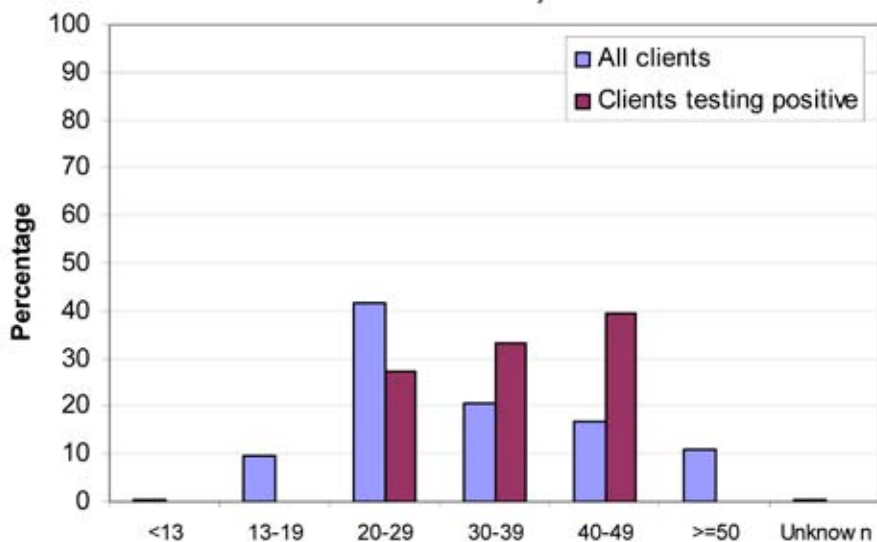
Figure 22. CTS clients testing HIV positive by risk, New Mexico, 2004



Source: NMDOH, HIV Prevention Program

According to NHIS data for CTS across the nation, most adults who were ever tested were between the ages of 25-34 and 35-44. Women were more likely than men to have ever had an HIV test for age groups 18-24, 25-34, and 35-44. Men were more likely than women to have ever had an HIV test for age groups 45-64 and 65+. Figure 23 below describes the age of the individuals tested at CTS sites in New Mexico compared to individuals who tested positive at those sites. The majority of the individuals tested were aged 20-29 while the majority of those testing positive were aged 40-49.

Figure 23. CTS clients and HIV positivity by age, New Mexico, 2004

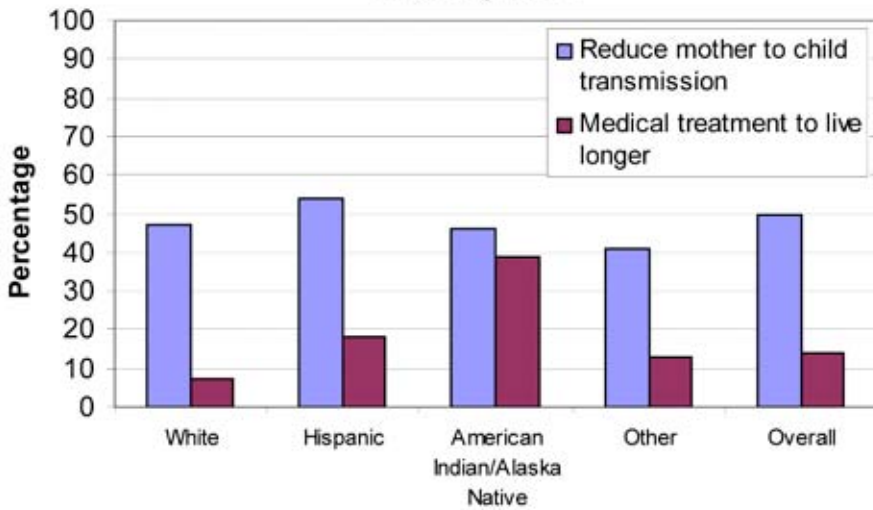


Source: NMDOH, HIV Prevention Program

Information on the general adult population can also be found in the NMDOH Behavioral Risk Factor Surveillance System (BRFSS), a state-based random-digit dialed telephone survey that is regularly conducted in New Mexico. BRFSS seeks to identify personal health attitudes and behaviors in individuals through a carefully designed survey instrument. Data are self reported and may be subject to recall bias, or participants may choose not to answer all questions. Since only non-institutionalized individuals who have telephones are able to participate, BRFSS may not be fully representative of the population at high risk for HIV.

In 2004, 11 questions related to HIV/AIDS were asked of BRFSS participants, about half of which are summarized here. Questions primarily addressed HIV awareness and testing. Of nearly 4,700 participants, 50% were unaware that there are treatments to reduce the transmission of HIV from mother to child. Overall, 14% of New Mexicans were also unaware that there are treatments to help people with HIV live longer. Figure 24 presents this data on lack of HIV awareness by race/ethnicity. Hispanics (54%) were more likely to be unaware of treatments to reduce mother to child transmission of HIV, while American Indians (39%) were more likely than other groups to be unaware of medical treatments for HIV.

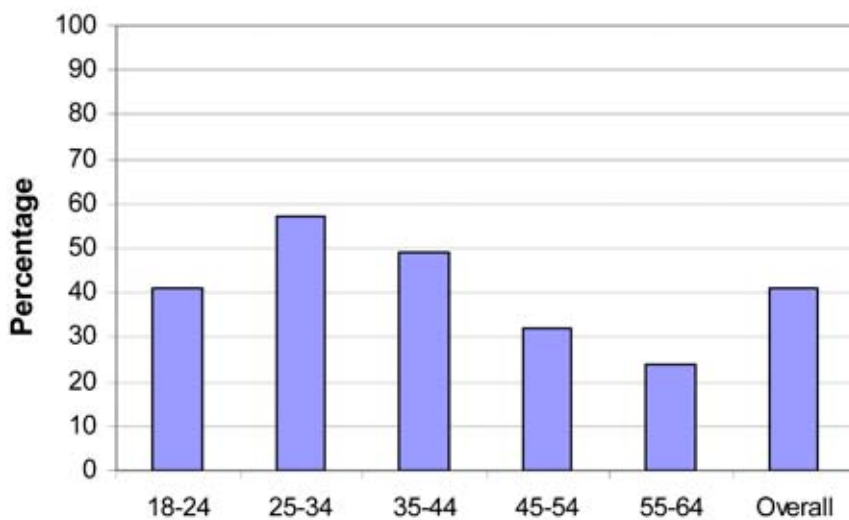
Figure 24. Adults lacking HIV awareness, New Mexico, 2004



Source: NMDOH, Survey Unit, BRFSS

Among all BRFSS participants, 41% reported having ever been tested for HIV. As shown in Figure 25, New Mexicans aged 25-34 years were most likely to have ever been tested for HIV. Participants who were least likely to report having ever been tested for HIV include American Indians (35%), persons with less than a high school graduate education (32%), and residents of southwest New Mexico (35%).

Figure 25. Adults that have ever been tested for HIV by age, New Mexico, 2004



Source: NMDOH, Survey Unit, BRFSS

The most important reasons reported for having tested for HIV included “It was done as a part of a routine medical check-up” (28%), “It was required” (23%), “Wanted to find out” (22%) and “Pregnancy” (15%). Of the 1,881 participants who have ever been tested for HIV, 35% were tested by a private doctor or Health Management Organization. The remaining were tested at a clinic (29%) or a hospital (26%). Of participants who tested at a clinic, 41% did so at a public health clinic.

About 5% of participants also reported having a possible risk factor for HIV. These risks included having one of the following in the past year: used intravenous drugs; received treatment for a sexually transmitted disease; given or received money or drugs in exchange for sex; and had anal sex without a condom. New Mexicans aged 18-24 years were more likely than any other age group to have reported risks for HIV. Participants with lower education or lower income levels were also more likely to have reported a risk for HIV.

Women/Children

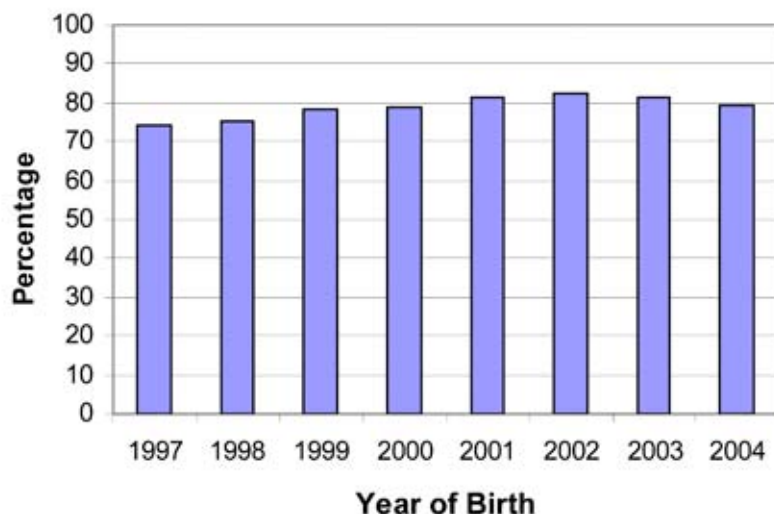
The teen birth rate in New Mexico for 2003 was 62.6 per 1,000 teens (aged 15-19 years). This was much higher than the national rate in 2003 which was 41.6 births per 1,000 teens. The teen birth rate in New Mexico in 2004 was 59.8 per 1,000 teens, indicating a slight decrease since 2003. Hispanic teens had the highest teen birth rate at 80.3 per 1,000 teens, followed by American Indians (63.3), African Americans (43.7), Whites (31.3), and Asians/Pacific Islanders (16.9).

Another source of general population data for women is the NMDOH Pregnancy Risk Assessment Monitoring System (PRAMS), which is part of the CDC initiative to reduce infant mortality and low birth weight. PRAMS is an on-going, population-based risk factor surveillance system designed to identify and monitor selected maternal experiences and behaviors that occur before and during pregnancy and during the child’s early infancy. This data is weighted for sample size.

In 2004, 45% of new mothers surveyed reported that they had not been trying to get pregnant. Of these women, 46% also reported they were not doing anything to prevent pregnancy. Forty-three percent of women said they did not do anything to prevent pregnancy because they did not mind if they got pregnant. Twenty-nine percent thought that they could not get pregnant at the time, 19% said their husband or partner didn’t want to use birth control, 10% reported that they thought they or their husband or partner was sterile, 8% reported side effects from birth control and another 7% reported problems getting birth control when they needed it.

Starting in 1997, new mothers surveyed by PRAMS were asked if a health care worker talked to them about getting tested for HIV. The percentage of women responding “yes” increased from 1997 (74%) to 2001 (81%) and remained steady through 2002 except for slight decreases in 2003 and 2004 (Figure 26). Currently, New Mexico has an opt-out policy for HIV testing in pregnant women; the success of this policy has not been directly measured. However in 2004, the question “At any time during your most recent pregnancy or delivery, did you have a test for HIV?” was added. Seventy percent of women responded “yes,” 19% responded “no,” and the remainder did not know if they had been tested.

Figure 26. Mothers of infants ever consulted on HIV testing, New Mexico, 1997-2004



Source: NMDOH, Maternal Child Health Epidemiology, PRAMS

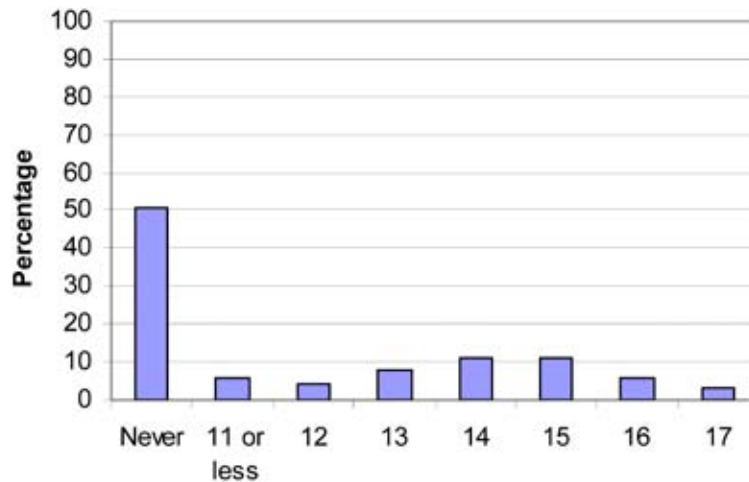
Adolescents

The NMDOH Youth Risk and Resiliency Survey (YRRS) conducted in New Mexico provides general population data on high school students in grades 9 through 12. Survey questions regarding illicit drugs and sexual behavior were examined in the context of risk for HIV infection.

Injection drug use is clearly linked to HIV infection and use of drugs and alcohol has been linked to increased risky behavior such as unprotected sex. According to the 2003 YRRS, there were significant increases over the 2001 results in most measures of use and ease of access to illicit drugs. The reported use of cocaine, inhalants, and heroin doubled or more in 2003. The use of marijuana and methamphetamines increased slightly during 2003 to 29% and 8%, respectively. A new question in 2003 also found that 2% of participants had injected illegal drugs two or more times and 3.7% had done so at least once in their lifetime.

Not all school districts that participated in YRRS allowed questions regarding sex to be part of the survey. Therefore, the following data represent most, but not all, of the participating districts. On the 2003 YRRS survey, 49% of students reporting having had sexual intercourse; 10% had done so prior to age 13. This rate of sexual intercourse prior to age 13 has doubled since 2001 (Figure 27). Of those respondents that reported ever having sexual intercourse, 28% said they had used alcohol or drugs before the last time they had sex and 61% reported using a condom the last time they had sex. Eighteen percent of adolescents reported one sexual partner in their lifetime. Ten percent of adolescents also reported having five or more lifetime partners.

Figure 27. Age at first sexual intercourse among high school students, New Mexico, 2003



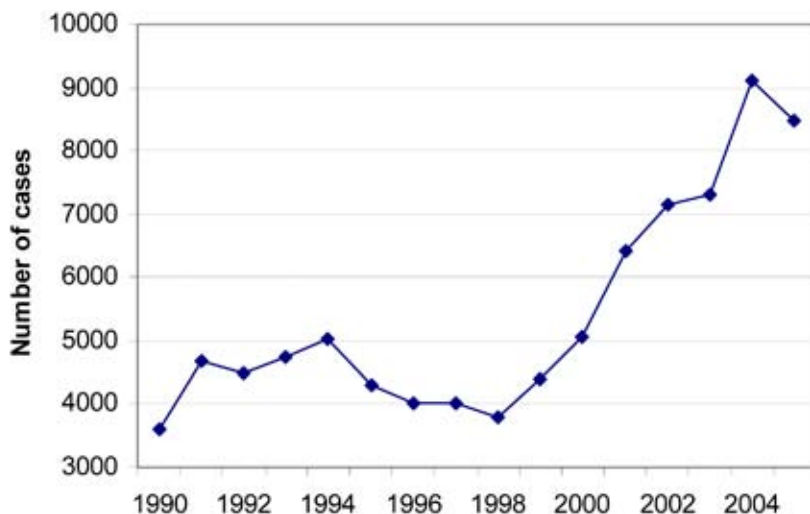
Source: NMDOH, Substance Abuse Epidemiology Unit, YRRS

STDs

Trends in the incidence of various STDs can also provide information on potential high risk sexual behaviors that can lead to HIV exposure. STD data can thus be used as an indirect measure of risk of HIV infection in the general population. The NMDOH STD Program collects surveillance data on chlamydia, gonorrhea, and syphilis.

Over the past 6 years, reported cases of chlamydia and syphilis have steadily increased in New Mexico, whereas reports of gonorrhea have more erratically increased. At the end of 2005, New Mexico had a rate of 438.7 cases of chlamydia per 100,000 population and ranked 4th in the nation for total cases (Figure 28). As shown in Figure 31, women bear the greater burden for chlamydia; infection with chlamydia can result in more serious consequence in women, including infertility. In 2005, Hispanics and African Americans had chlamydia rates that exceeded the rate for the entire state, at 587.5 and 725.9 per 100,000, respectively.

Figure 28. Incidence of chlamydia, New Mexico, 1990-2005

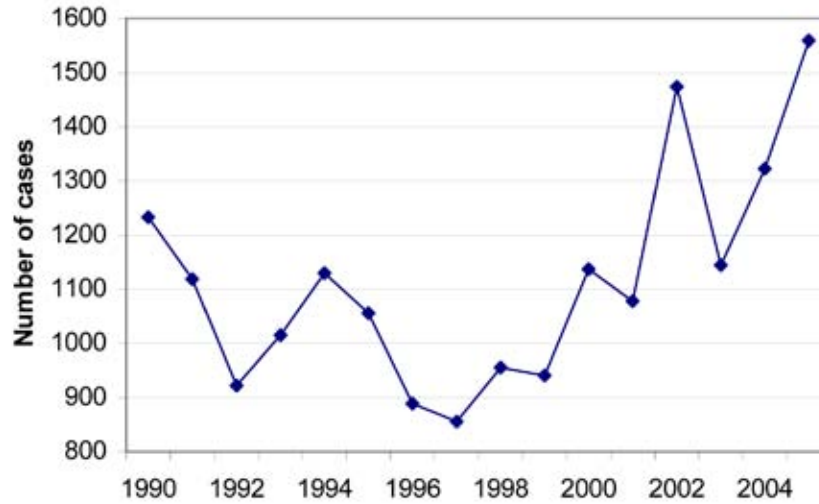


Source: NMDOH, STD Program

In 2005, the state also had a rate of 80.7 cases of gonorrhea per 100,000 population, ranking it approximately 27th in the nation (Figure 29). Though African Americans had a relatively small portion of the overall burden of gonorrhea (Figure 32), the case rate for disease in 2005 for that population was nearly five times that of all New Mexico (384.1 per 100,000 population).

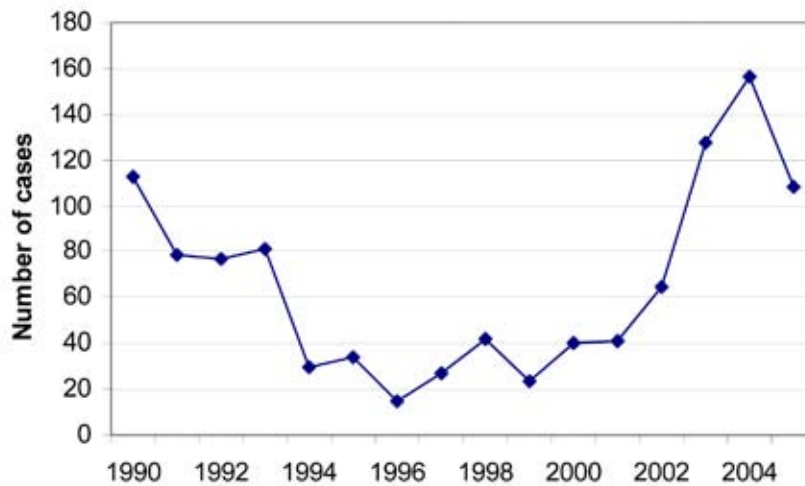
During 2005, the rate of primary and secondary syphilis declined in New Mexico to 2.9 cases per 100,000; this ranked New Mexico 14th in the nation. During that year, another 52 cases of early latent syphilis and 6 cases of congenital syphilis were also identified. Cases of primary, secondary and early latent syphilis are summarized in Figure 30. In the past five years, American Indians have been most affected by syphilis (Figure 32), much of which has been due to outbreaks in the Navajo Nation. The 2005 case rates for primary and secondary syphilis among both American Indians and African Americans also exceeded the rate for all of New Mexico, at 11.8 and 5.3 cases per 100,000 population, respectively.

Figure 29. Incidence of gonorrhea, New Mexico, 1990-2005



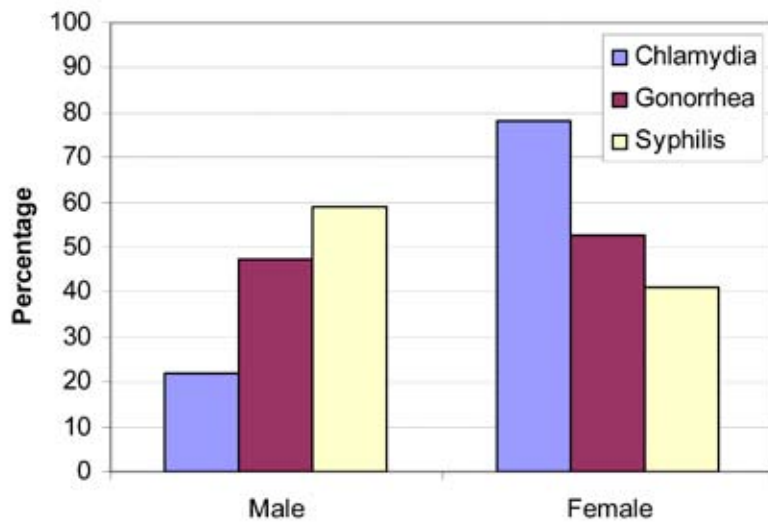
Source: NMDOH, STD Program

Figure 30. Incidence of primary, secondary, and early latent syphilis, New Mexico, 1990-2005



Source: NMDOH, STD Program

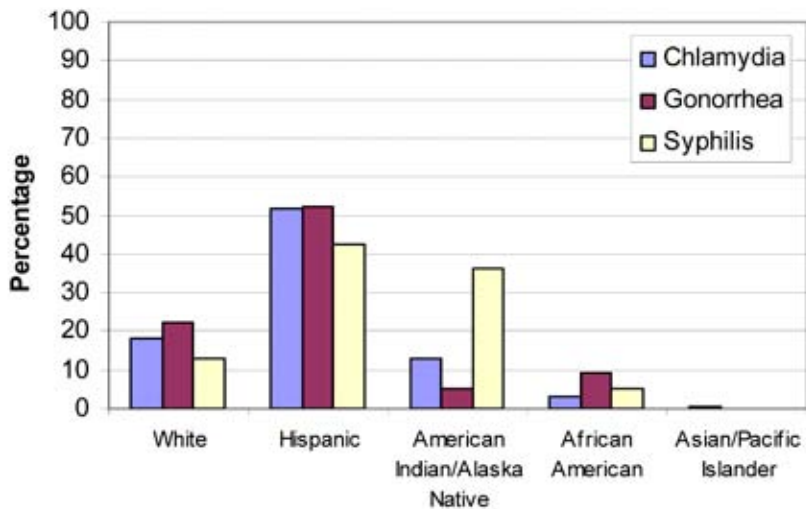
Figure 31. STD diagnoses by sex, New Mexico, 2001-2005



Source: NMDOH, STD Program

^aData excludes 70 cases for which sex was listed unknown.

Figure 32. STD diagnoses by race/ethnicity, New Mexico, 2001-2005



Source: NMDOH, STD Program

^aData excludes 6,096 cases for which race/ethnicity was listed as other or unknown.

SECTION 2: RYAN WHITE CARE ACT QUESTIONS

What are the patterns of service utilization of HIV-infected persons in New Mexico?

Highlights

- 82% of persons living with HIV/AIDS during 2005 received services funded by the Ryan White CARE Act (RWCA) Title II program.
- The majority of RWCA Title II clients were MSM and/or White.
- Nearly all RWCA Title II clients received medical care and case management.
- 78% of persons participating in the AIDS Drug Assistance Program received highly active anti-retroviral therapy.
- In 2005, concurrent diagnoses of HIV and AIDS accounted for 63% of all new AIDS cases reported.

Client Profile

In 2005, Ryan White CARE Act (RWCA) Title II funds served a total of 1,545 clients living with HIV/AIDS (Table 18). This reflects a majority (82%) of all PLWH/A in the state at that time.

RWCA clients were generally representative of the entire population of PLWH/A. Persons aged 25-44 years received the majority (53%) of RWCA services. PLWH/A identifying as White or MSM were slightly over-represented among RWCA clients; Whites comprised 47% of clients and 42% of PLWH/A, while MSM comprised 63% of clients and only 58% of PLWH/A.

Services Provided

The five providers that comprise the Health Management Alliance (HMA) system of care provide the majority of care services to persons living with HIV/AIDS in New Mexico. These providers, located strategically across the public health regions, provide comprehensive HIV services in all geographic areas of the state: University of New Mexico (UNM) Health Services/New Mexico AIDS Services (NMAS) and First Nations Health Source are in Albuquerque; Southwest CARE Center is in Santa Fe; Alianza of New Mexico is in Roswell; Camino de Vida Center for HIV Services is in Las Cruces. The First Nations Community Health Source focuses its care specifically to American Indians throughout the state. With the exception of First Nations Community Health Source, all HMA providers are reimbursed through the NMDOH HIV Services Program with both federal RWCA Title II and state funds. Only services supported by RWCA Title II funds are summarized here.

Table 18. Characteristics of RWCA Title II clients and persons living with HIV/AIDS, New Mexico, 2005

| | RWCA clients ^a N = 1,545 | PLWH/A ^b N = 1,880 |
|-------------------------------|--|----------------------------------|
| Sex | % | % |
| Male | 88 | 87 |
| Female | 12 | 13 |
| Race/Ethnicity | | |
| White | 47 | 42 |
| Hispanic | 44 | 46 |
| American Indian/Alaska Native | 4 | 7 |
| African American | 4 | 5 |
| Asian/Pacific Islander | < 1 | < 1 |
| Age at Diagnosis | | |
| < 13 | < 1 | 1 |
| 13-24 | 2 | 11 |
| 25-44 | 53 | 69 |
| 45-64 | 42 | 18 |
| 65+ | 1 | 1 |
| Mode of Exposure | | |
| MSM | 63 | 58 |
| IDU | 7 | 10 |
| MSM/IDU | 6 | 9 |
| Heterosexual | 13 | 11 |
| Other | 3 | 1 |
| Pediatric | 3 | 1 |
| NIR | 3 | 10 |

^aSource: NMDOH, HIV Services Program

^bSource: NMDOH, HIV & Hepatitis Epidemiology Program; excludes persons diagnosed in New Mexico and known to have either left the state or access providers out-of-state.

In 2005, services provided to RWCA Title II clients included medical care, dental care, mental health services, substance abuse treatment, and case management (Table 19). Nearly all clients received direct medical care (97%) and case management (95%). Only 1% of clients received dental care; New Mexico currently has a shortage of dental providers. As shown in Table 20, between 13% and 47% of clients used laboratory services in 2005. Much of these services were for screening for syphilis and hepatitis C.

Table 19. Utilization of services by RWCA Title II clients, New Mexico, 2005

| | RWCA clients that received services | | Total number of visits | Average number of visits per client |
|---------------------------|-------------------------------------|------|------------------------|-------------------------------------|
| | N | % | N | N |
| Medical Care | 1496 | 97.2 | 1496 | 5.4 |
| Dental Care | 8 | 1.0 | 8 | < 1 |
| Mental Health Services | 489 | 33.2 | 489 | 1.4 |
| Substance Abuse Treatment | 158 | 10.3 | 158 | 0.4 |
| Case Management | 1447 | 95.0 | 1447 | 18.4 |

Source: NMDOH, HIV Services Program

Table 20. Utilization of laboratory services by RWCA Title II clients, New Mexico, 2005

| | RWCA clients that received services | |
|-----------------------|-------------------------------------|------|
| | N | % |
| CD4 count | 205 | 13.1 |
| Viral load | 203 | 13.0 |
| Syphilis screening | 731 | 47.1 |
| Hepatitis C screening | 542 | 35.0 |
| TB screening | 267 | 17.3 |

Source: NMDOH, HIV Services Program

The HIV Services Program also manages the AIDS Drug Assistance Program (ADAP) which provides pharmaceutical therapies at no cost to PLWH/A. In 2005, a total of 243 clients were accessing ADAP (Table 21).

HAART, an aggressive anti-HIV treatment that includes a combination of protease and reverse transcriptase inhibitors, interrupts the HIV life cycle and may thereby reduce the amount of HIV in a person's body to undetectable levels. According to RWCA data (Table 22), 78% of clients served by ADAP received HAART or another therapy. Persons living with HIV/AIDS and receiving services outside of ADAP are not represented in this data; therefore, there may be more persons on HAART or other therapies. Patients may also not be on therapy due to other reasons, including issues related to side effects or adherence.

Table 21. Characteristics of clients enrolled in ADAP, New Mexico, 2005

| | ADAP clients ^a N = 243 | PLWH/A ^b N = 1,880 |
|-------------------------------|--------------------------------------|----------------------------------|
| Sex | % | % |
| Male | 87 | 87 |
| Female | 13 | 13 |
| Race/Ethnicity | | |
| White | 30 | 42 |
| Hispanic | 3 | 46 |
| American Indian/Alaska Native | 30 | 7 |
| African American | 0 | 5 |
| Asian/Pacific Islander | 5 | 1 |
| Unknown | 33 | - |
| Age at Diagnosis | | |
| < 13 | 0 | 1 |
| 13-24 | 0 | 11 |
| 25-44 | 57 | 69 |
| 45-64 | 39 | 18 |
| 65+ | 3 | 1 |

^aSource: NMDOH, HIV Services Program

^bSource: NMDOH HIV & Hepatitis Epidemiology Program; excludes persons diagnosed in New Mexico and known to have either left the state or access providers out-of-state.

Table 22. Antiretroviral therapy in RWCA Title II clients, New Mexico, 2005

| RWCA clients that received therapy | | |
|------------------------------------|------|----|
| | N | % |
| None | 292 | 19 |
| HAART | 1189 | 77 |
| Other | 15 | 1 |
| Total receiving therapy | 1204 | 78 |

Source: NMDOH, HIV Services Program

At the end of 2005, 1,565 clients were enrolled with HMA providers for their HIV services. The characteristics of clients enrolled with HMA providers did not necessarily correspond to the general characteristics of all PLWH/A (Table 23). Each HMA provider may focus their efforts on target populations in their given service area. Camino de Vida, which serves the southwest, had a larger proportion of Hispanic (59%) and IDU (12%) clients enrolled than is seen in the entire PLWH/A population. Likewise, Southwest CARE served more males (90%) and Whites (54%). Alianza served more females, Whites, African Americans, and IDU. The largest HMA provider, UNM/NMAS, had a larger proportion of clients that were White or MSM. As expected, First Nations which serves the American Indian community, had the largest proportion of American Indian and female clients. Overall, each HMA provider serves a larger proportion of heterosexual clients (14% to 30%) than was identified among PLWH/A (11%).

Table 23. Characteristics of clients enrolled with HMA providers and persons living with HIV/AIDS, New Mexico, 2005

| | Camino de Vida N = 195 | Southwest CARE N = 461 | Alianza N = 112 | UNM/ NMAS N = 777 | First Nations N = 20 | PLWH/A ^a N = 1,880 |
|-------------------------------------|---------------------------|---------------------------|--------------------|-------------------------|-------------------------|----------------------------------|
| Sex | % ^b | % | % | % | % | % |
| Male | 85 | 90 | 79 | 88 | 80 | 87 |
| Female | 14 | 10 | 21 | 11 | 20 | 13 |
| Transgender | 1 | 0 | 0 | 1 | 0 | - |
| Race/Ethnicity | | | | | | |
| White | 36 | 54 | 46 | 46 | 10 | 42 |
| Hispanic | 59 | 38 | 42 | 44 | 0 | 46 |
| American Indian/ Alaska Native | 1 | 5 | 1 | 5 | 80 | 7 |
| African American | 2 | 2 | 8 | 5 | 0 | 5 |
| Asian/ Pacific Islander | 1 | 0 | 1 | 1 | 0 | < 1 |
| > 1 race/ethnicity | 1 | 0 | 3 | < 1 | 10 | - |
| Unknown | 1 | < 1 | 0 | 0 | 0 | - |
| Age at Diagnosis | | | | | | |
| < 13 | 1 | 0 | 0 | 2 | 0 | 1 |
| 13-24 | 4 | 2 | 2 | 2 | 0 | 11 |
| 25-44 | 54 | 48 | 53 | 56 | 55 | 69 |
| 45-64 | 39 | 48 | 44 | 40 | 45 | 18 |
| 65+ | 2 | 2 | 2 | 1 | 0 | 1 |
| Mode of Exposure^c | | | | | | |
| MSM | 58 | 74 | 53 | 63 | 60 | 58 |
| IDU | 12 | 5 | 15 | 7 | 5 | 10 |
| MSM/IDU | 4 | 4 | 4 | 7 | 0 | 9 |
| Heterosexual | 19 | 14 | 24 | 14 | 30 | 11 |
| Other | 4 | 0 | 3 | 4 | 0 | 1 |
| Pediatric | 3 | 1 | 1 | 2 | 5 | 1 |
| NIR | 0 | 1 | 1 | 4 | 0 | 10 |

Source: NMDOH, HIV Services Program

^aSource: NMDOH, HIV & Hepatitis Epidemiology Program; excludes persons diagnosed in New Mexico and known to have either left the state or access providers out-of-state.

^bDue to rounding, percentages may not total 100%.

^cData based on only those clients that received at least one medical care visit during the reporting period; N differs as follows: Camino de Vida, N = 165; Southwest CARE, N = 445; Alianza, N = 109.

Late Diagnosis of HIV/AIDS

AIDS diagnoses are used by the CDC and state surveillance programs as a basic epidemiological indicator that can be compared across geographic areas and over time. All states now report HIV diagnoses, but due to coding issues this data will not be made available at a national level for some years. Thus, AIDS cases continue to be the basis upon which to compare data nationally.

Due to differences in testing behavior and treatment outcomes among people infected with HIV, there are substantial variations within the population presenting with AIDS in a given time period. Those who tested for HIV early in the course of the disease may not receive an AIDS diagnosis for many years, especially if they have received antiretroviral therapy. In contrast, those that fail to test early may present with a concurrent diagnosis of HIV and AIDS.

Concurrently diagnosed individuals, or “late testers,” present with more advanced service needs than “early testers” and are likely to have unknowingly transmitted HIV to others over a period of many years. Because the diagnosis of AIDS is subject to delays after diagnosis of HIV, and the actual disease process leading to AIDS takes many years, it is useful to define “concurrent diagnoses” to include cases in which documentation of AIDS may have followed diagnosis of HIV infection within a year.

Between 1998-2005, 804 diagnoses of AIDS were reported among residents of New Mexico (Table 24). More than half (57%) were diagnoses of AIDS within 12 months of HIV diagnosis, or concurrent diagnoses. In 2003, 46% of cases were concurrently diagnosed, which was higher than that reported for the U.S. at 39%. Most importantly, New Mexico has seen a jump in concurrent diagnoses of HIV and AIDS in the last two years; 64% in 2004 and 63% in 2005.

As shown in Table 24, two-thirds of all AIDS cases among Hispanics were diagnosed late; this proportion was far greater than for any racial/ethnic group. Concurrent diagnoses occurred most in persons aged 50+. The majority of AIDS diagnoses in each region were also concurrent, ranging from 54% to 61%. Larger proportions of MSM (58%) and persons reporting heterosexual contact (61%) were concurrently diagnosed than other risk groups.

A study being conducted by the University of New Mexico, supported by the HIV & Hepatitis Epidemiology Program, may also provide insight into late testing behavior. This study asks persons recently diagnosed with HIV to complete a survey that would help researchers determine better ways to prevent HIV infection in New Mexico. Preliminary results from this study show that 48% of persons who tested for HIV did so because of an illness. The majority of persons interviewed reported not having a regular health care provider and/or not having health insurance at the time of their positive HIV test. Taken together, these initial findings suggest that some delays in HIV testing may be related to access to care.

Table 24. Distribution of persons with and without a diagnosis of AIDS within 12 months of diagnosis of HIV infection, New Mexico, 1998-2005

| | ≥ 12 months | | < 12 months | | Total | |
|-------------------------------|-------------|-----------|-------------|-----------|------------|------------|
| | No. | % | No. | % | No. | % |
| Sex | | | | | | |
| Male | 287 | 41 | 409 | 59 | 696 | 100 |
| Female | 55 | 51 | 53 | 49 | 108 | 100 |
| Race/Ethnicity | | | | | | |
| White | 151 | 50 | 152 | 50 | 303 | 100 |
| Hispanic | 131 | 34 | 254 | 66 | 385 | 100 |
| American Indian/Alaska Native | 36 | 51 | 35 | 49 | 71 | 100 |
| African American | 21 | 55 | 17 | 45 | 38 | 100 |
| Asian/Pacific Islander | 3 | 43 | 4 | 57 | 7 | 100 |
| Age at Diagnosis | | | | | | |
| < 13 | 0 | 0 | 0 | 0 | 0 | 100 |
| 13-19 | 3 | 75 | 1 | 25 | 4 | 100 |
| 20-29 | 43 | 49 | 45 | 51 | 88 | 100 |
| 30-39 | 147 | 45 | 178 | 55 | 325 | 100 |
| 40-49 | 113 | 43 | 150 | 57 | 263 | 100 |
| 50+ | 36 | 29 | 88 | 71 | 124 | 100 |
| Region | | | | | | |
| 1, Northwest | 46 | 39 | 71 | 61 | 117 | 100 |
| 2, Northeast | 64 | 46 | 76 | 54 | 140 | 100 |
| 3, Bernalillo Co. | 150 | 42 | 206 | 58 | 356 | 100 |
| 4, Southeast | 28 | 46 | 33 | 54 | 61 | 100 |
| 5, Southwest | 53 | 41 | 76 | 59 | 129 | 100 |
| Mode of Exposure | | | | | | |
| MSM | 184 | 42 | 253 | 58 | 437 | 100 |
| IDU | 54 | 53 | 48 | 47 | 102 | 100 |
| MSM/IDU | 41 | 53 | 37 | 47 | 78 | 100 |
| Heterosexual | 39 | 39 | 60 | 61 | 99 | 100 |
| Other | 4 | 29 | 10 | 71 | 14 | 100 |
| Pediatric | 5 | 100 | 0 | 0 | 5 | 100 |
| NIR | 15 | 22 | 54 | 78 | 69 | 100 |
| Year of AIDS Diagnosis | | | | | | |
| 1998 | 42 | 41 | 61 | 59 | 103 | 100 |
| 1999 | 34 | 38 | 55 | 62 | 89 | 100 |
| 2000 | 36 | 36 | 63 | 64 | 99 | 100 |
| 2001 | 41 | 42 | 56 | 58 | 97 | 100 |
| 2002 | 50 | 56 | 40 | 44 | 90 | 100 |
| 2003 | 61 | 54 | 53 | 46 | 114 | 100 |
| 2004 | 38 | 36 | 67 | 64 | 105 | 100 |
| 2005 | 40 | 37 | 67 | 63 | 107 | 100 |
| Total | 342 | 43 | 462 | 57 | 804 | 100 |

Source: HIV & Hepatitis Epidemiology Program

SECTION 2: RYAN WHITE CARE ACT QUESTIONS

What are the number and characteristics of HIV-infected persons who are not receiving primary medical care for HIV?

Highlights

- With 75% of persons living with HIV/AIDS accessing laboratory services during 2005, New Mexico had a met need that exceeded the national average of 50% to 60%.
- In 2005, more persons living with AIDS accessed services than those living with HIV; PLWA had a 20% unmet need, while PLWH had a 32% unmet need.
- HIV positive persons who were not in care were more likely to be White or African American, aged 20-29 years, diagnosed in southwestern New Mexico, or identifying as IDU or MSM/IDU.

Unmet Need

Laboratory reports are an important source of data on unmet need for HIV/AIDS care. PLWH/A who are enrolled in medical care at any site, including those not funded through RWCA, will receive periodic laboratory testing. All laboratory reports indicative of HIV or AIDS, including Western Blots, viral loads, and CD4+ cell counts, are reportable to NMDOH by regulations set forth in the New Mexico Administrative Code. Therefore, this data covers a larger proportion of persons in care than RWCA service data. All information in the following section is based on laboratory reports collected by the HIV & Hepatitis Epidemiology Program, and not data from the HIV Services Program.

Data collected include date of last lab report, which is presumed to be the last date of services. Unmet need is calculated by matching this limited data with demographics, HIV/AIDS status, and residency status from HARS. Only those cases diagnosed in New Mexico and who are known to be currently residing in the state are considered in the denominator. Providers are regularly asked to report migrations out-of-state in order to keep this information current.

Met need is a percentage calculated by dividing the number of persons that received services by the total number of persons that have been reported to the Program. Likewise, unmet need is calculated by dividing the number of persons not receiving services by the total number of persons that have been reported.

Table 25 describes met and unmet need among PLWH/A in New Mexico during 2005. About 1,407 (75%) PLWH/A accessed medical care in New Mexico during 2005. More PLWA (80%) accessed services than PLWH (68%). PLWA may access services more often because of a greater need for case management of advanced disease. PLWH may not understand the importance of accessing early and regular services for their disease to avoid further progression to AIDS.

Table 25. Service needs for persons diagnosed in New Mexico and living with HIV/AIDS, New Mexico, 2005.

| | PLWH | PLWA | PLWH/A |
|--------------------------|------|------|--------|
| Received services | 539 | 868 | 1407 |
| Did not receive services | 256 | 217 | 473 |
| Total | 795 | 1085 | 1880 |
| Met Need | 68% | 80% | 75% |
| Unmet Need | 32% | 20% | 25% |

Source: NMDOH, HIV & Hepatitis Epidemiology Program

Profile

As shown in Table 26, the characteristics of persons who accessed services were similar to those of the entire population of PLWH/A known to reside in New Mexico in 2005. Slightly more Hispanics and persons identifying as MSM were in care. Conversely, more Whites (49%) and African Americans (7%) were not accessing care in New Mexico; Whites comprised 42% and African Americans 5% of all PLWH/A. Persons aged 20-29 years were less likely to be in care. Region 5, in southwest New Mexico, had a large proportion of persons not in care (27%) relative to the PLWH/A population known to have been diagnosed there (18%). Lastly, proportionally more HIV-positive IDU and MSM/IDU were not accessing services.

In 2005, a consumer survey was developed by NMDOH and reviewed by HMA Executive Directors and the New Mexico POZ Coalition. The survey was subsequently administered by mail in early spring to HIV positive clients of HMA providers. A total of 964 surveys were distributed, with 324 (33%) returned. Participants were generally very satisfied with the level of care they received; 78% or more stated approval of medical provider services, medical office experiences, social services, notification of patient rights, and overall services.

Table 26. Characteristics of persons diagnosed in New Mexico and living with HIV/AIDS by access to services, New Mexico, 2005

| | PLWH/A in care | | PLWH/A not in care | | All PLWH/A ^a | |
|-----------------------------------|----------------|-----|--------------------|-----|-------------------------|-----|
| | No. | % | No. | % | No. | % |
| Sex | | | | | | |
| Male | 1220 | 87 | 410 | 87 | 1630 | 87 |
| Female | 187 | 13 | 63 | 13 | 250 | 13 |
| Race/Ethnicity | | | | | | |
| White | 567 | 40 | 231 | 49 | 798 | 42 |
| Hispanic | 678 | 48 | 178 | 38 | 856 | 46 |
| American Indian/ Alaska Native | 106 | 8 | 27 | 6 | 133 | 7 |
| African American | 50 | 4 | 35 | 7 | 85 | 5 |
| Asian/Pacific Islander | 6 | < 1 | 2 | < 1 | 8 | < 1 |
| Age at Diagnosis | | | | | | |
| < 13 | 11 | < 1 | 9 | 2 | 20 | 1 |
| 13-19 | 29 | 2 | 18 | 4 | 47 | 3 |
| 20-29 | 285 | 20 | 137 | 29 | 422 | 22 |
| 30-39 | 558 | 40 | 188 | 40 | 746 | 40 |
| 40-49 | 401 | 29 | 84 | 18 | 485 | 26 |
| 50+ | 123 | 9 | 37 | 8 | 160 | 9 |
| Region | | | | | | |
| 1, Northwest | 177 | 13 | 59 | 12 | 236 | 13 |
| 2, Northeast | 285 | 20 | 53 | 11 | 338 | 18 |
| 3, Bernalillo Co. | 645 | 46 | 205 | 43 | 850 | 45 |
| 4, Southeast | 85 | 6 | 30 | 6 | 115 | 6 |
| 5, Southwest | 215 | 15 | 126 | 27 | 341 | 18 |
| Mode of Exposure | | | | | | |
| MSM | 850 | 60 | 232 | 49 | 1082 | 58 |
| IDU | 134 | 10 | 63 | 13 | 197 | 10 |
| MSM/IDU | 114 | 8 | 50 | 11 | 164 | 9 |
| Heterosexual | 173 | 12 | 31 | 7 | 204 | 11 |
| Other | 16 | 1 | 7 | 1 | 23 | 1 |
| Pediatric | 14 | 1 | 8 | 2 | 22 | 1 |
| NIR | 106 | 8 | 82 | 17 | 188 | 10 |
| Total | 1407 | 100 | 473 | 100 | 1880 | 100 |

Source: NMDOH, HIV & Hepatitis Epidemiology Program

^aExcludes persons diagnosed in New Mexico and known to have either left the state or access providers out-of-state.

APPENDICES

Definitions

AIDS – acquired immunodeficiency syndrome is characterized by severe HIV-related immunosuppression and associated conditions which include life-threatening illness. An HIV-infected person receives a diagnosis of AIDS after the development of a CDC-defined opportunistic infection or on the basis of a low CD4+ count (i.e., < 200 cells/microliter or <14% of total CD4+ cells).

Anonymous testing – HIV testing conducted without identifiers so that a person's name cannot be linked with a test result.

Antiretroviral therapy (ART) – anti-HIV treatments designed to reduce the levels of HIV in a person's body.

Confidential testing – HIV testing linked to a person's name, which is kept confidential under state laws. This prevents the potential for disclosure or discrimination and to protect the patient's right to privacy.

Cumulative cases – all cases, regardless of vital status, ever reported to NMDOH; since 1981 for AIDS and 1998 for HIV.

Epidemiology – the study of patterns and determinants of health, disease, and other conditions in populations. This is the science that underlies the public health practice of disease prevention and control. Epidemiologists seek to define the occurrence of disease in terms of person, place, and time.

Exposure categories – HIV/AIDS cases are classified as one of several exposure categories that are based on combined risk factors developed by the CDC.

- **MSM** – men who have sex with men; men who have engaged in male-male sexual contact, including both homosexual or bisexual contact.
- **IDU** – injection drug user; persons who have used illicit or nonprescription drugs that are injected.
- **MSM/IDU** – MSM who also inject or have injected drugs.
- **Heterosexual** – refers to heterosexual contact with a partner who is at increased risk for HIV infection. Such partners' risk must fall within the definition of the other exposure categories (i.e., IDU, a person who received a blood product, or a person with documented HIV infection).
- **Other** – this is a broad category that includes hemophiliacs who acquired blood products prior to 1985, persons who received blood products or clotting factors after 1985, persons who received transplants, occupational exposures, and other non-occupational exposures to blood.
- **Pediatric** – this includes perinatal cases in children resulting from vertical transmission from an HIV-positive mother and cases involving the previously defined risk factors (i.e., hemophilia, or non-occupational exposure to blood).

- **NIR** – no identified risk; these cases are in persons who have no reported history of exposure at the time of report date. This includes persons for whom surveillance protocols to document risk behavior information have not yet been completed, persons whose exposure history is incomplete because they have died, persons who have declined to disclose their risk behavior or deny any risk behavior, and persons who do not know the HIV status or risk behaviors of their sex partners.

Highly active antiretroviral therapy (HAART) – aggressive anti-HIV treatments that usually include a combination of protease and reverse transcriptase inhibitors, which interrupt the HIV life cycle and whose purpose is to reduce the level of HIV in a person’s body to undetectable.

HIV – human immunodeficiency virus is the causative agent of AIDS. An individual may be infected with HIV for several years before developing the symptoms or conditions associated with an AIDS diagnosis.

Incidence – the number of new cases of a disease or condition that occur in a specified population during a specified period of time. This is often expressed annually, e.g., the number of HIV cases diagnosed in the U.S. in 2001.

Incidence rate – the number of new cases that occur in a specified population during a specified period of time divided by the population at risk. This is often expressed as an annual incidence per 100,000 population, e.g., 5.2 cases per 100,000 population in the U.S. in 2001.

Opportunistic infection – an infection among HIV infected persons that results from a weak immune system. CDC has defined 26 AIDS indicator illnesses, including *Pneumocystis carinii* pneumonia (PCP) and Kaposi’s sarcoma (KS).

Prevalence – the number of cases in a specified population living with a disease or condition at a specific point or period of time.

Prevalence rate – the number of cases in a specified population living with a disease or condition at a specific point or period of time divided by the population at risk. This is often expressed as an annual prevalence per 100,000 population or as a percent.

Reporting delay – the time lag between diagnosis of a new case of HIV or AIDS and the report to NMDOH. To minimize effects of reporting delay, the HIV & Hepatitis Epidemiology Program allows 6 months to pass prior to calculating year end surveillance data.

Ryan White CARE Act (RWCA) – the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act was created to provide federal assistance to increase the availability of primary health care and support services for persons living with HIV/AIDS, to increase access to care for underserved populations, and to improve the quality of life of those affected by HIV infection. RWCA was

first enacted by Congress in 1990 and undergoes regular reauthorization. The Health Resources and Services Administration (HRSA) implements the RWCA and directs assistance through the following:

- Title I provides support to eligible metropolitan areas with the largest numbers of reported AIDS cases to meet emergency service needs of persons living with HIV.
- Title II provides support to all states and territories to improve the quality, availability, and organization of health care and support services for persons living with HIV and their families.
- Title III supports early-intervention outpatients HIV services through funding to public and private nonprofit entities.
- Title IV funds public and private nonprofit entities to conduct projects to coordinate services to children, youth, women, and families with HIV/AIDS.
- Part F provides support for Special Projects of National Significance to develop and evaluate innovative models of HIV/AIDS care, for AIDS Education and Training Centers to conduct education and training for health care providers, and for the HIV/AIDS Dental Reimbursement Program to assist with providing oral health services to HIV-infected patients.

Surveillance – the ongoing, systematic collection, analysis, and interpretation of outcome specific data. These activities are closely integrated with the timely dissemination of the data to those responsible for prevention and control of disease.

Abbreviations

ADAP – AIDS Drug Assistance Program

ART – antiretroviral treatment

BRFSS – Behavioral Risk Factors Surveillance System

CDC – Centers for Disease Control and Prevention

CPAG – Community Planning and Action Group

CTS – Counseling and Testing Services

HAART – highly active antiretroviral therapy

HARS – HIV/AIDS Reporting System

HMA – Health Management Alliance

HRSA – Health Resources and Services Administration

IDU – injection drug user

MSA – metropolitan statistical area

MSM – men who have sex with men

MSM/IDU – men who have sex with men and inject drugs

NMDOH – New Mexico Department of Health

PLWH/A – persons living with HIV/AIDS

RWCA – Ryan White CARE Act

SHAS – Supplement to HIV/AIDS Surveillance

STD – sexually transmitted disease

YRRS – Youth Risk and Resiliency Survey

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HIV  **HEPATITIS**
EPIDEMIOLOGY PROGRAM
NEW MEXICO DEPARTMENT OF HEALTH

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