

NEW JERSEY
INTEGRATED HIV
PREVENTION & CARE PLAN
INCLUDING THE STATEWIDE COORDINATED
STATEMENT OF NEED
CY 2027-2031



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Acknowledgments

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Section I: Executive Summary of Integrated Plan and SCSN

Introduction

New Jersey’s 2027–2031 statewide Integrated HIV Prevention and Care Plan, updates the 2022–2026 strategic plan, maintaining its stakeholder engagement framework while incorporating new data, insights, and priorities. The development process used a blended approach, combining prior planning activities with refreshed engagement efforts. Key stakeholders included Eligible Metropolitan Areas (EMAs), Transitional Grant Areas (TGAs), and the New Jersey HIV Planning Group (NJHPG). A consulting firm that facilitated the process and drafted the plan. Collaboration was supported through virtual and in-person meetings and shared project management tools. NJHPG and strategic planning workgroup members represented all required and most recommended stakeholder groups, including priority populations, Ryan White HIV/AIDS Program (RWHAP) Parts A–D and F, and their planning bodies. The integrated plan is informed by multiple data sources, including eHARS (as of December 2025), the Medical Monitoring Project (2021–2024), the National HIV Behavioral Surveillance (2024), EvaluationWeb, the NJ HIV Data System, an HIV provider survey, and statewide community conversations.

These data sources underpin the Integrated HIV Prevention and Care Plan. The resulting situational analysis draws on all available data to describe the HIV epidemic in New Jersey within the framework of the federal Ending the HIV Epidemic (EHE) initiative, which is grounded in four pillars—Diagnose, Treat, Prevent, and Respond—and emphasizes routinized testing, rapid treatment initiation, pre-exposure prophylaxis (PrEP), and data-driven outbreak response. They outline risk for HIV exposure using counseling, testing, and PrEP-related data, including the PrEP care continuum, and include incidence, prevalence, and key characteristics of people newly diagnosed with HIV and those living with HIV, along with the HIV care continuum. Additional input from community conversations and the provider survey further informed the integrated plan by identifying barriers to testing, prevention, care, and treatment, as well as strategies to improve testing uptake, linkage to care, retention, appointment adherence, viral suppression, and prevention among those at risk. These data are shared in the integrated plan through figures and a supporting narrative.

For each pillar, the analysis examines the state’s current landscape, including strengths, gaps, barriers, and unmet needs. It also incorporates perspectives from community members and service providers, highlighting both shared and differing experiences. Priority populations identified through this process aligned with the National HIV/AIDS Strategy (NHAS) 2022–2025. Findings from the situational analysis informed the year 1 priorities for this planning cycle.

New Jersey’s 2027–2031 overarching plan and yearly prioritization of goals and objectives reflect a commitment to improving health outcomes by reducing disparities, addressing social and structural barriers, and ensuring meaningful engagement of communities most impacted by HIV, while strengthening systems to deliver accessible, high-quality prevention, care, and treatment services. This commitment underpins all aspects of the plan. This commitment is reflected in cross-cutting focus areas that span the Ending the HIV Epidemic (EHE) pillars, including community engagement, addressing social and structural determinants of health, integration and coordination. Additional goals and objectives are organized by the four EHE pillars, with corresponding strategies and activities categorized at the system, program, policy, and stigma levels.

In 2023, the NJHPG was restructured to better support the implementation, monitoring, and jurisdictional follow-up of the integrated plan. NJHPG led implementation efforts in coordination with public and private stakeholders and with ongoing community engagement. Strategies and activities were identified and organized by system, program, policy, and stigma, with progress monitored quarterly and reported at least annually. Goals and objectives were evaluated using defined outcome measures for each pillar, along with existing state metrics used to track progress. NJHPG continued to strengthen its culture of continuous quality improvement, and stakeholder engagement to support ongoing plan refinement.

The final section of the plan includes letters of concurrence from the NJHPG, the Paterson-Bergen-Passaic TGA, the Secaucus-Jersey City-Hudson County TGA, and the Middlesex-Somerset-Hunterdon TGA. These TGAs will also submit the state plan and collaborate in its implementation and monitoring. Preparation of this integrated plan involved updating the objectives of the 2022-2026 integrated plan and ensuring alignment and incorporation of goals, objectives, and strategies from the existing state plan as described in Section VI. Supporting documents submitted to meet requirements include the New Jersey HIV Prevention and Care Plan–SCSN (CY 2027–2031), the New Jersey HIV Surveillance Epidemiologic Snapshot (2024), and the 2022 – 2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up. Rather than submitting the prior plan in full, its relevant components have been integrated into Section VI of this document.

Section II: Community Engagement and Planning Process

Jurisdictional Planning Process

The State of New Jersey approached the jurisdictional planning process through four primary strategies: engaging EMAs and TGAs; establishing a strategic planning workgroup; engaging the New Jersey HIV Planning Group (NJHPG); and retaining a consulting firm to facilitate and author the 2027–2031 Integrated HIV Prevention and Care Plan. The New Jersey Department of Health (NJDOH), Division of Syndemic and Substance Use Services (DSSUS), convened and facilitated two meetings with the state’s two EMAs and three TGAs to explore the development of a coordinated, statewide plan to strengthen integration and collaboration across jurisdictions.

New Jersey’s EMAs and TGAs include the Newark Eligible Metropolitan Area (NEMA—Essex, Union, Morris, Sussex, and Warren counties), the Philadelphia EMA (Burlington, Camden, Gloucester, and Salem counties), the Paterson-Bergen-Passaic TGA, the Secaucus-Jersey City-Hudson County TGA, and the Middlesex-Somerset-Hunterdon TGA. All three TGAs agreed to collaborate in the development and implementation of the state plan. While representatives from both EMAs actively contributed to the planning process, each EMA will submit its own jurisdictional plan.

The strategic planning workgroup, consulting firm, and DSSUS collaborated to create the integrated plan, with coordination and administrative support from the NJHPG support team. Building on the approach used for the 2022–2026 plan, the workgroup collaborated on all aspects of plan development and needs assessment processes, including the provider survey and focus group planning.

The needs assessment was informed by both quantitative and qualitative data and, for consistency, utilized the same survey and focus group questions developed for the 2022–2026 planning cycle. Key contributors included DSSUS, the NJHPG support team, working with the consulting firm. Data sources included the Enhanced HIV/AIDS Reporting System (eHARS) as of December 2025, the Medical Monitoring Project (2021–2024), the National HIV Behavioral Surveillance Project (2019–2024), EvaluationWeb, the NJ HIV Data System, AIDSVU, an HIV provider survey, and community conversations conducted across the state. Input from the strategic planning workgroup, NJHPG members, providers, and community participants ensured representation of New Jersey’s priority populations throughout the planning process.

Entities Involved in the Processes

The strategic planning workgroup and NJHPG members self-identified the stakeholder groups they represent (without disclosing personal identifiers) by completing a SurveyMonkey survey. Notably, some workgroup and NJHPG members self-identified as more than one stakeholder type. Table 1 below illustrates the number of stakeholders for each stakeholder category. New Jersey’s process involved representation from all required (denoted with an asterisk) and most suggested stakeholder categories.

Table 1: Planning Group Stakeholder

Key Stakeholders	Number
Health department staff*	2
Community-based organizations serving populations affected by HIV, as well as HIV service providers*	7
People with HIV, including members of a Federally recognized Indian tribe as represented in the population, and individuals co-infected with hepatitis B or C*	3
Populations at risk or with HIV representing priority populations	7
Behavioral or social scientist	8
Epidemiologists	1
HIV clinical care providers, including (RWHAP Part C and D)*	2
STD clinics and programs	3
Non-elected community leaders, including faith community members and business/labor representatives*	2
Community health care center representatives, including FQHCs*	10
Substance use treatment providers*	6
Hospital planning agencies and healthcare planning agencies*	2
Intervention specialists	6
Jurisdictions with CDC-funded local education agencies/academic institutions	1
Mental health providers*	5
Individuals (or representatives) with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility.	0
Representatives from state or local law enforcement and/or correctional facilities	0
Social services providers, including housing and homeless services representatives*	8
Local, regional, and school-based clinics; healthcare facilities; clinicians; and other medical providers	1
Medicaid/Medicare partners	0

Role of the RWHAP Part A Planning Council/Planning Body

Ryan White HIV/AIDS Program (RWHAP) Part A Planning Councils, and Planning Bodies participated in the strategic planning workgroup, with many members also serving on the NJHPG. Both EMAs—the Newark EMA Planning Council and the Office of HIV Planning, Philadelphia—were actively engaged in the process. In addition, all three TGAs were represented, including the Paterson-Passaic County-Bergen County HIV Health Service Planning Council, the Hudson County HIV/AIDS Planning Council, and the Middlesex-Somerset-Hunterdon HIV Health Services Planning Council.

Role of Planning Bodies and Other Entities

The NJHPG is the statewide planning body responsible for contributing to the development of the strategic plan. NJHPG supports the NJDOH DSSUS, in the planning, implementation, and evaluation of HIV prevention, care, and treatment services. It brings together prevention, care, and treatment

stakeholders to optimize resources and strengthen the efficiency and effectiveness of statewide planning efforts.

NJHPG consists of 36 elected members who reflect the state's geographic and demographic diversity, including providers, affected communities, and individuals at risk for or living with HIV. Members are selected through an application process, and public input is encouraged through monthly NJHPG and committee meetings. NJHPG, along with the Clinical Quality Management steering committee act as the state's RWHAP Part B planning bodies.

The state also collaborated with Ending the HIV Epidemic (EHE) planning bodies through participation from the Newark Eligible Metropolitan Area Planning Council and the Hudson County HIV/AIDS Planning Council—the two EHE jurisdictions in New Jersey—on the strategic planning workgroup. In addition, the NJDOH Director of HIV Services which houses the EHE activities, actively participated in the planning process.

Collaboration with RWHAP Parts – Statewide Coordinated Statement of Need (SCSN) Requirement

The State of New Jersey engaged RWHAP Parts A–D providers and Part F recipients throughout the planning process in multiple ways. These stakeholders participated as members of the NJHPG and the strategic planning workgroup. In addition, RWHAP Parts A–D providers and Part F recipients received the provider survey link to provide input on the SCSN.

Engagement of people with HIV – SCSN requirement

The DSSUS, in collaboration with RWHAP partners, engaged people with HIV at all stages of the planning process, including the needs assessment, priority setting, and goal and objective development. Individuals with HIV participated as members of the NJHPG and the strategic planning workgroup. In addition, five focus groups were conducted to gather input from people with HIV for the SCSN. People with HIV will continue to play a central role in implementation, monitoring, evaluation, and ongoing plan improvement through their participation in NJHPG and continued community engagement efforts.

Priorities

Key priorities identified through the planning and community engagement process include a sustained commitment to ending the HIV epidemic in New Jersey by reducing both incidence and prevalence over time. The state will advance strategies that address system-, program-, policy-, and stigma-related barriers to delivering effective and efficient prevention, care, and treatment services for individuals at risk for or living with HIV. New Jersey is committed to strengthening its response by scaling up effective programs, improving or discontinuing those that are not achieving desired outcomes, and implementing new approaches to better meet residents' evolving needs.

Updates to Other Strategic Plans Used to Meet Requirements

Withstanding the abovementioned strategies that address systems, programs, policies, and stigma, no portions of another local strategic plan were used to satisfy this requirement.

Section III: Contributing Data Sets and Assessments

Data Sharing and Use

The data used to inform planning included the Enhanced HIV/AIDS Reporting System (eHARS) as of December 2025; the Medical Monitoring Project (2021–2024); the National HIV Behavioral Surveillance Project (2019–2024); EvaluationWeb; the NJ HIV Data System; community conversations; and a provider survey. AIDSvu, eHARS and Medical Monitoring Project data provided information on the number of people living with HIV, as well as the demographic, geographic, socioeconomic, behavioral, and clinical characteristics of individuals newly diagnosed with HIV and those living with HIV, including individuals identified in clusters. Data on HIV counseling and testing, pre-exposure prophylaxis (PrEP), and clusters further characterized populations at risk for HIV exposure.

Together, these data sources and assessments informed New Jersey’s situational analysis and the prioritization of year 1’s goals and objectives for the Integrated HIV Prevention and Care Plan 2027-2031.

Epidemiologic Snapshot

At Risk for Exposure to HIV: Counseling and Testing

Table 2: Demographics of Persons Tested for HIV, New Jersey, 2022-2024

Demographics	2022		2023		2024		TOTAL	
Total tested	35,047		43,401		48,692		127,140	
	Clients	%	Clients	%	Clients	%	Clients	%
Gender								
Male	19,810	56.5%	24,638	56.8%	27,692	56.9%	72,140	56.7%
Female	15,214	43.4%	18,698	43.1%	20,954	43.0%	54,866	43.2%
Unknown	23	0.1%	65	0.1%	46	0.1%	134	0.1%
Race/Ethnicity								
Hispanic	13,026	37.2%	16,743	38.6%	18,719	38.4%	48,488	38.1%
Non-Hispanic Black	15,630	44.6%	18,396	42.4%	20,847	42.8%	54,873	43.2%
Non-Hispanic White	5,295	15.1%	6,657	15.3%	7,258	14.9%	19,210	15.1%
Non-Hispanic Other	915	2.6%	1,280	2.9%	1,577	3.2%	3,772	3.0%
Don’t know/refused	181	0.5%	325	0.7%	291	0.6%	797	0.6%
Age Range								
Unknown	25	0.1%	30	0.1%	64	0.1%	119	0.1%
< 13 years	9	0.0%	16	0.0%	15	0.0%	40	0.0%
13-19 Years	1,060	3.0%	1,609	3.7%	1,610	3.3%	4,279	3.4%
20-29 Years	8,520	24.3%	10,449	24.1%	11,581	23.8%	30,550	24.0%
30-39 Years	9,674	27.6%	12,080	27.8%	13,325	27.4%	35,079	27.6%

40-49 Years	7,032	20.1%	8,425	19.4%	9,872	20.3%	25,329	19.9%
50 Years and Over	8,727	24.9%	10,792	24.9%	12,225	25.1%	31,744	25.0%
Transmission Risk								
Men who have Sex with Men (MSM)	5,026	14.3%	6,302	14.5%	7,911	16.2%	19,239	15.1%
Injection Drug Use (IDU)	1,765	5.0%	2,169	5.0%	2,091	4.3%	6,025	4.7%
MSM/IDU	161	0.5%	194	0.4%	191	0.4%	546	0.4%
Heterosexual Males	12,812	36.6%	15,600	35.9%	17,083	35.1%	45,495	35.8%
Heterosexual Females	13,407	38.3%	16,043	37.0%	17,899	36.8%	47,349	37.2%
Other/Unknown	1,876	5.4%	3,093	7.1%	3,517	7.2%	8,486	6.7%

A total of 127,140 tests were conducted at New Jersey-funded testing sites from 2022 to 2024. The number of tests performed increased by 39% from 2022 to 2024 (from 35,047 to 48,692, respectively). They were conducted on 72,140 males (57%) and 54,866 females (43%). The majority were non-Hispanic Black: 54,873 (43%), followed by Hispanics: 48,488 (38%), and those aged 30–39 (35,079 or 28%) and 50 and over (31,744 or 25%). Transmission risk analysis show that Heterosexuals received the most tests [heterosexual females: 47,349 (37%) and heterosexual males: 45,495 (36%)], followed by males who have sex with males at 19,239 (15%). (Table 2)

Table 3: Continuum from NJDOH-funded HIV Testing to PrEP Services, New Jersey, 2022-2024

PrEP Data	2022		2023		2024		TOTAL	
Clients tested Negative**	34,464		42,730		48,043		125,237	
	Clients	%	Clients	%	Clients	%	Clients	%
Client screened for PrEP eligibility	31,409	91.1%	40,172	94.0%	45,560	94.8%	117,141	93.5%
Client eligible for PrEP referral - % of screened for eligibility	12,473	39.7%	17,873	44.5%	19,461	42.7%	49,807	42.5%
Client given a referral to a PrEP Provider - % of eligible for referral	7,222	57.9%	10,406	58.2%	14,297	73.5%	31,925	64.1%
Client provided with services to assist with linkage to a PrEP provider - % of given referral to provider	7,168	99.3%	9,048	86.9%	12,970	90.7%	29,186	91.4%
Ever heard of PrEP	15,729	45.6%	21,152	49.5%	24,971	52.0%	61,852	49.4%
Currently taking daily PrEP Medications	1,350	3.9%	2,216	5.2%	3,387	7.0%	6,953	5.6%
Used PrEP anytime in the last 12 months	1,517	4.4%	2,436	5.7%	3,672	7.6%	7,625	6.1%

** Duplicated clients

Approximately 6% of HIV tests were conducted among persons who were either currently taking or had a history of taking Pre-Exposure Prophylaxis (PrEP) (6,953 and 7,625 tests, respectively). The

proportion of individuals who reported hearing about PrEP increased from 15,719 (46%) to 24,971 (52%) between 2022 and 2024. Overall, between 2022 and 2024, 92,000 (72%) of those tested were at risk for HIV infection. During the same period, this resulted in 31,925 (26% of total tested & 64% of eligible clients for referral) were given a referral to PrEP provider and 29,186 (23% of total tested & 91% of referred) were receiving linkage services.

At Risk for Exposure to HIV: PrEP

Methods: Data were downloaded electronically from the NJ HIV Data System for 2022 to 2024. Persons at risk for HIV infection (PRH) included in the analyses were at least 13 years old and resided in New Jersey. The New Jersey PrEP continuum was evaluated overall and by year (2022, 2023, and 2024) and included the following data points: seen by a PrEP counselor, referred to a medical provider, kept the medical appointment, and received a prescription. The data are presented using descriptive statistics for New Jersey and six counties with at least 300 PRH in this period. The six counties include Essex, Hudson, Union, Bergen, Passaic, and Camden. Demographic characteristics included gender, race/ethnicity, age, and transmission risk.

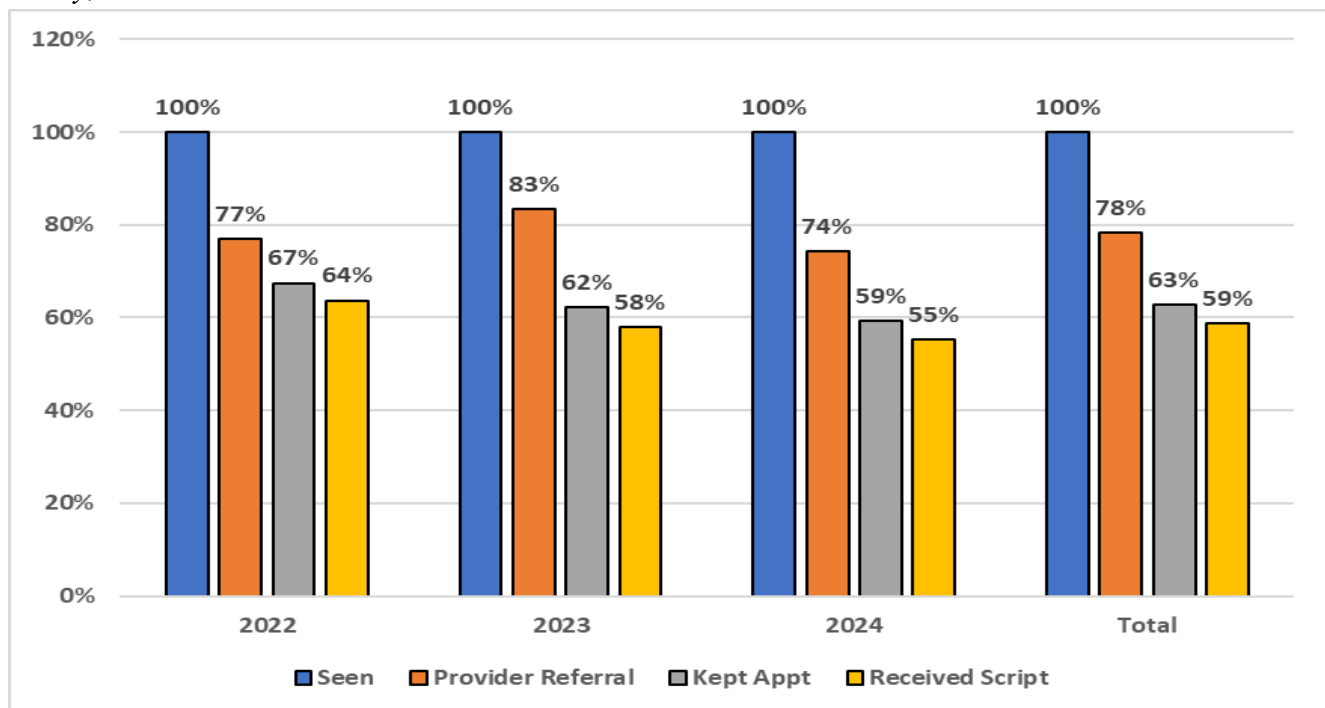
Table 4: Demographic Characteristics of Persons at Risk for HIV, at PrEP Sites, by Year, New Jersey, 2021-2024

DEMOGRAPHICS:	2022		2023		2024		TOTAL	
Persons at Risk for HIV	1,158		1,478		1,449		4,085	
	Clients	%	Clients	%	Clients	%	Clients	%
Gender								
Male	939	81.1%	1,113	75.3%	1,049	72.4%	3,101	75.9%
Female	189	16.3%	291	19.7%	331	22.8%	811	19.9%
Don't know/refused	30	1.2%	74	2.2%	69	2.1%	173	1.9%
Race/Ethnicity								
Hispanic	574	49.6%	756	51.2%	744	51.3%	2,074	50.8%
Non-Hispanic Black	324	28.0%	390	26.4%	426	29.4%	1,140	27.9%
Non-Hispanic White	203	17.5%	248	16.8%	210	14.5%	661	16.2%
Non-Hispanic Other	50	4.3%	63	4.3%	52	3.6%	165	4.0%
Don't know/refused	7	0.6%	21	1.4%	17	1.2%	45	1.1%
Age Distribution								
13 - 24 YEARS	244	21.1%	349	23.6%	313	21.6%	906	22.2%
25 - 34 YEARS	400	34.5%	469	31.7%	443	30.6%	1,312	32.1%

35 - 44 YEARS	323	27.9%	436	29.5%	404	27.9%	1,163	28.5%
45 - 54 YEARS	115	9.9%	141	9.5%	158	10.9%	414	10.1%
55 - 64 YEARS	60	5.2%	73	4.9%	104	7.2%	237	5.8%
65+ YEARS	16	1.4%	10	0.7%	27	1.9%	53	1.3%
Transmission Risk								
Men who have sex with men	803	69.3%	987	66.8%	824	56.9%	2,614	64.0%
Injection Drug Use	15	1.3%	21	1.4%	12	0.8%	48	1.2%
Woman at High Risk	172	14.9%	265	17.9%	300	20.7%	737	18.0%
Don't know/refused/Other	168	13.0%	205	11.0%	313	18.6%	686	14.2%

Overall, a higher proportion of men (75.9%) were screened as being at risk for acquiring HIV than women (19.9%). Hispanics (50.8%), followed by non-Hispanic Blacks (27.9%), were identified as at risk for HIV in New Jersey. The two highest age categories at risk for HIV were 25-34 years (32.1%) and 35-44 years (28.5%). Men who have sex with men represented the highest transmission risk (64%).

Figure 1: Pre-Exposure Prophylaxis (PrEP) Continuum of Care Among Public-Funded Sites, New Jersey, 2021-2024



From 2022–2024, 4085 persons at risk for HIV (PRH) in New Jersey were served at publicly funded PrEP sites. Of these, 3,202 (78%) were referred to a medical provider; among those referred, 2,561 (80%) attended their appointment, and 2,396 (94%) received a prescription.

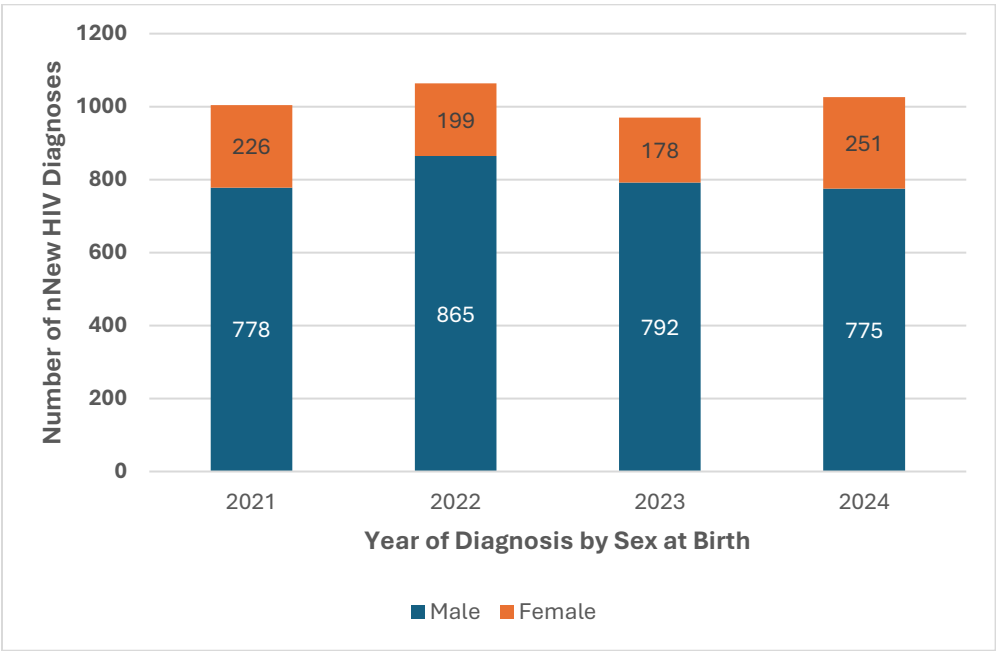
The number of PRH considering enrollment in PrEP services increased by 25%, from 1,158 to 1,449 between 2022 and 2024. Individuals served were primarily male. However, there was a decrease in the males served (81.1% to 72.4%) and an increase in the females served (16.3% to 22.8%). During this period, the proportion of Hispanic individuals and the proportion of non-Hispanic Black individuals remained steady while there was a decrease in the proportion of non-Hispanic White individuals (17.5% to 14.5%). Age distribution also shifted, with a decrease among individuals aged 25-34 (34.5% to 30.6%) and an increase among those aged 45 and above (16.5% to 20%). The overall HIV seroconversion rate among individuals receiving PrEP counseling services was 2.9 per 1,000 persons.

These findings should be interpreted with several limitations. Data are limited to publicly funded PrEP counselor sites (of which there are 29) and may not be generalizable to individuals receiving services in private practice settings. Demographic and risk information is self-reported and may be subject to social desirability bias.

Across the state, regardless of funding, the use of PrEP increased between 2022-2024. Rates of PrEP use went up in all age and racial/ethnic groups. Overall, the rate of PrEP use (per 100,000) went up, showing rates in 2022 at 116 (9,107 persons), in 2023 at 140 (10,992 persons), and in 2024 at 172 (13,555) ([AIDSVU](#)).

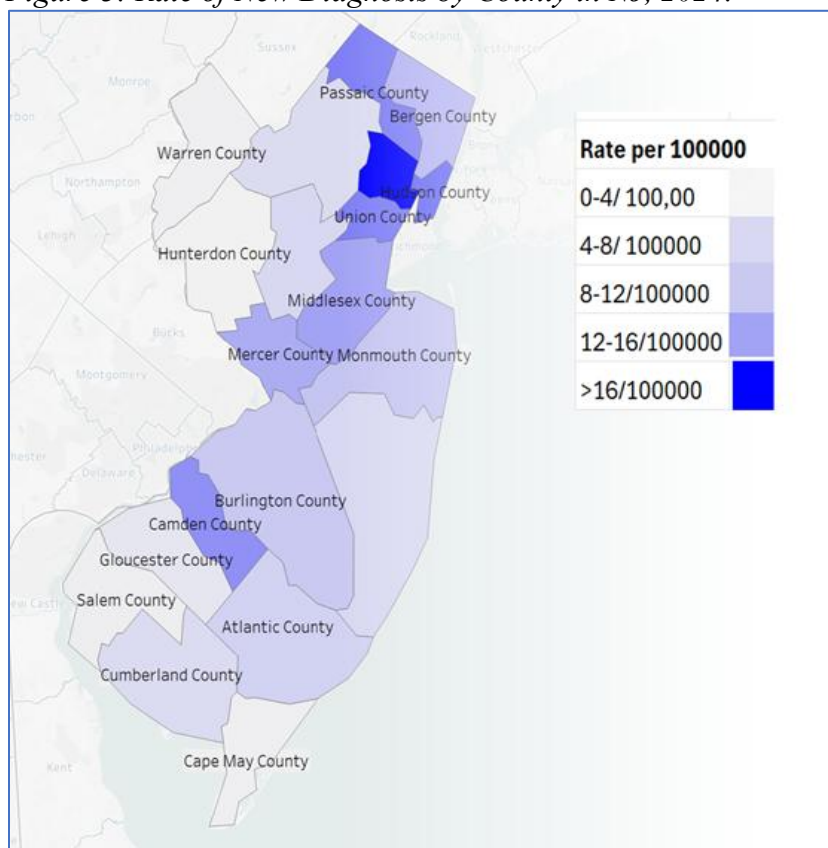
Diagnosis

Figure 2: HIV Diagnoses by Year of HIV Diagnosis and Sex in NJ, 2021-2024.



A total of 1,051 new diagnoses of HIV infection were reported in New Jersey in 2024, which was relatively steady from 1,021 cases in 2021 (Figure 3). The overall rate of new diagnoses was 11.4 per 100,000 people. This rate was higher in Essex and Hudson Counties, at 20 and 14 per 100,000 persons, respectively, accounting for over 1 in 4 new diagnoses.

Figure 3: Rate of New Diagnosis by County in NJ, 2024.



Each year, most new HIV diagnoses in New Jersey occur among males. However, the proportion among females increased to 24% in 2024, compared to 18% in 2023 (Figure 4). Despite this increase, diagnosis rates remain consistently higher among males. In 2024, the rate of new HIV diagnoses was 17 per 100,000 males, compared to 5.3 per 100,000 females (Figure 4).

Figure 4: Rate of HIV Diagnoses by Year of HIV Diagnosis and Sex at Birth in NJ, 2020-2024.

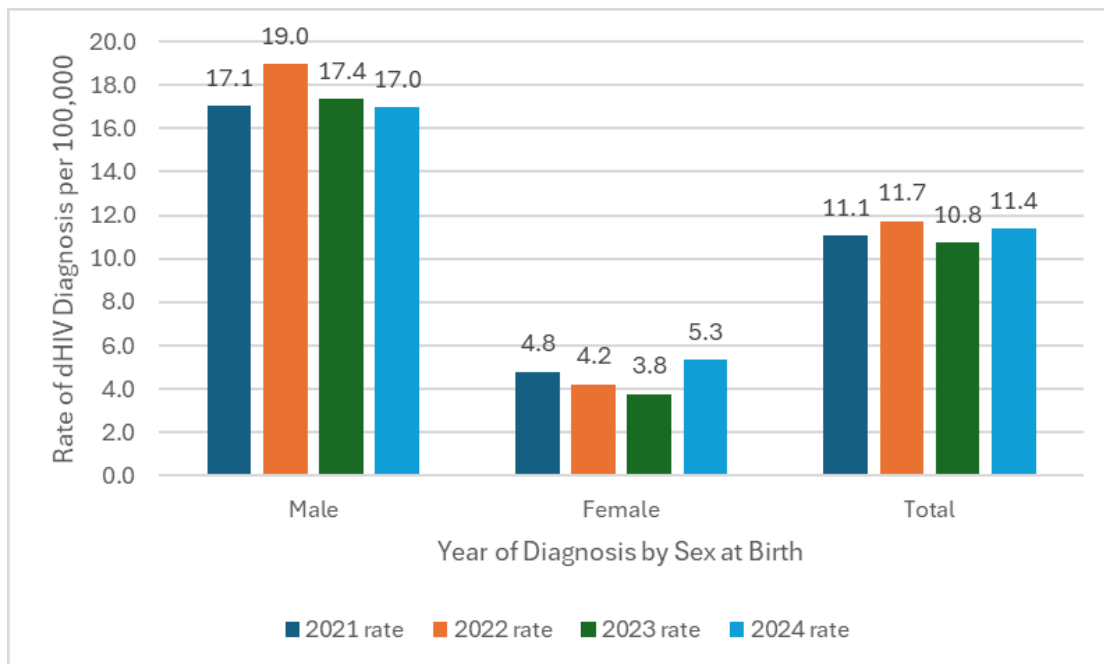


Figure 5: Rate of HIV Diagnoses Among Males by Race/Ethnicity in NJ, 2021-2024

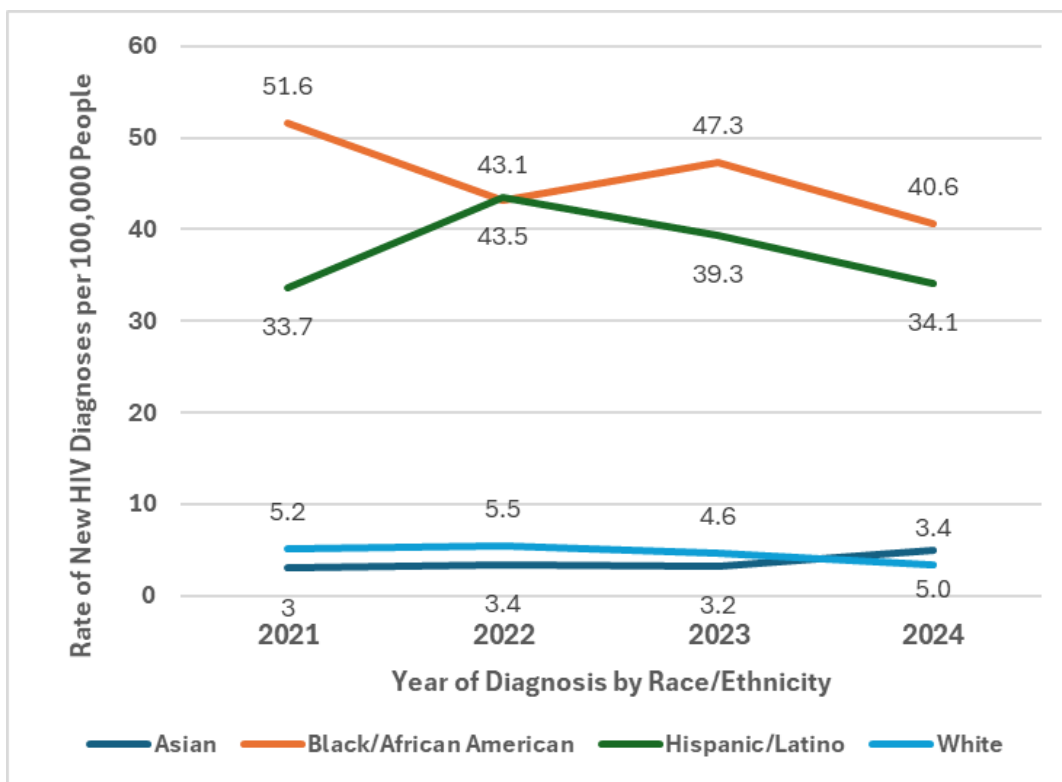
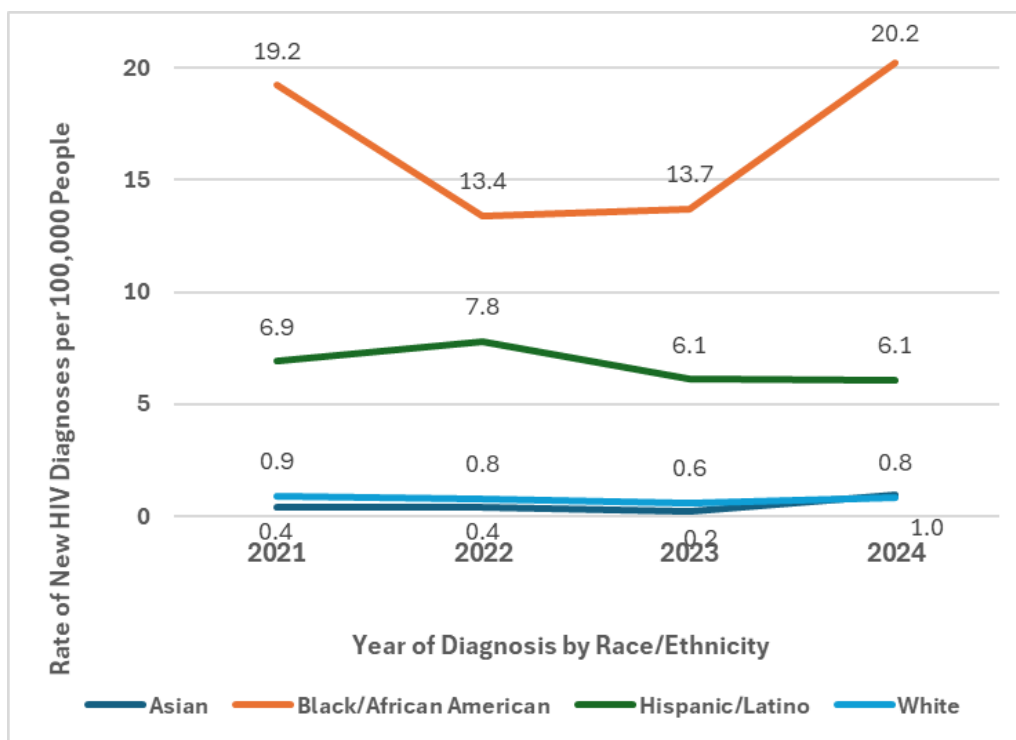


Figure 6: Rate of HIV Diagnoses Among Females by Race/Ethnicity in NJ, 2021-2024



Between 2021 and 2024, when compared to other races/ethnicities, the rate of new HIV diagnoses remained much higher among Black and Hispanic males (40.6 and 34.1 per 100,000 people, respectively) and Black and Hispanic females (20.2 and 6.1 per 100,000 people, respectively) (Figures 5 and 6).

Figure 7: Rate of HIV Diagnoses Among Males by Year and Age Group (in Years) at HIV Diagnosis in NJ, 2021-2024

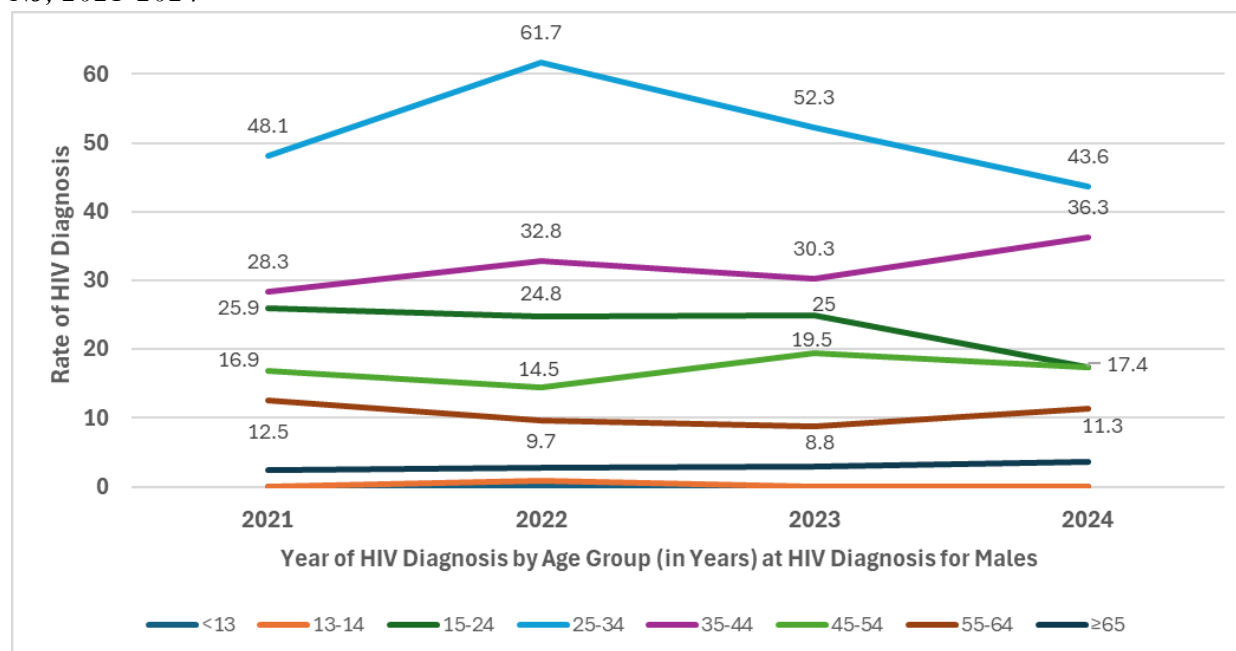
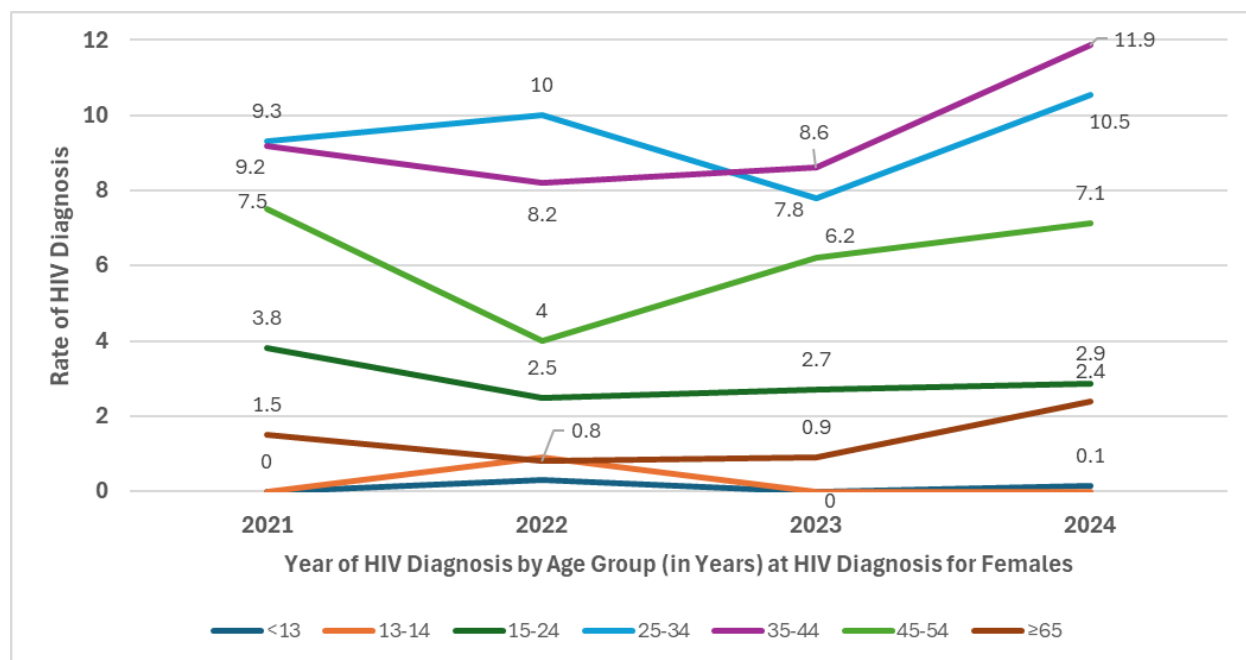
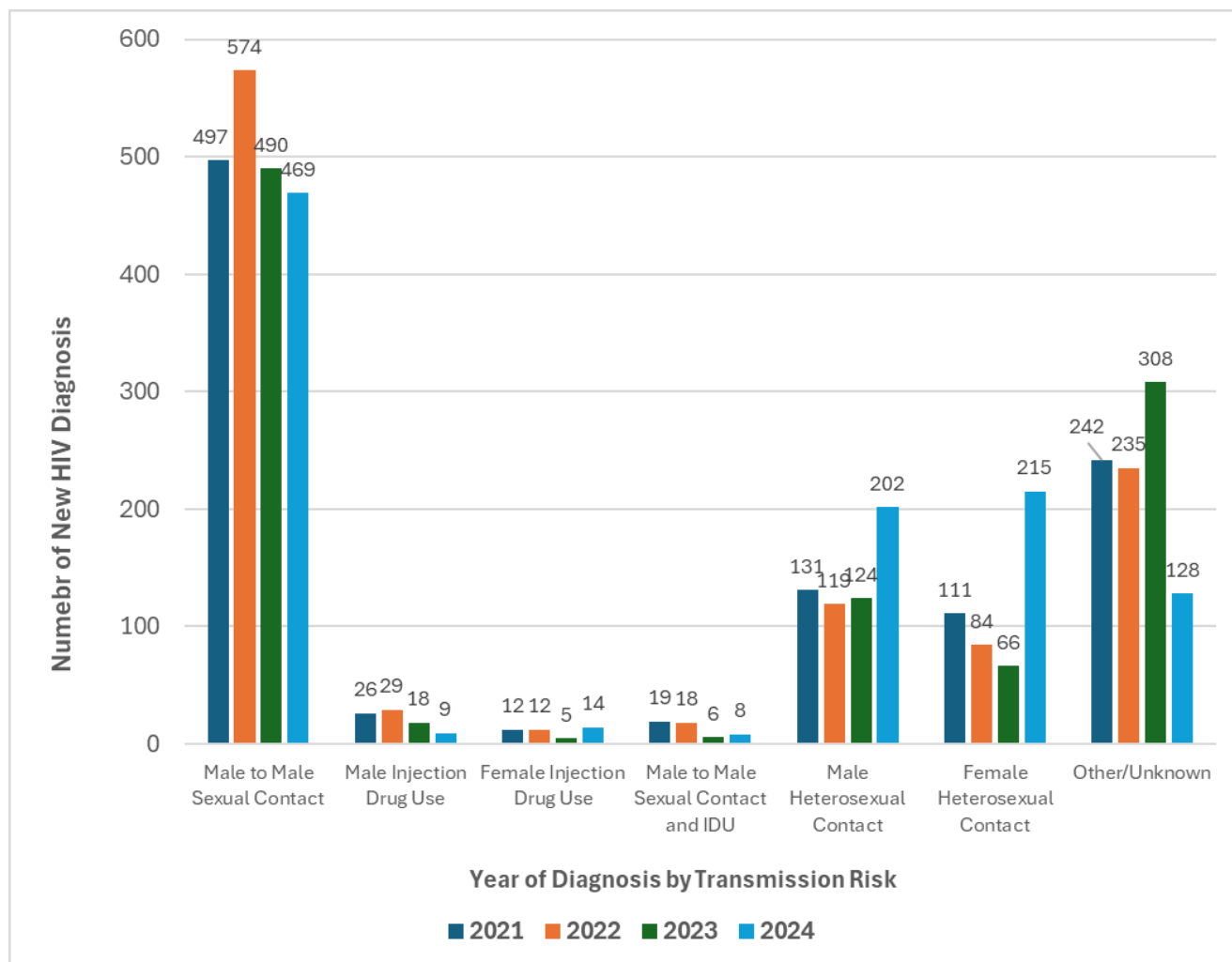


Figure 8: Rate of HIV Diagnoses Among Females by Year and Age Group (in Years) at HIV Diagnosis in NJ, 2021-2024.



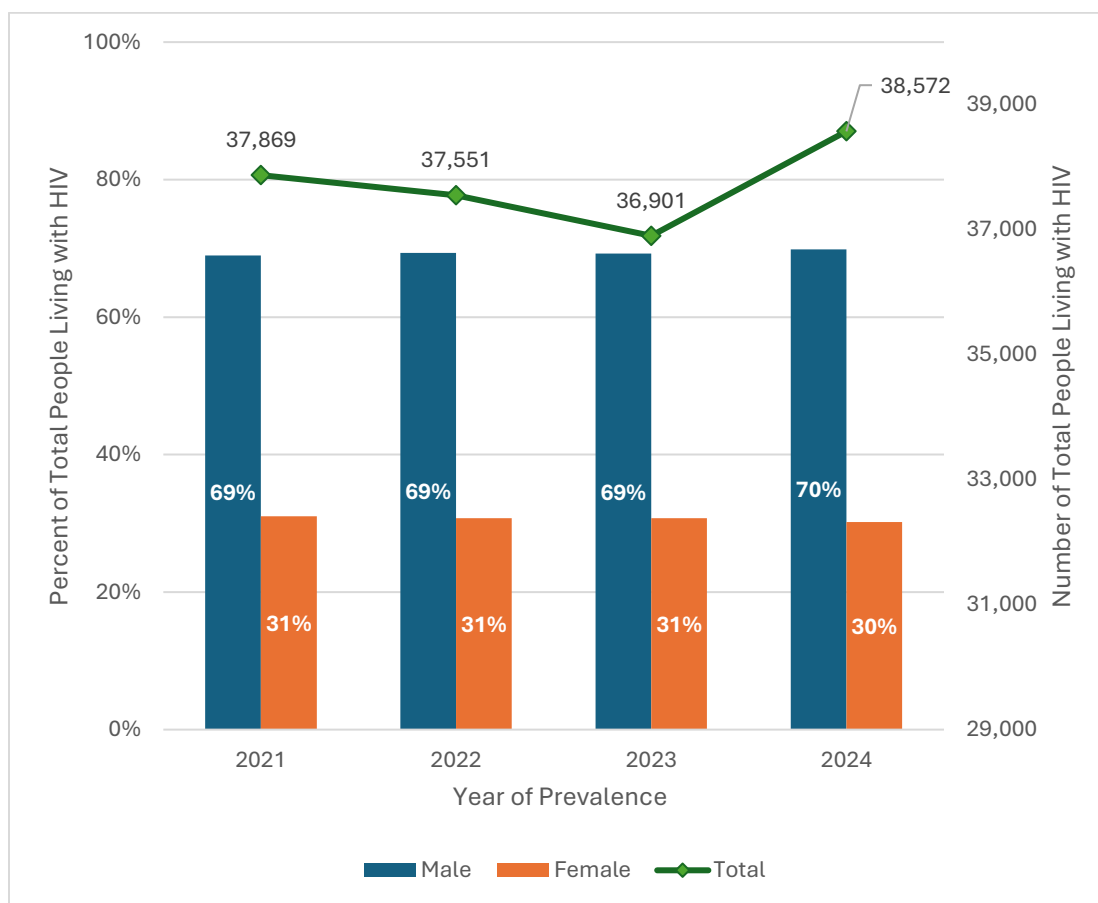
Both males and females aged 25-34 years and 35-44 years had higher rates of HIV diagnoses from 2021-2024, compared to older and younger age groups (Figures 7 and 8). While the rate of new HIV diagnoses among males 25-34 years decreased among males from 2022 to 2024, the rate of males 35-44 years and females 25-34 years and 35-44 years increased over the same period (Figures 7 and 8).

Figure 9: Number of HIV Diagnoses in NJ by Year of HIV Diagnosis and Transmission Category, 2021-2024.



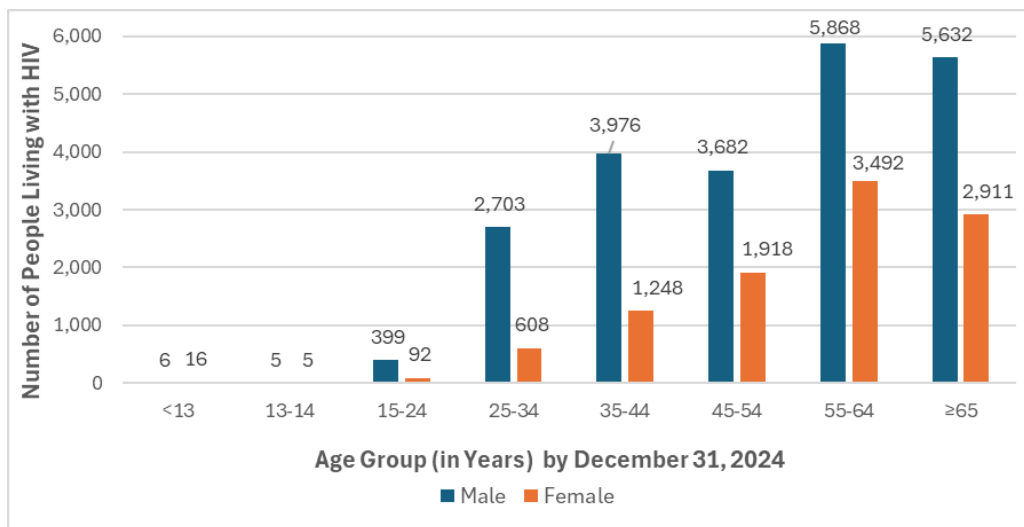
In 2024, the transmission category with the highest number of new HIV diagnoses was male-to-male sexual contact at 45% (n=469). (Figure 9).

Figure 10: Total Number and Percent of People Living with Diagnosed HIV Infection by sex at birth in NJ, 2021-2024.



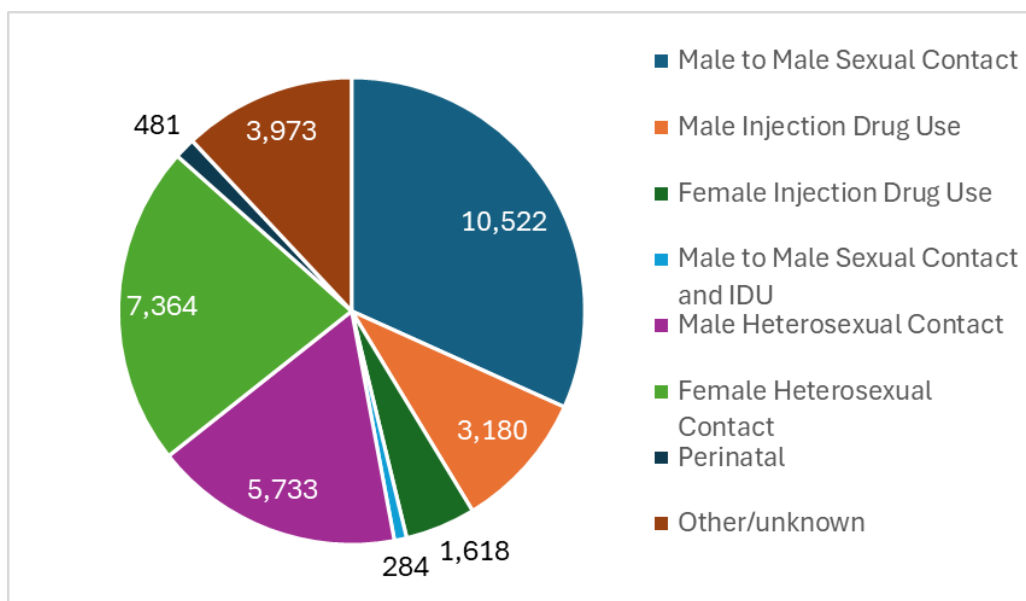
As of December 31, 2024, there were 38,572 persons living with HIV (PLWH), with a prevalence rate of 406 per 100,000 New Jersey residents (Figure 10). They resided primarily in Essex, Hudson, Middlesex, Passaic, and Union Counties, comprising about 60% of PLWH. Essex County had the highest prevalence rate among adults aged 13 and older at 953.8 per 100,000, while Ocean County had the lowest rate among adults at 122.3 per 100,000 persons. In 2021 through 2024, over two-thirds of those living with HIV were males (69%) and approximately 31% were females (Figure 10).

Figure 11: Number of Persons Living with Diagnosed HIV Infection by Sex and Age at the End of Year in NJ, 2024.



More than one in four PLWH (28.7%) were 55–64 years old, and approximately 55% were 55 or older (Figure 11), demonstrating the aging PLWH population in NJ.

Figure 12: Percent of Persons Aged 13+ Years Living with HIV by Transmission Category in NJ, 2024.

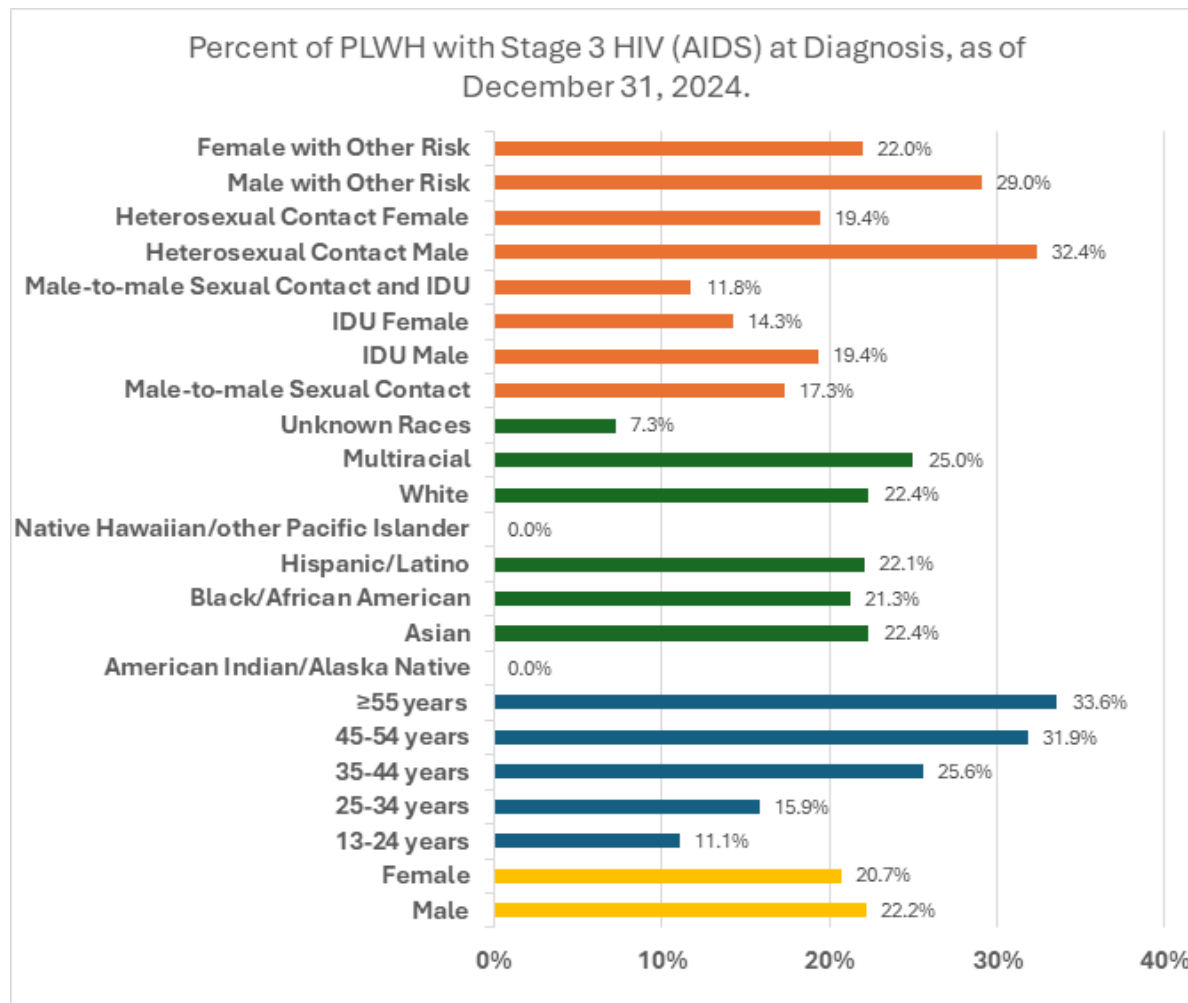


As of 2024, the most common mode of transmission reported by PLWH in NJ was MSM (31%), followed by female heterosexual contact (22%) and male heterosexual contact (17 %) (Figure 12).

This is consistent with trends in new diagnoses of HIV but also represents the disproportionate number of PLWH among men who have sex with men. Injection drug use among males represents 9% of transmission overall, and among females, it is 5% of overall transmission.

Late Diagnoses, 2021-2024

Figure 13: Percentage of Late Diagnosis (AIDS) Among All New Diagnoses Between 2021-2024 by Selected Characteristics



Approximately 22.0% of new diagnoses occurred at Stage 3 (AIDS) in New Jersey between 2021 and 2024 (Figure 13). There was no significant difference between Hispanic/Latino, Black/African American, and White groups with regard to the proportion diagnosed at Stage 3 (AIDS). Understandably, 47.4% of all people diagnosed at Stage 3 (AIDS) were male-to-male sexual contact transmission, which represented the most Stage 3 (AIDS) at diagnosis (n=1,981) (data not shown). The proportion of male-to-male sexual contact transmission diagnosed at Stage 3 (AIDS), however, represented the lowest rate compared to other transmission groups: males and females who reported heterosexual contact (32.4% and 19.4%, respectively) and females with an injection drug use history (14.3%) had higher proportions of Stage 3 (AIDS) at diagnosis. As expected, the proportion of people diagnosed at Stage 3 (AIDS) increases with age, and 34% of those aged 55 years and older were new Stage 3 (AIDS) diagnoses. People diagnosed at age 25-34 years, however, accounted for the largest proportion (30%) of new diagnoses at Stage 3 (AIDS).

Mortality Among PLWH, 2021-2024

In 2024, the death rate among PLWH in New Jersey was 5.4 per 100,000, reflecting a decline from 6.4 per 100,000 in 2021. Between 2021 and 2024, deaths from all causes were disproportionately higher among Black/African American males and females compared to other racial and ethnic groups (Figures 14 and 15). During this period, the highest proportion of deaths among individuals with known exposure categories occurred among men who have sex with men (MSM) (25%). Elevated proportions of deaths were also observed among males with a history of injection drug use (Figure 16).

Figure 14: Deaths Among Males with HIV in NJ by Race/Ethnicity, 2021-2024

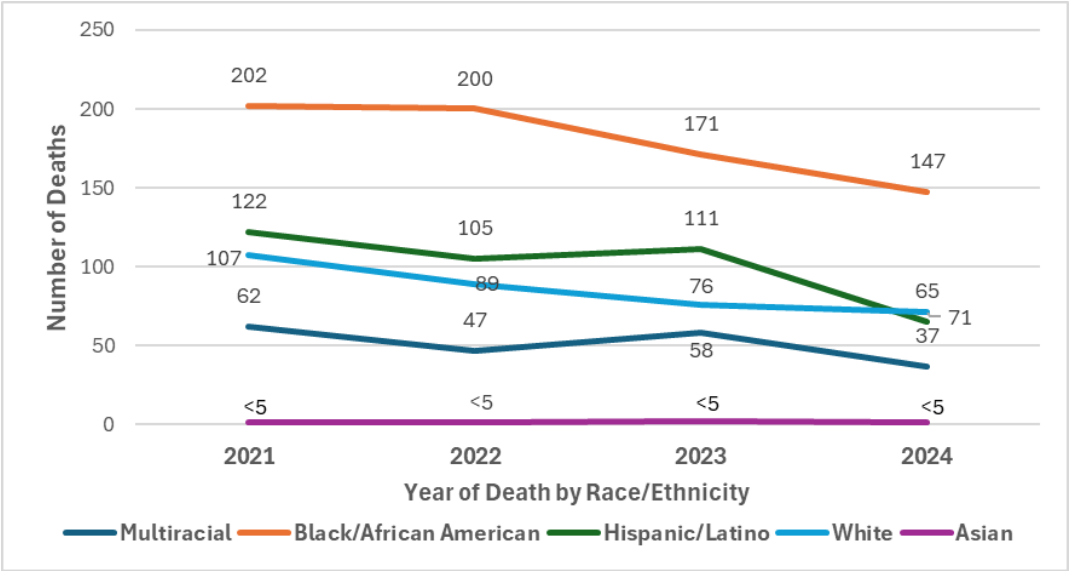


Figure 15: Deaths Among Females with HIV in NJ, by Race/Ethnicity, 2021-2024.

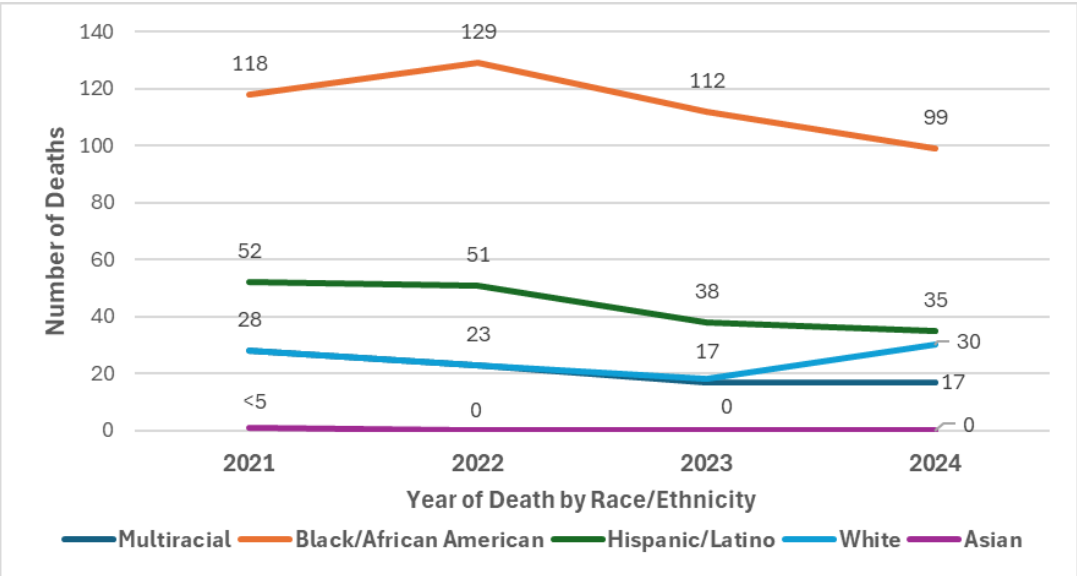
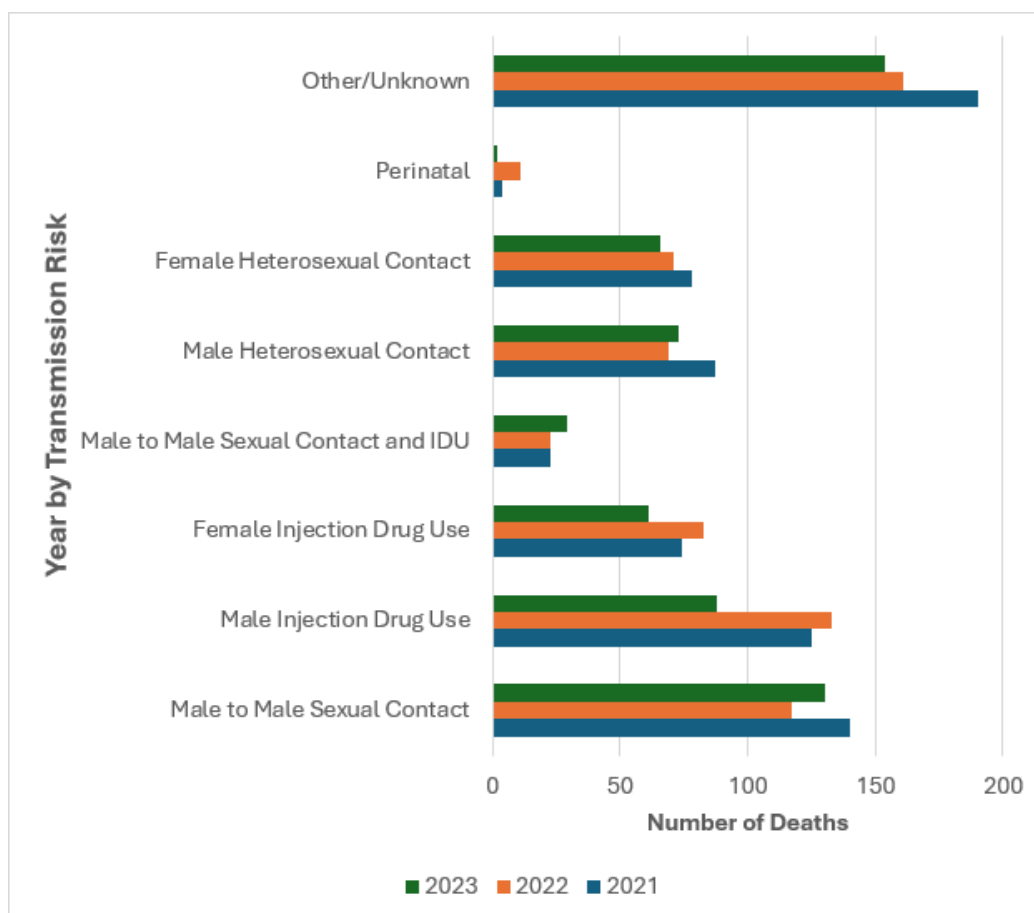


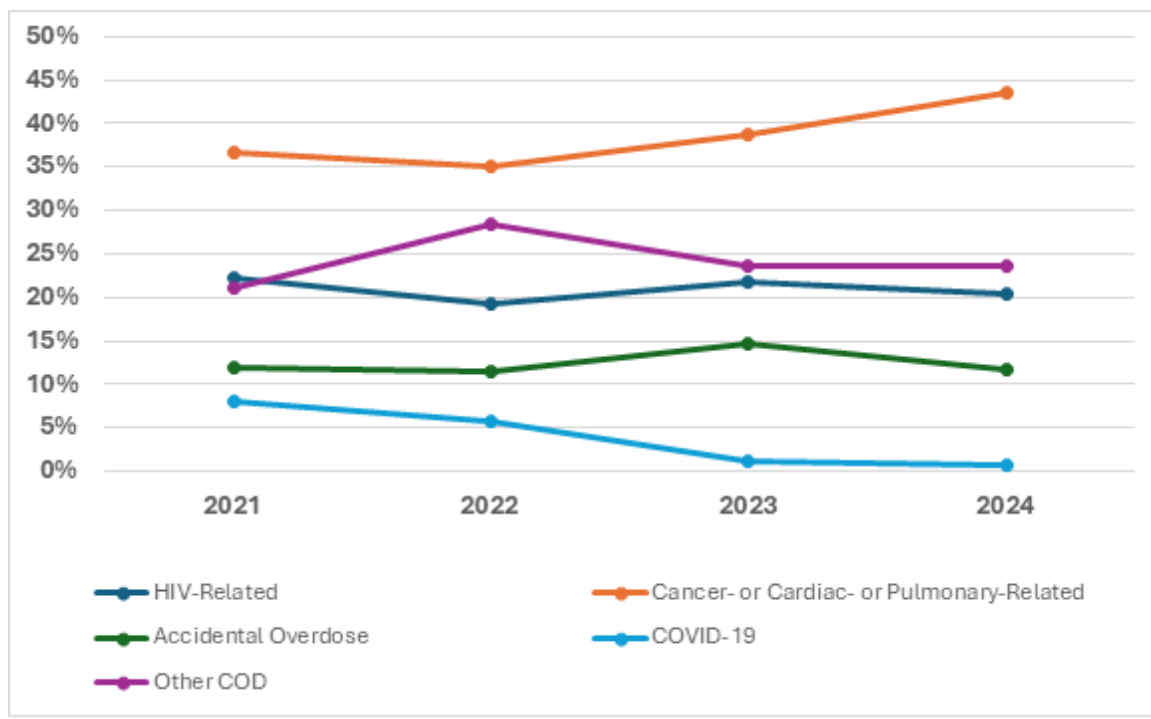
Figure 16: Number of Deaths Among Persons with Diagnosed HIV Infection Aged 13+ Years in NJ-by Year of Death and Transmission Category 2021-2023



A mean of 664 deaths occurred each year among people with HIV in 2021-2023. Of people with known transmission risk, the highest proportion of deaths was among those with male-to-male sexual contact (19%). 17% of males who injected drugs died in 2021-2023, though there were 34% fewer deaths in this group in 2023 than the year prior. Of those people known to be living with HIV in NJ with both male-to-male sexual contact and injection drug use, 26% died between 2021 and 2023.

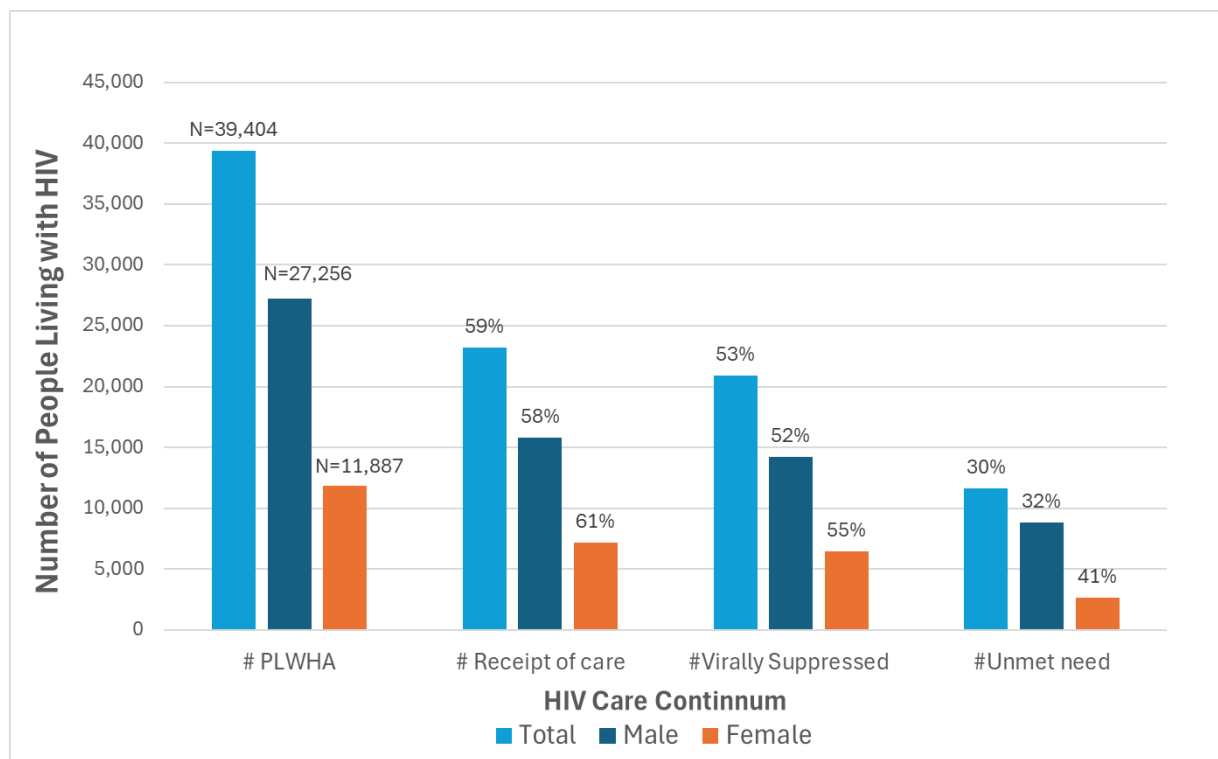
When assessing the primary cause of death (COD) on death certificates for New Jersey residents with HIV diagnoses, the majority of CODs for deaths 2021-2024 have been unrelated to HIV (Figure 17). While HIV is listed as the primary COD for 20% of deaths in 2024, 44% of deaths had a cardiac-, pulmonary-, or cancer-related ICD-10 code listed (Figure 17). Accidental overdoses have consistently accounted for approximately 12% of deaths among people with diagnosed HIV, from 2021-2024 (Figure 17). And of note, COVID-19 was a significant contributor to deaths among people with HIV diagnoses in New Jersey in 2021 and 2022, though the proportion of deaths decreased significantly in 2023 and 2024 (Figure 17).

Figure 17: Major Categories of Primary Cause of Death Among People Who Had Diagnosed HIV and Lived in New Jersey 2021-2024.



Care Continuum Among PLWH, 2021-2024

Figure 18: Care Continuum for Persons Living with Diagnosed HIV Infection by Sex in NJ, 2024



Of the persons living with HIV in 2024, 59% received care during the year, 53% achieved viral suppression, having a VL <200 copies/mL, and 30% had an unmet need, that is, did not have a CD4 or viral load in the reporting system. This was fairly consistent between male and female PLWH. Of note, multiple data quality issues have been identified in 2025 and early 2026, which will likely affect the continuum of care measurements for New Jersey, most notably, New York State is not reporting HIV data for New Jersey residents who seek care in New York to the NJDOH. A recent review of Hudson County residents not in care found many were in care, but NJ eHARS did not reflect this. NJDOH is working with New York State to resolve this reporting issue which they claim is required due to their state laws which prohibit them from sharing HIV data across state lines. Updated data will be disseminated to the public as soon as it becomes available.

Characteristics of PLWH 2020-2023 from Medical Monitoring Project data

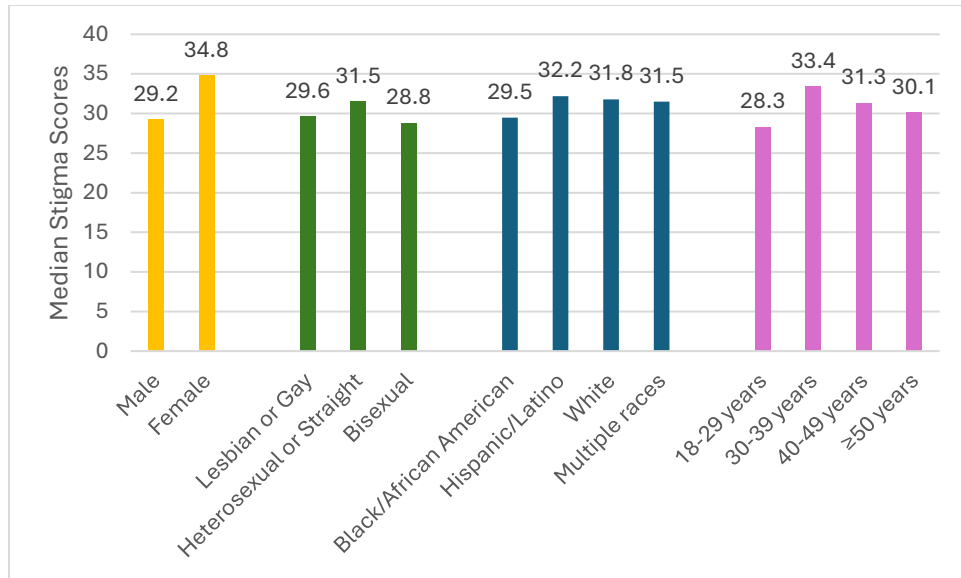
Via the Medical Monitoring Project (MMP), a total of 951 PLWH were interviewed from 2020 to 2023, and data were abstracted from their medical record for the most recent 12 months prior. Of the people interviewed, 66% reported living in households with annual incomes of less than \$40,000, 14% reported being unemployed, and 38% reported having a disability. Housing status was reported as 6% homeless, another 12% had moved in with others due to financial problems, and 2% reported eviction in the last 12 months. Many of the PLWH who were interviewed used public health insurance or coverage for care/medications in the past 12 months, including the Ryan White HIV/AIDS program (42%), Medicaid (43%), Medicare (29%), other public insurance (4%), and VA/Tricare/Champus (0.4%). People could report more than one type of health insurance or coverage. In total, 39% of PLWH visited an emergency department at least once, and 20% were admitted to the hospital.

Unmet need for services included case management (5.7%), medication through ADAP (5.3%), HIV peer group support (5.1%), patient navigation (4.3%), mental health services (7.2%), SNAP or WIC (16.5%), shelter or housing (16.4%), meal or food services (8.6%), and transportation services (6.2%). Of those 951 PLWH selected and interviewed for MMP, 98.9% have ever taken ART, with 97.6% currently taking ART.

Additional data available from MMP show that screening for sexually transmitted infections (STI) was suboptimal. Those who received one test included: gonorrhea (49%), chlamydia (49%), and syphilis (62%), and 44% were screened for all three STIs. An estimated 87% of PLWH were aware of treatment as a form of prevention; 44% of PLWH received counseling from a physician, nurse, or another healthcare worker about HIV and STI prevention and 29% had a one-on-one conversation with an outreach worker. Approximately 31% of PLWH received free condoms.

Finally, MMP data show the median score among PLWH who reported experiencing stigma was 31.6 (95% CI: 28.5, 34.6). Of note: 0 is the lowest level of stigma, 100 is the highest, and 38 is the national median. Upon closer analysis, when breaking out stigma scores across races (not separating out sex, sexual orientation or age), Hispanic/Latino were the group with the highest score at 32.2, followed by White at 31.8, third being represented by those identifying as Multiple Races at 31.5 and finally Black/African American at 29.5 (Figure 19).

Figure 19: Measured level of experienced stigma of participants of the Medical Monitoring Project interviews in 2024, by participant characteristics.



Section IV: HIV Prevention, Care, and Treatment Resource Inventory

See Appendix A – HIV Prevention, Care and Treatment Resource Inventory (separate attachment).

Inventory Narrative

The New Jersey Department of Health (NJDOH), Division of Syndemic and Substance Use Services (DSSUS) receives funding from several state and federal sources, including the Centers for Disease Control and Prevention (CDC), the Ryan White HIV/AIDS Program, and cooperative agreements with other divisions within the department and with other state agencies. DSSUS leverages resources by braiding multiple funding streams to address service gaps and strengthen HIV prevention, care, treatment, and supportive services throughout the state. The ability to review funding streams, including their flexibilities and limitations, supports the development of comprehensive and responsive programming for the division's grantees. New Jersey will continue to explore opportunities to leverage private funding in coordination with existing public funding sources.

DSSUS funds several programs using non-federal funding that supports evidence-based treatment for mental illness, substance use, and co-occurring infections statewide for people living with HIV and individuals at increased risk for HIV acquisition. DSSUS maintains a strong collaborative relationship with the New Jersey Department of Human Services (NJHHS), Division of Mental Health and Addiction Services (DMHAS), which facilitates coordination in the delivery of prevention, treatment, and recovery support services for persons at risk of an overdose.

Programs funded by DSSUS seek to maximize the quality and accessibility of health and supportive services available to people at risk for or living with HIV through a status-neutral approach to prevention and care. Funding is awarded to grantees that provide HIV-specific prevention, testing, linkage, treatment, and supportive services, as well as broader services that address social determinants of health. These services include, but are not limited to, housing assistance, food access, sexually transmitted infection (STI) testing and treatment, communicable disease testing and vaccination services, mpox vaccination, and evidence-based treatment for mental illness, substance use, and co-occurring infections that reduce HIV risk and improve overall health outcomes. Together, these investments provide a strong foundation for New Jersey's HIV prevention and care infrastructure and support the diverse needs of communities throughout the state.

New Jersey also continues to support integrated HIV prevention and care planning through collaboration with the NJHPG, which helps guide statewide priorities, resource coordination, and community engagement efforts.

Strengths and Gaps

One strength of the HIV prevention, care, and treatment resource inventory is that more than 60 organizations are funded across the state to provide a wide range of services. These services include HIV care and treatment, prevention, Ryan White services, sexually transmitted infection services, and evidence-based treatment for mental illness, substance use, and co-occurring infections. Another strength is that the resource inventory includes contact information for funded agencies and identifies focus populations served by many organizations.

One identified gap in the resource inventory is the limited presence of directly funded agencies in five New Jersey counties: Sussex, Warren, Cape May, Hunterdon, and Salem. While residents in these counties may access services through regional providers and neighboring counties, further analysis is needed to assess potential service gaps related to geographic accessibility, transportation, and service availability. The resource inventory also demonstrates that some counties have multiple funded agencies, while others have only one or two providers, highlighting the need for continued assessment of equitable service distribution statewide.

Approaches and Partnerships

NJDOH used the System for Administering Grants Electronically (SAGE) to complete the HIV prevention, care, and treatment resource inventory. In addition, the New Jersey Department of Human Services maintains the New Jersey Resource Directory to help identify supportive services that address social determinants of health. Resources available through the directory include income and financial assistance programs; housing and homelessness assistance; food assistance; health insurance and healthcare assistance; pharmaceutical assistance; employment services; transportation services; childcare assistance; legal and advocacy services; and mental health and addiction services.

An additional statewide resource is NJ 211, staffed by community resource specialists who assist residents in accessing basic needs and supportive services 24 hours a day, 7 days a week, year-round.

Section V: Needs Assessment

Provider Survey Results

Introduction: A 15-question provider survey was created and disseminated to HIV prevention, care, and treatment providers. The survey was distributed electronically using Airtable. The NJDOH DSSUS, and the NJHPG widely distributed the survey link. The link was open for **fourteen days**, and recipients received two reminders to complete the survey after the initial distribution. Forty-eight providers completed the survey before it closed.

Demographics

Question - Which Race or Races do you identify with? (n=48)

52% White

33% Black or African American

6% Other

4% both American Indian/Alaskan Native and Asian

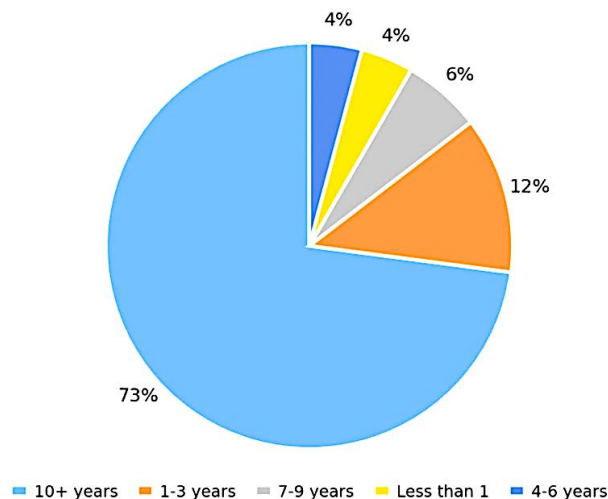
2% More than one Race

Question - What is your ethnicity? (n=48)

74.5% Non-Hispanic or Latino

25.5% Hispanic or Latino

Figure 20: Question - How long have you been providing HIV care services to patients? (n=48)



Most survey respondents self-identified as White (52%) or Black or African American (33%), with 25.5% indicating their ethnicity as Hispanic or Latino. Most providers have been providing HIV care services for 10 years or more (73%), followed by one to three years (12%) (Figures 20).

Question: What are the barriers to providing HIV testing services? (n=48)

1. From a select-all-that-apply list, participants identified several barriers to HIV testing. Highest ranked were:
2. Intensity of Client Needs (15 participants)
3. Recruiting clients to test (14 participants)
4. Staffing and Administrative Hurdles (23 participants)
5. Challenges working with partner organizations (6 participants)

Additional important areas mentioned include institutional policies and practices and other barriers not identified.

Question: What is needed to get more people tested for HIV? (n=48)

To increase the number of people tested for HIV, participants identified several key strategies:

1. Comprehensive Sexual Health and HIV Risk Education (30 participants)
2. Better Coordination and Integration of Services (28 participants)
3. PrEP (Pre-Exposure Prophylaxis) (26 participants)
4. Housing and PEP (Post-Exposure Prophylaxis) (24 participants)
5. Community Engagement and Culturally/Linguistically Appropriate Services (23 participants)
6. Transportation (21 participants)
7. Pre/Post Incarceration Release Case Management (20 participants)
8. Trauma-Informed Care and Access to Emergency Medication (18 participants)
9. Access to Free Condoms (17 participants)
10. Medical Care (15 participants)
11. Holistic Approaches to Social Determinants of Health and Access to Drop-in Centers (14 participants)

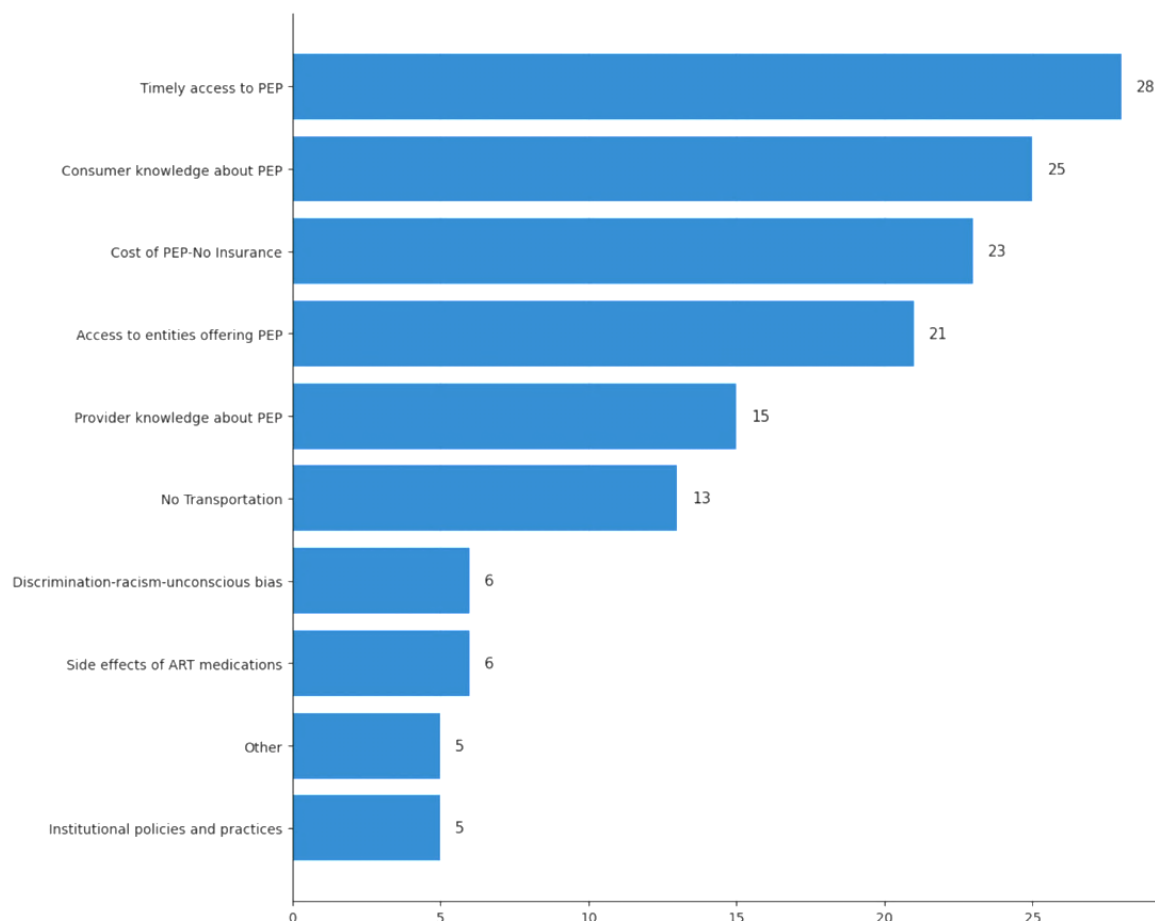
Additional important areas mentioned include rapid response to outbreaks, data-sharing, and better communication.

Question: What do you think is needed to keep people at risk for HIV negative? (n=48)

Asked what is needed to keep people HIV-negative, respondents indicated equally (29 participants), 'Better coordination and integration of services', 'Comprehensive sexual health incorporated into medical care', and 'Education on the risk of HIV'. These were followed by 'PrEP' (25

participants) and ‘Housing’ (24 participants). Twenty-three (23) participants indicated ‘Testing’, ‘PEP’, and ‘Community Engagement’. Responses indicating “other” did not provide additional write-in text or explanation.

Figure 21: Question: What prevents your patients from accessing PEP? (n=48)



Participants were asked what prevents clients from accessing PEP. Most respondents indicated timely access to PEP (28 participants), followed by consumer knowledge (25 participants), and then the cost of PEP without insurance (23 respondents). Responses indicating “other” did not provide additional write-in text or explanation. (Figure 21).

Question-What prevents your patients from accessing PrEP? (n=48)

Survey participants were asked what prevents their clients from accessing PrEP. Most respondents indicated ‘No insurance’ (29 participants), followed by ‘Consumer education about PrEP’ (27 participants) and ‘Lack of knowledge of PrEP as an HIV prevention tool (26 participants). Two responses indicating “other” indicated either that all their patients were HIV-positive or that they were not a prescriber. (Figure 27).

Question: What barriers prevent you from recommending or prescribing PEP or PrEP? (n=48)

Respondents were asked about barriers to recommending or prescribing PEP. The first barrier was lack of insurance (19 participants), followed by client nonadherence (12 participants). Cost, access, stigma were listed. “Other” responses indicated that they were not a prescriber.

Question: What agency factors are barriers to your patients receiving HIV care and treatment services? (n=48)

Participants were asked about agency-level factors that present barriers to clients receiving HIV care and treatment services. Respondents indicated equally (22 participants) ‘Engaging and retaining clients’ and ‘Intensity of client needs’. This was followed by ‘High agency staff turnover and decreased continuity of care (16 participants), ‘Other staffing and administrative hurdles’ (14 participants), and ‘Institutional barriers and policies’ (13 participants). “Other” responses include funding, fear, and patient non-adherence to DoxyPEP.

Question: What patient-level factors are barriers to your patients receiving HIV care and treatment services? (n=48)

Participants were asked about the patient-level factors that present barriers to receiving care. Most respondents indicated mental health (34 participants), followed by substance use and stressful life events equally (31 participants), and housing (28 participants). Another response stated, “Some patients are just fatigued from many, many years of treatment”. Some have lapses in insurance, and it can take time to get ADDP.

Question: What do people need to rapidly link to HIV medical care and treatment after receiving an HIV-positive diagnosis? (n=48)

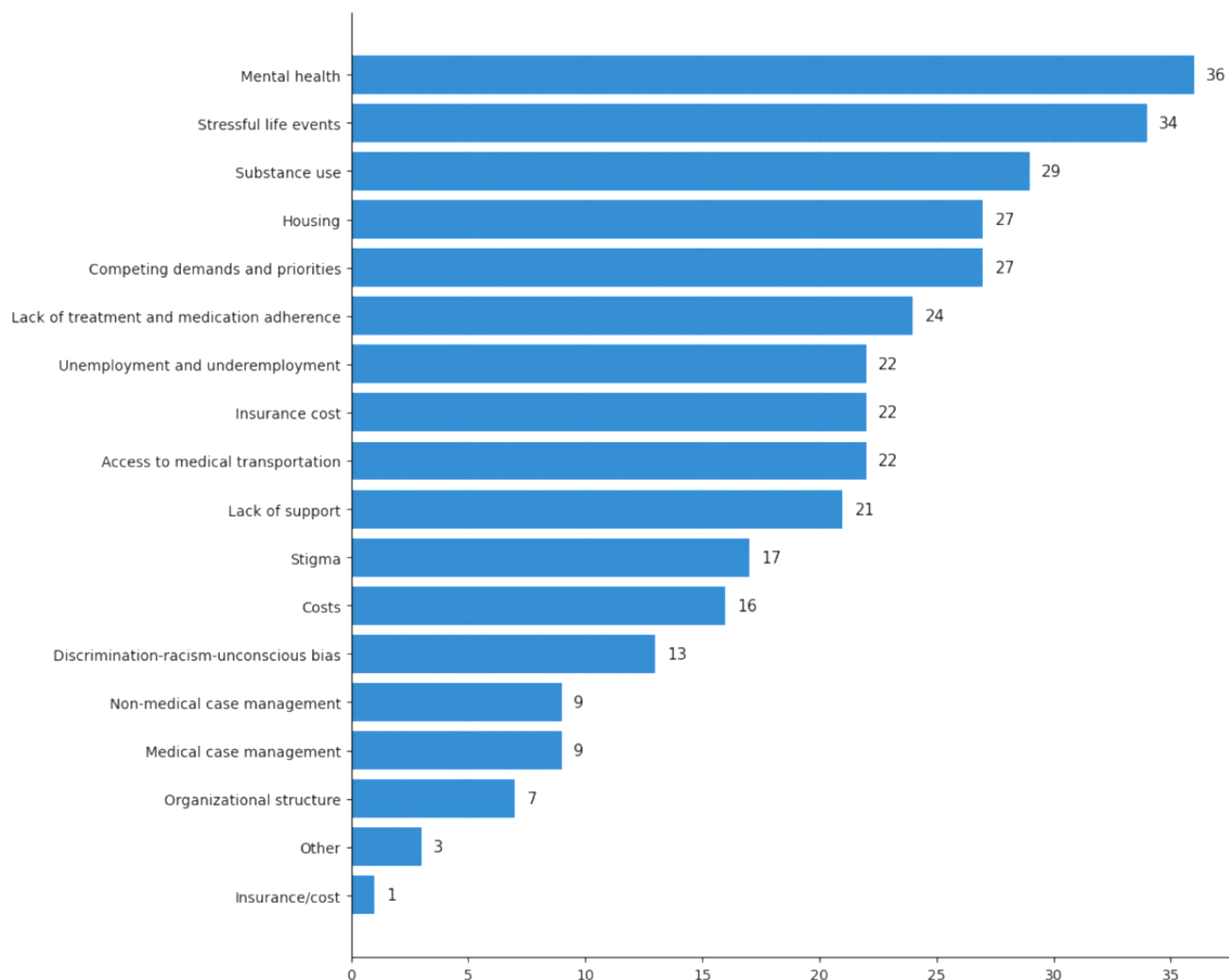
Survey respondents were asked what is needed to rapidly link to HIV medical care and treatment after receiving an HIV-positive diagnosis. Most respondents indicated medical transportation (26 participants), culturally competent and linguistically appropriate services (25 participants), and mental health (24 participants). Twenty-one (21) participants indicated equally behavioral interventions and services, medical case management services, new HIV diagnosis psychological support services, better coordination and integration of services, and HIV education and risk reduction, followed by ART prescribing providers (20 participants).

Question: What services do people with HIV need to keep them coming to scheduled medical appointments? (n=48)

Survey respondents were asked to identify the services people with HIV need to keep them coming to scheduled medical appointments. Most participants indicated medical transportation (33 participants),

followed equally by mental health services, health insurance premiums and cost-sharing assistance, housing, and case management services (30 participants). Responses indicating “other” did not provide additional write-in text or explanation.

Figure 22: Question: What prevents your clients from becoming/staying virally suppressed? (n=48)



Survey participants were asked what prevents clients from becoming/staying virally suppressed. Most respondents indicated mental health (36 participants), stressful life events (34 participants), and substance use (29 participants) (Figure 22).

Community Conversations

Introduction

Community conversations were convened as part of the HIV Integrated Plan needs assessment process to gather qualitative feedback from community members, people with HIV, providers, advocates, and other stakeholders regarding HIV prevention, care, treatment, and support services across New Jersey and the Philadelphia Eligible Metropolitan Area (EMA). These activities were designed to identify strengths, barriers, unmet needs, and opportunities to improve the HIV service-delivery system.

Community engagement activities included regional focus groups organized through the New Jersey HIV Planning Group (NJHPG), as well as Town Hall Meetings conducted by the Philadelphia Office of HIV Planning (OHP) in collaboration with the HIV Integrated Planning Council (HIPC) Comprehensive Planning, Prevention, and Positive Committees during the summer and fall of 2025.

Goals and Focus

The NJHPG Regional Focus Groups gathered community-driven perspectives on HIV testing, prevention, linkage to care, retention in care, treatment adherence, and barriers to HIV services.

The OHP/HIPC Town Halls were designed to 1) inform priority-setting and 2) to provide community-level feedback on housing, emergency financial assistance, benefits, access to care, and engagement in services.

Location and Structure

The NJHPG Regional Focus Groups were held in the Northern, Central, and Southern regions of New Jersey. The central New Jersey focus group was held in person. The northern and southern New Jersey focus groups were conducted virtually using Zoom. All participants received a \$50 Visa gift card in appreciation for their participation and feedback. Eight semi-structured questions guided each regional discussion.

The OHP/HIPC Town Halls included a brief grounding presentation followed by breakout group discussions focused on three key themes: housing, emergency financial assistance, and benefits and insurance-related issues. To promote equitable participation, in-person attendees received lunch and transportation assistance.

Fourteen (14) participants attended the New Jersey town hall. Most respondents were female, African American, over 50, heterosexual/straight, and residing in New Jersey. Respondents overall represented an aging population of people with HIV. The cohort's mean age was 48.43 years. More respondents were female (55.6%) than male (44.4%). The racial and ethnic composition of the New Jersey town hall participants was 70.0% Black/African American, 20.0% Hispanic or Latinx, and 10.0% White. Twenty-two percent (22.2%) reported annual incomes below \$10,000, 44.4% reported annual incomes of \$50,000 or more, and 33.3% preferred not to disclose income.

All participants reported having some form of health insurance or medical coverage. New Jersey participants reported higher rates of employer-based insurance coverage (50%), with Medicaid/Medical Assistance and Medicare coverage of 20% and 30%, respectively. However, 22.2% expressed concerns about losing insurance coverage.

Key Themes and Findings

The NJHPG Regional Focus Groups - Themes and Findings

Six focus groups (including one asynchronous response) were conducted in-person or virtually with persons with HIV across the State of New Jersey. A total of thirty-three individuals participated in the groups.

Participants emphasized the need for a comprehensive, person-centered HIV service system that makes testing, prevention, treatment, and supportive services easy to access and responsive to consumers. Across all areas, stigma, fear, misinformation, and lack of awareness about available services were identified as major barriers to testing, prevention, and ongoing engagement in care.

Participants stressed the importance of bringing HIV testing, prevention education, and outreach directly into trusted community settings through mobile services, home-testing options, peer-led outreach, and culturally responsive strategies. Participants also underscored the importance of stable housing, mental health support, food, childcare, transportation, support groups, and compassionate providers who treat individuals with dignity, respect, and compassion.

Question 1: What facilitates or supports people getting tested for HIV?

Theme	Supporting Quotes	Regional Location(s)
Incentives	“Offering a gift card or something like that”	Central Northern Southern
Community outreach/mobile testing	“I feel like those testing buses that go around are really helpful” “I would say outreach at community events because it's not personalizing it”	Central Northern Southern
Education and awareness	“Communication and presentation. Presentation for	Central

	the simple fact that you have to make an individual feel comfortable going to get tested and letting them know the results and letting them know that it is not a death sentence.”	Northern Southern
Peers	“With more information and we're seeing other people especially with women seeing other women living and thriving I think that's the hope like to give individuals hope that if there is a positive diagnosis that they can continue to live.”	Central Northern Southern
Stigma	“I'm not gonna go in there, they're gonna think something's wrong”	Central

Participants emphasized that offering incentives as part of HIV testing efforts is vitally important. They also stressed the need to make testing as accessible, convenient, and easy as possible by bringing services directly into communities. Suggested approaches included mobile testing vans located outside schools, community centers, and in neighborhood settings.

Participants also highlighted the importance of community outreach, particularly outreach led by peers living with HIV, as well as the availability of home-testing options. They noted that stigma and fear can discourage individuals from getting tested or following up on their results. For this reason, participants underscored the need to reduce barriers and ensure that HIV testing is simple, accessible, and available in trusted community-based settings.

Question 2: What prevention services are needed to keep people at-risk for HIV, negative?

Theme	Supporting Quotes	Regional Location(s)
PrEP education and access	“When it comes down to women and PrEP a lot of women even my daughter they don't even know about PrEP	Central Northern Southern

	they mostly think it's for men who are gay”	
Prevention services and education	“It is meeting people where they are at going to do outreach meet them where they're at go to the Barber shops go to the hair salons go to the laundromat”	Central Northern Southern
Targeted outreach	“I don't think we're doing enough to reach out to marginalized communities that are most impacted”	Central Northern Southern
Peer education	“Having people that are positive speak to other people that aren't positive to let them know how to avoid this so that way you don't end up with what I have”	Central Northern Southern

Participants stressed that prevention services must extend beyond HIV testing. Awareness and access to PrEP, PEP, and other prevention tools were reviewed as essential particularly for women, heterosexual individuals and other groups that participants believed are often overlooked. Sexual health education including condom use and healthy decision making was identified as a continuing need. Participants also highlighted the importance of mental health support and community outreach that meets people where they are.

Question 3: What do people need immediately after an HIV diagnosis to rapidly link them to care?

Theme	Supporting Quotes	Regional Location(s)
Immediate counseling	“People need immediately after an HIV diagnosis is counseling”	Central Northern Southern
Rapid linkage to care	“They have to be linked to an infectious disease doctor”	Central Northern Southern

Peer support/navigation	“When you first become positive when you first learn that you're positive you're devastated so to have someone on hand someone you can talk to you can speak to someone like to hold your hand through the beginning”	Central Northern Southern
Case management	“Someone that's going to talk to them and educate them, because most people are not educated about what HIV is, and also provide transportation to their first two treatments”	Central Northern Southern
Follow-up	“Somebody that would honestly call that person, reach out to them”	Central Northern Southern

Participants emphasized the need for immediate, compassionate counseling when an individual receives a positive HIV diagnosis. They also stressed the value of connecting newly diagnosed individuals with peers living with HIV, who can provide reassurance, share lived experience and reinforce that HIV is a manageable condition rather than a death sentence.

Participants further noted the importance of timely linkage to medical care, ideally on the same day as diagnosis or within a few days. They recommended ensuring that individuals have prompt access to case management services so they can understand the services and resources available to them and have someone available to answer questions and provide ongoing support.

Case management was viewed as especially critical because it can help newly diagnosed individuals access health insurance, and address potential barriers to care, including housing and transportation. Participants identified these services as essential to successfully connecting newly diagnosed individuals to care and helping them remain engaged in services.

Question 4: After an individual tests positive for HIV and is linked to medical care, what is needed to keep them coming to scheduled appointments?

Theme	Supporting Quotes	Regional Location(s)
Appointment reminders	“Reminders text messages if I don't get text messages I forget any way you can inundate me with reminding me that my appointment is whatever day I will make it”	Central Northern Southern
Provider outreach and engagement	“So I think following up on a client making sure you reiterate what they spoke to you about because that lets them know you care which makes me feel good so now somebody cares about me”	Central Northern Southern
Patient education	“Education is the key”	Central Northern Southern
Patient-centered care	“When I walk into [the agency] I feel like I'm home”	Central Northern Southern

Participants emphasized the importance of using practical tools to help individuals remain engaged in care and attend scheduled appointments. Suggested supports included appointment reminders by text message or phone call, as well as mobile applications that provide reminders for appointments and medication adherence.

Participants also discussed the importance of providers proactively reaching out to clients, particularly when appointments are missed or individuals appear to be disengaging from care. They stressed that individuals should feel respected, valued, and treated with dignity throughout their care experience.

Finally, participants highlighted the importance of self-love and self-care. They noted that individuals must recognize their own value and the importance of taking care of their health in order to remain engaged in treatment and care.

Question 5: What services assist persons with HIV who are prescribed ART, take their medications as directed, and achieve and maintain viral suppression?

Theme	Supporting Quotes	Regional Location(s)
Medication reminders	"I get up like clockwork and I take my meds at the same time every single day:	Central Northern Southern
Peer and social support	"Support groups panels like this [help people maintain viral suppression]"	Central Northern Southern
Housing and supportive services	"I feel that what they need is a stable, stable home so they could go to their doctor's appointments, so they could get on the medical treatment"	Central Northern Southern

Participants identified several services and supports that can help people with HIV who are prescribed antiretroviral therapy (ART) maintain medication adherence and achieve viral suppression. Practical tools include taking medications at the same time every day, reminder applications (phone apps), pill packs, and prescription refill notifications were viewed as especially helpful. Participants also emphasized the importance of access to an HIV specialist, routine blood work, and providers who consistently reinforce the importance of achieving and maintaining viral suppression.

Participants further identified support groups as an important source of encouragement and connection. Access to stable housing and other supportive services was also viewed as critical, as these supports can reduce barriers that may interfere with medication adherence and ongoing engagement in care.

Question 6: What are the barriers to accessing existing HIV testing?

Theme	Supporting Quotes	Regional Location(s)
Stigma	"I feel the number one barrier is stigma"	Central

		Northern Southern
Fear of diagnosis	“Sometimes they know but they really don't wanna know” “You're afraid to get tested you're in denial that you I don't have it I don't have it”	Central Northern Southern
Limited awareness	“Lack of education, lack of urgency”	Central Northern Southern

Participants most frequently identified stigma as a significant barrier to HIV testing. They also described low self-esteem, shame, and guilt as factors that may discourage individuals from seeking testing. Substance use was noted as an additional barrier for some individuals.

Participants further emphasized the need for culturally responsive outreach strategies that build trust, reduce stigma, and strengthen engagement within affected communities.

Question 7: What are the barriers to accessing existing prevention services?

Theme	Supporting Quotes	Regional Location(s)
Limited PrEP awareness	“Most people don't know that any anybody can take PrEP now”	Central Northern Southern
Misperceptions of risk	“It’s rare that you hear anything about HIV anymore”	Central Northern Southern
Stigma	“Someone finding out, someone knowing that you're getting [services]”	Central Northern Southern

Housing and supportive services instability	“...we need more affordable housing”	Central Northern Southern
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Participants felt that prevention services are often underutilized because many people are unaware that they exist. They also noted that some individuals do not believe they are at risk for HIV and, therefore, may not seek prevention services.

Additional barriers included lack of transportation and daily life struggles, such as access to food and childcare. Some participants also identified mental health challenges as a barrier to accessing prevention services. Finally, stigma and misinformation were noted as significant factors that can discourage individuals from accessing available prevention services.

Question 8: What are the barriers to accessing existing HIV care and treatment services?

Theme	Supporting Quotes	Regional Location(s)
Stigma	“Shame, self-esteem you know the continuance of the upkeep you know they might get depressing they might get overwhelming to where you get like why do I care why should I care I already have it but if you don't have the proper guidance or counseling or you know your team isn't set up”	Central Northern Southern
Housing instability	“[Being unhoused] then it becomes a barrier to some potentially a barrier for some people to be able to access care”	Central Northern Southern
Transportation challenges	“What are the barriers to accessing existing care and	Central Northern

	treatment services for people...transportation”	Southern
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Participants most frequently identified stigma and a lack of awareness about where to access services as barriers to obtaining existing HIV care and treatment services. Although some participants felt that it is relatively easy to identify available services when individuals actively seek them out.

Additional barriers included housing instability and transportation challenges. Participants also emphasized the importance of programs and service providers that address both medical and social needs. They described the benefits of receiving care in settings where providers are compassionate and welcoming, and where individuals feel like family.

The OHP/HIPC Town Halls – Themes and Findings

The New Jersey Town Hall findings highlighted several important themes related to HIV care engagement, access to services, and unmet supportive service needs among participants in the Philadelphia EMA.

Respondents emphasized that strong, long-term relationships with providers and case managers were critical to remaining engaged in care and maintaining positive health outcomes. However, participants also identified persistent barriers, including long travel distances to medical appointments, lengthy wait times for appointments and clinic visits, and concerns regarding the affordability and stability of health insurance coverage, particularly among individuals relying on employer-sponsored insurance. Although New Jersey participants reported fewer unmet service needs overall compared with participants from other EMA regions, housing assistance, legal services, and dental care emerged as the most frequently identified unmet needs. Transportation barriers and affordability concerns also contributed to gaps in care for some participants. Overall, the findings suggest that while many New Jersey participants were successfully engaged in care and insured, ongoing structural barriers related to transportation, service accessibility, and financial stability continue to affect the HIV care continuum and quality of life for people living with HIV in the region.

Access to Care and Service Utilization

Several participants reported barriers related to affordability and transportation, reporting the following:

- not receiving care in the previous year because they could not afford it.
- transportation barriers that prevented them from attending appointments.
- not receiving a viral load test within the past 12 months.

Unmet Service Needs

The most frequently identified unmet service needs included:

- Housing assistance
- Legal services

- Dental care

Breakout Discussion Themes

Several themes emerged consistently across the New Jersey breakout discussions:

- Long, travel distances to medical appointments represented a significant barrier to care.
- Participants expressed concern about the affordability and stability of insurance coverage, particularly among individuals who depend on employer-sponsored coverage.
- Strong and trusting relationships with providers and case managers were critical to maintaining engagement in HIV care.
- Participants frequently perceived providers and case managers as overextended or too busy, which negatively affected communication and support.
- Long appointment wait times and lengthy wait times within clinics were commonly identified as sources of frustration.

Participant-Identified Priorities

Participants emphasized several priorities for improving HIV care and support services:

- Strengthening provider-client relationships to support ongoing engagement in care.
- Reducing appointment wait times and service delivery delays.
- Improving transportation access.
- Addressing housing instability and financial barriers.
- Maintaining affordable and stable health insurance coverage.

Cross-Cutting Themes from NJHPG Focus Groups and OHP/HIPC Town Hall Meetings

- The impact of stigma across the continuum
- Stigma showed up in decisions about getting tested, whether to access prevention services, and among people who were diagnosed with HIV, in decisions about getting into care and on treatment
- Upon diagnosis, individuals need to experience compassion, receive accurate information about the possibilities afforded by care and treatment, and be offered hope along with a counter-narrative to stigma. Among the most credible and impactful sources of this information are peers **who are living with diagnosed HIV.**
- Patient-centered care is critical for ongoing engagement and viral suppression. **When providers create an environment where people feel welcomed, respected, and supported, trust is fostered, increasing the** likelihood of sustained engagement in care and successful treatment outcomes.
- Ongoing structural barriers that stem from poverty and a lack of financial stability, including transportation, housing, and access to health insurance
- There is limited awareness of PrEP, PEP, and other HIV prevention services, including what they are and who may benefit from them. The perception that PrEP and PEP are intended primarily for gay men, not for women or other populations, continues to persist.

Key Priorities Arising from the Needs Assessment

- Reducing Stigma
- Increasing community awareness and education
- Increasing awareness of PrEP and PEP services
- Address barriers to testing, prevention, care, and treatment
- Identifying, disseminating, and supporting programs and services that address the social determinants of health

Key Activities to Address Needs and Barriers Identified

During the Needs Assessment Process

- Development of evidence-based or evidence-informed programs and services tailored to priority populations
- Development and dissemination of materials, programs, and social campaigns to bring the public understanding of HIV current
- Working with key stakeholders to make PrEP and PEP more accessible and available
- Establishing public and private partnerships to address the social determinants of health

Approach Used to Complete the Needs Assessment

- People with HIV and key stakeholders were involved in completing the needs assessment as members of the New Jersey HIV Planning Group, attendees of the strategic planning work group, participants in community conversations, and respondents to provider surveys.

Section VI: Situational Analysis

Diagnose

Impact on New Jersey

As of May 2026, according to the Enhanced HIV/AIDS Reporting System (eHARS) and related surveillance data through December 2025, New Jersey continues to experience a substantial burden of HIV infection despite improvements in prevention, testing, and linkage services. Between 2022 and 2024, a total of 127,140 HIV tests were conducted at New Jersey-funded testing sites, representing a 39% increase in testing volume from 35,047 tests in 2022 to 48,692 tests in 2024. The majority of tests were conducted among males (57%) and among non-Hispanic Black residents (43%), followed by Hispanic residents (38%). Adults aged 30–39 years represented the largest age group tested (28%), followed by adults aged 50 years and older (25%). Heterosexual males and females accounted for the largest proportion of individuals tested, while men who have sex with men (MSM) accounted for 15% of testing encounters.

The HIV epidemic in New Jersey continues to disproportionately affect racial and ethnic minorities, MSM, and residents living in urban counties. In 2024, a total of 1,051 new HIV diagnoses were reported statewide, representing a rate of 9.4 per 100,000 residents.

Most new HIV diagnoses continue to occur among males; however, the proportion among females increased from 18% in 2023 to 24% in 2024. In 2024, the rate of new HIV diagnoses among males was 17 per 100,000 compared to 5.3 per 100,000 among females. Black and Hispanic populations continue to experience substantially higher rates of HIV diagnoses than White residents. Between 2021 and 2024, Black/African American males experienced diagnosis rates as high as 40.6 per 100,000, while Hispanic/Latino males experienced rates of 34.1 per 100,000. Black/African American females experienced rates of 20.2 per 100,000 compared to 6.1 per 100,000 among Hispanic/Latina females.

Adults aged 25–34 years and 35–44 years continue to experience the highest HIV diagnosis rates among both males and females. While rates among males aged 25–34 years declined between 2022 and 2024, rates increased among males aged 35–44 years and females aged 25–34 and 35–44 years.

Transmission patterns continue to demonstrate the disproportionate impact of HIV among MSM populations. In 2024, 45% of all new HIV diagnoses were attributed to male-to-male sexual contact. Female and male heterosexual transmission increased proportionally between 2023 and 2024, suggesting continued vulnerability among heterosexual populations and the need for expanded prevention messaging and testing.

Approximately 22% of all new HIV diagnoses between 2021 and 2024 occurred at Stage 3 (AIDS), indicating persistent challenges with early diagnosis and routine testing. Late diagnoses were more common among heterosexual males and females and among older adults, with 34% of persons aged 55 years and older diagnosed at Stage 3 (AIDS).

Strengths

Testing Services and Screening Capacity: NJDOH-DSSUS maintains a strong HIV testing infrastructure supported through publicly funded counseling and testing programs. Testing volume increased substantially between 2022 and 2024, reflecting expanded outreach and service delivery capacity. Approximately 72% of individuals tested for HIV during this period were screened for HIV risk, resulting in nearly 32,000 referrals for PrEP services and more than 29,000 linkage service encounters.

The state continues to strengthen integration between HIV testing and prevention services. Awareness of PrEP among individuals tested increased from 36% in 2022 to 42% in 2024, demonstrating improvements in prevention education and outreach. Publicly funded testing programs also maintain strong referral systems to prevention and linkage services.

New Jersey benefits from longstanding partnerships between NJDOH -DSSUS and community-based organizations, healthcare providers, and academic institutions that support HIV testing, laboratory oversight, surveillance, and quality assurance activities. These partnerships provide the infrastructure necessary to maintain and expand HIV screening and linkage initiatives statewide.

The New Jersey Department of Health (NJDOH) released its “Dear Colleague” letter urging routine HIV testing on March 23, 2023, The Official Web Site for The State of New Jersey. In this letter,

NJDOH emphasized the importance of implementing routine, opt-out HIV screening in healthcare settings as part of its strategy to end the HIV epidemic in the state by 2025. The guidance was issued in the context of the state's A Strategic Plan to End HIV in New Jersey by 2025, which aims to reduce new HIV infections by 75%, ensure 100% of people living with HIV know their status, and link 90% of diagnosed individuals to viral suppression. The Official Web Site for The State of New Jersey. The letter encouraged healthcare providers to integrate HIV testing into standard care, promote education about the benefits, and support the use of prevention tools like PrEP and PEP, alongside rapid initiation of antiretroviral therapy for those diagnosed.

Gaps

Despite increased testing activity, New Jersey remains challenged by late HIV diagnoses and disparities in testing access and utilization. Approximately one in five new diagnoses occurs at Stage 3 (AIDS), indicating missed opportunities for earlier testing and diagnosis.

Additional gaps include inconsistent implementation of routine HIV testing recommendations across healthcare settings, insufficient testing access in non-traditional and rural settings, and limited normalization of sexual health screening within primary care and community health systems. Certain geographic regions continue to experience limited prevention and testing infrastructure, particularly in counties with fewer funded agencies.

There is also a continued need to improve public awareness of HIV risk, treatment as prevention (U=U), and the availability of HIV prevention and testing services. Persistent stigma associated with HIV testing remains a barrier among priority populations.

Barriers

Participants identified several barriers to HIV testing. Stigma was a significant issue, with fear of being judged or discriminated against discouraging individuals from getting tested or following up on their results. Low self-esteem, characterized by shame and guilt, also played a role in discouraging testing. Substance use was noted as an additional barrier for some individuals. Accessibility and convenience were highlighted as critical factors, with a need for services to be brought directly into communities. Suggestions to improve accessibility included the use of mobile testing vans and home-testing options.

Community outreach was deemed essential, particularly peer-led outreach by individuals living with HIV. Additionally, there was an emphasis on the need for culturally responsive strategies to build trust, reduce stigma, and strengthen engagement within affected communities.

New Jersey requires expanded system-level and policy-level approaches to normalize routine HIV testing and sexual health assessments across healthcare settings. Provider education is needed to strengthen adherence to CDC testing guidelines, genotype testing, improve cultural responsiveness, and reduce unconscious bias. Public education efforts should focus on increasing awareness of HIV risk, reducing stigma, and encouraging individuals to request HIV testing during healthcare encounters.

There is also a need to expand testing services in non-traditional venues, increase access in underserved geographic areas, and strengthen partnerships with community organizations, schools, and healthcare systems to improve early diagnosis and linkage to prevention and care services.

Treat

Impact on New Jersey

As of December 31, 2024, there were 38,572 persons living with HIV (PLWH) in New Jersey, corresponding to a prevalence rate of 406 per 100,000 residents. Approximately 60% of PLWH resided in Essex, Hudson, Middlesex, Passaic, and Union Counties. Essex County experienced the highest prevalence rate at 953.8 per 100,000 adults aged 13 years and older.

The population of PLWH in New Jersey is aging. In 2024, approximately 55% of PLWH were aged 55 years or older, and 28.7% were aged 55-64 years. This trend highlights the growing need for comprehensive whole-person care that addresses chronic disease management, behavioral health, housing, transportation, and aging-related needs.

The HIV care continuum demonstrates ongoing challenges in retention in care and viral suppression. In 2024, 59% of PLWH received HIV medical care during the year, 53% achieved viral suppression, and 30% experienced unmet need, defined as having no reported CD4 or viral load test during the reporting period. While viral suppression outcomes were relatively similar between males and females, the continuum highlights substantial opportunities to improve retention and engagement in care.

The Medical Monitoring Project further demonstrates the socioeconomic and structural challenges affecting PLWH in New Jersey. Between 2020 and 2023, 66% of PLWH interviewed reported annual household incomes below \$40,000, 14% were unemployed, and 38% reported having a disability. Housing instability remained significant, with 6% reporting homelessness and an additional 12% reporting moving in with others due to financial problems.

PLWH also reported substantial unmet service needs. The most frequently identified unmet needs included SNAP/WIC services (16.5%), shelter or housing services (16.4%), meal and food services (8.6%), mental health services (7.2%), transportation services (6.2%), case management (5.7%), and medication assistance through ADAP (5.3%).

Mortality among PLWH has declined modestly, from 6.4 deaths per 100,000 in 2021 to 5.4 deaths per 100,000 in 2024. However, deaths remain disproportionately higher among Black/African American males and females and among individuals with histories of injection drug use.

Strengths

Rapid Linkage and HIV Care Infrastructure: New Jersey benefits from a strong Ryan White HIV/AIDS Program (RWHAP) infrastructure that supports comprehensive HIV medical care, core medical services, a comprehensive ADAP that continues to use an open formulary and support services across the state, providing HRSA-funded services to those whose income is up to 500% of the Federal Poverty Level. Linkage to care systems continues to support rapid engagement in HIV treatment through coordinated referral systems, linkage coordinators, and collaborative regional bodies.

The state's Early Intervention and Retention Collaboratives (EIRCs) provide regional coordination between testing and care agencies to improve linkage to care, retention in care, and HIV care continuum outcomes. These collaboratives help identify service gaps and coordinate care activities at the local level.

New Jersey also benefits from broad public insurance coverage and Ryan White program supports. Many PLWH access care through Medicaid, Medicare, and the Ryan White HIV/AIDS Program, improving access to medications and supportive services.

Gaps

Significant gaps remain in retention in care, viral suppression, and comprehensive support services outside of the Ryan White Network of providers. Only slightly more than half of PLWH achieved viral suppression in 2024, and nearly one-third experienced unmet need for HIV care services. Data reporting gaps exist as well with neighboring states to accurately describe the care status of PLWH in New Jersey. Within the Ryan White Network, the viral load suppression rate is much higher at 91.6%

Additional gaps include inadequate resources for comprehensive field-based outreach and follow-up, and limited availability of whole-person care models tailored to aging PLWH.

New Jersey also continues to face gaps in mental health services, substance use treatment, transportation assistance, housing support, and patient navigation services. There is also a need for expanded culturally and linguistically appropriate services for diverse populations.

Barriers

Participants identified several barriers to HIV treatment. Stigma was a significant issue, with negative perceptions and a lack of awareness about where to access services. Housing instability and transportation challenges were noted as barriers to consistent care and treatment. The lack of immediate counseling and support upon diagnosis was highlighted, emphasizing the need for compassionate counseling and connections with peers living with HIV.

Delayed linkage to care and limited access to case management services were also identified as challenges. Barriers to health insurance and difficulties in remaining engaged in care and adhering to medication schedules were significant concerns, with a need for practical tools like appointment reminders and medication adherence apps. Disengagement from care without proactive provider outreach and a lack of self-love and self-care were also noted. Access to HIV specialists and routine monitoring, as well as support groups, were identified as critical but often limited.

Finally, the importance of compassionate and welcoming care settings where providers are understanding and individuals feel like family was emphasized.

Needs

New Jersey requires expanded investment in retention and re-engagement initiatives, including community health worker programs, peer navigation, and field outreach services. Increased access to mental health care, substance use treatment, housing assistance, transportation, and food security services is essential to improve HIV outcomes.

The state also needs expanded whole-person care approaches for aging PLWH, including chronic disease management, behavioral health integration, and social support services. Additional needs include enhanced workforce development and training to improve cultural competence, trauma-informed care, and rapid ART initiation practices.

Community conversations and provider surveys further emphasized the need for psychological support services immediately following HIV diagnosis, expanded case management, medical transportation assistance, and comprehensive HIV education to improve treatment adherence and trust in healthcare systems.

Prevent

Impact on New Jersey

New Jersey continues to expand HIV prevention services through PrEP, PEP, and community-based prevention initiatives. Between 2022 and 2024, 4,331 persons at risk for HIV were served at publicly funded PrEP sites statewide. The majority were male (71.6%), Hispanic (47.9%), or non-Hispanic Black (32%), and approximately 81% were between 20 and 39 years old. MSM accounted for 60.4% of individuals identified as at risk for HIV.

The PrEP continuum demonstrates improvements in linkage and prescription outcomes. From 2022 to 2024, 70% of persons at risk for HIV were referred to medical providers, 81% attended appointments, and 95% received PrEP prescriptions. Referral rates, appointment attendance, and prescription receipt all improved during this period.

Despite these gains, the number of individuals considering enrollment in PrEP services declined by 40% between 2021 and 2024, suggesting ongoing challenges in prevention engagement and sustained prevention uptake. Additionally, HIV seroconversion among individuals receiving PrEP counseling services was 2.9 per 1,000 persons, indicating continued vulnerability among high-risk populations.

Strengths

PrEP and Prevention Infrastructure: New Jersey maintains a statewide network of publicly funded PrEP navigation sites and prevention programs that provide HIV prevention counseling, linkage to medical providers, and access to PrEP prescribers and medications. Prevention services increasingly integrate HIV testing, risk screening, counseling, and linkage support.

New Jersey continues to face gaps in PrEP uptake, stigma reduction, and access to prevention services. NJDOH has a thriving partnership with Rutgers - FXB. As a result of this partnership, NJ launched a “Take PrEP and Take Charge” campaign for women of color with over 130 million hits (on the [End the Epidemic NJ | Public health NJ](#) website) in 12 cities and seeks to replicate that success on future awareness campaigns.

Additional gaps include limited access to PEP services in certain geographic areas, insufficient integration of HIV prevention into broader healthcare systems, inadequate culturally responsive prevention messaging, and insufficient LGBTQ+ affirming and evidence-based treatment for mental illness, substance use, and co-occurring infections services.

New Jersey also continues to experience disparities in HIV prevention access among racial and ethnic minority populations, uninsured residents, and individuals affected by poverty, housing instability, and substance use.

Barriers

Participants identified several barriers to HIV prevention. A significant issue was the lack of awareness, with many people unaware that prevention services exist and some individuals not believing they are at risk for HIV, thereby not seeking prevention services. Stigma was another major barrier, discouraging individuals from accessing available prevention services. Misinformation also acted as a barrier, further complicating access to these services.

Transportation challenges, daily life struggles such as access to food and childcare, and mental health issues were noted as impediments to utilizing prevention services. Housing instability affected the consistent access to these services. There was a need for comprehensive services that extend beyond HIV testing to include PrEP, PEP, and other tools, along with essential sexual health education. Prevention services were often underutilized due to lack of awareness and perceived risk.

Community outreach that meets people where they are and mental health support were highlighted as critical components of prevention efforts. Finally, the importance of compassionate and welcoming care settings where providers are understanding and individuals feel like family was emphasized.

Needs

New Jersey requires expanded prevention education focused on HIV risk, PrEP, PEP, condoms, and evidence-based treatment for mental illness, substance use, and co-occurring infections. Community stakeholders emphasized the need for stigma reduction initiatives, expanded sexual health education in schools, increased access to condoms, and improved public awareness campaigns.

Additional needs include expanded access to PrEP and PEP services, particularly in underserved communities; improved integration of prevention into primary care and behavioral health systems; and stronger public-private partnerships to support prevention infrastructure and innovation.

The state also requires continued investment inequality improvement systems, and data infrastructure to monitor prevention outcomes and disparities.

Respond

Impact on New Jersey

New Jersey continues to maintain an active HIV cluster detection and response system through ongoing molecular and time-space cluster monitoring. As of May 2025, the state had identified multiple molecular cluster alerts, but few have met the CDC definition for being classified as a National Priority Cluster which includes 5 or more cases diagnosed in a 12-month period with similar HIV strains reported, and time-space cluster analyses are conducted monthly to rapidly detect increases in HIV diagnoses across geographic areas. Although New Jersey had not identified a new molecular cluster of national priority

within the previous year, additional individuals continued to create new small cluster groups or be linked to existing cluster groups or 2 to 3 individuals.

Current cluster data show that most individuals associated with molecular clusters are male and between the ages of 20 and 39 years, particularly among those aged 20–29 and 30–39. Men who have sex with men (MSM) and MSM who inject drugs represent the largest transmission categories associated with identified clusters. Cluster-associated individuals are disproportionately Black/African American and Hispanic/Latino residents, reflecting persistent racial and ethnic disparities in HIV transmission statewide.

Geographically, cluster-associated individuals are concentrated primarily in Essex, Hudson, Camden, Middlesex, Union, Cumberland, and neighboring counties, with some transmission linkages extending into New York jurisdictions. Time-space cluster alerts issued in February 2025 further highlighted the continued need for rapid surveillance, coordinated investigation, and timely public health response activities across affected communities.

Strengths

New Jersey has a strong statewide HIV surveillance and response infrastructure capable of identifying and responding to HIV clusters through coordinated public health activities. The state conducts monthly molecular and time-space cluster analyses to monitor transmission trends and identify areas of increased HIV diagnoses. Time-space clusters are addressed immediately, with many identified individuals already engaged in HIV care at the time of investigation.

The response system includes coordination among the New Jersey Department of Health, local health departments, epidemiologists, surveillance staff, healthcare providers, and community-based organizations. Existing surveillance systems, including eHARS, molecular cluster analysis, Medical Monitoring Project data, and behavioral surveillance systems, provide substantial epidemiologic capacity to support cluster detection and response efforts statewide. New Jersey also maintains established disease investigation protocols, legal authority, and public health response procedures that support communicable disease investigations and HIV cluster response activities.

Gaps

The primary gaps within the response pillar involve limited workforce capacity dedicated specifically to HIV cluster detection and response activities with the recent termination of DIS workforce funding. Trained Disease Intervention Specialist staff who are the core of a response team should an outbreak occur are not adequately funded. If an outbreak were to occur, NJDOH would require time to recruit, onboard and train necessary staff to ensure adequate response for a growing HIV cluster. Although New Jersey conducts routine molecular and time-space cluster analyses, the state has identified a need to expand genotype testing capacity in order to strengthen molecular cluster identification and improve the ability to detect transmission networks earlier. In 2024, NJDOH reported about half of persons newly diagnosed with HIV having a valid molecular testing result available in eHARS. Messaging to providers to order molecular testing has been ongoing.

Additional gaps include inconsistent real-time data sharing, limited local public health resources to support rapid outreach and investigation activities, and integration of behavioral health, supportive services, and care coordination into cluster response activities also remains limited in some jurisdictions. Further improvement is needed to ensure timely linkage to care, re-engagement in treatment, and sustained viral suppression among cluster-associated individuals. Note: Time-space clusters can be influenced by increased testing in areas which often “appears” like potential new “outbreaks” that are simply better access to testing

Barriers

Workforce shortages limit the personnel available to manage and respond to HIV clusters. Competing public health priorities divert attention and resources away from HIV cluster response. Limited funding results in insufficient financial resources for local response activities.

Engaging hard-to-reach populations, disproportionately affected by HIV transmission networks, presents significant challenges. Stigma, characterized by negative societal attitudes, discourages individuals from seeking care and participating in response efforts. Mistrust of healthcare and public health systems further complicates engagement.

Housing instability and behavioral health conditions, such as mental health and substance use disorders, impact individuals' ability to engage in care and achieve viral suppression. Social determinants of health, including economic status and education, negatively affect health outcomes and engagement in care. Delayed diagnosis due to various barriers reduces the effectiveness of interventions. Limited participation in partner services and the reduced effectiveness of rapid response interventions further diminish the overall impact of response efforts.

Needs

New Jersey requires continued investment in HIV cluster response infrastructure, including expanded workforce development, modernized surveillance and data systems, and increased genotype testing capacity to strengthen molecular cluster detection and response activities. Enhanced support for local health departments and better communication with LHDs and Community-based organizations is necessary to improve rapid outreach, investigation, and follow-up activities statewide.

Additional needs include stronger partnerships among healthcare systems, public health agencies, and community-based organizations to support coordinated prevention and care efforts. New Jersey also requires improved integration of prevention and treatment services into cluster response activities, enhanced partner services, and stronger systems to support rapid linkage to care, retention in treatment, re-engagement in care, and long-term viral suppression among individuals associated with HIV clusters.

Cross-Cutting Themes

Several themes emerged consistently across the Diagnose, Treat, Prevent, and Respond pillars. HIV-related stigma remains a significant barrier across the continuum of care and prevention. Social determinants of health, including housing instability, food insecurity, transportation limitations, poverty,

and behavioral health challenges, continue to affect prevention engagement, retention in care, and viral suppression outcomes.

Racial and ethnic disparities remain substantial throughout New Jersey’s HIV epidemic, particularly among Black/African American and Hispanic/Latino populations. Geographic disparities also persist, with Essex, Hudson, Middlesex, Passaic, Union, and Camden Counties carrying a disproportionate burden of HIV diagnoses and prevalence.

New Jersey’s HIV prevention and care systems benefit from strong statewide partnerships, publicly funded prevention and care infrastructure, and robust surveillance capacity. However, continued investment is needed to strengthen workforce capacity, improve retention and viral suppression outcomes, expand culturally responsive services, address social determinants of health, and reduce disparities across populations disproportionately affected by HIV.

The 2027–2031 New Jersey HIV Prevention and Care Plan will build upon these strengths while addressing identified gaps, barriers, and needs to improve health outcomes and reduce new HIV infections statewide.

Priority Populations

Based on the epi snapshot for people at risk for and with HIV in New Jersey, several priority populations have been identified. New Jersey’s priority populations are identified below. In New Jersey, Black and Hispanic residents experience the highest impact from HIV, both in terms of new infections and health outcomes.

Incidence and Prevalence Data:

- New Jersey reported 10.1 new HIV infections per 100,000 people in 2023.
- Though exact 2024 incidence rates by race/ethnicity are not yet published, historical data shows that Black and Hispanic individuals consistently have higher HIV incidence rates than white and Asian populations.

Health System and Care Access Disparities:

- Black and Hispanic residents are less likely to access quality care and have higher rates of preventable deaths.
- Nearly one in four Hispanic residents lack health insurance.
- Social determinants such as housing segregation, food access, and environmental factors contribute to HIV-related health inequities.

Why This Matters:

- Higher HIV incidence in Black and Hispanic communities is tied to structural inequities, including historical discrimination, limited access to preventive services, and barriers to timely diagnosis and treatment.

(From:

[NJ health system still underperforms for Black, Hispanic residents | NJ Spotlight News](#))

In addition, as of 2023 data, the highest percentage of new HIV diagnosis was among those identifying as MSM at 60.6%. In particular, those individuals between the ages of 25-34. (AIDSVU)³

Section VII: CY 2027-2031 Goals and Objectives

New Jersey's 2027–2031 goals and objectives reflect a commitment to improving health outcomes by reducing disparities, addressing social and structural barriers, and ensuring meaningful engagement of communities most impacted by HIV, while strengthening systems to deliver accessible, high-quality prevention, care, and treatment services. This commitment underpins all aspects of the plan. This commitment is reflected in cross-cutting focus areas that span the Ending the HIV Epidemic (EHE) pillars, including community engagement, addressing social and structural determinants of health, integration and coordination, and workforce development. Additional goals and objectives are organized by the four EHE pillars, with corresponding strategies and activities categorized at the system, program, policy, and stigma levels. New Jersey will build off of the original goals, key activities and strategies that were listed in the [2022-2026 plan](#). In this document, Year 1 priorities will be highlighted. Although progress has been shared with NJHPG members, Part A planning groups and community and stakeholders through attendance to HPG At-Large meetings, throughout the lifecycle of the sunseting plan, a companion progress report will be released annually. The final and comprehensive public-facing report out for the Integrated Plan 2022-2026 will be released December 2026. The new cycle of report outs for the 2027-2031 will begin December 2027, reporting on progress toward the goals, identify if a strategy is ongoing or completed and the release of the upcoming year's goals, key activities, and strategies. In this plan, year 1 (2027) goals (35) will be listed.

Goals and Strategies Across All Pillars

Goal 1: Incorporate community engagement through community conversations across all pillars by 2031.

Key Activities and Strategies:

- a) Program Activity 1.3: Include critical analysis and health communication skills in HIV programs to provide participants with tools to seek and identify accurate health information and to advocate for themselves and their communities. (NHAS 3.6.4)
- b) Stigma Activity 1.1: Work with communities to reframe HIV services and HIV-related messaging so that they do not stigmatize people or behaviors. (NHAS 3.3.2)

Goal 2: Address social and structural determinants of health (SDOH) and co-occurring conditions that

impede access to HIV services and exacerbate HIV-related disparities through identifying and collaborating with organizations internal and external to Ryan White programs that address SDOH, as evidenced through documented meetings, written agreements, and the inclusion of entities in New Jersey's HIV Prevention, Care, and Treatment Resource Inventory by 2031.

- a) Program Activity 2.2: Develop new and scale up effective, evidence-based or evidence-informed interventions that address intersecting factors of HIV, homelessness or housing instability, mental health and violence, and substance use. . (NHAS 3.4.6)

Goal 3: Work towards integrating and coordinating efforts that address the HIV epidemic among all partners and interested parties through evidence of stakeholder meetings and memorandums of agreement by 2031 (INTEGRATION).

- a) System Activity 3.1: Integrate programs to address the syndemic of HIV, STIs, viral hepatitis, substance use, and mental health disorders in the context of social and structural/institutional factors, including stigma, discrimination, and violence. (NHAS 4.1)
- b) System Activity 3.3: Enhance the quality, accessibility, sharing, and uses of data, including HIV prevention and care continuum data and social determinants of health data. (NHAS 4.3)
- c) System Activity 3.4: Foster public-private-community partnerships to identify and scale up best practices and accelerate HIV advances. (NHAS 4.4)
- d) System Activity 3.5: Improve mechanisms to measure, monitor, evaluate, and use the information to report progress and course correct as needed to achieve the strategy's goals. (NHAS 4.5)

Key Partners: Healthcare systems CEO, New Jersey Board of Medical Examiners, public and private payors, the Northeast Caribbean AETC (NECAETC), NJDOH, NJHPG, New Jersey Advisory Council on HIV, STIs and Viral Hepatitis, New Jersey State League of Municipalities, Legislatures, pharmacies, STI clinics, substance use treatment centers, mental/behavioral health providers, and family planning clinics.

Leading Entities: NJHPG and NJDOH

Potential Funding Sources: CDC, HRSA, state appropriations, foundations, private sector partnerships/corporate social responsibility, etc.

Estimated Funding Allocation: a proportion of HRSA Ryan White Part B funding (\$5,721,020) and CDC PS24-0047 funding for core and EHE prevention services (approximately 14,286,819)), and state appropriations (\$22,725,303).

Outcomes (reported annually, locally monitored more frequently): # of community conversations, # of stakeholder meetings and lists of attendees, # and type of MOAs/MOUs and Letter of Commitment regarding integration and coordination activities, and # and type of trainings with participant demographics. Outcomes will be monitored quarterly with annual reporting.

Monitoring Data Sources: Enhanced HIV/AIDS Reporting System (eHARS), Medical Monitoring Project (MMP), EvaluationWeb, PrEP Database, CDRSS, community conversations. and additional databases created to evaluate and monitor objectives and strategies,

Expected Impact on the HIV Care Continuum: Increase the number of people living with HIV linked to care, increase the number of at-risk HIV negative persons enrolled in PrEP, increase the number of

people living with HIV who are virally suppressed.

Diagnose

Goal 5: Work towards promoting access to testing so that 100% of persons living with HIV know their status, as evident through increased testing numbers, educational campaigns, the uptake of routine screening, and the expansion of testing in non-traditional sites by 2031.

Overarching Program Activities and Strategies:

- a) System Activity 5.1: Increase awareness of HIV-related disparities through data collection, analysis, and dissemination of findings.
- b) Program Activity 5.1: Increase knowledge of HIV among people, communities, and the health workforce in geographical areas disproportionately affected.
- c) Program Activity 5.2: Integrate HIV messaging into existing campaigns and other activities pertaining to other parts of the syndemic, such as STIs, viral hepatitis, substance use, and mental health disorders, as well as in primary care and general wellness, and as part of annual reproductive health visits and wellness visits.

Objective A: Work with all healthcare providers in the public and private sectors to conduct routinized HIV testing according to the Centers for Disease Control and Prevention guidelines and USPSTF recommendations (NHAS 1.2.1).

- a) Systems Activity 5.2: Work with NJ's healthcare systems to incorporate prompts in electronic health records to facilitate routine HIV testing. (NHAS 1.2.2)
- b) Program Activity 5.5: Provide or facilitate professional education and/or training to healthcare providers in the locations listed above on HIV, acute HIV infection, HIV testing, and how to properly support a client who has tested positive. (NHAS 1.1.2, 1.2.2)
- c) Program Activity 5.7: Work with emergency departments in key cities to ensure that they have staff who can perform HIV testing and counseling on-site at all times. (NHAS 1.2.2)
- d) Program Activity 5.8: Develop an awareness campaign about the Ryan White HIV/AIDS program and the state care network for non-Ryan White providers and encourage people to ask for testing if it is not offered during regular medical visits. (NHAS 1.1.1)
- e) Policy Activity 5.3: Work in collaboration with the New Jersey State League of Municipalities (NJLM) to include routine HIV screening and evidence-based treatment for mental illness, substance use, and co-occurring infections as topics presented at the annual NJLM Conference. (NHAS 1.1.2)

Objective B: Promote targeted testing for all New Jerseyans in priority populations.

- a) Systems Activity 5.5: NJDOH DSSUS shall take appropriate measures to provide more accurate, timely surveillance data to facilitate targeted testing initiatives. (NHAS 2.2.1)
- b) Program Activity 5.11: Use social media and dating/hook-up apps to advertise and perform outreach for engagement in HIV testing. Advertising campaigns should be varied and up to date. (NHAS 3.6.2)

Objective C: Provide expanded screening for HIV in non-traditional settings.

- a) Systems Activity 5.7: Work with non-traditional screening sites to ensure access to rapid, fourth-generation HIV testing. (NHAS 1.2.2)
- b) Systems Activity 5.9: Provide capacity building and technical assistance access from various stakeholders to help funded sites develop and/or enhance their ability to appropriately bill health insurance payers for HIV screening. (NHAS 3.4.2)
- c) Program Activity 5.12: Create an educational module and/or awareness campaigns to provide guidance on performing HIV screening and testing and how to ask your provider for an HIV test. (NHAS 3.4.3)
- d) Policy Activity 5.5: Work in collaboration with the New Jersey Local Boards of Health to provide educational training to staff members on HIV screening. (NHAS 1.2.1)

Key Partners: Healthcare systems CEO, New Jersey Board of Medical Examiners, public and private payors, the Northeast Caribbean AETC (NECAETC), NJDOH, NJHPG, New Jersey State League of Municipalities, Legislatures, pharmacies, STI clinics, substance use treatment centers, mental/behavioral health providers, and family planning clinics.

Leading Entities: NJHPG and NJDOH

Potential Funding Sources: CDC, HRSA, state appropriations, foundations, private sector partnerships/corporate social responsibility, etc.

Estimated Funding Allocation: a proportion of HRSA Ryan White Part B funding (\$5,721,020) and CDC PS24-0047 funding for core and EHE prevention services (approximately 14,286,819)), and state appropriations (\$22,725,303).

Outcomes (reported annually, locally monitored more frequently): Increase the number of people aware of their HIV status by 2.5% by 12.31.2031; # of educational campaigns; # of emergency departments routinely screening for HIV; # of non-traditional settings offering HIV testing. Outcomes will be monitored quarterly with annual reporting.

Monitoring Data Sources: Enhanced HIV/AIDS Reporting System (eHARS), Medical Monitoring Project (MMP), Counseling and Testing Data, PrEP Data and other data-resources.

Expected Impact on the HIV Care Continuum: Increase the number of people living with HIV linked to care, increase the number of at-risk HIV negative persons enrolled in PrEP.

Treat

Goal 6: Promote access and linkage to care so that 90% of persons diagnosed with HIV/AIDS are virally suppressed by 2031.

Objective A: Ensure access and linkage to HIV treatment for persons living with HIV.

The Overarching Strategy: Promote access to treatment as prevention (TasP)

- a) Program Activity 6.1: Expand and integrate non-medical case management and linkage-to-care support for all people with HIV across public and private healthcare sectors. This aims to

ensure comprehensive access to social services and adherence support, leveraging successful models beyond traditional programs like Ryan White. (NHAS 3.4.3 and 3.4.4)

- b) Program Activity 6.2: Adopt a “Test-and-Treat” protocol, known as “early treatment initiation, to assist clients who are newly diagnosed with HIV in getting linked to treatment quickly and disseminate an educational module in all clinical facilities. (NHAS 2.1.1 and 3.4.3)

Objective B: Promote retention in care for persons living with HIV.

- a) Systems Activity 6.3: Identify and eliminate barriers preventing individuals from engaging in or remaining in HIV care, while simultaneously addressing service gaps to interrupt rapid HIV transmission, particularly among men who have sex with men (MSM) and other key populations.
- b) Program Activity 6.3: Encourage HIV care and PrEP providers to make telemedicine services widely available to address barriers to care, such as transportation issues. (NHAS 2.3.3)

Objective C: Enhance and streamline support services for persons living with HIV.

- a) Systems Activity 6.7: Enhance relationships with relevant state agencies and care institutions across the state to make access to support services easier and more robust, thereby addressing complex health and social needs. (NHAS 4.2 and 4.4)
- b) Systems Activity 6.8: Work with partners to encourage state and county correctional facilities to provide linkage to care to the Ryan White HIV/AIDS Program for incarcerated individuals living with HIV in the county of their residence. (NHAS 3.4.4 and 3.4.6)
- c) Systems Activity 6.9: Identify opportunities to expand housing vouchers available for both Housing Opportunities for Persons with AIDS (HOPWA) and Section 8. Encourage coordination between HOPWA and Section 8. (NHAS 3.4.4 and 3.4.6)
- d) Program Activity 6.5: Encourage the reinstatement of faith-based public health programming to reach more individuals, combat stigma, and build supportive communities. (NHAS 3.1.5)

Objective D: Expand capacity to provide whole-person care to older adults with HIV and long-term survivors.

- a) Program Activity 6.6: Develop and implement a comprehensive, multi-sectoral strategy for healthy aging with HIV, focusing on identifying and integrating specialized models of care, addressing the unique psychosocial and behavioral health needs of older people with HIV and long-term survivors (including substance use, mental health, and social isolation), increasing the capacity and collaboration of a wide range of aging and medical service providers, and fostering multi-agency partnerships to address evolving challenges. (NHAS 2.5.1, 2.5.2, 2.5.3, and 2.5.5)

Key Partners: Public and private payors, medical societies, NJDOH, NJHPG, EMAs, TGAs, private sector, New Jersey congressional delegation, NECAETC, healthcare systems CEOs, other New Jersey state agencies, HOPWA, section 8 administrators, faith-based organizations, the attorney general’s office, and the New Jersey Division on Civil Rights.

Leading Entities: NJHPG, EMAs, TGAs, New Jersey Taskforce to End the HIV Epidemic, and NJDOH

Potential Funding Sources: CDC, HRSA, state appropriations, foundations, private sector partnerships/corporate social responsibility, etc.

Estimated Funding Allocation: a proportion of CDC PS24-0047 funding for core and EHE prevention services (approximately 14,286,819), state appropriations (\$22,725,303), and HOPWA funding (approx... \$2mil).

Outcomes (reported annually, locally monitored more frequently): Increase linkage to care by 5% by 12.31.2031, increase viral load suppression by 5% by 12.31.2031, # of campaigns, create a searchable public-facing resources/support services database, and summaries of several community conversations with older adults with HIV. Outcomes will be monitored quarterly with annual reporting.

Monitoring Data Source: Enhanced HIV/AIDS Reporting System (eHARS), Medical Monitoring Project (MMP), Counseling and Testing Data, Prep Data, and other data platforms and resources.

Expected Impact on the HIV Care Continuum: increase the number of people living with diagnosed HIV who are linked to care and increase the number of people with diagnosed HIV who are virally suppressed.

Prevent

Goal 7: Reduce the number of HIV infections by 75% with an equitable focus on New Jersey's priority, disproportionately infected and affected populations, by 2031.

Objective B: Promote full access to and the expansion of biomedical interventions to prevent and treat HIV.

Overarching Strategy 1: Promote access to post-exposure prophylaxis (PEP) for HIV prevention. (NHAS 1.3.3)

- a) Systems Activity 7.1: Develop a PEP protocol for emergency rooms and urgent care centers to assist providers in these settings in responding to potential HIV transmission. The protocol should follow CDC guidelines and specifically consider the needs of sexual assault survivors.
- b) Program Activity 7.1: Expand and streamline access to PrEP and PEP across New Jersey by implementing innovative delivery models like TelePrEP and Same-Day PrEP, and considering a broader prevention case management program for HIV-vulnerable populations with complex needs.
- c) Stigma Activity 7.1: Create culturally appropriate education and awareness campaigns that address HIV-related services

Overarching Strategy 2: Promote access to pre-exposure prophylaxis (PrEP) for HIV prevention (NHAS 1.3.3)

- d) Stigma Activity 7.2: The existing AIDS Education and Training Centers (AETCs) and other partners should work with educational entities in NJ to develop a continuing education module for providers on the PrEP process and prescribing.

Key Partners: Healthcare System CEOs, urgent care centers, NECAETC, NJHPG, NJDOH, Board of

Medical Examiners, medical societies, family planning clinics, other state agencies, and the private sector.

Leading Entities: NJHPG, NJDOH,

Potential Funding Sources: CDC, HRSA, state appropriations, foundations, private sector partnerships/corporate social responsibility, etc.

Estimated Funding Allocation: a proportion of CDC PS24-0047 funding for core and EHE prevention services (approximately 14,286,819)), and state appropriations (\$22,725,303).

Outcomes (reported annually, locally monitored more frequently): Increase by 7% the number of people prescribed PrEP by [12.31.2031](#); and create a searchable, public-facing resources/support services database. Outcomes will be monitored quarterly with annual reporting.

Monitoring Data Source: Enhanced HIV/AIDS Reporting System (eHARS), Medical Monitoring Project (MMP), Counseling and Testing Data, and PrEP Data.

Expected Impact on the HIV Care Continuum: Treatment as Prevention (TasP) increase the number of people living with diagnosed HIV who are linked to care; increase the number of people with diagnosed HIV who are virally suppressed; decrease the number of people living with diagnosed HIV with unmet need (without a CD4 or VL in the calendar year); and decrease the number of people living with diagnosed HIV in care but not virally suppressed (medication adherence).

Respond

Goal 8: Swiftly detect clusters by entering 75% of laboratory test results into the local HIV surveillance system 14 days after the date of specimen collection annually.

Key Activities and Strategies:

- a) Program Activity 8.1: Establish regional and statewide learning collaboratives to annually review data on new HIV diagnoses, identify priority populations and pinpoint areas for systemic improvement in HIV prevention and response. These collaboratives will ensure that all intervention strategies for HIV clusters comprehensively address transmission prevention, fostering a targeted and effective public health response. ([NHAS 1.3](#))

Key Partners: NJDOH, local health departments, NJHPG.

Leading Entity: NJDOH

Potential Funding Sources: CDC, HRSA, state appropriations, foundations, private sector partnerships/corporate social responsibility, etc.

Estimated Funding Allocation: a proportion of CDC PS24-0047 funding for core and EHE prevention services (approximately 14,286,819)), and state appropriations (\$22,725,303).

Outcomes (reported annually, locally monitored more frequently): Finalization of response plan and implementation by [12.31.2031](#). Outcomes will be monitored quarterly with annual reporting.

Monitoring Data Source: Enhanced HIV/AIDS Reporting System (eHARS), Medical Monitoring

Project (MMP), Counseling and Testing Data, Time and Space analysis, Geo-typing analysis and PrEP Data.

Expected Impact on the HIV Care Continuum: Increase the number of people living with diagnosed HIV infection (contact tracing/partner notification); increase the number of people living with diagnosed HIV who are linked to care; and increase the number of people with diagnosed HIV who are virally suppressed.

Updates on Other Strategic Plans Used to Meet Requirements

Withstanding the abovementioned strategies that address systems, programs, policies, and stigma, no portions of another local strategic plan were used to satisfy this requirement.

Section VIII: 2027 – 2031 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up

2027 – 2031 Integrated Planning Implementation Approach

The New Jersey HIV Planning Group (NJHPG) in partnership with the New Jersey Department of Health (NJDOH), is responsible for implementing the Integrated Plan. The NJHPG structure shown in Figure 34, includes six standing committees: the Executive Committee, Governance Committee, Data and Research Committee, Priority Setting Committee, Integrated Plan Committee, and Community Engagement Committee.

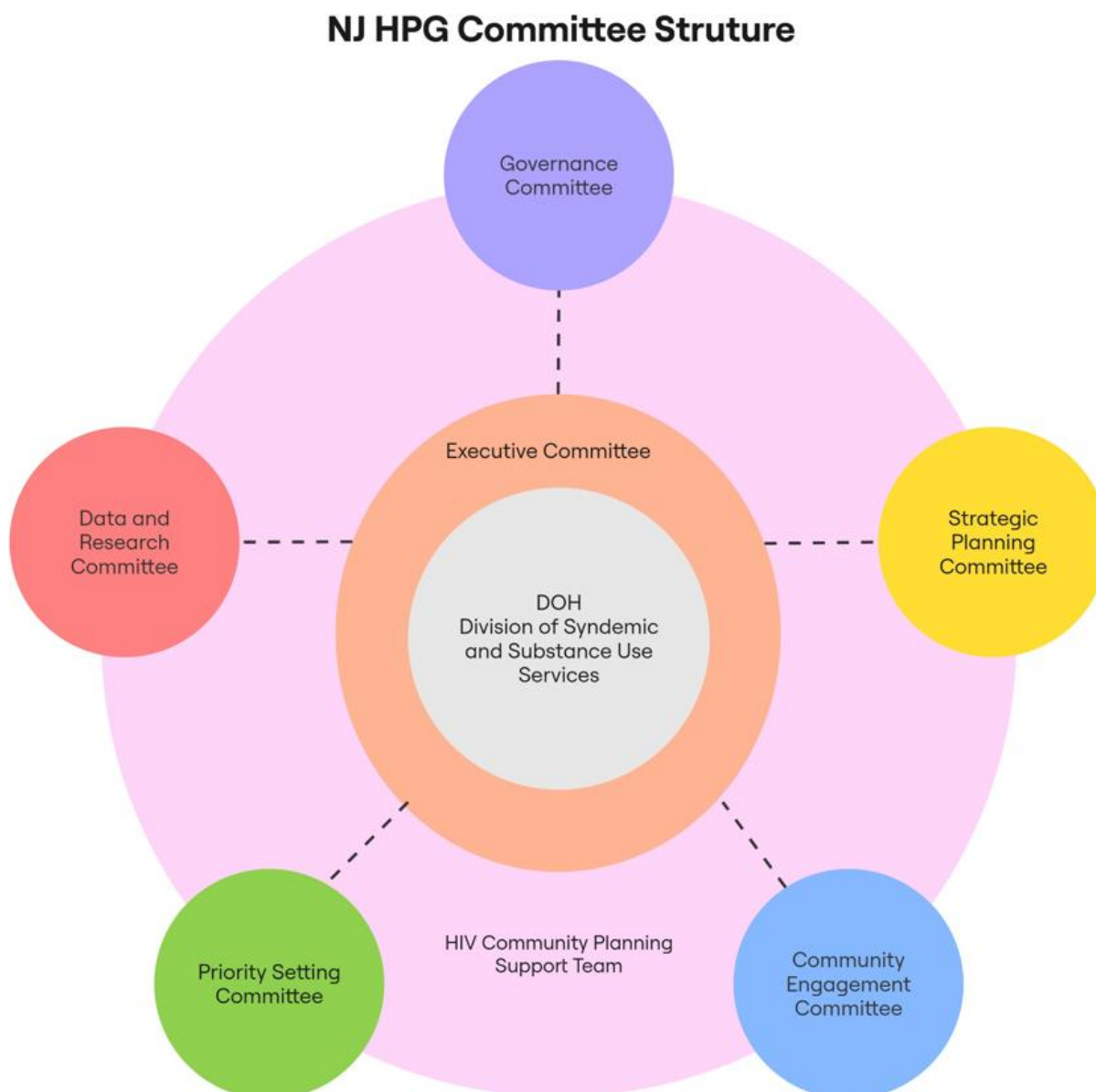
The New Jersey HIV Planning Group (NJHPG) established 10 objectives:

- Review the New Jersey Department of Health (NJDOH), Division of Syndemic and Substance Use Services (DSSUS) HIV Epidemiologic Profile
- Conduct a needs assessment
- Maintain a resource inventory
- Conduct a gap analysis
- Identify prevention strategies and interventions
- Identify care and treatment needs
- Prioritize populations and interventions
- Update, as required, the Statewide Coordinated Statement of Need (SCSN) document
- Produce a Statewide Integrated HIV Prevention and Care Plan

A key objective of the NJHPG/NJDOH partnership is to develop and support a comprehensive plan for the delivery of HIV care, treatment, and prevention services across New Jersey. The NJHPG structure also supports the NJDOH DSSUS in the planning, implementation, and evaluation of HIV prevention, care, and treatment services statewide.

People living with HIV are actively involved in the **New Jersey HIV Planning Group (NJHPG)** and statewide planning as voting members, active committee members, and offering public input during meetings. Their direct, lived-experience helps guides the implementation, monitoring, evaluation, and continuous improvement of New Jersey's Integrated HIV Prevention and Care Plan.

Figure 23: The Restructured New Jersey HIV Planning Group



Implementation

Process for Coordinating Partners

The NJHPG in coordination with the NJDOH is responsible for coordinating partners to support implementation of the State's Integrated HIV Prevention and Care Plan and advance the goal of leveraging strategic partnerships to prioritize efforts, focus resources, and implement evidence-informed interventions for individuals diagnosed with HIV. The NJHPG facilitates this coordination through quarterly meetings of the full planning body and monthly standing committee meetings, which include representation from public health agencies, healthcare providers, community-based organizations, and people with lived experience. A digital tool is maintained to provide updates on implementation progress, plan revisions, meeting information, and shared resources for stakeholders. An Integrated Plan tracking table is maintained to provide updates on implementation progress. In addition, the NJHPG and NJDOH convene public and private meetings with stakeholders to discuss plan revisions, shared resources, emerging and unmet needs, coordinate service delivery strategies, and align funding and interventions with statewide priorities, including linkage to care, retention in care, treatment access, and prevention services.

Explain how the plan will leverage and coordinate funding streams, including but not limited to HRSA-HAB and CDC funding.

The NJDOH DSSUS will continue to leverage HRSA-HAB and CDC funding, with input from the New Jersey HIV Planning Group and the Priority Setting Committee. Furthermore, DSSUS will continue to annually request, with justification, state-appropriated funding in New Jersey's annual budget to support HIV prevention, care, and treatment programs and services. Lastly, the Integrated Plan Committee of the New Jersey HIV Planning Group will identify and pursue foundation and private-sector funding (corporate social responsibility or environmental, social, and governance) to further support integrated plan activities and strategies.

Monitoring

The New Jersey HIV Planning Group and the NJDOH DSSUS will continue monitoring current and additional metrics toward goal achievement, using, in part, [NEW JERSEY HIV PLANNING GROUP Universal Reporting Tool](#) and [NEW JERSEY HIV PLANNING GROUP Monitoring and Evaluation Guidance](#). The data sources for monitoring include, but are not limited to, the Enhanced HIV/AIDS Reporting System (eHARS), the Medical Monitoring Project (MMP), EvaluationWeb, the NJ HIV Data System, surveys, and community conversations. Preliminary or baseline data will be assessed and shared with the NJHPG quarterly and annually. The quarterly updates will measure progress to date toward goal achievement and adjust the integrated plan, guided by data-to-action. Moreover, progress to date will be updated quarterly. The implementation section above describes how the jurisdiction will coordinate different stakeholders and funding streams to implement the plan's goals.

Evaluation

New Jersey currently measures progress toward goals with current measures, including but not limited to new diagnoses, knowledge of status, linkage to medical care, viral suppression, PrEP, homelessness, and stigma. These are aligned across the four pillars of diagnose, treat, prevent, and respond. The measures will be analyzed by and presented to the New Jersey HIV Planning Group

quarterly. Please see the methodology, the numerators and denominators for each measure, the inclusion and exclusion criteria, the sources of information, and the corresponding pillar for each measure.

1. Measure One: New Diagnosis
 - a. Pillar: Diagnose
 - b. Method: Number of new diagnoses in eHARS that meet the case definition
 - c. Numerator: The number of people who have received an HIV diagnosis, regardless of the stage of the disease (Stage 0, 1, 2, 3, or unknown) during a given time period, regardless of when they become HIV positive.
 - d. Denominator: N/A
 - e. Inclusion Criteria: Confirmation through laboratory or clinical evidence during a calendar year
 - f. Exclusion Criteria: N/A
 - g. Source: HIV surveillance data
2. Measure Two: Knowledge of Status
 - a. Pillar: Diagnose
 - b. Method: CD4 Based Model
 - c. Numerator: Estimated number of persons aged ≥ 13 years at diagnosis
 - d. Denominator: Estimated HIV Prevalence
 - e. Inclusion Criteria: N/A
 - f. Exclusion Criteria: N/A
 - g. Source: HIV surveillance data and CD4 data for persons aged ≥ 13 years at diagnosis
3. Measure Three: Linkage to Medical Care
 - a. Pillar: Treat
 - b. Method: N/A
 - c. Numerator: Number of persons who received a CD4 or viral load tests within 30 days after HIV diagnosis
 - d. Denominator: Number of persons with new HIV diagnosis in a given year
 - e. Inclusion Criteria: N/A
 - f. Exclusion Criteria: N/A
 - g. Source: HIV surveillance data
4. Measure Four: Viral Suppression
 - a. Pillar: Treat
 - b. Method: N/A
 - c. Numerator: Number of persons living with diagnosed HIV who have a low viral load (<200 copies per ml)
 - d. Denominator: Estimated number of persons aged ≥ 13 years living with diagnosed HIV
 - e. Inclusion Criteria: N/A
 - f. Exclusion Criteria: N/A
 - g. Source: HIV surveillance data
5. Measure One: PrEP
 - a. Pillar: Prevent
 - b. Method: N/A
 - c. Numerator: Number of persons who have been prescribed PrEP

- d. Denominator: Estimated number of persons who had indications for PrEP
 - e. Inclusion Criteria: N/A
 - f. Exclusion Criteria: N/A
 - g. Source: CDC and IQVIA Pharmacy database
6. Measure One: Homelessness
- a. Pillar: All
 - b. Method: N/A
 - c. Numerator: Point in Time Count of Sheltered and Unsheltered Persons with HIV/AIDS by HUD-assisted CoC Homeless Assistance Program in a given year
 - d. Denominator: N/A
 - e. Inclusion Criteria: N/A
 - f. Exclusion Criteria: N/A
 - g. Source: Continuums of Care (CoCs) by U.S. Department of Housing and Urban Development
7. Measure One: Stigma
- a. Pillar: All
 - b. Method: N/A
 - c. Numerator: The median score is derived from responses to a ten-item scale ranging from 0 (no stigma) to 100 (high stigma) that measures four dimensions of HIV stigma: personalized stigma since HIV diagnosis, current disclosure concerns, current negative self-image, and current perceived public attitudes about people living with HIV.
 - d. Denominator: N/A
 - e. Inclusion Criteria: N/A
 - f. Exclusion Criteria: N/A
 - g. Source: Medical Monitoring Program data

Improvement

Performance measures will be assessed quarterly and shared with the New Jersey HIV Planning Group; the healthcare, public health, and social services systems; and other public and private partners and stakeholders. Moreover, the Community Engagement Committee of the New Jersey HIV Planning Group will present progress on integrated plan performance measures to the community twice per year for inclusive feedback in making revisions and improvements to the plan. Revisions to the plan will occur at least annually, if not more frequently, with final decisions made by the NJHPG with input from collaborating partners and the community.

Reporting and Dissemination

The restructuring of the New Jersey HIV Planning Group included the development of a dedicated Integrated Plan Committee. As reiterated throughout the plan section, a dedicated webpage hosts the integrated plan, including a metric dashboard monitoring progress to date. NJHPG will engage and keep coordinating partners abreast of progress on the Integrated Plan through regular meetings. The state will continue monitoring the identified performance measures toward goal achievement quarterly. The quarterly progress on performance measures will be updated on the dedicated integrated plan webpage.

Including collaborating partners and the community in revisions to the plan will ensure stakeholders are aware of the improvements made.

Figure 24: Infographic on the Monitoring and Evaluation Process

**the Priority Setting Committee was formerly names the Integrated Plan Committee (seen in this infographic)*



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Appendix A: HIV Prevention and Care Service Inventory List

Inventory Narrative

The New Jersey Department of Health (NJDOH), Division of Syndemic and Substance Use Services (DSSUS) receives funding from several state and federal sources, including the Centers for Disease Control and Prevention (CDC), the Ryan White HIV/AIDS Program, and cooperative agreements with other divisions within the department and with other state agencies. DSSUS leverages resources by braiding multiple funding streams to address service gaps and strengthen HIV prevention, care, treatment, and supportive services throughout the state. The ability to review funding streams, including their flexibilities and limitations, supports the development of comprehensive and responsive programming for the division's grantees. New Jersey will continue to explore opportunities to leverage private funding in coordination with existing public funding sources.

Programs funded by DSSUS seek to maximize the quality and accessibility of health and supportive services available to people at risk for or living with HIV through a status-neutral approach to prevention and care. Funding is awarded to grantees that provide HIV-specific prevention, testing, linkage, treatment, and supportive services, as well as broader services that address social determinants of health. These services include, but are not limited to, housing assistance, food access, sexually transmitted infection (STI) testing and treatment, communicable disease testing and vaccination services, mpox vaccination, and evidence-based treatment for mental illness, substance use, and co-occurring infections that reduce HIV risk and improve overall health outcomes. Together, these investments provide a strong foundation for New Jersey's HIV prevention and care infrastructure and support the diverse needs of communities throughout the state.

An additional statewide resource is NJ 211, staffed by community resource specialists who assist residents in accessing basic needs and supportive services 24 hours a day, 7 days a week, year-round.

Funding Sources

HRSA Ryan White Part B funding (\$5,721,020)
CDC PS24-0047 funding for core and EHE prevention services (approximately \$14,286,819)
state appropriations (\$22,725,303)

Providers: HIV Care and Prevention Services

Statewide

Agency Name	Services	Service Area
Access One, Inc.	HIV Care Services: Emergency Financial Assistance; Medical Case Management; Non-Medical Case Management; Transportation.	Atlantic, Cape May, Cumberland, Mercer, Monmouth, Ocean
AHS Hospital Corp.	HIV Prevention Services: Community/Venue-Based Syndemic and HIV Testing; Linkage to HIV Care and PrEP Counseling and Navigation Services; PrEP.	Morris County
AIDS Resource Foundation for Children	HIV Care Services: Transitional housing; emergency housing hotline; placement.	Essex and surrounding counties
AtlantiCare Health Services, Inc.	HIV Prevention Services: HIV Testing; PrEP; PrEP medication assistance. HIV Care Services: Community Health Worker; adherence; Outpatient Ambulatory; Medical Case Management; Transportation; Mental Health.	Atlantic County
Buddies of New Jersey, Inc.	HIV Prevention Services: HIV and STI Testing.	Bergen County
Camden AHEC	HIV Prevention Services: HIV and STI Testing; PrEP. HIV Care Services: Non-Medical Case Management.	Camden County
Coalition on AIDS in Passaic County, Inc. - CAPCO	HIV Prevention Services: HIV Testing; PrEP; PrEP assistance.	Passaic County
Community Health Care, Inc. DBA CompleteCare Health Network	HIV Prevention Services: HIV Testing; Self-Testing; PrEP. HIV Care Services: Community Health Worker; Medical Transportation; Outpatient Ambulatory; Medical Case Management; Non-Medical Case Management; Mental Health.	Gloucester, Cumberland, Cape May and surrounding counties
Community Health Law Project	HIV Care Services: Legal Services.	Atlantic, Cape May, Cumberland, Mercer, Monmouth, Ocean County
Cooper Health System	HIV Prevention Services: HIV and STI Testing; PrEP. HIV Care Services: Medical Case Management.	Camden County
East Orange Health Department	HIV Prevention Services: HIV Testing; PrEP.	Essex County
EDGE New Jersey	HIV Prevention Services: HIV Testing; PrEP. HIV Care Services: Housing assistance.	Morris County
Henry J. Austin Health Center	HIV Prevention Services: Community/Venue-Based Syndemic and HIV Testing; Linkage to HIV Care and PrEP Counseling and Navigation Services; Telehealth; PrEP. HIV Care Services: Emergency housing; Outpatient Ambulatory; Medical Case Management; Non-Medical Case Management; Transportation; Mental Health; Dental Care.	Mercer County
HMH Hospitals Corporation- Jersey Shore	HIV Prevention Services: HIV and STI Testing. HIV Care Services: Outpatient Ambulatory; Medical Case Management; Non-Medical Case Management; Transportation; Dental; Community Health Worker.	Monmouth County
HMH Hospitals Corporation- Riverview	HIV Care Services: Outpatient Ambulatory; Emergency Financial Assistance; Medical Case Management; Transportation.	Monmouth, Ocean County
HMH Hospitals Corporation- Perth Amboy	HIV Prevention Services: HIV Testing; PrEP. HIV Care Services: Medical Case Management; Non-Medical Case Management.	Middlesex County
Hyacinth AIDS Foundation	HIV Prevention Services: Community/Venue-Based Syndemic and HIV Testing; Linkage to HIV Care and PrEP Counseling and Navigation Services; PrEP; PrEP assistance. Support Services: Health Education/Risk Reduction; Housing and housing case management; Community Health Worker.	Middlesex, Union, Essex, Hudson, Mercer County

Agency Name	Services	Service Area
Iris House, A Center for Women Living with HIV, Inc	HIV Prevention Services: HIV and STI Testing; PrEP. HIV Care Services: Community Health Worker.	Union County
Isaiah House	HIV Care Services: Community Health Worker; Housing; Medical Case Management.	Essex County
Jersey City Connections Inc DBA Hudson Pride CC	HIV Prevention Services: Community/Venue-Based Syndemic and HIV Testing; Self-Testing; Linkage to HIV Care and PrEP Counseling and Navigation Services.	Hudson County
Jersey City Medical Center	HIV Prevention Services: Free-Standing and Routine HIV Testing and Status Neutral Navigation; PrEP navigation. HIV Care Services: Community Health Worker; Medical Case Management.	Hudson County
Kennedy University Hospital Inc.	HIV Prevention Services: HIV Testing. HIV Care Services: Community Health Worker; Medical Case Management; Non-Medical Case Management; Medical co-pays; Mental Health.	Camden County
Monmouth Medical Center	HIV Prevention Services: HIV Testing; PrEP. HIV Care Services: Outpatient Ambulatory; Medical Case Management; Transportation; Mental Health.	Monmouth County
New Jersey Association on Correction	HIV Care Services: Housing.	Monmouth County
Newark Beth Israel Medical Center	HIV Prevention Services: Free-Standing and Routine HIV Testing and Status Neutral Navigation; PrEP; PrEP navigation; Self-Testing; HCV and STI Testing. HIV Care Services: Medical Case Management; Non-Medical Case Management; Emergency Financial Assistance; Community Health Worker; Mental Health.	Essex County
North Jersey AIDS Alliance Inc	HIV Prevention Services: Community/Venue-Based Syndemic and HIV Testing; Linkage to HIV Care and PrEP Counseling and Navigation Services; PrEP; mobile PrEP. HIV Care Services: Transitional Case Management for justice-involved and treatment/medication management.	Essex County
Ocean County Board of Health	HIV Prevention Services: HIV, HCV and STI Testing; PrEP. HIV Care Services: Outpatient Ambulatory; Emergency Financial Assistance; Medical Case Management; Transportation; Community Health Worker.	Ocean County
Paterson City	HIV Prevention Services: HIV Testing; PrEP.	Passaic County
Proceed, Inc.	HIV Prevention Services: HIV and STI Testing; PrEP; PrEP assistance. HIV Care Services: Community Health Worker.	Union County
Rutgers Biomedical and Health Sciences- IDP	HIV Prevention Services: Free-Standing and Routine HIV Testing and Status Neutral Navigation; STI Testing; PrEP; PrEP assistance. HIV Care Services: Community Health Worker; Medical Case Management; Transportation; Mental Health.	Essex County
Rutgers Biomedical and Health Sciences- DAYAM	HIV Prevention Services: HIV Testing; PrEP. HIV Care Services: Medical Case Management; Community Health Worker; Emergency housing assistance.	Essex County
Rutgers Biomedical and Health Sciences- RWJ New Brunswick	HIV Prevention Services: HIV Testing; PrEP.	Middlesex County
Rutgers Biomedical and Health Sciences- EBCH	HIV Prevention Services: Free-Standing and Routine HIV Testing and Status Neutral Navigation. HIV Care Services: Community Health Worker; Emergency housing; Medical Case Management; Transportation.	Hunterdon, Middlesex, Somerset County
Rutgers Biomedical and Health Sciences- Hotline	HIV Prevention Services: 24/7/365 HIV/STD Hotline.	Statewide
Rutgers Biomedical and Health Sciences- Central North Jersey	HIV Care Services: Dental Care.	Bergen, Camden, Cumberland, Essex, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Passaic, Somerset, Sussex County
Rutgers Biomedical and Health Sciences- South Jersey	HIV Care Services: Dental Care.	Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Salem County

Agency Name	Services	Service Area
Saint Barnabas Medical Center	HIV Prevention Services: Routine HIV testing and Status Neutral Navigation.	Bergen, Essex, Hudson, Middlesex, Morris, Passaic, Somerset, Union County
Saint Joseph's Hospital and Medical Center	HIV Prevention Services: Onsite and community HIV testing through a Rapid-Rapid Testing algorithm; case management for people interested in PrEP to navigate labs, quarterly HIV testing, and financial assistance for PrEP. HIV Care Services: Medical Case Management; Dental Care.	Passaic County
Saint Michael's Clinics, Inc	HIV Prevention Services: Free-Standing and Routine HIV Testing and Status Neutral Navigation; PrEP navigation; HCV and STI Testing. HIV Care Services: Community Health Worker; Medical Case Management.	Essex County
South Jersey Against AIDS, Inc DBA South Jersey AIDS Alliance	HIV Prevention Services: Community/Venue-Based Syndemic and HIV Testing; Linkage to HIV Care and PrEP Counseling and Navigation Services. HIV Care Services: Emergency Financial Assistance; Non-Medical Case Management; Transportation; Psychosocial Support Services; Health Education/Risk Reduction; Community Health Worker; Medical Case Management; Housing assistance.	Atlantic, Cape May, Cumberland County
The Center in Asbury Park	HIV Care Services: Housing.	Monmouth County
Trinitas Regional Medical Center	HIV Prevention Services: Community/Venue-Based Syndemic and HIV Testing; Linkage to HIV Care and PrEP Counseling and Navigation Services; PrEP; PrEP assistance.	Union County
Visiting Nurse Association of Central Jersey, Inc.	HIV Prevention Services: HIV and STI Testing; PrEP; PrEP assistance. HIV Care Services: Non-Medical Case Management.	Monmouth County
Zufall Health Center	HIV Prevention Services: HIV and STI Testing. HIV Care Services: Medical Case Management.	Essex County

Bergen-Passaic TGA

Agency Name	Services	Service Area
Bergen Family Center	Psycho Social Support Group; EIS; Medical Case Management; Medical Transportation; Mental Health Services; Referral for Health Care & Support Services	Bergen Passaic
Buddies of New Jersey	Psycho Social Support Group; EIS; Medical Case Management; Medical Transportation; Mental Health Services; Referral for Health Care & Support Services; Nutrition	Bergen Passaic
CAPCO	Psycho Social Support Group; EIS; Medical Case Management; Medical Transportation; Mental Health Services; Referral for Health Care & Support Services; Nutrition; Substance Abuse; Health Education/Risk Reduction	Bergen Passaic
City of Passaic / Passaic Alliance	Medical Case Management; Referral for Health Care & Support Services; Health Insurance Premium; Health Education/Risk Reduction	Bergen Passaic
Hackensack University Medical Center	Outpatient/Ambulatory Health Services; Medical Transportation	Bergen Passaic
Hyacinth AIDS Foundation	Medical Case Management/Treatment Adherence; EIS; Mental Health Services; Referral for Health Care & Support Services	Bergen Passaic
Northeast New Jersey Legal Services	Other Professional Services (Legal)	Bergen Passaic
Paterson Counseling Center	Medical Case Management; Outpatient/Ambulatory Services; Mental Health Services; Referral for Health Care & Support Services; Substance Abuse Treatment	Bergen Passaic

Agency Name	Services	Service Area
St. Joseph's Hospital - Comprehensive Care	Dental; EIS; Medical Case Management; Outpatient/Ambulatory Services; Mental Health Services	Bergen Passaic
St. Mary's Hospital	Medical Case Management; Outpatient/Ambulatory Services	Bergen Passaic
Straight and Narrow, Inc.	Medical Case Management; Referral for Health Care & Support Services; Substance Abuse Treatment	Bergen Passaic
Team Management 2000, Inc.	EIS; Medical Transportation; Medical Case Management; Substance Abuse Treatment; Health Education/Risk Reduction	Bergen Passaic

Hudson TGA

Agency Name	Services	Service Area
Center For Comprehensive Care	Outpatient Ambulatory Health Services; Medical Case Management; Health Insurance Premium and Cost Sharing; Mental Health; Oral Health; Medical Transportation; MAI Medical Case Management; MAI Outpatient Ambulatory Health Services.	Hudson County
North Hudson Regional Health	Outpatient Ambulatory Health Services; Medical Case Management; Mental Health; Substance Abuse; MAI Medical Case Management.	Hudson County
God's Love We Deliver	Home Delivered Meals.	Hudson County
Hyacinth	Other Professional Services (Legal).	Hudson County
Hudson Connections	MAI Outreach.	Hudson County

Middlesex-Somerset-Hunterdon TGA

Agency Name	Services	Service Area
Central Jersey Legal Services	Legal Services	Middlesex, Somerset, Hunterdon
Eric B. Chandler Health Center	Outpatient Medical Care; Medical Case Management; Oral Health (for EBCHC patients only); Support Groups	Middlesex, Somerset, Hunterdon
George Otolowski Mental Health Program	Mental Health	Middlesex, Somerset, Hunterdon
Hyacinths AIDS Foundation	Housing; Emergency Financial Assistance; Mental Health; Psychosocial Support	Middlesex, Somerset, Hunterdon
Legal Services for NW NJ	Legal Services	Middlesex, Somerset, Hunterdon
Middlesex County Office of Human Services	Food Program (must be referred by a medical case manager)	Middlesex, Somerset, Hunterdon
New Brunswick Counseling Center	Substance Use Treatment	Middlesex, Somerset, Hunterdon

Agency Name	Services	Service Area
Raritan Bay Medical Center	Outpatient Medical Care; Medical Case Management	Middlesex, Somerset, Hunterdon
Rutgers/RWJ Peds	Medical Case Management (insured patients only)	Middlesex, Somerset, Hunterdon
Robertwood Johnson Barnabus Dental Suite	Oral Health	Middlesex, Somerset, Hunterdon
Somerset Treatment Services	Mental Health Services for individuals with co-occurring disorder; Substance Use Treatment	Middlesex, Somerset, Hunterdon
Visiting Nurse Health Group	Medical Case Management; Outreach	Middlesex, Somerset, Hunterdon
Zufall Health-Plainsboro	Same as those offered in Somerville; services only available to their medical patients	Middlesex, Somerset, Hunterdon
Zufall Health-Somerville	Outpatient Medical Care; Health Insurance Assistance; Medical Case Management; Mental Health; Oral Health; Emergency Financial Assistance; Psychosocial Support; Transportation	Middlesex, Somerset, Hunterdon

Newark EMA

Agency Name	Services	Service Area
AIDS Resource Foundation	Emergency Financial Assistance; Transportation; Nutritional Services; Case Management	Essex County
Apostles House	Housing and Related Services; Emergency Financial Assistance; Nutritional Services; Non-Medical Case Management; Food Bank/Home-Delivered Meals (Nutritional Services)	Essex County
Broadway House	Medical Case Management; Outpatient Substance Use - Individual; Nutritional Therapy; Mental Health - Individual; Psychosocial Support	Essex County
Catholic Charities of the Archdiocese of Newark (Saint Bridget's)	Housing & Related Services; Outpatient Substance Use - Individual; Outpatient Substance Use - Group; Mental Health - Individual; Transportation; Non-Medical Case Management	Essex County
Community Health Law Project	Other Professional Services	Essex County
DHCW Special Care Clinic	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Health Insurance Premium Assistance; Emergency Financial Assistance; Early Intervention Services	Essex County
Hyacinth	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Outpatient Substance Use - Individual; Emergency Financial Assistance; Psychosocial Support; Mental Health - Individual; Non-Medical Case Management; Other Professional Services	Essex County
Isaiah House	Housing and Related Services; Non-Medical Case Management	Essex County
Newark Beth Israel	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Oral Health Care; Emergency Financial Assistance; Mental Health - Individual; Health Insurance Premium Payment Assistance	Essex County

Agency Name	Services	Service Area
Newark Community Health Centers	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Medical Nutritional Therapy; Mental Health - Individual; Oral Health Care; Early Intervention Services	Essex County
North Jersey Community Research Initiative (NJCRI)	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Substance Use Outpatient Care - Individual; Emergency Financial Assistance; Psychosocial Support; Mental Health - Individual; Food Bank/Home-Delivered Meals (Nutritional Services); Oral Health Care; Health Insurance Payment Assistance	Essex County
Positive Health Care, Inc.	Outpatient Substance Use - Individual; Emergency Financial Assistance; Psychosocial Support; Non-Medical Case Management	Essex County
Urban Renewal	Housing and Related Services; Transportation; Non-Medical Case Management	Essex County
St. James Social Services	Emergency Financial Assistance; Nutritional Services; Non-Medical Case Management	Essex County
St. Michael's - Peter Ho Clinic	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Outpatient Substance Use - Individual; Psychosocial Support; Mental Health - Individual; Dental; Health Insurance Premium Payment Assistance; Early Intervention Services	Essex County
Smith Center	Medical Case Management; Outpatient/Ambulatory Health Services; Mental Health - Individual; Medical Transportation	Essex County
Team Management	Outpatient Substance Use - Individual; Emergency Financial Assistance; Psychosocial Support; Mental Health - Individual; Transportation; Non-Medical Case Management	Essex County
Rutgers (Dental)	Dental	Essex County
Rutgers (FXB)	Medical Case Management; Primary Medical Care	Essex County
Rutgers (HIV Clinic)	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Outpatient Substance Use - Individual; Nutritional Therapy; Mental Health - Individual; Transportation; Early Intervention; Emergency Financial Assistance; Health Insurance Premium Payment Assistance	Essex County
Rutgers (START)	Medical Case Management; Primary Medical Care; Emergency Financial Assistance; Psychosocial Support; Mental Health - Individual; Health Insurance Premium; Early Intervention Services	Essex County
Central Jersey Legal	Other Professional Services	Union County
Iris House	Psychosocial Support; Transportation; Nutritional Services; Case Management	Union County
Neighborhood Health Center	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Outpatient Substance Use - Individual; Nutritional Therapy; Mental Health - Individual; Dental	Union County
PROCEED	Housing and Related Services; Emergency Financial Assistance; Psychosocial Support; Mental Health - Individual; Case Management	Union County
Trinitas Regional Medical Center EIP	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Psychosocial Support; Mental Health - Individual; Transportation	Union County

Agency Name	Services	Service Area
EDGE, New Jersey	Medical Case Management; Primary Medical Care; Outpatient Substance Use - Individual; Emergency Financial Assistance; Psychosocial Support; Mental Health - Individual; Transportation; Case Management; Health Insurance Premium; Early Intervention Services	Tri-County
Morristown Memorial Hospital	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Emergency Financial Assistance; Mental Health - Individual; Transportation; Dental; Health Insurance Premium; Early Intervention Services	Tri-County
CFCS Hope House	Medical Case Management; Emergency Financial Assistance; Psychosocial Support; Transportation; Nutritional Services; Case Management	Tri-County
Zufall Health Center	Medical Case Management; Primary Medical Care; Primary Medical Care - LABS; Emergency Financial Assistance; Nutritional Therapy; Mental Health - Individual; Transportation; Dental; Health Insurance Premium; Early Intervention Services	Tri-County

Providers: Substance Use Prevention and Treatment Services

DSSUS funds several programs using non-federal funding that supports evidence-based treatment for mental illness, substance use, and co-occurring infections statewide for people living with HIV and individuals at increased risk for HIV acquisition. DSSUS maintains a strong collaborative relationship with the New Jersey Department of Human Services (NJDHS), Division of Mental Health and Addiction Services (DMHAS), which facilitates coordination in the delivery of prevention, treatment, and recovery support services for persons at risk of an overdose.

Medication-Assisted Treatment Centers of Excellence

NJ Medication Assisted Treatment - Centers of Excellence were established by the NJ Department of Human Services to increase access to medications and other services that successfully treat substance use disorders. The COEs achieve this goal by educating and mentoring providers, growing networks of MAT providers, and research.

Center of Excellence	Institution
Northern COE	Rutgers New Jersey Medical School
Southern COE	Cooper University Health Care / Rowan University School of Osteopathic Medicine

Family Support Center Programs

Agency Name	Service Area
CarePlus New Jersey Family Support Center Program	Northern Region (Bergen, Essex, Hudson, Morris, Passaic, Sussex and Warren Counties)
Prevention Resources Family Support Center Program	Central Region (Hunterdon, Mercer, and Somerset Counties)
Prevention Links Family Support Center Program	Central Region (Middlesex, Monmouth, and Union Counties)
Center for Family Services - Family Support Center Program	Southern Region

Recovery Community Resource Centers

New Jersey's Regional Recovery Centers and Community Peer Recovery Centers (CPRC) provide peer support, information about substance use disorder treatment, recovery support services, and information about other community resources, in a supportive substance free environment. Most activities and services are led and driven by peers (i.e. individuals who have experienced substance use disorders and recovery, either directly or indirectly as a family member or friend). The Recovery Center offers social support and gives those in recovery a place where they feel that they belong, as well as a place where those in recovery can have the opportunity to give back to their community thereby fostering a sense of empowerment and independence.

Agency Name	County
The Recovery Center at Eva's Village	Passaic County
Living Proof Recovery Center (Center for Family Services)	Camden County
John Brooks Recovery Centers - All Roads Recovery Center (Atlantic City location)	Atlantic County
John Brooks Recovery Centers - All Roads Recovery Center (Pleasantville location)	Atlantic County
Bergen New Bridge Medical Center's Recovery Center	Bergen County
Capital Recovery Center (Cumberland County Human Services)	Cumberland, Salem, and Gloucester Counties
Center for Family Services - CFS Living Proof Recovery Center at Rowan College of South Jersey, Gloucester Campus	Gloucester County

Agency Name	County
Morris County Prevention is Key, Inc. - CARES: Center for Addiction Recovery, Education and Success (Newark location)	Essex County
Morris County Prevention is Key, Inc. - CARES: Center for Addiction Recovery, Education and Success (Dover location)	Morris County
The Center for Prevention and Counseling - Sussex County Recovery Community Center	Sussex County
Prevention Links - The Rise Up Recovery Center	Union County
Family Guidance Center of Warren County - Recovery Connections Recovery Center	Warren County

Appendix B: Cycle Summaries for the 122 Original Activities (NJHPG Recommendations)

Cycles of Recommendations

- Cycle 1: 2023
 - Program Activities: 5.8; 5.11; 5.13
 - Systems Activities: 5.3; 5.5; 6.12; 8.1
- Cycle 2: January-June 2024
 - Program Activities: 1.1; 1.2; 1.3; 2.1; 2.2
 - Systems Activities: 1.1
 - Stigma: 1.1
- Cycle 3: July-December 2024
 - Systems Activities: 3.1-3.5; 4.1; 4.2; 4.5; 4.6



2025-Cycle 4 Work Plan

TASKS	Goal 5: 21 Activities											
Integrated Plan	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Stigma Activity 5.3												
System Activity 5.4												
Policy Activity 5.5												
Program Activity 5.7												
Update the Integrated Plan												
Assign Goal 6												
Priority Setting	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Policy Activity 5.2												
Program Activity 5.3												
Program Activity 5.6												
Program Activity 5.9												
Program Activity 5.10												
Program Activity 5.12												



2025-Cycle 4 Work Plan

Community Engagement	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Program Activity 5.1 & 5.4												
Program Activity 5.2												
Stigma Activity 5.2 & 5.4												
Policy Activity 5.3												
System Activity 5.6												
System Activity 5.7 & 5.8												
Data & Research	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
System Activity 5.1												
Policy Activity 5.1												
Stigma Activity 5.1												
System Activity 5.2												
System Activity 5.9												
Update Resource Directory												



2026 Cycle 5 Work Plan

TASKS	Cycle 5 - 2026											
Integrated Plan	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Policy Activity 6.8												
Program Activity 6.11 – 6.14												
Stigma Activity 6.3 & 7.5												
GAC Activities												
Policy Activity 6.2												
Policy Activity 7.1												
Priority Setting	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Program Activity 6.1 & 6.3												
Program Activity 6.8, 6.9, & 7.10												
Program Activity 7.3 – 7.7 & 7.11												
Program Activity 8.1 & 6.4												
Program Activity 6.10												
Prep for 2027												



2026 Cycle 5 Work Plan

Community Engagement	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Stigma Activity 6.1, 6.2, 7.1, 7.2, & 7.4												
Stigma Activity 6.4 & 6.5												
Stigma Activity 6.6												
Program Activity 7.9 & System Activity 7.5												
System Activity 8.1, 8.2, & 6.4												
Prep for 2027												
Data & Research	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
System Activity 6.5												
System Activity 6.6 & 6.7												
System Activity 7.2 & 6.3												
System Activity 7.3												
Policy Activity 6.3 & 6.7												
Policy Activity 7.2 & 7.3												



Appendix C: Letters of Concurrence

Hudson County HIV/AIDS Services Planning Council

H.C.I.A., Ninth Floor
830 Bergen Avenue
Jersey City, New Jersey 07306

Telephone: (201) 324-6222 x 3212 e-mail: hudsonplanningcouncil@gmail.com

Dear New Jersey Department of Health,

The Hudson County HIV/AIDS Services Planning Council concurs with the following submission by the New Jersey Department of Health, Division of Syndemic and Substance Use Services (DSSUS) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (CY) 2027-2031

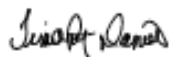
The Hudson County HIV/AIDS Services Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The Hudson County HIV/AIDS Services Planning Council concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The Hudson County HIV/AIDS Services Planning Council was involved in the plan development through the NJ DOH Strategic Planning Workgroup, and the plan was presented to our planning body and EIIHA Committee for review.

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Signature: Timothy Daniels, Chair

Date: 06/26/26





HIV HEALTH SERVICES PLANNING COUNCIL
MIDDLESEX-SOMERSET-HUNTERDON

Dear NJ Department of Health,

The Middlesex-Somerset-Hunterdon Transitional Grant Area (MSHTGA) concurs with reservations with the following submission by the New Jersey Department of Health, Division of Syndemic and Substance Use Services (DSSUS) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

MSHTGA has been provided a presentation that describes key elements of the plan in June of 2026. Based on this presentation, the NJHPG Prevention and Care Plan submission to the CDC and HRSA describes how programmatic activities and resources are being allocated to the most disproportionately affected people and communities and geographical areas with high rates of HIV. The MSHTGA HIV Health Services Planning Council Executive Committee concurs with reservations that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

MSHTGA members intentionally participated in NJ HIV Planning Group and the Integrated Care Plan committee. There is intentional overlap in membership NJHPG and MSHTGA Planning Council. MSHTGA Planning Council staff also participate in NJHPG. Very recently, a presentation was shared with MSHTGA Executive Committee that describes plan goals and activities that shared the information contained within NJHPG plan.

The signature confirms concurrence with reservations of MSHTGA with the Integrated Care Plan.

Signed:

Jose Roman

Jose Roman, Esquire

Planning Body Chair(s) Date: 23/06/26

Signature:

Email: jdroman@lsnj.org

Planning Council Support
Contact Name: Jennifer Pypiak

Email: mshtga.planning.council.fcc@gmail.com
Phone: 848-202-6131



Tuesday, June 23, 2026

Dear New Jersey Department of Health,

The Paterson-Passaic County-Bergen County HIV Health Services Planning Council concurs with the following submission by the New Jersey Department of Health, Division of Syndemic and Substance Use Services (DSSUS) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (CY) 2027-2031.

The Paterson-Passaic County-Bergen County HIV Health Services Planning Council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The Paterson-Passaic County-Bergen County HIV Health Services Planning Council concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.


Richard Miles (Jun 24, 2026 12:09:22 EDT)
Richard Miles
Planning Council Chair

24/06/26

Date

HIV/AIDS Bureau
Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

Division of HIV Prevention
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30329

Dear New Jersey Department of Health,

The Philadelphia HIV Integrated Planning Council (HIPC) concurs with the following submission by the New Jersey Department of Health, Division of Syndemic and Substance Use Services (DSSUS) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (CY) 2027-2031.

The HIPC has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The HIPC concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

Signatures:

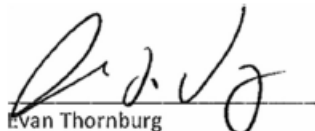
Date: June 11, 2026



Sharee Heaven
Community Co-Chair
Philadelphia HIPC



Tariem Burroughs
Community Co-Chair
Philadelphia HIPC



Evan Thornburg
Governmental Co-Chair

340 North 12th Street
Suite 320
Philadelphia, PA 19107
215-574-6760



Monday, June 29, 2026

Dear New Jersey Department of Health,

The New Jersey HIV Planning Group (NJHPG) concurs with the following submission by the New Jersey Department of Health, Division of Syndemic and Substance Use Services (DSSUS) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (CY) 2027-2031.

The NJHPG has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The NJHPG concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The NJHPG created and facilitated the Strategic Planning Committee with the goal of informing all aspects of the development of the Integrated HIV Prevention and Care Plan. Throughout several months, the HIV Community Planning Support Team supported both in-person and virtual meetings of the Strategic Planning Workgroup. The DSSUS and the NJHPG, with assistance from consultant Sandra Houston, worked in collaboration in the revision process for the Integrated HIV Prevention and Care Plan.

The signature(s) below confirms the concurrence of the planning body with the Integrated HIV Prevention and Care Plan.

With you in community,

On behalf of the New Jersey HIV Planning Group

Saquan J. Stevenson
Saquan Stevenson
Community Co-Chair

Laurie Litt
Laurie Litt
Community Co-Chair

