PUERTO RICO

INTEGRATED HIV SURVEILLANCE, PREVENTION AND CARE PLAN

2022-2026

DEPARTAMENTO DE SALUD

The Puerto Rico Integrated HIV Surveillance, Prevention and Care Plan, 2022-2026 was coordinated by the Department of Health of the Government of Puerto Rico and was developed through the collaboration of a diverse, multi-sectoral group comprised of representatives from the community with a HIV diagnose, non-profit and community-based organizations, prevention and treatment service providers, government agencies and the Academy.

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LIST OF ABBREVIATIONS

CBO – Community Based Organization
CDC - Centers for Disease Control and Prevention
CHCs - Community Health Centers, (Section 330 CHCs)
COC – Continuum of Care, Sistema de Cuidado Continuo para personas sin hogar
CPTETs - Centers for Prevention and Treatment of Transmissible Diseases, mentioned by its Spanish Acronym, Centros para la Prevención y Tratamiento de Enfermedades Transmisibles
HC – Heterosexual Contact
HIV - Human Immunodeficiency Virus
HOPWA - Housing Opportunities for Persons with AIDS Program
HPPG – HIV Prevention Planning Group
HRSA - Health Resources and Services Administration
HUD = Housing and Urban Department
MMP- Medical Monitoring Project
MSA San Juan – Caguas - Guaynabo – Metropolitan Statistical Area of San Juan
MHAASA - Administration of Mental Health and Anti-Addiction Services, mentioned by its Spanish Acronym, ASSMCA, Administración de Servicios de Salud y Contra la Adicción
MSM - Men who have Sex with Men
NECA/AETC - Northeast/Caribbean AIDS Education & Training Center
nPEP – non-occupational post-exposure prophylaxis
OCASET - Central Office for AIDS Affair and Transmissible Diseases, mentioned by its Spanish Acronym, Oficina Central para Asuntos del SIDA y Enfermedades Transmisibles
OCMA - Office of the Commissioner of Municipal Affairs
OITD - Office of Information and Technology Developments
PEP – Post-exposure prophylaxis
PLWA – People living with AIDS
PLWH – People living with HIV infection
PRDCR – Puerto Rico Department of Correction and Rehabilitation
PRDF – Puerto Rico Department of Family
PRDLHR – Puerto Rico Department of Labor and Human Resources
PRDOH –Puerto Rico Department of Health
PrEP – Pre-exposure prophylaxis
PRHIA - Puerto Rico Health Insurance Administration
PRPD- Puerto Rico Police Department
PRPHA- Puerto Rico Public Housing Administration
PID – Persons who inject drugs, (injection drug users IDUs)
RWBPB – Ryan White Part B Planning Body
San Juan EMA, SJEMA– San Juan Eligible Metropolitan Area
SJ MSA – San Juan – Caguas – Guaynabo Metropolitan Statistical Area
STI – Sexually Transmitted Infections
TB – Pulmonary Tuberculosis

SECTION I: EXECUTIVE SUMMARY OF THE PLAN AND SCSN

1. EXECUTIVE SUMMARY OF THE INTEGRATED PLAN AND SCSN

Puerto Rico (PR) is one of the jurisdictions in the United States (U.S.) with the highest incidence and prevalence of Human Immunodeficiency Virus (HIV). As of October 31, 2022, a total of 50,614 people have been diagnosed with HIV or AIDS in PR. In 2019, the archipelago, compared to the other states and territories ranked 14th with respect to HIV diagnoses, 7th in HIV prevalence, and 11th in the rate of Stage 3 (AIDS) diagnoses.

The Government of Puerto Rico, in coordination with a multiplicity of stakeholders from various sectors and the community with diagnosed HIV has focused its efforts over the past years on strengthening the HIV prevention and treatment service delivery system to ensure that all people are aware of their HIV status, prevent new diagnoses, and ensure that those diagnosed with HIV can achieve their maximum health potential, enjoy a full life, and enjoy their natural human and legal rights. Much has been achieved, but much remains to be accomplished. In this direction, integrated planning processes provide an opportunity to reflect on the results of these actions and to develop, together, approaches and strategies that will allow progress to be made in the eradication of HIV.

This document presents the Integrated Plan for HIV Surveillance, Prevention, and Treatment in PR, 2022-2026 (hereafter, Integrated Plan), in compliance with requirements established by the Health Resources and Services Administration (HRSA) and the Center for Disease Control and Prevention (CDC).

The developed Plan builds on lessons learned and best practices employed in the previous 2017-2022 plan. Based on the identified needs and the current context of Puerto Rico, four goals were established, which - in turn - are framed by the goals of the National HIV Strategy 2022-2025 and the 2019 Ending the HIV Epidemic pillars. These include:

- Prevent new HIV transmissions using proven interventions.
- Diagnose all people with HIV as early as possible.
- Treat HIV-positive people quickly and effectively to achieve sustained viral suppression.
- Respond in a coordinated and integrated manner to the syndemics of HIV, sexually transmitted infections (STIs), viral hepatitis, and behavioral and health issues.

To achieve these goals, the Plan incorporates specific objectives, strategies and actions based on the models of the HIV continuum of care and the neutral approach to the HIV situation, which respond to the following principles:

Illustration 1: Guiding principles of the Plan

A. APPROACH

For purposes of developing the Integrated Plan, the jurisdiction utilized a participatory planning and empowerment approach, similar to that employed in 2016, through which representatives from the community diagnosed with HIV, local and federal government entities, non-profit organizations, the academia and other stakeholders actively participated in identifying and prioritizing needs, defining goals and objectives, and designing strategies.

The process was organized in three phases: a first phase of organization and exploration; a second phase of diagnosis and situational analysis; and a third phase of Plan development.

Illustration 2: Organization of the planning process

A total of 119 persons, representatives of the previously mentioned stakeholders participated of the workshops and consultation sessions carried out. A final draft of the plan was published on the Department of Health's web page for comments from the public and interest groups.

B. DOCUMENTS SUBMITTED TO COMPLY WITH THE INTEGRATED PLANNING REQUIREMENTS

To comply with integrated planning guidelines published by CDC and HRSA, the Government of Puerto Rico presents this Integrated Plan, which builds on previous planning efforts, such as the Integrated HIV Surveillance, Prevention and Care Plan 2017-2021 and Ending the HIV Epidemic of 2019. In accordance with the guidelines, the following sections are included:

- Description of the planning and community integration process (Section II);
- Data sets and evaluations that contributed to the development of the Plan (Section III);
- Situational analysis (Section IV);
- Goals, objectives, and strategies (Section V); and
- Jurisdictional implementation, monitoring and follow-up (Section VI).

SECTION II: COMMUNITY INTEGRATION AND PLANNING PROCESS

1. PLANNING PROCESS OF THE JURISDICTION

For purposes of developing the Integrated Plan, the jurisdiction utilized a participatory and empowerment planning approach through which representatives from the community diagnosed with HIV, local and federal government entities, non-profit organizations, the academia and other stakeholders participated in the identification and prioritization of needs, the definition of goals and objectives, and the design of strategies. According to the literature on the subject, participatory planning processes provide an opportunity to educate while promoting the effective integration of communities in the decision-making and implementation processes. Therefore, part of the purpose of working with this approach was to strengthen existing collaborations and develop the basis for new collaborations necessary for the effective implementation of the Plan.

In order to work in accordance with this planning approach, the tasks were organized in three phases: a first phase of organization and exploration; a second phase of diagnosis and situational analysis; and a third phase of Plan development.

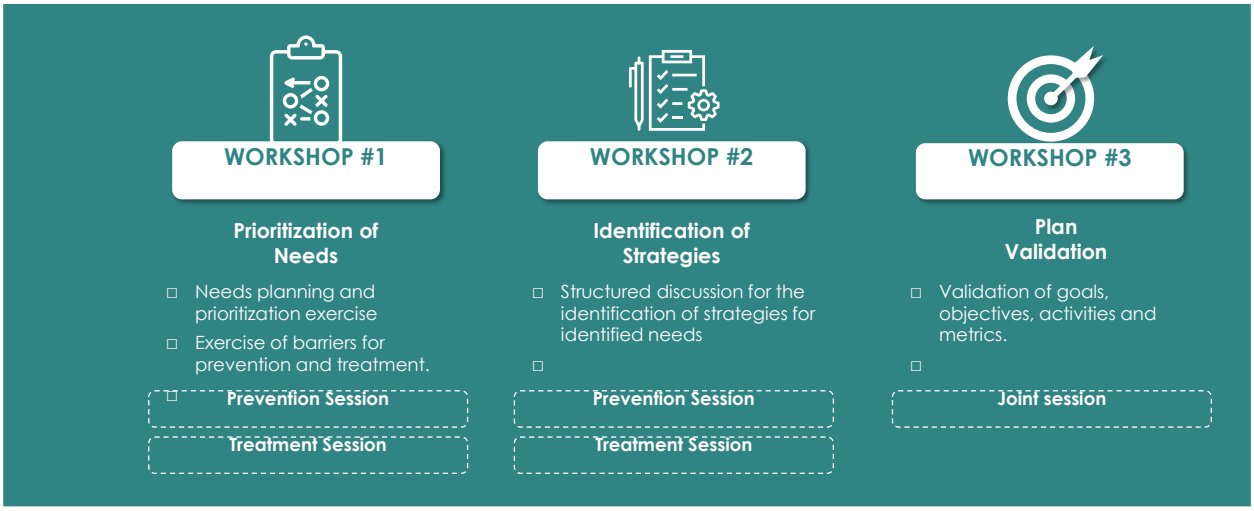
Illustration 3: Organization of the planning process

During the first phase, the Department of Health established a "Planning Committee" composed of staff from the agency's HIV related divisions and resources from the consultant team[1]. The Committee was in charge of developing and monitoring the work plan for the elaboration of the Integrated Plan, developing the consultation and participation methodology, and identifying the sources of information needed to conduct the analysis as well as the different stakeholders to invite to participate in the process.

Once the available sources of information were identified, the consultant team - together with the Planning Committee - analyzed and synthesized the information to be used as a reference in the community workshops conducted. A total of three rounds of workshops were held (during the second and third phases of the Plan). The first round of workshops was organized in two eight-hour sessions (prevention/diagnosis and treatment) and had the objective of validating the needs outlined in the sources of information identified, in order to establish the priority areas on which the Integrated Plan should focus. In addition, as part of this first workshop, stakeholders identified barriers and gaps in the service system as part of the situational analysis. The second round of workshops, on the other hand, aimed to develop goals, objectives and strategies based on the results of the initial round of workshops. It was also organized in two sessions. In terms of the methodology applied, during the workshops, the participants were organized into small working groups, and through guided exercises, the topics covered in each session were explored in depth. After each workshop, the information obtained from the groups was processed and integrated, to be presented to the full group in a future session for validation.

[1] Through a procurement process, in compliance with 2 CFR 200, the Department of Health contracted the services of the consulting and planning firm Estudios Técnicos, Inc. to collaborate as facilitators of the process.

Illustration 4: Consultation workshops conducted

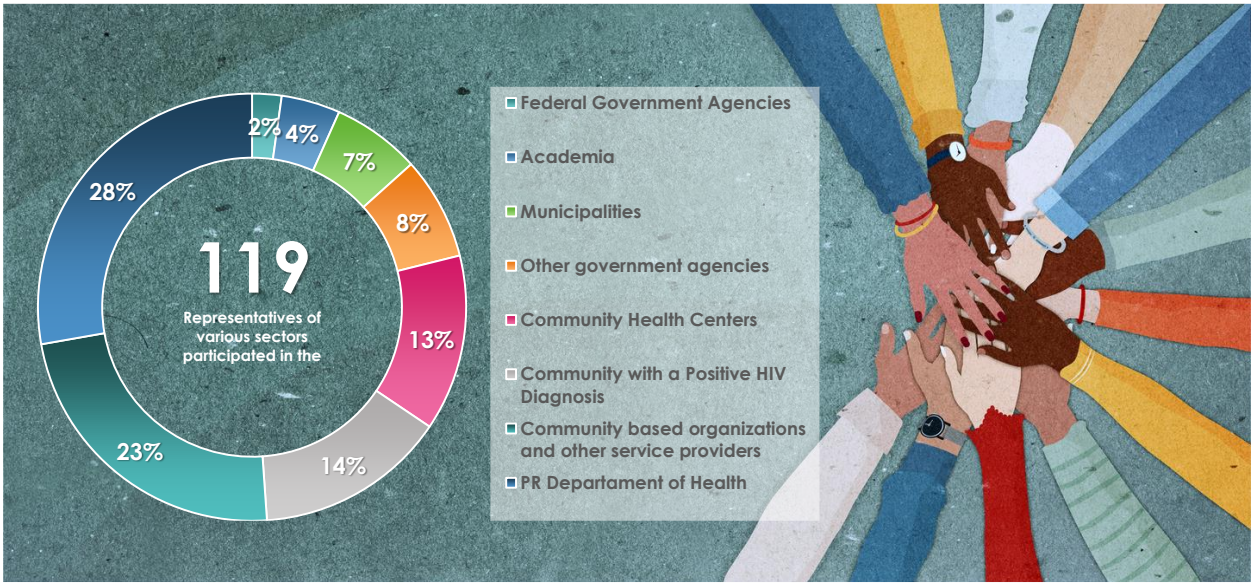


Finally, the third round of workshops was organized in a plenary session where the plan developed through this process was presented. The participants of this last session had the opportunity to have an in-depth discussion about the developed plan and its recommendations, as well as to complete an individual validation exercise where they evaluated the proposed plan based on the requirements of the CDC and HRSA planning guidelines and provided their recommendations. Once the recommendations gathered from this third workshop were incorporated, the plan was posted on the Department of Health's website for final comments. The Plan was available for comment for eight (8) days. At the end of the period, a total of ten (10) additional comments were received and addressed prior to final submission to CDC and HRSA.

A. ENTITIES INVOLVED IN THE PROCESS

The process to develop the Integrated Plan involved a broad and diverse participation of stakeholders related to HIV surveillance, prevention and care in Puerto Rico. As part of the Plan's organizational stage, a stakeholder matrix was developed to ensure that representatives from all sectors recommended in the integrated planning guidelines published by the CDC and HRSA were included. Through the workshop sessions and consultation, 119 people participated, including representatives of the community with a positive HIV diagnosis, the Department of Health, community organizations and other service providers, community health centers, actors that can assist in the response to clusters or outbreaks, other federal, state and local government agencies, researchers and academics, among other stakeholders.

Illustration 5: Representation by sector of the people who participated in the integrated planning process



The specific entities that were represented in the process are listed below.

Illustration 6: Entities and stakeholders represented in the planning process

Community diagnosed with HIV

Planning Advisory Bodies

HIV Prevention and Planning Group
Ryan White Part B/ADAP Planning Group
Ryan White Puerto Rico Interparty Committee
San Juan EMA Council (Ryan White Part A)

Planning Committee of the Department of Health of the Government of Puerto Rico

Family Health, Integrated Services and Health Promotion Auxiliary Secretariat
Ryan White Part B / ADAP Program
HIV/STD/Viral Hepatitis Prevention Division
Office of HIV/AIDS/STD Surveillance
OCASET

Entities in alphabetical order

AIDS Education and Training Center
AIDS Task Force, San Juan EMA
AIDS United
Ararat Center
ASPIRA of Puerto Rico, Inc.
Casa Elda Project
Center for Maternal and Infant Studies (CEMI) of the Medical Sciences Campus, UPR
Centers for the Prevention and Treatment of Communicable Diseases, Health Department
Department of the Family
Estancia Corazón
Graduate School of Public Health, University of Puerto Rico
Health Resources and Services Administration
HIV Treaters Association
Hogar Fortaleza del Caído
Homeless Continuum of Care System, PR 502
HOPWA Program, Department of Health
HOPWA Program, Municipality of San Juan
Hospital Ryder - Proyecto CIS
Infection Control Program
Iniciativa Comunitaria de Investigación, Inc. (ICI)
Intercambios PR
La Perla de Gran Precio, Inc
Lares Health Center
Latin American Center for Communicable Diseases (CLET)
Loiza Comprehensive Health Council, Inc
Med Centro, Inc
Medicaid Program
Migrants Health Center
Mothers, Children and Adolescents Division, Department of Health
Movimiento en Respuesta al VIH, Inc
Municipality of Bayamón, Bayamón Epidemiology Center
NeoMed Center, SIVIF Program / Ryan White Part C
Office of Intergovernmental and External Affairs- Region 2
Office of the Patient Advocate
PACTA, Inc.
Patillas Primary Health Services Center
Physician Correctional
PR CoNCRA, Inc. (Puerto Rico Community Network for Clinical Research)
Pre Vocational and Industrial Institute of PR, Arecibo and Mayagüez
Programa SIDA, Municipio Autónomo de San Juan
Puerto Rico Health Insurance Administration
Prymed, Ciales
Southern Region Consortium
TIES-EME ATF Project
Veteran's Attorney Office
Youth Advisory Council (CAJ) - Department of Health

Planning and consulting team

Estudios Técnicos, Inc.

B. ROLE OF THE RWHAP PART A PLANNING COUNCIL

The San Juan EMA, a recipient of Ryan White Part A funds, represents the geographic area with the highest incidence and prevalence of HIV in Puerto Rico. Although it is not a requirement for states to have representation from Part A council, it was understood that it was essential to have this perspective. To this extent, the council President, as well as other council members and representatives of the administrative body, participated in the three rounds of workshops held. They also contributed with information, plans and documents for the development of the Integrated Plan.

C. ROLE OF PLANNING BODIES AND OTHER ENTITIES

The Plan developed is the product of teamwork conducted by the stakeholders who participated in the process. In the case of Puerto Rico, there are two separate planning bodies for prevention and treatment: the Ryan White Part B/ADAP Program Planning Group and the Puerto Rico HIV Prevention Planning Group. In addition, representatives of the Ryan White Program parts constitute the advisory body called the Ryan White Interparts Committee in Puerto Rico. Through workshops designed as part of the participatory planning and empowerment process, representatives from both planning bodies, as well as other service entities, had the opportunity to provide input on prevention and care needs, existing resources to address them, barriers and gaps in the service delivery system. Based on the results of these conversations, they were able to establish goals and objectives and develop strategies to achieve them. Prior to initiating the planning process, each body had the opportunity to discuss the plan and its requirements in depth during their regular meetings. In addition, as part of the last workshop, representatives validated the content of the plan.

D. COLLABORATION WITH RWHAP PARTS - SCSN REQUIREMENT

As part of the integrated planning process, the need assessments being conducted in the jurisdiction by the Ryan White Part B program and the Health Department's Division of HIV/STI/Viral Hepatitis Prevention, as well as data from the epidemiological profile produced by the Office of Surveillance and other recent research, were used as a starting point. This information served as a basis for the Ryan White Program's Parts A-D and Part F recipients to discuss the issues in depth and - together with the other stakeholders - establish priority areas to be addressed during the sessions or workshops. This also took into consideration the need statements contained in the state and Ryan White Part A Ending the HIV Epidemic plans (EHE).

E. ENGAGEMENT OF PEOPLE WITH HIV- SCSN REQUIREMENT

The community diagnosed with HIV was represented and actively participated in all stages of the Plan's development. As mentioned in a previous section, the process for developing the Integrated Plan was based on a multi-method participatory planning and empowerment approach, which allowed for representation of people with a positive HIV diagnosis, including people co-diagnosed with hepatitis, to ensure that it was responsive to their needs.

In order to keep the community involved throughout the planning process, various approaches were used, including workshops, meetings, sending material via the Internet and telephone follow-up. The use of these different interactive mechanismss allowed community representatives to actively participate in the identification of needs, but also in the development of the strategies and activities that make up the Jurisdiction's Integrated Plan. Fourteen percent of the participants in the planning process are persons diagnoed with HIV.

For the purposes of implementing the Integrated Plan, a structure similar to that employed in 2017-2021 will be established, which included the creation of working groups with representatives from the community with a positive HIV diagnosis, discussion and presentation of progress reports before planning bodies and activities and other accountability efforts to which the community will also be invited.

F. PRIORITIES

Based on the current context in Puerto Rico and the needs identified as part of the integrated planning process, the following ten priority areas were identified:

1. Strengthen the system for the provision of HIV surveillance, diagnosis, prevention and care services and its human capital.
2. Promote the combination of economic resources and take advantage of the leverage that these funds allow, in order to maximize existing resources and have a greater impact.
3. Promote multisectoral planning and coordination to address the HIV, STI, viral hepatitis and mental health syndemic, in order to have an integrated system that provides equitable access to services.
4. Increase the availability of and equitable access to comprehensive, high quality, culturally sensitive services based on best practices, evidence-informed practices, and evidence-based practices for HIV prevention and treatment.
5. Implement ongoing education and counseling efforts to improve levels of knowledge about the epidemic and its prevention and care among service providers, at-risk behavior groups, people with a HIV positive diagnosis, and the general community.
6. Increase the scenarios and number of tests performed in Puerto Rico.
7. Address the social determinants of health.
8. Address the particular needs associated with the demographic transformation in Puerto Rico, as well as the mental health situation that has worsened following the natural disasters the Island has faced and, more recently, the pandemic.
9. Continue to promote early linkage to care and retention approaches to achieve viral suppression.
10. Continue to promote public policy changes aimed at integrating HIV, STI and viral hepatitis surveillance, prevention and treatment efforts.

G. UPDATES TO OTHER STRATEGIC PLANS USED TO MEET THE REQUIREMENTS OF THE INTEGRATED PLAN

To comply with the integrated planning guidelines issued by CDC and HRSA, the Government of Puerto Rico presents this new Integrated Plan, which builds on previous planning efforts, such as the Integrated HIV Surveillance, Prevention and Care Plan 2017-2021 and Ending the HIV Epidemic of 2019.

SECTION III: CONTRIBUTING DATA SETS AND ASSESSMENTS

1. DATA SHARING AND USE

For the purposes of developing the Integrated Plan, different sources of information were combined, including the epidemiological profile prepared by the HIV/STI Surveillance Program of the Office of Epidemiology and Research of the Puerto Rico Department of Health, the Ryan White Part B Program Needs Assessment of Persons with a Positive Diagnosis of HIV (2022), the HIV Prevention Needs Assessment in Puerto Rico (2022), conducted by the HIV/STI/Viral Hepatitis Prevention Division of the Department of Health, as well as other recent studies identified. This information was complemented by the conversations held and guided exercises conducted in the workshops as part of the integrated planning process.

For the development of the epidemiological profile, the Surveillance Program used various sources, including data from the P.R. AIDS Surveillance System, data from the Behavioral Surveillance System - NHBS, and Population and Housing data from the U.S. Census Bureau.

Within the framework of the Organic Law of the Puerto Rico Department of Health, Act No. 81-1912, Act No. 40-2012, Health Information Management and Exchange Act, Federal Public Law, 100-478, and the regulations and administrative orders derived therefrom, including AO 2020-440, all health professionals in Puerto Rico are required to report to the Department of Health all HIV-related laboratory results to the Surveillance Program.

In addition, the Surveillance Program has collaborative agreements for data exchange, one of which is with the AIDS Task Force of the Municipality of San Juan, a recipient of Ryan White Part A funds. This agreement is part of the "Data to Care" project, sponsored by the CDC to identify people with a positive HIV diagnosis who are not linked to treatment, as well as to update data related to viral suppression. As part of the agreement, the AIDS Task Force submits monthly reports through the HIV Surveillance reporting portal of laboratory results related to the algorithm for all phases of HIV diagnosis, including CD4, Viral Loads (qualitative and quantitative) and HIV molecular testing of participants receiving services through Part A sub-recipient agencies. The complete list of references used in the planning process is included as an attachment.

2. EPIDEMIOLOGIC SNAPSHOT

This section provides a background on the sociodemographic situation of Puerto Rico and the epidemiological profile of HIV, according to the guidelines published by the CDC and HRSA.

DEMOGRAPHIC CHARACTERISTICS OF THE PUERTO RICAN POPULATION IN THE YEAR 2021

The Archipelago of Puerto Rico comprises 78 municipalities divided into 8 Health Regions (Illustration 7).

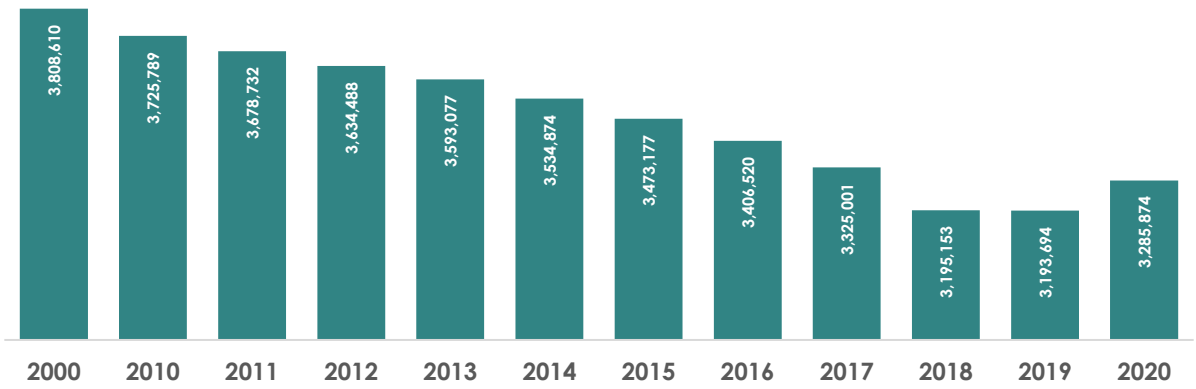
Illustration 7: Epidemiological Health Regions of Puerto Rico, 2021

AGUADILLA	ARECIBO	BAYAMÓN	CAGUAS	FAJARDO
1. Aguada	1. Arecibo	1. Barranquitas	1. Aguas Buenas	1. Ceiba
2. Aguadilla	2. Barceloneta	2. Bayamón	2. Aibonito	2. Culebra
3. Isabela	3. Camuy	3. Cataño	3. Caguas	3. Fajardo
4. Moca	4. Ciales	4. Comerío	4. Cayey	4. Luquillo
5. San Sebastián	5. Florida	5. Corozal	5. Cidra	5. Río Grande
	6. Hatillo	6. Dorado	6. Gurabo	6. Vieques
	7. Lares	7. Naranjito	7. Humacao	
	8. Manatí	8. Orocovis	8. Juncos	
	9. Morovis	9. Toa Alta	9. Las Piedras	
	10. Quebradillas	10. Toa Baja	10. Maunabo	
	11. Utuado	11. Vega Alta	11. Naguabo	
	12. Vega Baja		12. San Lorenzo	
			13. Yabucoa	

MAYAGÜEZ	METROPOLITANA	PONCE
1. Añasco	1. Canóvanas	1. Adjuntas
2. Cabo Rojo	2. Carolina	2. Arroyo
3. Hormigueros	3. Guaynabo	3. Coamo
4. Lajas	4. Loíza	4. Guánica
5. Las Marías	5. San Juan	5. Guayama
6. Maricao	6. Trujillo Alto	6. Guayanilla
7. Mayagüez		7. Jayuya
8. Rincón		8. Juana Díaz
9. Sabana Grande		9. Patillas
10. San Germán		10. Peñuelas
		11. Ponce
		12. Salinas
		13. Santa Isabel
		14. Villalba
		15. Yauco

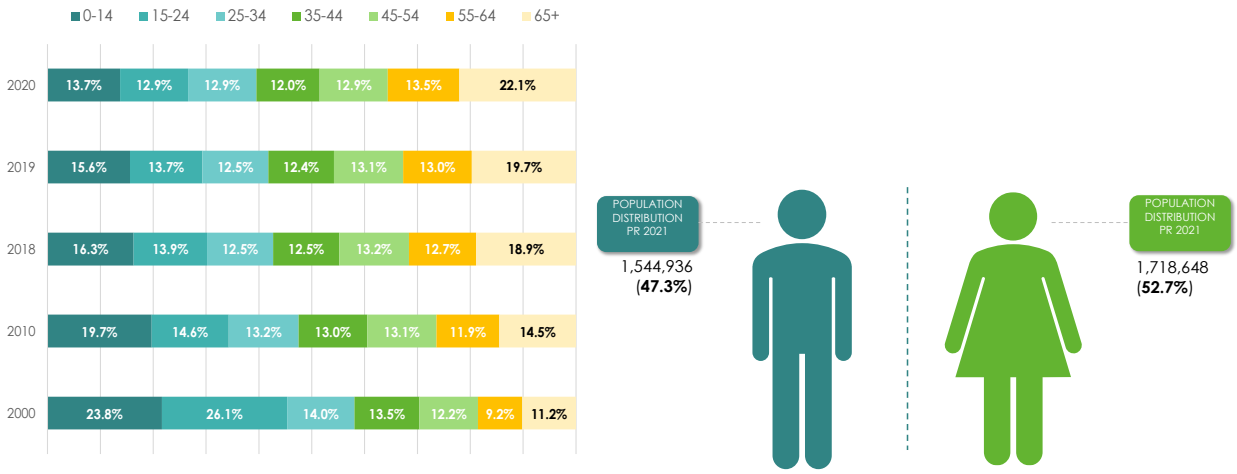
Puerto Rico's resident population was estimated at 3,263,584 as of 2020, representing a reduction of about 439,976 people over the last decade, or approximately 14% of the population as of 2010. This is due, among other factors, to the confluence of low birth and death rates and high net migration levels, which before Hurricane Maria in 2017, fluctuated around 60,000 people. In turn, this implies a demographic transformation toward an aging population, which has important implications for prevention and health care systems. As shown in the next graph, 36% of the population in 2020 will be 55 years of age or older. Meanwhile, the population distribution by sex at birth corresponds to 47.3% men and 52.7% women.

Graph 1: Population changes in Puerto Rico 2000-2020



Source: Population and Housing Census, various years.

Graph 2: Population by age and sex at birth



Source: Population and Housing Census, 2020.

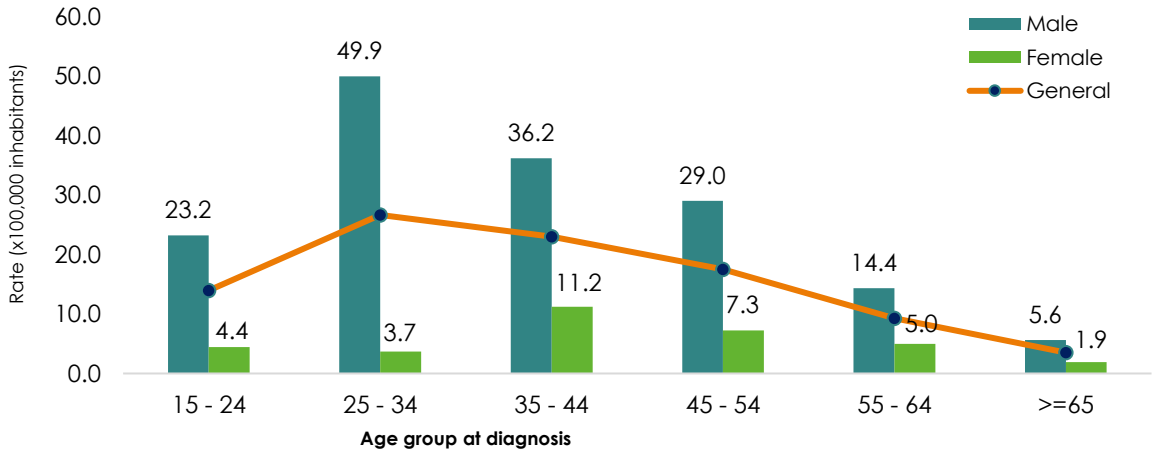
DESCRIPTION OF THE NEW HIV DIAGNOSES

A total of 402 cases of HIV infection were diagnosed in adults and adolescents during 2021. The crude rate for this year was 12.3 new HIV diagnoses by sex at birth per 100,000 inhabitants. The sex distribution indicates that the rate of HIV diagnoses in males is 4.2 times higher than the rate of HIV diagnoses in females (Illustration 8).

Illustration 8: Distribution of New Diagnoses, by Sex at Birth, PR 2021

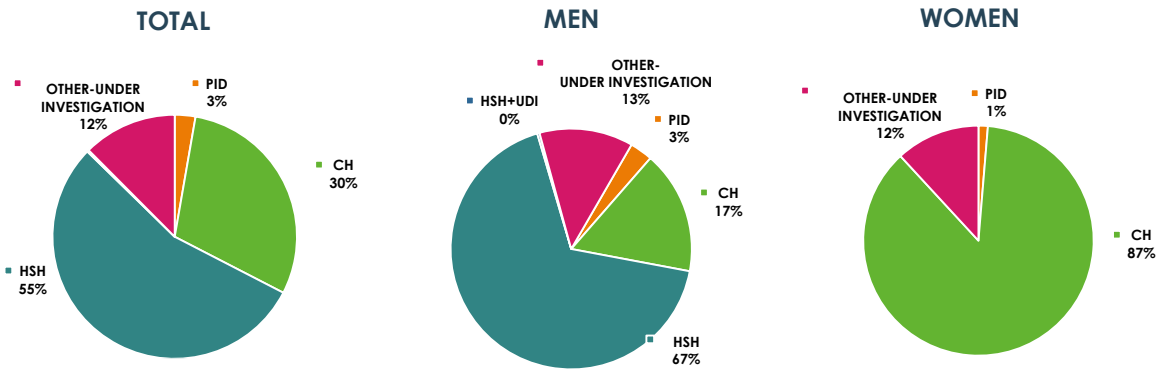
In the year 2021 the rates of new diagnoses increased among the age groups 15 to 24 until reaching the 25 to 34 age group. It then decreases between ages 35 to those over 65 years (Graph 3).

Graph 3: Rate of new HIV diagnoses by age group and sex, PR 2021



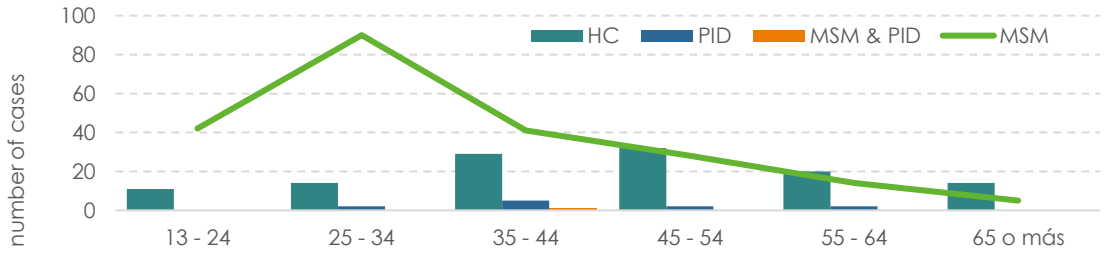
Male -to male sex without condom (55%) was the most frequently reported mode of transmission in Puerto Rico in 2021 followed by heterosexual contact without a condom (30%). Among men, condomless sex between men (67%) was the leading mode of transmission in 2021. While heterosexual contact (87%) was the most frequently reported mode of exposure in women (Graph 4).

Graph 4: Distribution of New HIV Diagnoses by Mode of Exposure in Adults and Adolescents ≥ 13 Years, Puerto Rico, 2021



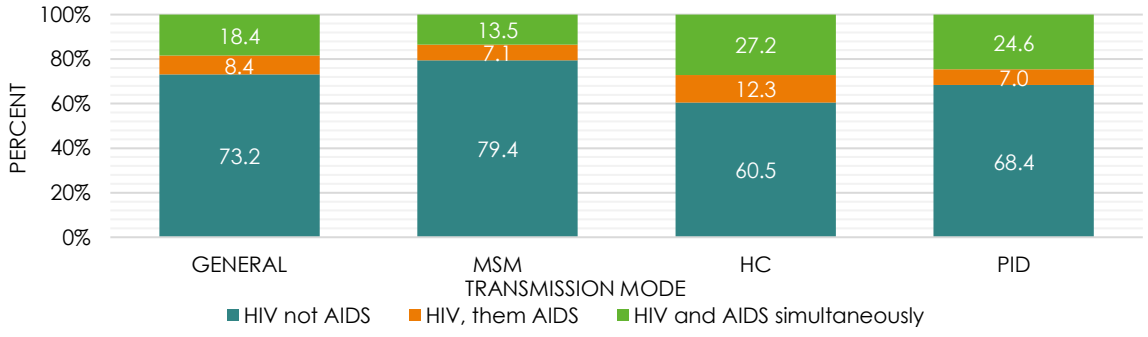
Sex between men without a condom is the primary mode of transmission among adolescents and adults between the ages of 13 to 44 years, while persons diagnosed with HIV between the ages of 45 and 65 years or older the primary mode of transmission is heterosexual contact (Graph 5).

Graph 5: Distribution of New HIV Diagnoses by Mode of Transmission and Age of Adults and Adolescents ≥13 Years, Puerto Rico, 2021.



The proportion of people diagnosed with HIV during 2021 who were in the most advanced stage of infection (AIDS) was highest among heterosexual people (27.2%), followed by people who inject drugs (24.6%), (Graph 6).

Graph 6: Distribution of New HIV Diagnoses by HIV Progression Category and Mode of Transmission of Adults and Adolescents ≥13 Years, PR 2021



The metropolitan region is home to most of the Puerto Rican population with a positive HIV diagnosis (37.8%). Positive diagnoses predominated among men with a positivity rate of 36.9% (Table 1).

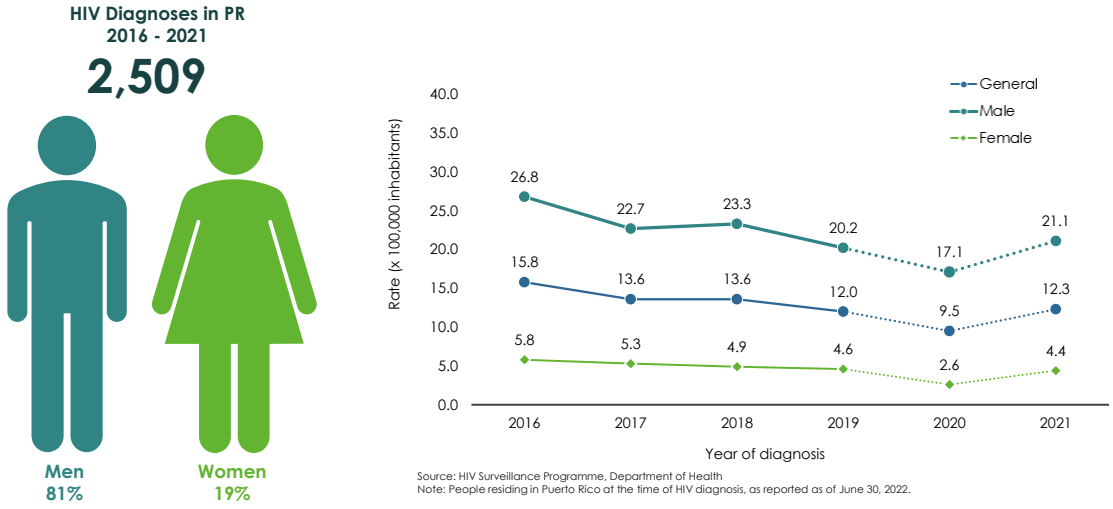
Table 1: Distribution of new HIV diagnoses by Epidemiological Health Regions of Adults and Adolescents ≥ 13 Years, PR 2021

Health Region	General			Men			Women		
	No. of diagnoses	%	Rate*	No. of diagnoses	%	Rate*	No. of diagnoses	%	Rate*
Aguadilla	15	3.7	7.1	13	4.0	12.7	2	2.6	1.8
Arecibo	29	7.2	7.1	25	7.7	12.7	4	5.3	1.9
Bayamón	72	17.9	13.0	58	17.8	22.1	14	18.4	4.8
Caguas	69	17.2	13.2	57	17.5	23.0	12	15.8	4.4
Fajardo	8	2.0	6.8	7	2.1	12.6	1	1.3	1.6
Mayagüez	16	4.0	6.0	13	4.0	10.2	3	3.9	2.2
Metropolitan	152	37.8	21.3	121	37.1	36.9	31	40.8	8.1
Ponce	41	10.2	8.7	32	9.8	14.2	9	11.8	3.7
Total	402	100.0	12.3	326	100.00	21.1	76	100.0	4.4

TRENDS IN NEW HIV DIAGNOSES, 2016 - 2021

During the period from 2016 to 2021, a total of 2,509 new HIV cases were diagnosed (regardless of whether it progressed to AIDS or not). The prevalence of new HIV diagnoses in males is (81%) while females have (19%) of new HIV diagnoses. The rate of HIV diagnoses shows a decrease during this period. It is possible that the data reflected for 2020 were altered by the impact of the pandemic (Graph 7).

Graph 7: Rate of New HIV Diagnoses by Sex, PR 2016 - 2021

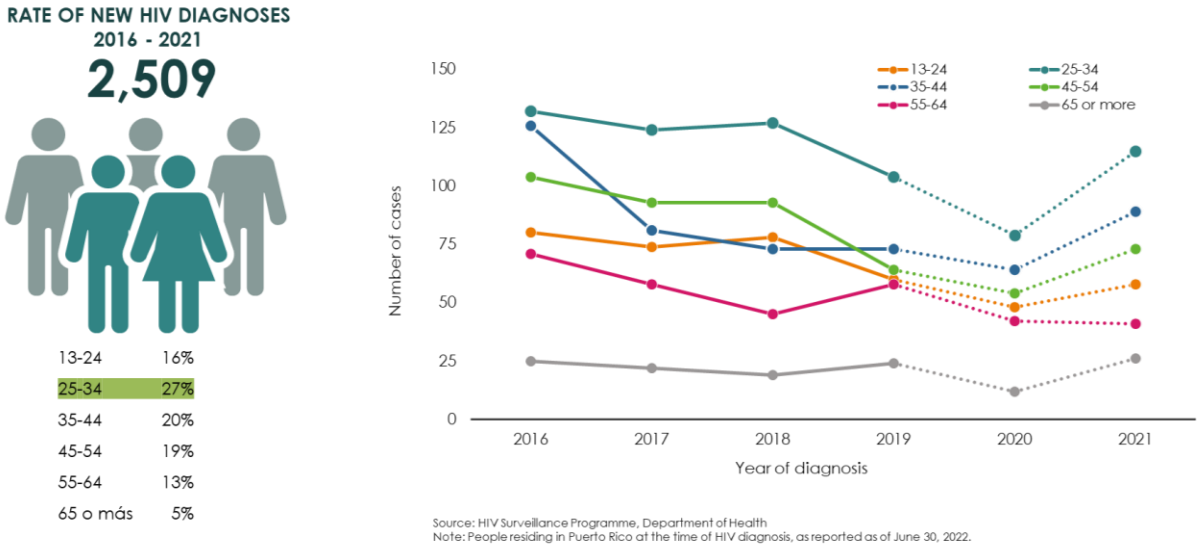


Source: HIV Surveillance Programme, Department of Health
Note: People residing in Puerto Rico at the time of HIV diagnosis, as reported as of June 30, 2022.

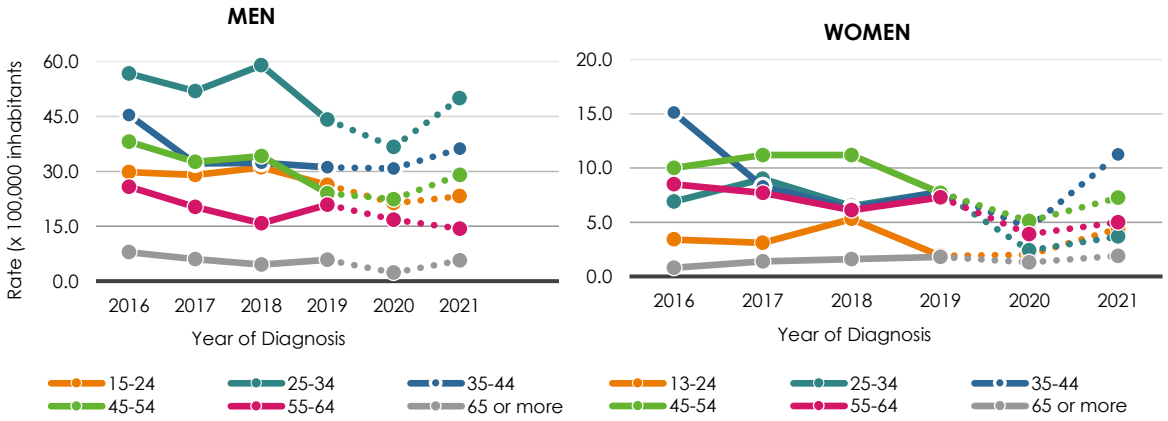
47% of new HIV diagnoses fluctuate between the ages of 25 and 44 years. The rate of HIV diagnoses shows a decrease during this period, until 2021 when new diagnoses are

regulated by age. It is possible that the data reflected for 2020 will be altered due to the impact caused by the pandemic (Graph 8). For 2021 compared to 2019 there is an increase in new diagnoses in both males and females (Graph 9).

Graph 8: Rate of New HIV Diagnoses by Age Group, PR 2016 - 2021

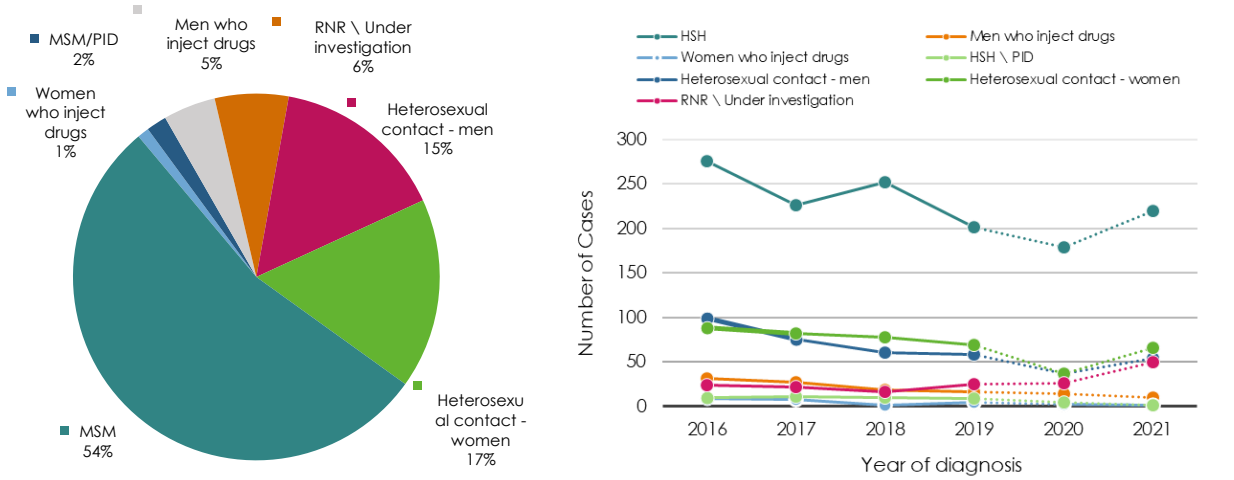


Graph 9: New HIV Diagnosis Rate by Age Group, PR 2016 - 2021



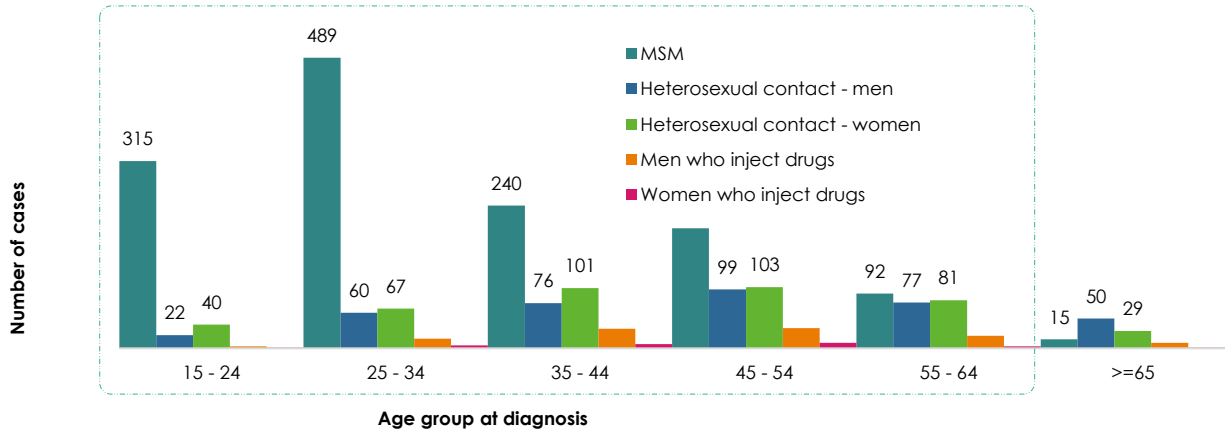
During the accumulated period from 2016 to 2021, heterosexual contact without condoms has the highest proportion of newly diagnosed HIV cases annually. The proportion of cases attributed to condomless sex between men increased during 2016 to 2021 while both the proportion of people who inject drugs and sex between heterosexuals decreased. In 2021, condomless sex between men continues to be the main mode of transmission among Puerto Ricans (Graph 10).

Graph 10: Distribution of Adolescents and Adults ≥13 Years Diagnosed with HIV by Mode of Transmission, PR 2016-2021



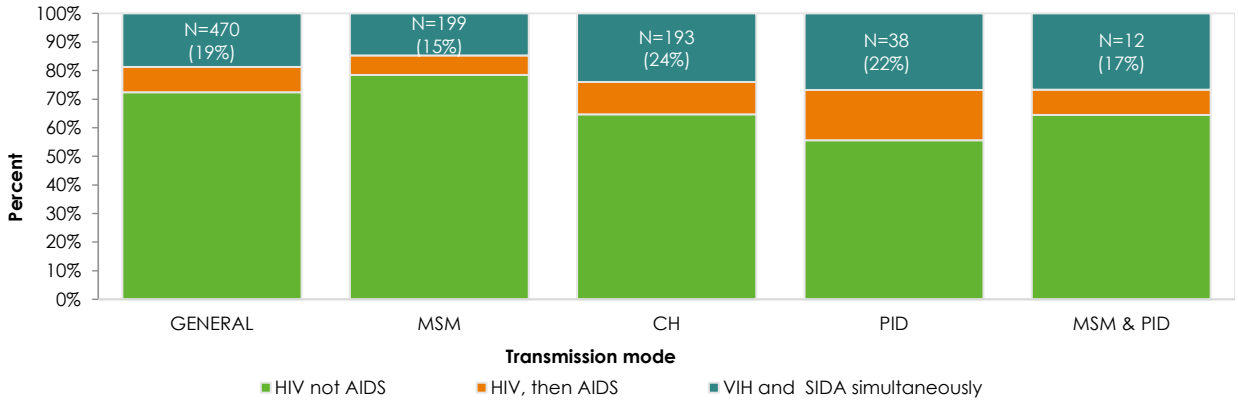
The distribution of new cases diagnosed during the period 2016 - 2021 indicates that male-to-male sex is the main mode of transmission among adolescents and adults aged 13 to 64 years (Graph 11).

Graph 11: Distribution of New HIV Diagnosis by Age and Mode of Transmission and Sex at Birth, PR 2016 - 2021



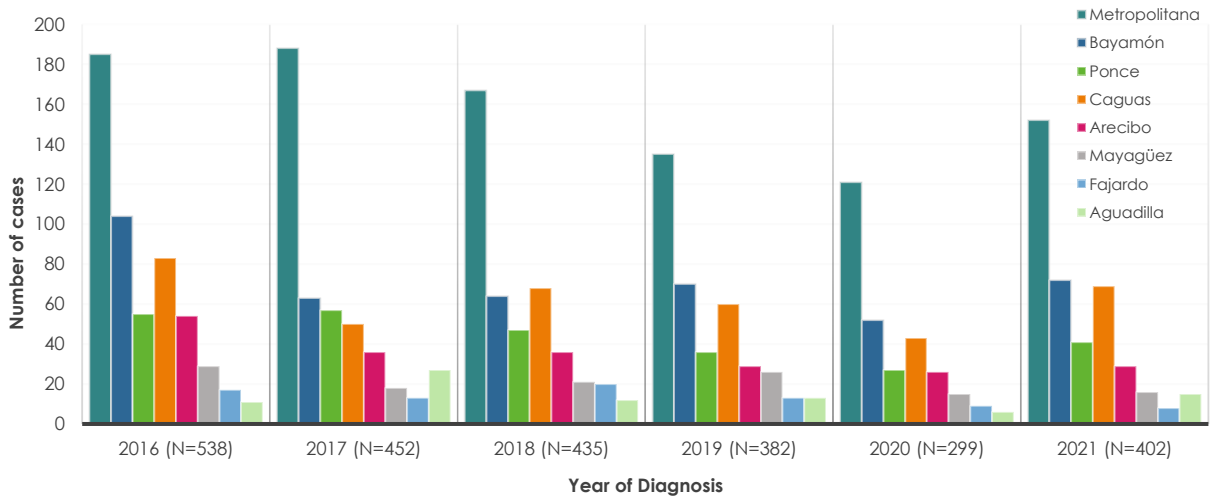
Approximately 1 in 5 adults and adolescents ≥13 years old diagnosed with HIV during the period from 2016 to 2021 was in the most advanced stage of infection (AIDS). The proportion was highest among heterosexual persons (24%) and persons who inject drugs (22%) (Graph 12).

Graph 12: Distribution of New HIV Diagnoses, by HIV Progression Category and Mode of Transmission of Adults and Adolescents ≥13 Years, PR 2016 - 2021.



The metropolitan region predominates as the region of residence at the time of diagnosis with the most HIV new cases diagnosed during the period from 2016 to 2021, followed by the Bayamón and Caguas regions respectively (Graph 13).

Graph 13: New HIV Diagnoses by Region of Residence at Time of Diagnosis, PR 2016 - 2021



The number of people with an HIV diagnosis residing in Puerto Rico at the end of 2021 is 16,617. For every 100,000 inhabitants of Puerto Rico, 509 have a HIV positive diagnosis. The prevalence of HIV in men is 2.7 times higher than the prevalence in women. Over one-third of the people with a positive HIV diagnosis reside in the Metropolitan Region. It is estimated that 9.4% (1,700) of people with a HIV positive diagnosis in Puerto Rico are unaware of their HIV status. Three out of every four people with a HIV positive diagnosis in Puerto Rico are 45 years of age or older

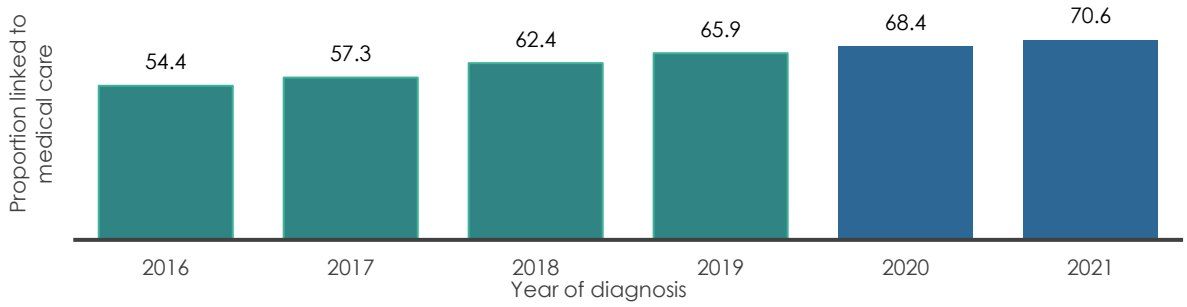
Table 2: HIV Prevalence by Health Region in PR, 2021

Health Region	Number of cases	%
Metropolitan	6,268	37.7
Bayamón	2,810	16.9
Caguas	2,141	12.9
Ponce	2,081	12.5
Arecibo	1,355	8.2
Mayagüez	861	5.2
Fajardo	584	3.5
Aguadilla	517	3.1
Total	16,617	100.0

HIV CONTINUUM OF CARE, PR 2021

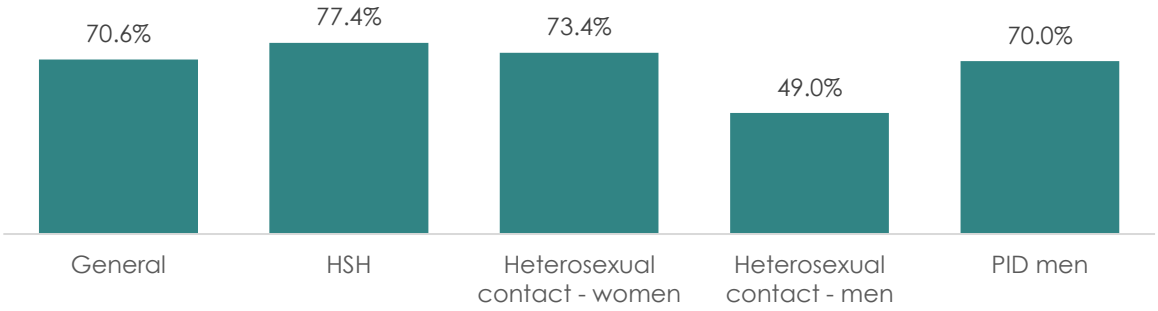
The proportion of people linked to medical care presents an increase during the period from 2016 to 2021 from 54.4% to 70.6% respectively (Graph 14). The National HIV Strategy in 2010 had set a target of 85% by 2020. The highest we have reached is 70.6% in 2021.

Graph 14: Number of People Linked to Medical Care During the First 30 Days After HIV Positive Diagnosis, PR 2016 - 2021



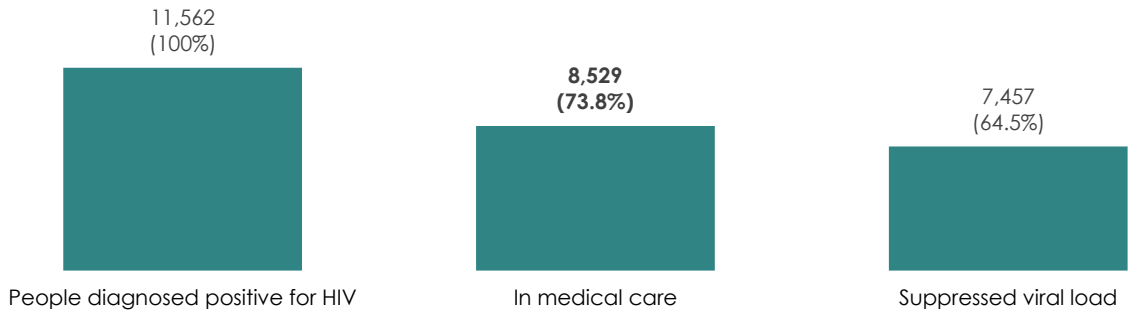
Persons with a positive HIV diagnosis and with mode of transmission of sex with a man without a condom have the highest percentage (77.4%) of persons linked to medical care during the first month after diagnosis. This was followed by women who had heterosexual contact (73.4%) (Graph 15)

Graph 15: Linkage to medical care of persons diagnosed with HIV during the first month after diagnosis, by mode of transmission and sex, PR, 2021



As of 2020, 11,562 persons ≥ 18 years had a diagnosis of HIV infection. An estimated 73.8% (n=8,529) were receiving medical care and 64.5% (n=7,457) had a suppressed viral load. The percentage of suppressed viral load is based on the number of persons with a laboratory test during 2016 - 2020 whose last viral load in 2020 was <200 copies/mL. (Graph 16).

Graph 16: Continuum of HIV Care in PR, 2020



People with a positive HIV diagnosis: persons ≥ 13 years old with a positive HIV diagnosis in Puerto Rico, diagnosed with HIV or who have had a positive HIV test, genotype, CD4 and/or viral load test reported to the Surveillance Program during the period 2016 - 2020

Database used: HIV Surveillance Program.

In Medical care: persons ≥ 13 years with a positive HIV diagnosis in Puerto Rico with a CD4 or viral load test in 2020.

Database used: HIV Surveillance Program.

Suppressed viral load: persons ≥13 years with a positive HIV diagnosis with a covered medical care need whose viral load in the year 2020 is <200 copies/mL.

Database used: HIV Surveillance Program.

UNMET HEALTH CARE NEEDS OF PEOPLE WITH A HIV-POSITIVE DIAGNOSIS IN PUERTO RICO, 2020

In 2020, 299 people were diagnosed with HIV in Puerto Rico. Of those, 23.1% were late diagnosed with HIV. By 2020, 11,562 persons residing in Puerto Rico had an HIV diagnosis or any HIV-related laboratory data during the period 2016 -2020. 73.8% were under care, while 26.2% were not under care in 2020.

At the end of 2020, 1,072 persons receiving medical care were not virally suppressed (12.6%). People who are not virally suppressed are more likely to transmit HIV to their partners through sexual contact and injection drug use (Table 3).

Table 3: Unmet Health Care Needs of People with a HIV-positive diagnosis in Puerto Rico, 2020

	Years
New HIV diagnoses	2020
Patterns of care	2020
Population size	2016-2020

Indicators	Number	Percentage	Source of Data
Late HIV Diagnoses			
Late Diagnoses	69	23.1%	HIV Surveillance Program
New Diagnoses	299		HIV Surveillance Program
Population Size			
Population Size	11,562		HIV Surveillance Program
Patterns of care			
Covered Need	8,529	73.8%	HIV Surveillance Program
Uncovered Need	3,033	26.2%	HIV Surveillance Program
Viral load, persons on medical care			
Suppressed viral load	7,457	87.4%	HIV Surveillance Program
Non suppressed viral load	1,072	12.6%	HIV Surveillance Program

Note: Data on *Late HIV Diagnoses and Patterns of Care* are presented for the year 2020; data on *Population size* are presented for the period 2016-2020.

Late HIV Diagnoses: Number of persons diagnosed with Stage 3 HIV infection within the first 3 months after initial HIV diagnosis.

Population Size: Number of people with a positive HIV diagnosis in Puerto Rico, diagnosed with HIV or who have had an (positive) HIV test, genotype, CD4 and/or viral load test reported to the Surveillance Program during the last 5 years.

Patterns of Care:

Covered Need:Number of people with a positive HIV diagnosis, with a CD4 or viral load test in the most recent year.

Uncovered Need:Number of people with a positive HIV diagnosis, without a CD4 or viral load test in the most recent year.

Viral Suppression:

Suppressed Viral Load: Number of persons with a positive HIV diagnosis, with covered need for medical care, whose most recent viral load is <200 copies/ml.

Unsuppressed Viral Load:Number of persons with a positive HIV diagnosis, with covered need for medical care, whose most recent viral load is >=200 copies/ml.

The following summarizes the information from the unmet needs report. Men who inject drugs (50%), people aged ≥45 years or older (37%), transgender people (27.9%), and heterosexual men (48.6%) were more likely to be late diagnosed with HIV.

The populations with the highest numbers of people without care were men who have sex with men (26.7%), heterosexual women (25.3%), men who inject drugs (30.9%), and men who inject drugs who have had sex with men without a condom (28.7%).

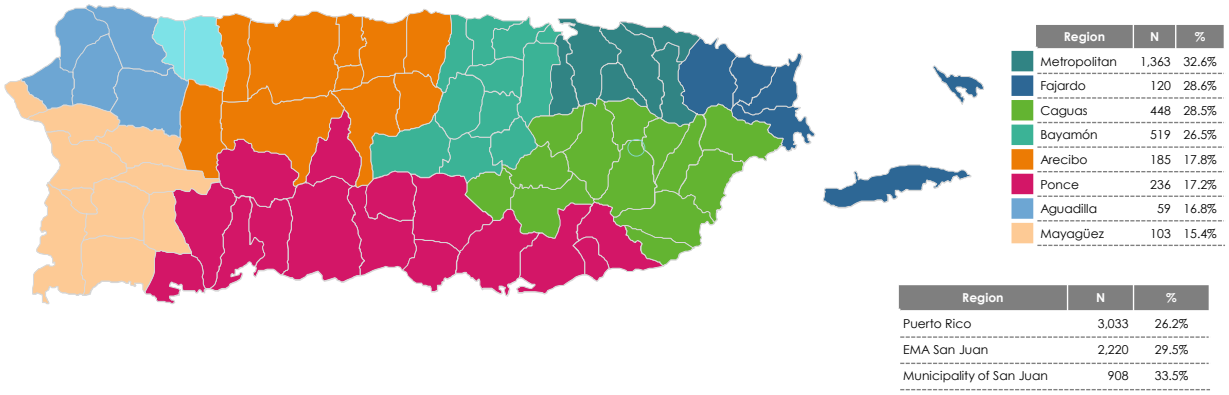
The highest proportion of persons under care who have not been virally suppressed are men (67.4%), persons aged 45-64 years (26.4%), men who have sex with men (32.6%), and heterosexual women (24.4%) (Table 4).

Table 4: Population Analysis - Puerto Rico, 2022

Demographic characteristics / transmission category	People with an HIV positive diagnosis	Number of new HIV diagnoses	Number of people with late diagnosis	Number of people under medical care	Number of persons unmet need	Under care, without viral suppression	% Late diagnoses	% Unmet need	Under care, without viral suppression	% Late diagnoses	% Unmet need	Under care, without viral suppression
Total	11,562	299	69	8,529	3,033	1,072	23.10%	26.20%	12.60%	100.00%	100.00%	100.00%
Gender												
Male	8,087	253	56	5,929	2,158	723	22.10%	26.70%	12.20%	81.20%	71.20%	67.40%
Female	3,446	43	12	2,574	872	345	27.90%	25.30%	13.40%	17.40%	28.80%	32.20%
Transgender	29	3	1	26	3	4	33.30%	10.30%	15.40%	1.40%	0.10%	0.40%
Age												
13 - 24	218	48	3	166	52	46	6.30%	23.90%	27.70%	4.30%	1.70%	4.30%
25 - 34	1,302	79	9	873	429	182	11.40%	32.90%	20.80%	13.00%	14.10%	17.00%
35 - 44	1,777	64	18	1,215	562	196	28.10%	31.60%	16.10%	26.10%	18.50%	18.30%
45 - 54	2,909	54	20	2,157	752	283	37.00%	25.90%	13.10%	29.00%	24.80%	26.40%
55 - 64	3,611	42	15	2,799	812	267	35.70%	22.50%	9.50%	21.70%	26.80%	24.90%
65+	1,745	12	4	1,319	426	98	33.30%	24.40%	7.40%	5.80%	14.00%	9.10%
Transmission category												
Males												
MSM	4,142	176	26	3,102	1,040	349	14.80%	25.10%	11.30%	37.70%	34.30%	32.60%
PID	1,555	14	7	1,075	480	165	50.00%	30.90%	15.30%	10.10%	15.80%	15.40%
MSM PID	487	4	1	347	140	28	25.00%	28.70%	8.10%	1.40%	4.60%	2.60%
Heterosexual Contact	1,708	37	18	1,281	427	144	48.60%	25.00%	11.20%	26.10%	14.10%	13.40%
Other/ Unidentified risk	195	22	4	124	71	37	18.20%	36.40%	29.80%	5.80%	2.30%	3.50%
Females												
PID	528	2	0	384	144	61	0.00%	27.30%	15.90%	0.00%	4.70%	5.70%
Heterosexual Contact	2,800	37	11	2,115	685	262	29.70%	24.50%	12.40%	15.90%	22.60%	24.40%
Other/ Unidentified risk	118	4	1	75	43	22	25.00%	36.40%	29.30%	1.40%	1.40%	2.10%

Island wide, an estimated 26.2% of individuals do not have their need for HIV medical care covered. The Metropolitan Health Region (32.6%), Caguas (28.5%), Fajardo (28.6%), and Bayamón (26.5%) presents the highest proportions of PVCV whose need for HIV medical care was not covered in 2020.

Illustration 9: Unmet Need by Health Region /EMA/ San Juan Municipality, 2020



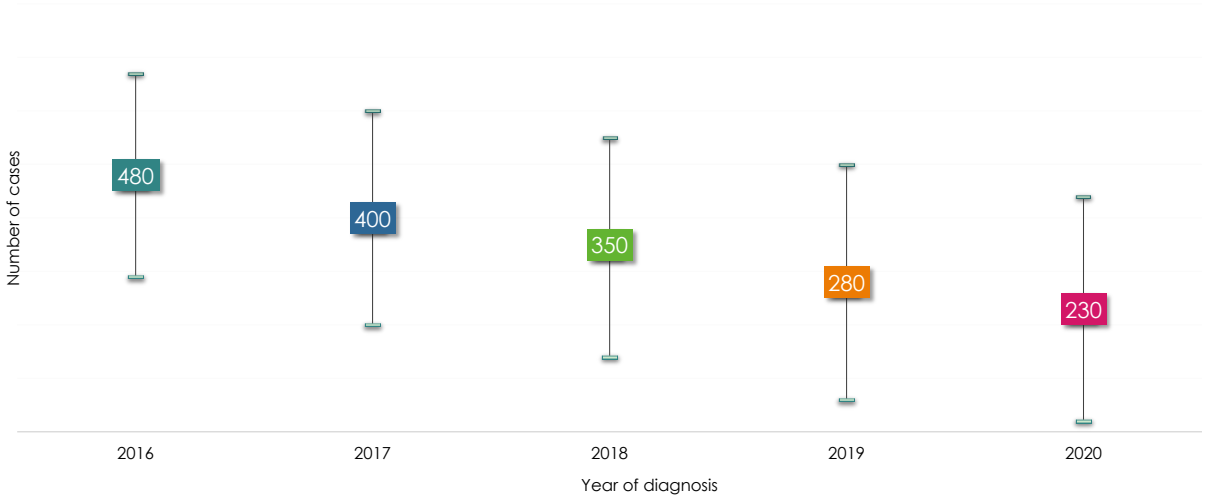
Region	N	%
Metropolitan	1,363	32.6%
Fajardo	120	28.6%
Caguas	448	28.5%
Bayamón	519	26.5%
Arecibo	185	17.8%
Ponce	236	17.2%
Aguadilla	59	16.8%
Mayagüez	103	15.4%

Region	N	%
Puerto Rico	3,033	26.2%
EMA San Juan	2,220	29.5%
Municipality of San Juan	908	33.5%

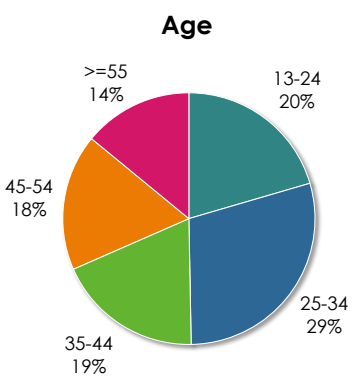
ESTIMATES OF HIV INCIDENCE AND PREVALENCE IN PUERTO RICO: 2016-2020

For the period from 2016 to 2020, the incidence of HIV cases in Puerto Rico has decreased (Graph 17). The incidence is reflected higher in men (83%), in people between the ages of 25 to 34 years (29%) and in men who have had sex with men without a condom (64%) (Graph 18).

Graph 17: HIV Incidence Estimates of Adolescents and Adults ≥13 Years, PR 2016 - 2020



Graph 18: HIV Incidence Estimates for Adolescents and Adults ≥13 Years, by Sex at Birth, Age, and Mode of Transmission, PR, 2016 - 2020

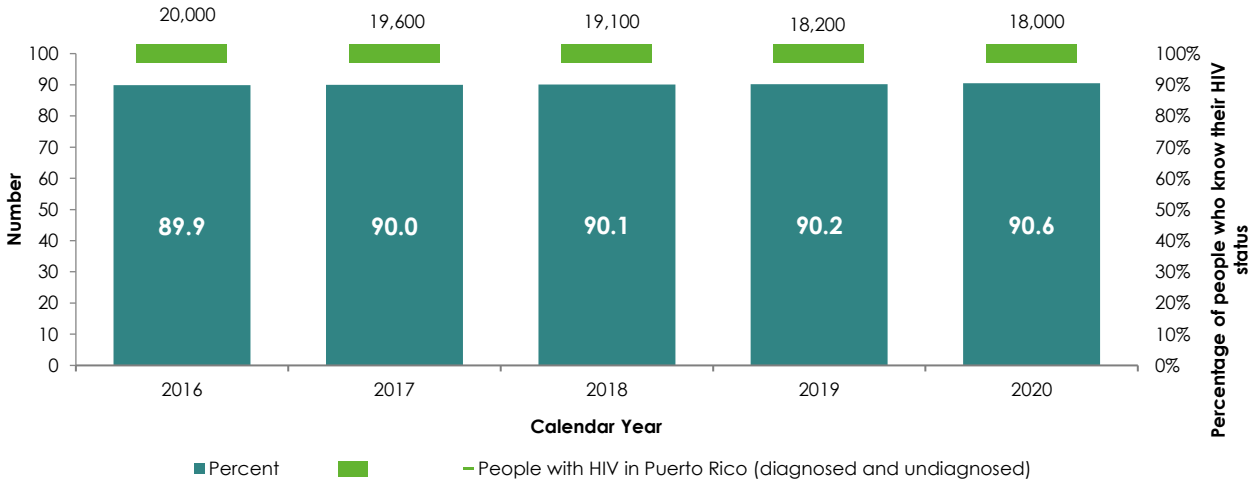


Transmission mode

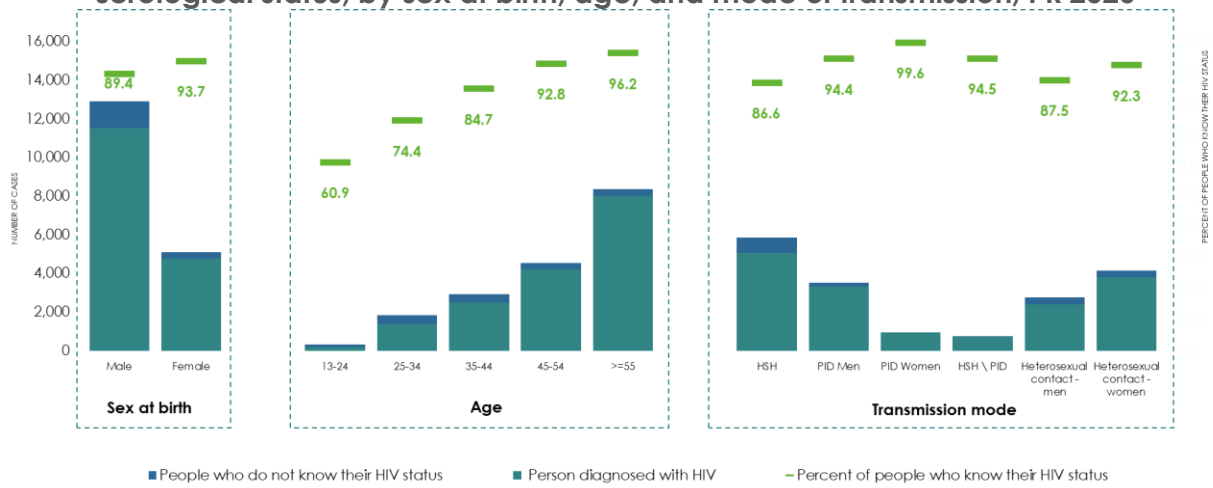
Transmission mode	Incidence
MSM	64%
PWID - men	4%
PWID - women	1%
MSM / PWID	2%
Heterosexual contact with men	14%
Heterosexual contact with women	15%

During the cumulative period from 2016 to 2020, the percentage of people with a positive HIV diagnosis who know their serological status continues to increase from 89.9% for 2016 to 90.5% for 2020 (Graph 19). Within this, 1,400 men, 790 men who had sex with men and 470 people within the ages of 25-34 years do not know their HIV status (Graph 20).

Graph 19: Prevalence Estimates and Percentage of People Who Know Their Serological Status, PR 2016 - 2020



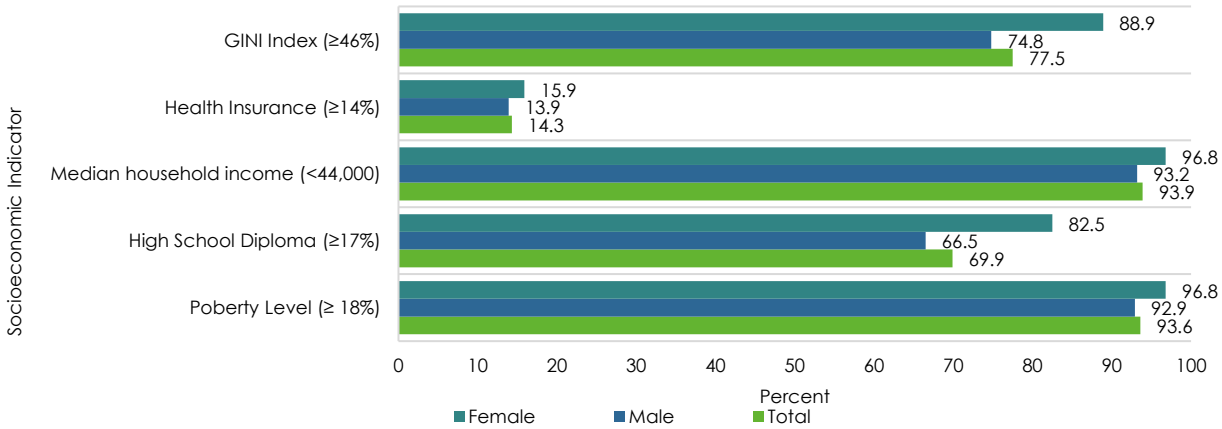
Graph 20: HIV prevalence estimates and percentage of people who know their serological status, by sex at birth, age, and mode of transmission, PR 2020



SOCIAL DETERMINANTS OF HEALTH AND HIV IN PUERTO RICO, 2019

A total of 88.9% of women diagnosed with HIV suffer from income inequality, while 93.9% of people diagnosed with HIV have a median household income. Only 69.9% of people have a high school diploma and more than 93% of people diagnosed with HIV in Puerto Rico live below the poverty level (Graph 21). The variables for each SDH indicator were categorized using empirically derived quartiles, and each quartile cutoff point was rounded to the nearest integer. The quartile cutoff points were determined using data from all census tracts in the 50 states, the District of Columbia and Puerto Rico.[2].

Graph 21: Socioeconomic Indicators of People with a positive HIV diagnosis in PR, 2019



Educational Level: Percentage of people residing in the census tract with the lowest proportion of high school graduates or its equivalent.

[2] Centers for Disease Control and Prevention. Social determinants of health among adults with diagnosed HIV infection, 2019. HIV Surveillance Supplemental Report 2022;27(No. 2). http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published March 2022. Accessed [08/01/2022].

Median household income: Median household income of persons residing in the census tract is less than $44,000 per year.

GINI Index: It measures the income inequality of people residing in the census tract and is greater than or equal to 46%.

Poverty Level: Percentage of persons residing in the census tract living below the federal poverty level is equal to or greater than 18%.

Medical Insurance Coverage: Percentage of people residing in the census tract with the proportion of health insurance coverage is greater than or equal to 14%.

NATIONAL HIV BEHAVIORAL SURVEILLANCE (NHBS)"

The Behavioral Study (ECO) is funded by the Centers for Disease Control and Prevention (CDC). This study is conducted in 20 Eligible Metropolitan Statistical Areas (AMES) in the United States and Puerto Rico. It is known nationally as the National HIV Behavioral Surveillance System (NHBS).

NHBS is an anonymous cross-sectional survey of populations at high risk for HIV infection: Venue Based Sampling (VBS), Men who have Sex with Men (MSM); and Respondent Driven Sampling (RDS) Intravenous Drug Users (IDU or PWID) and High Risk Heterosexuals (HET). It is conducted in 21 AMEs in the United States and Puerto Rico. In the case of Puerto Rico, it responds to the San Juan Eligible Metropolitan Area, composed of 30 municipalities mainly in the Metropolitan and Eastern Area.

Illustration 10: AME of San Juan

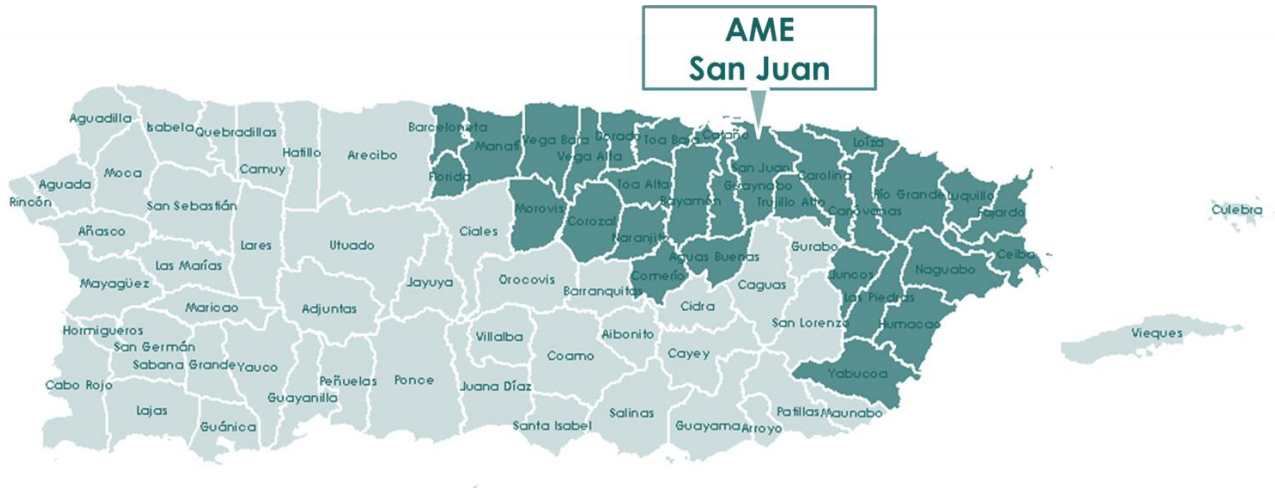


Table 5 presents the demographic characteristics of the last cycle of the MSM population for 2017. After applying the eligibility criteria, a total of 276 participants were included in 2017. The mean age was 38.78 (± 12.65) years, and the first three predominant age groups were 45 years and older with 40% followed by 25-34 years and 18-24 years with 30% and 15%, respectively. In terms of education, less than one-third of the participants have a high school diploma or less education and 62% of the participants have a higher level of education or a bachelor's degree. Approximately 75% of the sample reported being

employed at the time of the interview. In addition, 61% of participants reported having a household income equal to or greater than $20,000 in a year. More than three-quarters of the participants reported having health insurance coverage at the time of the interview. In terms of sexual orientation, 80% of participants identified themselves as homosexual.

Table 5: Sociodemographic characteristics among MSM population, for the Fifth cycle of NHBS, 2017

Characteristics	2017 n = 276 No. (%)
Age, years	38.78 ± 12.65
18-24	42 (15.2)
25-34	84 (30.4)
35-44	40 (14.5)
≥ 45	110 (39.9)
Education	
High school or less	33 (12.0)
Some college, technical school or associate degree	72 (26.1)
BS or higher education	171 (62.0)
Actually employed	
No[a]	79 (28.6)
Yes	197 (71.4)
Household Income [d]	
$0-$19,999	108 (39.3)
≥ $20,000	167 (60.7)
Currently has Health Insurance [d]	
No	36 (13.0)
Yes	240 (87.0)
Sexual Identity	
Heterosexual	7 (2.6)
Homosexual	228 (82.9)
Bisexual	40 (14.5)
Place of recruitment	
Bars/Dance Clubs	175 (63.4)
Sex environments	28 (10.1)
Other[e]	73 (26.5)

[a] Includes full-time students, homemaker, retired, disabled, and other employment not specified. [d]Not all columns sum to 100% due to missing values or rounding. [e]Includes cafes, restaurants, parks, beaches, social organizations, retail businesses, street locations and other venues where participants congregated. [§]Indicates data were not collected during the cycle.

Table 6 presents the sociodemographic characteristics in people who inject drugs (PWID) for the fifth cycle of NHBS. A total of 500 participants were recruited during the fifth cycle of NHBS in the San Juan Metropolitan Statistical Region. Of the total number of participants, 84% mentioned considering themselves to be male, while the predominant sexual orientation among the participants was heterosexual with 87%. The most predominant age groups were 40 to 49 years old, 30 to 39 years old and 50 to 59 years

old with 35%, 27% and 34%, respectively. At least 37% of the sample mentioned having studies equivalent to the tenth grade and 22% mentioned having an associate degree, technical or higher. Almost three parts of the sample, 76%, reported being unemployed at the time of the interview and 81% of the participants mentioned having an income less than or equal to $4,999. In terms of health insurance, 63% reported having some type of medical insurance. Of the participants, only 12% reported having been incarcerated in the past 12 months prior to the interview and 44% reported being homeless at the time of the interview.

Table 6: Sociodemographic characteristics in PID for fifth cycle NHBS, PR 2018.

Characteristics	2018 N = 500 n (%)
Gender	
Male	420 (84.0)
Female	76 (15.2)
Transgender	4 (0.8)
Age at interview (Mean ± DE)	45 ± 10
18-24 years	4 (0.8)
25-29 years	30 (6.0)
30-39 years	135 (27.0)
40-49 years	174 (34.8)
50-59 years	118 (23.6)
≥ 60 years	39 (7.8)
Education [d]	
Eighth grade or less	102 (20.4)
Ninth through eleventh grade	99 (19.8)
Tenth grade or equivalent	187 (37.4)
Associate degree, technical or higher	111 (22.2)
Employment status	
Employed	40 (8.0)
Disabled for employment	56 (11.2)
Unemployed	381 (76.2)
Other [a]	23 (4.6)
Annual Income [d]	
≤ $4,999	403 (80.6)
$5,000-$9,999	53 (10.6)
≥ $10,000	41 (8.2)
Health Insurance [d]	
No	184 (36.8)
Yes	316 (63.2)
Sexual orientation [d]	
Heterosexual	434 (86.8)
Homosexual	7 (1.4)
Bisexual	58 (11.6)
Incarcerated, p12md [d]	
No	343 (68.6)
Yes	62 (12.4)

Currently homeless [d]	
No	100 (20.0)
Yes	223 (44.6)

[a] Includes full-time/part-time students, retired/pensioner, caretaker of household chores, and other unspecified employment status. [d] Cells do not sum to 100% due to the presence of missing values. Note: Past 12 months (p12m) refers to the 12 months prior to the NHBS interview.

Table 7 presents the types of injectable drug used by people who inject drugs during the past 12 months prior to the interview for the fifth NHBS cycle in 2018. The most commonly used injectable drug during the past 12 months was heroin and cocaine together, speedball, with 85% of participants. This was followed by heroin and cocaine use, each separately, in the past 12 months at 63% and 44% respectively. During the past 12 months prior to the interview, crack use was reported by 16%, opioid use by 12% and crystal methamphetamine use by 10% of study participants.

Table 7: Type of injectable drug used by PID during the past 12 months, for the fifth cycle of NHBS, PR 2018

Type of injectable drug	2018 N = 500 n (%)
Heroin and cocaine (speedball) in the p12m [d]	
No	73 (14.6)
Yes	427 (85.4)
Heroin in the p12m [d]	
No	183 (36.6)
Yes	316 (63.2)
Powdered cocaine in the p12md [d]	
No	278 (55.6)
Yes	222 (44.4)
Crack in the p12m [d]	
No	419 (83.8)
Yes	81 (16.2)
Crystalline methamphetamine in the p12md [d]	
No	447 (89.4)
Yes	50 (10.0)
Opioid (Oxycontin) in the p12md [d]	
No	438 (87.6)
Yes	61 (12.2)

d: Cells do not sum to 100% due to the presence of missing values. Note: Past 12 months (p12m) refers to the 12 months prior to the NHBS interview.

On the other hand, Table 4 presents the types of injectable drug used in persons who inject drugs daily during the fifth cycle of NHBS in Puerto Rico for 2018. The most commonly used daily injectable drug was heroin and cocaine, speedball, with 76% of participants. This was followed by heroin use with 54%. Participants also reported daily use of powder cocaine with 35%, crack with 11%, and crystal methamphetamines and opioids with 7% use.

Table 8: Type of injectable drug used daily in PID, during the past 12 months, for the fifth cycle of NHBS, PR 2018.

Type of Daily Injectable Drug	2018 N = 500 n (%)
Heroin and cocaine (speedball)	
No	119 (23.8)
Yes	381 (76.2)
Heroin	
No	230 (46.0)
Yes	269 (53.8)
Powdered cocaine	
No	324 (64.8)
Yes	176 (35.2)
Crack	
No	446 (89.2)
Yes	54 (10.8)
Crystalline methamphetamine	
No	460 (92.0)
Yes	37 (7.4)
Opioid (Oxycontin)	
No	463 (92.6)
Yes	36 (7.2)

d Cells do not sum to 100% due to the presence of missing values

3. HIV PREVENTION, CARE AND TREATMENT RESOURCE INVENTORY

This section provides an inventory of the resources available in Puerto Rico to meet the surveillance, prevention, and treatment needs associated with HIV. It includes the entities that provide services, as well as the sources of local and federal funds available to address the different stages of the HIV Continuum of Care. Within this framework, the strengths and weaknesses of the service delivery system are also discussed, including the strategy for coordinating services related to problematic substance use and mental health.

ORGANIZATIONS AND AGENCIES PROVIDING SERVICES RELATED TO HIV PREVENTION AND CARE

The Department of Health of Puerto Rico (PRDOH) is the agency responsible for all matters related to health, sanitation, and welfare, by virtue of Act No. 81-1912, as amended, and the provisions of Section 5 and 6 of the Constitution of Puerto Rico of July 25, 1952. The Department establishes public policy on health, supervises the providers of health services in Puerto Rico, and ensures compliance with the rules for the general welfare of the population. It is also responsible for the physical and mental health of the people residing in Puerto Rico. The mission of the Department is to promote and preserve health as an indispensable condition for every human being to enjoy the physical, emotional, and social well-being that will allow him or her to fully enjoy life and thus contribute to the productive and creative efforts of society. In addition, pursuant to Act No. 11-1976, as amended, the Puerto Rico Comprehensive Health Services Reform Act, all functions

related to the agencies in charge of regulating the health-related professions in Puerto Rico were transferred to the Department of Health.

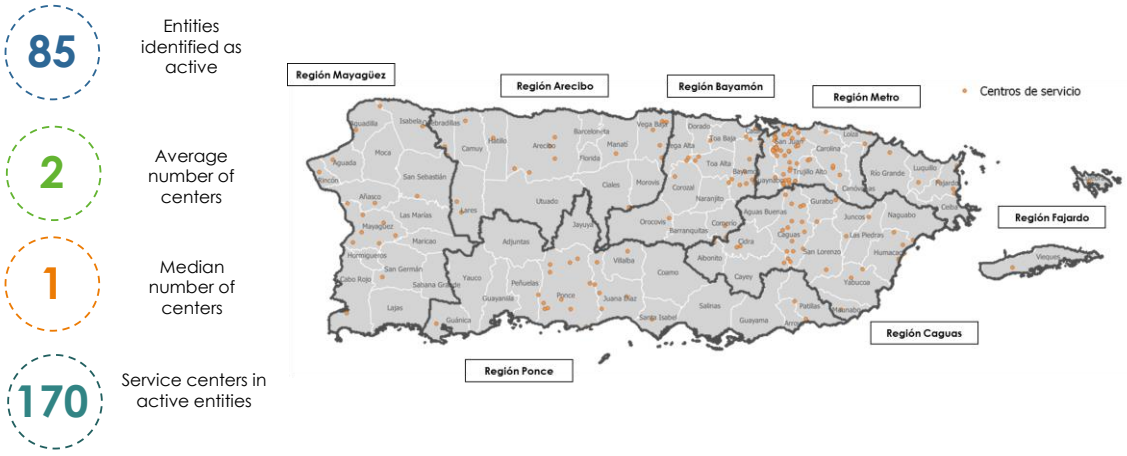
Based on this regulatory framework, the Puerto Rico Department of Health is the agency responsible for the surveillance of HIV cases and for developing and implementing public policies related to the issue. To address this area of responsibility, the agency has the Medicaid Program, which establishes the guidelines for coverage under the Government Health Plan for beneficiaries with a positive diagnosis of HIV or AIDS under the PR Medicaid State Plan; the Division of Epidemiology and its HIV/AIDS Surveillance Program; and the Assistant Secretary for Family Health, Integrated Services and Health Promotion, which has the Central Office for AIDS and Communicable Diseases Affairs (OCASET) from which HIV Prevention and Treatment services are offered. The latter operational unit has the following organizational structures or programs to provide HIV or AIDS care and prevention services:

- STI/HIV/Viral Hepatitis Prevention Division
- Ryan White Part B/ADAP Program
- Communicable Disease Prevention and Treatment Centers
- Pharmacy Unit
- HIV/AIDS Housing Opportunities for Persons with HIV/AIDS (HOPWA) Program
- Tuberculosis Control Program

This structure of services provided by the state through the Department of Health is complemented by the work of various government agencies, non-profit and private entities, to provide integral and comprehensive services related to HIV surveillance, prevention and care in Puerto Rico, as well as the provision of support services.

According to the inventory of HIV and STI Service Providers, published in 2021 as part of the activities of the 2017-2021 integrated plan, and reviewed for the purposes of this planning process, a total of 85 active entities providing HIV-related services were identified in Puerto Rico. These entities, both public and private, have an average of 2 centers or facilities from which they provide services, for a total of 170 service centers throughout the Island.

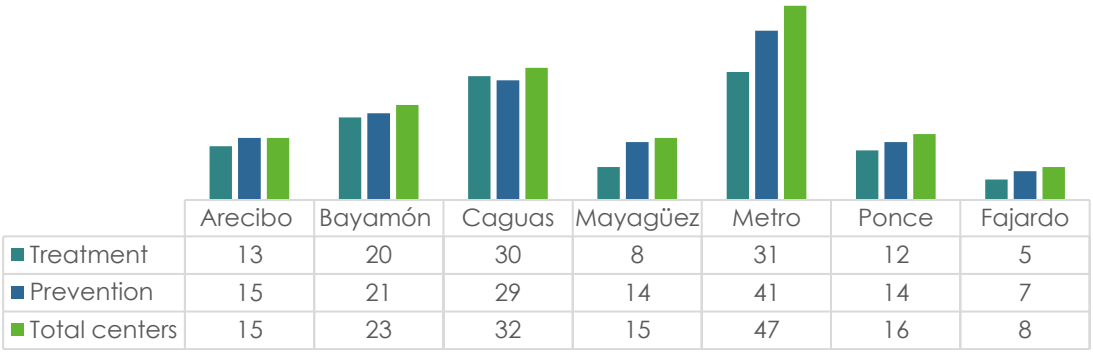
Illustration 11: Organizations providing HIV-related services in Puerto Rico



Source: Directory of HIV, STI, Viral Hepatitis and TB services (2021. Revised to 2022).

When examining the location of the service centers by region of the Department of Health, differences are observed. As illustrated in the following graph and tables, a significantly higher proportion is located in the Metropolitan Area compared to other regions of the Island. In fact, as mentioned below, in the workshops held, it was recognized that during the past few years there has been progress with respect to the coverage of services in geographic terms, but that differences persist by region.

Graph 22: Centers by type of services and geographic area of location



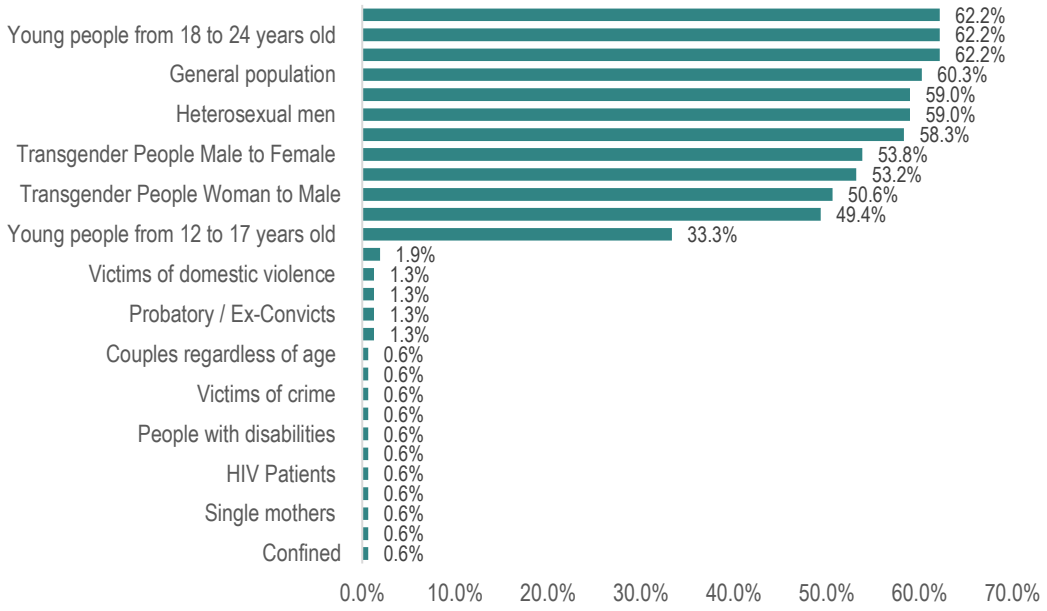
	Arecibo	Bayamón	Caguas	Mayagüez	Metro	Ponce	Fajardo
Treatment	13	20	30	8	31	12	5
Prevention	15	21	29	14	41	14	7
Total centers	15	23	32	15	47	16	8

Region	Total centers by region		Total treatment centers		Total prevention centers	
	Freq.	%	Freq.	%	Freq.	%
Arecibo	15	9.6%	13	10.9%	15	10.6%
Bayamón	23	14.7%	20	16.8%	21	14.9%
Caguas	32	20.5%	30	25.2%	29	20.6%
Mayagüez	15	9.6%	8	6.7%	14	9.9%
Metro	47	30.1%	31	26.1%	41	29.1%
Ponce	16	10.3%	12	10.1%	14	9.9%
Fajardo	8	5.1%	5	4.2%	7	5.0%
Total	**156**	**100.0%**	**119**	**100.0%**	**141**	**100.0%**

Source: Directory of HIV, STI, Viral Hepatitis and TB services (2021, Revised to 2022).

These entities offer services to the general population and those at higher risk for HIV/STI infections. Services are provided by multidisciplinary health professionals, including health educators, physicians, case managers, clinical professionals, behavioral science professionals, among others. The median number of people served by entities that provide prevention services is around 300 cases, while the median number of people served by entities that provide clinical care services is around 100.

Graph 23: Percentage of entities that reported providing services by type of population



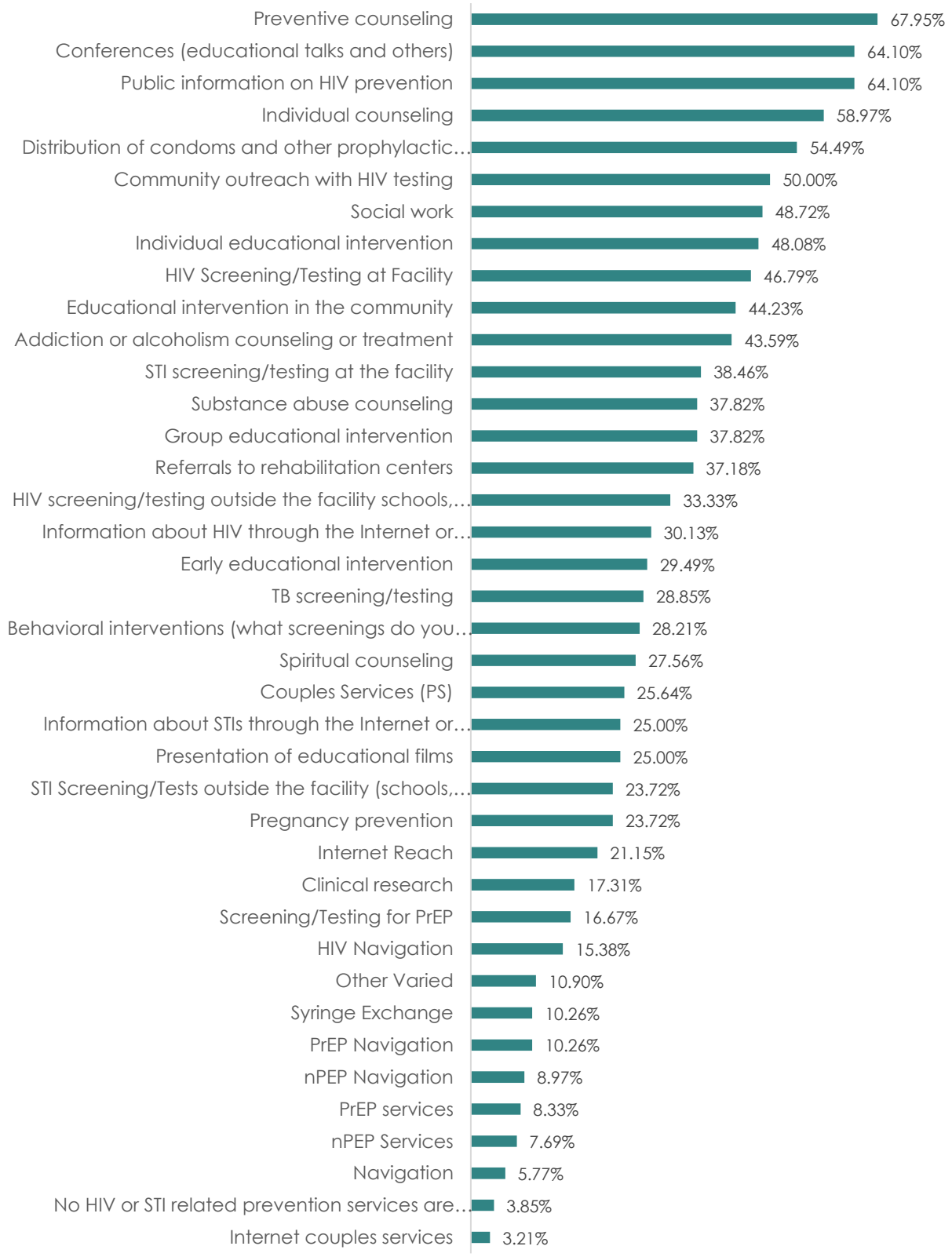
Source: Directory of HIV, STI, Viral Hepatitis and TB services (2021. Revised to 2022).

Graph 24: Human resources available for the provision of services

Source: Directory of HIV, STI, Viral Hepatitis and TB services (2021. Revised to 2022).

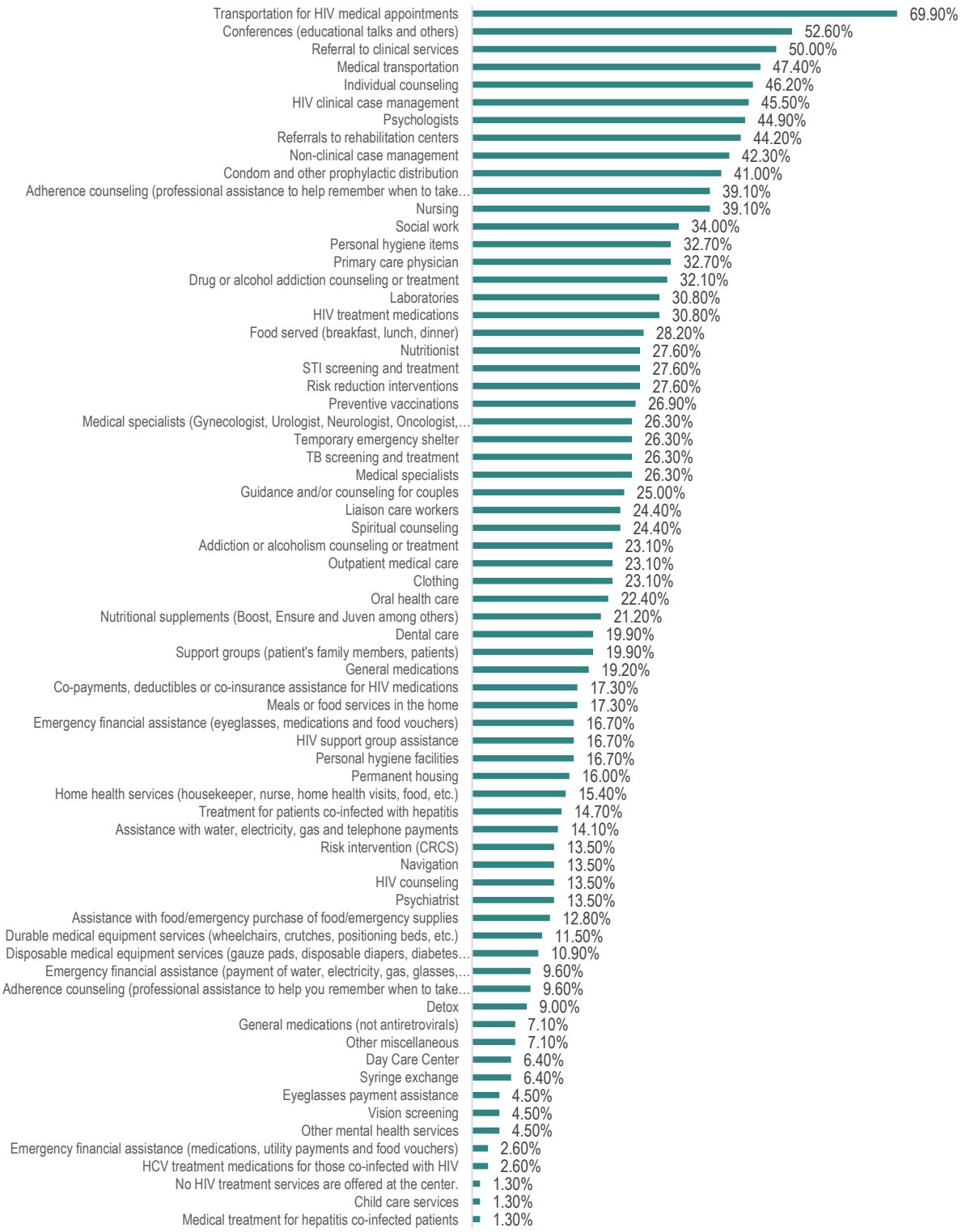
In terms of services provided to these populations, it was identified that 84% of the identified centers provide services related to HIV diagnosis and prevention, while 71% provide some service related to HIV care, including treatment and support services.

Graph 25: Diagnostic and preventive services provided by the identified centers



Source: Directory of HIV, STI, Viral Hepatitis and TB services (2021. Revised to 2022).

Graph 26: Treatment services provided by the identified centers



Source: Directory of HIV, STI, Viral Hepatitis and TB services (2021. Revised to 2022).

With respect to the integration of mental health and problematic substance use services, these are coordinated through community-based organizations that provide services to the population, as well as the Mental Health and Addiction Services Administration (ASSMCA). ASSMCA, created by Act No. 67-1993, as amended, and attached to the Department of Health, is the agency of the Government of Puerto Rico with the primary responsibility to carry out programs for the prevention, care, mitigation and solution of mental health and substance addiction or dependence problems in order to promote and preserve the biopsychosocial health of the people. Its mission is to ensure the delivery of high quality, cost-effective and evidence-based integrated mental health services through the development and implementation of innovative strategies offered in an environment of respect and diversity. ASSMCA has a Comprehensive Medication Assisted Treatment Clinic, through which specific services are provided to populations with a positive HIV diagnosis, as well as populations at risk of contracting the virus. These services include community outreach with HIV testing, individual counseling, preventive counseling, social work, among others.

SOURCES OF FUNDS AND RESOURCE LEVERAGE

The table below includes a description of the financial resources available in the jurisdiction from the federal and state government. Non-profit organizations can also access funds through foundations and other philanthropic entities. Over the past few years, Puerto Rico has faced great challenges with respect to its fiscal situation. In increasingly complex social, economic and environmental context, the demand for social and health services provided by the state and nonprofit organizations is increasing, while the resources to provide them are becoming increasingly limited. In this regard, there is a pressing need to identify available sources and ways in which resources can be leveraged to achieve greater impact.

The information included on available federal funds is based on annual allocations, as reported on USA Spending.gov. The information on local funds comes from the Office of Management and Budget of the Government of Puerto Rico and the Assistant Secretary of Family Health and Integrated Services of the Department of Health

Description of funds						Areas served and relationship to the continuum of care							
Source of funds	Program	Amount of funds $	Recipients	Subrecipients	Services provided	Surveillance	Prevention	Diagnosis	Link to care	Retention in care	Care	Viral load suppression	Support Services
CDC	HIV Prevention Activities, Non-Governmental Organization Based	$1,283,250	Department of Health	N/A	Provide assistance to nonprofit organizations to develop and implement effective, community-based HIV prevention programs. Seeks to promote coordination of HIV prevention efforts among community-based organizations, agencies providing HIV education and prevention services, and public organizations, including state and local health departments and substance abuse agencies.								
CDC	HIV Prevention Activities Health Department Based	$8,536,319	Department of Health	8	The funds provided by this program can be used to support, implement and evaluate HIV prevention programs implemented by the State. In particular, prioritize high-impact HIV prevention.								
CDC	Epidemiologic Research Studies of Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection in Selected Population Groups	$350,000	Department of Health	N/A	Provides funding for HIV epidemiological research.								

Description of funds						Areas served and relationship to the continuum of care							
Source of funds	Program	Amount of funds $	Recipients	Subrecipients	Services provided	Surveillance	Prevention	Diagnosis	Link to care	Retention in care	Care	Viral load suppression	Support Services
CDC	Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance	791421	Department of Health	N/A	Through this program, a behavioral biological surveillance system is established among high-risk populations (such as men who have sex with men, people who inject drugs, and heterosexuals at increased risk of HIV infection) in the metropolitan statistical areas with the highest HIV prevalence in the United States.								
CDC	Viral Hepatitis Prevention and Control	$315,000	Department of Health	N/A	Provides funding for the strengthening of viral hepatitis surveillance systems, as well as for the dissemination of information to understand trends and develop prevention and health interventions to respond to hepatitis A, B, and C.								
CDC	Strengthening STD Prevention and Control for Health Departments (STD PCHD)	$2,077,490	Department of Health	N/A	Prevent and control the three main STIs: chlamydia, gonorrhea and syphilis. The fund supports strategies and activities to eliminate congenital syphilis; prevent antibiotic-resistant gonorrhea; reduce primary and secondary syphilis; prevent STI-related pelvic inflammatory disease, ectopic pregnancy, and infertility; address STI-related outbreaks; and reduce STI-								

Description of funds						Areas served and relationship to the continuum of care							
Source of funds	Program	Amount of funds $	Recipients	Subrecipients	Services provided	Surveillance	Prevention	Diagnosis	Link to care	Retention in care	Care	Viral load suppression	Support Services
					related health disparities. Priority populations are adolescents and young adults, MSM, and pregnant women.								
CDC	DIS Workforce Development	$1,917,681	Department of Health	N/A	The objective of the investment is to support the outbreak response needs of the 21st century by 1. Expanding and improving the frontline public health workforce. 2.Conducting training and skills development of DIS personnel. 3.Building organizational capacity for outbreak response 4.Evaluate and improve recruitment, training and outbreak response efforts.								
CDC	Integrated HIV Programs for Puerto Rico Department of Health to Support Ending the HIV epidemic in San Juan, Puerto Rico	$2,011,055	Department of Health	1	Ensure the coordination and implementation of the national plan for the Elimination of HIV in Puerto Rico.								
HRSA	HIV Emergency Relief Project Grants (Ryan White Part A)	$10,786,318	Municipality of San Juan	22	Provide direct financial assistance to eligible metropolitan areas (EMA's) and transitional grant areas (TGA's)								

Description of funds						Areas served and relationship to the continuum of care							
Source of funds	Program	Amount of funds $	Recipients	Subrecipients	Services provided	Surveillance	Prevention	Diagnosis	Link to care	Retention in care	Care	Viral load suppression	Support Services
					that have been most severely impacted by the HIV epidemic for the purpose of improving access to a high quality, comprehensive, effective, cost-effective, community-based continuum of care for low-income HIV-positive individuals and their families.								
HRSA	Ending the HIV Epidemic: A Plan for America — Ryan White HIV/AIDS Program Parts A	$1,514,034	Municipality of San Juan	1	Provides funding to implement effective and innovative strategies, interventions, approaches and services to achieve the EHE initiative's objectives.								
HRSA	HIV Care Formula Grants B/ADAP, Part B Supplementary / ADAP ERF)	$28,198,074	Department of Health	8	**Core clinical services:** Outpatient health services, AIDS Drug Assistance Program, community-based home health care, medical nutrition therapy, oral health, and clinical case management. **Support services:** non-clinical case management, outreach services, emergency financial assistance, food bank/home delivered meals, housing, transportation to support a person diagnosed HIV positive to achieve better health outcomes.								

Description of funds						Areas served and relationship to the continuum of care							
Source of funds	Program	Amount of funds $	Recipients	Subrecipients	Services provided	Surveillance	Prevention	Diagnosis	Link to care	Retention in care	Care	Viral load suppression	Support Services
HRSA	Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Part C)	$6,750,283	10 non-profit organizations	N/A	Provide continuous primary and comprehensive HIV care on an outpatient basis. This includes: 1) Early Intervention (which may include HIV counseling, testing and referrals); 2) medical evaluation and clinical care; 3) other primary care services; 4) referrals to other health services.								
HRSA	Coordinated HIV Services and Access to Research for Women, Infants, Children, and Youth (Ryan White Part D)	$945,127	2 (nonprofit organization and institution of higher education)	N/A	Provide family-centered primary medical care and support services for HIV-positive women, infants, children, and youth.								
HRSA	FY 2022 RWHAP Part F Dental Reimbursement Program (DRP) Grant Awards	$27,931	1(one) Higher education institution	N/A	Dental Services Reimbursement Program								
HUD	Housing Opportunities for Persons with AIDS (HOPWA)	$8,158,968	Department of Health & Municipality of San Juan		The program is mandated through the Continuum of Care under HOPWA funding to coordinate, establish and implement Supportive Housing Services and Supportive Services.								
SAMHSA	Substance Abuse and Mental Health Services Projects of	$2,194,415	Mental Health & Addiction		The purpose of this program is to prevent and reduce substance abuse and HIV or AIDS								

Description of funds						Areas served and relationship to the continuum of care							
Source of funds	Program	Amount of funds $	Recipients	Subrecipients	Services provided	Surveillance	Prevention	Diagnosis	Link to care	Retention in care	Care	Viral load suppression	Support Services
	Regional and National Significance - Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs)		Services Administration		transmission among at-risk populations, including Hispanic/Latino young adults between the ages of 18-24. To meet the needs of these populations, CSAP seeks to develop agreements between MSIs and community-based organizations to provide integrated prevention programs for substance abuse, hepatitis C and HIV.								
Grand Total Federal Funds													
State Funds	Various	$5,348,597.53	N/A	N/A	Surveillance, prevention, treatment and support services provided through State Government agencies.								
State Funds	State Allocation	$429,500	Health Department	10	Funding of CBOs for the provision of shelter, transitional housing, day care, HIV screening and harm reduction services. As well as prevention and treatment intervention services for special populations.								

A. STRENGTHS AND GAPS

Over the past few years, the Government of Puerto Rico, in coordination with a multiplicity of actors from various sectors and the community with a positive HIV diagnosis, has focused its efforts on strengthening the system for the provision of HIV surveillance, prevention, and treatment services. This multisectoral effort aimed to ensure that all people know their HIV status, prevent new diagnoses, and that those with a positive HIV diagnosis can achieve their maximum health potential and enjoy a full life and the enjoyment of their natural human and legal rights. Among these efforts are the promotion of innovative and evidence-based practices in the provision of services, training of human resources, and diversification of services by type and geographic area. However, due to the current context in Puerto Rico, the profile of the epidemic, and the changes that have occurred in demographics and the social and economic environment, gaps in service provision persist. These gaps are related to the lack of economic resources and geographic coverage to meet a demand that has changed in terms of its nature and magnitude. The main areas in which gaps were identified during the integrated planning process are related to:

- Coverage and access to prevention interventions or strategies, including PrEP and Syringe Exchange;
- Treatment for problematic substance use, including injection and non-injection drugs;
- Routine testing in non-clinical settings;
- Mental health linked services;
- Transportation to services; and
- Home-based services for mobility-impaired populations, such as older adults.
- Other services aimed at addressing social determinants of health and socioeconomic needs of participants, such as housing, food and nutrition, utility assistance, and other support services.

As in other jurisdictions, Puerto Rico faces a number of challenges related to human capital, including human resource shortages, particularly of health professionals in medical specialty areas (HIV physicians, mental health professionals, dentists, and nutritionists, among others), the burn-out phenomenon due precisely to staffing shortages, level of knowledge about HIV, and attitudinal barriers or barriers related to the use of inclusive and culturally sensitive language. In fact, NECA's most recent training needs study (2022) identified a number of topics in which health professionals require training. These include behavioral health (19.2%); engagement in care (16.5%); antiretroviral therapy (16.2%); Hepatitis C (14.1%); viral suppression (14.0%); linkage to care (13.5%) HIV testing (10.5%); oral health 9.0%.

B. APPROACHES AND PARTNERSHIPS

For the purposes of developing the resource inventory presented in this section, different sources of information were combined, including a review of the directory of services published in 2021 as part of the 2017-2021 Integrated Plan projects, the service provider survey being conducted as part of the Needs Assessment of Persons with HIV for the Ryan White Part B Program, HIV Prevention Study provider survey for the Division of HIV/STI

Prevention, NECA Training Needs Study (2022), among other sources. These sources of information also served to identify stakeholders and new partners to participate in the planning process and future implementation. These new partners include organizations linked to the commercial sector, homeless continuum of care systems, and other government and community-based agencies that provide support services to the population.

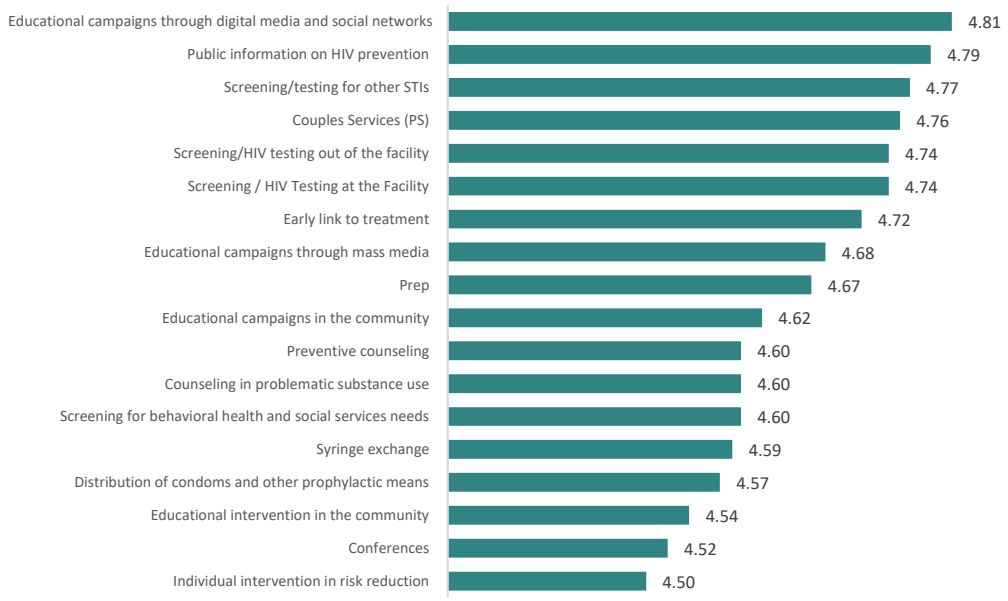
4. NEEDS ASSESSMENT

1. SERVICES PEOPLE NEED TO ACCESS HIV TESTING AND MAINTAIN A NEUTRAL STATUS IN SERVICES

As part of the integrated planning workshops conducted, participants identified those services that they consider important to ensure that people have access to HIV diagnosis and prevention and can remain negative.

In general, the majority of participants understood all of the services examined to be important or very important. Those services that were rated with the highest level of importance include, educational campaigns through digital media and social networks (4.81), availability of public information for HIV prevention (4.79), screening/testing for other STIs (4.77) and partner services (PS) (4.76) and screening or testing outside the facility as well as in clinical settings (4.74).

Graph 27: Level of importance of the different services related to HIV prevention



Note: the graph illustrates the average score obtained, based on a scale of 1 to 5 where 5 means the highest level of importance.

2. SERVICES THAT PEOPLE WITH HIV NEED TO STAY IN HIV CARE AND TREATMENT AND ACHIEVE VIRAL SUPPRESSION

This section discusses the services that are necessary for people with HIV to remain in care and treatment and to achieve viral suppression. As a starting point, it is important to present some of the highlights from the Ryan White Part B Program's ongoing Needs Assessment of People with a Positive HIV Diagnosis. The study combines several data collection methods, including a survey of people in treatment receiving services in Part B sub-recipient projects and people out of treatment[3], in-depth interviews with opinion leaders, and a survey of service providers[4].

Preliminary data from the Study, regarding the survey of the HIV-positive population, show a profile in which the majority of people on treatment are male (58.3%), have a median age of 57 years, are heterosexual (72.3%), have completed some high school grade or have a high school diploma, and are unmarried (49%). In addition, about half identify as white (48.2%), about one-third are retired or disabled (30.8%), with an annual income of less than $15,000. On the other hand, those out of treatment are predominantly male (71.7%), have a median age of 55 years, are heterosexual (62.3%), have a median education level of some high school grade or a high school diploma, are single (56.6%), a smaller proportion are white (41.5%), slightly more than a quarter are employed full-time (28.3%) and have an annual income of less than $15,000.

[3] For the purposes of the integrated planning process, the preliminary results of the surveys conducted to date (410 out of a sample of 525) were considered.

[4] For the purposes of the integrated planning process, the preliminary results of the surveys conducted to date (23 suppliers out of a sample of 56) were considered.

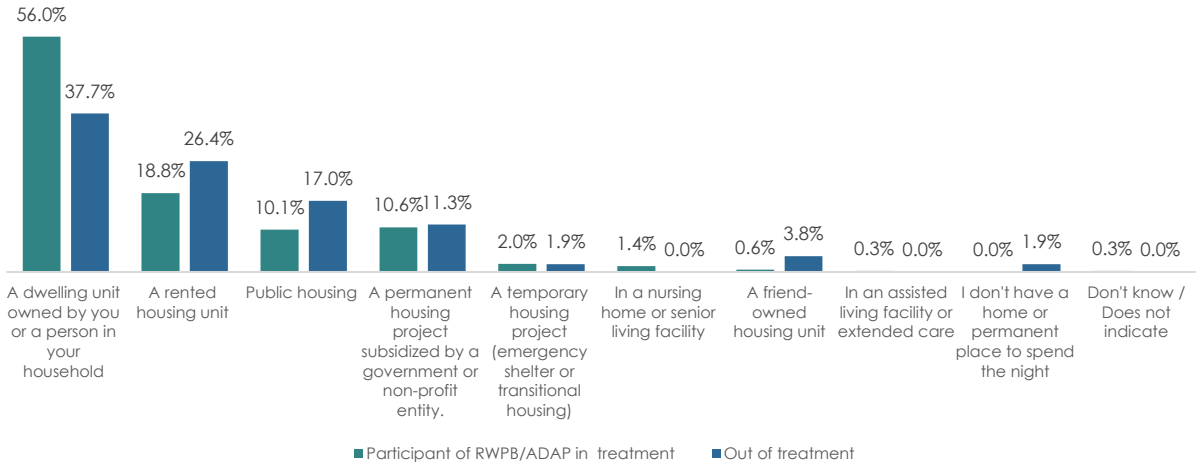
Table 9: Demographic profile

	In treatment participating in RWPB/ADAP	Out of treatment
Median age	**57**	**55**
Gender		
Male	58.3%	71.7%
Female	40.9%	28.3%
Transgender	0.6%	0.0%
Other gender neither masculine nor feminine (non-binary, gender fluid, agender, culturally specific gender)	0.3%	0.0%
Sexual orientation		
Heterosexual	72.3%	62.3%
Homosexual	21.6%	28.3%
Undecided	0.3%	0.0%
Bisexual	4.5%	7.5%
Pansexual	0.0%	1.9%
Transexual	0.3%	0.0%
Do not know	0.8%	0.0%
Do not want to answer	0.3%	0.0%
Median educational level	**High School / Twelfth year**	**High School / Twelfth year**
Marital Status: Never married (single)	**49.0%**	**56.6%**
Ethnic origin: Puerto Rican	**93.3%**	**88.7%**
Race		
White	48.2%	41.5%
Multiracial	30.5%	26.4%
Black or African American	19.3%	28.3%
Indian / Taíno	1.4%	1.9%
Don't know / Does not indicate	0.6%	1.9%

	In treatment participating in RWPB/ADAP	Out of treatment
Occupational status		
Retired or Disabled	30.8%	26.4%
Unemployed	18.5%	20.8%
Housewife	19.9%	11.3%
Full-time employee	16.2%	28.3%
Part-time employee	8.4%	5.7%
Self-employed or own a business	6.2%	7.5%
Studying	3.1%	0.0%
Does nit indicate	0.0%	0.0%
They have a medical health insurance	.06%	0.0%
Health insurance: *Plan Vital* (government health plan)	**86.6%**	**88.7%**
Beneficiary of programs for assistance in payment of medicines	**19.0%**	**39.6%**
Average number of people in the household	**2**	**2**
Person in the household who has a physical, intellectual or sensory condition or disability	**29.1%**	**41.5%**
Sources of household income or assistance (top 2)		
Nutritional Assistance Program (*PAN*)	74.5%	77.4%
Social Security	42.0%	22.6%
Median annual household income	**Less than $15,000**	**Less than $15,000**

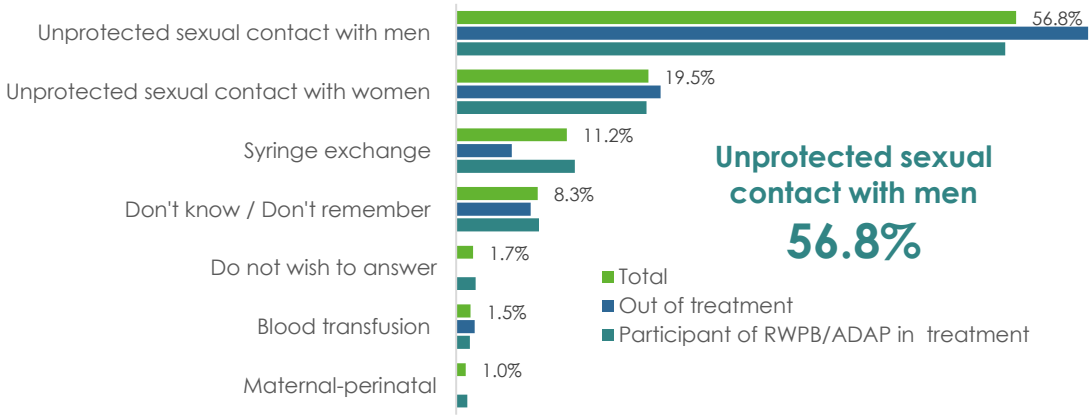
In assessing the housing aspect of where they reside or spend the night, slightly more than half (56%) of Ryan White Part B participants in treatment and one-third (37.7%) of out-of-treatment participants reside in a housing unit owned by them or a member of their household. With regard to a rented housing unit, 26.4% of out-of-treatment participants and 18.8% of in-treatment participants live in such a unit. In addition, 17% of out-of-treatment participants and 10.1% of treatment participants reside in a public housing project.

Graph 28: Housing

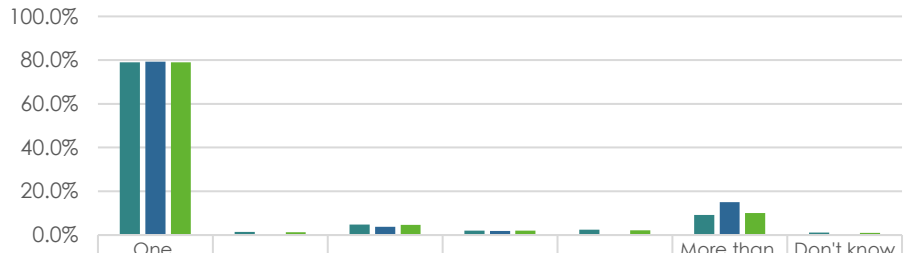


With respect to how HIV was transmitted, almost six out of ten participants (56.8%) contracted HIV through unprotected sexual contact with a man. To a lesser degree, unprotected sexual contact with a woman (19.5%) was also mentioned as another way of transmission HIV. Nearly eight in ten participants (79%) took one month or less to first visit a doctor, nurse or other health care provider to seek HIV medical care and only one tenth (10%) of participants took more than one (1) year to seek HIV medical care.

Graph 29: How did you contract HIV?



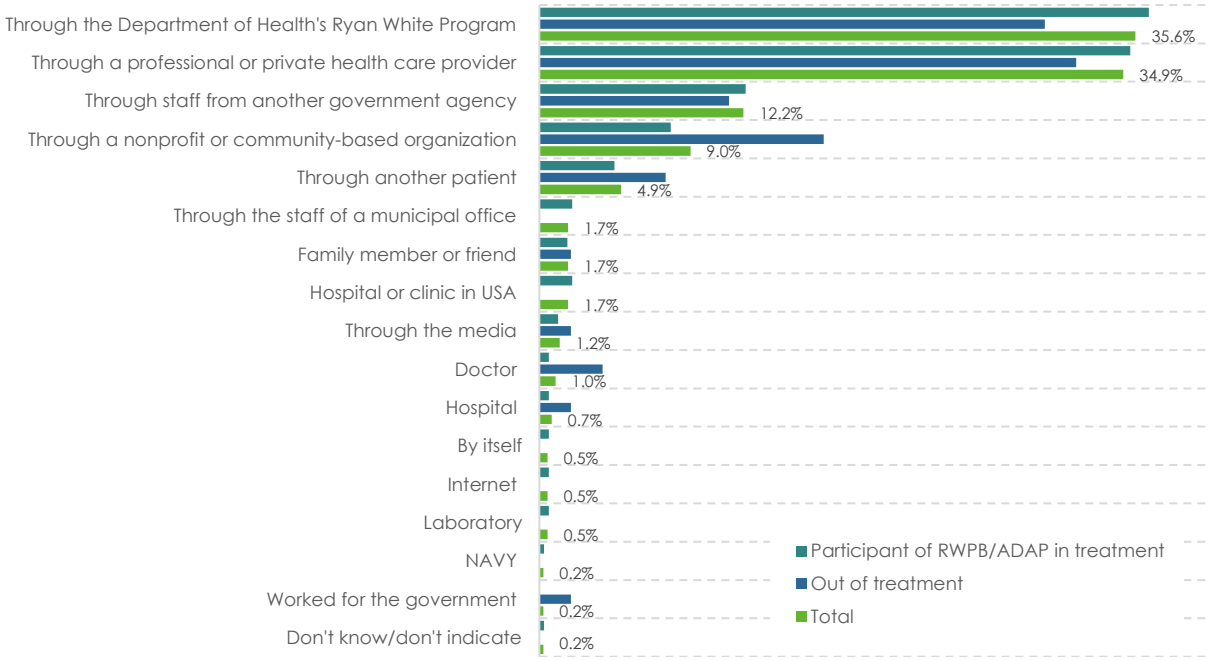
Graph 30: Since being diagnosed HIV-positive, how long after that did you first visit a doctor, nurse, or other health care provider for HIV care?



	One month or less	2 months	3-6 months	7-9 months	10-12 months	More than one (1) year	Don't know / Does not indicate
Participant of RWPB/ADAP in treatment	79.0%	1.4%	4.8%	2.0%	2.5%	9.2%	1.1%
Out of treatment	79.2%	0.0%	3.8%	1.9%	0.0%	15.1%	0.0%
Total	79.0%	1.2%	4.6%	2.0%	2.2%	10.0%	1.0%

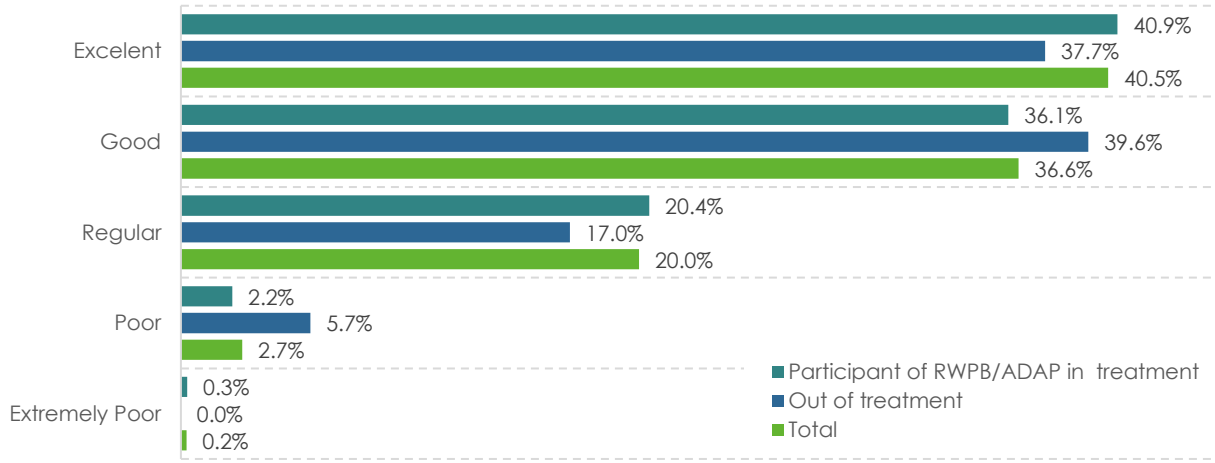
When asked how they initially learned or received information about the services that are available to persons diagnosed with HIV in their municipality or region, 35.6% learned about them through the Department of Health's Ryan White program while 34.9% learned about them from a private health care professional or provider.

Graph 31: How did you initially learn about or receive information about services available to HIV-positive people in your municipality or region?



Currently, almost eight out of ten participants (77.1%) describe their health condition as excellent or good. Only 2.9% of people say that their health is currently poor or extremely poor.

Graph 32: How they describe their current health condition



Note: The numerical base is the 410 people interviewed.

When asked about situations when accessing clinical and support services during the COVID-19 pandemic, 36.3% had no difficulty at all while 33.9% did not know or did not indicate. However, among the situations they experienced were difficulty in getting appointments with specialists (12.2%) and difficulties in getting appointments with the doctor to treat HIV (11.7%).

Graph 33: During the COVID-19 pandemic, which, if any, of the following situations have you experienced when accessing clinical and support services to care for your HIV-positive diagnosis?

Clinical case management (38.3%), outpatient primary care physician/HIV outpatient services (37.1%), and medical nutrition therapy/nutritional counseling (34.9%) were the clinical services most needed or requested by participants during the six months prior to the survey for the treatment of their HIV-positive diagnosis. As shown in the graph below, for most services, 85% or more of those who needed services received them. However, in the case of home-based services, the proportion of people who received them is much

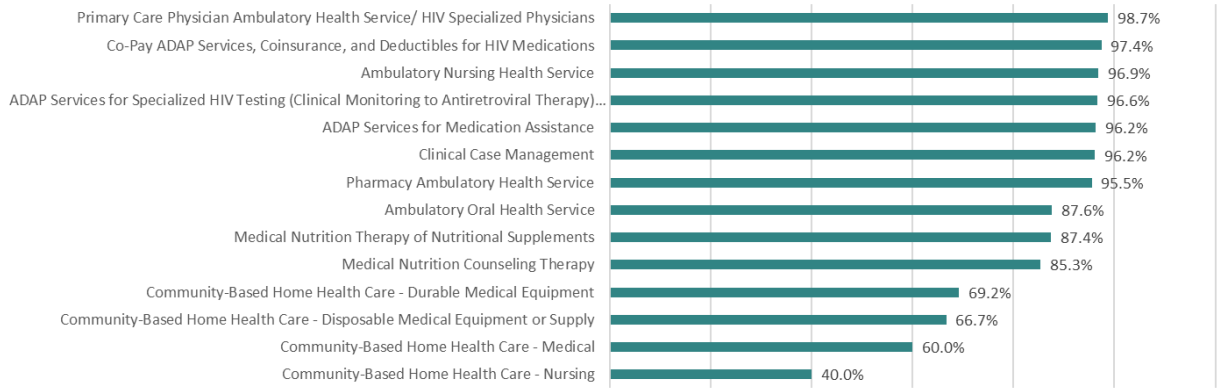
lower. On the other hand, the services received were described - with the exception of oral health services and home-based nursing services - as excellent or good by more than 90% of the people who received them.

Table 10: Clinical services needed or requested during the past six months for the treatment of your HIV-positive diagnosis

	In treatment, RWPB/ADAP participant		Out of treatment		Total	
	Freq.	%	Freq.	%	Freq.	%
Clinical Case Management	142	39.8%	15	28.3%	157	38.3%
Outpatient Health Service of Primary Physician/ Doctors Specialized in HIV	135	37.8%	17	32.1%	152	37.1%
Medical Nutrition Counseling Therapy	130	36.4%	13	24.5%	143	34.9%
Pharmacy Outpatient Health Service	120	33.6%	13	24.5%	133	32.4%
Medical Therapy of Nutritional Supplements	115	32.2%	12	22.6%	127	31.0%
ADAP Services for Specialized HIV Testing (Clinical Monitoring to Antiretroviral Therapy) and Hepatitis C	107	30.0%	10	18.9%	117	28.5%
ADAP Services for Medication Assistance	96	26.9%	10	18.9%	106	25.9%
Ambulatory Nursing Health Service	85	23.8%	11	20.8%	96	23.4%
Outpatient Oral Health Services	81	22.7%	8	15.1%	89	21.7%
Co-Pay ADAP Services, Coinsurance, and Deductibles for HIV Medications	72	20.2%	5	9.4%	77	18.8%
Community-Based Home Health Care - Durable Medical Equipment	12	3.4%	1	1.9%	13	3.2%
Community-Based Home Health Care - Disposable Medical Equipment or Supply	8	2.2%	1	1.9%	9	2.2%
Community-Based Home Health Care - Medical	3	0.8%	2	3.8%	5	1.2%
Community-Based Home Health Care - Nursing	5	1.4%	0	0.0%	5	1.2%
None of these services/ Don't know / Does not indicate	133	37.3%	21	39.6%	154	37.6%
No sabe / No indica	1	0.3%	0	0.0%	1	0.2%
Total	**357**		**53**		**410**	

Note: The numerical base is the 410 people interviewed. Being a multiple-choice question, an independent count is made for each of the answers mentioned and the sum of percentages can be different from 100%.

Graph 34: People who received the services they needed in the past six months



Note: The numerical base is the 410 people interviewed. Since this is a multiple response question, a separate count is made for each of the answers mentioned and the sum of percentages may be different from 100%.

Table 11: How they evaluate the quality of the services received

	In treatment, RWPB/ADAP participant	Out of treatment	Total
Primary Care Physician Ambulatory Health Service/ HIV Specialty Physicians	94.8%	75.0%	92.7%
Ambulatory Nursing Health Service	91.6%	80.0%	90.3%
Pharmacy Ambulatory Health Service	93.9%	83.3%	92.9%
Ambulatory Oral Health Service	86.1%	66.7%	84.6%
Clinical Case Management	97.1%	85.7%	96.0%
ADAP Services for Medication Assistance	97.8%	77.8%	96.1%
Co-Pay ADAP Services, Coinsurance, and Deductibles for HIV Medications	97.1%	80.0%	96.0%
ADAP Services for Specialized HIV Testing (Clinical Monitoring to Antiretroviral Therapy) and Hepatitis C	92.3%	77.8%	91.2%
Medical Nutrition Counseling Therapy	93.0%	87.5%	92.6%
Medical Nutritional Therapy of Nutritional Supplements	94.1%	90.0%	93.7%
Community-Based Home Health Care - Medical	100.0%	100.0%	100.0%
Community-Based Home Health Care - Nursing	50.0%	0.0%	50.0%
Community-Based Home Health Care - Durable Medical Equipment	100.0%	0.0%	100.0%
Community-Based Home Health Care - Disposable Medical Equipment or Supply	100.0%	0.0%	100.0%

Regarding the support services needed or requested during the six months prior to the study, emergency financial assistance for eyeglasses (34.1%), medical transportation (25.6%), financial assistance for the payment of utilities (water, electricity) (25.6%) and food bank and home delivered meals (25.6%) stand out. In this case, however, the situation is different, and it is observed that in most cases the proportion of people who needed services and received them is lower. Regarding the quality of the services received, the majority rated them as excellent or good, with the exception of utility assistance services and housing services.

Table 12: Support services you have needed or requested in the past six months for the treatment of your HIV-positive diagnosis

	In treatment, RWPB/ADAP participant		Out of treatment		Total	
	Freq.	%	Freq.	%	Freq.	%
Emergency Economic Assistance for Glasses	126	35.3%	14	26.4%	140	34.1%
Medical Transportation	95	26.6%	10	18.9%	105	25.6%
Financial assistance for payment of utilities (water, electricity)	90	25.2%	15	28.3%	105	25.6%
Food Bank and Meals at Home	91	25.5%	14	26.4%	105	25.6%
Non-Clinical Case Management	89	24.9%	13	24.5%	102	24.9%
Care Liaison Worker	45	12.6%	1	1.9%	46	11.2%
Hepatitis C Services Navigator	20	5.6%	1	1.9%	21	5.1%
Temporary Housing	17	4.8%	4	7.5%	21	5.1%
Community Outreach	16	4.5%	2	3.8%	18	4.4%
Emergency Financial Assistance for Hearing Aids	7	2.0%	1	1.9%	8	2.0%
None of these services	151	42.3%	25	47.2%	176	42.9%
Do not know / Does not indicate	3	0.8%	0	0.0%	3	0.7%
Total	**357**		**53**		**410**	

Note: The numerical base is the 410 people interviewed. Being a multiple-choice question, an independent count is made for each of the answers mentioned and the sum of percentages can be different from 100%.

Graph 35: Percentage of individuals who received the support services they needed during the past six months

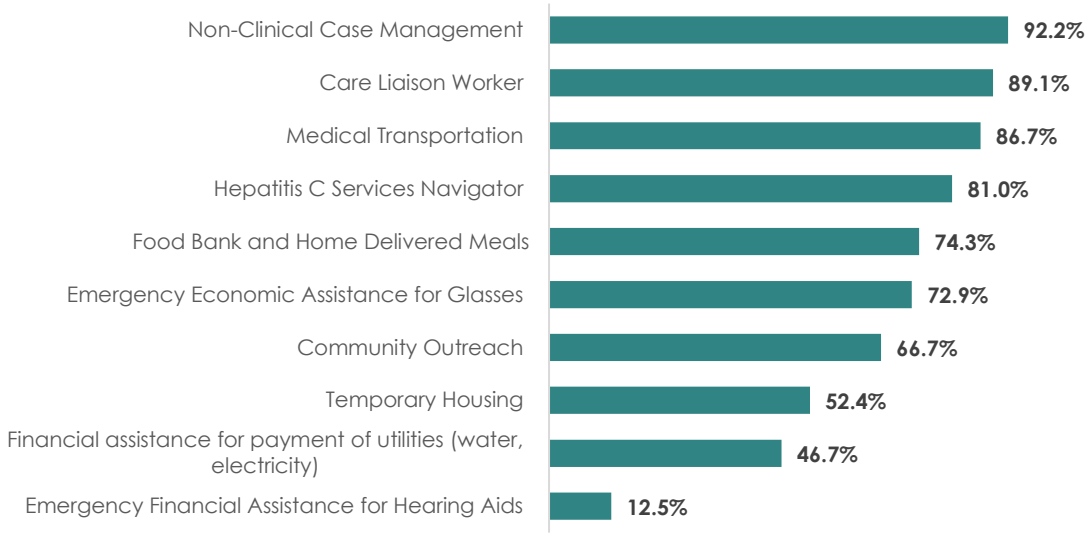


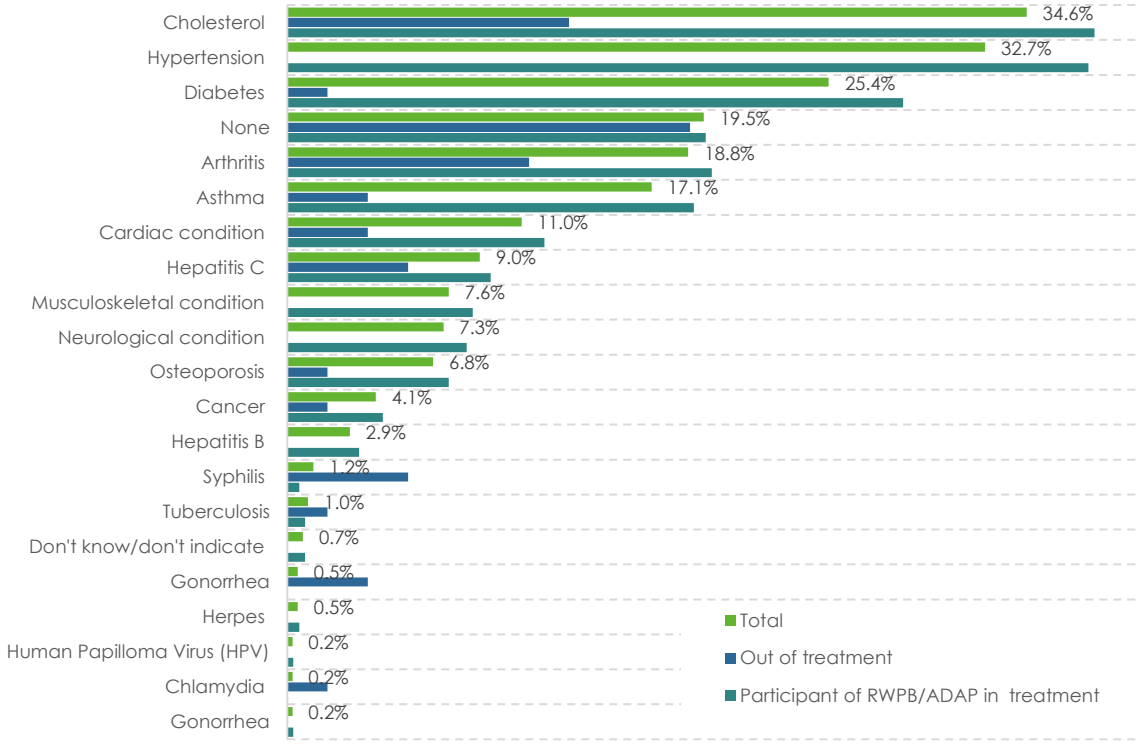
Table 13: Quality of support services you received. The table shows A "Excellent" and B "Good"."

	Participants of RWPB/ADAP	Out of treatment	Total
Non-Clinical Case Management	95.2%	90.0%	94.7%
Care Liaison Worker	100.0%	0.0%	97.6%
Hepatitis C Services Navigator	100.0%	100.0%	100.0%
Community Outreach	91.7%	0.0%	91.7%
Medical Transportation	94.0%	100.0%	94.5%
Financial assistance for payment of utilities (water, electricity)	84.4%	100.0%	85.7%
Emergency Economic Assistance for eyeglasses	97.9%	87.5%	97.1%
Emergency Financial Assistance for hearing aids	100.0%	0.0%	100.0%
Temporary Housing	77.8%	50.0%	72.7%
Food Bank and Home Delivered Meals	95.7%	88.9%	94.9%

In both instances or types of services, the main reasons expressed by participants as those that prevented them from accessing services were not knowing where to access them, transportation, that the service is not available in their area and, in the case of people outside of treatment, the cost of the services.

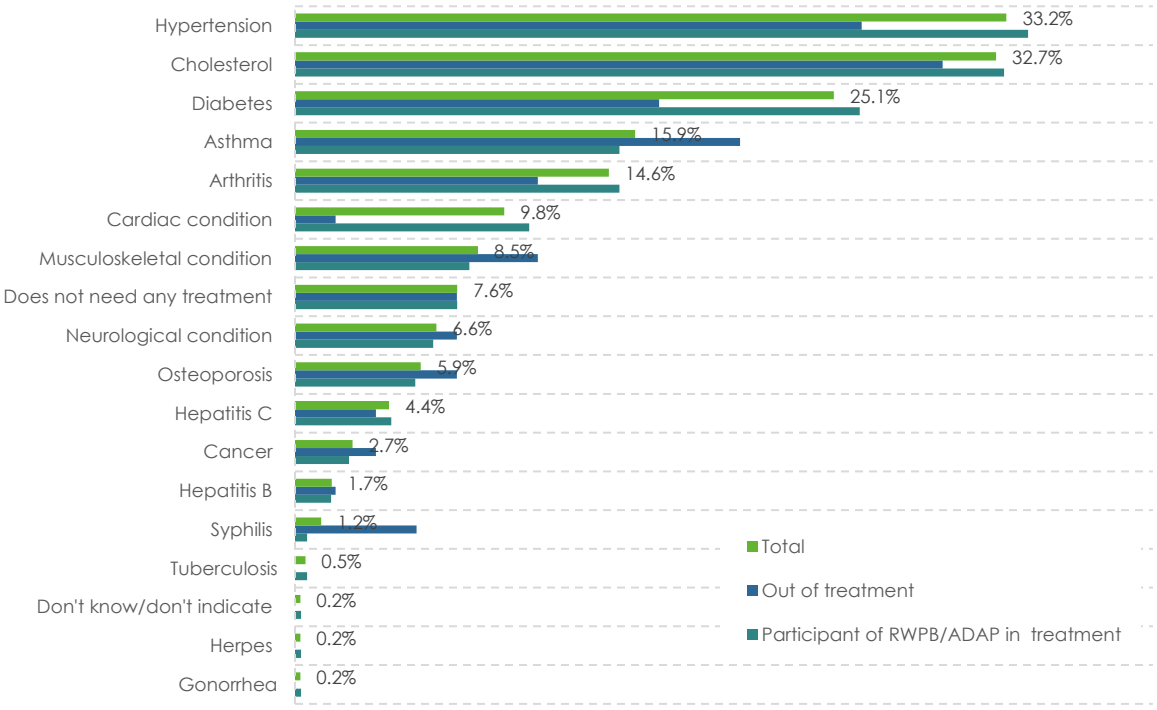
On the other hand, survey participants indicated that they have other health needs or conditions for which they have required services. The most frequently mentioned include cholesterol (34.6%), hypertension (32.7%) and diabetes (25.4%). Just over a third (33.2%) indicated that they have needed treatment or medication for hypertension, cholesterol (32.7%) and diabetes (25.1%). Of that group, 32% currently receive treatment for hypertension, 31.2% for cholesterol, and 23.9% for diabetes.

Graph 36: Other diagnosed conditions

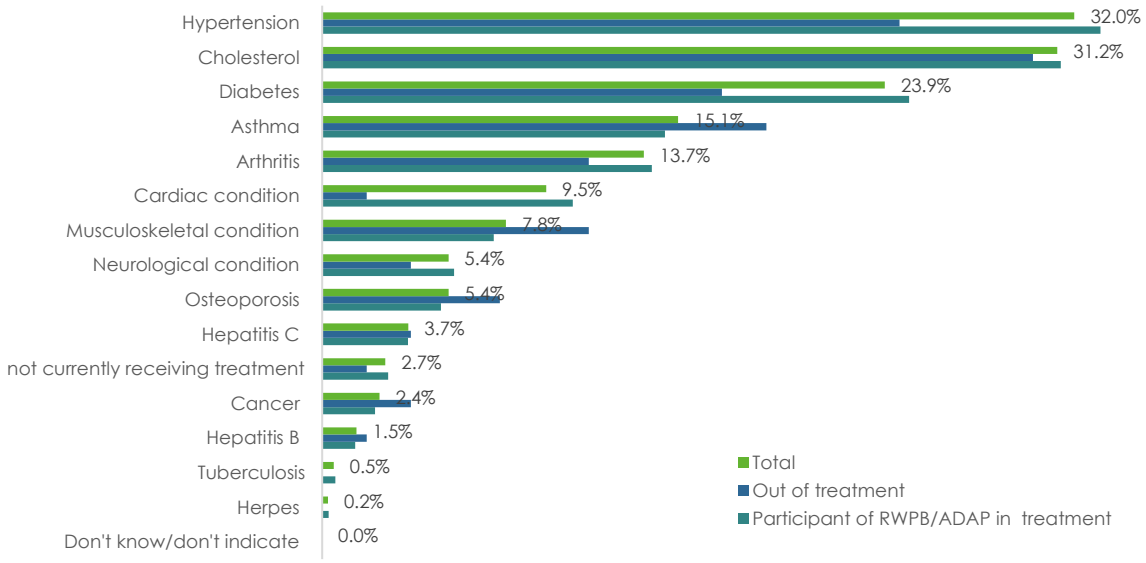


Note: The numerical base is the 410 people interviewed. Since this is a multiple response question, a separate count is made for each of the answers mentioned and the sum of percentages may be different from 100%.

Graph 37: People who have needed treatment or medication for these other conditions



Graph 38: Persons currently receiving treatment for those other conditions



Other research examined for purposes of the integrated planning process points to similar areas of need. As an example, the "Needs Assessment of Older LGBT+ Adults with a positive HIV diagnosis in Puerto Rico"[5], for example, reports how participants experience distress, which manifests in depression, anxiety, and social isolation. Similarly, food and housing insecurity among participants, the inability to obtain necessary services such as medical, mental health and complementary services. In addition, financial hardship either from losing their homes due to earthquakes and hurricanes or losing their jobs or businesses due to the COVID-19 pandemic.

The recommendations of the study point to the need to activate the strengths of this population (high educational level, resilience, assertiveness), recognize that the health system was designed for heterosexual, cisgender people and modify it, strengthen the use of social networks, and encourage diversity and training in the use of technology. The findings indicate that stigma is still present in the family context in Puerto Rico, people diagnosed HIV positive experience fear of disclosing their diagnosis, discrimination, avoid starting their own families or relationships, experience physical and verbal abuse by family members and even separation from family members. Also, fear of transmission of the virus based on non-scientific knowledge (e.g., touching persons with a diagnosis of HIV, sharing utensils, and kissing) is still present in the popular consciousness of society as well as in family structures. Persons with a diagnosis of HIV who decided to disclose reported that they felt discriminated against and not supported by their family members.

[5] Waves Ahead, Corp. and JSI Research & Training Institute Inc. (2021). Needs Assessment of Older LGBT+ Adults Living with HIV in Puerto Rico.

3. BARRIERS TO ACCESSING EXISTING HIV TESTING, INCLUDING STATE LAWS AND REGULATIONS, HIV PREVENTION SERVICES, AND HIV CARE AND TREATMENT SERVICES - ACCESSIBILITY

When discussing barriers to accessing HIV prevention services in Puerto Rico, stakeholders participating in the integrated planning process agreed on the following as the main barriers: stigma, geographic differences in the availability of services, bureaucratic processes in the entities that provide services, navigation of the service system/low visibility of services, non-inclusive or culturally sensitive language, human resources (recruitment of personnel, attitudinal barriers), and medical plan coverage (e.g., in the case of PreP). Among the populations most affected by the above barriers are youth (students), Sero discordant couples, older adults, populations by geographic area (east and west) and the homeless population.

Likewise, in relation to the main barriers in accessing care and support services, participants found fear and stigma, access of some populations to services, knowledge about the availability of services and their reach, self-esteem of participants and mental health, transportation and access to services and socioeconomic needs. When we focus on the system and service providers, we observe barriers such as geographic differences and outreach to certain populations, transportation, fragmentation of services, inclusive language, attitudinal barriers of some professionals (alienating the patient), human resources (shortage of specialists, housekeepers, mental health, among others) and a greater demand than the available supply. Finally, among the institutional and public policy barriers, we observed the coverage of insurance companies and the PR Government Health Plan, and the bureaucracy and time it takes for certain types of services (e.g., financial assistance).

A. PRIORITIES

The needs assessment conducted as part of the Integrated Plan reaffirmed the urgency of addressing the areas identified as gaps and identified other needs. These priority areas include:

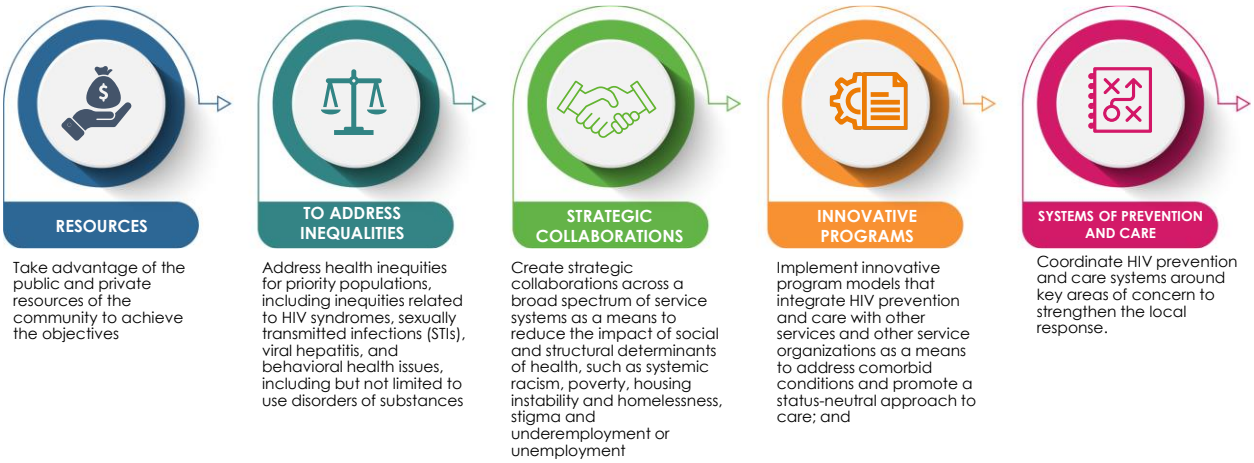
- Strengthen the system for the provision of HIV surveillance, diagnosis, prevention and care services and its human capital.
- Promote the combination of economic resources, using the leverage they allow, to maximize existing resources and have a greater impact.
- Increase the availability of and equitable access to comprehensive, high-quality, culturally sensitive services based on best practices, evidence-informed practices, and evidence-based practices for HIV prevention and treatment, including:
    - Testing in clinical and non-clinical settings
    - PrEP
    - Syringe exchange;
    - Treatment for problematic substance use, including injectable and non-injectable drugs;
    - Routine testing in non-clinical settings;
    - Mental health-related services;

  - Transportation to services
  - Specialized medical services to address co-morbidities; o Home-based services to address co-morbidities
  - Home-based services for mobility-impaired populations, such as older adults;
  - Other services aimed at addressing social determinants of health and socioeconomic needs of participants, such as housing, food and nutrition, utility assistance and other support services
- Implement continuous education and counseling efforts to improve levels of knowledge about the epidemic and its prevention and care among service providers, groups with risk behaviors, people with a positive HIV diagnosis, and the general community.
- Address the social determinants of health.
- Address the particular needs associated with the demographic transformation of the population in Puerto Rico, as well as the mental health situation that has worsened following the natural disasters the country has faced and more recently the pandemic.
- Continue to promote early linkage to treatment and retention approaches to achieve viral suppression.

B. ACTIONS TAKEN

The next section provides the details of recommended actions to be taken by the jurisdiction to address the needs identified as part of the integrated planning process. These actions are based on best practices and lessons learned during the previous planning period. These are, in turn, based on five guiding principles:

Illustration 12: Guiding principles of the Plan

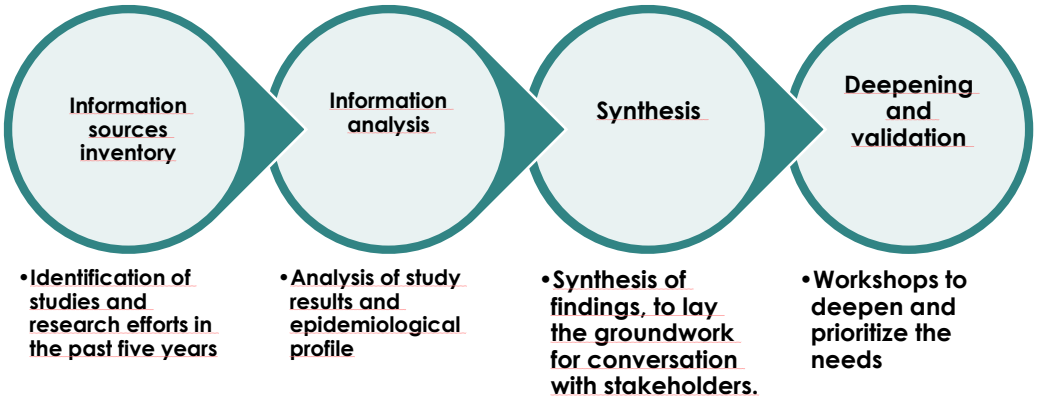


C. APPROACH TO IDENTIFICATION OF NEEDS

As explained in a previous section, needs were identified through a multi-method, participatory approach in which representatives from the HIV-positive community, government, non-profit and community-based organizations, other public entities, community health centers, municipal entities, federal government agencies and other

groups served as stakeholders in the plan and engaged in identifying and prioritizing needs

Illustration 13: Participatory process for needs identification



As a first step in identifying needs, an inventory was made of studies and sources of information generated over the past five years. These sources were analyzed and synthesized, and based on the information that emerged from them, a first workshop was designed, organized in two sessions, to expose the stakeholders to this information and, according to their diverse fields of expertise, to generate discussion on the needs. During the sessions, the participants were organized into small working groups, and through guided exercises, the needs, the groups most affected by these needs and gaps and barriers to access were explored in depth.

According to integrated planning guidance published by the CDC and HRSA, needs were defined as services necessary for individuals to access and maintain HIV prevention, care, and treatment. Barriers were defined as those that limit people's ability to access those services, including social barriers (cultural, stigma), public policy barriers, program or service delivery system barriers (e.g., infrastructure, funding, information systems), and barriers associated with limitations faced by participants themselves (transportation, homelessness, poverty, etc.). Gaps were defined as flaws in the service delivery system.

SECTION IV: SITUATIONAL ANALYSIS

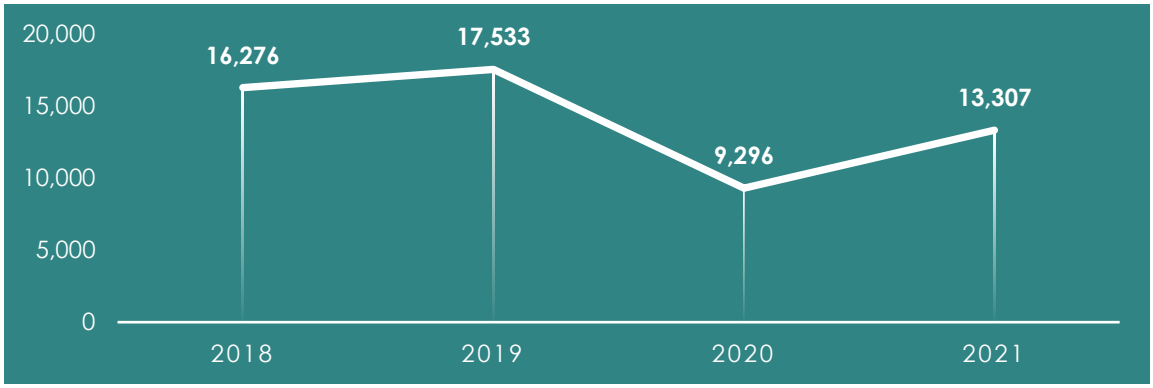
1. SITUATIONAL ANALYSIS

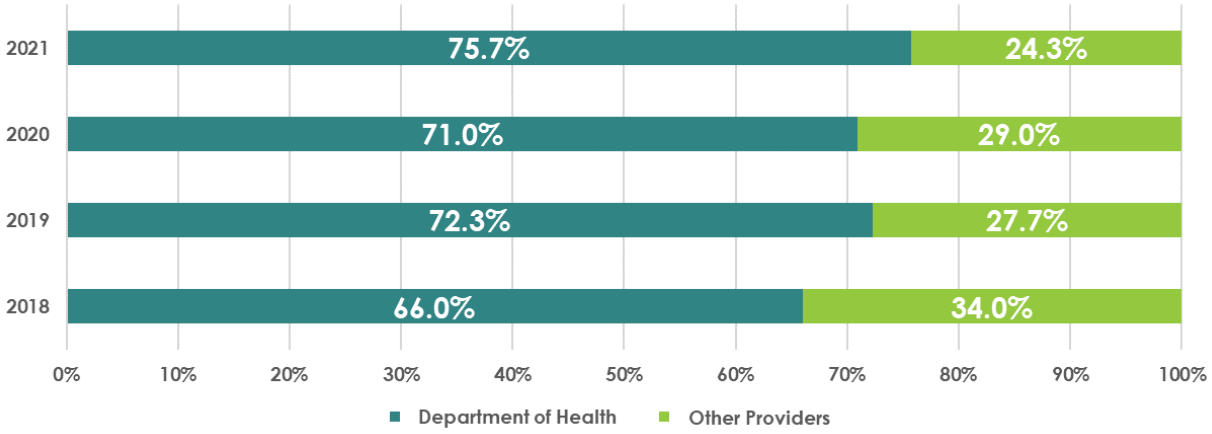
A. DIAGNOSIS AND PREVENTION

During the 2018-2021 period, a total of 56,412 tests for HIV diagnosis were performed in Puerto Rico. In 2021, when a total of 13,307 tests were performed, the Department of Health was responsible for performing 75.7% of these. Throughout the period, it is observed how the number of tests performed decreased, particularly in 2020 when the pandemic began, while in 2021 it increased, being barely 3,000 tests below those performed in 2018. In terms of the distribution by setting, although the number of tests in

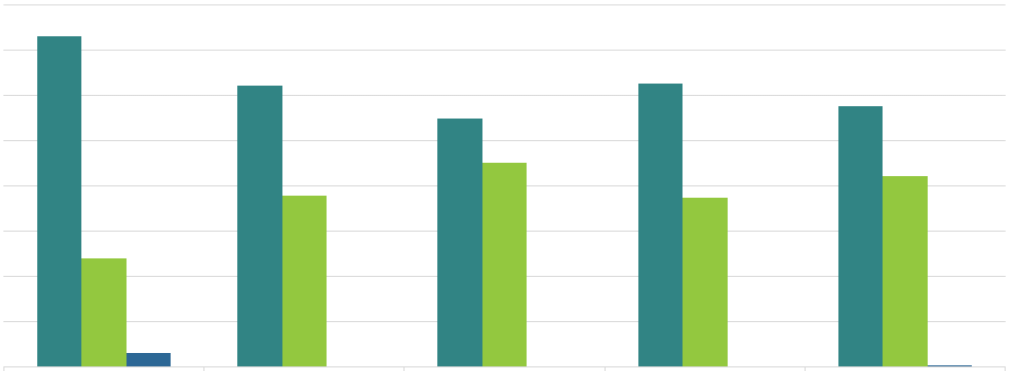
non-clinical settings has been lower during the period, when compared to those in clinical settings, this gap was significantly reduced. On the other hand, the male gender continues to be the majority group at the time of HIV testing (60.3%), and slightly more than half (54.4%) are between the ages of 20-39 years. In addition, in 2021, heterosexuals predominated (49.9%) as the main risk category tested and San Juan (3,767), Ponce (2,836), Mayagüez (2,066) and Caguas (1,632) stand out as the regions with the highest number of HIV tests performed.

Graph 39: HIV tests performed in Puerto Rico by year



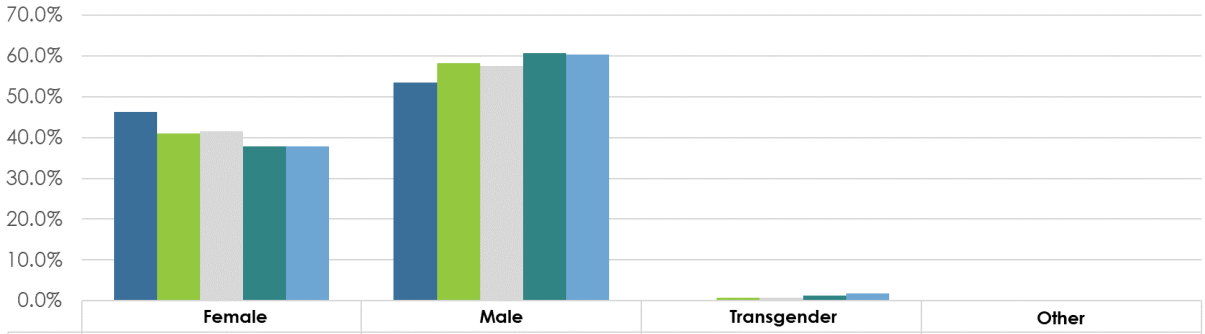


Graph 40: Tests performed by scenario

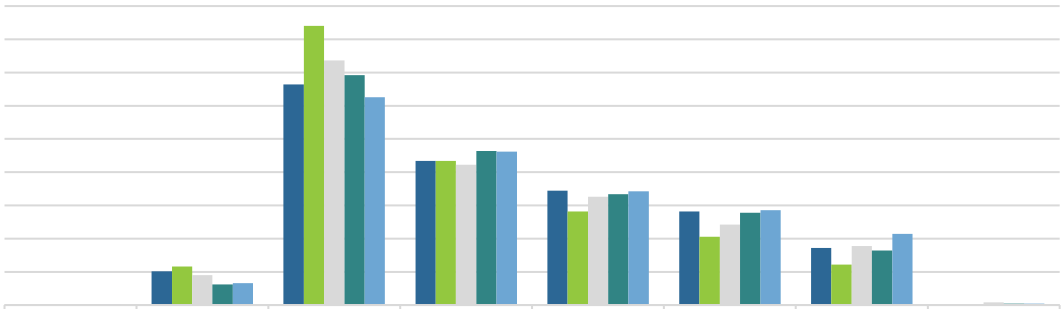


	2017	2018	2019	2020	2021
Clínico	73.1%	62.1%	54.9%	62.6%	57.6%
No-Clínico	23.9%	37.9%	45.1%	37.4%	42.2%
Desconocido	3.0%	0.0%	0.0%	0.0%	0.2%

Graph 41: Distribution of tests performed by gender and age

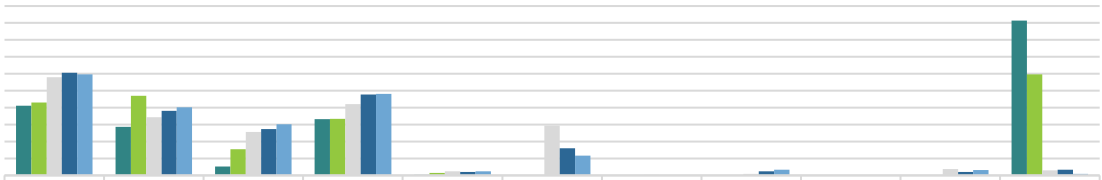


	Female	Male	Transgender	Other
2017	46.3%	53.5%	0.2%	0.0%
2018	41.0%	58.2%	0.8%	0.0%
2019	41.5%	57.6%	0.8%	0.1%
2020	37.9%	60.7%	1.3%	0.1%
2021	37.8%	60.3%	1.8%	0.1%



	<13	13-19	20-29	30-39	40-49	50-59	60 years or more	Unidentified
2017	0.0%	5.1%	33.2%	21.7%	17.2%	14.1%	8.6%	0.0%
2018	0.1%	5.8%	42.0%	21.7%	14.1%	10.3%	6.1%	0.0%
2019	0.0%	4.5%	36.8%	21.1%	16.3%	12.1%	8.9%	0.4%
2020	0.1%	3.1%	34.6%	23.2%	16.7%	13.9%	8.2%	0.2%
2021	0.1%	3.3%	31.3%	23.1%	17.1%	14.3%	10.7%	0.2%

Graph 42: HIV testing by risk category



	♀ Heterosexual	♂ Heterosexual	IDU	MSM	MSM/IDU	No sexual/IDU contact	Sex w/Transgender	Transgender	Transgender/IDU	WSW	Otro/Desc*
2017	20.6%	14.3%	2.6%	16.6%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	45.7%
2018	21.5%	23.5%	7.7%	16.7%	0.7%	0.0%	0.0%	0.0%	0.0%	0.0%	29.8%
2019	29.0%	17.2%	12.8%	21.0%	1.2%	14.7%	0.2%	0.5%	0.0%	1.9%	1.5%
2020	30.3%	19.1%	13.7%	23.9%	1.0%	8.0%	0.1%	1.2%	0.0%	1.0%	1.7%
2021	29.8%	20.1%	15.1%	24.1%	1.2%	5.8%	0.0%	1.7%	0.1%	1.6%	0.5%

Graph 43: Tests performed by region

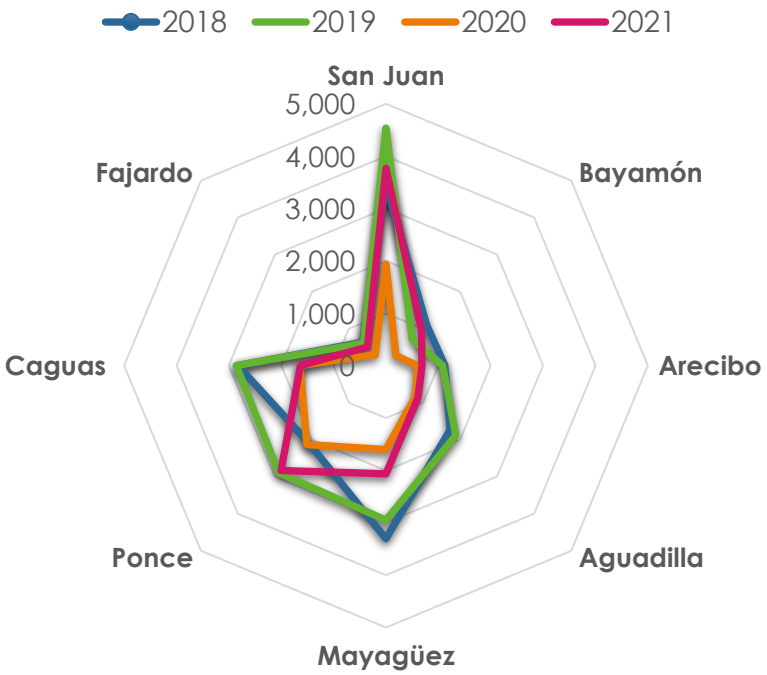


Table 14: Tests performed by region

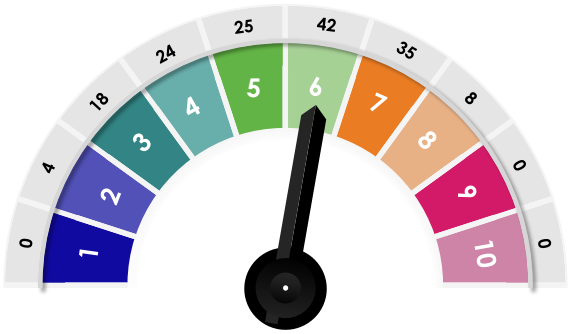
Region	2018	2019	2020	2021
San Juan	3,462	4,535	1,937	3,767
Bayamón	1,097	711	270	959
Arecibo	1,122	1,078	601	687
Aguadilla	1,732	1,886	814	859
Mayagüez	3,305	2,952	1,601	2,066
Ponce	2,087	2,897	2,133	2,836
Caguas	2,829	2,860	1,642	1,632
Fajardo	632	610	298	501

Educational campaigns are a key effort in HIV prevention and in motivating people to get tested. During the period under study, the Health Department conducted various educational campaigns, which revolved around three main objectives: 1) Raising awareness of the importance of taking preventive measures to avoid transmission of the HIV virus; 2) Promoting HIV testing (routine); and 3) Promoting the use of condoms.

Illustration 14: Excerpts from advertising campaigns

Based on these data, as well as the results of other research conducted on the topic, participants in the workshops conducted as part of the integrated planning process were asked to evaluate the level of progress in HIV prevention, based on a scale on which 10 signified the highest level of progress. According to them, the level of progress averaged 6.2 and a median of 6. Among the reasons they attributed to this level of progress were variations in the continuity of prevention strategies and successful strategies that are no longer implemented, a focus on prevention that changes depending on the funds available, a difference in the level of progress by groups and geographic areas (for example, the homeless, the elderly, youth, the Trans population), and a lack of alignment between the message, language and target audiences (including messages that are not culturally sensitive). Similarly, a fear of stigma and rejection persists, there is a lack of common/universal language among providers, there is the need to implement sexual education in schools, and prevention, which was affected by disasters and public health emergencies. Similarly, the fear of stigma and rejection persists lack of a common/universal language among providers, the need to implement sex education in schools, and prevention that was affected by disasters and public health emergencies.

Graph 44: Perception of the level of progress in HIV prevention in Puerto Rico



Average: 6.2 **Mean: 6.0**

As part of the discussion on the level of progress in HIV prevention, participants assessed the availability, accessibility and quality of HIV[6] testing and prevention services. In assessing the current system of HIV diagnosis and prevention service provision, the vast majority of participants rated the availability and accessibility of services as fair, that is, with a grade of C. However, they acknowledged that - once this barrier to access is overcome - the services received are generally good. Among the highest rated services were screening/testing for other STIs, HIV screening/testing at the facility, preventive counseling, distribution of condoms and other prophylactics, early linkage to treatment, and partner services (PS). On the other hand, in line with what is observed from the testing data discussed previously, off-site HIV screening/testing was the worst evaluated in terms of access.

Illustration 15: Gaps in the service system: Perception of availability, access, and quality of services

SERVICES	Availability					Access					Quality				
	A	B	C	D	F	A	B	C	D	F	A	B	C	D	F
Educational campaigns through digital media and social networks			■					■					■		
Educational campaigns through mass media			■					■					■		
Educational campaigns in the community			■					■					■		
Behavioral health and social services needs assessment			■					■					■		
Screening/testing for other STIs		■					■					■			
Screening/HIV testing at the facility		■					■					■			
Screening/HIV testing outside the facility			■						■				■		
Conferences			■					■				■			
Substance abuse counseling			■					■					■		
Preventive counseling		■						■				■			
Distribution of condoms and other prophylactic devices		■					■					■			
Early linkage to treatment		■					■						■		
Public information on HIV prevention			■					■				■			
Syringe exchange			■					■				■			
Educational intervention in the community			■					■					■		
Individual intervention in risk reduction			■					■				■			
PreP			■					■					■		
Couples Services		■						■				■			

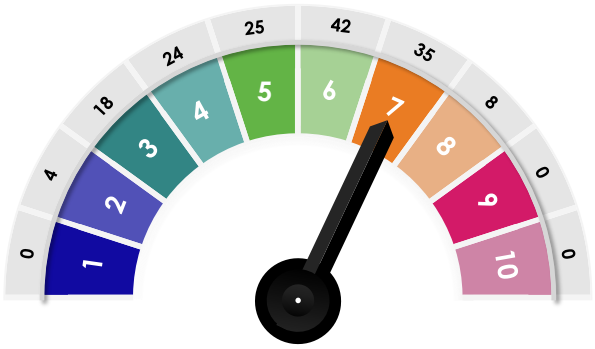
[6] Availability was defined as the supply of such services. Access was defined as the opportunity people have to acquire the service, considering the availability of the service; knowledge of its availability; the opportunities to obtain it (getting to it, being attended, and the ability to pay for it, if applicable, among other aspects). Quality, on the other hand, was defined as the service's capacity to meet the need for which it was designed through its different characteristics, in accordance with generally accepted standards.

B. TREATMENT

In the conversation held during the treatment sessions of the workshops conducted as part of the integrated planning process, participants ranked the level of progress in HIV treatment in Puerto Rico at an average of 7.12 and the median at 7, based on a scale in which 10 was the highest level. Thus, in general terms, most of the participants understand that there has been a significant level of progress during the past few years with regard to HIV care and treatment. Among the areas highlighted were: early linkage to treatment, access to medications and pharmacy services, new therapies and treatments, the role of the community with a positive diagnosis in their treatment, expertise and better knowledge of the condition, education efforts for health professionals, staff commitment and excellence, emergence of health service centers in diverse geographic areas (e.g. Center of the Island), coordination between the RWPB Program and health service clinics (e.g. Medications) and Integrated Health Centers.

Among the reasons why it is understood that we have not reached a 10, the following were mentioned: fluctuations in progress due to the effects of the natural disasters that have impacted Puerto Rico since 2017 and the pandemic, stigma, the need to continue educating people with a positive diagnosis on aspects related to care and treatment, geographic differences in the provision of services, human resources (difficulties in recruitment, lack of specialists, "burn out", attitudinal barriers, management of inclusive language), adequacy of physical facilities for the provision of services, limited availability of other complementary services, in the context of an aging population, whose needs have changed, and a cultural adaptation of services.

Illustration 16: Perception of the level of progress in HIV treatment in Puerto Rico



Average: 7.12 **Mean: 7.0**

According to the participants, there are certain aspects that limit linkage and retention in treatment. In linkage, there is a predominance of lack of knowledge among health professionals about how to order HIV testing, perceptions about the effectiveness of PrEP use that lead people not to get tested because they believe they will not contract the virus, fear and stigma, economic needs that come before the initial search for health care services, and limited outreach efforts in certain subpopulations (prisons, people with undefined immigration status, homeless people).

On the other hand, in retention, the participants mentioned differences in the availability of services in geographic terms, limitations in support services complementary to treatment (transportation, emergency financial aid, housing, home care), coverage of medical plan, of participants who are not covered under the Puerto Rico Government Health Plan (Plan Vital), human resources (shortage, education on HIV-related issues, management of communication with participants), complexity within the framework of other health conditions, socioeconomic situations that lead them to prioritize other needs and not necessarily their medical care, time management by the participants and emotional, psychological and peer support.

Regarding gaps in the service system and participants' perception of the availability, access, and quality of clinical services for HIV care, ADAP was the highest rated service with excellent availability, access, and quality. Pharmacy services were the second highest rated category after registering B+ in availability, access and quality. Clinical case management and nutritional physician therapy (nutritional counseling, nutritional supplements) were the other two services rated B (good) in availability, access and quality. It is worth noting that - in line with what was reported in the HIV-positive community survey - the quality of oral health had the worst grade of D, while medical specialists was the service with the lowest grade after indicating that it has a fair value in quality and C- in availability and access. When talking about other gaps related to health professionals, scarcity, geographic availability and sensitivity are highlighted. Among the personnel, HIV physicians, mental health professionals, dentists and nutritionists are mentioned.

Regarding gaps in the service system and perceptions of the availability, access and quality of support services, the care linkage worker was the highest rated among participants with B for availability and access, and A for quality. Non-clinical case management, care linkage worker, hepatitis C service navigator and community outreach services were rated as good while medical transportation and food bank and home delivered meals were rated as fair (C) among participants.

Outpatient health services such as HIV physicians and specialists to address comorbidities (70.37%), community-based home health care (64.81%) and nutritional therapy (53.70%) were the top three clinical services that should be strengthened in our jurisdiction as expressed by the participants. In assessing the top support services that should be strengthened in our jurisdiction, non-clinical case management (25.9%), hepatitis C service navigator (18.5%), linkage to care worker (18.5%) and peer accompaniment (5.6%) were highlighted.

Table 15: Perception of availability, access, and quality of clinical services

Clinical Services	Availability	Access	Quality
Ambulatory Health Services (in general).	B	C	B
Clinical Case Management	B	B	B
ADAP services: (medication assistance); co-payments, co-insurance and deductible assistance (HIAP); specialized HIV testing (clinical monitoring of anti-retroviral therapy) and specialized Hepatitis C testing.	A	A	A
Medical Nutrition Therapy (Nutritional Counseling, Nutritional Supplements).	B	B	B
Community Based Home Health Care (physician, nurse practitioner, durable medical equipment, disposable medical equipment, housekeeping and integrated services).	C	C	B
Other	C	C	C
Other | Mental Health	C	C	C
Other| Specialized Medical Doctors	C-	C-	C
Other | Oral Health	C	B	D
Other | Substance abuse	C	C	B
Other | Pharmacy	B+	B+	B+

Table 16: Perception of availability, access, and quality of support services

Clinical Services	Availability	Access	Quality
Non-Clinical Case Management	B	B	B
Care Liaison Worker	B	B	A
Hepatitis C Service Navigator	B	B	B
Financial assistance for utility payments (water, electricity, rent, medications, gas, food vouchers and emergency vouchers).	B	C	B
Temporary Housing	C	B	B
Food Bank and Home Delivered Meals	C	C	C
Other | Medical Transportation	C	C	C
Other | Community Outreach	B	B	B

C. RESPONSE

Through the integrated planning process, three areas were identified as critical to strengthen in order to have a more coordinated multisectoral response to address the HIV, STI, viral hepatitis and mental health syndemic, and to have a better capacity to respond to outbreaks. These areas, in turn, are related to the access and availability barriers identified as part of the resource inventory and needs analysis, and include:

- Strengthen measurement, monitoring and evaluation systems and mechanisms to continue promoting a culture of data use in decision making in response to the syndemic.
- Enhance the service delivery system and the capacities of its human resources through human resource training, coordination of multisectoral efforts, and leveraging or pooling of financial resources.

- Address public policy barriers or constraints that could impose burdens or affect the implementation of the strategies set forth as part of this Plan

D. PRIORITY POPULATIONS

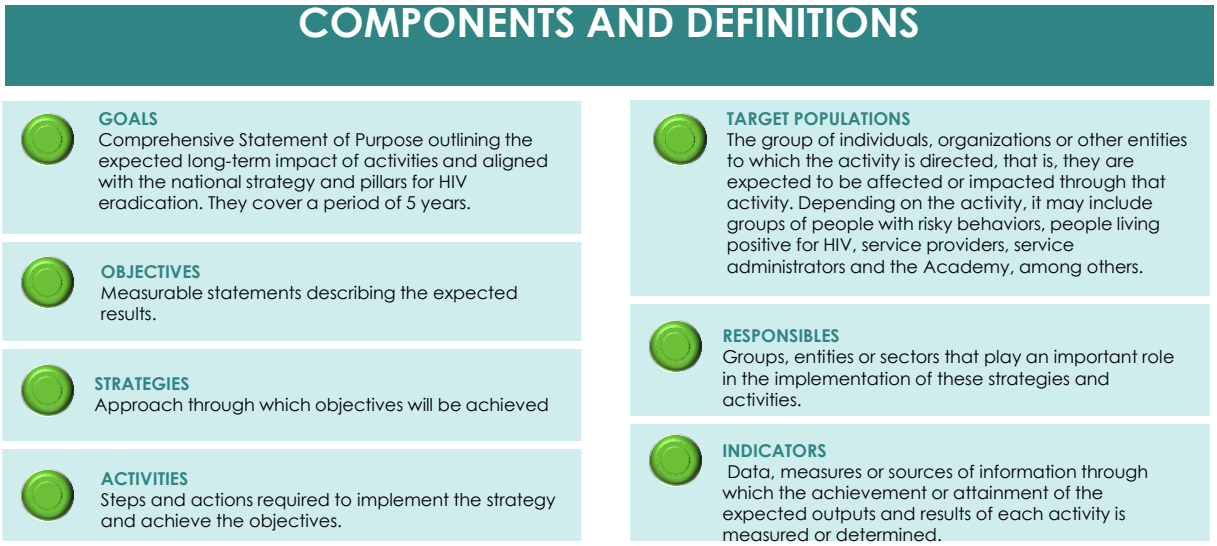
Based on the needs analysis and situational analysis conducted, a series of populations were identified in which prevention and treatment efforts should be focused, in accordance with neutral approaches based on the continuum of care model. The next section details the specific strategies and activities that are recommended and the populations to which they are directed.

Illustration 17: Priority populations

SECTION V: GOALS AND OBJECTIVES 2022-2026

This section presents the goals and objectives that emerged from the planning process, as well as the strategies and actions to achieve them. In accordance with CDC and HRSA guidelines, the plan was organized with respect to the following elements.

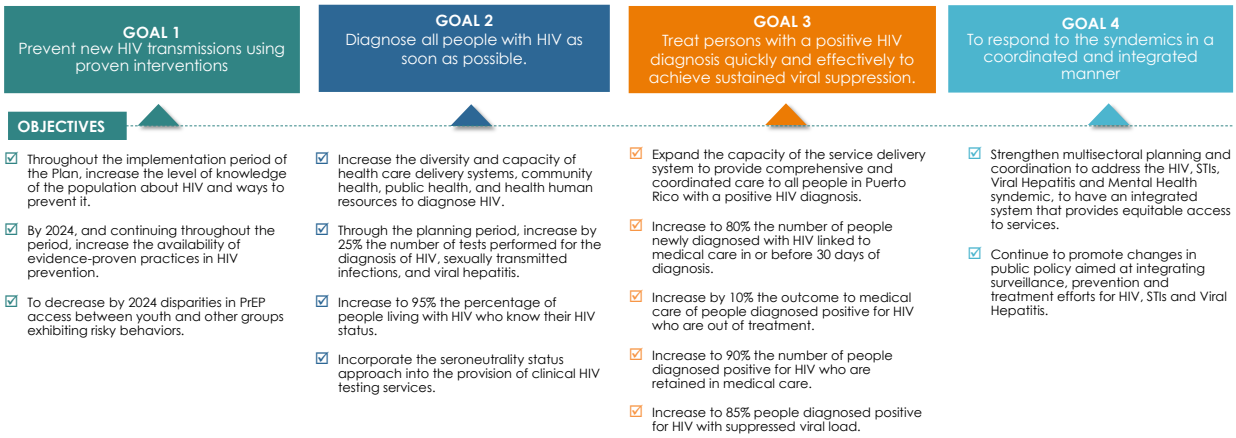
Illustration 18: Components of the Plan



1. DESCRIPTION OF GOALS AND OBJECTIVES

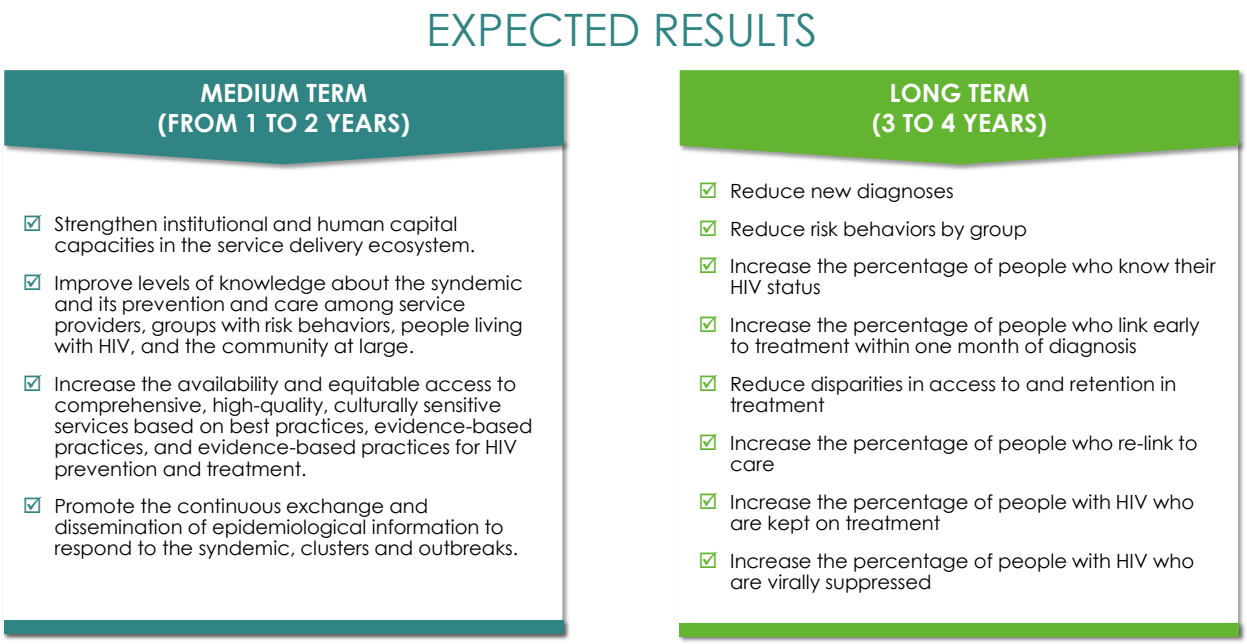
A total of four goals emerged from the planning process, related to the pillars of Prevention, Diagnosis, Treatment and Response.

Illustration 19: Plan goals and objectives



At the end of the Plan's implementation period in 2026, the following results are expected to be achieved:

Illustration 20: Expected results



A. PREVENTION:

Goal 1: Prevent new HIV transmissions using proven interventions.

OBJECTIVE 1.1: THROUGHOUT THE PLAN'S IMPLEMENTATION PERIOD, INCREASE THE POPULATION'S LEVEL OF KNOWLEDGE ABOUT HIV AND WAYS TO PREVENT IT.

Strategies	Target Populations	Activities	Key stakeholders	Potential sources of funds
Develop a massive and integrated communication campaign for HIV education and counseling, focused on prevention, and that it is implemented in a constant and consistent manner.	General population and priority segments or those most exposed to risk, young people (13 to 29 years old) and older adults.	Identify communities with lack of or difficult access to HIV information.	Community with a positive HIV diagnosis, Department of Health, Department of Education, Department of Corrections, Department of Family, community-based organizations and groups, community leaders, funding agencies, media, Department of Health Implementation Manager, Assistant Secretary and integrated student services, family and community. Community mobilization, municipalities and health plan providers.	CDC HIV Prevention Activities, Non-Governmental Organization Based HIV Prevention Activities Health Department Based Private sources of funds or corporate donations Foundations
		Develop messages with scientific evidence aimed at providing information in social networks, digital media and other scenarios.		
		Conduct lectures and programs at clinics to expose such information.		
		Establish collaborative agreements with base and non-profit organizations that serve subpopulations of interest (e.g., AARP).		
		Promote discussion of HIV in the school community.		
		Promote community educational events with information focused on the needs of the populations.		
		Involve health plan providers in efforts to amplify the preventive message.		

Strategies	Target Populations	Activities	Key stakeholders	Potential sources of funds
		Identify other available resources or funding sources to implement activities related to mass campaigns that can be conducted.		
Promote education of service providers and health professionals on HIV prevention.	Health service providers	Promote the empowerment and participation of people with a positive HIV diagnosis in training efforts for the human resources personnel working with HIV prevention and diagnosis.	Community with a positive diagnosis of HIV, DS, NECA/AETC, Service providers, Academy, health plan providers, Planning groups and Municipalities.	CDC HIV Prevention Activities, Non-Governmental Organization Based HIV Prevention Activities Health Department Based Private sources of funds or corporate donations Foundations
		Create partnerships with private or government-based medical plans to integrate them into training efforts for health professionals.		
		Strengthen the education program for the population through collaborations.		
		Expand training on the treatment of transgender people and the topic of gender perspective in schools.		
		Request that HIV prevention and treatment be included in government ethics courses.		
		Promote the inclusion of HIV prevention and treatment in university curricula.		
		Request as a professional licensure renewal requirement, continuing education on the topic of HIV.		
		Provide training to the medical community and guidance on best practices in HIV prevention and treatment.		
		Educate the people who head the legislature's health committees and their advisors about HIV prevention and treatment.		
Extend available information and awareness strategies on	Parents, youth, teachers, youth ages 13 and older, and the general public.	Create alliances for the creation of educational programs aimed at populations that may present risk behaviors.	Health Professionals, Department of Health, Department of Education,	CDC HIV Prevention Activities, Non-Governmental Organization Based

Strategies	Target Populations	Activities	Key stakeholders	Potential sources of funds
risky behaviors to the entire population		Promote the offer of workshops, trainings, orientations and other educational modalities on HIV.	HIV service providers and Municipalities.	HIV Prevention Activities Health Department Based Private sources of funds or corporate donations Foundations
		Evaluate the implementation of awareness efforts and strategies.		

OBJECTIVE 1.2: BY 2024, AND CONTINUING DURING THE PERIOD, INCREASE THE AVAILABILITY OF EVIDENCE-BASED PROVEN PRACTICES IN HIV PREVENTION.

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
Expand the availability of evidence-based proven practices in HIV prevention.	Groups presenting risk behaviors (youth, young people from 13 to 29 years old, MSM, people who inject drugs)	Identify evidence-based practices and best practices that have been shown to operate effectively in Puerto Rico, including PrEP and Syringe Exchange.	Department of Health, Academia, Community Based Organizations, Service Providers, Professional Associations, Planning Group, Community with a positive HIV diagnosis and Municipalities.	CDC HIV Prevention Activities, Non-Governmental Organization Based HIV Prevention Activities Health Department Based Private sources of funds or corporate donations Foundations
		Provide training to human resources on evidence-based practices implemented in Puerto Rico.		
		Identify sources of funds and partnerships through which equitable coverage of these practices (PrEP, Syringe Exchange and others identified) can be expanded.		
		Promote pilot projects in other interventions proven as best practices implemented in Puerto Rico.		
		Evaluate coverage and effectiveness in the implementation of evidence-based practices.		

OBJECTIVE 1.3: BY 2024, TO HAVE REDUCED DISPARITIES IN PREP ACCESS AMONG YOUTH AND OTHER GROUPS EXHIBITING RISKY BEHAVIORS.

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
Expand PrEP coverage by revising public policy associated with health insurance coverage and extending the supply of services.	Department of Health, health-related agencies and organizations, insurers, Medicaid program and ASES.	To delve deeper into public policy and economic barriers that affect access to PrEP.	Department of Health, regulatory entities such as the Insurance Commissioner, Insurers, pharmaceutical sector, Legislature, Medicaid Program and ASES; and Municipalities.	Program Income Insurers HIV Prevention Activities Health Department Based
		Address public policy and insurance coverage barriers to PrEP to increase access among men who have sex with men, injecting drug users and heterosexual women.		
		Conduct media campaigns aimed at disseminating information related to PrEP among the general population and key actors involved in public policy formulation to promote changes in current public policy.		
		Promote changes in public policy barriers that limit access to PrEP, including changes to the State Medicaid Plan to incorporate access to PrEP through the health plan of the Government of Puerto Rico.		
Promote education and the use of evidence-based information on PrEP as a method of HIV prevention.	Service providers, health professionals, persons with a positive diagnosis and their partners, general population, youth aged 13 years and older, and heterosexuals.	Promote the inclusion of PrEP education in university curriculums.	Department of Health, health agencies, insurance companies, *ASES* and community-based organizations, the community at large and Municipalities.	Program income Corporate donations Insurers HIV Prevention Activities Health Department Based
		Promote the inclusion of PrEP education in continuing education requirements for renewal of medical licenses/associations.		
		Conduct education efforts targeting health care providers and HIV-positive individuals and their partners.		
Promote availability and access to PrEP for the entire population.	Youth, youth aged 13 years and older and population at risk for HIV and heterosexuals.	Promote extended working hours in clinics and health provider centers.	Department of Health, insurance companies, ASES, service providers, CDC, community-based organizations and Municipalities.	Program Income Insurers HIV Prevention Activities Health Department Based
		Promote training of available and certified human resources in HIV PrEP and prevention.		
		Provide information and services on PrEP at health fairs and other community settings.		

B. DIAGNOSTIC

Goal 2: Diagnose all people who are HIV-positive as soon as possible.

OBJECTIVE 2.1: INCREASE THE DIVERSITY AND CAPACITY OF HEALTH CARE DELIVERY SYSTEMS, COMMUNITY HEALTH, PUBLIC HEALTH, AND HUMAN RESOURCES FOR HEALTH TO DIAGNOSE HIV

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
Increase the human resources available to perform HIV diagnostic tests.	Schools, universities, medical schools, resident physicians and community-based organizations, non-profit organizations and individuals with a positive HIV diagnosis.	Increase spaces for internships and residencies in the different health professions.	Department of Health, Department of Education, medical schools, hospitals, clinics, HIV-positive individuals, etc.	CDC HIV Prevention Activities, Non-Governmental Organization Based HIV Prevention Activities Health Department Based Epidemiologic Research Studies of Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection in Selected Population Groups Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance
		Establish collaborative agreements between schools, hospitals and clinics for HIV diagnosis.		
		Encourage the empowerment and participation of people with a positive HIV diagnosis in training efforts for human resources working with HIV diagnosis.		
		Encourage the use of simple, appropriate and culturally sensitive language about HIV among diagnostic service providers.		

OBJECTIVE 2.2: INCREASE THE NUMBER OF TESTS PERFORMED FOR HIV, SEXUALLY TRANSMITTED INFECTIONS, AND VIRAL HEPATITIS BY 25% OVER THE PLANNING PERIOD

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
Promote access to information and education on the availability and benefits of diagnostic tests in clinical and non-clinical settings.	Schools, universities, hospitals and clinical settings.	Review and strengthen the curriculum of health programs in educational institutions.	Planning groups, Community-based organizations, Department of Health, Department of Education, Department of Correction, Department of Family and Department of Housing, Hospital Association (delivery room and emergency room management).	CDC Organization Based HIV Prevention Activities Health Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection in Selected Population Groups Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance Ryan White Part C *Private sources of funds or corporate donations* *Foundations*
		Design and implementation of culturally competent educational campaigns focused on diverse populations and/or populations with risk behaviors to raise awareness about HIV, Hepatitis and other STIs.		
To expand the availability and accessibility of testing scenarios.	Youth, older adults, MSM, pregnant women, transgender people and people who inject drugs.	Development and promotion of recommendations to address barriers identified in laws/regulations/policies applicable to rapid test-related sample collection and the offering of rapid tests in non-traditional or non-clinical settings.	Community-based organizations, Department of Health, Department of Education, Department of Correction, Department of Family and Department of Housing, Hospital Association (labor and emergency room management), Laboratory Association College of Medical Technologists 330 Primary Care Centers[7].	
		Increase non-clinical settings where HIV testing is targeted to populations with at-risk behaviors.		
		Implement innovative and targeted HIV testing activities for at-risk populations.		
		Conduct orientation and information dissemination efforts on the availability of clinical testing sites.		

[7] 330 Primary Care Centers, are community-based and patient-directed organizations that deliver comprehensive, culturally competent, high-quality primary health care services to the nation's most vulnerable individuals and families, including people experiencing homelessness, agricultural workers, residents of public housing, and veterans.

OBJECTIVE 2.3: INCREASE THE PERCENTAGE OF PEOPLE WITH A POSITIVE HIV DIAGNOSIS WHO KNOW THEIR SEROLOGICAL STATUS TO 95%.

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
Integrate the offer of routine HIV testing in conjunction with educational campaigns.	General public, clinical setting, MSM, schools and youth population.	Expand and provide continuity of access and testing services through distribution of information at specific service points or visits to locations such as schools, correctional facilities, among others.	Department of Health, Department of Education, activists, CBOs, municipal clinics, community-based organizations, consultants, professional associations, medical directors, 330 Primary Care Centers and clinical laboratories.	CDC Organization Based HIV Prevention Activities Health Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection in Selected Population Groups
		Identify additional funding sources to increase the availability of testing services in combination with education strategies.		
		Establish or offer counseling services and support lines as a complement to testing.		
		Establish home testing distribution strategies.		

OBJECTIVE 2.4: INCORPORATE THE SERONEUTRALITY STATUS APPROACH IN THE PROVISION OF CLINICAL SERVICES FOR HIV SCREENING.

Strategies	Target Populations	Activities	Key stakeholders	Source of Funds
Strengthen institutional and human resource capacity for the integration of the sero-neutrality status approach.	General public, clinical setting, schools and youth population.	Develop and implement a training plan for the implementation of the HIV sero-neutrality approach for key program staff, managers, and providers.	Department of Health, Department of Education, activists, OCBs municipal clinics, community-based organizations, consultants, professional associations and medical directors.	
		Develop guidelines for the implementation of an HIV prevention cascade based on the sero-neutrality approach.		
		Integrate aspects related to the sero-neutral approach into education efforts for the general population and populations with risk behaviors.		

C. TREATMENT

Goal 3: Treat HIV-positive individuals rapidly and effectively to achieve sustained viral suppression.

OBJECTIVE 3.1: EXPAND THE CAPACITY OF THE SERVICE DELIVERY SYSTEM TO PROVIDE COMPREHENSIVE, COORDINATED AND EQUITABLE CARE TO ALL PEOPLE IN PR WITH A POSITIVE HIV DIAGNOSIS.

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
Addressing social and structural determinants that generate barriers in the care of HIV-positive individuals.	HIV-positive individuals by subpopulations or demographic groups and youth 15 years of age and older.	Promote the analysis and research to deepen the social and structural determinants that affect the health of people with a positive diagnosis of HIV. Identify evidence-based best practices to address social and structural determinants and the barriers they generate. Provide training to service providers in evidence-based practices to address social and structural determinants and the barriers they generate.	Department of Health, agencies and other organizations that provide social and health services, community leaders, Academia, Planning Advisory Bodies, 330 Primary Care Centers and Municipalities.	HRSA HIV Emergency Relief Project Grants (Ryan White Part A) HIV Care Formula Grants B/ADAP, Part B Supplementary / ADAP ERF) Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Part C) RWHAP Part D (WICY population with HIV) RWHAP Part F (NECA/AETC) Foundations State funds
Promote the provision of integrated HIV services that also address co-morbidities, co-infections and complications	Population with a positive HIV diagnosis, including groups with special needs such as people with comorbidities, older adults, people with problematic substance	Conduct a regional analysis to identify areas lacking health services or with limited offerings in terms of service schedules. Based on the conclusions of the analysis, promote flexible schedules, according to the needs of the population.	Department of Health, health care providers, Ryan White 330 Primary Care Centers Programs, NECA/AETC (RW	HRSA HIV Emergency Relief Project Grants (Ryan White Part A) HIV Care Formula Grants B/ADAP, Part B Supplementary / ADAP ERF

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
associated with HIV.	use, people with mental health conditions, heterosexual people, and Youth 15 years of age and older	Expand the diversity of health services offered by clinical and support centers so that HIV-positive individuals can receive the services they need in one place.	Part F) and Planning Advisory Bodies.	Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Part C) RWHAP Part D (WICY population with a positive HIV diagnosis) RWHAP Part F (NECA/AETC) SAMHSA Substance Abuse and Mental Health Services Projects of Regional and National Significance - Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs) Foundations State funds
		Promote partnerships among providers to offer specialized services for the treatment of HIV and co-morbidities.		
		Provide training on HIV-related issues among medical specialists and other mental health professionals.		
		Promote the incorporation of topics associated with HIV treatment and comorbidities in university curriculums and continuing education for health professionals.		
Expand the provision of integrated health services for the HIV-positive population in non-conventional settings, according to the special needs of the population.	Future medical professionals, current health care providers, researchers, public agencies, community groups, clinics and non-profit organizations.	Incorporate in the screening and individual interviews of service participants with a positive diagnosis of HIV, information fields that allow identifying special needs, such as socioeconomic, mental health, physical or mobility needs.	Department of Health, *ASES*, health care providers, 330 Primary Care Centers, Ryan White Programs and Planning Advisory Bodies. NECA/AETC.	HRSA HIV Care Formula Grants B/ADAP, Part B Supplementary / ADAP ERF) Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Part C) SAMHSA Substance Abuse and Mental Health Services Projects of
		Promote the provision of clinical and specialized services tailored to the needs of HIV-positive individuals in non-conventional settings, such as in the home, mobile units, aegis or assisted living homes, among others.		
		Promote the provision of in-home support services with a mental and physical health focus.		

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
		Offer training in technological literature to the population diagnosed with HIV, which promotes access to different modalities in the provision of health services.		Regional and National Significance - Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs) Foundations State funds

OBJECTIVE 3.2: INCREASE TO 80% THOSE NEWLY DIAGNOSED WITH HIV TO BE LINKED TO HEALTH CARE ON OR WITHIN 30 DAYS OF DIAGNOSIS

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
Expand and diversify activities to link the HIV-positive population to treatment services.	Newly diagnosed HIV-positive individuals, including injection drug users, youth, older adults, heterosexuals, and youth 15 years of age and older, among others.	Conduct educational activities to promote health care, access to treatment services and benefits where both the HIV-positive population and their families can participate. Review service delivery processes to identify alternatives to reduce the time it takes for a person to be tested and diagnosed by a physician, as well as factors that delay early linkage to treatment.	Department of Health, Ryan White Programs, Service Providers, 330 Primary Care Centers, NECA/AETC (Ryan White Part F Program), Clinical Case Managers, ASES/insurers, Planning Advisory Bodies and Treatment Liaison Staff	HRSA HIV Emergency Relief Project Grants (Ryan White Part A) HIV Care Formula Grants B/ADAP, Part B

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
		Educate healthcare professionals, clinical case management and liaison personnel, epidemiology technicians, and professionals in pharmacies, hospitals, emergency rooms, multidisciplinary teams and other personnel involved in the provision of services on the importance of early linkage to treatment.		Supplementary / ADAP ERF) Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Part C)
		Increase the number of providers trained and culturally sensitive in the management of the older adult population, MSM, young MSM, people who inject drugs and transgender population with positive HIV diagnosis.		
		Promote extended hours of service at health centers and increase spaces available for those patients who require immediate care and resort to the service centers without appointments.		

OBJECTIVE 3.3: INCREASE BY 10% THE RE-LINKAGE TO MEDICAL CARE OF PERSONS DIAGNOSED WITH HIV WHO ARE OUT OF TREATMENT.

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
Establish integrated systems to re-link people who have been out of treatment for six (6) months or more.	HIV-positive population out of treatment	Formalize follow-up activities for individuals who have disengaged from treatment services through the development of uniform protocols.	Department of Health, Ryan White Programs, HIV service providers, providers of other supportive and complementary services, case managers, Planning Advisory Boards, 330 Primary Care Centers and Municipalities, ASES, and treatment linkage personnel	HRSA HIV Care Formula Grants B/ADAP, Part B Supplementary / ADAP ERF) Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Part C)
		Continue to educate on culturally sensitive best practices aimed at treatment re-engagement.		
		Disseminate and enable the implementation of identified culturally sensitive best practices for treatment re-engagement.		
		Promote the provision of emotional and psychological support services, including peer interventions, to promote treatment re-engagement.		
		Promote the benefits of HIV treatment services in communities, settings where supportive and complementary services are provided, and in places frequented by populations with risk behaviors, such as medication-assisted clinics and methadone centers.		
		Provide training to the HIV-positive population in the use of technologies to access information about treatment services, including physicians, clinics, and service providers.		
		Conduct collaborative agreements with search units for re-linkage to care.		
		Continue to implement outreach activities aimed at contacting and re-linking people who have been out of treatment for more than six (6) months.		

OBJECTIVE 3.4: INCREASE TO 90% PEOPLE WITH HIV-POSITIVE DIAGNOSIS WHO ARE RETAINED IN MEDICAL CARE.

Strategies	Target Populations	Activities	Key stakeholders	Source of funds
To expand the offer of support services according to the profile of the populations that present the greatest challenges for retention.	Population with a positive HIV diagnosis, which, according to the epidemiological profile, present the greatest challenges for retention.	Generate a profile of populations with greater difficulty in maintaining treatment to facilitate decision making and targeting of resources to promote retention.	Department of Health, HIV service providers, other service providers and Planning Advisory Bodies, 330 Primary Care Centers, Ryan White Programs	HRSA HIV Care Formula Grants B/ADAP, Part B HUD Housing Opportunities for Persons with AIDS (HOPWA) SAMHSASubstance Abuse and Mental Health Services Projects of Regional and National Significance - Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs)
		Facilitate access to information for accessing treatment services including information regarding supportive or complementary services.		
		Increase supportive or complementary services, including but not limited to transportation and outreach services.		
		Through partnerships with other entities, promote population access to other services that impact the stability of people with a positive HIV diagnosis (mental health, access to employment and housing, among others).		
		Continue to educate about culturally sensitive practices aimed at retention in treatment.		
Promote the strengthening and retention of the human resources that provide treatment and support services.	Treatment and support services personnel	Develop and promote collaboration between health centers and the pooling of financial resources to improve the integration of different services and balance provider burdens.	Department of Health, NECA/AETC (Ryan White Part F Program), HIV service and support providers, Academia, Planning Advisory Bodies, 330 Primary Care Centers, Ryan White Programs and Municipality.	HRSA HIV Care Formula Grants B/ADAP, Part B HUD Housing Opportunities for Persons with AIDS (HOPWA) SAMHSASubstance Abuse and Mental Health Services Projects of Regional and National Significance - Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs)
		To train and provide adequate tools to avoid burnout of service providers in order to increase or sustain the supply of health services.		
		Promote the use of mechanisms such as multi- and interdisciplinary care team meetings and communications, as well as among the different providers.		

OBJECTIVE 3.5: INCREASE THE NUMBER OF HIV-POSITIVE INDIVIDUALS WITH SUPPRESSED VIRAL LOAD TO 85%.

Strategies	Target Populations	Activities	Key stakeholders	Source of Funds
Promote integrated, coordinated and focused care for the HIV-positive person that supports viral load suppression.	HIV-positive individuals, Clinical service providers and case managers Clinical service providers in general.	Maintain access to new HIV treatment medications in direct coordination with ASES.	Department of Health, NECA/AETC (Ryan White Part F Program), Academia, College of Physicians, Professional Associations and Examining Boards, HIV Treaters Association, ASES, Insurers, HIV Service Providers, 330 Primary Care Centers, Ryan White Programs and Planning Advisory Bodies.	HRSA HIV Emergency Relief Project Grants (Ryan White Part A) HIV Care Formula Grants B/ADAP, Part B Supplementary / ADAP ERF) Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Part C)
		Annual training of physicians, case managers and other clinical staff who provide services to HIV-positive individuals about new HIV treatment medications.		
		Encourage the use of best clinical practices for the care of HIV-positive individuals according to the HIV Treatment Guidelines.		
Promote quality improvement projects aimed at achieving viral load suppression in young people, people who inject drugs (PWID) and transgender population, among other groups where there is a high proportion of people in care without viral suppression.	Youth, PID and Trans population with positive HIV diagnosis and unsuppressed viral load, among other groups where there is a high proportion of people in care without viral suppression.	Identify the number of youth and PID and other HIV-positive populations who meet the criteria for unsuppressed viral load at each clinical site.	Department of Health, Ryan White Programs, HIV service providers, DS, HIV Surveillance Program, Planning Advisory Bodies, Interparts Committee, ASSMCA, 330 Primary Care Centers and Municipalities	HRSA HIV Care Formula Grants B/ADAP, Part B Supplementary / ADAP ERF) Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Part C)
		Implement quality improvement projects aimed at achieving viral suppression in youth, PID and other HIV-positive populations.		
		Monitor the viral loads of HIV-positive individuals identified at each clinical site.		

OBJECTIVE 3.5: INCREASE THE NUMBER OF HIV-POSITIVE INDIVIDUALS WITH SUPPRESSED VIRAL LOAD TO 85%. (CONT.).

Strategies	Target Populations	Activities	Key stakeholders	Source of Funds
Educate population groups with a low percentage of viral suppression about the services available and the importance of retention and adherence to treatment, respectively.	Groups where there is a high proportion of people in care without viral suppression, including Youth, PID and Trans population with positive HIV diagnosis who have unsuppressed viral load, among others.	Identify appropriate guidance strategies.	Department of Health, Ryan White Programs, HIV service providers, Academy, HIV Surveillance Program, Planning Advisory Bodies, Interparts Committee, ASSMCA, 330 Primary Care Centers and Municipalities	HRSA HIV Care Formula Grants B/ADAP, Part B Supplementary / ADAP ERF) Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Part C)
		Implement guidance strategies on available services and the importance of retention and adherence to treatment.		
		Evaluate the retention and adherence in care of the targeted groups.		

D. RESPONSE

Goal 4: To respond to the syndemics of HIV, sexually transmitted infections (STIs), viral hepatitis, and behavioral health in a coordinated and integrated manner

OBJECTIVE 1.1: STRENGTHEN MULTISECTORAL PLANNING AND COORDINATION TO ADDRESS THE HIV, STI, VIRAL HEPATITIS AND MENTAL HEALTH SYNDEMIC, IN ORDER TO HAVE AN INTEGRATED SYSTEM THAT PROVIDES EQUITABLE ACCESS TO SERVICES

Strategies	Target Populations	Activities	Key stakeholders	Source of Funds
Strengthen measurement, monitoring and evaluation mechanisms to continue promoting a culture of data use in decision making in response to the syndemic.	Department of Health, Planning Advisory Bodies, NECA/AETC, Academia.	Identification, development and/or review of metrics to understand and address syndemics in an integrated manner.	Department of Health, Academy, other agencies linked to the health system, Planning Advisory Bodies, Ryan White Programs, Health Care Providers, NECA/AETC (Ryan White Part F Program).	CDC Epidemiologic Research Studies of Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection in Selected Population Groups Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance
		Design and implement education strategies on the use of information to address syndemics in an integrated manner and respond effectively to outbreaks.		
		Establish accountability mechanisms for Integrated Surveillance, Prevention and Care Plan strategies.		

OBJECTIVE 1.1: STRENGTHEN MULTISECTORAL PLANNING AND COORDINATION TO ADDRESS THE HIV, STI, VIRAL HEPATITIS AND MENTAL HEALTH SYNDEMIC, IN ORDER TO HAVE AN INTEGRATED SYSTEM THAT PROVIDES EQUITABLE ACCESS TO SERVICES (CONT.).

Strategies	Target Populations	Activities	Key stakeholders	Source of Funds
Continue to promote the integration of services related to HIV, STIs, Hepatitis, and Hepatitis	Network of service providers	To assess, through an evaluation exercise of the directory of organizations, the status of the supply of services in order to balance the resources in accordance with the current unmet need.	Department of Health, Academia, other agencies linked to the health system, 330 Primary Care Centers, Ryan White Programs, Health Care Providers, NECA/AETC	
		Identify available and recurrent funds for service offerings.		
		Develop collaborative partnerships with actors that provide other services but have contact with communities lacking prevention and diagnostic services.		
		Promote pilot projects that combine the provision of services aimed at responding to syndemic.		

Objective 1.2: CONTINUE TO PROMOTE PUBLIC POLICY CHANGES AIMED AT INTEGRATING SURVEILLANCE, PREVENTION, AND TREATMENT EFFORTS FOR HIV, STIS AND VIRAL HEPATITIS

Strategies	Target Populations	Activities	Key stakeholders	Source of Funds
Reactivation of the Multisectoral Committee to strengthen public policy and promote greater linkage of the country's sectors related to the surveillance, prevention and treatment of HIV/AIDS, STIs, Hepatitis and TB in Puerto Rico.	Community living with a positive HIV diagnosis, Health Department, service providers, other related entities.	Promote the enactment of Executive Order related to the Committee.	Community with a positive HIV diagnosis, Health Department, service providers, other related entities	
		Identify the current status of public policy pieces developed as part of the plan.		
		Identify and prioritize public policy issue areas with which the Committee will work.		
		Formulate strategies to address identified public policy needs.		
		Present package of measures.		
		Disseminate information on measures adopted.		

SECTION VI: 2022-2026 INTEGRATED PLANNING IMPLEMENTATION, MONITORING AND JURISDICTIONAL FOLLOW UP

1. 2022-2026 INTEGRATED PLANNING IMPLEMENTATION APPROACH

A. IMPLEMENTATION

The approach for the implementation of the Integrated Plan 2022-2026, is based on lessons learned and best practices used in the implementation of the plan during the 2017-2021 period. As part of the Integrated Plan development process, a Planning Committee was established with representation from the staff of the divisions of the Puerto Rico Department of Health that work with HIV Surveillance, Prevention and Treatment. As was the case in 2017, this group will be established on a permanent basis, and members will be added as needed to implement the plan. The objective of this working group will be to provide guidance and feedback for the implementation of the Plan. To this extent, monthly working meetings will be held. In addition, throughout the process, reporting and accountability mechanisms will be established for the stakeholders who participated in the integrated planning process. The objective is to report on the level of progress in the implementation of the Plan and to obtain their input to refine aspects that are relevant to the implementation of the Plan.

B. MONITORING

As a companion document to the *Integrated Plan*, the Health Department - as it did during 2017-2021 - will develop a detailed evaluation plan that will allow for monitoring the implementation of the plan, focusing on the principles of process and performance evaluation.

Through an approach that will use various sources of information, data and indicators will be collected on the outputs of the activities established for each strategy and the results with respect to the four pillars of the Plan and their corresponding objectives. Based on previous experience, it is understood that the sources to be used will include:

- systematic reporting by service providers and recipients of funds for HIV prevention and treatment services;
- official information and statistics from:
  - HIV Surveillance System of the P.R. Department of Health;
  - studies commissioned by the Planning Advisory Bodies; and
  - data from other official sources such as:
    - Prevention: National Electronics Disease Surveillance System (NEDSS) Base System (NBS), Evaluation Web® (test-related), locally developed database for condom distribution intervention,
    - Treatment: CareWare Data System, local Ryan White Program database; Early Identification of Individuals with HIV Database, Care Link Workers (TEC Database), ADAP Data Base and the Pharmacy Benefit Manager (PBM) database;
    - database of the Puerto Rico Health Services Administration (ASES), and

- database available from the Department of Health's Assistant Secretary of Planning and Development (commercial health insurance utilization reports).

In instances where data relies on reports submitted by service providers, standardized guidelines and instruments will be developed for the collection of information on interventions that have been implemented.

Information collected through these sources will be aggregated and submitted to the Planning Advisory Bodies to keep them informed of the progress of the Integrated Plan and receive their input. The evaluation units of the Division of STD/HIV Prevention, Ryan White Part B/ADAP, HIV/AIDS Surveillance and OCASET will be in charge of the evaluation processes, accordingly.

C & D. EVALUATION AND IMPROVEMENT

The structure developed by the Division of STD/HIV Prevention and the Ryan White Part B/ADAP Program, under the direction of the Assistant Secretary for Family Health and Integrated Services and the Central Office of AIDS and Communicable Disease Affairs, will be used to evaluate and improve health outcomes. This evaluation will be conducted using data collected through the HIV Surveillance System and databases used by the prevention and treatment programs.

In the case of the HIV/STD/Viral Hepatitis Prevention Division, it has the Monitoring, Evaluation and Quality Assurance Section, which provides support to all other units related to HIV, STI and Viral Hepatitis prevention, and is responsible for implementing evaluation and quality assurance activities. The team of evaluators in this unit is responsible for the development of evaluation plans based on a participatory process with stakeholders.

As part of the routine processes for the implementation of evaluation and quality assurance plans, this group is responsible for monitoring and analyzing any changes in HIV epidemiology and their impact on prevention activities and interventions. Thus, monitoring and evaluation of prevention activities and interventions is conducted in light of observed changes in epidemiology. The information gathered is analyzed in terms of the behavior of the syndemia by geographic area, the needs identified in those areas and the resources, materials and funds available to address them. This analysis is translated, in turn, into concrete recommendations related to prevention services.

Advancing the continuum of care, the Ryan White Part B/ADAP Program will implement and evaluate the Integrated Plan through the Planning, Evaluation and Quality Improvement Unit. This Unit, led by the Ryan White Part B/ADAP Program Director, is responsible for identifying effective strategies and approaches that provide information to the Program and administrators to develop and/or modify existing protocols and procedures. In addition, it conducts studies and evaluations of different service areas, reviews work protocols and, together with the other Program units, seeks to develop and implement procedures that serve to improve treatment and support services to meet the needs of HIV-positive individuals. The Unit is composed of a planning analyst (Integrated

Plan Project Manager), a planning and evaluation specialist, an evaluator, two data management coordinators for CAREWare and other databases, and a data entry resource.

Among the roles assumed by the Unit are the management of the Quality Improvement Program, the Part B/ADAP Program Planning Group, the Ryan White Act Interagency Committee in PR, the system for collecting and analyzing the services provided to people diagnosed with HIV (CareWare) in the Program's service network and the databases generated to collect information on linkage, re-linkage and retention in care, and the implementation and evaluation of the federal and state work plans, including the Integrated Plan.

Through projects such as the Ryan White Part B/ADAP Planning Group and the Quality Improvement Program, it is ensured that priority issues and needs identified in the delivery of services to HIV-positive individuals are discussed through a community engagement process. Both projects involve representation and participation from HIV-positive individuals, the Academy, individuals with expertise in health care delivery, including sub-recipients of Ryan White Part B/ADAP funds and recipients of Ryan White Part A, C, D and F funds, among other collaborators.

Through the structure of the Ryan White Part B/ADAP Planning Group, ten regular meetings are held to identify needs, analyze and implement feasible strategies to address priority issues, including the Integrated Plan.

Another important project led by this unit that will assist in the implementation of the Integrated Plan is the White Part B/ADAP Quality Improvement Program. It has established an infrastructure based on three basic components, with clearly defined roles and responsibilities. These components include, as illustrated in the diagram below: the Quality Assessment, Planning and Improvement Unit; the Quality Guidance Committee; and the Integrated Quality Committee. Its mission is "to ensure that clinical and support services provided by Ryan White grantee organizations in Puerto Rico are accessible and in accordance with the latest treatment standards," while its vision states "agencies providing effective and efficient quality services aimed at improving the health and well-being of all people affected by HIV".

Within this structure, the Quality Guidance Committee is the unit responsible for reviewing and planning improvement activities. The committee meets quarterly and is composed of 12 members, including representatives from the HIV-positive community. Among its roles are review of data derived from CAREWare, improvement work plans, and specific quality improvement actions at all Ryan White-supported service levels.

The third component, the Comprehensive Quality Committee, comprised of representatives from all Ryan White Part B/ADAP Program providers, as well as representation from the external network including Parts A, C, & D and representatives from the HIV positive community, meets quarterly to discuss the implementation of the Quality Improvement Program and provide their input thereon. They are responsible for implementing the improvement plans in each of their entities, while collaborating with the Quality Guidance Committee. During meetings, as well as through other communication mechanisms, the Integral Quality Committee serves as a channel for

disseminating critical information related to the direction of the Quality Improvement Program. All organizations that are part of the Comprehensive Quality Committee are required to align their individual plans with those of the jurisdiction. Progress against the jurisdiction's plan is periodically reviewed by the Guidance Committee, and progress reports are made public during Comprehensive Quality Committee meetings.

E. REPORTING AND DISSEMINATION

Periodically, the Department of Health will issue progress reports and a space will be set aside during the periodic meetings held by the Planning Bodies to present reports on the progress and results of the Plan and receive their input.

At the end of each calendar year, an accountability activity will be held for participants in the planning process and the general public, and a report summarizing the outputs and results achieved will be published. The report will be shared and discussed with the Planning Advisory Bodies to identify changes to ensure compliance and progress on the Plan. Likewise, the report will be available on the Department of Health's website to receive feedback from the public.

SECTION VII: LETTERS OF CONCURRENCE

1. CDC PREVENTION PROGRAM PLANNING BODY CHAIR(S) OR REPRESENTATIVE(S)

GOVERNMENT OF PUERTO RICO
PUERTO RICO DEPARTMENT OF HEALTH

December 8, 2022

Ruth N. Moro, MD, MPH
Project Officer CDC/NCHHSTP/DHP/PDIB
Center for Disease Control and Prevention
Atlanta, GA

Dear Mrs. Moro:

The HIV Prevention Planning Group concurs with the following submission by the Puerto Rico Department of Health (PRDOH) 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, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The HIV Prevention Planning Group has reviewed the Puerto Rico Integrated HIV Surveillance, 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 planning body concurs that the Plan 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. For purposes of developing the Integrated Plan, the jurisdiction utilized a participatory planning and empowerment approach, through which representatives from the planning body and other stakeholders actively participated in identifying and prioritizing needs, defining goals and objectives, and designing strategies. Persons representing the planning body participated in the workshops and consultations held as part of the planning process and had the opportunity to further review the plan during the publication and comments period.

For the purposes of implementing the Integrated Plan, the PRDoH proposed a structure similar to that employed in 2017-2021, which included the creation of working groups with representatives from the planning bodies and the community with a positive HIV diagnosis, discussion and presentation of progress before planning bodies and other accountability efforts.

The signature below confirms the concurrence of the HIV Prevention Planning Group concurs with the Integrated HIV Prevention and Care Plan.

Sincerely,

Javier Vázquez Meléndez, MBA
Puerto Rico Department of Health
State Co-Chair HIV Prevention Planning Group

PO BOX 70184 SAN JUAN, PUERTO RICO 00936-8184 / T 787. 765-2929 X. 3611 www.salud.gov.pr

2. RWHAP PART B PLANNING BODY CHAIR OR REPRESENTATIVES

DEPARTAMENTO DE SALUD

December 8, 2022

José E. Au Lay, MD, MMS, MSHA
Senor Public Health Analyst
HRSA/HAB
Division of State HIV/AIDS Programs
5600 Fishers Lane
Rockville, MD 20857
e-mail: jaulay@hrsa.gov

Dear Dr. Au Lay:

The Ryan White Part B/ADAP Planning Body concurs with the following submission by the Puerto Rico Department of Health (PRDOH) 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, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.
The Planning Body has reviewed the Puerto Rico Integrated HIV Surveillance, 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 Ryan White Part B/ADAP Planning Body concurs that the Plan 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. For purposes of developing the Integrated Plan, the jurisdiction utilized a participatory planning and empowerment approach, through which representatives from the planning body and other stakeholders actively participated in identifying and prioritizing needs, defining goals and objectives, and designing strategies. Persons representing the planning body participated in the workshops and consultations held as part of the planning process and had the opportunity to further review the plan during the publication and comments period.

For the purposes of implementing the Integrated Plan, the PRDoH proposed a structure similar to that employed in 2017-2021, which included the creation of working groups with representatives from the planning bodies and the community with a positive HIV diagnosis, discussion and presentation of progress before planning bodies and other accountability efforts.
The signature(s) below confirms the concurrence of the Ryan White Part B/ADAP Planning Body with the Integrated HIV Prevention and Care Plan.

Sincerely,

Ansermo Fonseca
HIV Community Co-Chair
RW Part B Planning Body

Gonzalo Maldonado
Service Provider Co-Chair
RW Part B Planning Body

Yomary Reyes-Díaz, MPH, MHSA
State Co-Chair
RW Part B Planning Body

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