Regional Operational Plan (ROP) 2022

Strategic Direction Summary

May 5, 2022

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Contents

1.0 Vision and Goal Statement

The primary goal of the PEPFAR Caribbean Regional Program (CRP) is to support the governments of Jamaica and Trinidad and Tobago to achieve HIV epidemic control. Our vision has global best practices and policies as a foundation, with the use of data to drive programming decisions, while working with host government to improve the strategic information on which we based our activities.

In Jamaica, we are aligning our efforts with the National Strategic Plan on HIV which seeks to reach the UNAIDS 90-90-90 target by 2025, en route to reaching 95-95-95 by 2030. Our technical assistance will continue to drive advances in the 3rd pillar while also fomenting ambitious gains in the 1st and 2nd pillars. In Trinidad and Tobago, which is making swift progress towards achieving 95-95-95 in the 2nd and 3rd pillars, we will increase focus on the first pillar where progress has only been incremental.

Regionwide, in ROP22 we seek to diversify case finding, looking at multiple modalities that will provide the highest yields. We also seek to increase linkage to person-focused care and treatment services, while improving continuity of treatment to ensure viral load suppression and maintenance. Our programming will strengthen partnerships across all sectors, including public, private, and civil society organizations, while also building capacity that will allow for long-term sustainability. Our efforts to fight stigma and discrimination will contribute to an enabling environment, while prevention efforts help to decrease the number of new infections in Jamaica and Trinidad and Tobago.

Looking at the gaps in our cascade, we have outlined priority areas that all partners are working to address. Limited access to self-testing and gaps in index testing have affected case-finding results. This has had a ripple effect on the cascade in terms of initiating new patients on treatment. We are also seeing that competing priorities are affecting the health care behaviors of both males and females, further impacting continuity and suppression.

We have proposed interventions to address the gaps across the spectrum from prevention to viral load suppression. These include scaling up PrEP implementation in priority spaces; enhanced case finding with a strategic mix of testing modalities; the use of quality improvement (QI) to strengthen linkage to services; support for the increased quantification of never linked clients through the private sector as a PEPFAR specific strategy, along with welcoming back persons to care; optimization of antiretroviral therapy (ART) by supporting the governments of Jamaica and Trinidad & Tobago to lead dolutegravir-based (TLD) transition within facilities; and scaling up differentiated & person-centered services, among other interventions.

Further, in ROP22, we will continue many of the interventions used to mitigate the effects of the COVID-19 pandemic on our programming and people living with HIV (PLHIV), particularly where these interventions have shown success in meeting our core challenges. We will continue mentoring for health care workers (HCWs) for quality care of aging PLHIV and infection prevention and control (IPC) training via the learning management system, as well as expanding telemedicine activities, digital health interventions, and continuous quality improvement (CQI). Likewise, differentiated drug deliveries, community care services, socioeconomic support,

retention navigator outreach support, digitization of data collection tools, and adaptations for entry to care support will remain vital aspects of our program even as the COVID-19 situation improves in our region.

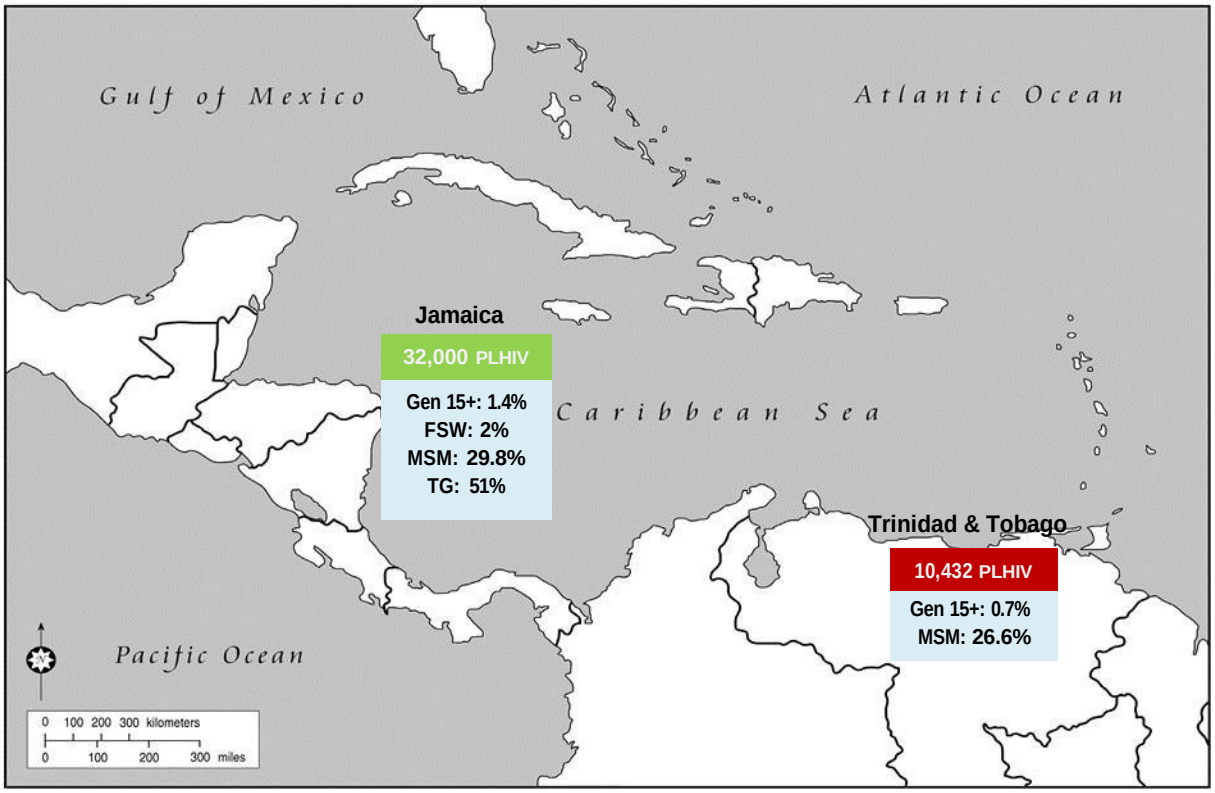
Active program and partner management will remain a cornerstone of our program as we focus on CQI and people-centered design. We will continue regular engagement with all stakeholders including partner governments, community representatives, civil society organizations, and multilateral donor partners to ensure that our program can effectively and sustainably reach our goals.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

HIV prevalence in the Caribbean Region is estimated to be 1.1% of the adult population (UNAIDS, 2020). Of the 5.2 million people in the PEPFAR-supported countries, approximately 43,000 are HIV positive (Figure 2.1.1). HIV prevalence in the general population was estimated to be 0.7% in Trinidad and 1.4% in Jamaica (2020). Jamaica has the greatest burden, representing 74% of PLHIV between the two focus countries.

Figure 2.1.1 HIV Prevalence and Burden in Countries Supported by the PEPFAR CRP in ROP22



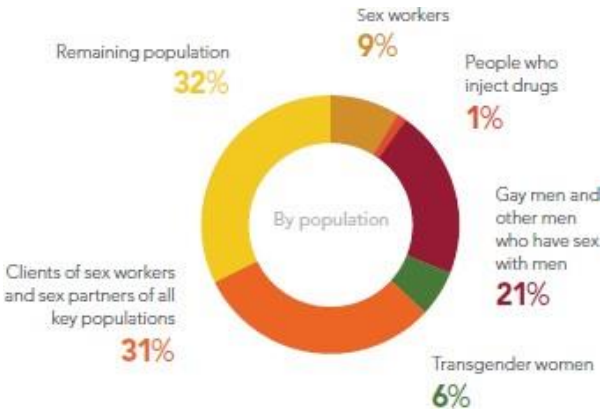
Source: UNAIDS Country Factsheets (2020)

At the heart of the epidemic across the region is pervasive stigma and discrimination (S&D), which remains a barrier to accessing prevention, care, and treatment services for all PLHIV and particularly key populations (KPs) living with HIV (KPLHIV). Other socio-cultural realities impede epidemic control, including gender inequities, gender-based violence, multiple concurrent partnerships, and intergenerational sex. In addition, there are other factors such as social norms influenced by religion; imbedded cultural attitudes, and practices of sexual expression that affect access to care by high-risk and KP groups. In some parts in the region, high levels of poverty, unemployment, and under-employment, especially among youth and women, impact vulnerability

to HIV. These factors contribute to the marginalization of KPs, often driving them "underground" and making it harder to reach them with HIV interventions and services.

Nevertheless, new HIV infections are estimated to have declined by 28% between 2000-2020, and AIDS-related deaths have declined by 51% over the same period (UNAIDS 2021). Sexual intercourse remains the predominant mode of transmission in the region.

Figure 2.1.2 Distribution of New HIV Infection by Population Group, Caribbean 2020

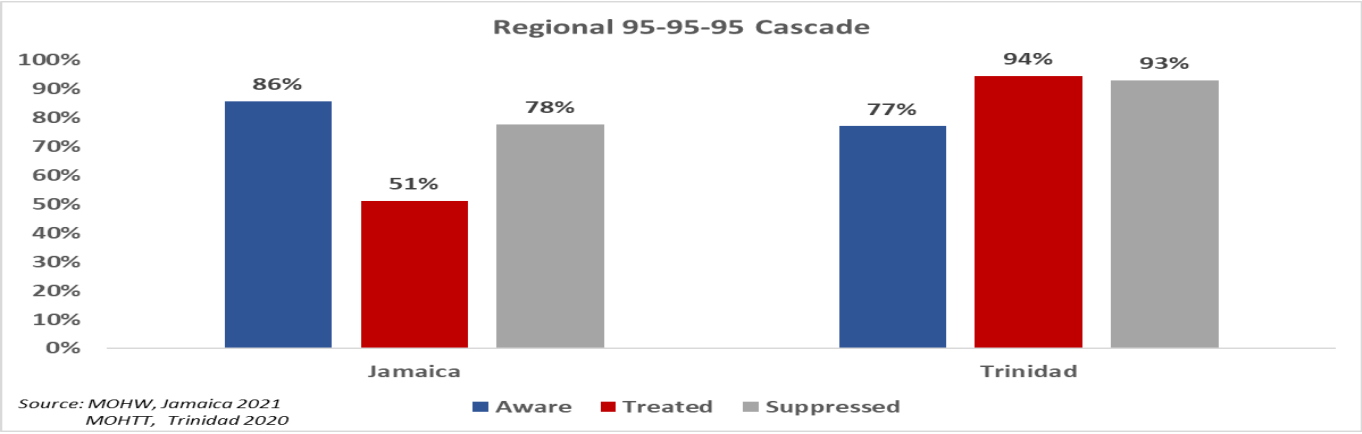


Source : UNAIDS Data, 2021

Clients of sex workers and sex partners of all key populations accounted for 31% of new infections, while men who have sex with men (MSM) represented 21% of new infections in the Caribbean in 2020. Efforts to reach men and boys, particularly MSM, are constrained by health services insufficiently tailored to their needs, limited community-based services, and S&D. In total, KPs and their sexual partners represented 68% of new infections in the region (Figure 2.1.2). KP-specific data are limited but suggest lower proportions of MSM and female sex workers (FSWs) receive treatment and achieve viral suppression.

Numbers of newly infected individuals per annum are estimated to be 1,400 in Jamaica and less than 200 in Trinidad and Tobago (UNAIDS 2020).

Figure 2.1.3 UNAIDS 95-95-95 Cascade in Jamaica and Trinidad & Tobago



The proportion of PLHIV diagnosed and aware of their HIV status is estimated to be 86% in Jamaica (Revised 2020 Spectrum estimates) and 77% in Trinidad and Tobago (2020 Spectrum estimates) (Figure 2.1.3). There is a need to strengthen case finding in Trinidad and Tobago. Even though both countries have adopted Treat All, Jamaica remains challenged with early linkage and retention in care resulting in sub-optimal ART coverage of 51% while in Trinidad and Tobago 94% of those diagnosed are on ART.

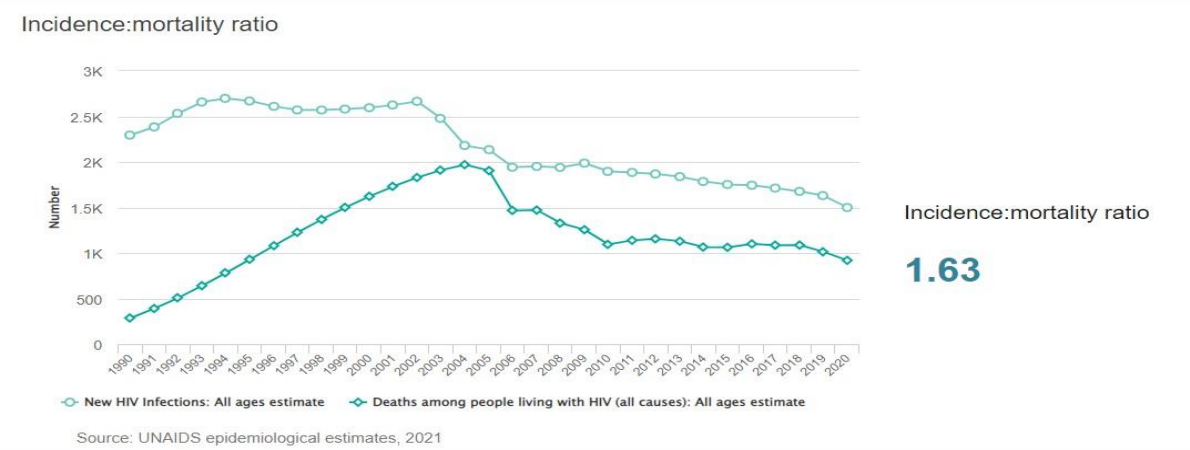
Jamaica - National statistics, disease burden and country profile

HIV prevalence among the general population in Jamaica is 1.4%. The epidemic is concentrated in certain key populations, namely men who have sex with men, with a prevalence of 29.8%; and women of trans experience, with a prevalence rate of 51% (Table 2.1.4). HIV prevalence among female sex workers (FSW) is similar to the general population prevalence at 2.0%. The incidence to mortality ratio is 1.63 (Figure 2.1.5).

Table 2.1.4 Epidemiological Data – Jamaica (2021)

	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	2,734,092	100	280,846	10	289,992	11	237,163	9	245,911	9	863,974	32	816,206	30	*STATIN 2019*
HIV Prevalence (%)		1.4%													UNAIDS, 2020
AIDS Deaths (per year)	<1,000														UNAIDS, 2020
# PLHIV	32,000														UNAIDS, 2020
Incidence Rate (Yr)		0.84													UNAIDS, 2020
New Infections (Yr)	1400														UNAIDS, 2020
Annual births	32,031														MOHW MCSR, 2021
% of Pregnant Women with at least one ANC visit	25,955	81%													MOWH PMTCT Programme Data 2021
Pregnant women needing ARVs	384														MOHW PMTCT Programme Data 2021
Notified TB cases (Yr)	34														MOHW National Surveillance Unit 2021
TB/HIV Co-infection (per year)	18	30%													WHO 2020
Estimated Population Size of MSM*	42,375														IBBS 2018
MSM HIV Prevalence	12,543	29.8 %													IBBS 2018
Estimated Population Size of FSW	18,700														IBBS 2017
FSW HIV Prevalence	370	2%													IBBS 2017
Estimated Total Transgender Population	3,841														IBBS 2018
Transgender prevalence	1958	51%													IBBS 2018

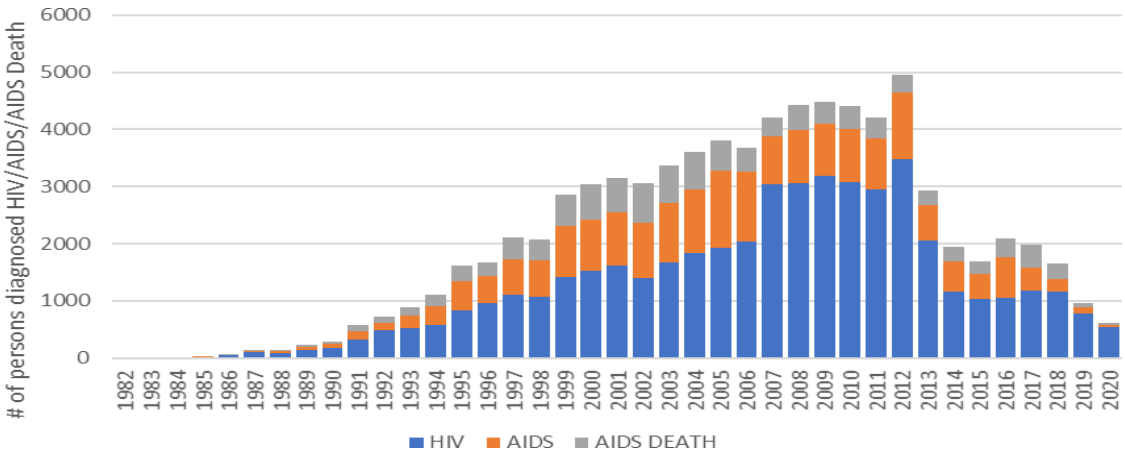
Figure 2.1.5 Trend of New Infections and Deaths among HIV Population in Jamaica



A total of 618 individuals were diagnosed with HIV in 2020 (Figure 2.1.6) with an equal distribution of males and females. The majority, 87%, of cases were classified as HIV, compared to 7% classified as AIDS. Additionally, 6% of cases were classified at death. The parishes of St. Catherine, St. Ann, St. James, Westmoreland, and Kingston & St. Andrew represent a combined 69% of newly reported cases for 2020.

Overall, there has been a downward trend in the number of cases diagnosed since 2012, as well as reduction in late diagnoses. It is important to acknowledge the impact of the COVID-19 pandemic with respect to HIV diagnosis. PAHO has noted that there is evidence that since the onset of the pandemic, the number of people being tested for HIV in both the Caribbean and Latin America has dropped sharply. As a result, eight Caribbean and Latin American nations – Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Jamaica, Peru, and Saint Lucia – reported about 4,000 fewer diagnoses of HIV in the first six months of 2020 compared to the same period in 2019. This view was endorsed by Jamaica's Ministry of Health and Wellness (MOHW) who noted that there was a decrease in the reporting for all but 1 parish for 2020.

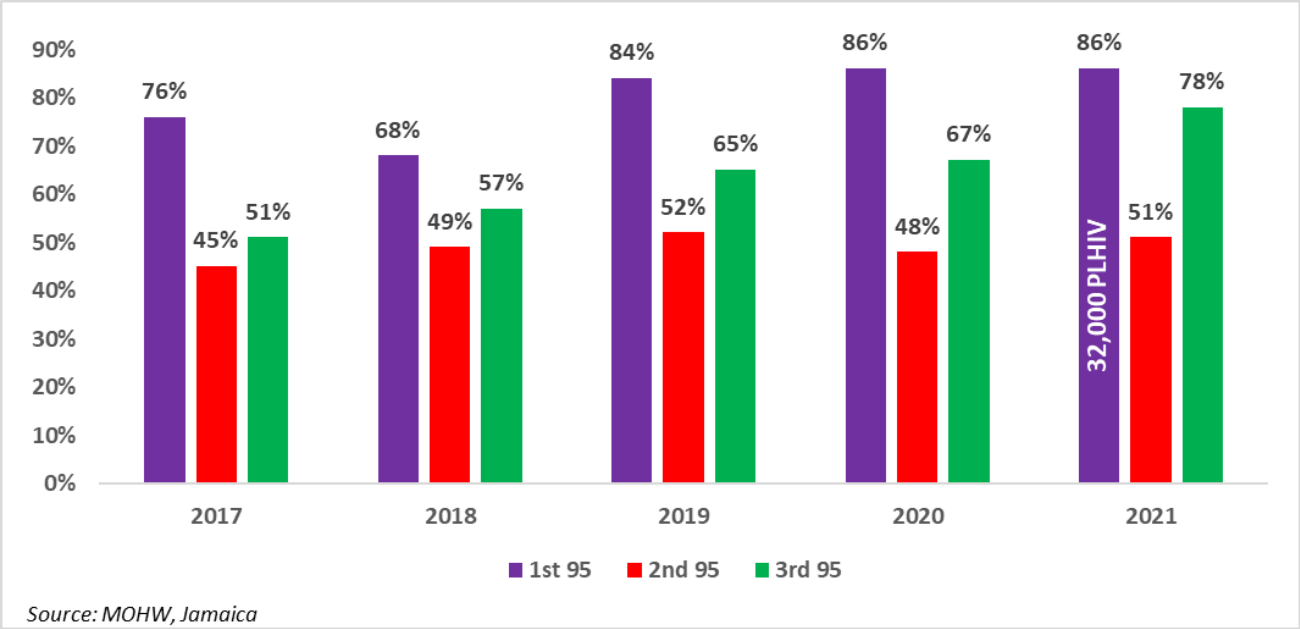
Figure 2.1.6 Number of Cases Reported by Disease State



Source: MOHW Jamaica 2021

The 2020 UNAIDS Spectrum estimates indicate a PLHIV population of 32,000. At the end of December 2021, 27,427 PLHIV were estimated to have been diagnosed; 14,030 were on ART; and 10,904 of those on ART (78%) were virally suppressed. Using the estimate of 32,000 total PLHIV, progress against the 95-95-95 targets is: 86-51-78 (Figure 2.1.7).

Figure 2.1.7 Jamaica National HIV Cascade 2017 - 2021



In quantifying the gaps in the cascade based on the estimated 32,000 PLHIV, there are 4,571 PLHIV who are undiagnosed and approximately 13,399 PLHIV diagnosed but not on ART. Of the 14,030 individuals on ART, 3,126 are not virally suppressed. There remain significant gaps in ART coverage and viral suppression.

All partners will work assiduously to resolve these gaps and to ensure that strategies and resources are aligned to serve the populations and groups most in need. Decreasing the number of diagnosed but not on ART is a critical first step in improving the full clinical cascade. Closing this ART coverage gap of 13,399 individuals will require tailored approaches to find, initiate and retain these PLHIV on ART.

Table 2.1.8 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression– Jamaica (2021)

Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)*	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	2,734,092	1.2%	32,617	27,605	14,030	43%	10,904 (33%)	50,048	793	*678*
Population <15 years	570,838		647		158	58%	82 (30%)			
Males 15-19	117,073		202		81	10%	50 (6%)			
Males 20-29	256,618		3139		768	14%	569 (10%)			
Males 30-39	207,187		6419		1154	15%	883 (12%)			
Males 40+	481,239		10854		4200	43%	3340 (34%)			
Females 15-19	112,045		203		142	25%	87 (15%)			
Females 20-29	249,513		1468		972	30%	661 (21%)			
Females 30-39	219,564		2941		1816	38%	1374 (28%)			
Females 40+	520,015		6744		4728	69%	3853 (56%)			
MSM	42,375	29.6%	12,543		735	6%	622 (5%)	6570	173	*77*
FSW	18,696	2%	542		102	19%	81 (15%)	7900	37	*3*
TWG	3,841	51%	1,958		36	2%	32 (2%)	298	12	*1*

Source: MOHW 2021 - *On ART Total > than disaggregate due to unknown age

Trinidad and Tobago - National statistics, disease burden and country profile

In Trinidad and Tobago, the HIV epidemic is both generalized and concentrated, as HIV prevalence is 1.1% in the adult population but as high as 26.6% among MSM, according to the results of a 2013 bio behavioral survey (BBS) conducted by the Ministry of Health and supported by PEPFAR (Table 2.1.9).

Table 2.1.9 Epidemiological Data – Trinidad (2020)

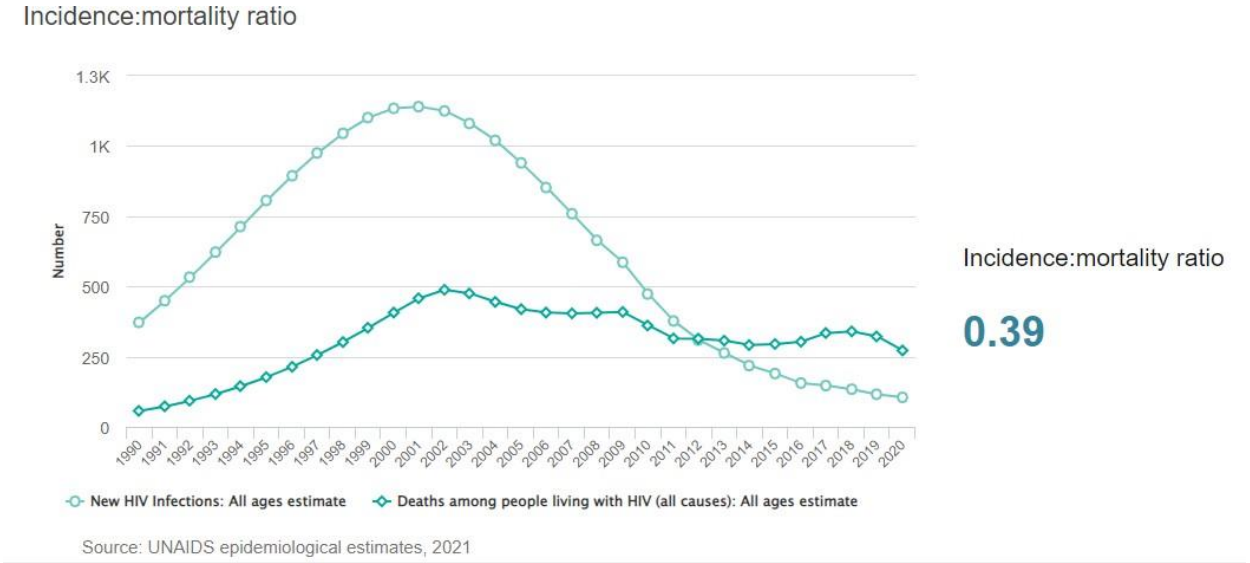
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			F		**M**		**F**		**M**		**F**		**M**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	1,367,557		138233		143323		108644		110305		434538		432514		Central Statistical Office (2021)
HIV Prevalence (%)		0.7													UNAIDS, (2020)
AIDS Deaths (2017)	88		0				2		3		34		49		HACUHIV Surveillance Report 2017
# PLHIV (2018)	11,897														MOH, 2018
Incidence Rate (2017)		0.12													UNAIDS, (2020)
New Infections (2017)	524														HACUHIV Surveillance Report 2017
Pregnant women needing ARVs	<119														UNAIDS, (2020)
Notified TB cases (Yr)	217														WHO, 2017
% of TB cases that are HIV infected	100%														WHO, 2017
MSM HIV Prevalence		26.6													UNAIDS Factsheet TT 2020

Table 2.1.10 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression (Trinidad & Tobago)

Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	**HIV Prev (%)**	**Estimated Total PLHIV (#)**	**PLHIV diagnosed (#)****	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	1,367,557	1.1%	10,432	7,704	7,268	70%	6,756 (93%)	1198	524	*270*
Population <15 years	281,556		263		21	8%				
Men >15 years	542,819		4,867		3,683	76%				
Women >15 years	543,182		5,302		3,534	67%				

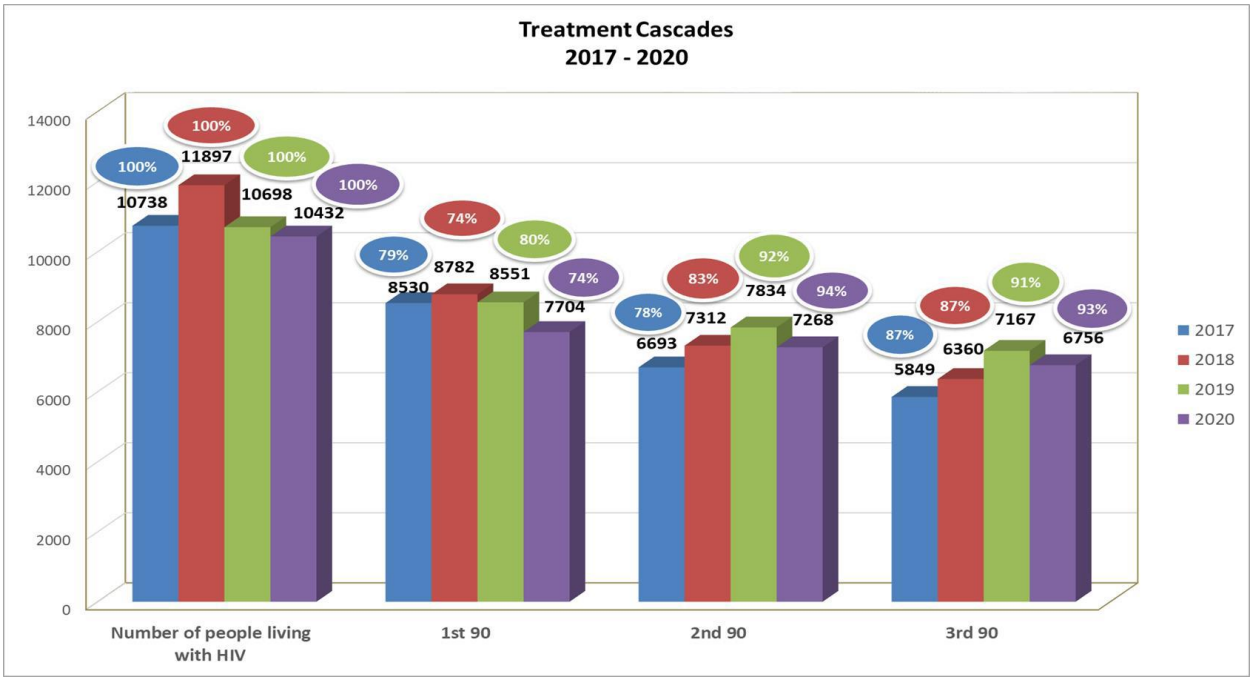
**Retained in care is used as a proxy for PLHIV diagnosed

Figure 2.1.11 Trend of New Infections and Deaths among HIV Population in Trinidad and Tobago



According to the UNAIDs data (2021), the incidence mortality ratio for Trinidad is 0.39. Since 2002, the number of new infections continues to decrease. Data showed a decrease in the number of HIV-related deaths between 2012 and 2015, after which the numbers of HIV-reported deaths remained relatively unchanged (Figure 2.1.11). In 2012, new infections trended below HIV deaths and continued to decrease, remaining below the number of deaths, indicating that Trinidad and Tobago has achieved epidemic control and is making significant progress toward the UNAIDS 95-95-95 goal.

Figure 2.1.12 Trinidad and Tobago National HIV Cascade 2017 - 2020



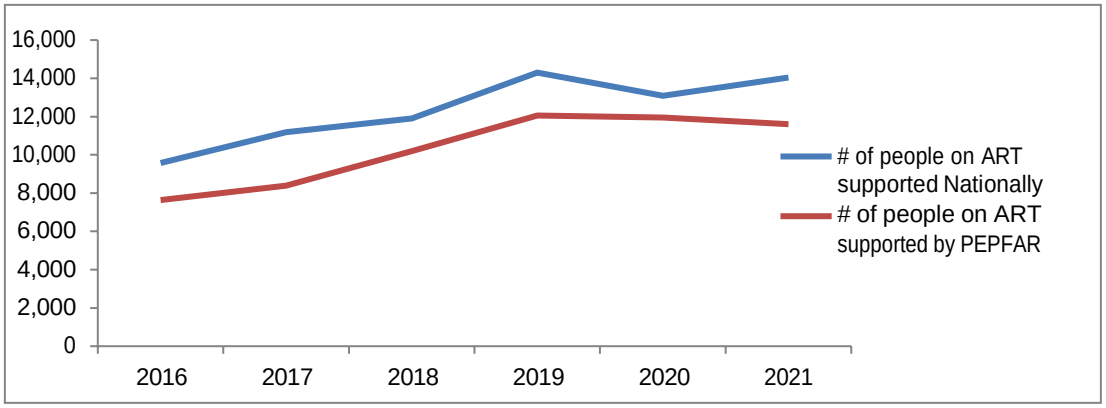
Source: MOHTT

The Trinidad and Tobago national treatment cascade (2020) indicate a PLHIV population of 10,432 (Figure 2.1.12). At the end of December 2021, some 7,704 PLHIV were estimated to have been diagnosed; 7,268 were on ART; and of those on ART, 93% were virally suppressed. Using the estimate of 10,432 total PLHIV, progress against the 95-95-95 targets was 74-94-93. Trinidad and Tobago has nearly attained the 95% goal in the 2nd and 3rd pillar with 94% on treatment and 93% of the virally suppressed. PEPFAR has supported this achievement through interventions to improve adherence and increase retention in care, as well as the implementation of quality improvement initiatives aimed at strengthening the delivery of care at two of the largest treatment facilities.

Caribbean Regional Program Context

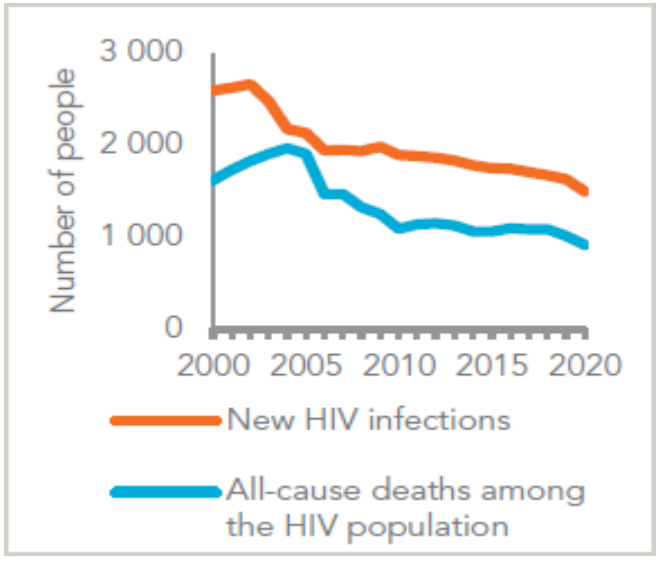
Jamaica

Figure 2.1.13 Updated National and PEPFAR trend for Individuals Currently on Treatment



Over the period 2016 – 2021 there has been a general upward trend in the number of people on ART; a similar trend is noted in both those supported by PEPFAR and supported nationally (Figure 2.1.13). The decline noted in 2019 both nationally and in PEPFAR supported sites is likely due to the refinement of the MOHW definition of numbers of people on ART.

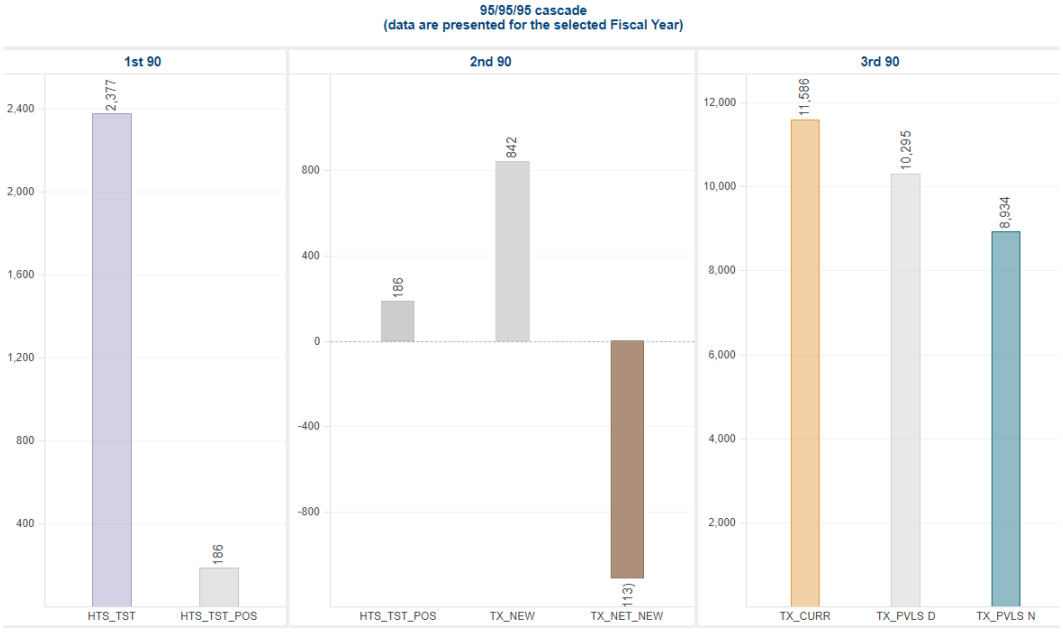
Figure 2.1.14 Updated Trend of New Infections and All-Cause Mortality Among PLHIV - Jamaica



Source: UNAIDS DATA 2021

For Jamaica over the past 15 years there has been a reduction in new infections and all-cause mortality. This is in keeping with the general direction to achieving epidemic control.

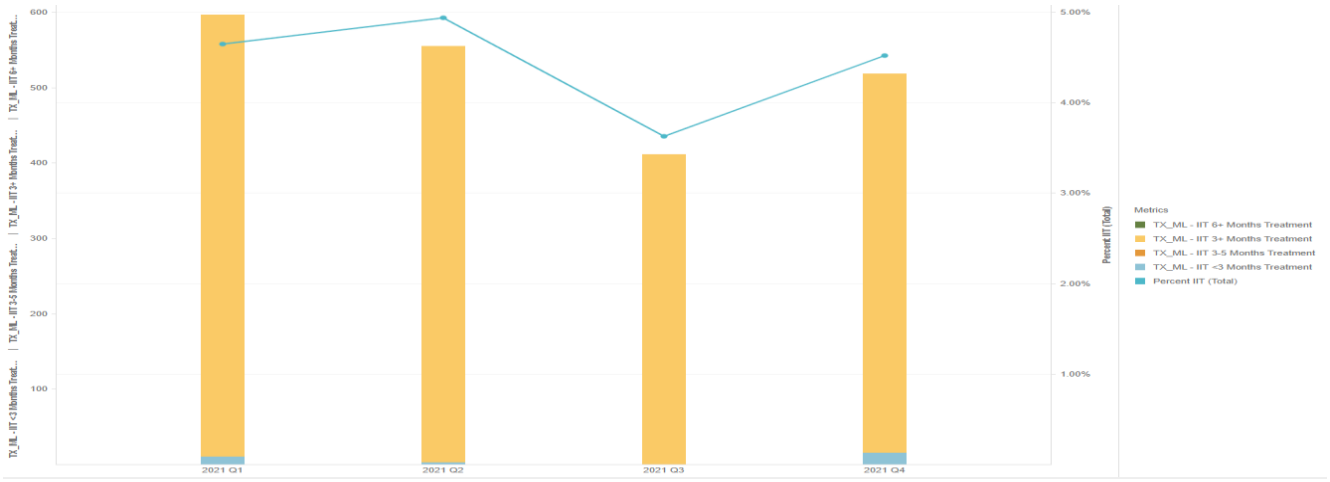
Figure 2.1.15 Assessment of ART Program Growth in FY 21: Jamaica



Source: Panorama: Clinical Cascade, Single OU dossier. Single OU, Overall Cascade

HTS_TST_POS accounted for 22% of TX_NEW (842) reported in FY21, with an overall negative NET_NEW of 1113.

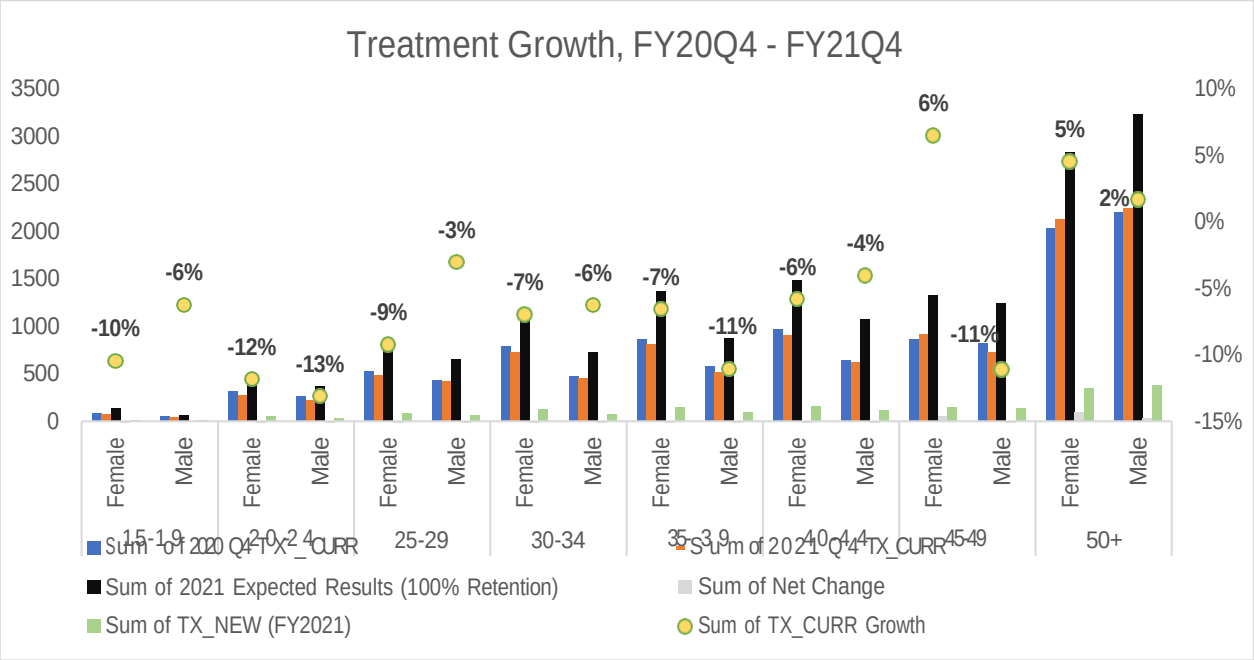
Figure 2.1.16 Quarterly Trends of Clients with Interruptions in Treatment from ART, FY21 Jamaica



Source: Panorama - Treatment - Single OU - Interruptions in treatment (IIT) chapter - IIT Trends page

The vast majority of clients who experienced an interruption in treatment occurred at greater than three months.

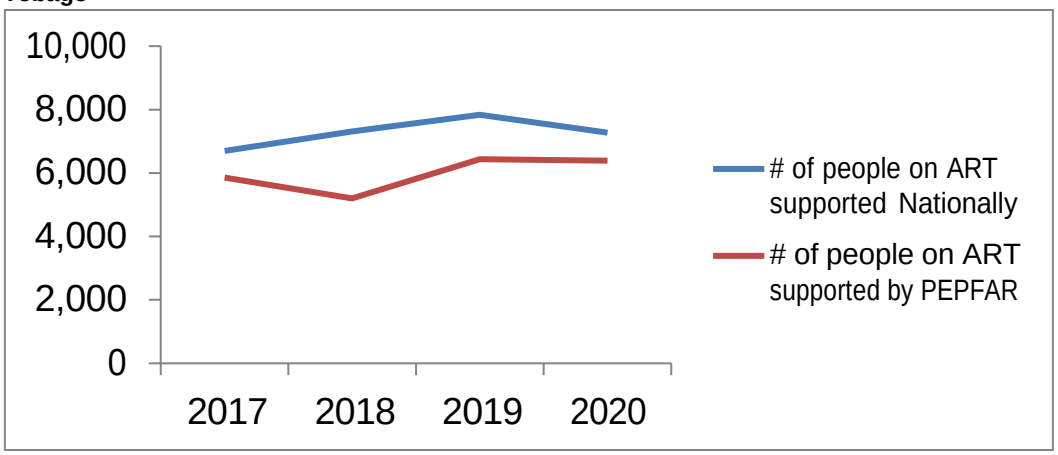
Figure 2.1.17 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4



Between FY 20 and FY21 there has been a negative net change in HIV treatment for all age and sex bands except for females 44-49 (5%) and 50+(6%) and males 50+ (2%). The largest negative growth was amongst the 20-24 age cohort, both males and females, at 13% & 12% respectively.

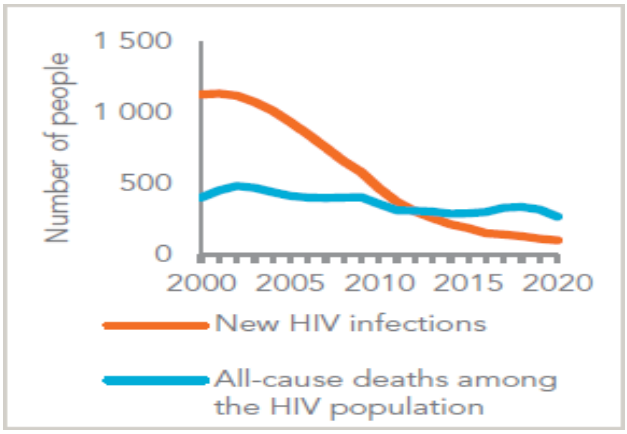
Trinidad and Tobago

Figure 2.1.18 Updated National and PEPFAR trend for Individuals currently on Treatment in Trinidad and Tobago



Nationally, between 2017-2019, there was an upward trend in the people on ART with a slight decrease in 2020. For PEPFAR supported sites, the upward trend started in 2018, but a slight downward trend was also seen in 2020. The decline noted in 2019 both nationally and in PEPFAR supported sites is likely due to the refinement of the MOHW definition of numbers on ART.

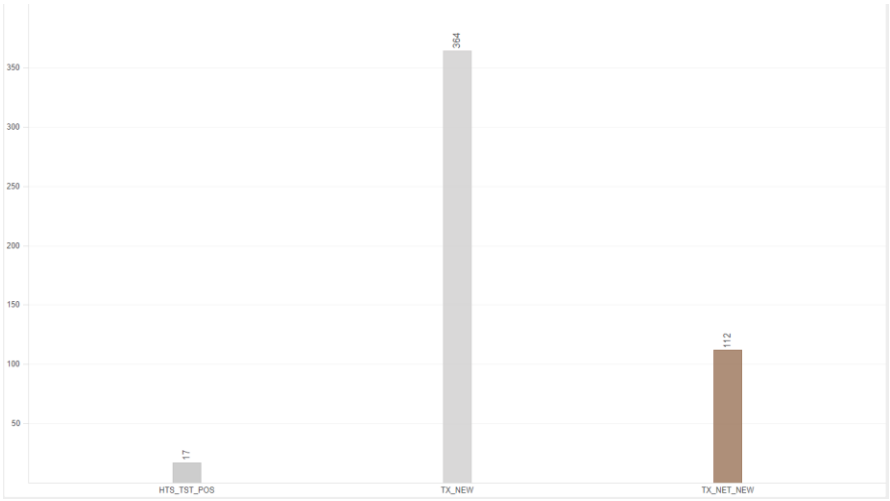
Fig 2.1.19 Updated Trend of New Infections and All-Cause Mortality Among PLHIV in Trinidad and Tobago



Source: UNAIDS DATA 2021

In examining the 20-year trends of new infection and All-cause mortality for Trinidad and Tobago, the UNAIDS Data (2020) shows a general decline in the number of new infections and All-cause mortality among the HIV population since 2005. While Trinidad has achieved and are sustaining their epidemic control, they are continuing to make progress towards the UNAIDS 95-95-95 goals.

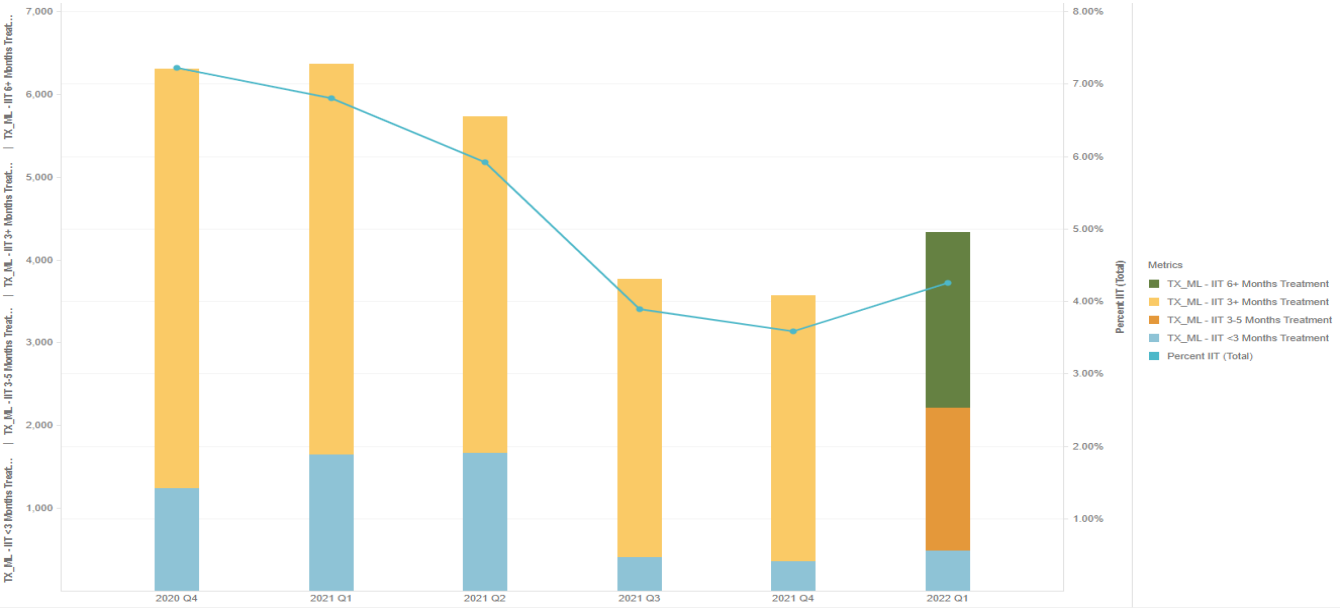
Figure 2.1.20 Assessment of ART Program Growth in FY 21: Trinidad & Tobago



Panorama: Clinical Cascade, Single OU dossier. Single OU, Overall Cascade

Approximately 5% of TX_NEW (364) is attributed to HTS_TST_POS. Trinidad had a positive net new of 112 in FY21.

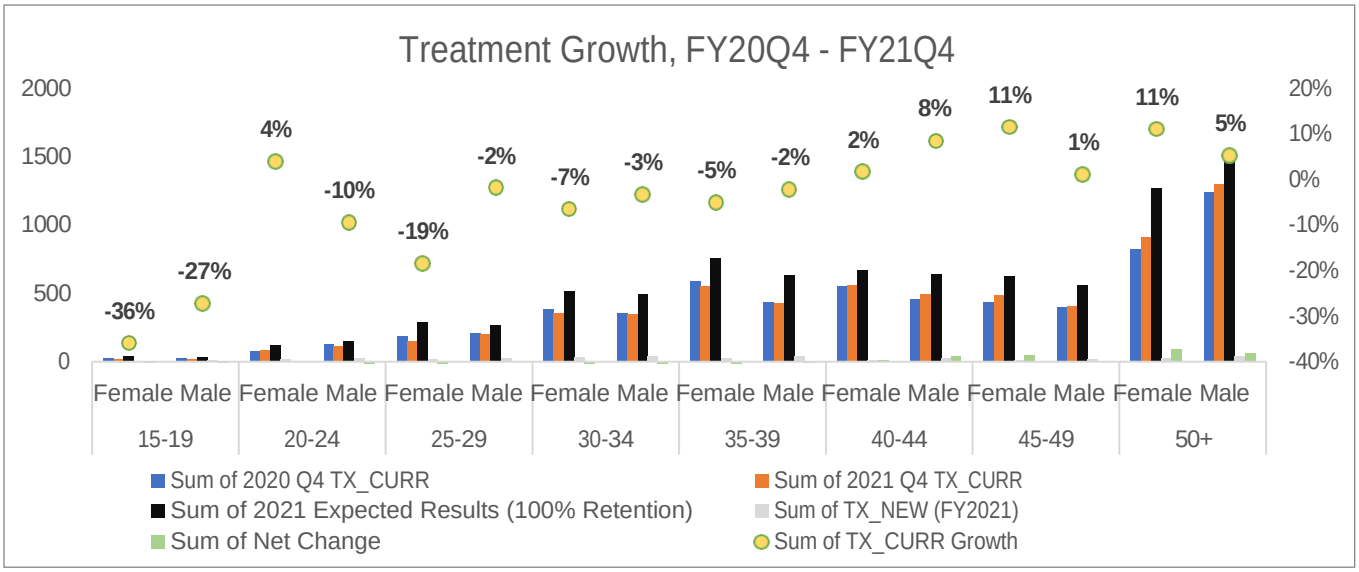
Figure 2.1.21 Quarterly Trends of Clients with Interruptions in Treatment from ART, FY21 Trinidad and Tobago



Source: Panorama - Treatment - Single OU - Interruptions in treatment (IIT) chapter - IIT Trends page

Most of the cases with interruption in treatment continue to occur among patients on treatment greater than 3 months.

Figure 2.1.22 Net Change in HIV Treatment by Sex and Age Bands 2020 Q4 to 2021 Q4 – Trinidad & Tobago



For Trinidad, there has been a negative net change in HIV treatment for all age and sex bands below 40 years between FY 20 and FY21. Generally, larger negative growth was shown amongst females than males. Females in the 45-49 year and 50+ age bands had positive growth in treatment number by 11% each.

2.2 New Activities and Areas of Focus for ROP22, Including Focus on Client ART Continuity

Jamaica

Cross-cutting: For ROP22, in addition to continuing case finding strategies and the ROP21 focus of retention strategies to improve TX_CURR (outlined in section 4), the Caribbean Regional Program will aim to strengthen support to improve an enabling environment and human rights, and reduce stigma and discrimination with the introduction of new partners and activities. This additional support will complement and improve S&D in both the non-governmental organization (NGO) spaces as well as with the public officials, facilities, and personnel. The additional details of these activities are highlighted in section 2.7 Stigma and Discrimination.

Prevention & Case finding: A strategic and effective mix of case finding strategies will be used to find the undiagnosed, prioritizing at-risk groups. This includes index testing, self-testing, social networking strategy, technical assistance for provider-initiated testing and counselling, and targeted outreach testing to include mobile testing. PrEP to reduce new infections among high-risk individuals will also be implemented at four NGO PEPFAR sites in Jamaica in ROP21, with a goal of accelerating scale up of PrEP services to public facilities island-wide.

Retention: Throughout ROP 21, the OU noticed that similar numbers of persons lost each quarter returned in the subsequent quarters. In ROP22, more information will be garnered on the Cycle of Interruption & Return to ART/Care, with continued enhancements to the patient retention & recovery protocol. PEPFAR will continue to offer access to care in all settings-public, community, and private, so that patients can access services best suited to their schedule and needs.

Planned telehealth activities will also be implemented in Jamaica on a phased basis during ROP22 to help facilitate ART continuity and retention of patients. In addition, there is also a plan for increased direct service delivery through the implementation of a digital health intervention to improve patient engagement in care and expand case management.

Trinidad & Tobago

In Trinidad and Tobago, the burden of HIV among MSM was last estimated at 26.6%, per a 2013 bio behavioral survey conducted by the Ministry of Health and supported by PEPFAR. A more recent population size estimate (PSE) is crucial to epidemic projections in monitoring coverage and planning of prevention, treatment and care programs. As performing a new BBS would be costly, it is more feasible to obtain updated data on MSM through a PSE at this time until funding for a full BBS can be secured. A multiplier method PSE will be supported in ROP 22 to update existing data on key populations estimates and assist in targeted case finding interventions.

Additional details of these projected new activities and those to be scaled up are highlighted in Section 2.7.

2.3 Investment Profile

The Government of Jamaica continues to take on more of the financing for the national HIV response. In ROP22, the Government of Jamaica is expected to provide the largest amount of funding from a single source, with PEPFAR and Global Fund as contributing donors. Investment Profile information is unavailable for Trinidad and Tobago.

Table 2.3.1 Investment Profile Jamaica, 2022

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Care and Treatment	$20,062,984	48%	1%	50%	0%	
HIV Care and Clinical Services	$8,369,031	0%	3%	97%	0%	
Laboratory Services incl. Treatment Monitoring	$652,788	0%	2%	98%	0%	
Care and Treatment (Not Disaggregated)	$11,041,165	88%	0%	12%	0%	
HIV Testing Services	$1,685,490	0%	32%	68%	0%	
Facility-Based Testing	$375,267	0%	0%	100%	0%	
Community-Based Testing	$783,380	0%	62%	38%	0%	
HIV Testing Services (Not Disaggregated)	$526,843	0%	11%	89%	0%	
Prevention	$3,995,441	69%	24%	8%	0%	
Community mobilization, behavior and norms change	$1,036,662	0%	71%	29%	0%	
Voluntary Medical Male Circumcision	$0					
Pre-Exposure Prophylaxis	$130,435	0%	100%	0%	0%	
Condom and Lubricant Programming	$0					
Opioid Substitution Therapy	$0					
Primary Prevention of HIV & Sexual Violence	$60,014	0%	100%	0%	0%	
Prevention (Not Disaggregated)	$2,768,330	99%	1%	0%	0%	
Socio-economic (incl. OVC)	$1,578,340	0%	81%	19%	0%	
Case Management	$0					
Economic Strengthening	$0					
Education Assistance	$0					
Psychosocial Support	$976,800	0%	72%	28%	0%	
Legal, Human Rights, and Protection	$342,164	0%	100%	0%	0%	
Socio-economic (Not Disaggregated)	$259,376	0%	89%	11%	0%	
Above Site Programs	$5,188,764	20%	10%	70%	0%	
HRH Systems	$7,325	0%	0%	100%	0%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$0					
Health Mgmt Info Systems, Surveillance, and Research	$2,659,537	0%	7%	93%	0%	
Laboratory Systems Strengthening	$439,040	0%	0%	100%	0%	
Public Financial Management Strengthening	$0					
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$1,069,579	0%	33%	67%	0%	
Laws, Regulations and Policy Environment	$1,013,283	100%	0%	0%	0%	
Above Site Programs (Not Disaggregated)	$0					
Program Management	$2,316,601	0%	39%	61%	0%	
Implementation Level	$2,316,601	0%	39%	61%	0%	
Total (incl. Commodities)	$35,840,903	40%	12%	47%	0%	
Commodities Only	$636,745	0%	6%	94%	0%	
% of Total Budget	2%					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.2 Investment Profile for HIV Commodities Jamaica, 2022

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022						
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Antiretroviral Drugs	$0					
Laboratory Supplies and Reagents	$304,500	0%	0%	100%	0%	
CD4	$0					
Viral Load	$240,000	0%	0%	100%	0%	
Other Laboratory Supplies and Reagents	$64,500	0%	0%	100%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$11,634	0%	0%	100%	0%	
Essential Medicines	$4,134	0%	0%	100%	0%	
Tuberculosis Medicines	$0					
Other Medicines	$7,500	0%	0%	100%	0%	
Consumables	$63,800	0%	51%	50%	0%	
Condoms and Lubricants	$0					
Rapid Test Kits	$31,581	0%	0%	100%	0%	
VMMC Kits and Supplies	$0					
Other Consumables	$32,219	0%	100%	0%	0%	
Health Equipment	$140,000	0%	0%	100%	0%	
Health Equipment	$140,000	0%	0%	100%	0%	
Service and Maintenance	$0					
PSM Costs	$116,812	0%	5%	95%	0%	
Total Commodities Only	**$636,745**	**0%**	**6%**	**94%**	**0%**	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.3 Annual USG Non-PEPFAR Funded Investment and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
CDC (Global Health Security)	$1,692,733	$1,378,000	3	$1,919,032	Strengthening emergency response, communicable disease surveillance & detection, field epidemiology training and COVID-19 vaccinations
USAID Global Health Americal Relief Plan and Global VAX	$6,200,000	$300,000	1		Addresses urgent needs GOJ COVID response and accelerate equitable access to and delivery of COVID-19 vaccinations. Reduce morbidity and mortality from COVID-19, mitigate transmission, and strengthen health systems, including to prevent, detect, and respond to pandemic threats
Total	**$7,892,733**	**$1,678,00**	**4**	**$1,919,032**	

Note: FY2022. The majority is COVID-related for urgent and emergency needs.

2.4 National Sustainability Profile Update

Sustainability is a critical element of PEPFAR's approach to reaching and maintaining epidemic control, to ensure that the gains made over the past years are not lost. To this end, it is vital that all stakeholders dedicate time, energy, and resources toward program sustainability.

In the region, governments continue to play an active role in increasing their investments in the health system, and for HIV programming in particular, to offset declining donor funding. In 2021, the Government of Jamaica contributed the largest amount of funding of any source towards HIV programming. Jamaica completed a sustainability analysis using the PEPFAR Sustainability Index Dashboard (SID) tool in 2019. With a focus on increasing domestic funding for HIV/AIDS programs, health accounts activities were also conducted. In Jamaica, a National AIDS Spending Assessment 2015–2017 was conducted in 2018 to provide the country with data to support decisions that ensure value for money and efficient and effective allocation of limited resources. This analysis is typically conducted every two years, though no assessment was conducted in 2020 due to the COVID-19 pandemic. Trinidad and Tobago's most recent SID was 2016, with an update planned for the next round.

In May and June 2019, Jamaica conducted a review of the Legal and Regulatory Framework for Social Contracting with progress made towards social contracting in subsequent years. These activities are critical as donors transition out of the Caribbean region, and for the sustainability of the HIV response.

In ROP22, the Caribbean Regional Program will provide bilateral support to Jamaica and Trinidad and Tobago. Resource mobilization will continue for the engagement of CSOs in Jamaica as partners, in decision-making, service delivery and service delivery monitoring. This is essential in an effective national HIV response. Access for KPs and PLHIV to services provided by CSOs with funding from the national budget will be a priority for PEPFAR in discussions with both Ministries of Health.

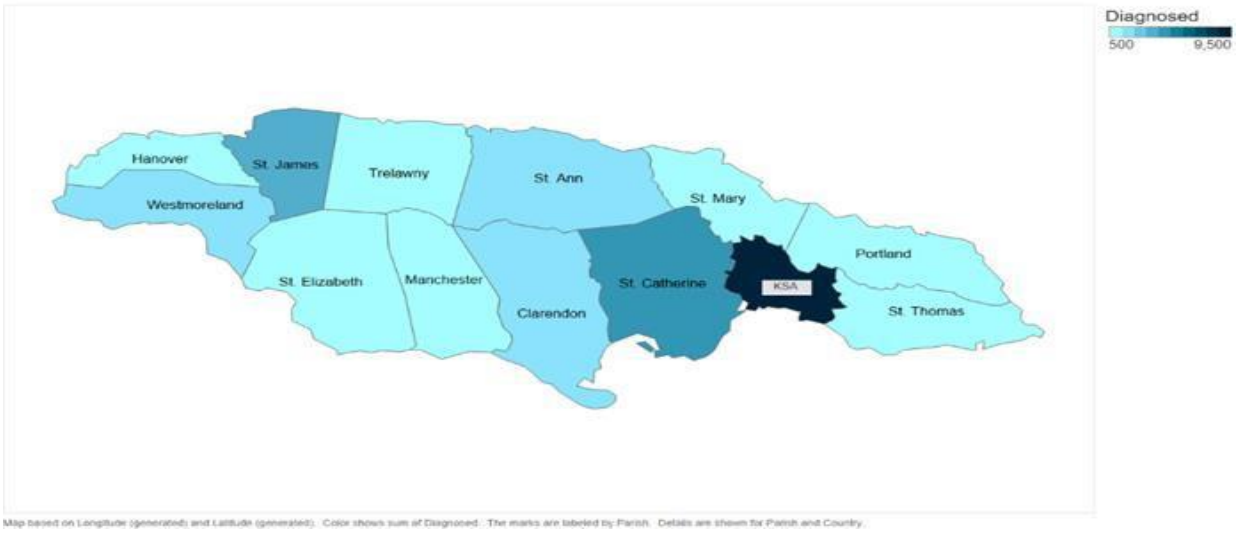
2.5 Alignment of PEPFAR investments geographically to disease burden

Based on the number of estimated PLHIV, proposed investments in Jamaica and Trinidad and Tobago represent the total USG/PEPFAR program budget for ROP 22. PEPFAR will continue to align resources with the higher burden country, Jamaica, while also taking into consideration other factors such as program results, the potential for success and impact, economic stability, sustainability assessments, host government investments, other donor funding, and country health regulatory frameworks. Investments in both Jamaica and Trinidad focus on site and systems-level activities that will ensure sustainability.

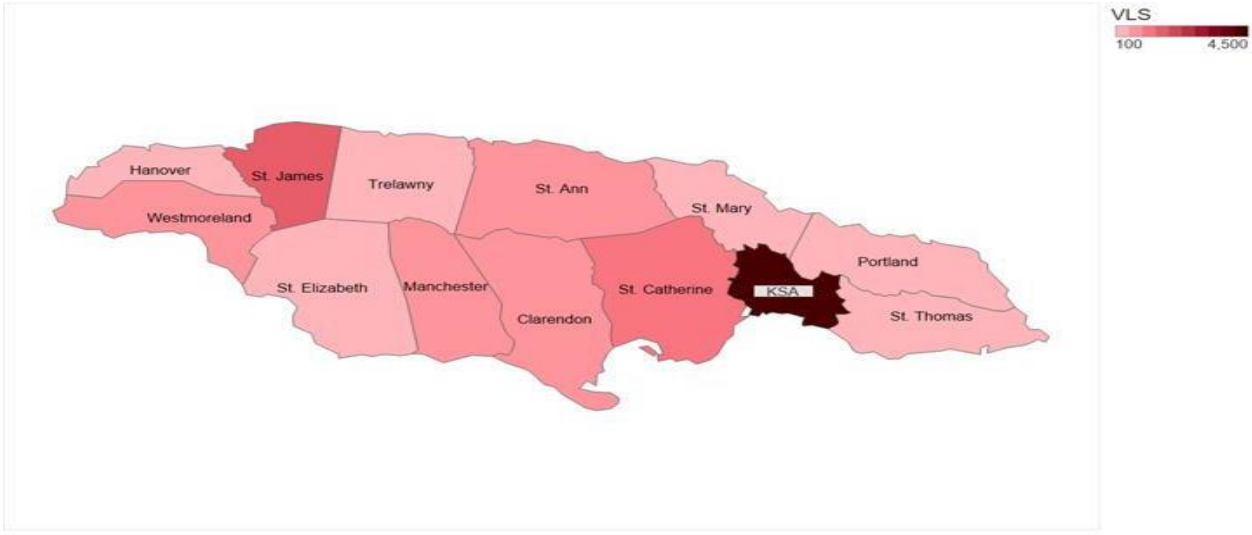
Despite an overall funding decrease of $6.2 million for the regional program (from $23.1 in ROP 21 to $17.9 in ROP 22), investments in Jamaica represents 87% ($15.7 million) of the budget and is allocated to support the national program to achieve epidemic control. Investment of the remaining budget is allocated to Trinidad and Tobago, 11 % ($2 million), with PEPFAR also providing interventions throughout the Caribbean via support to PANCAP, 1% ($193,880).

Figure 2.5.1 – HIV Coverage in Jamaica

The largest proportion of PLHIV diagnosed, on ART and virally suppressed are from KSA, St. Catherine and St. James. Major urban areas are in these parishes and account for 50% of Jamaica's population. Of the seventeen PEPFAR supported sites, nine are in these parishes.



Map based on Longitude (generated) and Latitude (generated). Color shows sum of TXCURR (TX_CURRa+ (PLHIV Diagnosed by Parish Jamaica all data)). The marks are labeled by Parish. Details are shown for Parish and Country.



Map based on Longitude (generated) and Latitude (generated). Color shows sum of VLS (VLS (PLHIV Diagnosed by Parish Jamaica VLS)). The marks are labeled by Parish. Details are shown for Parish and Country.

2.6 Stakeholder Engagement

The Caribbean Regional Program team actively engages external stakeholders, including representatives of partner governments, CSOs, and multilateral organizations. The PEPFAR Coordination Office (PCO) is the designated point of contact for ongoing interagency engagement. The PCO coordinates communications and meetings and provides opportunities for civil society and other partners to actively engage with the program. In addition, PEPFAR agencies engage closely with respective implementing partners to ensure optimal program results. Engagement opportunities include the following:

1. **ROP planning meetings:** Host governments, CSOs, and other partners are invited to participate in consultations for the regional program as well as in discussions for each respective country. During these meetings, PEPFAR's programming focus is shared and recommendations for PEPFAR-supported activities are solicited. Selected stakeholders representing partner governments and NGOs are also included at ROP meetings to formulate an inclusive strategy document.

2. **Quarterly POART reporting:** PEPFAR shares quarterly reports with external partners and engages them through conference calls or in-person meetings under the PEPFAR Oversight and Accountability Review Team (POART) umbrella. Program results, feedback from the Office of the Global AIDS Coordinator (S/GAC), and program updates are reviewed, allowing for discussions on best practices and strategies to overcome shared challenges.

3. **Technical meetings**: Where appropriate, PEPFAR employs technical working groups to engage civil society and other partners in consultations aimed at gathering inputs specific to the technical direction and geographic focus of the overall program, as well as use the engagement as a forum for training and knowledge sharing. PEPFAR supports the national response in Jamaica with participation in the Annual National HIV Reviews and annual programmatic reviews. PEPFAR is also represented on National technical working groups in Monitoring and Evaluation, Prevention, Case Finding and Care and Treatment led by the Ministry of Health and Wellness in Jamaica.

4. **Multilateral partner meetings**: PEPFAR advocates for and supports the attendance of local partners, including CSO representatives, at higher level meetings whether coordinated or funded by multilateral partners or PEPFAR, including UNAIDS, the Global Fund, or the Coordinating Country Mechanism (CCM). In the region, PEPFAR liaises closely with multilateral partners to ensure an efficient division of responsibilities and agreement on strategic priorities.

5. **Regional and other partner meetings:** PEPFAR collaborates with regional partners like UNAIDS, the Pan-Caribbean Partnership Against HIV/AIDS (PANCAP), and PAHO in the development, implementation, and reporting of the HIV activities and learning programs.

6. **Community-Led Monitoring:** The PEPFAR Caribbean Regional program will work with the CSOs in Jamaica and Trinidad and Tobago to independently monitor and highlight quality of service within facilities at all service-access points in treatment sites. This will provide information on barriers, develop workable solutions, and identify enablers to access. The Community-Led Monitoring activity will be offered to qualifying CSOs through the Small Grants program.

2.7 Stigma and Discrimination

The Caribbean region continues to experience stigma and discrimination as a barrier to accessing prevention, care, and treatment services.

In Trinidad and Tobago, establishing key population estimates in ROP22, as mentioned in section 2.2, is a critical step in ascertaining accurate treatment care and support services needed to these vulnerable populations. In addition, PEPFAR will support assessment of barriers and empower and sensitize health care workers, public and government officials on provision of care in safe and stigma free spaces for all PLHIV at both government and non-governmental facilities.

In Jamaica, the Stigma Index 2.0 survey was conducted in 2019 and reported in 2020.

Recommendations made were as follows:

- The government should develop policies and pass laws to protect PLHIV and members of key populations, and it should redefine policies that harm those people.
- Health care facilities should train their staff on how best to care for PLHIV and members of key populations, including treating their PLHIV clients as complete people not defined by a behavior or diagnosis and understanding the range of sexual orientations and gender identities they might encounter.
- Civil society organizations should advocate to governments on behalf of PLHIV and other key populations and educate government officials on how best to serve these populations.
- Civil society organizations and the government should educate PLHIV on their rights, including sexual and reproductive rights. These campaigns should use clear, simple language and emphasize the resources available to PLHIV.
- Civil society organizations should coordinate and provide formal and informal support structures for their members.

While improvements in the public sector facilities have been made, and there are KP friendly private and CSO spaces, there is still much that can be done to reduce factors contributing to the marginalization of PLHIV and members of key population groups.

Jamaica lacks an antidiscrimination legislation. Under the Jamaican Constitution, the Charter of Fundamental Rights & Freedoms guarantees equality before the law and equitable and humane treatment by a public authority. However, there are no specific provisions for discrimination based on health status, sexual orientation or gender identity. There is also currently no independent national human rights institution. However, the Public Defender (Interim) Act allows for the investigation of rights infringements and maladministration by public authorities.

In Jamaica there are a number of comprehensive initiatives to address stigma and discrimination including:

1. The Ministry of Health and Wellness, through the National Family Planning Board (NFPB), re-established its Legal and Policy Review Committee (LPRC) to provide legal and policy expertise towards the achievement of strategic outcome 4 of the National Strategic Plan on HIV 2020-2025. This is intended to "Promote respect for the human rights of all persons in relation to HIV and AIDS issues in community, policy, legislation and programs." The LPRC's work is intended, among other outcomes, to bolster efforts to eliminate HIV-related stigma and discrimination.

2. Non-Government Organizations (NGOs) developed a model anti-discrimination legislation that was presented to legislators for adoption, in 2020, this document is still doing the rounds in parliament, as at April 2022. The initiative formed a part of the Joint Civil Society Advocacy Plan and included NGOs outside of the national HIV response.

3. The Jamaica Partnership to Eliminate All Forms of HIV-Related Stigma and Discrimination, which commenced work in 2020, is focused on eliminating HIV related stigma and discrimination in healthcare, education, workplace, communities, and justice settings. The Partnership is a part of the global initiative being spearheaded by UNAIDS, UNDP, UN Women, the Global Fund, and the Global Network of People Living with HIV (GNP+) to harness the combined power of governments, civil society and the United Nations, to consign HIV-related stigma and discrimination to history. Civil society and host government representatives actively participate in the partnership.

3. Human rights violations perpetrated against people living with HIV and key and vulnerable populations are monitored by Jamaicans for Justice, Equality for All Foundation, Jamaican Network of Seropositives (JN+), Transwave Jamaica and Jamaica AIDS Support for Life. Documentation of these incidents are inputted and/or channeled through the Shared Incidents Database (SIDney) and Jamaica Antidiscrimination and Reporting System (JADS) which are managed by the Caribbean Vulnerable Communities Coalition (CVC) and JN+, respectively.

PEPFAR intends to improve enabling environment and human rights (EEHR) in Jamaica by supporting the national program to scale up efforts in ROP22 to reduce stigma and discrimination for all PLHIV in Jamaica. PEPFAR will support activities towards achievement of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration. These will focus on the progress toward advancement of equity, reduction

of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.

Specific support for Jamaica will be through UNAIDS and the MOHW-NFPB. PEPFAR's support will be towards:

- Increased engagement with regional political leaders and increasing advocacy and negotiation capacity among community led organizations.
- Revise national policies for schools and the workplace to enable persons access to services free from stigma and discrimination. The most recent review and update of these policies are both of which were last revised in 2010. Since then, there has been significant advancement in recommendations and guides for HIV in workplace and schools. In order to support and promote improvement in human rights for our PLHIV the process to revise the policies will commence in ROP22 with sensitization sessions, revision of key changes required and focus groups on recommendations and updates.
- Scale up of access to justice and community led peer support mechanisms which includes:
    - Train the trainers of key duty bearers on human rights principles. Key personnel across key governmental agencies including Ministry of Justice, Department of Correctional Services, Ministry of Education and Youth, Tax Administration of Jamaica and other governmental organizations will be trained as trainers to ensure capacity within the organizations are built and supportive supervision in built within these governmental agencies to improve their service to all PLHIV while serving them with dignity and respect as all citizens should receive.
    - Identification of health and human rights violations affecting PLHIV.
- Increase capacity of civil society organizations to monitor, evaluate and report on anti-discrimination related interventions
- Produce and disseminate new evidence and analysis of the HIV epidemic and its response in relation to the societal environment of the most marginalized communities

3.0 Geographic and Population Prioritization

Geographic Prioritization

The PEPFAR investments in the CRP focus primarily on Jamaica, which has the larger HIV burden (32,000 PLHIV), the higher number of new infections per year (approximately 1,400), and the lower treatment coverage rate (44%) when compared to Trinidad and Tobago. PEPFAR will support programming across the four regions in Jamaica and focus on the two largest treatment sites in Trinidad and Tobago.

Selected PEPFAR priority parishes of Kingston and St. Andrew, St. Catherine and St. James, Manchester, Trelawny, Westmoreland, Clarendon and Hanover are in high burden geographic areas that experience high patient volume. Site-level successes in these locations have a direct influence on the government's ability to establish the requisite policies, practices, and financial investments necessary to reach the UNAIDS 95-95-95 targets by 2030. In ROP 22, PEPFAR's support for the continued roll out of the private sector network of doctors, pharmacies and laboratories across the island will help to retain clients on treatment.

As of December 2021, PEPFAR supported sites serve 98% of the PLHIV in the Western Region (3142/3208), 83% of the PLHIV in North East Region (1335/1614), 81% of PLHIV in the South East Region (5668/7038) and 76% of PLHIV in the Southern Region (1384/1826). This allows PEPFAR to continue to support 84% of the total PLHIV in care in Jamaica in all the facilities supported.

Care and Treatment support in Trinidad and Tobago is focused in two of Trinidad's five regional health authorities (RHA) including the largest NGO treatment facility in the North West Regional Health Authority (NWRHA) and the largest government treatment facility in South West Regional Health Authority (SWRHA). There is also support at the community level to improve case finding strategies implemented with additional support in ROP22 of expanding support to integrative services to facilitate prevention, testing, care and treatment in single facilities and thereby reduce the challenges with linkage from testing to treatment sites.

Population Prioritization

ROP22 prioritizes the populations most at risk in both Jamaica and Trinidad and Tobago through support to governments, CSOs and the private sector. PEPFAR's role is to strengthen HIV prevention, care, and treatment services, to all PLHIV, including targeted support for key populations (KP) specifically men-who-have-sex-with-men (MSM).

Currently, PEPFAR supported sites in Trinidad and Tobago account for 83% of all PLHIV linked to care on the twin islands. With sparse data to delineate the gaps and priority populations, PEPFAR will support a key population estimate while continuing to scale up case finding and retention strategies in Trinidad and Tobago. Having a more recent PSE will provide updated data for high-risk groups that are frequently stigmatized and hard to reach. This will facilitate a more targeted approach to case finding and retention strategies among MSMs. As Trinidad and Tobago progresses towards the achievement of the UNAIDS 95-95-95 goals, there will be

continuing efforts to increase focus on case finding, linkage and retention across all ages and genders until PSE data becomes available to streamline a more targeted approach.

Figure 3.2 Jamaica New Diagnosis Data, 2020- Stage at Diagnosis

Stage at Diagnosis	Total	Males	Females
HIV	538 (87%)	270 (87%)	268 (88%)
AIDS	43 (7%)	21 (7%)	22 (7%)
DEATH	37 (6%)	21 (7%)	16 (5%)
TOTAL DIAGNOSIS	**618**	**312**	**306**

Source: MOHW Jamaica

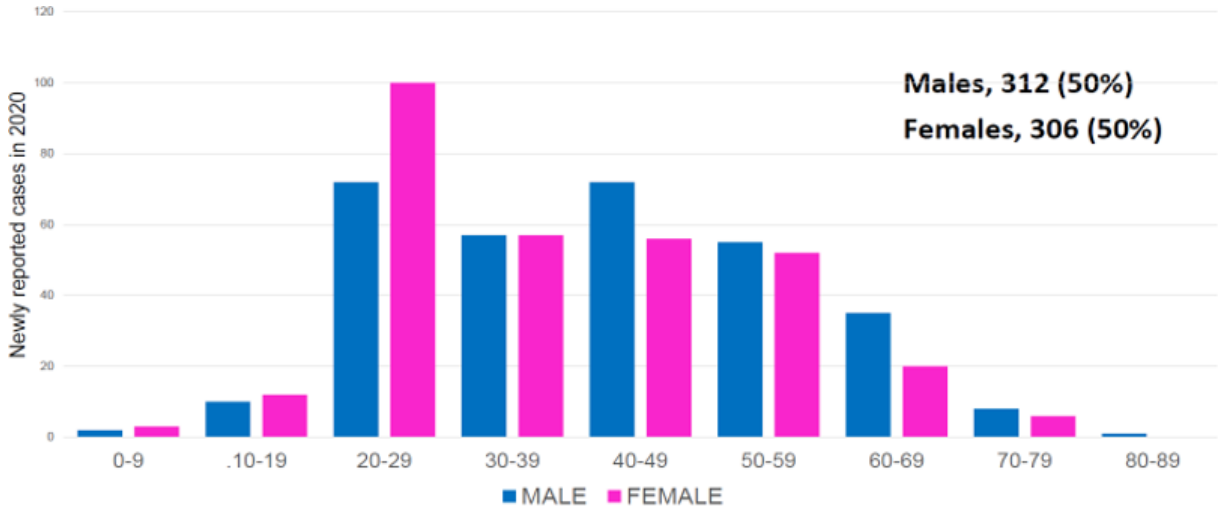
The 2020 National Data from Jamaica suggests that newly diagnosed cases are equally distributed among the sexes with 7% being diagnosed with Advanced HIV disease and 6% diagnosed at death (Figure 3.2). Program data shows that the ART coverage gap is more significant among males, who account for 60% of the estimated PLHIV but only 45% of ART patients. Achieving epidemic control in the Caribbean will require tailored services to reach underserved population such as youth, men, and MSM and their partners (including women). Surveillance data indicates that 20% of people diagnosed with HIV (mostly women) reported no obvious HIV risk factors (Figueroa et al, 2020). Around half of the women over 40 years of age diagnosed with HIV in Jamaica are diagnosed at later stages of HIV infection.

Despite overall progress, disproportionately low investments by national governments in interventions that address KP needs and reduce S&D limits the impact of national HIV responses. Legislation and cultural norms either exacerbated or failed to reduce S&D. This limited access and uptake of key HIV services among KP resulted in many remaining “underground” or “hidden,” and unwilling to disclose their same-sex sexual activity to their clinical service providers.

Available data indicate that approximately 34% of MSM have had a sexual relationship with a woman in the last year (2022 UNAIDS Investment Case), and about 53% of them identify as bisexual or heterosexuals and are therefore extremely hard to reach. Furthermore, males are less frequent users of public health services and are less likely than females to receive HIV-related education, information, or testing as part of a wellness or other health visits. For these reasons, community-level support and engagement, and active work within and among the social and sexual networks of men and young men is critical to reaching men and especially MSM and ensuring their access to prevention, care, and treatment services, as these may represent the majority of undiagnosed PLHIV.

Per initial data provided by the Ministry of Health and Wellness, in 2020, there were a total of 618 persons newly diagnosed with HIV; of that 8% were self-disclosed MSM and 16% were youth 15-24 (across all populations) with a larger percentage being female.

Figure 3.3 Jamaica New Diagnosis Data, 2020- by age and sex



Source: MOHW Jamaica

Based on evidence of higher HIV rates and risky behavior between younger men, the host government has also seen a need for an increased focus on male youths, and also adolescent and young females. PEPFAR CRP's overall approach will intensify its case finding focus on these most at risk populations.

Also of priority is the area where most of the programmatic gap exists in reaching 95-95-95. The MOHW reports through Global Fund 2020 progress report that 85 % of people diagnosed in 2019 were linked to care. However, the proportion of PLHIV remaining on ART 12 months after initiation is around 80 % and declines further after two years of commencement of therapy (Burrows et al 2020). This indicates that despite recent improvements in the initial linkage, low levels of retention on ART remain the most significant weakness in the response. As of December 2021, 13,399 patients were diagnosed but not on ART. Of the 13,399 clients who are diagnosed but not on ART, 8,737(65%) are never linked, 3,893 (29%) have interruption in treatment and 53 (0.4%) are linked but not on ART. Of all those who were never linked, the majority (57%) were males. PEPFAR supports 84% of the treatment care and support arm of the Jamaica national HIV response, 50% of case finding activities and 18% of MSM prevention targets. MOHW provides prevention, treatment, and psychosocial support for pediatric, adolescent, and adult populations. Government sites address all steps in program support and system-level interventions, including prevention, case finding, linkage, ART optimization and treatment continuity, and has the greatest capacity for advanced AIDS management through primary and secondary care.

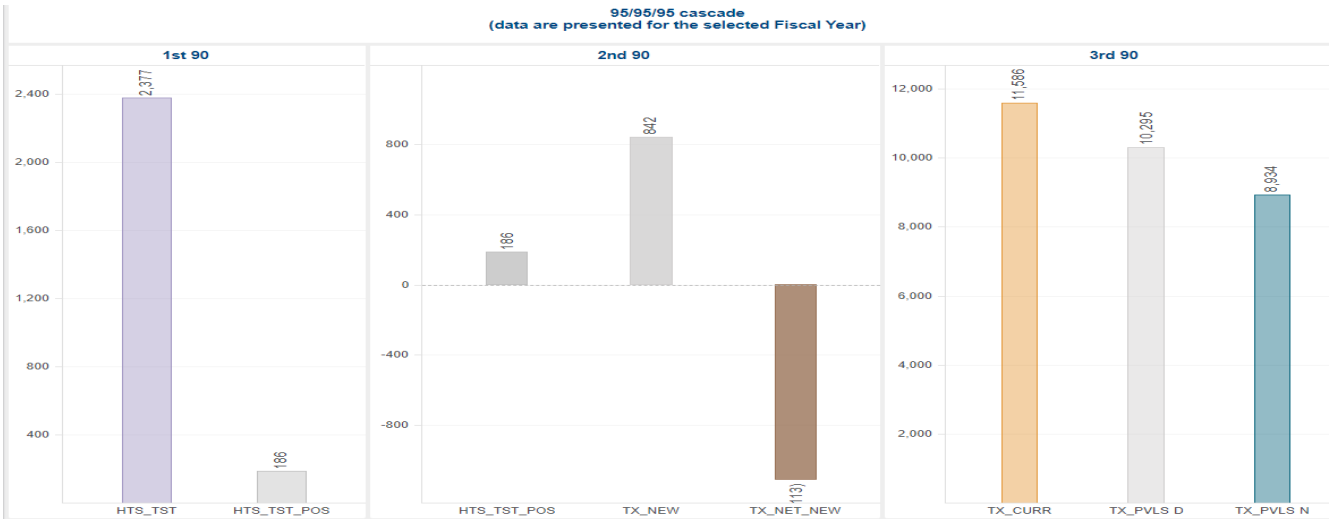
Table 3.4 Current Status of ART Saturation

Prioritization Area	Total PLHIV/% of all PLHIV for ROP22	# Current on ART (FY21)	# of SNU COP21ROP21 (FY22)	# of SNU ROP22 (FY23)
Scale-up Saturation – Trinidad & Tobago	10,432/78%	6431	8617	8,157
Scale-up Aggressive - Jamaica	32,000/56%	11586	15014	18,051

4.0 Client-Centered Program Activities for Epidemic Control

The diagrams below (Figure 4.0.1-4.0.4) present an overview of the gaps across the clinical cascade, as well as key strategies to overcome them for Jamaica and Trinidad and Tobago.

Figure 4.0.1 Overview of 95/95/95 Cascade, Jamaica FY21



Source: Panorama - Clinical Cascade- Single OU dossier - Overall cascade

Figure 4.0.2 Jamaica ROP 22 Gaps Strategies and Key Interventions

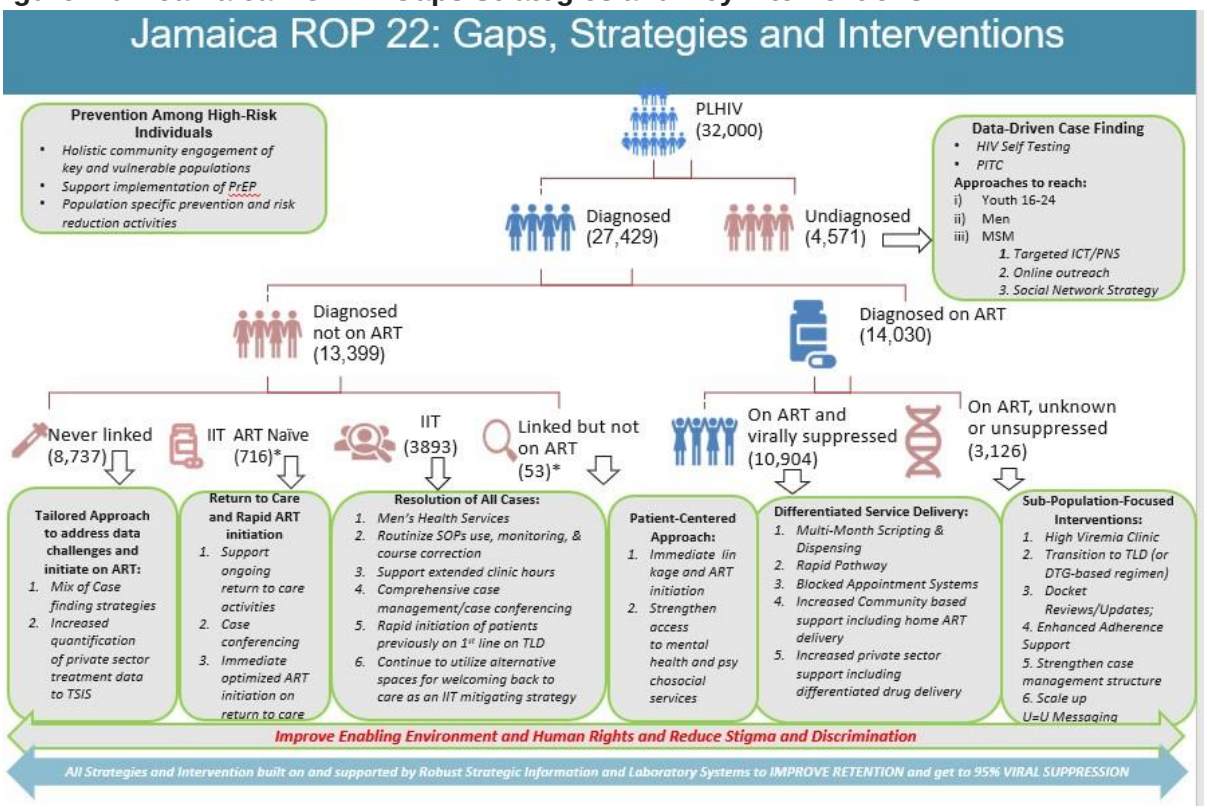


Figure 4.0.3 Overview of 95/95/95 Cascade, Trinidad & Tobago FY21

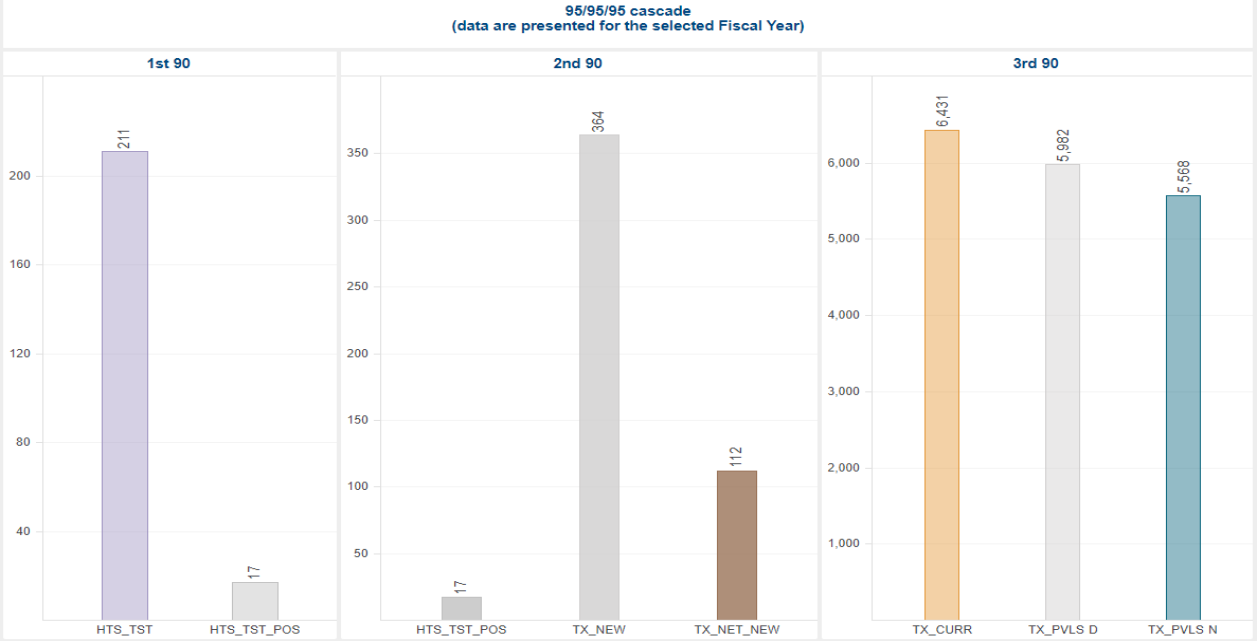
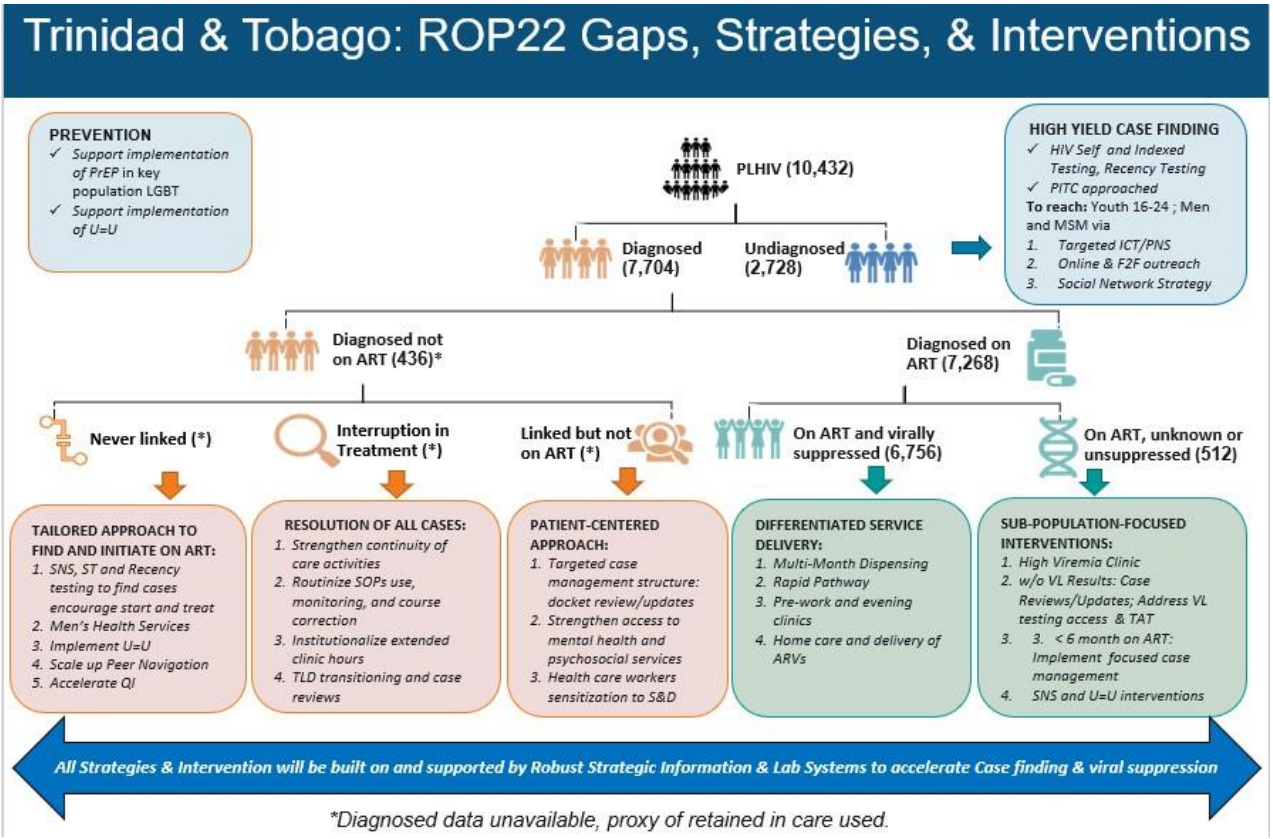


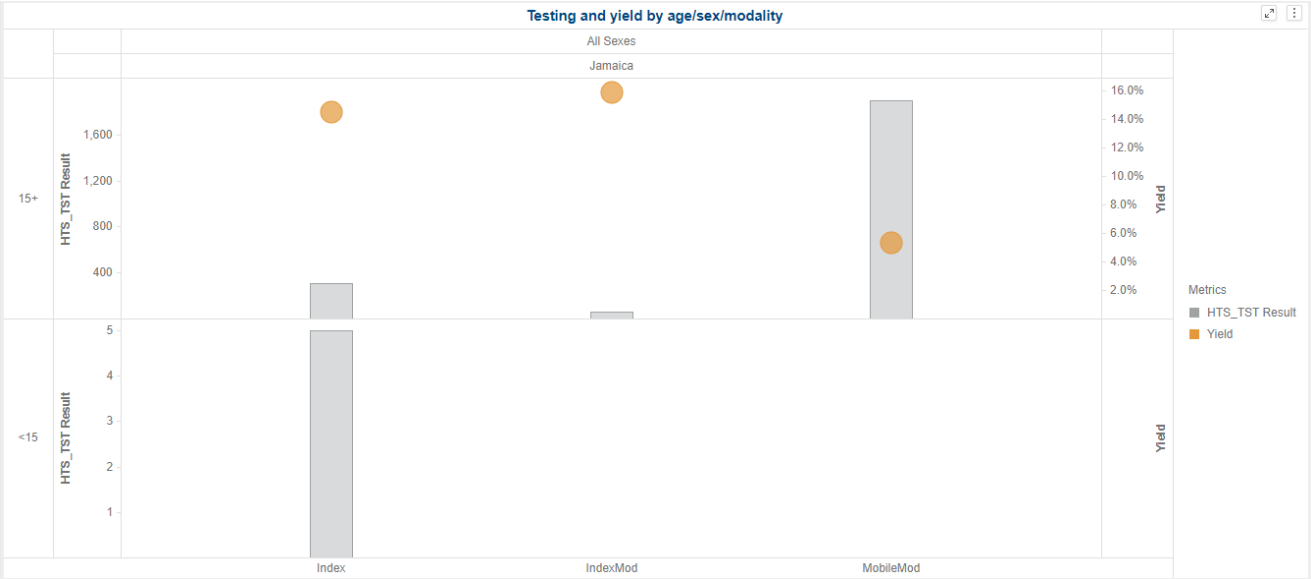
Figure 4.0.4 Trinidad and Tobago ROP 22 Gaps Strategies and Key Interventions



4.1 Finding people with undiagnosed HIV and getting them started on treatment

Jamaica

Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21



Outcomes and Impact

ROP22 strategies will contribute to the government reaching the first 95 target by diagnosing an additional 458 PLHIV. A strategic mix of strategies based on setting and target population will be employed throughout the OU. The expected results include a shift in the national numbers with index testing accounting for 43% of newly diagnosed cases and community based models accounting for the remaining 57%. The specific case finding interventions which will receive PEPFAR support in the CRP include:

- Improved case finding through the scale up of safe and ethical index testing
- Increased testing from online and mobile outreach, with rapid initiation on treatment
- Increased technical assistance for MOHW provider-initiated testing and counseling (PITC)
- Expanded uptake of HIV self-testing
- Expansion of Social Network testing Strategy

In Jamaica, index case testing and partner notification services (ICT/PNS) coupled with robust monitoring and evaluation are implemented in both community-based and facility settings nationwide. ICT/PNS will continue to be expanded at treatment facilities for newly diagnosed cases, patients reinitiating treatment, and the unsuppressed. Index case testing will continue to be upgraded and reviewed to ensure that it is aligning with standards for the provision of safe and ethical index testing including ensuring adequate screening and plan for intimate partner violence and adverse event monitoring. Social media will continue to be employed to create demand for HIV testing among MSM, MSMW, and youth. This will drive the demand for a variety of testing modalities including HIV Self Testing.

National HIV Self Testing guidelines with intimate partner violence (IPV) screening were developed in ROP21 and this modality will continue to be scaled up nationally in ROP22. Strategies tailored to women will continue to be implemented. Case finding will be expanded among MSM, high risk men as well as among sexually active youth through social network strategies. There will be strengthened technical assistance in support of the MOHW recommendation to test inpatient hospital admissions for HIV. Recency testing will be added to the national testing policy guidelines to detect, characterize, monitor, and intervene on recent infections identified.

i. Reaching MSM

Effective control of the epidemic must address issues of stigma and discrimination. Psychologists and contact investigators continue to provide tailored counseling to index clients who emphasize enabling messages across these areas to elicit sexual contacts for testing and treatment initiation. Findings from the MSM/TG IBBS done in Jamaica reveal that 51.6% of these men identified as bisexual (876 Study, 2017). This suggests a need for nuanced communication with male clients, as providers need to educate men and all partners on the benefits of testing.

Case-finding strategies for MSM will continue to cater to males of different age groups in urban and rural areas. These strategies will be aimed at men, regardless of their sexual identity, and assumes that some of them will have sex with both men and women therefore preventing transmission to both male and female partners of MSM will also be addressed. Caribbean Men's Internet Survey (CARIMIS) (2014) reported that within a month, 84% of gay and bisexual men 18 years and older in the Caribbean visited websites, including dating sites, for the purposes of dating and socializing. This establishes the internet as a primary medium for MSM engaging with partners, rather than physical spaces. In Jamaica, independent of place of residence, 76% of men from the IBBS reported meeting sexual partners online through social media sites (e.g., Facebook, Grinder, and Jamaica's Vibes connect).

Case-finding initiatives will continue to adapt face-to-face outreach to online and social media (Figure 4.1.3). The intervention is specifically designed to target young MSM, bisexual men, and MSM who do not self-identify as "gay," as well as those who were not being served by other traditional outreach activities. Further, developing on the findings from the ICT National Assessment 2017 in Jamaica, PEPFAR will continue the high-impact online outreach intervention to reach high-risk MSM through the most trafficked websites and refer them for appropriate testing services. NGOs, who dominate the community space, will continue to use ICT platforms in their case finding efforts, with modifications to enhance linkage & retention as well. PEPFAR's support to the national program will strengthen the public support of access to information, initiation of online contact with off lining, linkage to testing and treatment services as needed. Social media networking can reach men of all ages, with access to internet in Jamaica estimated at 56% and mobile phone usage rates consistently rising, with subscriptions exceeding the country's 2.7 million population.

The private setting also pivoted to using the ICT platform to engage newly diagnosed PLHIV. With the possibility of establishing relationships with private labs, referred clients can be tracked throughout the cascade, via testing and linkages for PLHIV. With the private setting emerging as

a KP friendly space, it could also facilitate reaching some MSM and their partners, whether male or female.

As the national program continues to increase its case finding strategies to the MSM population, PEPFAR will support scale up of social network strategy as a targeted case finding support for MSM in the public space. This intervention will aim to identify and test MSM and their partners who have never been tested and link them to appropriate treatment and prevention services as needed, including PrEP.

Regional outreach workers and other NGOs will utilize the evidenced-based approaches of self-testing and index testing as key strategies for case finding. Index testing will be facilitated in facility and community settings to reach target populations and link them to HIV treatment and prevention services as needed. PEPFAR is mandated to ensure safe and ethical delivery of index/partner testing services to eligible individuals (for reaching male and female partners). This includes adverse events monitoring, QA/QI for all index testing ensuring WHO minimum standards. Barriers faced by clients to uptake testing will also be addressed through HIV self-test kit distribution, refresher trainings and supportive supervision.

ii. Tailoring case-finding approaches for younger men

In Jamaica, among young men ages 15-24, the average age of sexual debut is 15 (KAPB, 2017). Transactional sex is reported among 54% of boys ages 15-19 years (National HIV/STI Program, 2012). A core set of interventions will continue to reach younger segments of the population who do not know their status, including: HIV self-testing (HIVST), index testing, online outreach, partner notification, social network strategies and men's health services that include an adolescent-friendly component.

As part of the suite of interventions to find more people living with HIV (and link those who test negative to HIV prevention services), self-testing plays an important role for individuals under 30 who opt not to go to a health facility and those who may not return after a first encounter. This intervention is accompanied with information on referral services including counseling through peer supporters and community support networks for young men.

iii. Tailoring case-finding approaches for women

Almost half of newly diagnosed females in 2017 reported the history of an STI at diagnosis. Additionally, 23% of cases in 2017 reported multiple sexual partners. The vast majority (98%) of newly diagnosed women identify as heterosexual. A higher than usual percentage (52%) of women 40 years and older being diagnosed with early-stage infections and a rising number of adolescent and youth females being diagnosed with HIV will lead to a focus on these age groups and demographics. The remaining 48% of newly diagnosed cases are women presenting with late-stage HIV or AIDS. Strategies to reach undiagnosed women therefore considers that this subpopulation includes:

1. Adolescent and Youth Females aged 16-24;
2. Female partners of diagnosed HIV positive (heterosexual and bisexual) males; and
3. Women of childbearing age who do not access/use family planning services.

HIV self-testing, index testing, and partner notification are critical approaches that have the potential to identify women who are undiagnosed. These approaches can be applied to the respective subgroups based on their needs and access to services to increase more timely case detection.

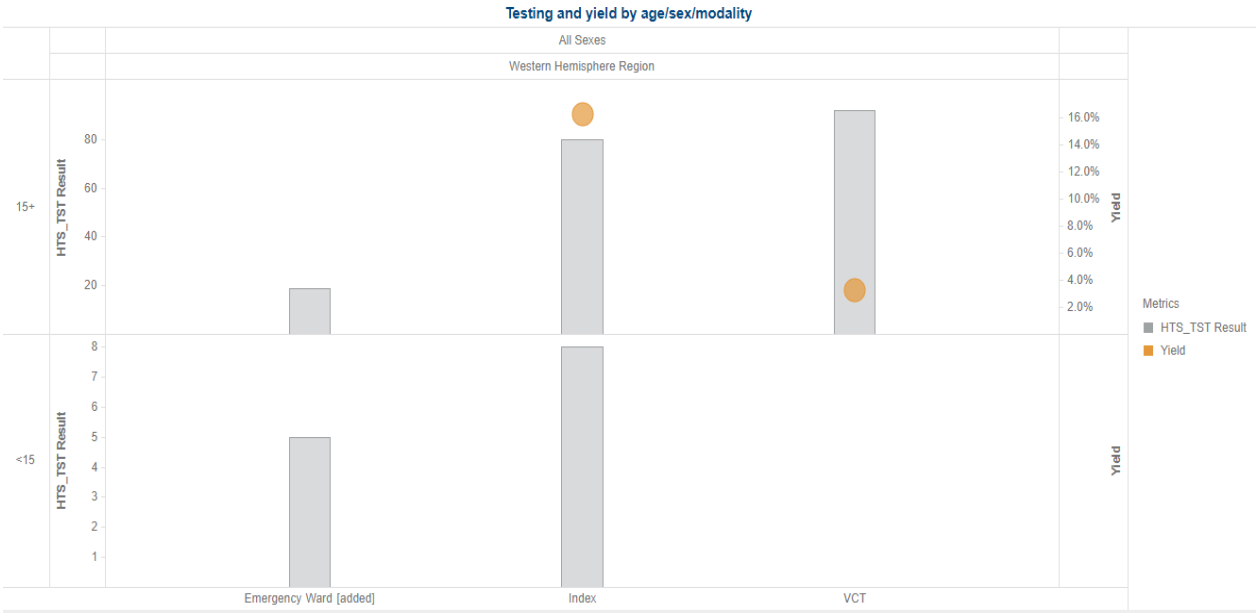
Implementation of partner services for all male patients (prioritizing those who are unsuppressed and newly diagnosed) will identify female partners and serve as a platform to diagnose new cases amongst women. Female partners of newly diagnosed heterosexual males at early stages of HIV infection may be more recently infected. Timely implementation of index and recency testing amongst the subgroup of males may identify more recent infections. Index testing amongst diagnosed men and newly diagnosed MSMW, who are in committed relationships/married to women, are likely to contribute to case finding among women. Expanded strategies are needed to ensure uptake of services by women at high risk who are not currently accessing family planning or other gynecological services. With the implementation and expansion of HIV self-test, the goal is to reach women and their partners attending ANC. Based on the results of the HIV screening test, women would be referred to locations for comprehensive STI/HIV testing as needed. HIVST will also facilitate reach of those adolescent and youth females who have never been tested and may not consider themselves to be at an elevated risk.

iii. Tailoring case-finding approaches for older men and women

Over 50% of males and females are diagnosed over the age of 40 years. Strategies to reach undiagnosed peri-menopausal and menopausal women will continue to include HIV testing at service delivery points beyond annual sexual health checks. Males will continue to be reached through male focused health outreach interventions, HIVST and SNS. Health promotion within geographic hotspots (informed by surveillance data) is used to support combination prevention and HIV/STI testing services for those over 40. Index testing amongst diagnosed men and newly diagnosed MSMW, who are in committed relationships/married to women, are likely to contribute to overall case finding in this age group.

Trinidad and Tobago

Figure 4.1.2 Testing Volume and Yield by Modality and Age/Sex, FY21 Trinidad & Tobago



In Trinidad and Tobago, of the estimated 10,432 PLHIV, 7,704 (74%) PLHIV know their status. Using the data for patients retained in care as a proxy, 2,206 persons need to be diagnosed to achieve the first 95. As the MOH finalizes 2020 data, the team anticipates an updated estimate of the first 95 that can be used to focus case finding efforts.

While the gap in the achievement of the UNIADS 95-95-95 for Trinidad lies in the 1st 95, PEPFAR funding supports approximately 10% of this gap with local sources supporting most funds used to close this gap.

To increase case finding, high impact and targeted testing interventions will be expanded. These include: index case testing, self-testing, recency testing and social network strategy (high risk men, including MSM and MSMW). The Government will continue to focus on provider-initiated testing and counseling (PITC) offered at all points of patient contact with the healthcare system.

Improving the quality of the data will also help with achievement of the first 95. Ongoing data validation exercises to match data from surveillance, treatment and the national death registers will ensure the alignment of the HIV surveillance register with confirmed deaths. In addition, a plan to complete a key population estimate to improve the implementation of targeted interventions will be completed in ROP22.

Regionwide

As a region, CRP will scale up implementation of a number of case finding strategies, each reaching specific target populations in an effort to support achievement of the 1st 95 in both Trinidad and Tobago and Jamaica while ensuring these are done with safe and ethical standards and a goal of improving linkage to treatment or preventive services as identified.

Figure 4.1.3 Strategic Mix of Case Finding Modalities and Approaches for CRP ROP22

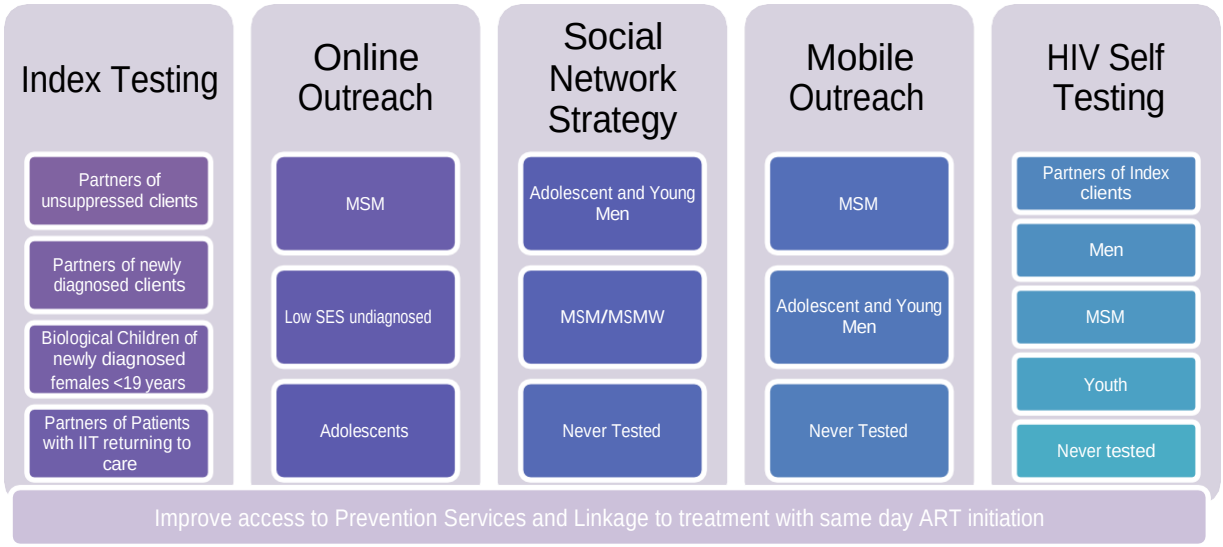


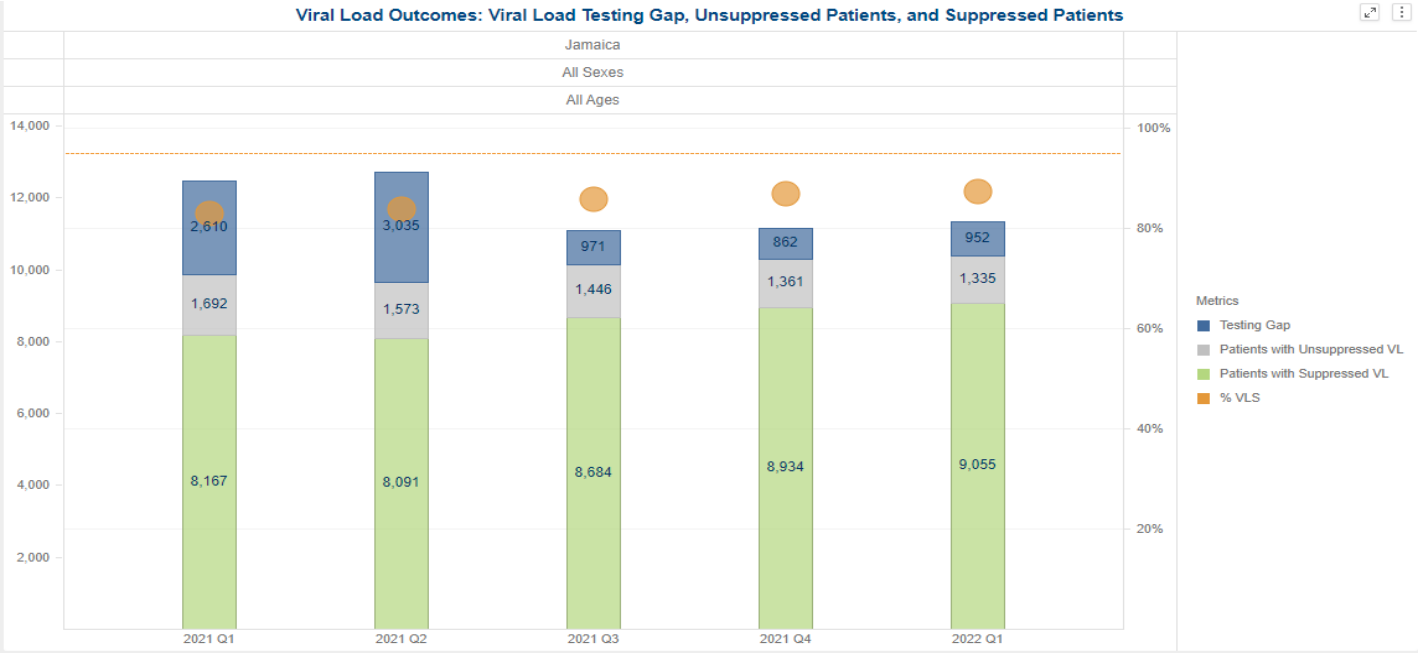
Figure 4.1.3 highlights the key modalities that will be implemented in the CRP as we support our countries towards closing the gaps in key targeted highlighting the primary case finding strategy, safe and ethical index testing – which will also be supported by technical assistance for government initiated PITC – with the complimentary case finding activities of online outreach, social network strategy and HIV self-testing. These modalities will be paired with measurable and effective linkage to prevention and treatment services.

4.2 Ensuring viral suppression and ART continuity

Jamaica

It is estimated that only 74% of ART patients are virally suppressed leaving a gap of 26% of PLHIV who are unsuppressed or with unknown viral loads (Figure 4.2.1).

Figure 4.2.1Viral Load Outcomes, FY21, Jamaica



Source: Panorama: Viral Load: Single OU – VL Outcomes

Examining the data for those unsuppressed across age bands, there is a correlation between age and viral suppression. Where viral suppression improves as age increases.

FY22 Q1 VIRAL LOAD SUPPRESSION - Jamaica								
	15-19	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50+**
Female	66%	78%	83%	83%	87%	88%	89%	89%
Male	80%	88%	89%	88%	88%	87%	86%	88%

Of those unsuppressed, the proportion declines as the age bands increase from early adulthood onward. However, this must be analyzed within the context that an increase in population size also occurs simultaneously for the older age groups. Comparing differences between the sexes, in older age bands, there is a slightly higher proportion of males unsuppressed compared with their female counterparts in the 35-39, 45-49, and 50+ age bands.

In designing strategies for the unsuppressed population, the contextual factors within each age band should be noted. For example, the barriers to suppression for an adolescent differ from those of an adult given general differences in resources, work/family obligations, etc. In addition, policy shifts are needed to provide an enabling environment that offers comprehensive client-centered services and facilitates treatment adherence with individualized differentiated care services. Ensuring patients can benefit from multi-month dispensing will reduce the financial and economic costs of frequent ART pick-up, a reported barrier for remaining in care. The transition

to TLD for new PLHIV, men, and women will be significant in supporting adherence and viral suppression.

The strategies and interventions presented below are designed to address the gaps and needs that are specific to each of the distinct groups of patients on ART, namely: those new initiated or re-initiated on ART, those on ART <6 months, those on ART >6 months and suppressed; and those on ART >6 months and unsuppressed.

Tailored Strategies and Approaches by Sub-Population

i. **Patients Newly Initiated or Re-initiated on ART:** New diagnosis data emphasize the need to tailor interventions to address populations at highest risk. Targeted U=U campaign will help to improve the health outcomes and self-esteem of individuals; reduce the stigma associated with HIV; and help control the HIV epidemic. All newly initiated or re-initiated on ART will be offered TLD as the first line regimen as recommended MOHW adoption of WHO's December 2018 guidelines to improve tolerability and antiretroviral efficacy and decrease rates of treatment discontinuation. We will also focus on differentiated models of care that meet the needs of younger people, especially 20-29 year olds.

ii. **Patients on ART <6 months and Ineligible for viral load test:** Per MOHW national guidelines, viral load is assessed after six months of treatment. Treatment coordinators will be assigned to closely monitor these patients at their facilities to ensure treatment adherence and that a viral load test is given after six months. Results will be reviewed with the care team for next steps.

iii. Patients on ART for More Than Six Months

a. ***On Treatment and Virally Suppressed*:** Ensuring patients who are on treatment and virally suppressed are provided with adequate differentiated care to maintain their retention and treatment adherence is critical to achieving the 3rd 95. Optimization of ART will continue with the TLD transition plan as the cohorts become eligible. As part of the phased approach to TLD transition, this population will be considered for transition in ROP22 according to MOHW forecasting, quantification, and procurement plan.

***Six-month multi-month dispensing**:* The MOHW has issued guidance to empower all HIV treating physicians to prescribe and request six months dispensing for patients who have been adherent and stable for over 12 months, and by the end of FY23, more than 3,000 patients will be on six-month prescription/dispensing. Quality Improvement activities will ensure close follow-up of pharmacy pick-up times with reminders for patients and pharmacy pre-packaging to reduce time. To increase efficiency, community ART delivery and private pharmacy networks will continue to be engaged to increase access to medication pick-up points. This will address the long wait time to pick up medication that has been identified as a common challenge by patients nationally.

Additionally, the MOHW is exploring the procurement and use of prescription bottles designed to hold up to three months medication rather than dispensing only one-month supply capacity.

The rapid pathway (RP) model: This intervention will provide expedited outpatient care for clinically stable patients. The MOHW will provide guidance to all treatment facilities on implementation of this strategy in ROP22. This is important given the findings from the previous patients return to care campaign survey which highlighted long wait time at clinics as a barrier to retention on ART and cause of defaulting clinic attendance. This is especially important in the SERHA and WRHA, which when combined serve over 65% of those on ART. By end of FY23, at least 50% of all patients on ART for >six months and suppressed (~3,600) will be receiving these fast-tracked services. Quality Improvement activities through rapid iterative testing will ensure effective implementation and review by patients and staff.

b. ***<u>On Treatment, Unknown Suppression or Unsuppressed</u>***

i. ***<u>Virally unsuppressed</u>*****:** Gender and age proportions in this group is similar to the overall population on ART. Focused interventions for this group include:

Differentiated care model for unsuppressed patients with particular focus on high viral load patients (VL >100,000 copies/ml): Since September 2019, all virally unsuppressed patients and those with high viral loads have been assigned to regional multidisciplinary teams for case review. These teams are integrated with existing site multi-disciplinary teams reviewing and formulating individualized enhanced adherence plans with assistance from clinical mentors. The teams will continue to develop plans to implement “high viremia clinics” with a package of services, including peer support, guided by the findings of the reviews, and informed by other programmatic and survey data.

The interventions will continue to be part of an intensified case management, including enhanced adherence counseling and monitoring, combined with index case partner notification and testing services. For index cases who do not disclose their partners, guidance and referral for self-testing will be provided. Laboratory investigations, particularly more frequent viral load testing services, will be made available as part of the packages of services. A high viral load register will be implemented, coupled with high VL alerts from the lab, to follow the progression of these patients toward suppression.

ARV Optimization: Following the enhanced adherence counseling and monitoring, as per national guidelines, patients who remain unsuppressed will be transitioned to TLD. Patients who continue to be unsuppressed while on 2nd line and having had interventions in the high viremia clinic for 3 months will have an evaluation to determine if HIV Drug Resistance testing should be

performed. Their ART regime will be optimized based on the results. Healthcare workers will continue to follow up with patients to ensure viral suppression is attained. By the end of FY 23, over 90% of the ~2,400 will be virally suppressed.

ii. ***No recent viral load test*:** Gender and age proportions in this group is similar to the overall population on ART. Focused interventions for this group include:

Intervention - *Docket Review and Update:* The regional multidisciplinary teams, or QI teams, referred to above will prioritize review of dockets and records to ascertain their status, develop action plans, and ultimately, resolve all cases. The teams will determine if viral load testing was completed in the last 12 months but not documented in patient dockets and the treatment database. If results are not located in the treatment database, the LIS database will be reviewed to determine if the test was performed. Once resolved, the Treatment Coordinator will follow up and ensure the results are located and patients' information is updated with the results in TSIS.2, LIS, and the dockets.

Strategies to be implemented across all categories of patients on ART:

The following interventions have been implemented with positive outcomes and will be expanded in ROP22 for maximum impact on retention and adherence:

a. ***Integrated Care Model:*** This model of care supports integrated healthcare services into selected HIV treatment sites and will be continued in the North East Region and the Western Region. The aim is to provide PLHIV with easily accessible critical services that are patient centered and culturally appropriate. These services address important barriers to maintaining treatment regimens and engagement in care. Mental health, sexual and reproductive health, treatment literacy, and social support services are also included. This comprehensive approach to service delivery encompasses the provision of services at the HIV treatment sites and where necessary, referrals for specialist care that is closely monitored.

b. Treatment Literacy around U=U: The package of interventions will support adaptation and implementation of the U=U campaign to educate and empower patients. Healthcare workers will be trained, and IEC material will be developed and disseminated.

c. Extended clinic hours: Extended clinic hours to address problems faced by people who cannot attend clinic during regular working hours, which was identified by most patients interviewed during the return to care campaign.

d. Private pharmacy network: Engagement with the private pharmacy network to increase access to medication pick-up points and to alleviate the concerns of patients experiencing challenges with traveling to clinics.

e. Decentralized ART distribution: KP-accessible decentralized ART distribution through NGOs and community/NGO peer support program. NGOs and venues friendly to KPs will facilitate access to services for this population at higher risk of defaulting on treatment related to stigma and discrimination.

f. Improving treatment database utility: Strengthening the functionality of the MOHW's Treatment database (TSIS 2.0) to include appointment reminders and close tracking of missed appointments.

g. VL coverage: Support increased VL coverage to 100% for eligible PLHIV by providing TA to maximize lab capacity, and improve the electronic lab information system to reduce turn-around time (TAT). Demand creation strategies will also be implemented to increase VL uptake by eligible PLHIV to 100%

h. Improving Strategic Information: The Government of Jamaica continues to build strategic information capacity to improve the accuracy and reliability of HIV/AIDS data. This will support effective strategic planning, as well as the optimal delivery of health services. Priority will continue to be placed on improving the national HIV case-based surveillance system to better monitor progress toward epidemic control.

i. **Accelerate Quality Improvement (QI)**: Strengthening of the continuous quality improvement (CQI) strategy will help to rapidly and effectively respond to the changing contexts that result from bringing a substantial number of PLHIV back to care and maintaining them on ART. Based on analyses of site data, CQI activities will identify HIV service-provision gaps and health system weaknesses. The healthcare team, in collaboration with patients, will devise plans to quickly overcome these barriers. Ongoing mentorship with facility staff will be important for capacity building and transfer of knowledge and skills.

- PEPFAR will continue to support the implementation and scaling up of the National QI plan, Regional QI plans, and site QI plans.
- Strengthen the monitoring and evaluation of facility, regional, and national performance of key indicators by integrating data into QI reporting and triangulating data analysis to better understand the root causes of barriers and facilitators to program quality.
- Leverage existing indicators and establish custom indicators to monitor the progress of quality improvement processes and outcomes that demonstrate impact.
- Intensify collaboration with MOHW, Regional Health Authorities (RHAs), and site-level staff to clearly define roles and responsibilities within quality improvement plans to increase buy-in, accountability, performance, and sustainability.
- Increase coaching and supervision of treatment site staff QI efforts to ensure quality management practices are incorporated at all levels of HIV treatment and care services, by building the capacity of QI coaches at parish, regional and national levels through webinars, QI ECHO and learning sessions.

j. Expand Multi-Month Scripting and Dispensing (MMSD):

MMSD is a differentiated ART delivery method that can improve patient outcomes, result in cost savings, and increase patient retention. Expansion will be possible via:

- Implementation of differentiated service delivery models, including six-month scripting and dispensing, to decrease the patient burden at facilities, minimize patient wait times, and improve ARV coverage.
- Providing six months of ART and six-month clinical consultations to all stable ART patients, including fast tracking for ART refills.
- Immediately investigating late or missed pickups by individuals receiving a MM supply.
- Immediately investigating late patients who have missed appointments, defaulted, and had IIT.

Outcomes and Impact

Implementation of the above strategies will achieve the following:

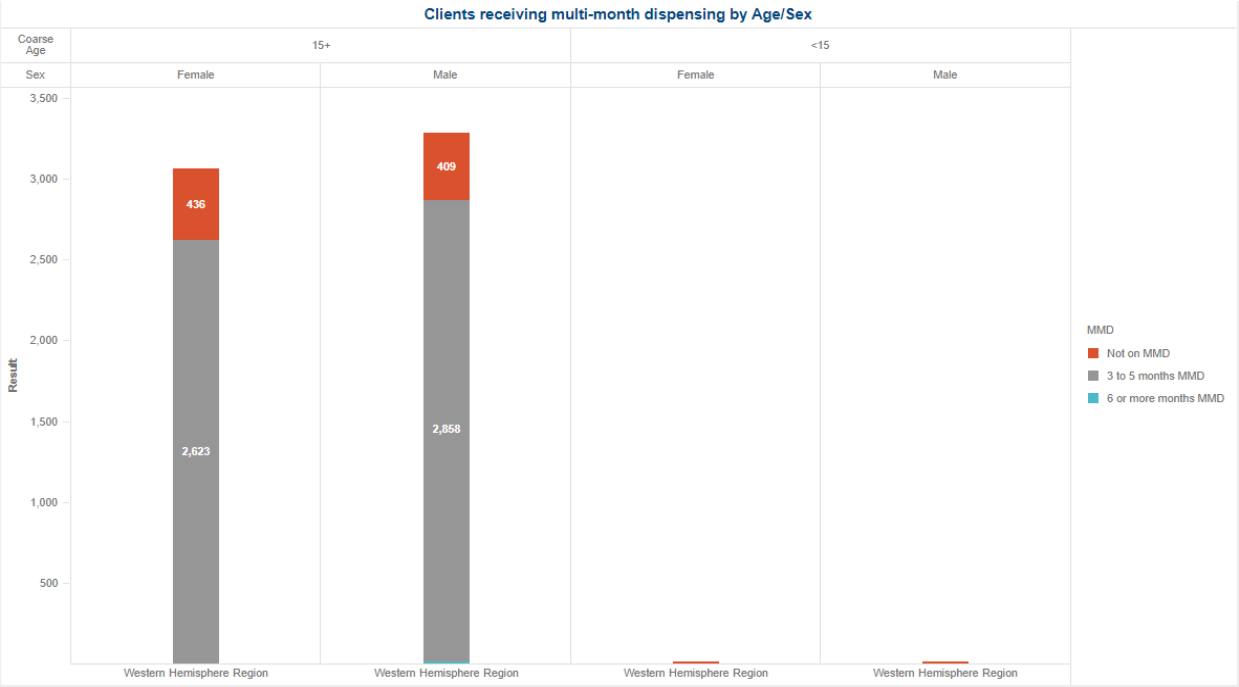
- For patients on ART, viral load testing to be accessible and provided to all eligible patients (95% coverage).
- Viral suppression among all patients on ART should improve to 90% by September 2022.

Trinidad and Tobago

To improve retention, PEPFAR will support the MOH in expanding interventions and strategies to reduce interruption in treatment and return to care those patients previously diagnosed. Support will be provided across all treatment sites to aggressively target clients who have missed clinic appointments, those who recently dropped out of care, and pending cases. Similar to the Entry To Care activities, patients returned to care will be surveyed to understand and, fine tune interventions to address their reasons for abandoning care and treatment. In addition, to improve retention for those most at risk of interruptions, extended hour clinics and viremia clinics will be expanded.

To continue to bolster the country's implementation of Treat All, PEPFAR will work with the MOH to continue to implement the updated national care and treatment guidelines allowing patients who are currently in care but not yet initiated on ART to be prioritized as a focus for interventions. Support will also be provided to expand patient literacy in Treat All via PLHIV peer support workers. Continued implementation of the national TLD transition plan, expansion of multi month dispensing (Figure 4.2.2) and other differentiated models of care will also be supported by PEPFAR to support our client centered services as a standard of care for all PLHIV in Trinidad and Tobago. The PEPFAR-supported treatment sites will continue to support satellite sites to facilitate six-month ARV supplies and enhanced viral load monitoring for stable patients.

Figure 4.2.2 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY22 Trinidad & Tobago

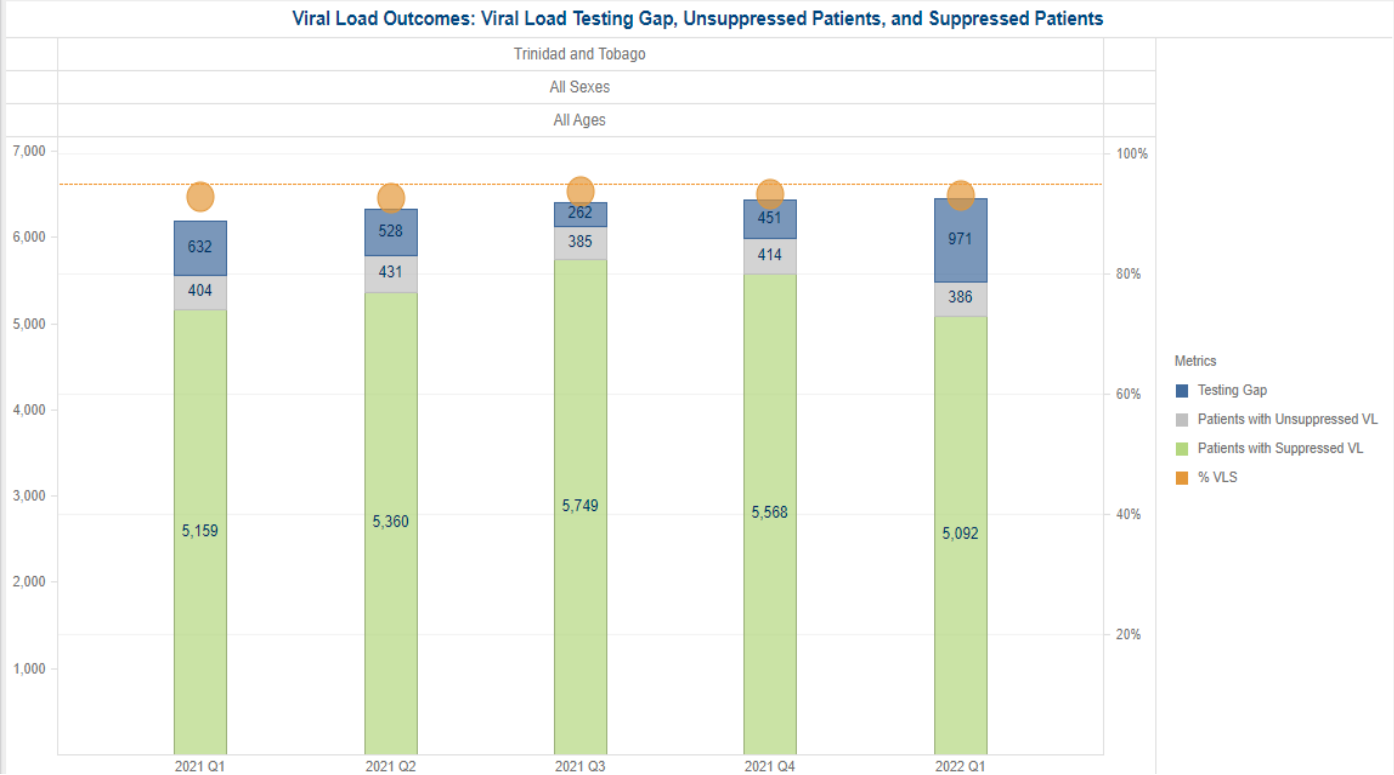


Source: Treatment Single OU Dossier; Treatment Overview chapter; Multi-month Dispensing by Age/Sex page; current quarter, by sex

PEPFAR will continue to expand the HIV ECHO telementoring program with the goal of providing regular clinical updates and case consultation for healthcare workers across the region. PEPFAR will continue to support the clinical preceptorship program for less experienced HCWs providing HIV care. There will also be increased technical assistance for the development and adaptation of educational materials and tools based on the health literacy needs of patients, aimed at increasing retention. Finally, focus will be placed on comprehensive training for staff, including in the areas of mental health, substance use, trauma-informed care, sexual and reproductive health, and anal healthcare.

An estimated 93% of PLHIV on ART in Trinidad and Tobago are virally suppressed (Figure 4.2.3). Nonetheless, there is room for enhancing the data management system (to decrease turnaround time for test results); and supply chain (to ensure stock outs do not occur). There is a need to strengthen routine viral load testing, monitoring, and reporting, as well as to increase the use of viral load data to target adherence support for patients.

Figure 4.2.3 Viral Load Outcomes, FY21 Trinidad & Tobago



Source: Panorama: Viral Load: Single OU – VL Outcomes

Site level docket reviews will be implemented to target all unsuppressed patients. The review will focus on various aspects of clinical management, such as, the length of time on ART, different ART regimens that the patient was exposed to, whether adherence issues were addressed, presence of comorbidities and/or psychosocial issues that could be preventing attainment of viral suppression. Based on findings, individualized strategies will be developed to assist each patient to become virally suppressed.

To support the continued scale up of viral load testing, the Government recently acquired a new Abbott m2000 Instrument for viral load testing through a reagent rental agreement, transitioned from a manual to electronic inventory management system, strengthened the CELLMA Health Information System (HMIS), and installed a laboratory information system (LIS) at the Eric Williams Medical Sciences (EWMSC) Complex, Pathology Lab and the Medical Research Foundation of Trinidad and Tobago (MRFTT) Lab. This system now interfaces with other data systems and ensures the availability of timely and accurate data for HIV patient management and country wide laboratory surveillance. Trinidad now has 3 viral load testing sites operating in country. In ROP 22, PEPFAR will continue to support roll out of these activities to strengthen the National Laboratory network.

Building of Human Resource Capacity

Human resource capacity will be strengthened through the recruitment and training of staff at both the national and regional levels. This will enable the scale up of testing, as well as the provision of high-quality treatment services.

Improving Quality in HIV Services

To improve the quality in the delivery of HIV testing, treatment, and care services, Quality Improvement policies, standards, and associated targets need to be established. Increased emphasis will be placed on implementing QI activities at testing and treatment facilities.

Laboratory Strengthening

Further strengthening of the laboratory capacity will enable universal access to quality diagnostic services, and in turn, improve HIV treatment services. The Government has embarked on a plan to strengthen the national and regional health authority laboratories by ensuring effective policies and procedures are in place and establishing functional quality committees. The EWMSC Diagnostic Pathology Lab which performs both VL and EID testing was accredited in December 2019. It is the first public sector clinical lab in the country to achieve this. Ongoing support will help to accredit the Public Health laboratory in FY 22, which performs HIV serology and TB testing. The San Fernando General Hospital lab which became the third VL testing site in country will also be supported with lab capacity building and CQI initiatives. Technical assistance will continue to support the expansion of HIV drug resistance testing as a referral service and improve the quality of HIV rapid and self-testing.

Improving Strategic Information

The Government will continue to build strategic information capacity to improve the accuracy and reliability of HIV/AIDS data. This will support effective strategic planning, as well as the optimal delivery of health services. Priority will also be placed on improving the national HIV case-based surveillance system to better monitor progress toward epidemic control.

Reducing Stigma and Discrimination

While there have been great strides, ignorance about HIV and the stigma associated with persons living with HIV remain, affecting, for example, KP access to prevention, testing and treatment services. KP-friendly services are being provided by the MRFTT, including during their extended hours clinics tailored to the needs of KPs and youth. Similar clinics are to be implemented in Ward 2 San Fernando Hospital, the second largest treatment site in Trinidad and Tobago with ROP22 plans including support of the national program in providing stigma free services at all treatment sites.

4.3 Prevention:

HTS Prevention for high-risk negatives:

HIV testing services are integrated as a critical aspect of HIV prevention services and linking individuals who test HIV negative to person-centered comprehensive prevention services. In ROP 22, PEPFAR will support a combination-prevention package and continue support to behavioral and structural programs that will address sexual risk reduction and self-efficacy while driving the demand for HIV services and the reduction of stigma and discrimination.

PrEP for priority populations & sero-discordant couples

The introduction of PrEP as a bio-medical option to prevent new infections will be implemented in facility and community-based settings for sero-discordant couples and all HIV negative clients at high risk of becoming HIV infected.

Effective social network and risk network approaches will complement peer outreach by engaging previously unidentified clients and their contacts for HIV prevention services. Where high risk negative clients are identified, PrEP education and other services such as STI screening and risk reduction counseling that will help them to remain HIV-negative will be recommended. In ROP22, PrEP will be offered through PEPFAR, Global Fund and Host Government support at five facilities in the region, four in Jamaica and one in Trinidad and Tobago.

Treatment as Prevention

PEPFAR will continue to support activities related to returning patients to care; and retention in care for those clients found through prevention interventions. Activities implemented at the facility-level will also leverage PEPFAR community-based support, such as peer navigators, and clinician-focused Continuous Quality Improvement (CQI) activities. Peer navigators will help create demand for services, assist with return to care strategies and medication adherence as well as reinforce the value of viral load testing in support of U=U to create demand for testing. CQI efforts will reinforce activities related to interruption in treatment, retention in care, and medication adherence.

Key Populations

A comprehensive package of key population interventions will identify KPLHIV, who will be linked to treatment and KP who are negative will be linked to prevention activities including PrEP. Care and retention interventions (including retention and “return to care”) will support the Ministries of Health with initiating new patients on treatment.

To maximize program impact, key strategies will be employed to support the achievement of the first 95 to include targeted outreach, events with MSM, and social network strategy including the use of the Enhanced Peer Outreach Approach (EPOA) to increase access to the targeted population. Focused HIV testing through sexual and social networks of key populations to improve the efficiency of HIV testing efforts is a very effective case-finding strategy. Further, HIV self-testing has demonstrated effectiveness in reaching individuals who may not otherwise test and is especially suited to reaching key populations and their risk networks. It also provides the opportunity to link those who screen HIV positive to treatment.

Focused and targeted testing ensures linkage to treatment and prevention services will be supported using validated risk screening tools to find MSM and men at high risk for HIV acquisition. This will include peer-based and hotspot approaches, venue-based outreach, and mobile service outreach. These strategies will be included in the comprehensive suite of services provided to key populations to ensure they are linked to all applicable services.

Efforts will focus on reaching, finding, and engaging, key populations using a combination of facility and community-based strategies and promoting timely linkages and referrals to HIV-related services. Outreach strategies to reach MSMs, their partners and those who are at highest risk of HIV will target five high burden parishes of Kingston, St. Catherine, St. Ann, St. James and Westmoreland.

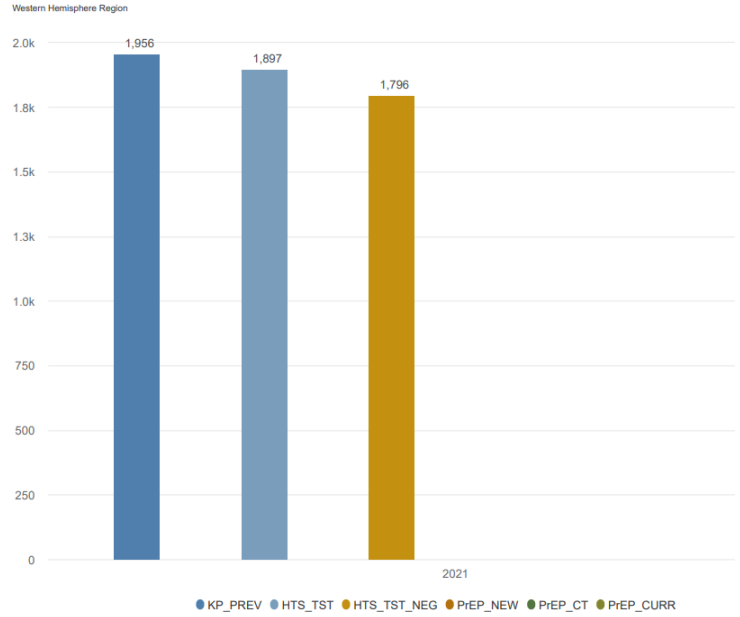
MSM are increasingly using electronic media to expand their social networks and meet individuals with similar sexual orientation. To respond to this, employing ICT strategy, using social media platforms, and dating services sites, will continue to be used to disseminate key messages with a focus on off-lining individuals and calling target groups to action in relation to knowing their HIV status. This intervention will also improve reach to higher risk and more "hidden" populations and promote health-seeking behavior.

The program will also link individuals who are HIV negative to biomedical prevention services (PrEP, condoms, and lubricants) and link to treatment all those found positive and continue engagement of those who are negative. MSM will also be referred to and linked to other relevant clinical services such as STI screening and anal care services.

The program will continue to integrate case management approach that links MSM to health systems to facilitate same-day or rapid ART initiation for those who test positive for HIV.

Key personnel will be engaged by NGOs to deliver this program, ensuring a combination of skills and expertise with adequate supervision. Program Managers will be engaged to promote effectiveness and efficiency of the strategies.

Figure 4.3.1 Prevention Continuum by Key Population Group – Jamaica



4.4 Additional Program Priorities

While there are no new policy guidelines for ROP22, CRP has implemented modifications to increase program effectiveness in the form of:

1. A scale up of PrEP for prevention. Building on a prior pilot, five PEPFAR-supported sites will offer PrEP to targeted populations. Guidelines for adoption are being driven by this implementation, and will accelerate a wider national implementation in subsequent years. Please reference section 4.3 for further details. This will impact Minimum Program Requirement (MPR) #7.
2. A scale up of self-testing for case finding, as well as index testing with an assessment of IPV. Please reference section 4.1. This will impact MPR #6.
3. A scale up to TLD transition for all patients will impact retention on ARVs and by extension viral suppression. Please reference section 4.1 for further details. This will impact MPR #2.

Plans to ensure scale up of index testing in alignment with the PEPFAR Guidance on Implementing Safe and Ethical Index Testing were detailed in section 4.1. Ongoing monitoring & accountability will take place through SIMS assessments and monthly and quarterly monitoring activities with implementing partners.

A review of data from ROP20 and ROP21 implementation periods has also led to the following decisions on programmatic direction:

a. For case finding, based on the less-than-ideal performance with a mainly index testing focus in ROP21, the region will employ a strategic mix of modalities for ROP 22.
b. ART initiation and retention strategies will be implemented for initiating previously diagnosed PLHIV on treatment, as well as welcoming back persons to care after interruption in treatment. PEPFAR will support the continued onboarding and quantification of persons seeking care in the private space and incorporating their treatment data into the nation's database while also facilitating engagement between the private and public sectors in the resolution of interruption in treatment cases.
c. Noting the retention challenges brought about by the COVID-19 epidemic; the region will regularize person-centered interventions initiated as mitigation responses to the COVID-19 epidemic. These include telemedicine activities, differentiated drug deliveries, home clinic visits, socio-economic support and other adaptations aimed at decreasing interruptions in treatment.
d. After achieving much success with viral suppression in the last two years of implementation, we will continue to support viral suppression but will shift focus to improving retention at all our sites by leveraging strengths already within the system, while building the site level capacity to continuously utilize its data for real time programmatic changes as needed.

CRP plans to continue to support community-led monitoring activities through our small-grant program. In Jamaica, lessons learned from previous CLM activities will be used to improve upon program design. In Trinidad and Tobago, we will work with CSOs to increase understanding of community-led monitoring and drive demand for CLM activities.

4.5 Commodities

Host government funds and procures the majority of commodity requirements through either domestic sources or other donors, e.g. Global Fund. CRP commodity procurement is approximately 1% of our program budget and falls under six major supply categories: essential medications, rapid test kits, self-test kits, viral load reagents, TB kits and OI testing reagents, sample collection, and safety supplies. Overall, the commodity budget has been reduced by 50% from ROP21 due to more accurate costing of the VL reagents based on consumption rates and decrease in cost for support of decentralization post-initiation. In ROP22, approximately one-third of our commodity procurements will support viral load reagents to assist with decentralization, as well as support for creatinine and Cr Ag tests to support the roll out of PreP. Procurement will continue for HIV Self testing kits to scale up distribution of and access to HIV testing.

4.6 Collaboration, Integration and Monitoring

CRP collaborates with all stakeholders to address challenges across the clinical cascade. Internally, technical working groups composed of all PEPFAR agencies jointly review data and share information related to challenges, successes, and potential modifications to improve program effectiveness. This ensures synchronization, applying best practices regionally.

The PEPFAR Coordinator, with technical support from all agencies, participates in coordination meetings with host government, other donors, and civil society representatives to advance consistent messaging on policy priorities and identify areas for heightened focus. As the two largest donors to HIV/AIDS efforts in the region, PEPFAR and GFATM also meet regularly to maintain collaboration and complementarity between our programs.

IPs in the CRP are managed based on PEPFAR's Oversight & Accountability Response Team guidance and feedback each quarter. Planning and corrective actions are done in conjunction with partners through a quarterly partner meeting for the CRP. MER indicators with entry of results into DATIM from each IP are also used to ensure alignment with the PEPFAR strategy. In ROP 22, refresher sessions are also being planned to ensure all IPs are reporting on all indicators according to PEPFAR's latest standardized MER guidance.

Human Resources for Health (HRH)

In Jamaica, PEPFAR will invest in HRH by developing and delivering HCW training on clinical management, telehealth, adolescents' disclosure protocol, motivational interviewing, infection prevention and control, STI & sexual and reproductive health, and other trainings. Some training may occur through the Learning Management System (LMS), which will continue to be maintained. There will be investment in strengthening the capacity of in-service training unit at the MOHW.

In Trinidad and Tobago, there will be investment in HRH by expanding and operationalize use of the Learning Management System to institutionalize in-service training at the national level. In addition, there will also be implementation of training for HCW including: the clinical management of HIV, mental health and psychosocial service delivery, sensitized care for KPs, and PLHIV treatment literacy. Finally, there will be support of the development and implementation of a national Psychosocial Coordination Unit to oversee and strengthen HIV service delivery.

4.7 Targets by population

Table 4.8.1 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY22)	Additional patients required for 80% ART coverage	Target current on ART (APR FY23) *TX_CURR*	Newly initiated (APR FY23) *TX_NEW*	ART Coverage (APR 23)
Scale-Up Saturation – Trinidad & Tobago	**10,432**	**8,617**	**--***	**8,157**	**714**	**78%**
Scale-Up Aggressive – Jamaica	**32,000**	**17,876**	**7,724**	**18,051**	**4,187**	**56%**
Total	**42,432**	**26,493**	**7,724**	**26,208**	**4,901**	**62%**

*- Based on expected current on ART (APR FY22) patients required for 80% expected coverage would have been achieved.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Barriers to sustained epidemic control were identified through consultation with stakeholders and review of data from MER and SIMS. Key systems barriers include planning and coordination, policies and governance, service delivery, human resources for health, quality management, laboratory, epidemiological and health data, and data for decision-making ecosystem. For Jamaica, elements were mapped against 2019 SID where most of the key barriers identified scored as emerging sustainability needing some additional investment.

In Jamaica, Table 6 investments will be used to overcome lack of technical capacity to implement HIV self-testing and improve on the EEHR environment. Our investments will also address lack of sufficient HRH and insufficient standardization in the human resources arena. Our laboratory support will improve the efficiency of HIV rapid testing and expanding VL coverage by eliminating policy constraints and advancing decentralization of the service. Our support for strategic information and data improvements will not only improve interoperability between health systems but also the utilization and understanding of data to inform clinical and programmatic decision making.

In Trinidad and Tobago, investments will be used to improve technical capacity for QI activities and maintaining quality service delivery. Our HRH investments will improve training standardization, counteract gaps in service due to an aging HRH workforce, and improve national level oversight mechanisms to coordinate mental health and psychosocial services. Our investments will expand and improve the provision of quality laboratory services. As in Jamaica, we will support integration and increased efficiency of information systems with a goal to improve the data for decision-making ecosystem.

Region-wide, we will support planning and coordination between Caribbean countries that have been slow to effect policy guidelines that assure minimum program requirements are met across the region.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

CRP seeks to improve efficiency in our management and operations. We propose to fill vacant and re-purposed positions for technical staff, while flatlining management and operations support.

We made changes in our staffing footprint and organizational structure to account for ability to fill specific positions, transition of staff, and program gaps and needs. Our proposed staffing footprint includes 25.5 FTEs of which six are part of the HIV Prevention, Care and Treatment team. We will transition an SI contract position to local staff, create a position in Trinidad and Tobago to support program expansion, repurpose a Key Population position, and add a communications specialist (unfilled) position to the CDC CoAg Manager duties. The Key Populations position was repurposed to an interagency Regional Local Capacity & Sustainability Specialist which was approved in October 2021 and is currently undergoing classification. The process to complete classification, obtain approvals and recruit for proposed positions that are currently vacant may extend beyond the ROP22 timeframe.

Our SIMS team will continue to lead and facilitate SIMS requirements. The PEPFAR Coordinator's office will continue to host the small-grants program for community-led monitoring, with the Deputy PEPFAR Coordinator leading the efforts.

Given the burden and impact of COVID-19 work on the team, CDC hired a term-limited Global Health Security (GHSA) Epidemiologist to coordinate COVID-19 response across the region. Incumbent is from the Jamaica Ministry of Health and Wellness Strategic Information (SI) team and has been invaluable in contributing to PEPFAR CRP's SI work. CRP is proposing that this position is maintained and cost-shared (0.5) by PEPFAR beginning in ROP22. Maintaining this position will not only support the region in any emergency, but also offer additional support in interagency SI work for the PEPFAR program.

Lab is a cross cutting area for our HIV program and supports broader health systems capacity. The region previously had more than 3 lab positions but are currently down to one locally employed staff in Barbados. CRP is proposing to fill the vacant lab position established for Jamaica to have someone on the ground to support our lab expansion activities proposed (scaling up VL testing, VL decentralization, recency, expansion of LIS, and continued quality assurance).

Currently, only one person supports and coordinates PEPFAR and U.S. government health priorities in Trinidad and Tobago despite the country receiving 11% of our funding. Given PEPFAR's continued support, expanded portfolio and our final push to help TT meet 95-95-95, we are proposing a clinical advisor for Trinidad and Tobago. See Figure 6.1, for PEPFAR CRP proposed staffing for ROP 22.

Figure 6.1 PEPFAR CRP ROP 22 Proposed Staffing

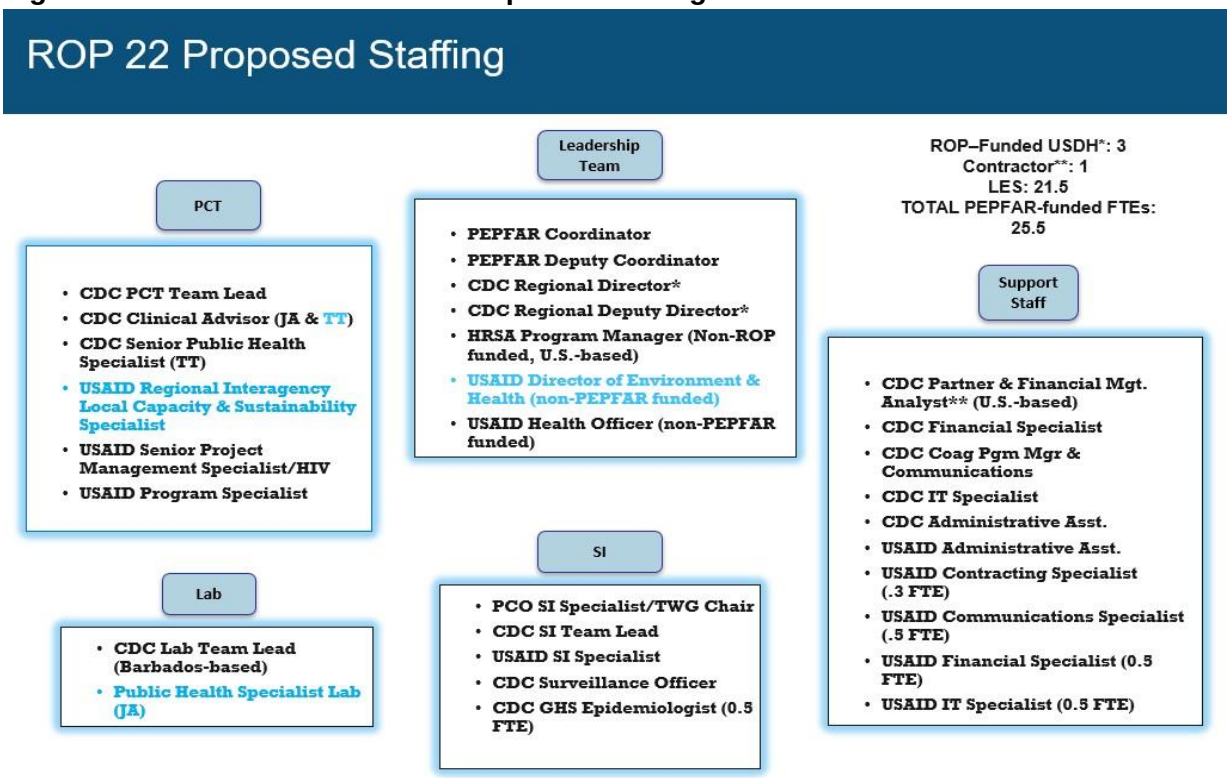


Table 6.2 summarizes the CRP CODB over the last six years and proposed for ROP 22. ROP 22 CODB is the lowest ever. CRP has seen savings in CODB based on shifting of human resources from contract to local staff, consolidating and sharing of human resources and savings in travel as a result of COVID-19 mitigation measures. PCO has reduced CODB based on duplicate budgeting in the current year. USAID reduced their CODB based on lower ICASS, training and staff travel costs. CDC is proposing level funding but using savings to fill positions discussed above. Given CODB is primarily for staff, if not fully approved, it will impact CRP's ability to travel for monitoring and evaluation, maintain staff levels and fill critical positions.

Table 6.2: PEPFAR CRP Historical CODB

CODB Budget							
Agency	**ROP16**	**ROP17**	**ROP18**	**ROP19**	**ROP20**	**ROP 21**	**ROP 22 (proposed)**
DOD	$365,000	$240,000	$0	$0	$0	$0	$0
HHS/CDC	$4,554,362	$4,200,445	$3,600,445	$3,396,002	$3,128,06	$3,000,00	$3,000,000
PC	$80,587	$0	$0	$0	$0	$0	$0
State	$494,506	$447,500	$536,255	$771,635	$770,215	$814,183	$651,556
USAID	$2,857,782	$3,021,842	$2,557,949	$930,945	$821,827	$821,826	$670,841
Grand Total	**$8,352,237**	**$7,909,787**	**$6,694,649**	**$5,098,582**	**$4,720,10**	**$4,636,00**	**$4,307,305**

APPENDIX A -- PRIORITIZATION

Continuous Nature of Prioritization to Reach Epidemic Control

Table A.1 PEPFAR Supported Treatment Coverage at APR by Age and Sex

SNU	ROP	Prioritization	Results Reported	PEPFAR Supported Treatment Coverage at APR by Age and Sex																						Overall TX Coverage
				1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Jamaica	ROP 18	Scale-up: Aggressive	APR 19	17%	9%	23%	4%	10%	8%	32%	21%	44%	45%	46%	48%	45%	40%	41%	40%	41%	39%	36%	36%	32%	26%	35%
	ROP 19	Scale-up: Aggressive	APR 20	3%	5%	4%	1%	4%	7%	43%	27%	63%	38%	60%	24%	61%	17%	57%	20%	59%	23%	53%	30%	64%	44%	39%
	ROP 20	Scale-up: Aggressive	APR 21	1%	1%	2%	0%	5%	7%	38%	22%	52%	25%	51%	19%	54%	14%	51%	16%	53%	21%	53%	25%	65%	44%	36%
Trinidad & Tobago	ROP 18	Scale-up: Saturation	APR 19	0%	4%	5%	5%	10%	4%	79%	67%	*	*	*	*	*	*	90%	98%	60%	70%	50%	49%	38%	51%	65%
	ROP 19	Scale-up: Saturation	APR 20	4%	8%	5%	5%	3%	4%	53%	49%	*	*	*	*	*	*	79%	91%	60%	66%	49%	49%	38%	49%	61%
	ROP 20	Scale-up: Saturation	APR 21	0%	8%	5%	0%	3%	4%	34%	36%	*	*	*	*	*	*	75%	89%	61%	72%	55%	49%	42%	52%	62%

***- Due to disparities is age/sx disaggregation data for Trinidad & Tobago there are instances with the numerator is greater than the denominator.**

APPENDIX B – Budget Profile and Resource Projections

B1. ROP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 ROP22 Budget by Program Area, Jamaica

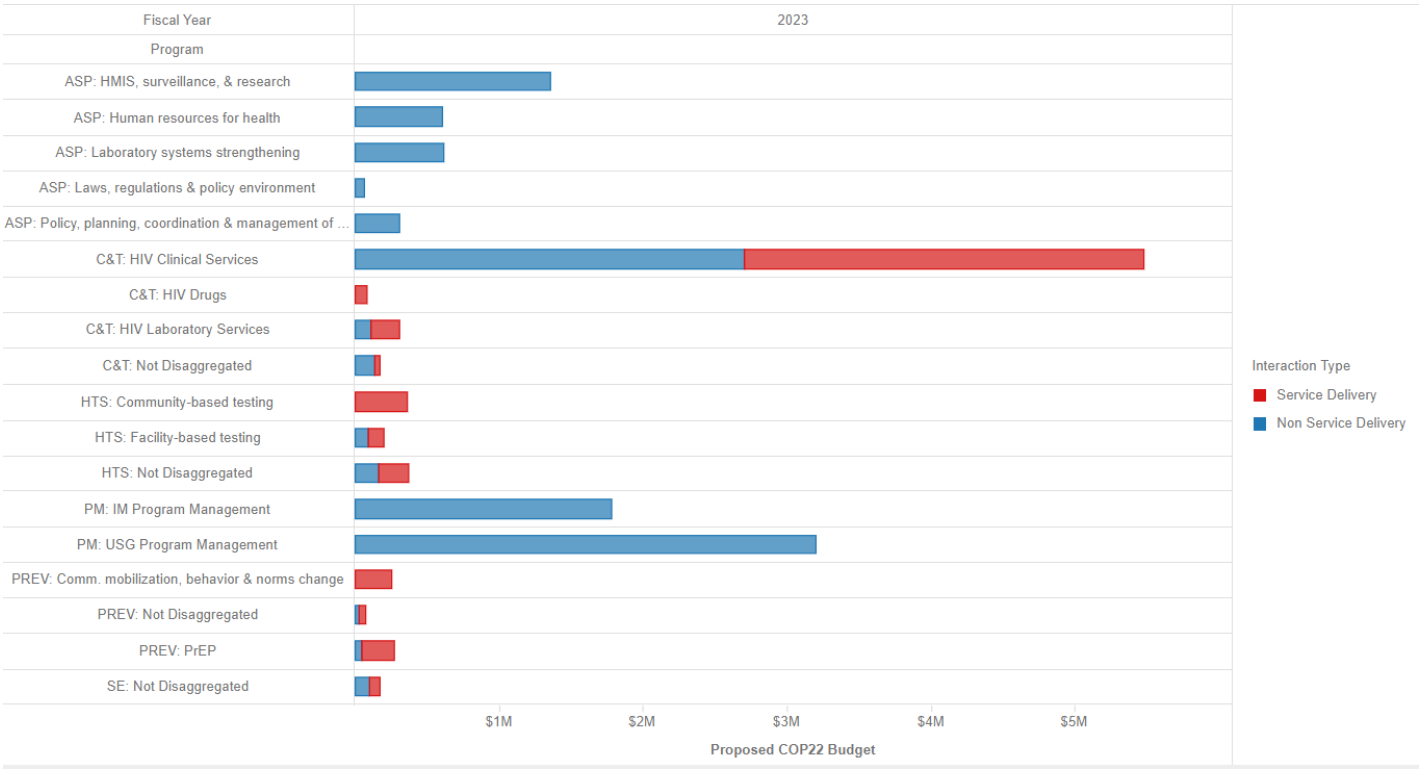


Table B.1.2 ROP22 Budget by Program Area, Trinidad and Tobago

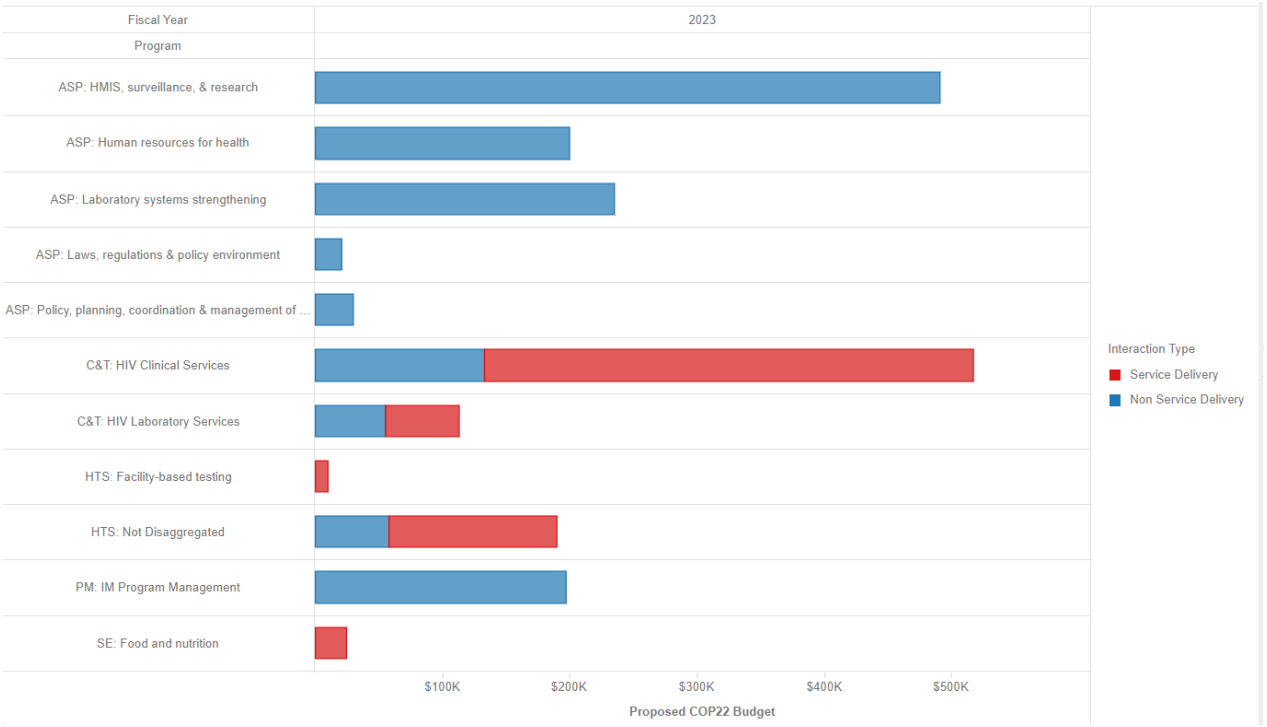


Table B.1.3 ROP22 Budget by Program Area, WESTERN HEMISPHERE REGION (PANCAP)

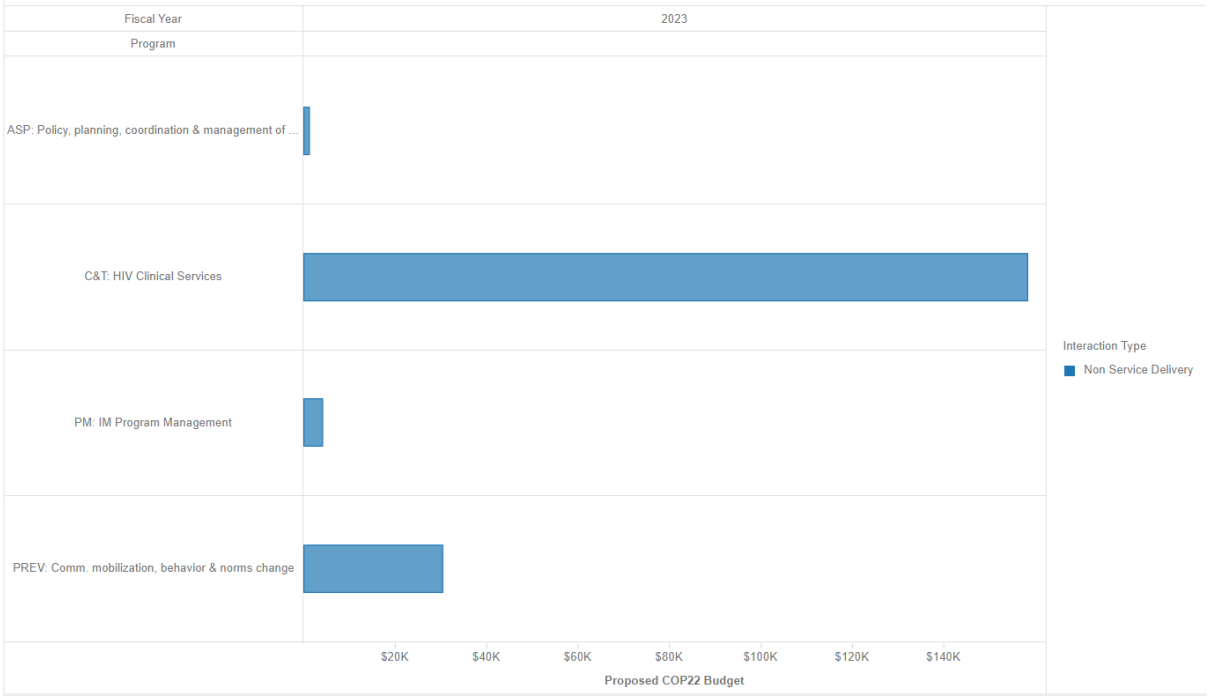


Table B.1.4 ROP22 Budget by Program Area, JAMAICA

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$11,314,995**	**$4,363,517**	**$15,678,512**	**72%**	**28%**	**100%**
C&T	**Total**	**$2,951,439**	**$3,085,905**	**$6,037,344**	**49%**	**51%**	**100%**
	HIV Clinical Services	$2,705,410	$2,771,938	**$5,477,348**	49%	51%	**100%**
	HIV Drugs		$77,000	**$77,000**		100%	**100%**
	HIV Laboratory Services	$110,747	$197,000	**$307,747**	36%	64%	**100%**
	Not Disaggregated	$135,282	$39,967	**$175,249**	77%	23%	**100%**
HTS	**Total**	**$252,771**	**$681,919**	**$934,690**	**27%**	**73%**	**100%**
	Community-based testing		$359,335	**$359,335**		100%	**100%**
	Facility-based testing	$89,209	$111,742	**$200,951**	44%	56%	**100%**
	Not Disaggregated	$163,562	$210,842	**$374,404**	44%	56%	**100%**
PREV	**Total**	**$74,905**	**$522,588**	**$597,493**	**13%**	**87%**	**100%**
	Comm. mobilization, behavior & norms change		$250,000	**$250,000**		100%	**100%**
	Not Disaggregated	$31,342	$45,000	**$76,342**	41%	59%	**100%**
	PrEP	$43,563	$227,588	**$271,151**	16%	84%	**100%**
SE	**Total**	**$101,019**	**$73,105**	**$174,124**	**58%**	**42%**	**100%**
	Not Disaggregated	$101,019	$73,105	**$174,124**	58%	42%	**100%**
ASP	**Total**	**$2,948,697**		**$2,948,697**	**100%**		**100%**
	HMIS, surveillance, & research	$1,353,218		**$1,353,218**	100%		**100%**
	Human resources for health	$607,387		**$607,387**	100%		**100%**
	Laboratory systems strengthening	$612,368		**$612,368**	100%		**100%**
	Laws, regulations & policy environment	$67,061		**$67,061**	100%		**100%**
	Policy, planning, coordination & management of disease control programs	$308,663		**$308,663**	100%		**100%**
PM	**Total**	**$4,986,164**		**$4,986,164**	**100%**		**100%**
	IM Program Management	$1,783,874		**$1,783,874**	100%		**100%**
	USG Program Management	$3,202,290		**$3,202,290**	100%		**100%**

Table B.1.5 ROP22 Budget by Program Area, TRINIDAD & TOBAGO

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$1,419,449**	**$608,159**	**$2,027,608**	**70%**	**30%**	**100%**
C&T	**Total**	**$187,519**	**$442,219**	**$629,738**	**30%**	**70%**	**100%**
	HIV Clinical Services	$132,519	$384,219	**$516,738**	26%	74%	**100%**
	HIV Laboratory Services	$55,000	$58,000	**$113,000**	49%	51%	**100%**
HTS	**Total**	**$58,222**	**$141,940**	**$200,162**	**29%**	**71%**	**100%**
	Facility-based testing		$10,000	**$10,000**		100%	**100%**
	Not Disaggregated	$58,222	$131,940	**$190,162**	31%	69%	**100%**
SE	**Total**		**$24,000**	**$24,000**		**100%**	**100%**
	Food and nutrition		$24,000	**$24,000**		100%	**100%**
ASP	**Total**	**$976,870**		**$976,870**	**100%**		**100%**
	HMIS, surveillance, & research	$490,902		**$490,902**	100%		**100%**
	Human resources for health	$200,000		**$200,000**	100%		**100%**
	Laboratory systems strengthening	$235,000		**$235,000**	100%		**100%**
	Laws, regulations & policy environment	$20,968		**$20,968**	100%		**100%**
	Policy, planning, coordination & management of disease control programs	$30,000		**$30,000**	100%		**100%**
PM	**Total**	**$196,838**		**$196,838**	**100%**		**100%**
	IM Program Management	$196,838		**$196,838**	100%		**100%**

Table B.1.6 ROP22 Budget by Program Area, WESTERN HEMISPHERE REGION (PANCAP)

Program	Metrics	Proposed COP22 Budget		Percent of Proposed COP 22 Budget	
	Sub-Program	Non Service Delivery	Total	Non Service Delivery	Total
Total		**$193,880**	**$193,880**	**100%**	**100%**
C&T	**Total**	**$158,205**	**$158,205**	**100%**	**100%**
	HIV Clinical Services	$158,205	**$158,205**	100%	**100%**
PREV	**Total**	**$30,365**	**$30,365**	**100%**	**100%**
	Comm. mobilization, behavior & norms change	$30,365	**$30,365**	100%	**100%**
ASP	**Total**	**$1,310**	**$1,310**	**100%**	**100%**
	Policy, planning, coordination & management of disease control programs	$1,310	**$1,310**	100%	**100%**
PM	**Total**	**$4,000**	**$4,000**	**100%**	**100%**
	IM Program Management	$4,000	**$4,000**	100%	**100%**

Table B.1.7 ROP22 Total Planning Level, by Country

Fiscal Year	2023	2023
Country	Proposed COP22 Budget	Percent to Total
	$17,900,000	**100%**
Jamaica	$15,678,512	88%
Trinidad and Tobago	$2,027,608	11%
Western Hemisphere Region	$193,880	1%

Table B.1.8 ROP22 Total Planning Level, by Initiative

Country	Fiscal Year	2023
	Initiative Name	Proposed COP22 Budget
		$17,900,000
Jamaica	Community-led Monitoring	$35,000
	Core Program	$15,643,512
Trinidad and Tobago	Community-led Monitoring	$15,000
	Core Program	$2,012,608
Western Hemisphere Region	Core Program	$193,880

Table B.1.9 ROP22 Total Planning Level, by Funding Account

Country	Fiscal Year	2023	2023
	Funding Account	Proposed COP22 Budget	Percent to Total
		$17,900,000	**100%**
Jamaica	Applied Pipeline	$882,142	5%
	GAP	$1,593,750	9%
	GHP-State	$13,202,620	74%
Trinidad and Tobago	Applied Pipeline	$585,272	3%
	GHP-State	$1,442,336	8%
Western Hemisphere Region	GHP-State	$193,880	1%

Table B.1.10 ROP22 C&T Earmark

Country	2023 C&T Earmark	2023 Percent to ROP22 total ($17.9M)
	$9,037,618	**50.5%**
Jamaica	$7,863,610	43.9%
Trinidad and Tobago	$1,012,470	5.7%
Western Hemisphere Region	$161,538	0.9%

Table B.1.11 ROP22 Resource Allocation by Program and Beneficiary, JAMAICA

Metrics	Proposed COP22 Budget							Percent to Total						
Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Total	**$6,037,344**	**$934,690**	**$597,493**	**$174,124**	**$2,948,697**	**$4,986,164**	**$15,678,512**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Females					$19,500		**$19,500**					1%		**0%**
Key Pops	$139,967	$363,795	$350,000		$20,500		**$874,262**	2%	39%	59%		1%		**6%**
Males	$109,843	$26,510	$63,514				**$199,867**	2%	3%	11%				**1%**
Non-Targeted Pop	$5,787,534	$544,385	$183,979	$174,124	$2,908,697	$4,986,164	**$14,584,883**	96%	58%	31%	100%	99%	100%	**93%**

Table B.1.12 ROP22 Resource Allocation by Program and Beneficiary, TRINIDAD & TOBAGO

Metrics	Proposed COP22 Budget						Percent to Total					
Beneficiary	C&T	HTS	SE	ASP	PM	Total	C&T	HTS	SE	ASP	PM	Total
Total	**$629,738**	**$200,162**	**$24,000**	**$976,870**	**$196,838**	**$2,027,608**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Males	$2,000	$46,486				**$48,486**	0%	23%				**2%**
Non-Targeted Pop	$627,738	$153,676	$24,000	$976,870	$196,838	**$1,979,122**	100%	77%	100%	100%	100%	**98%**

Table B.1.13 ROP22 Resource Allocation by Program and Beneficiary, WESTERN HEMISPHERE REGION (PANCAP)

Metrics	Proposed COP22 Budget					Percent to Total				
Beneficiary	C&T	PREV	ASP	PM	Total	C&T	PREV	ASP	PM	Total
Total	**$158,205**	**$30,365**	**$1,310**	**$4,000**	**$193,880**	**100%**	**100%**	**100%**	**100%**	**100%**
Key Pops	$31,641	$6,073			**$37,714**	20%	20%			**19%**
Non-Targeted Pop	$126,564	$24,292	$1,310	$4,000	**$156,166**	80%	80%	100%	100%	**81%**

B.2 Resource Projections

With the absence of one-time funding used to mitigate the effects of COVID-19 on PLHIV and HIV response programming, CRP's ROP22 budget represents a decrease from ROP21. That said, the team recognized that continuing many of the COVID-19 mitigation activities were crucial to ensuring robust and efficient person-centered services. In determining resources required to sustain program activities, CRP noted that need for continued activities in both Jamaica and Trinidad and Tobago, with more focus needed in Jamaica given the gaps needed to reach 95-95-95. In addition, the team recognized the need for continued above-site investments to ensure sufficient progress towards meeting the Minimum Program Requirements.

In looking at site level programing, particularly in Jamaica, resources were aligned to provide the most funding to the areas with the highest burden. Due to the budgetary environment, we were unable to fund all programs at a level commensurate with ROP21 funding but have been able to maintain programming that will advance progress towards reaching 95-95-95 goals.

APPENDIX C – Tables and Systems Investments for Section 6.0

The Key Systems Barriers-E, Table 6-E tab, and SRE Tool-E tab of the Table 6 and SRE Excel workbook should be saved as a PDF and attached here in Appendix C.

The final Excel workbook should be considered a part of the SDS and submitted at the same time.

Jamaica


Table 6 Jamaica


Key Systems barriers Jamaica


SRE Tool-SaSR Jamaica

Trinidad and Tobago


Table 6 Trinidad


Key Systems Barriers Trinidad


SRE Tool-SaSR Trinidad

Western Hemisphere


Table 6 Western Hemisphere


Key Systems Barriers Western Hemispher

APPENDIX D– Minimum Program Requirements

This should be addressed in narrative in the sections above however in this section succinctly note if the program is meeting or not meeting the minimum program requirement. Address assessment of MPRs by SNU and by proportion of sites meeting standards, as applicable. The minimum requirements for continued PEPFAR support include:

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	In process. Both countries have adopted Test and Start policies at the national level.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	In process. A TLD transition plan is in effect for both countries with the first cadres of patients already transitioned.
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	In process. MMD is authorized and implemented in Trinidad and Tobago. In Jamaica, MMD has been authorized by the MOHW though stock levels remain an issue, particularly in the COVID-19 supply environment and MMD data is unavailable.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	N/A
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	N/A

Case Finding	
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	In process. Innovative and inclusive case finding is underway, with safe and ethical index testing, in both countries. Self-testing is being scaled up.
Prevention and OVC	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	In process. PrEP scaleup in Jamaica will continue from FY22. In Trinidad and Tobago, PrEP implementation will begin via NGOs in FY23.
8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	N/A
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	In process. Both countries are committed to provide stigma-free, life-saving treatment to improve health outcomes for key populations. Likewise, both countries continue to make strides toward equality and the reduction of stigma and discrimination in HIV services.
10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related	N/A

services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	In process. In both countries there is continued support for CQI practices and use of SIMS data for program improvement.
12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	In process. We continue to implement U=U and viral load literacy messaging in both countries.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	In process. We continue to make progress towards local partner funding in both countries.
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	In process. Partner governments in both countries demonstrate evidence of year on year increases in expenditures for the HIV response.
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	N/A
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	In process. We continue to partner with both Jamaica and Trinidad and Tobago on surveillance systems improvements. Additional engagement is needed in Jamaica to promote improvements in patient-level tracking.

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

Jamaica has made strides in the HIV response and has been actively strengthening its ability to quantify its efforts. Its successes have been achieved with significant support from both international and domestic resources. As international funding dwindles in a contracting economic environment, the challenge of averting a reversal of the gains is central to all planning processes. Challenges of HIV testing uptake especially among key populations, stigma and discrimination, retention in care and adherence are among the notables in ending the AIDS Epidemic in Jamaica.

Trinidad and Tobago has achieved epidemic control and is poised to be one of the first nations in the Caribbean to achieve the UNAIDS 95-95-95 goal. Targeted technical assistance to improve systems and eliminate barriers will ensure gains are not reversed during and after the COVID-19 pandemic. Sustainability of efforts are integral to program planning.

1. Misalignments between Investments and Outcomes

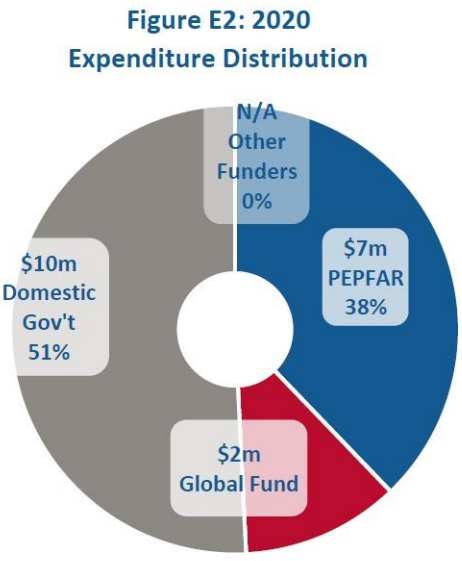
While expenditure data for Trinidad and Tobago is limited, the expenditure distribution for Jamaica shows the domestic government provided approximately half of expenditures in 2020 (Figure E.1.1.).

Figure E.1.1. HIV Program Expenditure Distribution, 2020

Total 2020 Expenditure*
$19,483,476

Total 2020 PLHIV
32,000

Total 2020 Expenditure per PLHIV*
$609



- ***Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control:***

Section 2.3 and Figures E.1.2 and E.1.3, below provide a breakdown of expenditure trends by interaction type. As data is limited to the previous two years only, it is difficult to discern medium- to long- term trajectories. In Jamaica, we note that site-level non-service delivery has increased as our interventions seek to assist sites in improving implementation of international best practices. In Trinidad and Tobago, site level non-service delivery decreased, reflecting the national programs' stabilization towards a level needed to sustain achievements.

Figure E.1.3. Assessing Jamaica's PEPFAR Expenditure Trends by Interaction Type and Epidemic Control Status

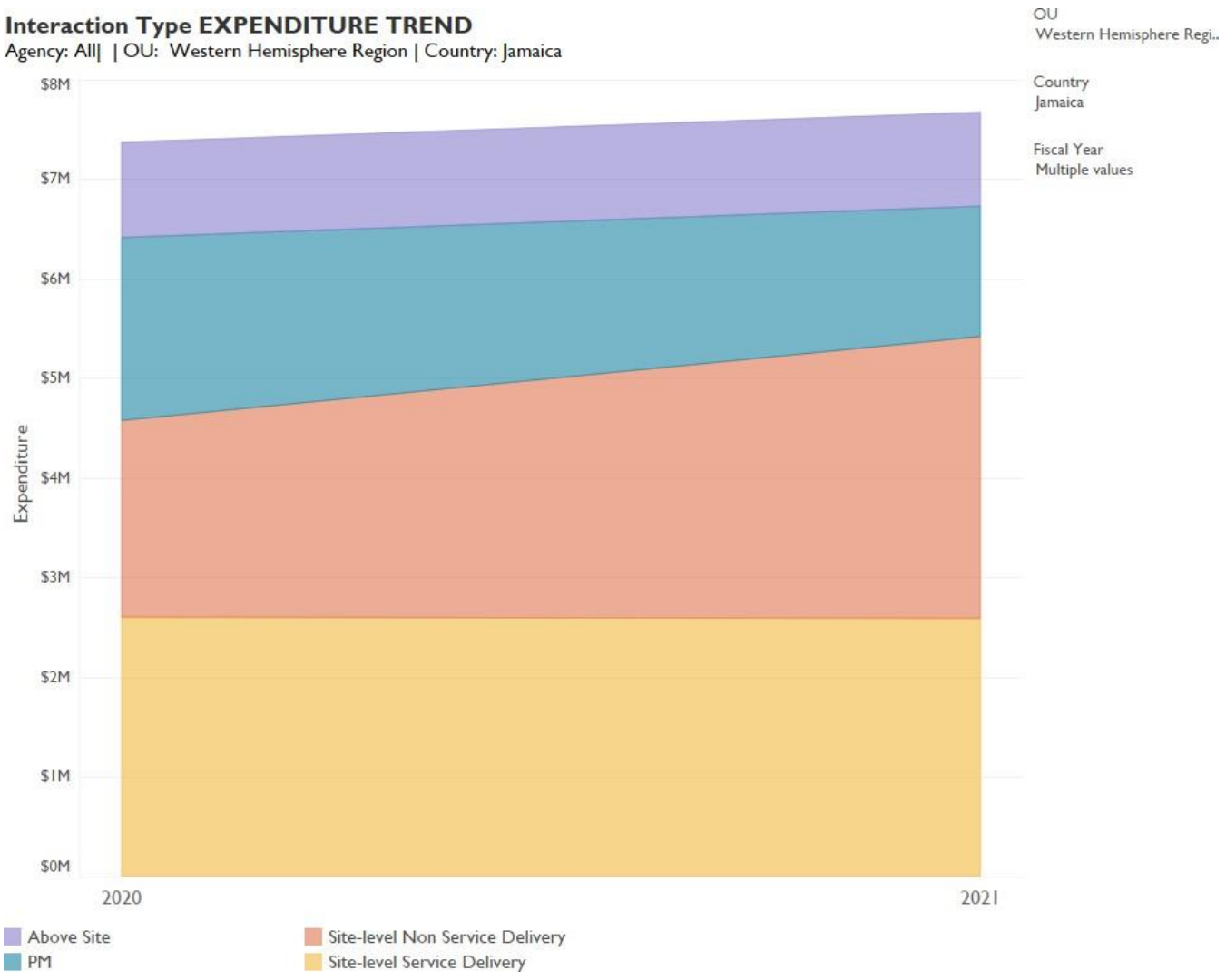
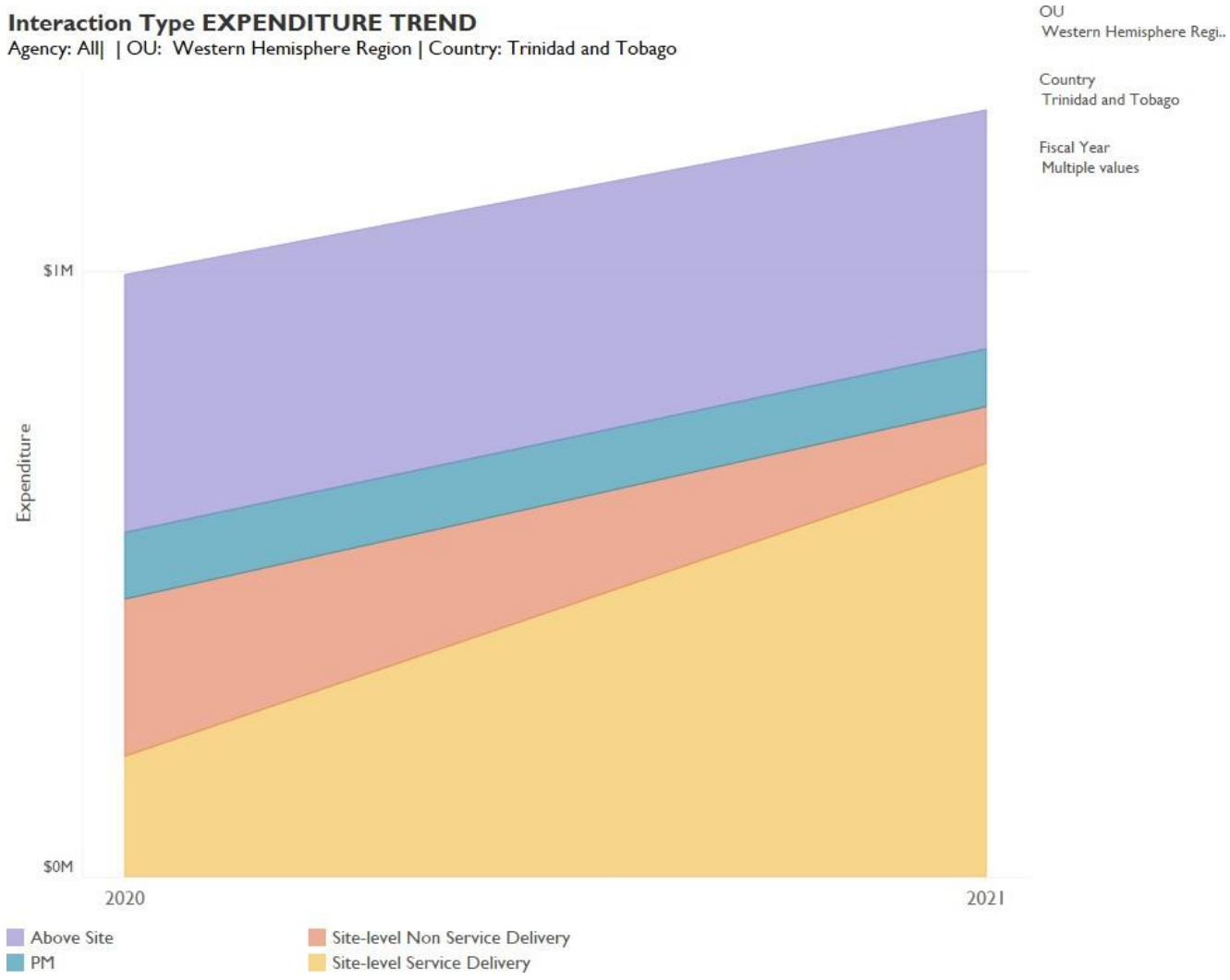


Figure E.1.4. Assessing Trinidad and Tobago's PEPFAR Expenditure Trends by Interaction Type and Epidemic Control Status



- ***HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:***

In both Jamaica and Trinidad and Tobago, HRH remuneration is primarily for care and treatment activities.

Figure E.1.5. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery, Jamaica

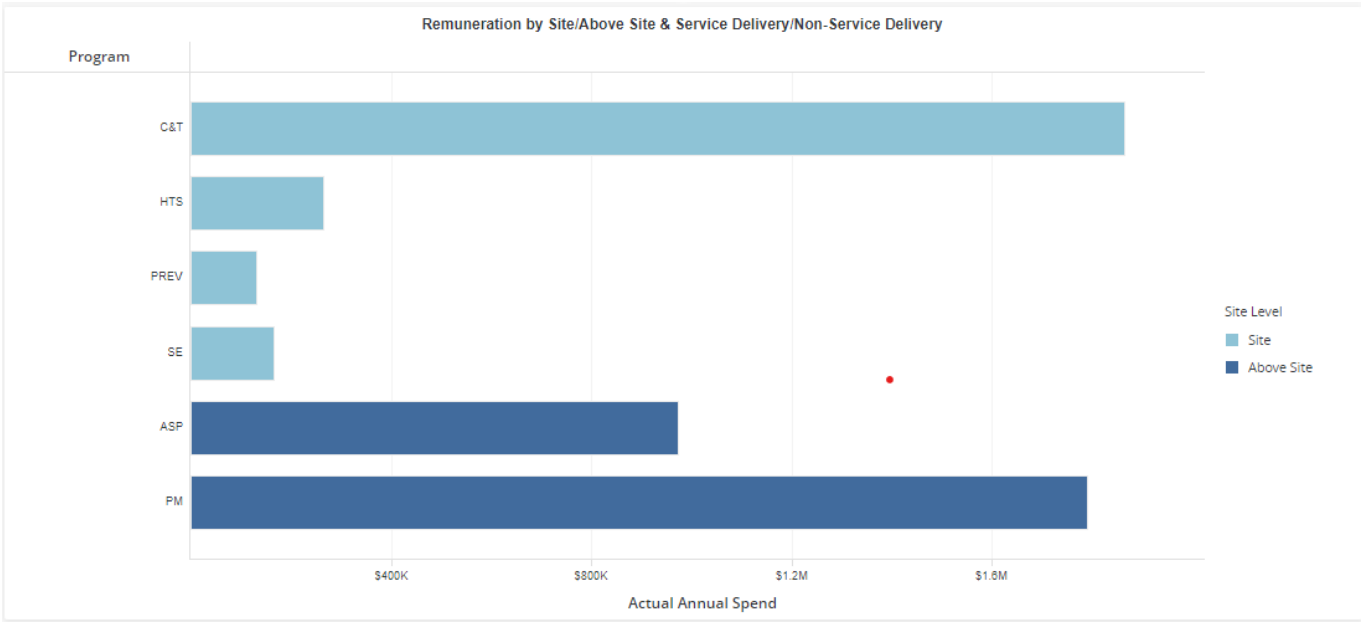
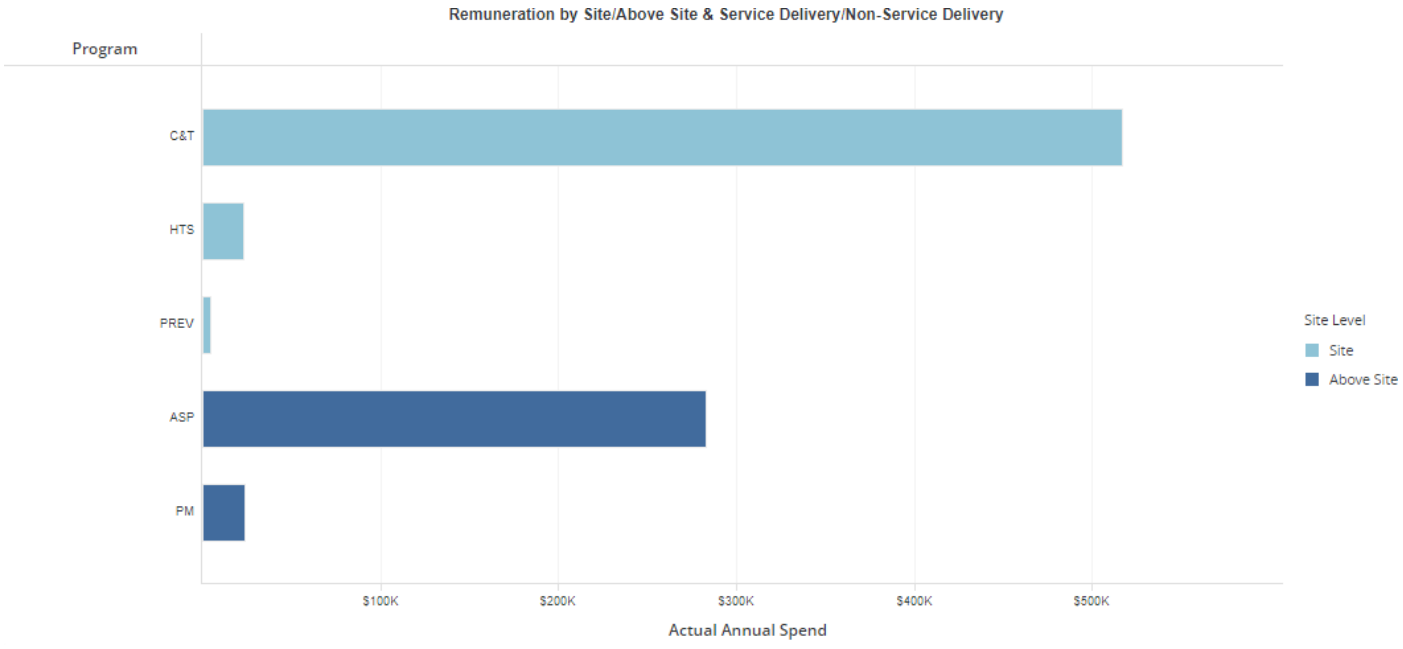
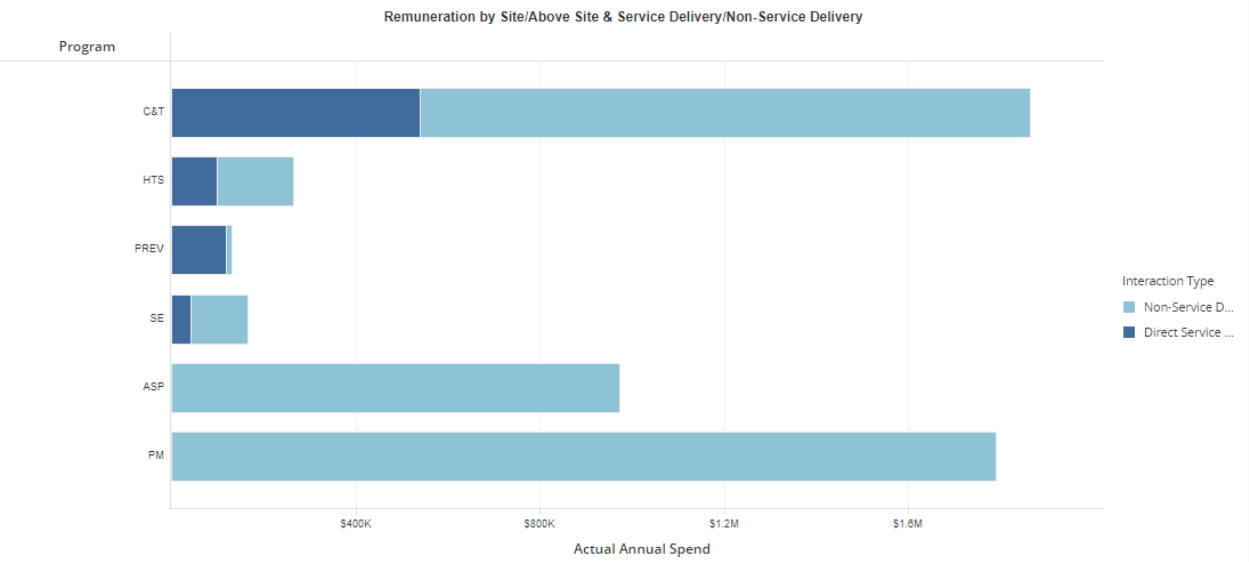


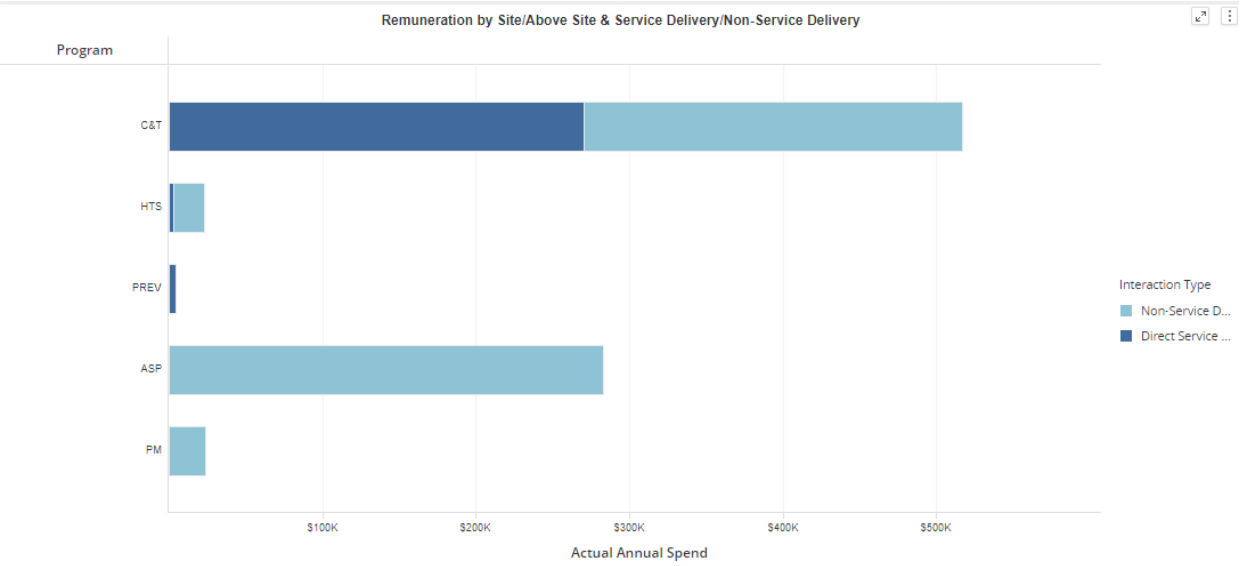
Figure E.1.6. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery, Trinidad and Tobago



E.1.7 Remuneration by Program Area and Service Delivery/Non-Service Delivery, Jamaica



E.1.8 Remuneration by Program Area and Service Delivery/Non-Service Delivery, Trinidad & Tobago



2. Areas for Transition

The host governments support most of the HIV response in both Caribbean focus countries. Host governments should continue to provide funding for ARV medications and most HRH expenditures. In the medium-term host governments should look to self-sufficiency in quality management/quality improvement based on capacity built using PEPFAR provided technical

assistance. Host countries may also incorporate improvements made to laboratory systems and processes.

3. Engagement with Partner Country Governments in ROP22 to Ensure Sustainability of Core Elements of the HIV Response

The CRP Team regularly engages with partner governments on sustainability efforts and programmatic elements are designed with long-term sustainability in mind.