Western Hemisphere / Caribbean Region

Regional Operational Plan

ROP 2023

Strategic Direction Summary

May 17, 2023

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Vision, Goal Statement and Executive Summary

Vision and Goal Statement

The PEPFAR Caribbean Regional Program's ROP23 goal is to support the governments of Jamaica and Trinidad and Tobago to achieve HIV epidemic control, move toward the UNAIDS targets of 95-95-95, and end HIV as a public health threat by 2030, while sustainably strengthening public health systems.

Our ROP23 plan aligns with the National Strategic Plans (NSP) of both Jamaica and Trinidad and Tobago, currently in draft form. Jamaica's NSP takes a proactive approach to controlling the HIV epidemic through a multi-sectoral response with civil society organizations (CSO), and the private and public sector that together contribute to achieving the country's *Vision for Health* 2030 and the U.N. sustainable development goals. A major outcome from the ROP23 Planning Meeting is the GoJ articulation of continued leadership and ownership of the HIV response, with concrete objectives for an integrated, person-centered response to HIV care and treatment. In response, the ROP23 plan includes a concept model for direct service delivery of integrated care for PLHIV in the public sector, which is aimed at closing the gaps in the treatment cascade and accelerating progress to sustained HIV epidemic control.

In Trinidad and Tobago, our plan likewise supports the vision of the National AIDS Coordinating Committee (NACC) for "A future without new HIV infections, reduced AIDS related deaths and no stigma or discrimination associated with living with HIV" and the government of Trinidad and Tobago's Vision 2030 towards achieving the Millennium and Sustainable Development Goals (MDGs and SDGs).

PEPFAR CRP plans to drive transformative change in its HIV/AIDS programming through the implementation of PEPFAR's 5x3 strategy with support for health equity for key and priority populations; sustaining the response; strengthening public health systems and security; transformative partnerships with government, civil society, and the private sector; following the science and three strategic enablers; community leadership; innovation; and leading with data.

Executive Summary

The Strategic Direction Summary (SDS) describes in detail the priorities and activities that the Caribbean Regional Program will undertake in partnership with stakeholders and our implementing partners throughout ROP 23. PEPFAR CRP's programming aligns with the PEPFAR five-year strategy and host government's National Strategic Plans for HIV.

Section 1 of this SDS describes how the CRP will focus efforts to ensure equitable access to prevention, care, and treatment services for all, with a focus on priority populations including adolescents, men, migrants, and key populations (KP). We will expand access to PrEP and high-quality status neutral testing methods. We will also step up linkage and retention across age and sex bands with differentiated service delivery based on the needs of differing groups

and individuals. Our programmatic shift to direct service delivery in public sector sites will also allow us to provide targeted care to address equity gaps and improve treatment adherence and outcomes.

Sections 2 and 3 of the SDS covers support for sustainability efforts in the region with a focus on our partner governments' leadership of their HIV/AIDS responses. We will continue to provide financial and technical assistance to strengthen the ability of these national HIV responses to provide responsive patient-centered care. This includes our support to the public, private, and CSO sectors as part of the multi-sectoral response. Notably, we will undertake a new approach in ROP 23 to support the Government of Jamaica's integration plan with the implementation of a concept model for direct service delivery and integrated health care provision at several public sites. We will also continue support for laboratory, quality management, data and HRH system strengthening.

Section 4 of the SDS discusses the transformative partnerships critical to the successful execution of ROP23. These include the government, civil society, private sector, academic, U.S.-based, and multilateral entities that partner with PEPFAR to support integrated national plans.

Section 5 of the SDS addresses the CRP's strategies and plans for surveillance and applied epidemiology. This includes our support for enhancing electronic data systems, strengthening case-based surveillance, and implementing evidence- and science-based approaches.

The SDS also addresses the CRP's ROP23 support for community leadership via our support to CSOs and for community-led monitoring. It details innovative approaches to prevention, treatment, care, and data for decision making. It also discusses plans for additional efforts to address priority gaps in data usage and analysis.

In sum, PEPFAR's 5x3 strategy will support host countries to strengthen prevention efforts, close gaps in the treatment cascade, and optimize health systems to sustainably reach 95-95-95 and end the HIV pandemic by 2030.

Table A 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression

	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 (#)
JAMAICA										
Total population	2,734,092	1.3	30,489	27,185	14,558	54%	78%	N/A	N/A	N/A
Population <15 years	570,838	N/A	445	135	128	95%	25%	N/A	N/A	N/A
Men 15-24 years	245,911	N/A	1,402	544	313	58%	67%	N/A	N/A	N/A
Men 25+ years	816,206	N/A	13,367	12,716	6,159	48%	78%	N/A	N/A	N/A
Women 15-24 years	237,163	N/A	1,415	768	471	61%	66%	N/A	N/A	N/A

Women 25+ years	863,974	N/A	13,860	13,022	7,482	57%	80%	N/A	N/A	N/A
MSM (IBBS 2018)	42,400	29.8%	12, 534	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FSW (IBBS 2017)	18,700	2%	370	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TG (IBBS 2018)	3,800	51%	1,958	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TRINIDAD & TOBAGO										
Total population	1,365,805	1.0	11,084	N/A	7,217	65%	80%	N/A	N/A	N/A
Population <15 years	281,194	N/A	242	N/A	43	18%	40%	N/A	N/A	N/A
Men 15-24 years	110,164	N/A	187	N/A	146	78%	75%	N/A	N/A	N/A
Men 25+ years	431961	N/A	5,040	N/A	3,531	70%	80%	N/A	N/A	N/A
Women 15-24 years	108,505	N/A	275	N/A	115	42%	70%	N/A	N/A	N/A
Women 25+ years	433,981	N/A	5,340	N/A	3,382	63%	80%	N/A	N/A	N/A

Table 1: Regional 95-95-95 Cascade

Source: MOHW Jamaica 2022; MOHTT Trinidad 2022 N/A = Not Available

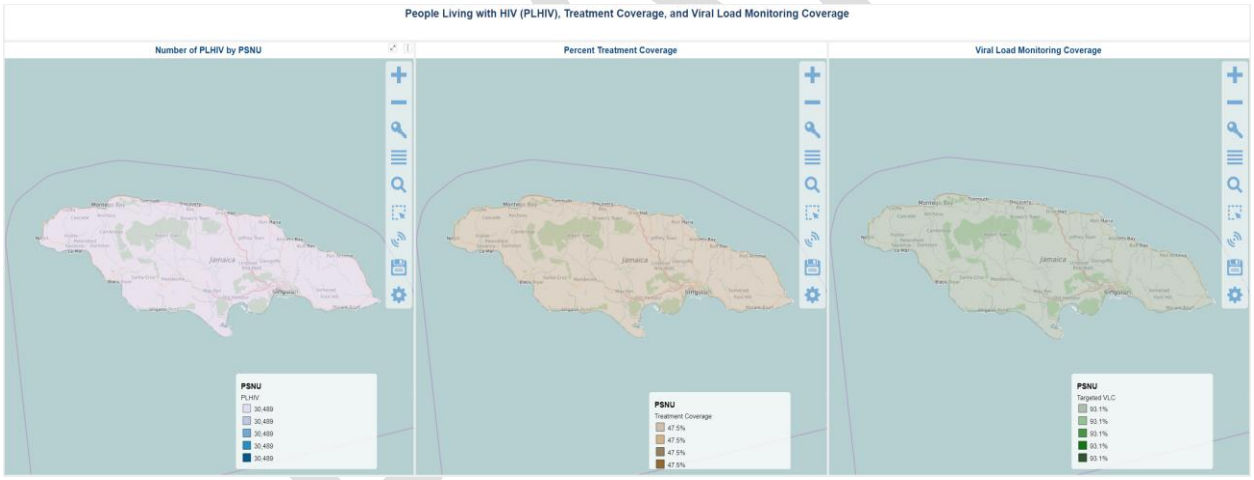

Figure 1: Jamaica PLHIV, Treatment and Viral Load Coverage Maps

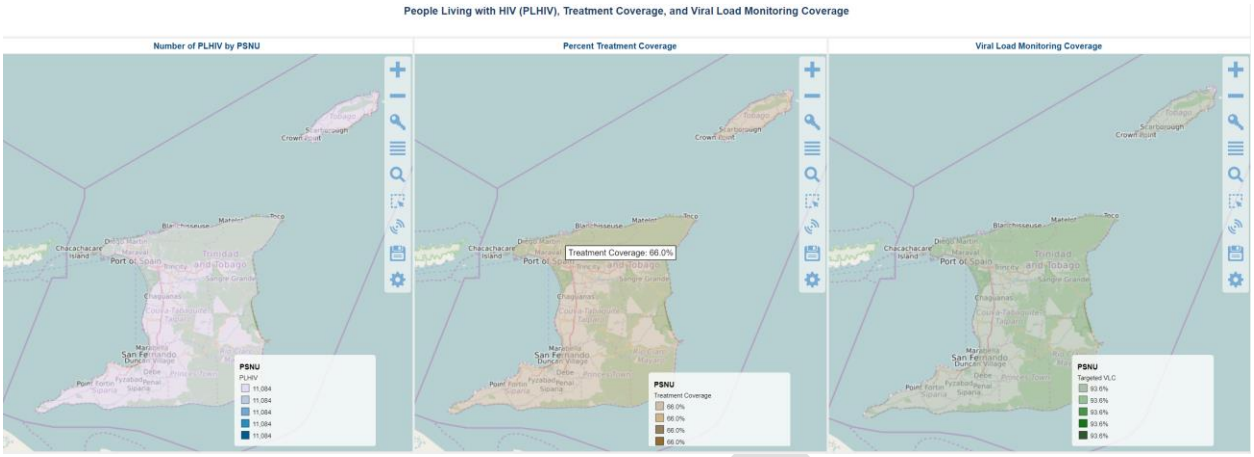

Figure 2: Trinidad & Tobago PLHIV, Treatment and Viral Load Coverage Maps

Table B: Current Status of ART Saturation – Trinidad & Tobago & Jamaica				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP23**	**# Current on ART (FY22)**	**# of SNU COP22 (FY23)**	**# of SNU COP23 (FY24)**
Scale-up: Saturation – Trinidad & Tobago	26.66%	6,303	1	1
Scale-up: Aggressive - Jamaica	73.34%	12,054	1	1
Total Sub-Region	**100%**	**18,357**	**2**	**2**

Table 2: Current Status of ART Saturation for Trinidad & Tobago and Jamaica

Source: Panorama, COP23 PAW

PILLAR 1: HEALTH EQUITY FOR PRIORITY POPULATIONS

To end HIV/AIDS as a public health threat by 2030 in the Caribbean region, during ROP 23, PEPFAR will work with host governments and national stakeholders to identify and address contributors to persistent gaps. These include those in HIV prevention, case finding, initiation and retention in treatment, viral load testing access and suppression; service gaps for key and priority-populations including adolescents, and men; and policy, procedural and legislative gaps concerning equity, stigma, and discrimination. In Trinidad and Tobago, PEPFAR will also support activities to increase quality service delivery for KPs and migrants seeking refuge from South American crises and conflicts, who face challenges in care and are further affected by language barriers.

Access to PrEP will be expanded via additional sites, capacity building and continued promotion through traditional and social media. Self-testing (HIVST) modalities in facility and community settings will also be scaled up to increase awareness of status and risk reduction. To accelerate case finding, PEPFAR will continue to focus on expanding high quality testing options for adolescents and KPs and employ use of safe and ethical index testing with fidelity, including index for unsuppressed PLHIV, and provider-initiated testing and counseling (PITC) will be optimized in

high-yield service delivery points such as inpatient and sexually transmitted infection (STI) clinics, and social network services (SNS) in KP networks. Recent infection surveillance data will be used to further characterize recent HIV infections and monitor priority populations.

Linkage and retention on ART require work across all age bands and sex. This requires interventions for youth & adolescents, working/middle-aged persons, and ageing PLHIV in Jamaica, noting that those ages 35-49 bear the highest burden of the epidemic. In Trinidad & Tobago, adolescents & adults ages 35-49 will be targeted, noting that those age groups bear the highest burden of the epidemic. Same day linkage to ARV treatment for PLHIV will be strengthened and sustained. The program will continue to work with its partners to provide person-centered differentiated services, including multi-month dispensing (MMD) to maintain PLHIV in care and to provide support for timely and quality VL services for all populations.

A programmatic shift to add direct service delivery (DSD) to the current TA approach aims to give PEPFAR-supported sites reinforcement in:

- Implementing entry and return to care surges
- Offering extended hours and reducing wait times
- Providing courtesy, compassionate, and confidential client-centered care
- Directly providing quality HIV prevention, care and treatment services
- Strengthening government systems to sustainably provide services.

This DSD transition will also serve as a model for adoption by non-PEPFAR supported sites as part of the host governments' plans for fully integrated health care models. Furthermore, ROP23 entry to care (ETC) and return to care (RTC) surges aim to improve linkage and retention on ART and increase the number of PLHIV on treatment in both countries.

Below is a summary of gaps, strategies, and programmatic shifts by UNAIDS pillars as plans for CRP's ROP 23.

1.1. Prevention

Preventing new infections among the populations most likely to transmit or acquire HIV is critical as the countries move toward epidemic control. In ROP23, PEPFAR will have an increased focus on prevention including status neutral testing modalities to link positive individuals to treatment, and negative individuals to prevention (see diagram 1.a.). For the populations that remain virally unsuppressed, providers will reinforce U=U messaging, step-up adherence counseling, and assure clients are on optimal treatment regimen. The epidemiologic data also points to the populations with highest estimated incidence or highest numbers of new infections. Adolescent girls and young women aged 15-24 account for the highest number of new infections in Jamaica. Men ages 20-29 are second highest. To promote equity, the CRP prevention strategy will advance PrEP and expand prevention interventions beyond KP programming to also include priority populations that are at highest risk including AGYW, and more broadly adolescent and young adults. The dynamics of sexual networks and relationships, including generational mixing,

socio-economic disparities, and disparate approaches for engaging new sexual partners, are relevant for the prevention strategies. In ROP 23, prevention strategies and interventions will be tailored for each subgroup in the key and priority populations and uncovering the contributing factors to the epidemic.

Key Populations

Jamaica- – MSM

In Jamaica, high HIV prevalence among MSM (29%) coupled with inconsistent condom use, high risk sexual behaviors, and multiple concurrent partnerships impact transmission dynamics for both male and female partners of MSM. MSM are highly stigmatized and ROP 23 programming will support equitable access to services and interventions tailored to each MSM sub-population.

The 2017 IBBS (most recent available data) showed that 26% of newly diagnosed males did not state their sexual practices and 53% of men in the study identified as heterosexual or bisexual. This suggests a need for careful and nuanced communication strategies aimed at men, assuming some of them will have sex with both men and women, regardless of their disclosure or expressed sexual identity. In addition, 76% of men in the study reported meeting sexual partners online through social media sites (e.g., Facebook, Grinder, and Jamaica's Vibesconnect). This indicates that the internet is an important medium for engagement with MSM. Key populations will continue to be reached by peer outreach workers through a mix of interpersonal and virtual outreach programs with stigma free and KP friendly services implemented under an explicit set of principles that protect human rights and dignity, and in spaces that are stigma free and KP friendly. The interventions will be specifically designed to target MSM especially young MSM, bisexual men, and MSM who do not self-identify as "gay," and those who were not being served by other traditional outreach activities. We will expand the high-impact online outreach to the most trafficked websites and refer those reached for appropriate testing services. Status neutral testing strategies for MSM will cater to males of different age groups in urban and rural areas. CSOs will also further refine the strategy of hotspot mapping in the targeted parishes to ascertain the hang out spots of both key and priority populations. Peers will support status neutral testing approaches, linking those who test positive to treatment and those who test negative to prevention interventions including bio-medical prevention services.

Priority Populations

Jamaica Females and Males 18-29

The Jamaica National Prevention Strategy describes early sexual debut, low risk perception, low self-efficacy, low SRH knowledge, low condom use, low negotiation skill, low HIV/AIDS health literacy, multiple and concurrent partnerships, high levels of recreational drug-use and sexual experimentation, and peer pressure, as some reasons for increase in risk and incidence among females and males ages 18-29. The most recent Knowledge Attitude Behavior Practice (KABP) showed a 2% increase in multi-partners with significant increase among the 15–24-year-olds, a

7-10% decrease in knowledge of HIV and its transmission modes among females and males surveyed and a decrease in knowledge of condom use (as protective) by 4-5% among respondents.

Further, a recent study (Bourne et al. 2023), considered post-COVID sexual behaviors of Jamaican females ages 18+ years. The study, "Social Media and Transactional Sex among Jamaican Females Ages 18+ years: post-COVID-19", showed that nearly 33% of respondents reported engaging in transactional sex. The study suggests an increase in transactional sex due to economic disparities highlighting the socioeconomic vulnerabilities of Jamaican women.

In ROP23, PEPFAR will scale up and expand the CSO community outreach efforts by providing evidence-based prevention interventions and services tailored to priority population at risk females and males (18-29) to ensure equitable access and gender equity. Acknowledging that the target population for prevention programming spans age cohorts of teens, young adults and part of the productivity sector, the CSOs will develop a comprehensive package of prevention interventions and services which will be age, culture and contextually appropriate to the age/sex cohorts in both urban and rural areas and mapped to the targeted parishes and hang out spots of the targeted priority populations. Further, prevention efforts will create impact online through outreach on the most trafficked websites of the targeted population. CSOs will also expand PrEP education and strengthen the clinical package of HIV prevention services for the priority populations at high risk of contracting HIV.

In the public sector through the National Family Planning Board (NFPB) PEPFAR will focus on AGYW and plans to support campaigns to improve knowledge and awareness among adolescents and young adults will be increased in partnership with the MOHW, and with pilot programming in a region with a higher prevalence of HIV. As engagement with this cohort is carried out, needs for age-appropriate gender-based violence (GBV) services will be identified, and clients referred appropriately.

PEPFAR will support NFPB to build the capacity of the mentors within this program in the areas of LIVES and LOVES to ensure a more GBV and trauma informed approach is being provided. The host government will also receive support from PEPFAR to implement and monitor effective prevention strategies for adolescent girls and young women. Trainer of trainer models will be utilized for LIVES and LOVES with further step-down trainings to ensure this improved standard for prevention services will permeate throughout all parishes in the island and provide sustainability in this area for the national program. While this will improve the capacity, it is essential that this program when implemented is also monitored and evaluated to ensure consistent high-quality services are implemented with fidelity in a consistent and person-centered manner.

Finally, across public, private and CSO sectors, the health equity fund will support utilization of digital space to reach females 15-24 especially and other priority and key populations who prefer to access their information virtually. Utilizing this strategy will increase access to prevention information, access to self-testing, and linkages to PrEP and other HIV services across the island.

Trinidad and Tobago –AGYW and Migrants

Adolescent girls and young women, particularly those from lower socioeconomic backgrounds, often experience inadequate schooling due to poverty, gender-based violence and other discriminatory cultural inequities. These all contribute to their vulnerability to HIV and a life not lived to their full potential. Appropriate prevention and safeguarding of this population are critical as they enter young adulthood, they are statistically part of the productive (working) sector of the population. There is need to offer a safe space for these at-risk women and girls to access HIV prevention services. To truly address some of the existing structural inequalities that impact their vulnerability to HIV, PEPFAR will continue to play an active part of the multisectoral approach to collaboration with community, faith-based, and non-governmental organizations.

Since 2020 16,523 Venezuelan nationals have registered in Trinidad and Tobago with 13,500 participating in the 2021 re-registration process. In addition to those documented, it is estimated that there are approximately 40,000 unregistered Venezuelan migrants living currently in TT. The Ministry of Health of Trinidad and Tobago, to ensure the right to health to the growing migrant population, has published the Policy for Treating with Non-Nationals (2019) with respect to the Provision of Public Health Care Services. This policy affords non-nationals access to HIV prevention, care, and treatment services at no cost. However, while this policy was enacted, many persons within migrant communities are unaware of this opportunity and do not readily engage with traditionally accessed services. Additionally, UNHCR highlights that these migrants are disproportionally vulnerable and marginalized. With limited human rights protections they experience various structural, sexual, sociocultural, educational, and even racial discriminations compounded by their status as migrants, asylum seekers, refugees, or internally displaced persons. As a result, migrant populations have a greater risk for poorer health in general with increased risk of engaging in transactional sexual behavior thereby increasing their risk for HIV. This risk is perpetuated by limited access to HIV prevention and treatment services, whether by choice, lack of awareness, or other structural barriers including language. PEPFAR CRP ROP 23 Health Equity LIFT project intends to strengthen communications (e.g., address language barrier), service delivery, and provide an environment for migrant AGYW to access existing HIV services in country. The project will aid the Ministry of Health in expanding the delivery of innovative and culturally sensitive health services with appropriate communication media. To better access this critically underserved population, the non-governmental organizations (NGOs) network would also be leveraged to encourage Venezuelan migrant including the AGYW's participation in acute HIV prevention, care, and treatment services, while also expanding partnerships and building the capacity at the Ministry of Health and other local NGOs.

Table 1.1: Summary of Gaps, Strategies, and Programmatic Shifts for Key and Priority Populations - Jamaica and Trinidad and Tobago
Jamaica

Priority Population	Gap	Strategic Direction	Programmatic Shift
Adolescents & Youth **(18-24)**	Highest HIV incidence nationally with few targeted interventions. Decline in knowledge, attitude, beliefs and practices around HIV.	Advancing gender equitable programming Improve knowledge, address stigma, and increase testing in region with high HIV prevalence	Through CSOs targeting priority population youth males and females 18-29. Health Equity proposal to pivot prevention through a health app for access to HIV/STI information with link to services
Key Populations (MSM)	Second highest HIV prevalence nationally, with inadequate services in the public sector	Comprehensive package of KP(MSM) prevention services including biomedical prevention (PrEP)	Scale up PrEP direct service delivery for KPs at PEPFAR supported public sites
Productivity Sector **(25-49)**	Second highest HIV incidence nationally with few targeted interventions. Low risk perception	Precision prevention targeting this sector	Scale up ITC, social media and traditional media as applicable. Support PrEP demand creation in STI high risk clinics, Scale up of ITC; with condom promotion.
Trinidad and Tobago			
Priority Population	**Gap**	**Strategic Direction**	**Programmatic Shift**
Migrant Populations (AGYW)	Low uptake of prevention services as they are a marginalized population	HIV Prevention Communication Strategy EEHR strategy for S&D	Increase knowledge & awareness in duty bearers Support policy and Advocacy with GoTT collaborate with FBOs & CSOs for HIV/SRH conveyance

Table 3: Summary of Gaps, Strategies, and Programmatic Shifts for Key and Priority Populations

1.2 Status Neutral Testing and Case Finding

Jamaica

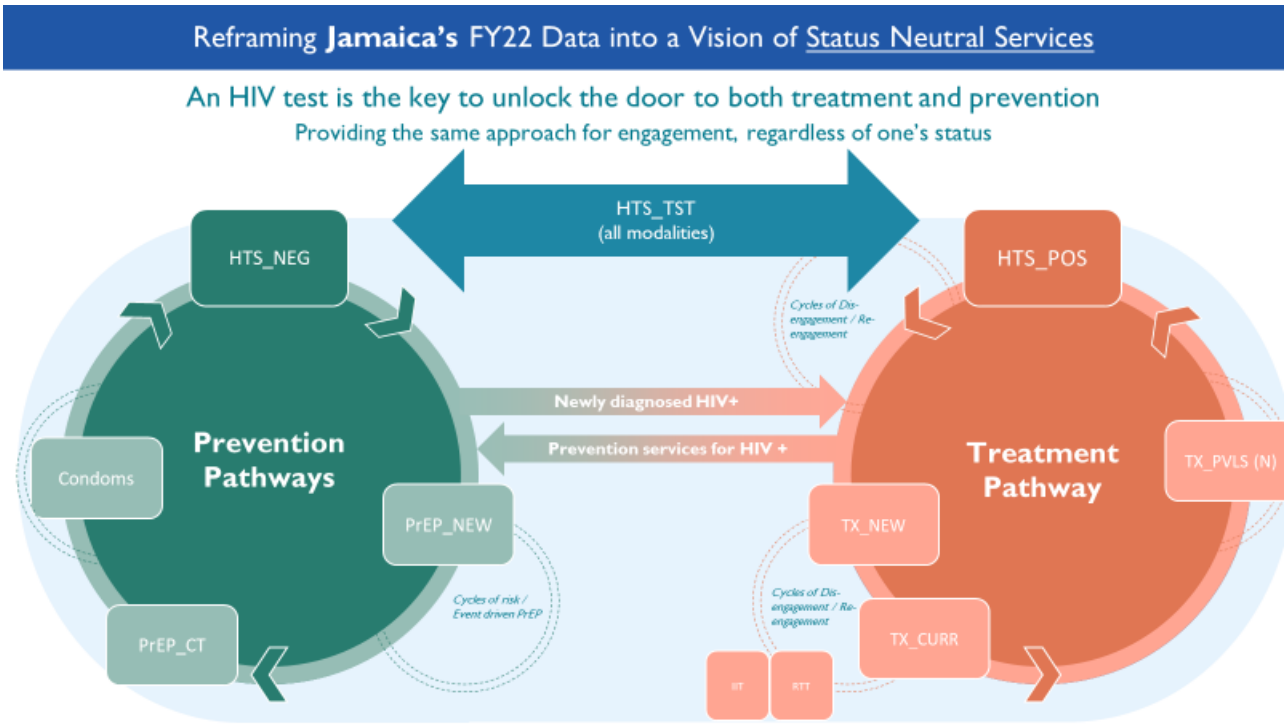

Figure 3: Reframing Jamaica's FY22 Data into a Vision of Status Neutral Services

In Jamaica, PEPFAR will expand the status neutral testing strategies ensuring linkage to treatment for persons diagnosed with HIV and connecting persons who test negative to combination comprehensive prevention services. Self-testing will be used in CSO, and public and private sectors 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 especially for individuals under 30 who opt not to go to a health facility and those who may not return after a first encounter.

An optimal mix of testing strategies will be employed that include proven approaches and best practices. In the CSO setting, these include testing of social and sexual networks of people diagnosed with HIV infection and will optimize a strategic mix of facility-based index testing and partner notification, targeted community mobile testing, and self-testing. These interventions will include referral services and counseling through peer supporters and adolescent-friendly community support networks for young men. Through support to the public sector National Family Planning Board, PEPFAR will support SNS strategies to reach MSM for testing. In the public and private sectors, index testing will be the primary case-finding modality. In ROP 23 a particular focus on fidelity in index testing is expected to improve results including testing of contacts of PLHIV who are not suppressed. In addition, in the public sector, provider-initiated testing and counseling (PITC) will be optimized in high-yield service delivery points such as inpatient and sexually transmitted infection (STI) clinics.

CSO case-finding initiatives will continue to adapt face-to-face outreach to online and social media. These interventions are 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. High-impact online outreach intervention to reach high-risk MSM through the most trafficked websites and refer them for appropriate testing services will also continue. CSOs will continue to make effective use of ICT platforms in their case finding efforts, with modifications to enhance linkage & retention as well. Social media networking can reach men of all ages, with access to internet in Jamaica estimated at 82% and mobile phone usage rates consistently rising, with subscriptions exceeding the country's 2.9 million population.

Trinidad and Tobago

PEPFAR's support for ROP 23 will be continued engagement through current testing modalities including HIV index testing and HIV self-testing. We will also support the Ministry of Health of (MOH) Trinidad and Tobago as they engage in mobile testing opportunities for outreach and to increase access to those who are unable to attend public health services for testing. The MOH has also been engaging in Opt-out testing at Regional Health Authorities (RHAs) nationwide. Provider-initiated HIV testing and counseling (PITC) is a PEPFAR supported activity as it refers to HIV testing and counseling which is routinely recommended by health care providers to persons attending health care facilities as a standard component of medical care. We will therefore provide optimal technical assistance and support for the country in this capacity as well.

Supporting our gap areas specifically our adolescents is critical in ensuring access to prevention services for them is a priority. This will include access to HIV self-test kits, index testing and HIV testing through STI clinics on special days will be supported and targeted for this population. Overall, PEPFAR aims to support rapid linkage to care and treatment services or engagement in prevention programming and empowerment as assessed.

Table 1.2: Case Finding and Testing
Summary of Gaps, Strategies, and Programmatic Shifts for Key and Priority Populations - Jamaica and Trinidad and Tobago

Jamaica			
Priority Population	**Gap**	**Strategic Direction**	**Programmatic Shift**
Key Populations (MSM)	Targeted case finding inadequate in the public sector	Continued SNS in the public sector for MSM. Continued Mobile Testing for KPs Continued Index Testing	Index Testing with fidelity

Productivity Sector **(25-49)**	Second highest gap in diagnosis nationally	Continued Mobile Testing for KPs Continued Index Testing	Index Testing with fidelity
Men	More males need to be diagnosed across all age bands	SNS Continued Mobile Testing for hidden KPs. Continued Index Testing	
Adolescents and Youth **(18-24)**	Highest incidence of new HIV diagnoses among AGYW, and higher incidence among younger people	Outreach events and Mobile Testing SNS Continued Index Testing	
Trinidad and Tobago			
Priority Population	**Gap**	**Strategic Direction**	**Programmatic Shift**
Men	Rate of new infections greater among men, males have highest risk behavior	SNS Index testing Mobile Testing	Re-engage SNS-mobile facilities. Initiate mobile testing
Productivity Sector (25-49)	High rates of new infections compared to other age bands	SNS Index testing Mobile Testing	

Table 4: Case Finding and Testing Summary of Gaps, Strategies, and Programmatic Shifts for Key and Priority Populations

1.3. Retention

Table 1.3: Retention Summary of Gaps, Strategies, and Programmatic Shifts for Key and Priority Populations - Jamaica and Trinidad and Tobago				
Jamaica				
Priority Populations	**Gap**	**Strategic Direction**	**Program Shifts**	**PEPFAR Resource Alignment with National HIV Response**
Adolescents and Youth **(18-24)**	Poor linkage to care and IIT in transition from pediatric to adult clinics	Increase HCW Capacity to provide quality care for adolescent PLHIV. Maintain and improve Rapid ART initiation, Person Centered Care, Equitable Health Services for vulnerable groups, Differentiated Service Delivery and Community Leadership Increase number of persons entered and returned to care	Increase number of DSD sites to increase control of service delivery, impact of existing intervention and targeting of interventions to demographic and functional cohorts. This includes expansion of transition clinics for Adolescents, and expansion of Differentiated service delivery (extended hours, digital health intervention, virtual consultations, medication delivery) for working people. Entry to care and return to care campaigns and enhancement of return and recovery protocol	A DSD increase facilitates PEPFAR-led proof of concepts and optimization of care to lay the foundation for the national response, focused on Primary Health Care Reform and integration of HIV services into comprehensive curative consultations. This emphasizes whole of system strengthening and leveraging of resources for efficiency across age, sex and functional cohorts
Productivity Sector **(25-49)**	Never linked 7800 and IIT at 5,599 accentuated by cycling out of care			These PEPFAR-supported campaigns accelerate and accentuate the ongoing national activities (Return and recovery).
Ageing **(50+)**	Retention messaging have been short, inconsistent, and non-targeted	Reinforce U=U strategy Increase HCW Capacity to provide quality care for older PLHIV	Purposeful, consistent communication for all age bands (especially ageing PLHIV) to start and maintain treatment.	U=U=U (Undetectable =Untransmittable=You) is the local approach to the U=U campaign and emphasizes individual responsibility.
Trinidad and Tobago				

Priority Populations	Gap	Strategic Direction	Program Shifts	PEPFAR Resource Alignment with National HIV Response
Adolescents and Youth **(18-24)**	Need for improved initiation and retention on ART	Adolescent Transition, retention and viral suppression needs. Telehealth Services	Entry to Care / Return to Care Surge	These PEPFAR-supported activities accelerate and accentuate the ongoing national activities (Return and recovery).
Productivity Sector **(25-49)**	Need for improved initiation and retention on ART	Increase entry to care for ART naïve patients. Improve retention in care. Increase Differentiated Service Delivery utilization	Improve Linkage to and Retention in care (upscaling psychosocial services) Psychosocial care	

Table 5: Retention Summary of Gaps, Strategies, and Programmatic Shifts for Key and Priority Popualtions

1.4 Suppression

Table 1.4: Suppression **Summary of Gaps, Strategies, and Programmatic Shifts for Key and Priority Populations - Jamaica and Trinidad and Tobago**				
Jamaica				
Priority Populations	**Gap**	**Strategic Direction**	**Program Shifts**	**PEPFAR Resource Alignment with National HIV response**
Adolescents and Youth **(18-24)**	Incidence of significant drug resistance in Treatment-experienced adolescents.	Ensure optimal, patient-centered peer support system to the unsuppressed (Focus on fidelity/ comprehensive coverage)	HIV Drug Resistance testing	Lab strengthening
Productivity Sector **(25-49)**	Presentation for sampling affected by PLHIV social priorities	Increase VL testing coverage and improve reliability and timeliness of results.	Optimize decentralization of VL network Improve LIS-Clinical interface to	Electronic lab interface strengthening

		Increase Differentiated Service Delivery utilization	enhance workflow and productivity	

Table 6: Suppression Summary of Gaps, Strategies, and Programmatic Shifts for Key and Priority Popualtions

1.5 Addressing Stigma & Discrimination (S&D), Human Rights, and Structural Barriers

Jamaica

PEPFAR's support in ROP 23 will continue to build and sustain partnerships with UNAIDS and Jamaica. During ROP 22, the CRP began financial collaboration with UNAIDS to address issues of stigma and discrimination and will continue to expand on this across the region. PEPFAR will support ongoing capacity building within the civil society organizations and strengthening capacity of youth led CSOs in areas of advocacy and strategic political engagements. In addition, PEPFAR will support addressing the legislative barriers for PLHIV as well as fostering an environment within the private sector to improve safe workspaces and services for all people including those from key populations or living with HIV.

Trinidad and Tobago

PEPFAR's support in ROP 23 aims to build a partnership with UNAIDS and the MOH in Trinidad and Tobago to address S&D barriers on various levels. This includes a deeper level sensitization for decision makers of the impacts of S&D and conceptualization of all-inclusive policies for LGBTQIA affected and impacted communities by the discriminatory legislation currently in place. This is work that will be continued based on the foundation set from ROP22 that commenced a health care worker sensitization training of trainers in Gender Diversity and Sexuality and Inclusion for front line staff as well as a similar appreciation for our policymakers and duty bearers at the government level. In addition to UNAIDS support, PEPFAR will also provide support through the National AIDS Coordinating Committee (NACC) for capacity building within the non-governmental organizations (NGOs) in areas of advocacy and strategic political engagements including provision of ample technical assistance in the revision and updates to national HIV workplace policies, national strategic plans and support the sharing of best practices from neighboring countries.

PILLAR 2: SUSTAINING THE RESPONSE

Sustainability of efforts are integral to program planning in the region. Host governments lead the response in all countries of the region and provide most of the funding for the HIV response. The governments of the Jamaica and Trinidad and Tobago are responsible for sustainability frameworks which are integrated into their respective National Strategic Plans (NSPs). Stakeholders provide comment and input into the NSPs and coordination of planned implementation is led by each country's HIV coordinating entity. In both Jamaica and Trinidad and Tobago, PEPFAR supports building the capacity of local civil society organizations as well as local government institutions through government-to-government mechanisms. This support will be discussed further under Pillar 4: Transformative Partnerships.

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 donor funding dwindles in a contracting economic environment, the challenge of averting a reversal of the gains is central to all planning processes. Challenges of stigma and discrimination, retention in care and adherence are among the notable barriers to in ending the AIDS Epidemic in Jamaica.

The Ministry of Health and Wellness has been mandated by the Government of Jamaica to coordinate and lead the implementation of the national HIV response, which has taken a comprehensive, multi-sectoral approach. The National HIV/STI Control program was established in the Ministry of Health and a National AIDS Committee (NAC) was formed to ensure the active participation of all sectors and stakeholders. Representation on the NAC included Government Ministries and Agencies, CSOs, professional associations, trade unions, faith-based organizations, PLHIV, and the private sector. Currently, the NAC is not functional in this role, however there are plans to reestablish the NAC as part of the new National Strategic Plan (NSP). In the absence of the NAC, the Country Coordinating Mechanism (CCM) has assumed a

coordinating role for grantees under the Global Fund, including the MOHW, regional health authorities (RHA), and CSOs. Multi-lateral donors including PEPFAR, PAHO, and UNAIDS, participate in the CCM to coordinate with GF and host government activities.

Currently the Government is working to finalize the NSP for 2023-2030, developed in consultation with stakeholders and partners, including PEPFAR. The overarching priority is to prevent HIV transmission, minimize HIV-related morbidity and mortality, and promote health through an effective multi-sectoral approach. The NSP compliments the Vision for Health 2030, a 10-year Strategic Plan developed in response to a comprehensive situational analysis, whereby gaps of the health system were identified and recommendations proposed. To attract patients towards utilizing primary care, the plan has identified the need to restructure the categories of public sector health centers and reduce them from 5 to 3 categories/types: Community, District and Comprehensive. This ensures that health centers provide services that are in demand by patients presently, including HIV and STI services, and possess the staff, equipment, and adequate infrastructure to provide quality care. Currently services for PLHIV are fragmented, resulting in multiple health center visits to access HIV services, other disease management services, pharmacy, and laboratory services.

Trinidad and Tobago 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 after the COVID-19 pandemic. The National AIDS Coordinating Committee (NACC) based in the Office of the Prime Minister leads and coordinates Trinidad and Tobago's multisectoral response. The NACC coordinates the activities of 17 government entities, civil society, and the private sector providing technical support and legal and research guidance. The NACC is charged with ensuring synchronized operations, deconflicted coordination, and M&E on behalf of the broader response. The NACC also functions to mobilize NGOs and increase empowerment and coordination of PLHIV.

2.1. Donor Financing

The government of Jamaica contributes approximately 51% to its HIV response. PEPFAR and the GF contribute 36% and 13%, respectively. Jamaica is currently in the second year of implementation of its three-year GF grant. As an Upper Middle-Income country, Jamaica's GF programming is targeted for KPs including MSM, TG, and FSW. The Jamaica grant supports HIV testing, prevention, care and treatment support, differentiated HIV testing services, EEHR, community systems strengthening, and health management information systems and M&E.

PEPFAR is the main donor to Trinidad and Tobago's HIV response. As a High-Income Country, Trinidad and Tobago is ineligible for GF grant. Domestic government resources in Trinidad and Tobago account for approximately 80% of the HIV response.

Both Jamaica and Trinidad and Tobago are beneficiary countries of the GF Multi-Country HIV Grant to CARICOM. The CARICOM grant supports the region to consolidate the sustainability of prevention, treatment, and care services for KPs.

2.2. Integration

In ROP 23, PEPFAR will shift its support to the public sector through the addition of direct service delivery sites.

To close the clinical cascade gaps and accelerate progress to attain the 95-95-95 targets and sustained HIV epidemic control, PEPFAR proposes to transition some public sites from Technical Assistance (TA) to a hybrid model of Direct Service Delivery (DSD). This strategic shift will also support the Government of Jamaica's Vision for Health 2030, with a focus on integration of services and primary health care reform. GOJ will remain the primary provider of services, including core staffing and maintaining the ARV procurement process, while PEPFAR support will augment service delivery and leverage HIV program infrastructure to provide comprehensive and quality health services through a one-stop-shop approach. It is anticipated that each client will experience a more efficient flow of services including full disease management during one visit. Through this integrated approach, additional support services will be introduced along with the use of digital platforms where possible, to increase client-caregiver interactions. The integrated client-centered care approach will address comorbidities posing a public health threat for PLHIV, including TB, Hypertension, opportunistic infections, and mental health services.

PILLAR 3: PUBLIC HEALTH SYSTEMS AND SECURITY

The overall goal of the PEPFAR Caribbean Regional Program (CRP) is to support the governments of Jamaica and Trinidad and Tobago to achieve HIV epidemic control. Over the past 10 years, PEPFAR's financial and technical assistance has been utilized to strengthen the national HIV/AIDS responses based on international best practices and policies, while reinforcing sustainability and country ownership. The CRP will continue to provide technical assistance, training opportunities, and targeted support to mitigate the gaps and improve patient centered care. During ROP 23, priority will be given to systems improvements through adaptation of local best practices and revision of procedures that govern prevention, care, treatment service delivery, laboratory services and data management, to address ongoing systems-level gaps which restrict public health effectiveness.

3.1. PEPFAR Systems Strengthening

Key systems gaps identified by CRP include, low treatment coverage, low retention in HIV treatment services; insufficient personnel and inconsistent adherence to SOPs that hamper the timeliness and quality of HIV data; the high cost of reagents, consumables, and supplies; insufficient adoption and implementation of international best practices; and fragmented information systems that prevent timely reporting and strategic use of data for decision making.

The CRP has designed a program to address these systemic issues, complement site level interventions and support progress toward epidemic control. Benchmarks have been defined to measure progress, all of which align with the best practices to achieve national targets. For

example, at the systems level the benchmarks of success for elimination of operational and systemic care and treatment barriers include updating treatment guidelines to include further expansion of MMD, design of differentiated service delivery centers, accelerate TLD transition rate and retention strategies. For strategic information, benchmarks include linkage of fragmented data systems through support for the establishment of a case-based surveillance platform, completion of Data quality assessments (DQA), availability of site level dashboards and timely HIV surveillance reports. For Laboratory strengthening, benchmarks include laboratory accreditation and quantitative targets for scaling up viral load testing.

Full implementation of activities to link data systems enhancing interoperability and development of an integrated repository will provide the ability to utilize surveillance data to inform programs about the number of new diagnoses, PLHIV linked and initiated on ART, and current PLHIV on treatment, retained and virally suppressed. Real-time surveillance data will also inform cascade analyses and identify groups who are most in need of initiation and retention interventions based on analyses of surveillance data by finely disaggregated sex and age bands. Personnel will be supported at various levels within Jamaica Ministry of Health and Wellness and Trinidad and Tobago Ministry of Health to ensure surveillance data can be utilized to inform national activities, including those at PEPFAR-supported facilities. This integration of national level data to inform site level service delivery interventions will fill gaps in treatment services across the cascade. All these activities serve to monitor the impact of proposed Above site investments and address the key system gaps identified.

3.2. Laboratory Systems Strengthening

Several systems barriers existed which prevented effective laboratory workflow and efficient monitoring of patient status in the past few years. These include –

1. Frequent Equipment Down Time: Equipment typically experienced unplanned downtime more than once per year. In Jamaica there was no back up system; therefore, all sites/patients were unable to access VL testing from the centralized system during these periods. Interventions aim to eliminate unplanned equipment downtime during the year.
2. Variable Turnaround Time (TAT) for VL Results: TAT averaged between five days and one month. Initiatives are needed to reduce and standardize TAT across the country. Interventions will reduce TAT by 75% to less than seven days.
3. High Cost of Reagents: The high cost of all molecular tests, especially CD4, VL, and DR, inhibited rapid scale up. Interventions will lower the cost of reagents by 25%.
4. Limited Human Resource Capacity: The molecular labs are short-staffed, which affected rapid scale up. Interventions will increase productivity by 50%.

In Jamaica, laboratory systems strengthening activities are designed to address the most important cross-cutting issues and effectively support the care and treatment program. Currently there are over 40 HIV testing sites in Jamaica (both Government and NGO) offering services using the national serial rapid test algorithm. The PEPFAR HIV rapid test continuous quality improvement initiative (RTCQII) currently covers 22 sites and aims to reduce error rates below

5%. The National Public Health Laboratory (NPHL) will continue using the ePT database to manage in country External Quality Assessment (EQA), which also supports quality assurance (QA) for the Self testing and index-testing programs. Monitoring of HIV VL remains a key measure for PLHIV on treatment, to determine the response to medication and indicate virologic failure. The NPHL serves as the reference laboratory and provides, among other services, HIV confirmatory testing, CD4, VL and HIV drug resistance testing for the country. Annually the laboratory performs approximately 25,000 VL tests and around 1,500 EID samples, sent from over 30 sites. PEPFAR is currently supporting decentralization of the testing by providing a second machine to increase country capacity, eliminate backlogs, lessen downtime, and reduce TAT. The annual number of tests is projected to increase by 15-20% within the next year, as more patients are initiated on treatment and cohorts steadily increasing thereafter. The NPHL with PEPFAR support currently has the capacity to perform HIV drug resistance (HIVDR) testing in-country as a routine test. As a result, the MOHW convened a Drug Resistance advisory board, comprising of clinicians and the NPHL to review patient cases and manage demand creation for routine HIV DR tests. The database of results from the testing will inform the national treatment guidelines and be used to assist in the successful transition to TLD, with patients currently failing treatment being switched to the new regimen immediately. With these interventions, the risk of patients failing treatment due to drug resistance will steadily decrease.

In Trinidad, PEPFAR will support the country to scale up access to VL testing, monitor HIV drug resistance, and provide continuous quality improvement in laboratories providing critical diagnostics support throughout the continuum of care. A package of activities is proposed to improve laboratory quality and assurance, including the rapid test continuous quality improvement initiative (RTCQII), VL network strengthening, quality management system (QMS) activities, HIVDR testing by referral, introduction of CD4 rapid test kits for Advanced HIV Disease (AHD) screening, expansion of STI testing, including Syphilis rapid testing and HIV recency testing. These activities will address the high cost of reagents, preventing the rapid scale up of testing and improve access to services. The benchmarks for these activities are an increase in the number of patients receiving HIVDR testing, at least 95% of ART patients receiving one VL test per year, and at least two laboratories attaining Tier 3 of the Stepwise Improvement process.

In Jamaica and Trinidad, support will be provided to source essential HIV commodities at a lower cost, to enable the country to obtain substantial cost savings while ensuring quality and continuous supply. Furthermore, the cost savings and access available through the pooled procurement mechanisms will enable the Ministry to apply savings to their other interventions.

3.3. Quality Management Approach

Strengthening of the continuous quality improvement (CQI) strategy will help to respond rapidly and effectively to changing needs that result from bringing a substantial number of PLHIV back to care and maintaining them on ART. Based on the analysis of site level data, CQI activities will identify HIV service provision gaps and health system weaknesses. The healthcare team, in collaboration with patients, will quickly devise plans to overcome these barriers. Ongoing

mentorship with facility staff will be important for capacity building and transfer of knowledge and skills. To accelerate quality improvement the following is proposed -

- Fast track the development and implementation of a National QI plan, Regional QI plans, and sites QI plans.
- Strengthen the monitoring and evaluation of facility, regional and national performance on 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 progress of quality improvement processes and outcomes that demonstrate impact.
- Intensify collaboration with MOHW, Regional Health Authorities 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 for QI efforts of treatment site staff 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.
- Integrate Quality improvement practices and monitoring of quality indicators at all regional hospital laboratories and blood collection sites, coupled with ongoing capacity building to ensure harmonization of practices.
- Intensify mentorship activities throughout the national laboratory network and ensure consistent participation in internal and external quality assurance programs.

3.4. 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. Additional training will occur through the Learning Management system (LMS), first started in Jamaica, which will continue to be maintained and expanded into a similar platform for Trinidad. There will be continued investment in strengthening the capacity of the in-service training unit at Jamaica MOHW.

In Trinidad and Tobago, investments in HRH will expand and operationalize the use of the LMS to institutionalize in-service training at the national level. In-service training for HCWs will cover: the clinical management of HIV, mental health and psychosocial service delivery, sensitized care for KPs, and PLHIV treatment literacy. Finally, there will be support for the development and implementation of a national Psychosocial Coordination unit to oversee and strengthen HIV service delivery.

Ongoing interventions to be scaled: The following interventions have been implemented with positive outcomes and will be expanded in the FY for maximum impact on program effectiveness:

a) Strengthening the functionality of the Jamaica MOHW Treatment database (TSIS 2.0) to include appointment reminders and close tracking of missed appointments.

b) Support for increased Viral Load coverage for eligible PLHIV by providing both TA and Site level improvements to maximize Laboratory capacity and improve the electronic Laboratory Information system to reduce turnaround time for results.
c) Continue monitoring gaps and implementing corrective actions for the Laboratory diagnostic platforms to ensure high quality testing services for all patients.
d) Strengthening Human resource capacity through the recruitment and training of staff at both the national and regional levels, to enable scale up of testing, as well as the provision of high-quality treatment services.
e) Improving the accuracy and reliability of HIV/AIDS data, to 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.
f) The implementation of active case-based surveillance in Jamaica by strengthening data management and reporting systems (digitization of paper forms), and strengthening human resource capacity to facilitate the routine quality improvement and use of strategic information.
g) Linking laboratory, pharmacy and treatment data, and matching death data to improve the accuracy of the first 95 estimates, expanding data quality improvement activities to verify completeness and concordance of data and establishing routine site-level data reviews. These activities will ensure that treatment cascades are correctly updated, and the most accurate and highest quality data are available for analysis and use by supported countries.

3.5. Global Health Security Agenda

Following establishment of the Global Health Security Agenda (GHSA) in 2014, the Caribbean Community (CARICOM) – an organization of 15 Caribbean nations and dependencies called for the establishment of a Regional Coordination Mechanism on Ebola, which evolved into the Regional Coordinating Mechanism for Health Security (RCMHS) to drive regional multi-sectoral coordination to prepare, detect and respond to public health threats. CARICOM committed to GHSA, and Caribbean Public Health Agency (CARPHA) is the primary public health agency supporting the Caribbean region and is committed to strengthening health systems among CARICOM Member States.

In additional to bilateral funding to countries in the region, U.S. Centers for Disease Control and Prevention (CDC) has provided over USD $8.5 million to the Caribbean Public Health Agency (CARPHA) through a cooperative agreement between HHS/CDC and CARPHA to strengthen health systems among CARICOM member states. Funding sources include GHS, CARES Act, PEPFAR ARPA funding, and HHS/CDC direct funding. As part of U.S. government's Global Health Security efforts, CDC's support for international accreditation of CARPHA laboratory, establishment of a Field Epidemiology Training Program, and disease surveillance at country and regional levels has strengthened capacity to prevent, detect and effectively respond to health threats in the Caribbean region.

PEPFAR CRP will leverage the capacity developed through USG support to further strengthen Global Health Security in the Caribbean region.

Pillar 4: Transformative Partnerships

4.1. Government

Jamaica

PEPFAR is committed to supporting and strengthening the strong collaborative partnership with the Government of Jamaica (GoJ) to promote and ensure alignment between United States and Jamaica's health priorities. The GoJ continues to lead in providing direction for the national HIV program and services for PLHIV. An updated National Strategic Plan (NSP) for 2023-2028, which outlines Jamaica's HIV priorities, has been tabled in parliament for approval. The revised NSP is intended to support the national HIV program in achieving the 90-90-90 treatment targets and providing guidance and direction for the HIV program.

The Government of Jamaica has demonstrated financial commitment to the HIV response and is the main source of funding for the national program. To ensure sustainability, the GoJ plans to integrate the HIV program with treatment services for other health conditions and ensure that gains achieved are maintained beyond donor support. In ROP 23, PEPFAR will continue to support the country with HIV service delivery, human resource for health capacity building, strengthening public health systems – including laboratory systems and strategic information, and providing technical support to the GoJ to achieve HIV epidemic control.

PEPFAR will continue to provide technical assistance and expertise through its participation in various technical working groups, including Prevention, HIV Self Testing, Elimination of Mother to Child Transmission, and TLD Transition. PEPFAR actively participates in the national annual review for the HIV/STI program and is available to support the MOHW's resumption of the Monitoring and Evaluation Research Group and to convene the Laboratory Strengthening Technical Working Group.

Trinidad and Tobago

PEPFAR has a strong 20-year collaborative partnership with the Government of the Republic of Trinidad and Tobago (GORTT) in its bilateral agreement between United States and Trinidad and Tobago that promotes high quality HIV health care priorities for PLHIV. The GORTT continues to prioritize and lead its national HIV program response with pride. An updated National Strategic Plan (NSP) for 2023-2028 is underway, and it intends to further strengthen the national HIV program in achieving the 95-95-95 treatment targets and PEPFAR has been asked to provide technical guidance in supporting the NSP planning.

4.2. CSO and Private sector

Jamaica

Civil society organizations (CSO) and the private sector play a critical role in the Jamaican HIV response by providing services at a community level. They offer clients a choice to seek services that best respond to their individual needs and circumstances. The GoJ recognizes the importance of Private and CSO HIV services and this is highlighted in Jamaica's vision for a multisectoral HIV response in the country's HIV National Strategic Plan. The Jamaica public sector is strained especially with space and human resources and does not have the capacity to serve all the PLHIV. PEPFAR will continue to support both the CSO and private sector to provide quality comprehensive HIV services integrated in primary health care, complementing the public sector, in support of the country's HIV response.

Importantly, CSOs serve a majority of key populations including MSM and TG, who have a significantly higher prevalence of HIV compared to the general population. KP face difficulty in accessing HIV care in the public spaces, due to stigma and discrimination and legal barriers. The CSOs have been instrumental in dramatically improving access, availability, and acceptability of HIV prevention, care and treatment services for KP including the provision of HIV testing and counseling; linkage to and provision of treatment for PLHIV; PrEP for HIV negative individuals; and referrals to health, legal and social services. With the consistent provision of safe spaces and confidential quality services and support, CSOs have developed important trusting relationships with the communities they serve.

CSOs are also important in addressing the enabling environment and advancing human rights. The CSOs together with multilateral and other organizations are working to protect fundamental human rights, address stigma and discrimination and equality. CSOs' work under this component includes advocacy interventions to address stigma and discrimination, and advance social justice and legislative and policy reform; reducing gender barriers for women and gender non-conforming males; monitoring and documentation of human rights violations; and sensitization, information, and referrals regarding rights for PLHIV.

The PEPFAR supported CSO have demonstrated success. The CSOs provided 90% of the overall OU testing and 59% of TST_POS in FY 22 as well as low IIT and 95% viral suppression rates among MSM. CSOs piloted PrEP in 2020 and the program has transitioned to regular programming with PrEP clinics once a week across all sites in FY 23. In ROP 23, with a flat lined budget, PEPFAR will continue its support to CSOs comprehensive KP programming including supporting PrEP at similar levels and will expand targeted outreach activities to priority population males and females eighteen to twenty-nine years.

The private sector physicians, laboratories and pharmacies have always served PLHIV since its detection in Jamaica because they are trusted providers offering confidential and convenient services. This coupled with stigma of HIV and barriers to care in public health facilities make the private sector an important choice to PLHIV who seek privacy, convenience, and professionalism.

The private sector is critical in expanding the access to, and utilization of, HIV-specific primary health care services to help close the gap to reach epidemic control in Jamaica.

PEPFAR supports a public-private partnership through a network that primarily comprises 72 trusted individual private doctors who are embedded in communities or neighborhoods and 11 private laboratory networks with 42 locations across the island. The network offers high quality, confidential, client-centered differentiated care and it also helps to unburden public facilities. The network assures the standardization and continuous quality assurance of services across all its providers. All clinicians in the network are required to be accredited and registered by the Medical Council of Jamaica and approved after training as an HIV service provider by the HIV/STI/TB Unit at the MOHW. Another important aspect of the network is the provision of surveillance data. The network utilizes the two electronic databases managed by the MOHW (Treatment Services Information System and the National HIV Prevention Database) for the collection and reporting of all relevant HIV testing, treatment, and prevention data. This aspect is critical because linking the private sector PLHIV data to the public database will assist Jamaica's account for diagnosed PLHIV previously considered never linked to care within the public system.

During FY22, the network has grown by 86% over the past year and TX_CURR doubled, and it contributed 70% of the OU's net new results. Over half of the clients in the network were referred from the public sector. Ninety percent of the clients in the network are considered low income and 52% of clients are over 50 years of age. The primary reasons clients cited for seeking services in the network were privacy and confidentiality and staff friendliness and professionalism. While there is strong potential to expand the network by recruiting new providers and actively on-boarding new clients, with a flat-lined budget, PEPFAR will support passive growth with attention to quality assurance in FY 24.

4.3. Academic and US-based

The PEPFAR program in Jamaica will continue and expand the Health Resources and Services Administration (HRSA) Skills Sharing Program (SSP). This a capacity building program between U.S. based HRSA funded providers and PEPFAR supported clinical sites to further strengthen HIV service delivery and patient outcomes through the PEPFAR Program. By providing onsite support related to gap areas and on-going virtual technical assistance, the SSP program will share best practices and expertise from domestic HRSA funded sites and clinicians. These providers typically have experience at Ryan White clinics and/or Centers of Excellence and address identified gaps and barriers impeding HIV epidemic control.

Through SSP, U.S.-based HRSA funded providers with expertise in key gap areas, quality improvement, psychosocial services, and virtual distance-based learning provide clinical and technical/quality improvement support to a Ministry of Health led Quality Improvement Collaborative (QIC) focused on improving viral suppression (VLS). HRSA funded providers serve as peer mentors based on areas of clinical and technical expertise and are paired with USG Implementing Partners (IPs), in partnership with their respective USG Agencies, as well as work closely to support regional QI mentors. Above site, QI IPs are included in the project to ensure

spread of best practices throughout all sites in the QIC and to ensure sustainability of QI and expertise developed from virtual training sessions gleaned through the project.

In Jamaica, the SSP areas of focus will be to strengthen VLS in PLHIV who remain virally unsuppressed. The focus of SSP clinician expertise will be on adolescents and young adults – particularly adolescent girls and young women – as well as strengthening mental health support. These areas have support from the Ministry of Health and Wellness (MOHW) HIV, STI, and Tuberculosis Unit (HSTU) leadership. Topics of SSP expertise proposed by HSTU leadership are in secondary HIV care and also HIV drug resistance; interventions as needed in these areas will be developed in collaboration with respective USG interagency leads. The proposed sites are MOHW public sites and private sites in the Northeastern Regional Health Authority, Western Regional Health Authority, Southern Regional Health Authority, and Southeastern Regional Health Authority.

There will be two capacity building site visits to Jamaica, accompanied by on-going virtual support. The site visit will be a landscape assessment to assess needs at PEPFAR-supported HIV Care and Treatment sites. For those sites that choose to participate in SSP, HRSA funded providers will:

- Provide peer-to-peer clinical skills and knowledge building support to improve VLS, particularly among unsuppressed adolescents and young adults, and PLHIV needing mental health support.
- Offer additional multidisciplinary QI support to the current QI collaborative in place through provision of additional best practices and interventions and methods for improving spread/scale-up.
- Ascertain best methods, types of support needed, and schedule for on-going virtual support.
- Decide which measures and outcomes will be used to evaluate the impact and effectiveness of the project at each clinic site and overall.

Academic institutions also support the PEPFAR HIV response in the Caribbean, both in Jamaica as well as Trinidad and Tobago. Clinicians from the University of Washington have provided clinical expertise through HIV Extension of Community Healthcare Outcome (ECHO) sessions in both countries. ECHO is a regularly scheduled HIV consultation session for all HIV care and treatment sites in the country that helps to support the goal of HIV epidemic as it facilitates the provision of accessible, cost-efficient clinical mentoring as well as continuing professional education. Project ECHO also fosters the development of peer networks and communities of practice that increase provider satisfaction. The one-hour sessions include a didactic presentation followed by the presentation of a challenging case by a healthcare worker seeking expert advice. The didactic presentations and case recommendations are provided by a panel of local and international experts (Psychiatrists, Pediatricians, HIV Clinicians, Social Workers, and QI Specialists) with HIV, mental health, and quality improvement experience. In addition to experts from the University of Washington, experts from other academic institutions may also provide support. The ECHO program adjusts to meet the changing needs of PLHIV and health care workers and continues to be an impactful activity as it successfully reaches greater than two hundred individual healthcare workers each quarter.

In Jamaica, the University of Washington clinicians also provides psychosocial expertise and technological support to the PEPFAR program. There is an easily accessible high-quality clinical consultation for clinicians at HIV/STI treatment sites through a Therapeutic Consult Group, which has quarterly Psychosocial Support Team meetings. In addition, University of Washington psychiatrists and mental health experts support implementation of the World Health Organization (WHO) Ensuring Quality In Psychological Support (EQUIP) platform. Through the Digital Initiative Group at I-TECH (DIGI), the University of Washington will continue to support PEPFAR in Jamaica during ROP23 with roll out of the HealthJam digital library and two-way texting app to support patient retention and viral load suppression, as well as adaptation of a Continuous Quality Improvement (CQI) app that originate from the University of Maryland and is being adapted to the Jamaica context.

Finally, PEPFAR has also collaborated with University of the West Indies (UWI) to contribute to creation and implement of a transition protocol for adolescents living with HIV (ALHIV). This was needed as ALHIV are a potentially vulnerable population as they transition from pediatric from adolescent care. PEPFAR primarily supported the adolescent disclosure component of the transition protocol and initiating field-testing. During ROP23, PEPFAR anticipates these activities to primarily transition to UWI leadership but may continue to provide support.

Regionally, PEPFAR supports the Caribbean Community's (CARICOM's) mandate to end the HIV/AIDS epidemic in the region through the Pan Caribbean Partnership Against HIV AIDS (PANCAP). As a registered training site with the University of Washington and Johns Hopkins Universities, PANCAP provides technical assistance and capacity building to varied cadres of health care workers across the member states of CARICOM in the HIV response. Courses in the Clinical Management of HIV; Leadership & Management in Public Health; and Epidemiology in Public Health & Public Health Practice are among the courses offered. Acceptance to courses prioritizes health staff from PEPFAR-supported countries.

Pillar 5: Follow the Science

The Government of Jamaica and PEPFAR Caribbean Regional Program are committed to following the science and utilizing data to drive programming decisions, policies, and guidance. For ROP23 and onwards, as Jamaica and Trinidad are progressing towards the 95-95-95 targets, closing the remaining gaps will require embracing and elevating the best new scientific innovations and ensuring that programming is data-driven. By supporting and enhancing surveillance, PEPFAR will ensure the deployment of next generation surveillance methods and lean into community-led monitoring to enhance ownership of program results.

During ROP23 planning, PEPFAR CRP conducted deep-dive analyses of the available country data to understand the potential programmatic implications and inform program strategies and target setting. The strategic direction, program shifts, and alignment of resources for PEPFAR for ROP23 is in keeping with the data that highlights the major gap for both countries being in the

2nd 95 with needs to mop up and attain the first and third 95, as it relates to Pillar 5 for the OU within the context of the national HIV response.

PEPFAR recognizes the data gaps to inform programmatic decision-making for all populations. In alignment with Pillar 1, PEPFAR continues to prioritize addressing knowledge gaps in ROP23. Reaching and serving KP / PP with HIV prevention, care, and treatment services is essential to achieving and maintaining HIV epidemic control. As Jamaica and Trinidad & Tobago gets closer to reaching epidemic control, understanding the characteristics and needs of key and priority populations, including their knowledge of HIV status, ARV treatment status, and VLS rates are amongst the highest priorities.

Enhancing Existing Electronic Data Systems

During ROP23, PEPFAR CRP will continue to invest in strengthening data quality and information system to ensure availability and use of high-quality and timely information critical to reaching and sustaining epidemic control. PEPFAR will continue to support surveillance, and treatment information systems improvements including full implementation digitized reporting forms. PEPFAR will continue to enhance system integration, functionality, and utility of systems.

Case-based Surveillance

Person-centered routine health data for all PLHIV or case-based surveillance continues to be a priority for PEPFAR to monitor the trend of the HIV epidemic and provide evidence-based evaluation of programs. In collaboration with the GOJ, PEPFAR CRP aims to continue to improve HIV surveillance to identify program gaps, new cases and potential clusters in accordance with strict data security and confidentiality guidelines. The routine surveillance of all PLHIV cases will also enable the country to improve their national estimates of HIV burden through UNAIDS global AIDS monitoring indicators. Strengthening routine person-centered surveillance data will be critical to effectively support closing the gaps for all PLHIV, linking clients to treatment, retaining clients on treatment, and maintaining viral suppression and targeted prevention services when needed.

PEPFAR CRP will continue to implement recent infection surveillance in COP23 in triangulation with routine surveillance data to monitor the trajectory of the epidemic, to provide real-time information on traits of recent infections and impact public health response through providing national recency testing across the island. As outlined by S/GAC and PEPFAR, PEPFAR CRP will work with the Jamaica and Trinidad & Tobago health ministries to ensure that recency results will not be returned to patients, and that the viral load will be processed for rapid test for recent infection (RTRI) cases in accordance with a recent infection testing algorithm.

Evidence-based science-based approaches / Implementation/ Operational Research

Evidence-based science-based approaches play an important role in filling important knowledge gap by contextualizing epidemiological data and clarifying socio-demographic and economic factors that may be contributing to attitudes and practices that impact health behavior and the program's strategic direction. PEPFAR CRP will continue to support CRP countries to support the development and implementation of science agendas, development of surveillance strategic plans, review, and reporting of HIV epidemiological data and integrated biobehavioral surveys and population size estimation activities.

Strategic Enablers

6.1. Community Leadership

CLM remains a focus for Jamaica and Trinidad and Tobago in ROP 23, noting its importance as one of three key enablers in PEPFARs strategy. The PEPFAR Coordination Office locally administers CLM through the Ambassador's Small Grant Program, in support of improving client-centered HIV services. The program goals are intended to improve client experiences and retention on HIV treatment, drive action to address issues identified as barriers by persons living with HIV and help to center their very perspectives and needs in HIV treatment. It is also designed to fund projects that focus on reducing stigma and discrimination. In ROP 23, there are plans to reallocate funding from ROP 22 to increase the grant amount for both Jamaica and Trinidad and Tobago, in a bid to increase uptake in applicants as well as increase their ability to cover more areas.

The CLM Small Grant has supported improvements in HIV services at site level, which forms part of a greater health systems strengthening approach being undertaken by the government. Currently, CLM implementation is in its second iteration, and it is anticipated that the findings from the Community Scorecard Initiative will be used by PEPFAR to further inform program direction for Jamaica. Findings will be shared with the government with the hope that information will be used to address the challenges that negatively impact access to healthcare and enjoyment of human rights, especially HIV services for PLHIV and key populations.

As part of the ROP 23 process, a planning retreat was held with government, CSOs, multilateral and other stakeholders, with the main objective to facilitate a shared understanding of PEPFARs strategy and to garner input from stakeholders to inform ROP 23 planning and implementation. For the CSOs who are the main implementers of CLM, they continue to voice opinions which include areas such as support for training in advocacy, which for them is an area that is significantly lacking, hence, impeding their ability to effectively influence government. Other input by CSOs included the need to build political will, more work needed in relation to stigma and discrimination and the legal and policy environment, and overall, for CLM, to ensure that the right people, i.e., government, receives the report with clear recommendations that can be implemented.

PEPFAR is committed to continue providing capacity building, improving access to justice, increasing the community of knowledge, and reducing stigma and discrimination in collaboration with our UNAIDS and other multilateral partners.

Community leadership is a central ingredient for long-term sustainability of the HIV response. As PEPFAR has increasingly involved community, we have learned that communities play a vital role in holding PEPFAR and our partners accountable for HIV impacts. For communities that are increasingly bearing the greatest burden of the HIV/AIDS pandemic, it is critical to ensure that they are leading the conversation on how to address their needs. We will continue to engage the unique assets, capacities, and comparative advantage of communities, including faith-based organizations, KP-led organizations, women-led organizations, community health workers organizations, and PLHIV-led organizations, to drive meaningful, people-centered, and sustained impact.

6.2. Innovation

HIV prevention, treatment, care and data for decision making have been supported by incremental and breakthrough innovations, advancing the program in various stages of PEPFAR's involvement.

ROP 23 plans to leverage financing models to drive programmatic scale via synergistic cost sharing with other donor agencies and between linked programs. This includes focusing on activities that have impact across UNAIDS pillars (e.g. HIVST as prevention and case finding), and synergizing DSD, technical assistance and hybrid programs for greatest efficiency.

Opportunities exist at site-level PDSAs (Plan Act Study Do) which are center-led pilot activities aimed at assessing proposed interventions for potential scale up. Examples can be found in the Men's Gold star clinic for encouraging retention and suppression in men. Above-site innovations through technical assistance aim to increase uptake, e.g., QR code inclusion in paper-based media messaging. Additionally, PEPFAR supports these through implementing partner development and refinement of SOPs, monitoring and evaluation, and procurement of equipment and supplies as required, e.g., Internet access, stationary, etc.

In the same line of suggesting and supporting above site and site boosters in prevention and testing, care and treatment and SI, potential opportunities exist in our pursuits to:

- Address cycling out of patients through improving the clinical experience.
- Addressing linkage to care challenged by local protocols that limit confirmation to laboratory technicians/ technologies, contact investigators or social workers.
- Address time consuming nature of data capture, report generation and interpretation for decision making though automation.
- Scaling up innovations that have been successful.
- Combining activities where resources can be synergized to increase efficiency, e.g. Entry and Return to Care acceleration.

Current innovations that have shown improved performance are grouped as follows:

- In ROP 23 the CRP will use innovative strategies to improve prevention activities looking at both the biomedical and non-biomedical approaches:
    - A focus on adolescent and youth prevention interventions in a manner to reach the youths where they are for prevention messaging and interventions and testing. This will increase awareness of HIV among youth and promote healthy sexual practices as a choice.
    - Bridging the challenge with unattached youth in receiving adequate prevention interventions using standardized curricula.
    - Peer education models will be implemented for the key target groups including MSM, AGYW, ABYM and women in reproductive years.
    - Scaling up biomedical prevention approaches through PrEP, including supporting access for PrEP services in the public spaces as well as continued through NGO facilities.
- Innovative strategies for case finding will continue to be implemented in ROP 23. Interventions which look at scaling up and diversifying current case finding strategies will be implemented including:
    - Scaling up HIV Self Testing. During ROP 22 there were significant delays in implementation of HIVST in both countries. We however will continue to expand and consistently supply HIVST kits across the region to increase access to all persons desirous of this modality with focuses on populations who are less likely to access health services using traditional methods including men and youths. This will also include partnerships to expand distribution and access points to industries which focus on males or under 30 populations e.g., Business processing offices, Taxi Operator associations and the hotel and tourism industry.
    - Social Network Strategy will be scaled up and revitalized in CRP across both countries. Jamaica will continue to use this modality to reach members of the key population and their high risk social and sexual networks. Trinidad will see the implementation of SNS through a mobile unit to increase privacy and confidentiality as well as uptake.
    - Diversification of Testing Modalities will be maintained during ROP 23 including Provider-initiated testing services, STI testing, Index testing and index – SNS hybrid testing services to reach the last 4% in Jamaica, and these will be scaled up in TT to address gaps in the first 95.
- Activities that support linkage and retention
    - Cadre diversification for screening, confirmation, linkage as facilitated by national protocols.
    - ARV delivery models, including decentralized collection sites.
    - Tele-monitoring and telemedicine for psychiatric support
- Activities that support Viral load coverage and suppression
    - Automatic electronic flagging from health center-based databases for VL testing, appointments, medication pickups, adherence, home sampling collection, coordination between medication pick up and VL uptake dates.
    - Data collection tool for staff-client contact assignment.
- Activities that support data management
    - Use of tablets for CIs
    - Optical Mark Recognition (OMR) paper to electronic data collection
    - Integration of field data systems

- Successful activities during Covid-19 (all were discontinued due to a variety of cultural, traditional, logistic, and financial reasons)
    - Prewriting prescriptions
    - Virtual client checkups

Going forward, PEPFAR plans to support and expand all previous innovations as facilitated by local laws, policies and acceptance, with emphasis on extended hours, electronic facilitation, and ART compliance. The interagency also plans to revisit COVID-19 driven successes and advocate for virtual assistance options. Finally, introduction of new innovations in technological application and in service delivery hybridization promise to seek out and open site level flood gates.

The PEPFAR supported public private partnership (PPP) has leveraged innovation through health financing and digital health platforms. The private sector plays an integral role in providing universal access to health for all Jamaicans. The most recent Jamaica Survey of Living Conditions (2019) shows that similar proportions of Jamaicans visit a private or public health facility (46.6% and 47.6 % respectively); with a greater distribution in the rural areas that favored private facilities compared to public ones (48.4% and 45.2% respectively). Jamaica's Primary Health Care Reform (2021-2030) and the National Strategic Plan for HIV (2023-2028) also recognize the importance of inclusion of private providers to increase accessibility to good quality, equitable health care to the Jamaican population.

The PPP uses health financing innovation through a needs-based reimbursement model, where services from private providers to vulnerable low-income Jamaicans are supported. The aim for this service delivery model, currently funded by PEPFAR, is to be financially accessible to the GOJ in the future. As such the following steps have been implemented and are ongoing:

- An active Project Steering Committee, chaired by the Permanent Secretary of Health, for good governance and sustainability.
- Replication of the model in the PPP for NCDs used by the MOHW.
- Evaluation of financial outcomes and accessibility of model to the GOJ in the long term

To aid the latter point noted above, a *Value for Money Analysis* (VFM) was also carried out on the PEPFAR supported PPP. A VFM analysis is a type of analysis that is used to determine whether a public-private partnership has achieved value for money in practice. This analysis assesses the value for money of a PPP as compared to public sector provision of the same good or service. Frequently, VFM analysis of an existing PPP is used as a test case to determine whether a given type of project should be scaled up. This analysis focuses on five factors: effectiveness, economy, efficiency, equity, and sustainability. Results of this initial VFM demonstrate cost savings for the PEPFAR supported PPP, noting ARVs are a public good; and that HR tasks in the public sector are not HIV specific.

Additionally, digital health platforms are used to impact direct service delivery for PLHIV in the PPP, as well as assess the impact of services. The Online Reservation Application (ORA) digital platform allows persons to uptake HIV prevention, care & treatment services within the privacy and confidentiality of their own space, at their own time; a part of the hallmark of the person-centered approach delivered within this space. Clients are also able to provide feedback on the

services received, completing the loop in ensuring PLHIV remains the north star of decisions made in the direct delivery of HIV services.

6.3. Leading with Data

The PEPFAR support in ROP22 was guided by gaps identified by the UNAIDS 12 Component Assessment conducted by the MOHW in 2018. From this assessment, gaps were identified in all 12 pillars, but major improvement was needed in the following areas:

- Data collection and use
- Data linkage and triangulation
- Data Quality
- Program evaluation
- Development of a research agenda to guide program planning.

PEPFAR complemented the work being done by the Global Fund and the Inter-American Development Bank and supported strengthening of HIV case-based surveillance system and the Treatment Services Information System and the reporting processes. Poor data quality was addressed through data quality audit and remedial action support.

While there has been marked improvement in these areas, additional work is needed and in ROP23, the priority areas will be:

- Finalization of digitization process of reporting templates for the HIV case-based surveillance system
- Applying DQA to assess and improve current systems and protocols
- Improving program performance metrics for monitoring and evaluation and
- Supporting the national HIV research agenda and some of the scientific products necessary for program planning.

Target Tables

Target Table 1 ART Targets by Prioritization for Epidemic Control							
Prioritization Area	**Total PLHIV (FY23)**	**New Infections (FY23)**	**Expected Current on ART (FY23)**	**Current on ART Target (FY24) *TX_CURR***	**Newly Initiated Target (FY24) *TX_NEW***	**ART Coverage (FY24)**	**ART Coverage (FY25)**
Scale-Up Aggressive - Jamaica	30,489	N/A	18,051	14,487	942	47.5%	
Scale-Up Saturation – Trinidad & Tobago	11,084	N/A	8,157	7,310	492	66.0%	
Total	**41,573**	**N/A**	**26,208**	**21,797**	**1,434**	**52.4%**	

Table 7: ART Targets by Prioritization and Country

Source: Panorama, ROP23 PAW

Target Table 2 Target Populations for Prevention Interventions to Facilitate Epidemic Control - Jamaica				
Target Populations	**Population Size Estimate* (SNUs)**	**Disease Burden***	**FY24 Target**	**FY25 Target**
PP_PREV_Male	373,691	N/A	350	[redacted]
PP_PREV_Female	361,558	N/A	350	
KP_PREV_MSM	42,400	N/A	1850	
TOTAL	**777,649**	**N/A**	**2550**	

Table 8: Target Populations for Prevention Interventions to Facilitate Epidemic Control in Jamaica

SOURCE: Panorama, ROP23 PAW; STATIN Jamaica Population Est 2019; IBBS 2018

Core Standards

The core standards include:

1. **Offer safe and ethical index testing to all eligible people and expand access to self-testing**.
    - Jamaica utilizes a dedicated cadre of staff, Contact Investigators, to conduct index testing. The CI's is a professional health body in Jamaica and all CIs undergo a 12 month post professional training with exit examination requirements and along with providing contact tracing for HIV are trained to manage STIs and other emerging and infectious diseases of public health concern. All CIs are rigorously trained in accordance with the Contact Investigator Training Curriculum, to adhere to WHO 5c's and focus on quality-of-service provision for clients with monthly reporting requirements and adverse events monitoring and reporting. The national program requires contact tracing and testing for all contacts including children under the age of 19 years old with a mother who is HIV positive or status unknown.

2. **Fully implement "test-and-start" policies.**
    - Jamaica first launched the test and start policy in January 2017 adopting the 2015 WHO guidelines, and extends for all age, sex and risk groups in individuals with no acute contraindication to rapid initiation. PEPFAR directly supports this national response through quality assurance to PEPFAR supported sites addressing rate limiting steps, and indirectly through above site systems strengthening via technical working group input, and staff funding for cadres that link patients more directly to care, e.g., social workers at SNS sites in Jamaica, or peer navigator at the QPCC&C testing site in Trinidad.

3. **Directly and immediately offer HIV-prevention services to people at higher risk.**
    - In accordance with the recently reviewed Prevention Orientation Manual in Jamaica, all clients receive services and referrals in a status neutral approach. For persons with HIV negative testing results, based on risk assessments done prior to testing, risk reduction services, commodities including oral PrEP and condoms

are offered. Services such as oral PrEP are distributed and prescribed by a clinician at health facilities across the island and the MOHW is currently undertaking a national expansion of this services with training being completed in all 14 parishes including private physicians. PrEP is procured alongside the national HIV ARVs and is available free of charge inclusive of all monitoring and testing required.

- Post exposure prophylaxis is offered to all exposed persons in Jamaica free of charge on a case-by-case basis. This is done after consultation with the prescribing clinician no later than 72 hours post exposure for both HIV and Hepatitis B infection. TLD is the nationally recommended regimen for PEP with PI based regimens as an alternative.

4. **Provide orphans and vulnerable children (OVC) and their families with case management and access to socioeconomic interventions in support of HIV prevention and treatment outcomes**.
    - While PEPFAR does not support OVC programming directly, Jamaica has a robust case management system to support OVC and their families for improved HIV treatment outcomes. Jamaica provides supplemental nutrition for the first year of life free of charge to all HIV exposed infants.

5. **Ensure HIV services at PEPFAR-supported sites are free to the public.**
    - In 2006, the Jamaica Government abolished user fees for all services, and medications, including those for HIV and related services.
    - The National Health Fund is responsible for the provision of all ARVs, medications for opportunistic infections and TB, other VEN list pharmaceuticals, and some equipment and supplies for public sites. and all ARVs locally, including for private provision.
    - PEPFAR currently supports and will continue to offer support cost-free care in FY 24 through system strengthening to build the robustness and sustainability of care. Specifically, this includes provision of equipment and supplies under maintenance contracts that can be progressively handed over to the GOJ, training of trainers to counteract attrition and need for costly contracted retraining, and, if future supported under PEPFAR, collaboration with the GOJ to support integration, and major push for closing the gap under HIV services. (See Clinical Management of HIV disease- Guidelines for Medical Practitioners, 2017)

6. **Eliminate harmful laws, policies, and practices that fuel stigma and discrimination, and make consistent progress toward equity.**
    - PEPFAR provides policy support for elimination of harmful laws, policies, and practices. Opportunities remain for additional advocacy.

- Jamaica has an active Partnership Against All Forms of Discrimination, co-chaired by the State Minister of Health and Wellness. There is also an active Enabling Environment and Human Rights Working Group.
- The National AIDS Coordinating Committee in Trinidad and Tobago works with member ministries and organizations to combat stigma and discrimination across society.
- Policy shifts are required by governments in both Jamaica and Trinidad and Tobago to eliminate harmful laws, policies, and practices that fuel stigma and discrimination against PLHIV and impacted communities, particularly KPs.

7. **Optimize and standardize ART regimens.**
    - In 2020, the Ministry of Health and Wellness, Jamaica initialed the phased provision of Dolutegravir based regimes, and at the time of this document, achieved 54%conversion of those on ART, with planned completion of transition by October 2023.
    - This is extended to all age and sex groups, and includes sensitization and training of clinicians, adherence counsellors and other support staff in optimizing and supporting adherence to regimes. It also includes vertical and horizontal communication of availability and prescribing protocols with pharmacists and clinicians.
    - Trinidad and Tobago's policy also supports transition to dolutegravir use, with 10% of the PLHIV population on ART transitioned to DTG based regimes. Being classified as a high-income` jurisdiction, the country does not benefit from subsidies or price negotiations available to LMIC countries of the Caribbean. This threatens to lead to delays in DTG transition, as T and T will have to pay full price in observation of drug patents until 2026, and strongly depends on government will procure.

8. **Offer differentiated service delivery models.**
    - Both Jamaica and Trinidad and Tobago practice and endorse Differentiated service delivery, which includes extended hours for clinical consultations and in some areas, VL phlebotomy, block appointments, multi-month dispensing (MMD) up to 12 months, and decentralized drug distribution as both countries facilitate dispensing in multiple private and public domains. Outside of national protocols, site level services may include medication delivery and mobile phlebotomy. This was established pre-Covid-19 but suffered a great deal due to the high resource demands and physical distancing that the pandemic placed on the system.
    - PEPFAR currently supports extended hours clinics through funding of sessional staff for both Jamaica and TT, while the other differentiated service options are fully managed by local entities. For FY 24 and perhaps beyond, PEPFAR will continue to support the countries with this endeavor, while transitioning cost to host

government. Additionally, tele health services being developed under PEPFAR are to be scaled up to increase virtual consultation options for PLHIV.

9. **Integrate tuberculosis (TB) care.**
    - All patients at every visit must be evaluated for TB infection. Symptom directed screening is initiated with the following: Cough > 2 weeks, fever and weight loss.
    - Diagnosis typically begins with the client's history and examination. Investigations include:
        i. Mantoux test (>5mm in the HIV co-infected patient)
        ii. Chest X-ray
        iii. Sputum analysis for acid-fast bacilli, culture and sensitivity.
    - Asymptomatic cases with a positive Mantoux test >5mm and a negative chest x-ray are diagnosed as Latent TB.
    - In Jamaica, treatment for TB requires admission to Hospital. For extra-pulmonary disease, treatment is normally extended to between 9-12 months depending on the site of infection.
    - In Trinidad and Tobago, laboratory confirmation of TB is driven by clinical demand without a standard algorithm and continues to be based on smear microscopy. Currently 2 Lateral Flow-Urine Lipoarabinomannan (LF-LAM) assays are being evaluated for use in detecting active TB in PLHIV with advanced HIV disease. It is expected that the assays would provide additional value in diagnosing/detecting TB in PLHIV when used in conjunction with other traditional TB diagnostic tools (AFB, culture, Gene Xpert).

10. **Diagnose and treat people with advanced HIV disease (AHD).**
    - As outlined in Jamaica's Clinical Management of HIV Disease Guidelines for Medical Practitioners 2017, the MOHW subscribes to and follows the WHO Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection: Recommendations for a Public Health Approach, which includes - The provision of antiretroviral therapy regardless of CD4 count, Expansion of preventative technologies and Target setting for viral load suppression rates, and does cover the package of diagnostics and treatment.

11. **Optimize diagnostic networks for VL/EID, TB, and other coinfections**.
    - CRP commodity procurement is approximately 1% of the program budget and falls under 5 major supply categories: rapid test kits, self-test kits, viral load reagents, PrEP, OI testing reagents and safety supplies.
    - VL/EID testing in Trinidad is conducted at 3 sites, utilizing multiplex instruments which cover the needs of all patients. TB and OI monitoring is performed at the Public Health lab providing coverage to all regions.

- VL/EID testing is currently centralized in Jamaica. PEPFAR has provided support to decentralize and increase access and coverage. Work is ongoing to expand TB and OI screening in all regions.

12. **Integrate effective quality assurance (QA) and continuous quality improvement (CQI) practices into site and program management.**
    - Quality assurance and Continuous quality improvement practices are implemented by the CRP to address the key systems barriers – initiatives include HRH capacity building, Data Quality assessments, Lab quality improvement, supportive supervision, QI coaching, Lab internal and external quality assessment programs.
    - Jamaica is currently finalizing the National Strategic plan (NSP) for 2023-2030 developed in consultation with stakeholders including PEPFAR.
    - Trinidad is developing a new National Strategic plan for HIV and AIDS (TTNSP) 2023-2028 and the National Policy on HIV and AIDS 2023-2030, in which PEPFAR has been providing input and feedback.

13. **Offer treatment and viral-load literacy.**
    - U=U messaging is offered at sites in both regions. Treatment counselling is also provided for individuals. Counselling includes peer aspects and messaging to promote self-empowerment and enhanced treatment and viral-load literacy.

14. **Enhance local capacity for a sustainable HIV response.**
    - PEPFAR continually seeks to expand local partners to enhance sustainability. In Jamaica, local partner JASL has grown strong capacity enabling it to on-board other local organizations as sub-awardees. In Trinidad and Tobago, PEPFAR works closely with the largest NGO provider of HIV care and treatment services, Medical Research Foundation Trinidad and Tobago (MRFTT).

15. **Increase partner government leadership.**
    - Host governments fund and procure the majority of commodity requirements, i.e. ARVs and Lab reagents, through either domestic sources or other donors, e.g. Global Fund.

16. **Monitor morbidity and mortality outcome.**
    - Continuing into ROP23, CRP will work with host governments to support the development of science agendas and the review of epidemiological data including morbidity and mortality for better analysis on a frequent basis to improve the national HIV programs and public health response.

17. **Adopt and institutionalize best practices for public health case surveillance.**
    - In ROP23, CRP will continue to support the strengthening and development of surveillance systems to ensure best practices for public health surveillance and enhance systems interoperability and quality data for decision making to improve the person-centered care.
    - Continued active development of data systems and data visualization processes.

USG Operations and Staffing Plan to Achieve Stated Goals

CRP seeks to improve efficiency in our management and operations. We made changes in our staffing footprint and organizational structure to address gaps and improve performance. Our current staffing footprint includes 25.5 FTEs, with staff across the HIV Prevention team, Care and Treatment team, Strategic Information (SI) team, Laboratory and M&O staff.

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.

CDC has increased efficiency and made changes in its organizational structure and management and operations support to improve program performance, with a staffing footprint of 13.5 FTEs. This includes the restructuring of Prevention Care and Treatment Team Lead role to two: Prevention Team Lead and Care and Treatment Lead. In, addition, the Global Health Security (GHS) Epidemiologist position has been transitioned from a two-year term limit to a full-time permanent position, effective March 1, 2023, with the position cost-share between PEPFAR (0.5) and GHS (0.5) and providing support to the SI and Care and Treatment teams, with back-up support for Laboratory System Strengthening.

USAID gained efficiencies in CODB as it reduced the LOE of the 4 support positions, Finance, IT, Contracts and Communications from 50% to 20% respectively with the increased share of other programs and other health funding. The Office Director of Environment and Health position was filled in August 2022.

APPENDIX A -- PRIORITIZATION

Epidemic Cascade Age/Sex Pyramid – Jamaica

Figure A.1

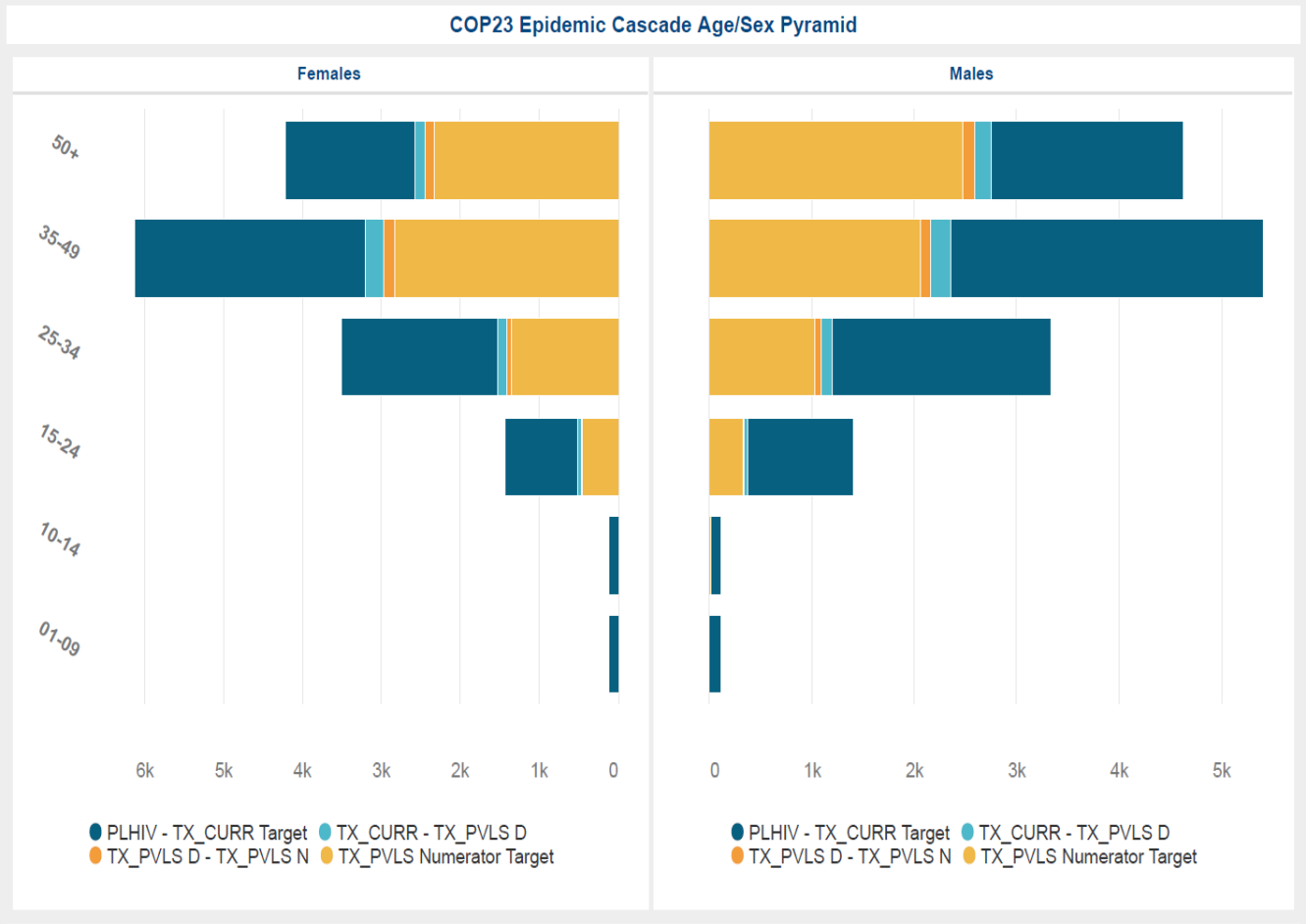

Figure 4: Jamaica COP23 Epidemic Cascade by Age and Sex

Source: Panorama, ROP23 PAW

Epidemic Cascade Age/Sex Pyramid – Trinidad & Tobago

Figure A.1.2

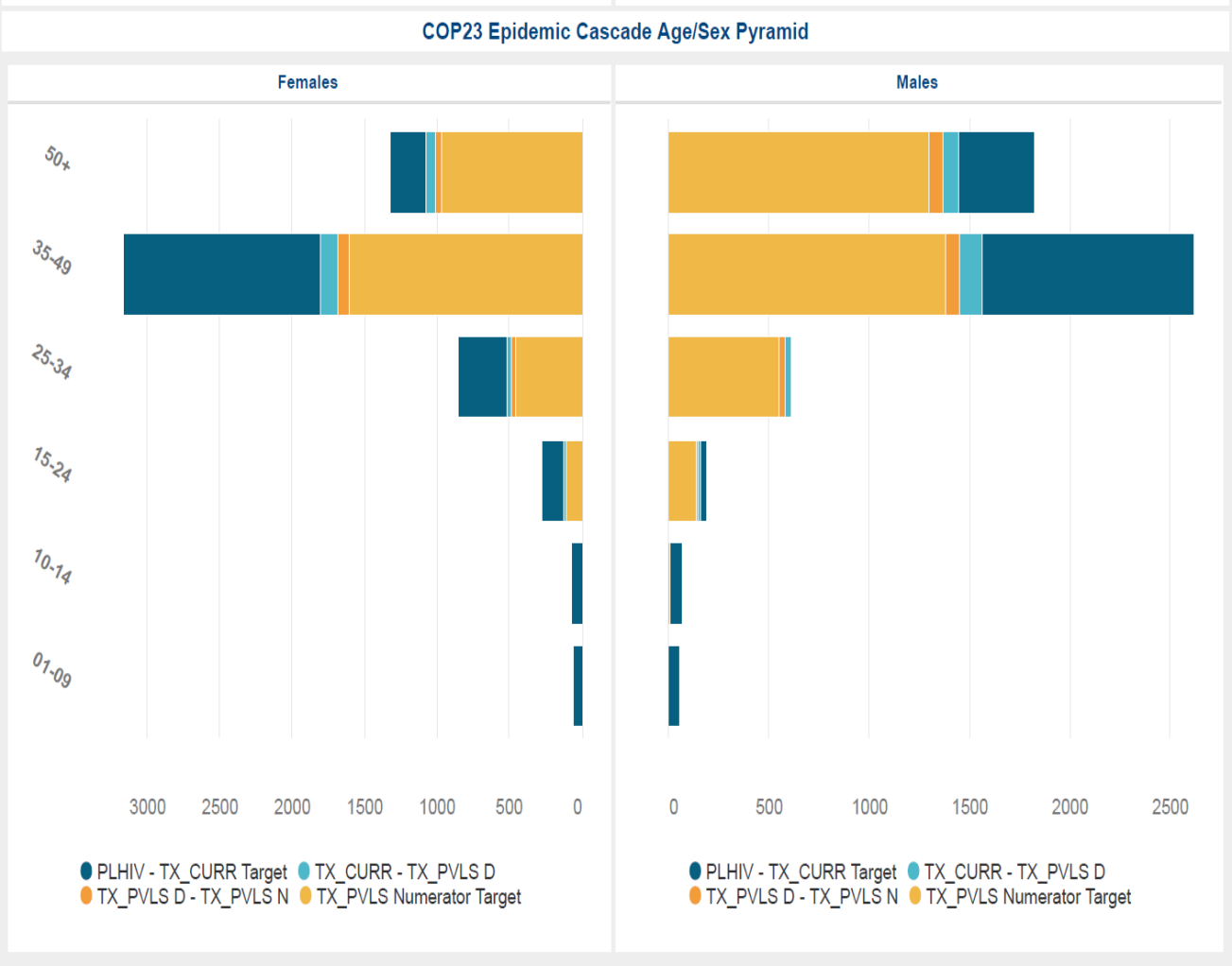

Figure 5: Trinidad & Tobago COP23 Epidemic Cascade by Age and Sex

Source: Panorama, ROP23 PAW

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1 ROP 22, ROP 23/FY 24 Budget by Intervention

JAMAICA

Operating Unit	Country	Intervention	Budget	
			2023	2024
Western Hemisphere Region	**Total**		**$15,678,512**	**$15,916,072**
	Jamaica	ASP>HMIS, surveillance, & research>Non Service Delivery>Key Populations	$20,500	
		ASP>HMIS, surveillance, & research>Non Service Delivery>Non-Targeted Populations	$1,332,718	
		ASP>Health Management Information Systems (HMIS)>Non Service Delivery>Non-Targeted Populations		$737,314
		ASP>Human resources for health>Non Service Delivery>Non-Targeted Populations	$607,387	$306,770
		ASP>Laboratory systems strengthening>Non Service Delivery>Non-Targeted Populations	$612,368	$586,026
		ASP>Laws, regulations & policy environment>Non Service Delivery>Key Populations		$15,000
		ASP>Laws, regulations & policy environment>Non Service Delivery>Non-Targeted Populations	$67,061	$217,945
		ASP>Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations		$60,234
		ASP>Policy, planning, coordination & management of disease control programs>Non Service Delivery>Non-Targeted Populations	$308,663	
		ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Non-Targeted Populations		$30,000
		C&T>HIV Clinical Services>Non Service Delivery>Key Populations	$100,000	$100,000
		C&T>HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	$2,605,410	$2,084,075
		C&T>HIV Clinical Services>Service Delivery>Non-Targeted Populations	$2,771,938	$4,432,542
		C&T>HIV Drugs>Service Delivery>Non-Targeted Populations	$77,000	
		C&T>HIV Laboratory Services>Non Service Delivery>Non-Targeted Populations	$110,747	$43,365
		C&T>HIV Laboratory Services>Service Delivery>Non-Targeted Populations	$197,000	$212,000
		C&T>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$135,282	
		C&T>Not Disaggregated>Service Delivery>Key Populations	$39,967	
		HTS>Community-based testing>Non Service Delivery>Key Populations		$17,000
		HTS>Community-based testing>Non Service Delivery>Non-Targeted Populations		$31,590
		HTS>Community-based testing>Service Delivery>Key Populations	$359,335	$302,360
		HTS>Community-based testing>Service Delivery>Non-Targeted Populations		$102,000
		HTS>Facility-based testing>Non Service Delivery>Non-Targeted Populations	$89,209	$506,631
		HTS>Facility-based testing>Service Delivery>Non-Targeted Populations	$111,742	$298,539
		HTS>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$163,562	
		HTS>Not Disaggregated>Service Delivery>Key Populations	$4,460	
		HTS>Not Disaggregated>Service Delivery>Non-Targeted Populations	$206,382	
		PM>IM Program Management>Non Service Delivery>Non-Targeted Populations	$1,783,874	$1,730,033
		PM>USG Program Management>Non Service Delivery>Non-Targeted Populations	$3,202,290	$3,148,275
		PREV>Comm. mobilization, behavior & norms change>Service Delivery>Key Populations	$250,000	
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>AGYW		$237,560
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Non-Targeted Populations		$65,000
		PREV>Non-Biomedical HIV Prevention>Service Delivery>Key Populations		$250,000
		PREV>Non-Biomedical HIV Prevention>Service Delivery>Non-Targeted Populations		$40,000
		PREV>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$31,342	$47,813
		PREV>Not Disaggregated>Service Delivery>Non-Targeted Populations	$45,000	
		PREV>PrEP>Non Service Delivery>Key Populations		$36,000
		PREV>PrEP>Non Service Delivery>Non-Targeted Populations	$43,563	$63,000
		PREV>PrEP>Service Delivery>Key Populations	$100,000	
		PREV>PrEP>Service Delivery>Non-Targeted Populations	$127,588	$215,000
		SE>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$101,019	
		SE>Not Disaggregated>Service Delivery>Non-Targeted Populations	$73,105	

Table 9: Jamaica ROP23 FY24 Budget by Intervention

TRINIDAD & TOBAGO

Operating Unit	Country	Intervention	Budget	
			2023	2024
Western Hemisphere Region	**Total**		**$2,027,608**	**$2,080,608**
	Trinidad and Tobago	ASP>HMIS, surveillance, & research>Non Service Delivery>Non-Targeted Populations	$490,902	
		ASP>Health Management Information Systems (HMIS)>Non Service Delivery>Non-Targeted Populations		$187,000
		ASP>Human resources for health>Non Service Delivery>Non-Targeted Populations	$200,000	$180,000
		ASP>Laboratory systems strengthening>Non Service Delivery>Non-Targeted Populations	$235,000	$175,000
		ASP>Laws, regulations & policy environment>Non Service Delivery>Non-Targeted Populations	$20,968	$32,999
		ASP>Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations		$61,751
		ASP>Policy, planning, coordination & management of disease control programs>Non Service Delivery>Non-Targeted Populations	$30,000	
		ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Non-Targeted Populations		$15,000
		C&T>HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	$132,519	$194,483
		C&T>HIV Clinical Services>Service Delivery>Non-Targeted Populations	$384,219	$696,975
		C&T>HIV Laboratory Services>Non Service Delivery>Non-Targeted Populations	$55,000	$43,000
		C&T>HIV Laboratory Services>Service Delivery>Non-Targeted Populations	$58,000	$60,000
		HTS>Community-based testing>Service Delivery>Non-Targeted Populations		$52,256
		HTS>Facility-based testing>Non Service Delivery>Non-Targeted Populations		$65,000
		HTS>Facility-based testing>Service Delivery>Non-Targeted Populations	$10,000	
		HTS>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$58,222	
		HTS>Not Disaggregated>Service Delivery>Non-Targeted Populations	$131,940	
		PM>IM Program Management>Non Service Delivery>Non-Targeted Populations	$196,838	$186,644
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>AGYW		$20,000
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Non-Targeted Populations		$8,500
		PREV>Non-Biomedical HIV Prevention>Service Delivery>AGYW		$25,000
		PREV>Violence Prevention and Response>Non Service Delivery>AGYW		$8,000
		SE>Food and nutrition>Service Delivery>Non-Targeted Populations	$24,000	$14,000
		SE>Psychosocial support>Service Delivery>Non-Targeted Populations		$55,000

Table 10: Trinidad and Tobago COP23 FY24 Budget by Intervention

WESTERN HEMISPHERE REGION (PANCAP Mech ID 82195)

Operating Unit	Country	Intervention	Budget	
			2023	2024
Western Hemisphere Region	**Total**		**$193,870**	**$193,870**
	Western Hemisphere Region	C&T>HIV Clinical Services>Non Service Delivery>Key Populations	$31,641	$31,641
		C&T>HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	$126,554	$126,554
		PREV>Comm. mobilization, behavior & norms change>Non Service Delivery>Key Populations	$6,073	
		PREV>Comm. mobilization, behavior & norms change>Non Service Delivery>Non-Targeted Populations	$24,292	
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Key Populations		$6,073
		PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Non-Targeted Populations		$24,292
		ASP>Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations		$1,310
		ASP>Policy, planning, coordination & management of disease control programs>Non Service Delivery>Non-Targeted Populations	$1,310	
		PM>IM Program Management>Non Service Delivery>Non-Targeted Populations	$4,000	$4,000

Table 11: Western Hemisphere Budget by Intervention for Mechanism 82195 PANCAP

Table B.1.2 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Program Area

JAMAICA

Operating Unit	Country	Program	Budget	
			2023	2024
Total			**$15,678,512**	**$15,916,072**
Western Hemisphere Region	**Total**		**$15,678,512**	**$15,916,072**
	Jamaica	C&T	$6,037,344	$6,871,982
		HTS	$934,690	$1,258,120
		PREV	$597,493	$954,373
		SE	$174,124	
		ASP	$2,948,697	$1,953,289
		PM	$4,986,164	$4,878,308

Table 12: Jamaica FOP23 FY24 Budget by Program Area

TRINIDAD & TOBAGO

Operating Unit	Country	Program	Budget 2023	Budget 2024
Total			**$2,027,608**	**$2,080,608**
Western Hemisphere Region	**Total**		**$2,027,608**	**$2,080,608**
	Trinidad and Tobago	C&T	$629,738	$994,458
		HTS	$200,162	$117,256
		PREV		$61,500
		SE	$24,000	$69,000
		ASP	$976,870	$651,750
		PM	$196,838	$186,644

Table 13:Trinidad and Tobago FOP23 FY24 Budget by Program Area

WESTERN HEMISPHERE REGION (PANCAP Mech ID 82195)

Operating Unit	Country	Program	Budget 2023	Budget 2024
Western Hemisphere Region	**Total**		**$193,870**	**$193,870**
	Western Hemisphere Region	C&T	$158,195	$158,195
		PREV	$30,365	$30,365
		ASP	$1,310	$1,310
		PM	$4,000	$4,000

Table 14: Western Hemisphere Region Budget by Program for Mechanism ID 82195 PANCAP

Table B.1.3 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Beneficiary

JAMAICA

Operating Unit	Country	Targeted Beneficiary	Budget 2023	Budget 2024
Total			**$15,678,512**	**$15,916,072**
Western Hemisphere Region	**Total**		**$15,678,512**	**$15,916,072**
	Jamaica	AGYW		$237,560
		Key Populations	$874,262	$720,360
		Non-Targeted Populations	$14,804,250	$14,958,152

Table 15: Jamaica COP23 FY24 Budget by Targeted Beneficary

TRINIDAD & TOBAGO

Operating Unit	Country	Targeted Beneficiary	Budget	
			2023	2024
Total			**$2,027,608**	**$2,080,608**
Western Hemisphere Region	**Total**		**$2,027,608**	**$2,080,608**
	Trinidad and Tobago	AGYW		$53,000
		Non-Targeted Populations	$2,027,608	$2,027,608

Table 16: Trinidad and Tobago COP23 FY24 Budget by Targeted Beneficary

WESTERN HEMISPHERE REGION (PANCAP Mech ID 82195)

Operating Unit	Country	Targeted Beneficiary	Budget	
			2023	2024
Western Hemisphere Region	**Total**		**$193,870**	**$193,870**
	Western Hemisphere Region	Non-Targeted Populations	$193,870	$193,870

Table 17: Western Hemisphere Region Budgets for Mechanism 82195 PANCAP

Table B.1.4 COP 22, COP 23/FY 24, COP 23/FY 25 Budget by Initiative

JAMAICA

Operating Unit	Country	Initiative Name	Budget	
			2023	2024
Total			**$15,678,512**	**$15,916,072**
Western Hemisphere Region	**Total**		**$15,678,512**	**$15,916,072**
	Jamaica	Community-Led Monitoring	$35,000	$35,000
		Core Program	$15,643,512	$15,643,512
		LIFT UP Equity Initiative		$237,560

Table 18: Jamaica COP23 FY24 Budget by Initiative

TRINIDAD & TOBAGO

Operating Unit	Country	Initiative Name	Budget	
			2023	2024
Total			**$2,027,608**	**$2,080,608**
Western Hemisphere Region	**Total**		**$2,027,608**	**$2,080,608**
	Trinidad and Tobago	Community-Led Monitoring	$15,000	$15,000
		Core Program	$2,012,608	$2,012,608
		LIFT UP Equity Initiative		$53,000

Table 19: Trinidad and Tobago COP23 FY24 Budget by Trinidad and Tobago

WESTERN HEMISPHERE REGION (PANCAP Mech ID 82195)

Operating Unit	Country	Initiative Name	Budget	
			2023	2024
Western Hemisphere Region	**Total**		**$193,870**	**$193,870**
	Western Hemisphere Region	Core Program	$193,870	$193,870

Table 20: Western Hemisphere Region Budget by Initiative for Mechanism 82195 PANCAP

B.2 Resource Projections

The PEPFAR team met with country governments, civil society organizations and other key stakeholders in Jamaica and Trinidad & Tobago, to identify and discuss programmatic gaps, and to prioritize activities, with a goal to achieve and sustain epidemic control in each country, despite flat-lined PEPFAR resources.

In Jamaica, in response to government's request to model primary health care integration and to overcome the stall in progress towards 95-95-95, PEPFAR will support a shift back to DSD activities for two HIV sites, as well as entry-to-care (ETC) and return-to-care (RTC) surges. Cost data on previous RTC surge (2019), as well as discussions with the Ministry of Health and Wellness and other partners currently implementing DSD, have informed budget estimates to support these initiatives. As there is no increase in resources for ROP23, the PEPFAR country team identified funding to support the shifts by identifying efficiencies and trade-offs in current ROP22 programming, for example: reducing non-service delivery spend where possible, discontinuing activities with relatively low impact on results, identifying activities that will/ can be completed by end of FY23.

In Trinidad & Tobago, PEPFAR resources will continue to primarily support 2nd 95 through implementation of ETC/ RTC surge campaign, and will assist the country to address challenges with stigma and discrimination. Current ROP22 strategic information and laboratory strengthening activities will be completed or scaled down, to offset the costs of the aforementioned initiatives in ROP23.

In both countries, resources have been allocated appropriately to implementing partners to maximize impact and results. Budgets and interventions have been entered into the FAST to reflect these shifts.

APPENDIX C – Above site and Systems Investments from PASIT and SRE

The barriers to reaching and maintaining epidemic control were identified through consultation with stakeholders and review of currently available data. The key systems gaps identified by the CRP include – Low treatment coverage, low retention in HIV treatment services, insufficient personnel, inconsistent adherence to SOPs/Guidance, high cost of reagents, consumables and supplies, fragmented information systems, data quality issues and high stigma and discrimination.

The CRP has designed a program to address these systemic issues in collaboration with the Ministries of Health. The major activities included in the PASIT also address some of the most important Core Standards and support the achievement of the three UNAIDS indicators (95-95-95). These above-site activities are complementary and synergistic with the proposed site level interventions for this FY.

Enabling Environment and Human Rights

Recognizing the persistent challenge of stigma and discrimination (S&D) on our ability to link and maintain people on care, we have expanded our activities and collaboration on enabling environment and human rights. Being a focal country for collaboration on S&D will ensure that coordinated donor action between PEPFAR, UNAIDS and Global Fund (GF) can inform not only the activities in Jamaica, but also serve as a model for collaboration on S&D for other countries, including Trinidad and Tobago. Collaboration with the Jamaica Partnership to Eliminate all forms of HIV-related S&D, which serves as the coordinating mechanism for these activities, allows for more effective programming, and improved monitoring of outcomes to inform future S&D interventions. CRP is expanding the work with the Jamaica MOHW and stakeholders while partnering with UNAIDS to increase political engagement, advocacy, justice and community-led peer support mechanisms, while enabling CSOs to monitor, evaluate and report on anti-discrimination related interventions, and extend new HIV evidence to the most marginalized communities in Jamaica. Trinidad and Tobago (TT) face similar issues with S&D and issues related to equitable treatment of persons affected by HIV. PEPFAR plans to support advocacy efforts to implement education and sensitization sessions for policy makers to support a human rights-based approach to laws and regulations in TT.

Human Resources for Health

PEPFAR supports Human Resources for Health to ensure high quality HIV services and facilitates innovative activities to train, deploy and monitor the impact of HRH. Activities enable the health workforce to overcome challenges such as insufficient site staffing, high clinician turnover, provider rotation, and migration of HCW to developed countries. The Key Populations Preceptorship (KPP) aims to sensitize HCWs to unique needs and challenges of KPs when seeking health care and promotes provision of tailored services to KPs. In ROP 23, the CRP will diversify the cadres of HCW that are skilled in the provision of person-centered services to priority

populations. KPP can also be expanded to healthcare professional students at the University of the West Indies, by creating readily accessible standardized modules developed from content used at in-person sessions. These and other sessions will be housed on the Learning Management System (LMS), known as the Caribbean Health e-Learning portal. The LMS will also host topics focusing on provision of health services for Older and Aging PLHIV, Adolescent HIV Care, Sexual and Reproductive Health, and other high priority subject areas in Jamaica. The LMS will be expanded in this FY to Trinidad and Tobago, where similar HCW training and professional development activities are needed to strengthen the HIV response. PEPFAR also supports the National Quality Improvement Learning Network, through which the Quality Improvement (QI) key driver and measurement strategy to promote PLHIV retention and viral load suppression sites was developed. The QI hub, hosted on the LMS, serves as a resource for HCW using these tools and lessons in their core work.

Strategic Information

The availability of high-quality strategic information (SI) to monitor country data is challenged by human resource constraints and the existence of separate data streams, managed through a combination of paper-based and electronic systems. Technical assistance for strategic information will be provided to improve data through the review of Spectrum estimates, linking laboratory, pharmacy, and treatment data, matching death data to improve the accuracy of the first 95 estimates, data quality improvement interventions through improved completeness and concordance of data, digitization of data tools, and establishing routine site-level data reviews. There will be a focus on strengthening the health information system to ensure timely availability of surveillance and program monitoring data. These improvements will ensure that the treatment cascades are correctly updated, and that the most accurate and highest quality data are available for analysis and use by the countries. These activities are aligned with addressing the data gaps for each subpopulation targeted as part of the CRP Strategy –

1. **Strengthen/upgrade Data Management systems to improve the timeliness & Quality of surveillance and Program monitoring data:** Support will be provided to MOHs to review the current reporting procedures to offer solutions for entry of case surveillance data at the subnational level, to support timely reporting to national level and use of data to inform subnational planning.
2. **Strengthen the capacity of the MOH to implement active surveillance**: In Jamaica, active surveillance is an integral part of data collection and reporting. A major challenge is the limited human resource capacity to conduct routine visits and complete follow-up contact tracing activities. To address this, PEPFAR will support the hire/retention of surveillance personnel to ensure active surveillance activities are brought to scale and timely data is available to inform planning and monitoring
3. **Strengthen the systems/process for routine analysis of data**: PEPFAR will continue providing support to monitor the MER indicators and support the write up and dissemination of the Annual HIV Epidemiological Report. Data Quality Assessments & improvement activities to update the tools.

4. **Continue strengthening electronic data management system**: The Treatment services database and the Lab Information are linked to ensure that patient data is interconnected. PEPFAR will continue providing systems support including Malware for data security.

In Trinidad and Tobago, discrete databases for case-based surveillance and treatment data prevent the ability to track PLHIV across the continuum of care and lead to delays in access and analysis of data. Support will provide –

1. **Linking and strengthening of HMIS and LIS**: Secure HIV databases which track both positives and negatives and encourage the transition from paper-based to electronic systems.
2. **Data Quality Assessments:** will be supported to clean, collate and update data sources to identify gaps in the clinical cascade and improve the quality of data available for decision making
3. **Strengthen Case based surveillance:** PEPFAR will continue supporting staff for timely collection, data entry, analysis, production of timely reports and real-time use of data for programmatic feedback

Laboratory Strengthening

Several systems barriers existed which prevented effective Laboratory workflow, rapid scale up and efficient monitoring of patient status. Activities to support program improvement include –

1. **Implementation of HIV Rapid recency testing:** support will be provided to implement the Recency rapid Incidence testing algorithm (RITA). PEPFAR will assist the MOHW to analyze the data obtained to design strategic aimed at decreasing the number of new infections and locate any transmission hotspots
2. **HIV Rapid test continuous improvement initiative**: The program will continue to monitor the reduction in HIV testing errors and provide quality assurance panels and hosting of the electronic reporting dashboard, ePT. The quality of Rapid, Self and index testing is supported by the initiatives implemented.
3. **HIV Viral load network strengthening:** Monitoring of HIV Viral load (VL) access and coverage remains a key measure for program success. Currently VL coverage ranges between 80-90% across Jamaica with differences seen in all regions and sites. PEPFAR will continue focusing on decentralizing the VL service to increase capacity to support the patient load and address surges in PLHIV on treatment.
4. **Support for Lab Accreditation and QI**: Quality Improvement policies, standards and activities support all aspects of the diagnostic process and assists in the monitoring of the delivery of services.

In Trinidad and Tobago, a package of activities is proposed to improve Laboratory quality improvement and assurance. Laboratory systems strengthening activities continue to support service improvements in Trinidad, to include:

1. **Support for screening Advanced HIV disease patients:** PEPFAR support will assist with the validation and eventual implementation of the CD4 rapid test kits for Advanced HIV disease. The MOH currently has limited capacity to test CD4 samples as a routine monitoring test and to screen late presenters. This support will assist in bridging that gap.
2. **HIV rapid test continuous quality improvement initiative:** The program will continue to monitor the reduction in HIV testing errors and provide quality assurance panels and hosting of the electronic reporting dashboard, ePT.
3. **Support for HIV Drug resistance:** Technical assistance will continue to support the expansion of HIV drug resistance testing as a referral service.
4. **Support for Lab Accreditation and QI**: Quality Improvement policies, standards and activities support all aspects of the diagnostic process and assists in the monitoring of the delivery of services.
5. **HIV Viral load network strengthening**: Viral load testing will be scaled up to address increasing numbers of ART patients. Technical assistance will be provided to identify existing gaps and find areas for improvement in the diagnostic workflow. Monitoring the processes will determine if the tests are performed and returned in a reasonable timeframe to assist with effective patient management.

PASIT ROP23

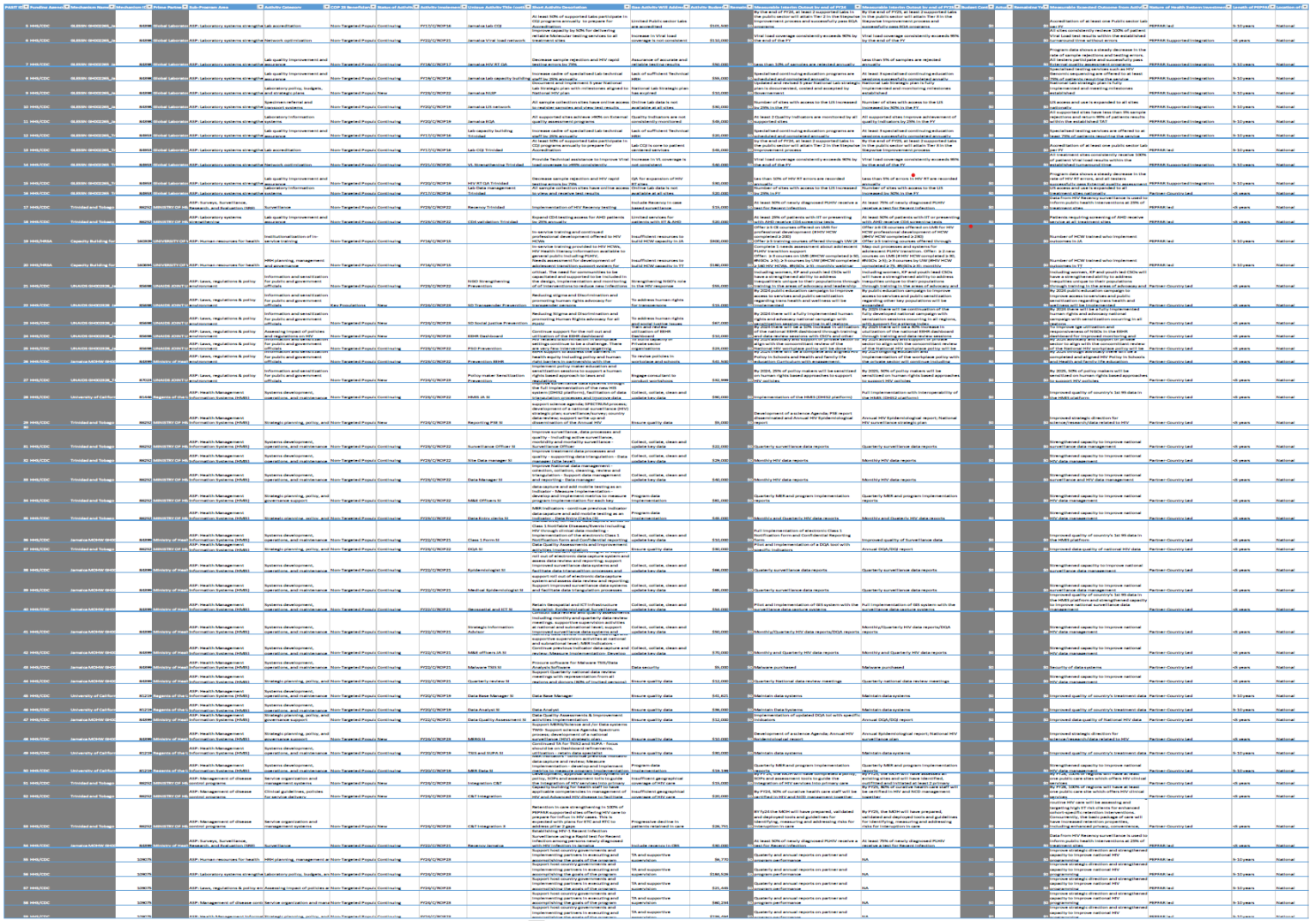

Table 21: PASIT Overview

Prior Year SRE ROP23

Caribbean

Prior year SRE ROP23 Input

PASIT ID	USG funding	Name of the IM responsible for	NEW name of	Name of implem	NEW name of	Mechanism ID of the	Activity Categor	NEW	TSI UID of the	COP23 program area	COP23 beneficiar	COP23 activity	Previous COP	Activity description	Activity type	Activity title	Primary study question	Is the acti	COP year/fisc	Activity end	Current st	CHECK	Notes
17	HHS/CDC	Trinidad and Tobago MOH CoAg GH002491	MINISTRY OF HEALTH			86252 Surveillance			AlwrkahlhsX	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Non-Targeted Populations	$15,000	$20,000	Establishing HIV-1 Recenct Infection Surveillance using a Rapid test for Recent infection among persons Newly diagnosed with HIV infection in Trinidad	Surveillance	HIV Recency testing in Trinidad	To determine the proportion of individuals with recent HIV infection, as evaluated by RTRI, among newly diagnosed HIV positive persons in	COP	COP21/FY22	COP24/FY25	Ongoing	Yes	
54	HHS/CDC	Jamaica MOHW GH002357	Ministry of Health			84399 Surveillance			Rldxcpcjxlp	ASP: Surveys, Surveillance, Research, and Evaluation (SRE)	Non-Targeted Populations	$30,000	$30,000	Infection Surveillance using a Rapid test for Recent infection among persons Newly diagnosed with HIV infection in Jamaica	Surveillance	HIV Recency testing Jaamica	proportion of individuals with recent HIV infection, as evaluated by RTRI, among newly diagnosed	COP	COP21/FY22	COP24/FY25	Ongoing	Yes	

Table 22: Prior Year SRE

APPENDIX D – Optional Visuals

Overview of 95/95/95 Cascade, FY23

Jamaica

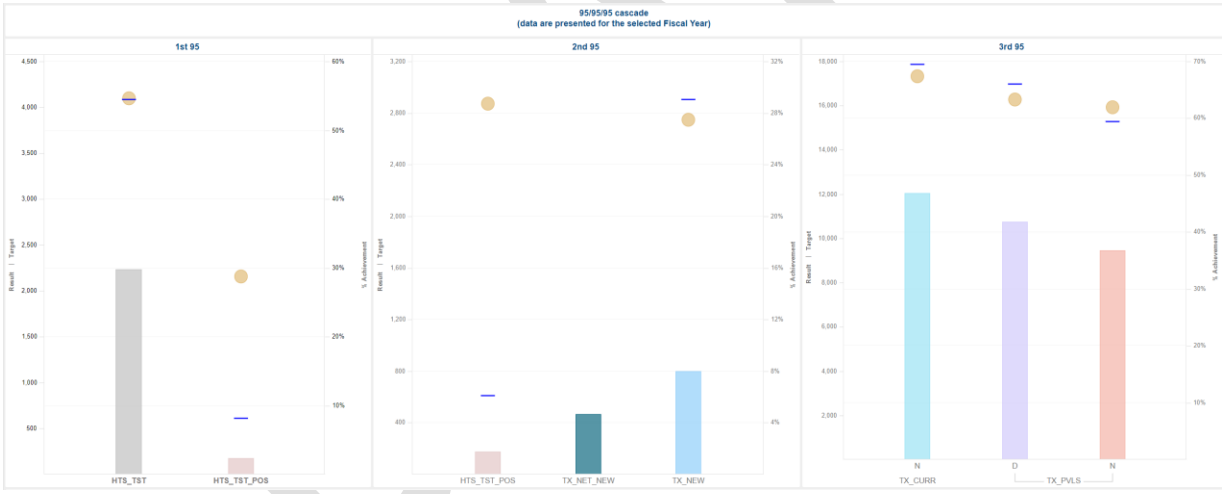

Figure 6: Jamaica 95-95-95 Cascade for FY23

Trinidad & Tobago

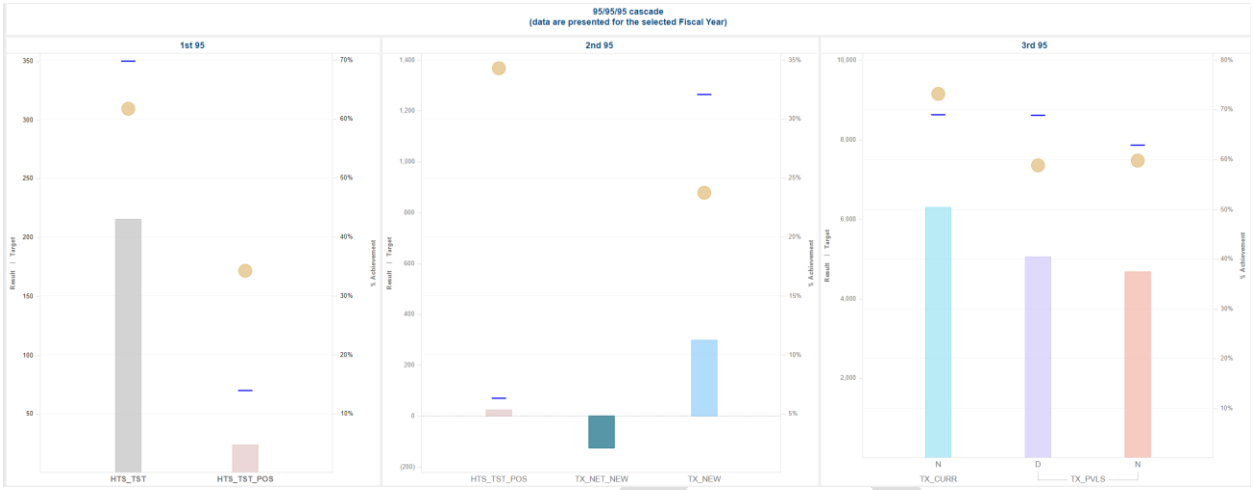

Figure 7: Trinidad and Tobago 95-95-95 Cascade for FY23

Panorama: Clinical cascade, Single OU dossier, overall cascade page

Clients Gained/Lost from ART by Age/Sex, FY22 Q4

Jamaica

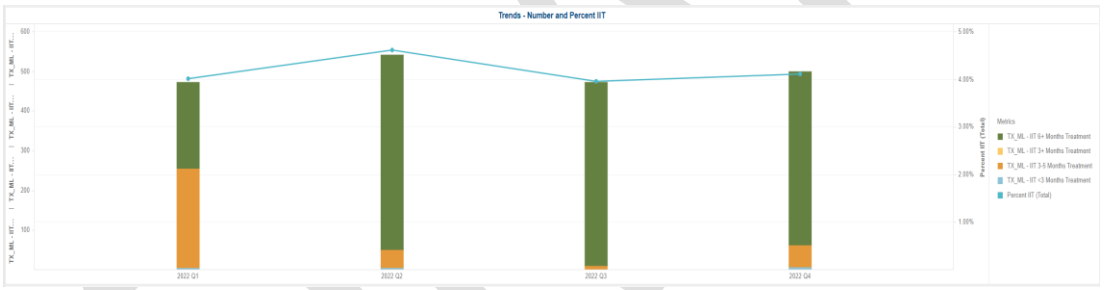

Figure 8: Jamaica Interruption in Treatment Trends

Panorama: Treatment, single OU dossier, interruptions in treatment (IIT) chapter, IIT Trends

Trinidad & Tobago

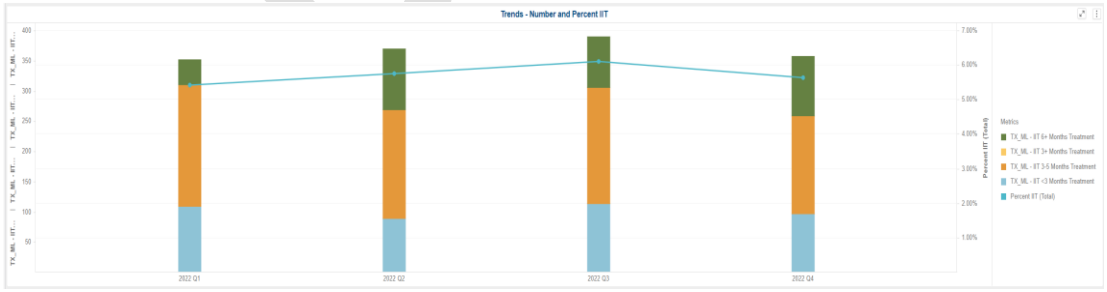

Figure 9: Trinidad and Tobago Interruption in Treatment Trends

Panorama: Treatment, single OU dossier, interruptions in treatment (IIT) chapter, IIT Trends