DEPARTMENT OF

HEALTH

GOVERNMENT OF PUERTO RICO

PUERTO RICO 2027 - 2031

INTEGRATED HIV SURVEILLANCE, PREVENTION, AND TREATMENT PLAN

June 2026

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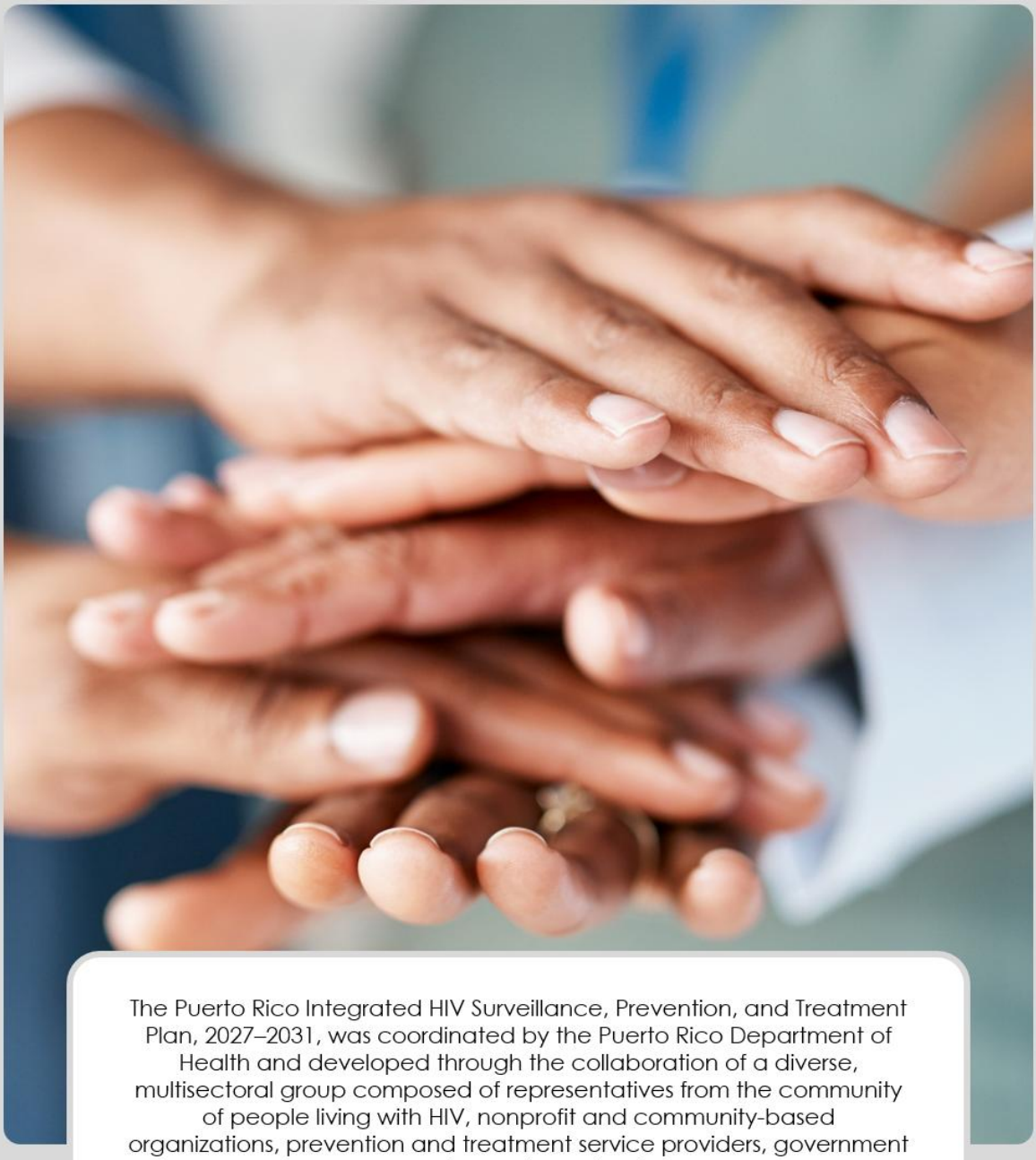

The Puerto Rico Integrated HIV Surveillance, Prevention, and Treatment Plan, 2027–2031, was coordinated by the Puerto Rico Department of Health and developed through the collaboration of a diverse, multisectoral group composed of representatives from the community of people living with HIV, nonprofit and community-based organizations, prevention and treatment service providers, government agencies, and academia.

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LIST OF ABBREVIATIONS

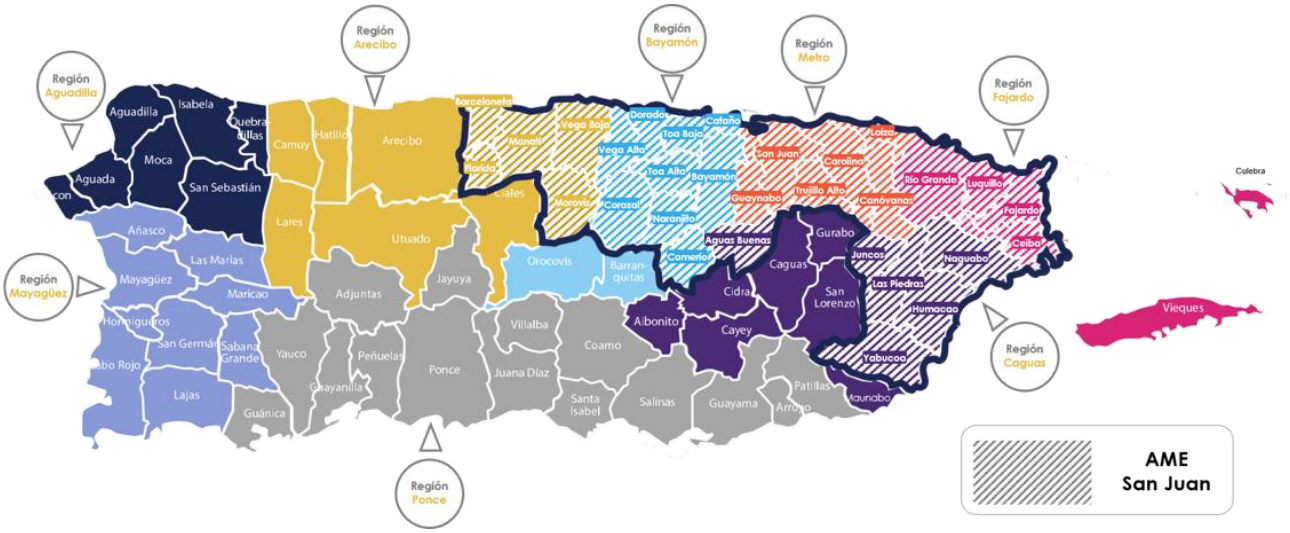
ADAP	AIDS Drug Assistance Program
ADAP ERF	ADAP Emergency Relief Fund
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ASES	PR Health Insurance Administration (acronym in Spanish)
ASSMCA	PR Administration of Mental Health and Anti-Addiction Services (acronym in Spanish)
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CoC	Continuum of Care
CPTETs	Centers for the Prevention and Treatment of Transmissible Diseases (acronym in Spanish)
EHE	Ending the HIV Epidemic in the U.S.
EMA	Eligible Metropolitan Area
FQHC	Federally Qualified Health Center
GPPV	HIV Prevention Planning Group (acronym in Spanish)
HC	Heterosexual Contact
Hep C	Hepatitis C
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
IPA	Independent Practice Association
MSM	Men Who Have Sex with Men
NECA AETC	Northeast Caribbean AIDS Education and Training Center
NHAS	National HIV/AIDS Strategy
nPEP	Non-Occupational Post-Exposure Prophylaxis
PEH	People Experiencing Homelessness
PEP	Post-Exposure Prophylaxis
PRDF	Puerto Rico Department of the Family
PrEP	Pre-Exposure Prophylaxis
PRDOCR	Puerto Rico Department of Corrections and Rehabilitation
PRDOH	Puerto Rico Department of Health
PRDOLHR	Puerto Rico Department of Labor and Human Resources
GPRWBA	Ryan White Part B/ADAP Planning Group (acronym in Spanish)
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RSI	Rapid Start Initiative (Rapid Start Protocol)
RWHAP	Ryan White HIV/AIDS Program
SAMHSA	Substance Abuse and Mental Health Services Administration
SPCEIT	Section for the Prevention and Control of Transmissible Diseases and Infections (acronym in Spanish)
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TB	Tuberculosis
U=U	Undetectable = Untransmittable
VH	Viral Hepatitis

SECTION I: INTRODUCTION OF INTEGRATED PLAN AND SCSN

1. INTRODUCTION

This document presents the Puerto Rico Integrated HIV Surveillance, Prevention, and Care Plan for the 2027–2031 period (hereinafter referred to as the Integrated Plan), developed in compliance with the requirements established by the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) for the jurisdiction of Puerto Rico and the San Juan Eligible Metropolitan Area (San Juan EMA). The Integrated Plan incorporates the Statewide Coordinated Statement of Need (SCSN), which serves as a fundamental component of the planning process by identifying the priority HIV prevention and care needs in Puerto Rico and guiding the coordination of resources and services to address them.

Illustration 1: Geographic Area Covered by the Plan



Puerto Rico continues to be one of the jurisdictions in the United States with the highest HIV incidence and prevalence rates. As of October 31, 2025, a total of 52,869 persons had been diagnosed with HIV in Puerto Rico. In addition, in 2023, Puerto Rico ranked eighteenth among U.S. states and territories in the number of HIV diagnoses and eighth in the prevalence of persons with an HIV positive diagnosis. Within this context, over the past several decades, the Government of Puerto Rico, in collaboration with community-based organizations, service providers, academic institutions, government agencies, and people with an HIV positive diagnosis, has implemented numerous initiatives aimed at strengthening the HIV surveillance, prevention, and care system. These efforts have contributed to improving access to essential services, promoting early diagnosis, reducing new infections, and increasing retention in care and viral suppression among individuals diagnosed with HIV.

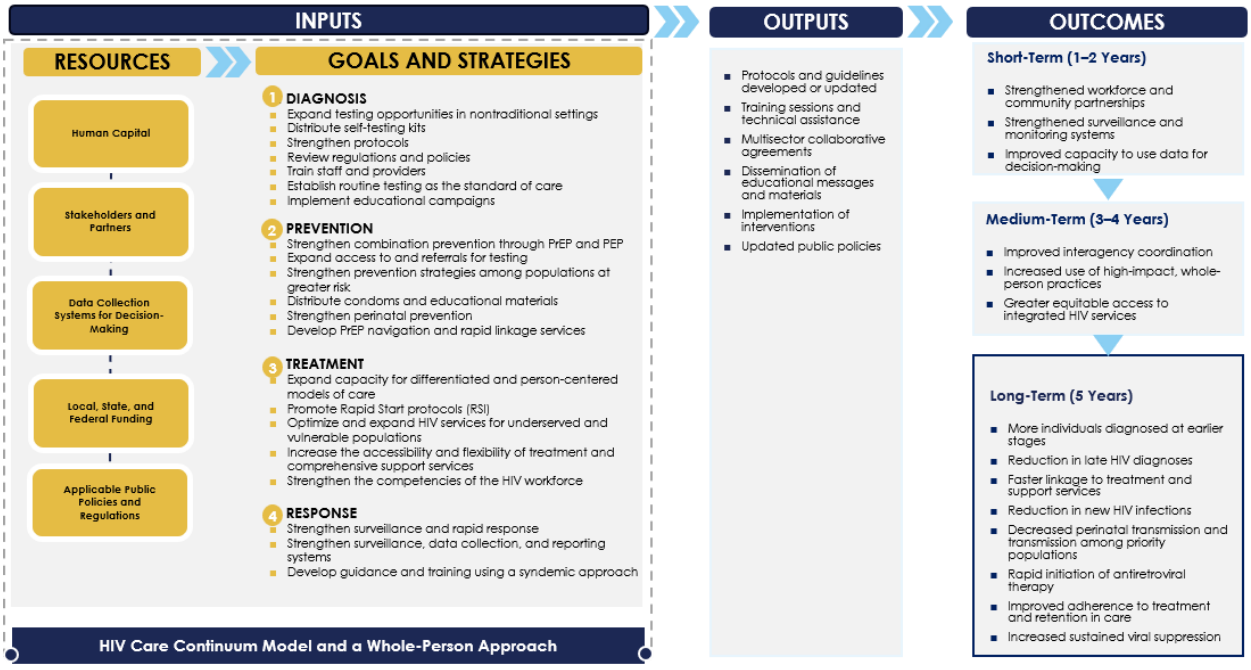
This Integrated Plan was developed through a participatory planning process that engaged 165 key stakeholders involved in the HIV response in Puerto Rico. Its development was informed by an analysis of the jurisdiction's epidemiological situation, a review of relevant scientific and programmatic literature, and the findings of needs assessments conducted by the San Juan Eligible Metropolitan Area Ryan White Part A

Program, the Ryan White Part B/ADAP Program, and the Puerto Rico Department of Health STD/HIV/Viral Hepatitis Prevention Program. In addition, the Plan incorporates input gathered through community consultations involving stakeholders, service providers, people with an HIV positive diagnosis, and representatives of populations disproportionately affected by the epidemic.

The development of the Plan was also informed by the findings, achievements, challenges, and lessons learned during the implementation of the 2022–2026 Integrated Plan. An analysis of progress made and persistent gaps helped identify priority areas for strengthening the HIV response and guided the development of new goals, objectives, and strategies for the 2027–2031 period.

Based on the identified needs and the current context in Puerto Rico, four strategic areas related to HIV diagnosis, prevention, treatment, and response were established. These areas are aligned with national HIV-related goals and the strategies promoted through the Ending the HIV Epidemic (EHE) initiative. To achieve these goals, the Plan incorporates specific objectives, strategies, and actions grounded in the HIV care continuum model and a whole-person approach, recognizing the importance of comprehensively addressing the clinical, social, structural, and behavioral factors that influence persons' health and well-being.

Illustration 2: Theory of Change for the Integrated Plan



a. Approach

To meet the requirement for submission of an Integrated Plan, the jurisdiction developed a new strategic planning instrument using a participatory, collaborative, and evidence-based approach. The planning process promoted the active involvement of people with an HIV positive diagnosis, representatives of populations disproportionately affected by the epidemic, state and federal government agencies, community-based and nonprofit organizations, service providers, academic institutions, and other key stakeholders involved in Puerto Rico's HIV response. The activities carried out to develop the Plan were

organized into three main phases, which are described in greater detail in a subsequent section (Section II).

b. Documents Submitted to Meet Requirements

In accordance with the Integrated HIV Prevention and Care Plan Guidance for developing the 2027–2031 Plan issued by the CDC and HRSA, Puerto Rico is submitting this new Integrated Plan, which incorporates the Statewide Coordinated Statement of Need (SCSN).

The Plan was developed as a comprehensive document for both the jurisdiction and the San Juan Eligible Metropolitan Area (EMA), bringing together the principal findings, analyses, and strategies derived from the planning process described above. To address the requirements established in the federal guidance, the document includes the following sections:

- Description of the planning process and community engagement activities (Section II);
- Datasets, information sources, and assessments that contributed to the development of the Plan (Section III);
- Situational analysis of the epidemic and of the HIV prevention and care systems (Section IV);
- Goals, objectives, and strategies for the 2027-2031 period (Section V);
- Framework for implementation, monitoring, evaluation, and oversight of the Plan (Section VI); and
- Letters of Concurrence from the corresponding planning bodies (Section VII).

SECTION II: COMMUNITY ENGAGEMENT AND PLANNING PROCESS

1. JURISDICTION PLANNING PROCESS

Planning Steps - To develop the Integrated Plan, the jurisdiction adopted a participatory and collaborative planning approach through which persons with an HIV-positive diagnosis, representatives of populations disproportionately affected by the epidemic, state and federal government agencies, community-based and nonprofit organizations, service providers, academic institutions, and other key stakeholders actively participated in the identification and prioritization of needs, the development of goals and objectives, and the design of the strategies included in the Plan.

The purpose of this approach was to promote the integration of diverse sectors into the decision-making process, strengthen existing collaborations, and foster new partnerships that will contribute to the effective implementation of the Integrated Plan. To facilitate the development of the Plan, activities were organized into three main phases: an organization and preparation phase, a situational assessment and analysis phase, and a plan development phase.

Illustration 3: Organization of the Planning Process

During the first phase, the Puerto Rico Department of Health and the San Juan EMA Ryan White Part A Program established a Planning Committee composed of staff from the agency's HIV-related divisions and representatives from the consulting team. The Committee was responsible for developing and monitoring the work plan for the preparation of the Integrated Plan, designing the participation and consultation methodology, identifying the information sources required for the analysis, and selecting the stakeholders to be invited to participate in the planning process.

During the second and third phases, three rounds of participatory workshops were conducted. The first round was designed to validate the needs identified through the analysis of secondary data sources, establish the priority areas of the Integrated Plan, and identify existing barriers and gaps within the service system. The second round focused on the development of goals, objectives, and strategies based on the priorities previously identified. Finally, the third round consisted of a plenary session to validate the draft Integrated Plan and gather final recommendations. Once the recommendations resulting from this process were incorporated, the revised draft of the Integrated Plan was posted on the Department of Health's website to solicit additional feedback from the community and other interested stakeholders before preparation of the final version.

Groups Involved - The planning process included broad and diverse participation from stakeholders involved in HIV surveillance, prevention, and care in Puerto Rico. As part of the organizational phase, a stakeholder matrix was developed to ensure representation from the sectors recommended in the integrated planning guidance issued by CDC and HRSA, as well as from other collaborators relevant to the HIV response in the jurisdiction. Through the various work sessions, workshops, and consultation rounds, 165 individuals participated on behalf of a wide range of sectors, including persons with an HIV-positive diagnosis, state and federal government agencies, community-based and nonprofit organizations, health care and support service providers, community health centers, academic and research institutions, entities involved in responding to HIV clusters or outbreaks, and other stakeholders associated with HIV surveillance, prevention, and care systems.

Usage of Data Sources - As part of the planning process, a variety of quantitative and qualitative information sources were identified and analyzed to support decision-making. These sources included the Puerto Rico epidemiologic profile, HIV surveillance systems, needs assessments conducted by the San Juan Eligible Metropolitan Area Ryan White Part A Program, the Ryan White Part B/ADAP Program, and the Puerto Rico Department of Health STD/HIV/Viral Hepatitis Prevention Program. Programmatic data, findings from recent research studies, relevant scientific and technical literature, and other information

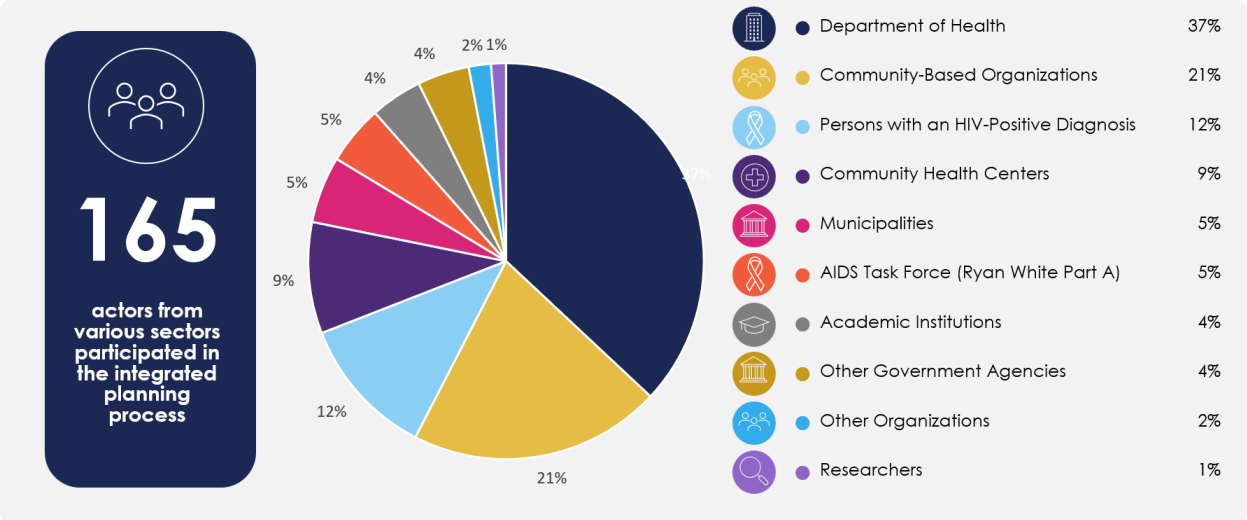
related to HIV prevention, care, and treatment needs in Puerto Rico were also considered. Findings derived from these sources served as the basis for validating needs, identifying priorities, analyzing barriers and gaps within the service system, and developing the goals, objectives, and strategies included in the Integrated Plan.

Representation from People and Communities Disproportionally Impacted by HIV - The planning process incorporated the active participation of persons with an HIV-positive diagnosis and representatives of communities disproportionately affected by the epidemic. Their involvement occurred primarily through consultation workshops and other communication and feedback mechanisms implemented throughout the planning process, including a dedicated planning process website where the draft Plan was posted for public comment.

c. Entities Involved in the Process

As previously noted, the process for developing the Integrated Plan included broad and diverse participation from stakeholders involved in HIV surveillance, prevention, and care in Puerto Rico. As part of the organizational phase of the Plan, a stakeholder matrix was developed to ensure representation from all sectors recommended in the integrated planning guidance issued by CDC and HRSA. Through the workshops and consultation rounds, 165 persons participated, representing the community of persons with an HIV-positive diagnosis, the Puerto Rico Department of Health, community-based organizations and other service providers, advisory bodies (Ryan White Part B/ADAP Planning Group, the Ryan White Part A Planning Council, the HIV Prevention Planning Group, the Puerto Rico Ryan White Inter-Part Committee, community health centers, stakeholders who can assist in responding to HIV clusters or outbreaks, federal, state, and local government agencies, researchers and academics, and other key stakeholders.

Graph 1: Sector Representation of Participants in the Integrated Planning Process



The following entities were represented in the planning process.

Illustration 4: Entities and Stakeholders represented in the planning process

- **Community of Persons with an HIV-Positive Diagnosis**
- **Planning Advisory Bodies**
  - Ryan White Part A Planning Council
  - Ryan White Part B/ADAP Planning Body
  - HIV Prevention Planning Group
  - Puerto Rico Ryan White Inter-Part Committee
- **Department of Health Planning Committee**
  - Assistant Secretariat for Integrated Health Services (SASSI, as its acronym in Spanish)
  - Ryan White Part B/ADAP Program
  - STD/HIV/Viral Hepatitis Prevention Program
  - HIV Surveillance System

Entities Represented in the Planning Process (Alphabetical Order)

- AIDS Healthcare Foundation
- AIDS Program – Dr. Manuel Díaz García Center, San Juan Capital City
- AIDS Task Force Ryan White Part A/MAI
- APSAPS
- ARARAT Center
- ASPIRA
- ATF - TIES
- Bayamón Epidemiology Center
- Bill's Kitchen
- Casa Joven del Caribe, Inc.
- Castañer General Hospital
- CAVV
- Centro de Salud de Lares, Inc.
- Civil Rights Commission
- CLETS
- CoC 503 – Moriviví Coordinating Organization
- Community Legal Office
- Comprehensive Cancer Center
- Control V – Department of Health, San Juan Capital City
- COSSMA
- CPTET Arecibo
- CPTET Bayamón
- CPTET Caguas
- CPTET Carolina
- CPTET Fajardo
- CPTET Mayagüez
- CPTET Ponce
- Department of Correction and Rehabilitation
- Department of the Family
- Department of the Family – CoC 502
- Eligible Metropolitan Area (EMA) Part A
- Esperanza para la Vejez
- Fortaleza del Caído Residential Program
- GAMMA Project, University of Puerto Rico Medical Sciences Campus
- Guara Bi, Inc.
- Healthcare Integrated Program Services, Inc.
- HealthproMed
- Hepatitis Surveillance Program, Department of Health
- HIV-Free Ending HIV Epidemic Initiatives, Department of Health, San Juan Capital City
- Hogar CREA
- HOPWA
- IPVI PR
- Loíza Comprehensive Health Council
- Más Salud Center, Municipality of San Juan
- Maternal and Child Studies Center, University of Puerto Rico Medical Sciences Campus
- Med Centro, Inc.
- Medicaid
- MEDX
- Movimiento en Respuesta al VIH, Inc.
- Municipality of San Juan
- Municipality of San Juan TIES-EHE Project
- Neomed Gurabo
- Organization Coordinadora Moriviví
- PACTA, Inc.
- Physician Correctional
- PR CONCRA
- Prepven
- Puerto Rico Health Insurance Administration (ASES)
- Ryan White Part B/ADAP Program
- Ryan White Part F – NECA AETC (University of Puerto Rico Medical Sciences Campus)
- School Health Program, Department of Education
- School of Health Professions, University of Puerto Rico - Medical Sciences Campus
- Science, Technology and Research Trust
- Southern Puerto Rico Regional Consortium
- Waves Ahead
- Youth Advisory Council, Department of Health

d. Role of the Ryan White Part A Planning Council

The San Juan Eligible Metropolitan Area (EMA), the recipient of Ryan White Part A funding, represents the geographic area with the highest HIV incidence and prevalence in Puerto Rico. The Council Co-Chairs, as well as other Council members and representatives of the administrative agency, participated in all three rounds of workshops conducted as part of the planning process. They also contributed information for the development of the Plan, particularly the San Juan EMA Needs Assessment, which serves as one of the foundations of the SCSN.

e. Role of Planning Bodies and Other Entities

In Puerto Rico, there are two planning bodies responsible for prevention and care planning: the Ryan White Part B/ADAP Planning Group and the Puerto Rico HIV Prevention Planning Group, with representation from both programs on each advisory body. In addition, representatives from the Ryan White HIV/AIDS Program (RWHAP) Parts constitute an advisory body known as the Puerto Rico Ryan White Inter-Part Committee. Through the workshops designed as part of the participatory planning process, representatives of the planning bodies, including its Co-Chairs, as well as other service organizations, had the opportunity to provide input regarding prevention and care needs, existing resources to address those needs, and barriers and gaps within the service delivery system. Based on the results of these discussions, goals and objectives were established, and strategies were developed to address them. Prior to the initiation of the planning process, each planning body had the opportunity to discuss the Plan and its requirements in depth during their regular meetings. In addition, after the draft Plan was developed, they allocated time on their agendas to review the document and submit their letters of concurrence.

f. Collaboration with RWHAP Parts – SCSN Requirement

The development of the Integrated Plan and the SCSN was based on a coordinated process of analysis, consultation, and planning that incorporated the participation of representatives from the various Ryan White Program (RWHAP) components in Puerto Rico. The process was informed by the results of needs assessments conducted by the Ryan White Part B/ADAP Program, the San Juan Eligible Metropolitan Area (EMA) Ryan White Part A Program, and the Puerto Rico Department of Health STD/HIV/Viral Hepatitis Prevention Program, complemented by information from the epidemiologic profile, surveillance systems, and other relevant sources. Findings were analyzed and discussed during integrated planning activities with the participation of representatives from Ryan White Parts A, B, C, and D, as well as recipients and collaborators associated with Part F. This process facilitated the identification and prioritization of needs, service gaps, and opportunities to strengthen integration and coordination among the various components of the HIV response system. It also promoted alignment of goals, strategies, and priorities across the Ryan White programs, the Department of Health's prevention efforts, and initiatives implemented under the Ending the HIV Epidemic (EHE) Initiative.

g. Engagement of People with HIV – SCSN requirement

As previously described, the planning process was grounded in a participatory and empowerment-based approach that promoted the involvement of people with an HIV-positive diagnosis, including persons with viral hepatitis coinfection, throughout all stages of the planning process. To achieve this, a variety of consultation and engagement mechanisms were utilized, including workshops, meetings, distribution of review materials

through electronic platforms, and telephone follow-up. These mechanisms enabled persons with an HIV-positive diagnosis to actively participate in needs assessment activities, the identification and prioritization of areas requiring attention, discussions regarding barriers and gaps in the service system, and the development of goals, objectives, strategies, and activities included in the Integrated Plan. Overall, 12% of participants in the planning process were people with an HIV-positive diagnosis. The participation of people with HIV-positive diagnosis will continue throughout implementation of the Integrated Plan. Their representation will be encouraged in the workgroups and coordination structures established to monitor the Plan's goals and strategies. Their involvement will also be promoted in monitoring, evaluation, and continuous quality improvement processes through periodic review of progress, discussion of results with planning bodies, and participation in community consultation and accountability activities.

h. Priorities

As a result of the needs assessments, epidemiologic analysis, and community engagement activities, the following priorities were identified to strengthen the HIV response in Puerto Rico during the 2027–2031 period. These priorities are discussed in greater detail in the Needs Assessment section.

Illustration 5: Plan Priorities

i. Updates to Other Strategic Plans Used to Meet Requirements

Puerto Rico did not use sections from other local strategic plans to satisfy the requirements of this section of the Integrated Plan. The *2027–2031 Integrated Plan for HIV Surveillance, Prevention, and Care* was developed as a new strategic planning instrument through a participatory planning process. However, the planning process included a review of achievements, challenges, lessons learned, and priorities identified through previous planning initiatives and processes, including those developed under the Ending the HIV Epidemic (EHE) Initiative.

SECTION III: CONTRIBUTION OF DATASETS AND ASSESSMENTS

1. DATA SHARING AND USE

For the development of the Integrated Plan, multiple quantitative and qualitative data sources were used to describe the HIV situation in Puerto Rico, identify prevention and treatment needs, analyze barriers to accessing services, and inform the development of priorities, goals, and strategies. Key sources included the epidemiologic profile prepared by the Puerto Rico Department of Health HIV Surveillance System; the Puerto Rico Ryan White Part B/ADAP Needs Assessment (2026); the San Juan Eligible Metropolitan Area (SJEMA) Ryan White Part A Needs Assessment (2026); the Puerto Rico HIV Prevention Needs Assessment (2023–2024); as well as other relevant studies, reports, and scientific literature. This information was complemented by input obtained through workshops, consultations, and participatory activities conducted as part of the planning process.

The data collected made it possible to characterize the epidemic, identify disproportionately affected populations, assess service needs and barriers to access, analyze gaps across the prevention and care continuums, and establish the priorities that guide this Integrated Plan. The epidemiologic profile was developed using data from the Puerto Rico HIV/AIDS Surveillance System, the National HIV Behavioral Surveillance (NHBS) system, and the U.S. Census Bureau.

The use and management of these data are conducted in accordance with the applicable legal and regulatory framework. Pursuant to the Organic Act of the Puerto Rico Department of Health, Act No. 81-1912, as amended; Act No. 86-2026, known as the Puerto Rico Health Information Exchange Promotion and Establishment Act; Act No. 81-1983, as amended, known as the Sexually Transmitted Disease Prevention and Treatment Act; and applicable regulations and administrative orders, including Administrative Order No. 597, as amended, issued by the Puerto Rico Department of Health, all healthcare professionals in Puerto Rico are required to report HIV-related laboratory results to the Department of Health's Surveillance Program. In addition, the Surveillance Program maintains collaborative agreements for the exchange and use of data with key entities within the HIV prevention and care system. These include an agreement with the Ryan White Part B/ADAP Program and the San Juan Municipal AIDS Task Force, the recipient of Ryan White Part A funds, as part of the CDC-sponsored Data to Care initiative.

2. EPIDEMIOLOGICAL PROFILE

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

Demographic characteristics of the Puerto Rican population in the year 2024

Puerto Rico comprises 78 municipalities divided into 8 Health Regions (Illustration 6). 22.9% of the island's total population resides in the Metropolitan Region, which includes the municipality of San Juan, one of the areas selected for the first phase of the EHE.

The resident population of Puerto Rico was estimated at 3,203,295 in 2024, representing a 2.5% decrease compared to the 2020 census data (Table 1). Most municipalities experienced a decline in population during this same period, including those in the Metropolitan Region.

The median age of Puerto Rico's residents in 2024 was 45.6 years. Women accounted for 52.8% of the total population (Table 2). The median age of women was higher than that of men, at 47.5 and 43.4 years, respectively. Approximately 30% of the island's total population was between the ages of 13 and 34 in 2024. A higher percentage of women were 65 years of age or older compared to men, 26.6% and 22.4%, respectively. Conversely, a higher proportion of adolescents and young men aged 13 to 24 was observed compared to women of the same age, 29.9% and 26.3%, respectively.

Illustration 6: PRDOH Epidemiological regions

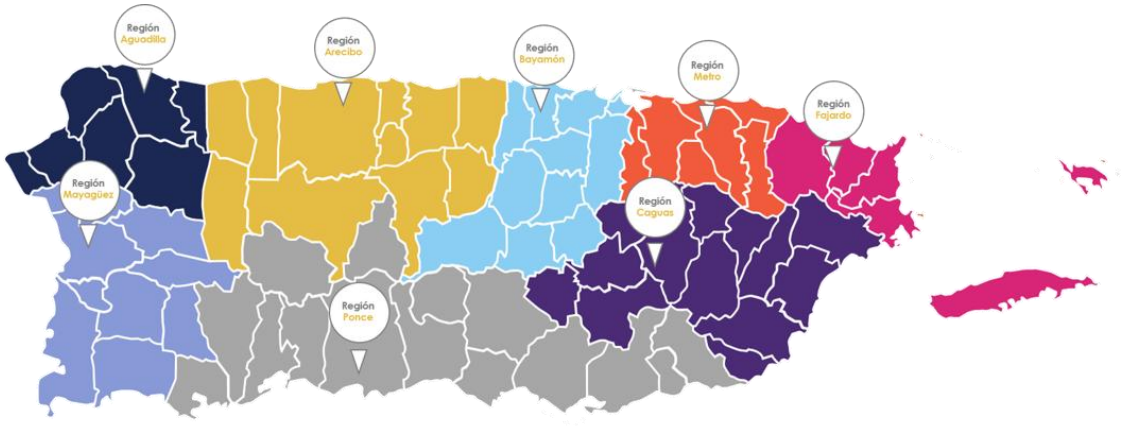


Table 1: Population Change in Puerto Rico, 2020–2024

	Population estimates				
	2020	2021	2022	2023	2024
Puerto Rico	3,285,874	3,262,711	3,220,137	3,203,792	3,203,295

Source: Federal Census Bureau, several years.

Table 2: Population Distribution by Age and Sex, PR, 2024

Age group	General		Men		Women	
	Number	Percentage	Number	Percentage	Number	Percentage
0-12	304,684	9.5	156,034	10.3	148,650	8.8
13-24	456,890	14.3	231,973	15.3	224,917	13.3
25-34	440,512	13.8	220,159	14.6	220,353	13.0
35-44	376,963	11.8	178,695	11.8	198,268	11.7
45-54	405,147	12.6	190,339	12.6	214,808	12.7
55-64	430,312	13.4	196,543	13.0	233,769	13.8
≥65	788,787	24.6	338,416	22.4	450,371	26.6
Total	**3,203,295**	**100.0**	**1,512,159**	**100.0**	**1,691,136**	**100.0**
Median age	***45.6***		***43.4***		***47.5***	

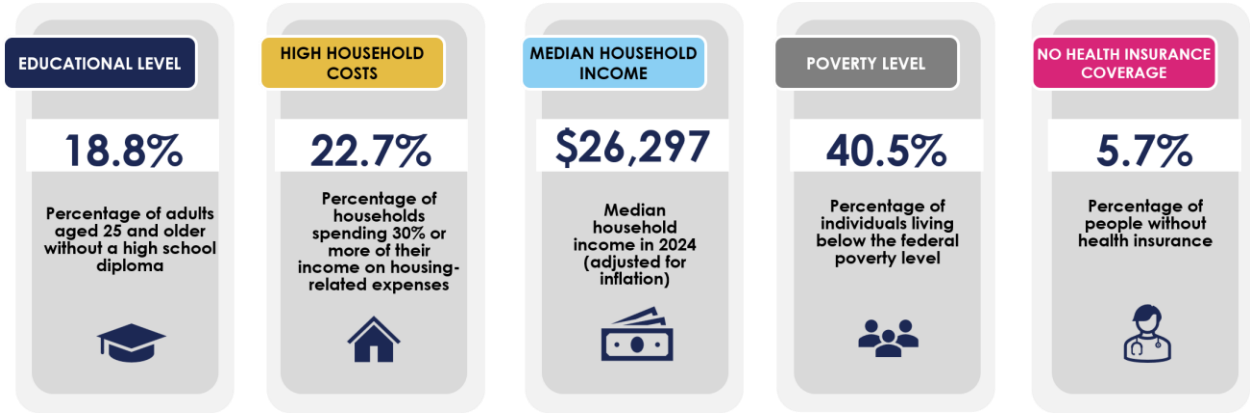
Source: Federal Census Bureau, Population Estimate for Puerto Rico as of July 1, 2024.

Social determinants of health – General population

According to the World Health Organization, the social determinants of health are the conditions in which people are born, grow up, live, work, and age, and which have a significant impact on the health and well-being of populations. Data from the Census Bureau's Community Survey indicate that the socioeconomic situation of Puerto Rico residents is characterized by a high proportion of people aged 25 and over who have not graduated from high school (18.8%), people living below the federal poverty level

(40.5%), and households that spend 30% or more of their income on housing-related costs. Furthermore, the inflation-adjusted median household income was $26,297 in 2024, 3.2 times lower than the national median household income (Illustration 7).

Illustration 7: Social determinants of health—general population, Puerto Rico, 2020–2024



Source: U.S. Census Bureau, Puerto Rico Community Survey, 2020–2024.

Description of new HIV diagnoses in 2024

A total of 346 cases of HIV infection were diagnosed in adolescents and adults aged 13 and older in 2024. The HIV diagnosis rate for that year was 11.9 per 100,000 population. The distribution by sex indicates that the HIV diagnosis rate among men is 5.8 times higher than the HIV diagnosis rate among women (Table 3).

Table 3: Distribution of new HIV diagnoses among adolescents and adults aged 13 and older by sex, PR 2024

Sex	HIV diagnoses in adolescents and adults ≥13 years	Percentage	Population (adolescents and adults ≥13 years)	Diagnosis rate (per 100,000 inhabitants)
Male	289	83.5%	1,356,125	21.3
Female	57	16.5%	1,542,486	3.7
Total	**346**	**100.0%**	**2,898,611**	**11.9**

Most HIV cases are diagnosed between the ages of 25 and 34 (Table 4). In 2024, 121 people between the ages of 25 and 34 were diagnosed with HIV, representing 35.0% of all cases diagnosed that year. The diagnosis rate increases with age, peaking among 25- to 34-year-olds, and then declines after age 35.

The distribution of new HIV diagnoses by age and sex shows that men aged 25 to 34 and women aged 35 to 44 had the highest rates in 2024. Compared to women, the rate of new HIV diagnoses is, on average, 9 times higher in men aged 25 to 34 and 3.7 times higher in men aged 55 and older (Table 4).

Table 4: Rate of new HIV diagnoses among adolescents and adults ≥ 13 years of age-by-age group and sex, PR 2024

Age Group	Men			Women			General		
	Number	Percentage	Rate*	Number	Percentage	Rate*	Number	Percentage	Rate*
13 - 24	39	13.5	16.8	6	10.5	2.7	45	13.0	9.8
25 - 34	109	37.7	49.5	12	21.1	5.4	121	35.0	27.5

Age Group	Men			Women			General		
	Number	Percentage	Rate*	Number	Percentage	Rate*	Number	Percentage	Rate*
35 - 44	60	20.8	33.6	14	24.6	7.1	74	21.4	19.6
45 - 54	43	14.9	22.6	12	21.1	5.6	55	15.9	13.6
55 - 64	20	6.9	10.2	6	10.5	2.6	26	7.5	6.0
≥ 65	18	6.2	5.3	7	12.3	1.6	25	7.2	3.2
Total	**289**	**100.0**	**21.3**	**57**	**100.0**	**3.7**	**346**	**100.0**	**11.9**

* Rate per 100,000 inhabitants

In 2024, unprotected sex between men was the most frequently reported mode of HIV transmission in Puerto Rico (58.7%), followed by unprotected heterosexual contact (31.8%). Among men, unprotected sex between men (70.2%) was the primary mode of transmission, while heterosexual contact (89.5%) was the most frequently reported mode of transmission among women (Table 5).

Table 5: Distribution of new HIV diagnoses by mode of transmission among adolescents and adults aged ≥ 13 years, Puerto Rico, 2024

Mode of HIV transmission	General		Men		Women	
	Number	Percentage	Number	Percentage	Number	Percentage
Heterosexual contact	110	31.8	59	20.4	51	89.5
PWID	10	2.9	9	3.1	-	1.7
MSM	203	58.7	203	70.2	0	0.0
MSM+IDU	5	1.4	5	1.7	0	0.0
Other - under investigation	18	5.2	13	4.5	-	8.8
Total	**346**	**100.0**	**289**	**100.0**	**57**	**100.0**

Unprotected sex between men is the primary mode of transmission among adolescents and adults aged 13 to 44. The primary mode of transmission for people diagnosed with HIV who are 45 years of age or older is unprotected heterosexual contact (Table 6).

Table 6: Distribution of New HIV Diagnoses by Mode of Transmission and Age of Adults and Adolescents ≥13 Years, Puerto Rico, 2024

Age Group	MSM	Heterosexual contact	PWID	MSM+IDU	Other - under investigation	Total
13 - 24	33	10	0	-	-	45
25 - 34	91	23	-	0	6	121
35 - 44	39	24	-	-	5	74
45 - 54	24	24	5	-	-	55
55 - 64	10	12	0	0	-	26
≥ 65	6	17	-	0	-	25
Total	**203**	**110**	**10**	**5**	**18**	**346**

Note: The hyphen indicates that the cell size is less than 5.

Approximately one in seven adolescents and adults aged 13 years and older diagnosed with HIV in 2024 were in Stage 3 HIV (AIDS), increasing the likelihood of complications and premature death. The proportion of people diagnosed late with HIV was higher among men (14.5%), people aged 65 years and older (32.0%), and men who inject drugs (55.6%), suggesting that they do not access medical care promptly (Table 7).

Table 7: Distribution of late HIV diagnoses by demographic characteristics and mode of transmission among adolescents and adults aged ≥13 years, PR 2024

Characteristics	HIV diagnoses in 2024	Stage 3 (AIDS)	
		Number	Percentage
Sex			
Men	***289***	***42***	***14.5***
Women	57	6	10.5
Age at diagnosis			
13-24	45	-	-
25-34	121	13	10.7
35-44	74	13	17.6
45-54	55	8	14.5
55-64	26	-	15.4
≥65	***25***	***8***	***32.0***
Transmission mode			
MSM	203	22	10.8
PWID			
Men	***9***	***5***	***55.6***
Women	-	-	-
MSM and PWID	-	-	40.0
Heterosexual contact			
Men	59	12	20.3
Women	51	6	11.8
Other - under investigation			
Men	13	-	-
Women	5	0	0.0
Total	**346**	**48**	**13.9**

Note: The hyphen indicates the cell size is less than 5.

Most people diagnosed with HIV in 2024 were residing in the Metropolitan Region at the time of diagnosis (38.2%), followed by the Bayamón (17.3%) and Caguas (13.9%) regions. 50.9% of women diagnosed with HIV in 2024 resided in the Metropolitan Region (Table 8).

Table 8: Distribution of new HIV diagnoses among adolescents and adults aged ≥ 13 years, by epidemiological health regions, PR 2024

Health region of residence at the time of diagnosis	General			Men			Women		
	Number	Percentage	Rate	Number	Percentage	Rate	Number	Percentage	Rate
Aguadilla	6	1.7	3.1	5	1.7	5.4	-	-	-
Arecibo	35	10.1	9.5	31	10.7	17.8	-	-	-
Bayamón	60	17.3	12.2	53	18.3	23.0	7	12.3	2.7
Caguas	48	13.9	10.3	42	14.5	19.3	6	10.5	2.4
Fajardo	13	3.8	12.6	11	3.8	22.9	-	-	-
Mayagüez	14	4.0	5.9	13	4.5	11.6	-	-	-
Metropolitana	132	38.2	20.7	103	35.6	35.6	29	50.9	8.3
Ponce	38	11.0	9.4	31	10.7	16.1	7	12.3	3.3
Total	**346**	**100.0**	**11.9**	**289**	**100.0**	**21.3**	**57**	**100.0**	**3.7**

Note: The hyphen indicates that the cell size is less than 5.

Trends in new HIV diagnoses among adolescents and adults aged ≥ 13, PR 2020–2024

Between 2020 and 2024, a total of 1,811 new cases of HIV were diagnosed in Puerto Rico (regardless of whether the infection progressed to Stage 3). The diagnosis rate among adolescents and adults aged 13 years and older in 2024 was 11.9 per 100,000 population. The diagnosis rate was 5.8 times higher among men than among women in 2024 (Table 9). During the 2020–2021 period, HIV data were impacted by the COVID-19 pandemic; therefore, 2021 was used as a baseline to assess HIV trends. During the 2021–2024 period, the number of HIV diagnoses and the overall diagnosis rate decreased by 16.2% and 27.4%, respectively. However, among men, a 6.0% increase in the diagnosis rate was observed during the 2021–2023 period, followed by a 24.7% decrease in 2024. Among women, the diagnosis rate decreased by 30.3% during the 2021–2024 period.

Table 9: Rate of New HIV Diagnoses Among Adolescents and Adults Aged ≥ 13, by Sex, Puerto Rico 2020–2024

	2020		2021		2022		2023		2024	
Sex	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
Men	259	20.9	327	26.7	301	25.2	335	28.3	289	21.3
Women	43	3.3	86	6.6	57	4.5	57	4.6	57	3.7
Total	**302**	**11.8**	**413**	**16.4**	**358**	**14.5**	**392**	**16.1**	**346**	**11.9**

During the 2020–2024 period, 54.3% of HIV diagnoses were among people aged 25 to 44. In the 2020–2021 period, HIV data were affected by the COVID-19 pandemic; therefore, 2021 was used as a baseline to assess HIV trends. The rate of HIV diagnoses shows a decline during the 2021–2024 period across all age groups, with the exception of the 25–34 age group. During the 2021–2023 period, the number and rate of diagnoses in this group increased by 18.3% and 17.1%, respectively (Table 10).

Table 10: Number of new HIV diagnoses in adolescents and adults ≥ 13 years, by age group, PR 2020 – 2024

Age at diagnosis	2020		2021		2022		2023		2024	
	Number	**Rate**	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
13 - 24	49	11.6	59	14.3	46	11.5	51	13.0	45	11.6
25 - 34	84	19.9	120	27.8	126	29.2	142	32.6	121	27.5
35 - 44	65	16.5	96	24.9	76	20.1	79	21.1	74	19.6
45 - 54	50	11.8	72	17.3	57	13.9	53	13.0	55	13.6
55 - 64	42	9.5	39	8.8	33	7.5	48	11.1	26	6.0
≥ 65	12	1.7	27	3.6	20	2.6	18	2.3	25	3.2
Total	**302**	**11.8**	**413**	**16.4**	**358**	**14.5**	**392**	**16.1**	**346**	**11.9**

Source: HIV/AIDS Surveillance, Epidemiological Surveillance Section, Division of Epidemiology and Research.
Note: Persons diagnosed with HIV in Puerto Rico, as reported through December 31, 2025.

Among men, most HIV diagnoses during the period 2020–2024 occurred between the ages of 25 and 34. Among women, most cumulative diagnoses were observed between the ages of 35 and 44 (Table 11). The trend in HIV diagnoses by age shows differences by sex. Among men, a decrease in the diagnosis rate was observed in all age groups except the 25–34 age group. Among women, a decrease was observed in all age groups.

Table 11: HIV diagnosis rate in adolescents and adults ≥ 13 years, by age group and sex, PR 2020 – 2024

Age at diagnosis	2020		2021		2022		2023		2024	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
Men										
13 - 24	45	21.0	49	23.2	43	21.1	49	24.5	39	16.8
25 - 34	77	36.6	110	51.3	113	52.5	126	57.8	109	49.5
35 - 44	56	30.2	68	37.3	67	37.6	68	38.4	60	33.6
45 - 54	41	20.6	55	28.1	40	20.7	39	20.4	43	22.6
55 - 64	34	16.7	27	13.4	25	12.5	40	20.2	20	10.2
≥ 65	6	1.9	18	5.6	13	4.0	13	3.9	18	5.3
Women										
13 - 24	-	-	10	4.9	-	-	-	-	6	2.7
25 - 34	7	3.3	10	4.6	13	6.0	16	7.3	12	5.4
35 - 44	9	4.3	28	13.7	9	4.5	11	5.6	14	7.1
45 - 54	9	4.0	17	7.7	17	7.9	14	6.5	12	5.6
55 - 64	8	3.3	12	5.0	8	3.4	9	3.8	6	2.6
≥ 65	6	1.5	9	2.1	7	1.6	5	1.1	7	1.6
Total	**302**	**11.8**	**413**	**16.4**	**358**	**14.5**	**392**	**16.1**	**346**	**11.9**

Note: The hyphen indicates that the cell size is less than 5.
Source: HIV/AIDS Surveillance, Epidemiological Surveillance Section, Division of Epidemiology and Research.
Note: Persons diagnosed with HIV in Puerto Rico, as reported through December 31, 2025.

Over the period from 2020 to 2024, unprotected sex between men accounted for the largest proportion of new HIV diagnoses each year. In 2024, unprotected sex between men remains the primary mode of HIV transmission in Puerto Rico (Table 12).

Table 12: Distribution of HIV diagnoses among adolescents and adults aged ≥13 years, by mode of transmission, 2020–2024

Mode of transmission	Year of HIV diagnosis											
	2020		2021		2022		2023		2024		Total frequency	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
MSM	185	61.3	240	58.1	207	57.8	254	64.8	203	58.7	1,089	60.1
Heterosexual contact	76	25.2	140	33.9	103	28.8	119	30.4	110	31.8	548	30.3
PWID	18	6.0	12	2.9	21	5.9	11	2.8	10	2.9	72	4.0
MSM & PWID	-	-	-	-	-	-	0	-	5	1.5	15	0.8
Other - under investigation	19	6.3	19	4.6	23	6.4	8	2.0	18	5.2	87	4.8
Total	**302**	**100.0**	**413**	**100.0**	**358**	**100.0**	**392**	**100.0**	**346**	**100.0**	**1,811**	**100.0**

Note: The hyphen indicates that the cell size is less than 5.

The distribution of new HIV diagnoses during the 2020–2024 period indicates that unprotected sex between men is the primary mode of transmission among adolescents and adults aged 13 to 44, while unprotected heterosexual contact is the primary mode of transmission among people aged 45 and older (Table 13).

Table 13: Distribution of HIV diagnoses among adolescents and adults ≥13 years, by age, mode of transmission, and sex, 2020–2024

	Mode of transmission					
Age at diagnosis	**MSM**	**Contacto heterosexual**	**PWID**	**MSM & PWID**	**Other – under investigation**	**Total**
13 - 24	204	38	0	-	5	250
25 - 34	464	95	11	5	19	594
35 - 44	208	130	26	6	20	390
45 - 54	117	132	19	-	18	287
55 - 64	73	84	11	0	20	188
≥65	23	69	5	0	5	102
Total	**1,089**	**548**	**72**	**15**	**87**	**1,811**

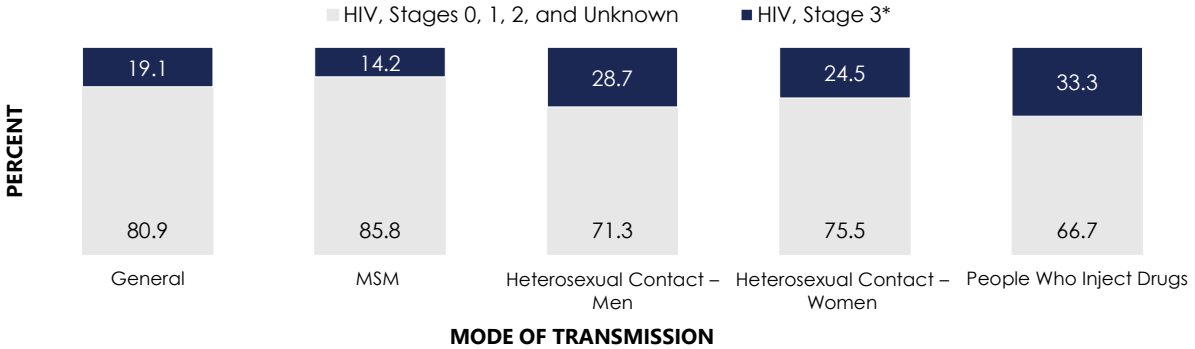
Approximately 1 in 5 adolescents and adults aged 13 and older diagnosed with HIV between 2020 and 2024 were in Stage 3 of the infection (AIDS). The proportion of people diagnosed with HIV at a late stage decreased by 42.6% during this period. People who inject drugs and heterosexual men have the highest proportions of late HIV diagnoses, at 33.3% and 28.7%, respectively (Graph 2 and Table 14).

Table 14: Distribution of new HIV diagnoses among adolescents and adults ≥13 years, by HIV progression category and mode of transmission, 2020–2024

Mode of transmission	**Late HIV diagnoses**											
	2020		**2021**		**2022**		**2023**		**2024**		**2020 - 2024**	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Heterosexual Contact Men	18	45.0	17	29.3	16	30.2	16	24.6	12	20.3	79	28.7
Heterosexual Contact Women	10	27.8	19	23.2	17	34.0	15	27.8	6	11.8	67	24.5
People who inject drugs	7	43.8	6	54.5	-	-	-	-	5	55.6	24	33.3
MSM	29	15.7	52	21.7	24	11.6	28	11.0	22	10.8	155	14.2
Total	**69**	**22.8**	**100**	**24.2**	**65**	**18.2**	**63**	**16.1**	**48**	**13.9**	**345**	**19.1**

Note: The hyphen indicates that the cell size is less than 5.

Graph 2: Distribution of new HIV diagnoses among adolescents and adults ≥13 years, by HIV progression category and mode of transmission, 2020–2024



* Stage 3 classification is based on the first CD4 test performed or documentation of an AIDS-defining condition within the first 3 months (≤91 days) following an HIV diagnosis.

The Metropolitan Region (38.2%) stands out as the region of residence at the time of diagnosis with the highest number of new HIV cases diagnosed during the 2020–2024 period, followed by the Bayamón region (16.6%) and Caguas (14.1%) (Table 15).

Table 15: New HIV diagnoses, by region of residence at the time of diagnosis, PR 2020–2024

Department of Health region of residence at the time of diagnosis	Year of HIV diagnosis											
	2020		2021		2022		2023		2024		Total frequency	
	Number	%	Number	%	Number	%	Number	%	Number	%	Number	%
Aguadilla	6	2.0	12	2.9	5	1.4	12	3.1	6	1.7	41	2.3
Arecibo	26	8.6	28	6.8	42	11.7	49	12.5	35	10.1	180	9.9
Bayamón	52	17.2	79	19.1	50	14.0	60	15.3	60	17.3	301	16.6
Caguas	45	14.9	72	17.4	42	11.7	48	12.2	48	13.9	255	14.1
Fajardo	9	3.0	13	3.2	6	1.7	12	3.1	13	3.8	53	2.9
Mayagüez	15	5.0	12	2.9	21	5.9	21	5.4	14	4.1	83	4.6
Metropolitana	122	40.4	153	37.1	148	41.3	137	35.0	132	38.2	692	38.2
Ponce	27	8.9	44	10.7	44	12.3	53	13.5	38	11.0	206	11.4
Total	**302**	**100.0**	**413**	**100.0**	**358**	**100.0**	**392**	**100.0**	**346**	**100.0**	**1,811**	**100.0**

Source: HIV/AIDS Surveillance, Epidemiological Surveillance Section, Division of Epidemiology and Research.
Note: Persons diagnosed with HIV in Puerto Rico, as reported through December 31, 2025.

HIV Prevalence in Puerto Rico - 2024

At the end of 2024, the number of people with an HIV-positive diagnosis in Puerto Rico was 16,751. For every 100,000 residents of Puerto Rico, 522.9 have been diagnosed with HIV. The prevalence of HIV among men is 2.8 times higher than the prevalence of HIV among women. 37.7% of people diagnosed with HIV reside in the Metropolitan Region. 76.4% of people diagnosed with HIV living in Puerto Rico are 45 years of age or older (Table 16).

Table 16: Prevalence of HIV diagnoses by demographic characteristics and mode of transmission, PR, 2024

Demographic characteristics / mode of transmission	Number	Percentage	Prevalence per 100,000 inhabitants
Sex			
Men	11,951	71.3	790.3
Women	4,800	28.7	283.8
Age group			
13 – 24	148	0.9	32.4
25 – 34	1,468	8.8	333.3
35 – 44	2,328	13.9	617.6
45 – 54	3,354	20.0	827.9
55 – 64	5,334	31.8	1,239.6
≥65	4,119	24.6	522.2
Mode of transmission			
MSM	5,723	34.2	-
Heterosexual contact women	3,735	22.3	-
PWID men	2,900	17.3	-
Heterosexual contact men	2,315	13.8	-
PWID women	852	5.1	-
MSM & PWID	662	4.0	-
Other - under investigation	564	3.4	-
Health Region			
Metropolitan	6,317	37.7	898.7
Bayamón	2,791	16.7	512.8
Caguas	2,168	12.9	422.8
Ponce	2,089	12.5	462.4
Arecibo	1,418	8.5	349.2
Mayagüez	846	5.1	324.5
Fajardo	602	3.6	527.0

Demographic characteristics / mode of transmission	Number	Percentage	Prevalence per 100,000 inhabitants
Aguadilla	520	3.1	246.8
Total	**16,751**	**100.0**	**522.9**

Linkage to medical care, PR 2024

Early linkage to medical care reduces HIV-related complications and premature mortality. The proportion of people linked to medical care decreased from 73.6% to 68.5% between 2021 and 2024 (Table 17). The highest percentage observed was 73.6%, in 2021.

Table 17: Proportion of people linked to medical care within the first 30 days following a positive HIV diagnosis, PR 2020–2024

Link to medical care	2020	2021	2022	2023	2024
≤30 days	66.6	73.6	71.2	64.0	68.5
> 30 days	33.4	26.4	28.8	36.0	31.5

In 2024, people diagnosed with HIV between the ages of 55 and 64 had the highest rate of linkage to care within the first month following diagnosis (80.8%); followed by men who attributed their HIV infection to unprotected heterosexual contact (72.9%) and men who have sex with men (70.0%) (Table 18). On the other hand, the lowest proportion of linkage to medical care was documented among men who have sex with men and inject drugs, and people who inject drugs, at 70.0% and 60.0%, respectively.

Table 18: Link to medical care for people diagnosed with HIV during the first 30 days after diagnosis, by selected demographic characteristics and mode of transmission, PR, 2024

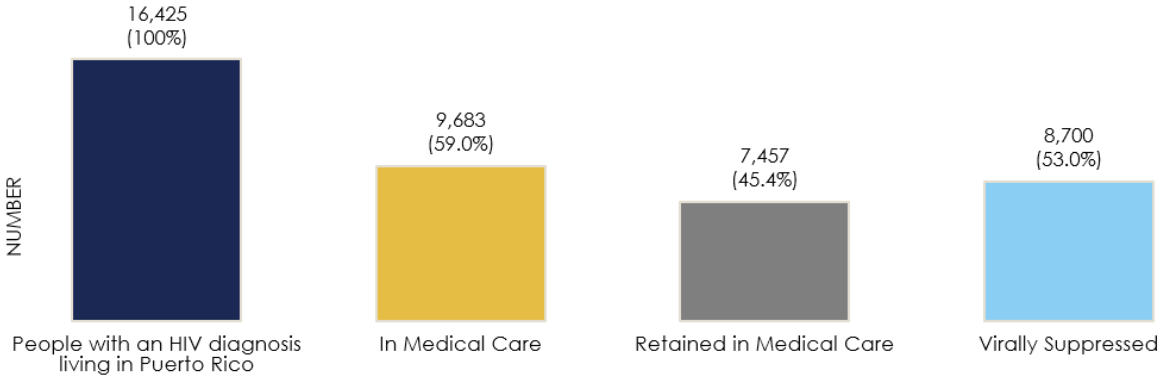
Demographic characteristics / mode of transmission	HIV diagnoses	Medical care ≤ 30 days	
	Number	Number	Percentage
Sex			
Men	289	198	68.5
Women	57	39	68.4
Age at the time of diagnosis			
13-24	45	29	64.4
25-34	121	81	66.9
35-44	74	55	74.3
45-54	55	35	63.6
55-64	26	21	80.8
≥65	25	16	64.0
Mode of transmission			
Men who have sex with men	203	142	70.0
People who inject drugs	10	6	60.0
Men who have sex with men and inject drugs	5	-	-
Heterosexual contact			
Men	59	43	72.9
Women	51	33	64.7
Other			
Men	13	6	46.2
Women	5	5	100.0
Total	**346**	**237**	**68.5**

HIV Care Continuum in Puerto Rico, 2024

As of December 31, 2024, a total of 16,425 adolescents and adults ≥ 13 years of age diagnosed with HIV were residing in Puerto Rico. According to data reported to HIV/AIDS Surveillance, 59.0% were receiving medical care and 45.4% were retained in medical care in 2024; while 53.0% had achieved viral suppression. (Graph 3).

Ryan White Programs (Excluding ADAP) in Puerto Rico counts with data reported that shows higher percentages. In 2024, these Programs had 12,448 participants with 92.4% retained in medical care and 93.8% virally suppressed (Graphs 4, 5 and 6).

Graph 3: HIV Care Continuum PR, 2024

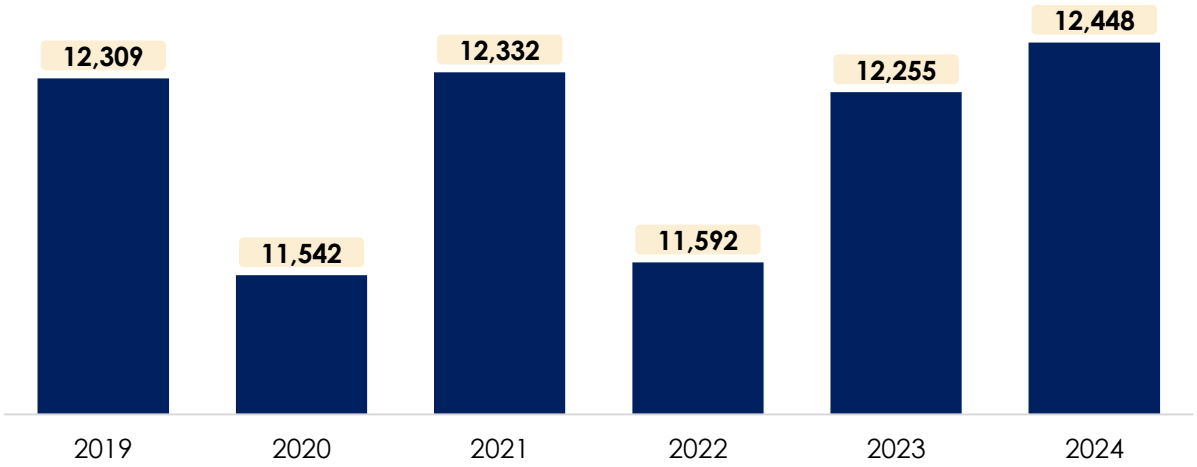


HIV CARE CONTINUUM

People with an HIV diagnosis	Number of persons aged ≥13 years diagnosed with HIV through 2023 and residing in Puerto Rico at the end of 2024.
In Medical Care	Number of persons aged ≥13 years diagnosed with HIV through 2023 and residing in Puerto Rico at the end of 2024, with ≥1 CD4 test or viral load test reported to the HIV/AIDS Surveillance System.
Retained in Medical Care	Number of persons aged ≥13 years diagnosed with HIV through 2023 and residing in Puerto Rico at the end of 2024, with two or more CD4 tests or viral load tests, performed at least three months apart, reported to the HIV/AIDS Surveillance System.
Virally Suppressed	Number of persons aged ≥13 years diagnosed with HIV through 2023 and residing in Puerto Rico at the end of 2024, whose most recent viral load in 2024 was <200 copies/mL.

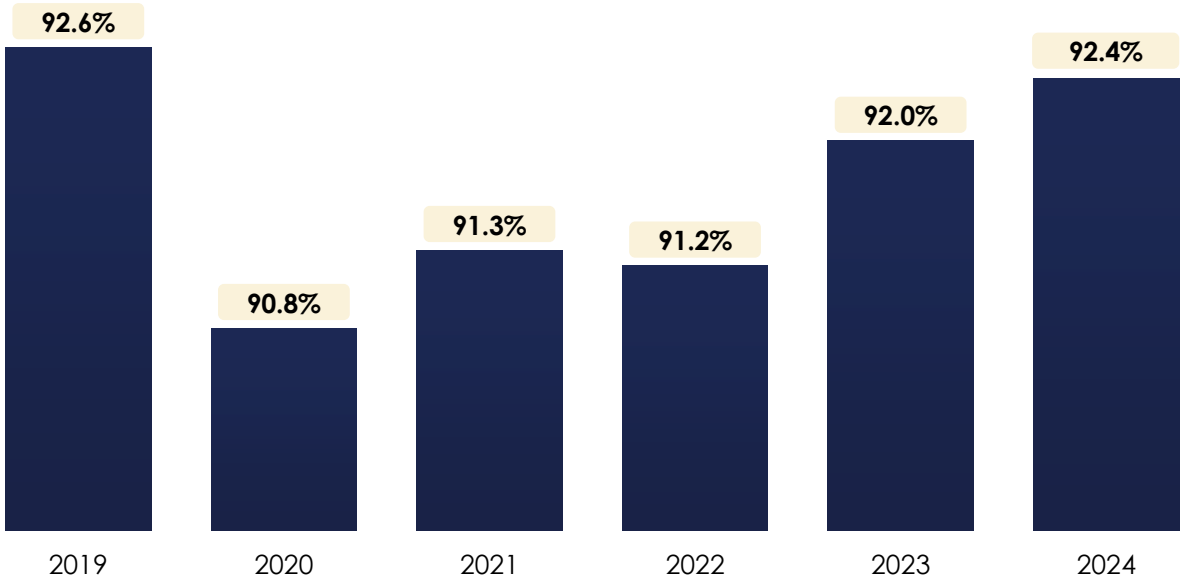
Source: HIV/AIDS Surveillance, Epidemiologic Surveillance Section, Division of Epidemiology and Research.
Note: Persons diagnosed with HIV in Puerto Rico, based on reports received through December 31, 2025.

Graph 4: Participants in Ryan White Programs (Excluding ADAP) - Puerto Rico



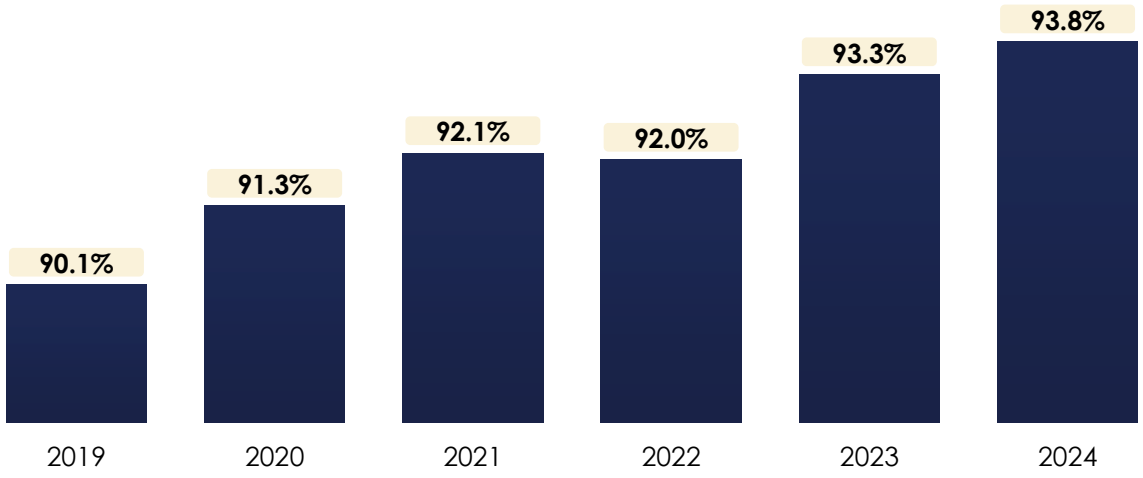
Source: Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019-2024.

Graph 5: Participants in Ryan White Programs (Excluding ADAP) - Puerto Rico – Retained in Care By Year



Source: Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019-2024.

Graph 6: Percentage of Persons with an HIV Diagnosis that are Virally Suppressed: Participants in Ryan White Programs (Excluding ADAP) - Puerto Rico



Source: Ryan White HIV/AIDS Program Annual Client-Level Data Report 2019-2024.

Unmet healthcare needs among people diagnosed with HIV in Puerto Rico, 2025

In 2025, 355 people were diagnosed with HIV in Puerto Rico. Of these, 16.3% were diagnosed with HIV at a late stage. As of 2025, 10,647 residents of Puerto Rico had been diagnosed with HIV or had any HIV-related laboratory test results during the 2021–2025 period. 86.2% were receiving medical care, while 13.8% were not under medical care.

By the end of 2025, 11.4% of people receiving medical care had not achieved viral suppression. People who are not virally suppressed are more likely to transmit HIV to their partners through sexual contact and/or injection drug use (Table 19).

Table 19: Unmet Healthcare Needs Among People with an HIV Positive Diagnosis in Puerto Rico, 2025

Indicators	Number	Percentage	Data source
Late HIV diagnoses			
Late diagnoses	58	16.3%	HIV Surveillance System
New diagnoses	355		HIV Surveillance System
Population size			
Population size	12,347		HIV Surveillance System
Care patterns			
Met need	10,647	86.2%	HIV Surveillance System
Unmet need	1,700	13.8%	HIV Surveillance System
Viral load, people in care			
Viral load suppressed	9,438	88.6%	HIV Surveillance System
Viral load not suppressed	1,209	11.4%	HIV Surveillance System

Note: Data on late HIV diagnosis and patterns of care are presented for the year 2022; data on population size are presented for the period 2021–2025.

Late HIV Diagnoses	Number of persons diagnosed with Stage 3 HIV infection within the first 3 months after their initial HIV diagnosis.
Population Size	Number of persons with an HIV-positive diagnosis in Puerto Rico who were diagnosed with HIV or who have had an HIV test, genotyping test, CD4 test, or viral load test reported to the HIV Surveillance System during the past 5 years.
Care Patterns	
Need Met	Number of persons diagnosed with HIV who had a CD4 test or viral load test during the most recent year.
Unmet Need	Number of persons diagnosed with HIV who did not have a CD4 test or viral load test during the most recent year.
Virally Suppressed	Number of persons diagnosed with HIV whose need for medical care was met and whose most recent viral load was <200 copies/mL.
Not Virally Suppressed	Number of persons diagnosed with HIV whose need for medical care was met and whose most recent viral load was ≥200 copies/mL.

The subpopulations with the highest proportion of people not in medical care in 2025 are those aged 13 to 24 (25%), men who inject drugs (17%), and men who have unprotected sex with other men (13.4%).

The subpopulations with the highest proportion of people receiving medical care who did not achieve viral suppression by the end of 2025 are people aged 35 to 44 (27.6%), men with heterosexual contact (11.2%) and women who inject drugs (12.8%) (Table 20).

Table 20: Population analysis – Puerto Rico, 2025

		Total	Numeric inputs					Within Categories			Across Categories		
	Category	# persons with an HIV positive diagnosis	# new diagnoses	# late diagnoses	# in medical care	# with unmet needs	# in care without viral suppression	% late diagnosed	% with unmet needs	% in care without viral suppression	% late diagnosed	% with unmet needs	% in care without viral suppression
A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	**Total**	12,347	355	58	10,647	1,700	1,209	16.3%	13.8%	11.4%	100.0%	100.0%	100.0%
2	**Sex**												
	Men	8,803	278	42	7,540	1,263	817	15.1%	14.3%	10.8%	72.4%	74.3%	67.6%
	Women	3,487	72	15	3,057	430	382	20.8%	12.3%	12.5%	25.9%	25.3%	31.6%
	Unknown Biological Sex	57	5	1	50	7	10	20.0%	12.3%	20.0%	1.7%	0.4%	0.8%
3	**Race**												
	American Indian / Alaska Native	1	1	0	1	0	1	0.0%	0.0%	100.0%	0.0%	0.0%	0.1%
	Black/African American	10	1	0	6	4	2	0.0%	40.0%	33.3%	0.0%	0.2%	0.2%
	Hispanic/Latino[1]	12,259	342	56	10,586	1,673	1,187	16.4%	13.6%	11.2%	96.6%	98.4%	98.2%
	White	74	11	2	51	23	18	18.2%	31.1%	35.3%	3.4%	1.4%	1.5%
	Multiracial	3	0	0	3	0	1	0.0%	0.0%	33.3%	0.0%	0.0%	0.1%
4	**Age**												
	13-24	132	46	2	99	33	26	4.3%	25.0%	26.3%	3.4%	1.9%	2.2%
	25-34	1,300	119	19	1,066	234	231	16.0%	18.0%	21.7%	32.8%	13.8%	19.1%
	35-44	1,854	80	10	1,559	295	431	12.5%	15.9%	27.6%	17.2%	17.4%	35.6%
	45-54	2,296	51	10	1,967	329	269	19.6%	14.3%	13.7%	17.2%	19.4%	22.2%
	55-64	3,753	44	12	3,331	422	154	27.3%	11.2%	4.6%	20.7%	24.8%	12.7%
	65+	3,012	15	5	2,625	387	98	33.3%	12.8%	3.7%	8.6%	22.8%	8.1%
5	**Transmission Category**												
	Male:												
	Male-to-Male Sexual Contact	5,135	193	24	4,447	688	479	12.4%	13.4%	10.8%	41.4%	40.5%	39.6%

	Total	Numeric inputs					Within Categories			Across Categories		
Category	# persons with an HIV positive diagnosis	# new diagnoses	# late diagnoses	# in medical care	# with unmet needs	# in care without viral suppression	% late diagnosed	% with unmet needs	% in care without viral suppression	% late diagnosed	% with unmet needs	% in care without viral suppression
Injection Drug Use (IDU)	1,293	6	1	1,073	220	95	16.7%	17.0%	8.9%	1.7%	12.9%	7.9%
Male-to-Male Sexual Contact/IDU	436	2	0	374	62	41	0.0%	14.2%	11.0%	0.0%	3.6%	3.4%
Heterosexual contact	1,733	53	13	1,494	239	167	24.5%	13.8%	11.2%	22.4%	14.1%	13.8%
Other / No identified risk	206	24	4	152	54	35	16.7%	26.2%	23.0%	6.9%	3.2%	2.9%
Female:												
Injection Drug Use (IDU)	476	0	0	421	55	54	0.0%	11.6%	12.8%	0.0%	3.2%	4.5%
Heterosexual contact	2,876	60	14	2,535	341	301	23.3%	11.9%	11.9%	24.1%	20.1%	24.9%
Other / No identified risk	135	12	1	101	34	27	8.3%	25.2%	26.7%	1.7%	2.0%	2.2%
Unknown Biological Sex:												
Sexual contact	49	5	1	44	5	10	20.0%	10.2%	22.7%	1.7%	0.3%	0.8%
Injection Drug Use (IDU)	1	0	0	1	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Sexual contact/IDU	3	0	0	1	2	0	0.0%	66.7%	0.0%	0.0%	0.1%	0.0%
Other / No identified risk	4	0	0	4	0	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Estimates of HIV Incidence and Prevalence in Puerto Rico: 2019 – 2023

It is estimated that the number of incident HIV cases during the period 2019-2023 reached 1,480. Incident HIV cases during this period have decreased by 6.2%.

Table 21: Estimated HIV incidence rates among adolescents and adults ≥13 years, PR 2019 – 2023

Year	Number of cases	IC95% inferior	IC95% superior
2019	320	140	500
2020	310	110	520
2021	320	120	510
2022	230	100	450
2023	300	120	500

The incidence of HIV is higher among men (83.8%), people aged 25 to 34 (35.1%), and men who have unprotected sex with men (67.6%) (Table 22).

Table 22: Estimated HIV Incidence Rates for Adolescents and Adults ≥13 Years, by sex, age and mode of transmission, PR, 2019 – 2023

Demographic characteristics / transmission mode	Number	Percentage
Sex		
Male	1,240	83.8
Female	240	16.2
Age		
13 - 24	300	20.3
25 - 34	520	35.1
35 - 44	310	20.9
45 - 54	170	11.5
55 - 64	140	9.5
≥65	40	2.7
Mode of transmission		
MSM	1,000	67.6
PWID	20	1.4
MSM & PWID	10	0.7
Heterosexual contact	450	30.4
Total	**1,480**	**100.0**

During the period 2019–2023, the percentage of people who know their HIV status increased from 90.0% in 2019 to 91.6% in 2023 (Table 23). It is estimated that 8.4% (1,500) of people with an HIV positive diagnosis in Puerto Rico are unaware of their status.

Table 23: Estimated HIV prevalence and percentage of people who know their serological status, PR 2019 – 2023

Year	Percentage of people who know their HIV serological status	Percentage of people who are unaware of their HIV serological status	People with an HIV-positive diagnosis in Puerto Rico (diagnosed and undiagnosed)
2019	90.0	10.0	18,200
2020	90.3	9.7	18,000
2021	90.6	9.4	18,000
2022	91.1	8.9	18,000
2023	91.6	8.4	18,000

Adolescents and adults aged 13 to 24 have the highest proportion of people unaware of their HIV status, at 43.9%, followed by adults aged 25 to 34 (26.8%). Generally, the older the age group, the lower the proportion of people unaware of their HIV status. Men who have sex with men have the highest proportion of people unaware of their HIV status when categorized by mode of HIV transmission.

Table 24: Estimates of HIV prevalence and percentage of people who know their serological status, by sex, age and mode of transmission, PR 2023

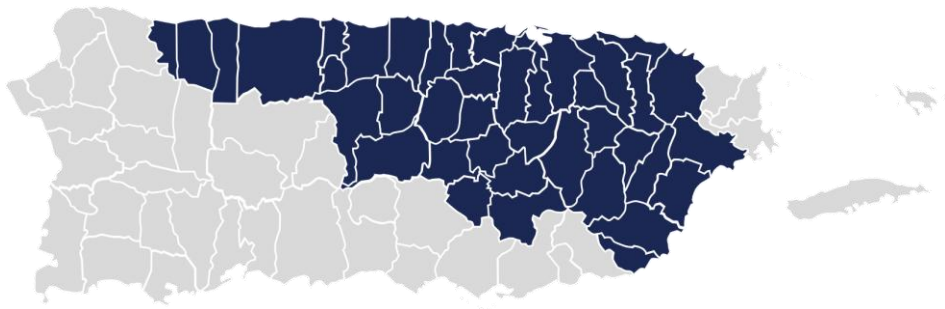
Demographic characteristics / mode of transmission	Percentage of people who know their HIV status	Percentage of people who do not know their serological HIV status
Sex		
Men	90.5	9.5
Women	94.5	5.5
Age group		
13-24	56.1	43.9
25-34	73.2	26.8
35-44	85.3	14.7
45-54	92.7	7.3
55-64	96.8	3.2
≥65	98.7	1.3
Transmission mode		
MSM	87.1	12.9
PWID Men	98.0	2.0
PWID Women	99.7	0.3
MSM and PWID	96.3	3.7
Heterosexual contact with men	88.4	11.6
Heterosexual contact with women	93.4	6.6

National HIV Behavioral Surveillance (NHBS) of the HIV Surveillance Program

The Behavioral Survey (BSS) is funded by the Centers for Disease Control and Prevention (CDC). This study is conducted in 22 Eligible Metropolitan Statistical Areas (ESAs) in the United States and Puerto Rico. It is known nationally as the National HIV Behavioral Surveillance System (NHBS).

The NHBS is an anonymous, cross-sectional survey of populations at risk for HIV infection: Venue-Based Sampling (VBS) for men who have sex with men (MSM) and Respondent-Driven Sampling (RDS) for people who inject drugs (PWID) and high-risk heterosexuals (HET). It is conducted in 22 ESAs in the United States and Puerto Rico. In Puerto Rico, it corresponds to the eligible Metropolitan Statistical Area (ESA) of San Juan, comprised of 40 municipalities, primarily in the San Juan Metropolitan Area and the eastern part of the island (Illustration 8).

Illustration 8: San Juan – Caguas – Guaynabo EMA



Municipalities: Aguas Buenas, Aibonito, Arecibo, Barceloneta, Barranquitas, Bayamón, Caguas, Camuy, Canóvanas, Carolina, Cataño, Cayey, Ciales, Cidra, Comerío, Corozal, Dorado, Florida, Guaynabo, Gurabo, Hatillo, Humacao, Juncos, Las Piedras, Loíza, Manatí, Maunabo, Morovis, Naguabo, Naranjito, Orocovis, Quebradillas, Río Grande, San Juan, San Lorenzo, Toa Alta, Toa Baja, Trujillo Alto, Vega Alta, Vega Baja, y Yabucoa.

Table 25 presents the demographic characteristics of the latest cohort of MSM for the year 2023. After applying the eligibility criteria, a total of 511 participants were included in 2023. The mean age was 39.2 (± 11.9) years, and the top three predominant age groups were 25–34 years (34.8%), followed by 35–44 years and 55 years or older (27% and 15.5%, respectively). Regarding education, more than half of the sample (55.4%) had less than a high school education, 24.9% were high school graduates, and 19.8% of the participants had some college education or were college graduates. Approximately 80% of the sample reported being employed at the time of the interview. In addition, 25.6% of participants reported an annual income of $20,000 or less, while 37% reported an annual income of $75,000 or more.

Table 25: Sociodemographic Characteristics of the MSM Population, for the Seventh Cycle of the NHBS, San Juan EMA 2023

Characteristics	2023 n = 511 No. (%)
Age, years	**39.2 ± 11.9**
18-24	41 (8.0)
25-34	178 (34.8)
35-44	138 (27.0)
45-54	75 (14.7)
55+	79 (15.5)
Gender	
Male	496 (97.1)
Female	15 (2.9)
Education level	
Less than High School	283 (55.4)
High School Graduate	127 (24.9)
Some college or college graduate	101 (19.8)
Place of birth	
United States	54 (10.6)
Puerto Rico	442 (86.5)
Cuba	2 (0.4)
Other	13 (2.5)
Currently employed	
No[a]	104 (19.2)
Yes	418 (80.8)
Household Income [d]	
$0-$19,999	131 (25.6)
$20,000-$39,999	104 (20.4)
$40,000-$74,999	87 (17.0)
≥75,000	189 (37.0)
Currently has Health Insurance [d]	
No	59 (11.6)
Yes	451 (84.4)
Recruitment location	
Bar/Nightclub	366 (70.1)
Dating apps	124 (23.8)
Other[e]	32 (6.1)

Note: [a]Includes full-time students, housewives, retirees, people with disabilities, and other unspecified occupations. [d] The columns do not add up to 100% due to missing values or rounding. [e] Includes cafes, restaurants, parks, beaches, social organizations, retail businesses, street locations, and other places where participants gathered.

Table 26 shows the prevalence of pre-exposure prophylaxis (PrEP) use among men who have sex with men participating in the NHBS at the San Juan EMA, where 30% reported having used the medication in the past twelve months, while 70% reported not having used it.

Table 26: Use of pre-exposure prophylaxis (PrEP) among men who have sex with men (MSM) for the 7th Cycle of the National Health Budget Survey (NHBS), San Juan EMA 2023

PrEP Use	2023: N = 511 No. (%)
PrEP	
No	262 (70.0)
Yes	112 (30.0)

Table 27 presents the sociodemographic characteristics of people who inject drugs (PWID) for the seventh cycle of the NHBS. A total of 500 participants were recruited during the seventh cycle of the NHBS in the San Juan Metropolitan Statistical Area. Of the total participants, 87.7% identified as male. The most prevalent age group is 25 to 44 years old, followed by 50 to 59 years old and finally 45 to 49 years old, at 31.4%, 26.8%, and 16.5%, respectively. At least 82.3% of the sample reported having completed some years or graduated from high school, and 17.4% reported having attended college for several years, holding an associate's degree, or having graduated from college. Nearly three-quarters of the sample, 69%, reported being unemployed at the time of the interview, and 94.6% of participants reported having an income of $14,999 or less. Regarding health insurance, 70% reported having some form of health coverage. Meanwhile, 25.8% reported having been incarcerated in the 12 months prior to the interview, and 79.4% reported being homeless at the time of the interview.

Table 27: Sociodemographic Characteristics of PWID Participants in the Seventh Cycle of the NHBS, San Juan EMA 2024

Characteristics	2024: N = 407 n (%)
Gender	
Male	357 (87.7)
Female	44 (10.8)
Does not indicate	6 (1.5)
Age at the time of the interview (mean ± SD)	46.4 ± 10.7 years
18-24 years	3 (0.7)
25-34 years	51 (12.5)
35-44 years	128 (31.4)
45-49 years	67 (16.5)
50-59 years	109 (26.8)
≥ 60 years	49 (12.0)
Education [d]	
A few years of high school or high school graduate	335 (82.3)
A few years of college, associate's degree, or college graduate	71 (17.4)
Graduate studies	1 (0.3)
Employment status	

Characteristics	2024: N = 407 n (%)
Unable to work due to health reasons	66 (18.6)
Unemployed	245 (69.0)
Other[a]	44 (12.4)
Annual income[d]	
$0-$14,999	383 (94.6)
$15,000-$34,999	13 (3.2)
≥ $35,000	9 (2.2)
Health Insurance[d]	
No	118 (29.0)
Yes	285 (70.0)
Incarcerated, p12m[d]	
No	302 (74.2)
Yes	105 (25.8)
Currently homeless[d]	
No	84 (20.6)
Yes	323 (79.4)

a Includes full-time/part-time students, retirees, homemakers, and other unspecified employment statuses. d Cells do not total 100% due to missing values. Note: "Past 12 months (p12m)" refers to the 12 months prior to the NHBS interview.

Table 28 presents the types of injectable drugs used by people who inject drugs (PWID) during the 12 months prior to the interview for the seventh cycle of the NHBS in 2024. The most used injectable drug over the past 12 months was a combination of heroin and cocaine, known as a "speedball," reported by 86.5% of participants. This was followed by the use of fentanyl and heroin alone, at 85.9% and 72.2%, respectively. During the 12 months prior to the interview, 57% of study participants reported using powdered cocaine, 33% reported using crack, and 26.8% reported using crystal meth.

Table 28: Type of injectable drug used in PWID over the past 12 months, for the seventh cycle of the NHBS, San Juan EMA 2024

Types of injectables drugs	2024: N = 407 n (%)
Heroin and cocaine (speedball) during the p12m	
No	55 (13.5)
Yes	352 (86.5)
Heroin during the p12m[d]	
No	113 (27.8)
Yes	294 (72.2)
Powdered cocaine during the p12m	
No	175 (43.0)
Yes	232 (57.0)
Crack during the p12m[d]	
No	273 (67.0)
Yes	134 (33.0)
Crystal meth during the p12m[d]	
	297 (73.2)
No	109 (26.8)
Yes	

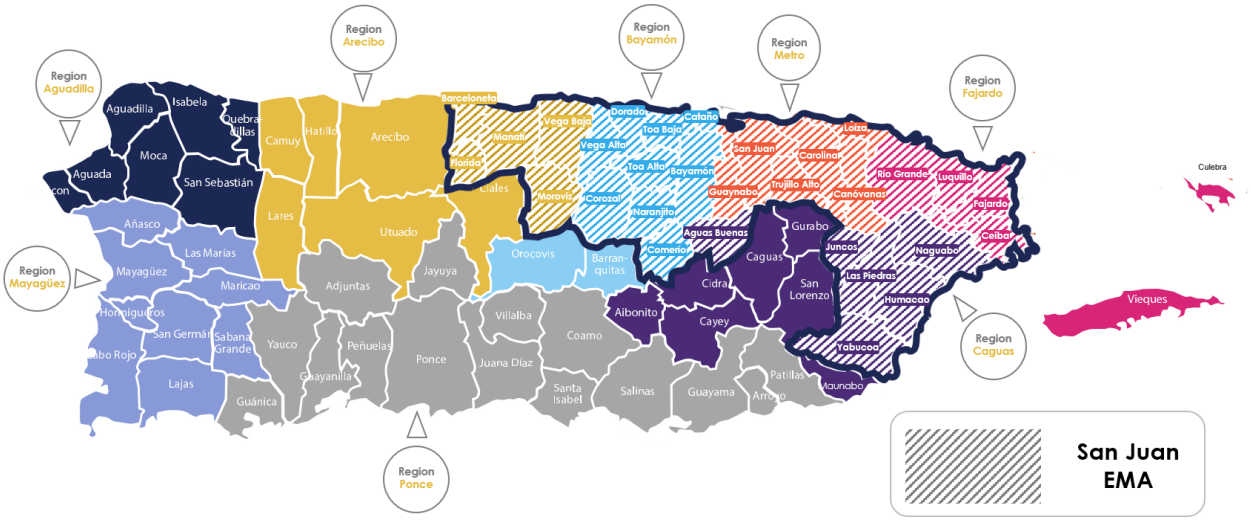
Types of injectables drugs	2024: N = 407 n (%)
Fentanyl during the p12m[d]	55 (14.1)
No	335 (85.9)

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

San Juan Eligible Metropolitan Area

The San Juan EMA under the Ryan White Part A Program is composed of 30 municipalities located primarily in the northeastern region of Puerto Rico and represents approximately 52% of Puerto Rico's population (Illustration 9).

Illustration 9: Municipalities belonging to the San Juan Metropolitan Area



Municipalities conforming the San Juan EMA: Aguas Buenas, Barceloneta, Bayamón, Canóvanas, Carolina, Cataño, Ceiba, Comerío, Corozal, Dorado, Fajardo, Florida, Guaynabo, Humacao, Juncos, Las Piedras, Loíza, Luquillo, Manatí, Morovis, Naguabo, Naranjito, Río Grande, San Juan, Toa Alta, Toa Baja, Trujillo Alto, Vega Alta, Vega Baja y Yabucoa.

During the cumulative period from 1980 to 2024, a total of 31,263 residents of the San Juan EMA were diagnosed with HIV, representing 59% of all HIV cases reported in Puerto Rico (Graph 7).

The historical trend of HIV diagnoses in the San Juan EMA has shown an overall decline since the early 1990s, suggesting progress in prevention strategies, early diagnosis efforts, and access to antiretroviral treatment for managing HIV infection. Between 2021 and 2024, the number of HIV diagnoses decreased by approximately 20%. In contrast, HIV prevalence remained relatively stable during the same period.

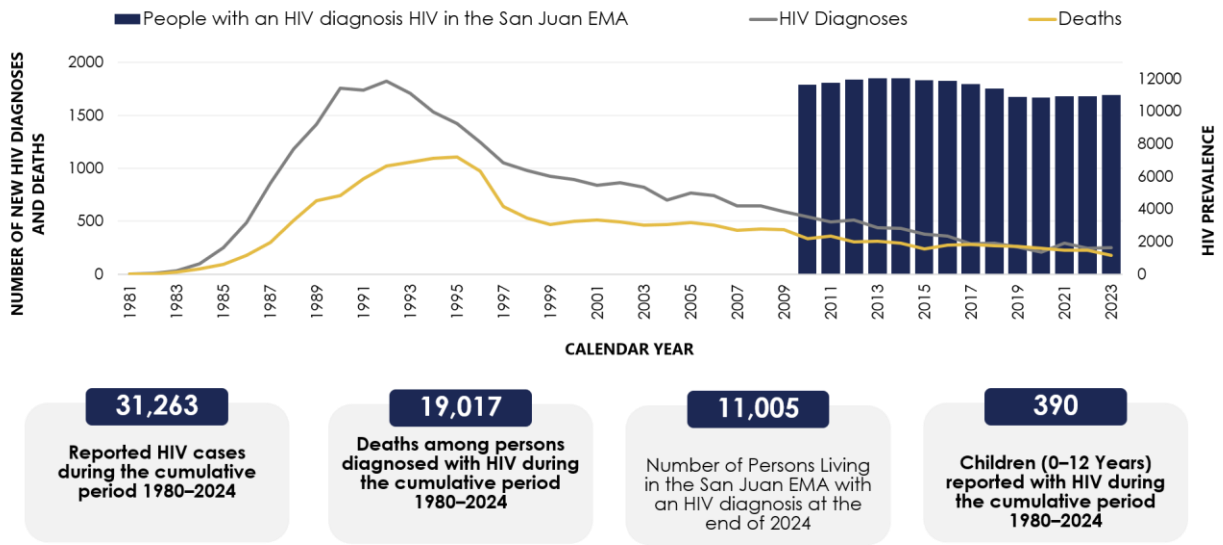
Table 29: Summary of HIV Cases Reported at San Juan EMA, 1981–2024

Year	Diagnostics	Deaths	People with a diagnosis
1981	2	1	—
1982	10	3	—
1983	35	18	—
1984	100	52	—
1985	250	92	—
1986	490	179	—
1987	855	300	—

Year	Diagnostics	Deaths	People with a diagnosis
1988	1182	506	—
1989	1416	696	—
1990	1758	745	—
1991	1735	903	—
1992	1822	1020	—
1993	1708	1056	—
1994	1530	1093	—
1995	1420	1107	—
1996	1243	971	—
1997	1053	638	—
1998	981	528	—
1999	927	471	—
2000	893	497	—
2001	842	510	—
2002	865	494	—
2003	823	465	—
2004	697	470	—
2005	769	490	—
2006	745	461	—
2007	647	417	—
2008	644	427	—
2009	588	418	—
2010	541	337	11637
2011	494	361	11735
2012	510	305	11928
2013	440	310	12021
2014	435	296	12016
2015	380	240	11911
2016	360	277	11871
2017	290	282	11670
2018	291	270	11396
2019	259	262	10872
2020	209	247	10842
2021	294	227	10902
2022	243	229	10909
2023	250	177	10980
2024	237	169	11005

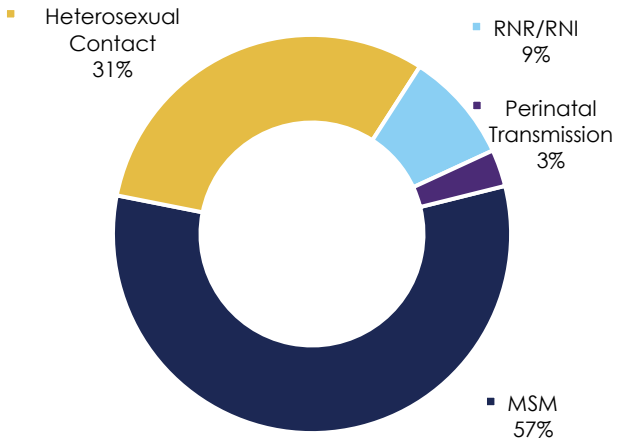
Note: Persons living with HIV with residence in the San Juan EMA available for the period 2010-2024.

Graph 7: Summary of HIV Cases Reported at San Juan EMA, 1981–2024



In 2024, 237 residents of the San Juan EMA were diagnosed with HIV, representing 68.5% of all diagnoses reported that year. Unprotected male-to-male sexual contact was the most frequently reported mode of transmission among San Juan EMA residents, followed by unprotected heterosexual contact, accounting for 57.2% and 31.4% of cases, respectively. These patterns are consistent with the epidemiological trends observed across Puerto Rico as a whole (Graph 8).

Graph 8: Distribution of Adolescents and Adults Aged 13 Years and Older Diagnosed with HIV, San Juan EMA, 2024



n=237

In 2024, most HIV diagnoses occurred among individuals aged 25–34 years. The distribution of diagnoses by age and sex assigned at birth shows that males accounted for the largest proportion of cases across all age groups (Table 30).

Table 30: Distribution of Adolescents and Adults Aged 13 Years and Older Diagnosed with HIV, by Age Group and Sex Assigned at Birth, San Juan EMA, 2024

Age group	Men (%)	Women (%)
13–24	85.7	14.3
25–34	78.6	21.4
35–44	78.6	21.4
45–54	80.9	19.1
55–64	90.5	9.5
≥65	85.7	14.3

Analysis by transmission category (Table 31) shows that unprotected male-to-male sexual contact was the most frequently reported mode of HIV transmission in the San Juan EMA (n=132). Among males, the proportion attributing HIV infection to male-to-male sexual contact is more compared to the other categories. Among females, heterosexual contact remained the predominant transmission category, accounting most of all cases (n=135).

Table 31: New HIV Diagnoses by Transmission Category and Sex Assigned at Birth, San Juan EMA, 2024

Transmission mode	Men	Women	General
PWID	5	1	6
Heterosexual contact	44	35	79
MSM	132	0	132
MSM & PWID	4	0	4
Unreported risk / investigation	10	6	16
Total	**195**	**42**	**237**

Table 32 shows that the distribution of HIV diagnoses by transmission category and age follows a pattern similar to that observed throughout the jurisdiction. Among adolescents and adults aged 13–44 years, male-to-male sexual contact was the predominant mode of HIV transmission, whereas among individuals aged 45 years and older, heterosexual contact was the most frequently reported transmission category.

Table 32: New HIV Diagnoses by Transmission Category and Age at the Time of Diagnosis, San Juan EMA, 2024

Age group	MSM	Heterosexual contact
13–24	23	8
25–34	52	17
35–44	28	15
45–54	16	17
55–64	11	11
≥65	2	11
Total	**132**	**79**

N=237
Source: HIV/AIDS Surveillance Program, Epidemiological Surveillance Section, Division of Epidemiology and Research.
Note: The numbers presented in the figure represent the number of cases among individuals residing in the San Juan EMA at the time of HIV diagnosis, as reported through June 30, 2025.

Not all municipalities within the San Juan EMA experience the same HIV burden. Table 33 presents the municipalities with the highest number of cases in 2024. Residents of the municipality of San Juan accounted for approximately 43% of all cases in the San Juan EMA, followed by the municipalities of Bayamón, Carolina, Toa Baja, and Guaynabo. Collectively, these five municipalities comprised 68% of all cases in the San Juan EMA.

Table 33: Municipalities with the highest number of HIV diagnoses, San Juan EMA 2024

Municipality of residence at the time of diagnosis	Number of cases	Percentage	Rate*
San Juan	101	42.6	27.6
Bayamón	20	8.4	12.7
Carolina	16	6.7	11.3
Toa Baja	14	5.9	11.1
Guaynabo	10	4.2	12.4
Vega Baja	9	3.8	20.6
Humacao	9	3.8	10.1
Manatí	7	2.9	18.1
Toa Alta	6	2.5	9.1
Vega Alta	5	2.1	14.4

Note: Municipalities not shown in the table had between 0 and 4 new HIV cases in 2024.

In 2024, 12.7% of new HIV diagnoses were classified as Stage 3 HIV (AIDS) at the time of diagnosis (Table 34). Males (13.8%), individuals aged 45–54 years (22.5%), and males who attributed their HIV infection to heterosexual contact (20.5%) had the highest proportions of late HIV diagnoses.

Table 34: Late HIV diagnoses, by mode of transmission among adults and adolescents ≥13 years, San Juan EMA, 2024

Demographic Characteristics/ Transmission mode	Number of HIV Diagnoses	Number of Late Diagnoses	Percentage of Late Diagnoses
Sex at birth			
Men	195	27	13.8%
Women	42	3	7.1%
Age			
13–24	34	2	5.9%
25–34	74	5	6.8%
35–44	50	7	14.0%
45–54	40	9	22.5%
≥55	39	7	17.9%
Transmission mode			
MSM	132	12	9.1%
Heterosexual contact (women)	35	3	8.6%
Heterosexual contact (men)	44	9	20.5%
General	237	30	12.7%

Note: A late HIV diagnosis is defined as progression to Stage 3 HIV (AIDS) within the first three months following the initial HIV diagnosis.

During the 2020–2024 period, male-to-male sexual contact remained the primary mode of HIV transmission in the San Juan EMA. Between 2021 and 2024, HIV diagnoses by transmission category and sex showed a declining trend among men who have sex with men (n=-30), men who inject drugs, and heterosexual men. Heterosexual women experienced the largest decline (n=-28) (Table 35).

Table 35: HIV Diagnoses by Mode of Transmission and Sex at Birth, San Juan EMA, 2019–2024

Transmission mode	2020	2021	2022	2023	2024
MSM	135	162	130	155	132
Heterosexual contact (women)	22	63	42	44	35
Heterosexual contact (men)	27	46	34	42	44
PWID (men)	11	8	15	6	6
PWID (women)	3	2	3	0	4
MSM & PWID	11	12	19	3	16
Total	**209**	**293**	**243**	**250**	**237**

The distribution of HIV diagnoses by age group in the San Juan EMA during the 2020–2024 period (Table 36) indicates that young adults, particularly those aged 25–34 years, continued to account for the largest proportion of cases annually, followed by individuals aged 35–44 years. Between 2021 and 2024, all age groups experienced a decline in the number of new HIV diagnoses compared with previous years (2021-2023).

Table 36: HIV Diagnoses by Age Group at the Time of Diagnosis at San Juan EMA, 2020–2024

Age group	2020	2021	2022	2023	2024
13–24	32	41	27	27	34
25–34	59	79	79	86	74
35–44	50	70	56	52	50
45–54	37	52	43	43	40
55–64	25	29	23	29	25
≥65	6	22	15	13	14
Total	**209**	**293**	**243**	**250**	**237**

In 2024, 69.6% of individuals in the San Juan EMA were linked to medical care within the first 30 days following their HIV diagnosis. During the 2020–2024 period, linkage to care in the San Juan EMA showed fluctuations in the percentage of individuals linked to medical care within the first 30 days. These variations may reflect differences in access to healthcare among the populations most affected by HIV, as well as the healthcare system's capacity to respond promptly to new diagnoses (Table 37).

Table 37: Proportion of Individuals Linked to Medical Care Within the First 30 Days Following HIV Diagnosis, San Juan EMA, 2020–2024

Year	Link to medical care ≤30 days (%)
2019	64.6
2020	66.2
2021	71.8
2022	69.1
2023	64.0
2024	69.6

HIV PREVALENCE, EMA SAN JUAN

At the end of 2024, approximately 11,005 people diagnosed with HIV were living in the San Juan EMA, representing about two-thirds of all individuals diagnosed with HIV in Puerto Rico. Table 38 shows the distribution of cases by sex assigned at birth, age group, and mode of transmission. The groups with the highest number and proportion of cases

were males (71.1%), individuals aged 55 years and older (57.2%), men who have sex with men (34.4%), and heterosexual women (22.3%) (Table 38).

Table 38: Distribution of people with an HIV-positive diagnosis residing in the San Juan EMA at the end of 2024, by sex assigned at birth, age, and mode of transmission

Demographic characteristics / Transmission mode	Number	Percentage
Sex at birth		
Men	7826	71.1%
Women	3179	28.9%
Age		
13–24	86	0.8%
25–34	878	8.0%
35–44	1578	14.3%
45–54	2165	19.7%
55–64	3466	31.5%
≥65	2832	25.7%
Transmission mode		
MSM	3791	34.5%
Heterosexual contact (women)	2456	22.3%
PWID (men)	1805	16.4%
Heterosexual contact (men)	1604	14.6%
PWID (women)	581	5.3%
MSM & PWID	390	3.5%
Total	**11005**	**100.0%**

Table 39 presents the prevalence of HIV among adolescents and adults aged 13 years and older in the San Juan EMA at the end of 2024. As with new diagnoses, the impact of HIV is greatest in the municipalities of San Juan (38.2%), Bayamón (11.0%), Carolina (8.6%), Toa Baja (4.4%), and Guaynabo (4.4%). These five municipalities have the highest proportion of residents with an HIV-positive diagnosis and, collectively, account for 68.8% of all cases in the San Juan EMA.

Table 39: People with an HIV-positive diagnosis residing in the San Juan EMA, 2024

Municipality	Number	Percentage
San Juan	4200	38.2
Bayamón	1214	11.0
Carolina	944	8.6
Toa Baja	486	4.4
Guaynabo	461	4.4
Trujillo Alto	298	2.7
Vega Baja	282	2.6
Humacao	262	2.4
Canóvanas	220	2.0
Toa Alta	210	1.9
Vega Alta	207	1.9
Río Grande	206	1.9
Fajardo	202	1.8
Cataño	185	1.7
Juncos	184	1.7

Municipality	Number	Percentage
Manatí	171	1.6
Loíza	170	1.5
Dorado	139	1.3
Yabucoa	116	1.1
Las Piedras	108	1.0
Corozal	98	0.9
Luquillo	91	0.8
Barceloneta	86	0.8
Naranjito	83	0.8
Morovis	83	0.8
Naguabo	80	0.7
Aguas Buenas	76	0.7
Comerío	59	0.5
Ceiba	56	0.5
Florida	28	0.3
Total	**11005**	**100.0**

At the end of 2024, 58.4% of people diagnosed with HIV and residing in the San Juan EMA were receiving medical care for HIV, 42.5% were retained in HIV medical care, and 51.8% had achieved viral suppression (Table 40). In contrast, HRSA data for 2024 reported higher percentages, with 91.9% of participants retained in medical care and 93.4% achieving viral suppression (Tables 42 and 43).

Table 40: HIV Care Continuum, San Juan EMA, 2024

Indicator	Number	Percentage
Persons diagnosed with HIV residing in the San Juan EMA	10,908	100.0
Receiving medical care	6,369	58.4
Retained in medical care	4,631	42.5
Virally suppressed	5,655	51.8

Table 41: Ryan White Program (non-ADAP) clients - EMA San Juan

2020	2021	2022	2023	2024
7,057	7,851	6,839	7,110	7,843

Fuente: Ryan White HIV/AIDS Program Annual Client-Level Data Report 2020-2024.

Table 42: Retention in care - EMA San Juan

2020		2021		2022		2023		2024	
No.	%	No.	%	No.	%	No.	%	No.	%
5,011	90.5	5,775	90.3	5,317	90.8	5,530	92.1	5,954	91.9

Fuente: Ryan White HIV/AIDS Program Annual Client-Level Data Report 2020-2024.

Table 43: Viral suppression - EMA San Juan

2020		2021		2022		2023		2024	
No.	%	No.	%	No.	%	No.	%	No.	%
4,984	90.3	5,966	91.1	5,461	91.2	5,745	92.8	6,114	93.4

Fuente: Ryan White HIV/AIDS Program Annual Client-Level Data Report 2020-2024.

3. HIV PREVENTION, CARE AND TREATMENT RESOURCE INVENTORY

Services – The PRDOH is the agency responsible for all matters related to health, sanitation, and public welfare under Act No. 81-1912, as amended, and the provisions of Sections 5 and 6 of the Constitution of Puerto Rico of July 25, 1952. The Department establishes public health policy, oversees healthcare providers throughout Puerto Rico, and ensures compliance with regulations that safeguard the general well-being of the population. It is also responsible for protecting the physical and mental health of all individuals residing in Puerto Rico. The Department's mission is to promote and preserve health as an essential condition that enables every individual to achieve physical, emotional, and social well-being, thereby allowing them to fully enjoy life and contribute productively and creatively to society. Furthermore, pursuant to Act No. 11- 1976, as amended, the Comprehensive Health Services Reform Act of Puerto Rico, all functions related to the regulation of health professions in Puerto Rico were transferred to the Department of Health.

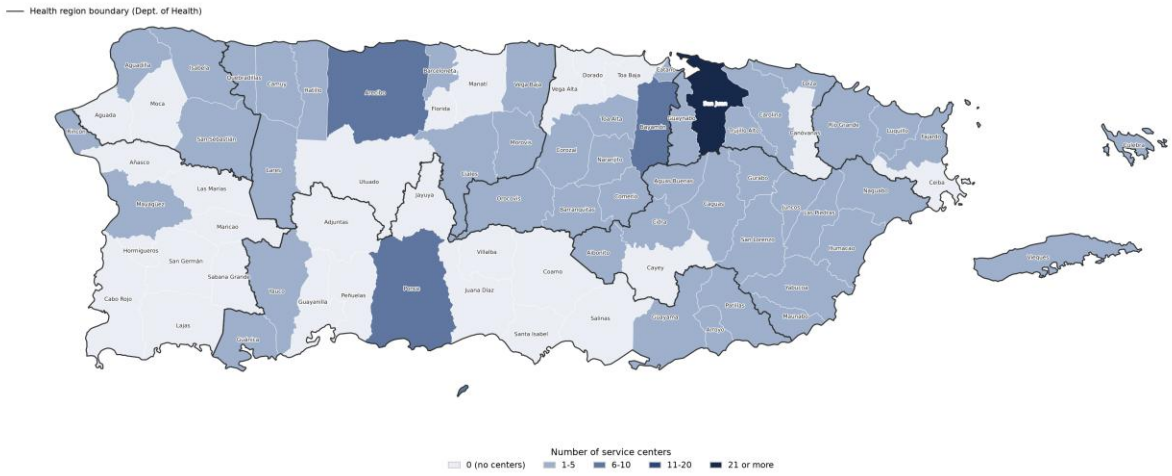
Within this statutory framework, the PRDOH serves as the agency responsible for HIV surveillance and for developing and implementing public policies related to HIV prevention, care, and treatment. To fulfill these responsibilities, the Department includes the Puerto Rico Medicaid Program, which establishes coverage guidelines under the Government Health Plan for beneficiaries diagnosed with HIV in accordance with the Puerto Rico Medicaid State Plan; the Division of Epidemiology and Research, which operates the HIV Surveillance System; and the Assistant Secretariat for Comprehensive Health Services (SASSI), which houses the Division of Disease Prevention and Control. Within this division is the Section for the Prevention and Control of Communicable Diseases and Infections (SPCEIT), which is responsible for delivering HIV prevention and treatment services. This operational unit includes the following organizational structures and programs that provide HIV prevention and care services: the STI/HIV/Viral Hepatitis Prevention Program; the Communicable Disease Prevention and Treatment Centers; the Ryan White Part B/ADAP Program; the Housing Opportunities for Persons with AIDS (HOPWA) Program; and the Tuberculosis Control Program.

The network of services provided by the Commonwealth through the PRDOH is complemented by the efforts of numerous government agencies, nonprofit organizations, and private entities that deliver HIV-related surveillance, prevention, treatment, and supportive services throughout Puerto Rico.

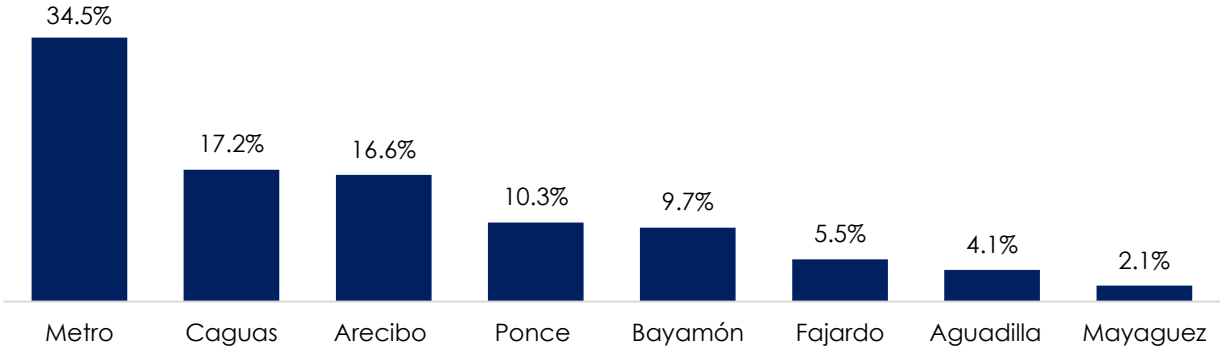
According to the inventory of HIV service providers conducted as part of the Integrated HIV Planning process, 118 service provider organizations were identified, collectively operating 145 service sites across Puerto Rico. Of these, 110 are direct service delivery sites. Among these direct service sites, 90.3% provide HIV care and treatment services,

including clinical care, laboratory services, and other medical and support services. Slightly more than one-fifth (22.1%) provide HIV prevention services, while a similar proportion (20.7%) offer mental health and/or substance use treatment services. The geographic distribution of service sites reveals a significant concentration in the Metro Health Region, where 34.5% of the identified providers are located. This is followed by the Caguas (17.2%), Arecibo (16.6%), Ponce (10.3%), and Bayamón (9.7%) Health Regions. In contrast, the Fajardo, Aguadilla, and Mayagüez Health Regions have a lower concentration of service providers, which may present challenges in terms of access to and availability of HIV-related services for residents of these areas.

Illustration 10: Entities and centers that provide HIV related services in Puerto Rico



Graph 9: Distribution of the service centers of facilities by region of the PRDOH



Funding Sources and Services Provided – The table below presents a description of the financial resources available within the jurisdiction from federal and local government sources, as well as foundations, together with the services supported through these funding streams.

Description of the funds			Areas addressed and relation to the continuum of care							
Funding Source	Program	Services provided through the funds	Surveillance	Prevention	Diagnose	Linkage to care	Retention on care	Care	Viral suppression	Supportive services
CDC	HIV Prevention Activities, Non-Governmental Organization Based	Supports nonprofit organizations in developing community-based HIV prevention programs and promotes coordination among community-based organizations, prevention and education providers, public health agencies, and substance use–related programs.								
CDC	HIV Prevention Activities Health Department Based	Supports the implementation and evaluation of state-administered HIV prevention programs, with a particular emphasis on high-impact HIV prevention strategies.								
CDC	Epidemiologic Research Studies of Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection in Selected Population Groups	Provides funding for HIV epidemiologic research.								
CDC	Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Virus Syndrome (AIDS) Surveillance	Supports the establishment of a behavioral surveillance system among high-risk populations in metropolitan statistical areas with the highest HIV prevalence in the United States.								
CDC	Viral Hepatitis Prevention and Control	Provides funding to strengthen Viral Hepatitis surveillance systems and to disseminate information needed to understand trends and develop effective prevention and public health interventions.								
CDC	Strengthening STD Prevention and Control for Health Departments (STD PCHD)	Supports strategies to prevent and control chlamydia, gonorrhea, and syphilis, reduce STI-related complications, and respond to disease outbreaks.								
CDC	DIS Workforce Development	Strengthens public health workforce capacity to improve preparedness and response to disease outbreaks through workforce expansion and training.								
CDC	Integrated HIV Programs for Puerto Rico Department of Health to Support Ending the HIV Epidemic in San Juan, Puerto Rico	Ensures the coordination and implementation of Puerto Rico's Ending the HIV Epidemic (EHE) Plan.								

Description of the funds			Areas addressed and relation to the continuum of care							
Funding Source	Program	Services provided through the funds	Surveillance	Prevention	Diagnose	Linkage to care	Retention on care	Care	Viral suppression	Supportive services
HRSA	HIV Emergency Relief Project Grants (Ryan White Parte A)	Provides direct financial assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) most severely affected by the HIV epidemic to improve access to continuous, comprehensive, effective, cost-efficient, and high-quality HIV care.								
HRSA	Ending the HIV Epidemic: A Plan for America — Ryan White HIV/AIDS Program Parts A	Provides funding to implement effective and innovative strategies, interventions, approaches, and services to achieve the goals of the Ending the HIV Epidemic (EHE) initiative.								
HRSA	HIV Care Formula Grants B/ADAP, Supplemental Part B / ADAP ERF	Supports the provision of clinical and supportive services designed to promote access to treatment, continuity of care, treatment adherence, and the overall well-being of people with an HIV-positive diagnosis.								
HRSA	Grants to Provide Outpatient Early Intervention Services with Respect to HIV Disease (Ryan White Parte C)	Provides comprehensive outpatient primary HIV medical care, including: (1) Early Intervention Services (which may include HIV counseling, testing, and referrals); (2) medical evaluation and clinical care; (3) other primary healthcare services; and (4) referrals to additional health services.								
HRSA	Coordinated HIV Services and Access to Research for Women, Infants, Children, and Youth (Ryan White Parte D)	Provides family-centered primary medical care and support services for women, infants, children, and youth with an HIV-positive diagnosis.								
HRSA	RWHAP Part F Dental Reimbursement Program (DRP) Grant Awards	Dental Reimbursement Program.								
HUD	Housing Opportunities for Persons with AIDS (HOPWA) – State allocation	Through the Continuum of Care under the Housing Opportunities for Persons with AIDS (HOPWA) Program, coordinates, establishes, and implements housing assistance services complemented by supportive services.								
HUD	Housing Opportunities for Persons with AIDS (HOPWA) – Municipality of San Juan allocation	Through the Continuum of Care under the Housing Opportunities for Persons with AIDS (HOPWA) Program, coordinates, establishes, and implements housing assistance services complemented by supportive services.								

Description of the funds			Areas addressed and relation to the continuum of care							
Funding Source	Program	Services provided through the funds	Surveillance	Prevention	Diagnose	Linkage to care	Retention on care	Care	Viral suppression	Supportive services
SAMHSA	Substance Abuse and Mental Health Services Projects of Regional and National Significance – Minority Serving Institutions (MSIs) Partnerships with Community-Based Organizations (CBOs)	Seeks to prevent and reduce substance use and HIV transmission among at-risk populations, particularly Hispanic/Latino young adults aged 18–24, by promoting partnerships between Minority-Serving Institutions (MSIs) and community-based organizations to deliver integrated substance use, hepatitis C, and HIV prevention interventions.								
State Allocations	Various	Supports HIV surveillance, prevention, treatment, and supportive services provided through Puerto Rico state government agencies.								
State Allocation	Daycare and Services to Homeless	Provides funding to faith-based and community-based organizations (FBOs/CBOs) to deliver shelter services, transitional housing, adult day care, HIV screening, harm reduction services, and prevention and treatment interventions for special populations.								
Foundations	Grant programs from foundations	Provides nonrecurring appropriations to nonprofit organizations, primarily to support supportive services.								

a. Assessment of Strengths and Gaps across the HIV Prevention and Care Gap

The resource inventory conducted for the Integrated Plan demonstrates that Puerto Rico has an extensive infrastructure of HIV-related surveillance, prevention, treatment, and support services. This network includes programs funded by the Centers for Disease Control and Prevention (CDC), the U.S. Department of Housing and Urban Development (HUD), and the various parts of the Ryan White HIV/AIDS Program, as well as primary health centers, community-based organizations, behavioral health providers, housing programs, and other public and private entities. Altogether, 118 organizations operating 145 service sites dedicated to HIV-related services were identified across 48 municipalities.

Among the system's primary strengths is the availability of interventions spanning the entire HIV prevention and care continuum, including epidemiologic surveillance, HIV testing, evidence-based prevention strategies, access to antiretroviral therapy, clinical services, clinical and non-clinical case management, psychosocial support, and a broad range of supportive services designed to promote retention in care and viral suppression. In addition, coordination mechanisms exist among surveillance, prevention, and treatment programs, facilitating service integration and continuity of care.

Despite these strengths, the analysis identified significant disparities in the distribution and accessibility of resources. Although most essential services are available throughout the

jurisdiction, a substantial proportion of specialized and supportive services remain concentrated in the San Juan Metropolitan Area and other urban centers. Even within the Eligible Metropolitan Area (EMA), the concentration of services declines as the distance from San Juan and the metropolitan core increases. Consequently, residents of rural municipalities, geographically isolated regions, and Puerto Rico's island municipalities face greater barriers related to transportation, provider availability, and access to specialized services.

The assessment also identified important gaps across the care continuum, particularly in mental health services, oral health care, substance use disorder treatment, rehabilitation services, housing, and other supports that address the social determinants of health. Similarly, existing capacity remains insufficient to meet the demand for housing assistance, food assistance, utility assistance, and transportation services.

In the area of prevention, the findings highlight opportunities to strengthen access to and utilization of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), promote the integration of routine HIV testing into clinical settings, improve follow-up associated with HIV self-testing, and expand access to emerging prevention modalities, including long-acting injectable antiretroviral medications. The analysis also identified barriers related to administrative processes, eligibility requirements, provider training, and the continued persistence of HIV-related stigma.

Finally, based on this analysis and the perspectives of consulted stakeholders, several populations were identified as continuing to experience disproportionate barriers to accessing and fully benefiting from available services. These include people who use substances, people experiencing homelessness, men who have sex with men (MSM), youth, older adults, residents of rural communities, and individuals facing economic or social barriers.

b. Approaches and Partnerships

The HIV prevention, care, and treatment resource inventory for Puerto Rico was developed using a multi-method approach that combined the review of existing programmatic information with consultations involving service providers and other key stakeholders within the HIV service system.

As part of this process, provider directories from the Puerto Rico Department of Health's HIV/STI/Viral Hepatitis Prevention Program, the Ryan White Part B/ADAP Program, the Ryan White Part A Program for the San Juan Eligible Metropolitan Area (EMA), and the Project TIES provider directory developed for the Ending the HIV Epidemic (EHE) initiative were reviewed. This information was supplemented through reviews of publicly available directories of HOPWA subrecipients, Section 330 Community Health Centers, Ryan White Part C recipients, the specialized laboratory directory maintained by the Ryan White Part B/ADAP Program, and directories of substance use treatment providers.

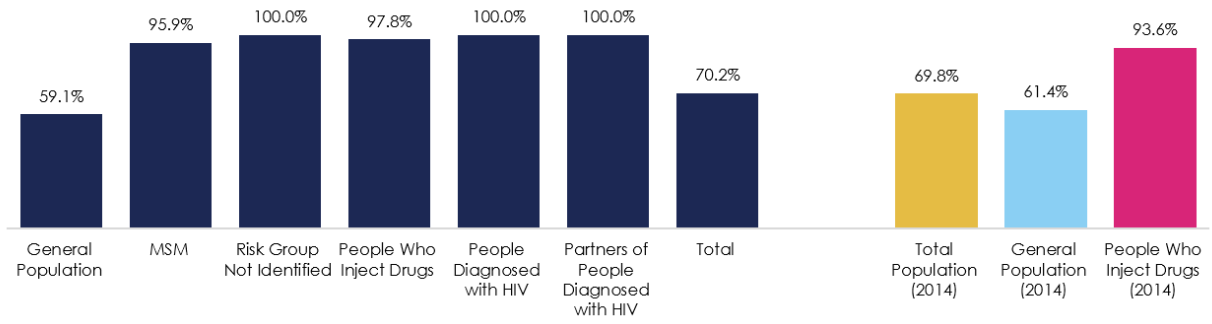
The information gathered from these sources was further complemented by input obtained during the Integrated Planning workshops, which included participation from service providers, community-based organizations, government agencies, people with an HIV-positive diagnosis, and other stakeholders involved in Puerto Rico's HIV response. These multiple sources made it possible to validate existing service capacity, identify system strengths and service gaps, and assess opportunities to strengthen coordination

among the HIV prevention, care, and treatment systems. The process also facilitated the engagement of new collaborators, including organizations serving people experiencing homelessness, behavioral health and substance use treatment providers, and other entities addressing the social determinants of health.

4. NEEDS ASSESSMENT

HIV Testing and Prevention Services - Early diagnosis is one of the essential components of the HIV response, representing the entry point to the continuum of care and prevention. Although Puerto Rico has made significant progress in the availability of HIV testing and in diversifying the settings where testing is offered, the findings of the Department of Health's HIV Prevention Needs Assessment and the 2027–2031 integrated planning process reveal persistent gaps in access to, utilization of, and follow-up for testing services. The most recent epidemiological data estimates that approximately 8.4% of people diagnosed with HIV in Puerto Rico are unaware of their diagnosis. Furthermore, although most participants in the assessment reported having taken an HIV test at some point, significant differences were observed among population groups, with the general population reporting the lowest levels of utilization.

Graph 10: People who have ever been tested for HIV



Source: HIV Prevention Needs Assessment (PRDOH, 2023–2024)

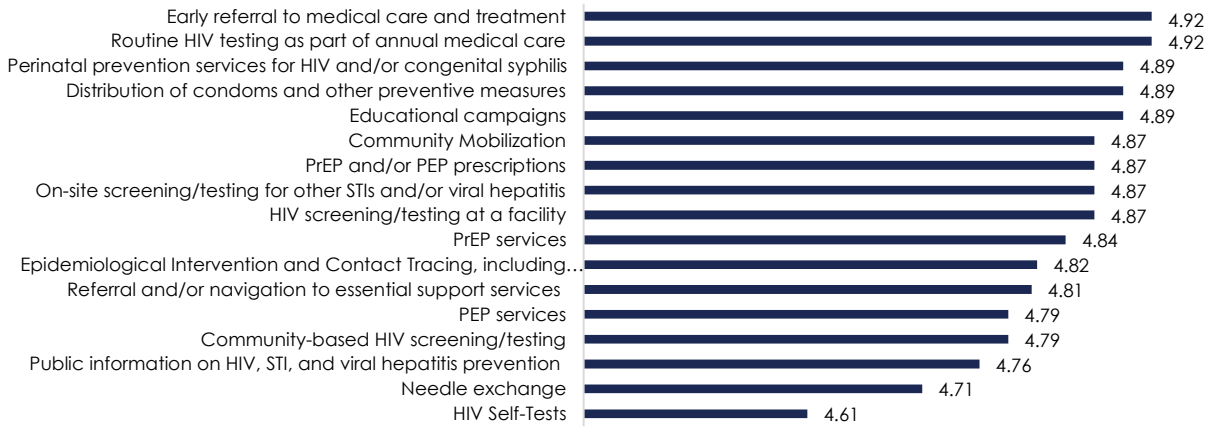
Among those who had never been tested, the most frequent reasons were related to a low self-perceived risk, including the belief that testing was unnecessary, the absence of behaviors perceived as risky, or having only one sexual partner. Workshop participants also identified additional barriers, such as stigma associated with HIV and sexuality, the limited incorporation of routine testing in some clinical settings, a lack of training among some health care providers, and the absence of standardized referral and follow-up mechanisms for people accessing services. The findings also highlight opportunities to strengthen strategies aimed at keeping people HIV-negative through broader access to integrated prevention services. In this regard, identified needs include expanding PrEP and PEP, integrating HIV testing with screening for sexually transmitted infections and viral hepatitis, distributing condoms and other preventive methods, and strengthening educational campaigns and community mobilization activities. In particular, they mentioned the use of HIV self-tests, recognized as a valuable tool for expanding access among populations facing barriers related to confidentiality, stigma, or geographic access. However, participants also pointed out the need to strengthen mechanisms for

counseling, result reporting, and follow-up to ensure timely access to prevention or treatment services.

Furthermore, during discussions with stakeholder groups, geographic disparities were explored in depth. According to those who participated in the planning process, a significant portion of the prevention infrastructure remains concentrated in the San Juan metropolitan area, while rural communities and remote municipalities face greater barriers related to service availability, transportation, and access to specialized providers.

Based on these findings, the assessment identified the need to strengthen routine HIV testing in clinical settings, expand community-based and mobile testing, increase access to self-testing with effective follow-up mechanisms, expand PrEP and PEP services, integrate HIV testing with other sexual health services, and strengthen navigation and early referral to care. In an exercise designed to prioritize services by level of importance for HIV diagnosis and prevention, workshop participants assigned high priority to early treatment linkage services, routine HIV testing, perinatal prevention, educational campaigns, community mobilization, and access to PrEP and PEP, reaffirming the importance of maintaining an integrated approach that combines diagnosis, prevention, and early linkage to services. Some participants identified other services as being highly important, with mental health services being the most frequently mentioned.

Graph 11: Level of importance of various services related to HIV diagnosis and prevention



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

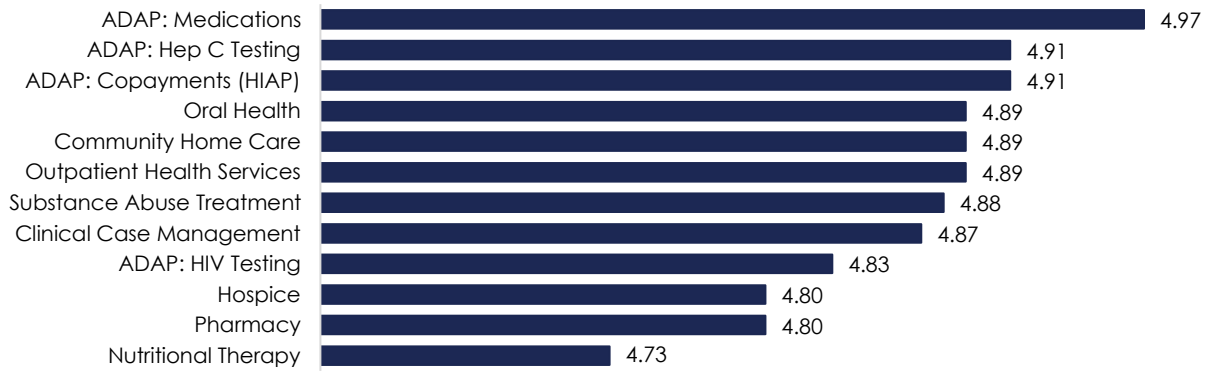
HIV Care and Treatment - According to the needs assessments conducted for the Ryan White Part A and Ryan White Part B/ADAP programs, keeping people with an HIV-positive diagnosis engaged in care and achieving viral suppression requires a combination of clinical and support services that address both medical needs and the social determinants that affect treatment continuity. The findings of both assessments indicate that, although Puerto Rico has a robust network of clinical services and high levels of access to antiretroviral treatment, retention in care depends on the system's ability to provide integrated services that facilitate adherence, reduce barriers to access, and respond to the changing needs of the population.

The results of the Ryan White Part B/ADAP needs assessment indicate that services related to continuous access to antiretroviral medications, clinical follow-up, service

coordination, and health monitoring remain essential components for sustaining retention in care and viral suppression. Likewise, the assessment of the San Juan Eligible Metropolitan Area (EMA) identified outpatient health services, clinical case management, mental health, oral health, substance use treatment, and medication assistance as priorities, highlighting that clinical needs are closely linked to economic, social, and behavioral factors that can affect treatment adherence.

Furthermore, the findings from the focus groups held during the integrated planning process - which was conducted as part of the planning process for the 2027–2031 Integrated Plan - reinforce these conclusions. Participants agreed that all of the clinical services evaluated are important or very important for keeping people engaged in care and achieving viral suppression. Among the clinical services that received the highest average importance scores are the HIV Drug Assistance Program (ADAP), with an average score of 4.97 on a five-point scale; hepatitis C testing and the copayment assistance (HIAP) and cost-sharing programs (4.91 each); oral health services, outpatient health services, and home- and community-based health care (4.89 each); outpatient substance use treatment (4.88); clinical case management (4.87); ADAP: HIV Testing (4.83); pharmacy and hospice services (4.80); and medical nutritional therapy (4.73).

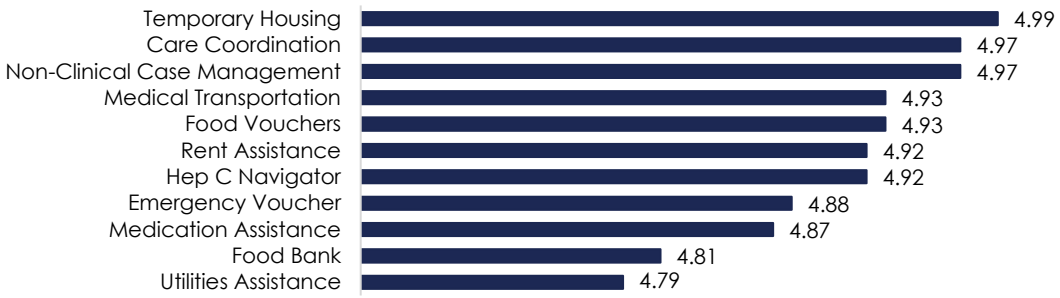
Graph 12: Level of importance of clinical services related to HIV treatment



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

Similarly, the focus groups highlighted the importance of support services for sustaining ongoing participation in care. The support services rated highest included temporary housing (4.99), care linkage services (4.97), non-clinical case management (4.97), medical transportation (4.93), food stamps (4.93), rent assistance (4.92), hepatitis C navigation services (4.92), emergency vouchers (4.88), medication-related assistance (4.87), food banks (4.81), and utility bill assistance (4.79). These results reflect the recognition that economic and social stability is an indispensable component of treatment adherence and retention in care.

Graph 1 : Level of importance of support services related to HIV treatment



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

The integrated analysis of the Ryan White Part A needs assessments for the San Juan Eligible Metropolitan Area (EMA), Ryan White Part B/ADAP, and the results of the first planning workshop identified areas of convergence that reflect the main needs related to retention in care and viral suppression in Puerto Rico. By cross-referencing these results, it becomes clear that, in addition to specialized clinical services, there are social determinants and structural barriers that continue to affect the ability of people with an HIV-positive diagnosis to remain connected to care and fully benefit from treatment.

Illustration 11: Priority need areas identified in the needs assessments and consultation with stakeholders as part of the integrated planning process

	Puerto Rico		San Juan EMA	
	Top 10 services with the greatest need according to the RWPB Needs Assessment	Services with the greatest availability gaps according to the first workshop session	Top 10 most requested services, but not received most frequently, according to the needs assessment	Services with the greatest availability gaps according to the first workshop session
1	Eyeglasses	Temporary housing	Oral health services	Food bank
2	Oral health services	Food bank	Food bank / Home-delivered meals	Temporary housing
3	Vision evaluation	Rental assistance	Emergency financial assistance	Medical transportation
4	Financial assistance for electricity bills	Utility assistance	Housing services	Utility assistance
5	Financial assistance for water bills	Food vouchers	Medical transportation	Emergency vouchers
6	Food vouchers	Emergency vouchers	Psychosocial support / Home- and community-based health services	Food vouchers
7	Emergency vouchers	Medication assistance	Mental health services	Medication assistance
8	Financial assistance for rent	Hospice	Home health care services	Rental assistance
9	Nutritional supplements	Oral health	Medical nutrition therapy	Hospice
10	Financial assistance for gas bills	Substance use treatment	Outpatient health services	Oral health

Areas of Greatest Convergence Across the Sources Consulted

1. **Housing and residential stability.**
2. **Food security and nutritional support.**
3. **Financial assistance for basic needs (utilities, rent, and emergencies).**
4. **Comprehensive health services, with an emphasis on oral health, mental health, and psychosocial support.**
5. **Accessibility and continuity of care, including medical transportation, home-based services, and medication assistance.**

Note: The categories are based on a triangulation analysis of the results from four core questions in the needs assessments and the consultation conducted as part of the workshops. The ranking of the top ten identified needs or gaps in services for each question is used.

In this regard, one of the areas of greatest consensus identified was the need to strengthen support related to housing stability. Housing services, including temporary

housing and rent assistance, consistently emerged among the most needed services and the main gaps identified in both Puerto Rico and the San Juan Metropolitan Area (AME).

Food security and access to nutritional support constituted a second priority area. Nutritional supplements, food banks, food stamps, and other food-related services appeared repeatedly among the needs identified in the various sources consulted. A third area of convergence relates to the need to strengthen financial assistance aimed at covering basic needs. Needs assessments consistently identified assistance with payments for electricity, water, gas, rent, and other utilities as among the most frequently requested yet least received services. Similarly, workshop participants highlighted emergency financial assistance and economic support as essential components for reducing the barriers that many people with an HIV-positive diagnosis face in staying in care and treatment.

Furthermore, the sources consulted highlighted the importance of expanding access to comprehensive health services that complement HIV-related medical care. These include oral health services, mental health services, psychosocial support, nutritional therapy, and rehabilitation services. Finally, the various sources agreed on the need to improve access to services and support that facilitate continuity of care. Medical transportation services, home health care, psychosocial support, medication assistance, and other support services emerged as essential components for reducing geographic, functional, and economic barriers. These services are particularly important for people with mobility limitations, complex health conditions, long-term care needs, or those living in areas with limited access to specialized services.

Barriers to Access - Needs assessments conducted by the HIV/STI/Viral Hepatitis Prevention Program, the Ryan White Part B/ADAP Program, and the Ryan White Part A Program, as well as discussions held during the integrated planning process, show that people with an HIV-positive diagnosis and disproportionately affected populations continue to face barriers that limit timely access to prevention, diagnosis, treatment, and support services. These barriers include individual, social, economic, geographic, and systemic factors that affect different stages of the HIV care continuum.

HIV Testing Barriers - According to the Prevention Needs Assessment, one of the main barriers to HIV testing continues to be a low perception of risk. Many people who had never been tested indicated that they did not consider it necessary because they believed they were not exposed to risky situations or were in monogamous relationships. Additionally, workshop participants noted that the stigma associated with HIV and sexuality continues to limit some people's willingness to seek testing services or discuss risky behaviors with health care providers. Barriers were also identified related to the implementation of routine testing in certain clinical settings, the limited training of some health professionals on HIV prevention, and the need to strengthen follow-up mechanisms associated with HIV self-testing to ensure timely access to prevention, diagnostic confirmation, or treatment services.

Challenges with State Laws and Regulations - Participants in the planning process identified various regulatory, administrative, and public policy factors that may affect timely access to HIV prevention, care, and treatment services. Although significant progress has been made in recent years in expanding services and coordinating

between programs, stakeholders highlighted the need to continue strengthening regulatory frameworks and administrative processes to facilitate access to evidence-based interventions, including aspects such as case reporting by service providers. Among the barriers identified are eligibility criteria and administrative requirements associated with access to biomedical prevention strategies, including PrEP and PEP. Participants noted that certain clinical, documentation, or eligibility requirements may limit or delay timely access to these interventions, particularly among populations with higher levels of vulnerability. Likewise, bureaucratic processes related to insurance providers, authorizations, and other administrative procedures were identified that can delay service delivery or hinder coordination among providers. These barriers are particularly relevant for services that require multiple points of coordination, such as medical transportation, specialized referrals, and certain support services. The groups also highlighted the existence of regulatory and operational limitations that can hinder the adoption and implementation of new technologies and prevention and diagnostic strategies, including certain types of rapid tests and other innovative models of service delivery. Similarly, the groups identified a reliance on primary care providers for prescribing certain preventive interventions, which can restrict access in communities with a shortage of healthcare professionals or limited availability of services.

HIV Prevention, Care, and Treatment Service Access Issues - The most consistent barrier identified across all sources consulted is related to the social determinants of health. Needs assessments revealed high levels of unmet needs in areas such as housing, food security, utility assistance, emergency financial assistance, and medical transportation. These needs directly affect people's ability to attend medical appointments, adhere to treatment, and remain connected to care. Geographic barriers also emerged repeatedly during the planning process. Those consulted during the planning process noted that many specialized services continue to be concentrated in the San Juan metropolitan area and other urban areas, while people living in rural or remote municipalities face greater difficulties related to transportation, provider availability, and access to certain clinical and support services.

Likewise, participants identified limitations in the availability of mental health, oral health, rehabilitation, substance use disorder treatment, and other specialized services. These gaps take on particular significance given the aging of the HIV-positive population and the increasing prevalence of co-occurring chronic conditions that require multidisciplinary care.

Finally, stigma and discrimination remain cross-cutting barriers that affect both access to prevention services and retention in care. Participants noted that fear of rejection, involuntary disclosure of their diagnosis, and experiences of stigmatization in various social and service settings can limit the use of available resources and negatively affect treatment continuity.

a. Priorities

Needs assessments conducted by the Ryan White Part A Program, the Ryan White Part B/ADAP Program, and the Department of Health's HIV/STI/Viral Hepatitis Prevention Program, along with consultations and workshops held as part of the integrated planning process, identified the key needs, gaps, and opportunities for strengthening the HIV

response in Puerto Rico during the 2027–2031 period. The findings reflect the need to continue strengthening the continuum of prevention, diagnosis, treatment, and response, while addressing the social and structural determinants that affect the health and well-being of people with an HIV-positive diagnosis and populations disproportionately affected by the epidemic.

Based on this process, the following priorities were identified for the jurisdiction:

- **Strengthen early diagnosis and timely access to services** by expanding testing for HIV, STIs, and viral hepatitis; promoting self-testing; reducing barriers associated with stigma; and strengthening early care linkage processes.
- **Expand evidence-based prevention strategies**, including access to PrEP and PEP, community education, distribution of preventive methods, and the development of interventions targeting populations disproportionately affected by HIV and with low perceived risk.
- **Strengthen rapid and timely access to treatment and continuity of care** by promoting rapid referral to medical services, early access to antiretroviral treatment, retention in care, treatment adherence, and sustained viral suppression.
- **Address the social determinants of health and strengthen support services**, including housing, food security, utility assistance, transportation, service navigation, and other essential supports for the stability and well-being of people with an HIV-positive diagnosis.
- **Expand access to comprehensive health services** through whole-person service approaches that address areas such as mental health, oral health, psychosocial support, rehabilitation, and the management of co-morbid conditions that affect quality of life and health outcomes.
- **Reduce geographic disparities and other barriers to accessing services** by strengthening telemedicine strategies, home-based services, transportation solutions, and a more equitable distribution of resources and services throughout the jurisdiction.
- **Reduce stigma and strengthen education and training** by promoting culturally relevant campaigns, evidence-based information, and competency development among providers, professionals, and communities.
- **Strengthen coordination, integration**, **and the strategic use of data** by improving interoperability among surveillance, prevention, and treatment systems; enhancing information sharing between programs; and utilizing data for decision-making, resource allocation, and outcome evaluation.
- **Strengthen the capacity to respond to clusters, outbreaks, and emerging situations related to HIV** through greater coordination among surveillance, prevention, and treatment efforts; the strengthening of epidemiological intervention activities; and the active participation of community organizations and affected populations.

b. Action Taken

Over the past few years, Puerto Rico has implemented various initiatives to address the barriers identified in HIV prevention, diagnosis, and treatment systems. The results of the workshops held as part of the planning process reflect a positive perception of the

progress made, although they also highlight the need to continue strengthening these efforts to address the barriers that persist today.

In the area of diagnosis and prevention, participants highlighted the expansion of rapid and self-administered HIV tests, greater integration of testing in clinical and community settings, the strengthening of biomedical prevention strategies - including PrEP and PEP- and increased education, community outreach, and coordination among prevention and surveillance programs. In the area of treatment, significant progress was recognized in access to antiretroviral treatment, the implementation of rapid initiation models, the expansion of telemedicine, and the strengthening of case management and patient navigation services. The consolidation of the network of clinical and support services that facilitates the referral, retention, and follow-up of people with an HIV-positive diagnosis across the continuum of care was also highlighted. Participants further highlighted significant improvements in system coordination and integration, including the implementation of a uniform eligibility system for Ryan White programs, the strengthening of collaboration mechanisms between the Department of Health, Ryan White programs, and provider organizations, and greater integration among surveillance, prevention, and treatment systems through data-sharing initiatives and efforts to track people who have fallen out of care.

Finally, progress was recognized in strengthening the HIV workforce through continuing education initiatives led by the AETC, targeting clinical providers, support staff, and other health professionals in areas such as antiretroviral treatment, case management, behavioral health, whole-person care, and new prevention and treatment strategies.

c. Approach

The needs assessment for Puerto Rico's Integrated Plan for HIV Surveillance, Prevention, and Treatment 2027–2031 was conducted using a multi-method, participatory approach that combined quantitative and qualitative data from various sources. The process was based on the results of the most recent needs assessments conducted by the Ryan White Part B/ADAP Program, the Ryan White Part A Program of the San Juan Eligible Metropolitan Area (EMA), and the Department of Health's HIV/STI/Viral Hepatitis Prevention Program, supplemented by epidemiological data from the HIV Surveillance System, programmatic information from HRSA- and CDC-funded programs, and relevant scientific literature.

The findings from these sources were presented and discussed during the first of three planning workshops held to develop the Integrated Plan. Participants included representatives from the Ryan White Parts A, B, C, and D programs; Part F grantees and partners; community organizations; service providers; government agencies; academic institutions; people with an HIV-positive diagnosis; and representatives of populations disproportionately affected by the epidemic. Activities included needs assessment exercises, validation of findings, identification of gaps, and prioritization of areas for intervention.

The participation of people with an HIV-positive diagnosis was a central component of the process. They participated in both the needs assessments and the planning activities, providing information about their experiences, barriers to access, service needs, and recommendations for strengthening the response to HIV.

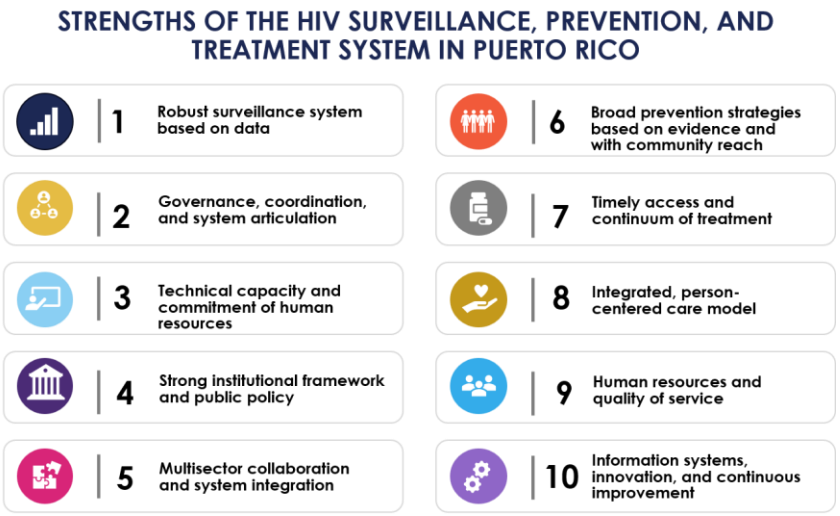
SECTION IV: SITUATIONAL ANALYSIS

1. SITUATIONAL ANALYSIS

The present situational analysis summarizes the findings of the participatory planning process carried out during the first quarter of 2026 as part of the development of Puerto Rico's Integrated Plan for HIV Surveillance, Prevention, and Treatment 2027–2031. The analysis covers the entire HIV prevention and care continuum at the jurisdictional level. Although the San Juan Eligible Metropolitan Area (EMA) accounts for most resources and cases, the analysis encompasses the entire geographic area of the jurisdiction, in compliance with the SCSN requirement.

a. Strengths

The integrated planning process identified multiple strengths that have contributed to reenforcing the HIV response in Puerto Rico and that constitute a solid foundation for the implementation of the 2027–2031 Integrated Plan. Needs assessments and consultations with people with an HIV-positive diagnosis and other key stakeholders revealed significant progress in programmatic infrastructure, technical capacity, and the integration of surveillance, prevention, treatment, and support systems.



One of the main strengths identified is the existence of a robust epidemiological surveillance system that makes it possible to monitor the evolution of the epidemic, identify emerging trends, and guide programmatic decision-making. Participants highlighted the availability of up-to-date information and the strengthened integration among surveillance, prevention, and treatment systems, which facilitates the identification of needs, the prioritization of populations, and the monitoring of outcomes. The institutional framework underpinning the HIV response in Puerto Rico was also identified as a strength. The existence of legislation, regulations, and specialized programmatic structures—along with coordination mechanisms among the Prevention Program, the Surveillance Program, the Ryan White programs, community organizations, municipalities, and academic institutions—has contributed to a more integrated and coordinated response.

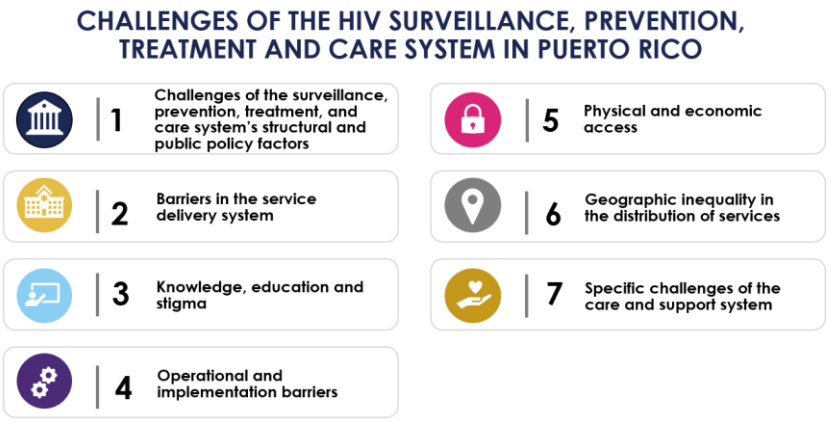
In the area of prevention, participants highlighted the availability of a network of services based on strategies supported by scientific evidence. Among the strengths noted were the expansion of HIV testing in clinical and community settings, the strengthening of

educational campaigns, the growth of PrEP and PEP services, the implementation of harm reduction strategies, and an increased capacity to target interventions toward populations and communities most vulnerable to HIV. In the area of treatment and care, participants highlighted the system's ability to ensure access to antiretroviral treatment and essential clinical services. Among the most significant advances cited were the availability of medications through ADAP, the implementation of rapid treatment initiation models, the high levels of viral suppression achieved by the jurisdiction, and efforts aimed at strengthening retention in care and treatment adherence. Likewise, the implementation of a uniform eligibility system has helped simplify administrative processes and facilitate access to services throughout the Ryan White network. Another important strength mentioned is the existence of a whole-person, comprehensive care model that combines clinical services, case management, psychosocial support, service navigation, and other complementary supports. This approach facilitates continuity of care and allows for more effective addressing of the medical and social needs of people with an HIV-positive diagnosis. Participants also highlighted the active participation of people with an HIV-positive diagnosis in planning and decision-making processes as a distinctive feature of the system.

Finally, the strength of human capital and the growing incorporation of innovation and technology into service delivery were recognized. The availability of experienced professionals with specialized training, along with ongoing education and professional development initiatives, enhances the quality of the services provided. Added to this are the expansion of telemedicine, the use of digital tools for monitoring and coordinating services, and the strengthening of information systems as elements that have contributed to improving access, efficiency, and the responsiveness of Puerto Rico's HIV care system.

b. Challenges

Despite the strengths identified by participants in the planning process, needs assessments, and discussions held during the process point to a series of structural, operational, and programmatic challenges that limit the effectiveness of the HIV prevention, treatment, and response system in Puerto Rico.



One of the main challenges identified relates to structural and public policy barriers that affect access to prevention services. Participants noted that eligibility requirements associated with interventions such as pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), including clinical criteria, age restrictions, and administrative requirements, can limit timely access to these strategies, particularly among young people and other priority populations. Likewise, it was emphasized that reliance on primary care providers for PrEP prescriptions can restrict access in communities where there is a shortage of professionals trained in or familiar with these interventions.

Participants also expressed concern about the sustainability of certain prevention and education activities due to their heavy reliance on federal funding.

During the planning workshops, challenges related to the organization and operation of the service delivery system were also highlighted. Although Puerto Rico has an extensive network of clinical and community resources, participants noted that the availability of services does not always translate into effective access. Among the challenges identified are the inconsistent implementation of routine HIV testing in some clinical settings, the fragmentation of certain referral and service navigation processes, and difficulties in ensuring consistent coordination among the various components of the system. In the area of treatment, barriers associated with the administrative processes of some health services or health plans were also noted, including difficulties related to authorizations, coordination of services, and access to benefits such as medical transportation.

Another significant challenge identified was the persistence of stigma, discrimination, and knowledge gaps related to HIV. Participants noted that stigma continues to affect many people's willingness to get tested for HIV, access prevention services, or remain connected to care. Likewise, a low perception of risk was identified in some population groups, as well as the persistence of incorrect or outdated information about HIV among certain segments of the population and some health care professionals. Participants noted that situations of rejection or differential treatment toward people diagnosed with HIV still occur in some service delivery settings, including experiences related to dental care and other specialized services.

Operational challenges that affect the system's efficiency and responsiveness were also identified. These include limitations in the interoperability of some information systems, the complexity of data collection and reporting processes, difficulties in sharing information between programs and providers, and the need to strengthen mechanisms for tracking people who have dropped out of care. Furthermore, the excessive workload of clinical, prevention, and case management staff was identified as a factor that can affect the quality of services and the system's ability to respond to growing needs.

Economic and physical access barriers continue to pose another significant challenge. Participants indicated that the costs associated with services, medications, transportation, and other essential supports can limit access for people with limited financial resources. Likewise, the lack of transportation and travel difficulties were identified as major barriers to accessing prevention, treatment, and support services, particularly among people with functional limitations, older adults, and residents of communities far from major service centers. In this regard, the unequal geographic distribution of resources constitutes another major challenge for the jurisdiction. Both the prevention and treatment workshops agreed that many specialized services continue to be concentrated in the San Juan Metropolitan Area. As a result, residents of rural regions, municipalities in the center of the island, the eastern region, the south, the west, and the island municipalities face greater difficulties related to the availability of providers, access to specialists, transportation, and continuity of services. These geographic disparities contribute to inequalities in access to preventive interventions, clinical services, and complementary support.

Finally, participants identified significant challenges related to support services and comprehensive care. Needs assessments revealed persistent gaps in areas such as utility assistance, food security, housing, medical transportation, medication assistance, and oral health services. An insufficient availability of mental health and behavioral health services was also identified, particularly outside the metropolitan area, as well as limitations in access to rehabilitation services, psychosocial support, and long-term care. These gaps directly affect people's ability to remain engaged in care, adhere to treatment, and achieve sustained viral suppression.

c. Identified Needs

Based on the prioritization exercises and needs assessments, the following priority areas of need were identified:

- Strengthen early diagnosis and timely access to services
- Expand evidence-based prevention strategies
- Strengthen rapid and timely access to treatment and continuity of care
- Addressing the social determinants of health and strengthening support services
- Expanding access to comprehensive health services
- Reduce geographic disparities and other barriers to accessing services
- Reduce stigma and strengthen education and training
- Strengthen coordination, integration, and the strategic use of data
- Strengthen the capacity to respond to clusters, outbreaks, and emerging situations related to HIV

Analysis of Structural and Systemic Problems by EHE Pillar

EARLY DIAGNOSIS OF PEOPLE WITH AN HIV-POSITIVE DIAGNOSIS

Puerto Rico has made significant progress in strengthening its diagnostic capacity through the expansion of rapid HIV testing, the availability of self-tests, and greater integration of screening services across various clinical and community settings. Likewise, the strengthening of the epidemiological surveillance system and its integration with prevention programs has enabled a more strategic use of data to direct screening activities toward the most vulnerable populations and geographic areas.

However, structural and systemic factors persist that continue to limit timely diagnosis. Findings from needs assessments and workshops showed that the availability of tests does not always translate into effective use of services. The implementation of routine testing remains inconsistent in some clinical settings, and in certain contexts, providers continue to resist incorporating HIV screening into regular clinical practice. Compounding this issue is the reliance on primary care physicians as the point of entry for many screening services, which creates additional barriers in regions with a shortage of providers or a high patient load.

Geographic inequalities also affect the capacity for early diagnosis. The concentration of prevention and screening services in the metropolitan area limits access for people living in rural municipalities, inland regions, and island municipalities. Furthermore, factors such as low-risk perception—particularly among older adults, heterosexual women, and residents of rural communities—along with HIV-related stigma and limited health literacy, continue to delay voluntary seeking of testing services and contribute to diagnoses at more advanced stages of infection.

TREATING RAPIDLY AND EFFECTIVELY TO ACHIEVE VIRAL SUPPRESSION

The jurisdiction has significant strengths to support access to and continuity of treatment. These include the availability of antiretroviral medications through ADAP, the adoption of rapid treatment initiation models, high levels of retention in care and viral suppression, as well as the existence of a uniform eligibility system that facilitates access to services through the Ryan White network. Similarly, stakeholders highlighted the existing coordination among programs, providers, and community organizations as a fundamental element for continuity of care.

However, the social determinants of health continue to represent one of the main obstacles to achieving sustained results. Needs related to housing, food security, utility payments, transportation, and financial support consistently emerged as some of the primary unmet needs identified in both the needs assessments and the workshops. These conditions directly affect people's ability to remain connected to care, attend medical appointments, and adhere to antiretroviral treatment.

The stakeholders consulted also identified systemic barriers related to the administrative processes of health plans and providers, including authorizations, referrals, and coordination of benefits. Added to this is the limited availability of specialists in key fields such as psychiatry, neurology, and gynecologic oncology outside the metropolitan area. The shortage of mental health and behavioral health services was a particular cause for concern. Finally, the increasing digitization of certain services and administrative processes poses challenges for people with limited access or digital literacy.

PREVENTING NEW INFECTIONS THROUGH EVIDENCE-BASED INTERVENTIONS

In recent years, Puerto Rico has significantly strengthened its prevention capacity by expanding biomedical and behavioral strategies, including PrEP, PEP, HIV testing, educational campaigns, and harm reduction programs. The growing integration of surveillance, prevention, and treatment allows resources to be directed toward priority populations and geographic areas with the highest epidemiological burden.

Despite these advances, structural barriers persist that limit the reach and effectiveness of preventive interventions. Participants identified restrictions related to eligibility criteria, administrative requirements, and the need for an authorized provider to prescribe PrEP as obstacles to expanding its use. These barriers particularly affect young people and populations with limited access to medical services. Stigma related to HIV continues to represent a significant barrier to the use of preventive services. Furthermore, people who use drugs, including those who inject substances, were identified as a population that continues to face particular barriers to accessing evidence-based prevention strategies. Participants also highlighted the need to strengthen provider training in HIV prevention

and to ensure the sustainability of educational and community mobilization campaigns, particularly given the reliance on federal funding to finance many of these activities.

RESPONDING RAPIDLY TO CLUSTERS AND OUTBREAKS

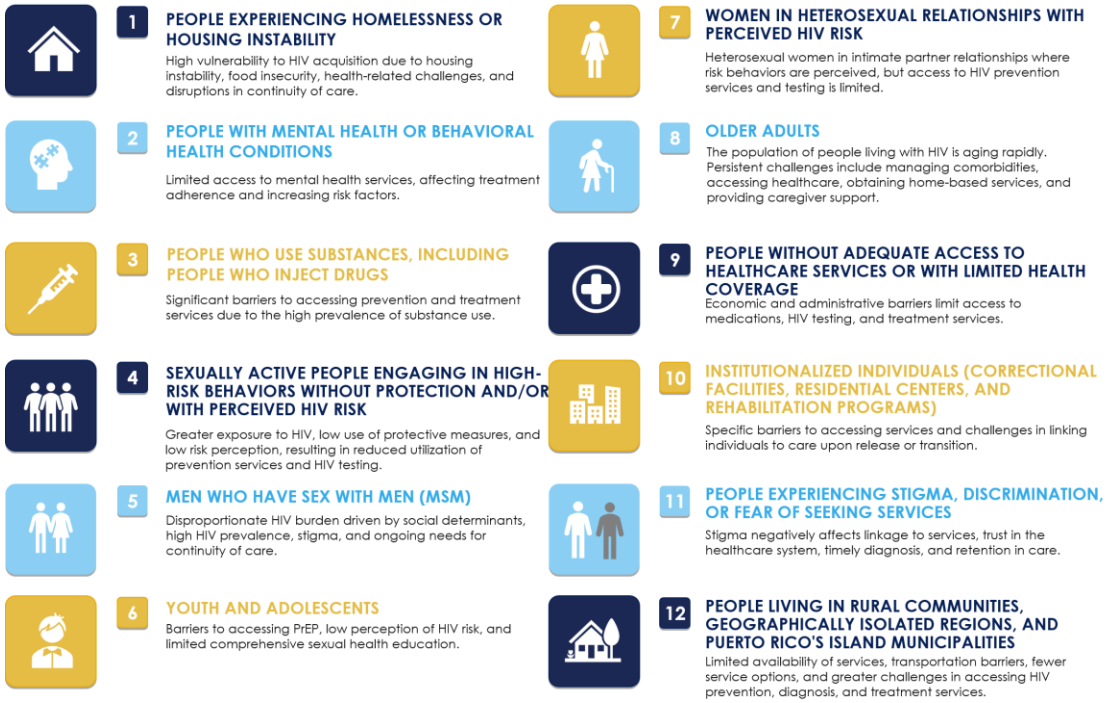
Puerto Rico's capacity to respond to potential HIV clusters or outbreaks is bolstered by a robust surveillance system, formal interagency coordination structures, and a network of community organizations with extensive experience in providing HIV-related services. Participants identified the growing integration between surveillance, prevention, and treatment as a strength, as it facilitates the early identification of epidemiological events and the mobilization of resources to respond to them.

However, during the planning workshops, systemic challenges were identified that could limit the speed and effectiveness of the response. These include the fragmentation of some information systems, limitations in the interoperability of data platforms, the concentration of human and programmatic resources in the metropolitan area, and the limited operational capacity available in some rural or geographically isolated regions. Reliance on federal funds to sustain certain response activities and a shortage of specialized personnel to carry out field interventions were also identified as factors that could affect the capacity to respond to emerging events.

a. People and communities disproportionately affected by HIV

Epidemiological analyses, needs assessments, and the integrated planning process show that the HIV epidemic in Puerto Rico continues to disproportionately affect populations facing multiple social, economic, geographic, and health-related vulnerabilities. These conditions influence both the risk of contracting HIV and the ability to access prevention, diagnosis, treatment, and support services in a timely manner. Through the planning process, the following populations were identified as those disproportionately affected by HIV.

Illustration 12: Populations and communities disproportionately affected by HIV in Puerto Rico



The geographic dimension emerged as a cross-cutting factor that amplifies many of these vulnerabilities. Residents of rural municipalities, communities in the central, eastern, western, and southern regions of the island, as well as on the municipal islands, face greater barriers to accessing HIV testing, biomedical prevention services, specialists, mental health care, and support services. The concentration of resources and providers in the San Juan metropolitan area continues to create inequalities in access to essential services for HIV prevention and care. Based on this, the Integrated Plan adopts a whole-person approach aimed at reducing the inequities affecting populations disproportionately impacted by the epidemic, thereby strengthening equitable access to prevention, diagnosis, treatment, and support services throughout the jurisdiction.

SECTION V: GOALS AND OBJECTIVES

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

1. DESCRIPTION OF GOALS AND OBJECTIVES

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

a. Diagnosis

DIAGNOSIS GOAL
To diagnose all people with HIV in Puerto Rico as soon as possible after infection, through an integrated, accessible, and syndemic screening system that ensures immediate linkage to care and breaks the chain of transmission.

Objective 1

By 2031, increase the number of HIV tests conducted in non-traditional settings and through self-tests distributed by the public and community systems by at least 30% (compared to the 2026 baseline), with a structured follow-up protocol that documents the result and ensures linkage to care.

Strategies	Target Populations	Key Activities
1.1 Expand the scope of HIV screening in non-traditional settings through collaborative agreements between the Department of Health, San Juan EMA, CBOs, and host organizations.	■ MSM ■ People under 18 and young adults (ages 18–24 and 25–34) ■ Older adults ■ Sex workers ■ Homeless people or those with unstable housing ■ People who inject drugs (PWID) and others with problematic substance use ■ The general population in geographic areas with identified *clusters*	1.1.1 Request and maintain up-to-date epidemiological data on people with a positive diagnosis, using data from the PRDOH's HIV Surveillance System to identify *clusters* and priority settings.
		1.1.2 Promote collaborative approaches with community-based and non-traditional settings to facilitate decentralized access to testing for HIV, STIs, hepatitis C, and tuberculosis (TB).
		1.1.3 Establish collaborative partnerships with multinational pharmacies, community pharmacies, and department stores that distribute HIV self-tests to strengthen voluntary mechanisms for reporting results, post-test counseling, and timely referral to confirmatory testing, prevention, and treatment services.
		1.1.4 Deploy mobile units from the PRDOH and CBOs based on the map of *clusters* and priority areas, in coordination with San Juan EMA and EHE.
		1.1.5 Design and implement an intervention model for non-traditional settings: protocol for offering the test, obtaining consent, administering the test, managing results, and referral.
		1.1.6 Implement targeted educational campaigns, including collaborations with community content creators, to promote the use of self-tests and screening in non-traditional settings.

Strategies	Target Populations	Key Activities
1.2 Implement a plan for the distribution of HIV self-tests throughout Puerto Rico, which may include an incentive system, a structured follow-up protocol, and referral for confirmatory testing, medical care, treatment, and/or PrEP, as appropriate.	■ MSM ■ Minors under 18 and young adults (ages 18–24 and 25–34) ■ Older adults. ■ People in custody ■ People in long-term care facilities ■ Sex workers ■ Homeless people or those with unstable housing ■ People who inject drugs and others with problematic substance use ■ The general population in geographic areas with identified *clusters*	1.2.1 Develop and implement a self-test distribution plan with targeting criteria by subpopulation and geographic area. 1.2.2 Establish a protocol for professional follow-up of self-tests that includes a support hotline, a standardized tool for collecting results, an incentive system, and referral to confirmatory testing and services. 1.2.3 Create and maintain an up-to-date directory of CBOs and providers for rapid referral from non-traditional settings and self-testing. 1.2.4 Establish collaborative agreements with existing helplines (*PAS* helpline and others) so that they also address HIV-related cases.
1.3 Support and maintain standardized protocols for identifying sexual or injection contacts of the "index patient," including confidential notification, testing, and referrals for prevention (PrEP, condoms, and others) or treatment as appropriate	■ MSM ■ Women, minors under 18, and young adults (ages 18–24 and 25–34) ■ Older adults ■ Sex workers ■ Homeless people or those with unstable housing ■ People in institutions ■ People who inject drugs and others with problematic substance use ■ The general population in geographic areas with identified *clusters*	1.3.1 Establish partnerships with community organizations, clinics, public health programs, educational institutions, and other strategic allies to increase awareness, understanding, and support for Partner Notification and Contact Tracing activities. 1.3.2 Implement and sustain a continuous epidemiological intervention system that identifies, contacts, and links people potentially exposed to HIV to services through contact tracing of index cases, ensuring confidentiality, the quality of the process, and integration with clinical and community services.
Responsible Parties	■ PRDOH: Division of Epidemiology and Research - HIV Surveillance System and Hepatitis C Surveillance System; SPCEIT - STD/HIV/Hepatitis Prevention Program ■ EHE Recipient - San Juan and Jurisdiction	

Key Partners	■ San Juan EMA ■ CBO ■ Community pharmacies and pharmacy chains ■ Community event organizers ■ Department of Housing and HOPWA providers ■ Department of Recreation and Sports; municipalities ■ Department of Correction and Rehabilitation ■ Department of Education ■ Ombudsman for the Elderly ■ Programs to Address Substance Use Disorders ■ Case managers and community volunteering ■ Clinical Laboratories ■ Planning Advisory Boards
Performance Measures	■ Numerator: Number of HIV tests conducted in non-traditional settings during the period. ■ Denominator: Total number of HIV tests conducted in Puerto Rico during the period. ■ Target percentage: ≥30% increase in testing in non-traditional settings by 2031 compared to the 2026 baseline. ■ Numerator: Number of self-tests distributed to priority populations with documented results and follow-up status. ■ Denominator: Total number of self-tests distributed to priority populations during the period. ■ Target percentage: ≥80% of self-tests distributed with documented results and follow-up status. ■ Number of active collaborative agreements with non-traditional settings (annual). ■ Number of operational mobile units and deployment routes per quarter. ■ Number and percentage of reactive test results detected in non-traditional settings referred for confirmatory testing within ≤7 days. ■ Number of people referred to PrEP from screening settings (cross-referenced with the Prevention table). ■ Data source: PRDOH HIV Surveillance System, CBO records (CAREWare, in-house systems), reports from San Juan EMA. ■ Associated national indicator: EHE "Diagnose" pillar (accelerate diagnosis in priority populations); contributes to the first 95 of the 95-95-95 targets.
Progress toward national targets	Related to the EHE Diagnosis pillar and contributes to increasing knowledge about HIV status.
Funding sources	■ CDC, HRSA, HUD (HOPWA), SAMHSA, state funds, foundations, and the private sector

Objective 2

By 2031, ensure that at least 75% of adults (≥18 years) receiving routine annual medical care in Puerto Rico have a documented HIV test within the past 12 months as part of the standard clinical protocol, in alignment with the CDC and USPSTF recommendations for universal screening, and with existing state law.

Strategies	Target Populations	Key Activities
2.1 Review and update PRDOH and ASES regulations to institutionalize routine HIV testing as part of annual preventive care and as an element of State care plans.	■ The general adult population receiving annual medical care ■ New patients in primary care settings. ■ Health care providers and clinical staff ■ Patients at high-risk subspecialty clinics (STIs, hepatitis, TB, sexual health)	2.1.1 Update and disseminate the standardized clinical protocol, including implementation guidelines for primary care clinics, 330 Centers, and health insurers. 2.1.2 Integrate routine testing as a clinical quality measure monitored by ASES and private insurers.
2.2 Train health professionals and primary care providers on routine screening, consent management, communication of results, and immediate referral to care.	■ General adult population receiving annual medical care ■ New patients in primary care settings ■ Healthcare providers and clinical staff ■ High-risk patients in subspecialty clinics (STIs, hepatitis, TB, sexual health)	2.2.1 Annually train, through NECA/AETC and in partnership with the Academy, primary care providers on routine testing, informed *opt-out*, and immediate referral. 2.2.2 Implement mass public awareness campaigns targeting the general population and providers on the importance of routine testing, in coordination with syndemic training initiatives.
2.3 Establish interagency agreements with the Academy, health plans, and regulatory agencies to institutionalize the practice as a standard of care.	■ The general adult population receiving annual medical care ■ New patients in primary care settings ■ Health care providers and clinical staff ■ Patients in high-risk subspecialty clinics (STIs, hepatitis, TB, sexual health)	2.3.1 Establish collaborative agreements with academic institutions (schools of medicine, public health, nursing, and others) to integrate the protocol into undergraduate, residency, and continuing education curricula.

Responsible parties	■ PRDOH: Division of Epidemiology and Research - HIV Surveillance System; SPCEIT - STD/HIV/Hepatitis Prevention Program ■ RWHAP Part C ■ RWHAP Part F – NECA/AETC ■ EHE Recipients — San Juan and Jurisdiction

Key Partners	■ Academia (Schools of Medicine, Public Health, and Nursing; residency programs) ■ Primary Care Association; Hospital Association; Puerto Rico College of Physicians and Surgeons; ■ *FQHCs* and municipal and private primary care clinics ■ ASES and government health plans; private health plans ■ Office of the Commissioner of Insurance of Puerto Rico ■ Insurance companies and PBMs (screening coverage and reimbursement) ■ Professional associations and continuing education centers ■ Planning advisory bodies
Performance Measures	■ Numerator: Number of adults (≥18 years) receiving annual medical care with a documented HIV test in the past 12 months. ■ Denominator: Total number of adults with a documented annual medical care visit during the period. ■ Target percentage: ≥75% coverage of HIV testing during routine annual medical care by 2031. ■ Number of *FQHCs* and primary care clinics that formally adopt the *opt-out* protocol. ■ Number of providers trained annually in the routine screening protocol. ■ Number of academic curricula that incorporate the protocol. ■ Enforcement of the regulation institutionalizing the practice. ■ # and % of routine tests with reactive results linked to care within ≤15 days (cross-reference with D-1 and Treatment Objective 1). ■ Associated national indicator: first 95 of the 95-95-95 (known status); EHE Diagnosis pillar; NHAS Goal 1, Objective 1.2.F19).
Progress toward national goals	Contributes to the EHE Diagnosis pillar and increases knowledge about HIV status. Routine HIV screening in general clinical settings has been a current CDC recommendation since 2006 (universal *opt-out* screening).
Funding Sources	■ HRSA, CDC, ASES / Medicaid Puerto Rico, private health plans, state funds

Objective 3

By 2031, expand access to HIV testing by at least 25% (compared to the 2026 baseline) among populations with low perceived risk, specifically adult men, young adults aged 18–29, and adults aged 60 and older, through community-based strategies and partnerships with non-traditional service providers that reduce social and cultural barriers.

Strategies	Target Populations	Key Activities
3.1 Design and implement a public education and communication strategy on HIV and early detection targeted at populations with a low self-perceived risk.	■ Adult men ■ Young adults aged 18–29 (students in public and private schools, college students)	3.1.1 Develop and implement a multi-channel information campaign (social media, one-pagers, health fairs, outreach through the Department of Education and the Department of Family Affairs).

Strategies	Target Populations	Key Activities
	■ Adults aged 60 and older ■ Nursing staff, legal guardians, parents, and caregivers	3.1.2 Produce and distribute informational materials on HIV, early detection, and consent
		3.1.3 Conduct health fairs that include testing
3.2 Establish partnerships with settings and organizations that serve these populations on a daily basis (care centers, senior centers, gyms, universities, correctional facilities, community health fairs) to integrate testing services with a whole-person approach.	■ Adult men ■ Young adults aged 18–29 (students in public and private schools, college students) ■ Older adults aged 60 and older ■ Inmates ■ Nursing staff, legal guardians, parents, and caregivers	3.2.1 Establish collaborative agreements with care centers, umbrella organizations, affiliated laboratories, universities, sports centers and gyms, municipal recreation agencies, and detoxification centers.
		3.2.2 Coordinate with the Department of Corrections and Rehabilitation to provide access to testing in correctional facilities as part of syndemic screening.
3.3 Train staff at these facilities on stigma, empathy, and non-judgmental HIV screening practices.	■ Service Providers	3.3.1 Implement workshops on empathy, stigma reduction, and a whole-person approach for staff at partner organizations (umbrella organizations, gyms, care centers, universities).
Responsible Parties	■ PRDOH: Division of Epidemiology and Research—HIV Surveillance System; SPCEIT—STD/HIV/Hepatitis Prevention Program ■ RWHAP Part C ■ RWHAP Part F - NECA/AETC ■ EHE Recipients — San Juan and Jurisdiction	
Key Partners	■ Department of Family Affairs ■ Department of Education ■ Department of Sports and Recreation ■ Ombudsman for Older Adults ■ Department of Corrections and Rehabilitation ■ Municipalities ■ Universities and Sports Centers ■ Rehabilitation Centers ■ CBOs ■ Long-term care ■ Higher education institutions ■ Agencies focused on sexual and reproductive health ■ Parents, caregivers, and legal guardians ■ ASES and public and private health plans ■ Planning advisory bodies	

Performance measures	■ Numerator: Number of HIV tests administered to individuals in subpopulations with low-risk self-perception (adult men, young adults aged 18–29, older adults aged 60+) in community and non-traditional settings. ■ Denominator: Total number of HIV tests administered to these subpopulations at the 2026 baseline. ■ Target %: ≥25% cumulative increase by 2031. ■ Number of active collaborative agreements with religious organizations, universities, sports centers, and care centers. ■ Number of health fairs with testing conducted annually. ■ Number of active awareness campaigns and estimated reach per channel. ■ Number of staff from partner organizations trained annually on stigma and empathy. ■ Rate of positive test results detected in these settings relative to the total screened subpopulation. ■ Optional complementary measure: # of peers trained in stigma reduction + pre/post measurement of attitudes ■ Associated national indicator: EHE Diagnosis pillar; first 95 of the 95-95-95 targets; NHAS Goal 3 (Objective 3.4 — social determinants and cultural barriers as conditions for access).
Progress toward national targets	Contributes to the EHE Diagnosis pillar, to increasing knowledge about HIV status, and to addressing social determinants as conditions for access.
Funding Sources	■ CDC, HRSA, ASES / Medicaid Puerto Rico, private health plans, state funds, foundations

b. Treatment

GOAL OF TREATMENT
To treat people diagnosed with HIV quickly and effectively to achieve sustained viral suppression.

Objective 1

By 2031, ensure that at least 85% of people newly diagnosed with HIV are linked to care within 15 days of learning their diagnosis.

Strategies	Target Populations	Key Activities
1.1 Strengthen the capacity of the HIV care system to ensure early linkage to care, focusing on a whole-person model that optimizes the continuity, quality, and effectiveness of services	■ People newly diagnosed with HIV, with a focus on: - Young adults (25–44) - Women and pregnant women - Citizens returning to the jurisdiction - Youth aged 13 and older - MSM ■ Providers and Clinical Staff	1.1.1 Design and implement a standardized care protocol to ensure early referral to care for newly diagnosed HIV cases 1.1.2 Provide training to clinical staff, linkage staff, and other providers to promote the use of evidence-based practices for diagnosis and linkage to care (e.g., navigation and peer interventions). 1.1.3 Implement educational, advocacy, and outreach efforts targeting diverse populations, including schools and universities, regarding linkage to care 1.1.4 Promote the differentiated intervention model among providers, including the establishment of individualized plans from the outset and interdisciplinary case discussion approaches. 1.1.5 Implement mechanisms to continuously identify barriers and pressing service needs. 1.1.6 Strengthen processes for the collection, management, and dissemination of indicators related to diagnosis and care linkage
Responsible Parties	■ Department of Health (SPCEIT—RWHAP Part B/ADAP Program and STD/HIV/Hepatitis Prevention Program—and Division of Epidemiology and Research—HIV Surveillance System) ■ RWHAP Part A—MAI and the TIES Project of the Municipality of San Juan ■ RWHAP Part C ■ RWHAP Part D ■ RWHAP Part F – NECA/AETC ■ EHE Recipient — San Juan and Jurisdiction	
Key Partners	■ Clinical and Hospital Laboratories ■ ASES and government health plans; private health plans ■ Hospitals (Delivery Rooms and Emergency Rooms) ■ IPAs ■ Municipal, state, private, and community health centers ■ 330 Centers (*FQHCs*) ■ Interdisciplinary staff (case managers, social workers, navigators, treatment outreach/linking staff, peer counselors, and health promoters) ■ Planning Advisory Boards ■ Department of Education ■ Higher education institutions	

Performance Measures	■ Number of people with a new HIV diagnosis linked to care within 15 days of diagnosis (numerator) ■ Total number of people with a new HIV diagnosis during the period (denominator) ■ Percentage of early linkage (≤15 days) relative to the total number of new diagnoses for the year ■ Median number of days from diagnosis to first HIV clinic visit ■ Number of providers trained in the standardized early linkage protocol
Progress toward national goals	The first component of the Continuum of Care advances; it directly contributes to the federal goal of the treatment pillar. It helps reduce the time between diagnosis and referral and accelerates access to antiretroviral treatment, an essential prerequisite for achieving 95% HIV viral suppression under the National Strategic Plan 2021–2025 (95-95-95).
Funding Sources	■ HRSA, CDC, CDC-EHE, ASES / Medicaid, private health plans, foundations, state funds

Objective 2

By 2031, increase by at least 10% the number of people newly diagnosed with HIV who are prescribed antiretrovirals within 7 days of receiving their diagnosis.

Strategies	Target Populations	Key Activities
2.1 Establish and promote the implementation of rapid initiation protocols (RIPs)	■ People newly diagnosed with HIV ■ Healthcare providers and HIV care providers	2.1.1 Identify current administrative, public policy, and systemic barriers that limit early access to antiretrovirals (Readiness Instrument) 2.1.2 Develop recommendations for changes to public policy and administrative processes to address the identified barriers 2.1.3 Develop a rapid initiation protocol, including streamlining clinical processes to ensure or guarantee prescribing within 7 days 2.1.4 Promote and train the HIV workforce on the protocol and on rapid initiation of ART 2.1.5 Promote the differentiated intervention model among providers, including the establishment of individualized plans from the outset and approaches to interdisciplinary case discussions.

Responsible Parties	■ Department of Health (SPCEIT-RWHAP Part B/ADAP Program) ■ RWHAP Part A MAI - TIES Project ■ RWHAP Part C ■ RWHAP Part D ■ RWHAP Part F - NECA/AETC ■ EHE Recipient - San Juan
Key Partners	■ HIV Health and Care Service Providers

	■ Health Promoters, Care Liaison Workers, Navigators/Peer Supporters, Case Managers ■ ASES and government health plans; private health plans ■ Pharmaceutical companies ■ Clinical laboratories ■ Pharmacies ■ Municipal, state, private, and community health centers ■ 330 Centers (*FQHCs*) ■ Public and private hospitals ■ Case managers ■ Professional associations and continuing education centers ■ Legislature ■ Planning Advisory Bodies
Performance Measures	■ Number of people with a new HIV diagnosis who receive an ART prescription within 7 days of learning their diagnosis (numerator) ■ Total number of people with a new diagnosis during the period (denominator) ■ Percentage of rapid ART initiation (≤7 days) relative to the total number of new HIV cases who are aware of their diagnosis ■ Annual percentage change from the baseline (≥10% cumulative increase by 2031) ■ Number of facilities that formally adopt the Rapid Initiation Protocol (RIP) ■ # of providers trained in RIP and rapid prescribing
Progress toward national targets	Accelerates the transition from diagnosis to effective treatment, contributing to the treatment pillar. Every day that the time between diagnosis and viral suppression is reduced lowers the risk of community transmission and improves individual prognosis.
Funding Sources	■ HRSA, ASES / Medicaid, Foundations, State funds, Private health plans

Objective 3

By 2031, increase re-engagement in treatment by at least 10% among people previously diagnosed with HIV who have dropped out of care.

Strategies	Target Populations	Key Activities
3.1 Optimize and expand the provision of HIV treatment services targeting vulnerable populations, incorporating mechanisms for the continuous identification of and effective	■ People previously diagnosed with HIV who have been out of care for ≥6 months ■ People with an unsuppressed viral load identified in databases ■ Subpopulations at higher risk of dropping out: youth	3.1.1 Implement mechanisms for the ongoing identification of structural barriers that impede treatment adherence in order to address related needs 3.1.2 Strengthen the use of databases to identify people who have been out of treatment for ≥6 months 3.1.3 Train staff and providers in evidence-based practices and best practices for retention and re-engagement in care 3.1.4 Implement agreements with universities and professional associations to

Strategies	Target Populations	Key Activities
response to emerging needs.	aged 13–24, men who have sex with men (MSM), people with substance use disorders, and individuals returning to the jurisdiction ■ People who are homeless or have unstable housing	promote the diversification and strengthening of the workforce (navigators, liaison workers, and community outreach workers) 3.1.5 Promote the implementation of differentiated and whole-person care models 3.1.6 Establish partnerships with other entities to promote access for people diagnosed with HIV to other essential services that address their identified needs
Responsible Parties	■ Department of Health (SPCEIT- RWHAP Part B/ADAP and HOPWA Programs) ■ RWHAP Part A MAI – TIES Project ■ RWHAP Part C ■ RWHAP Part D ■ RWHAP Part F - NECA/AETC ■ EHE Recipient - San Juan ■ HOPWA (Municipality of San Juan)	
Key Partners	■ HIV Health and Care Service Providers ■ ASES and government health plans; private health plans Federal and state social service programs ■ Puerto Rico Department of Family Affairs ■ Patient Advocate ■ Higher education institutions ■ 330 Centers (*FQHCs*) ■ Planning Advisory Boards	
Performance Measures	■ Number of previously diagnosed individuals re-linked to care after ≥6 months out of treatment (numerator) ■ # of individuals identified in databases as out of care for ≥6 months (denominator) ■ Percentage of re-enrollment relative to identified individuals out of care ■ Annual percentage change from baseline (≥10% cumulative increase by 2031) ■ Number of additional navigators and linkage workers or trained ■ Number of partnerships established	
Progress Toward National Goals	Re-engages people who identified themselves as being outside the continuum of care, closing critical retention gaps and reducing transmission associated with treatment interruption. Contributes to the second pillar (treatment retention 95-95-95).	
Funding Sources	■ HRSA, ASES / Medicaid, private health plans, state funds	

Objective 4

By 2031, ensure that at least 90% of people diagnosed with HIV remain in care.

Strategies	Target Populations	Key Activities
4.1 Expand the system's capacity to provide differentiated, whole-person care	■ People with an HIV-positive diagnosis	4.1.1 Develop a profile of the populations facing the greatest challenges in retaining care 4.1.2 Implement mechanisms for the ongoing identification of structural barriers that hinder treatment adherence in order to address the needs related to these barriers 4.1.3 Establish partnerships with other organizations to promote access for people with an HIV-positive diagnosis to other essential services to address the identified needs 4.1.4 Expand support and complementary services, including, but not limited to, transportation and outreach services 4.1.5 Promote the implementation of differentiated and whole-person care models 4.1.6 Educate and train both providers and participants on the importance of retention
Responsible Parties	■ Department of Health (SPCEIT-RWHAP Part B/ADAP Program; Division of Epidemiology and Research-HIV Surveillance System) ■ RWHAP Part A MAI – TIES Project ■ RWHAP Part C ■ RWHAP Part D ■ RWHAP Part F - NECA/AETC ■ EHE Recipient - San Juan	
Key Partners	■ Puerto Rico Department of Health (HIV/STD/Hepatitis Prevention Program) ■ Municipal, state, private, and community health clinics ■ HIV health and care providers ■ Government agencies that coordinate support services (transportation, housing, food) ■ ASES and government health insurance plans; private health insurance plans ■ Department of Corrections and Rehabilitation ■ Higher education institutions ■ CBOs and community-based social organizations ■ 330 Centers (FQHCs) ■ Planning Advisory Bodies ■ Department of Family Affairs	
Performance Measures	■ Number of people with an HIV-positive diagnosis retained in care, defined as ≥2 separate HIV clinic visits at least 90 days apart within a 12-month period (numerator) ■ Total number of people with an HIV-positive diagnosis registered in the system (denominator) ■ % of retention in care among those with a positive HIV diagnosis	

	■ Percentage of retention by subpopulation identified in the generated profile of populations receiving medical care
Progress Toward National Goals	Maintains the retention step on the continuum, with retention being the strongest predictor of sustained viral suppression.
Funding Sources	■ HRSA, ASES/Medicaid, private health plans, state funds for housing, substance use disorders, family, and others.

Objective 5

By 2031, expand the capacity of the service delivery system to increase the percentage of sustained viral suppression among people diagnosed with HIV in Puerto Rico, through a differentiated and whole-person care model.

Strategies	Target Populations	Key Activities
5.1 Increase the accessibility and flexibility of the system in providing care services tailored to the identified needs of the population	■ People with an HIV-positive diagnosis retained in care ■ Providers	5.1.1 Communicate the identified needs to relevant stakeholders who can collaborate in strengthening the system of differentiated, whole-person care. 5.1.2 Establish systems and procedures to facilitate collaboration among the identified stakeholders 5.1.3 Align service plans with the needs identified through current studies and assessments of the population of people with an HIV-positive diagnosis in Puerto Rico 5.1.4 Implement services tailored to the identified needs of the population 5.1.5 Develop a continuous monitoring plan to evaluate the strategies implemented

Responsible parties	■ Department of Health (SPCEIT-RWHAP Part B/ADAP Program) ■ RWHAP Part A ■ RWHAP Part C ■ RWHAP Part D ■ EHE Recipient - San Juan
Key Partners	■ Municipal, state, private, and community health clinics ■ HIV health and care providers ■ Government agencies that coordinate support services ■ ASES and government health plans; private health plans ■ Higher education institutions and population needs assessment centers ■ CBOs ■ Planning Advisory Bodies

Performance measures	■ Number of people with an HIV-positive diagnosis with sustained viral suppression, defined as a viral load <200 copies/mL in all tests over the past year (numerator) ■ Total number of people with an HIV-positive diagnosis retained in care (denominator) ■ % of sustained viral suppression among all people retained in care ■ Number of differentiated care models implemented based on current needs assessments ■ Existence and validity of the continuous monitoring plan for the Treatment Target
Progress toward national targets	Contributes to the National Goal promoted through the Integrated Planning Guidelines to achieve sustained viral suppression. This indicator measures the overall success of the HIV treatment system; when people with an HIV-positive diagnosis achieve undetectable viral suppression, they do not transmit the virus (U=U / Undetectable = Untransmittable).
Funding Sources	■ HRSA, ASES / Medicaid, private health plans, state funds.

Strategies	Target Populations	Key Activities
5.2 Strengthen and diversify the competencies and skills of the HIV-related workforce through training in intervention models focused on vulnerable populations	■ Healthcare and HIV care providers ■ Higher Education Institutions ■ Service administrators ■ Community clinics ■ Primary Health Care Association ■ Hospital Association ■ Nonprofit Organizations	5.2.1 Identify the competencies to be strengthened in the workforce related to HIV issues 5.2.2 Provide training on differentiated intervention guidelines and whole-person models 5.2.3 Facilitate the integration of practical experiences in the field of HIV (internships, clinical rotations) into educational programs for health professionals in training

Responsible Parties	■ RWHAP Part F — NECA/AETC ■ Department of Health (SPCEIT) ■ RWHAP Part B/ADAP Program) ■ RWHAP Part A ■ RWHAP Part C ■ RWHAP Part D ■ EHE Recipient — San Juan
Key Partners	■ Higher Education Institutions ■ Medical, Public Health, and Nursing Schools; Residency Programs ■ Accrediting Agencies ■ Healthcare and HIV Care Providers ■ Professional Associations ■ Community clinics and CBOs ■ 330 Centers (FQHCs) ■ Planning Advisory Bodies ■ Municipal, state, private, and community health clinics

Performance metrics	■ Number of providers and interdisciplinary staff trained annually in whole-person intervention models and models targeting vulnerable populations ■ Number of HIV-related internships and clinical rotations integrated into educational programs for health professionals in training ■ Number of academic curricula that incorporate topics related to HIV and vulnerable populations ■ Geographic coverage of AETC training (regions of Puerto Rico covered annually)
Progress toward national objectives	Strengthens the capacity of the service delivery system to implement the four components of the Continuum of Care.
Funding sources	■ HRSA, ASES / Medicaid, Private Health Insurance Plans, Foundations, State Funds

Strategies	Target Populations	Key Activities
5.3 Development and strengthening of multisectoral partnerships for the treatment of HIV and comorbidities relevant to the epidemiological profile of the population served, as well as in priority areas of support services (psychosocial, housing, home-based services)	■ HIV health and care service providers ■ Department of Education ■ Higher Education Institutions ■ Service administrators ■ Community clinics ■ Primary Health Care Association ■ Hospital Association ■ Nonprofit Organizations	5.3.1 Formalize collaboration agreements between HIV programs and key sectors 5.3.2 Develop a standardized referral system to strengthen coordination with other service providers to address the population's clinical and support needs 5.3.3 Develop a directory of service programs listing offerings, requirements, and points of contact to facilitate the referral system 5.3.4 Strengthen the uniform eligibility system for Ryan White Programs in Puerto Rico to increase the platform's utilization and efficiency.

Responsible Parties	■ Department of Health (SPCEIT) ■ RWHAP Part B/ADAP Program ■ OIAT ■ RWHAP Part F — NECA/AETC ■ RWHAP Part A ■ RWHAP Part C ■ RWHAP Part D ■ EHE Recipient — San Juan
Key Partners	■ HIV Health and Care Service Providers ■ Municipal, state, private, and community health clinics ■ Primary Care Association; Hospital Association ■ Government agencies that coordinate support services ■ ASES and government health plans; private health plans ■ Higher education institutions ■ UPR-RCM Multidisciplinary Clinics

	■ UPR Comprehensive Cancer Center ■ Department of Housing ■ Department of Family Affairs ■ ASSMCA ■ Patient Advocate ■ Planning Advisory Bodies
Performance Measures	■ Number of active Memoranda of Understanding (MOUs) between HIV programs and key sectors ■ Number of referrals completed through the standardized system (manual and digital) ■ % of transition from manual to digital referral system ■ Validity and use of the directory of service programs ■ Increase in the level of use of the Ryan White uniform eligibility system in Puerto Rico
Progress toward national goals	Strengthens multisectoral coordination. Partnerships reduce duplication of efforts, optimize limited resources, and extend the system's reach beyond direct recipients of federal funds.
Funding Sources	■ HRSA, ASES / Medicaid, Private Health Insurance Plans, Foundations, State Funds

c. PREVENTION

GOAL OF PREVENTION
To prevent new HIV transmissions in Puerto Rico through an integrated model of community-based, biomedical, and epidemiological prevention that ensures access to evidence-based interventions throughout Puerto Rico.

Objective 1

By 2031, implement an integrated community-based prevention model with a syndemic approach, including screening for HIV, STIs, viral hepatitis, and TB, PrEP/PEP services, and referral mechanisms to services, with at least one strategy in each of Puerto Rico's health regions.

Strategies	Target Populations	Key Activities
1.1 Develop a comprehensive prevention guide (condoms, information on STIs, PrEP, PEP, referral mechanisms, and others) applicable to community,	■ General population ■ Children under 18 and young people (elementary and high school students) ■ Healthcare professionals and administrative staff ■ Homeless individuals or those with unstable housing	1.1.1 Establish a working group to develop the combined prevention guidelines, in alignment with the syndemic guidelines of the Response Goal.
		1.1.2 Develop and disseminate educational materials and campaigns targeting settings frequented by people aged 13 to 24, with an emphasis on prevention, holistic well-being, and access to health and support services.

Strategies	Target Populations	Key Activities
school, and clinical settings.	■ Pregnant women ■ Parents, guardians, and school staff ■ PWID	1.1.3 Train administrative and decision-making staff who develop and implement the guidelines, as well as health professionals, community leaders, and school staff.
1.2 Establish an infrastructure of multisectoral collaborative agreements in each health region (PRDOHs, CBOs, municipalities, schools, primary care physicians, pharmacies) that reduces duplication of efforts and formalizes the "who does what" through an up-to-date *stakeholder mapping*.	■ General population ■ Children under 18 and adolescents (elementary and high school students). ■ Healthcare professionals and administrative staff ■ Homeless individuals or those with unstable housing. ■ People incarcerated. ■ People who do not seek services due to stigma. ■ Pregnant women. ■ Parents, guardians, and school staff	1.2.1 Develop and maintain an up-to-date regional stakeholder mapping that documents resources, capacities, and gaps by health region, in coordination with the Primary Health Care Association and CBOs. 1.2.2 Establish formal collaborative agreements between the PRDOH, CBOs, municipalities, primary care physicians, community pharmacies, and educational institutions to strengthen the multisectoral component of prevention. 1.2.3 Create and maintain an interagency platform or directory listing regional prevention services (condoms, education, screening, PrEP/PEP, referrals), accessible to the public and providers.
1.3 Ensure continuous access to condoms, educational materials, screening tests, and referrals through a regional network of CBOs and service points with strengthened technical and financial capacity.	■ General population ■ Youth (elementary and high school students). ■ Healthcare professionals and administrative staff ■ Homeless people or those with unstable housing. ■ People incarcerated. ■ People who do not seek services due to stigma. ■ Pregnant women. ■ Parents, caregivers, and school staff. ■ PWID	1.3.1 Promote continuous access to condoms and informational materials at key locations by region (CBOs, pharmacies, healthcare centers, gyms, community events, schools, in accordance with the legal framework applicable to minors).
1.4 Strengthen prevention services targeting people who inject drugs (PWID) to reduce new transmissions of HIV, viral hepatitis,	■ PWID ■ People with substance use disorders ■ People at high risk for HIV and viral hepatitis ■ Homeless individuals or those with unstable housing.	1.4.1 Identify and diversify funding sources to strengthen the capacity of community-based organizations (CBOs). 1.4.2 Continue community outreach activities targeting PWID in areas identified as having high vulnerability and risk, focusing on education,

Strategies	Target Populations	Key Activities
and STIs, promote safe practices, and increase access to integrated health services in Puerto Rico.	■ Communities with high social vulnerability and limited access to health services.	materials, and linking them to health services. 1.4.3 Train staff and community partners in prevention services for PWID, stigma management, and a whole-person approach.
Responsible Parties	■ PRDOH: Division of Epidemiology and Research - HIV Surveillance System and Hepatitis C Surveillance System; SPCEIT - STD/HIV/Hepatitis C Prevention Program; CPTETs ■ EHE Recipients - San Juan and Jurisdiction	
Key Partners	■ Department of Education ■ Department of Family Affairs ■ Association of Health Professionals; Puerto Rico College of Physicians and Surgeons; Primary Health Care Association ■ Primary care physicians and primary care centers ■ Municipalities ■ 330 Centers / *FQHCs* ■ CBOs ■ San Juan EMA ■ Peer educators, health promoters, navigators, and community leaders ■ Parents, guardians, and teaching staff ■ Community event organizers; sports centers and gyms ■ Community pharmacies and pharmacy chains ■ ASES and government health plans; private health plans ■ Commissioner of Insurance ■ Higher education institutions (schools of medicine, public health, nursing, health communication, and others) ■ Foundations and the private sector ■ Planning advisory bodies	
Performance Measures	■ Numerator: Number of health regions with at least one documented, active, and sustained strategy based on the integrated community prevention model (with active collaborative agreements and provision of the minimum components: condoms + education + screening + referral to PrEP/PEP). ■ Denominator: Total number of health regions in Puerto Rico. ■ Target %: 100% of health regions with at least one active strategy by 2031. ■ Number of formal collaborative agreements in effect per region and by type of partner (CBOs, municipalities, schools, pharmacies). ■ Number of condoms distributed annually by region and by service point. ■ Number of people reached by educational campaigns and syndemic modules, by subpopulation.	

	■ Number of health professionals, school staff, and community leaders trained annually. ■ Validity and use of stakeholder mapping and the regional platform/directory. ■ Number and percentage of people referred from the integrated model to PrEP, PEP, syndemic screening, and treatment services. ■ Associated national indicator: EHE Prevent pillar (combined prevention model); contributes to the reduction of new infections (75% by 2025, 90% by 2030; 2017 baseline = 37,000 new infections annually) and to the top 95 via integrated syndemic screening.
Progress Toward National Goals	Contributes to the EHE Prevention pillar and advances the federal goal of reducing new infections by 75% by 2025 and 90% by 2030.
Funding Sources	■ CDC, ASES / Medicaid Puerto Rico, private health plans, state funds, Foundations, and the private sector

Objective 2

By 2031, increase effective PrEP coverage among residents of Puerto Rico to at least 50% through the implementation of Rapid Linkage to PrEP, the diversification of navigation services, the standardization of prescribing practices, and mandatory continuing education for healthcare providers.

Strategies	Target Populations	Key Activities
2.1 Implement a Rapid Linkage to PrEP protocol throughout Puerto Rico that ensures the prescription and initiation of the medication within a short timeframe following initial contact (screening, reactive non-HIV self-test, exposure event, or direct request), using standardized clinical eligibility criteria and a PrEP prescription model.	■ MSM (men who have sex with men) ■ Sex workers. ■ Sero discordant couples. ■ People who inject drugs. ■ People with recurrent STIs ■ Adolescents and young adults with a clinical indication (in accordance with the legal framework applicable to minors). ■ People in geographic areas with identified *clusters*. ■ Healthcare providers who can prescribe	2.1.1 Develop and implement the Rapid Linkage to PrEP protocol, with standardized prescribing criteria (a model equivalent to that for contraceptives) and differentiated workflows based on setting (clinical, community-based, self-testing, post-exposure). 2.1.2 Align the protocol with the syndemic screening workflow and the syndemic screening guidelines so that any person with a reactive STI test result is evaluated for PrEP during the same visit. 2.1.3 Develop and maintain a dashboard tracking PrEP prescriptions and adherence for continuous monitoring of coverage by subpopulation and by region.

Strategies	Target Populations	Key Activities
2.2 Expand the network of PrEP-prescribing providers through *public health detailing* interventions, mandatory continuing education, and coordination with the Insurance Commissioner and insurance companies to standardize the approval, coverage, and reimbursement of PrEP.	■ Healthcare providers who can prescribe	2.2.1 Implement *public health detailing* interventions with primary care physicians, gynecologists, infectious disease specialists, and sexual health specialists, with an emphasis on areas with a lower density of prescribers. 2.2.2 Establish continuing education programs, with CME credits, on PrEP/PEP, in partnership with the Puerto Rico College of Physicians and Surgeons, NECA/AETC, and schools of medicine and nursing. 2.2.3 Coordinate with the Insurance Commissioner and insurers (government and private health plans) to standardize criteria for PrEP approval, coverage, and reimbursement, eliminating unnecessary prior authorization barriers.
2.3 Diversify and strengthen PrEP navigation services and ensure post-prescription follow-up to maintain adherence.	■ Clinical Service Providers and Case Managers	2.3.1 Expand the network of PrEP navigation services through collaborative agreements with CBOs (San Juan EMA, Control V, and others), offering extended, non-traditional hours and a blended approach (in-person, virtual, and telehealth). 2.3.2 Implement peer navigation with an emphasis on priority populations (Latino MSM, people in rural areas) to support adherence and post-prescription follow-up. 2.3.3 Increase public outreach regarding PrEP through targeted campaigns, in coordination with the integrated community prevention model.
Responsible Parties	■ PRDOH (SPCEIT-HIV/STI/Hepatitis Prevention Program, CPTETs; Division of Epidemiology and Research-HIV Surveillance System and STI Surveillance) ■ EHE Recipient - San Juan and Jurisdiction	

Key partners	■ Healthcare providers ■ Puerto Rico College of Physicians and Surgeons; Primary Health Care Association ■ 330 Centers / *FQHCs* ■ San Juan EMA ■ CBOs ■ Insurance Commissioner ■ ASES and government health plans; private health plans ■ Higher education institutions (schools of medicine, public health, and nursing) ■ Pharmaceutical companies and community pharmacies ■ Case managers ■ Planning advisory bodies ■ Substance use and harm reduction programs
Performance measures	■ Numerator: Number of people with a clinical indication for PrEP residing in Puerto Rico who receive a prescription and at least one documented fill during the period. ■ Denominator: Estimated number of people in Puerto Rico with a clinical indication for PrEP (federal/jurisdictional epidemiological estimate). ■ Target %: ≥50% effective PrEP coverage by 2031.
Progress Toward National Goals	Contributes to the prevention pillar of the EHE and to the promotion of PrEP/PEP and other strategies as part of a combination prevention approach. It also advances the federal goal of reducing new infections by 90% by 2030.
Funding sources	■ EHE Initiative - San Juan and Jurisdiction, CDC, ASES / Medicaid, Puerto Rico, Private Health Insurance Plans, Pharmaceutical Copay Assistance Programs, State Funds, Foundations, and the Private Sector

Objective 3

By 2031, eliminate perinatal HIV transmission in Puerto Rico to no more than one (1) case per year and reduce the incidence of congenital syphilis to less than half of the 2026 baseline, through a Puerto Rican registry of pregnant women with syndemic screening (HIV, syphilis, viral hepatitis, other STIs, TB), referral to care and treatment, effective interagency coordination (PRDOH, WIC, PAN, Medicaid/ASES, hospitals), universal availability of prophylactic medications in hospitals, and training of obstetric and pediatric healthcare personnel.

Strategies	Target Populations	Key Activities
3.1 Create and operate a Puerto Rican registry of pregnant women focused on prenatal evaluations, syndemic	■ Pregnant women (universal coverage throughout all trimesters and in the delivery room for women without prior prenatal care). ■ Women of reproductive age.	3.1.1 Design and implement, in partnership with the PRDOH's HIV Surveillance System, BioPortal, and laboratories, a Puerto Rico-wide registry of pregnant women with syndemic screening, including clear referral pathways for reactive results.

Strategies	Target Populations	Key Activities
screening (HIV, syphilis, hepatitis B and C, other STIs, TB), outcomes, and referral to care and treatment, with interoperability with BioPortal, laboratories, and the PRDOH Surveillance System.	■ Newborns of mothers with HIV and/or syphilis (postnatal care and prophylaxis). ■ OB/GYN providers, pediatricians, obstetric and pediatric nurses, and infectious disease specialists. ■ Family planning and sexual health staff. ■ Women in situations of increased vulnerability (substance use, unstable housing, no documented prenatal care).	3.1.2 Maintain a mandatory syndemic screening protocol at least twice during pregnancy (first and third trimesters) and in the delivery room for women without prior documentation, using rapid testing when applicable. 3.1.3 Integrate the registry with the syndemic screening guidelines, ensuring that every woman with a reactive result is immediately placed in clinical care.
3.2 Establish formal interagency and intersectoral coordination among the PRDOH, WIC, PAN, Medicaid/ASES, hospitals with delivery rooms, health plans, family planning services, OB/GYN, pediatrics, infectious disease specialists, and clinical laboratories, with mechanisms for data sharing and referral.	■ Pregnant women (universal coverage throughout all trimesters and in the delivery room for women without prior prenatal care). ■ Women of reproductive age. ■ Newborns of mothers with HIV and/or syphilis (postnatal care and prophylaxis). ■ OB/GYN providers, pediatricians, obstetric and pediatric nurses, and infectious disease specialists. ■ Family planning and sexual health staff. ■ Women in situations of greater vulnerability (substance use, unstable housing, no documented prenatal care).	3.2.1 Strengthen and operationalize the Perinatal Infection Prevention Board as the permanent inter-agency and intersectoral coordination body for the planning, implementation, monitoring, and evaluation of strategies aimed at eliminating perinatal transmission of HIV, congenital syphilis, and viral hepatitis from a syndemic perspective, with the participation of the PRDOH, WIC, PAN, Medicaid/ASES, hospitals with delivery rooms, private health plans, family planning services, and associations of OB/GYNs, pediatricians, infectious disease specialists, and clinical laboratories. 3.2.2 Formalize data-sharing agreements among participating agencies to overcome the barrier documented in the workshop ("data is not shared") and prevent loss of continuity of care between prenatal care, delivery, postnatal care, and pediatric care. 3.2.3 Coordinate, in collaboration with WIC, PAN, 330 Centers, family planning programs, community organizations, hospitals, and prenatal care providers, mechanisms for the early identification and referral of pregnant women who

Strategies	Target Populations	Key Activities
		are not enrolled in regular prenatal care, prioritizing the most vulnerable populations, to facilitate timely access to syndemic screening, prenatal services, care linkage, and ongoing follow-up.
3.3 Promote timely access to rapid tests and prophylactic medications (antiretrovirals for perinatal prophylaxis and penicillin for maternal syphilis) in all hospitals with delivery rooms, as well as the technical capacity of obstetric, nursing, and pediatric staff.	■ Pregnant women (universal coverage throughout all trimesters and in the delivery room for women without prior prenatal care). ■ Women of reproductive age. ■ Newborns of mothers with HIV and/or syphilis (postnatal care and prophylaxis). ■ OB/GYN providers, pediatricians, obstetric and pediatric nurses, and infectious disease specialists. ■ Family planning and sexual health staff. ■ Women in situations of increased vulnerability (substance use, unstable housing, no documented prenatal care).	3.3.1 Ensure, in partnership with the Insurance Commissioner, ASES, private health plans, and the Department of Health, universal availability of rapid tests for HIV, syphilis, viral hepatitis, and TB, as well as prophylactic medications (antiretrovirals for perinatal prophylaxis, parenteral penicillin for maternal and congenital syphilis) in all hospitals with delivery rooms. 3.3.2 Develop and offer periodic training sessions for obstetric, pediatric, nursing, and infectious disease personnel on syndemic screening, perinatal prophylaxis, and the clinical management of HIV, maternal/congenital syphilis, other STIs, and TB during pregnancy and infant care. 3.3.3 Conduct educational campaigns focused on prenatal prevention targeting women of reproductive age, pregnant women, and their partners, in coordination with the integrated community prevention model. 3.3.4 Conduct community outreach and educational activities in municipalities and regions with limited access to services, aimed at promoting perinatal prevention, education on HIV, syphilis, viral hepatitis, other STIs, and TB, as well as the importance of early prenatal care, timely screening, and referral to health services.
Responsible Parties	■ PRDOH (SPCEIT-HIV/STI/Hepatitis Prevention Program, CPTETs; Division of Epidemiology and Research-HIV Surveillance System, STI Surveillance, and Hepatitis C Surveillance System) ■ EHE Recipient - San Juan and Jurisdiction	
Key Partners	■ Department of Health (Section for Mothers, Children, and Adolescents) ■ WIC (Women, Infants, and Children) Program ■ Nutritional Assistance Program (PAN) ■ Medicaid Puerto Rico / ASES	

	■ Hospitals with delivery rooms (public and private) ■ OB/GYN Association; Pediatrics Association; Infectious Diseases Society; Puerto Rico College of Physicians and Surgeons; Nursing Association ■ Family Planning Group ■ Clinics providing prenatal care ■ 330 Centers / *FQHCs* ■ Clinical laboratories ■ Insurance Commissioner ■ Insurance Companies and Health Plans ■ Higher education medical institutions (Schools of Medicine and Nursing; UPR-RCM) ■ CBOs ■ Department of Family Affairs ■ Planning Advisory Bodies ■ Substance Use and Mental Health Programs
Performance Measures	■ Numerator: Number of confirmed cases of perinatal HIV transmission during the period. ■ Denominator: Total number of live births in Puerto Rico during the period (population-based reference). ■ Target % (perinatal HIV): Maintain ≤1 case per year of perinatal HIV transmission (elimination target, aligned with CDC and WHO). ■ Numerator: Number of confirmed cases of congenital syphilis during the period. ■ Denominator: total number of live births in PR during the period. ■ Target % (congenital syphilis): ≥50% reduction from the 2026 baseline by 2031. ■ Percentage of pregnant women with at least one documented HIV test in the first trimester. ■ Percentage of pregnant women with documented syndemic screening (HIV + syphilis + HepC + other STIs) at least two points during pregnancy. ■ Percentage of women with a reactive HIV and/or syphilis test result during pregnancy who are referred for treatment within ≤7 days. ■ % of hospitals with delivery rooms that have documented universal availability of rapid tests and prophylactic medications. ■ Number of OB/GYN, pediatric, and nursing providers trained annually. ■ Number of formal data-sharing agreements in effect between agencies (PRDOH, WIC, PAN, Medicaid/ASES, hospitals). ■ Coverage of the Puerto Rico Pregnant Women Registry (proportion of documented pregnancies).
Progress toward national goals	It contributes to the "Prevent" pillar of the EHE and to the federal and WHO goal of eliminating perinatal HIV transmission. Within the most recent federal framework, the NHAS 2022–2025, it advances Goal 1 (Targets 1.2 and 1.3) through its component of universal screening and perinatal biomedical prevention, and Goal 4 (Target 4.1) through programmatic integration with syphilis (whose congenital transmission is a target of the syndemic response). The NHAS does not set a specific

	percentage target for perinatal HIV transmission precisely because the rate in the U.S. is already very low, but elimination remains a goal.
Funding Sources	■ HRSA, CDC, EHE Initiative - San Juan and Jurisdiction, Medicaid Puerto Rico / ASES, Private health plans, State funds, Foundations, and the private sector

d. Response

GOAL OF RESPONSE
To respond to HIV in Puerto Rico in a coordinated, integrated, and data-driven manner through a cohesive system of information, intersectoral coordination, sustainable public policy, attention to the social determinants of health, and epidemiological surveillance capacity that enables the timely identification of and response to *clusters*, gaps, and emerging service needs.

Objective 1

By 2031, strengthen the rapid response capacity to HIV in Puerto Rico through the strategic use of epidemiological data, intersectoral coordination, and the implementation of localized prevention, outreach, and treatment strategies, ensuring a timely response in communities at highest risk of transmission and improving access to integrated HIV services.

Strategies	Target Populations	Key Activities
1.1 Establish and operate a Permanent Interagency *Task Force* for an Integrated HIV Response, in effect for the entire duration of the plan, responsible for leading this objective.	■ Department of Health, ASES, and other executive branch agencies ■ Recipients of federal funds with direct responsibility for the plan (RWHAP A/B/C/D/F, EHE, CDC HIP-HDS, and surveillance). ■ Planning advisory bodies and community representation	1.1.1 Draft and issue an Executive Order or Administrative Order from the Secretary of Health that formally establishes the *Task Force*, specifying its term, mandate, minimum composition, and institutional succession mechanism. 1.1.2 Appoint formal members and establish operating procedures 1.1.3 Define a recurring agenda and expected outcomes (review of indicators, coordination decisions, responses to changes in federal regulations, escalation of barriers, and response to signals from the surveillance system).
1.2 Promote the updating of the relevant public policy framework for the integrated response to HIV	■ Central Government (Executive Branch and Department of Health) ■ Legislative Assembly ■ ASES and Insurance Commissioner ■ Fund Recipients	1.2.1 Conduct, in partnership with academia and other stakeholders, an analysis of public policy gaps that affect the integrated response to HIV, as well as areas where compliance needs to be strengthened. 1.2.2 Prioritize, in consultation with *the Task Force* and advisory bodies, the most urgent regulatory updates

Strategies	Target Populations	Key Activities
	■ Planning advisory bodies	1.2.3 Move forward, as applicable, with the submission of legislative proposals or regulations in collaboration with members of the legislative branch.
1.3 Strengthen data collection and reporting systems related to HIV surveillance to facilitate early referral to treatment and the continuous monitoring of epidemiological information, thereby supporting evidence-based decision-making.	■ Department of Health HIV Surveillance System and BioPortal. ■ Clinical and hospital laboratories (mandatory reporting network) ■ RWHAP A/B/C/D/F and EHE Recipients ■ ASES, government and private health plans (administrative data on coverage and services)	1.3.1 Identify barriers to compliance with electronic reporting. 1.3.2 Make the necessary adjustments at the system and/or public policy level to address these barriers. 1.3.3 Train clinical providers on reporting requirements. 1.3.4 Develop and deploy real-time operational *dashboards* with automatic alerts for the early identification of molecular and geographic *clusters*, delays in care coordination, and drops in viral suppression.
Responsible Parties	■ Department of Health (SPCEIT - RWHAP Part B/ADAP and STD/HIV/Hepatitis Prevention Program; Division of Epidemiology and Research - HIV Surveillance System) ■ EHE Recipient - San Juan and Jurisdiction ■ RWHAP Part F – NECA/AETC	
Key Partners	■ BioPortal and the PRDOH HIV Surveillance System ■ Clinical and hospital laboratories ■ ASES and government health plans; private health plans ■ CDC *Division of HIV Prevention* ■ Higher education institutions ■ Nonprofit organizations and community-based organizations in priority areas and populations ■ RWHAP Part C ■ RWHAP Part D	
Performance Measures	■ # of barriers identified ■ # of adjustments made to the data collection and reporting system and/or # of updated laws, regulations, or administrative orders ■ # of providers trained on reporting requirements	
Progress Toward National Goals	Contributes to the detection of and response to *clusters* and outbreaks by using data for geographic and population-based prioritization. It also supports the pillar of an integrated response.	
Funding sources	■ CDC, EHE Initiative — San Juan and Jurisdiction, HRSA, State funds	

Objective 2

By 2031, promote the implementation of a syndemic screening approach (HIV, sexually transmitted infections, hepatitis C, and TB) in clinical and community settings to ensure timely linkage to medical care for people who test positive.

Strategies	Target Populations	Key Activities
2.1 Develop standardized clinical guidelines for simultaneous syndemic screening (HIV + STIs + HepC + TB) that include STI test combos and are applicable in clinical and community settings, with management models for providers.	■ Service providers, laboratories, and other clinical staff	2.1.1 Establish a technical committee to develop the syndemic guidelines and validate them. 2.1.2 Publish and disseminate the guidelines, with attached clinical models for peer educators and navigators, and formally incorporate them into the State Preventive Care Guidelines. 2.1.3 Provide annual training to providers, clinical staff, peers, and health promoters on the syndemic approach, through NECA/AETC and partnerships with universities.
2.2 Strengthen the clinical and educational capacity of the workforce to operate under the syndemic approach.	■ Health and HIV Care Service Providers	2.2.1 Promote the integration of syndemic content into the curricula of medical and nursing schools in Puerto Rico, as well as into accredited continuing education programs. 2.2.2 Provide training on topics related to the syndemic approach.

Responsible parties	■ Department of Health (SPCEIT - RWHAP Part B/ADAP and STD/HIV/Hepatitis Prevention Program, Division of Epidemiology and Research - HIV Surveillance System) ■ Recipient: EHE – San Juan and Jurisdiction ■ Ryan White Part F (NECA/AETC)
Key Partners	■ Clinical and hospital laboratories ■ ASES and government health plans; private health plans ■ Insurance Commissioner ■ Puerto Rico College of Physicians and Surgeons; Primary Care Association; Hospital Association ■ Schools of Medicine, Public Health, and Nursing (UPR-RCM and others) ■ 330 Centers / *FQHCs* ■ CBOs ■ HIV Health and Care Service Providers ■ Planning Advisory Committees ■ Recipients of Ryan White C and D Funds
Performance Measures	■ Guidelines developed and disseminated ■ Number of providers, clinical staff, and other stakeholders trained on the developed guidelines

	■ Proposals for integrating syndemic content into professional curricula and continuing education courses ■ Number of training sessions on syndemic content ■ Number of professionals trained in syndemic content
Progress toward national objectives	Contributes to the pillars of EHE detection and response, as well as to the use of data for geographic and population-based prioritization. It also supports the national goal of improving the speed and accuracy of diagnosis and referral.
Funding Sources	■ HRSA, CDC, EHE Initiative — San Juan and Jurisdiction, State Funds

SECTION VI: 2027-2031 INTEGRATED PLANNING IMPLEMENTATION, MONITORING, AND JURISDICTIONAL FOLLOW-UP

1. 2027-2031 INTEGRATED PLANNING IMPLEMENTATION APPROACH

a. Implementation

The implementation of the 2027–2031 Integrated Plan will be grounded in the principles of inter-program coordination, community participation, evidence-based decision-making, and continuous improvement. The jurisdiction will leverage the collaborative structures developed during the integrated planning process and the lessons learned during the implementation of previous plans to ensure the achievement of the established goals and objectives.

As the primary coordination mechanism, a Standing Committee for the Implementation of the Integrated Plan will be established, composed of representatives from the HIV/STI/Viral Hepatitis Prevention Program, the San Juan Eligible Metropolitan Area (EMA), the Ryan White Part B/ADAP Program, and the HIV Surveillance System. This committee will work in coordination with the *Task Force* recommended as part of the previously presented strategies. The Implementation Committee will be responsible for coordinating the implementation of the strategies, promoting the integration of activities across programs, and facilitating the resolution of barriers that may affect the achievement of the objectives. The composition, roles, meeting frequency, decision-making procedures, and documentation of the Implementation Committee's agreements may be defined at a later stage through a work plan, operational protocol, or monitoring and evaluation plan.

The implementation of the Plan will also promote the inclusion of new partners identified during the planning process, including emerging community organizations, entities involved in housing, mental health, and substance use treatment, academic institutions, service systems for people experiencing homelessness, and other relevant sectors to address the social determinants of health. Similarly, the active participation of people with an HIV-positive diagnosis and priority populations, as well as planning advisory bodies, will be encouraged in the review and monitoring of the implemented strategies.

The jurisdiction will continue to utilize and coordinate multiple funding sources to support the Plan's implementation, including funds from the Centers for Disease Control and Prevention (CDC), *the* Ryan White HIV/AIDS *Program (HAB/HRSA), Housing Opportunities for Persons With AIDS* (HOPWA), Medicaid (CMS), community health centers, and other state and federal sources. Coordination among these resources will maximize the reach of interventions, reduce duplication, and more effectively address the needs identified during the planning process.

b. Monitoring

Monitoring of the Integrated Plan will be conducted through a continuous system for tracking process, outcome, and impact indicators associated with each of the established goals and objectives. As part of this effort, the jurisdiction will develop a Monitoring and Evaluation Plan that will define the indicators, data sources, responsible parties, data collection schedules, and mechanisms for analyzing and disseminating results.

Monitoring will utilize information from multiple systems and data sources, including the HIV Surveillance System, *CareWare*, ADAP, Prevention Program information systems, the San Juan AME, linkage and retention in care databases, Medicaid systems, provider reports, and other available official sources.

The monitoring results will be reviewed periodically by the Standing Implementation Committee and shared with planning advisory bodies—Planning Groups (Prevention Planning Group, Ryan White Part B/ADAP, San Juan Planning Council, Ryan White Puerto Rico Interagency Committee)—community partners, and other relevant stakeholders. This process will enable the coordination of activities among prevention and treatment programs, the alignment of efforts with other existing plans, and the reduction of duplicated activities or potential gaps in service delivery.

Regular meetings will be held to review progress, identify deviations from established goals, and establish corrective actions when necessary. Likewise, coordination of schedules, activities, and priorities will be promoted among the various programs and funding sources involved in the Plan's implementation.

c. Evaluation

The evaluation of the Integrated Plan will focus on measuring progress toward achieving the established goals and objectives, as well as determining the effectiveness of the strategies implemented. The process will include the evaluation of indicators related to the pillars of Diagnosis, Treatment, Prevention, and Response, as well as measures linked to the reduction of disparities and the social determinants of health.

The evaluation units of the HIV/STI/Viral Hepatitis Prevention Program, the Ryan White Part B/ADAP Program, Ryan White Part A at the AME in San Juan, the HIV Surveillance System, and other collaborating entities will be responsible for analyzing the collected data and preparing periodic performance reports.

At a minimum, the indicators will be reviewed quarterly, and the results will be presented to the Standing Implementation Committee and the relevant planning bodies. Annually, an event will be held to communicate progress and achievements to stakeholders and participants in the planning process. The findings to be presented at the annual event

will also be used to identify strengths, areas for improvement, and emerging needs that require programmatic adjustments.

d. Improvement

The jurisdiction will adopt a continuous improvement approach based on the systematic use of data, community participation, and periodic evaluation of results. Recommendations derived from monitoring and evaluation processes will be used to adjust strategies, reallocate resources when necessary, and strengthen the system's responsiveness.

People with an HIV-positive diagnosis, populations disproportionately affected by HIV, service providers, and other partners will continue to actively participate in reviewing results and identifying opportunities for improvement through regular meetings. Decisions regarding modifications to the Plan will be discussed and documented through the formal governance mechanisms established for its implementation.

As mentioned, in addition to periodic reviews, the jurisdiction will conduct an annual assessment of the Integrated Plan's progress to determine whether the strategies continue to adequately address epidemiological trends, community needs, and changes in the programmatic and funding environment.

e. Reporting and Dissemination

The jurisdiction will maintain an ongoing process of communication and accountability with partners, people with an HIV-positive diagnosis, populations disproportionately affected by HIV, and the general public.

The results of monitoring, evaluation, and continuous improvement activities will be shared periodically through planning body meetings, progress reports, community presentations, and other communication mechanisms. In addition, an annual progress report will be prepared summarizing the progress made, the challenges identified, and the actions implemented to strengthen the response to HIV.

These reports will be distributed among the partners of the Integrated Plan and will be made available to the public through the official channels of the Department of Health and the AME of San Juan. Furthermore, periodic community feedback sessions will be held to present the results, gather recommendations, and promote the ongoing participation of people with an HIV-positive diagnosis and other priority populations in the implementation of the Plan.

SECTION VII: LETTERS OF CONCURRENCE

CONCEJO DE
PLANIFICACIÓN VIH/SIDA
AME DE SAN JUAN

June 26, 2026

Víctor M. Ramos Otero, MD
Secretary
Puerto Rico Department of Health

Dear Secretary Ramos Otero:

The San Juan Eligible Metropolitan Area (EMA) Planning Council concurs with the following submission by the Puerto Rico Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Surveillance, Prevention, and Care Plan (Integrated Plan), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

The San Juan EMA Planning Council has reviewed the Puerto Rico Integrated HIV Surveillance, Prevention, and Care Plan 2027-2031 submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected people and communities and geographical areas with high rates of HIV. The planning body concurs that the Integrated HIV Surveillance, Prevention, and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The San Juan EMA Planning Council provided input through a series of workshops and meetings conducted as part of the Integrated Plan development process, focusing on needs identification, strategy development, and validation. The Integrated Plan was also made available for public review through publication on the Department of Health's website, which provided a comment period for the submission of feedback and recommendations.

This Integrated Plan is for Puerto Rico as a jurisdiction and for the San Juan EMA.

The signature(s) below confirms the concurrence of the San Juan EMA Planning Council with the Integrated HIV Surveillance, Prevention, and Care Plan.

Miguel A. Delgado Ramos
Co-Chair
San Juan EMA Planning Council

José López Maymí
Co-Chair
San Juan EMA Planning Council

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DEPARTMENT OF HEALTH
GOVERNMENT OF PUERTO RICO

June 25, 2026

Víctor M. Ramos Otero, MD
Secretary
Puerto Rico Department of Health

Dear Secretary Ramos Otero:

The Ryan White Part B/ADAP Planning Group concurs with the following submission by the Puerto Rico Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (Integrated Plan), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

The Ryan White Part B/ADAP Planning Group has reviewed the Puerto Rico Integrated HIV Surveillance, Prevention, and Care Plan 2027-2031 submission to the CDC and HRSA to verify that it describes how programmatic activities and resources will be allocated to the most disproportionately affected people and communities and geographical areas with high rates of HIV. The planning body concurs that the Integrated HIV Surveillance, Prevention, and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The Ryan White Part B/ADAP Planning Group provided input through a series of workshops and meetings conducted as part of the Integrated Plan development process, focusing on needs identification, strategy development, and validation. The Integrated Plan was also made available for public review through publication on the Department of Health's website, which provided a comment period for the submission of feedback and recommendations.

This Integrated Plan is for Puerto Rico as a jurisdiction and for the San Juan Eligible Metropolitan Area (EMA). The signature(s) below confirms the concurrence of the Ryan White Part B/ADAP Planning Group with the Integrated HIV Surveillance, Prevention, and Care Plan.

Yomary Reyes Díaz, MPH, MHSA
State Co-Chair
Ryan White Part B/ADAP Planning Group

Anselmo Fonseca Galindo
Community Co-Chair
Ryan White Part B/ADAP Planning Group

Gonzalo Maldonado Reyes
Services Providers Co-Chair
Ryan White Part B/ADAP Planning Group

DEPARTMENT OF HEALTH
GOVERNMENT OF PUERTO RICO

DEPARTAMENTO DE SALUD
GOBIERNO DE PUERTO RICO

June 24, 2026

Víctor M. Ramos Otero, MD
Secretary
Puerto Rico Department of Health

Dear Secretary Ramos Otero:

The HIV Prevention Planning Group concurs with the following submission by the Puerto Rico Department of Health in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan (Integrated Plan), including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

The HIV Prevention Planning Group has reviewed the Puerto Rico Integrated HIV Surveillance, Prevention, and Care Plan 2027-2031 submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected people and communities and geographical areas with high rates of HIV. The planning body concurs that the Integrated HIV Surveillance, Prevention, and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The HIV Prevention Planning Group provided input through a series of workshops and meetings conducted as part of the Integrated Plan development process, focusing on needs identification, strategy development, and validation. The Integrated Plan was also made available for public review through publication on the Department of Health's website, which provided a comment period for the submission of feedback and recommendations.

This Integrated Plan is for Puerto Rico as a jurisdiction and for the San Juan Eligible Metropolitan Area (EMA).

The signature(s) below confirms the concurrence of the HIV Prevention Planning Group with the Integrated HIV Surveillance, Prevention, and Care Plan.

Javier Vázquez Meléndez, MBA, MPA
Director
STD/HIV/VH Prevention Program
Puerto Rico Department of Health
and State Co-Chair HIV Prevention Planning Group

GLOSSARY

	Term	Definition
#	**330 Health Center**	Federally Qualified Health Center (FQHC) funded under Section 330 of the Public Health Service Act.
A	**Adherence**	The degree to which an individual follows a prescribed regimen (e.g., taking ART or PrEP on time and consistently).
	AETC	AIDS Education and Training Center — a network of HIV clinical provider training programs funded under HRSA Part F. NECA AETC is the regional center serving Puerto Rico through the University of Puerto Rico Medical Sciences Campus.
B	**BioPortal**	Puerto Rico Department of Health application that allows medical facilities, hospitals, and clinical laboratories to report laboratory test results. Reporting through this platform supports a strengthened surveillance system and enables timely and proactive case follow-up.
C	**CAREWare**	HRSA clinical and service information management system used by RWHAP recipients to report HIV Care Continuum outcomes and programmatic performance measures.
	CDR	Cluster Detection and Response — CDC strategy for the timely detection of and intervention in HIV transmission clusters (molecular and social transmission networks). A core component of the Respond pillar of the Ending the HIV Epidemic (EHE) initiative.
	Cluster	A group of epidemiologically or molecularly linked cases indicating active and recent transmission. Triggers accelerated response activities under CDR.
	Combination Prevention	Strategy that integrates biomedical interventions (PrEP, PEP, condoms, Doxy-PEP), behavioral interventions (education, navigation), and structural interventions (access, public policy) for HIV prevention.
	Congenital Syphilis	Syphilis transmitted from mother to child during pregnancy or childbirth.
D	**Differentiated Service Delivery Model**	A whole-person approach that adapts and simplifies HIV services according to the needs of persons with a positive diagnosis or at risk for HIV while reducing strain on the health system. Its principles apply across the entire continuum of care, from prevention and testing to treatment, follow-up, and integration with other health conditions (WHO, 2020).
	Dx	Diagnosis.
H	**Health Regions**	Geographic health regions designated by the Puerto Rico Department of Health.
	HIV Care Continuum	Framework used to measure progress among persons with an HIV-positive diagnosis from diagnosis through sustained viral suppression.
	HIV Self-Testing	Rapid HIV test that persons can perform on their own. Enables diagnosis outside clinical settings and requires follow-up protocols for confirmation and linkage to care.
I	**IPA**	Independent Practice Association — a group of independent physicians who join together to negotiate contracts with insurers, manage costs, and coordinate health care services.
L	**Linkage to Care**	Linkage to HIV clinical care following a reactive HIV diagnosis. A key metric associated with the second 95 target (through Treat) and the Diagnose and Treat pillars of EHE.
M	**MAI**	Minority AIDS Initiative — supplemental federal funding targeted to minority populations disproportionately affected by HIV. Operates within RWHAP and CDC programs.
	MOU / MOUs	Memorandum/Memoranda of Understanding between organizations or entities.
N	**NAP**	Puerto Rico Nutritional Assistance Program — the local equivalent of SNAP.
	Nontraditional Settings	Settings that provide confidential, accessible, and less intimidating alternatives to hospitals or traditional clinics for HIV testing. Examples include community events, public spaces, and private residences.

O	**OB/GYN**	Obstetrician/Gynecologist.
	Opt-Out Screening	Testing approach in which HIV testing is routinely included as part of standard medical care. The provider informs the person that testing will be performed, and the person must verbally or in writing decline the test if they do not wish to participate.
P	**PBM**	Pharmacy Benefit Manager — an organization that administers prescription drug benefits.
	PEP	Post-Exposure Prophylaxis — an antiretroviral regimen initiated within 72 hours after a potential HIV exposure.
	Planning Advisory Bodies	HIV Prevention Planning Group (GPPV), Ryan White Planning Group, San Juan Planning Council, and Ryan White Inter-Part Committee.
	PrEP	Pre-Exposure Prophylaxis — preventive antiretroviral medication for HIV-negative individuals with a clinical indication.
	Pregnancy Registry	Archipelago-wide registry of pregnant women receiving syndemics screening, including test results and linkage to care. Supports prenatal care coverage and reduces perinatal HIV transmission and congenital syphilis.
	Project TIES	Federal EHE initiative implemented by the Municipality of San Juan, focused on Pillar 2 (rapid linkage to treatment) and Pillar 4 (coordinated response to new outbreaks).
	Public Health Detailing	Strategy involving one-on-one educational outreach visits to health care providers to influence clinical practices (e.g., PrEP prescribing), modeled after pharmaceutical detailing but focused on public health objectives.
R	**Rapid Linkage to PrEP**	Protocol that ensures PrEP prescription and initiation within a short timeframe following initial contact (screening, exposure event, or direct request).
	Re-engagement	Process of identifying and reconnecting persons with an HIV-positive diagnosis who have fallen out of care. A key HIV Care Continuum and treatment outcome measure.
	Retention in Care	Ongoing participation of a person with an HIV-positive diagnosis in continuous clinical care, typically measured as at least two medical visits or viral load tests within a 12-month period separated by at least three months.
S	**San Juan EMA**	Eligible Metropolitan Area comprising 30 municipalities in Puerto Rico. Recipient of Ryan White Part A funding.
	SDOH	Social and structural factors that affect health outcomes, such as housing, transportation, food security, education, and involvement with the criminal justice system.
	SPNS	Special Projects of National Significance (RWHAP Part F) - innovation funding that supports demonstration projects and new models of HIV care.
	Sustained Viral Suppression	Maintenance of viral suppression over an extended period (≥12 months with all viral load results at or below 200 copies/mL).
	Syndemic / Syndemic Approach	The coexistence and mutual reinforcement of two or more epidemics within a population, where biological and social interactions amplify adverse health outcomes.
	Syndemic Screening	Screening strategy that simultaneously offers testing for HIV, other sexually transmitted infections (STIs), and viral hepatitis (particularly Hepatitis C), recognizing the epidemiologic overlap of these conditions.
U	**UDS**	Uniform Data System — HRSA's standardized reporting system for Section 330 Health Centers and a key source of primary clinical data.
	USPSTF	U.S. Preventive Services Task Force.
V	**Viral Suppression**	HIV viral load below the level of detection, typically defined as fewer than 200 copies/mL.
W	**WIC**	Women, Infants, and Children — USDA federal nutrition assistance program for pregnant women, breastfeeding women, infants, and children up to age five.
	WICY	Women, Infants, Children, and Youth — population groups served under the Ryan White HIV/AIDS Program (RWHAP).