

ACCESS TO HIV POST-EXPOSURE PROPHYLAXIS (PEP) FOR KEY AND VULNERABLE POPULATIONS IN THE ENGLISH-SPEAKING CARIBBEAN:

UNDP HIV, Health and Development
Regional Hub for Latin America and the Caribbean



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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
ARVs	Antiretroviral medicines
CSO	Civil society organization
FGD	Focus group discussion
HIV	Human immunodeficiency virus
MSM	Men who have sex with men
OECS	Organization of Eastern Caribbean States
LGBT	Lesbian, gay, bisexual, and transgender
NSP	National Strategic Plan
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV/AIDS
PEP	Post-exposure prophylaxis for HIV
PLHIV	People living with HIV
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNDP HHD	UNDP HIV, Health and Development
WHO	World Health Organization

EXECUTIVE SUMMARY

UNDP is a founding co-sponsor of the Joint UN Programme on HIV/AIDS (UNAIDS) and a partner of the Global Fund to fight AIDS, Tuberculosis and Malaria. UNDP leverages its strengths and mandates to eradicate poverty, end inequalities and get back on track to end AIDS by 2030. In line with the Global AIDS Strategy 2021 – 2026, the UNDP Strategic Plan 2022-25 and its HIV and Health Strategy 2022-2025, UNDP supports countries to regain lost ground on HIV and reach those left behind.

An estimated 330,000 people were living with HIV in the Caribbean in 2021, with approximately 5,700 AIDS-related deaths and 14,000 new HIV infections¹. Key populations and their sexual partners accounted for almost 68 percent of all new HIV infections in 2020. However, participants at the inter-agency meeting noted a lack of research on the use of post-exposure prophylaxis (PEP) for HIV by key and vulnerable populations in the region.

In December 2020 following an inter-agency assessment on HIV prevention in LAC, co-hosted with the Pan American Health Organization (PAHO), UNDP initiated this study to examine PEP's availability, accessibility, and acceptability and expand PEP access among key and vulnerable populations as part of combination HIV prevention in the English-speaking Caribbean.² These groups include men who have sex with men, people who use drugs, sex workers, transgender persons, and sexual assault survivors. This study employed qualitative research methods involving a desk review of HIV National Strategic Plans and treatment guidelines and in-depth interviews and focus group discussions with more than 55 stakeholders. Stakeholders included National AIDS Program Coordinators, HIV doctors, and members of civil society organizations (CSOs) and community groups representing key and vulnerable populations. This study experienced limitations due to COVID-19-related restrictions and strained program capacities and the eruption of the *La Soufrière* volcano in Saint Vincent and the Grenadines.

PEP has been recognized as a valid method for HIV prevention for more than two decades. PEP is the use of antiretroviral medicines (ARVs) to prevent HIV infection as part of combination HIV prevention. PEP is the only way to reduce the risk of HIV infection in people who have been exposed to the virus. The treatment consists of a 28-day course of three ARVs started immediately after an event that might have exposed a person to HIV.

¹ UNAIDS (2022). *UNAIDS Global AIDS Update 2022*. Geneva, Switzerland.

² The countries involved in this study are Antigua and Barbuda, Barbados, Belize, Commonwealth of Dominica, Grenada, Guyana, Saint Kitts and Nevis, Saint Lucia, and St. Vincent and the Grenadines.

Since 2014, the World Health Organization (WHO) has recommended that PEP be offered and initiated as early as possible to all individuals with exposure that has the potential for HIV transmission, ideally within 72 hours. WHO does not distinguish between occupational and non-occupational HIV exposure. WHO recommends enhanced adherence counseling for all people initiating PEP and that health workers give patients the entire 28-day treatment course at the initial assessment.

National AIDS Programs in the English-speaking Caribbean have made tremendous progress in recent years. Nonetheless, the results of this study demonstrate that vital work remains to be done to fully integrate PEP as part of combination HIV prevention for key and vulnerable populations.

The study results reveal that National AIDS Programs do not comprehensively, consistently or accurately incorporate PEP into their HIV National Strategic Plans (NSPs) or treatment guidelines. One-third of the NSPs in the region do not mention PEP, and three-quarters do not clearly commit PEP for use by key and vulnerable populations for non-occupational HIV exposure. This study also found that the national HIV treatment guidelines in four study countries do not fully align with the WHO PEP guidelines. The Organization of Eastern Caribbean States (OECS) HIV/STI Guidelines used by four countries in this study more closely align with WHO guidelines but still fail to fully comply with global standards.

During interviews and focus group discussions, the heads of National AIDS Programs, HIV doctors, CSOs, and community groups representing key populations raised a series of concerns about PEP's availability, accessibility, and acceptability. Interviewees and focus group participants explained that PEP is not universally accessible for all people exposed to HIV. Instead, health workers and female sexual assault survivors can often access the treatment while others, such as men who have sex with men, sex workers, and transgender persons, cannot. They also noted that PEP drug regimens and prescription and counseling practices do not meet WHO standards and that PEP treatment protocols are often inaccessible in their countries.

Interviewees and focus group participants in this study further highlighted programmatic and administrative challenges restricting PEP's availability and accessibility for key and vulnerable populations. These include low capacity among health workers to prescribe and administer PEP, the centralization of PEP in a limited number of health facilities, operational challenges such as limited clinic hours, ARVs and diagnostics stock-outs, and a false prevention dilemma whereby

programs pit PEP against PrEP instead of embracing the treatments as complimentary tools for combination HIV prevention.

Insufficient knowledge and awareness of PEP among the public, civil society, health workers, and key and vulnerable populations were among the most frequent concerns raised during interviews and focus group discussions. Members of CSOs and community groups emphasized that their clients and communities often do not know what PEP is or mistakenly believe it is only for health workers or female sexual assault survivors. They explained that this lack of knowledge results in low demand for PEP among people exposed to HIV who are eligible for the treatment.

Members of CSOs and community groups representing key populations, HIV doctors, and program administrators also raised urgent concerns about law enforcement's involvement in the provision of PEP. These concerns included the requirement that sexual assault survivors obtain a police report to access PEP, the harassment, discrimination, and stigmatization of sexual assault survivors, the lack of specially trained police units for sexual assault cases, and burdensome reporting requirements complicating procedures to obtain PEP.

Discrimination and stigmatization of people living with HIV and key populations, including men who have sex with men, people who use drugs, transgender persons, and sex workers, were also among the most critical concerns voiced during interviews and focus group discussions. Several CSOs and community groups ranked stigma and discrimination against PLHIV and key populations as the number one barrier to PEP's accessibility and acceptability in their countries. HIV doctors and program administrators also acknowledged that stigma and discrimination in health care and their broader communities are significant factors affecting patients' willingness to seek and accept PEP.

In light of these study results, UNDP recommends a series of actions to pave the way forward to universal PEP access in the English-speaking Caribbean for key and vulnerable populations as part of combination HIV prevention. To strengthen programs, UNDP recommends that National AIDS Programs align their PEP treatment protocols with WHO guidelines, including PEP eligibility, drug regimens, prescription practices, and adherence counseling. UNDP further recommends that HIV programs allocate sufficient and sustainable funding for PEP, review and improve HIV-related procurement practices, sensitize and strengthen health workers' capacity for PEP, foster strong coalitions with communities and civil society, enhance public knowledge and awareness of PEP, decentralize and streamline PEP services at clinics, and consider social contracting for PEP.

To empower communities and civil society, UNDP recommends that National AIDS Programs increase the involvement of CSOs and community groups representing key and vulnerable populations in PEP-related programs and decision-making. UNDP also recommends that CSOs and community groups with support from donors and international and regional organizations elevate their knowledge and capacity to advocate for PEP and consider providing PEP treatment linkage for their clients, communities, and members.

UNDP acknowledges that investigating sexual assault cases is a core function of law enforcement agencies and recommends that governments reimagine the role that police play in the processes by which sexual assault survivors access PEP. Authorities should ensure accountability for police harassment and discrimination of people living with HIV and key populations. Governments should also mandate and support trauma-informed police training and sensitization, establish specialized police units for sexual assault cases, and review and revise PEP-related police reporting procedures. UNDP also recommends that National AIDS Programs eliminate the requirement that sexual assault survivors obtain a police report before accessing PEP.

Ending inequalities and getting on track to end AIDS by 2030 is only possible by fully leveraging existing HIV prevention tools and strategies. To this end, HIV PEP must be a core component of combination HIV prevention in the English-speaking Caribbean—available, accessible, and acceptable to all people exposed to HIV, including key and vulnerable populations.

I. INTRODUCTION

UNDP is a founding co-sponsor of the Joint UN Programme on HIV/AIDS (UNAIDS) and a partner of the Global Fund to fight AIDS, Tuberculosis and Malaria. UNDP leverages its strengths and mandates to eradicate poverty, end inequalities and get back on track to end AIDS by 2030. In line with the Global AIDS Strategy 2021 – 2026, the UNDP Strategic Plan 2022-25 and its HIV and Health Strategy 2022-2025, UNDP supports countries to regain lost ground on HIV and reach those left behind.

In Latin America and the Caribbean, UNDP’s HIV and Health team works closely with national governments, regional health institutions, and civil society and community groups to support the HIV response through its 25 Country Offices and Regional Hub in Panama City, Panamá.

In early 2020, UNDP’s HIV and Health Team for Latin America and the Caribbean hosted an inter-agency assessment of strategic information on HIV prevention in the region in close collaboration with the Pan American Health Organization (PAHO).

What is PEP?

PEP is post-exposure prophylaxis for HIV. PEP is a method to prevent HIV infection as part of combination HIV prevention. PEP consists of a short course of antiretroviral medicines (ARVs) started immediately after an event that might have exposed a person to HIV. The World Health Organization recommends that PEP be offered to all people who have potentially been exposed to HIV within 72 hours of their potential exposure, regardless of the source.

Source: WHO Guidelines on PEP, 2014

Participants noted the lack of research on the availability, accessibility, and acceptability of post-exposure prophylaxis (PEP) for HIV among key and vulnerable populations in the region. Despite that PEP should be a core component of combination HIV prevention, the information stakeholders provided during the meeting indicated that PEP is not universally accessible in the region, especially for key and vulnerable populations. In response, in December 2020, this study to better understand PEP's availability, accessibility, and acceptability and expand PEP access among key and vulnerable populations as part of combination HIV prevention in the English-speaking Caribbean.

A. Study Aim, Scope, and Objectives

The aim and scope of this study are to promote universal access to PEP in the English-speaking Caribbean as part of combination HIV prevention through an interrogation of PEP's availability,

accessibility, and acceptability among key and vulnerable populations.³ These groups include men who have sex with men, people who use drugs, sex workers, transgender persons, and sexual assault survivors. The study countries are Antigua and Barbuda, Barbados, Belize, Commonwealth of Dominica, Grenada, Guyana, Saint Kitts and Nevis, Saint Lucia, and St. Vincent and the Grenadines. Countries agreed to participate in the study through their Ministries of Health in coordination with the Permanent Secretaries of Health and the heads of the National AIDS Programs.

This study pursued the following objectives:

- (1) Identify, review, and assess the level of implementation of national and regional PEP policies and treatment protocols;
- (2) Develop concrete and targeted recommendations for universal PEP access in line with WHO guidelines, covering occupational and non-occupational events—i.e., exposure during consensual sex, injection drug use, or sexual assault—including for LGBT persons, minors, men who have sex with men, people who use drugs, and sex workers; and
- (3) Publish and make available the study results and recommendations in a public report for all stakeholders in the region.

B. Study Design and Methodology

This study employed qualitative research methods to collect and analyze information about the availability, accessibility, and acceptability of PEP for key and vulnerable populations in the English-speaking Caribbean. These methods included a desk-based policy and literature review, in-depth interviews, and focus group discussions. To note, the qualitative research methods used in this study do not allow for generalizable results for the entire population of people exposed to HIV or all the National AIDS Programs in the region.

Desk-based research involved collecting national and regional HIV strategic plans and treatment guidelines and analyzing them based on global standards and guidelines, as well as a review of relevant social science, epidemiological, and other literature. The lead researcher also communicated extensively by email and WhatsApp with public health officials and members of civil society in the study countries to obtain the most up-to-date national strategic plans and treatment guidelines.

The lead researcher conducted 11 semi-structured, in-depth interviews with 15 key stakeholders via video conferencing. Interviewees included the heads of National AIDS

³ The study protocol entitled *Access to Post-Exposure Prophylaxis (PEP) for HIV in the English-Speaking Caribbean* is available on file with the UNDP HHD Regional Hub for Latin America and the Caribbean.

Programs, doctors specializing in HIV care, and representatives of HIV civil society and community groups. The lead researcher conducted five focus group discussions with more than 40 health workers and members of HIV civil society organizations (CSOs) and community groups representing key populations in the study countries. Overall, this study involved interviews or focus group discussions with more than 55 people in the region. Complete lists of the individuals who participated in the interviews and focus group discussions and the questionnaires used by the lead researcher are available in the Appendices.

C. Study Limitations

This study involved limitations during the collection of information. COVID-19-related restrictions in the lead researcher's country and the study countries constrained the collection of information during this study. Restrictions on travel required the lead researcher to conduct interviews and focus group discussions via video conferencing. The COVID-19 pandemic and response, including COVID-19 vaccination roll-out in the study countries also severely restricted the capacity of the Ministries of Health, including National AIDS Program Coordinators and infectious disease doctors, making it difficult to reach and conduct interviews with health officials and physicians. As a result, the study took longer than anticipated to complete, and the lead researcher was unable to conduct interviews or focus groups or collect HIV strategies or guidelines for some countries.

The eruption of the *La Soufrière* volcano in Saint Vincent and the Grenadines also negatively affected the collection of information in this study. The volcano started with an effusive eruption on December 27, 2020 and continued with explosive eruptions and pyroclastic flow for several days, beginning on April 9, 2021.⁴ Significant ashfall from the April eruptions occurred throughout Saint Vincent and the Grenadines and Barbados and Saint Lucia.⁵ The volcanic eruptions and fallout interrupted the study, limited the participation of individuals from the affected countries, and prevented the lead researcher from obtaining documents from Saint Vincent and the Grenadines.

II. STUDY BACKGROUND AND CONTEXT

National AIDS Programs in the English-speaking Caribbean have made significant progress over the past decade. HIV nonetheless remains a serious public health challenge in the region. The COVID-19 pandemic and natural disasters have exacerbated this challenge and disrupted health

⁴ Smithsonian Institution, *Global Volcanism Program: Soufrière St. Vincent*, <https://volcano.si.edu/volcano.cfm?vn=360150>.

⁵ Ibid.

systems, straining financial, technical, and human resources. Work lies ahead in ensuring interventions and services reach the most vulnerable, including key and vulnerable populations. Guaranteeing universal access to HIV post-exposure prophylaxis (PEP) as part of combination HIV prevention in accordance with global standards should be central to these efforts.

A. HIV and HIV Prevention in the Caribbean

An estimated 330,000 people were living with HIV in the Caribbean in 2021, with approximately 5,700 AIDS-related deaths and 14,000 new HIV infections.⁶ These represent a 50 percent decrease in AIDS-related deaths and a 28 percent decrease in new HIV infections in the region between 2010 and 2021. Approximately 82 percent of PLHIV in the Caribbean knew their status, 83 percent of them were on treatment, and 61 percent of all people with HIV were virally suppressed in 2021.

Key populations and their sexual partners accounted for 83 percent of all new HIV infections in the Caribbean in 2021. Gay men and other men who have sex with men represented 26 percent of new infections. Sex workers constituted 8 percent and people who inject drugs constituted 1 percent of new infections in 2021. Transgender women accounted for 10 percent of new HIV infections in the Caribbean, five times the global figure of 2 percent. Together, the clients of sex workers and the sex partners of all key populations accounted for 38 percent of all new HIV infections in the region.

In 2020, UNAIDS declared that the roll-out of comprehensive HIV prevention interventions in the Caribbean was incomplete.⁷ A 2017 analysis of HIV prevention in Latin America and the Caribbean by PAHO and UNAIDS reports

HIV Key and Vulnerable Populations

WHO and UNAIDS define HIV key populations to include five main groups that experience high risks and burdens of HIV and often lack adequate access to services: men who have sex with men, people who inject drugs, people in prisons and other closed settings, sex workers, and transgender persons.

WHO and UNAIDS distinguish HIV key populations from vulnerable populations. Vulnerable populations comprise groups that are vulnerable to HIV infection in certain contexts because of social, cultural, or legal circumstances, such as infants, migrant and mobile workers, and women and girls. Vulnerable populations are not uniformly affected by HIV in all countries or contexts.

Source: UNAIDS Global AIDS Report 2022

⁶ Unless otherwise noted, the data in this section come from: UNAIDS (2022). *UNAIDS Global AIDS Update 2022*. Geneva, Switzerland.

⁷ Joint United Nations Programme on HIV/AIDS (UNAIDS). *Seizing the Moment: Tackling entrenched inequalities to end epidemics*. Global AIDS Update. Joint United Nations Programme on HIV/AIDS (UNAIDS). Geneva: UNAIDS, 2020.

that while all the countries in the region provided PEP in some circumstances, only a third offered PEP for HIV exposure during consensual sex.⁸

The 2017 PAHO/UNAIDS report further identifies structural factors that restrict access to HIV prevention services for key populations in the region. These include stigma and discrimination in health care, gender-based violence, criminalization of HIV transmission, nondisclosure, and exposure, and criminalization of behaviors that define key populations, such as same-sex sexual behavior, drug use, and sex work. The UNAIDS 2021 *Global AIDS Update* reinforces these concerns. The report indicates that sexual minorities in the Caribbean are exposed to "harsh social stigma and discrimination" and calls for an integrated approach to HIV, sexual and reproductive health, and gender-based violence services to reach adolescent girls, young women, and key populations.⁹

PAHO and UNAIDS have also called on countries in the Caribbean to expand the criteria for prescribing PEP based on WHO guidelines (see the next section); increase the availability of PEP in small clinics and health centers outside of cities; improve knowledge about PEP among non-specialist health workers and key populations; and eliminate administrative barriers to accessing PEP within 72 hours of HIV exposure, such as police reports or medical examinations for sexual assault survivors.¹⁰

The *Caribbean Regional Strategic Framework on HIV and AIDS, 2019-2025* from the Pan Caribbean Partnership Against HIV and AIDS (PANCAP) calls on countries in the region to provide PEP as part of combination HIV prevention.¹¹ The *Organization of Eastern Caribbean States (OECS) Regional Strategic Framework, 2021-2026* calls on OECS Member States to develop national policies and provide clinical and implementation training on PEP for non-occupational HIV exposure as part of a comprehensive package of HIV prevention services tailored to meet the needs of key and vulnerable populations.¹² The *OECS Key Population HIV Prevention Strategy, 2021-2025* also designates PEP as an integral component of a minimum package of combination HIV prevention services for key and vulnerable populations.¹³

⁸ Pan American Health Organization, Joint United Nations Programme on HIV/AIDS (UNAIDS). *HIV Prevention in the Spotlight: An analysis from the perspective of the health sector in Latin America and the Caribbean*, 2017. Washington, D.C.: Pan American Health Organization & UNAIDS, 2017.

⁹ UNAIDS, *supra* note 6.

¹⁰ Pan American Health Organization, UNAIDS, *supra* note 8.

¹¹ Pan Caribbean Partnership Against HIV and AIDS (PANCAP). *Caribbean Regional Strategic Framework on HIV and AIDS (CRSF) 2019-2025*. Georgetown: PANCAP, 2018.

¹² OECS Regional Coordinating Mechanism (RCM). *OECS Regional Strategic Framework 2021-2026*. OECS RCM, 2021.

¹³ Organization of Eastern Caribbean States (OECS). *OECS Key Population HIV Prevention Strategy, 2021-2025*. Castries: OECS, 2020.

B. Global Standards and Guidelines for PEP

Post-exposure prophylaxis (PEP) is the use of antiretroviral medicines (ARVs) to prevent HIV infection. It consists primarily of a 28-day course of ARVs started immediately after an event that might have exposed a person to HIV. PEP is the only way to reduce the risk of HIV infection in people who have been exposed to the virus.

WHO strongly urges countries to provide PEP as part of their National AIDS Programs and to incorporate the WHO PEP guidelines into their HIV treatment guidelines.¹⁴ In the 2021 UN Political Declaration on HIV and AIDS, Heads of UN Member States committed to increasing national leadership and resource allocation for PEP and ensuring PEP's availability for people recently exposed to HIV by 2025.¹⁵ PAHO also encourages countries to provide PEP as part of their HIV programs in accordance with the WHO PEP guidelines.¹⁶

PEP is a central component of combination HIV prevention as recommended by WHO, PAHO, UNAIDS, the OECS, and PANCAP. Combination prevention employs a mix of behavioral, biomedical, and structural interventions tailored to specific individuals and communities to achieve maximum impact in reducing HIV exposure, transmission, and infections. PEP represents a core biomedical intervention as part of combination HIV prevention.

PEP has been recognized as a valid method for HIV prevention in occupational settings for more than two decades.¹⁷ Since as early as the 1980s, physicians have used ARVs for PEP following occupational exposure to HIV.¹⁸ By the early 2000s, health workers had extended the practice to non-occupational situations, including for cases of sexual assault.¹⁹ Studies from that time demonstrated that PEP is also effective after non-occupational HIV exposure, including following consensual sexual activity or injection drug use.²⁰

¹⁴ World Health Organization. *Interim Guidelines: Updated Recommendations on First-Line and Second-Line Antiretroviral Regimens and Post-Exposure Prophylaxis and Recommendations on Early Infant Diagnosis of HIV: Supplement to the 2016 Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection*. Geneva: World Health Organization, 2018 [hereinafter 2018 WHO PEP Guidelines]; World Health Organization. *Guidelines: Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach*. Geneva: World Health Organization, 2021.

¹⁵ UN General Assembly. Res. A/75/L.95. *Political Declaration on HIV and AIDS: Ending Inequalities and Getting on Track to End AIDS by 2030*. June 7, 2021.

¹⁶ Pan American Health Organization, *Guidelines: HIV Pre-Exposure Prophylaxis and HIV Non-Occupational Post Exposure Prophylaxis*. Washington, D.C.: PAHO, 2019.

¹⁷ Cardo, Denise M., et al. "A Case-Control Study of HIV Seroconversion in Health Care Workers after Percutaneous Exposure." *The New England Journal of Medicine* 337.21 (1997): 1485-1490.

¹⁸ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). *PEP for HIV Prevention: FAQs, A Guide for Health Care Providers*. Atlanta: CDC, 2021.

¹⁹ World Health Organization, International Labour Organization. *Post-Exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO Guidelines on Post-Exposure Prophylaxis (PEP) to Prevent HIV Infection*. Geneva: World Health Organization, 2007.

²⁰ Kahn, James O., Jeffrey N. Martin and Michelle E. Rola. "Feasibility of Postexposure Prophylaxis (PEP) against Human Immunodeficiency Virus Infection after Sexual or Injection Drug Use Exposure: The San Francisco PEP Study." *The Journal of Infectious Diseases* 183.5 (2001): 707–714.

Since 2014, WHO has recommended that PEP be offered and initiated as early as possible to all individuals with exposure that has the potential for HIV transmission, ideally within 72 hours.²¹ WHO does not distinguish between occupational and non-occupational HIV exposure.²² HIV testing of the person exposed and the source of exposure should be done, if possible. An assessment for PEP eligibility may also include a consideration of the background HIV prevalence and local epidemiological trends. The only circumstances under which WHO does not recommend PEP for individuals exposed to HIV are the following: (1) when the exposed individual is already HIV positive; (2) when the source is established to be HIV negative; and (3) exposure to bodily fluids that does not pose a significant risk: tears, non-blood-stained saliva, urine, and sweat.

PEP is a Core Component of Combination HIV Prevention

Combination HIV prevention employs a mix of behavioral, biomedical, and structural interventions tailored to specific individuals and communities to achieve maximum impact in reducing HIV exposure, transmission, and infections. PEP should be provided as a core biomedical intervention as part of combination HIV prevention.

Source: UNAIDS Combination Prevention discussion paper

Incorporating the 2018 WHO Interim Guidelines on PEP, the 2021 WHO Consolidated Guidelines on HIV recommend a 28-day, three-drug regimen for PEP for adults and adolescents:

- ⇒ Tenofovir disoproxil fumarate (TDF) + Lamivudine (3TC) (or Emtricitabine - FTC) is recommended as the preferred backbone regimen.
- ⇒ Dolutegravir (DTG) is recommended as the preferred third drug.
 - Atazanavir with ritonavir (ATV/r), Darunavir with ritonavir (DRV/r), Lopinavir with ritonavir (LPV/r), and Raltegravir (RAL) may be considered alternative third drug options when available.

Earlier WHO guidelines recommended EFV as an alternative third drug for PEP. However, the updated WHO PEP guidelines explain that data now exists suggesting EFV is associated with high rates of treatment discontinuation due to central nervous system events.²³ WHO therefore recommends that EFV should only be used as a third drug for PEP when no other options are available.

²¹ World Health Organization. *Guidelines on Post-Exposure Prophylaxis for HIV and the Use of Co-Trimoxazole Prophylaxis for HIV-Related Infections among Adults, Adolescents and Children: Recommendations for a Public Health Approach*. Geneva: World Health Organization, 2014 [hereinafter 2014 WHO PEP Guidelines].

²² In addition to the 2018 WHO PEP guidelines, WHO has recommended PEP specifically for key populations and survivors of sexual violence in separate guidelines. World Health Organization. *Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations: 2016 Update*. Geneva: World Health Organization, 2016; World Health Organization. *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines*. Geneva: World Health Organization, 2013.

²³ Wiboonchutikul S, Thientong V, Suttha P, Kowadisaiburana B, Manosuthi W. *Significant intolerability of efavirenz in HIV occupational postexposure prophylaxis*. J Hosp Infect. 2016;92:372–7.

WHO recommends a different three-drug, 28-day PEP regimen for children ages 10 and younger:

- ⇒ AZT + 3TC is recommended as the preferred backbone regimen.
 - ABC + 3TC or TDF + 3TC (or FTC) can be considered as alternative regimens.
- ⇒ DTG is recommended as the preferred third drug.
 - ATV/r, DRV/r, LPV/r, and RAL may be considered as alternative third drug options when available.

WHO recommends enhanced adherence counseling for all individuals initiating PEP. WHO also recommends that health workers give patients the entire 28-day course of PEP at the initial assessment, as opposed to providing "starter packs" that only contain a portion of the treatment. The 2014 WHO PEP guidelines note that 54 observational studies found that the percentage of individuals completing a 28-day course of PEP was higher among those who received the entire 28-day prescription at their initial assessment than those who received only part of the treatment course.²⁴ WHO also recommends that people taking PEP be tested for HIV three months after their exposure.

For more than a decade, WHO has also recognized countries' human rights duties related to the provision of PEP.²⁵ These include legal obligations under the rights to health, informed consent, non-discrimination, and privacy and confidentiality. WHO has further declared that eligibility for PEP should be grounded in the principles of equity and non-discrimination and that there should be no financial or administrative barriers to PEP. In this respect, WHO emphasizes that a person's involvement in activities prohibited by law in a country, such as sex work, drug use, or same-sex sexual activity, should not impede their access to PEP as part of combination HIV prevention.

III. STUDY RESULTS

The section presents the results of this study on access to HIV post-exposure prophylaxis (PEP) for key and vulnerable populations in the English-speaking Caribbean in two parts. The first part comprises the review of HIV strategic plans and PEP treatment protocols in the region based on WHO guidelines. The second part presents the information collected during in-depth interviews and focus group discussions about PEP's availability, acceptability, and accessibility among key and vulnerable populations in the English-speaking Caribbean.

²⁴ 2014 WHO PEP Guidelines, supra note 21.

²⁵ World Health Organization. *Post-Exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO Guidelines on Post-Exposure Prophylaxis (PEP) to Prevent HIV Infection*. World Health Organization & International Labour Organization. Geneva: World Health Organization, 2007.

Figure 1: HIV National Strategic Plans and Treatment Guidelines in the Study Countries

	HIV National Strategic Plans	National HIV Treatment Guidelines	Regional HIV Treatment Guidelines
Antigua and Barbuda	<i>National Strategic Plan (NSP) for HIV/AIDS in Antigua and Barbuda, 2012-2016</i> ²⁶	<i>National HIV AIDS Care, Treatment Prevention Guidelines, 2013</i>	n/a
Barbados ²⁷	<i>National Strategic Plan for HIV 2014-2018: Investing for Results</i>	<i>HIV Management Guidelines, 2015</i>	n/a
Belize	<i>Belize National Strategic Plan on HIV/STIs, Viral Hepatitis and TB, 2021-2025</i>	<i>Clinical Management Guidelines for HIV/AIDS, 2021</i>	n/a
Commonwealth of Dominica	<i>National HIV/AIDS Strategic Plan: Commonwealth of Dominica, 2018-2022</i>	n/a	<i>OECS HIV/STI Guidelines, 2017</i>
Grenada	<i>Grenada National HIV/AIDS Strategic Plan, 2012-2016</i>	n/a	<i>OECS HIV/STI Guidelines, 2017</i>
Guyana	<i>National HIV Strategic Plan, 2021-2025</i>	<i>National Guidelines for Management of HIV-Infected and HIV-Exposed Adults and Children, January 2014/2015 Revision</i>	n/a
Saint Kitts and Nevis	<i>National AIDS Workplan and Community-Based Health Services Workplan, 2021</i>	n/a	<i>OECS HIV/STI Guidelines, 2017</i>
Saint Lucia	<i>St. Lucia National HIV and AIDS Strategic Plan 2011-2015</i> ²⁸	n/a	<i>OECS HIV/STI Guidelines, 2017</i> ²⁹
St. Vincent and the Grenadines ³⁰	[not available]	[not available]	[not available]

²⁶ The lead researcher was unable to confirm the currentness of this NSP with the Antigua and Barbuda Ministry of Health and the Environment.

²⁷ The lead researcher obtained the Barbados HIV treatment guidelines and NSP from a licensed physician in the country. He was unable to confirm the currentness of these documents with the Barbados Ministry of Health and Wellness.

²⁸ The lead researcher was informed by the Director of a CSO in Saint Lucia that a national policy on HIV and AIDS has been promulgated for 2019-2022 but he was unable to locate the document online or obtain it from the Saint Lucia Ministry of Health and Wellness despite extensive efforts.

²⁹ The lead researcher was informed by the Director of a CSO in Saint Lucia that Saint Lucia uses the regional OECS HIV/STI Guidelines, 2017 but he was unable to confirm this with the Saint Lucia Ministry of Health and Wellness despite extensive efforts.

³⁰ The lead researcher was unable to locate the St. Vincent and the Grenadines HIV NSP or national treatment guidelines online, and the ongoing eruption of the *La Soufrière* volcano during 2020 and 2021 made it difficult to communicate with the Ministry of Health, Wellness and the Environment.

A. HIV National Strategic Plans and PEP Treatment Protocols Review

HIV National Strategic Plans (NSPs) establish priorities for national HIV responses and set forth the framework for National AIDS Programs. HIV treatment guidelines at the national and regional levels contain PEP protocols. This section reviews HIV NSPs and PEP protocols in the English-speaking Caribbean to determine their compliance with the WHO PEP guidelines and better understand how National AIDS Programs integrate PEP into their HIV prevention strategies. Figure 1 below contains the HIV NSPs and treatment guidelines reviewed in this study.³¹

1. *HIV National Strategic Plans*

Figure 2 below presents the results of the review of the HIV NSPs in the study countries. Three questions are used to assess whether PEP is fully integrated into HIV NSPs: (1) Is PEP included in the NSP?; (2) Is PEP committed for non-occupational HIV exposure, including for key populations?; Is PEP prioritized as part of combination HIV prevention?

Overall, National AIDS Programs in the region do not comprehensively incorporate PEP into their HIV NSPs. One-third of the NSPs do not mention PEP. In three-quarters of the NSPs, National AIDS Programs do not clearly commit PEP for use by key populations for non-occupational HIV exposure. Instead, these NSPs refer to PEP for occupational exposure and exposure during sexual assault, such as rape. By contrast, two countries explicitly commit to providing PEP for key populations for non-occupational HIV exposure. Two-thirds of the study countries appropriately prioritize PEP as part of combination HIV prevention. In these NSPs, National AIDS Programs establish PEP as one component of combination HIV prevention alongside behavioral and structural interventions.

³¹ As noted above in the Study Design and Methodology, the lead researcher communicated with public health officials in each study country to obtain the most up-to-date HIV NSPs and treatment guidelines. Despite extensive efforts, it was not possible to reach public health officials in every country to obtain the documents or to confirm the currentness of documents found online. It is indicated in a footnote in Figure 1 when this was the case.

Figure 2: PEP in HIV National Strategic Plans

	Is PEP included in the NSP?	Is PEP committed for non-occupational HIV exposure, including for key populations?	Is PEP prioritized as part of combination HIV prevention?
Antigua and Barbuda	✓	✗ (see p. 45)	✓ (see pp. 41-42, 45)
Barbados	✓	✗	✓ (see p. 14)
Belize	✓	✓ (see pp. 11, 27, 41-42)	✓ (see pp. 39, 41-42)
Commonwealth of Dominica	✓	✓ (see p. 18)	✓ (see p. 18)
Grenada	✗	✗	✗
Guyana	✓	✗ (see pp. 34-35, 45, 75)	✓ (see pp. 21, 23, 28, 74)
Saint Kitts and Nevis	✗	✗	✗
Saint Lucia	✗	✗	✗
St. Vincent and the Grenadines	[NSP not available]	[NSP not available]	[NSP not available]

2. PEP Treatment Protocols

Figure 3 below presents the results of a review of the PEP protocols in the study countries' HIV treatment guidelines based on the 2021 WHO PEP guidelines. Four countries in the study use national treatment guidelines; four countries follow the 2017 Organization of Eastern Caribbean States (OECS) HIV/STI Guidelines;³² the treatment guidelines for one country were not available for review. The four categories highlighted in the review are (1) eligibility for PEP, (2) PEP treatment regimens, (3) prescription practices, and (4) adherence counseling. The categories represent central components of the WHO PEP guidelines and areas of concern stemming from information gathered during interviews and focus group discussions conducted for this study.

Overall, the four countries that follow national HIV treatment guidelines do not comply with the WHO PEP guidelines. Three of these countries fail to make PEP universally available for all kinds of HIV exposure, both occupational and non-occupational. None of the countries use PEP treatment regimens for adults or children that fully align with the WHO guidelines. All four countries with national HIV treatment guidelines also fail to meet PEP prescription and adherence counseling standards. These countries do not direct health workers to provide the entire 28-day treatment course at the initial assessment, and they do not require adherence counseling at the initiation of PEP treatment.

One of the countries with national HIV treatment guidelines stands out in fulfilling the WHO's universal eligibility standard for PEP. In this country, PEP is provided for all kinds of HIV exposure, both occupational and non-occupational, and for all key and vulnerable populations who otherwise meet the treatment's requirements.

The OECS HIV/STI Guidelines also fulfill the WHO's universal PEP eligibility standard and they provide for adherence counseling at the treatment's initiation, meeting two of the four categories in this review. However, like the national treatment guidelines in this study, the OECS guidelines do not fully align with WHO's preferred PEP treatment regimens for adults or children, and they do not explicitly direct health workers to provide the entire 28-day treatment course at the initial eligibility assessment.

³² PAHO representatives informed UNDP HHD's Regional Hub for Latin American and the Caribbean during a briefing following the study that all six of the OECS countries in this study implement the OECS HIV/STI Guidelines. However, the lead researcher was only able to confirm this directly with the National AIDS Programs in four countries as illustrated in Figure 3.

Figure 3: HIV Treatment Guidelines Compliance with WHO PEP Guidelines

	Universal Eligibility (occupational and non-occupational exposure)	Appropriate Drug Regimen		Entire Treatment Course at Initial Assessment	Adherence Counseling at Treatment Initiation
		ADULT	CHILD		
Antigua and Barbuda	✗ (see pp. 12, 41, 46-47)	✗ (see p. 47)	✗ (see p. 47)	✗ (see pp. 41, 47)	✗ (see pp. 41, 47)
Barbados	✗ (see p. 66)	✗ (see p. 68)	✗ (see p. 68)	✗ (see pp. 62, 64, 66-68)	✗ (see pp. 62, 64-65, 66-68)
Belize	✓ (see pp. 41, 43)	✗ (see p. 46)	✗ (see pp. 40-46)	✗ (see pp. 40-46)	✗ (see pp. 40-46)
Guyana	✗ (see pp. 126-127)	✗ (see p. 127)	✗ (see p. 127)	✗ (see pp. 126-128)	✗ (see p. 127)
OECS HIV/STI Guidelines (Commonwealth of Dominica, Grenada, Saint Kitts and Nevis, Saint Lucia)	✓ (see p. 145)	✗ (see p. 148)	✗ (see p. 148)	✗ (see pp. 145, 147-149)	✓ (see p. 149)
St. Vincent and the Grenadines	[Treatment guidelines not available]	[Treatment guidelines not available]	[Treatment guidelines not available]	[Treatment guidelines not available]	[Treatment guidelines not available]

B. PEP’s Availability, Accessibility, and Acceptability in the English-Speaking Caribbean

The section presents the information collected during in-depth interviews and focus group discussions with the heads of National AIDS Programs, HIV doctors, and representatives of CSOs and community groups representing key populations in the English-speaking Caribbean. In some cases, the information is discussed in light of the previous section's review of HIV NSPs and treatment guidelines. For a complete list of the individuals who participated in the interviews and focus group discussions and the questionnaires the lead researcher used during these discussions, please see the Appendices.

Overall, the information gathered through qualitative research in this study raises significant concerns while highlighting meaningful opportunities to promote the availability, accessibility, and acceptability of HIV PEP as part of combination HIV prevention among key and vulnerable populations in the region.

Available, Accessible, and Acceptable

The UN Committee on Economic, Social and Cultural Rights establishes “availability, accessibility, and acceptability” as components of the human right to health. Availability implies that functioning health facilities, goods, and services are available in sufficient quantity. Accessibility requires that health facilities, goods, and services are accessible to everyone along the dimensions of non-discrimination and physical, economic, and information accessibility. Acceptability means that health facilities, goods, and services must be culturally appropriate, respectful of minorities and communities, sensitive to gender and life-cycle requirements, and respectful of medical ethics, including confidentiality.

Source: Committee on Economic, Social and Cultural Right (CESCR). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*. U.N. Doc. E/C.12/2000/4, August 11, 2000.

1. PEP Treatment Protocols and Practices: Eligibility and Other Concerns

The PEP treatment protocols and practices in the study countries restrict the accessibility and acceptability of PEP, particularly for key populations, including men who have sex with men, people who use drugs, sex workers, and transgender persons. Out-of-date drug regimens, a lack of adherence counseling, and the inaccessibility of the PEP treatment protocols themselves also present central challenges in the region.

a. PEP Eligibility

As illustrated in Figure 3 above, the HIV treatment guidelines in three of the study countries restrict the eligibility of PEP in ways that make it inaccessible for individuals exposed to HIV who would be eligible under the WHO guidelines. One country only provides PEP for health workers exposed to HIV. Another provides PEP only to health workers and sexual assault survivors exposed to HIV. The third country provides PEP for non-occupational HIV exposure. However, it excludes "[p]eople who engage in behaviours that result in frequent, recurrent exposures that would require sequential or near-continuous courses of ART." For people subject to ongoing high-risk exposure to HIV, WHO recommends that health workers discuss the option of transitioning from PEP to PrEP, rather than withhold PEP and risk HIV infection.³³

During focus group discussions, members of CSOs and community groups representing key populations corroborated these concerns about PEP eligibility. Stakeholders in countries where PEP is unavailable for key populations expressed confusion and frustration that the treatment was unavailable for people exposed to HIV during consensual sex. Even in countries where treatment protocols recommend PEP for all people exposed to HIV, members of civil society and community groups explained that there is a "general sense" that PEP is only for health workers and rape survivors. The Director of an LGBT CSO asserted that, although PEP should be available for all people exposed to HIV in her country, health workers often only offer it to people they deem "PEP-worthy," excluding LGBT persons and other key populations. The Director of a transgender rights organization explained that in her experience women who consent to unprotected sex for money are not aware of PEP or that it should be available to them.

"I cannot comprehend why PEP is only available for health care workers and survivors of sexual assault."

Member of a civil society organization representing LGBT persons during a focus group discussion in March 2021.

HIV doctors and health workers also raised concerns about PEP eligibility during interviews and focus groups discussions. During a focus group with physicians in a country where PEP is technically available for all kinds of exposure to HIV, several doctors explained that the treatment was nonetheless only accessed by health workers and in some cases sexual assault survivors. One physician noted that no one has ever requested PEP from her for HIV exposure during consensual sex. The Medical Director of a centrally located HIV and tuberculosis clinic

³³ 2018 WHO PEP Guidelines, supra note 14.

asserted that PEP is primarily for health workers' occupational exposure to HIV. She further stated that she did not know "if the Ministry of Health procures medications for people with risky lifestyles."

Similarly, the National AIDS Program Coordinator in a country where PEP is available for all kinds of exposure under the HIV treatment guidelines stated during an interview that he believes PEP should not be available to people exposed to HIV during consensual sex. He contended that increasing the availability of PEP for key populations would encourage risky, unprotected sex and lead to drug resistance. He explained that PEP is only made available in the country to sexual assault survivors who report to the police, health workers exposed to HIV on the job, and other first-line workers such as police officers and emergency responders exposed in the line of duty. The HIV Clinical Care Coordinator in another country noted that, although the country's PEP protocol covers HIV exposure during consensual sex, very few people exposed in this way seek treatment. The Program Coordinator of the infectious disease unit in a third country likewise acknowledged that while PEP is technically available to all people exposed to HIV it is primarily provided to health workers and sexual assault survivors.

By contrast, HIV doctors in other countries explained during interviews that they offer PEP to all people exposed to HIV regardless of how the patient was exposed. Other physicians shared their belief that PEP should be widely available for all kinds of HIV exposure to prevent new infections. An HIV doctor in a country that restricts access to PEP to health workers and sexual assault survivors suggested that the National AIDS Program should consider making PEP available for "high-risk groups," including men who have sex with men, miners, serodiscordant couples, and sex workers.

b. PEP Treatment Regimens, Prescription Practices, and Adherence Counseling

As displayed in Figure 3 above, none of the HIV treatment guidelines used in the study countries fully align with the preferred drug regimens for adults or children or the prescription practice recommended by WHO. The four countries using national HIV treatment guidelines do not require adherence counseling at the initiation of PEP treatment as recommended by WHO. Only the OECS HIV/STI Guidelines call for adherence counseling at the initiation of PEP. These concerns impact the acceptability of PEP—i.e., the tolerability of the drug regimen, providing the entire 28-day treatment course at the initial assessment, and offering adherence counseling to each person starting PEP.

During focus group discussions, HIV doctors and members of CSOs and community groups representing key populations raised issues related to PEP treatment regimens. Three individuals offered to discuss their own experiences taking PEP. They described intense side effects that nearly forced them to stop their treatment, including anxiety, insomnia, nightmares, other psychological symptoms, and gastrointestinal problems. The side effects they described mirrored those associated with the ARV efavirenz (EFV).³⁴ The lead researcher of this study confirmed with one of the individuals that he received EFV as part of his PEP treatment. An HIV doctor and the former Director of an HIV treatment center in another country revealed that the discontinuation of PEP due to side effects associated with EFV was among the most significant challenges she faced in her practice. Notably, in 2018, WHO removed EFV from its list of preferred and alternative drugs for PEP because of EFV's association with high rates of discontinuing PEP due to adverse central nervous system events.³⁵

HIV doctors and program administrators in four countries described PEP prescription practices that do not align with the WHO PEP guidelines during interviews and focus group discussions. In these countries, doctors explained that people exposed to HIV are given a "starter pack" that contains three to ten days of the 28-day treatment course, requiring patients to come back to review the remainder of the treatment. By contrast, the National AIDS Program Coordinator and HIV Clinical Care Coordinator in a country where the PEP treatment protocol does not direct health workers to provide the entire 28-day course explained that they nonetheless do provide each patient the entire treatment at the initial assessment. As noted above, the 2014 WHO PEP guidelines refer to numerous studies finding that the proportion of people who complete the full PEP treatment is higher among those who receive the entire 28-day prescription at their initial assessment than those who receive only part of the treatment.³⁶

As Figure 3 above demonstrates, the regional OECS HIV/STI treatment guidelines align with WHO's recommendation that health workers provide adherence counseling at the initiation of PEP treatment. The four national treatment guidelines reviewed in this study do not provide for adherence counseling at the beginning of PEP. Members of CSOs and community groups representing key populations also noted concerns regarding adherence counseling during focus group discussions. One individual who offered to speak about her own experience taking PEP reported that she did not receive any adherence counseling despite that she experienced severe side effects, including anxiety and other psychological problems. Another focus group

³⁴ See National Institutes of Health Office of AIDS Research, *Drug Database: Efavirenz*, <https://clinicalinfo.hiv.gov/en/drugs/efavirenz/patient> (May 17, 2021).

³⁵ WHO now recommends that EFV only be used as a third drug when no other options are available. 2018 WHO PEP Guidelines, *supra* note 14. Also, see Wiboonchutikul et al., *supra* note 23.

³⁶ 2014 WHO PEP Guidelines, *supra* note 21.

participant in a second country explained that in her experience psychosocial support was largely unavailable in the public health system, including for HIV prevention services.

c. Accessibility of PEP Treatment Protocols

The PEP treatment protocols as established in the HIV treatment guidelines in the study countries are generally inaccessible to the public, CSOs, and community groups. The lead researcher communicated directly via email and official UNDP correspondence with the study countries' Ministries of Health and National AIDS Programs to obtain the treatment guidelines and confirm whether they were current. Except for the OECS HIV/STI guidelines, the up-to-date national HIV treatment guidelines of the study countries were not available online during this study. In one study country, the lead researcher was unable to obtain information about the HIV treatment guidelines from the Ministry of Health despite more than a year of efforts via email and communication with third parties, including the Global Fund Regional Coordinating Mechanism and a local CSO.

During interviews and focus group discussions, HIV doctors and members of CSOs and community groups representing key populations shared similar experiences. Interviewees and focus group participants often revealed that they did not have direct access to PEP treatment protocols or were generally unfamiliar with the specific content of the guidelines. For example, the Coordinator of the National AIDS Program in one study country noted that physical copies of the PEP treatment protocol were generally not available in clinics around the country.

2. *Programmatic and Administrative Challenges*

Programmatic and administrative challenges in the study countries limit the availability, accessibility, and acceptability of PEP, particularly for key populations such as men who have sex with men, people who use drugs, sex workers, and transgender persons. Challenges include health workers' capacity to provide PEP, access to PEP in public clinics, stock-outs of ARVs and diagnostics, and an inaccurate understanding of the relationship between PEP and pre-exposure prophylaxis (PrEP) for HIV prevention.

a. Health Workers' Capacity for PEP

During interviews and focus group discussions, HIV doctors and members of CSOs and community groups representing key populations raised concerns about the capacity of health workers in the study countries to prescribe and administer PEP. These include unfamiliarity with PEP treatment protocols and processes, a failure to prescribe PEP in circumstances where

it is clinically indicated, a lack of basic adherence counseling, breaches of patient confidentiality, and a lack of sensitivity to the needs of key populations.

Interviewees and focus group participants also noted that only specialized physicians could prescribe and administer PEP in some clinics. In

"We need health workers to accept PEP."

An HIV doctor during an interview in June 2021.

their experiences, limiting authorization to prescribe PEP restricts the accessibility of the treatment, as PEP is only available during the hours when these specialized physicians are receiving patients. During an interview, an HIV doctor in a country with rural and remote areas further highlighted that the limited ability to prescribe and administer PEP among health workers reduces the treatment's accessibility in remote areas with a shortage of specialized physicians.

By contrast, several HIV doctors interviewed for this study demonstrated a high level of expertise and experience prescribing and administering PEP. Some of these physicians described years of experience administering PEP as medically indicated, providing adherence counseling, and showing sensitivity to the challenges faced by their patients, including key populations. Some of these doctors nonetheless also expressed concern that the limited capacity among health workers to prescribe and administer PEP restricts the accessibility of the treatment.

b. Health Facilities Challenges

During interviews and focus group discussions, National AIDS Program Coordinators, HIV doctors, and members of CSOs and community groups representing key populations indicated that issues related to health facilities limit access to PEP. They emphasized the highly centralized distribution of PEP, the divide between rural and urban areas, transportation challenges, and operational issues.

The centralization of HIV prevention services such as PEP was among the most common challenge raised by interviewees and focus group participants. PEP is only available in a limited number of centrally located public clinics specializing in HIV care in urban areas in some study countries. The centralization of HIV facilities and services impacts both the accessibility and acceptability of PEP. HIV doctors, program coordinators, and members of CSOs and community groups noted several concerns associated with highly centralized HIV services. First, centrally located urban clinics are not physically accessible for people living in rural or remote areas. Second, transportation to such clinics is often expensive and difficult to arrange. Third, centrally

located clinics specializing in HIV care are often well-known throughout the community and the country. As a result, members of CSOs and community groups explained that in their experiences people are reluctant to attend such clinics for fear of being "outed" as a person living with HIV. As people living with HIV (PLHIV) and key populations are still highly stigmatized in the study countries (see section III(B)(5) below), people exposed to HIV may not seek care at a clinic strongly associated with HIV.

By contrast, the Ministry of Health in one of the study countries has decentralized HIV services including PEP, integrating them into primary care facilities across the country. The National AIDS Program Coordinator in another country explained that the country's Ministry of Health had plans to decentralize HIV services to make them available in community clinics and family planning centers. However, the program was interrupted by the COVID pandemic. During a focus group discussion, a physician in another country discussed her experience providing PEP at a CSO through a program funded by a donor. The doctor explained that, among other things, the program aimed to expand access to HIV prevention by promoting the decentralization of HIV services. During an interview, an HIV doctor in another country described a public-private partnership (PPP) under which the Ministry of Health partners with private clinics to expand the availability of HIV prevention services outside the public sector. The PPP also extends eligibility for PEP beyond what is provided for by the country's HIV treatment guidelines, making it available to all people exposed to HIV.

HIV doctors and members of CSOs and community groups representing key populations reported operational issues at health facilities that restrict the accessibility of PEP in the study countries. Several interviewees and focus group participants emphasized that limited hours of operation and long wait times at clinics providing PEP make the treatment inaccessible for some. They noted that limited clinic hours and long wait times are particularly problematic for people exposed to HIV who must initiate PEP within 72 hours after their exposure. They further highlighted that these operational challenges have a more significant impact in systems where HIV services are highly centralized and available only in urban areas.

c. ARVs and Diagnostics Stock-Outs

National AIDS Program Coordinators, HIV doctors, and members of CSOs revealed during interviews and focus group discussions that stock-outs of ARVs and HIV diagnostics negatively impact the availability of PEP and testing equipment used during the PEP treatment process. They highlighted the unprecedented effect the COVID pandemic has had on the procurement and distribution of ARVs, but some noted that stock-outs also occurred before the pandemic. An HIV doctor at the national treatment center in a study country discussed a stock-out of HIV

testing kits that occurred prior to COVID. In these circumstances, the doctor explained that he had no choice but to ask his patients to pay for testing at a private clinic. However, he explained that this created a significant challenge for their treatment. The Director of a CSO with experience working in the public health system reported that stock-outs of the fixed-dose combination of TDF-FTC have occurred for up to three months at a time in the past.³⁷ He further noted the concern that ARV stock-outs might disproportionately affect access to PEP if the Ministry of Health prioritizes ARVs for PLHIV over those exposed to the virus.

d. PEP v. PrEP: A False Prevention Dilemma

The perception that expanding eligibility and access to PEP is at odds with promoting the use of PrEP for HIV prevention does not align with global standards for combination HIV prevention.³⁸ The false choice between PEP or PrEP arose during an interview and was implied during other discussions conducted for this study. PEP and PrEP are complementary tools to prevent new HIV infections as part of combination HIV prevention. Providing PrEP to people at high risk of HIV infection is not mutually exclusive with ensuring access to PEP for all people exposed to HIV, including key and vulnerable populations.

3. Knowledge and Awareness of PEP

Insufficient knowledge and awareness about PEP among the public, civil society, health workers, and key populations were among the most frequent

"We're lost when it comes to talking about PEP."

Member of a civil society organization representing transgender persons during a focus group discussion in April 2021.

concerns raised during interviews and focus group discussions. National AIDS Program Coordinators, HIV doctors, and members of CSOs and community groups representing key populations highlighted the lack of information and low awareness as critical challenges to PEP's availability, accessibility, and acceptability.

During focus group discussions, members of CSOs and community groups emphasized that their clients and communities often do not know what PEP is or mistakenly believe it is only for health workers or female sexual assault survivors. They noted that this lack of knowledge

³⁷ Truvada is the brand name for a fixed-dose combination ARV medication comprising tenofovir disoproxil fumarate and emtricitabine. Truvada is used for both PEP and PrEP.

³⁸ World Health Organization. *Policy Brief: Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, 2016 Update*. Geneva: World Health Organization, 2017; Joint United Nations Programme on HIV/AIDS (UNAIDS). *Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections: Discussion Paper*. Geneva: UNAIDS, 2010.

results in low demand for PEP among people who are eligible for the treatment. In these circumstances, people at risk of HIV infection following exposure to the virus may not seek PEP, may seek the treatment too late, or may only learn about PEP if a health worker happens to mention it.

"One big challenge is our own people—nurses and doctors aren't aware of PEP, so they don't promote it."

An HIV doctor during an interview in June 2021.

Notably, during two focus group discussions involving members of CSOs and community groups from eight of the study countries, several participants acknowledged that they were hearing about PEP for the first time or had only limited or inaccurate knowledge about the treatment. In several instances, focus group participants confused PEP with PrEP or acknowledged that they did not understand the difference between the two treatments.

National AIDS Program Coordinators and HIV doctors underscored that the public and communities most affected by HIV lack complete and accurate knowledge about PEP. They also highlighted low levels of knowledge about PEP among health workers as a critical challenge to expanding access and use of the treatment. For example, during an interview, an HIV doctor and program administrator described a recent incident in which a health worker was exposed to HIV through a pinprick. The doctors at her clinic were unaware of PEP, so she was forced to attend another clinic. Unfortunately, she could not reach the clinic within 72 hours and therefore could not take the treatment. As in the discussions with members of CSOs and community groups, HIV doctors also acknowledged gaps in their knowledge about PEP and the treatment protocol during interviews for this study.

4. Law Enforcement's Involvement in the Provision of PEP

Members of CSOs and community groups representing key populations raised urgent concerns during interviews and focus group discussions about law enforcement's involvement in the provision of PEP in the study countries. These include the requirement that sexual assault survivors obtain a police report to access PEP, the harassment, discrimination, and stigmatization of sexual assault survivors, the lack of specially trained police units for sexual assault cases, and burdensome reporting requirements complicating procedures to obtain PEP.

A National AIDS Program Coordinator, HIV doctors, and members of CSOs and community groups indicated during interviews and focus group discussions that sexual assault survivors in some countries must file a police report to

"You have to come with a police statement to access PEP here."

Member of a civil society organization representing LGBT persons during a focus group discussion in April 2021.

access PEP. Members of community groups representing key populations asserted that requiring sexual assault survivors to go to the police station to report their assault before obtaining PEP discourages them from seeking treatment. Focus group participants further noted that law enforcement procedures prolong the process to obtain PEP, placing survivors at risk of missing the 72-hour window during which they may start the treatment. During an interview, an HIV doctor noted the same challenge with delays from police procedures as one of the most critical barriers to PEP. Another HIV doctor also highlighted grave concerns about law enforcement's involvement in the provision of PEP. He emphasized that patients who have recently been traumatized from sexual assault face overwhelming challenges trying to navigate the law enforcement process to obtain PEP.

A National AIDS Program Coordinator and members of CSOs and community groups reported horrendous instances of police harassment and discrimination of key populations who report sexual violence. These include cases where law enforcement officers refused to file reports for sex workers and transgender sexual assault survivors and instances of harassment and verbal and physical abuse of men who have sex with men, sex workers, and transgender persons. The interviewees and focus group participants who shared these stories explained that these experiences of harassment and discrimination strongly discourage key and vulnerable populations from seeking PEP if they are exposed to HIV during a sexual assault. The National AIDS Program Coordinator further explained that some law enforcement officials simply do not accept that sex workers or men who have sex with men can be sexually assaulted and therefore refuse to acknowledge these crimes.

The Coordinator of a National AIDS Program and members of CSOs and community groups highlighted the lack of specially trained law enforcement units to handle cases involving sexual assault as a crucial concern for the accessibility and acceptability of PEP. They highlighted concerns about police officers' harassment and discrimination of key populations and noted the challenges and sensitivities in handling sexual assault cases involving vulnerable groups, such as minors and migrants. In both circumstances, they asserted that police officers in their countries lack trauma-informed training and sensitization to handle these cases effectively and encourage other survivors to report abuse and obtain PEP.

HIV program administrators, HIV doctors, and members of CSOs and community groups cited burdensome reporting requirements associated with accessing PEP following a sexual assault as a barrier to the treatment.

“Protecting my health is more important than going to a police station.”

Member of a community group representing transgender persons during a focus group discussion in March 2021.

Even in cases that do not involve police harassment or discrimination as described above, interviewees and focus group participants explained that reporting and documentation requirements pose a significant challenge for sexual assault survivors trying to obtain PEP. They noted that in some cases reporting procedures extend beyond the 72 hours during which a survivor may initiate PEP. In other cases, survivors may simply exit the process due to the burden, length, and intrusiveness of the procedures required at the police station and health centers. HIV doctors and program administrators cited redundant paperwork and procedures among the various institutions involved in the process as a key contributing factor.

5. Discrimination and Stigmatization of People Living with HIV and Key Populations

Discrimination and stigmatization of people living with HIV (PLHIV) and key populations, including men who have sex with men, people who use drugs, transgender persons, and sex workers, were among the most frequently voiced concerns during interviews and focus group discussions. National AIDS Program

“They do not see us as humans. They refer to us as ‘them people.’”

Member of a coalition of sex workers during a focus group discussion in March 2021.

Coordinators, HIV doctors, and members of CSOs and community groups representing key populations all raised urgent concerns about the impact of stigma and discrimination in the health system and elsewhere on the accessibility and acceptability of PEP.

“Accessibility is not just about walking in to get a health service; it’s about suffering stigma and discrimination at the police station, at the clinic, and elsewhere.”

Member of a community group representing transgender persons during a focus group discussion in March 2021.

Several members of CSOs and community groups ranked stigma and discrimination against PLHIV and key populations as the number one barrier to the accessibility and acceptability of PEP in their countries. In addition to harassment and discrimination by law

enforcement officers, they explained that PLHIV and key populations experience stigmatizing and discriminatory treatment from health workers when they seek HIV services including PEP. The Director of a CSO with experience working in the public health system reported that health workers sometimes deny people PEP based upon discriminatory judgments of the patient's sexual behavior. Another CSO member shared that a client had declined PEP after potential HIV exposure because he was asked "a million and one" intrusive and stigmatizing questions by a health worker during the initial assessment.

"Stigma and discrimination are the biggest barriers to PEP in our country."

Member of a coalition of sex workers during a focus group discussion in March 2021.

As noted above, members of CSOs and community groups also reported that some HIV clinics in their countries are strongly associated with stigmatizing and discriminatory experiences. They explained that people are reluctant to seek services like PEP at these facilities. Instead, focus group participants emphasized that people exposed to HIV often first seek help at CSOs and community groups where they feel more comfortable.

"Stigma starts at school. It's being taught to children on a daily basis."

Member of a community group representing youth during a focus group discussion in March 2021.

HIV doctors and program administrators also acknowledged that stigma and discrimination in health care and the broader communities are significant factors affecting patients' willingness to seek and accept PEP. An HIV doctor referred to "shame" and the fear of

being exposed as a key challenge preventing key populations from accessing PEP. Another HIV doctor and program administrator cited stigmatizing attitudes and discriminatory treatment of PLHIV and key populations by health workers as a significant problem in their health system. Echoing concerns raised by members of CSOs and community groups, another HIV doctor observed that people often do not seek PEP in the primary HIV treatment center in the capital city due to privacy and other concerns.

By contrast, HIV doctors and program administrators in some countries expressed compassion and demonstrated sensitivities to the needs of key populations during interviews. For example, during an interview with an HIV doctor and program administrator, they stressed the importance of outreach to key populations and typically stigmatized groups. They also highlighted their efforts to provide their patients counseling, access to social services, and education about human rights. An HIV doctor in another country emphasized his concern during an interview for the poor treatment of key populations seeking PEP in emergency rooms and other places of first contact within the health system. He explained that in contrast to this poor-quality care he approaches the provision of PEP as a holistic process, including adherence counseling and access to a social worker, rather than merely the prescription of medication.

“If you are trans, a sex worker, or gay, you get pushed around at some point in time in the health system.”

Member of a community group representing transgender persons during a focus group discussion in March 2021.

IV. THE WAY FORWARD

The section sets out recommendations to promote universal access to HIV post-exposure prophylaxis (PEP) for key and vulnerable populations as part of combination HIV prevention in the English-speaking Caribbean. The way forward is presented here in three parts based on the study results in the previous section. The first part provides recommendations to strengthen HIV programs to ensure PEP's availability, accessibility, and acceptability, particularly for key and vulnerable populations. The second part presents recommendations to support civil society and communities to participate fully in the expansion of PEP in the region. The third part sets out recommendations to reimagine law enforcement's role in the processes by which sexual assault survivors access PEP.

A. Strengthening HIV Programs

Achieving universal access to PEP in the region requires strengthening National AIDS Programs. This part lays out seven recommendations to enhance HIV programs and expand access to PEP for key and vulnerable populations as part of combination HIV prevention.

1. Align PEP Protocols with WHO PEP Guidelines as Part of Combination HIV Prevention: Universal Eligibility, Updated Drug Regimens and Prescription Practices, and Adherence Counseling

National AIDS Programs should review and revise their HIV treatment guidelines to align their PEP protocols with the WHO PEP guidelines.³⁹ National AIDS Programs should further integrate updated PEP protocols as part of combination HIV prevention in their national strategic plans as called for by the *Caribbean Regional Strategic Framework on HIV and AIDS, 2019-2025*, the *OECS Regional Strategic Framework, 2021-2026*, and the *OECS Key Population HIV Prevention Strategy, 2021-2025*.

PEP protocols should establish universal eligibility for PEP for all kinds of potential HIV exposure—both occupational and non-occupational—including during consensual sex and injection drug use. National AIDS Programs should also update PEP drug regimens in line with WHO guidelines, including adding DTG as the preferred third drug. PEP protocols should direct health workers to provide patients the entire 28-day treatment course at their initial assessment, rather than PEP "starter packs." Patients receiving PEP should be provided enhanced adherence counseling at the start of their treatment. Enhanced adherence counseling may comprise a baseline individual needs assessment, adherence counseling and education sessions, and follow-up telephone calls.⁴⁰

2. Ensure Adequate and Sustainable Financial Resources and Procurement Policies for PEP

Ministries of Health and National AIDS Programs with support from donors should dedicate sufficient financing to expand access to PEP as part of their budgets for HIV services and broader efforts to strengthen health systems. Financing for PEP should be recurring and sustainable to ensure advances in PEP access are maintained and expanded. National AIDS Programs should also review and revise their procurement policies and practices to prevent stock-outs of ARVs and HIV diagnostics. Procurement policies should account for a potential increase in the use of ARVs to facilitate the expansion of PEP access as part of combination HIV prevention.

³⁹ 2018 WHO PEP Guidelines, supra note 14.

⁴⁰ 2014 WHO PEP Guidelines, supra note 21.

Budget line items should include activities recommended in this report to promote universal access to PEP. Ministries of Health and National AIDS Programs should allocate funds to expand access to ARVs for PEP, sensitize and strengthen health workers' capacity for PEP across health systems, foster strong relationships with CSOs and community groups, design and implement public education and awareness campaigns for PEP, decentralize and streamline PEP services, and examine the possibility of social contracting for PEP.

3. Sensitize and Strengthen Health Worker Capacity to Provide PEP

National AIDS Programs should partner with other agencies in the Ministry of Health, professional associations, and international and regional organizations to sensitize and strengthen the capacity of health workers throughout the health system to provide PEP as part of high-quality care and prevention. Sensitization for PEP should prioritize people-centered care for key populations and sexual assault survivors, including minors. Sensitization should aim to eliminate stigmatizing and discriminatory treatment of key populations in health care and enhance the acceptability of PEP.

Capacity strengthening should include regular training and other resources to ensure health workers across the health system are comfortable prescribing and providing PEP in line with updated treatment protocols as part of combination HIV prevention. Among other things, this should include creating and distributing easily readable, stand-alone hard copies of PEP treatment protocols to all health facilities where PEP is available.

4. Foster Strong Coalitions with Communities and Civil Society

National AIDS Programs should foster strong coalitions with CSOs and community groups representing key and vulnerable populations, integrating them into the design and implementation of PEP policies and interventions as part of combination HIV prevention. These organizations include groups representing men who have sex with men, migrants, miners, people who use drugs, serodiscordant couples, sex workers, transgender persons, women and sexual assault survivors. To ensure meaningful participation and sustainability, National AIDS Programs should formalize and mandate engagement with CSOs and community groups through program policies and permanent consultative bodies comprising program administrators, HIV doctors and other health workers, CSOs, and community groups. HIV programs should also consider sponsoring joint workshops, online forums, and other regular events to share knowledge and experiences around PEP.

5. Enhance Public Knowledge and Awareness of PEP

National AIDS Programs should design and implement innovative campaigns with support from donors to enhance public knowledge and awareness of PEP as part of combination HIV programming. Education and awareness campaigns should particularly target key and vulnerable populations, including men who have sex with men, migrants, miners, people who use drugs, serodiscordant couples, sex workers, transgender persons, and sexual assault survivors. National AIDS Programs should work closely with CSOs and community groups in designing and implementing PEP education and awareness campaigns.

6. Decentralize and Streamline PEP Services

National AIDS Programs should work with other agencies in the Ministry of Health with support from donors and international and regional organizations to decentralize HIV prevention services, including as part of primary health care. Decentralization should make PEP widely available in health facilities across the country, including in rural and remote areas and smaller clinics in urban areas. National AIDS Programs should also consider making PEP available free of charge in private clinics.

National AIDS Programs should review operational procedures and streamline PEP services in all health facilities that provide the treatment. This review should include new facilities providing PEP following decentralization efforts. Streamlining should include expanding hours of operation and implementing a system by which people seeking PEP are not made to wait for long periods to ensure they access the treatment within 72 hours after being exposed to HIV.

7. Consider Social Contracting for PEP

National AIDS Programs with support from donors and where necessary international and regional organizations should consider social contracting for PEP as part of combination HIV prevention.⁴¹ Program administrators and HIV doctors should engage CSOs and community groups to better understand the financial, human, and technical resources they require to provide PEP to their clients, communities, and members. If CSOs and community groups

⁴¹ For an examination of social contracting for HIV services see UNDP, Global Fund, Open Society Foundation. *A Global Consultation on Social Contracting: Working Toward Sustainable Responses to HIV, TB, and Malaria through Government Financing of Programmes Implemented by Civil Society: Meeting Report*. New York City: UNDP, Global Fund & Open Society Foundation, 2017; UNDP. *Guidance Note for the Analysis of NGO Social Contracting Mechanisms: The Experience of Europe and Central Asia*. New York City: UNDP, 2019.

demonstrate sustained interest, National AIDS Programs should work closely with these organizations to design and implement a social contracting program for PEP. Such programs should provide for the authorization of CSOs and community groups to prescribe and administer PEP in their own facilities and should provide full support for such groups in the form of sufficient financial and technical resources.

Social contracting is the mechanism by which civil society organizations (which include and serve key populations) receive government funding to deliver health prevention, treatment, care and support services (see <https://www.undp-capacitydevelopment-health.org/en/transition/social-contracting>)

B. Empowering Communities and Civil Society

Civil society and community groups representing key and vulnerable populations should play a central role in expanding access to PEP in the region. This part presents three recommendations to empower communities and civil society to advance universal access to PEP as part of combination HIV prevention.

“The policies fit into what *they* want, not what we want. We need to be part of the decision-making for HIV.”

Member of a coalition of sex workers during a focus group discussion in March 2021.

1. Increase the Involvement of Communities and Civil Society in PEP-Related Programs and Decision-Making

National AIDS Programs should increase the involvement of CSOs and community groups representing key and vulnerable populations in PEP-related programs and decision-making. Among other things, National AIDS Programs should involve CSOs and community groups in the review and revision of PEP treatment protocols, the integration of updated PEP protocols into combination HIV prevention, the sensitization of health workers, the design and implementation of public education and awareness campaigns, and the development of plans to decentralize and streamline PEP services in health facilities.

2. Elevate Civil Society and Community Groups' Knowledge and Capacity to Advocate for PEP

With support from National AIDS Programs, donors, and international and regional organizations, CSOs and community groups representing key and vulnerable populations should dedicate resources to elevate the knowledge and capacity of their clients, communities, and members for PEP. These efforts should include developing in-person and online PEP education programs and other resources. Building on this, CSOs and community groups should organize and advocate with Ministry of Health decision-makers to enhance PEP's availability, accessibility, and acceptability.

3. Consider Providing Treatment Linkage for PEP

With support from National AIDS Programs, donors, and where necessary international and regional organizations, CSOs and community groups representing key and vulnerable populations should consider providing treatment linkage for PEP. Working closely with National AIDS Programs and with support from donors, CSOs and community groups should consider developing basic capabilities to link their clients, communities, and members exposed to HIV with health facilities where PEP is available, accessible, and acceptable in line with updated treatment protocols.

C. Reimagining the Role of Law Enforcement

The investigation of sexual assault cases is a core function of law enforcement agencies. However, the role of law enforcement in the provision of PEP to sexual assault survivors should be reimagined. This part sets forth four recommendations to rethink the role of the police to expand access to PEP, especially for key and vulnerable populations.

1. Ensure Accountability for Harassment and Discrimination

Law enforcement officers responsible for the harassment and discrimination of sexual assault survivors, including key and vulnerable populations, should be held accountable. Internal and external mechanisms should be available for individuals subject to police harassment or discrimination to report and seek remedies and accountability for their mistreatment. Law enforcement officers responsible for and involved in such mistreatment should be held accountable and subject to sensitization and trauma-informed training to prevent further abuses.

2. Eliminate Police Report Requirements for PEP

Sexual assault survivors should not be required to obtain a police report to access PEP. Policies and practices requiring sexual violence survivors to report to the police before accessing PEP should be eliminated. A survivor's decision to report a sexual assault to the police should be separate, independent and delinked from accessing PEP.

3. Mandate and Support Trauma-Informed Training and Sensitization and Specialized Police Units

Law enforcement agencies and relevant government Ministries and departments with support from donors and international and regional organizations should mandate and support trauma-informed training and sensitization of all police officers and establish specialized units to handle sexual assault cases. Among other things, training and sensitization should prioritize learning and direct engagement with key and vulnerable populations, including men who have sex with men, migrants, people who use drugs, sex workers, transgender persons, and sexual assault survivors. CSOs and community groups representing key and vulnerable populations should be involved in designing and implementing aspects of the training and sensitization activities and the development of new standards and operating procedures for specialized units handling sexual assault cases.

4. Review and Revise Reporting and Documentation Procedures

National AIDS Programs and law enforcement agencies should work together to review and revise sexual assault reporting and documentation procedures related to the provision of PEP. HIV programs and police should streamline procedures to eliminate redundancies, promote efficiency, and ensure all aspects are trauma-informed and sensitize to the needs of sexual assault survivors with particular concern for key and vulnerable populations.

APPENDICES

List of Interviewees

Antigua and Barbuda

Delcora Williams, *Manager, National AIDS Program*
Dr. Maria Pereira, *Clinical Care Coordinator for HIV/AIDS, National AIDS Program*

Belize

Elisa Castellanos, *Executive Director, Tikkun Olam Belize*

Commonwealth of Dominica

Lester Guye, *Coordinator, National HIV and AIDS Response Program*

Grenada

Jonell Benjamin, *Program Coordinator, National Infectious Disease Control Unit*
Dr. Gillian Benjamin, *Clinical Physician and Clinical Care Coordinator, National Infectious Disease Control Unit*

Guyana

Dr. Tariq Jagnarine, *Program Manager, National AIDS Programme Secretariat*
Shevonne Benn, *Care and Treatment Coordinator, National AIDS Programme Secretariat*
Dr. Jarelle Branford, *General Physician, National Care and Treatment Center*
Dr. Keisha Chin, *STI Coordinator, National AIDS Programme Secretariat*
Dr. Ruth Ramos Gonzalez, *Physician, Midway Specialty Care Center Guyana; (former) Director, National Care and Treatment Center*

St. Vincent and the Grenadines

Donna Bascombe, *Acting Director, National HIV/AIDS Program*
Dr. Josie Davy, *Clinical Care Coordinator for HIV, National HIV/AIDS Program*

Regional

Marcus Day, *Director, Caribbean Drug and Alcohol Research Institute*
Joan Didier, *Executive Director, St. Lucia AIDS Action Foundation; Director, OECS Global Fund Grant Regional Coordinating Mechanism; Board Member and Founding Member, Caribbean Vulnerable Communities*

List of Focus Group Participants

Barbados (civil society and community groups)

Shaquille Greene, *Lyfe (youth division of Equals)*
 Dr. Nastassia Rambarran, *Equals*
 Raven Sapphire, *Butterfly Barbados, Equals*

Belize (civil society and community groups)

Eva Borgos, *Belize CSO HUB*
 Derricial Castillo-Salazar, *Our Circle*
 Dalila Ical, *Independent Advocate and Journalist*
 Kevin Mendez, *BYEC*
 Zahnia Canul, *TIA-Belize*
 Kyla Ciego, *Belize Family*
 Kendale Trapp, *Empowerment Yourself Belize Movement (EYBM)*
 Kenny White, *Belize Trans Color (BTC)*
 Star Reyes, *UC-Trans*
 Keron
 Diego Grajales, *CNET+*

Belize (health workers)

Dr. Mariana Ancona, *Medical Officer and General Practitioner, Central Region*
 Dr. Russell Manzanero, *Epidemiologist, Ministry of Health; (former) Military Infectious Disease Specialist*
 Dr. Janine McFied, *Medical Coordinator, TB/HIV Clinic, Central Region*
 Dr. Francis Morey, *Deputy Director of Health Services, Ministry of Health*
 Dr. Angelica Salazar, *Pediatrician, Northern Regional Hospital*

Guyana (civil society and community groups)

Denise Carr, *Guyana Sex Worker Coalition*
 Miriam Edwards, *Guyana Sex Worker Coalition*
 Cracey Fernandes, *Guyana Trans United; Guyana Sex Worker Coalition*
 Christopher France, *Society Against Sexual Orientation Discrimination (SASOD)*
 Kevin Hohenkirk, *Society Against Sexual Orientation Discrimination (SASOD)*
 Candace McEwan, *Guyana Trans United*
 Kinesha Stewart, *Guyana Sex Worker Coalition; Caribbean Sex Worker Coalition*

Regional/OECS (civil society and community groups)

Alexandrina Wong, *Women Against Rape, Antigua and Barbuda*
 Orden David, *MESH Antigua, Antigua and Barbuda*
 Alverna Inniss, *MESH Antigua, Antigua and Barbuda*
 Ro Ann Mohhamed, *EQUALS and SHE, Barbados*
 David Hodge, *DOMCHAP, Dominica*
 Sylvester Jo Baptiste, *DOMCHAP, Dominica*
 Kerlin Charles, *MESH Grenada, Grenada*
 Milton Coy, *Grenada Human Rights Organization, Grenada*
 Sean Frederick, *VincyCHAP, Saint Vincent and the Grenadines*
 Jessica St. Rose, *United and Strong, Saint Lucia*
 Yakub Nestor, *Tender Loving Care, Saint Lucia*
 Tynetta My Koy, *Saint Kitts and Nevis Alliance, Saint Kitts and Nevis*
 Lavonne Wise, *Women Coalition of Saint Croix and ECADE, Saint Croix*
 Danielle Greer
 J. Lubin
 Lucien Govaard

In-Depth Interview Questionnaires

1. *National AIDS Program Coordinators*

Key Information Interview Questionnaire:
NATIONAL AIDS PROGRAM COORDINATORS
March 2021

Personal Information:

1. Please tell me your full name, position title, and department, and for how long you've been in this position.

Role in the Provision of PEP:

2. Please describe your role in the provision of PEP in your country.

PEP Policy:

3. When was the HIV PEP protocol first written and when was it last updated?
4. For which kinds of HIV exposure are people eligible for PEP under the current policy-e.g., occupational, sexual assault, consensual sex, injection drug use?

PEP Program Successes and Challenges:

5. Please describe some of the successes achieved in the implementation of the PEP program in your country.
 - a. What are the policy and programmatic features that contribute to these achievements?
6. What are some of the key challenges to ensuring PEP is available and accessible to all who need it in your country?
 - b. Are there policy, programmatic, or administrative issues that contribute to these challenges?
 - c. Are there cultural, legal, or social issues that contribute to these challenges?

Recommendations to Enhance PEP Policies and Programs:

7. In your view, are there policy, programmatic or administrative reforms that would enhance the availability, accessibility and acceptance of PEP in your country? If so, please explain.
 - a. What are the primary reforms needed to ensure PEP is available in clinics around the country, including in smaller health centers and clinics outside of urban areas?

- b. How can the program be enhanced to ensure PEP is easily accessible to members of HIV key populations, such as sex workers and their clients, transgender persons, people who inject drugs, and men who have sex with men?
 - c. How can the program ensure PEP is easily accessible to minors who are survivors of sexual violence?
8. [Question(s) related to specific aspects of the country's policies or program, drafted based on the initial desk-based policy review.]

Final Thoughts:

9. How can UNDP support in addressing the challenges to universal PEP access you've described here today?
10. Is there anything else you believe is essential for UNDP to know about the provision of PEP in your country that we have not already discussed?

2. Health Workers

Key Information Interview Questionnaire:

HEALTH WORKERS

January 2021

Personal and Professional Information:

1. Please tell me your full name, title, and for how long you've been in this position.
2. What kind of health worker are you and at which clinic do you work?

Role in the Provision of PEP:

3. Please describe your role in the provision of PEP in your country.

Successes and Challenges in the Provision of PEP:

4. Please describe some of the successes you've experienced in the provision of PEP in your work.
5. What are some of the key challenges you face in ensuring people who need PEP can access it in time and complete the entire treatment course?
 - a. Are there policy, programmatic, or administrative issues that contribute to these challenges?
 - b. In your view, are there cultural, legal, or social issues that contribute to these challenges?

Recommendations to Enhance PEP Policies and Programs:

6. In your view as a physician, are there policy, programmatic or administrative reforms that would enhance the availability, accessibility and acceptance of PEP in Guyana? If so, please explain.
 - a. What are the primary reforms needed to ensure PEP is available in clinics around the country, including in smaller health centers and clinics outside of urban areas?
 - b. How can the program be enhanced to ensure PEP is easily accessible to members of HIV key populations, such as sex workers and their clients, transgender persons, people who inject drugs, and men who have sex with men?
 - c. How can the program ensure PEP is easily accessible to minors who are survivors of sexual violence?
7. [Question(s) related to specific aspects of the country's policies or program, to be drafted based on the initial desk-based policy review.]

Final Thoughts:

8. How can UNDP support in addressing the challenges to universal PEP access you've described here today?
9. Is there anything else you believe is essential for UNDP to know about the provision of PEP in your country that we have not already discussed?

3. Civil Society and Community Groups

Key Information Interview Questionnaire:

CIVIL SOCIETY AND COMMUNITY GROUPS

February 2021

Personal and Organizational Information:

1. Please tell me your full name and your organization's name.
2. Where is your organization based, and what is the nature and scope of its work?

Role in Promoting Access to PEP:

3. Please describe your organization's role in promoting access to PEP in your country or the region.
4. What kinds of partners do you work with for your work on PEP?

Successes and Challenges in Work on PEP:

5. Please describe some of the successes your organization has achieved in its work on PEP.
6. What are some of the key challenges your organization faces in ensuring people who need PEP can access and initiate the treatment in time?
 - a. Are there policy, programmatic, or administrative issues that contribute to these challenges?
 - b. In your view, are there cultural, legal, or social issues that contribute to these challenges?

Recommendations to Enhance PEP Policies and Programs:

7. Are there policy, programmatic or administrative reforms that would enhance the availability, accessibility and acceptance of PEP in your country? If so, please explain.
 - a. What are the primary reforms needed to ensure PEP is available in clinics around the country, including in smaller health centers and clinics outside of urban areas?
 - b. How can the program be enhanced to ensure PEP is easily accessible to members of HIV key populations, such as sex workers and their clients, transgender persons, people who inject drugs, and men who have sex with men?
 - c. How can the program ensure PEP is easily accessible to minors who are survivors of sexual violence?
8. [Question(s) related to specific aspects of the country's policies or program, to be drafted based on the initial desk-based policy review.]

Final Thoughts:

9. How can UNDP support your organization in promoting universal PEP access in your country?
10. Is there anything else you believe is essential for UNDP to know about the provision of PEP in your country that we have not already discussed?

Focus Group Discussion Questionnaires

1. *Civil Society and Community Groups*

Focus Group Discussion Questionnaire:
CIVIL SOCIETY AND COMMUNITY GROUPS
February 2021

Participants:

1. ...
2. ...
3. ...

Organizational Information:

1. Please briefly describe your organization's work, including whether you work specifically on access to PEP.

Access to PEP:

2. From your experience, what are some of the most significant challenges to accessing HIV PEP in your country?
 - a. Are there policy, programmatic, or administrative issues that contribute to these challenges?
 - b. In your view, are there cultural, legal, or social issues that contribute to these challenges?

Enhancing PEP Policies and Programs:

3. Are there policy, programmatic or administrative reforms that would enhance the availability, accessibility and acceptance of PEP in your country? If so, please explain.
 - a. What are the primary reforms needed to ensure PEP is available in clinics around the country, including in smaller health centers and clinics outside of urban areas?
 - b. How can the program be enhanced to ensure PEP is easily accessible to members of HIV key populations, such as sex workers and their clients, transgender persons, people who inject drugs, and men who have sex with men?
 - c. How can the program ensure PEP is easily accessible to minors who are survivors of sexual violence?
4. [Question(s) related to specific aspects of the country's policies or program, to be drafted based on the initial desk-based policy review.]

Final Thoughts:

5. How can UNDP support your organizations in promoting universal access to PEP in your country?

6. Is there anything else you believe is essential for UNDP to know about PEP that we have not already discussed?

2. *Health Workers*

Focus Group Discussion Questionnaire:

HEALTH WORKERS

June 2021

Participants:

1. ...
2. ...
3. ...

Role in the Provision of PEP:

1. Please describe your roles in the provision of PEP in your country.

Successes and Challenges in the Provision of PEP:

2. Please describe some of the successes you've experienced in the provision of PEP in your work.

Recommendations to Enhance PEP Policies and Programs:

3. In your view as a physician, are there policy, programmatic or administrative reforms that would enhance the availability, accessibility and acceptance of PEP in Guyana? If so, please explain.
 - a. What are the primary reforms needed to ensure PEP is available in clinics around the country, including in smaller health centers and clinics outside of urban areas?
 - b. How can the program be enhanced to ensure PEP is easily accessible to members of HIV key populations, such as sex workers and their clients, transgender persons, people who inject drugs, and men who have sex with men?
 - c. How can the program ensure PEP is easily accessible to minors who are survivors of sexual violence?
4. [Question(s) related to specific aspects of the country's policies or program, to be drafted based on the initial desk-based policy review.]

Final Thoughts:

5. How can UNDP support in addressing the challenges to universal PEP access you've described here today?