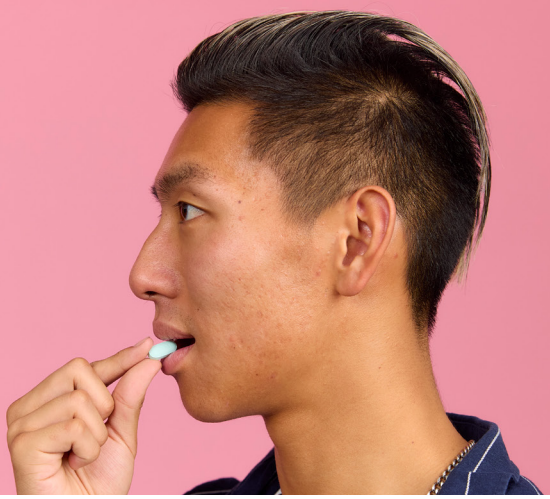
Burnett Foundation Aotearoa



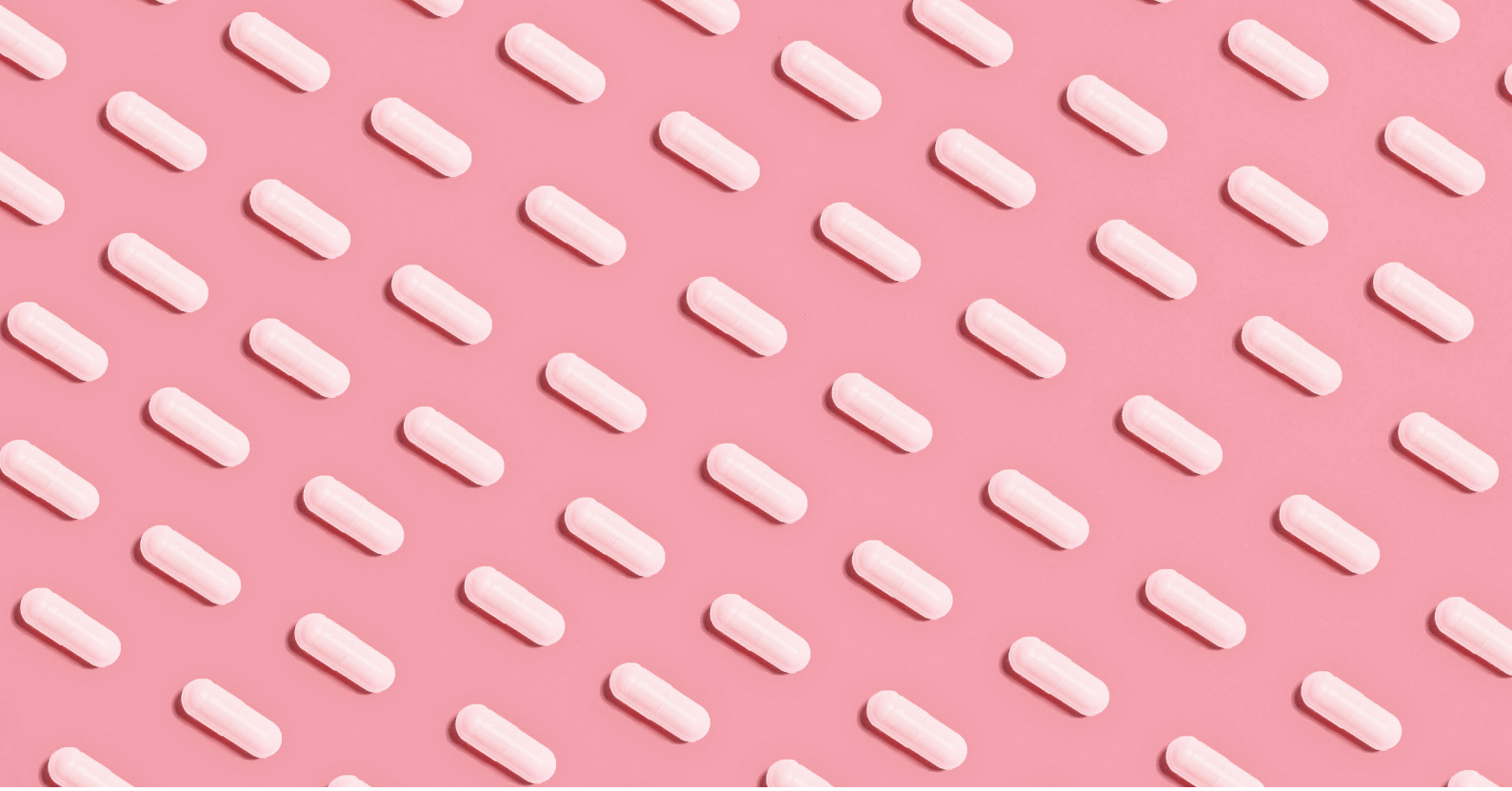
Position statement: PEP

Post-exposure prophylaxis (PEP) is a course of antiretroviral drugs to prevent HIV acquisition, taken by someone who is HIV-negative after they experience an incident of possible HIV exposure. It has an important role to play as part of a combination HIV prevention approach to ending new HIV transmissions in Aotearoa New Zealand by 2030. To ensure the benefits are equitable, we need to remove all barriers to accessing PEP for those who need it.

Gay and bisexual men, alongside all cisgender men who have sex with men (MSM), and people in their sexual networks, are disproportionately at risk of acquiring HIV in Aotearoa New Zealand, and consequently most likely to benefit from accessing PEP.

Burnett Foundation Aotearoa advocates for and promotes the following:

- PEP education being a standard component of sexual health for all cisgender MSM, and their sexual partners (regardless of gender identity).
- prescriber guidelines being expanded to allow anyone who has likely been exposed to HIV through penetrative sexual contact or intravenous drug use to access fully funded PEP within 72 hours of exposure.
- PEP access being further expanded by supporting a community health model, including enabling pharmacists, nurses, and/or peer educators to provide PEP.



PEP reduces the risk of HIV acquisition

PEP consists of a course of 2 or 3 drugs (depending on clinical guidance) for 28 days, taken as soon as possible and no more than 72 hours after a singular high-risk exposure to HIV.[1] The person should test for HIV after completing their course of PEP, and then again for HIV and other STIs 12 weeks after they finish their course of PEP to confirm they have not acquired HIV. If they have acquired HIV, they should immediately be referred to ongoing care to access treatment appropriate to their needs.

PEP is only for singular incidents; it is not intended to prevent the acquisition of HIV through regular exposure. If someone is regularly at risk of acquiring HIV, they should speak to their clinician about accessing a prescription for pre-exposure prophylaxis, or PrEP (which can begin immediately after their course of PEP). They should also test regularly, use condoms foranal and vaginal sex, and/or access sterile injection equipment. It is not recommended for someone taking PrEP as prescribed to take PEP if potentially exposed to HIV through sex.

Accessing PEP is an important aspect of bodily autonomy. Although consistent options such as condoms and PrEP are ideal, access to PEP allows for the fact that not all higher-risk activities will be anticipated beforehand. PEP's effectiveness in reducing the likelihood of acquiring HIV after a higher-risk activity can benefit both physical and mental health.

People should consult their clinician to see if PEP is appropriate if exposed through intravenous drug use.

Non-occupational PEP

Anyone who experiences an occupational exposure to HIV (such as a needlestick injury in a healthcare worker) should access PEP through their employer immediately. This position statement focuses on non-occupational PEP, or nPEP. However, the distinction between occupational and non-occupational PEP can be misleading; sex workers have the potential to be exposed to HIV through their occupation, for instance, but are not automatically included within Pharmac access criteria for funded PEP. Any exposure outside a medical setting is considered non-occupational exposure for the purpose of prescribing guidelines.

Current guidelines

Current prescriber guidelines issued by the New Zealand Sexual Health Society are based on a calculated estimate of risk based on both the mode of transmission to facilitate a potential exposure (i.e. anal sex), as well as the sexual network in which people belong. To access funded PEP, the exposure must have been within 72 hours AND meet any one of the following criteria:[2]

- Condomless anal intercourse OR receptive vaginal intercourse with a known HIV-positive person with either an unknown viral load, or a viral load greater than 200 copies per ml.
- Shared intravenous drug use with a known HIV-positive person.
- Non-consensual intercourse, and a clinician thinks PEP is required.
- Condomless anal intercourse with a person from a country with a high HIV prevalence OR higher-risk group (including MSM) whose status is unknown.

If someone does not meet any of these criteria, they might still benefit from PEP if they engaged in condomless anal intercourse, receptive vaginal intercourse, or shared intravenous drug use equipment with someone of unknown HIV status or a detectable viral load. In such cases, the exposure must have been less than 72 hours ago, and it might be possible to access a prescription for unfunded PEP, paying out of pocket. Currently, only a clinician can decide whether someone can access a prescription for PEP.

PEP is not recommended for oral sex, non-penetrative sex, for the inserting partner for vaginal sex, or if someone has a sexual partner with a suppressed viral load.[a]

For the purposes of these guidelines, a High Prevalence Country is defined as having a prevalence of >1% in the general population, and clinicians are encouraged to check seroprevalence here. However, variance is not only between countries but also concentrated to different risk groups. It is important to balance the need for expanded access to PEP with the way HIV stigma still fuels misinformation about how HIV is transmitted.[3]

These clinical guidelines are population-level guidelines, and there is a risk that applying these to individuals (i.e. statements on high-prevalence countries or communities) could contribute to ongoing homophobia, transphobia, racism, xenophobia, and HIV stigma.[3] It is also important to be careful in how assessment of individual risk occurs, with consideration of what these may say about a 'group' a person belongs to. Homophobia, transphobia, racism, and both the criminality and stigma toward drug use can contribute to high levels of internalised shame, which can be compounded by the fear of HIV acquisition. An individual's risk will depend on numerous factors not captured in these broad guidelines (e.g, sexual networks, drug use, etc). Burnett Foundation Aotearoa continues to advocate for more expansive criteria that allows for this clinical discretion.

a WHO HIV viral load measurements: unsuppressed (>1000 copies/mL), suppressed (detected but ≤1000 copies/mL) and undetectable (viral load not detected by test used). People with an undetectable viral load have zero risk of transmitting HIV through sexual contact; people with a suppressed viral load have almost zero/negligible risk of transmitting HIV through sexual contact.

Accessing PEP

As of 2022, any relevant prescriber can supply funded PEP; it is usually accessed through sexual health clinics or the emergency department. Although GPs can also prescribe PEP, the Deputy Health and Disability Commissioner has confirmed that since prompt access is essential—it is effective only within 72 hours of exposure—PEP should be provided to patients in their first access to a relevant prescriber, rather than being diverted to their regular primary care provider.[4] Increasing ease of access, as well as decreasing the time between exposure and treatment, are critical components to meeting our 2030 target of eliminating new local HIV transmissions.

Transitioning from PEP to PrEP

If someone regularly engages in a higher-risk activity or is part of a sexual network with a higher prevalence of HIV, transitioning from a one-time PEP prescription to ongoing PrEP is encouraged.[9] Ideally, a clinician would confirm someone's HIV negative status 12 weeks after ending their 28-day PEP regimen before initiating PrEP. However, some people are regularly at high risk of acquiring HIV, so a 12-week window between exposure and testing might not be realistic. In such cases, that person should be tested for HIV upon completing their course of PEP, and then immediately transition onto PrEP and into a system of regular testing.

Innovative PEP delivery models

Internationally, there has been movement toward innovative approaches such as allowing pharmacists, nurses, and/or peer educators to prescribe PEP,[5, 6, 7, 8] or making PEP available over-the-counter (OTC). Burnett Foundation Aotearoa is confident that pharmacists, nurses, and peer educators should be able to prescribe PEP with the appropriate support, and advocates for increasing access through innovative models. Expanded access to PEP needs to be accompanied with better universal sexual health education, so people have an evidence-based understanding of when PEP could be appropriate.

Currently, no country has yet implemented a prescription-free, OTC model for PEP access; Burnett Foundation Aotearoa supports further research into whether OTC PEP would increase access while still prioritising safety (particularly adherence and follow up testing). Any expansion in accessibility must always be supported by knowledgeable physicians, nurses, pharmacists, and peer educators who can provide PEP information, HIV/STI testing, and transition into PrEP as needed.

People who infrequently (0-4 times per year)[10] engage in activities with a higher risk of HIV exposure sometimes find daily or even episodic PrEP unsuitable for themselves, either because of the cost or inability to anticipate timing of exposure. For only this demographic (people experiencing higher risk but not frequently), PEP-in-pocket (PIP)—in which they are proactively prescribed a 28-day course of PEP to self-initiate when needed—has demonstrated success in preventing new acquisitions of HIV.[11, 10] This is not currently recognised within prescriber guidelines in Aotearoa New Zealand, but Burnett Foundation Aotearoa would support PIP as an additional strategy to expand PEP access

Equitable uptake of PEP will support our goal to end new, local transmissions of HIV in Aotearoa New Zealand by 2030

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