Position on Universal Access to Anti-HIV Medication

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Problem Statement

The connection between forced or unwanted sex and HIV transmission is well documented in the literature (Campbell, Lucea, Stockman, & Draughon, 2013; Draughon, 2012;Dunkle & Decker, 2013). The medical and anti-sexual violence communities have long recognized the value of anti-HIV medication, or non-occupational postexposure prophylaxis (nPEP), for people who have been sexuallyassaulted.Postexposure prophylaxis (PEP) for HIV following a sexual assault is recommended by the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), and several stateand provincial guidelines as an effective biomedical HIV prevention strategy.(CDC, 2010; Government of Alberta, 2010; New York State Department of Health AIDS Institute, 2010; WHO, 2007). In the U.S.,the CDC has developed guidelines for the assessment of risk and for the use of nPEP aimed at preventing HIV infection given the evidence that HIV seroconversion has occurred in persons whose only known risk factor was sexual assault/abuse. Despite this awareness and medical practice, provision of the nPEP regimen continues to be inconsistent, with patient access often dependent upon the geographic location, treating agency or even provider seen for post-assault health care.Currently sexual assault nurse examiner care is not a guarantee that people who have been sexuallyassaultedwill have access to nPEP, with issues such as cost, perceived duplication of services with local health departments, and negative impact on prosecution being reasons to not provide the medication, as cited in recent research (Campbell et al., 2006).

Position

We believe that globally, systems should be in place to support universal access to nPEP for all people who have been sexually assaulted. Further, we recognize that creating universal access is only a first step. Economic barriers must be addressed to ensure that individuals are able to fully access nPEP and that their healthcare providers and organizations are able to provide it. Access to anti-HIV medication should not depend on cooperation with law enforcement or be restricted by other economic, political, or social factors. Additionally, we recognize the importance of a collaborative, trauma-informed approach to HIV counseling, testing, and treatment that includes skilled healthcare providers and sexual assault advocates. Ample training, funding, and supports should be provided to these critical providers to ensure that universal access to nPEP is within reach of every survivor and that every survivor is supported in making an informed choice about whether or not this regimen is the best option for them.Recognizing these issues, we recommend that:

1. *Health care providers treating sexual assault patients include HIV risk assessment and potential prophylaxis as a standard component of the medical-forensic examination.*The U.S. Department of Justice's *National Protocol for Sexual Assault*

Medical Forensic Examinations, 2nd Edition clearly states that "…the possibility of HIV exposure from the assault should be assessed at the time of the examination. The possible benefit of PEP in preventing HIV infection should also be discussed with the patient if the details of the assault pose an elevated risk for HIV exposure. These particular factors may include: the likelihood that the assailant has HIV, the time elapsed since the event, the exposure characteristics, and local epidemiology of HIV/AIDS" (DOJ, 2013, p. 113). HIV risk assessment and nPEP should be a part of baseline sexual assault clinical education, with regular clinical updates available to ensure both competency and currency around this issue.

2. *Anti-HIV medications be available where and when patients present after sexual assault.* To the extent possible[1], patients who want nPEPneed to be able to obtain it as a component of their sexual assault medical-forensic examination, rather than potentially have to visit additional agencies at a later time in order to initiate the medication regimen.Provision of nPEP should be supported by institutional policies that are current and well understood by staff in order to facilitate the process and ensure consistent access within the agency. Appropriate counseling regarding follow-up testing and medication side-effects are needed at the time of provision so that patients are able to make fully-informed decisions about choosing nPEP.
3. *People who have been sexually assaultednot be expected to carry the financial burden for HIV nPEP.* Communities should have a streamlined and accessible process for nPEP payment so that medication costs are not a barrier. Payment for anti-HIV medications is a complex issue. Some communities have a simple process for paying for nPEP so that individuals are not burdened with the cost. Other locations may require healthcare providers, patients, and advocatesto navigate a complex web of rules and procedures in attempting to obtain medications. Removing the payment barrier would ensure access to nPEP regardless of where a person who has been sexually assaulted presents for services and the extent of their economic resources to pay for such medication.
4. *People who have beensexually assaulted have access to advocacy and supportive services before, during and after HIV testing and nPEP provision*. Advocacy and support services are a critical component of the sexual assault response (International Association of Forensic Nurses, 2008). Individuals who are well-supported appear to be more likely to complete the nPEP regimen (Du Mont et al., 2008); victim advocacy and other support services should be offered regardless of whether the person chooses to have the sexual assault evidence collection kit completed. The additional challenge of the potential exposure to HIV in conjunction with surviving a sexual assault underscore the importance of timely access to victim advocacy and support services regardless of criminal justice involvement. (National Sexual Violence Resource Center, 2008).

[1] We understand that because some sexual assault healthcare programs are located within community-based agencies and not hospitals, onsite provision of nPEP might be impossible. In these cases it is critical that formal relationships are created with a local emergency department to collaborate on the care of patients who wish to receive anti-HIV medications.

Rationale

There is well-documented evidence highlighting the interrelationship between sexual violence and HIV (Campbell et al., 2013; Draughon, 2012).The risk of HIV transmissionmay significantly increase due to the types of oral, anal and genital trauma seen in sexual assaults. The patient's exposure to bodily fluids and the presence ofsexually transmitted infections (STIs) or genital lesions in the assailant or patientmay also potentially increase the risk of HIV transmission (CDC, 2010).

Not every sexual assault patient will want HIV nPEP, but for those that do, it should be universally accessible. Communities have a vested interest in ensuring access to HIV nPEP. Anti-HIV medication as an intermediary factor to reduce the link between sexual violence and HIV transmission seems to be a socially and economically cost-effective prevention remedy. One recent study found that the cost of nPEP for 151 high-risk sexual assault patients was less than half of the direct lifetime cost of care for a *single* HIV seroconversion (Griffith, Ackerman, Zoellner, & Sheffield, 2010). Anti-HIV medications would serve to reduce an individual's vulnerability as well as increase a community's ability to avoid infection.

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