AIDS Action Europe

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AIDS Action Europe - Policy Paper on HIV PEP

What is HIV PEP? HIV Post-Exposure Prophylaxis (PEP) involves taking antiretroviral medications to prevent HIV after a recent potential exposure to the virus. PEP should be started within 24 hours after HIV exposure and no later than 72 hours of exposure and requires taking the medications daily for 28 days to be effective. An HIV PEP regimen with two ARV drugs can be effective, but a three-drug combination is preferred. PEP is effective in preventing HIV when taken correctly regardless of the route of exposure, whether through sexual exposure, sexual assault, sharing needles for drug use, or occupational exposure.[1]

Background

HIV PEP is an effective HIV prevention tool recommended by the World Health Organization (WHO) for all potential exposures. However, access to and uptake of PEP remains low, resulting in missed opportunities to prevent new HIV transmissions. While HIV pre-exposure prophylaxis (PrEP) has gained significant attention over the past decade, HIV PEP, despite being available much longer as a prevention tool than HIV PrEP, has received less interest. This is particularly concerning, as PEP offers important additional prevention benefits as part of combination prevention, especially with the expanded access to PrEP.[1]

Challenges and gaps

Policies and guidelines for HIV PEP often restrict its access by limiting eligibility primarily to cases of occupational exposure or sexual assault. As a result, individuals exposed to the virus in non-occupational circumstances (e.g. sexual exposure or sharing needles) remain excluded from PEP access.

According to a 2024 rapid assessment conducted by AIDS Action Europe, several countries, including Hungary, Lithuania, Poland, and Bulgaria, have national policies that restrict PEP access exclusively to cases of occupational exposure or sexual assault. These narrow constraints overlook other situations for possible HIV exposure, such as sharing needles, sexual exposure where no other protection was used or where protection failed,, thereby limiting broader access to this prevention tool. Even in countries like Romania, where national policy indicates that PEP should be accessible to everyone who needs it, in practice, access is predominantly limited to occupational exposures.[2]

The AAE assessment identified systemic and institutional barriers to accessing PEP, even in countries where PEP is available for non-occupational exposures. These barriers include stigma, discrimination, and geographical limitations, all of which hinder access to PEP and, more broadly, to essential HIV prevention and other HIV services.

In most cases reported to AAE, PEP is only available at HIV clinics, which are typically located in larger urban areas and have limited working hours. In countries where PEP is available through emergency departments, individuals often face long waiting times and

[1] Guidelines for HIV post-exposure prophylaxis. Geneva: World Health Organization; 2024. Licence: CC BY-NCSA 3.0 IGO.https://www.who.int/publications/i/item/9789240095137
[2] Guidelines for HIV post-exposure prophylaxis, World Health Organization; Rapid assessment conducted by AIDS Action Europe in 2024, the responses were provided by national CSOs

may encounter healthcare providers who are not fully aware of the time-sensitive nature of starting PEP. In countries such as France, where PEP can only be obtained in hospitals, the required initiation within 48 hours presents additional challenges due to overcrowded, understaffed facilities and the scarcity of hospitals in rural areas.

Ensuring timely access to PEP is crucial for reducing the risk of HIV transmission following exposure. The WHO recommends a triple-drug regimen for PEP, aligning with the standard of care for antiretroviral therapy.[3] Evidence from animal studies and pharmacokinetic modelling indicates that a two-drug regimen may not be effective if initiated 24 hours or more after exposure. However, the addition of a third drug can extend the window of efficacy, making PEP potentially effective if taken up to 48-72 hours post-exposure.[4]

Gaps in knowledge among healthcare workers, as highlighted in a 2024 special report by the European Centre for Disease Prevention and Control (ECDC) on HIV stigma in healthcare settings, present another critical challenge. The ECDC report, based on a survey conducted in cooperation with the European AIDS Clinical Society (EACS) among healthcare professionals, revealed that many lacked knowledge about the U=U[5] concept, PEP, and PrEP. *Alarmingly, 44% of healthcare workers did not agree with the scientifically proven statement that 'a short course of HIV medicines after possible exposure to HIV (post-exposure prophylaxis) prevents the virus from taking hold in your body.'* [6]

The ECDC report also uncovered a proportion of healthcare workers who expressed reluctance to provide care to key populations, including people who use drugs, men who have sex with men, sex workers, and transgender persons.[7] Such stigmatising attitudes not only perpetuate discrimination but also deter individuals from seeking essential HIV services, including PEP.

The AAE assessment confirmed that general awareness of PEP among key populations remains significantly low. While a few countries reported relatively solid awareness among gay, bisexual, and queer men who have sex with men (GBQMSM), other key populations, including people who use drugs, sex workers, and transgender persons, tend to have low awareness about PEP and its availability.

The assessment also highlighted disparities in the affordability of PEP across EU countries. In some countries, such as Estonia, Bulgaria, Hungary, Poland, and the Czech Republic, the costs of PEP for non-occupational exposure are not covered by public health insurance, forcing individuals to pay out of pocket, a burden that makes it inaccessible to those who need it most.

As outlined in the WHO guidelines on HIV PEP, community-based healthcare models have demonstrated the potential to address stigma and foster trust through the involvement of community health workers and peers. These models are particularly well-suited to reach and build stronger relationships with underserved populations.[8]

Furthermore, substantial evidence shows that delivering PEP in community settings, tailored to the needs of key population groups, significantly improves uptake and ensures timely

3 Guidelines on post-exposure prophylaxis and the use of co-trimoxazole propyhlaxis for HIV-related infections among adults, adolecents and children: recommendations for a public health approach. Geneva: World Health Organization; 2014, https://apps.who.int/iris/bitstream/handle/10665/145719/9789241508193_eng.pdf?sequence=1
4 Mayer KH, Allan-Blitz LT. Post-exposure prophylaxis to prevent HIV: new drugs, new approaches, and more questions. Lancet HIV. 2023;10:e816-e24.
5 Undetectable = Untransmittable
6 https://www.ecdc.europa.eu/en/publications-data/hiv-stigma-healthcare-setting-monitoring-implementation-dublin-declaration
7 As above
8 Same as 1

access.[9] As a part of a combination prevention strategy, this approach has been shown to be not only cost-effective but, but also, cost-saving (as demonstrated in the San Francisco study[10]).

However, the availability of PEP within community settings remains limited, often due to restrictive national policies. Furthermore, in many countries, community healthcare providers are frequently either not authorised or not adequately trained to prescribe PEP, creating an additional barrier to access. Based on the AAE assessment, Spain is one of the few countries in the EU that offers community-based PEP services, though its availability may not be widespread.[11]

Restrictive policies on access to PEP, coupled with the structural barriers mentioned above, severely limit its uptake. These findings underscore the urgent need to address geographical disparities, improve provider knowledge, ensure its affordability, and enhance awareness tailored to key populations.

In order to utilise PEP to its full potential as part of HIV combination prevention, AIDS Action Europe has made the following recommendations to improve HIV PEP´s accessibility, availability, affordability, and acceptability of PEP.

Recommendations

Eligibility to PEP

- Review and revise national policies to ensure that PEP eligibility includes all non-occupational exposures, including sexual exposure and exposure through injecting drug use.

Settings

- Eliminate policies limiting PEP delivery to only HIV hospitals or emergency departments.
- Expand PEP delivery in a broader range of settings, including pharmacies, police stations, online platforms, drop-in centres, and mobile clinics. Expanding points of PEP provision can reduce delays, improve accessibility and acceptability, and better meet the needs of underserved communities.[12]
- Provide PEP in community settings. This delivery model addresses stigma and contributes to increased PEP uptake, while being cost-effective.
- Establish and strengthen partnerships between community healthcare settings, HIV clinics, and HIV specialists for improved care provision. Adapt from established good practices, such as Bulgaria's PrEP service delivery, which integrates visiting doctors into community settings.

[9] Pinkerton SD, Martin JN, Roland ME, Katz MH, Coates TJ, Kahn JO. Cost-effectiveness of Postexposure Prophylaxis After Sexual or Injection-Drug Exposure to Human Immunodeficiency Virus. Arch Intern Med. 2004;164(1):46-54. doi:10.1001/archinte.164.1.46; Pinkerton SD, Martin JN, Roland ME, Katz MH, Coates TJ, Kahn JO. Cost-effectiveness of HIV postexposure prophylaxis following sexual or injection drug exposure in 96 metropolitan areas in the United States. AIDS 2004 October 21;18 (15):2065-73. 32. Pinkerton SD, Martin JN, Roland ME, Katz MH, Coates TJ, Kahn JO. Cost-effectiveness of postexposure prophylaxis after sexual or injection -drug exposure to human immunodeficiency virus. Archives of Internal Medicine 2004 January 12;164 (1):46-54;Roland ME. Enhancing the potential benefits of HIV post-exposure prophylaxis. AIDS. 2006

[10] Kahn JO, Martin JN, Roland ME,Bamberger JD, Chesney M, Chambers D et al. 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 2001;183 (5):707-14

[11] Same as 2

[12] As recommend by the WHO Guidelines Development Group recommends the WHO Guideline for HIV PEP

Affordability of PEP

- Ensure that non-occupational PEP is included in the reimbursement schemes of national health insurances.

Service delivery where PEP is available

- Expand the range of providers authorised to prescribe and distribute PEP, as recommended by WHO. This approach has demonstrated effectiveness, acceptability, and cost savings while improving equity in access.[13]
- Provide PEP training for healthcare staff, police officers, first responders, community healthcare providers, and emergency department personnel.
- Provide training and supervision for healthcare staff on stigma and discrimination against key populations.

Timely delivery

- Ensure prompt initiation of PEP, ideally within the first 24 hours of exposure.
- Standardise the use of a three-drug regimen for PEP, as recommended by WHO, especially for individuals starting treatment after 24 hours of exposure.
- Develop rapid response protocols for PEP administration, particularly in emergency departments.

Combination prevention

- Consider using PEP as an entry point to promote awareness, access, and uptake of PrEP "with PEP serving as a bridge to PrEP for individuals with repeated exposures to HIV." [14]
- Ensure that PrEP users who experience challenges in adherence or discontinue use have access to PEP as a preventive measure.

Awareness and outreach

- Develop and distribute information materials through appropriate channels and settings to ensure both accessibility and relevance.
- Tailor messaging to address the needs and concerns of specific key population groups, using language and content that resonate with their experiences.
- Actively engage peers and community healthcare providers in awareness-raising initiatives to build trust, enhance credibility, and improve the effectiveness of outreach efforts.

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[13] WHO Guidelines for HIV post-exposure prophylaxis; Magid Herida 1, Christine Larsen, Florence Lot, Anne Laporte, Jean-Claude Desenclos, Françoise F Hamers, Cost-effectiveness of HIV post-exposure prophylaxis in France (see Footnote 7)
[14] WHO Guidelines for HIV post-exposure prophylaxis