New Zealand AIDS Foundation
Te Tūāpapa Mate Āraikore o Aotearoa

31 October 2019

PHARMAC
PO Box 10254
The Terrace
Wellington 6143

Dear Matt Tyson,

Submission of feedback on PHARMAC's decision to widen patient eligibility criteria for post-exposure prophylaxis

We are writing in support of PHARMAC's proposal to widen access to post-exposure prophylaxis following non-occupational exposure to HIV (nPEP).

The New Zealand AIDS Foundation (NZAF) is a registered charity and non-governmental organisation funded through contracts with the Ministry of Health and independent fundraising to provide a range of HIV and AIDS related services, including: HIV prevention and health promotion, HIV testing, counselling and support, research, policy, and information services.

NZAF support the decision to widen the patient eligibility criteria for nPEP to include receptive anal sex with a person of unknown HIV status which was condomless or where a condom failed, if with a person from a high-prevalence country or community. **We request clarification within the special authority criteria on who these high-prevalence communities and countries are for ease of prescribing.** This is in line with research suggesting HIV transmission in New Zealand is driven by people who are unaware that they are living with HIV. Saxton et al. (2015) estimated there to be approximately 600 people in New Zealand with undiagnosed HIV, with 1 in 5 gay and bisexual men living with HIV unaware they had the virus. Widening the eligibility criteria to increase access to nPEP will help to reduce the transmission of HIV in New Zealand.

We also **support the provision to widen the nPEP prescriber group to include sexual health physicians, nurse practitioners and general practitioners who have undergone appropriate training**. Restricting the prescribing and approval process of antiretrovirals for nPEP to HIV specialists was problematic as this is a limited list of individuals who are available in only half of the twenty DHBs across the country. It meant that not all sexual health clinics and emergency departments had access to an HIV specialist, and therefore the requirement to obtain an approval from an HIV specialist created a delay, which is an issue as nPEP must be commenced within 72 hours of a potential exposure, and its effectiveness decreases with time from exposure. Expanding the prescriber group enables greater access to nPEP nationwide, and a smoother pathway to prescription for clinicians and patients.

NZAF National Office
31 Hargreaves St, St Mary's Bay, Auckland 1011
PO Box 6663 Wellesley St, Auckland 1141

+64 9 303 3124
contact@nzaf.org.nz
www.nzaf.org.nz

We are greatly encouraged that PHARMAC is using evidence-driven decision-making with references to best-available evidence on the likely transmission rates per act. However, we reflect that these data are best estimates utilising complex and international data. The estimates aggregate source patients by treating those with viral loads lower than 50 copies/mL jointly with virally suppressed individuals, and therefore provide underestimation of risk per exposure from persons without viral suppression, especially from those in early stages of infection who are unlikely to know their status. **These estimates need to be contextualised to the New Zealand HIV epidemic and social considerations**, by ensuring consideration of:

- New Zealand having a small and highly connected gay and bisexual community
- New Zealand recently having the highest number of new diagnoses ever recorded in 2016
- It being more likely that an individual will come into contact with undiagnosed partners

We encourage PHARMAC to further consider how these criteria will be implemented in practice, with funding for exposures through insertive anal sex restricted to only cover situations when the source is known to be living with HIV (with a detectable or unknown viral load), regardless of potential source community or country of origin background. The often-anonymous nature of exposures makes this impractical, therefore when the source is not contactable or chooses not to disclose their status then nPEP should still be made available. Furthermore, provision of nPEP should not be delayed while establishing the source status. For these reasons and for the clarity of criteria, we believe **nPEP should also be made available for insertive anal sex when the source is of unknown status but from a high-prevalence community (i.e. MSM) or country.**

Evidence for this includes:

- The ASHM guidelines (2016) estimate the risk of transmission per exposure to a source of unknown status is 1/1600 for insertive anal sex (uncircumcised) and 1/9000 for insertive anal sex (circumcised). They recommend nPEP be made available for each of these encounters if the source is from a high-prevalence community or country.
- The World Health Organisation guidelines state that in some cases patients who have a risk between 1 in 1000 and 1 in 10,000 may wish to consider nPEP, particularly if additional circumstances suggest increased risk (as determined by the epidemiology). Insertive anal sex therefore also falls within these criteria when with an individual from a high prevalence community or country.
- European AIDS Clinical Society (EACS) recommends nPEP initiation following exposure to viraemic HIV or a status-unknown source through both insertive or receptive anal sex in the presence of HIV risk factors (which may include high community prevalence).
- The necessity to disclose sexual practice with clinicians could be a barrier, with Ludlam et al. (2015) finding half of gay and bisexual men are not open with their GP about their sexual orientation or behaviour. These barriers were greater among non-European ethnicities, due to issues in accessing and navigating healthcare. This is especially a concern with receptive anal intercourse as it can be associated with shame for some individuals, and therefore this restriction could prevent some people coming forward. It has been suggested that disclosing receptive anal intercourse may be associated with additional stigma than experienced by other gay and bisexual men (McGill & Collins, 2015). This barrier is further underscored by feedback from patients accessing pre-exposure prophylaxis (PrEP) who report feeling shame at needing to disclose receptive anal sex to their GP.

While the risk of transmission from an unknown source for vaginal sex is typically low in the New Zealand context and nPEP is not recommended, ASHM (2019) state that some discretion is needed and **nPEP for vaginal sex should be considered if the source is a man who also has sex with men or from a high-prevalence country**. Similarly to the provisions we propose for insertive anal intercourse, we would encourage widening these criteria to reflect the higher community prevalence. This is especially pertinent to trans men having vaginal sex with men, as they are part of tightly networked communities and can practice similar risk behaviours to cisgender men who have sex with men.

Finally, we would encourage PHARMAC to reconsider the need for starter packs in more settings outside of the hospital and hospital pharmacy. With the cost of the medication reducing significantly, and its ability to now be prescribed by a much wider group of practitioners in more settings, **we seek clarification on the need for a restriction on this medication so that it cannot be requested through a practitioner's supply order**. Having nPEP available through sexual health clinics, emergency departments and after hours (urgent care) clinics would help to reduce any delay in accessing nPEP, which is important given the time-sensitive nature of the medication.

Yours sincerely,

Jason Myers
Chief Executive

REFERENCES

ASHM. (2016). National guidelines for post-exposure prophylaxis after non-occupational and occupational exposure to HIV. Available at: https://www.ashm.org.au/products/product/978-1-920773-47-2

ASHM. (2019). PrEP Guidelines Update. Prevent HIV by Prescribing PrEP. Sydney, 2019.

EACS Guidelines Version 9.1. (2018). Available at: https://www.eacsociety.org/files/2018_guidelines-9.1-english.pdf

Ludlam, A., Saxton, P., Dickson, N.P., & Hughes, A. (2015). General practitioner awareness of sexual orientation among a community and internet sample of gay and bisexual men in New Zealand. *Journal of Primary Health Care,* 7(3). 204-212.

McGill, C. M. and Collins, J. C. (2015), Creating Fugitive Knowledge Through Disorienting Dilemmas: The Issue of Bottom Identity Development. New Horizons in Adult Education and Human Resource Development, 27: 29-40.

Saxton, P.J., Hughes, A. J., & Giola, M. (2015). HIV prevention today: with coordinated action, we can end transmission. *New Zealand medical journal*, *128*(1426), 8-15.