

**HIV Post-Exposure Prophylaxis after Non-Occupational  
Exposure:**  
*Report and Recommendations for Provider Training and Toolkit  
And Patient Materials*

*New York City Alliance Against Sexual Assault*

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## **Introduction**

Sexual assault is a very traumatic experience for those who have had to endure it, and counseling around it is both critical and challenging. Counseling is critical for the patient who needs to receive vital information about their situation, and in some cases the information that can make a great difference in their lives after the assault. However, due to the trauma inherent to sexual assault, it is very challenging for the providers to strike a balance between empathizing with the patient and conveying important information around HIV Post-exposure Prophylaxis (PEP) – a very important component of care provided for people who have had exposure to HIV through occupational or non-occupational exposure including sexual assault. HIV infection has been known to occur after sexual assault but the exact rate is unknown due to ethical reasons around control study and the feasibility limitations given the low per contact transmission. This project focused primarily on PEP provided for non-occupational exposure (nPEP) including sexual assault.

Protection against exposure is still the most effective way of preventing HIV transmission, but this is not usually possible in cases of sexual assault. PEP is a 28-day treatment of combination antiretroviral drugs taken twice a day as a preventative measure against HIV infection after exposure. nPEP (post-exposure prophylaxis under the circumstances of non-occupational exposure), therefore becomes the next viable option in the face of unintended exposure. The efficacy of PEP has been widely debated, but its biological plausibility has been accepted based on scientific findings from data sources such as studies on case-controlled studies of occupational exposure, and animals with

exposure to the simian immunodeficiency virus (SIV), and mother-to-child transmission. Risk reduction was found to be brought down from 25.1 percent to 9.3 percent (CDC MMWR, January 2005).

The general procedure for administering care to a sexual assault patient, is that he/she first presents to the Emergency Room and would be seen by a medical provider or a Sexual Assault Forensic Examiner (where there is a SAFE or SART program) as the first point of contact who will then carry out a physical examination and discuss treatment option. For the programs that have Rape Crisis Advocates (RCAs), the patient would then get further support and counseling from the RCA. If the patient has opted for the HIV PEP treatment, then a physician (if the SAFE is not one) would then sign off on the prescription for an HIV PEP starter kit of approximately 4 days, which will be given to the patient at the ER with further instructions to visit the HIV Clinic for the rest of their HIV PEP medication supply. At the HIV Clinic, the patient is seen by a physician and may also be seen by a Social Worker for any other type of counseling. Consented baseline tests for HIV are conducted at the HIV Clinic and not at the ER to find out the HIV status of the patient prior to the assault, as a positive HIV status would require a different course of treatment from the PEP. The patient is required to return to the HIV Clinic to receive the results of his/her HIV test. The physician will discuss any lab test results with the patient. Then the patient receives the rest of their HIV PEP supply. The HIV Clinic will also provide subsequent HIV tests after the preliminary baseline HIV test, to check for any HIV infection from the actual assault.

This project sought to look at providers' (primarily the Sexual Assault Forensic Examiners who are the first point of contact with sexual assault survivors that present themselves for assistance and care at the Emergency Room of health facilities with SAFE programs) challenges in providing counseling around HIV PEP especially in the compounded case of sexual assault and to recommend a toolkit that would help to decrease the challenges. This project also sought to look at how patients find the information and materials they are given, and make recommendations that would improve the efficiency of the information materials that are given especially to the sexual assault survivors, who in a lot of cases, might find it particularly difficult to follow or retain the information given to them on their visit to the emergency room.

In looking at the issue of HIV nPEP and the related matter of low uptake, a recent study by Linden et al (July 2005) stressed the importance of follow-up of patients to ensure adherence to the medication. Only complete compliance has been said to have a greater effect on preventing infection. The study also addressed the HIV nPEP prescribing practices of providers and alluded to a statistically significant pattern of those who got offered nPEP as being exposed to an unknown assailant, had insurance, or were young. It is therefore important to look at how best to minimize any biases or differential treatment by ensuring that providers have the training and toolkit that can help them make these decisions, and that when patients decide to take HIV nPEP they have the information and follow-up required to ensure their complete adherence to the medication for the most effective results.

## **Methodology**

This project relied on various qualitative research methods in order to gather as much information as possible on existing provider training material and toolkits, and patient literature. These methods included: (i) in depth interviews with a variety of clinicians to gain a fuller picture of the way system works currently, and to see if gaps exist and how best to plug them with an efficient toolkit; (ii) a number of documents and publications on counseling and service provision around HIV PEP were examined; and (iii) locally, attempts were made to interview a couple of sexual assault and occupational patients who had undergone counseling and possibly taken the HIV PEP, but it was very difficult to get any to respond. The sexual assault survivors understandably, were not keen on speaking about their experience even though the assault itself was not going to be addressed in the planned interviews. However, a response was received by email from a survivor in South Africa who was willing to share her experience and suggestions on HIV nPEP. Where they exist, patient literature received was reviewed from different hospitals here in New York City, from other parts of the United States and other parts of the world.

## **Challenges/Barriers for Providers around HIV nPEP**

Based on interviews with a Sexual Assault Forensic Examiner, Rape Crisis Advocate Coordinator, Medical Director of an HIV Clinic, Social Worker, and a Survivor, the following challenges/barriers for providers emerged:

- Conveying information across to the survivor – All the interviewees mentioned this as one of the main challenges because of various factors –

- The state of mind of the patient – sometimes unstable at the time they present at the ER due to trauma, intoxication, etc, making it almost impossible for him/her to fully comprehend the information or instructions at that time.
- The knowledge of the physician in charge at the ER on the day – some physicians were said to be less knowledgeable on HIV or HIV PEP, than the counselors, so sometimes patients got conflicting messages. The counselor might try to tease out from the patient the HIV PEP information supposedly given by the physician, only to find it was not given.
- Occasional tension between the members of the team – where the advocate is trying to get the physician to inform the patient on HIV PEP and the physician is reluctant to do so, and it is the physician who can recommend it, not the advocate.
- Provider’s comfort level at addressing HIV or HIV PEP especially in non-occupational exposure cases. Providers seem to feel more comfortable dealing with and providing prophylaxis for Hepatitis-B, tetanus, sexually transmitted diseases, or pregnancy than with HIV PEP.
- Difficulty in assessing the risk level of some of the patients – either from the provider or the patient. There is the possibility of patients not remembering or relating all the details of the incident, and the possibility of wrongfully judging the risk level of the patient.
- “Implicit theories” –provider’s notions of what comprises risk. Despite the fact that HIV PEP should be mentioned as an option to patients by

law, some providers would rather not do so based on their own perceptions and their own attitudes towards the issue.

- Communication and counseling skills – There is the need to help clinicians develop communication skills such that they can strike the delicate balance between how much to tell the patient and how to tell them. The wrong approach could cause the patient to block out the information or balk at the best option treatment for him/her. The state guidelines requirement to mention the need for safer sex practices after the assault to the patient was only found in few of the facility guidelines for providers that were reviewed, which may indicate that they may not all be addressing that aspect.
- Cost of the antiretroviral drugs in the PEP kit may act as a deterrent to the provider mentioning or offering nPEP to a low risk patient. The cost of the 28-day regimen is approximately \$700 to \$1,000, and basically patients are not meant to pay for themselves. However, it is not consistent on who funds the treatment. Mostly, there is some coverage through the Crime Victims Board reimbursements for those not covered by private insurance or for the portion that their insurance cannot cover. Sometimes it is the hospital program that absorbs the cost, at other times it is the Community Health Department that covers the cost for the uninsured.
- Low uptake of or poor adherence to nPEP by the patient even when their risk level is considered high due to:
  - Patient's self-assessment of low risk being infected with HIV

- Poor counseling and support service around HIV nPEP
- Patient's poor or limited information on HIV nPEP
- Patient's non-tolerance of nPEP side-effects
- Poor follow-up system with sexual assault patients – Due to the nature of the cases, some patients do not want follow-up, however some of them are not in the best state of mind to consciously refuse it. From the interviews, it appeared that even the consent received from the patients can be questionable because the patients' state of mind is not usually stable at that point. If patients are started on HIV PEP starter packs for the first 4 days of the 28-day treatment, then it is important that they are helped to understand they need to return for the rest and adhere to the treatment for it to be effective.
- Lack of staffing to facilitate proper continuum of care around HIV PEP was an issue raised by smaller programs. While some of the better staffed and well established programs do not have this challenge, some facilities lack the personnel to follow through on the various aspects of care required by the sexual assault patient.

### **Existing Training and Toolkits for Providers**

In the United States, New York and California have recommended guidelines for providers offering HIV PEP after non-occupational exposure including sexual assault.

The World Health Organization also has guidelines for medico-legal care for victims of sexual violence, but suggests that providers defer to their local guidelines, which may be more relevant to their locations.

Many of the hospital facilities have produced their own toolkit for providers who counsel around HIV PEP. Some are very comprehensive – dealing with all prophylactic treatment to be made available to sexual assault survivors who present to the ER. These prophylactic treatments such as vaccination, emergency contraceptive, and antibiotics, and necessary tests are made for Hepatitis B, Tetanus, pregnancy (if the woman is of reproductive age and has not had permanent birth control), or sexually transmitted diseases, including antiretroviral for HIV prophylactic treatment. Others have dedicated material on HIV nPEP including counseling (even to the language used) scripts, checklists for what should be done in the process, consent and information materials to be explained to the patient including resources for the patients, and resources for the provider. A couple of the toolkits currently used had a clear chart of whose duty was what, and who to refer different aspects of the process to. Some just had a simple checklist of what should be covered in the process with the patient (and some had a complete packet which included consent sheets, with PEP medication info attached for the provider to use). From the interview findings, it showed that some SAFEs find these charts a little cumbersome. Checklists are thought to be very useful at the start of their SAFE responsibilities, and even though they refer to them less later on, they still find it useful to have just in case. For those who did not have a responsibility chart, they seemed to seek information or clarification in an ad hoc way, rather than a set down system. In one of the interviews, the interviewee did not seem clear about where to refer unusual/exceptional cases.

Some of the provider materials give information on how to assess the risk level of exposure since it is on this basis that nPEP is offered, rather than the HIV status of the assailant which may be unknown and difficult to get. High risk sexual exposures include unprotected receptive or insertive anal or vaginal intercourse, oral with ejaculation, and exposure to blood like from a bite from a known HIV positive assailant or if the HIV status is not known. Some further risk factors are also listed such as the trauma through forceful penetration, several sexual assailants, known drug user (past or present), an assailant known with multiple partners, men that have sex with men, and if the assailant or the victim has STDs. A guideline from South Africa included as high risk exposure when the victim is unconscious but does not deny sexual assault. Types of exposure where nPEP is not considered necessary by the New York and California guidelines include kissing, oral-to-oral contact, human bites with no blood, mutual masturbation, receptive penile-oral contact without ejaculation, insertive penile-oral contact, oral-anal contact, and oral-vaginal contact without blood exposure, ejaculation on intact skin, and digital or object penetration. Some of the providers guidelines from other states broke down the risk of exposure to “High”, “Low”, and “No” risk; or “Measurable”, “Possible” and “No” risk. One provider protocol included three categories - to “recommend” when assailant HIV status is known, to “offer” when there is a high risk, and to “consider” when there was low risk. Some of the hospital guidelines outside New York City gave instances where HIV nPEP should not be offered such as preventive medication for someone who is habitually exposing themselves. A situation which is nationally stated as not to offer HIV nPEP is for sexual assault victims who present after the 72-hour time

limit, because the nPEP is not effective then. Some of the provider guidelines encourages that primary prevention be mentioned in the counseling sessions.

While these protocols did well to let the providers know how to handle the patient when they come to the ER, there did not seem to be much information on how the rest of the system worked. In discussions with ER clinicians, these clinicians were not fully aware of the specifics of what the HIV clinic did, and vice versa. They knew generally that that was another major component in the system, but they did not know if they were giving similar messages, if there were any roles they had that were redundant, or if there were services that they assumed were handled by the other group and vice versa, which were not being handled.

The materials produced for providers by their various facilities may have some things in common, but also have different areas of focus which will then differ from facility to facility.

Some of the provider material had a lot of information which would be good to increase the providers' knowledge on HIV nPEP, but there where some meant for handy reference that still had too much information on them, which a SAFE that was interviewed had said she would not be keen on using because reading from the sheet would give the patient the feeling that the provider was not knowledgeable and therefore could not be trusted.

Training is mostly provided for Sexual Assault Forensic Examiners (SAFEs) in New York City through the New York City Alliance Against Sexual Assault. Some hospitals have further trained more SAFEs for their program. This has its dangers because if there is different training done by various facilities, the knowledge levels would differ, some important components of a more standardized training would be lost, and the patients would get different standards of care. This was found to be the case in Ontario, Canada, where services differed from province to province, and they worked towards standardizing the care through standardized guidelines. While there are a couple of state standardized guidelines in the United States, one of the interviewees who had not attended the standardized training, was not aware of a basic part of it, which must have been missed out in her facility-conducted training.

### **Existing Patient Information on HIV nPEP**

There were not a lot of patient information, and most of them had the problem of being too wordy or too technical. Most of the patient information sourced from various facilities tried to be comprehensive – touching on the rights of the survivor, their emotional situation, prophylactic treatments for other issues including HIV, technical language and information on the medication and its side effects. Some also mentioned some resources (personnel and financial) for the patients if they need it. There was also included when and where to go for their next appointment. For some of these materials, there was too much information that it would be easy for a patient to miss some of them. Some emboldened the important information, but then there seemed to be a lot of emboldened parts that it defeated the purpose. Many of the patient information seemed

more suited to the provider than to a patient. This may be as a result of the providers preparing these patient materials only with their understanding of what is important for the patient to know, than seeking and incorporating the feedback of the patients who are expected to use the materials. As was clearly stated by the survivor we reached, it is very important that patient materials be very simple and clear. A patient literature that currently exists which seem to have achieved this simplicity and user-friendliness is Women's Crisis Support in California colorful six-fold pamphlet titled "PEP – What You Need To Know", which addresses in a couple of sentences, questions such as what PEP is, why they should take it (including a brief statistics on risk of transmission), when to take PEP, what happens if they should stop taking it, what the side effects are, what to do after leaving the ER, where to get it (including important telephone numbers), any restrictions in taking PEP, where to get support (with contact details), and what to do if they decide not to take the PEP. Another patient literature that kept the language simple and yet gave comprehensive information was the booklet produced by AIDS Law Project in South Africa titled "Preventing HIV After Rape". The information addresses the needs of the patient in a way that anyone under any circumstances should be able to follow. Another observation was that some of the patient materials came only in English which would be a problem if a Spanish speaker or non-English speaking immigrant were to present at the ER with sexual assault exposure to HIV.

### **Recommendations for Toolkit and Training for Providers**

The State of California's guidelines on nPEP states "*The great disparity in availability of PEP in California is due to mostly to the lack of information and guidance available to*

*treatment providers.”* This will largely stand as the same situation in other locations and emphasizes the importance of getting the training and toolkits to the providers to enable them more efficiently carry out this sensitive task.

- A comprehensive toolkit with the information that applies to different aspects around HIV nPEP counseling should be produced. It would be most useful if this was done from a central point and disseminated to all facilities. This will ensure that there is more standardized information on HIV PEP available to all providers and provision of care to all sexual assault patients. This toolkit should include:

1. *A front sheet that serves as a procedural checklist* – A simple list of the process that the provider should go through in administering care to the patient.

*Good examples of existing material:* St. Luke’s Protocol on HIV nPEP

*Need to create new material:* Yes

*Ideas on how to create material:* Good examples can be looked at and modified by each hospital’s SAFE coordinator to suit their own facility. It would be best if this list can be further simplified and constrained to a page.

2. *A script for counseling around HIV to help with communicating with patients* – A script that will give guidance on what and how information should be conveyed to the patient.

*Good examples of existing material:* Procedures Manual (South Africa) Pilot Study (UCSF & University of Cape Town)

*Need to create new material:* Yes

*Ideas on how to create material:* It would be useful to have a script that providers can defer to, especially if they have any discomfort or communication challenges on the issue. The script can be tailored to be relevant to the location. A professional counselor can develop and test patient-appropriate words through focus group, and check for simplicity so that any literacy level can understand.

3. *Technical information for the provider* – This technical information is for the knowledge and better understanding of the provider. (NB: *The portion of the script for communicating information on medication to the patients would be very different from this provider technical information; the language with the patient will remain simple and free of technical jargon.*)

*Good examples of existing material:* Rhode Island Practitioners' Guidelines on HIV nPEP

*Need to create new material:* Maybe

*Ideas on how to create material:* The Rhode Island Practitioners' Guidelines is very comprehensive in giving the technical information the provider needs to dispense HIV nPEP, but it may require a further review by some HIV specialists to make sure that all the essential information required is covered, and by some sexual assault experts to ensure that all the criteria for treatment under the state guidelines are covered by this document for quality of care.

4. *Clinician guidelines for assessing risk levels* – This will help simplify the sensitive task of understanding if HIV nPEP is the appropriate treatment for the patient.

*Good examples of existing material:* Mercy/Unity SANE Program HIV Risk Assessment Tool (simple), and Rhode Island Practitioners' Guidelines (comprehensive) on HIV nPEP

*Need to create new material:* Maybe

*Ideas on how to create material:* These two documents are good examples of possible ways of assessing risk. A recommendation would be to have the simple one style handy for the provider while with patient, and the more comprehensive should be part of the more technical information for the better understanding of the provider. Sexual assault experts may have to review the content of both documents on criteria to ensure quality of care to the patient.

5. *Communication guidelines for clinicians* – This is just to give the provider tips on how to communicate with the patients in a simple way that can enable them make an informed decision on taking the HIV PEP.

*Good examples of existing material:* None found

*Need to create new material:* Yes

*Ideas on how to create material:* A trained counselor and or communicator can help put a brief sheet on communication tips targeted toward helping the provider build their communication skills and enabling them convey sensitive information to a possibly distraught patient.

6. *Information on how HIV PEP treatment cost is handled by that facility* – This helps the provider give the patient information on who is covering the cost of treatment in that program, so it does not deter the provider from offering the HIV nPEP, and also does not deter patients from taking the HIV nPEP if they need.

*Good examples of existing material:* Rhode Island Practitioners' Guidelines on HIV nPEP

*Need to create new material:* Yes

*Ideas on how to create material:* SAFE coordinators should research and give clear information on the financial resources available to the patient from within the facility (if applicable) and outside. The heads of SAFE programs may also seek to expand the funding options to cover HIV nPEP treatment to patients.

7. *A chart of who is responsible for the different roles in the system of counseling and treatment around HIV PEP* – This will help providers efficiently provide care to the patient by directing appropriately to where or who they can get relevant services from within the facility.

*Good examples of existing material:* Mount Sinai ED Sexual Assault Protocol

*Need to create new material:* Yes

*Ideas on how to create material:* The Mount Sinai document gives very comprehensive information on roles. However, a document that quickly gives the roles and responsibilities at a glance may be easier to use, especially while attending to a patient. Each role should have all its responsibilities listed under it

for easy reading. Also, it might be handy to have a pictorial version (chart). This should also help address the issues of loss to follow-up of patients, as any gaps in the care system will then be easily identified and plugged. Monitoring and follow-up are very important services for the nPEP – “*Clinicians should closely monitor people receiving nPEP to detect ARV-induced toxicities ...assess for adherence [and] drug tolerance*” – New York HIV nPEP Guidelines.

8. *A checklist of other components of the process* – This will help providers know the responsibilities and services of other parts of the system (e.g. the ER should know what exactly the HIV clinic handles, and vice versa) to enable smooth referrals especially in cases that present unusual situations.

*Good examples of existing material:* None found

*Need to create new material:* Yes

*Ideas on how to create material:* The head of the SAFE program in consonance with other members of the system should draw up a comprehensive list of responsibilities and services, and also produce a pictorial version.

9. *An internal resource sheet* – This will help providers make referrals in exceptional/unusual situations.

*Good examples of existing material:* None found

*Need to create new material:* Yes

*Ideas on how to create material:* This is different from a list of roles and corresponding responsibilities mentioned above. This tool will have the name and

contact of clinicians within the facility's system with their general areas of expertise that can help a provider know who to contact where an unusual situation is presented. It basically lets the provider know who will be in the best position to assist or respond to a peculiar case.

10. *An external resource list* – This will be helpful to the provider for referral purposes and helpful to the patient in accessing a wider range of services.

*Good examples of existing material:* SAVI Program at Mount Sinai Patient Information Packet

*Need to create new material:* Yes

*Ideas on how to create material:* Mount Sinai's SAVI Program resource list covers a comprehensive range of services, but this was produced for the patient. While it is important for the patient to have it, the provider should have it in their toolkit so they can highlight what is necessary for the patient and possibly set up referrals for the patient. Research should be done for reputable organizations (especially locally) that offer certain relevant services to sexual assault patients. Another aspect of the external resource list is that a wide range of local, national (and if relevant, international) resources (e.g. websites, experts, organizations) should be listed for where providers can get updated information on HIV nPEP and or services (consultancies).

- Training is another important issue because there is the need for providers to get the required training before they handle these sensitive cases:

- Programs must provide standardized training around HIV PEP. All SAFEs should attend the SAFE training provided by the Alliance to make sure that the level of knowledge and skills are uniform across the city. If hospitals find it challenging to send large numbers of staff for training at a time, then they could discuss a training-of-trainers session with the Alliance, where the skills and information needed to train others (and keeping the uniform focus) can then be delivered and transferred.
- Refresher courses or update meetings should be held from time to time. This would be particularly useful for those who may have been trained by a trainer in the hospital setting to make sure they are updated. One of the interviewees stated that these update meetings are already held in their hospital settings but it was really the responsibility of the provider to stay updated. While it is good for SAFE teams to meet within their hospital settings, it would be good for SAFEs from various facilities to meet occasionally to share information and possibly also get update/refresher training. New SAFE programs can find this very useful as they can pick up tips from more established SAFE programs.
- The attitudes of providers should be addressed by training. It may help providers to confront their own biases if a component of the training targeted that, and maybe overcome them. Statements in the New York nPEP guidelines and the World Health Organization's nPEP guidelines on cost-effectiveness in high risk situations [only] and caution in providing

nPEP should be clarified to providers so that this does not become a bias in their administering the treatment to patients.

- Providers may have the technical knowledge but if they lack the communication and counseling skills, it may be difficult for them to efficiently pass across the information patients need.
- SAFEs should meet with other personnel involved in the process of providing care for the sexual assault patient. They should from time to time meet with Rape Crises Advocates, physicians, social workers, and HIV clinic personnel, to better understand each other's roles, challenges, and possible better follow-up strategies – since that is one gap through which patients seem to fall when taking HIV PEP. For example, RCAs currently do general follow-up counseling, so it may be possible for them to include follow-up counseling around HIV PEP when they have access to the patients and it should be addressed in their training. The New York nPEP guidelines state that *“the rape crisis counselor may become the crucial link between the survivor and the provider, clarifying communication and facilitating follow-up care for the survivor ...[and] play a pivotal role in helping the survivor better understand the potential benefits of prophylaxis and its side effects, the complex dosing schedule, and the importance of adherence.”* Even within the HIV clinic, the physicians know they do not hand patient materials but they are not sure if the social workers working in the clinic give patients materials. There is a gap in flow of information, which may need to be addressed directly. A

component of the training should encourage facilities to bring all the personnel involved together occasionally and better sharing of information between the team members and the different units, thereby minimizing the weaknesses and utilizing their strengths.

- If possible, the Alliance should develop HIV nPEP training for all the physicians responsible for signing off on HIV PEP prescriptions at all SAFE programs, to give them a better understanding of what the nPEP is set to achieve and minimize any lack of knowledge or any attitudinal issues that they may have around HIV nPEP for sexual assault.

### **Recommendations for HIV nPEP patient material**

A survivor expressed the lack of interest in being counseled at that time because she is not in the state of mind to listen to all that information till later, so that shows how important easy-to-read information material can be.

- The New York nPEP guidelines states that “*nPEP be communicated simply and clearly to patient, considering his/her emotional state and ability to comprehend the nature of the ARV treatment.*” Patient material should have simple important messages in simple language so that anybody can read and understand it (e.g. AIDS Law Project booklet). Technical language and jargon should be left out because they may be overwhelming to a patient who is dealing with trauma and emotional instability.
- Patient pamphlets should be colorful to make it more attractive to pick up and read. Wordy information sheets may put the patient off, so length of information

should be kept to a minimum making it easy to read and remember (e.g. Women's Crisis Support's PEP pamphlet), and using different font sizes and color make it easier to follow.

- HIV PEP should have its own pamphlet and not be joined with others so that it can be singled out by the counselor and stressed, along with the appointment sheet for the next day at the HIV clinic. When it is buried in the midst of other information, it may get overlooked. The patient may focus on his/her right and how to best deal with their emotional issues, which are important, but may not deem the PEP treatment worthy of the same attention. The PEP information should be short and simple enough for a counselor to walk through with the patient and be handed to the patient when they are given their medication.
- The most important information such as the fact that they have received a starter pack and the need for adherence should be highlighted if there is a lot of other information on the sheet, so that it is clear that they need to pay attention to that.
- Patient material should be available in other languages especially where there are large groups of the population who speak a foreign language, so as to be able to cater to any patient from those groups. For facilities in New York City, it is important they have Spanish copies of patient literature. The New York State Department of Health found it important to produce Emergency Contraceptive pamphlets for rape survivors in 11 languages and should do same for HIV nPEP.
- Patient literature should be available in all SAFE programs. It is important that the patients have something they can read later on that might help them further understand what they have been told in the ER or the HIV clinic.

- It may be necessary to get a standardized HIV literature produced with the input of survivors to make sure that it is literature that patients can easily understand. The literature can also be produced from a central point and disseminated to all SAFE programs, because where they do not exist, it may be that there is no capacity to produce it in-house, and where they do exist but are too technical it may also be attributed to the same. The Alliance could partner with the New York State AIDS Institute to design a package which the drugs go into, which would also include the PEP information pamphlet and the appointment card with important contact numbers. This will ensure that the patient has information with the medication and vital contact information all in one package.
- The starter packs can have a simple sticker on the cover that states that it is a starter pack and they should return for the rest, with a number for them to call. Even if they abandon the literature, when they pick up the pack they must see that sticker, which is a constant reminder.
- If there is a designated area for sexual assault patients, it may be possible to produce a simple video that gives the vital information on HIV nPEP which can be watched while they are waiting for a part of the process. It may help to get some of the information through.

## **Conclusions**

While it may not be possible to act on all these recommendations, working on them would yield positive results. These recommendations have been made in consonance with what the current literature around nPEP had to say, and the findings from the interviewees.

HIV nPEP is a very important preventive strategy that can seem overwhelming and intimidating, so anything to make it less challenging for providers and patients to deal with, the better for all involved.

## **Appendices attached:**

- Focus Group Guide
- Provider Interviews
- Survivor Response