Post-exposure ARV-based prophylaxis (PEP) is approved for use in Europe and should be started as soon as possible after HIV risk exposure, but always within 48/72 hours.[1,2]

Treatment should be continued for 28 days, unless the possible source of HIV infection is determined to be HIV negative. PEP has consistently been shown to reduce HIV transmission in animal studies and was originally introduced to reduce transmission following needle stick injuries. Apart from occupational PEP and PEP in situations of sexual assault, in most countries PEP is also recommended to individuals having had anal (or vaginal) intercourse without a condom with partner of unknown HIV serostatus or HIV positive with detectable viral load, seeking care within 48/72 hours.[3]

The most common use of non-occupational PEP is in discordant couples (where the index partner is not on ART or has not achieved undetectable level of viral load) due to condom breakage or failure. Most European guidelines also specifically include individuals having had unprotected receptive anal intercourse with a homosexual or bisexual man of unknown HIV-status (with or without presence of HIV risk factors) as eligible for PEP. In 2015, based on the results of the PARTNER study, the EACS recommendations on PEP were revised to reflect that if an HIV-positive source person has documented undetectable plasma HIV-RNA, PEP is no longer recommended.[4]

PEP has not been associated with an increase in high-risk sexual behaviour among MSM, and has rarely been promoted as a main prevention method to the MSM population.[5] Awareness of PEP and perceived access to PEP is low among MSM in most European countries, indicating that PEP is not a first-line prevention intervention. A Danish study showed only a modest increase in requests for PEP despite having a PEP-knowledgeable MSM population and easy access to the

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[1] European AIDS Clinical Society. EACS Guidelines, Version 8.0. June 2016 (www.eacsociety.org/files/guidelines_8.0-english-revised_20160610.pdf)

[2] British Association for Sexual Health and HIV. UK Guideline for the use of HIV Post-Exposure Prophylaxis Following Sexual Exposure (PEPSE), 2015 (www.bashh.org/documents/HIV%20PEPSE%202015%20Consultation%20Doc.pdf)

[3] European Centre for Disease Prevention and Control. HIV and STI prevention among men who have sex with men. Stockholm: ECDC; 2015. http://ecdc.europa.eu/en/publications/Publications/hiv-sti-prevention-among-men-who-have-sex-with-men-guidance.pdf

[4] European AIDS Clinical Society. EACS Guidelines, Version 8.0. June 2016

[5] Martin JN, Roland ME, Neilands TB, Krone MR, Bamberger JD, Kohn RP, et al. Use of postexposure prophylaxis against HIV infection following sexual exposure does not lead to increases in high-risk behavior. AIDS. 2004.

treatment.[6] A study evaluating Amsterdam's PEP program found a similar trend of a very modest increase in PEP requests, however 75% of requests were from MSM. In EMIS, less than 2% of respondents in 26 of the 38 countries included reported ever having accessed PEP; the remaining countries reported slightly higher use, with respondents in France reporting the highest use, still only 9%.[7] The low use of PEP in most European settings could be explained by low awareness or low perceived needs. Access is also an important issue and in the 2010 EMIS survey, about one-third of European countries reported that PEP could not be accessed for free.[8]

Questionnaire on PEP use distributed among Network of Low HIV Prevalence Countries in Central and South East Europe (NeLP)[9] members in June 2016 documents that the **issue of access to PEP is even more critical in the region of Central and South East Europe**. While in all NeLP countries PEP is available in case of occupational exposure, in four countries it was reported as unavailable in case of sexual exposure (Albania, Bulgaria, Hungary and Macedonia). Out of 17 participating NeLP countries, **PEP can be accessed for free in case of non-occupational exposure only in seven countries** (Austria, Croatia, Cyprus, Greece, Montenegro, Serbia and Slovenia), which is considerably less than in Western Europe where PEP is available free of charge after sexual exposure in almost all countries (Belgium, Denmark, France, Germany, Ireland, Italy, Luxembourg, the Netherlands, Norway, Portugal, Spain, Sweden, Switzerland and the UK).

There is a large variation across Europe with respect to how often PEP is considered and prescribed for HIV prevention. **Among NeLP countries only two countries reported more than 100 PEP prescriptions per year** (Poland/250 and Greece/500). The case of Greece is in particular relevant to other NeLP countries as it demonstrates that even if PEP is available free of charge in case of sexual exposure, its use is still low and unlikely to cause a significant financial burden to the public health budgets. This finding is consistent with EMIS 2010 study, which included other European regions as well. High cost of PEP should, therefore, not be a major obstacle for PEP prescription.

In the NeLP region PEP is most often prescribed by HIV specialists. However, a lesson learnt from countries where PEP is available free of charge in

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[6] Lunding S, Katzenstein TL, Kronborg G, Lindberg JA, Jensen J, Nielsen HI, et al. The Danish PEP registry: experience with the use of postexposure prophylaxis (PEP) following sexual exposure to HIV from 1998 to 2006. Sex Transm Dis. 2010

[7] The EMIS Network. EMIS 2010: The European Men-Who-Have-Sex-With-Men Internet Survey: Findings from 38 countries. Stockholm: 2013.

[8] Ibid.

[9] www.nelp-hiv.org

case of sexual exposure suggests that given PEP's very limited time window for its effective use (PEP to be started ideally < 4 hours after the exposure, and no later than 48/72 hours), general practitioners and/or emergency room staff should also be authorized to prescribe PEP.

In the Czech Republic that largest sub-population group among new HIV diagnosed cases are MSM (78,2 % in 2015).[10] Czech AIDS Help Society advocates that MSM who have been exposed to HIV – regardless of the reason for exposure – have a right to be informed about all potential interventions, including knowledge about what PEP is and where it can be obtained. PEP should be available free of charge to all MSM exposed to HIV regardless the mode of exposure. Free of charge PEP prescription cannot be denied on moral grounds - EMIS findings suggest that condom accidents and a consistent lack of knowledge on how to use condoms correctly, rather than carelessness, are associated with exposure to HIV and related experience of PEP.[11]

We also strongly support the ECDC Guidance suggesting that knowledge about PEP should be promoted to MSM and that PEP should be provided at clinics targeting MSM or sexual health where feasible. PEP should be offered to MSM having had sex without a condom with a HIV positive partner of unknown viral load status, and additionally to MSM who have had receptive anal sex with a partner of unknown HIV status and who seek care within 48–72 hours.

[10] Annual HIV Report, National AIDS Reference Laboratory, State Public Health Institute 2015, www.szu.cz/tema/prevence/rocni-zpravy-o-vyskytu-a-sireni-hiv-aids-v-cr

[11] The EMIS Network. EMIS 2010: The European Men-Who-Have-Sex-With-Men Internet Survey: Findings from 38 countries. Stockholm: 2013.

Summary of questionnaire results

n=17	PEP available in case of		Free of charge for		Prescribed by	Number of prescriptions in the last year		Comments
	Occupational exposure	Sexual exposure	Occupational exposure	Sexual exposure				
Albania	Y	N	N	N	HIV specialists	up to 4		
Austria	Y	Y	Y	Y	HIV specialists, GPs			
Bosnia and Herzegovina	Y	Y	Y	N		3 to 5		
Bulgaria	Y	N	Y	N	HIV or epidemiology specialists	1 to 2		
Croatia	Y	Y	Y	Y	Infectious diseases specialists	14	8 occupational, 6 non-occupational	Copayment of 20% for those without supplementary health insurance.
Cyprus	Y	Y	Y	Y	HIV specialists	up to 30		
Czech Republic	Y	Y	Y	N	HIV specialists			Free of charge PEP can be prescribed only by HIV specialists, any other MD can prescribe a paid PEP
Greece	Y	Y	Y	Y	HIV specialists and emergency room staff	500		
Hungary	Y	N	Y	N	HIV specialists			
Macedonia	Y	N	N	N				
Montenegro	Y	Y	Y	Y	HIV specialists	up to 10		
Poland	Y	Y	Y	N	HIV specialists	250		
Romania	Y	Y	Y	N	HIV specialists, infectious diseases specialists	65	58 occupational, 7 non-occupational	Sexual exposure prescription limited to serodiscordant couples
Serbia	Y	Y	Y	Y	HIV specialists			
Slovakia	Y	Y	Y	N	HIV specialists	up to 10		
Slovenia	Y	Y	Y	Y	HIV specialists	up to 5		
Turkey	Y	Y	N	N	Infectious diseases specialists			