Éditorial/Editorial

Research indicates that the medications used to treat an HIV infection can also be used to prevent a person who has been exposed to HIV from seroconverting, i.e., from becoming HIV-positive. Because it takes 48 to 72 hours before HIV is detectable in a person's regional lymph nodes, the immediate period after HIV exposure constitutes an important window when these medications can be used for HIV post-exposure prophylaxis (henceforth referred to as HIV PEP). While the evidence about this prevention strategy is far from perfect, research involving occupational exposures to HIV (e.g., needle-stick injuries), animal model studies for sexual exposure to HIV, and case reports indicate that HIV PEP induces an 80% reduction in HIV seroconversion after exposure to HIV. Accordingly, international recommendations suggest the use of HIV PEP in all cases of exposure to HIV, whether the exposure occurred through sexual contact or otherwise. Guidelines to structure this intervention exist in the United States, the United Kingdom, and Austalia. In Canada, however, no such guidelines for HIV PEP exist.

Of even greater concern in the Canadian context is that HIV PEP is expensive, totalling approximately $1650CAD for the required 28-days of treatment. For individuals with private medical insurance that partially or completely covers pharmaceuticals, such costs are diminished. For example, a private insurance plan that covers 90% of medication costs still leaves a person paying $165CAD out-of-pocket. While this new figure is greatly improved, it may still constitute a significant enough barrier to prevent some persons who require HIV PEP from accessing a prevention strategy that will reduce their subsequent potential for HIV seroconversion.

To alleviate such financial barriers to HIV PEP, in some jurisdictions, these medications are publicly funded; e.g., after occupational exposures. Another situation where HIV PEP is often dispensed without charge is sexual assault. In these situations, the person who was sexually assaulted is typically offered and provided with HIV PEP medications at no cost to them.

However, unless it relates to a sexual assault, opportunities to obtain publicly funded HIV PEP are not afforded to gay, bisexual, and other men who have sex with men, notwithstanding the fact that, in Canada, nearly 50% of all new and previous HIV diagnoses involve a man who has sex with men. This situation constitutes not only an outright mismanagement of an effective HIV prevention strategy, but also it constitutes a blatant disregard for the health and wellbeing

of gay, bisexual, and other men who have sex with men. Indeed, these highly expensive but efficacious medications are provided in many situations when HIV exposure is limited, but they are not subsidized in the more likely cases when a gay, bisexual, or man who have sex with men is potentially or actually exposed to HIV. Therefore, men who have sex with male partners who are serodiscordant—i.e., one partner is HIV-positive and the other is HIV-negative—are not granted this opportunity. Similarly, men who have had casual sex with a male partner of unknown HIV status are equally not given access to financially subsidized HIV PEP, even though they, again, are more likely than many other persons to be exposed to HIV.

An additional barrier to HIV PEP is that, almost everywhere in Canada, these medications can only be obtained by visiting a local emergency department, which involves a potential wait for access and the requirement to explain to an emergency room physician, registered nurse, or nurse practitioner the reason for requiring HIV PEP; i.e., a person needs to detail their HIV exposure. While an emergency room visit for an occupational exposure to HIV may not deter many persons from accessing HIV PEP, the situation is markedly different for sexual exposures to HIV. Research highlights that many persons avoid accessing HIV PEP due to fears, or previous experiences, of stigmatization by emergency room staff when they explain that their potential HIV exposure occurred through sexual contact. These concerns and experiences of stigmatization are exacerbated for persons who are non-heterosexual, thus exacerbating the inaccessibility of HIV PEP for many gay, bisexual, and other men who have sex with men.

In Canada, the outcome of the current situation surrounding HIV PEP is that these medications, which constitute an important and effective HIV prevention strategy, are otherwise inaccessible by some of the persons who require access to them most. Because gay, bisexual, and other men who have sex with men are most affected by HIV, and therefore are most likely to become infected with HIV based on enhanced exposure probabilities, it is important that HIV PEP becomes readily available. To accomplish such an undertaking, two changes are required. First, HIV PEP would need to be financially subsidized to ensure equal and equity access to these medications, and, second, the delivery of HIV PEP would need to become community-based. The latter modification to healthcare service delivery should diminish the deterrent effects that emergency rooms have on some gay, bisexual, and other men who have sex with men's willingness to access care. In the absence of these changes, the current healthcare system will remain biased against a subset of men who are unequally burdened by HIV in Canada.

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