

March 30, 2005

Dr. Julie Gerberding
Centers for Disease Control and Prevention
1600 Clifton Road
Atlanta, GA 30333

Dear Dr. Gerberding,

We are writing as representatives of a group of over 100 community prevention providers and advocates in response to current CDC recommendations on post-exposure prophylaxis (PEP) to people exposed in non-occupational settings.

We agree that access to PEP should not be limited to those exposed due to their occupation and commend the CDC for their progress in this area. We would like to share our concerns and recommendations about the implementation of broader access to PEP, as follows:

1) PEP must be accompanied by information, training and guidance to community service providers.

Providers must be aware of the complexities of PEP, including the restrictions on its use and the serious side effects that may accompany it. It is not clear to us, at this point, how community providers will be expected to determine who is eligible to receive PEP; these considerations must be made with strong community involvement and be open to adaptation and interpretation. Though it is easy to draw a parallel between emergency contraception and PEP, the two are markedly different for a number of reasons, and this must be made clear both to community service providers and communities affected by or at risk for HIV.

We also feel strongly that information and training regarding PEP must be provided to first responders to survivors of sexual violence. This includes all levels of health care workers, police officers, rape crisis counselors and community support providers.

2) PEP must not be implemented at the expense of other prevention efforts.

We are interested to learn how CDC views PEP within the context of Advancing HIV Prevention (AHP) and other ongoing prevention efforts. We believe that additional funds should be allocated for PEP and related services, and that already limited AHP funds not be reallocated for this purpose. Though a useful tool, PEP cannot take the place of effective and consistent behavioral prevention interventions. We are concerned that a redistribution of AHP funds to include PEP will put already-meagerly funded prevention programs under greater strain.

3) There must be high-level and consistent community involvement in strategies for rolling out and evaluating the provision of PEP.

Involving at-risk communities must be done in a culturally competent way that does not jeopardize the communities. We are concerned that the appearance of a “morning-after” drug for HIV exposure could have misleading and damaging effects in communities most at risk of HIV.

Basic access issues present a significant barrier to many communities at high risk for HIV transmission. People already marginalized from health care systems face greater challenges in accessing PEP within 72 hours after possible transmission. We feel that not only must PEP be made available at all levels of community health care, but it must be offered as part of a comprehensive HIV prevention package, including counseling, risk reduction, and harm reduction services.

We recommend that communities affected by and at risk of HIV help plan and implement operational research to determine how PEP will be received and the feasibility of its provision in diverse community settings. In addition, community organizations must be providers, as well as evaluators, of PEP.

4) There are significant challenges to making PEP more broadly available through reliable and transparent mechanisms, with questions of infrastructure and financing to be addressed.

We feel it is imperative that PEP be made available in prisons and jails, as well as through clinics, emergency rooms, and different medical sub-specialties. It is important that we address issues of funding, such as whether PEP will be covered by Medicaid, private health insurance, and/or other existing public health financing mechanisms. We would like to further discuss the role of CDC in facilitating increased resources for PEP provision.

Greater availability of tools for HIV prevention is a goal we all share, and we are pleased the CDC has clarified a policy for greater accessibility to PEP. However, we feel the contextual issues surrounding HIV prevention must be taken into account and at-risk communities must have a voice in deciding implementation procedures.

We are asking that the CDC convene an open meeting with ourselves and other community providers and advocates to discuss these concerns and to set an agenda for moving forward with PEP as a tool for HIV prevention.

Sincerely,

Julie Davids
Executive Director
Community HIV/AIDS Mobilization Project

Mark McLaurin
Director of Federal Affairs
New York AIDS Coalition

CC: Ron Janssen, Director, Division of HIV/AIDS Prevention, CDC
Janet Cleveland, Deputy Director of Prevention Programs, Division of HIV/AIDS Prevention, CDC