AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: (Assigned by HOD)
(A-26)

Introduced by: Women Physicians Section

Subject: Ensuring Access to Full HIV Post-Exposure Prophylaxis (PEP) Courses for Survivors of Sexual Assault

Referred to: Reference Committee (Assigned by HOD)

Whereas, it is estimated that 1.2 million people in the United States are living with HIV, yet about 1 in 8 people do not know they have the disease[1]; and

Whereas, the CDC reported that 56% of new HIV diagnoses in 2022 were amongst people aged 13-24 years old[2]; and

Whereas, post-exposure prophylaxis (PEP) uses antiretroviral (ARV) medications to reduce the risk of human immunodeficiency virus (HIV) transmission when initiated within 72 hours of exposure[3]; and

Whereas, completion of a full 28-day HIV post-exposure prophylaxis (PEP) regimen is recommended to maximize effectiveness in preventing HIV infection[3]; and

Whereas, individual studies demonstrate variable uptake and completion rates, including acceptance rates near 59–62% in some settings and completion rates ranging from approximately 29% to 66% across cohorts[4,5,6,7]; and

Whereas, strategies such as dispensing medication before discharge, providing trauma-informed counseling, and ensuring coverage of the full PEP regimen have been identified as mechanisms to improve adherence and reduce barriers[3]; and

Whereas, financial barriers, insurance status, trauma-related decision-making challenges, and logistical barriers contribute to failure to initiate or complete prescribed PEP regimens[1,4,5,6]; and

Whereas, up to 69% of sexual assault survivors are between the ages of 12-34 years of age[10]; and

Whereas, survivors of sexual assault may be exposed to HIV, with estimated per-act transmission risks of approximately 0.1–0.2% for vaginal assault and 1–3% for anal assault when assailant HIV status is unknown, and trauma or concurrent sexually transmitted infections may increase transmission risk[8,9]; and

Whereas, sexual assault survivors experience some of the lowest PEP completion rates among exposure groups, with approximately 40% completing a full regimen in meta-analysis studies and substantially lower completion documented in some U.S. cohorts[3,4]; and

Whereas, sexual contact through unprotected intercourse with an infected partner remains the most common method of HIV spread[11]; and

Whereas, although HIV transmission after sexual assault is relatively uncommon, documented seroconversions have occurred and longitudinal studies demonstrate increased HIV acquisition risk among sexual assault survivors compared with unexposed populations[9,12,13]; and

Whereas, women account for approximately 18–19% of new HIV diagnoses in the United States, with persistent racial disparities disproportionately affecting Black women, underscoring the importance of equitable access to HIV prevention strategies following sexual assault[14]; and

Whereas, some jurisdictions, including New York State, now require hospitals to provide a full 28-day HIV PEP regimen to sexual assault survivors to reduce structural barriers to completion[15]; therefore be it

RESOLVED, that our American Medical Association encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault; and be it further

RESOLVED, that our AMA amend H-20.900 “HIV, Sexual Assault, and Violence” as follows:

> Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested ~~in six months~~ at recommended intervals consistent with current clinical guidelines if the initial test is negative, and that strict confidentiality of test results be maintained; and
>
> (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, ~~and~~ (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use, and (c) encourages hospitals, health systems, and affiliated payers to consider policies ensuring provision of the full recommended course of HIV post-exposure prophylaxis for survivors of sexual assault

Fiscal Note: (Assigned by HOD)

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RELEVANT AMA POLICY

8.1 Routine Universal Screening for HIV

Physicians' primary ethical obligation is to their individual patients. However, physicians also have a long-recognized responsibility to participate in activities to protect and promote the health of the public. Routine universal screening of adult patients for HIV helps promote the welfare of individual patients, avoid injury to third parties, and protect public health.

Medical and social advances have enhanced the benefits of knowing one's HIV status and at the same time have minimized the need for specific written informed consent prior to HIV testing. Nonetheless, the ethical tenets of respect for autonomy and informed consent require that physicians continue to seek patients' informed consent, including informed refusal of HIV testing.

To protect the welfare and interests of individual patients and fulfill their public health obligations in the context of HIV, physicians should:

(a) Support routine, universal screening of adult patients for HIV with opt-out provisions.
(b) Make efforts to persuade reluctant patients to be screened, including explaining potential benefits to the patient and to the patient's close contacts.
(c) Continue to uphold respect for autonomy by respecting a patient's informed decision to opt out.
(d) Test patients without prior consent only in limited cases in which the harms to individual autonomy are offset by significant benefits to known third parties, such as testing to protect occupationally exposed health care professionals or patients.
(e) Work to ensure that patients who are identified as HIV positive receive appropriate follow-up care and counseling.
(f) Attempt to persuade patients who are identified as HIV positive to cease endangering others.
(g) Be aware of and adhere to state and local guidelines regarding public health reporting and disclosure of HIV status when a patient who is identified as HIV positive poses significant risk of infecting an identifiable third party. The doctor may, if permitted, notify the endangered third party without revealing the identity of the source person.
(h) Safeguard the confidentiality of patient information to the greatest extent possible when required to report HIV status.

[Issued: 2016]

H-20.920 HIV Testing

(1) General Considerations
a) Persons who suspect that they have been exposed to HIV should be tested so that appropriate treatment and counseling can begin for those who are seropositive;
b) HIV testing should be consistent with testing for other infections and communicable diseases;
c) HIV testing should be readily available to all who wish to be tested, including having available sites for confidential testing;
d) The physician's office and other medical settings are the preferred settings in which to provide HIV testing;
e) Physicians should work to make HIV counseling and testing more readily available in medical settings.
(2) Informed Consent Before HIV Testing
a) Our AMA supports the standard that individuals should knowingly and willingly give consent before a voluntary HIV test is conducted, in a manner that is the least burdensome to the individual and to those

administering the test. Physicians must be aware that most states have enacted laws requiring informed consent before HIV testing;
b) Informed consent should include the following information: (i) patient option to receive more information and/or counseling before deciding whether or not to be tested and (ii) the patient should not be denied treatment if they refuse HIV testing, unless knowledge of HIV status is vital to provide appropriate treatment; in this instance, the physician may refer the patient to another physician for care;
c) It is the policy of our AMA to review the federal laws including the Veteran's Benefits and Services Act, which currently mandates prior written informed consent for HIV testing within the Veterans Administration hospital system, and subsequently to initiate and support amendments allowing for HIVtesting without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with HIV in federally operated health care facilities;
d) Our AMA supports working with various state societies to delete legal requirements for consent to medically indicated HIV testing that are more extensive than requirements generally imposed for informed consent to medical care.
(3) HIV Testing Without Explicit Consent
a) Explicit consent should not always be required prior to HIV testing. Physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
b) General consent for treatment of patients in the hospital should be accepted as adequate consent for the performance of HIV testing;
c) Model state and federal legislation should be developed to permit physicians, without explicit informed consent and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection;
d) Our AMA will work with the Centers for Disease Control and Prevention, the American Hospital Association, the Federation, and other appropriate groups to draft and promote the adoption of model state legislation and hospital staff guidelines to allow HIV testing of a patient maintaining privacy, but without explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids; and to allow HIV testing, without any consent, where a health care worker has been placed at risk by exposure to body fluids of a deceased patient.
(4) HIV Testing Procedures
a) Appropriate medical organizations should establish rigorous proficiency testing and quality control procedures for HIV testing laboratories on a frequent and regular basis;
b) Physicians and laboratories should review their procedures to assure that HIV testing conforms to standards that will produce the highest level of accuracy;
c) Appropriate medical organizations should establish a policy that results from a single unconfirmed positive ELISA test never be reported to the patient as a valid indication of HIV infection;
d) Appropriate medical organizations should establish a policy that laboratories specify the HIV tests performed and the criteria used for positive, negative, and indeterminate test results;
e) Our AMA recommends that training for HIV blood test counselors encourage patients with an indeterminate Western blot to be advised that three-to-six-month follow-up specimens may need to be submitted to resolve their immune status. Because of the uncertain status of their contagiousness, it is prudent to counsel such patients as though they were seropositive until such time as the findings can be resolved.
(5) Routine HIV Testing
a) Routine HIV testing should include appropriate informed consent and pre-test and post-test counseling procedures;
b) State medical associations should work to create state laws that encourage hospitals and other medical facilities to initiate routine HIV testing programs; and
c) Supports coverage of and appropriate reimbursement for routine HIV testing by all public and private payers.
(6) Opt-out HIV Testing
a) Opt-out HIV testing should be provided with informed consent for individuals who may have come into contact with the blood, semen, or vaginal secretions of an infected person in a manner that has been shown to transmit HIV infection. Such testing should be encouraged for patients for whom the physician's knowledge of the patient's serostatus would improve treatment. Opt-out HIV testing should be regularly provided for the following types of individuals who give an informed consent: (i) patients at sexually transmissible disease clinics; (ii) patients at drug abuse clinics; (iii) individuals who are from areas with a

high incidence of AIDS or who engage in high-risk behavior and are seeking family planning services; and (iv) patients who are from areas with a high incidence of AIDS or who engage in high-risk behavior requiring surgical or other invasive procedures;
b) The prevalence of HIV infection in the community should be considered in determining the likelihood of infection. If opt-out HIV testing is not sufficiently accepted, the hospital and medical staff may consider requiring HIV testing.
(7) Mandatory HIV Testing
a) Our AMA opposes mandatory HIV testing of the general population;
b) Mandatory testing for HIV infection is recommended for (i) military personnel; (ii) donors of blood and blood fractions; breast milk; organs and other tissues intended for transplantation; and semen or ova for artificial conception;
c) All entrants into federal and state prisons should be offered HIV screening, but it should only be mandatory when risk factors are present;
d) Our AMA will review its policy on mandatory testing periodically to incorporate information from studies of the unintended consequences or unexpected benefits of HIV testing in special settings and circumstances.
(8) HIV Test Counseling
a) Pre-test and post-test voluntary counseling should be considered an integral and essential component of HIV testing. Full pre-test and post-test counseling procedures must be utilized for patients when HIV is the focus of the medical attention, when an individual presents to a physician with concerns about possible exposure to HIV, or when a history of high-risk behavior is present;
b) Post-test information and interpretation must be given for negative HIV test results. All negative results should be provided in a confidential manner accompanied by information in the form of a simple verbal or written report on the meaning of the results and the offer, directly or by referral, of appropriate counseling and potentially pre-exposure prophylaxis treatment;
c) Post-test counseling is required when HIV test results are positive. All positive results should be provided in a confidential face-to-face session by a professional properly trained in HIV post-test counseling and with sufficient time to address the patient's concerns about medical, social, and other consequences of HIV infection.
(9) HIV Testing of Health Care Workers
a) Our AMA supports routine voluntary HIV testing of physicians, health care workers, and students in appropriate situations;
b) Employers of health care workers should provide, at the employer's expense, serologic testing for HIV infection to all health care workers who have documented occupational exposure to HIV;
c) Our AMA opposes HIV testing as a condition of hospital medical staff privileges;
d) Physicians and other health care workers who perform exposure-prone patient care procedures should know their immune or infection status with respect to HIV.
(10) Counseling and Testing of Pregnant People for HIV
Our AMA supports the position that there should be universal HIV testing of all pregnant people, with patient notification of the right of refusal, as a routine component of perinatal care, and that such testing should be accompanied by basic counseling and awareness of appropriate treatment, if necessary. Patient notification should be consistent with the principles of informed consent.
(11) HIV Home Test Kits
a) Our AMA does not oppose HIV home collection test kits that are linked with proper laboratory testing and counseling services, provided their use does not impede public health efforts to control HIV disease;
b) Standardized data should be collected by HIV home collection test kit manufacturers and reported to public health agencies.
(12) College Students
Our AMA encourages undergraduate campuses to conduct confidential, free HIV testing with qualified staff and counselors.
[CSA Rep. 4, A-03; Appended: Res. 515, A-06; Reaffirmed: BOT Rep. 1, A-07; Appended: Res. 506, A-10; Modified: CSAPH Rep. 01, A-20; Modified: Speakers Rep. 02, I-24]

H-20.918 Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission
In view of the significance of the finding that treatment of HIV-infected pregnant people with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

(1) Given the prevalence and distribution of HIV infection among individuals in the United States, the potential for effective early treatment of HIV infection, and the significant reduction in perinatal HIV transmission with treatment of pregnant people with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all individuals. The ideal would be for all people to know their HIV status before considering pregnancy.

(2) Universal HIV testing of all pregnant people, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.

(3) The final decision about accepting HIV testing is the responsibility of the patient. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for patients and their infant.

(4) To assure that the intended results are being achieved, the proportion of pregnant people who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of patients accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.

(5) Pregnant people who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.

(6) When HIV infection is documented in a pregnant person, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for their own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to the infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to the patient and the infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for the patient and their infant is the right and responsibility of the patient. When the serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.

(7) Appropriate medical treatment for HIV-infected pregnant people should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the patient presents for prenatal or intrapartum care.

(8) To facilitate optimal medical care for pregnant people and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both individuals. Ideally, this information will be included in the confidential medical records. Physicians providing care for a pregnant person or their infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the pregnant patient and their infant, consistent with applicable state law.

(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for patients presenting in labor and those presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both pregnant patients and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected pregnant people, should be maintained.
[CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Speakers Rep. 02, I-24]

H-80.998 Sexual Assault Survivor Services
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
[Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17]

H-80.991 Coverage for Care for Sexual Assault Survivors
Our American Medical Association advocates for federal and state efforts to reduce financial barriers that limit sexual assault survivors' ability to seek physical and mental health care and social services after sexual assault, including funds to cover emergency, acute inpatient, and follow up services including testing, medications, and counseling without out-of-pocket costs for any patient.
[Res. 805, I-24]

H-20.900 HIV, Sexual Assault, and Violence
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.
[CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18]