



Government of South Australia
Department of Health

Communicable Disease Control Branch (CDCB)

Non-Occupational Post-Exposure Prophylaxis (nPEP) for HIV

**Standard Operating Procedure 1
Telephone triage**

*Providing telephone triage after non-
occupational exposure to HIV*

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Non-Occupational Post-Exposure Prophylaxis (nPEP) for HIV
Standard Operating Procedure 1 - Telephone triage
Providing telephone triage after non-occupational exposure to HIV

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1. Introduction

This Standard Operating Procedure (SOP) describes the operational and clinical decision making aspects of the non-occupational Post-Exposure Prophylaxis (nPEP) Hotline. In conjunction with the South Australian (SA) Department of Health (2007) *Guidelines for the management of non-occupational exposure to HIV*, it provides the minimum standards required to assess and manage calls from people who have had an actual or potential non-occupational exposure to HIV.

2. Acronyms

FSW	Female Sex Worker
HBIG	Hepatitis B Immunoglobulin
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSP	HIV seroprevalence
IDU	Injection Drug User(s)
MSM	Men who have sex with men
PEP	Post Exposure Prophylaxis
nPEP	non-occupational Post Exposure Prophylaxis
RN	Registered Nurse
SOP	Standard Operating Procedure(s)
STI	Sexually Transmissible Infection

3. Rationale for post exposure prophylaxis

It is recognised that HIV may be transmitted by significant exposure to blood or other body substances, as a result of unprotected sexual activity or injecting drug use. There is evidence that PEP for human immunodeficiency virus (HIV) may prevent infection in some circumstances.

PEP following occupational exposures in the health care setting is now a universally accepted practice. In the face of the evidence about efficacy of PEP in this setting, it is clear that appropriate post-exposure management should be available to all persons with similar risks of transmission whether or not the risk occurs during the course of one's occupation. The provision of nPEP is seen as an integral part of an overall strategy for the prevention of HIV.

4. The SA Department of Health nPEP Management System

The South Australian Department of Health nPEP Management System has three levels of response: telephone triage, emergency response, and follow up. The responsibilities and functions of the system are outlined in the policy document *Guidelines for the management of non-occupational exposure to HIV*.

5. Function of the Hotline

The nPEP Hotline is a 24 hour a day, 7 day a week hotline for members of the public who have or think they may have had a sexual or other non-occupational exposure to HIV. Callers access the service by dialling 1800 022 226 .This is a statewide service. Anyone can call the nPEP hotline service - no referral is necessary.

Calls are answered by a Registered Nurse (RN) in the call centre. The RN will conduct a risk assessment based on the information provided by the caller, help the caller decide whether to access nPEP and, depending on the outcome, will either refer to an nPEP distribution point, provide information, or refer the caller to another service. The RN will also record call statistics.

6. Target callers

While anyone can call the nPEP Hotline, the service will be targeted and promoted to people potentially at highest risk of HIV transmission from a single exposure. These are: men who have sex with men and partners of HIV positive people. Injection Drug Users (IDU) who can identify a specific risk exposure (as opposed to a long term history of sharing injection equipment) and survivors/victims of rape or sexual assault may also have exposures which make them eligible to access nPEP.

7. Principles

Key principles for responding to callers enquiring about nPEP are:

- Call centre staff have a duty of care to the caller;
- Access to nPEP after an eligible exposure to HIV is seen as a medical emergency as it can potentially prevent the development of a disease with significant morbidity and mortality. Therefore the provision of a risk assessment should occur as soon as possible;
- Call centre staff are expected to treat callers with respect and to maintain a professional and non-judgemental manner; and
- Self-disclosure by call centre staff and giving personal opinions is not appropriate.

8. Immediate action - first aid or recent sexual assault

Most patients will present some time after the exposure has occurred. If the exposure has only just occurred or if the patient asks for information about what should happen immediately after the exposure, Appendix 1 of this SOP outlines recommended immediate first aid action after a potential exposure to HIV and other Blood Borne Viruses.

Recent sexual assault

If a patient discloses that the risk exposure occurred during a recent rape or sexual assault, in addition to providing information about nPEP, it is important to also offer information about sexual assault services available. If the person chooses to access medical care from a sexual assault service, nPEP can be addressed as part of the forensic and/or medical service. Patients in metropolitan Adelaide can be referred to Yarrow Place by ringing (08) 8226 8787 or 1800 817 421, 24 hours per day, 365 days of the year. If the

patient is in a regional area, they should be referred to an Emergency Department or local medical sexual assault service provider if available.

If the assessment provided by the sexual assault service is not possible within 72 hours of the assault, another nPEP referral option should be sought.

If the patient declines referral to a rape and sexual assault service, they should be assisted to undertake an nPEP risk assessment either via the nPEP hotline or with the service provider to whom they have presented.

In the case of sexual assault by an unknown assailant, it will likely be impossible to determine if the assailant is HIV positive or at high risk of HIV. In this circumstance, if the exposure event is classified as an eligible risk exposure, additional factors should be discussed with the patient to determine if the assailant is at increased risk of HIV. This may also assist in providing an accurate summary of the level of risk to the victim/survivor. If it is determined that the assailant is at an increased risk of HIV, then nPEP should be administered in accordance with these guidelines. If it is not possible to determine if the assailant is at increased risk of HIV, nPEP may be administered at the discretion of a physician with the patient's consent if the patient presents within the 72 hour timeframe.

9. Determining reason for call

The RN answering the call should first determine the reason for the call. If the caller is asking about nPEP, an electronic *Call Data Sheet* (Appendix 2) should be started for the call via the nPEP Caller Database.

10. Using the Call Data Sheet

The *Call Data Sheet* serves two main purposes.

- It provides a memory aid and checklist for the RN to ask all the questions necessary to assess the caller's risk and provide appropriate referral and information; and
- It provides a record of the types and numbers of calls and their outcomes to enable the SA Department of Health to assess if the service is meeting its target population and if the nPEP Management System is working appropriately. For this reason it needs to be completed as accurately as possible.

Appendix 3 of this SOP explains each section of questions on the *Call Data Sheet*.

The *Call Data Sheet* should only be used as a guide to obtaining information. Sensitive and private information will be most easily obtained by having a conversation with the caller. Sticking too rigidly to the format of the *Call Data Sheet* may be too interrogatory and inhibit the caller from providing information.

Not all callers will provide all the information that can be recorded on the *Call Data Sheet*. The RN should complete it as fully as possible. If the information related to a particular section was not obtained, it should be left blank.

Callers should be reassured that all data collected is anonymous and they will not be able to be identified from the data recorded.

It may be possible with Caller ID systems to see the number of the phone from which the caller is ringing. This number should never be recorded on the *Call Data Sheet*.

11. Rationale for nPEP Risk Assessment

The National Guidelines for Post Exposure Prophylaxis after Non-Occupational Exposure to HIV¹ state that:

Risk of HIV transmission = risk/single exposure multiplied by the risk of source being HIV positive.

The National Guidelines recommend nPEP when the risk of HIV acquisition from a given event is equal to or greater than 1:15,000. These guidelines do not recommend nPEP for lower risk exposures.

Appendix 4 provides risk tables which appear in the National Guidelines, outlining the estimated risk associated with types of non-occupational exposures and how the level of risk will differ depending on what is known about the source person.

12. Conducting the nPEP Risk Assessment

Performing a risk assessment is the essential function of the telephone triage system. The risk assessment is done:

- to determine if the caller is eligible for HIV nPEP - in which case they need to be referred to an nPEP starter pack distribution point immediately;
- to determine if callers should be referred for prophylaxis or treatment for other infections - such as HBV, tetanus, or STIs;
- to reassure people who are not at risk or are at very low risk of transmission of blood borne pathogens; and
- to be able to give callers relevant information about safe behaviours.

The following information assumes the caller is the person at risk, if someone is calling on another's behalf these questions should be assumed to be about the person at risk.

The *Call Data Sheet* will guide the RN to obtain the information necessary to do a risk assessment. Appendix 3 of this SOP explains how the questions on the *Call Data Sheet* relate to risk assessment.

Each call to the nPEP Hotline should be carefully assessed. The decision to recommend or not recommend nPEP is based on: knowledge about the transmission of HIV; guidance from the risk and HIV prevalence tables in this SOP; and by considering the following questions which form the basis of the Risk Assessment Protocol (Appendix 5):

- What happened?
- When did it happen?
- Who did it happen with?
- Where did it happen?

These questions are very personal and may be embarrassing for some callers (and for some RNs.) They should be asked in a professional but compassionate way which does not imply any judgement of the caller and does not lead the caller into answering a particular way.

The RN should use neutral professional language and explain terminology when necessary

A comprehensive Risk Assessment Protocol is provided in Appendix 5 and should be the primary tool guiding the risk assessment process.

Appendix 6 provides a list of high prevalence countries, including the relevant seroprevalence, which may also be required when conducting the risk assessment.

The presence of another STI in either the source or the exposed person can significantly increase the transmission of HIV.

In general, the higher the viral load of an HIV positive source, the greater the risk of HIV transmission from a given exposure.

13. Clients in rural areas

Appendix 7 provides a list of metropolitan and regional distribution points for nPEP starter packs.

Clients that do not have ready access to one of the starter pack distribution sites or specialist service providers, especially in the case of rural and remote South Australia, need to make arrangements to access medications from an existing distribution point. This may involve telephone liaison with a distribution centre and an arrangement to courier or fly a full 28 day course of medication to the client.

For an exposed person who has accessed a starter pack from a regional starter pack distribution point, contact should be made with Clinic 275 (sexual health clinic) on the next business day following starter pack administration. Arrangements should be made to undertake a telephone risk assessment with a sexual health physician. If this risk assessment indicates that the exposure was significant and that nPEP should be continued, the sexual health physician will arrange for the remainder of the 28 day course to be couriered to the patient. The contact phone number for Clinic 275 is (08) 8222 5075 or 1800 806 490 for country callers.

Arrangements should also be made to access serological testing and pre-HIV test discussion. In this situation, arrangements may be made with a metropolitan centre to provide pre and post test discussion and delivery of results by telephone.

14. Facilitating caller decision making

Information about risk and nPEP

The role of the RN is to provide information to help the caller decide whether they have been at risk and whether to refer to an nPEP service provider.

Once the risk assessment is completed the RN should feedback the level of risk to the caller and whether they are eligible for nPEP.

It can be difficult to determine and explain level of risk. Some exposures are definitely no or low risk and rarely some are high risk, but the majority lie in a "grey area".

If the caller decides they are at risk and they consider taking nPEP, they need to be given the information about the nPEP medications, in order to make an informed decision about whether to proceed.

15. Referral

If after the risk assessment and information about nPEP medications, the caller decides to take nPEP, they should be referred to the nPEP starter pack distribution point (Appendix 7) which is the closest or most convenient for them to attend. They should be advised to attend as soon as possible.

NB: Only the services listed in Appendix 7 and 8 can prescribe nPEP. Most GP's cannot prescribe nPEP. Only GP's who are recognized or accredited to prescribe anti-HIV drugs (\$100 prescribers) can prescribe nPEP.

It is advisable for the RN to contact the distribution point in advance of the caller's attendance. This ensures that the caller is seen as soon as possible. To do this the RN will need to gain the permission and a first name from the caller.

Some callers may not have been at risk of HIV, but could have had a risk for

- HBV
- Pregnancy, or
- STIs.

Callers at risk of HBV, who have not been vaccinated for HBV, can be referred to the follow-up services in Appendix 8 or any General Practitioner.

Women at risk of pregnancy from the exposure should be advised to attend a General Practitioner or sexual health clinic for emergency contraception.

Callers at risk of STIs should be advised to visit a sexual health centre within the next 5 days for a sexual health screen.

Sometimes callers do not require referral for nPEP. These may include those:

- with low risk exposures;
- who call more than 72 hours after the exposure;
- who elect not to take nPEP; or
- with general information questions.

Referral for these callers depends on the nature of the call and is judged on a case by case basis. The *Referral List* in Appendix 9 gives information about services which may be appropriate for some callers.

16. Advice on safe practices

If the caller is assessed to be at any risk of HIV infection from this or previous exposures, the RN should suggest that they take steps to protect any current or future partners until they are sure they have not contracted HIV. This would be determined by an HIV antibody test at 3 months after the exposure (if they did not take nPEP) or 6 months (if they did start nPEP.) Taking these steps would also protect the caller from HIV in the future.

Safe practices include:

- **Safe sex.** A detailed guide to safe sex practices is provided in Appendix 10 of this SOP;
- **Safe needle use.** Callers should be advised not to share needles or any injecting equipment and to only use each needle and syringe once before discarding;

- **Work practices.** Most people do not have to modify work practices, but a small group of health workers (some specialist surgeons, dentists and midwives) are required not to perform certain procedures if they are infected with HIV. Such a worker with a significant exposure should be advised to contact the Department of Health or their professional organisation for advice;
- **Breastfeeding.** Women with HIV in Australia are advised not to breastfeed because of the risk of the baby becoming infected with HIV. A woman with a significant exposure should also be advised not to breastfeed; and
- **Blood donation.** A person with a possible exposure to HIV should be advised not to donate blood, skin, or organs for the six month following the exposure.

17. Closing the call

The RN should ensure that the caller has all the information they need and encourage them to contact the agency they were referred to.

Reference

1. Australian Government Department of Health and Ageing (2007) *National guidelines for post-exposure prophylaxis after non-occupational exposure to HIV*
www.ashm.org.au/uploads/File/2007-national-NPEP-guidelines.pdf

Appendix 1: Immediate action - First Aid

Recommended action to be taken as soon as possible after a person has been exposed to blood or other body fluids that have the potential to transmit HIV, hepatitis B (HBV), and/or hepatitis C (HCV):

If the exposure involves a cut or puncture

Encourage bleeding, then wash with soap and water. Where water is not available, use of a non-water cleanser, such as an alcohol based hand rub, should replace the use of soap and water for washing cuts or punctures of the skin or intact skin. Nothing stronger - such as antiseptics - should be used because these may irritate the surface of the skin and facilitate the passage of infected material into the blood stream.

If the exposure involves unprotected sex, condom breakage, slippage, or the condom coming off inside

In the case of anal intercourse, go to the toilet and try to expel the semen or carefully remove the condom from the rectum. In the case of vaginal intercourse, carefully remove the condom and wipe around the vulva.

Douching the vagina or rectum is **not recommended**. Douching may spread infected material over a greater surface and may also irritate the lining of the rectum/vagina and facilitate the passage of infected material into the blood stream.

If blood or other body substances get in the eyes

Rinse them, while they are open, gently but thoroughly with water or normal saline. If contact lenses are worn, rinse the eyes first, then remove contact lenses and wash as usual.

If blood or other body substances get in the mouth

Spit out the substance and then rinse the mouth with water several times. Brushing the teeth or gargling with mouth washes which contain alcohol e.g. Listerine after unprotected oral sex is **not recommended**. Tooth brushing and mouth washes that irritate the mucous membranes of the mouth may facilitate the spread of and infection with infected material.

If clothing is contaminated

Remove the clothing and launder; shower if necessary. (This should not be done before talking to a doctor in cases of rape or sexual assault as it may destroy vital legal evidence.)

Appendix 2: Call Data Sheet

The Call Data Sheet has been used to develop the software application to be used by call centre operators taking calls to the nPEP hotline. The questions which will be asked by call centre operators are dependant on the caller's response to previous questions. Consequently, the call data sheet includes all of the questions that *may* be asked rather than all of the questions that *will* be asked of all callers.

This Call Data Sheet is indicative only and questions in the software application may be added, deleted or otherwise altered by the Communicable Disease Control Branch in collaboration with the call centre provider.

1. CALLER INFORMATION

Call date: Call Time:

Caller's Year of birth: Caller's Post Code:

2. REASON FOR CALL

- PEP for Exposure Information about PEP
 Other (please specify) Already on PEP

3. CALLER DETAILS

- Person at risk Health Care Worker
 Other/on behalf of person at risk

NOTE: People (male or female) may call the nPEP hotline following a rape or other unwanted sexual experience where they didn't or couldn't consent to having sex.

A suggested dialogue for broaching this issue with a caller is provided in Appendix 3: 'Using the Call Data Sheet'. This Appendix also provides advice re: managing the referral of clients who have experienced sexual assault.

4A. WAS SEXUAL ASSAULT INVOLVED?

- Yes No

4B WAS DRUG RELATED DURESS INVOLVED? (This question will only be asked if sexual assault occurred)

- Yes No

5. TIME/DATE OF EXPOSURE

Date of Exposure: Time of Exposure:

6. LOCATION OF RISK

- Sex on Premises venue Beat
 Person at risk's home Source Person's home
 Other (specify) n/a
 In Australia (specify state if not SA) Outside Australia (specify country)

7. PERSON AT RISK - GENDER

- Male Female
 Transgender Other (specify)

8. PERSON AT RISK - SEXUALITY

- | | |
|--|---|
| <input type="checkbox"/> MSM (Male who has sex with men) | <input type="checkbox"/> Heterosexual |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Other (<i>specify</i>) |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> n/a |

9. SEXUAL EXPOSURE DETAILS

- | | |
|---|---|
| <input type="checkbox"/> Unprotected <i>Receptive</i> Anal Intercourse (URAI) <i>with</i> ejaculation | <input type="checkbox"/> Unprotected Receptive Anal Intercourse (URAI) <i>without</i> ejaculation |
| <input type="checkbox"/> Unprotected Insertive Anal Intercourse (UIAI) <i>with</i> ejaculation | <input type="checkbox"/> Both URAI <i>with</i> Ejaculation & UIAI |
| <input type="checkbox"/> Both URAI <i>without</i> Ejaculation & UIAI | <input type="checkbox"/> Unprotected Receptive Vaginal Intercourse (URVI) <i>with</i> ejaculation |
| <input type="checkbox"/> Unprotected Receptive Vaginal Intercourse (URVI) <i>without</i> ejaculation | <input type="checkbox"/> Unprotected Insertive Vaginal Intercourse (UIVI) |
| <input type="checkbox"/> Unprotected Receptive Oral Intercourse (UROI) <i>with</i> ejaculation | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Other (<i>specify</i>)..... | |

10. WAS A CONDOM USED?

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Partial slippage |
| <input type="checkbox"/> No | <input type="checkbox"/> Condom removed by partner |
| <input type="checkbox"/> Breakage | <input type="checkbox"/> Not Sure |
| <input type="checkbox"/> Slipped off | <input type="checkbox"/> N/A |

11. CALLER'S DRUG USE (AT TIME OF EXPOSURE)

- | | |
|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Injected drug (<i>specify</i>)..... |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Non-injected drug (<i>specify</i>) |
| <input type="checkbox"/> Other (<i>specify</i>)..... | <input type="checkbox"/> Prescription medication (<i>specify</i>) |

12. DRUG RELATED EXPOSURE DETAILS

- | | |
|--|--|
| <input type="checkbox"/> Needle sharing | <input type="checkbox"/> Other drug related exposure (<i>details</i>)..... |
| <input type="checkbox"/> Other equipment sharing | <input type="checkbox"/> n/a |

13. OTHER EXPOSURE DETAILS

- | | |
|---|---|
| <input type="checkbox"/> Needlestick Injury | <input type="checkbox"/> Other (<i>specify</i>) |
|---|---|

14. SEX WORKER EXPOSURE DETAILS

- | | |
|---|---|
| <input type="checkbox"/> Australian sex worker | <input type="checkbox"/> Other Nationality (<i>specify</i>) |
| <input type="checkbox"/> Sex with (Female) Sex Worker | <input type="checkbox"/> Sex with (Male) Sex Worker |

15. PARTNER TYPE (IF SEXUAL EXPOSURE)

- | | |
|----------------------------------|--------------------------------|
| <input type="checkbox"/> Regular | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Casual | <input type="checkbox"/> Other |

16. PARTNER/SOURCE SERO-STATUS

- | | | |
|---------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> HIV negative | <input type="checkbox"/> HBV negative | <input type="checkbox"/> HCV negative |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> HBV positive | <input type="checkbox"/> HCV positive |
| <input type="checkbox"/> HIV unknown | <input type="checkbox"/> HBV unknown | <input type="checkbox"/> HCV unknown |

17. PARTNER/SOURCE HIV ANTIRETROVIRAL TREATMENT

- Yes Unsure No N/A

18. PARTNER/SOURCE VIRAL LOAD

- Undetectable Unsure
 Detectable N/A

19. PERSON AT RISK LAST HIV TEST

- Never Within last 3 - 12 months
 Within last 3 months More than 12 months

20. PERSON AT RISK LAST SEXUAL HEALTH SCREEN

- Never Within last 3 - 12 months
 Within last 3 months More than 12 months

21. PERSON AT RISK SEROSTATUS

- | | | |
|---------------------------------------|---|---------------------------------------|
| <input type="checkbox"/> HIV negative | <input type="checkbox"/> HBV not immune | <input type="checkbox"/> HCV negative |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> HBV immune (vaccination or past infection) | <input type="checkbox"/> HCV positive |
| <input type="checkbox"/> HIV unknown | <input type="checkbox"/> HBV unknown | <input type="checkbox"/> HCV unknown |

22. PEP ELIGIBILITY (REFER TO GUIDELINES)

- Meets Guidelines Does NOT meet Guidelines (over 72 hours since exposure)
 Does NOT meet Guidelines (Low/No Risk) N/A

23. PERSON AT RISK PEP HISTORY

- Yes (taken before) No (never taken PEP)

24. REFERRAL INFORMATION FOR PEP

- Accident & Emergency (*specify*) S100 prescriber (*specify*)
 Clinic (*specify*) N/A

25. REFERRAL INFORMATION GENERAL

- | | |
|---|---|
| <input type="checkbox"/> Psychosocial support/counselling | <input type="checkbox"/> HIV/PEP Information |
| <input type="checkbox"/> Medical (GP/clinic) | <input type="checkbox"/> Sexual health screen |
| <input type="checkbox"/> Emergency contraception | <input type="checkbox"/> Gay/lesbian support service |
| <input type="checkbox"/> HBV vaccination | <input type="checkbox"/> Rape or sexual assault service |
| <input type="checkbox"/> Other (<i>specify</i>)..... | |

26. CALLER CONSENT TO DISCUSS ASSESSMENT WITH REFERRAL POINT

- Yes (*If yes, record first name here*) No

27. OPTIONAL CALLER FEEDBACK

Where did you hear about the nPEP Hotline?

Additional Comments:

.....

Appendix 3: Using the Call Data Sheet

Assessing caller exposure risk and nPEP eligibility

1. Caller information

If callers express reservations at providing this information, the RN should explain that:

- They are not obliged to provide this information to receive the service;
- The information collected cannot identify them; and
- The information is for research and funding purposes only.

2. Reason for call

This should be asked in a way to invite the caller to talk: for example “Can you tell me a bit about why you have called so I can help you?”

If it seems the caller is asking about nPEP, a call data sheet should be started for the call.

3. Caller details

If the caller has not already identified whether they are calling about a personal risk or on behalf of another, this should be elicited by a question.

4. Was sexual assault involved?

Some people (male or female) may call the nPEP hotline following a rape or other unwanted sexual experience where they didn't or couldn't consent to having sex.

If a patient discloses that the risk exposure occurred during a recent rape or sexual assault, in addition to providing information about nPEP, it is important to also offer information about sexual assault services available. If the person chooses to access medical care from a sexual assault service, nPEP can be addressed as part of the forensic and/or medical service. Patients in metropolitan Adelaide can be referred to Yarrow Place by ringing (08) 8226 8787 or 1800 817 421, 24 hours per day, 365 days of the year. If the patient is in a regional area, they should be referred to an Emergency Department or local medical sexual assault service provider if available.

If the assessment provided by the sexual assault service is not possible within 72 hours of the assault, another nPEP referral option should be sought.

If the patient declines referral to a rape and sexual assault service, they should be assisted to undertake an nPEP risk assessment either via the nPEP hotline or with the service provider to whom they have presented.

In the case of sexual assault by an unknown assailant, it will likely be impossible to determine if the assailant is HIV positive or at high risk of HIV. In this circumstance, if the exposure event is classified as an eligible risk exposure, additional factors should be discussed with the patient to determine if the assailant is at increased risk of HIV. This may also assist in providing an accurate summary of the level of risk to the victim/survivor. If it is determined that the assailant is at an increased risk of HIV, then nPEP should be administered in accordance with these guidelines. If it is not possible to determine if the

assailant is at increased risk of HIV, nPEP may be administered at the discretion of a physician with the patient's consent if the patient presents within the 72 hour timeframe.

A suggested dialogue for broaching the issue of sexual assault with a caller is outlined below:

"Some people may call the nPEP hotline following a rape or other unwanted sexual experience where they didn't or couldn't consent to having sex. If this has happened to you and you would like to talk about it, I can provide you with information about a referral to a sexual assault service and they can talk with you about nPEP there. This would need to happen as soon as possible so that, if you need it, you can access nPEP within 72 hours of the potential exposure to HIV. If you would prefer not to talk about it with me, I can continue to conduct the risk assessment for nPEP to help you decide whether to access it or not."

5. Time/date of exposure

This is the first of the 3 variables which affect nPEP eligibility. If the exposure occurred more than 72 hours ago, the caller should be informed they will not be eligible for nPEP. They should be invited to discuss the circumstances of the exposure so that the RN can give them feedback on their level of risk. They may also benefit from referral to one of the agencies in the *Referral List*.

6. Location of risk

A "sex on premises venue" is a privately operated premises where casual male to male sex occurs - such as a sauna or bathhouse.

A "beat" is a public place where men have casual - usually anonymous - male to male sex - this could be a park, toilet, beach, etc.

Information about the type of location may help with judging whether the source person is at high risk. For instance, if the exposure was male to male unprotected intercourse at a sex on premises venue, it may be that the source person has put himself at risk in a similar setting before and may therefore be at higher risk of HIV.

Occasionally calls may be about risks which happened in other states or countries. Baseline HIV seroprevalence varies greatly between countries. Knowing the baseline HIV seroprevalence in the country in which the exposure occurred may influence the decision regarding the appropriateness of nPEP. Appendix 6 provides a list of high prevalence countries, including the relevant seroprevalence, which may also be referred to when conducting the risk assessment.

Baseline HIV seroprevalence must reach approximately 6.5% before an estimated risk of approximately 1:15,000 following unprotected insertive anal/vaginal or unprotected receptive vaginal intercourse occurs. Baseline HIV seroprevalence must reach approximately 1% before an estimated risk of approximately 1:15,000 following unprotected receptive anal intercourse occurs.

7. Person at risk - Gender

At times it is not possible to identify gender by voice on the telephone, this may need to be clarified by the RN.

8. Person at risk - Sexuality

Because callers may not identify with common labels for sexual behaviour, the most appropriate way to determine this may be to ask: "If you have sex is it with men, women,

or both?" For the purpose of this assessment, the caller's behaviour is important, not how they identify themselves.

9. Sexual exposure details

This section should only be completed if the caller reports a sexual exposure. Specific information about the sexual behaviour is important to determine level of risk.

"Unprotected" means that no barrier such as a condom was used or that the condom was not effective (because of breakage or slippage) - see question 9.

The repertoire of human sexual behaviour is varied. It is impossible to list each and every sexual event or to estimate the risk of HIV transmission attached to each event. For some sexual and non-sexual events however, risk estimates can be provided. This information is contained in the risk tables in Appendix 4. It is important to know that risk estimates are precisely that, estimates. Some things may make a risk higher or lower. In order for the transmission of HIV to occur, potentially infectious fluid (blood, semen, vaginal secretions etc) from the *source* must gain access into the body of the *exposed* person.

Sexual transmission of HIV occurs:

- commonly through unprotected *penile-anal* intercourse. The receptive partner is at greater risk, but the insertive partner can also get infected;
- commonly through unprotected *penile-vaginal* intercourse. The female is at greater risk, but the male partner can also get infected;
- rarely through unprotected *oral sex* - though it has occasionally been reported;
- rarely through *other sexual exposures* e.g. sharing sex toys, anal or vaginal 'fisting', contamination of skin with infectious bodily fluids when skin integrity is compromised, and sperm contamination of intact mucosa e.g. the conjunctiva of the eye, but these are all considered to be lower risk exposures.

Anal sex and the transmission of HIV

Unprotected anal sex is the most efficient means of sexual HIV transmission. It is clear from many epidemiological studies that most HIV transmission between MSM occurs via unprotected anal intercourse. Studies of homosexual men have consistently shown that the receptive partner in unprotected anal intercourse is at higher risk of HIV infection.

This is because:

- Rectal mucous membranes have more receptors to bind HIV;
- Rectal tissue is more easily traumatised, leading to more easy access for HIV;
- The area susceptible to infection is much larger for the receptive person (entire lining of the rectum) than in the insertive person (the penis and exposed urethra);
- The receptive person may be exposed to a larger quantity of infectious fluid (ejaculate) than the insertive person (infected rectal secretions and or blood from possible cuts or abrasions); and
- The receptive person retains the secretions within the body after sex while the insertive person is only exposed during the sex act.

Even though the receptive person is at higher risk during anal sex, studies have shown that HIV infection can also occur among men reporting only unprotected insertive anal intercourse. It has been estimated that about 20% of HIV infection in Australian MSM is

acquired through unprotected insertive anal sex. The estimated risk of HIV acquisition from unprotected receptive anal sex or unprotected insertive anal sex with an HIV positive source is 1:120 and 1:1000 respectively.

Vaginal sex and the transmission of HIV

Vaginal sex can transmit HIV to either the male or the female partner. Semen carrying HIV can enter the body of the receptive partner through the lining of the vagina/cervix. Blood carrying HIV can enter the body of the insertive partner through specialised cells on the inner lining of the foreskin (uncircumcised men), or abrasions, cuts or lesions on the penis. The estimated risk of HIV acquisition from unprotected receptive or insertive vaginal sex with an HIV positive source is 1:1000.

In general, because of the low prevalence of HIV in the heterosexual population in Australia, nPEP is not indicated after vaginal intercourse unless the source is known to be positive, or the exposure occurred in a high prevalence country or with a partner from a high prevalence country (See Question 16 for more details.)

Oral sex and the transmission of HIV

Oral sex is much less risky than anal or vaginal sex. However, well-documented cases of HIV transmission through oral exposure to semen or vaginal fluids have been documented. Unprotected fellatio (mouth to penis contact) and cunnilingus (mouth to vulva contact) cannot be considered to be totally safe practices. The relative inefficiency of HIV transmission through unprotected oral sex suggests that the likelihood of HIV transmission by the oral route is many times less likely than penile-vaginal or penile-anal intercourse.

nPEP is not generally indicated for oral sex. It may be considered if the source is known to be HIV infected and unprotected receptive oral sex has occurred with ejaculation and the exposed person has recent dental work; mouth ulcers; dental, gum or throat disease, or a concurrent STI in the throat.

A useful way to think about HIV risk and oral sex is to look at behaviour. While safe sex guidelines recommend condom use for oral-penile contact and dental dams for cunnilingus, it is rare to find MSM using condoms for oral-penile sex. If unprotected oral-penile sex were an efficient way to transmit HIV then the epidemic in MSM would be several times larger than it is.

Pre-cum

Callers may be concerned about the risk of HIV transmission when unprotected receptive oral sex has occurred without ejaculation but with varying amounts of pre-cum. Pre-cum is pre-ejaculatory fluid which some men produce in varying amounts when aroused and prior to ejaculation. HIV is present in pre-cum. However because the amount of potentially infectious fluid is not great, the risk of HIV acquisition is probably less than if ejaculation into the mouth occurs. nPEP is not indicated after exposure to pre-cum regardless of the HIV status of the source.

Other sexual exposures

nPEP may be considered after sex toys are shared when the source is known to be HIV infected and the exposed person is penetrated by the sex toy without cleaning after use by the source or without protection with an unused condom.

nPEP may be considered after vaginal or anal fisting when:

- The person doing the fisting is HIV infected, does not wear gloves **and** has a cut or sore on his/her hands which is bleeding or weeping; and
- The person receiving the fisting is HIV infected **and** blood or genital secretions from the vagina or rectum contaminate a sore, cut or abrasion on the 'fisters' ungloved hand.

10. Was a condom used?

Sex in which a condom is used and does not break is not considered a risk for transmission of HIV or HBV. If the caller is not sure if the condom broke, they should be asked if there was semen collected in the tip of the condom on withdrawal.

11. Caller's drug use (at time of exposure)

This question is to assess if alcohol or other drug use was a factor in the exposure. People often take more risks when using alcohol or other drugs, they also may not remember details about the exposure clearly, or even be sure if there was an actual exposure.

Injected drugs could include: heroin, speed, methadone, steroids, cocaine, crystal, etc. Non-injected drugs could include: heroin, marijuana, LSD, speed, amyl, cocaine, ecstasy, crystal, etc. Prescription medications could include: oral methadone, Viagra, etc.

12. Drug related exposure details

This section should only be completed if the caller reports a drug use related exposure. The RN should clarify terminology used for injecting equipment. Needles and syringes used to inject drugs are often called "fits" in Australia.

HIV is efficiently transmitted when HIV contaminated injection drug equipment is shared. The risk of HIV acquisition from sharing an HIV contaminated 'fit' is estimated at 1:150.

nPEP may be indicated if the exposure was a single episode of needle sharing, when the exposed person injected using a needle which had been recently used by another person. nPEP would not be indicated in the case of ongoing needle sharing over a period of time.

13. Other exposure details

This section should only be completed if the caller reports a non-sexual, non-drug use exposure.

Needle stick injuries (non-occupational)

These injuries (also called "community needlestick injuries") are relatively common. They occur on the beach, in parks, in lane-ways, and in gardens. Occasionally they occur when police officers are searching a suspect. They cause a great deal of distress and little harm. Less commonly, assault with a 'fit' occurs in the course of an attempted robbery.

There is no documented case in the international literature of HIV transmission from a discarded needle (there is one case of HCV transmission and one of probable HBV transmission).

nPEP is **not** indicated for injuries from discarded needles. nPEP may rarely be considered if it is known that the needle and syringe has just been used (witnessed) **and** there is visible, fresh blood in the syringe barrel, **and** the wound bleeds.

Bites

Rarely, HIV transmission has been documented between children by biting. In general, nPEP is not indicated after bites. The exposed person should however be referred to a medical practitioner for treatment with antibiotics as specified in the current *Antibiotic Guidelines*.

Contamination of non-intact skin

PEP may be considered if the source is known to be HIV infected and non-intact skin (cut, abrasion, sore) is contaminated by potentially infectious bodily fluids (sperm, blood, vaginal fluids).

14. Sex worker exposure details

This section should only be completed if a commercial sex worker was the source of the exposure.

The HIV seroprevalence in Australian born female sex workers (FSW) is 0.1%. nPEP is not recommended for sexual exposures to Australian born FSW when the HIV status is unknown.

HIV seroprevalence in FSW in SE Asia, or in SE Asian sex workers working in Australia may be significantly higher. Information about the country in which the sexual event occurred and/or the country of origin of the local female sex worker is useful when assessing risk following unprotected sex with a FSW. See Appendix 6 for seroprevalence of HIV for other countries.

nPEP is indicated if the exposed person is a male who has had unprotected anal sex with a male commercial sex worker.

15. Partner type

Questions 15 - 18 relate to what is known about the source person.

This question relates to a sexual exposure. If the source was a casual sexual partner, it may be more difficult to assess their risk of being HIV infected.

16. Partner/source sero-status

This question relates to any type of exposure. Only known or reported status should be recorded here, not assumptions or judgements.

The *National guidelines for post-exposure prophylaxis after non-occupational exposure to HIV*¹ recommend the use of nPEP after an estimated risk of transmission of greater than 1:15,000. The RN is not expected to calculate these risk thresholds, but they help to explain in which circumstances nPEP is recommended and why.

HIV infection

This is a key variable when assessing risk and deciding if PEP is appropriate. When the source is known to be HIV infected the decision to recommend PEP (after considering what happened and when it happened) is usually straightforward. Appendix 4 provides risk estimates for HIV transmission from a given event when the source is known to be HIV infected. All of these estimated risks exceed the nPEP threshold of 1:15,000.

Estimating risk when the HIV status of the source is unknown

The likelihood of the exposure event transmitting HIV along with the known HIV prevalence in the source helps guide the nPEP decision making process when the HIV status of the source is unknown. A mathematical equation can be used to calculate risk when the source HIV status is unknown. This is calculated using the Estimated Risk attached to the event (ER) and the estimated HIV seroprevalence (HSP) in the source. For example, the ER for unprotected receptive anal intercourse is 1:120 and the HIV seroprevalence in Sydney MSM is 14%.

$$1/120 \times 14/100 = 14/12000 = 1:857$$

Thus the estimated risk of HIV acquisition from unprotected receptive anal intercourse with a Sydney MSM of unknown HIV status is 1:857. This estimated risk is greater than the 1:15,000 threshold for recommending PEP so PEP is indicated. HIV seroprevalence in MSM varies between State capitals - all being lower than Sydney. In practice this differentiation is not made and nPEP is recommended for unprotected male to male receptive/insertive anal intercourse regardless of assumed variation in MSM HIV seroprevalence between States.

The estimated risk for unprotected receptive or insertive vaginal intercourse is 1:1000 and the background heterosexual Australian HSP is 0.1%.

$$1/1000 \times 1/1000 = 1/1000000 = 1:1,000,000$$

Thus the estimated risk of HIV acquisition from unprotected receptive or insertive vaginal intercourse with an Australian heterosexual man or women of unknown HIV status is 1:1,000,000. This is much less than the 1:15,000 threshold for recommending PEP. PEP is not indicated. This can be a difficult message to communicate to a heterosexual caller concerned about an episode of unprotected sex. On the one hand nPEP is not recommended (the risk of HIV infection from the event is minimal) but on the other hand condom use is advocated every time sex with a casual partner occurs. This appears to be a mixed message - always use a condom despite a risk of 1:1,000,000. A useful way to discuss this with a heterosexual caller is to inform the caller that the risk of a serious adverse event from the anti-HIV drugs used in PEP is greater than the risk of HIV acquisition from unprotected receptive or insertive vaginal sex with an Australian of unknown HIV status. It is because of this that PEP is not recommended. It is also useful to indicate that there are guidelines governing the use of PEP and that the guidelines do not recommend the use of PEP for a minimal risk event.

Anal intercourse is not an activity that is exclusive to MSM. Heterosexual couples also engage in anal sex. The ER for unprotected anal intercourse is 1:120 and the background heterosexual Australian HSP is 0.1%.

$$1/120 \times 1/1000 = 1/120000 = 1:120,000$$

Thus the risk of HIV acquisition following unprotected receptive anal intercourse between Australian heterosexual men and women of unknown HIV status is 1:120,000. This estimated risk is also less than the 1:15,000 nPEP threshold. PEP is not indicated.

Exposures to non-Australian heterosexual sources may however reach the 1:15,000 nPEP threshold. For example, the risk of HIV acquisition from unprotected receptive or vaginal intercourse with a South African recently arrived from Cape Town with unknown HIV status is 1:5319, three times the risk of the upper limit. This is because the background HIV seroprevalence in South Africans is 18.8%. nPEP is clearly indicated in this case.

The risk tables in Appendix 4 provide estimates of risk for unprotected heterosexual sexual exposures when the HIV status of the source is unknown. The HIV prevalence tables in Appendix 6 provide information on the estimated HIV seroprevalence globally. Baseline HIV seroprevalence must reach approximately 6.5% before an estimated risk of approximately 1:15,000 following unprotected insertive anal/vaginal or unprotected receptive vaginal intercourse occurs. Baseline HIV seroprevalence must reach approximately 1% before an estimated risk of approximately 1:15,000 following unprotected receptive anal intercourse occurs.

Sex with transsexuals and transgender people

Information concerning HIV seroprevalence in this discrete population is lacking. With no evidence to the contrary, PEP is recommended for unprotected receptive or insertive *anal* intercourse with a transsexual or transgender person

Other factors that may increase or decrease HIV transmission

The results from multiple studies indicate that the presence of another STI (herpes, gonorrhoea, chlamydia, etc) in either the source or the exposed person can significantly increase the transmission of HIV. Some STIs can be present with few or no symptoms.

In general, the higher the viral load of the source the greater the risk of HIV transmission from a given exposure. (See Question 18.)

HBV infection

HBV is transmitted by the same routes as HIV and is more easily transmitted. If the exposed person is not immune to HBV through vaccination or immunity (See Question 21), they may also be at risk of HBV transmission. nPEP for HBV - HBV immunoglobulin (HBIG) - should be considered. If the person has not been vaccinated, it is appropriate to suggest future vaccination.

HCV infection

Unlike HIV and HBV, HCV is only transmitted by direct blood to blood contact. Sexual transmission of HCV is therefore possible, but uncommon. Such transmission only occurs where the blood of a person with HCV enters the bloodstream of another person. Transmission of HCV is more commonly transmitted through contaminated needles and syringes used to inject drugs and other types of injecting equipment (swabs, tourniquets, etc.) There is no nPEP for HCV. If a person has a possible exposure to HCV, the RN should advise them to see a general practitioner for regular testing. This is because if seroconversion is detected early, a course of early treatment (rather than prophylaxis) may clear the virus.

17. Partner/source HIV treatment

This question is only asked if the source is known to be HIV infected. If the source is on effective antiretroviral treatment, they are probably less infectious for HIV. This would not change recommendations to start nPEP, but may be of some reassurance to the caller.

This question is also asked because if the nPEP service provider can determine which antiretroviral medications the source has taken, it may affect the nPEP medications the

exposed person is prescribed. The caller should be advised to take all this information with them to the nPEP service provider, if they elect to take nPEP.

18. Partner/source viral load

This question is only asked if the source is known to be HIV infected. Viral load is a predictor of HIV transmissibility. Broadly speaking, the higher the viral load of the source the greater the risk of HIV transmission from a given exposure. People with an undetectable viral load are less likely to transmit HIV. There are individuals, however, who have undetectable levels of virus in plasma yet have significant amounts of virus in the genital tract, viral load can vary over time.

For these reasons nPEP is still recommended for a significant exposure to an HIV infected source even if the viral load is undetectable.

19. Person at risk -last HIV test

This question is to determine if the exposed person has previously been tested for HIV and when.

20. Person at risk -last sexual health screen

This question is to determine if the exposed person has had a previous sexual health screen and when. Transmission of HIV is more likely if the exposed person has a concurrent STI.

21. Person at risk serostatus

Only known or reported status should be recorded here, not assumptions or judgements.

HIV infection: nPEP should not be prescribed for a person who is already HIV positive.

HBV immunity: If the exposed person is immune to HBV they do not need HBV nPEP.

22. PEP eligibility

At this point, the RN should consider all the above factors to assess whether the caller meets the guidelines for nPEP eligibility.

There are many factors - discussed above - which affect HIV transmission, but the key information is contained within the Risk Assessment Protocol which is provided in Appendix 5 of this Standard Operating Procedure.

It can be difficult to determine and explain level of risk. Some exposures are definitely no or low risk and rarely some are high risk, but the majority lie in a "grey area" in between. If there is no obvious, clear cut answer to this question, it is probably wise to err on the side of caution. The caller will be assessed again before nPEP is prescribed.

The RN should try to put it into perspective for the caller by discussing the three variables relating to nPEP eligibility:

- the time since the exposure (When did it happen?)
- the type of exposure (What happened?)
- the likelihood that the source is positive (Who did it happen with and where did it happen?)

It is not appropriate for the RN to give personal information or opinions to the caller. Sometimes callers will ask "What would you do?" or "What do you think I should do?" An appropriate response would be something like: "I am here to give you the information and support you need to help you make the decision that is right for you."

Some callers may insist on presenting for nPEP despite being assessed as having low or no risk of HIV transmission. This type of call is difficult to manage. Points to consider:

- The RN should reassess the risk with the caller and gently probe about undisclosed risk - 'Is there anything else that happened to you that you find difficult to tell me?';
- This SOP is adapted from National and International Guidelines concerning the indications for and use of nPEP. They are sufficient defence should a caller ever complain about your decision and are thought to be sufficient defence should a caller ever acquire HIV infection from a risk event assessed as low to no risk and not appropriate for nPEP. However this has not been tested in a court of law either nationally or internationally. With this in mind you always have the option of stating that if the caller wants to take the matter further he/she is free to attend an emergency department for further assessment; and
- Document this type of call carefully on the Call Data Sheet.

If the caller decides they are at risk and they consider taking nPEP, the RN should give the following information about the nPEP medications.

- nPEP is a course of pills which are taken (by mouth) twice a day for 28 days. The exposed person can stop taking the medication at any time, but they will not get the full benefit;
- nPEP is not a proven treatment and there have been cases reported overseas where it did not work. However efficacy is estimated at about 80%. There have been no reported seroconversions to HIV in people taking nPEP in Australia;
- nPEP is most effective when taken as soon as possible after the exposure. It is not thought to be effective if taken more than 72 hours after the exposure;
- To work properly the pills need to be taken at the times prescribed every day without missing a dose;
- nPEP should not be taken by someone who already has HIV;
- Some people experience side effects on the medication. These side effects may be mild, may be able to be managed with other medications (for nausea and/or headache), or may be extremely uncomfortable;
- When the person goes to an nPEP service provider they will be assessed again and if nPEP is considered appropriate they will be asked to provide consent to the medications and will be given a 5 day supply;
- Before the 5 days is up, they will have to go to a specialist service provider for the rest of the medications; and
- They will be advised to have an HIV test shortly after starting nPEP and once or twice more during the course and at 6 months after the exposure

23. Person at Risk PEP history

This question will ascertain whether the caller has utilised PEP for a non-occupational exposure previously. Any previous PEP utilisation should be reflected by a positive response to this question, whether PEP was accessed in South Australia or elsewhere.

24. Referral information for PEP

If the caller decides to take nPEP, they should be referred to the nPEP starter pack distribution point (Appendix 7) which is the closest or most convenient for them to attend. They should be advised to attend as soon as possible.

NB: Only the services listed in Appendix 7 and 8 can prescribe nPEP. Most GP's cannot prescribe nPEP. Only GP's who are recognized or accredited to prescribe anti-HIV drugs (S100 prescribers) can manage nPEP.

25. Referral information general

Sometimes callers do not require referral for nPEP. These may be:

- Callers with low risk exposures;
- Callers who call more than 72 hours after the exposure;
- Callers who elect not to take nPEP; and
- Callers with general information questions.

Referral for these callers depends on the nature of the call and is judged on a case by case basis. The *Referral List* in Appendix 9 of this SOP gives information about services which may be appropriate for some callers.

Some callers may not have been at risk of HIV, but could have had a risk for HBV, pregnancy, or STIs.

Callers at risk of HBV, who have not been vaccinated for HBV, can be referred to the follow-up services in Appendix 8 or any General Practitioner.

Women at risk of pregnancy from the exposure should be advised to attend a General Practitioner or sexual health clinic for emergency contraception.

Callers at risk of STIs should be advised to visit a sexual health centre within the next 5 days for a sexual health screen.

26. Caller consent to discuss assessment with referral point

If the caller decides to take nPEP, it is advisable for the RN to call to tell the distribution point that the caller will be attending. This is to try to ensure that the caller is seen as soon as possible as some services may not be very experienced with nPEP. To do this the RN will need to get the permission of the caller and (at least) a first name.

Information that should be conveyed to the nPEP starter pack distribution point:

- Name of caller;
- When he/she is expected to attend;
- Level of risk as assessed by telephone triage;
- That the caller should be seen as soon as possible and the case be treated as urgent; and
- Any other risks which may need prophylaxis - such as emergency contraception, hepatitis B immunoglobulin, or tetanus toxoid.

Appendix 4: Risk tables

The National Guidelines for Post Exposure Prophylaxis after Non-Occupational Exposure to HIV¹ recommend nPEP when the risk of HIV acquisition from a given event is equal to or greater than 1:15,000. These guidelines do not recommend nPEP for lower risk exposures.

Risk of HIV acquisition when the source is KNOWN to be HIV infected

Type of exposure	Estimated risk of HIV acquisition
Receptive anal intercourse	1:120
Use of contaminated injecting equipment	1:150
Occupational needlestick injury	1:1000
Receptive vaginal intercourse	1:1000
Insertive anal or vaginal intercourse	1:1000
Receptive fellatio with or without ejaculation	Not measurable
Insertive fellatio	Not measurable
Cunnilingus	Not measurable
Bites	Not measurable
Exposure of intact mucous membrane - conjunctival, oral or nasal mucosa	Not measurable
Exposure of non-intact skin	Not measurable
Community needlestick injury	No measurable

Risk of HIV acquisition by exposure to a heterosexual source who is NOT an IDU when the HIV status is UNKNOWN (Australian HIV seroprevalence 0.1%)

Type of exposure	Estimated risk of HIV acquisition
Receptive anal intercourse	1:120,000
Receptive vaginal intercourse	1:1 million
Insertive anal or vaginal intercourse	1:1 million
Receptive fellatio with or without ejaculation	Not known
Insertive fellatio	Not known
Cunnilingus	Not known
Bites	Not known
Exposure of intact mucous membrane - conjunctival, oral or nasal mucosa	Not known
Exposure of non-intact skin	Not known

Risk of HIV acquisition by exposure to a heterosexual source who IS an IDU when the source HIV status is UNKNOWN (Australian IDU HIV seroprevalence 1%).

Note: nPEP is recommended **only** for receptive anal intercourse and the use of contaminated injecting equipment risk 1:12,000 and 1: 15,000 respectively. nPEP is **not recommended** for insertive or receptive vaginal intercourse.

Type of exposure	Estimated risk of HIV acquisition
Receptive anal intercourse	1:12,000
Use of contaminated injecting equipment	1:15,000
Receptive vaginal intercourse	1:100,000
Insertive anal or vaginal intercourse	1:100,000
Receptive fellatio with or without ejaculation	Not known
Insertive fellatio	Not known
Cunnilingus	Not known
Bites	Not known
Exposure of intact mucous membrane - conjunctival, oral or nasal mucosa	Not known
Exposure of non-intact skin	Not known

Appendix 5: Risk Assessment Protocol

When nPEP should be recommended

1. if eligible exposure; and
2. if source is known to be HIV positive or at High Risk; and
3. if it is 72 hours or less since the exposure; and
4. if the patient gives informed consent to take nPEP.

In some circumstances, nPEP may be administered at the discretion of the physician if the information required to determine the level of risk is not available. For example, for victims/survivors of sexual assault by an unknown assailant, it may be impossible to determine if the assailant was HIV positive or at high risk of HIV. In this scenario, nPEP may be administered with the physician’s discretion and the patient’s consent.

nPEP medications should be administered to the exposed person if conditions 1 AND 2 AND 3 AND 4 are met

1. The exposure was an eligible risk exposure:

- sharing injecting equipment
-
- OR
- unprotected intercourse (insertive or receptive, anal or vaginal) - no condom used or condom slippage/breakage
-
- OR
- the person was giving oral sex (their mouth was in contact with their partner’s penis or vagina) and they had mucosal disease or significant lesions in the mouth or throat
-
- OR
- another sexual exposure (e.g. sharing sex toys, anal or vaginal ‘fisting’, contamination of skin with infectious bodily fluids) only if skin integrity is compromised, and there is significant sperm or blood contamination of non-intact mucosa

AND

2. The source person is HIV positive

OR at high risk of HIV:

- a male who has sex with men
-
- OR
- an Injection Drug User
- nPEP IS NOT RECOMMENDED following insertive or receptive vaginal sex or insertive anal sex with an Australian-born injection drug user but IS RECOMMENDED following receptive anal intercourse
-
- OR
- a person from a country with an HIV prevalence of over 1%¹, if the exposure is receptive anal intercourse
- Angola, Bahamas, Barbados, Belize, Benin, Botswana, Burkina Faso, Burundi, Cambodia, Cameroon, Central African Republic, Chad, Congo, Democratic Republic of Congo, Cote d’Ivoire, Djibouti, Dominican Republic, Equatorial Guinea, Eritrea, Estonia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, Jamaica, Kenya, Lesotho, Malawi, Mali, Moldova, Mozambique, Myanmar, Namibia, Niger, Nigeria, Papua New Guinea, Russian Federation, Rwanda, Sierra Leone, South Africa, Sudan, Suriname, Swaziland, Tanzania, Thailand, Togo, Trinidad and Tobago, Uganda, Ukraine, Zambia, Zimbabwe

OR

- a person from a country with an HIV prevalence of over 6.5%¹ if the exposure is receptive vaginal intercourse or insertive vaginal/anal intercourse

Botswana, Central African Republic, Cote D'Ivoire, Gabon, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe

OR

- a sex worker outside of Australia

AND

3. The time since exposure:

- The patient presents within 72 hours of exposure
-

AND

4. The patient consents to nPEP

Circumstances in which nPEP is not indicated

A person **will not be eligible** for HIV nPEP after the following exposures unless there are unusual factors which increase the risk of exposure (as described above):

- needlestick from a discarded needle;
- bite or clenched fist injury;
- skin exposure;
- receiving oral sex;
- oral-anal sex; and
- heterosexual (vaginal) intercourse is not considered enough of a risk to be eligible for nPEP unless the source is known to be positive or at high risk of HIV (see above).

Reference

¹ www.globalhealthfacts.org/

Appendix 6: Country prevalence data

Baseline HIV seroprevalence in the general (non-MSM, non-IDU, non-FSW) population by country

Baseline HIV prevalence must reach approximately 6.5% before an estimated risk of approximately 1:15,000 following unprotected insertive or receptive vaginal intercourse or unprotected insertive anal intercourse occurs.

Baseline HIV prevalence must reach approximately 1% before an estimated risk of approximately 1:15,000 following unprotected receptive anal intercourse is reached.

The table below provides an alphabetical list of countries estimated to have a baseline HIV prevalence of over 1% for the general population (non-MSM, non-IDU, non-FSW). Countries with a seroprevalence over 6.5% are highlighted in bold text. These figures are necessarily estimates and relate to 2005.

Adult HIV/AIDS Prevalence Rate (aged 15-49 years) 2005¹

Angola	3.7%
Bahamas	3.3%
Barbados	1.5%
Belize	2.5%
Benin	1.8%
Botswana	24.1%
Burkina Faso	2.0%
Burundi	3.3%
Cambodia	1.6%
Cameroon	5.4%
Central African Republic	10.7%
Chad	3.5%
Congo	5.3%
Congo (Dem. Republic of)	3.2%
Cote d'Ivoire	7.1%
Djibouti	3.1%
Dominican Republic	1.1%
Equatorial Guinea	3.2%
Eritrea	2.4%
Estonia	1.3%
Gabon	7.9%
Gambia	2.4%
Ghana	2.3%
Guinea	1.5%

Guinea-Bissau	3.8%
Guyana	2.4%
Haiti	3.8%
Honduras	1.5%
Jamaica	1.5%
Kenya	6.1%
Lesotho	23.2%
Malawi	14.1%
Mali	1.7%
Moldova (Republic of)	1.1%
Mozambique	16.1%
Myanmar	1.3%
Namibia	19.6%
Niger	1.1%
Nigeria	3.9%
Papua New Guinea	1.8%
Russian Federation	1.1%
Rwanda	3.1%
Sierra Leone	1.6%
South Africa	18.8%
Sudan	1.6%
Suriname	1.9%
Swaziland	33.4%
Tanzania (United Rep. of)	6.5%
Thailand	1.4%
Togo	3.2%
Trinidad and Tobago	2.6%
Uganda	6.7%
Ukraine	1.4%
Zambia	17.0%
Zimbabwe	20.1%

Appendix 7: Distribution points for starter packs

*Metropolitan and Regional Health Services holding HIV nPEP Starter Packs**

Regions	Location of Starter Packs	Telephone/Fax Contact
Metropolitan	Clinic 275	Ph: 8222 5075
	O'Brien Street Clinic	Ph: 8231 4026
	Royal Adelaide Hospital	Ph: 8222 4000
	Flinders Medical Centre	Ph: 8204 5511
	Noarlunga Hospital	Ph: 8384 9222
	Womens and Childrens Hospital	Ph: 8161 7044
	Queen Elizabeth Hospital	Ph: 8222 6000
	Modbury Hospital	Ph: 8161 2000
	Lyell McEwin Hospital	Ph: 8182 9000
Metropolitan-Private Hospitals	St Andrews Hospital 8am - 10pm **Facility fee applicable**	Ph: 8408 2222
Eyre Regional Health Service	Port Lincoln Health Service	Ph: 8683 2200 Fax: 8683 2014
	Ceduna District Health Service	Ph: 8626 2110 Fax: 8626 2191
Hills Mallee Southern Regional Health Service	Kangaroo Island Health Service (Kingscote)	Ph: 8553 4200 Fax: 8553 4299
	Murray Bridge Soldier's Memorial Hospital	Ph: 85356777 Fax: 85356700
	South Coast District Hospital (Victor Harbour)	Ph: 8552 0500 Fax: 8552 0507
Mid North Regional Health Service	Port Pirie Regional Health Service	Ph: 8632 1222 Fax: 8632 5801
Northern and Far Western Regional Health Service	Coober Pedy Hospital and Health Service	Ph: 8672 5009 Fax: 8672 5704
	Port Augusta Hospital and Regional Health Service	Ph: 8648 5500 Fax: 8648 5877
	Roxby Downs Health Service	Ph: 8671 9020 Fax: 8671 9062
Riverland Health Authority	Riverland Regional Health Service (Berri)	Ph: 8580 2400 Fax: 8580 2498
South East Regional Health Service	Bordertown Memorial Hospital	Ph: 8752 9000 Fax: 8752 9080
	Mount Gambier and Districts Health Service	Ph: 8721 1200 Fax: 8721 1579

Wakefield Health	Central Yorke Peninsula Hospital (Maitland)	Ph: 8832 2626 Fax: 8832 2262
	Burra, Clare Snowtown Health Service (Clare)	Ph: 8892 2300 Fax: 8892 2115
Nganampa Health Council	Umuwa Clinic, Umuwa, Anangu Pitjantjatjara Yankunytjatjara Lands	Ph: 8954 9040 Fax: 8956 7850
Other regional services	Royal Flying Doctor Service- Port Augusta Base	Ph: 8642 2044 Fax: 8641 0461

* nPEP starter packs will usually be held in the Emergency Department of the health services listed.

Appendix 8: Healthcare facilities providing follow-up services

- Clinic 275 Sexual Health Clinic: 275 North Terrace, Adelaide, No appointment or referral necessary. Clinic times: Monday, Thursday, Friday: 10am-4.30pm and Tuesday-Wednesday: 11am-6.30pm, Phone: 8222 5075. Free service;
- O'Brien Street Practice: 17 O'Brien Street, Adelaide, Phone 8231 4026 for appointment. No referral necessary. Bulk Billing available;
- Dr Sam Elliot, Westfield Marion, 297 Diagonal Road, Oaklands Park, Phone: 8358 2044 for appointment. No referral required, Bulk Billing available;
- Dr Joe Levy, Level 1, 47 Gawler Place, Adelaide, Phone 8212 7175 for appointment. No referral required, Bulk Billing available for healthcare or concession card holders or Gap fee to pay.
- Dr Ross Philpot, SA Infectious Diseases Services, 135 Hutt Street, Adelaide, Phone 8232 4511 for appointment. Referral required, Private practice, Gap fee to pay.

Appendix 9: Referral list

Agency	Services provided	Contact details	Hours of operation
Alcohol and Drug Services			
Alcohol Drug and Information Service (ADIS)	ADIS is a 24-hour telephone information, counselling, and referral service for the general public, concerned family and friends, students and health professionals. ADIS is staffed by trained professionals with experience in the alcohol and other drug field. Also provides details of Clean Needle Program outlets in SA where clean injecting equipment can be accessed.	1300 13 1340	24 hours, 7 days a week.
SAVIVE	SAVIVE is the injecting drug users' community program of the AIDS Council of South Australia. It works to promote better health for people who inject drugs, their families and the broader community.	(08) 8334 1699	Monday to Friday 9am - 5:30pm
Counselling Services			
MOSAIC Counselling	MOSAIC is a free and confidential counselling service available to children, adolescents, women and men affected by HIV or hepatitis C, including family, friends and carers of someone who is diagnosed with, or at risk of Hepatitis C or HIV.	Metropolitan callers: (08) 8223 4566 Country callers: 1800 182 325	Monday to Friday 9am - 5pm
Gay and Lesbian Community Services	GLCS responds to any counselling and advice requests.	(08) 8422 8400 or 1800 182 233 for country callers	Monday to Friday 7pm - 10pm and Saturday and Sunday 2pm - 5pm.
Culturally and Linguistically Diverse Services			
P.E.A.C.E	Provides support and education services in relation to HIV and hepatitis C for people from a Culturally and Linguistically Diverse background.	(08) 8245 8100	Monday to Friday 9am - 5pm
Indigenous Services			
Nunkuwarrin Yunti	Nunkuwarrin Yunti is the foremost Aboriginal and Torres Strait Islander community controlled centre in Adelaide, South Australia, providing health care and community support services to Aboriginal and Torres Strait Islander people. Also provides access to a Clean Needle Program.	(08) 8223 5217	Monday to Friday 9am - 5pm

Sexuality Services			
Gay Men's Health	<p>Services for gay and same sex attracted men, including:</p> <ul style="list-style-type: none"> • free, confidential counselling • phone information and support on sexuality, HIV / AIDS, general health and social issues. • accommodation support • Thursday night drop-in 	<p>Man2Man Info Line (08) 8334 1617 Country callers 1800 671 582 http://www.acsa.org.au/GMHmain.html</p>	Monday to Friday 9.30am - 5pm.
Bfriend	<p>Bfriend is a programme of UnitingCare Wesley Adelaide providing support for people of all ages who are wondering about their sexuality/gender identity and/or people who are newly identifying as same sex attracted/gay/lesbian/bisexual/transgender/intersex/queer.</p>	<p>(08) 8202 5805 or (08) 8202 5192. http://www.ucwesleyadelaide.org.au/bfriend/about.htm For more on the Culturally and Linguistically Diverse project, call (08) 8202 5894</p>	Monday to Friday 9am - 5pm.
The Inside Out Project	<p>This is a project of The Second Story Youth Health Service for young men under 26 who are gay, bisexual, transgender, attracted to other guys, or questioning their sexuality. Inside Out provides counselling, workshops, support groups, advocacy, HIV/AIDS counselling and testing, and links with other agencies.</p>	<p>Contact:</p> <ul style="list-style-type: none"> • Central Office (08) 8232 0233 • Northern Office (08) 8255 3477 • Southern Office (08) 8326 6053 • Inside Out Project web site: http://www.insideout.cyh.com 	Monday to Friday 9am - 5pm
Sexual health and sexual assault services			
SHine SA	<p>SHine SA is the leading sexual health agency in South Australia. SHine SA provides a confidential Sexual Healthline phone service. SHine SA also offers a therapeutic counselling service provided by professional sexual health counsellors. The service is available to individuals, couples and families. Counsellors also conduct group sessions and provide advice and referral on sexual health related concerns.</p>	<p>Telephone: 1300 883 793 Fax: (08) 8300 5399 Toll free: 1 800 188 171 (country callers only) TTY: (08) 8300 5300 East/West Team (08) 8300 5300 Northern Team (08) 8252 7955 Southern Team (08) 8325 8164 http://www.shinesa.org.au</p>	Monday to Friday 9am - 1pm. Call for appointment.

Sexual health and sexual assault services (cont)			
Yarrow Place	Yarrow Place is the lead public health agency responding to adult rape and sexual assault in South Australia. Yarrow Place also employs an Aboriginal Sexual Assault worker.	(08) 8226 8777 Toll Free in SA: 1800 817 421 After Hours and Emergency: (08) 8226 8787 http://www.yarrowplace.sa.gov.au	24 hour service with after hours calls diverted to Crisis Care. On-call Crisis Response Workers and Doctors are available in the case of recent sexual assault.
Youth services			
Second Story Youth Healthline	The Second Story is the youth section of Children, Youth and Women's Health Service. The Second Story is a free, confidential health service for young people aged 12 to 25 years. The Youth Healthline service provides accurate health information, 24 hours a day, 7 days a week.	1300 13 17 19	24 hours, 7 days a week.
Other			
AIDS Council of SA	Volunteers provide accurate, up-to-date information, support and referrals on a range of HIV/AIDS and related issues. Information about gay and lesbian friendly services and businesses.	(08) 8334 1611 Toll free 1800 888 559 Toll free country line 1800 671 582 TTY 8362 1306 http://www.acsa.org.au	Monday to Friday from 9am - 5pm.
Hepatitis C Council of SA	Provides: Education and awareness that targets focus populations and contributes to prevention efforts, Advocacy and Information and support for those affected by hepatitis C. Hepatitis C Council of SA also operates an Info and support phonline.	Info and Support line: (08) 8362 8443 or 1800 021 133 for country callers. http://www.hepccouncilsa.asn.au	Monday to Friday 9am - 5pm
SA Sex Industry Network (SA SIN)	SIN aims to improve the working lives of sex workers and is committed to promoting pride and empowerment though the sex industry.	(08) 8334 1666 http://www.acsa.org.au/SINmain.html	Tuesday to Friday 9:30am - 5pm.

Appendix 10: Safe sex information

Safer Sex and Condoms

(Reproduced with permission of STD Services and Clinic 275)

Why safe sex is important

Sexually transmitted diseases (STDs) are infections spread through sexual activity – vaginal, oral or anal.

Although some STDs can be easily treated, there is no cure for other infections. Some STDs, for example HIV, hepatitis B and chlamydia, can have serious health consequences.

A person can have any of the sexually transmitted infections without symptoms. They may be unaware they have an infection and may be passing it on each time they have sex.

You won't always know if someone you have sex with is able to give you an infection. That's why it's important to protect yourself by having safer sex.

Reducing the risk

The only way to be 100% sure of not getting an STD is never to have sex. So when you do have sex, you need to reduce the risk of catching an infection (or passing on an STD you may not know you have!)

There are various strategies to use. Choose a method that suits your situation – they don't all work for everyone.

- Have an STD check-up after sex with a new partner. If you have caught an infection it may be possible to treat it before complications develop. The sooner you know you have an STD, the less likely you are to pass it on to someone else.
- If you are in a stable relationship and neither person has other sexual partners, you can both have an STD check-up. If both partner's results are negative, it may be OK to have unprotected sex. Discuss this with a doctor or health adviser.
- If you have sex with more than one partner, or if you often change partners, consider having fewer partners. The more people you have sex with, the more likely it is that one of them will have an STD.
- Be very careful if you have sex with people you don't know well. You are less likely to know if they have an STD or have had a check-up recently.
- Use safer sex practices when you have sex, unless you are certain you and your partner do not have any STDs. You would both need an STD check-up to be sure of this.

Safer sex practices

Safe sex means not allowing your partner's body fluids (blood, semen, vaginal fluids) into your body and vice versa.

It also means covering or avoiding contact with parts of the body that might be infectious through skin-to-skin contact (e.g. herpes sores, warts).

With some forms of sex, it is possible to avoid the transfer of body fluids, e.g. massage and mutual masturbation ("hand jobs").

Safer oral sex

Oral sex has a lower risk of transmitting most (but not all) STDs. If you have oral sex, you can reduce the risk of infection by following these guidelines:

- Use condoms. (Flavoured ones are available!)
- Use dental dams (see below).
- Don't get semen or blood in your mouth.
- Avoid oral sex if you have mouth ulcers or bleeding gums. Don't brush your teeth immediately before oral sex
- If you get cold sores, don't give your partner oral sex when you have an outbreak. (This is because cold sores are caused by the herpes virus).

Using condoms

- Use condoms that meet Australian and International Standards.
- Check the use by date on the packet.
- Open the packet carefully. (Figure 1)
- Be careful not to snag the condom with rings or fingernails. Check which way the condom unrolls but *don't unroll it* before putting it on.
- Use the condom for the whole time you are having intercourse. Put the condom on when the penis is hard and erect and before the penis touches the vagina or anus.
- Squeeze the teat on the end of the condom between two fingers. This expels the air so there is room for semen. Place the condom against the tip of the penis. (Figure 2)
- Gently unroll the condom down to the base of the penis. If you don't get it on the first time, throw the condom away and start again. (Figure 3)
- Use a water soluble lubricant. This is *essential* for anal intercourse. Rub it on the outside of the condom. Lubricant makes intercourse more comfortable and helps prevent the condom breaking. Some water based lubricants include *Wet Stuff, KY, Lubafax, Le Gel, Glyde* and *Muko*. It's important to use a water-based lubricant; oils can weaken condoms and cause them to break.
- The penis should be withdrawn immediately after ejaculation. Hold the rim of the condom to stop any spillage. (Figure 4) Slip the condom off carefully.
- You can only use a condom once. If you want to have sex again, put on a new condom.
- Don't flush used condoms down the toilet. Wrap them in paper and put them in a bin.

Looking after condoms

Condoms that break put you at risk of catching an STD. They may be damaged by:

Heat: Keep condoms in a cool, dry place (not the glove box of a car).

Oil: Oil-based lubricants can cause condoms to perish. *Never* use baby oil, vaseline or petroleum jelly.

Teeth: Do not use your teeth to open the condom package. During oral sex, teeth may break the condom.

Friction: *Always* use a water-based lubricant to prevent condoms breaking.

Age: Make sure the use by date has not expired.

Dental dams: the other barrier for oral sex

Latex barriers or *dental dams* are squares of ultra-thin latex that can be put over a partner's vulva or anal area during oral sex.

Some are thin and silky, and they come in a variety of flavours. Alternatively you can cut an unrolled condom to the tip and make a latex barrier.

Where you can get condoms

- supermarkets
- chemists
- vending machines
- Family Planning Association
- Youth Services
- Aboriginal Medical Service
- AIDS Council.
- sex-worker organizations

More information

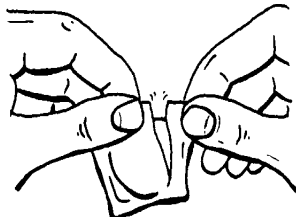
STD Services web site: www.stdservices.on.net/std/prevention/

Disclaimer

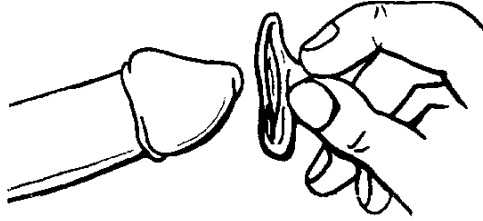
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STD Services June 2007

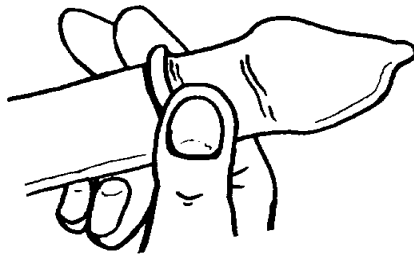
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