The Republic of Uganda

Ministry of Health

Technical Guidance on Pre-Exposure Prophylaxis (PrEP) for Persons at Substantial Risk of HIV Infection in Uganda

December, 2022

DISCLAIMER

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FOREWORD

Uganda is committed to ending HIV as an epidemic and AIDS as a public Health threat by the year 2030. This will be achieved through implementing strategies that lead to zero discrimination, zero death due to HIV related illnesses and zero new infections. To reduce new HIV infections, the country has adopted the combination HIV prevention strategy focusing on structural, behavior and biomedical interventions. Among the biomedical interventions, the country adopted the use of antiretroviral drugs for prevention including Pre-Exposure Prophylaxis (PrEP).

Oral PrEP implementation started in July 2017, and by the end of 2021 a total of approximately 180,000 clients had been initiated on PrEP in 350 facilities across 65 districts in the country. The implementation of PrEP has faced a number of challenges, including barriers to uptake, continuation and effective use. Furthermore, offering laboratory screening tests before PrEP initiation and HIV testing for PrEP refills have proved challenging for programs. With the publication of new World Health Organization (WHO) guidance, especially on HIV testing and laboratory screening for oral PrEP, and the coming on board of new effective PrEP products (the dapivirine vaginal ring and long acting injectable cabotegravir, which were approved by WHO and adopted by the country as additional options for PrEP users), there was need to review and update the PrEP technical guidelines.

This technical guidance is an important document that guides the implementation of PrEP as an HIV prevention option in Uganda. I would like to extend my gratitude to the Technical Working Group and to the different individuals who contributed to the review of this document for their tireless efforts. Furthermore, I thank the US President's Emergency Plan for AIDS Relief, which funded the review of this guide through the Makerere University Walter Reed Program, and the U.S. Agency for International Development's MOSAIC project. It is my sincere hope that this guide will be utilized by the health care workers and the stakeholders in their efforts to reduce the incidence of HIV in Uganda.

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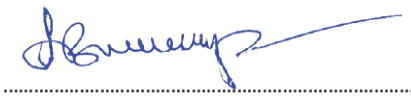

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ABBREVIATIONS

3TC	Lamivudine
AFAB	Assigned Female at Birth
AHI	Acute HIV Infection
AIDS	Acquired Immune Deficiency Syndrome
AMAB	Assigned Male at Birth
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CAB-LA	Long-acting Injectable Cabotegravir
CDC	Centers for Disease Control and Prevention
CDDP	Community Drug Distribution Points
DXA	Duo-energy X-ray Absorptiometry
ED	Event-drive
eGFR	Estimated Glomerular Filtration Rate
FP	Family Planning
FTC	Emtricitabine
GFR	Glomerular Filtration Rate
HBsAg	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
IPC	Infection Prevention and Control
KP	Key Population
MoH	Ministry of Health
OPD	Outpatient Department
PEP	Post-exposure Prophylaxis
PEPFAR	US President's Plan for AIDS Relief
RH	Reproductive Health
SMC	Safe Male Circumcision
STI	Sexually Transmitted Infection
TDF	Tenofovir Disoproxil Fumarate
UAC	Uganda AIDS Commission
UNAIDS	Joint United Nations Programme on HIV/AIDS
UPHIA	Uganda Population-based HIV Impact Assessment
USAID	United States Agency for International Development
WHO	World Health Organization

GLOSSARY OF TERMS

Term	Working definition
Adolescent Girls and Young Women	10–24 years
Adolescents	10–19 years
Adult	18 years of age and older
ART	Antiretroviral therapy is a combination of ARV drugs used to achieve viral suppression. It is usually given for life.
ARV	Antiretroviral drugs
Children	Persons younger than 18 years
Combination HIV Prevention	Behavioral, biomedical and structural interventions to achieve maximum impact on reducing HIV transmission and acquisition
Cascade of HIV Care/Continuum of Care	Sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving viral suppression
Health Service Provider	Anyone who renders health care, including doctors, nurses, clinical officers, and counselors
Key Populations	Groups with a greater likelihood of exposure to HIV irrespective of the epidemic type or local context. In Uganda, these populations include sex workers, MSW, transgender persons, people who inject drugs and people in incarcerated settings.
PEP (Post-exposure Prophylaxis)	Short-term use of ARV drugs to reduce the likelihood of acquiring HIV after potential exposure
PrEP (Pre-exposure Prophylaxis)	The use of ARV drugs by persons who do not have HIV to prevent the acquisition of HIV before exposure to HIV
Sero-different Couples	Couples where one partner is living with HIV and the other partner is HIV negative
Sex Workers	Female, male and transgender people who receive money and goods in exchange for sexual services, either regularly or occasionally
Substantial Risk	HIV incidence greater than 3 per 100 person–years
Treatment as Prevention	The use of antiretroviral treatment to decrease the risk of HIV transmission due to suppressed viral loads
Vulnerable Populations	Groups of people who are particularly susceptible to HIV infection in certain situations or contexts, such as adolescent girls, orphans, street children, people with disabilities, and migrant and mobile workers
Youth	Ages 15–24 years
Cisgender	Refers to people whose gender identity matches their sex assigned at birth. The Latin prefix “cis” stands for “on the same side,” while the prefix “trans” stands for “on the opposite side.” Cisgender may also

	be defined as those who have "a gender identity or perform a gender role society considers appropriate for one's sex." This has a more positive connotation than "normal" or "non-transgender."
Transgender	A person who has a gender identity that is different from his or her sex assigned at birth. Transgender people may be male to female (female appearance) or female to male (male appearance). It is preferable to describe a transgender person as "he" or "she" according to their gender identity, i.e., the gender that they identify with, not their sex at birth.

1.0 INTRODUCTION TO THIS GUIDE

1.1 Background

Uganda has one of the highest HIV and AIDS disease burdens, with a prevalence of 5.5% among adults ages 15-49 years, 7.1% among females, and 3.8% among males. Approximately 1.3 million adults 15 years and older are living with HIV (UPHIA, 2020). The Joint United Nations Programme on HIV/AIDS (UNAIDS) 2020 Spectrum estimates that the HIV incidence rate is 0.95 per 1,000 persons; 570 young women ages 15–24 years acquire HIV each week in Uganda (UNAIDS 2020 spectrum estimates).

Uganda adopted the HIV combination prevention strategy consisting of structural, behavioral and biomedical interventions. The biomedical interventions include safe male circumcision (SMC), condoms, antiretroviral (ARV) drugs for prevention and treatment (prevention of vertical transmission, pre-exposure prophylaxis[PrEP] and post-exposure prophylaxis [PEP]) and harm reduction. The adoption of the combination prevention strategy contributed to key achievements, with a significant reduction in new HIV infections from 123,000 in 2015 to 53,000 in 2018 and 38,000 in 2020 (UNAIDS, 2020). Despite these achievements, new HIV infections are still unacceptably high, even with the inclusion of oral PrEP in the combination HIV prevention strategy.

PrEP is the use of ARV drugs by people who are HIV-negative to prevent HIV acquisition before potential HIV exposure. In 2021 and 2022, the World Health Organization (WHO) provided new HIV prevention guidance that includes additional options for PrEP: the dapivirine vaginal ring (hereafter referred to as the “PrEP ring” or “the ring”) and long-acting injectable PrEP. These provide yet another opportunity to expand the available options for individuals in need of HIV prevention.

The PrEP ring and long-acting injectable cabotegravir (CAB-LA) are offered as additional prevention choices for persons in need of HIV prevention as part of combination HIV prevention package. PrEP ring and CAB-LA can be used discreetly and provide an opportunity to address challenges to effective use of oral PrEP faced by clients.

These guidelines provide a framework for health workers to provide daily and event-driven (ED) oral PrEP, PrEP ring and CAB-LA.

1.2 Rationale

Uganda adopted oral PrEP in 2017 and has since rolled it out in a phased-funded approach. Since 2017, oral PrEP has been scaled up from six sites in four districts to 351 sites in over 65 districts across the country. By end of June 2022, over 250,000 clients had ever initiated oral PrEP. Despite these achievements, there have been challenges: oral PrEP uptake is at 60% among those eligible, and only 20% of those who initiated oral PrEP continue to take it. A root cause analysis (RCA) attributed these levels of uptake and continuation to the burden of daily pill taking and drug fatigue, poor access to the facilities that offer oral PrEP due to travel and

transport challenges, the high mobility of some clients, forgetting to take the drug, fear of being seen taking drugs with packaging similar to that of ARVs used for treatment, lack of food, perceived low risk, lack of information, fear of side effects, poor counseling, negative attitudes of the service providers toward oral PrEP (e.g., thinking that it encourages transactional sex), and knowledge gaps (RCA, 2020).

After WHO in 2021 and 2022 recommended including the PrEP ring and CAB-LA as part of HIV combination prevention, Uganda adopted these new options for PrEP users. This decision necessitated the review and update of Uganda's Technical Guidance on PrEP for Persons in need of HIV prevention.

1.3 Purpose of the PrEP Guidelines

The purpose of these guidelines is to provide a framework for health service providers to deliver quality PrEP services at all levels of the health system.

1.4 Objectives of the PrEP Guidelines

To provide guidance to health service providers on:

1. Client screening for eligibility, offering appropriate linkage and referrals for PrEP services
2. Initiation and monitoring of clients on PrEP
3. Recording and reporting of PrEP services

1.5 The Review of the PrEP Guidelines

The review of these PrEP Guidelines was a consultative process spearheaded by the Ministry of Health and involving a number of stakeholders. A task force was constituted to review existing studies, policies, strategies, WHO guidance and various reports on PrEP and to develop an initial draft. Meetings to refine the draft were conducted with implementing partners, health development partners, technical working groups, PrEP service providers, district health teams, civil society organizations and PrEP beneficiaries.

1.6 Target Audience for the PrEP Guidelines

The target audience for these PrEP guidelines include policy makers, funding agencies, implementers, advocates, service providers, beneficiaries and any other stakeholders involved in PrEP service delivery.

1.7 Guiding Principles

Access: Identify individuals with increased need of HIV prevention and ensure access to HIV interventions including PrEP

Integration: Integrate PrEP into other HIV prevention programs, including sexual and reproductive health services

Quality of care: Provide PrEP within a framework of quality health service provision

Public health and rights-based approach: PrEP can enable and empower individuals to have an informed choice of HIV prevention options, using a public health approach. This approach includes confidentiality, access to non-discriminatory health care, privacy, informed decision-making and shared responsibility.

Choice: As more PrEP products become available, informed choice is an important factor to consider in client-provider interactions and decision-making, especially because clients who can choose a preferred product are more likely to use it effectively. Providing additional choices for PrEP and supporting clients to select their preferred methods offers the potential to increase uptake and effective use of PrEP.

2.0 USE OF PrEP

2.1 Overview of PrEP

PrEP is an important biomedical intervention element of the comprehensive Combination HIV Prevention Strategy. PrEP is the use of ARV drugs by HIV-negative individuals to reduce the risk of HIV acquisition. The level of effectiveness provided by PrEP is strongly correlated with effective use, meaning it is important for clients to use PrEP methods as prescribed. Current PrEP methods in use in Uganda do not prevent pregnancy and sexually transmitted infections (STIs) other than HIV.

These guidelines focus on Tenofovir Disoproxil Fumarate (TDF)-based daily and ED oral PrEP, the monthly "PrEP ring" and CAB-LA.

2.2 Oral Daily PrEP

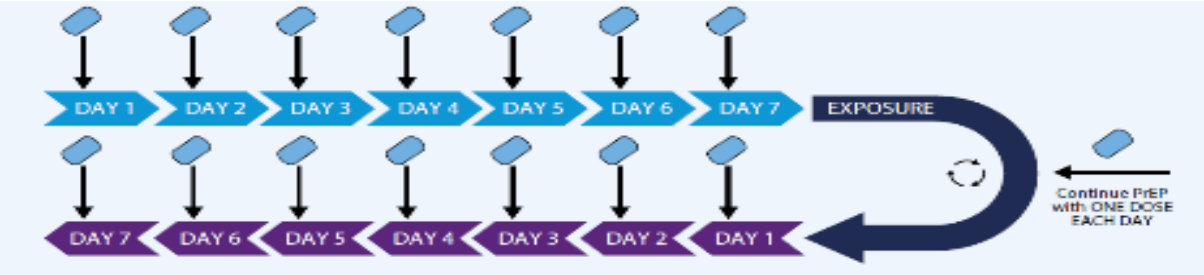
Oral daily PrEP taken as a once daily combination pill of TDF + FTC or TDF+ 3TC is effective and safe for preventing HIV acquisition by HIV negative individuals at substantial risk of HIV infection.

Oral daily PrEP is offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention strategy that includes; use of condom, and condom-compatible lubricants, STI screening and management, harm reduction, risk-reduction counselling, screening and management of intimate partner violence (IPV) and other gender-based violence (GBV), and effective antiretroviral treatment for partners living with HIV, among others.

Table 1: Summary table of starting and Stopping oral daily PrEP

Population	Starting oral daily PrEP	Using oral daily PrEP	Stopping oral daily PrEP
Cisgender women and trans and gender diverse people assigned female at birth	1 dose daily for 7 days before exposure	1 dose per day	1 dose daily for 7 days after last potential exposure

Figure 1: Example of daily oral PrEP use



2.3 Event-driven PrEP

Event-driven PrEP (ED-PrEP), also called on-demand PrEP or 2+1+1, is effective in reducing the likelihood of HIV acquisition during sex for cisgender men, trans and transgender and gender diverse people Assigned Male at Birth (AMAB) who are not using estradiol-based exogenous hormones.

ED-PrEP is appropriate for people AMAB who are not using estradiol-based exogenous hormones and who;

- find it more convenient to have infrequent sex (for example, fewer than two times per week on average)
- are able to plan for sex at least two hours in advance
- can delay sex for at least two hours

To start ED-PrEP, a double dose should be taken two to 24 hours before potential sexual exposure. Clients should be encouraged to take the loading dose as close to 24 hours before exposure as possible.

Daily or event-driven PrEP can be safely offered to persons with hepatitis B, so a wait for hepatitis B test results should not delay initiation. If tested for hepatitis B, clients who are negative can be offered hepatitis B vaccination (per national hepatitis guidelines, if available).

2.3.1 Additional Guidance for ED-PrEP Use

Clients AMAB who are not using estradiol-based exogenous hormones may benefit from providers walking through some scenarios to support their effective use of ED-PrEP. See *Figures 2–7* below.

Figure 2: Example of ED-PrEP use for sex one time or in one day

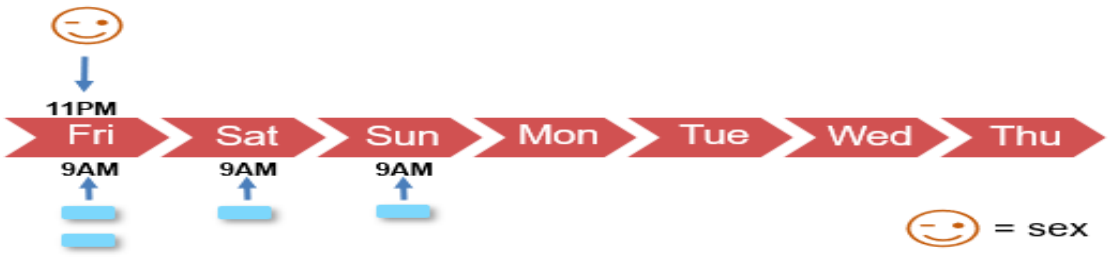


Figure 3: Example of ED-PrEP use for sex on multiple consecutive days

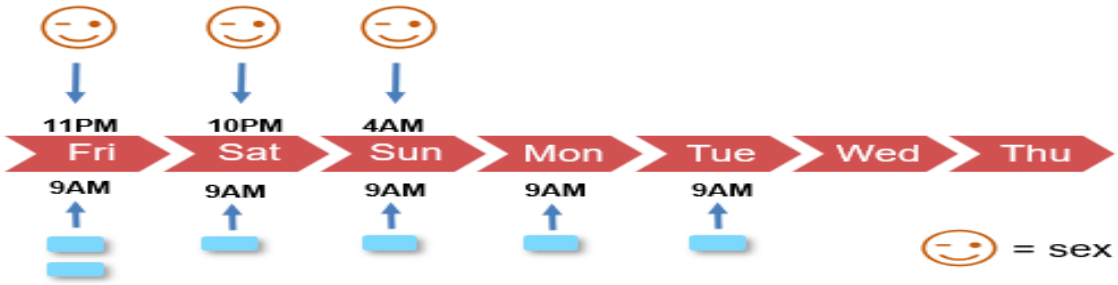


Figure 4: Example of ED-PrEP use for sex on multiple non-consecutive days

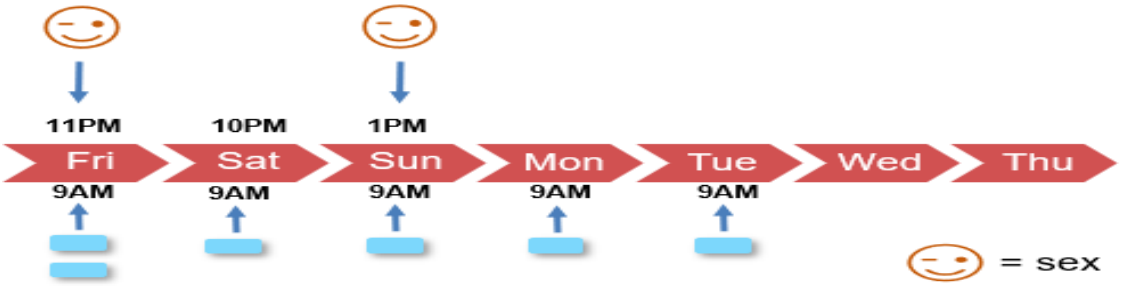
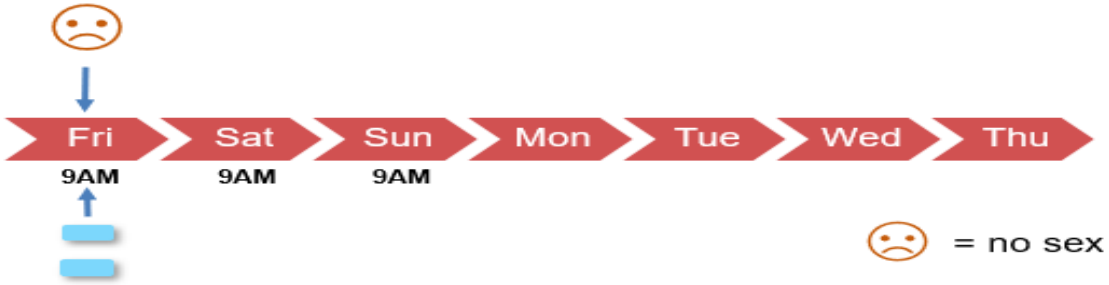


Figure 5: Example of ED-PrEP use when sex does not occur



2.3.2 Switching between ED-PrEP and Oral Daily PrEP

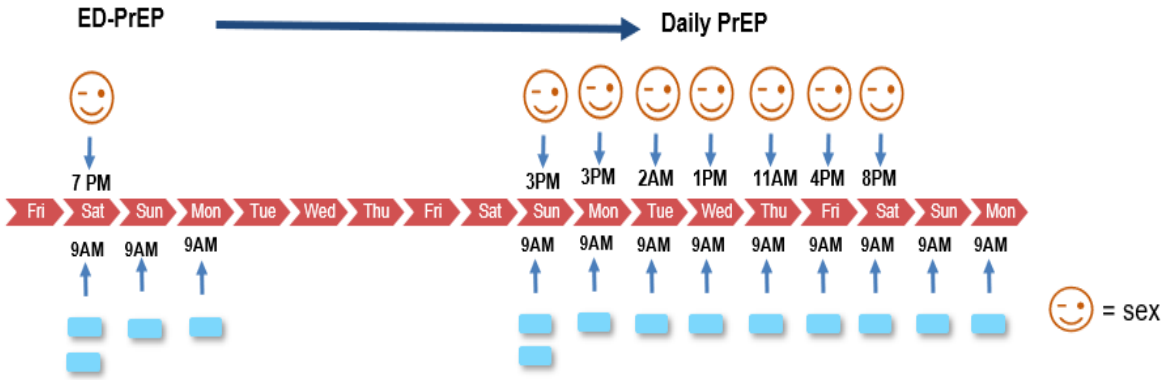
Clients AMAB who are not using estradiol-based exogenous hormones may switch between ED-PrEP and daily oral PrEP as their needs for HIV prevention evolve. Clients may decide to switch back and forth between ED-PrEP and daily oral PrEP due to changes in relationship status or sex partner(s), behavioral changes, moving to a new location, or any situation affecting the frequency and predictability of sex, or when a client's preferred PrEP option changes.

For clients who are taking ED-PrEP, transitioning to daily oral PrEP may be appropriate if sex becomes more frequent and/or less predictable.

There is no limit on the number of times a client can switch between ED-PrEP and daily oral PrEP. To transition from ED-PrEP to daily oral PrEP, a client should continue daily dosing indefinitely after the last exposure. Daily dosing would continue until sex becomes less frequent and more predictable again, or for as long as the client prefers the daily dosing option

To transition, a client should continue with daily dosing oral PrEP for as long as they are still at substantial risk (see *Figure 6*).

Figure 6: Example of transitioning from ED-PrEP to daily PrEP for AMAB clients



For clients AMAB who are not using estradiol-based exogenous hormones and who are taking daily oral PrEP, transitioning to ED-PrEP may be appropriate if sex becomes less frequent and more predictable. To transition, a client should stop daily dosing two days after last potential exposure, and then start following the ED-PrEP regimen until sex becomes less frequent and/or more predictable. See *Figure 7* below.

Figure 7: Example of transitioning from daily PrEP to ED-PrEP for AMAB

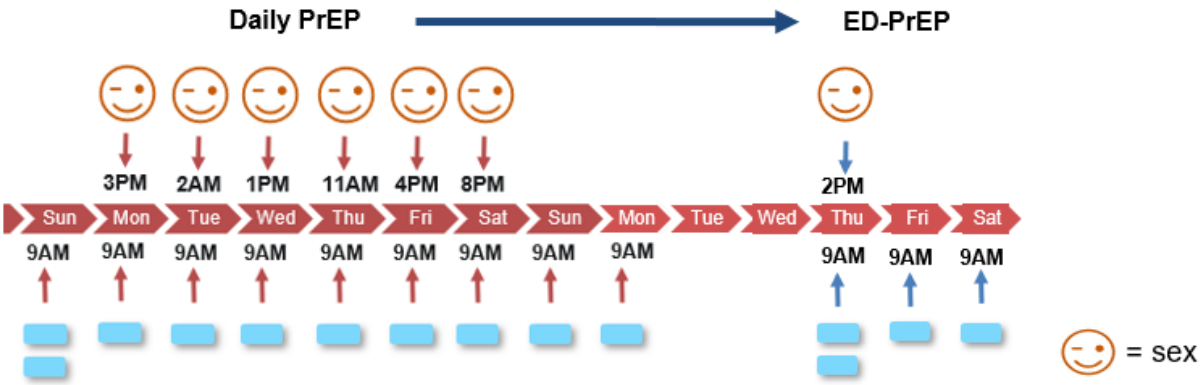


Table 2: Summary table of starting and stopping ED PrEP

Population	Starting ED PrEP	Using ED PrEP	Stopping ED PrEP
Cisgender men, transgender and gender-diverse people assigned male at birth who: • have sexual exposure • are not taking exogenous estradiol-based hormones (hepatitis B virus is not a contraindication)	Double dose 2–24* hours before sexual exposure * ideally closer to 24 hours	1 dose per day	1 dose per day until 2 days after day of last potential sexual exposure

2.4 PrEP Ring

The PrEP ring may be offered as an additional prevention choice for women at substantial risk of HIV infection as part of combination HIV prevention strategy. It is a flexible silicone vaginal ring that slowly releases the antiretroviral drug dapivirine, which is a non-nucleoside reverse transcriptase inhibitor, into the vaginal mucosa over the course of one month. The ring must be in place for at least 24 hours before it is maximally effective. The ring may be offered as an option for people assigned female at birth (AFAB) who wish to prevent HIV acquisition through receptive vaginal sex and are unable or do not want to use other PrEP options, or when other PrEP options are not available. The ring must be inserted correctly into the vagina and worn for one month without removal.

The PrEP ring has a shelf life of five years. It should be stored at room temperature away from direct light and out of reach of children. Offering the ring in community settings would increase access to HIV prevention options, especially for those who are not currently accessing PrEP services in clinical settings.

If a client wishes to discontinue use of the ring, they can remove it. Ideally, clients who are discontinuing PrEP use will alert their providers and receive support to use other HIV prevention practices if they are still having ongoing exposure to HIV.

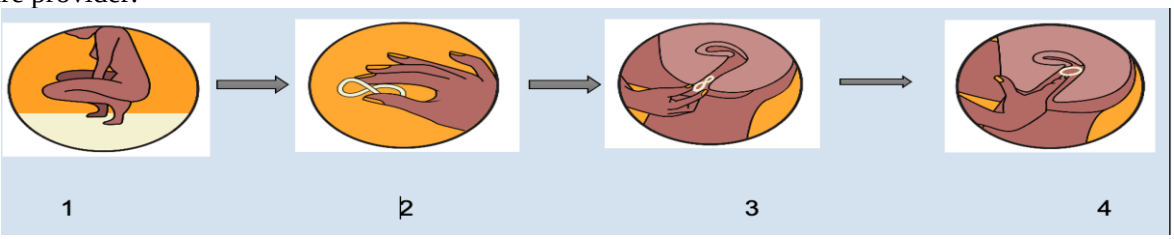
2.4.1 PrEP Ring Insertion and Removal

2.4.1.1 Inserting the PrEP Ring

Clients should be given initial information, demonstration and support on ring insertion and removal, and once confident, clients can continue to use the ring on their own. Some clients are comfortable using the ring on their own with minimal support from their first use. However, for clients who prefer support, a health care provider can help insert the ring or confirm placement. The ring is inserted by hand; there is no need to use a speculum or other tools to insert the ring. Clear visual instructions should be offered with the ring. Ring insertion steps for clients are listed in Box 1.

Box 1. Ring insertion steps for clients

1. Get into a position that is comfortable for inserting the ring, such as squatting, lifting one leg, or lying down. If a health care provider is assisting you, you should be in a reclining position.
2. With clean hands, squeeze the ring between the thumb and forefinger, pressing both sides of the ring together so that the ring forms a “figure 8” shape.
3. Use the other hand to open the folds of skin around the vagina.
4. Place the tip of the ring into the vaginal opening and use your fingers to push the folded ring gently up into the vagina.
5. Push the ring as far toward the lower back as possible. If the ring feels uncomfortable, it is probably not inserted far enough into the vagina. Use a finger to push it as far up into the vagina as is comfortable.
   *Ring insertion should be painless. If you have any bleeding or discomfort upon insertion, contact your health care provider.

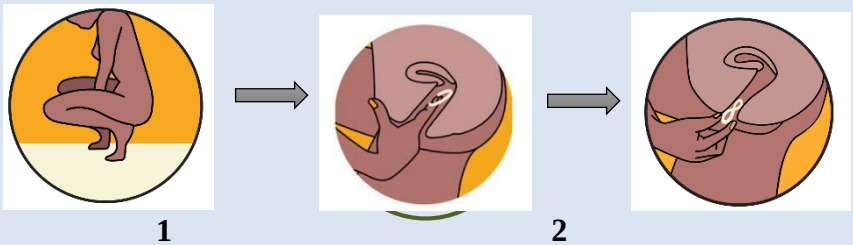


Clients can remove the ring with or without the help of a health service provider. However, for clients who prefer support, a health service provider should help remove the ring. The ring is removed by hand; there is no need to use a speculum or other tools to remove the ring. If a client is being assisted by a health service provider, they should be in a reclining position during removal. Ring removal steps for clients are listed in *Box 2*.

Box 2. Ring removal steps for clients

1. Get into a position that is comfortable for removing the ring, such as squatting, lifting one leg, or lying down.
2. With clean hands, insert one finger into the vagina and hook it around the edge of the ring.
3. Gently pull the ring out of the vagina.

**Ring removal should be painless. If you have any bleeding or discomfort upon removal, contact your health care provider.*



1 **2** **3**

2.4.2 Switching from the PrEP ring to other PrEP options

Table 3: Switching between PrEP Options

PrEP ring to Oral PrEP	PrEP ring to CAB-LA
• After removal of the ring, the client should take oral PrEP for at least 7 days before a potential exposure. • If the client is to have sex before taking oral PrEP for at least 7 days, they should: ▪ Use a condom for at least 7 days after removal of the ring, * or ▪ Take oral PrEP for at least 7 days before removal of the ring.	• The client should get a CAB-LA injection after removal of the ring and should not have unprotected sex for at least 7 days after the injection. • If the client is to have sex within 7 days of removing the ring and receiving a CAB-LA injection, they should: ▪ Use a condom for at least 7 days after removal of the ring, * **or** ▪ Get a CAB-LA injection 7 days before removal of the ring.
* If a client stops using a condom after the 7 days, they will be at increased likelihood of exposure to STIs and (for clients AFAB) pregnancy.	

2.4.3 Contraindications for PrEP Ring Use

The ring should not be provided to people with:

- An HIV-positive test result according to the national HIV testing algorithm
- Known exposure to HIV in the past 72 hours (because such clients may derive more benefit from PEP if the potential for HIV exposure was high
- Signs of acute HIV infection (AHI) (see *Box 3*) and potential exposure within the past 14 days
- Inability to commit to effectively use the ring and attend scheduled follow-up visits
- Allergy or hypersensitivity to active substance or other substances listed in the product information sheet

2.5 Long-Acting Injectable PrEP

Long-acting injectable cabotegravir (CAB-LA) may be offered as an additional prevention choice for people at substantial risk of HIV infection, as part of combination prevention approaches.

Injectable cabotegravir is a long-acting drug which is an integrase inhibitor. It is effective in preventing HIV among people at substantial risk of acquiring HIV. It is administered in the buttock; 600mg month 1 and month 2, and then once every 8 weeks. It is contraindicated in people who are Hypersensitive to any active substances in CAB-LA. CAB-LA could be a good choice for people who value discretion, are familiar and comfortable with needles and/or have difficulty storing or taking oral PrEP.

CAB-LA is an intramuscular injection long-acting form of PrEP with the first two injections administered 4 weeks apart, followed thereafter by an injection every after 8 weeks.

2.6 Considerations for Provision of PrEP

2.6.1 Eligibility

The following are the five eligibility elements for PrEP:

1. **Seronegative**: Only seronegative clients will be initiated on PrEP.
2. **No suspicion of acute HIV infection:** Clients with AHI ("flu-like" symptoms AND recent exposure to HIV) will not be offered PrEP until they are proved to be HIV

3. **At substantial risk of HIV infection**. PrEP will be offered to only clients who are deemed to be at substantial risk of HIV infection. They include individuals who:
    - Have multiple sexual partners of unknown HIV status
    - Engage in transactional sex including sex workers
    - Use or abuse drugs, substances and alcohol
    - Have had more than one episode of an STI within the last twelve months
    - HIV negative partners in a Sero-different relationship if the HIV positive partner is not on ART or when his/her viral load has not been suppressed.
    - Recurrent users of PEP
    - Individuals who engage in anal sex
    - Adolescent girls and Young Women (AGYW) who are at substantial risk of HIV
    - Pregnant women and lactating mothers at substantial risk of HIV
    - Key populations who are unable and unwilling to achieve consistent use of condoms
      People actively asking for PrEP
4. **Willingness to use PrEP as prescribed**. The Client should show willingness and readiness to start and adhere to PrEP ARVs.
5. **Free from contraindication for use of their chosen PrEP method**.

NOTE:

The decision to take PrEP should be made voluntarily by the individual client after receiving information on the risks and benefits of PrEP use.

People who are actively seeking to use PrEP should be comprehensively assessed for eligibility and considered for other prevention services

2.7 Steps for Initiating Clients on PrEP

2.7.1 Step 1: Screen for Substantial risk for HIV.

Assess the client for need for HIV prevention using the questions below;

Does the client:

- Have multiple sexual partners of unknown HIV status?
- Engage in transactional sex, including sex work?
- Use or abuse/inject drugs and or substances?

- Use or abuse alcohol?
- Have a history of more than one episode of an STI within the last 12 months?
- Have an HIV-positive partner who is not on ART or is on ART but not virally suppressed?
- Have recurrent use of PEP?
- Engage in anal sex?
- Belong to a key population group and say they are unable and/or unwilling to achieve consistent use of condoms?
- Ask for PrEP at the visit?

2.7.2 Step 2: Determine HIV Status of the Client.

- HIV testing and counseling should be conducted per national guidelines.
- In the absence of the recommended national HIV testing, HIV self-testing can be used for follow-up and refills for oral PrEP and the PrEP ring. If the results are positive with HIV self-testing, repeat the HIV test using the National Testing Algorithm.
- If the HIV status is unknown, conduct HIV testing to confirm status, and:
    - If HIV positive, refer to a care facility
    - If HIV negative, proceed with PrEP initiation
- If the test result is inconclusive, defer PrEP and follow the national algorithm until a definitive HIV test result has been obtained for all clients who are not pregnant or breastfeeding. In the meantime, counsel the client on other HIV prevention options.
    - If the definitive results from re-testing come back positive, refer the client for ART; if the results are negative, proceed with PrEP initiation.
    - If the results are inconclusive again, do a DNA PCR test.
    - For pregnant and breastfeeding people with inconclusive HIV test results, refer to PMTCT guidelines.
- For CAB-LA, the HIV test should also follow the national HIV testing algorithm.

2.7.3 Step 3: Assess for PEP Indication.

- Clients exposed to HIV within the past 72 hours: If a client reports an exposure to HIV within the past 72 hours, screen for PEP indication instead of PrEP and provide PEP according to national guidelines. Educate clients on the differences among PEP, PrEP, and ART and offer HIV exposure reduction counselling. After 28 days of PEP, a client may be transitioned from PEP to PrEP without a gap if they are HIV-negative and meet other criteria for PrEP use.

2.7.4 Step 4: Assess for Acute HIV Infection.

- Clients suspected to have AHI: If client presents with signs and symptoms of AHI (see *Box 3)* and possible exposure to HIV in the previous 14 days, the client is suspected to have AHI. In the absence of HIV testing that can reliably detect HIV given these clients' potential exposures and time frames, defer PrEP for four weeks and provide HIV exposure reduction counseling, as well as STI screening, diagnosis, and management, if available. Repeat HIV testing after four weeks; if the client is HIV-negative and meets other criteria for PrEP use, the client can start PrEP.

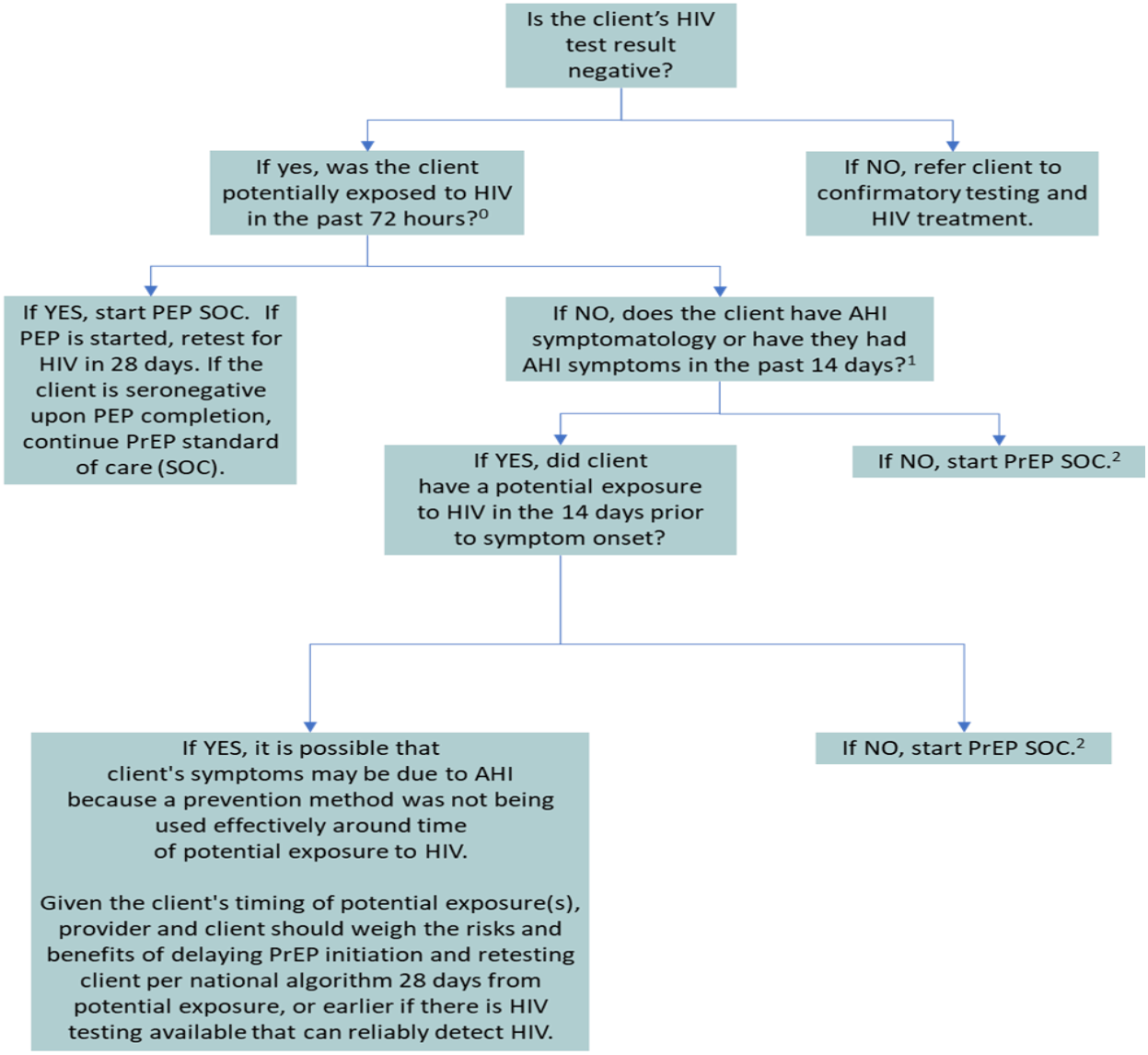
Box 3: Acute HIV infection

Severity of the syndrome ranges from mild non-specific "viral"' or "flu-like" symptoms to a severe infectious mononucleosis like-illness with immune dysregulation and transient profound CD4 depletion.

Symptom	**Sign**
Malaise	Fever, sweating
Anorexia	Generalised lymphadenopathy
Myalgias	Non-exudative pharyngitis
Headache	Aphthous ulceration
Sore throat	Truncal rash (maculopapular or urticarial)
Sore glands	

- **NOTE:** ***Rule out AHI and, if symptoms are reported, confirm HIV-negative status by fourth-generation HIV test or other HIV antigen test if available (which will reduce but not eliminate the "window" period).***

Figure 8: PrEP Initiation – HIV Exposure and AHI Assessment



0 An answer of "NO" to this question means no potential past exposure to HIV at all or potential HIV exposure that was 73+ hours ago.

[1] Two-thirds of people will have symptoms of AHI within 2–4 weeks of HIV acquisition (Letizia et al. 2022). Signs/symptoms mimicking acute HIV infection (sore throat, fever, sweats, swollen glands, mouth ulcers, headache, rash, and muscle aches) are commonly due to illnesses other than HIV; providers need to use discretion in determining whether the symptomatology is consistent with HIV or may be explained by an alternative cause.

[2] To make informed choice prior to starting PrEP, the client should be aware that available HIV testing may not have been able to detect HIV if the client acquired HIV fewer than 28 days ago and that there is a possibility the HIV test may not have detected HIV acquired beyond 28 days ago. The client should also be aware that while they do not have symptoms of AHI, they could be pre-symptomatic or be part of the one-third of individuals who do not develop symptoms of AHI after acquiring HIV.

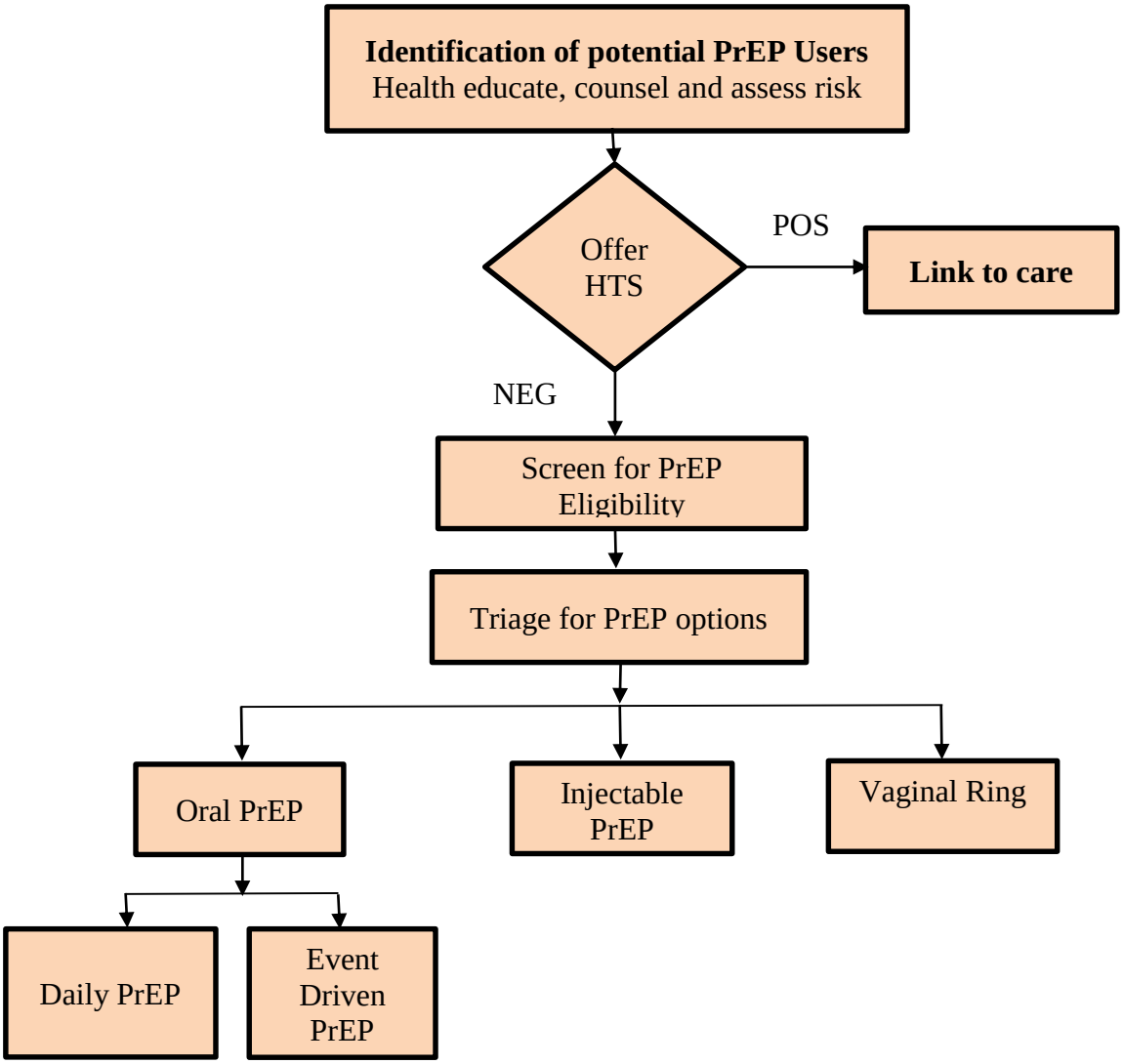
2.7.5 Step 5: Assess HIV Status of Sexual Partner.

If any sexual partner is known to be living with HIV, determine whether they are receiving ART. If the person is receiving ART, determine the duration on ART and whether they have achieved viral load suppression. If the person is not receiving ART, link them to care.

Consider PrEP for a client whose partner is HIV-positive and not on ART, has not been on ART for six months or is not adhering to the ART regimen, or has been on ART for more than six months but has **not achieved** viral suppression.

NOTE: A risk assessment of partner(s) is done to ascertain recurrent history of potential exposure to HIV according to the list of considerations in Step 1 above (unprotected sex with someone who is HIV positive or of unknown HIV status, experience of coercive sex, recurrent use of PEP, etc.).

Figure 9: Algorithm for offering PrEP



2.7.6 Step 6: Screen for Co-infections

2.7.6.1 Hepatitis B

Assess for hepatitis B infection before initiating oral PrEP and CAB-LA. If a client is fully vaccinated (three doses), it is not necessary to screen for hepatitis B. If negative, the client is eligible for oral PrEP, the ring and CAB-LA and should be advised to receive hepatitis B vaccination. Testing clients who are using PrEP for hepatitis B at or within three months of PrEP initiation is strongly suggested where feasible. Daily or event-driven PrEP and the PrEP ring can be safely offered to persons with hepatitis B, so a wait for hepatitis B test results should not delay initiation. If tested for hepatitis B, clients who are negative can be offered hepatitis B vaccination (per national hepatitis guidelines). Clients with hepatitis B who are not interested in oral PrEP should be referred to relevant management/treatment services. Clients who stop using oral PrEP should also be referred to relevant management/treatment services because stopping oral PrEP has implications for the management of hepatitis B.

If a client tests positive for hepatitis B:

- Refer for management of hepatitis B according to the national hepatitis B management guidelines and offer other HIV prevention options other than CAB-LA.
- Reassess the client after management of hepatitis B.

A hepatitis B test is not a requirement for initiation of the PrEP ring.

CAB-LA should not be initiated in people with acute viral hepatitis and should be discontinued if hepatotoxicity is confirmed. If a client is tested and the hepatitis B surface antigen (HBsAg) test is reactive (indicating hepatitis B virus [HBV] infection), needs for HIV prevention and hepatitis B treatment should be evaluated on a case-by-case basis, and PrEP and HBV treatment providers should (where possible) jointly manage these cases.

For people eligible for HBV treatment per WHO guidance, oral PrEP should be offered as the preferred PrEP option. Even where there is no indication for treatment for HBV, oral PrEP should be strongly considered, as it will both suppress hepatitis B and prevent HIV. CAB-LA is not active against hepatitis B.

Lack of availability of or access to hepatitis B testing should not be a barrier to PrEP initiation or use. If hepatitis B testing is conducted, PrEP can be initiated before the results are available.

2.7.6.2 Hepatitis C

Testing for hepatitis C is strongly encouraged at or within the first three months of PrEP initiation and every 12 months thereafter where PrEP services are provided to populations with increased likelihood of hepatitis C acquisition. Daily or event-driven PrEP and the PrEP ring can be safely offered to persons with hepatitis C, so a wait for hepatitis C test results should not delay initiation.

CAB-LA should not be initiated in people with acute viral hepatitis and should be discontinued if hepatoxicity is confirmed. If a hepatitis C serology test is reactive and chronic infection has been confirmed, hepatitis C treatment should be offered per WHO guidelines, and PrEP and hepatitis C treatment providers should (where possible) jointly manage these cases.

CAB-LA is not active against hepatitis C. There are no known drug–drug interactions between CAB-LA and treatment drugs for hepatitis C, but data are scarce. Alternative PrEP and HIV prevention options should be considered.

NOTE:
Non-availability of hepatitis B screening services or results should not delay initiation of oral PrEP and CAB-LA.

People with hepatotoxicity and hepatitis B should not be offered CAB-LA.

A hepatitis B test is not a requirement for initiation of PrEP ring.

2.7.7 Step 7. Assess for Contraindications to PrEP

2.7.7.1 Oral PrEP (TDF/FTC or TDF/3TC)

Oral PrEP should **NOT** be provided to people with:

- An HIV-positive test result according to the national HIV testing algorithm
- Potential exposure to HIV in the past 72 hours (these clients should be offered PEP)
- Signs of acute HIV infection (AHI) (see *Box 3*) *AND potential exposure to HIV within the past 14 days*
- Unwillingness or inability to commit to effectively using oral PrEP
- Allergy or hypersensitivity to an active substance or other substances listed in the product information sheet
- Known kidney function impairment, indicated by an estimated glomerular filtration rate (eGFR) of under 60 mL/min per 1.73m^2 or a creatinine clearance of less than 60 mL/min

Kidney function assessment is necessary for people using TDF-based oral PrEP; however, the absence of kidney function test should not delay initiation of PrEP. See *Table 4* below.

Table 4: Suggested procedures for assessing kidney function for oral PrEP users

Population (s)	Baseline Screening	Follow-up Screening
Individuals 29 years and younger with no kidney-related comorbidities[0]	Optional	If not conducted or if baseline test is normal,[1] follow-up is optional until 30 years of age or if kidney-related comorbidities develop. If baseline test result suggests at least mild loss of kidney function,[2] follow-up measurements every six to 12 months are suggested.
Individuals 30–49 years with no kidney-related comorbidities[0]	Conduct once at initiation or during a follow-up visit one to three months after initiation.	If baseline test is normal,[1] further screening is optional until 50 years of age or if kidney-related comorbidities develop. If baseline test result suggests at least mild loss of kidney function,[2] follow-up measurements every six to 12 months are suggested.
Individuals 50 years and older	Conduct once at initiation or during a follow-up visit one to three months after initiation.	Conduct follow-up measurements every six to 12 months.
Individuals of any age with kidney-related comorbidities[0]		
Individuals with previous measurement of kidney function suggesting at least mild loss of kidney function[2]		

[0]Kidney-related comorbidities include chronic kidney disease or risk factors such as diabetes or hypertension. People who are pregnant may be at an increased risk of kidney-related adverse events, and conditions such as preeclampsia may cause kidney impairment, so pregnant people can be considered for more frequent kidney function monitoring.

[1]eGFR ≥90 mL/min per 1.73 m2 or creatinine clearance of ≥90 mL/min

[2]eGFR <90 mL/min per 1.73 m2 or creatinine clearance of <90 mL/min

- **Low bone mineral density:** Duo-energy X-ray Absorptiometry (DXA) scans are not required before the initiation of PrEP or for the monitoring of persons while they are taking PrEP. TDF-based oral PrEP has been associated with decrease in bone mineral density; however, studies have shown that these are usually infrequent, are subclinical, did not result

in clinical events, were not progressive and reversed on stopping PrEP. TDF-based oral PrEP should be used with caution in persons with a history of fragility fractures or significant risk factors for osteoporosis including;

- Individuals with untreated or uncontrolled conditions known to affect bone metabolism (e.g., thyrotoxicosis, tuberculosis, diabetes mellitus, hepatitis C or renal disease)
- Individuals taking medications known to interfere with bone metabolism (steroids, anti-convulsants, bisphosphonates and cancer drugs)
- Post-menopausal women
- Women who have had a hysterectomy and/or oophorectomy

NOTE: ***Non-availability of renal function tests or results should not delay initiation of PrEP.***

2.7.7.2 PrEP Ring

The ring should not be provided to people with:

- An HIV-positive test result according to the national HIV testing algorithm
- Known exposure to HIV in the past 72 hours (because such clients may derive more benefit from PEP if the potential for HIV exposure was high)
- Signs of AHI (see *Box 3*) and potential exposure within the past 14 days
- Unwillingness or inability to commit to effectively using PrEP ring
- Allergy or hypersensitivity to an active substance or other substances listed in the product information sheet

2.7.7.3 Long-acting Injectable Cabotegravir

CAB-LA should not be provided to people with:

- Allergy or hypersensitivity to an active substance or other substances listed in the product information sheet
- Hepatotoxicity and/or hepatitis B
- An HIV-positive test result according to the national HIV testing algorithm
- Potential exposure to HIV in the past 72 hours (these clients should be offered PEP)
- Signs of AHI (*Box 3*) *AND potential exposure within the past 14 days*
- Some co-administered anticonvulsants or anti-mycobacterials
- Unwillingness or inability to commit to effectively using CAB PrEP
- Allergic or hypersensitivity reaction(s) with previous use of CAB or other integrase inhibitor medications

2.8 Preparation for Initiation of PrEP

For most clients, PrEP can be initiated the same day. However, in some scenarios, as outlined below, deferred PrEP initiation is recommended. Clients must meet five criteria to begin PrEP use. They must be:

- Seronegative
- Having no suspicion of acute HIV infection:
- At substantial risk of HIV infection.

- Willing to use PrEP as prescribed.
- Free from contraindication for use of their chosen PrEP method.

2.8.1 Counseling

Education and counseling for clients considering PrEP, or clients already on PrEP, are important to ensure clients can make informed choices and effectively use PrEP.

PrEP counseling should be based on the following right to health-based principles:

- Be client-driven and person-centered, based on their needs, resources and preferences
- Be based on a foundation of respect and include an open, honest relationship between provider and client
- Recognize that behavior change can take time
- Validate and normalize client concerns and seek to affirm and encourage client efforts and not be prescriptive or judgmental
- Focus on the identification of small wins and achievable next steps in reducing potential exposures and/or making effective use easier
- Include contingency planning when common barriers are encountered
- Promote choice among available options based on user preferences and acceptability

2.8.1.1 Topics for Initial PrEP Counseling

- Sexual behaviors
- Alcohol and drug use
- Plan for preventing HIV and other STIs
- Mental health
- Prevention needs and interest in and willingness to take PrEP
- Experience of gender-based violence, including intimate partner violence
    - Provide appropriate GBV and IPV response, including first-line support and referral where necessary, and support clients to identify ways to effectively use and continue PrEP. *(Clients experiencing GBV, including IPV, should not be prohibited from receiving PrEP if they can effectively use it.)*
- Contraceptive needs
- Key messages on PrEP, PEP, and specific PrEP methods, including starting, stopping and effective use of chosen method

During counselling, ascertain that the client:

- Is motivated to follow PrEP as prescribed
- Is willing and able to adhere to PrEP dosing
- Is willing and able to attend PrEP monitoring visits, including HIV counseling and testing, adherence counseling, clinical review and adverse events monitoring
- Understands that the protection provided by PrEP is not complete and that PrEP must be used as part of a package of HIV prevention services (inclusive of condoms, SMC, risk reduction counseling and STI management)
- Understands that PrEP is safe and effective in pregnancy and during breastfeeding

- Does not have misconceptions about PrEP — identify and discuss any myths or misconceptions that may be held by the client

NOTE: For clients opting to use the PrEP ring, counsel them on cervical cancer screening. Offer screening to those who accept. If they don't accept, go ahead and offer the PrEP ring.

2.8.1.2 Common Myths or Misconceptions About PrEP

Table 5: Myths and misconceptions about PrEP

Myths and misconceptions	How to address
You can develop resistance to ART drugs because of PrEP.	You cannot develop resistance when you are HIV negative.
If I start PrEP, I will have to take it for the rest of my life.	You can start PrEP and stop PrEP, depending on your level of risk, through discussions with your health service provider.
My friend is HIV-positive and takes antiretrovirals. I can take his medicines and it's the same, right?	Wrong! All HIV medicines are not the same, and one has to use the right ones for PrEP. You should consult with your health service providers to learn more about all the factors that taking PrEP entails. Additionally, you should never share drugs with anyone.
Oral PrEP causes dangerous side effects.	The most common side effects of oral PrEP are stomach upset and loss of appetite, but these side effects usually go away within the first month. About one in 200 people using PrEP experiences kidney problems. That is why you will need to make sure you see your health service provider and have your blood screened every six months if needed.
PrEP promotes unsafe sex.	NO, it doesn't! However, PrEP does not protect against other STIs and pregnancy, so it should be used in combination with other prevention methods.
Can PrEP be used by LGBTQI individuals?	Yes. Using PrEP will reduce their chances of acquiring HIV.
Can I use PrEP when I am on injectable or oral contraceptives?	Yes. PrEP has no effect on injectable or oral contraceptives.
A PrEP ring can disappear into the uterus or the abdomen.	No. The entrance to the uterus (cervix) is always closed, blocking entrance of the ring during intercourse.
The ring protects me against unwanted pregnancy.	No, the PrEP ring doesn't protect you from unwanted pregnancies.
CAB-LA injection protects me from unwanted pregnancies.	No, CAB-LA injection does not protect you from unwanted pregnancies.

NOTE: ***These myths should be addressed through counseling by health team members.***

2.8.2 Baseline Investigations

After eligibility and motivation for PrEP use have been documented, mandatory baseline investigations should be completed (see *Table 4*). If resources permit, a DXA scan to measure bone mineral density among individuals who report a history of pathologic fracture or a family history of osteoporosis should be considered. Unavailability or inability to cover the costs of a DXA scan should not preclude PrEP use.

Table 6: Baseline investigations

Investigation	**PrEP options**		
	Oral PrEP (including ED PrEP)	Injectable PrEP	PrEP Ring
HIV test	Mandatory	Mandatory	Mandatory
Renal function	Recommended	Not necessary	Not necessary
Hepatitis B screening	Recommended	Recommended	Recommended
STI screening	Recommended	Recommended	Recommended
Pregnancy test	Not necessary	Mandatory	Recommended

Key messages

- Review results from baseline investigations and confirm that the creatinine clearance is <60mls/min.
- Commence hepatitis B vaccination if the Hep B surface antibody test is negative and if the vaccine is available.
- Provide STI treatment if needed.
- Counsel and educate the client about potential PrEP side effects and their management.
- Educate the client about the signs and symptoms of AHI and the need to return for urgent HIV testing in case of manifestation of these signs and symptoms.
- Ascertain and address barriers to adherence.

2.8.3 Other Considerations for PrEP Initiation

Table 7: Other considerations for PrEP initiation

Consideration	Explanation
Pregnancy testing and provision of contraceptives	Assess fertility intentions and offer pregnancy testing and contraception or safer conception counseling. Regular pregnancy testing is recommended for clients who are using the ring. PrEP should still be provided even if these services are not available or if the client is unable to or does not wish to access these services. These services should not be barriers to accessing PrEP. If a client is pregnant, link them to antenatal care (ANC) and pregnancy options counseling (see *Management of Clients in Specific Situations* below).
GBV inquiry and response, including IPV	Clients who are identified as experiencing GBV, including IPV, can be provided appropriate services or referrals as needed and available. PrEP should still be provided even if these services are not available or if the client is unable to or does not wish to access these services. These services should not be barriers to accessing PrEP.
Assessment for mental health and substance use disorders and provision of supportive services or referrals as needed	Clients with mental health or substance use concerns should not be prohibited from receiving PrEP if they can effectively use PrEP. Screen for mental health concerns, including depression and substance use disorders, that might increase potential HIV exposure or affect effective use of PrEP and provide or link to follow-up services as needed. PrEP should still be provided even if these services are not available or if the client is unable to or does not wish to access these services. These services should not be barriers to accessing PrEP.
Provision of or referral to Safe Male Circumcision services	Clients who may benefit from SMC can be provided with or referred to SMC services in alignment with national guidelines. PrEP should still be provided even if these services are not available or if the client is unable to or does not wish to access these services. These services should not be barriers to accessing PrEP.

Screening for and treatment of non-communicable diseases	Clients may have additional health needs that may come up during a visit with a health service provider or may be discovered through further assessment. Provide clients with relevant health care services or refer them to appropriate services as needed and available. PrEP should still be provided even if these services are not available or if the client is unable to or does not wish to access these services. These services should not be barriers to accessing PrEP.

2.9 Initiation of PrEP

- Provide PrEP counseling and help client decide on their chosen PrEP method.
- Provide risk-reduction and PrEP medication adherence counseling, as well as condoms.
- Initiate and agree on a medication adherence plan.
- Prescribe the chosen method:

2.9.1 Initiating Oral PrEP

A once daily pill of TDF (300mg) and FTC (200mg)	Preferred
A once daily pill of TDF (300mg) and 3TC (200mg)	Alternative

- Initially, provide a one-month TDF/FTC or TDF/3TC prescription (one tablet orally, daily) together with a one-month follow-up date.
- For people AMAB not using estradiol based exogenous hormones who wish to use ED-PrEP, still prescribe enough oral PrEP for daily use should they need to use it. This means initially, provide a one-month TDF/FTC or TDF/3TC prescription together with a one-month follow-up date
- Counsel the client on the side effects of TDF/FTC or TDF/3TC.

2.9.2 Initiating PrEP ring

- Provide instructions and/or demonstration of how to insert the ring
- Counsel on potential side effects of the PrEP ring.
- Initially, provide a one-month PrEP ring prescription together with a one-month follow-up date.

2.9.3 Initiating CAB-LA

- Provide initiation injection 1.
- Counsel on potential side effects of CAB-LA.
- Schedule next appointment in four weeks for initiation injection 2.

NOTE: ***In the event that an individual has an incidental exposure to HIV infection before initiation of PrEP, they should be given PEP per the PEP guidelines. However, individuals who have recurrent PEP use (three or more yearly) should be prepared for and initiated on PrEP.***

2.10 Side Effects of PrEP

Table 8: Side effects of PrEP

	System	Symptoms/signs	Management
Oral PrEP (daily and ED)			
	Gastrointestinal (GI)	Nausea, vomiting and weight loss	Supportive counseling and symptomatic treatment (anti-emetics) of these self-limiting symptoms are often sufficient.
	Renal	Transient increase in serum creatinine Very rarely: Proteinuria, decreasing GFR and Fanconi's syndrome	Avoid concomitant use of other nephrotoxic drugs such as aminoglycosides. Clients with creatinine clearance <60 ml/min (<1.2 mg/dl) should not be placed on PrEP.
	Musculoskeletal	Reduction in bone density	Stop use of oral PrEP.
PrEP Ring			
	Urinary tract system	Urinary tract infections	• Ring users should be counseled on possible signs and symptoms. • If they experience any urinary or reproductive tract changes, they should contact their health care provider.
	Reproductive system	Vaginal discharge and itching	• Ring users should be counseled on possible signs and symptoms. • If they experience any urinary or reproductive tract changes, they should contact their health care provider.

	Reproductive system	• Pelvic and lower abdominal pain	• Ring users should be counseled on possible signs and symptoms • If they experience any urinary or reproductive tract changes, contact your health care provider
CAB-LA (the symptoms are usually mild and will resolve within 5 days)			
	Neural	Headache	Counseling
	Gastrointestinal (GI)	Nausea and diarrhea	Counseling
	Musculoskeletal	Injection site reaction (ISR) and tiredness	Counseling

2.11 Drug–Drug interactions

2.11.1 Drug Interactions with Oral PrEP

Tenofovir should not be co-administered with Adefovir. Other drugs listed below can be co-administered but may require close monitoring and alteration of dosage or timing of administration.

The ARV drugs used for oral PrEP have no known interactions with contraceptive hormones and do not affect the levels of gender-affirming hormones used by transgender individuals. There is some indication that the use of estradiol-based exogenous hormones may reduce oral PrEP drug levels in people AMAB, which is why daily oral PrEP is recommended for these individuals, but ED-PrEP is not. There are no known interactions between oral PrEP medications and alcohol or recreational drugs. However, if a client or potential client thinks that their use of alcohol or other substances is interfering or may interfere with them taking oral PrEP as directed, their PrEP provider should provide support and referrals and, where needed, offer additional prevention options, including the use of condoms and condom-compatible lubricant and linkage to harm reduction services when they are available.

Table 9: Common drugs which may interact with emtricitabine (FTC) or tenofovir (TDF)

Drug name	FTC/3TC	TDF
Adefovir		X
Cimetidine		X
Digoxin	X	X
Furosemide	X	X
Metformin	X	X
Naproxen	X	X

Ofloxacin	X	X
Streptomycin	X	X
Sulfadoxine/pyrimethamine	X	X

2.11.2 Drug Interactions with CAB-LA

Drug name	CAB-LA
Anticonvulsants (carbamazepine, phenobarbital, phenytoin)	X
Antimycobacterial medications (rifampin, rifapentine)	X
Persons using gender-affirming hormones (estradiol, testosterones) can use CAB-LA.	

NOTE: X means do not co- administer

Some anticonvulsants (carbamazepine, oxcarbazepine, phenobarbital, and phenytoin), and some antimycobacterial medications (rifampin, sometimes named rifampicin, and rifapentine) may interact with CAB-LA and reduce its efficacy by significantly decreasing concentrations of cabotegravir in blood plasma. These drugs should not be co-administered with CAB-LA, and clients using them may need to select a different PrEP method or HIV prevention strategy. After a client completes rifampin or rifapentine, they can be considered for CAB-LA after two weeks.

There are no known interactions between CAB-LA and recreational drugs or alcohol, but alcohol and drug use could affect the ability to attend necessary health appointments, potentially resulting in missed injections. If a client or potential client thinks that their use of alcohol or other substances is interfering or may interfere with effective use of CAB-LA, the provider should engage the client to understand what support or referrals might be valuable to support effective use while also discussing additional prevention options, including other PrEP methods and the use of condoms and condom-compatible lubricant.

Clients using either methadone or rifabutin may still be able to use CAB PrEP, but additional cautions may be warranted. Clients using methadone could require medication dose adjustments to maintain the effectiveness of the medication while they are using CAB PrEP, while clients using rifabutin may require dose adjustments of CAB PrEP, specifically more frequent injections. Clients using high-dose aspirin in the past week, such as non-steroidal anti-inflammatory drugs for pain or anticoagulants or other antiplatelets, may have a higher likelihood of bruising or bleeding at the injection site and should be made aware and counseled on mitigation strategies, if relevant.

If a client is using CAB PrEP and is diagnosed with tuberculosis (TB), they will need to temporarily discontinue CAB PrEP and receive treatment with a standard rifampin-based regimen. In the interim, the client may use another PrEP method or HIV prevention strategy. If the client completes TB therapy and wishes to continue with CAB PrEP, they should be

assessed for CAB PrEP use and can restart CAB PrEP with initiation injection 1. CAB PrEP can be started two weeks after a client completes TB therapy.

Clients who receive TB preventative treatment with once-weekly rifapentine-isoniazid for 12 weeks (also known as 3HP) should temporarily discontinue CAB PrEP for the duration of their rifapentine use. Clients can restart CAB PrEP two weeks after completing 3HP.

2.11.3 Drug Interactions with the PrEP Ring

No data are available on concurrent use of vaginally administered antimicrobial products for vulvovaginal infections and the PrEP ring; therefore, concomitant use is not recommended.

Evaluations of co-administered use of miconazole and the ring have not been fully resolved, and clients should be advised to use additional preventative measure for HIV when co-treated with vaginal miconazole.

Co-administration of clotrimazole as a water-based vaginal cream with the ring was well-tolerated; however, given methodological issues that limit the reliability of the pharmacokinetic results of both clotrimazole and dapivirine, concurrent use should be undertaken with caution.

Because there are no data on concomitant use of the ring and metronidazole or clindamycin, and no current data on concomitant use of the ring and other vaginal rings (contraceptive rings or diaphragms), concurrent use is not recommended.

There are no known interactions between dapivirine and contraceptive hormones, hormones used for gender-affirming hormone therapy, alcohol or recreational drugs. However, if a client or potential client thinks their use of alcohol or other substances is interfering or may interfere with effective use of the ring, the provider should engage the client to understand what support or referrals might be valuable to support effective use while also discussing additional prevention options, including other PrEP methods and the use of condoms and condom-compatible lubricant.

2.12 How Long It Takes for PrEP to Be Effective

- Oral PrEP: seven days
- Event-driven PrEP: two hours for AMAB
- Injectable PrEP: seven days
- PrEP ring: 24 hours

Clients should be counseled on using another HIV prevention strategy (such as condoms) between when they start PrEP and when it is expected to become fully effective.

2.13 Minimum Package of Services to Be Offered with PrEP

The following minimum package of services must be provided to clients receiving PrEP in accordance with the national guidelines.

- HIV testing services (HTS)
- Linkage to ART services for those diagnosed with HIV; the offer of PEP and complete PEP standard of care for those with an exposure to HIV within 72 hours.
- Syndromic STI management
- Condoms and lubricants
- Pregnancy screening
- Contraception
- TB screening
- GBV/IPV
- Counseling

2.14 PrEP Follow-up Visits

Once on PrEP, clients should return after one month for assessment and confirmation of HIV-negative test status, assessment for early side effects, and discussion of any difficulties with effective use and any other client concerns.

After the initial visit, the subsequent clinic visit should be after one month, two months, and then every three months thereafter for oral PrEP and the PrEP ring. For CAB-LA, subsequent follow-up should be after four weeks, and then every eight weeks. Some ring users may prefer to return used rings to the health service provider/service provision point. If clients choose to return used rings, those rings should be disposed of along with other medical waste, such as used gloves, in accordance with the National Infection Prevention and Control (IPC) guidelines. Needles and syringes that have been used for CAB-LA injections should also disposed of in accordance with the IPC guidelines.

2.14.1 Essential Components of PrEP Follow-up Visits

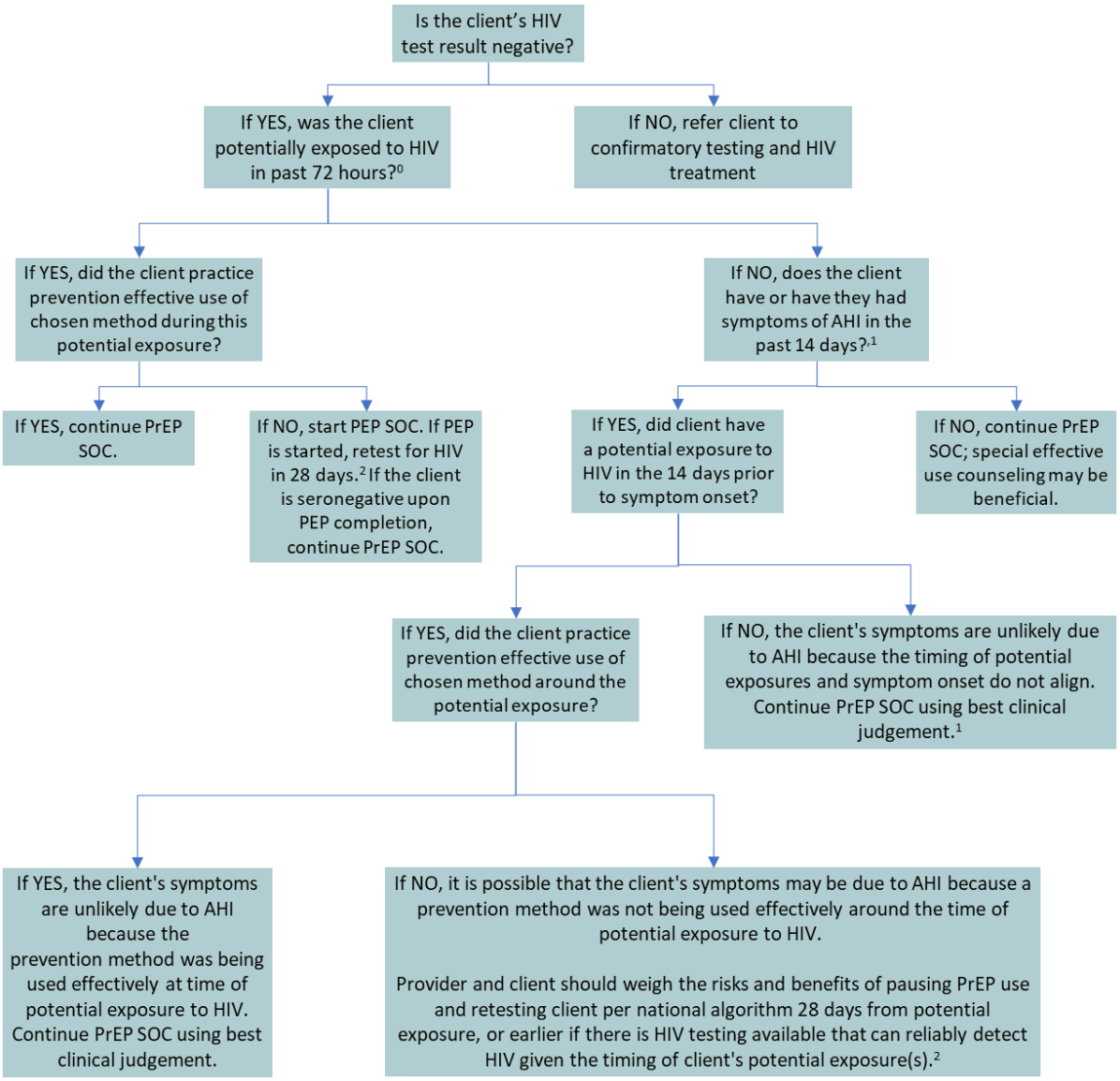
2.14.1.1 Component 1: HIV Testing and Counseling

HIV testing and counseling should be conducted per national guidelines one month after a client starts oral PrEP or the PrEP ring and every three months thereafter. For CAB-LA, HIV testing should be conducted per national guidelines four weeks after a client's first injection and every eight weeks thereafter. This testing is conducted to inform decisions on whether to continue or discontinue PrEP.

2.14.1.2 Component 2: Assessments

At each follow-up visit, clients should be assessed for effective PrEP use and provided with support to identify and address challenges with effective PrEP use. It is essential that this be done in an open-ended, non-judgmental manner. A neutral assessment of PrEP use allows for a constructive discussion that can support the client in finding solutions to effective use challenges. If effective use is poor, the client should be assessed for PEP indication and symptoms of AHI. *Figure 10* outlines the algorithm for these assessments.

Figure 10: PrEP follow-up – HIV exposure, AHI and adherence assessment



[0] An answer of "NO" to the question "Potentially exposed to HIV in past 72 hours?" means no potential past exposure to HIV at all or potential HIV exposure that was 73+ hours ago.

[1] Two-thirds of people will have symptoms of AHI within 2–4 weeks of HIV acquisition (Letizia et al. 2022). Signs/symptoms mimicking acute HIV infection (sore throat, fever, sweats, swollen glands, mouth ulcers, headache, rash, and muscle aches) are commonly due to illnesses other than HIV; providers need to use discretion in determining whether the symptomatology is consistent with HIV or may be explained by an alternative cause.

[2]If HIV testing that can reliably detect HIV given these clients' potential exposures and time frames is available, PrEP may be started earlier than 28 days if results are nonreactive.

2.14.1.3 Component 3: Counseling

- Review the patient's understanding of PrEP, tolerance to the medication and any barriers to adherence, as well as any side effects.
- Review the patient's risk exposure profile and perform risk reduction counseling.
- Evaluate and support PrEP adherence at each clinic visit.
- Evaluate the patient for any symptoms of STIs at every visit and treat as needed.
- Evaluate creatinine clearance six months after initiation, and then annually if clinically indicated.

2.14.1.4 Component 4: PrEP Prescription Refill

At follow-up visits, clients should be provided with enough PrEP to avoid having to return to pick up a resupply each month. Clients who have some medication supply in reserve tend to show better effective use. This should be discussed with clients on a case-by-case basis because some clients may prefer to return to the clinic more frequently and not have to worry about discreetly storing their PrEP. In some situations, and based on client needs and preferences, it may be appropriate to separate clinical follow-up visits from PrEP refills.

For clients who may use ED-PrEP, a full refill may not be needed at each follow-up visit. At each visit, ask these clients how many full bottles of oral PrEP they have at home and provide enough bottles so that they can use oral PrEP daily should they need to. Generally, this would mean prescribing them three minus the number of bottles the client has at home.

For oral PrEP and the PrEP ring, schedule the client's next visit at least a week before their pill supply will run out based on daily use or at least a week before the client should change the last ring they have been given, at least every three months. When possible, follow-up visits should be coordinated with visits for other services to reduce the number of times a client must return to receive services.

For CAB-LA, it is important that the client return on the scheduled visit date for their injection. If they cannot make it to the clinic on the scheduled date, they should go to the clinic +/- 7 days from the due date.

Table 10: Summary of PrEP initiation and follow-up visit procedures

Visit	Recommended procedures
Screening	• Educate about the risks and benefits of PrEP. • Assess eligibility, willingness and readiness to take PrEP, as well as motivation using the 5 As.* • Assess HIV risk. • Conduct HIV counseling and testing. • Perform the following laboratory assessments: serum creatinine level, hepatitis B and STI screening, rapid syphilis test and pregnancy testing. • Treat underlying conditions and refer for management. • Provide contraceptive counseling and offer services.
PrEP initiation	• Conduct HIV counseling and testing. • Confirm eligibility (including investigation results and a calculation of creatinine clearance if indicated). • Commence hepatitis B immunization (if indicated). • Provide STI treatment for self and partner/s (if indicated). • Educate client about PrEP side effects and their management. • Educate client about signs and symptoms of AHI. • Discuss behaviors that promote bone health, such as weight-bearing exercise, maintaining adequate calcium and vitamin D intake and avoiding alcohol, tobacco and recreational drugs. • Initiate a medication adherence plan. • Provide condoms and lubricant. • Provide PrEP as prescribed. • Schedule a one-month follow-up appointment.
One-month follow-up	All activities for PrEP initiation visit, PLUS: • Perform an HIV test. • Assess tolerability and side effects. • Assess product use adherence (product count) and offer adherence counseling support. • Provide contraceptive counseling and offer services. • Provide hepatitis B vaccination (if indicated). • Provide a two-month supply of oral PrEP or PrEP rings. • Give a second initiation injection of CAB-LA 4 weeks from the first injection. • Schedule a two-month follow-up appointment (or eight weeks for CAB-LA).
Two-month follow-up and three-monthly	• Repeat procedures done at one-month follow-up. • Repeat serum creatinine and calculate creatinine clearance at six-month follow-up and 12-monthly thereafter (for oral PrEP). • Conduct three-monthly STI screening.

maintenance visits	• Complete hepatitis B immunization (if indicated). • Provide a three-month supply of oral PrEP or PrEP rings. • Provide a CAB-LA injection and appointments for every eight weeks.
Note: All these visits should be clinical visits conducted by nurses, clinical officers, doctors and other authorized prescribers. * 5As: 1) **Assess** for reasons for the visit, 2) **Advise** based on the assessment and risk reduction, 3) **Agree** on a plan of action, 4) **Assist** in implementation of the action plan and 5) **Arrange** for follow-up visits	

2.14.2 Risk-reduction Counselling

Risk-reduction counseling is a behavioral intervention that attempts to decrease an individual's chances of acquiring HIV and other STIs. It should be implemented together with adherence counseling at all follow-up visits for clients using PrEP. Risk-reduction counseling can be provided by any trained health service provider and should address the 5 As:

1. Assess: Explore the context of the user's specific sexual practices. Health service providers should also be aware that clients may not always perceive their own risk or may be in denial about it. Assess which of the client's behaviors are associated with higher likelihood of HIV exposure.

2. Advise: Reflect on the client's main concerns, identify their sexual health protection needs and advise accordingly. Strategize with the client on how to manage these concerns and needs.

3. Agree on which strategies the client is willing to explore.

4. Assist: Assist and guide the client on how to implement the strategies.

5**. Arrange** for follow-up visits.

2.14.3 Adherence Support

2.14.3.1 Oral PrEP (including daily and ED PrEP)

Adherence to daily or ED-PrEP regimens is important in order to maintain the efficacy of this intervention. Adherence counseling and pill counting should be implemented at each clinic visit. Critically evaluate the client for possible barriers to adherence and support them client to overcome them. Discuss possible adherence reminders, such as using cell phone reminders and pill boxes, linking pill taking with a daily routine activity and having a PrEP adherence buddy.

2.14.3.2 PrEP Ring

The ring must be in place for at least 24 hours before it is maximally effective. If a client wishes to discontinue the use of the ring, they can remove it. If the ring comes out within the 28-day period, it can be re-inserted after it is washed with clean water. However, if the ring falls in a dirty place, it should not be re-inserted. The client should insert another ring if available or

return to the health service provider. If removed and re-inserted, the ring must be in place for at least 24 hours to reach maximum protection.

2.14.3.3 CAB-LA

Adherence to the injection schedule is important to effective use of CAB-LA. If a client is unable to attend a schedule injection appointment, they should come +/-7 days from the appointed date to receive their injection. If they are unable to return within seven days of the appointment, they should contact their health service provider about how to continue using CAB-LA or to discuss switching to a different HIV prevention strategy.

When scheduling initiation injections 1 and 2, providers can consider the date of initiation injection 1 as Day 0. Initiation injection 2 should be scheduled four weeks later, on approximate Day 28. There is a +/- 7-day window for receiving initiation injection 2. Once initiation injections 1 and 2 have been completed, follow-up visits should be scheduled beginning eight weeks after initiation injection 2 and every eight weeks after each follow-up injection. There is a +/- 7-day window for receiving follow-up injections.

Ideally, a client with ongoing exposures to HIV who is interested in CAB PrEP would have the following injection schedule (free of delays or discontinuations):

- Initiation injection 1
- Initiation injection 2: four weeks after initiation injection 1 +/- 7 days

Follow-up injections: eight weeks after initiation injection 2 +/- 7 days, with continuing follow-up injections every eight weeks, continuing for as long as the client wants to remain on CAB PrEP and has potential exposures to HIV.

Note:

1. ***Male condoms can be used with all PrEP options (CAB-LA, oral PrEP and the PrEP ring).***
2. ***Female condoms can be used with all PrEP options, including the PrEP ring.***

Table 11: Testing and assessments for clients on PrEP

Service	**Visits**				**PrEP options**
	Visit 0 (Initiation)	Visit 1 (1 month)	Visit 2 (3 month)	Visit 3 (6 months)	
*HIV antibody test	X	X	X	X	Oral PrEP, ED PrEP, CAB-LA & PrEP Ring
**Serum creatinine test	X			X (thereafter, annually)	Oral PrEP, ED PrEP
***Hepatitis B test	X				Oral PrEP, ED PrEP

STI screening and management	X	X	X	X	Oral PrEP, ED PrEP, CAB-LA & PrEP Ring
Risk assessment	X	X	X	X	Oral PrEP, ED PrEP, CAB-LA & PrEP Ring
PrEP adherence counseling	X	X	X	X	Oral PrEP, ED PrEP, CAB-LA & PrEP Ring
Assessment of side effects and adverse drug reactions (management as needed)		X	X	X	Oral PrEP, ED PrEP, CAB-LA & PrEP Ring
Assessment of contraindications to PrEP use	X	X	X	X	Oral PrEP, ED PrEP, CAB-LA & PrEP Ring
GBV/IPV inquiry and response	X	X	X	X	Oral PrEP, ED PrEP, CAB-LA & PrEP Ring
Assessment of mental health status and alcohol/other substance use disorders	X	X	X	X	Oral PrEP, ED PrEP, CAB-LA & PrEP Ring
Pregnancy testing	X	X	X	X	CAB-LA & PrEP Ring (optional for Oral PrEP)
Family planning and condom use	X	X	X	X	Oral PrEP, ED PrEP, CAB-LA & PrEP Ring

*Clients continuing PrEP can self-test when the standard HIV testing is not available.

**Serum creatinine tests are not required for initiation and continuation of clients using the ring and CAB-LA for those below 30 years.

*** Hepatitis B testing should not delay PrEP initiation. It can be done at any time during the visits if it was not done at baseline. Hepatitis B vaccination is recommended for clients testing hepatitis B negative.

NOTE: ***PrEP clients using PrEP rings or oral PrEP should interface with a qualified health worker at least once every six months if they have been given a multimonth supply of their chosen method. Clients using CAB-LA should have follow-up injection visits with a qualified health worker every eight weeks after their two initiation injections (four weeks apart) while they are still receiving CAB-LA.***

2.15 Community Engagement for PrEP

Roles of community-based organizations:

- Advocacy to create awareness and demand for PrEP.
- Providing information about PrEP, its availability and where to access it
- Mobilizing people at substantial risk of acquiring HIV for PrEP uptake
- Identifying how PrEP should be integrated within the existing community sexual and reproductive health services
- Identifying and linking clients to community distribution points for PrEP
- Distributing condoms and other HIV prevention commodities to people at substantial risk of acquiring HIV, including sex workers who should be empowered to insist on their use
- Encouraging adherence to PrEP
- Follow-up of clients on PrEP

2.16 Unscheduled PrEP Visits

- Determine if the reason for the visit is PrEP-related, e.g., adverse drug reactions.
- Assess and manage the reason for the unscheduled visit according to national guidelines.
- Provide counseling on HIV exposure reduction and effective use of PrEP.
- Agree on a follow-up schedule.

2.17 Discontinuation of PrEP

PrEP should be discontinued under the following circumstances:

- Acquisition of HIV
- Changed life situations resulting in lowered risk of HIV acquisition
- Intolerable toxicities and side effects
- Chronic non-adherence to the prescribed dosing regimen for PrEP
- Personal choice
- HIV-negative person in a stable HIV Sero different relationship when the positive partner has sustained viral load suppression. They should however continue using condoms correctly and consistently
- Started use of contraindicated medications
- Decision to switch to another HIV prevention strategy
- Safety concerns, such as estimated creatinine clearance of <60 mL/min or an eGFR of <60 mL/min per 1.73m2 (if known) for clients using oral PrEP (appropriate clients should also be counseled on using the PrEP ring, if applicable) or confirmed hepatotoxicity for clients using CAB-LA

2.17.1 Guidance on Discontinuation of PrEP

- Assess the client for reasons for discontinuation of PrEP. If a client is at low risk and they choose to discontinue, they should continue PrEP before stopping according to the guidance for each PrEP option. If the risk is still high, counsel, educate and advise the client to continue PrEP per the guidance for each PrEP option and offer other HIV prevention options.
- Perform an HIV test according to the national HIV testing algorithm.
- If a client tests HIV positive, ensure linkage to care and treatment. If the test is negative, establish linkage to risk reduction support services.
- Clients with hepatitis B who are stopping oral PrEP should be referred to relevant management/treatment services because stopping oral PrEP may have implications for the management of hepatitis B infection.

2.17.1.1 Discontinuation of Daily Oral PrEP

- Assess the client for reasons for discontinuation of PrEP.
- If a client is at low risk, and they choose to discontinue, they should continue PrEP for at least seven days after last HIV exposure before stopping.
- If a client is non-adherent or still has a likelihood of exposure to HIV, counsel them on other prevention options.
    - Perform an HIV test according to the national HIV testing algorithm.
    - For clients with chronic hepatitis B who stop TDF-based oral PrEP, regular monitoring to detect relapse and management of hepatitis B are important. Clients taking TDF for treatment of hepatitis B who wish to stop oral PrEP can be switched to a TDF-only regimen.

2.17.1.2 Discontinuation of Event-driven PrEP

Clients discontinuing ED PrEP should take PrEP for two days after the last sexual encounter. Perform the HIV test according to the National Testing Algorithm.

2.17.1.3 Discontinuation of PrEP ring

If a client wishes to discontinue use of the ring, they can remove it. The ring can be reinserted after removal until the 28-day period has expired; however, levels of dapivirine in the vagina drop quickly after ring removal, and therefore removal is not recommended during the 28-day period. Because of the quick drop in levels of dapivirine in the vagina after ring removal, the need for other HIV prevention measures should be reinforced after removal if potential exposure to HIV continues. If removed and reinserted, the ring must be in place for at least 24 hours to reach maximum protection. It is not known how long the ring must remain in place after a potential exposure to be maximally effective. Ideally, clients who are discontinuing PrEP use should be encouraged to discuss discontinuation and be supported by providers to use other HIV prevention practices, if needed.

2.17.1.4 Discontinuation of Long-acting CAB-LA

- Continuation of oral PrEP after discontinuation of CAB-LA will depend on the reason for stopping and the risk of HIV exposure after stopping CAB-LAIf the reason for stopping is reduced/no risk, then there is no need for continuity with oral PrEP.
- If there is re-emergence of risk or ongoing risk or intolerance, continue with oral PrEP or another prevention option. If a client tests HIV positive, ensure linkage to care and treatment. If a client is HIV negative, establish linkage to risk-reduction support services.

If a client decides to stop using CAB-LA, they may stop receiving injections. The amount of cabotegravir in the blood remains at effective levels for at least eight weeks after the final injection. The time after the last CAB-LA injection when cabotegravir remains in the body but at levels that may not prevent HIV is known as the "tail period." The "tail period" can last for up to a year, but this time frame varies for people based on sex assigned at birth.[1] Data on HIV acquisition during the tail period are limited. For those who do acquire HIV during this time, delayed diagnosis of HIV may be possible and could result in HIV drug resistance, meaning that medicines used to treat HIV may be less effective or not work at all. As with all PrEP methods, if a client discontinues CAB-LA, they should use another PrEP method or HIV prevention strategy during the tail period if exposure to HIV is possible.

If a client has a potential exposure to HIV during the tail period while not using an HIV prevention strategy, they should speak to a health care provider as soon as possible because PEP may be appropriate and ideally should be started as soon as possible within 72 hours of potential exposure.

NOTE: On discontinuing PrEP, document the following in the PrEP register:

- ***Reasons for PrEP discontinuation***
- ***Recent medication adherence***
- ***Reported sexual behavior in past three months***
- ***Duration on PrEP***
- ***Date of start and discontinuation, as well as any gaps in treatment***

Advise the client to return for an HIV test one month after discontinuation.

2.17.2 Re-initiation of PrEP

Any person who wishes to resume taking PrEP medications after having stopped should undergo all the same pre-prescription evaluation as a person being newly initiated on PrEP. In addition, a frank discussion should be held to clarify how circumstances have been changed

[1] Landovitz RJ, Li S, Grinsztejn B, Dawood H, Liu AY, Magnus M, et al. Safety, tolerability, and pharmacokinetics of long acting injectable cabotegravir in low-risk HIV uninfected individuals: HPTN 077, a phase 2a randomized controlled trial. PLoS Med. 2018 Nov 8;15(11):e10026900.

since discontinuation of the medication, the reason for resuming PrEP and the commitment to use it consistently.

If a client misses visits for three months or more, rescreen them for potential restart and, if they are clinically eligible, administer PrEP according to the guidance on the chosen PrEP option. At the time of writing, WHO does not have guidance on missing injections and does not make recommendations about when a client taking PrEP should be considered discontinued or what procedures are required for restarting someone on PrEP once they have discontinued. If the client does not want to continue CAB-LA, providers should support clients by counseling them on alternative PrEP methods or another HIV prevention strategy if the client is still potentially exposed to HIV while choosing to stop CAB-LA use. The following are potential scenarios adapted from the United States Food and Drug Administration Apretude Label for those clients who miss injection visits, based on the length of time between injections:

Table 12: Injection Dosing Recommendations after Missed Injections

Injection Dosing Recommendations after Missed Injections		
Missed injection type	*Time since last injection*	Recommended action for provider
Initiation injection 2	≤ 8 weeks since initiation injection 1	Proceed with initiation injection 2 and schedule the follow-up injection for 8 weeks later as a follow-up visit
	> 8 weeks since initiation injection 1	Assess the client for contraindications for CAB-LA using the initiation procedure and, if contraindications are absent, re-administer initiation injection 1 that day and schedule initiation visit 2 in 4 weeks. Follow-up visits should be scheduled every 8 weeks thereafter.
Follow-up injection	≤ 3 months since last injection	Proceed with administering follow-up injection that day and schedule the subsequent follow-up injection for 8 weeks later as a follow-up visit.
	> 3 months since last injection	Rescreen for potential restart and, if contraindications are absent, re-administer initiation injection 1 that day and schedule initiation injection 2 in 4 weeks. Follow-up visits should be scheduled every 8 weeks thereafter.

2.17.3 Strategies to Reduce the Likelihood of Antiretroviral Resistance

Feasibly exclude acute HIV infection before initiating PrEP by conducting:

- An antibody HIV test before commencing or re-prescribing PrEP C
- A clinical screening to detect signs and AHI — history of fever, sore throat, rash, joint pain, cough in the past month — and a targeted examination (temperature, Ear nose and throat, and skin exam) (see AHI information in *Box 3*)

If symptoms or signs of acute HIV infection are found:

- **At screening:** Postpone PrEP until the symptoms subside and confirm the client's HIV-negative status using the National Testing Algorithm. Offer other prevention options.
- **At screening:** Do not initiate PrEP until confirmatory HIV tests are completed using the National Testing Algorithm. Offer other prevention options.
- **At follow-up:** Withhold PrEP while awaiting results of testing using the National Testing Algorithm. Offer other prevention options.
- Support the client to maximize adherence and include adherence counseling at each visit.

Stop PrEP if a client no longer meets the requirements for PrEP eligibility.

3.0 Management of Clients in Specific Situations

This section outlines management of clients in specific situations.

3.1 Management of Creatinine Elevation Among Oral PrEP Users

Very few clients experience creatinine elevation. Most creatinine elevations are self-limiting, can be addressed without stopping oral PrEP, and are caused by dehydration, exercise, diet, diabetes mellitus, hypertension, liver failure, or hepatitis C virus. Some may reflect a false-positive test result. Rule out and manage other causes of elevated creatinine.

If the estimated creatinine clearance is <60 mL/min or the eGFR is <60 mL/min per 1.73m^2, the kidney function test should be repeated on a separate day before stopping oral PrEP. Oral PrEP should be stopped if the repeat test results also show the estimated creatinine clearance is <60 mL/min or the eGFR is <60 mL/min per 1.73m^2. These clients should be counseled on other HIV prevention strategies, including other PrEP methods. Kidney function usually returns to normal levels after stopping oral PrEP. Oral PrEP can be restarted if an estimated creatinine clearance of ≥60 mL/min or eGFR of ≥60 mL/min per 1.73m^2 is confirmed one to three months after stopping oral PrEP. If kidney function does not return to normal levels after stopping PrEP, other causes of kidney insufficiency should be evaluated.

3.2 Management of HIV Seroconversion

Seroconversion on PrEP refers to a positive HIV test as follows:

- **Oral PrEP:** During PrEP use or within seven days after the last dose
- **PrEP ring:** During PrEP ring use
- **CAB-LA:** During use or within three months of the last injection

If a client seroconverts while on PrEP or after starting PrEP:

- Discontinue PrEP use immediately.
- Confirm HIV status using the National Testing Algorithm.
- Immediately link the client to care and initiate on ART (per national ART guidelines).
- Document the seroconversion and possible reason for seroconversion (non-effective use or PrEP failure, i.e., breakthrough HIV while adherent to PrEP).
- If available and indicated, link the client to HIV drug resistance testing.

3.3 Management of Side Effects and Adverse Drug Reactions

Side effects should be managed symptomatically, and counseling should be offered. Any side effects should be recorded in client records regardless of severity (refer to *Table 6*).

In some cases, side effects may cause a client to discontinue PrEP use. If PrEP is discontinued, record the outcome in the PrEP register. Side effects and potential adverse drug reactions for each method are found in the overviews of each method above.

3.4 Pregnancy and Breastfeeding

Given the increased likelihood of HIV acquisition during pregnancy and the postnatal period, as well as reassuring safety data, oral PrEP use is a reasonable option for people who are pregnant or breastfeeding. There is no safety-related rationale for disallowing or discontinuing oral PrEP use during pregnancy and breastfeeding.

Data are limited on the use of CAB-LA during pregnancy and breastfeeding. Dolutegravir, a medication in the same drug class as cabotegravir, was found safe to use during pregnancy, and the very limited data available from a small number of women who became pregnant in clinical trials suggest CAB-LA may be safe during pregnancy and breastfeeding. There are no data on whether cabotegravir is present in human milk, impacts human milk production, or affects breastfeeding infants among clients using CAB-LA.

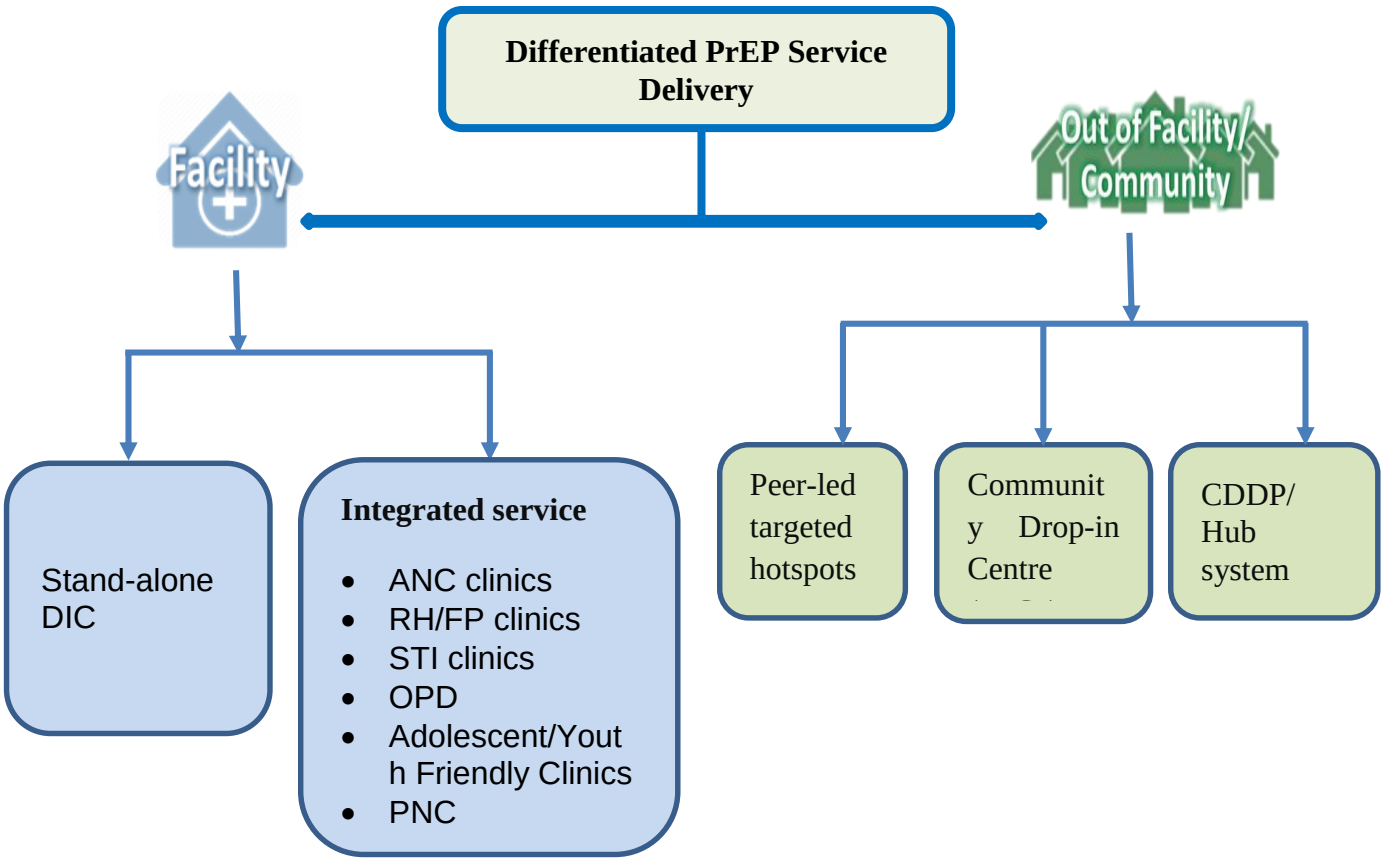
Due to the potential for adverse reactions and residual concentrations of cabotegravir in systemic circulation for 12 months or longer after CAB-LA injections are discontinued, clients who are or may become pregnant or are breastfeeding, especially during the tail period, should be counseled on the risks and benefits of using CAB-LA. Research is ongoing.

4.0 PrEP Service Delivery

4.1 Differentiated Service Delivery for PrEP

PrEP will be differentiated into facility and community-based models (see *Figure 11*)

Figure 11: Differentiated service models for PrEP



4.1.1 Facility-based Model

PrEP will be offered at sites accredited to provide PrEP through integration of PrEP service delivery points in other facilities, which may include: ANC clinics, reproductive health (RH)/family planning (FP) clinics, outpatient departments (OPDs), STI treatment centers, adolescent/youth-friendly clinics and postnatal clinics. A PrEP service point needs trained, non-stigmatizing, non-judgmental staff to provide high-quality HIV testing in order to identify people who are HIV-negative, at substantial risk of HIV and ready to receive the follow-up and regular HIV testing required for PrEP.

Other needs include:

- Reliable systems for prescribing and dispensing medicines

- Linkage to HIV treatment services for those found to be HIV-positive
- Appropriate laboratory facilities (or referral systems) for monitoring renal function and hepatitis B screening
- Other HIV prevention services, including the provision of condoms and lubricants
- Integration within broader sexual and reproductive health services, including managing sexually transmitted infections and providing contraceptives to women who need them
- Good referral pathways or integration with social and legal support, counseling and harm–reduction services are also important for many people who might benefit from PrEP.

4.1.2 Community service delivery models for PrEP

The community service delivery model will entail three approaches: through peers, drop-in centers (DIC) and the PrEP Hub system.

The peer-led approach: The peer educators will mobilize clients for PrEP services in their hotspots. Through targeted outreach, the trained health workers will educate and screen clients for PrEP and initiate clients on PrEP. PrEP refills can be provided by peers where necessary, except for CAB-LA refills.

Community drop-in centers approach: The DIC team (coordinator/staff/peers) will mobilize clients on the DIC's scheduled PrEP days. A trained health worker from a supervising health facility or a co-located clinic will provide PrEP services (health education and PrEP screening, initiation and refill) for the clients at the DIC. These outreach services should be integrated with other RH services for PrEP clients.

The community PrEP Hub system approach/Community Drug Distribution point (CDDP): The health facility will prepare and pack the required medicines, commodities and supplies for PrEP refills for the different communities. A health worker will make a list of expected refills, schedule days to visit communities and communicate that schedule to the focal resource of each community (e.g., VHT, peers) who will organize the clients. Clients will be offered PrEP refills, risk reduction counseling, HIV testing, and STI treatment and management at a specified time in a scheduled period. The health worker will proceed to each community as planned to offer PrEP services. These outreach services should be integrated with other reproductive health services for the PrEP clients.

5.0 RECORDING AND REPORTING FOR PREP

The following tools will be used to record and report on PrEP service delivery:

1. PrEP screening tool
2. PrEP client facility card
3. PrEP client card
4. Pre-PrEP register
5. PrEP register
6. PrEP quarterly reporting form
7. PrEP quarterly cohort summary form
8. Appointment book
9. PrEP medicine dispensing log
10. PrEP referral form

The following indicators will be reported on at district and national level:

1. Cumulative No. of clients ever screened for PrEP at this facility at the end of the previous quarter
2. Number of new clients screened for PrEP at this facility in the reporting quarter
3. Number of clients eligible for daily PrEP at this facility in the reporting quarter
4. Number of clients eligible for ED PrEP at this facility in the reporting quarter
5. Number of clients eligible for injectable PrEP at this facility in the reporting quarter
6. Number of clients eligible for the PrEP ring at this facility in the reporting quarter
7. Cumulative No. of clients ever started on daily PrEP at this facility at the end of the previous quarter
8. Cumulative No. of clients ever started on ED PrEP at this facility at the end of the previous quarter
9. Cumulative No. of clients ever started on injectable PrEP at this facility at the end of the previous quarter
10. Cumulative No. of clients ever started on the PrEP ring at this facility at the end of the previous quarter
11. Number of new clients started on daily PrEP at this facility during the reporting quarter
12. Number of new clients started on ED PrEP at this facility during the reporting quarter
13. Number of new clients started on injectable PrEP at this facility during the reporting quarter
14. Number of new clients started on the PrEP ring at this facility during the reporting quarter
15. Number of clients on daily PrEP transferred in the reporting quarter
16. Number of clients on ED PrEP transferred in the reporting quarter
17. Number of clients on injectable PrEP transferred in the reporting quarter
18. Number of clients on the PrEP ring transferred in the reporting quarter
19. Number of clients on daily PrEP testing HIV positive in the reporting quarter
20. Number of clients on ED PrEP testing HIV positive in the reporting quarter

21. Number of clients on injectable PrEP testing HIV positive in the reporting quarter
22. Number of clients on the PrEP ring testing HIV positive in the reporting quarter

5.1 Indicator Matrix

INDICATOR	DATA SOURCE	NUMERATOR /DENOMINATOR
1. Cumulative No. of clients ever screened for PrEP at this facility at the end of the previous quarter	Pre-PrEP Register	Not applicable
2. Number of new clients screened for PrEP at this facility in the reporting quarter	Pre-PrEP Register	Not applicable
3. Number of clients eligible for PrEP at this facility in the reporting quarter	Pre-PrEP Register	Not applicable
4. Cumulative No. of clients ever started on PrEP at this facility at the end of the previous quarter	PrEP Register	Not applicable
5. Number of new clients started on PrEP at this facility during the reporting quarter	PrEP Register	Not applicable
6. Number of clients transferred in the reporting quarter.	PrEP Register	Not applicable
7. Number of clients on PrEP testing HIV positive in the reporting quarter	PrEP Register	Not applicable