2023

Pre-exposure prophylaxis

for the prevention of HIV infection in Sri Lanka

A clinical practice guideline

National STD/AIDS Control Programme
SRI LANKA

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Introduction

Many HIV prevention strategies are being used worldwide and biomedical prevention methods are now becoming popular. Pre-exposure prophylaxis (PrEP) is one of these preventive methods, where anti-retroviral medications are used to prevent acquisition of HIV among sexually active at-risk populations. Several high-quality clinical trials have proven the effectiveness of PrEP in reducing the HIV transmission and safety among Men who have sex with men (MSM), [trials: iPreX, Proud, Ipergay] including young MSM of 15-25 years [Project PrePare], among heterosexual population [Partners in PreP], among People who inject drugs (PWID) [Bangkok trial], and among Transgender women (TGW) [Iprex]. In addition to oral PrEP, novel therapies such as long-acting injectable ART (IM cabotegravir) is now recommended for the use of PrEP [HPTN 083 and 084].

Sri Lankan context

Even though Sri Lanka is still a country of a low HIV epidemic with a prevalence of less than 0.1%, a rising trend of HIV cases has been reported among certain populations such as MSM during the recent years. HIV sentinel surveillance conducted among key population groups in 2019 found that the highest prevalence of HIV was among MSM (1.5%), followed by transgender women (1.4%).

In 2021, 59% were reported as having gay or bisexual behaviours among the men who were newly diagnosed with HIV. Furthermore, 14% from the reported number of HIV cases in 2021 were within the age group of 15-24 years and 88% of them were young men reflecting recently acquired infections among them. Therefore, it is important to give more attention to these high-risk groups and strengthen the measures of prevention among them. As PrEP is an effective and safe method of prevention, it needs to be implemented into the existing preventive package of at-risk population, properly among these high-risk groups.

Setting to provide PrEP

Initiation, refill and follow up services of PrEP should be available at island wide STD clinics. In addition, dedicated PrEP clinics can be introduced with the demand. By using Know4sure website or directly contacting STD clinics, an appointment can be booked for PrEP services.

If the venereologist feels the client is at high risk of HIV acquisition, and not starting PrEP as soon as possible will put him/her at more risk, initiation of PrEP could be considered at community level but, need to make sure that client is linked to STD services for the follow up at the earliest. All PrEP eligible clients attending to out-patient departments and other health facilities should be referred to the nearest STD clinics for initiation and follow up of PrEP.

Extensive adherence counselling is needed to initiate and maintain PrEP. This is to explore the barriers to adherence and to provide support and strategies to improve PrEP adherence. Already available ART counselling services in the STD clinics can be utilized for counselling PrEP clients as well.

In addition, baseline testing facility and STI screening also can be arranged through STD clinics and the proper linking to follow up services and PrEP refill is ensured by linking to the STD clinics. Some clients such as younger PrEP users and PrEP clients with other health, mental, emotional and social needs may benefit from frequent visits to STD clinics.

Following information should be discussed with all PrEP clients.

- PrEP dose and schedule (daily PrEP or on demand PrEP depending on the client's behaviour)
- Lead-in time to protection
- Common side effects and their management
- Adherence and efficacy of PrEP
- Risk of HIV infection and development of resistance from sub optimal adherence
- Symptoms of HIV seroconversion
- Potential risk of other STIs and need for regular STI screening.
- Safe sex counselling and condom promotion
- Discontinuation of PrEP

Risk assessment and PrEP recommendation

All sexually active adults and adolescents should be informed about PrEP for prevention of HIV acquisition. This information will enable them to both respond openly to risk assessment questions and to discuss PrEP with persons in their social networks and family members who might benefit from its use.

According to the published data in many countries, many MSMs are likely to take PrEP if it was offered to them, therefore MSM are a key population to which PrEP should be offered even in Sri Lankan context.

It is well recognized that there are other risk behaviours and vulnerability factors that increase the risk of HIV acquisition, and these should be taken into consideration on a case-by-case basis by clinicians when considering eligibility for PrEP and assessing HIV risk.

Men who have sex with men (MSM)

Recommendation 1:

PrEP should be offered to HIV-negative MSM who are identified as being at elevated risk of HIV acquisition through condomless anal sex in the previous 6 months and ongoing condomless anal sex.

Recommendation 2:

PrEP should be offered to HIV-negative MSM having condomless anal sex with partners who are HIV positive unless the partner has been on ART for at least 6 months with more than 95% adherence and a plasma viral load of <200 copies/mL preferably obtained within the last 1 year.

Recommendation 3:

PrEP can be considered on a case-by-case basis in MSM with the following factors **other than** condomless anal sex in previous 6 months that may put them at increased risk of HIV acquisition.

- Bacterial STI or HCV infection in past 6 months,
- Requested Post-exposure prophylaxis following sexual exposure (PEPSE) in the previous 6 months particularly repeated courses.
- Belongs to other key populations.
- Engages in chemsex or group sex.

Heterosexual population

Recommendation 1:

PrEP should be offered to HIV-negative heterosexual men and women having condomless sex with partners who are HIV positive unless the partner has been on ART for at least 6 months with more than 95% adherence and a plasma viral load of <200 copies/mL preferably obtained within the last 1 year.

Recommendation 2:

PrEP should be offered on a case-by-case basis to heterosexual men and women with the following factors that may put them at increased risk of HIV acquisition.

- Requesting Post-exposure prophylaxis following sexual exposure (PEPSE) in the previous 6 months particularly repeated courses
- One partner belongs to other key population.
- Partner engages in chemsex or group sex.
- Inability to negotiate and/or use condoms (or employ other HIV prevention methods) with sexual partners, Coercive and/or violent power dynamics in relationships (e.g., intimate partner/domestic violence)

Trans people (TG)

Recommendation 1:

PrEP should be offered to HIV-negative trans women who are identified as being at elevated risk of HIV acquisition through condomless anal sex in the previous 6 months and ongoing condomless sex.

Recommendation 2:

PrEP should be offered to HIV-negative trans women and trans men having condomless sex with partners who are HIV positive unless the partner has been on ART for at least 6 months with more than 95% adherence and a plasma viral load of <200 copies/mL preferably obtained within the last 1 year.

Recommendation 3:

PrEP could be considered on a case-by-case basis in trans women and trans men with the following factors other than condomless anal sex that may put them at increased risk of HIV acquisition.

- Bacterial STI or HCV infection in past 6 months

- Requesting Post-exposure prophylaxis following sexual exposure (PEPSE) in the previous 6 months particularly repeated courses,
- Belongs to other key population.
- Engages in chemsex or group sex.
- Inability to negotiate and/or use condoms (or employ other HIV prevention methods) with sexual partners, Coercive and/or violent power dynamics in relationships (e.g., intimate partner/domestic violence)

People who inject drugs (PWID)

PrEP can be considered on a case-by-case basis in people who inject drugs in an HIV outbreak situation or with other factors that put them at increased risk of HIV acquisition such as ongoing behavioural risk factors of other key population.

Female sex workers (FSW)

Recommendation 1:

PrEP should be offered to HIV-negative female sex workers who are identified as being at elevated risk of HIV acquisition through condomless sex in the previous 6 months and ongoing condomless sex.

Recommendation 2:

PrEP should be offered to HIV-negative female sex workers having condomless sex with partners who are HIV positive unless the partner has been on ART for at least 6 months with more than 95% adherence and a plasma viral load of <200 copies/mL preferably obtained within the last 1 year.

Recommendation 3:

PrEP could be considered on a case-by-case basis in female sex workers with the following factors other than condomless sex that may put them at increased risk of HIV acquisition.

- Bacterial STI in past 6 months
- Requesting Post-exposure prophylaxis following sexual exposure (PEPSE) in the previous 6 months particularly repeated courses
- Belongs to other key population.
- Partner engages in chemsex or group sex.
- Inability to negotiate and/or use condoms (or employ other HIV prevention methods) with sexual partners, Coercive and/or violent power dynamics in relationships (e.g., intimate partner/domestic violence)

Baseline assessment

Baseline HIV test

Baseline HIV testing is mandatory prior to starting PrEP since initiation in the context of un-diagnosed HIV infection could lead to development of antiretroviral resistance. Therefore, identifying clients with possible acute infection is critical to ensure persons with HIV are not exposed to drug pressure from PrEP.

Baseline HIV testing with a combined antigen/antibody serology test is strongly recommended prior to commencing PrEP. For individuals who have not had any risk exposures during the last 4 weeks, PrEP can be started with a negative fourth-generation blood-based POCT on the day, or a negative combined HIV antigen/antibody test within the past 4 weeks.

If blood-based POCT is negative, and the client has no symptoms suggestive of seroconversion illness, clinicians can consider starting same-day PrEP while awaiting the results of the laboratory based combined HIV antigen/antibody test. Oral POCT tests should not be used because of lower sensitivity, particularly during the window period. However, WHO suggests that HIVST could be considered for PrEP initiation outside of clinics, although current evidence is limited. Clinicians should not accept any kind of self-reported negative results.

HIV viral load should be considered where a high-risk exposure has occurred within 4 weeks. PrEP is deferred in clients reporting condomless sex in the previous 4 weeks who have symptoms suggestive of HIV seroconversion until an HIV RNA result is available.

Hepatitis B (HBV) screening

Baseline screening for HBV should be arranged in those of unknown HBV status to exclude active HBV infection. HBV vaccination can be initiated in those who are non-immune.

PrEP for clients who have HBV infection (either known or first diagnosed as part of a PrEP evaluation) should start PrEP in consultation with a consultant gastroenterologist. It is recommended that assessment by a gastroenterologist for those with evidence of chronic HBV with regard to continuing therapy or safety of stopping PrEP therapy. PrEP may be started pending results of HBsAg, but results should be reviewed at the earliest possible time as both TDF and FTC are active against HBV and stopping these drugs may cause severe hepatic flares. Generally, On-demand PrEP dosing is not the ideal choice for clients with chronic HBV infection.

As HBV prevalence is low in Sri Lanka, in clients with positive HBV screening test, hepatology opinion should be taken prior to PrEP initiation.

Hepatitis C (HCV) screening

Baseline screening for HCV is recommended in MSM and other groups at risk of HCV.

Important: WHO recommends that Lack of HBV and HCV testing should not be a barrier to PrEP initiation or use. PrEP can be initiated before HBV and HCV test results are available.

Rapid point-of-care tests are available for HCV serology & HBV screening and WHO has prequalified several RDTs.

STI screening

Full STI screen at baseline is recommended including syphilis serology and NAA~~T~~ testing for gonococcal and chlamydial infection at sites of exposure (genital, rectal, pharyngeal). Syphilis point of care test can be used to screen for syphilis. Unavailability of NAAT for gonococcal and chlamydial infection should not be used as a barrier for PrEP.

Renal assessment

Baseline renal function is assessed with a serum creatinine, eGFR and urinalysis but PrEP can be commenced while waiting for the results. Among HIV-positive persons prescribed TDF-containing regimens, it can cause decreased renal function and occasional cases of acute renal failure, including Fanconi's syndrome.

Factors that may indicate an individual is at higher risk of chronic kidney disease (CKD) include being aged 50 years or above, being on concomitant medication associated with renal impairment, or the presence of comorbidities such as hypertension and diabetes.

A number of studies have demonstrated that the CKD-EPI equation is more accurate than the Cockcroft–Gault formula or the MDRD estimate, especially at higher GFR >60 mL/min/1.73 m 2. The most effective way to calculate eGFR is therefore using the CKD-EPI equation.

The CKD-EPI equation (www.kidney.org/professionals/kdoqi/gfr_calculator)

A detailed medical history prior to PrEP is essential to identify clients at greater risk of adverse events who might require closer renal or bone monitoring.

Lipid profile

All persons prescribed TAF / FTC for PrEP should have monitoring of triglyceride and cholesterol levels every 12 months. Baseline lipid profile may be helpful in such patients.

Pregnancy Test for females

If an individual is pregnant when starting PrEP or becomes pregnant while on PrEP, they may continue PrEP during pregnancy or breastfeeding if there is an ongoing risk of HIV acquisition, after discussing the potential risks of TDF-FTC. As pregnancy is not a contra indication for PrEP, pregnancy testing is not essential at baseline.

Tests not indicated routinely

Current evidence showed that DEXA scans to monitor bone mineral density, liver function tests, and hematologic assays are not indicated for clients commencing PrEP.

Same-day PrEP initiation is not appropriate for following clients

- Clients who express ambivalence about starting PrEP (e.g., need more time to think)
- Clients for whom blood cannot be drawn for laboratory testing.
- Clients with signs/symptoms and sexual history indicating possible acute HIV infection.
- Clients with history of renal disease or associated conditions (e.g., hypertension, diabetes)
- Clients who do not have a confirmed means of contact should laboratory test indicate a need to discontinue PrEP (e.g., HIV infection, unanticipated renal dysfunction)
- Clients who may not be easily contacted for return appointments.
- Clients with mental health conditions that are severe enough to interfere with understanding of PrEP requirements (adherence, follow-up visits)

Prescribing PrEP for initiation and follow-up

Recommended oral medication

- The fixed-dose combination of TDF (300mg)/FTC (200mg) in a single daily dose is recommended for PrEP in MSM, trans women, trans men and heterosexual men and women at risk of acquiring HIV.
- TAF (25mg)/FTC (200mg) has recently been approved for daily PrEP use by men and transgender women at sexual risk. However, it is not approved for PrEP use by women at risk through receptive vaginal sex.
- Either TDF/FTC or TAF/FTC can be used when eGFR ≥60 ml/min. TAF/FTC is indicated for patients with eGFR <60 ml/min but ≥30 ml/min.
- TDF alone can be considered for only heterosexual men and women for PrEP where FTC is contraindicated.
- Clinicians may prefer TAF/FTC for persons with previously documented osteoporosis or related bone disease but routine screening for bone density is not recommended for PrEP clients.
- Pregnancy and breastfeeding are not a contraindication for starting PrEP.

Recommended injectable medications

Cabotegravir injections may be especially appropriate for those who have had difficulty with adherence issues of oral PrEP, those who prefer injections every 2 months to an oral PrEP dosing schedule and clients with significant renal disease. Recommended dosage is 600 mg of Cabotegravir injected into gluteal muscle every 2 months. 30 mg daily oral Cabotegravir is optional for a 4-week lead-in prior to injections.

What not to use for PrEP

- No other antiretroviral regimens should be used for PrEP except a daily oral dose of TDF/FTC or TAF/FTC or injections of Cabotegravir every 2 months.
- Do not prescribe other than continuous daily dosing of oral PrEP with the exception of MSMs.
- On demand oral PrEP can be considered for MSM. Only TDF/FTC can be used for this regimen.
- Do not provide oral PrEP as expedited partner therapy.

Lead-in period

- Recommended lead in period for daily dosing (**with single dose** TDF/FTC), the time to protection for vaginal and anal sex is estimated as 7 days.
- For on-demand dosing in anal sex is estimated as 2–24 hours **following a double dose** of TDF/FTC. Data is not available on the time to protection following TAF/FTC.

Frequency of dosing

- **Daily dosing for oral PrEP**

  To achieve the maximum benefit from oral PrEP, TDF/FTC or TAF/FTC should be taken daily for both anal and vaginal sex.

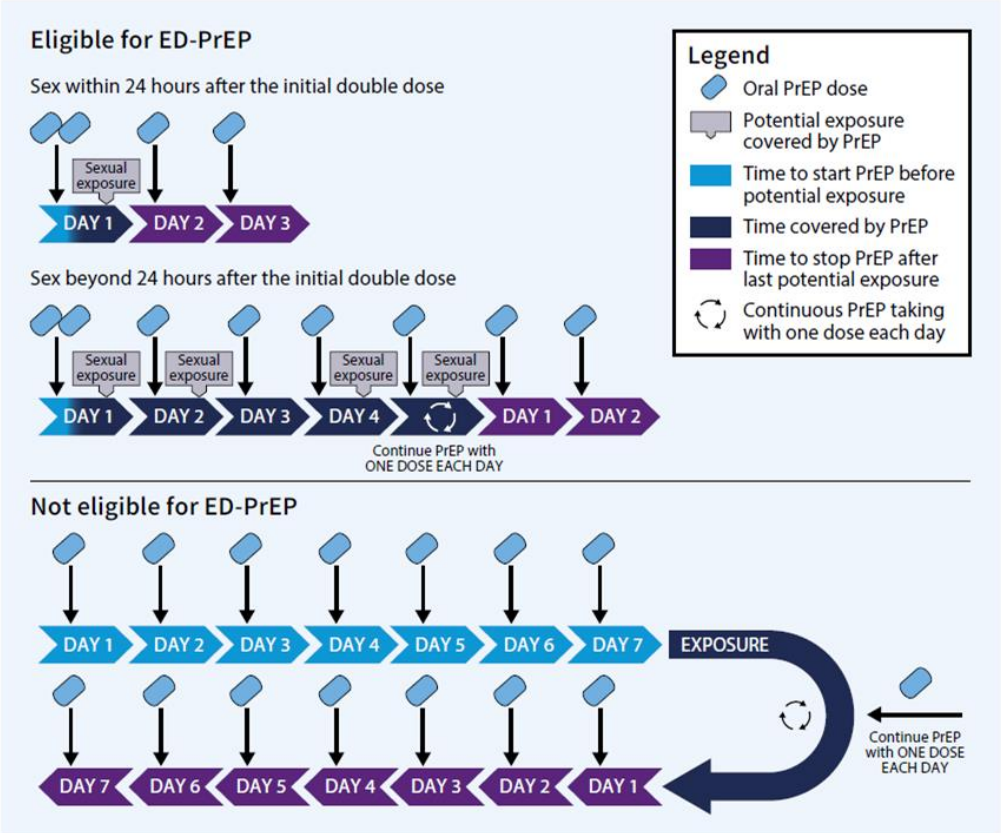
  If clients who engage in anal sex wish to shorten the lead in period can take a double dose of TDF/FTC. The clinician should discuss and monitor adherence at initial and follow up visits.

- **On-demand/Event driven (ED) dosing for oral PrEP**

  This is generally recommended for MSM having infrequent sexual events. In addition, on demand oral PrEP can be used to prevent sexual acquisition of HIV by trans and gender diverse people assigned male at birth who are not taking exogenous oestradiol-based hormones. On-demand dosing has not been investigated in heterosexual men and women.

  Two tablets of TDF/FTC loading dose have to be taken 2 to 24 hours before sex, followed by a third single dose at 24 hours and a fourth single dose at 48 hours. In the event of multiple consecutive episodes of sexual intercourse, clients should be instructed to take one tablet daily until 48 hours after the last sexual intercourse. When restarting PrEP, clients should be advised to take a loading dose of two pills unless the last PrEP dose was less than 1 week earlier, in which case they were instructed to take only one pill. On-demand dosing has not been investigated in heterosexual men and women or in trans women and trans men and should not be offered.

Fig. 1. How to start and stop oral PrEP for those eligible for ED-PrEP and those not eligible



- **Dosing for injectable PrEP**

  After the initial Cabotegravir injection, the second dose is given in one month and thereafter every 2 months.

Adherence

During the initial visit, adherence should be thoroughly discussed with the client including how to overcome side effects, how to decide a schedule that suits their daily routine, introducing reminder tools such as setting up alarms, providing services for substance abuse and addressing mental health issues. Clear instructions need to be provided on how to take their medications (when to take and how many pills to be taken etc.)

In the event of missed pills – Clients should be informed to take a single missed dose as soon as they remember it unless it is almost the time for the next dose. If it's time for the next dose, clients should skip the missed dose and continue with the regular dosing schedule.

For MSMs, who are on daily oral PrEP, should be encouraged to take pills daily at a scheduled time. However, if they take PrEP tablets every other day (4 doses per week) still they are protected against HIV infection.

Discontinuation and restarting PrEP

PrEP can be discontinued for many reasons such as client factors: client choice, changed life situations resulting in lowered risk of HIV acquisition, intolerable toxicities, chronic nonadherence to the prescribed dosing regimen or scheduled follow-up care visits or acquisition of HIV while on PrEP.

Discussions on how to safely discontinue should be done with the clients at the initiation as well as discontinuation of PrEP.

Pregnancy is not an indication to stop PrEP, especially if there is an ongoing risk of HIV.

Patients with HBV infection who discontinue taking oral PrEP should be monitored closely for hepatitis flares.

Upon discontinuation of PrEP for any reason, the following should be documented in the clinic record:

- HIV status at the time of discontinuation.
- Reason for discontinuation; and
- Recent medication adherence and reported sexual risk behaviour.

If a client wishes to restart PrEP after a period of discontinuation, they must undergo the same process as discussed under initiation of PrEP for a new client. They should undergo an HIV test to rule out HIV infection before restarting.

The need for restarting PrEP and the commitment to complete adherence must be discussed and documented in the clinic records.

Discontinuation of oral PrEP

Protection from oral PrEP will wane over by 7-10 days of discontinuation of daily PrEP use. Therefore, the clients should be informed about other preventive methods as acquisition of HIV cases soon after discontinuation have been reported. Indications of non-occupational PEP should also be discussed.

Discontinuation of long acting Cabotegravir (CAB)

Clients who wish to discontinue CAB injections for PrEP or those who are a month or more late for an injection should be counselled about:

- How to safely discontinue or restart CAB injections for PrEP

- The risk of developing drug resistant HIV during the period of waning drug levels (the “tail period”)
- Need for daily oral PrEP or other effective HIV prevention methods if ongoing risk of HIV exposure is expected.

CAB levels slowly wane over many months after injections are discontinued. Therefore, it is of utmost importance that the clients are educated about this “tail period” and the risk of developing resistance to CAB or other INSTIs if HIV is acquired during this time.

It is also important to note that CAB PrEP has been associated with delayed seroconversion and detection of HIV acquisition as for daily oral PrEP. CAB injections can be restarted at any point after determining HIV negative status with HIV-1 RNA testing.

When helping clients to discontinue CAB PrEP safely, clinicians should:

- Re-educate them about the “tail” and the risks during declining CAB levels.
- Assess ongoing risk/indications.
- If PrEP is indicated, prescribe daily oral TDF/FTC or TAF/FTC beginning within 8 weeks after last injection.
- Educate about nPEP

Drug interactions

Before initiating oral or injectable PrEP drug interactions should be checked by the clinician for both medically prescribed and recreational drugs.

https://hiv-druginteractions.org/checker

Supply of PrEP medicines

Number of tablets supplied per person depends on the way they are going to use PrEP. If a person is prescribed daily PrEP, 1 month supply can be provided at initial visit. Case by case assessment is needed for prescriptions for a longer period. If someone opts for on demand PrEP, 30 tabs of TDF/FTC or TAF/FTC can be provided for a 3-month period.

If someone started on CAB injections as PrEP, no other ART should be combined.

Indications for non-occupational post-exposure prophylaxis(nPEP) following suboptimal adherence to PrEP

The decision on when to start nPEP following suboptimal adherence to PrEP will depend on the length of time since the last dose of PrEP and the site of exposure.

Where potential HIV exposure has occurred through anal sex;

If at least three tablets of TDF-FTC have been taken within the previous 7 days, PrEP can be restarted with a single dose of TDF-FTC and continued as before (thus fulfilling a minimum of four doses per week) without the need for full nPEP. Where fewer than three tablets have been taken within the last 7 days or where the last dose was more than 7 days ago, nPEP should be given.

Where potential HIV exposure has occurred through vaginal sex;

If PrEP adherence has been suboptimal, the threshold for starting nPEP is likely to be lower and should be considered if more than 48 hours have elapsed since last dosing or if fewer than six tablets have been taken within the previous 7 days.

Monitoring on PrEP

Initial follow up visit should be arranged in 1 month. Further follow up visits should be planned in 1 - 3 monthly intervals.

Regular follow up assessments for people who are on PrEP, permits clinicians to review the adherence and side effects of PrEP. In addition, follow up appointments facilitate discussions around changes in risk behaviour to determine the need for ongoing PrEP use. Screening and treating sexually transmitted infections, regular assessment of HIV status, risk reduction are other benefits of having follow up appointments.

Management of short-term side effects

TDF/FTC can have short-term side effects including nausea, flatulence, abdominal pain, dizziness and headaches. These symptoms occur early and mostly disappear within the first month. They can be managed with analgesics and anti-emetics.

Follow-up monitoring for people receiving TDF/FTC or TAF/FTC for PrEP

Follow-up monitoring is same for on demand and daily PrEP. If a person returns more than 3 months later for refill, consider them as a new client and start from baseline screening.

1 **HIV testing**

HIV testing should be arranged every 3 monthly whiles on PrEP. HIV testing should be done using either laboratory antigen/antibody test or blood based POCT. HIV seroconversion should be considered in any individual presenting with symptoms suggestive of primary HIV infection and should be advised to return to STD clinic soon if they experience such symptoms.

2 **STI Screening**

As a part of the risk reduction strategy, a 3-monthly STI screen should be advocated. This consists of screening for GC, NGU and Syphilis with standard testing methods. Patients should be advised to return to an STD clinic if they experience any symptoms suggestive of sexually transmitted infection.

3 Renal functions

- To date, there have not been any major concerns with regard to renal toxicity by PrEP. However, a small decrease in eGFR may be seen which resolves after stopping PrEP.
- As a baseline, urinalysis, serum creatinine and eGFR should be done. If eGFR >90 mL/min/1.73m^3, and the age of the person is <50yrs with no other concomitant factors for renal disease, eGFR can be done annually.
- If eGFR is 60-90 mL/min/1.73m^3 with additional risk factors for renal disease (age >50 years, use of nephrotoxic medications, hypertension or diabetes) more frequent renal monitoring (at least biannual) is required.
- If eGFR is <60 mL/min/1.73m^3 for TDF based PrEP and <30 mL/min/1.73m^3 for TAF based PrEP, the risks and benefits of continuing PrEP should be assessed on a case-by-case basis and nephrologist opinion should be considered. Cabotegravir can be considered for such clients.
- A rise in serum creatinine or fall in eGFR is not a reason to stop PrEP if eGFR remains >60 mL/min/1.73m^3 for TDF and >30 mL/min/1.73m^3 for TAF based PrEP but warrants frequent monitoring.
- Routine urinalysis for proteinuria is not recommended if baseline is normal and testing for tubular proteinuria with specific markers also not recommended.
- Dose adjustments of TDF/TAF for PrEP is not recommended for people with renal disease.

4 Hepatotoxicity

Liver function tests are not recommended routinely and can be considered if indicated.

5 Bone monitoring

Routine bone density monitoring at baseline or during follow up is not recommended for PrEP users. Supplementation with vitamin D and calcium can be considered if additional risks for osteopenia or osteoporosis is present.

6 Hepatitis C

There is no evidence of increased risk of HCV if there is no IV drug use. Consider Hep C testing if the PrEP client is injecting drugs as well.

7 Hepatitis B

If negative at baseline, check vaccination status and arrange accordingly. If positive, need to liaise with a Gastroenterologist.

8 Pregnancy test

Arrange pregnancy test if indicated during the follow up visits. PrEP can be continued even if client becomes pregnant while on PrEP and having ongoing risk for HIV acquisition.

9 Other

Annual monitoring of cholesterol levels and weight is recommended for people on TAF based PrEP. FBC, Liver functions or DEXA scans are not recommended routinely.

Following table summarizes the monitoring and clinical follow up of people prescribed TDF/TAF based PrEP.

	Baseline	Follow up			
		1 month	*3 Months*	*Every Subsequent visit*	*Remarks*
HIV testing	√	√	√	√	3 monthly
Assess for acute HIV	√	√	√	√	Every visit
STI screen	√	-	√	√	Every 3 monthly or if symptomatic
Renal Functions	Urinalysis, S. creatinine, eGFR	-	-	-	Annually (More frequently if high renal risk)
Hepatitis B	√	-	-	-	Check Vaccination
Hepatitis C	√	-	-	-	Test If indicated
Lipid profile	-	-	-	-	Annually if on TAF

Follow-up monitoring for people receiving IM Cabotegravir (CAB) for PrEP

Once CAB injections are initiated, patients should return in 1 month and every 2 monthly thereafter.

- **Month 1, For second injection**
    - Perform HIV RNA test. This is the preferred test to be used for clients on CAB due to the prolonged drug exposure following injection and assess for symptoms of acute HIV infection.
    - Inquire about injection site reactions.
    - Prescribe painkillers when needed.

- **Every two monthly and thereafter**
    - HIV RNA test, STI screening

Quarterly visit documentation

During each visit, attention needs to be focused on following areas.

- Reason for continuing PrEP
- Prescribed regimen and reasons for poor adherence (if there are any)
- Assessment of side effects of PrEP
- HIV and STI screening
- HIV risk reduction advice

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