Ministry of Health

# Malawi Service Delivery Guidelines and Standard Operating Procedures for the Provision of HIV Pre-Exposure Prophylaxis using Oral or Long-acting Injectable Options.


2nd Edition, 2024

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## Tables and Figures

# 1 Acknowledgments

These Guidelines have been developed through the collaborative effort of many individuals and organizations under coordination of Department for HIV/AIDS, STI and Viral Hepatitis of the Ministry of Health. The Malawi Ministry of Health is grateful to all members of the PrEP Subcommittee for their technical inputs under the leadership of the Director Rose Nyirenda.

The Ministry of Health is indebted to all bilateral and multilateral development partners, implementing partners, civil society organizations (CSOs), and local communities who collectively contributed to the write-up and review of thisdocument. The guidelines have been developed following WHO normative guidance and other international frameworks adapted to the national context.

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# 2 Acronyms & Abbreviations

| | |
|---|---|
| ADR | Adverse drug reaction |
| AGYW | Adolescent girls and young women |
| AHI | Acute HIV infection |
| ALT | Alanine aminotransferase |
| ANC | Antenatal clinic |
| APRI | Aminotransferase and platelet ration index |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| AST | Aspartate aminotransferase |
| BBSS | Biomedical Behavioural Surveillance Survey |
| BMI | Body mass index |
| CAB-LA | Long Acting Injectable Cabotegravir |
| CHAM | Christian Health Association of Malawi |
| CMS | Central Medical Stores |
| CO | Clinical Officer |
| CSOs | Civil Society Organizations |
| Cr Cl | Creatinine clearance |
| DIC | Drop-in centre |
| DTG | Dolutegravir |
| EC | Expert clients |
| ED-PrEP | Event Driven PrEP |
| eGFR | Estimated glomerular filtration rate |
| EMTCT | Elimination of Mother to Child Transmission |
| FBC | Full blood count |
| FTC | Emtricitabine |
| FP | Family planning |

| | |
|---|---|
| FSW | Female Sex Worker |
| HDA | HIV Diagnostic Assistant |
| HBsAg | Hepatitis B surface antigen |
| HBV | Hepatitis B virus |
| HIV | Human Immunodeficiency Virus |
| HIVST | HIV self-test |
| HTS | HIV Testing Services |
| DCSA | Disease Control Surveillance Assistant |
| ID | Identification |
| IEC | Information, education and communication |
| MA | Medical Assistant |
| MCH | Maternal and Child Health |
| MDHS | Malawi Demographic Health Survey |
| MO | Medical officer |
| MOH | Ministry of Health |
| MSM | Men who have sex with men |
| MSW | Male Sex Workers |
| NSAIDS | Non-steroidal anti-inflammatory drugs |
| PEP | Post-exposure prophylaxis |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of mother to child transmission |
| POC | Point of Care |
| PrEP | Pre-exposure prophylaxis |
| sCR | Serum Creatinine |

| | |
|---|---|
| SOPs | Standard Operating Procedures |
| STI | Sexually transmitted infection |
| TDF | Tenofovir disoproxil fumarate |
| TDF/3TC | Fixed dose combination of Tenofovir Disoproxil Fumarate (TDF) plus Lamivudine (3TC) |
| VL | Viral Load |
| VMMC | Voluntary Male Medical Circumcision |
| WHO | World Health Organization |

# 3 Foreword

Evidence shows that Oral PrEP and Long-Acting Injectable PrEP reduce the risk of contracting HIV during sexual intercourse by more than 90% when taken as prescribed. It is for this reason that the Extended National HIV Strategic Plan 2023-2027 emphasizes the role of Oral and Long-Acting Injectable PrEP in reducing new HIV infections in Malawi.

Malawi has adopted the UNAIDS targets, including that by 2025, 95% of people at risk of HIV infection use appropriate, person-centered, and effective combination prevention options. To achieve this ambitious target, there is a need to sustain the gains made in achieving the UNAIDS 95.95.95 treatment targets and scale up comprehensive evidence-based HIV combination prevention approaches targeting those at substantial risk and most affected geographical areas. In expanding the use of oral and Injectable Pre-exposure Prophylaxis (PrEP), the country has adopted public health, human rights and people-centered approaches, prioritizing universal health coverage, gender equality, and health-related rights including accessibility, availability, acceptability and quality.

Implementation of PrEP services is being undertaken in a phased in approach, prioritizing facilities/sites based on the estimated number of clients at substantial risk, capacity of facility/site and referral mechanisms, availability of trained and skilled professional health workers, infrastructure and laboratory capacity/proximity. Public health facilities, CHAM, Drop-in Centers, and Private and NGO facilities will deliver Oral PrEP to allow access to marginalized populations. Additionally, Long-Acting Injectable PrEP will be delivered through an Implementation Science Study in selected facilities in Blantyre and Lilongwe before scaling up to the rest of the districts.

Drawing lessons from studies implemented in the region as well as implementation research among Adolescents Girls and Young Women (AGYW) and Female Sex Workers (FSW) in Malawi, community educators and advocates will be used to increase awareness about PrEP in their communities and sub populations. Additionally, PrEP services will be integrated within HIV, STI ,Family planning, Antenatal, Postnatal and Child Health services.

The document is a guideline to support funders, implementing partners, district health team leads and service providers in implementing Oral and Long-Acting Injectable PrEP in Malawi. It will also promote standardization in the delivery of PrEP services in healthcare settings and in the community.

It is the view of the Ministry that all stakeholders in the HIV space will subscribe to the government's commitment in supporting the implementation of Oral and Long-Acting Injectable PrEP as stipulated in this guideline.

Dr Samson Mndolo

**SECRETATRY FOR HEALTH**

# 4 Introduction and background

## 4.1 Introduction

Malawi has adopted the UNAIDS targets, including that by 2025, 95% of people at risk of HIV infection use appropriate, prioritized, person-centred and effective combination prevention options. According to the 2023-2027 Revised & Extended National Strategic Plan, HIV incidence declined significantly in all age groups in the general population, now estimated below the moderate risk threshold of 0.3% annual incidence.

## 4.2 Risk in Adolescent girls and young women (AGYW)

A 2022 new UNAIDS risk stratification tool which provided detailed incidence estimates for adolescent girls and women for all the twenty-eight (28) health districts and the four (4) cities, shows only 9 districts with AGYW incidence of >0.2%, with most AGYW aged 15 -29 years (shifted towards older ages) into sex work while the rest have multiple partners.

UNAIDS AGYW risk stratification estimates for 2022, for 8 districts with AGYW incidence >0.2% (rounded values)

| | **YWKP 15-19 years** | | **KP 20-29 years** | | **Multiple partners 20-29** | |
|---|---|---|---|---|---|---|
| **Area** | Pop size | **New inf** | Pop size | **New inf** | Pop size | **New inf** |
| Zomba | 2,200 | **30** | 3,600 | **70** | 18,100 | **90** |
| Balaka | 800 | **10** | 1,400 | **80** | 10,100 | **50** |
| Chiradzulu | 600 | **10** | 1,100 | **90** | 8,700 | **60** |
| Blantyre | 1,400 | **30** | 3,700 | **100** | 36,200 | **230** |
| Thyolo | 1,500 | **30** | 2,600 | **60** | 16,400 | **100** |
| Mulanje | 1,600 | **20** | 2,600 | **60** | 17,600 | **90** |
| Phalombe | 800 | **10** | 1,300 | **20** | 6,900 | **40** |
| Lilongwe City | 1,600 | **30** | 4,400 | **100** | 30,400 | **160** |
| **Total** | **10,500** | **170** | **20,700** | **580** | **144,400** | **820** |

## 4.3 Risk of vertical transmission among pregnant and breastfeeding women

Incident HIV infections in pregnant and breastfeeding women (PBFW) carry an extremely high risk (over 30%) of infant transmission. Infants infected via incident maternal infection are often missed or diagnosed late in the PMTCT program. This is because their mothers are not follow-up during breastfeeding period, despite HIV negative test during pregnancy and at discharge after delivery. It is therefore crucial for the goal of elimination of mother-to-child transmission (eMTCT) to identify high risk PBFW through Antenatal, postnatal clinics, family planning and child health clinics, offer HIV testing, combination prevention packages that includes male partners. PrEP for PBFW with a known HIV infected partner is indicated whenever the viral load of the partner is unknown or unsuppressed (1000+ copies/ml)

## 4.4 Sexually transmitted infections

In the era of low and declining HIV incidence, one particularly promising approach for reaching a large proportion of high-risk individuals with primary prevention is through STI clinics. Malawi registers over 440,000 STI patients across the whole country per year, but this represents only about half of all estimated symptomatic STI infections in the population. HIV status ascertainment among STI patients in public clinics reached 91% in 2022 and 18% were HIV positive (routine MOH service reports), while the rest were HIV negative therefore a potential target group for PrEP services. Equally key populations remain a high-risk population.

## 4.5 Targeting for meaningful impact

The low HIV incidence levels across most subgroups in all districts and the shift to slightly older ages, implies that meaningful impact and value for money can only be achieved if prevention interventions are tailored to the levels of incidence, highly effective, easy to target to subgroups with substantial risk and easy to scale to high coverages. Integration of HIV prevention services within STI, ANC, postnatal, family planning and child health services is a promising strategy to improve access to services by key populations, and people in the general population who are at substantive HIV risk, including adolescents, women, and men.

## 4.6 Rationale for the use of oral and long-acting injectable PrEP

HIV pre-exposure prophylaxis (PrEP) has emerged as a highly effective prevention method for people at substantive risk. The World Health Organization (WHO) recommends specific antiretroviral combination regimens (tenofovir/emtricitabine or tenofovir/lamivudine) for oral use and an injectable long-acting option (cabotegravir - CAB-LA). The WHO has also recommended the dapivirine vaginal ring (DPV-VR), a female-initiated option to reduce the risk for women who find the other PrEP options unsuitable.

Oral PrEP and long injectable Cabotegravir- reduces the risk of getting HIV from sex by about 99% when taken as prescribed. The effectiveness of oral daily PrEP is highly dependent on PrEP adherence; it is less effective when not taken consistently. However, oral PrEP may be only 74%

effective among people who inject drugs. In clinical trials, CAB-LA has shown to be 80% more effective than oral PrEP, as it eliminates the challenges with adherence to oral PrEP.

The dapivirine vaginal ring (DVR) is a silicone ring that is continuously worn in the vagina where it slowly releases the antiretroviral drug dapivirine over 28 days. It must be replaced monthly. The effectiveness of the DPV-VR is estimated between 27% (ASPIRE trial) and 35% (The Ring Study). Results from the open-label extension studies of the trials showed increases in ring use and effectiveness. Modelling estimates based on these trials suggest a risk reduction of over 50% may be possible. Meanwhile, Malawi is planning to conduct a cost-benefit analysis to inform policy direction.

## 4.7 Development process

Malawi has operationalized the 2021 Oral PrEP guidelines in both public and private clinics, with saturation in high HIV burden districts. In mid-2023, event driven Oral PrEP was adopted, including delivery of PrEP through integrated community service delivery models. With the release of WHO normative guidance on long-acting injectable CAB-LA and its adoption thereof, it was necessary that the old 2021 guideline and standard operating procedure document be revised to incorporate the emerging approaches.

The HIV, STI and Viral Hepatitis Directorate therefore consolidated both oral and long-acting injectable regimen guideline and standard operating procedure. The draft was validated by stakeholders, reviewed by the National Essential Medicines Committee, the Health Service Delivery Technical Working Group and finally endorsed by the Senior Management Committee of Ministry of Health.

The documents contains the standard of care for any client who is eligible for PrEP. It is for use by policy makers, funders, services providers and advocates in the implementation of Oral and long acting injectable Pre exposure prophylaxis regimens.

# 5 Eligibility Screening for Oral and Injectable PrEP

**Key facts: PrEP eligibility**

- For all potential PrEP clients:
  - Screen and educate about substantial risk (see **Table 1** on **page 16**) to determine **need** for PrEP,
  - discuss the personal situation to determine the **ability** to use PrEP and identify **suitable PrEP options**,
  - screen for **potential contraindications** (see **section 5.2**. on **page 16**)
- Offer PrEP **only** to people at substantial risk of HIV infection.
  - Inform all potential PrEP clients about the available options.*
  - Explain which options may be appropriate for the client.*
  - Encourage clients to choose their preferred PrEP option.*
  - Allow clients to transition between different PrEP options.*
  - * **Note:** CAB-LA supplies will be initially limited. See **section 5.3** on **page 18** for considerations how to prioritize.
- Event-Driven oral PrEP (ED-PrEP) is **only** suitable for **men** who are:
  - at substantial risk for HIV,
  - able to reliably plan sex at least two hours in advance,
  - are expected to have at least 4 days between risky sex episodes.
- If taken correctly, ED-PrEP is effective for men having penile-vaginal and anal sex.
- **No test – no PrEP:** a negative HIV test result is mandatory before oral or injectable PrEP initiation and for each follow-up prescription.
  - Follow the standard testing protocols in the *Malawi Integrated Testing Guidelines*.
- Contraindications for **CAB-LA**:
  - advanced liver disease
  - current use of rifampicin, rifapentine, carbamazepine, oxcarbazepine, phenobarbital, phenytoin
- Maternal and infant safety will be monitored in pregnant and breastfeeding women taking long acting injectable cabotegravir.

## 5.1 Assessing the need for PrEP

### 5.1.1 Strategy for risk counselling and decision support

1. **Reassure** the client about strict confidentiality and non-judgemental attitudes.
2. Clients may under- or over-estimate their own risk.
3. **Educate** clients about the listed risk factors.
4. **Encourage** the client to relate their potential risk and partner history over the last 3 months but **emphasize that they are not required to disclose** their specific risk behaviours.
5. The purpose is to assist the client in predicting their HIV acquisition risk over the next 3 months. Explain that PrEP has no effect on past risk, but only the future risk is relevant for the decision when to take PrEP.
6. **Let the client decide** if they think they will benefit from PrEP. **Do not use persuasion or coercion** to encourage or discourage PrEP use.

**Table 1: Substantial risk factors determining the need for PrEP**

| Clients with any of the following current or anticipated risk factors in the next 3 months may benefit from PrEP |
|---|
| 1. Current or recent STI (last 6 months, self-report or clinical diagnosis)<br>2. Transactional sex: paid for condomless sex, or received money or goods for condomless sex, including sex workers and clients.<br>3. Condomless sex with a known HIV infected regular partner who is not on ART or with viraemia 1000+ on their most recent VL result.<br>4. Condomless sex with regular partner with unknown HIV status who has other high-risk sexual partners.<br>5. Anal intercourse with non-regular partner without condom.<br>6. Injecting drug use with needle sharing. |

## 5.2 Assessing the suitability of PrEP options

**Explain** the suitability of different PrEP options using **Table 2** below:

**Table 2: Suitability of PrEP options and potential contraindications**

| | Event-driven oral PrEP (TDF/3TC) | Continuous oral PrEP (TDF/3TC) | Injectable PrEP (CAB-LA) |
|---|---|---|---|
| Expected period of substantial HIV risk (minimum) | 1+ weeks | 2+ weeks | 3+ months |
| Risk type | sex only | sex or needle sharing | sex or needle sharing |
| Ability to plan sex at least 2 hours[1] in advance | mandatory | not needed | not needed |
| Client gender | men only[2] | any | any |
| Minimum age | 15+ years | 15+ years | 15+ years |
| Minimum weight | 30+ kg | 30+ kg | 35+ kg |
| Negative HIV test result on the day of PrEP initiation or continuation, using national HIV testing algorithm | mandatory | mandatory | mandatory |
| Rule out clinical signs of acute HIV infection | mandatory | mandatory | mandatory |
| Ability and commitment to adhere to follow-up visit schedule | 3-monthly | 3-monthly | 1 month and then 2-monthly |
| Rule out kidney function risk factors | mandatory[3] | mandatory[3] | not needed |
| Rule out severe liver damage | not needed | not needed | mandatory |
| Use of other interacting meds | see **Table 9** on **page 37** | | |

[1] The first dose of ED-PrEP (2 tablets) should ideally be taken 24 hours before risky sex. 2 hours before is the absolute minimum period required.

[2] ED-PrEP is also suitable for transgender women (born male but identifying as female) who are not using gender-affirming hormones.

[3] Kidney function screening is only needed for clients at elevated risk of kidney disease. See criteria in **Table 3** on **page 11**.

## 5.3 Managing limited supplies of CAB-LA

**Key facts: Managing limited supply of CAB-LA**

- There is currently only one global supplier of CAB-LA with **limited production capacity**. The discounted cost of CAB-LA for low-income countries is still very high at an estimated USD 36 (MKW 60,000) per vial (end 2023).
- More CAB-LA from generic manufacturers at lower cost is expected from 2027.
- Malawi has been given early access to a limited quantity through a US Government donation.
- For the foreseeable future, CAB-LA demand may exceed available supplies.
    - From 2024, 36 **selected facilities in Lilongwe and Blantyre districts** will begin to provide CAB-LA through an implementation study (Path2Scale). Roll-out to additional sites and districts will start as soon as sufficient supplies are available.
    - Even at the initial selected facilities, the number of existing PrEP clients may exceed the available supplies.
    - The Ministry of Health will issue a circular to all selected facilities with the maximum number of clients that can be started on CAB-LA each quarter. Adherence to this policy will be audited during quarterly site supervision.
- Follow the instructions below to fill the available slots with clients who may benefit most from early access to CAB-LA.
    - CAB-LA supplies are prioritized to ensure that clients who have already started and want to continue can do so without risking stock-outs.

- **Prioritize** existing and new PrEP clients who meet all of the following criteria:
    - Expected high risk period longer than 3 months.
    - Many high-risk exposure events each week.
    - Observed or anticipated challenges with adherence or contraindications for oral PrEP.

## 5.4 Restarting PrEP after previous side effects

- Both oral and long-acting injectable PrEP are generally well tolerated (see potential side-effects in **Table 10** on **page 40**).
- However, before re-starting PrEP: ask all clients if they have previously experienced any side-effects on PrEP.
- Do not re-start clients who previously experienced serious side-effects on the same PrEP regimen. Consider the alternative PrEP regimen instead.

### 5.4.1 Assessing for kidney disease

- Oral PrEP (TDF/3TC or TDF/FTC) can rarely cause or worsen kidney problems.
    - People with other risk factors for kidney disease are at higher risk from taking oral PrEP.
- Do not initiate or continue oral PrEP in clients with known kidney disease (estimated glomerular filtration rate (eGFR) <60ml/min)
    - PrEP re-initiation is not usually recommended in such clients, but can be considered if eGFR normalizes to ≥90ml/min.
    - Recommend alternative prevention interventions instead: injectable long-acting PrEP (CAB-LA), condoms, VMMC, etc.
- Before initiation on oral PrEP, actively look for the kidney disease risk factors in **Table 3.**
    - Clients with any of the listed risk factors need a creatinine blood test to estimate the eGFR within 3 months of starting PrEP and 12-monthly during follow-up.
    - Do not wait for the creatinine (eGFR) result before initiating PrEP, but discontinue oral PrEP if the eGFR is <60ml/min.

**Table 3: Kidney function screening criteria for oral PrEP**

| Risk factors: any of the following, at initiation or during follow-up | Renal function screening needed |
|---|---|
| • Age 40 years +<br>• Hypertension<br>• Diabetes mellitus<br>• BMI <18.5 kg/m$^2$<br>• On nephrotoxic medications[4]<br>• Known CrCl <90ml/min<br>• Other renal impairment signs | • Routine creatinine clearance (CrCl) needed within 1 month of starting PrEP and 12-monthly during follow-up |
| • None | • CrCl not needed at baseline and during follow-up |

### 5.4.2 Assessing for liver disease

- Do not initiate clients with advanced liver disease or acute hepatitis on CAB-LA.

[4] Repeated or long-term use: ibuprofen, diclofenac, rifampicin, gentamycin, penicillins, cephalosporins, omeprazole, etc.

- In clients with heavy alcohol use: consider HIV prevention benefits versus increased risk from liver disease. Check liver function tests (alanine aminotransferase = ALT) after every 6 months on CAB-LA if possible. Switch to alternative prevention options if ALT is increasing on CAB-LA.
- Refer all clients with suspected liver disease for evaluation and management at the hepatitis clinic.
- Test for Hepatitis B virus (HBV) before initiation of CAB-LA
- Do not initiate CAB-LA in clients with a positive Hepatitis B test (hepatitis B surface antigen).
    - Refer all Hepatitis B positive clients for further evaluation and treatment.
    - Continuous oral PrEP TDF/FTC or TDF/3TC is a good option for HBsAg positive clients as it will both suppress HBV and prevent HIV acquisition. Such clients should be followed up by the hepatitis treatment providers, not at the PrEP clinic.

# 6 Testing PrEP Clients for HIV, Hepatitis B and Syphilis

**Key facts: HIV, HBV, and Syphilis testing for PrEP**

- Follow the current standard (2023 Integrated Testing Guidelines) protocols for testing of HIV, hepatitis B and syphilis among PrEP clients.
- A negative HIV test result on the day of PrEP initiation or PrEP follow-up prescription is mandatory. **No HIV test = no PrEP**
    - Oral fluid **HIV self-tests** can be used for **demand creation and self-screening**, but professional blood-based tests are needed to confirm negative status at PrEP initiation and follow-up.
    - Do not start or continue PrEP for clients with an **inconclusive HIV test** result as they may be seroconverting. Suspend / defer PrEP for 2 weeks and repeat the HIV test.
- Confirmation of hepatitis B (HBsAg) negative status on the day of CAB-LA initiation or within 3 months is mandatory.
    - Clients who have previously completed a series of 3 HBV vaccinations are well protected from hepatitis B and don't need to be tested for HBsAg. (All people born after 2002 have likely received the pentavalent infant vaccination and are fully protected.)
    - Offer hepatitis B vaccination to HBsAg negative clients.
- Routinely test all PrEP clients for syphilis at the time of PrEP initiation and 12-monthly thereafter.
    - Offer hepatitis B vaccination to HBsAg negative clients.
    - Clients who have previously completed a series of 3 HBV vaccinations are well protected from hepatitis B and don't need to be tested for HBsAg. (All people born after 2002 have likely received the pentavalent infant vaccination and are fully protected.)
    - Manage all syphilis positive PrEP clients according to the national STI guidelines.

## 6.1 Ruling out HIV infection for PrEP initiation and continuation

- Use professional (blood-based) HIV testing following the national Integrated Testing Guidelines to rule out HIV infection for all clients who want to initiate, re-initiate or continue oral or injectable PrEP.
- A negative HIV test result is required on the day of PrEP initiation or follow-up prescription.

- Clients with an inconclusive (discordant) HIV test result: Defer PrEP initiation or suspend PrEP continuation for 2 weeks. Repeat the HIV test and manage according to the Integrated Testing Guidelines.

## 6.2 Assessment for HIV post-exposure prophylaxis (PEP)

- Offer a 28-day course of PEP to clients with a high-risk exposure in the last 72 hours (see PEP chapter in the Malawi Guidelines for Clinical Management of HIV in Children and Adults).
- Once a client completes PEP after 28 days:
    - Confirm HIV negative test result.
    - Transition client to PrEP without interruption. PrEP follow-up is the same as for clients starting PrEP without PEP.

## 6.3 HIV, syphilis and HbsAg testing milestones for PrEP clients

- Follow the schedule in **Table 4** to decide who to test when and where for HIV, syphilis, and HBV.

**Table 4: Integrated testing schedule for oral and injectable PrEP**

<table>
<tr><th></th><th>ED or continuous oral PrEP</th><th>CAB-LA</th></tr>
<tr><td>Setting</td><td>Health facility, community outreach or mobile clinic (e.g. van)</td><td>Health facility or mobile clinic (e.g. Special Van)</td></tr>
<tr><td rowspan="2">HIV test</td><td colspan="2">Before initiation: professional blood-based tests<br>(Self-testing can only be used for demand creation and self-screening)</td></tr>
<tr><td>Every 3 months when continuing PrEP: conduct professional blood-based test.</td><td>Every 2 months when continuing PrEP: conduct professional blood-based test</td></tr>
<tr><td>HBsAg test</td><td colspan="2">Before or within 3 months of initiation unless previously vaccinated. Offer vaccination if HBsAg test is negative.</td></tr>
<tr><td>Syphilis test</td><td colspan="2">Before initiation and 12-monthly thereafter at refill visits.</td></tr>
<tr><td>Syndromic STI screening</td><td>Before initiation and every 3 months at refill visits</td><td>Before initiation and every 2 months at injection visits</td></tr>
</table>

**Figure 1 HIV testing algorithm**

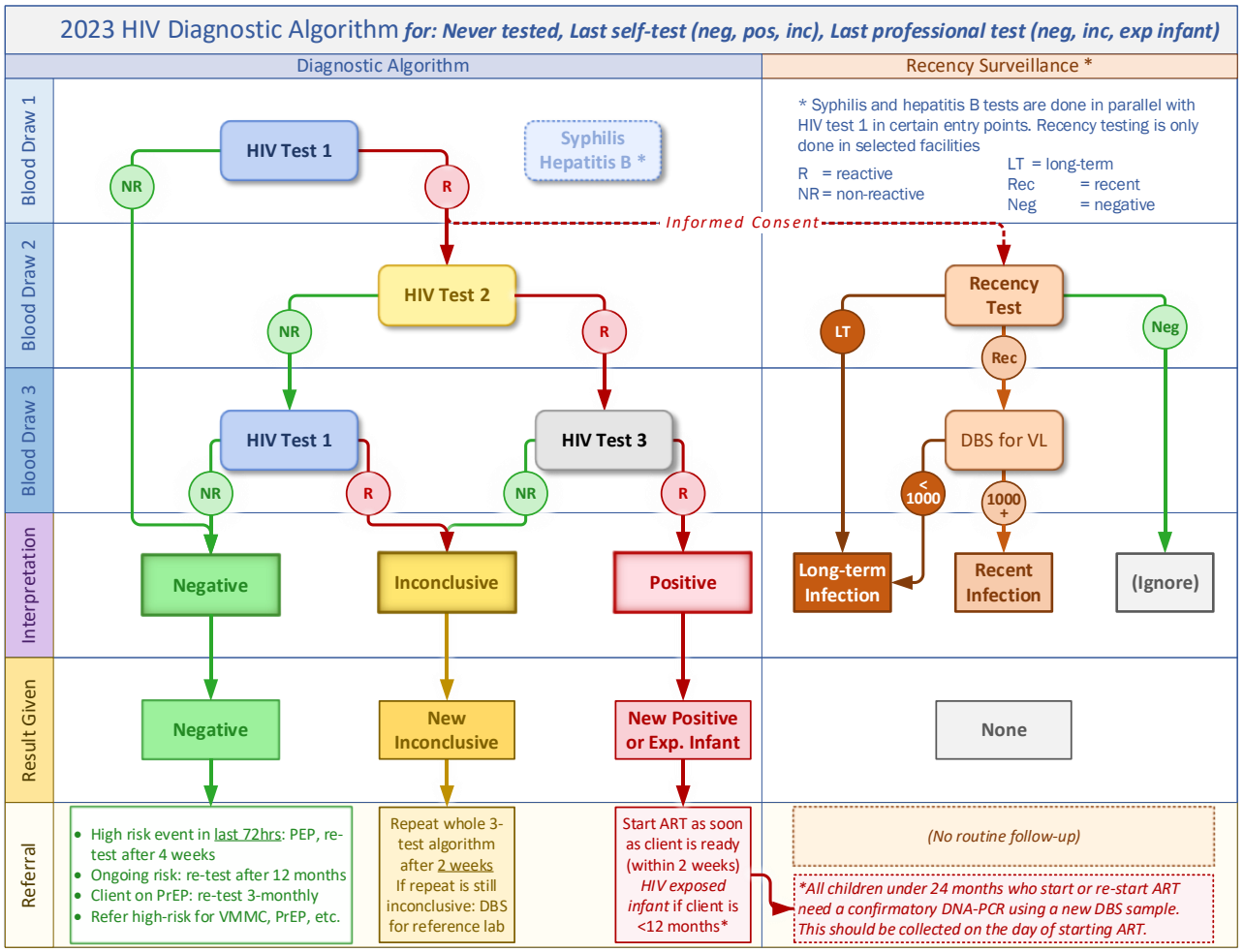
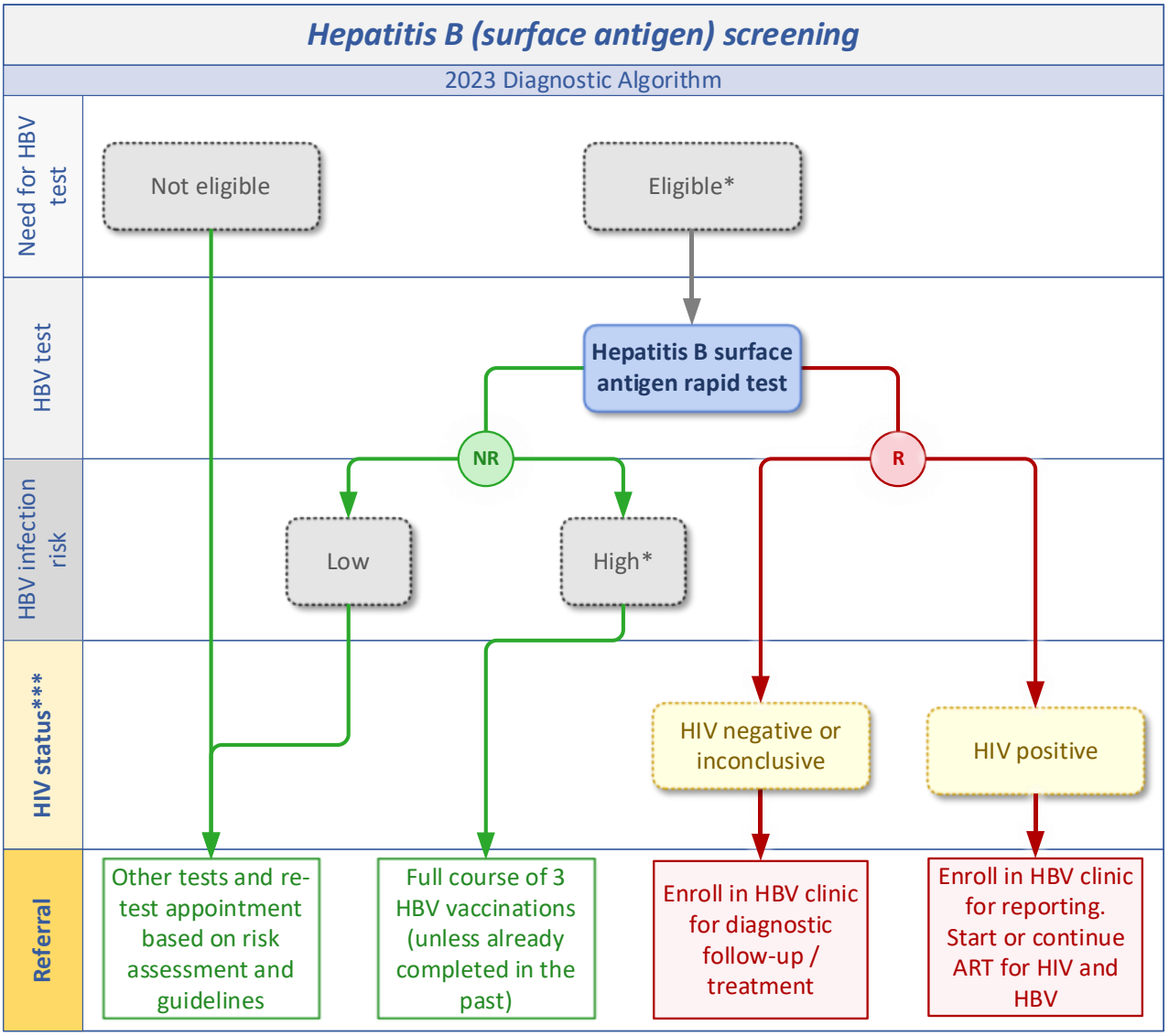


**Figure 2 Hepatitis B screening algorithm**

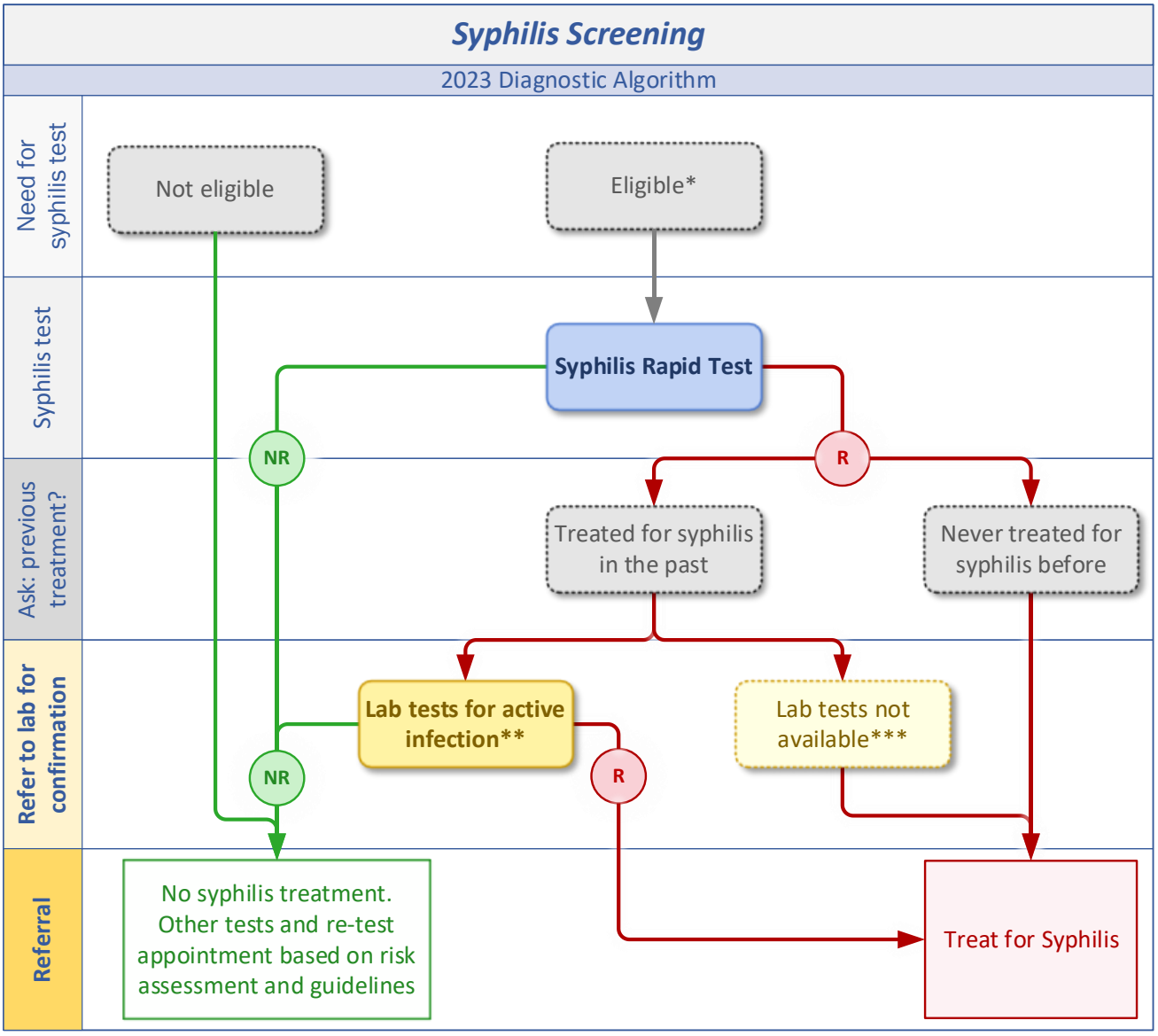



** **Eligibility for HBV testing***: see **Table 5** in Integrated Testing Guidelines for who and when to test for Hepatitis B.

**** Table 5** shows high risk groups who should be referred for a course of 3 HBV vaccinations unless they have previously completed 3 HBV vaccinations: FSW, TG, MSW, MSM, PWID, prisoners, PrEP clients, children 0-14 years born to HBV positive women, STI patients, general population at ongoing HIV risk or after high-risk event, health workers, sex partners of HBV index clients, sex partners of STI patients, presumed hepatitis patients, in-patients.

**** **HIV status must be ascertained** for all HBV positive clients. Perform a new HIV test using the full 3-test algorithm unless the client is already known to be HIV positive.*

**Figure 3 Syphilis screening algorithm**




** **Eligibility for syphilis testing***: see **Table 5** in Integrated Testing Guidelines for who and when to test for syphilis.

*** **Lab test for active infection***: Clients with a previous syphilis infection usually have a positive rapid test for life, even if the infection was cured. Additional lab tests (RPR or VDRL) are needed to confirm a new, active syphilis infection.

**** **Lab tests not available:*** Lab tests for confirmation of active syphilis infection may not be available at all sites. In this case, refer for presumptive syphilis treatment to ensure that any potentially new syphilis infection is treated.

## 6.4 Acute HIV infection screening

**Key facts: Acute HIV infection screening**

- Prospective PrEP clients are at higher risk of recent HIV infection. Recent infection can be present both at the time of initiation or during follow-up due to PrEP adherence challenges.
- In the first 3 months after acquiring HIV, rapid antibody tests may still be non-reactive, giving a false negative result. This is called the "window period".
- Clients who start or continue taking PrEP during the window period may never develop proper antibodies and may go undiagnosed for a long time.
    - ARVs used for PrEP regimens are not sufficient for treating HIV infection, leaving the virus to replicate at low levels.
    - HIV drug resistance can develop quickly under these circumstances, and the standard ART regimens may not work anymore for this client.
- 3 HIV tests used in the diagnostic algorithm have different sensitivity.
    - Inconclusive outcomes may be an indication of recent or partially suppressed HIV infection (e.g.: Test 1 reactive, Test 2 non-reactive, Test 1 repeat reactive).
    - Defer PrEP initiation or continuation for clients with inconclusive HIV test outcomes. Re-test after 14 days and manage according to the re-testing outcome.
- It is important to minimize the possibility of recent infection using symptom screening for acute HIV infection (see **Table 5**)

**Table 5: Acute HIV infection symptom screening**

| | Potential AHI Symptom | | | Action |
|---|---|---|---|---|
| **1.** | Fever | Y | N | **Ask:** in the last 4 weeks, have you had any of the following symptoms? |
| **2.** | Night sweats | Y | N | |
| **3.** | Sore throat | Y | N | **Note:** symptoms may feel like malaria, common cold, flu. |
| **4.** | Swollen glands | Y | N | |
| **5.** | Mouth ulcers | Y | N | **Defer** PrEP initiation or re-start if any of these symptoms are present. |
| **6.** | Headache | Y | N | |
| **7.** | Rash | Y | N | |
| **8.** | Generalized body pain | Y | N | **Investigate** clients with **symptom 1 or 2** also for TB. Other potential TB symptoms include persistent cough and unintended weight loss. |
| **9.** | Intense fatigue | Y | N | |

# 7 Client Education and Counseling on PrEP Options

Potential PrEP clients need detailed information about the practical implications, advantages, and disadvantages of the available options.

Give **ALL** the following information to all potential PrEP clients at the first visit, and as needed during follow-up visits. Always adhere to the basic counselling guidelines.

- Client education and counselling requires:
    - Professional health care providers who have been trained and certified in both oral and injectable PrEP regimen provision (Medical officers, Nurse Midwife Technicians, Registered Nurses, Medical assistants, Clinical officers,)
    - A private setting that guarantees confidentiality.
- The objective is to enable the client to choose the prevention option that best suits their needs and priorities after discussing their lifestyle choices and the practicalities of follow-up.
    - Encourage clients to ask questions. Respond fully and honestly. If you are unsure about the correct answer, let the client know you will find out for them.
    - Explain all details about the available PrEP regimens listed in Error! Reference source not found.**Table 6** and confirm correct understanding.
    - Explain the rationale for prioritizing clients for CAB-LA during the initial period of limited supplies. See **section 5.3** on **page 18**.

**Table 6: Comparison of event-driven oral, continuous oral PrEP and injectable CAB-LA**

| Consideration | Event-driven oral PrEP (TDF/FTC) | Continuous oral PrEP (TDF/FTC) | Injectable PrEP (CAB-LA) |
|---|---|---|---|
| **Eligibility** | | | |
| Minimum period of risk | 1+ weeks | 2+ weeks | 3+ months |
| Expect at least 4 days between risky sex acts | recommended | not needed | not needed |
| Ability to plan sex at least 2 hours in advance | mandatory | not needed | not needed |
| Client | men with sexual exposure (vaginal or anal) only[5] | any gender; sexual and needle exposure | any gender; sexual and needle exposure |
| Minimum age | 15+ years | 15+ years | 15+ years |
| Minimum weight | 30+ kg | 30+ kg | 35+ kg |
| **Effectiveness** | Very effective when taken as prescribed before and after each risky act. Effectiveness is dose-dependent: much less if any doses are missed. | Very effective when taken consistently each day. Effectiveness is dose-dependent: much less if any doses are missed. | >99% effective if injected on schedule. Effectiveness declines if follow-up injection is delayed. |
| **Privacy** | Tablets may be hard to hide | Tablets may be hard to hide | No meds to take other than injections unless bridging tabs for postponed injections |

[5] ED-PrEP is also suitable for transgender women (born male but identifying as female) who are not using gender-affirming hormones.

| Consideration | Event-driven oral PrEP (TDF/FTC) | Continuous oral PrEP (TDF/FTC) | Injectable PrEP (CAB-LA) |
|---|---|---|---|
| **Convenience** | Take tabs only before and after sex, or daily for as long as protection is needed. HIV test, STI screening and counselling every **3 months** at PrEP clinic (facility or community). | Take daily tabs. HIV test, STI screening and counselling every **3 months** at PrEP clinic (facility or community). | Injection in buttocks **after 1 and then every 2 months**. No meds to take at home. HIV test, STI screening and counselling every **2 months** at PrEP clinic. |
| **Time to protection** | Protection starts **2 hours** after taking the first double dose.[6] Must take an additional tablet on day 1 and 2 after the last risky sex. | Protection starts **7 days** after taking the tablets each day continuously. | Protection starts **7 days** after the first injection. Protection remains if follow-up injections are received on time. |
| **Duration of protection** | Only for the duration of use. Must continue 1 tablet per day for **2 days after the last sex**. | Only for the time of continued uninterrupted use.<br>Must continue 1 tablet per day for **7 days after the last sex**. | CAB remains in the body for 1 year after the last injection. However, after 2 months, drug levels may no longer be protective. |
| **Drug resistance risk** | New infection may occur due to poor PrEP adherence, continued use after acquiring infection leads to drug-resistance. Standard ART may not work. | New infection may occur due to poor PrEP adherence, continued use after acquiring infection leads to drug-resistance. Standard ART may not work. | HIV acquisition during long wash-out period (3-12 months) may potentially lead to drug resistance. Standard ART may not work. |
| **Pregnancy and breastfeeding** | Not suitable for women | Considered safe | Considered safe, but data is limited. |

[6] The first dose of ED-PrEP (2 tablets) should ideally be taken 24 hours before risky sex. 2 hours before is the absolute minimum period required.

# 8 Prescribing and Administration of PrEP Options

**Key facts: Prescribing of PrEP**

- The ARV regimen for use as **oral PrEP** is tenofovir disoproxil fumarate (TDF) 300 mg and lamivudine (3TC) 300 mg, taken daily as a fixed-dose combination tablet. TDF/FTC (emtricitabine) may also be used.
    - Prescribe and dispense oral PrEP only in unopened whole tins.
    - Give enough tablets to allow clients to take it continuously until the next visit, even if they intend to use it event driven.
    - Ask clients to bring back unused tablets at each visit. Potentially reduce the amount newly dispensed to allow them to use up any remaining tablets first.
- The **injectable PrEP** regimen is long-acting cabotegravir (CAB-LA); 600mg (3mL) are injected into the buttocks muscle (intragluteal) at initiation, after 30 days, and every 60 days thereafter.
- Use PrEP before, during, and after periods of substantial risk of HIV acquisition.
    - See **Table 6** on **page 29** for how long before and after risk either oral and injectable PrEP must be taken, depending on the client gender and exposure type.

**Table 7 Available oral PrEP regimens**

| | **Criterium** | **Standard** | **Alternative** |
|---|---|---|---|
| Minimum weight | 30+ kg | TDF/3TC (300mg/300mg) | TDF/FTC (300mg/200mg) |
| Start dose | Men[7] | 2 tablets stat | |
| | Women[8] | 1 tablet stat | |
| Continuation dose | All | 1 tablet once daily, approximately 24 hours apart | |

[7] Men with sexual exposure (vaginal or anal) only, including transgender women (born male but identifying as female) who are not using gender-affirming hormones.

[8] Women with ssexual (vaginal or anal) and/or needle-sharing exposure, including transgender women who are using gender-affirming hormones.

**Table 8: Task list for initiation and follow-up visits for Oral and Long acting injectable PrEP regimens**

| | Task | Initiation | Re-initiation | 1st Follow-up | Subsequent visit | Discontinuation visit |
|---|---|---|---|---|---|---|
| 1. | PrEP education | • | • | • | • | • |
| 2. | Test for HIV | • | • | • | • | • |
| 3. | Screen for PEP need | • | • | | | |
| 4. | Screen for AHI symptoms | • | • | | | |
| 5. | Test for syphilis | • | • | | • 12-monthly | |
| 6. | Test for HBV | • | • | | | |
| 7. | Screen + treat STI | • | • | • | • [9] | • |
| 8. | HIV risk + PrEP need assessment | • | • | • | • | • |
| 9. | Confirm commitment to continue | • | • | • | • | choose alternative prevention |
| 10. | Adherence support | • | • | • | • | |
| 11. | Screen and manage side effects / ADR | | • | • | • | • |
| 12. | Check PrEP contraindications | • | • | • | • | (•) |
| 13. | Screen for kidney risk (oral PrEP)[10] | • | • | • | • | |

[9] Clients with a previous syphilis infection are likely to remain syphilis rapid test positive for life, even if the previous infection was cured and there is no active infection. Treat all clients with positive syphilis rapid test unless further lab testing has ruled out current active infection. This means annual repeat syphilis testing will lead to annual presumptive re-treatment.

[10] Kidney function screening is only needed for clients at elevated risk of kidney disease. See criteria and management on **page 11**.

| | Task | | Initiation | Re-initiation | 1st Follow-up | Subsequent visit | Discontinuation visit |
|---|---|---|---|---|---|---|---|
| 14. | Screen for liver damage (CAB-LA) | | • | • | • | • | |
| 15. | Prescribe | CAB-LA (all clients): 600mg IM stat. See **Table 11** on **page 44** for specific guidance. | • | • | • | • | Switch to oral PrEP if continued high risk |
| | | Oral PrEP **Men**[11] **with sexual exposure only**: 2 tabs 24 hours (minimum 2 hours) before risky sex, 1 tab on day 1 and 2 after risky sex. | • | • | • | • | Just stop |
| | | Oral PrEP **Women**[12] **and clients who are sharing needles**: 1 tab for 7 days continuous before risky exposure and for 7 days after last risky exposure. | • | • | • | • | Just stop |
| 16. | Dispense PrEP | | • | • | • | • | (•) |
| 17. | Give next appointment | CAB-LA | Next visit after 30 days | Next visit after 30 days | Next visit after 60 days | Next visit after 60 days | every 90 days for HIV testing for 1 year |
| | | Oral PrEP | Next visit after 90 days | Next visit after 90 days | Next visit after 90 days | Next visit after 90 days | None |
| 18. | Assess need + provide contraception | | • | • | • | • | • |
| 19. | Dispense condoms and lubricants | | • | • | • | • | • |
| 20. | Refer uncircumcised males for VMMC | | • | • | • | • | • |

[11] Men with sexual exposure (vaginal or anal) only, including transgender women (born male but identifying as female) who are not using gender-affirming hormones.

[12] Women with sexual (vaginal or anal) and/or needle-sharing exposure, including transgender women who are using gender-affirming hormones.

## 8.1 Managing PrEP clients with recent high-risk events (PEP vs. PrEP)

**Key facts: Managing recent high HIV-risk events (PEP vs. PrEP)**

- Some prospective PrEP clients have high-risk recent exposure events and may benefit from PEP (post-exposure prophylaxis) if it occurred **within the last 72 hours**.
- Start PEP immediately following the Malawi Clinical Management of HIV in Children and Adults Guidelines.
- PrEP can be continued seamlessly after PEP completion and confirmation of HIV negative test result.

## 8.2 Cabotegravir Long Acting (CAB-LA)

### 8.2.1 How to give CAB-LA

1 Follow universal infection prevention standards.

2 Shake the vial vigorously for 10 seconds so that the suspension looks uniform. Don't mix or dilute with other fluids.

3 Draw up the entire contents (3ml = 600mg) of the suspension into a 3 or 5ml syringe. Small air bubbles are no problem.

4 Give the injection as soon as possible after drawing up the syringe. Do not place the syringe in the fridge or freezer. Discard any filled syringe that was kept for more than 2 hours.

5 Use a 5cc syringe to ensure intramuscular and not subdermal injection, depending on the thickness of the fat tissue.

6 Hold the syringe with the needle pointing up. Press the plunger to the 3-mL dosing mark to remove extra liquid and any air bubbles.

7 Clean the injection site with an alcohol wipe. Allow the skin to air dry before continuing.

8 Firmly drag the skin covering the injection site, displacing it by about 2.5 cm. Hold in this position for the injection.

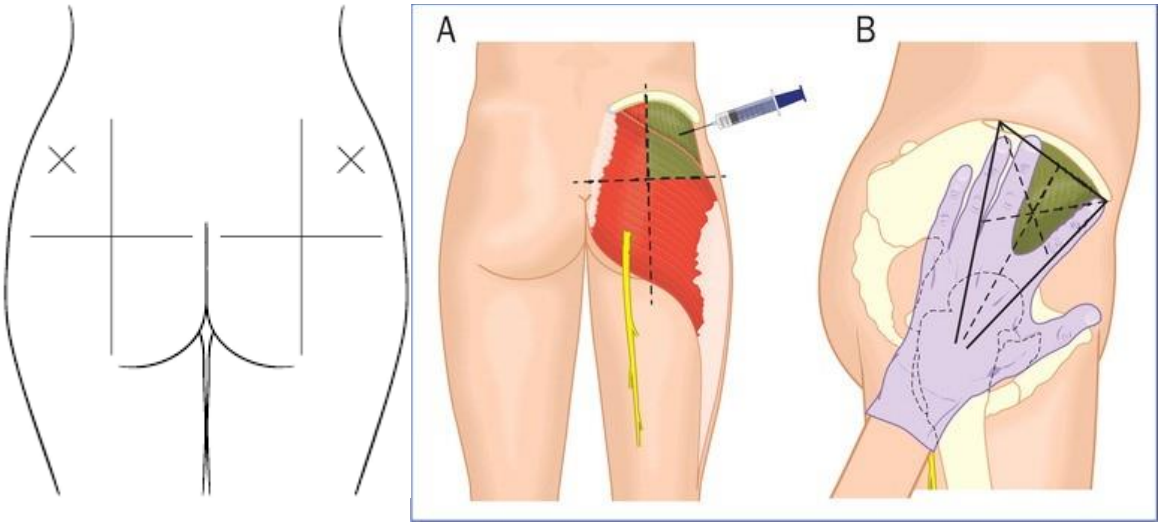
9 Inject in the upper outer quadrant of the buttocks while still holding the skin stretched. Don't use any other injection site.

10 Withdraw the needle and release the stretched skin immediately.

11 Apply pressure to the injections site with gauze pad. Don't massage the area.

12 Dispose all sharps and other single use items appropriately.

**Figure 4: CAB-LA injection site in the upper outer quadrant of the gluteal region**




### 8.2.2 Scheduling PrEP follow-up appointments

- Schedule appointments in 30, 60 or 90 days, depending on the PrEP option and sequence of the visit.
- Example: a 2-month appointment is in 60 days; a 3-month appointment is in 90 days.
- Remind clients that they should present on the appointment date, but maximum 7 days earlier or 7 days later.
- Follow the standard visit schedules by PrEP option shown in **Table 8** on **page 32**.

    - Oral PrEP (continuous and ED):

### 8.2.3 Using Oral PrEP as Bridge to Postpone reinjection appointments

What is an Oral PrEP Bridge?

- CAB-LA injections are scheduled as follows:
    - 1st injection at initiation
    - 2nd injection 30 days after 1st injection
    - 3rd injection 60 days after 2nd injection.
    - 4th and any subsequent injection 60 days after the last.
- Sometimes clients know that they will be late for their next injection visit. **Ask clients to tell you if they** know in advance that they will not make it to their next injection appointment in time.
- Start taking oral PrEP from the day when the next injection was due. Continue taking oral PrEP until the postponed injection is given.
- The oral PrEP will effectively bridge the gap to the delayed injection.

- Dispense oral PrEP in full tins only (30 tabs). Give enough tins to cover the full duration of the intended bridge.
- Explain that taking an **oral PrEP bridge for longer than 30 days** requires re-initiation of CAB-LA (next follow-up injection 1 month after the re-initiation visit).

# 9 Drug interactions

All current PrEP regimens are generally well tolerated and have a low risk of side effects. However, PrEP is a prophylactic intervention, not treatment of an acute disease. Potential risks of drug-drug interactions and side-effects need to be avoided more strictly than for patients on ART.

- Educate clients about the medications that should be avoided while on PrEP.
- Recommend a PrEP option that avoids drug-drug interactions for clients who are taking other drugs shown in **Table 9**.
- Advise against starting or continuing PrEP if the risk of drug-drug interactions cannot be avoided. Recommend alternative prevention methods in this case.

**Table 9: Drug-drug interactions of PrEP options with commonly used medications**

**Green:** Combination causes no problems.
**Yellow:** Avoid combination. Monitor for increased side-effects if unavoidable.
**Red:** Do not combine without specialist advice.

| Drug Name | Treatment | TDF/FTC | TDF/3TC | CAB-LA |
|---|---|---|---|---|
| **Gentamycin** | STI, bact. infections | **1** | **1** | **3** |
| **Acyclovir** | Herpes zoster, genital | **2** | **2** | |
| **Benzathine penicillin** | STI | | | **3** |
| **Metronidazole** | STI, bact. infections | | | |
| **Clotrimazole (topical)** | STI | | | |
| **Azithromycin** | STI, bact. infections | | | |
| **Doxycycline** | STI, bact. infections | | | |
| **Rifabutin** | TB | | | **4** |
| **Rifampicin, rifapentine** | TB | | | **5** |
| **Carbamazepine, phenytoin, phenobarbital** | Epilepsy | | | **5** |
| **Ibuprofen, aspirin, diclofenac, oth. NSAID** | Fever, pain | **6** | **6** | |
| **Hormonal contraceptives** | Contraception | | | |
| **Alcohol, recreational drugs** | Enjoyment | | | |
| **Feminizing hormones: oestrogens, etc.** | Transgender | | | |

**1** Avoid combination due to kidney damage. For STI treatment, use alternatives: ceftriaxone, azithromycin, cefuroxime, cefixime, erythromycin.

**2** Avoid combination due to kidney damage. Pause oral PrEP during herpes treatment. Abstain or use condoms until healed.

**3** May be combined but choose different injection site.

**4** Avoid combination as it may make CAB-LA less effective.

**5** Do not combine as it makes CAB-LA ineffective. Resume CAB-LA only after completing TB treatment.

**6** Avoid regular or high dose use of NSAID while on oral PrEP to reduce the risk of kidney damage.

# 10 Assessment and management of side effects

**Key facts: Side effects and adverse reactions of PrEP**

- Both oral and long-acting injectable PrEP are generally well tolerated.
- Minor side effects are relatively common but usually self-limiting and do not require discontinuation of PrEP.
- Common side effects include:
  - headache, dizziness,
  - nausea, diarrhoea, and
  - feeling fatigued or feverish
- CAB-LA commonly causes localized pain, swelling and bruising at the injection site.
  - These injection site reactions usually improve with continued use.
  - Use local cooling such as wet cloth or ice-packs and take Panadol to manage the pain.
- Actively ask for side effects at each visit
  - Document all reported side-effects.
  - Counsel and manage symptomatically.
  - Submit an ADR reporting form for all severe and unusual side effects.

## 10.1 Client education on side effects

- Explain possible side effects to all clients before starting PrEP. The goal of client education is:
  - **Anticipate** side effects that may occur.
  - **Understand** how to prevent or minimize side effects.
  - **Know** when to seek medical care for more serious symptoms.
- Reassure that unpleasant symptoms usually improve on their own and become less with continued use. Proper information will prevent surprised that might result in premature PrEP discontinuation.

## 10.2 Management and reporting of side effects and adverse drug reactions (ADRs)

- Manage all side effects symptomatically and provide counselling.
- Refer wherever necessary.
- Record all side effects and possible PrEP discontinuations on the PrEP client card and in the PrEP clinic register.

- For all severe and unusual side effects: submit an **ADR reporting form** to the district pharmacovigilance focal person for submission to the National Pharmacovigilance Centre at Pharmacy and Medicines Regulatory Authority (PMRA)
- Submit an electronic report via cellphone (Medsafe-360) if possible. **Dial *360#** and follow the instructions.
- The pharmacovigilance focal person is responsible for collecting and summarizing all ADRs to the District Health Management Team (DHMT). S/He collaborates with district program coordinators (ART, TB, Malaria, Family planning, etc.)

**Table 10: Side effects of oral and injectable PrEP**

| Possible side effects | Signs | Oral PrEP (TDF/FTC or TDF/3TC) | Injectable PrEP (CAB-LA) |
|---|---|---|---|
| Injection reactions | Pain, swelling. Brusing more common after aspirin or anticoagulant use. Worsening pain may be abscess. | None | About 1/3 of all clients. Mostly mild and usually improves with continued use. **Go to hospital if severe.** |
| Liver damage | Loss of appetite, nausea, jaundice, LFT↑ | None | Very rare. Stop CAB-LA and investigate if suspected. |
| Headache, dizziness | Usually improves with continued use | Rare | Rare |
| Nausea | Usually improves with continued use | Common | Rare |
| Diarrhoea | Usually improves with continued use | Rare | Rare |
| Fatigue | Usually improves with continued use | Rare | Rare |
| Weight gain | usually less than 5kg | None | Common. May increase with continued use. |
| Depression | sleep disturbance, suicidal thoughts | None | Potential (rare). Stop CAB-LA, refer for mental health assessment |
| Feverish | Usually improves with continued use | Rare | Rare |
| Hypersensitivity | Fever, body aches, generalized blistering rash, mouth sores, shortness of breath | None | Very rare. **Go to hospital without delay.** Never give CAB again. |
| Kidney damage | CrCl <60ml/min | Very rare | None |

# 11 Supporting adherence and persistence

- **Educate** the client about the strong connection between PrEP adherence and effectiveness.
    - PrEP needs to be used consistently before, during and after periods of risk.
    - The client is free to take a "PrEP holiday" between periods of substantial risk, but PrEP needs to be re-started 24 hours (men) or 7 days (women) before the next risk event.
- **Work** with the client to find solutions for potential adherence and persistence barriers.
    - Avoid judgement.
    - Offer concrete advice for practical problems.
    - Ask the client if they anticipate potential challenges with their next appointment. Dispense adequate supplies to bridge potential gaps.
- **Discuss** other effective prevention options that can be used as a back-up or alternative.
- **Praise** the client for good adherence and persistence.
- **Offer** to contact the client by phone to remind them about missed appointments and to provide adherence support (if logistically feasible at the facility)
    - **Ask for and document** explicit consent for phone follow-ups on the PrEP client card.
    - **Confirm** at each refill visit that the client is still comfortable with being contacted by phone.

## 12 Switching PrEP regimens

- Encourage clients to choose the most appropriate PrEP regimen based on eligibility criteria (see **Table 2**) and practical considerations.
- Discuss the rationale for prioritization for CAB-LA during the initial period of limited supplies. See **section 5.3** on **page 18**.
- For clients who are struggling or not satisfied with their current PrEP regimen: discuss appropriate alternative PrEP regimens and other prevention options.
    - Offer to choose. Clients may switch to a different appropriate PrEP regimen at any follow-up visit.
    - Clients on oral PrEP can switch to injectable PrEP and vice versa.
    - Switching can be done for continuation (without gap) or as re-initiation after PrEP interruption.
    - Do not take oral and injectable PrEP at the same time. While no adverse effects are expected, there is no added benefit.

# 13 Discontinuing and restarting PrEP

## 13.1 Quitting PrEP

- Advise clients to inform the service provider when they want to discontinue PrEP.
- The duration of PrEP use may vary, and individuals are likely to start and stop PrEP depending on their risk assessment at different periods in their lives, including changes in sexual relationship status, behaviours, and ability to adhere to a PrEP maintenance program.
- Discuss the options for discontinuing PrEP. Don't be judgmental - PrEP use is a personal decision. PrEP can be stopped for any of the following reasons:
    - Positive HIV test
    - Client request
    - Safety concerns, such as persistent creatinine clearance <60ml/min
    - No longer at substantial risk
    - Persistent side effects
    - Preference to use another effective prevention method.
- Document the reason for stopping PrEP.
- If a client develops Hepatitis B whilst on PrEP: refer to Hepatitis B service provider/specialist. TDF (one of the ARVs used in oral PrEP) is also effective treatment for Hepatitis B.
    - If on continuous oral PrEP: continue, refer to Hepatitis provider for follow-up.
    - If on ED PrEP: refer to Hepatitis provider for follow-up. Switch to continuous oral PrEP (= HBV treatment) may be needed.
    - If on CAB-LA: refer to Hepatitis provider. Switch to continuous oral PrEP (= HBV treatment) may be needed.

## 13.2 Reducing the risk of new infection after stopping CAB-LA

- Counsel clients who want to stop CAB-LA that:
    - The risk of contracting HIV will return 2 months after the last injection, but low levels of the drug will remain for up to 12 months.
    - There is a risk of developing drug resistant virus if infection occurs within 1 year after stopping CAB-LA.
    - Drug resistance can make ART ineffective.
- Recommended risk reduction strategies for clients at continued risk:
    - Start oral PrEP instead. **Start oral PrEP** on the day when the next CAB-LA injection was due.
    - Use other effective HIV prevention strategies, such as correct and consistent use of condoms.
- Important: instruct the client to inform their health worker about previous CAB-LA use if they are diagnosed HIV infected in future.

## 13.3 Starting CAB-LA Again After Discontinuing

See **Table 8** on **page 32** for the specific tasks needed to re-initiate clients on CAB-LA.

## 13.4 Restarting PrEP

**Table 11: Classification of continuation vs. re-initiation by PrEP options**

| PrEP option | Time since missed visit | Classification | Action (follow all other tasks in **Table 8**) |
|---|---|---|---|
| oral ED PrEP | 0-2 months | Continuation with gap | Dispense for 3 months |
| | >2 months | Re-initiation | Dispense for 3 months |
| continuous oral PrEP | 0-2 months | Continuation with gap | Dispense for 3 months |
| | >2 months | Re-initiation | Dispense for 3 months |
| CAB-LA: initiation visit | 0-2 months | Continuation with gap | inject now, next injection after 2 months |
| | >2 months | Re-initiation | inject now, next injection after 1 month |
| CAB-LA: 2nd or later visit | 0-3 months | Continuation with gap | inject now, next injection after 2 months |
| | >3 months | Re-initiation | inject now, next injection after 1 month |

- Follow all tasks for PrEP initiation or continuation in **Table 8** on **page 32**.

# 14 Managing clients who seroconvert

- Clients who seroconvert have a risk of developing drug resistance.
- Offer counselling and patient education before starting ART.
- Start the clients on standard start regimen of 13A.
- Monitor patient's VL at 6 months for any signs of non-suppression and drug resistance.

# 15 Condom and lubricant promotion and dispensing

- Actively promote consistent condom and lubricant use for all PrEP clients to prevent STI, unplanned pregnancies and breakthrough HIV infections that may occur with inconsistent PrEP use.
- Dispense PrEP together with condoms and lubricant corresponding to the next appointment.
- Ask how many condoms the client may need until the next PrEP clinic appointment.
    - Ask if they would like to receive the total amount needed today, or if they will source additional condoms elsewhere.
    - Dispense the full requested number of condoms to ensure consistent use is promoted.
- Rationing of condom dispensing may be necessary if supplies are limited. In this case, aim to give at least 30 male condoms or 5 female condoms if requested.

# 16 Special Considerations for PrEP during pregnancy and breastfeeding

**Key facts**

- HIV acquired during pregnancy or breastfeeding is associated with a risk of HIV transmission to the infant.
- There is no evidence for safety concerns for injectable PrEP in pregnancy and breastfeeding. More data will be collected in an ongoing implementation study (Path2Scale).
- Do not start or continue oral or injectable PrEP in women with suspected or confirmed pre-eclampsia, eclampsia, HELLP syndrome.
- With optimal adherence, daily oral PrEP and CAB-LA are very effective for HIV prevention in pregnancy and breastfeeding.

## 16.1 Starting PrEP during pregnancy and breastfeeding

- Ask all women if they are pregnancy or breastfeeding at the current clinic visit.
- Apply same clinical eligibility steps described in **chapter 5** for clients who are not pregnant and not breastfeeding to those who are pregnant or breastfeeding.
- If the client is eligible, start PrEP and continue PrEP throughout pregnancy and breastfeeding if needed.
- Continuous oral PrEP and CAB-LA have **no known interactions** with family planning methods and medications commonly used during pregnancy and the postnatal period.
- Routinely monitor pregnancy and birth outcomes for all women on PrEP using available tools.

## 16.2 Contraindications to Starting PrEP in pregnant and breastfeeding women.

The general PrEP contraindications also apply to pregnant and breastfeeding women.

***Note: Do not start or continue oral or injectable PrEP in women with suspected or confirmed pre-eclampsia, eclampsia, HELLP syndrome.***

## 16.3 Key Additional Counselling Messages

- For women with high-risk behaviour who live in high HIV burden districts, the potential benefits of PrEP for mothers outweigh the potential risks.
- While there is still limited experience with CAB-LA, there is currently no indication that PrEP increases the chance of birth defects, miscarriage, or other complications during pregnancy, birth, or after birth.
- PrEP use during pregnancy and breastfeeding has not been shown to cause baby to be too big or too small.

- The amount of PrEP drug that may pass to the baby during pregnancy and breastfeeding is insignificant and has not been shown to cause any health problems for babies.
- PrEP does not have any known negative interactions with the medications and supplements commonly prescribed for women in pregnancy and breastfeeding.
- PrEP has not been shown to have any impact on ability to become pregnant in the future.
- Align PrEP visits with ANC to minimize visits to the facility
- Advise pregnant and breastfeeding to attend antenatal care, deliver at a facility with a skilled birth attendant, and attend postnatal care.

***Note: Pregnant or breastfeeding PrEP clients do not need any additional laboratory or other diagnostic tests.***

## 16.4 Counselling

### 16.4.1 Weighing benefits and risks, based on approval status

- Pregnant and breastfeeding clients taking CAB-LA may be at risk of adverse pregnancy and birth outcomes and risks to the breastfeeding infant whenever there is detectable CAB in the body of the pregnant/breastfeeding client.
    - Inform the clients of the benefits and risks, including unknowns, through counselling, so that they may make an informed decision that reflects their circumstances
    - Inform Individuals on CAB-LA who become pregnant or start breastfeeding of the possible benefits and risks, including unknowns, through counselling, so that they may make an informed decision.
    - Provide modern contraception and counselling to clients with the potential to become pregnant who wish to use CAB-LA but only if not breastfeeding
    - Conduct pregnancy testing and counselling to clients with the potential to become pregnant who wish to use CAB-LA but only if not pregnant

### 16.4.2 Counselling on Tail-Phase for Pregnancy and Breastfeeding

- Inform clients starting CAB-LA that CAB will remain detectable in their body for about a year after the last injection so that they make informed decision for use of CAB LA
- Provide modern contraception and pregnancy testing to clients with the potential to or intention of becoming pregnant or starting breastfeeding at the Discontinuation Visit and Post-Discontinuation Monitoring Visits

# 17 Service delivery

HIV incidence in Malawi has declined significantly in all age groups in the general population, now estimated below the moderate risk threshold of 0.3% annual incidence. According the 2022 UNAIDS risk stratification tool adolescents and young women aged 15 – 29 years are either into sex work or have multiple partners with concentration in selected districts across the country. Key populations, pregnant and breastfeeding women are also among the targeted high risk and priority populations. HIV incidence in Malawi is further associated with high population density. Differentiated models of HIV combination preventions services which include PrEP will therefore be delivered to targeted high risk populations and their sexual partners. Make available information regarding service delivery points and allow client service delivery preference proposed in the guideline.

## 17.1 Health facility model including drop-in centres.

- Use infrastructure with adequate space for client privacy and confidentiality, security of client records and commodities.
- Deliver Oral and long-acting injectable Cabotegravir using trained and certified service providers (Medical Officers, Registered Nurses, Clinical Officers, Medical Assistants, Nurse Midwife Technicians and Community Midwife Assistants
- Screen and initiate eligible clients on Oral and injectable PrEP at Sexually Transmitted Infection, Family Planning, antenatal and postnatal care service delivery points/clinics.
- Create demand for HIV combination prevention including PrEP at GBV One-Stop Centre, child health, EPI, OPD, medical, gynaecology clinics, wards and other service delivery points in the health facility.
    - Screen all clients for GBV and refer accordingly.
    - Link eligible clients to direct PrEP service delivery points.

## 17.2 Community models

### 17.2.1 Integrated mobile outreach models

- Deliver both Oral and **long-acting injectable PrEP ONLY using Integrated outreach Vans** which have in built spaces to deliver a package of services at designated sites including at emergency and humanitarian settings.
- Create space for client privacy and confidentiality, security of client records and commodities.
- Deliver services using Ministry of Health trained and certified service providers (Medical Officers, Registered Nurses, Clinical Officers, Medical Assistants, Nurse Midwife Technicians, Community Nurses.
- Integrate Oral and long acting injectable Cabotegravir with screening and treatment for STIs, Contraceptives, Cervical Cancer screening, GBV, at moonlighting, Dream Girls Clubs and other similar services.
- Refer to Standard Operating Procedures for integration of HIV/SRH/MNCH/GBV services.

### 17.2.2 Integrated outreach at a health post

- Create space within the health post for client privacy and confidentiality, security of client records and commodities.
- Deliver a minimum package of HIV prevention interventions at a health post to antenatal and postnatal women including other high risk adolescent girls and young women and their partners using Community Midwife Assistants.
- Deliver HIV testing, **Oral PrEP prescription**, **dispensing,** integrated with antenatal, postnatal, family planning, youth- friendly, GBV services, and at humanitarian settings.
- Offer follow up continuation visits and refills for clients initiated at a health facility or Drop-In centre.

### 17.2.3 Private clinics

- Provide PrEP in health facilities registered by Medical Council of Malawi and accredited by Ministry of Health (HIV Directorate)
- Deliver integrated HIV combination prevention intervention including PrEP using Ministry of Health trained and certified health providers with fidelity to standard operating procedures.
- Where clients have medical insurance, certified private clinics may provide paying services for Oral and Long Acting using non-Global Fund HIV commodities.
- Use tool to report data to relevant district health office at the district council.

## 17.3 Integrated service delivery models

### 17.3.1 Integration into Sexually Transmitted Infections clinics

**Key facts**

- All HIV negative STI patients are automatically eligible for PrEP referral due to the biological evidence for high-risk behavior.
- Offer HIV, syphilis and hepatitis B testing to all STI clients in the STI room.
- Offer treatment of STIs. Offer PrEP in the STI room as standard operating procedures.
- Provide information on HIV combination prevention such as use of condoms and Voluntary medical male circumcision

### 17.3.2 Integration with family planning services

**Key facts**

- Provide information of the risk of vertical transmission of HIV, syphilis and hepatitis B
- Determine HIV risk profile for every client who accesses family planning services.
    - Conduct HIV, syphilis and Hep B testing to every **high** HIV risk client.
- Clients who are at substantial risk of HIV acquisition are also at substantial risk of unplanned pregnancy. Provide ECs together with PrEP.
- Provide PrEP alongside condoms in the Family planning clinic.
- Clients already on a regular family planning method need PrEP adherence counselling.
- Proceed to offer PrEP services following Standard operating procedures.
- All contraceptives can be taken together with PrEP.
-

*Refer to the Malawi Family Planning guidelines for prescribing and administration of available emergency and continuous contraceptives.*

### 17.3.3 Integration with Antenatal and Postnatal services

**Key facts**

- Provide information on the risk of vertical transmission of HIV, syphilis and hepatitis B.
- Conduct **HIV risk assessment eligibility** to the client at every ANC and postnatal clinic visit.
- Offer HIV, syphilis and hepatitis B testing among all antenatal women.
    - **HIV testing is offered again between 6 and 9 months of breastfeeding.**
- Create demand for PrEP services in all ANC and postnatal clinics among high-risk HIV negative women and their partners.
- Establish PrEP champions among ANC clients to conduct Peer education and counselling.
- Offer HIV self-test kit for screening of sexual partners who are at home.
- Discuss special considerations for PrEP among pregnant and breastfeeding women.
- Offer PrEP alongside other HIV combination prevention methods such condoms.
- Initiate PrEP and counsel on PrEP adherence.

### 17.3.4 Integration with child health services (targeting breastfeeding women)

**Key facts**

- Child health services offer opportunities for breast feeding women to access information on the risk of vertical transmission of HIV, syphilis and hepatitis B HIV combination prevention services.
- Provide HIV risk information at all child health clinics (OPD, U5, immunization, nutrition).
- Conduct **HIV risk assessment eligibility** to every breastfeeding woman who visits the child health clinic.
- Offer HIV testing to every breastfeeding woman with high HIV risk, repeat at 6 and 9 months of breastfeeding.
- Conduct routine HIV status ascertainment for all sick children (OPD, in-patient).
- Provide information on HIV prevention combination services including PrEP and link to PrEP service delivery points.

### 17.3.5 Visit Schedule and Visit Components

- Align PrEP visits with ANC, EPI or FP visits to minimize visits to the facility
- Provide Family planning counselling and method of contraception as based on client choice at all visits in the postnatal period.
- Advise pregnant and breastfeeding to attend antenatal care, deliver at a facility with a skilled birth attendant, and attend postnatal care.

# 18 Supply Chain management

## 18.1 Commodity management at National level

PrEP Commodities form part of the National HIV supply chain management system managed by DHA.

- Annual forecasting, quantification and supply planning informs in-country and pipeline management of all PrEP needs.
- Maintain stock levels at maximum- minimum level of 9-6 months at central level and 4 -2 months at health facility level.
- Bi-monthly commodity deliveries will be done from the central warehouse to accredited PrEP facilities using quarterly data from the TB/HIV supervision. DHAMIS supply chain module will be utilized for stock on hand, consumption, adjustments, quantity required for the expected clients by product.

## 18.2 Commodity management at Health Facility level

- The Pharmacy in-charge (Pharmacist or designate) is responsible for management and accountability of HIV commodities including PrEP.
- At service delivery points, clinicians will requisition PrEP commodities from the pharmacy/drug store using Requisition/Issue vouchers (RIV). Upon issuance, stores manager must update stock card with balance at hand (SOH).
- Restocking of health facilities will be done by central warehouse on bi-monthly interval or through interfacility redistribution upon authorization by DHA using the Toll free service.

## 18.3 Commodity management for community outreach level

- Health care provider at community level is in-charge of management and accountability of HIV commodities including PrEP to the mother health facility.
- After every community outreach activity, commodity returns must be returned to the mother facility in a secure lockable room/cabinet.
- Accountability will be done by physical counting of supplies at the end of every week and during handover to a new team lead

### 18.3.1 Commodity management for private pharmacy level

- Health care provider at private pharmacy level is in-charge of management and accountability of HIV commodities including PrEP to the mother health facility.

- On a biweekly basis, commodity requisitions and accountability must be done to the mother facility. Maximum – minimum level will be set at 2-1 months at private pharmacy level.
- Physical counting of supplies must be done every end of week and during handover to a new team lead to ensure proper accountability.

### 18.3.2 Recording and Reporting for PrEP supplies

- Documentation for commodities within the health facility and community outreach clinics must be maintained and accessible by supervisors who support the PrEP/ART program. These include:
    - Stock cards
    - Requisition/Issue vouchers (RIV)
    - Relocation books
    - Daily Activity registers (DARs)
- Communication to DHA supply chain should use email (hivdeptlogistics@gmail.com) or calling the Toll - free lines (5 9 1 9 1 – Airtel & 6882 – TNM) for any commodity related issues for:
    - support with additional supplies from central warehouse,
    - authorization codes for inter-facility stock transfer (redistribution),
    - authorization codes for disposal of expired/obsolete stocks,
    - receipt of damaged or inappropriate stocks,
    - serious (suspected) side effects for any medicines.

Table 12 below shows the different commodity groups managed by DHA for PrEP implementation.

**Table 12 Commodity groups managed centrally.**

| # | Commodity group | Commodity | Supply* |
|---|---|---|---|
| 1 | Rapid Test kits | HIV Test kits, HIV Self-Test<br>Hepatitis B Tests<br>Syphilis Tests | E |
| 2 | ARVs | TDF/FTC 300/200mg Tablets<br>TDF/3TC 300/300mg Tablets<br>Cabotegravir Injection | E |
| 3 | Assorted consumables | Needles/Syringes 5ml; Alcohol swabs, Sharps container, Disposable Gloves | E |
| 4 | Laboratory reagents | Creatinine Test | S |

Supply*: **E** = item managed exclusively through HIV Program. **S** = items supplemented by Diagnostics department for HIV Program

# 19 Monitoring and Evaluation

**Key facts**

- The HIV program relies heavily on accurate and timely data for planning, reporting to donors and for drug procurement and distribution.
- Data analysis and reporting is done from Client cards and clinic registers at most facilities, but electronic systems for monitoring are used at sites with many clients.
- Cohort analyses are needed to report outcomes of clients in PrEP follow-up. Cohort reports look at the current / latest status of all clients enrolled in follow-up and require a review of all client records to classify primary and secondary outcomes before data can be aggregated for reporting.
- Reports from facilities are to be completed within 5 working days after the endof the reporting period.
- PrEP reporting will be further integrated into the regular Health Management Information System. Quarterly PrEP facility reports will be entered directly into the District Health Information System at the District Health Offices for nationalreporting.

## 19.1 Definitions

**PrEP site**

A facility is counted as PrEP site if they had retained at least one client still taking PrEP atthe end of the reporting period.

**PrEP Eligibility Assessment Outcomes**

In addition to the HIV risk assessment that is repeated by the PrEP provider at the PrEP clinic,all clients that presents at the PrEP clinic are assessed of their eligibility to start PrEP using the. Not all clients who present for PrEP assessment will proceed to start. Document all clientswho presented for the initial PrEP assessment in this register.

- PrEP eligibility assessment outcomes refers to the outcomes of the PrEP initiation assessment at the baseline for all clients who present at the PrEP clinic
- **Start PrEP**: Eligible, ready and received the first tin of ARVs for PrEP.
- **Refused:** Eligible, no contraindications, but client decided not to start PrEP.
- **Low HIV Risk**: Client was advised not to start PrEP based on the low HIV risk assessment done at the PrEP clinic by the provider.

- **Acute HIV Infection**: PrEP initiation was suspended because of suspected acute HIV infection.
- **Initial HIV +Result**: Positive HIV test result at baseline PrEP assessment.
- **Suspected Kidney Failure**: PrEP initiation was suspended because of impairedkidney function (suspected or confirmed).

**PrEP Registration Type**

Refers to the client's status at the time of registration at this PrEP clinic

- **First time**: Never taken PrEP before – disaggregated by age and sex. Circle the appropriate sex and age group for clients who initiate PrEP for the first time.
- **Transfer in**: Received PrEP from another site before and is currently on PrEP or has interrupted for less than 7 days. Count as Transfer In regardless if the Client bringshis old client card or not ('official' or 'unofficial' transfer).
- **Re-initiation**: Received PrEP from another site in the past but has NOT been takingit for 7 days or more as of the day of registering at this clinic.

## 19.2 PrEP Primary Outcomes

The following outcomes are applicable for clients in PrEP follow-up See Figure 1 below summarizing the outcomes.

❖ **Defaulted/Lost to follow-up**

Clients are counted as 'defaulted' in the cohort report if they have not returned to the clinic and are not known to have transferred out, stopped (Quit/side-effects) or died. Assign this outcome 2 months after the client is expected to have run out of PrEP.

- Clients may revert to "retained on PrEP" when the next cohort analysis is done if they return to the clinic and continue ART.

**Died**

Clients are counted as 'died' if there is a reliable report about the client's death. 'Died' is used regardless of any cause for clients who were taking PrEP.

**HIV Positive**

Client Stops PrEP after testing HIV positive during their scheduled follow-up visit HIV testing.Link the client to start ART.

**Side Effects**

Client Stops PrEP after developing significant side effects which are associated with PrEP. The client might also decide to stop PrEP due to their own reported side effects which might not be determined by the clinician.

**Low HIV Risk**

Client stops PrEP because the HIV risk is no longer considered significant. The client may re- start PrEP once the HIV risk is considered high.

**Quit**

Client decides to stop PrEP although s/he is eligible, has no contraindications and is at significant HIV risk acquisition.

**Transfer-Out**

The client wants to continue to another site. Issue the client card to the client which will be used by the receiving facility when registering the client as a transfer-in

- Enter all clients who are classified as **re-initiation** in a new line in the PrEP clinic register. Mark the client as a re-start. Clients who continue with gap continue with their previous entry in the PrEP register and on the same client card.

## 19.3 Management of interruption of PrEP

**PrEP discontinued**: This is a final outcome for the current course of PrEP. If these clients reinitiate PrEP, they are "restarting" PrEP. Use different PrEP ID in registering the client in theregister and issue a new PrEP card if the client is still HIV negative, still at risk, clinically eligible,and willing to restart.

### 19.3.1 Clients requesting a transfer out

If a client wants to move and is motivated to stay on PrEP, inform the client of other facilities that offer the chosen PrEP option.

- Record outcome as “Transfer Out” in the PrEP register and client card.
- Update the register and hand over the Client Card to submit at the next facility.

### 19.3.2 Clients transferring in

- Write transfer-in date and original facility in comment section.
- Use the new facilities’ continuous PrEP serial number.
- Continue with routine PrEP follow up schedule.
- See M&E section for details.