**Template Guidelines for Post-Exposure Prophylaxis**

*Last updated December 2024*

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| The intent of this document is to provide adaptable guidelines to support the development and adoption of national guidelines that align with World Health Organization (WHO) post-exposure prophylaxis (PEP) recommendations and guidance. The document includes prompts for national-level consideration during the guideline adaptation process. Areas specifically requiring national updates are indicated in red font; sections for additional consideration by policymakers, shown in green boxes, are informed by regulatory bodies, available product information, and country-level insights. Once a decision has been made about the considerations in green boxes, text can be added, and the green boxes can be removed.  The content of this document was sourced largely from:   * [Guidelines for HIV Post-exposure Prophylaxis](https://www.who.int/publications/i/item/9789240095137) from WHO (July 2024) * [Provider Module for Oral and Long-acting PrEP](https://www.who.int/tools/prep-implementation-tool#modules) from WHO (July 2024) * [Updated Differentiated and Simplified Pre-exposure Prophylaxis for HIV Prevention](https://www.who.int/publications/i/item/9789240053694) from WHO (July 2022) * [Consolidated Guidelines on HIV Viral Hepatitis and STI Prevention, Diagnosis, Treatment, and Care for Key Populations](https://www.who.int/publications/i/item/9789240052390) from WHO (July 2022) * [Consolidated Guidelines on HIV Prevention, Testing, Treatment, Service Delivery and Monitoring: Recommendations for a Public Health Approach](https://www.who.int/publications/i/item/9789240031593)from WHO (July 2021)   This document was developed by MOSAIC (Maximizing Options to Advance Informed Choice for HIV Prevention) in close collaboration with the U.S. Agency for International Development (USAID) and The Global Fund to Fight AIDS, Tuberculosis and Malaria. The document is made possible by the generous support of the American people through the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and USAID. The contents are the responsibility of the MOSAIC project and do not necessarily reflect the views of PEPFAR, USAID, or the U.S. Government. MOSAIC is a global cooperative agreement (Cooperative Agreement 7200AA21CA00011) led by FHI 360, with core partners Wits RHI, Pangaea Zimbabwe, LVCT Health, Jhpiego, and AVAC. |

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# List of Acronyms

|  |  |
| --- | --- |
| **3TC** | Lamivudine |
| **ABC** | Abacavir |
| **ART**  **ARV** | Antiretroviral treatment  Antiretroviral |
| **DRV/r**  **DTG** | Daruvanir/ritonavir  Dolutegravir |
| **EFV** | Efavirenz |
| **FTC** | Emtricitabine |
| **GBV** | Gender-based violence |
| **HBV** | Hepatitis B virus |
| **HIVST** | HIV self-testing |
| **LIVES** | Listen, Inquire, Validate, Enhance safety and Support |
| **LPV/r** | Lopinavir/ritonavir |
| **PEP** | Post-exposure prophylaxis |
| **PrEP** | Pre-exposure prophylaxis |
| **RAL** | Raltegavir |
| **STI** | Sexually transmitted infection |
| **SW** | Sex worker |
| **TDF** | Tenofovir disoproxil fumarate |
| **WHO** | World Health Organization |

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| **Executive Summary**  Post-exposure prophylaxis (PEP) has been largely underutilized but remains a critical strategy for comprehensive HIV prevention. Key elements of PEP use and provision are the following:   * Timely access to PEP is critical. PEP should ideally be started within 24 hours of a potential exposure to HIV and no later than 72 hours. * Any individual with a known or suspected exposure within this timeframe should be offered PEP. * PEP should be used daily until 28 days after the potential exposure to HIV. Adherence counseling is crucial. * While two drug regimens are effective, three drug regimens are preferred. In [country] the preferred PEP regimen is [insert regimen]. * Before starting PEP, individuals should have an HIV test. If HIV tests are unavailable or results are delayed but an individual is suspected to have had an exposure to HIV, PEP should be started regardless. After the 28-day course has been completed, a follow-up test should be conducted. * PEP use can be an entry point to promote awareness, access and use of HIV prevention strategies and products, including pre-exposure prophylaxis (PrEP). * Task sharing and community delivery are key strategies to improve PEP uptake and access. |

# Post-exposure Prophylaxis

Post-exposure prophylaxis (PEP) is the use of antiretroviral (ARV) drugs by individuals who are presumed to be HIV negative after a potential exposure to HIV to reduce the probability of HIV acquisition. PEP should be offered as early as possible—ideally within 24 hours but not later than 72 hours after exposure—to individuals with suspected or known exposure to HIV.[[1]](#footnote-2) Timely access to PEP is crucial.

## Evidence for PEP

Evidence supporting the use of ARVs for PEP comes from animal studies and a single case control study in health care workers that demonstrated ARV drugs could prevent the establishment of chronic HIV infection if administered within a short time following exposure.[[2]](#footnote-3),[[3]](#footnote-4) Systematic reviews of the effectiveness of PEP suggest that the use of ARV drugs following occupational and nonoccupational exposure reduces the likelihood of acquiring HIV when administered as PEP and is likely to be cost-effective in groups most likely to be exposed to HIV.[[4]](#footnote-5),[[5]](#footnote-6) The efficacy of ARV drugs in preventing HIV following exposure is further supported by the effectiveness of ARV drugs in preventing perinatal transmission of HIV and PrEP.[[6]](#footnote-7)

As with any prevention intervention, effectiveness depends on high levels of effective use and completion of the prescribed course; however, reported completion rates are currently suboptimal for PEP in most settings.[[7]](#footnote-8),[[8]](#footnote-9) Other factors that may influence PEP effectiveness include the timing of initiation, type and degree of the potential exposure to HIV, and possible drug resistance. Given these considerations, PEP may never be considered 100% effective and should form part of a wider strategy for avoiding acquiring HIV, as well as be part of broader approaches to reducing exposure to other bloodborne viruses that individuals with likelihood of exposure to HIV may also be exposed to, including hepatitis B virus (HBV) and hepatitis C virus.

## Approved Drugs for PEP

An HIV PEP regimen with two ARV drugs is effective, but three drugs are preferred. PEP is taken for 28 days.

### Adults and Adolescents[[9]](#footnote-10),[[10]](#footnote-11)

In [country], either tenofovir disoproxil fumarate (TDF) 300 mg/ emtricitabine (FTC) 200 mg or TDF 300 mg/lamivudine (3TC) 300 mg can be used for PEP, with dolutegravir (DTG) 50mg as the preferred third drug, to be taken daily for 28 days.

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| **For consideration:** When DTG is not available, atazanavir/ritonavir (ATV/r), daruvanir/ritonavir (DRV/r), lopinavir/ritonavir (LPV/r), and raltegavir (RAL) may be considered as alternative third drug options for PEP. |

The current preferred drug for PEP for adults and adolescents in [country] is [TDF/XTC (i.e., TDF/FTC or 3TC) + DTG].

Data have been published suggesting that efavirenz (EFV) is associated with high rates of discontinuing HIV PEP because of central nervous system events.[[11]](#footnote-12) EFV should therefore be used as a third drug option only when no other options are available.

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| **For consideration:** To support early initiation, those who have access to oral PrEP (a two-drug regimen) can use those pills to start their PEP course sooner and attend a PEP service as soon as possible for a PEP assessment and transition to a three-drug regimen. |

### Children

In [country], abacavir (ABC) 120mg/3TC 60mg is recommended as the preferred backbone regimen for children weighing less than 30kg. The regimen can be given twice daily or once daily, depending on the weight band of the child. Azidothymidine (AZT) 60mg/3TC 30mg or TDF/3TC (or FTC) can be considered as an alternate regimen. DTG 50mg is recommended as the preferred third drug with the approved DTG dosing for children under 30kg. When available, ATV/r, DRV/r, LPV/r, and RAL may be considered as alternative third drug options for PEP. For children, both solid and liquid formulations may be available. More detail on simplified dosing of ARV drugs for PEP for children can be found here: <https://iris.who.int/bitstream/handle/10665/378181/B09093-eng.pdf>

Potential Side Effects of PEP

Antiretroviral medication used for PEP may have various side effects. Many of these side effects are mild but may require management of symptoms. The side effects can include:

* Diarrhea
* Headaches
* Nausea or vomiting
* Fatigue

It is important when using these medications that clients are monitored for side effects and drug toxicity. It is also important, as part of the counseling, to educate patients on the possible side effects, the need to return to the clinic if necessary for urgent follow-up, and the importance of adherence to the full PEP course even as side effects occur. Support from peers, parents, guardians, or partners can also help clients navigate side effects and their own adherence to PEP.

If a client is using PEP after a traumatic event, taking PEP may remind them of the experience. This could cause symptoms that look like side effects (e.g., headaches or nausea). These symptoms may make it harder for a client to use PEP every day, but they can be managed with provider support. This information should also be shared, along with a recommendation to return to the clinic as needed, as part of counseling for clients using PEP after a traumatic event.[[12]](#footnote-13)

## PEP and Other Drug Interactions

TDF/FTC or TDF/3TC in combination with DTG may interact with several drugs, including some used in the management of common conditions such as diabetes, TB, and seizure disorders. Many of these drug interactions change the efficacy of DTG. In such cases, providers should use clinical judgement to determine whether to increase the dosage of DTG depending on other drugs the client is using simultaneously over the 28-day course of PEP by a client and given existing comorbidities. Providers should check for drug interactions for all drug combinations here: <https://www.hiv-druginteractions.org/>.

PEP is safe to be used concurrently with emergency contraceptives or any other type of contraception. There are no known interactions between PEP medications and alcohol or recreational drugs. However, if a client or potential client thinks that their use of alcohol or other substances is interfering or may interfere with them taking PEP as directed, their provider should provide support and referrals and, where needed, offer additional prevention options.

## Contraindications for PEP Use

PEP should **NOT** be provided to people with:

* An HIV-positive test result obtained using the national HIV testing algorithm
* Allergy or hypersensitivity to an active substance or other substances listed in the product information sheet

## PEP Use

PEP should be started as soon as possible after a potential exposure to HIV, ideally within 24 hours but not later than 72 hours. PEP should be used daily until 28 days after the potential exposure to HIV. Any individual with a known or suspected exposure should be offered PEP. PEP should always be provided per client request without waiting for further reporting or documentation.

Known or suspected exposures that may warrant PEP include parenteral exposure (e.g., needle-stick injury or use of shared injection equipment) or mucous membrane exposure (e.g., via sexual exposure or splashes to eye, nose, or oral cavity).

Exposure that does not require PEP includes:

* When the individual who was potentially exposed is already living with HIV
* Exposure to bodily fluids that do not pose a significant risk: tears, non-blood-stained saliva, urine, and sweat

PEP does not prevent pregnancy or sexually transmitted infections (STIs) other than HIV. Pregnancy is not a contraindication for PEP. Evidence suggests that the recommended regimen for PEP is safe to take while pregnant or breastfeeding. See *Potential Side Effects of PEP*.

During PEP use, HIV acquisition and transmission can be complemented by other HIV prevention strategies, such as condom and condom-compatible lubricant use; harm reduction and treatment for drug use; and effective antiretroviral treatment (ART) for partners living with HIV, as needed. Provider engagement with a client to understand what advice or referrals might be valuable to support effective use can further reduce the likelihood of HIV acquisition.[[13]](#footnote-14)  After PEP completion, these continue to be vital services for HIV prevention, with the addition of PrEP for the client.

#### Transitioning from PEP to PrEP

Some people needing PEP will have repeated or ongoing potential exposures to HIV. Health care providers should discuss with people presenting for PEP whether they may benefit from and be interested in transitioning to PrEP after completing the PEP course in addition to exploring other HIV prevention strategies and products. In this way, PEP use can be an entry point to promote awareness, access, and use of HIV prevention strategies and products, including PrEP. Repeated PEP use can be an indication that a client may benefit from PrEP, though PrEP should not be restricted to only those clients with repeat PEP use.

Immediate transition to PrEP is preferable for individuals with ongoing potential exposures to HIV and the desire to take up PrEP. People who complete the 28-day PEP regimen and wish to use PrEP can start PrEP without a gap if they have a negative HIV test result on completion of PEP and do not have any contraindications to the chosen PrEP product.

PrEP may not be wanted or needed after every instance of PEP use. Some people at continuing likelihood of exposure may prefer not to take PrEP and may want to use other methods of HIV prevention, including PEP. Some exposures may be isolated events that do not require continuing prevention, such as a health care-associated exposure (for example, a needlestick injury) or some cases of sexual exposure, such as sexual assault.

#### Transitioning from PrEP to PEP

People using PrEP as directed would not usually need PEP. However, if PrEP is not used as directed, is stopped, or is used during a potential HIV exposure that wouldn’t be covered by a specific product (e.g. the PrEP ring does not prevent HIV during anal sex or parenteral exposures) there may be a chance of acquiring HIV if exposure occurs. PEP can be an important HIV prevention strategy during these periods. In this situation, providers should consider the:

* PrEP product used (oral PrEP containing TDF, the PrEP ring or CAB PrEP)
* Type of exposure to HIV (anal sex, vaginal sex, or parenteral/injecting)
* Person’s sexual and/or drug-use networks
* Time since PrEP was last used
* Ability of the client to adhere to the 28-day PEP regimen

**Table 1. PEP for People using PrEP or Who Have Recently Stopped PrEP**

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| **Method** | **Client** | **PrEP Use** | **Type of Exposure** | **Consider PEP?** |
| ***Oral PrEP containing TDF*** |  | *Doses taken in the 7 days before exposure* | | |
| People assigned male at birth not taking gender-affirming hormones | 4-7 | Any exposure | No, continue oral PrEP if desired |
| 0-3 | Sexual | Yes |
| People assigned female at birth or male at birth and taking gender-affirming hormones | 6-7 | Any exposure | No, continue oral PrEP if desired |
| 0-5 | Yes |
| ***PrEP ring*** |  | *Ring placement* | | |
| All PrEP ring clients | PrEP ring in place | Vaginal sex 24 or more hours after ring insertion | No, continue using PrEP ring |
| Vaginal sex within 24 hours of ring insertion | Yes |
| Anal sex or parenteral exposure | Yes |
| PrEP ring not in place | Vaginal sex within 24 hours of ring removal | Yes |
| Anal sex or parenteral exposure | Yes |
| ***CAB PrEP*** |  | *Delayed injection/time since stopping CAB PrEP* | | |
| All CAB PrEP clients | Scheduled follow-up injection delayed ≤7 days\* | Any exposure | No, continue CAB PrEP |
| Scheduled follow-up injection delayed >7 days OR >2 months since stopping CAB PrEP | Yes |

\*There is a seven-day window for receiving follow-up CAB PrEP injections, that is, seven days earlier or seven days later. Individuals presenting for their scheduled CAB PrEP injection within this window would not need PEP.

*Table 1 adapted from 2024 WHO Guidelines for HIV Post-Exposure Prophylaxis*

In [country], if someone is exposed to HIV and has stopped PrEP or missed doses and already has oral PrEP at home, they can begin PEP immediately by taking this two-drug combination, and then should attend an appropriate service as soon as possible to add the third ARV drug. Clients without oral PrEP at home should attend an appropriate service for PEP immediately.

PEP, alongside other HIV prevention strategies and products, should be discussed with and available for people who stop CAB PrEP to prevent HIV acquisition during the tail period (the period after stopping CAB PrEP when cabotegravir remains within a person’s system but at levels too low to protect against HIV acquisition).

## PEP Initiation Visit

To begin PEP use, clients must be free from contraindications for use of PEP.

The four essential components of PEP initiation visits are: 1) assessments, 2) HIV testing, 3) PEP counseling, and 4) PEP prescription.

### Component 1: Assessments

**Assess Client Need for First Aid**

In some cases, clients may have broken skin or other wounds or have experienced sexual violence. Assess client needs and immediately provide first aid and first-line support for gender-based violence (GBV) if necessary, including STI testing and treatment and emergency contraception. A wait for test results should not delay further assessment or initiation of PEP.

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| **For consideration:** Immediate care may also be provided, including first-line support for gender-based violence, if needed. Supportive LIVES (Listen, Inquire, Validate, Enhance safety, and Support) tools for routine enquiry can be found [here](https://www.prepwatch.org/resources/sop-job-aid-ipv-prep-services/). Although the job aid is specific to PrEP methods, it can also be used with PEP clients. |

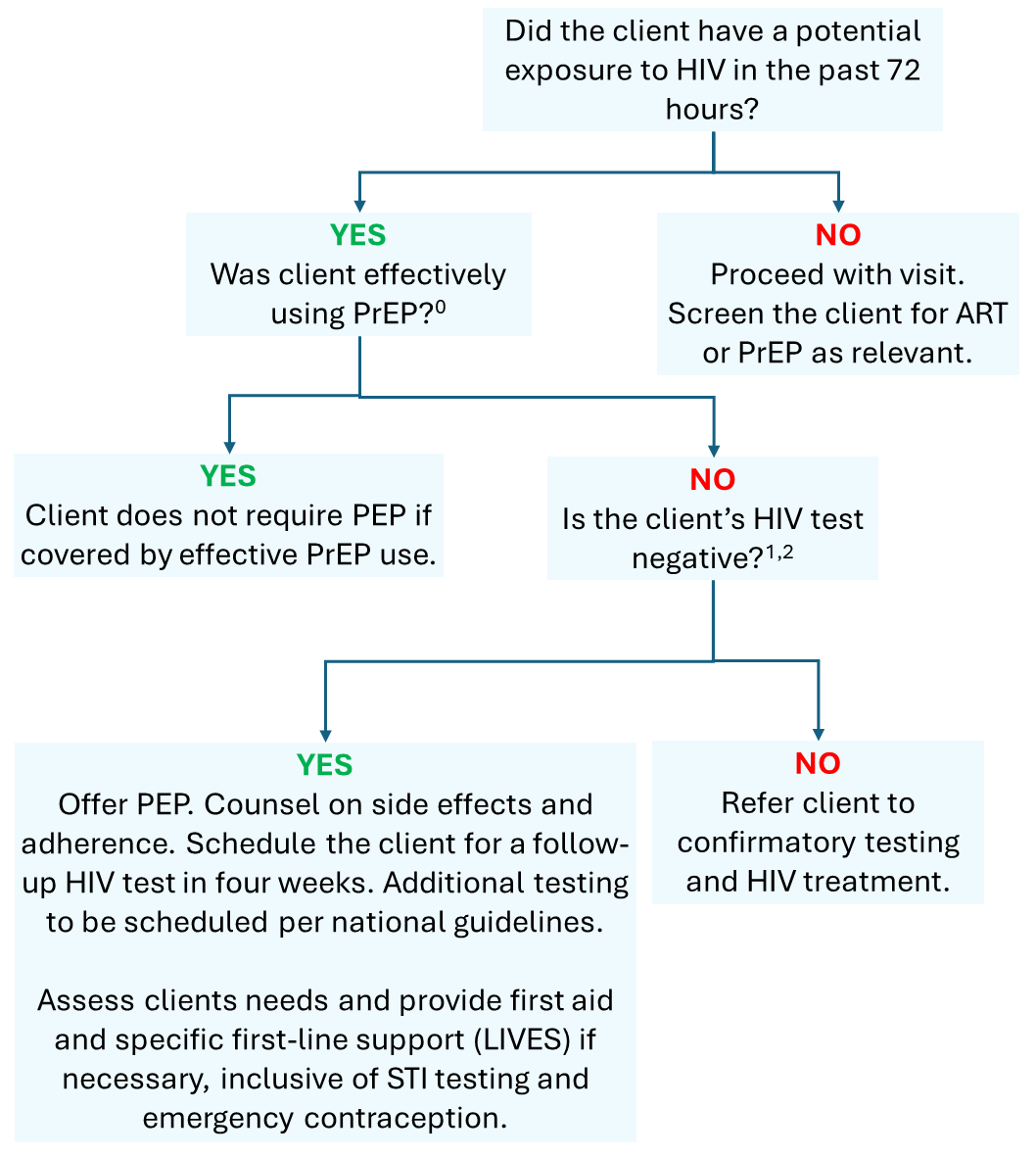
**Assess Client Need for PEP**

PEP should be offered and initiated as early as possible for all individuals with an exposure that has the potential for HIV transmission, preferably within 24 hours but not longer than 72 hours after the exposure. Providers should consider the range of essential interventions and referrals that should be offered to clients presenting after 72 hours to ensure early diagnosis of HIV and linkage to services. If a client does not want to disclose the details of exposure, this should not create a barrier to receiving PEP. *Diagram 1* outlines key components of PEP assessment.

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| **For consideration**: For clients to access PEP within the required time frame, police documentation or involvement should not be required to access PEP. HIV testing, confirmation of the potential exposure source, or additional testing (e.g., STI or pregnancy) should not be required prior to accessing PEP and should not delay initiation of PEP. Where possible, the starting dose for PEP can be offered immediately to the client upon indication for PEP to avoid delay in initiation during prescription filling or other potential delays in service delivery. |

Discuss the potential exposure with the client. If a client is taking PrEP but not using it effectively, has stopped PrEP, or has an exposure that is not covered by the PrEP product they are using, they should be considered for PEP. In cases that do not require PEP, the client should be offered HIV testing and informed about PrEP.

**Diagram 1. PEP Assessment**



0 Effective use criteria vary by PrEP method. Refer to Table 1.

1 Do not wait for HIV test results before starting PEP

2 If HIV tests are unavailable but the client is suspected to have had an exposure, PEP should be started regardless.

### Component 2: HIV Testing

Individuals who might benefit from PEP should receive HIV testing as soon as possible. In situations where immediate HIV testing is not available, assessment of the HIV status should not be a barrier to initiating PEP and HIV testing, and counseling should be undertaken as soon as possible. HIV self-testing (HIVST) can be considered for PEP initiation.

HIV testing should be conducted per national guidelines.

* If the test result is negative, a client can continue through the initiation visit and may be able to start PEP.
* If the test result is positive, the client must not be initiated on PEP but should receive further testing per the national algorithm and, if the result is confirmed positive, the client should be immediately initiated on or referred for ART.
* If the test result is inconclusive, follow national guidelines, including retesting at 14 days.[[14]](#footnote-15) Delays in obtaining a definitive HIV test should not delay PEP initiation because timely access to PEP is essential for its efficacy.

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| **For consideration:** WHO recommends that HIV self-testing can be used to support PEP services, e.g., starting PEP. HIVST has been shown to facilitate PrEP initiation and improve adherence and continuation. It may have the same effect on PEP access, uptake, and the transition from PEP to PrEP. |

### Component 3: PEP Counseling

All individuals seeking PEP should be counseled.

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

* Be client-driven and person-centred, based on their needs, resources, and preferences
* Be based on a foundation of respect and include an open, honest relationship between provider and client
* Validate and normalize client concerns, seek to affirm and encourage client efforts, and not be prescriptive or judgmental
* Ensure privacy, confidentiality, and informed consent
* Focus on identifying small wins and achievable next steps in reducing potential exposures and/or making effective use of combination HIV prevention easier
* Include contingency planning when common barriers are encountered
* Promote choice among available HIV prevention options based on client preferences and acceptability

Topics for PEP counseling:

* Appropriate first-line support for GBV, , such as creating a safety plan for taking PEP and offering referral where necessary, and support to help clients identify ways to effectively use and continue PEP through 28 days
* Importance of adherence to the full 28-day PEP course and discussion of strategies to support adherence
* Age-specific considerations for children and adolescents
* Risks and benefits of PEP
* Potential drug–drug interactions and possible side effects and toxicity (see *PEP and Other Drug Interactions*), including the possibility of trauma-related symptoms for clients using PEP after a traumatic event
* Symptoms of acute HIV infection and what to do if they develop. Persons experiencing skin rash or flulike symptoms while on or after taking PEP should be advised to return to a PEP site for an urgent review to exclude an HIV seroconversion.
* The importance of a follow-up HIV test at three months following potential HIV exposure
* Sexual behaviors
* Alcohol and drug use
* Mental health
* Contraceptive needs
* HIV prevention needs and strategies on the use of combination HIV/STI prevention, including option to transition immediately from PEP to PrEP if HIV test is negative after 28 days

Adherence counseling is critical. This can include discussion of the importance of adherence, side effect management, and strategies to help a client remember to take the pill every day. Other strategies used to increase adherence can include baseline individual needs assessments, counseling and education, and follow-up calls or texts by providers or peers.

### Component 4: PEP Prescription

In accordance with ART guidance, trained non-physicians, midwives, nurses. and other nonclinical health providers can initiate and dispense ARV drugs for PEP. [[15]](#footnote-16)

Clients are to be prescribed and provided the full 28-day course of ARV drugs for PEP in alignment with the recommended drug options (see *Approved Drugs for PEP*). If clients are interested in starting PrEP, they can switch directly from PEP to PrEP after assessment for contraindications to the chosen PrEP method. Clients not interested in starting PrEP should be tested for HIV in three months.

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| **For consideration:** For some, an additional 28-day PEP supply (“PEP in pocket”) can be provided in case of subsequent exposure.[[16]](#footnote-17) If offering PEP-in-pocket, provide counseling on when and how to use and adhere to PEP-in-pocket, as well as any follow-up visit requirements. |

### Additional Components of PEP Initiation Visit

The following components could be offered alongside PEP services as part of comprehensive, person-centred care, depending on a client’s needs and preferences. This list is not exhaustive, and the services needed will vary by individual and population. PEP should still be provided even if these services are not available or if the client is unable to or does not wish to access these services. Provision of any of these services should not delay PEP initiation.

**Table 2. Additional components of PEP initiation visit**

| **Component** | **Action** |
| --- | --- |
| Screening, testing, and treatment of other STIs | PEP can be used if the client has STIs other than HIV and during treatment of STIs other than HIV. Manage STIs per STI standard treatment guidelines. If testing is not possible, symptomatically manage STIs per STI standard treatment guidelines. PEP can be safely offered to persons with hepatitis B (HBV), so a wait HBV test results should not delay initiation. |
| Pregnancy testing and provision of emergency contraception or other contraceptives | Pregnancy testing should be offered to individuals presenting for PEP who aren’t pregnant but might become pregnant. Assess fertility intentions and offer contraception or safer conception counseling. For those who want it, emergency contraception should be offered as soon as possible.  If a client is pregnant, link them to antenatal care and pregnancy options counseling. |
| Provision of GBV services | Clients who are experiencing GBV should be provided appropriate services as needed and available following national recommendations. |
| Assessment for mental health and substance abuse disorders and provision of supportive services or referrals as needed | Screen for mental health concerns, including depression and substance abuse disorders, which might increase potential HIV exposure or affect effective use of PEP, and provide or link clients to follow-up services as needed. Clients with mental health or substance use concerns should not be prohibited from receiving PEP. |
| Screening for and treatment of noncommunicable diseases | Clients may have additional health needs that may come up during a visit with a health care provider or may be discovered through further assessment. Provide clients with relevant health care services or refer them to appropriate services as needed and available. |

## PEP Follow-Up Visits

PEP follow-up visits have one essential component: HIV testing and counseling

### HIV Testing

HIV testing should be conducted per national guidelines. All PEP clients should be scheduled for an HIV test at the end of the 28-day course and again three months after completion.

* If the test result is negative, a client can continue through the follow-up visit and may be able to start or continue PrEP if they are interested and its use is not contraindicated for them.
* If the test result is positive, the client should receive further testing per the national algorithm and, if the result is confirmed positive, the client should be immediately initiated on or referred for ART.
* If the test result is inconclusive, repeat the test after 14 days and follow national guidelines based on the results. Counsel on the use of condoms or other HIV prevention strategies in the meantime.

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| **For consideration:** WHO recommends the use of rapid or HIV self-test as the testing strategy for PEP. HIVST has been shown to facilitate PrEP initiation and improve adherence and continuation and may have the same affect on PEP access, uptake, and the transition from PEP to PrEP. Clients may be provided with a self-test at the same time as PEP for use upon completion of the 28-day course and would not have to present to follow-up if the test is not reactive. |

### Potential Components of PEP Follow-Up Visits

Depending on which services were offered at initiation, some of the potential components of PEP initiation visits may also be considered during follow-up visits.

Clients should be counseled on and offered PrEP or other HIV prevention strategies. If a client is interested in starting PrEP upon completion of PEP, they can switch directly from PEP to PrEP after a negative HIV test result at day 28 and assessment for contraindications to PrEP use. These clients should be managed similarly to any other client starting PrEP. Clients not interested in starting PrEP upon completion of PEP should be tested for HIV again three months after completing PEP and counseled on comprehensive prevention strategies if they still anticipate exposure to HIV. More detail can be found above in the *Transitioning from PEP to PrEP* and *Transition from PrEP to PEP* sections above.

### Management of Side Effects and Adverse Drug Reactions

Side effects should be managed symptomatically. Counseling to support management of side effects should be provided. Any side effects should be recorded in client records and other relevant forms for reporting side effects and adverse drug reactions. If a client is using PEP after a traumatic event, taking PEP may remind them of the experience. This could cause symptoms that look like side effects (e.g., headaches or nausea). These symptoms may make it harder for a client to use PEP every day, but they can also be managed with provider support.

## Who Can Deliver PEP and Where?

WHO recommends both task sharing and community delivery of PEP. Timely access to PEP is critical for effectiveness, and there are clear benefits to provision in community settings and by all types of providers, including nurses, pharmacists, community health workers, and lay providers. PEP can be successfully integrated in any setting with appropriately trained individuals who have been authorized to provide components of PEP initiation and/or follow-up visits according to national guidelines. Task sharing is a key strategy for dispensation, distribution, provision, and monitoring of PEP. Community delivery of PEP should complement delivery in other settings, with strong linkages and referral pathways. Diversified delivery models and community-based distribution may reach individuals missed by clinical services.[[17]](#footnote-18),[[18]](#footnote-19),[[19]](#footnote-20)

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| **For consideration:** Community settings can include a wide range of options, including but not limited to pharmacies, community-based organizations, drop-in centres, mobile clinics, and online delivery. |

1. WHO. Guidelines for HIV post-exposure prophylaxis [Internet]. Geneva: WHO; 2024 [cited 2024 Nov 18]. Available from: <https://www.who.int/publications/i/item/9789240095137#:~:text=PEP%20is%20most%20effective%20when,28%2Dday%20prescription%20for%20PEP> [↑](#footnote-ref-2)
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