CLINICAL PROTOCOL AND THERAPEUTIC GUIDELINES FOR PRE-EXPOSURE PROPHYLAXIS

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INDEX

LIST OF ABBREVIATIONS

ARV Antirretrovirales
3TC Lamivudina
CI 95% I95% confidence
ClCr Dcreatinine epuración
CV-HIV Carga viral HIV-1
DFC Dfixed dose combined
ELISA Enzyme inmunoanálisis
FTC Emtricitabina
HCV Hepatitis C virus
MSM whohave sex with men
STI Isexually transmitted infections
MSP and BS Ministry of PublicHealth and Welfare
WHO World Health Organization
PEP Post-Exposure Prophylaxis
PrEP Pre-Exposure Prophylaxis
TARV Terapia antirretroviral
TDF Tenofovir
TDF/FTC Tenofovir/e mtricitabina
TR Tis fast
TTS Trans sexworker
UDI Cinjecting drug users
VHA Hepatitis A Virus
HBV Hepatitis B virus
HCV Hepatitis C virus
HIV Human immunodeficiency virus

1. INTRODUCTION

Despite enormous advances in HIV infection control, in some places, the number of people becoming infected continues to grow. Every year new infections continue to occur and be diagnosed in all countries of the world, including industrialized countries where preventive measures are available. It is evident that the male condom and other barrier methods, despite their proven efficacy, have not had the effect that is needed for the control of the epidemic so complementary interventions are required to prevent HIV transmission with acombined preventiona bordaje[1,2],[1].

Treatment of HIV infection not only provides benefit to the individual health of the person receiving it, but also benefits the community by therefore 20000 as the most effective way to prevent HIV transmission. Undoubtedly, diagnosing infected people and treating them as early as possible is the strategy in which efforts and resources are most worth investing if the epidemic is to be truly controlled. But it has been shown that as the only strategy it is insufficient. There is a high proportion of infected and undiagnosed people who can [2] inadvertently transmit the HIV virus and this could be why the epidemic continues despite the fact that most people diagnosed are adequately treated.

In this sense la Pre-Exposure HIV Prophylaxis (PrEP, from English Pre-Exposure Prophylaxis), What consists of the use of drugs antirretrovirales (ARV), which in adequate concentrations can prevent the entry of the virus to the nucleus of the host cell[1]Reducing the risk of acquiring the infection, is a strategy more prevention that was demonstrated effective and safe in people with an increased risk of acquiring the infection for HIV[3].

Already since 2012 the WHO recommended considering the use of TDF or TDF/FTC as an additional intervention for HIV prevention in serodiscordant couples, and for trans men and women who have sex with[4]men. Since 2015 WHO recommends offering PrEP as an additional prevention strategy for people at considerable risk of HIV infection as part of combined HIV prevention.[56]

The WHO defines a considerable risk as HIV incidences greater than 3% person/year. These incidences have been identified in some subgroups of men who have sex with men, trans women and heterosexual men and women who have sex with undiagnosed or untreated HIV partners.

PrEP has been shown to be effective in reducing the risk of acquiring HIV infection through sexual contact in gay and bisexual men, transgender womenor and in heterosexual men and women who have sex with HIV patients, as well as in people who injectdrugs. Clinical trials and observational studies havePrEP with FTC/TDF has shown great benefits in terms of preventing HIV transmission, with risk reductions of more than 85% in some studies. The efficacy is very[7]dependent on adherence to the prescribed pattern,[8], ,[910],[11],.[12]

In Paraguay as in the rest of Latin America, the HIV/AIDS epidemic is concentrated in some risk groups that represent the majority of new cases of infection, such as gays and other men who have sex with men and TTS. In addition, the growth of HIV infection in adolescents and young people is highlighted[4],[13],.[14]

In addition to being at increased risk of acquiring HIV, these people are often subject to situations of discrimination, being subjected to stigma and prejudice, thus increasing their vulnerability to HIV/AIDS.

Therefore, PrEP is inserted as a new additional prevention strategy available in some Health services of the MSP and BS with the aim of reducing HIV transmission and contributing to the achievement of the goals related to the end of the epidemic.

2. IMPORTANT CONCEPTSS

2.1 COMBINED PREVENTION

PrEP should be offered as an additional prevention option within a comprehensive package of prevention services.

This means that PrEP is part of combined HIV prevention strategies, which include, in addition to PrEP:

1. Regular HIV testing;
2. Timely diagnosis and appropriate treatment of other sexually transmitted infections (STIs);
3. Antiretroviral treatment and viral control monitoring for people withHIV;
4. Access to and regular use of male, female condoms and lubricants;
5. Counseling for risk reductions,
6. Harm reduction interventions, including access to sterile syringes;
7. Post-exposure HIV prophylaxis (PEP);
8. Immunizations for HBV, HAV, HPV.

It is of fundamental importance to recognize that no isolated prevention intervention is sufficient to reduce new infections and that different risk factors for exposure, transmission and infection operate, dynamically, in different social, economic, cultural and political conditions.

As the name itself suggests, "combined prevention" suggests the "combined" use of preventive methods, according to the possibilities and choices of each individual, without excluding or superimposing one method on another[1,] considering the continuous work on changing risk behaviors.

2.2 HIV PRE-EXPOSURE PROPHYLAXIS

HIV Pre-Exposure Prophylaxis (PrEP) involves the use of antiretrovirals (ARVs) to reduce the risk of acquiring HIV infection. The efficacy and safety of PrEPhave already been demonstrated in various clinical studies and subpopulations, and its effectiveness has been evidenced in demonstration studies[3]. The level of protection correlates strongly with the level of adhesion.

In the iPrExstudy, which evaluateddaily oral PrPE in men who have sex with men(MSM) and trans women, there was a 44% reduction in the risk of HIV acquisition with daily use of single tablet of emtricitabine (FTC) combined with tenofovir desoproxil fumarate (TDF). The efficacy of prophylaxis was strongly associated with adherence: in participants with detectable blood levels of the medication, the reduction in HIV incidence was 95% [4].

Among heterosexual people, the overall efficacy of PrPEwas 62% in the TDF2 study, being 49% among women and 80% among men included in study[7.] In heterosexual serodiscordant couples, PrEP was also shown tobe effective, with an overall 75% reduction in the risk of HIV infection in

the Partners PrEPstudy. Again, efficacy was higher among men (84%) than among women (66%)[8].

The FEM-PrEP study, which included only women at risk of HIV acquisition in three African countries, saw a risk reduction of only 6%, and the study was discontinued early because of its low utility. Although reported adherence to medication was high among study participants, adherence through laboratory tests was very low. A similar result was seen in the VOICE study, which included African women and observed similar problems in adherence to study medication.[1516]

Among people who injected drug users (IDUs), the Bangkok, Tenofovir study showed a 49% reduction in the risk of HIV infection with oral PREP[9.]

The effect of PrPE was also evaluated in the IPERGAY study on demand, i.e. with the use of medication before and after exposure, rather than the traditional daily/continuous use scheme. In this scenario, an 86% reduction in the risk of HIV acquisition was observed, even with the use of fewer monthly tablets[6].

Even in conditions far removed from the reality of clinical research, PrEP has been shown to be effective for HIV prevention. In the PROUD study, which evaluated the open-up use of PrEPin MSM at risk of HIV infection, an 86% efficacy of the intervention was observed. Recently, several studies have analyzed the best strategies for implementing P[17]rEP fordifferent populations and contexts.[18]

PREP is highly effective when used correctly. The linear correlation between adherence levels and efficacy was demonstrated in clinical trials involving different population segments.

3. POPULATIONS AND CONTEXTS AT INCREASED RISK FOR HIV ACQUISITION

Certain population segments, due to specific vulnerabilities, are at higher risk of becoming infected with HIV, in different social contexts and types of epidemic. These populations, being at greater risk, should be a priority target for the use of PrEP.

In Paraguay, we are in a concentrated epidemic, since the prevalence of HIV infection in the general population is 0.4% (according to a study carried out by PRONASIDA in 2012), while some population segments demonstrate higher HIV prevalences[10]. These population subgroups are gay and other MSM, sex workers, and trans people.

Studies conducted in Paraguay demonstrated HIV prevalence rates of 1.34% among women sex workers from Asunción, Central,Alto Paraná, Pte. Hayes, Amambay Caaguazú; [19]20.7% in MSM population in Asunción, Central, Caaguazú and Alto Paraná,[20] 23.03% among trans people from Asunción, Central Alto Paraná and Caaguazú.[21]

To determine the increased risk of infection in HIV exposure, the following should also be considered:

- Repetition of and/or vaginal sexual practices with penetration without condom use
- Frequency of sexual intercourse with casual partners

- Number and diversity of sexual partners
- Frequency of STI episodes
- Repeated use of Post-exposure Prophylaxis (PPE)
- Frequency of exchange of sex for money, or valuables, or housing, and/or drugs, etc.
- Sexual intercourse under the effect ofdrugs, Chensex.

3.1Serodiscordant couples or relationships

There is considerable scientific evidence indicating the low transmissibility of HIV sexually when an HIV-positive person is on antiretroviral therapy (ART) for more than six months, with an undetectable viral load and does not have any[22]STIs,[23],[24],[25].

Therefore, PrEP is not indicated in couples and serodiscordant relationships where the HIV-positive partner is on ARV treatment for more than 6 months with undetectable viral load control, in the last 6 months.

PrEP can be used by the HIV-negative partner as an adjuvant in the prevention of HIV transmission when the HIV-positive partner:

- You are not receiving antiretroviral therapy (ART) or
- You have not yet reached viral suppression, or
- There is no documentation of it.
- When the SERONEGATIVE PARTNER has doubts about the efficacy of the treatment or
- When you have other partners besides your HIV-positive partner who is receiving treatment.
- When the couple's adherence to treatment has not been adequate

4 POPULATIONS AND CRITERIA FOR THE INDICATION OF PREP

4.1 Criteria for receiving PrEP[2]

- HIV-negative result
- Absence of suspected acute HIV infection
- Significant risk of HIV infection (priority populations)
- No contraindications to receiving PrEP medications
- Willingness to use PrEP as prescribed, including regular testing for HIV infection.

In all situations, evaluate whether PrEP should be daily or intermittent, based on the frequency of risk relationships, and the user's ability to plan for those relationships. This decision should be made jointly between the medical professional and the user.

Table 1, below, presents the definitions of the priority population segments for indication of PREP,after negative HIV test.

The questions about risk situations mentioned in Table 1, considered as PrEP indication criteria, should be raised. If the answer is "sì" to any of the questions, the use of PrEP should be raised.

Table 1 - Poblacionis priority tos and criteriafor indicating PrEP[1,2],[26]©

Priority populations	DEFINITION	CRITERION OF INDICATION OF PRE

Gays and other men who have sex with men (MSM)	Men who are sexually and/or affectively related to other men	That in the previous 6 months have had anal (receptive or insertive)or vaginal sexual reactions, without condom use, Y/O - More than two sexual partners, - Recurrent episodes of Sexually Transmitted Infections(STIs), - Repeated use of Post-Exposure Prophylaxis (PEP), - Use of psychoactive substances during sexual intercourse
Trans people	People who express a gender different from the sex defined at birth. This definition includes: transsexual men and women, transgenders, transvestites and other people with non-binary genders	
Sex workers	Men, women, and trans people who receive money or benefits in exchange for sexual services, regularly or occasionally	
Hiv-discordant couples for HIV	Heterosexual or homosexual association in which one person is infected with HIV and the other does not®	Anal or vaginal intercourse with an HIV-infected person with no suppressed viral load or no recent documentation of viral suppression, no condom
Injectable drug users (UDI)	People who inject drugs	IDs that share syringes

© PrEP maybeindicated in other risk situations according to epidemiological research on the risk profile of the person: for example, with a partner with risk factors for HIV; client of sex workers; partner of bisexual men; people in a situation of social vulnerability exposed to unprotected sexual contacts at high risk of HIV infection; etc.

® H to document suppressed viral load of the HIV-positive partner after 6 months of antiretroviral treatment.[27]

4.2 Intermittent PrEP (demand the 2+1+1)[28]

The decision to use continuous or intermittent PrEP should be made jointly between the medical professional and the user. As well as the decision to switch from one method to another during follow-up consultations, which should be evaluated according to changes in user behavior.

4.2.1 Indication of the use of turn signal (on demand or 2+1+1)

- MSM population, which
- You have infrequent sex (for example, sex less than 2 times a week on average), which
- You can plan sex at least 2 hours in advance or who can delay sex for at least 2 hours
-

4.2.2 Contraindication to the use of intermittent (on demand or 2+1+1)

- Transgender women
- Transgender men who have vaginal sex/frontal sex
- Men who have vaginal or anal sex with women
- People with chronic hepatitis B virus infection.

4.2.3 What is PrEP on demand or 2 + 1 + 1, and how they should be used

On-demand PrEP involves the use of a double dose (two pills, which serves as a loading dose) of TDF/FTC (or TDF/3TC) between two and 24 hours before sex; then a third pill 24 hours after the first two pills, and a fourth pill 48 hours after the first two pills (Fig. 1).
This is an alternative to daily dosing for men who have sex with men.
This 2 + 1 + 1 dosage is the only on-demand regimen that has proven to be effective.
Dosage 2 + 1 + 1 is useful when it comes to an isolated sexual act. If more sex acts occur during the following days, a single PrEP pill can be continued daily as long as sex continues, with a single pill daily for the two days after the last sexual act.

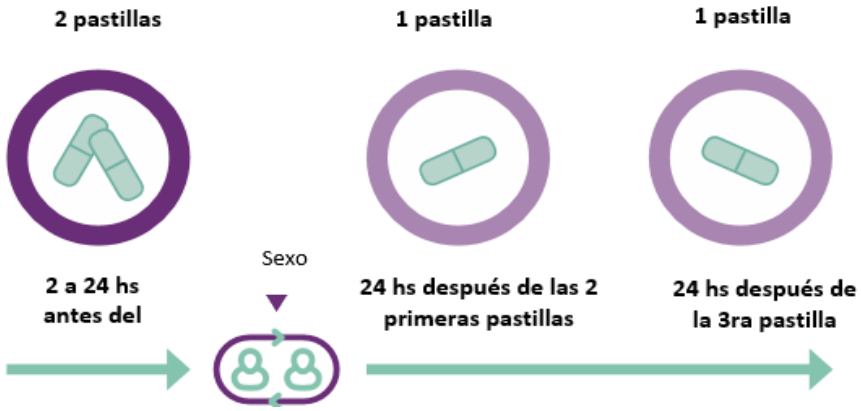


Figure 1. Outline of how to take PrEP on demand (2 + 1 + 1)

4.2.4 Benefits of PrEP on Demand in MSM

PrEP on demand is highly effective in reducing the risk of contracting HIV in MSM, and has the following additional benefits:

- Provides options and convenience for MSM who may be at high risk of contracting HIV for short periods or have sex less than 2 times per week on average;
- It serves as an option for men who have sex with men who can anticipate, plan, or delay their sexual events;
- Reduces the load of pills;
- It saves costs, as fewer pills may be needed.

Teens would need more support for prep use and adherence on demand.

4.3 Contraindications to receiving PrEP

PrEP is contraindicated in the following cases:
• HIV infection;
• Signs or symptoms of acute HIV infection (fever, adenomegaly, headache, pharyngitis, skin rush), likely recent exposure to HIV;
• Creatinine clearance calculated <60 ml/min (if this is known);
• Allergy or contraindication to any medication in the PrEP scheme.

5 INITIAL CLINICAL EVALUATION

The evaluation of the eligibility criteria for PrEP must be made within a relationship of bond and trust that allows to understand the situations of vulnerabilities and risks involved in sexual practices, as well as the objective conditions of adherence to the use of the drug.

5.1 INITIAL SELECTION CONSULTATION

At the initial screening consultation, the health team should be organized to perform the procedures and examinations listed in Table 2.

Table 2 - Components of the initial consultation of PREP

INITIAL EVALUATION	
Focus on risk and vulnerability management	
Evaluation of understanding and motivation for the initiation of PrEP	
Evaluation of the indication of immediate use of PEP, in case of recent exposure(within the last 72 hours)	
Exclusion of the possibility of HIV infection (through testing and evaluation of signs and symptoms of acute HIV infection)	
Identification and treatment of sexually transmitted infections	
Request serologies for viral hepatitis A, B and C	
Evaluate the need for vaccination against hepatitis A virus (for MSM population) and hepatitis B if it brings serologies or wait for the next control with the results to decide on vaccination	
Request studies of renal and hepatic functions	
Evaluation of the history of pathological fractures	
Evaluate according to sexual practices the use of continuous or intermittent PrEP	
EXAMSREQUESTED AT THE FIRST CONSULTATION	
Tests	**Method**
HIV Testing	Rapid test (TR) for HIV, on the same day, using **blood** sample
	Do ELISA for HIV
Syphilis test	Syphilis test: rapid test and VDRL
Identification of other STIs (chlamydia and gonococcus)	Anal swab, if available
Hepatitis A test	Investigation of IgG HAV or total anti-HAV in MSM patients
Hepatitis B© test	HBsAg (e.g. rapid test) and anti-HBs research
Hepatitis C test	Anti-HCVresearch (e.g., rapid test)
Kidney function ®	Dosage of urea and serum creatinine. Simple urine to evaluate for protein.
Liver function	Liver enzymes

©In patients who refer to being vaccinated for HBV,evaluate seroconversion (Anti-HBs) within one month of the last dose or later. If seroconversion (presence of anti-HBS positive) is confirmed, it is not necessary to repeat tests for hepatitis B. ®If the person has any risk factors for kidney disease, such as hypertension or diabetes mellitus, request proteinuriat 24 hours and renal ultrasound.

PrEP candidates, who are within the populations and criteria for indication according to Table 1, may initiate HIV-negative prophylaxis, and wait for the results of the other screening tests (Table 2), by the time of their return in 30 days, without delaying initiation.

5.1.1 Approach to risk management

Based on the knowledge of prevention alternatives, the individual should be discussed about the possibility of risk management, in accordance with their sexual practices. This approach recognizes that choices are made by considering different cultural belongings, community inserts, and life histories, which will influence the ways in which prevention methods are adopted throughout life.
It should be noted that risk management considers the principle that people are autonomous and able to make decisions in their best interests if they have all the information necessary to reduce their risk of HIV infection.
The discussion on risk management should take into account the user experience with other prevention methods; their sexual practices; the type and frequency of sexual associations; sexual and reproductive health history; and contexts of vulnerability and exposure to HIV.

5.1.2 Evaluation of understanding and motivation for the initiation of PREP

The candidate for the use of PrEP must understand what this strategy consists of and how it is inserted in the context of managing their own risk of acquiring HIV infection to assess their motivation to initiate the use of PrEP. People should be explained that PrEP is a safe and effective method in the preventionof HIV, with rare adverse events, which, when they occur, are transient and capable of being managed clinically.

Discuss with the patient the use of continuous and intermittent PrEP to decide on the best method that suits the user's situation.

It should be reinforced that the effectiveness of this strategy is directly related to the degree of adherence to prophylaxis. Daily and regular use of medication is critical for protection against HIV[3] in cases of continuous PrEP.

However, it should be emphasized that the use of PREP does not prevent other ITS or viral hepatitis, nor pregnancy, so it is necessary to guide the person on the use of condoms.

Among those who clearly demonstrate their willingness to initiate prophylaxis and present high-riskpractices forHIV, the demonstrative studies indicate that PRPEis significantly more protective the shorter the user's waiting[29]time,[30].

5.1.3 Evaluation of the indication for POST-exposure HIV Prophylaxis

POST-Exposure HIV Prophylaxis (PEP) is one of the HIV prevention strategies. Once it has been identified that the person was potentially exposed to HIV within the last 72 hours, immediate initiation of PE P should berecommended, according to the PEP protocol.[31]

Individuals with momentary indication of PEP may be future candidates for PrEP. The transition to PrEP canbe made at the end **of** the **28 days of PEP** use and the exclusion of **HIV infection.**

5.1.4 HIV testing (excluding HIV infection)

For the indication of the use of PrEP, the previous diagnosis of HIV infection should be excluded, because the introduction of PrEP in those whoare already infected may result in the selection of resistant strains.

A rapid HIV test (TR), prequalified by WHO, using a whole blood sample, obtained by digital puncture or by venous puncture, serum or plasma (as indicated in the package leaflet of the test used) is recommended.

A rapid test (TR1) is performed and, if the result is non-reactive, the diagnosis is defined as "non-reactive sample for HIV" and the person may be a candidate for PrEP.
If TR1 is reactive, TR2 should be performed; if this presents a non-reactive result, i.e. discordant results between TR1 and TR2, the tests should be repeated. In the event of a discrepancyof the results, a sample should be collected by veni puncture and sent to the laboratory to be subjected to one of the diagrams defined for laboratory. Wait for laboratory results for the indication of PrEP or ART.

If rapid tests are not available, laboratory tests (immunoassays) may be used to track HIV infection.

People with recent risk exposure, especially in the last 30 days, should be guided as to the possibility of infection, even with non-reactive results in the tests performed. If HIV infection is confirmed, P[3233]rEP is no longer indicated.

In case of clinical suspicion of acute HIV infection(fever, adenomegaly, pharyngitis, headache, cutaneous rush, et c.)hiv viral load test should be performed, in order to establish the diagnosis. If HIV infection is confirmed, it should be referred to the consultation for initiation of treatment. If infection is ruled out indicate PrEP.

If the person brings a negative pre-TEST for HIV to the screening consultation, a new HIVtest is recommended,however. In all consultations for PrEP (initial and follow-up) it is necessary to perform a new RT for HIV.

5.1.5 Testing and treatment of STIs

Individuals eligible for PrEP are at increased risk for the acquisition of STIs, as they share the same routes of transmission with HIV. Studies show that people with ITS andnon-ulcerative reproductive tract infections have a 3- to 10-fold increased risk of becoming infected with HIV, with an 18-fold increase when the disease occurs with genital ulcers.[34]

Rapid test and VDRL test tests and chlamydia and gonococcus studies should be performed for syphilis when available, instituting treatment when indicated, in accordance with treatment protocols.

5.1.6 Pviral hepatitis rolland vaccination for hepatitis A and B

Hepatitis B and C

Sexually active individuals (especially MSM and Trans) and people who use drugs have an increased risk of acquiring B-virus hepatitis(HBV) and C-virus hepatitis[35](HCV). Initial investigation of viral hepatitis B and C is recommended,[36]the serological profile of which should be documented in all persons with indication of PrEP.

Studies conducted so far indicate that carriers of chronic HBV infection cansafelyuse Pr[37]EP.

Candidates for PrEP with a diagnosis of chronic viral hepatitis B should be referred for evaluation by the specialist, without this implying delay in the initiation of PrEP, with the aim of investigating the presence of disease activity, degree of liver fibrosis, safety of concomitant use of TDF/FTC and evaluation of treatment for this condition, in the course of the follow-up.

As TDF and FTC are active against HBV replication, it can be replicated again with the suspension of the use of PrEP, being important, therefore, the evaluation of the specialist is essential to define the need or not of treatment for chronic HBV before discontinuing PrEP.

Vaccination for HBV is recommended for all people in any age group (three doses of the vaccine). HBV vaccine is indicated regardless of the availability of anti-HBs testing.

Hepatitis A

Considering that the main means of transmission of hepatitis A virus (HAV) is fecal-oral, also occurring by oral anal sexual transmission, it is recommended:

- To evaluate the user of PrEP for an eventual episode of acute hepatitis A virus infection.
- To verify the susceptibility of the user to PrEP by means of the investigation of specific serological examination (anti-HAV IgG or total anti-HAV).

At the time of consultation, PrEP users should also be instructed on prevention measures, during sexual practice, in relation to hepatitis A virus infection, which are: sanitization of the hands, genitals, peritoneal and anal region before and after sexual intercourse, as well as sanitization of vibrators, and vaginal plugs.

If antibody research (anti-HAV IgG and anti-HAV total) is non-reactive, vaccination against HAV should be indicated.

5.1.7 Evaluation of renaland hepatic function and history of pathological fractures

Renal function should be assessed by serum creatinine dosing, with estimated creatinine clearence (ClCr)* calculation. The use of TDF can lead to a progressive loss of renal function, evaluated by the estimation of ClCr, and may occur, in rare cases, acute renal failure and Fanconi syndrome.

However, significant compromise in renal function was not observed in clinical trials and demonstration studies conducted. It is not uncommon for a discrete change in clearance to occur, fully reversible with discontinuation of medication use.

Request renal function examination on the day of the first dispensing of PrEP,to be evaluated in the next control at 30 days. And PrEP is continued or suspended according to the result of the estimated ClCr.

Given the potential renal toxicity of TDF, PREP is not indicated for individuals with ClCr ≤ 60 mL/min.

Request dosage of liver enzymes. The presence of elevation of these enzymes should guide the diagnostic investigation of otherpathologies,such as hepatitis virus infection, alcoholic liver disease and metabolic diseases.

* ClCr = [(140 - age) x weight] ÷ (serum creatinine x 72)] × 0.85 in women. Age in years, weight in kg and serum Cr in mg / 100mL;

Persons with indication of PrEP with a history of pathological fracture should be evaluated by the specialist before the decision to initiate the use of PrEP.

5.2 Prescripción de PREP

Candidates for PrEP at high risk of acquiring HIV should be evaluated at the first consultation and if there is no history of risk for liver or kidney disease, suspected acute HIVinfection, or mental disorders, or another condition that makes the onset deferred, PrEP should be started at the first consultation, and request the studies to be evaluated in the control at 30 days.

If there is suspicion of pathologies or conditions that could contraindicate PrEP, the user should be summoned in two weeks to verify the results of tests requested in the initial consultation and prescription of PrEP if there are no contraindications.
In any case, the first prescription will be for 30 days.

6 ANTIRETROVIRAL SCHEME FOR PrEP

The recommended scheme for use in PrEP is the combination of the antiretrovirals tenofovir desoproxil fumarate (TDF) and emtricitabine (FTC), whose efficacy and safety have been demonstrated with few adverse effects associated with their use.

It is indicated for PrEP the combination of Tenofovir associated with Emtricitabine, in combined fixed dose TDF/FTC 300/200mg, one tablet a day, orally, in continuous or **intermittentuse.**

Studies show that the pharmacokinetics of TDF and FTC vary according to body[38]tissue. The data suggest that high levels of cellular concentration of the drugs occur from the seventh day of continuous use of the medication for exposures by anal and vaginal relationship[39,40,41,42,43,44,45]. Therefore, it is necessary to guide the user on the need for use of the barrier condom and/or other prevention methods during that period.

In all cases, about 7 (seven) days of use of PREP are necessary to achieve optimal protection.

7 TRACKING PEOPLE IN PREP USE

7.1 Control after 30 days

- Making new RT for HIV
- Assessment of the presence of symptoms ofacute HIV infection
- Evaluation of the results of the selection examinations (according to table 2)
- Evaluation of motivation for the use of PrEP
- Prescription of PrEP
    - Guidance on strategies for better adherence
    - Report on the potential side effects and the transient nature of these
- Risk management evaluation and combined prevention.
- Evaluation of the PrEP method used, for its continuity or change of method.

A complete history should be performed with assessment of socioeconomic factors, comorbidities and concomitant medicinal products, possibility of adverse events and assessment of additional risks. It is appropriate to reinforce the need for combined prevention, using the set of strategies most appropriate to the needs and characteristics of each individual.

If the person returns in more than three months, the complete initial evaluation planned for the selectionmust be carriedout.

Keep in mind that PrEP is not considered as a lifelong intervention, but as a method to improve prevention during periods when people are at increased risk of becoming infected with HIV.

7.2 Subsequent consultations

The 3rd consultation will be made two months from the 2nd consultation, which would be 3 months after the indication of PrEP, and then the consultations will be every 3 months. In cases of detecting low adherence or some other clinical condition that requires closer controls, the controls will be done monthly and then according to evaluation.

In follow-up consultations, the following should be evaluated:

- Clinical and laboratory accompaniment
- Assessment of adverse events
- Assessment of adherence, risk exposures and prevention guidance
- Access to other prevention interventions (condoms and lubricants)
- Evaluation of continuing or changing with the regimen initially indicated (daily or intermittent)
- Orientation of cuando interrupt togo prEP

Subsequent ARV dispensations will not be automatic, it will depend on the medical evaluation and prescription of prophylaxis.

The performance of the TR for HIV at each visit is mandatory.

During clinical accompaniment, attention should be paid to the possibility of acute HIV infection, alerting the person to the main signs and symptoms, and guiding them to immediately seek the health service upon suspicionof infection. In case of suspected acute infection, PrEP should be discontinued immediatelyand HIV viral load performed. If HIV infection is confirmed, it should be referred to the consultation for initiation of treatment. If infection is ruled out indicate PrEP.

Table 3 presents the periodicity of the activities related to the follow-up of the individual in use of PrEP.

Table 3 – Clinical and laboratory follow-up of people in use of PrEP

FOLLOW-UP OF PEOPLE IN PrEP		
Evaluations		**Periodicity**
Evaluation of signs or symptoms of acute HIV infection		At every PrEP visit
Patient weight (in Kilograms)		At every PrEP visit
Assessment of adverse effects of PrEP		At every PrEP visit
Assessment of accession		At every PrEP visit
Risk exposure assessment		At every PrEP visit
Evaluate following or changing the PrEP method		At every PrEP visit
Assess prep continuity		At every PrEP visit
Dispensing ARVs after prescription		Quarterly
Tests	**Method**	**Periodicity**
HIV Testing	Rapid test for HIV, using whole blood, serum, or plasma samples, on the day of the consultation	At every PrEP visit
Syphilis test	VDRL or rapid test if previous result was negative	Quarterly
Identification of other STIs (chlamydia and gonococcus)	Anal or urethral swab (if available)	Quarterly
Hepatitis B antigen test for individuals who do not have post-vaccine seroconversion.	HBsAg search (e.g. TR) (c)	Depending on the seroconversion of the vaccine to HBV.
Hepatitis C test	Anti-HCV Research (e.g., TR)	Sannual annual
Monitoring of renal function (d), (e)	Calculated creatinine clearence Dosage of urea and serum creatinine Evaluation of proteinuria (isolated urine sample)	Emestral or annual S (possibly depending on other risk factors for renal toxicity)
Liver function monitoring	Liver enzymes (GOT/GPT)	Emestral or annual (possibly depending

		on other risk factors for livertoxicity)
Pregnancy test		when necessary

(a) 1nd dispensation for 30 days, the 2nd dispensation for 2 months and then quarterly. (b) in cases of patients with previous syphilis, non-treponemal tests such as VDRL or RPR should be done, (c) In patients vaccinated for HBV, seroconversion (Anti-HBs) should be evaluated one month after the last dose or later. After seroconversion (post-infectious or post-vaccination), there is no need to repeat tests for hepatitis B. If HBV Ag s is negative refer for vaccination (d) If the person has any risk factors for kidney disease, such as high blood pressure or diabetes mellitus, do 24-hour proteinuria and renal ultrasound. (e) Increased serum creatinine is not grounds for discontinuation of treatment, provided that ClCr≥60mL/min

Adolescents and young people (24 years and younger) may benefit from more frequent consultations to address the changing habits and multiple needs seen in this age group. Young people also benefit from access to social services, a non-judgmental and accessible clinical staff, and flexible office hours.

Self-administered HIV testing (HIV self-testing) can be considered part of prEP demand-side activities. However, before starting PrEP it is always necessary to do tests in the office.[4647]

7.3 Assessment of adverse events

Persons using PrEP should be informed of the possibility of adverse events arising from the use of ARVs. In available clinical trials, adverse events were unusual and resolved within the first month of the use of PrEP[1,2,3.]

The health professional should inform the user that the expected adverse events (nausea, headache, flatulence and edema) are transient and that there is a possibility of using symptomatic medication for the resolution of symptoms.
In addition, users should be counseled about signs and symptoms of acute HIV infection that require immediate medical evaluation.

7.4 Evaluation of drug interactions

FTC/TDF has no restrictions on the consumption of food or alcoholic beverages.

There are no known interactions between FTC/TDF and contraceptive hormones, hormones used for feminization purposes by transgender women, or hormones used for masculinization by transgender men.[48]

FTC/TDF do not interact with the drugs that are most commonly used and can be taken safely at the same time as antidepressants or drugs for tuberculosis or malaria.

There is no known interaction between PrEP drugsand recreational drugs, or commonly used medications.

7.5 Strategies for accession to PrEP

PrEP tablets can be taken at any time of the day, with or without food. Recommend that if there was forgetting the shot at the usual time that you take it when you remember.

Adherence to ARVs is critical for PrEP to be effective and efficient. Efficacy depends on adherence to the prescribed regimen, with a minimum threshold of less than 4 tablets per week having been established in men who have sex with men, and in transgender women[43] in the use of hormones for feminization and in women, less than 6 tablets per week [44]. Accession must be addressed in all consultations, from a simple and open means of communication. The following points should be considered:

- Evaluation of the adherence of the person using PrEP to the taking of medication and other HIV prevention measures;
- Identification of barriers and facilitators of adhesion, avoiding value judgments;
- Reinforcement on the relationship between good adhesion and effectiveness of PrEP;
- Identification of the best strategies to ensure adherence, such as associating the taking of the drug with events that are part of the individual's daily routine;
- Identification of possible alert mechanisms for taking medication, such as alarm clocks, alarms, telephone messages.
- Use of pharmacy data to evaluate the dispensing history of the medicine in the period between consultations and the tablet count at each dispense;
- Evaluation and management of adverse events.

It is recommended that adherence monitoring with younger and lower schooling users be carried out in shorter time intervals and more closely, especially in the initial phase of use, since studies demonstrating PrEP have indicated lower interest rates and adherence in these subpopulations.[49]

The discordant results in the prevention of HIV transmission in heterosexual women could be due to a very low adherence rate in this population. New studies, with significant improvement in adherence in this group could yield new results.

7.5 By discontinuing PREP

PREP should be discontinued in the following cases:

- Diagnosis of HIV infection;
- The person's desire not to use the medication anymore;
- Change in the context of life, with a significant decrease in the frequency of sexual practices with potential risk of infection;
- Persistence or relevant adverse events;
- Low adherence to PrEP, even after an individualized approach to adherence.

If there has been sexual intercourse with potential risk of HIV infection, it is recommended that the user maintain the use of PrEP for a period of 30 days from the date of potential exposure before discontinuing its use.

For users who interrupt the use of PrEP, it is oriented:

- Anti-HIV testing in the 4-week period after discontinuation of prophylaxis.

If during the use of PrEP the diagnosis of HIV infection is made, immediately discontinue the PrEP, and perform a viral load test and genotyping pretreated and initiate ART as soon as

possible, as recommended by the Clinical Protocol and Therapeutic Guidelines for the Management of HIV Infection in Adults.

In the event of the suspicion of acute HIV infection, the PrEP should be suspended, request a viral load and evaluate with this result the onset of ART or continuity of PreP.
In individuals with chronic hepatitis B, with liver disease using PrEP, Tenofovir should not be discontinued. Discontinuation of PrEP in people with HBV liver disease may lead toincreased liver enzymes and liver decompensation and death in cirrhotic patients. If HIV infection is confirmed, the new scheme should keep Tenofovir. In individuals with chronic hepatitis B without liver disease, request evaluation from the specialist before discontinuing PrEP to assess the need or not for treatment for hepatitis B. In these cases request during the follow-up anti s HBV and anti e HBV before the possible cure.

At the time of the decision to discontinue PrEP, the serological status of the person who was in use of PrEP, adherence until then, the reasons for discontinuity of the drug and risk situations should be documented.

The importance of the user using other preventive methods and being tested regularly for HIV and other STIs should also be clarified, as well as the possibility of resuming the use of PrEP, if situations of increased probability of exposure to HIV or of using PEP in situations of time exposure still occur or recur.

If the person wishes to restart prophylaxis after a period of discontinuation, the initial approach should be performed again, check eligibility criteria and reintroduce the drug.

7.6 PrEP during conception,gestation and lactation

Studies show that HIV-negative women, with the desire to become pregnant from HIV-positive couples or with frequent situations of potential exposure to HIV, can benefit from the use of PrEP safely, throughout pregnancy and lactation, to protect themselves and the[50]baby,[51].

In clinical studies with adult heterosexual couples in which PrEP was shown to be safe and effective in reducing HIV infection[5,8,]prophylaxis was discontinued when pregnancy was detected. During these trials, no health problems were associated with the use of PrEP in women at the beginning of gestation or in the newborn.

It is known that the risk of HIV acquisition increases during[52]pregnancy, as well as the risk of vertical transmission of HIV when the pregnant woman is infected during pregnancy or lactation,[53]so in case there is a risk of becoming infected by HIV the pregnant woman should[54]indicate PrEP.

PrEP may be offered or maintained during pregnancy and/or while breastfeeding to women at significant risk of HIV infection

8. Additional information

NATIONAL STRATEGY FOR THE IMPLEMENTATION OF PRE-EXPOSURE HIV PREP PROPHYLAXIS IN PARAGUAY-2019

Following the World Health Organization (WHO) recommendation of September 2015 that oral pre-exposure or pre-exposure prophylaxis (PrEP) should be offered as another prevention option to people at significant risk of HIV infection as part of combined prevention strategies, Paraguay, taking into account HIV prevalence in the key population, has considered the introduction of PrEP and begin its implementation in the country.

The country believes that PrEP should not replace or compete with other HIV prevention interventions that are effective and well established, such as comprehensive condom provision programs for sex workers, gay,bisexual men and other men who have sex with men and trans people.

When PrEP is offered to people at significant risk of HIV infection, it is important to take a human rights-based, person-centred approach to public health.

THE PROCESSES FOR IMPLEMENTATION ARE AS FOLLOWS:

1. Eligibility Criteria for PrEP Use:

1. HIV-negative person
2. Belonging to the Key Population: MSM, TRANS, Serodiscordants.
3. There are no suspicions of Acute HIV infection (Acute RetroviralSyndrome).
4. Significant risk of HIV infection*
5. There are no contraindications to PrEP drugs (TDF/FTC or TDF/3TC)
6. I expressly want to use PrEP, and to be tested for HIV systematically.

*** Significant risk of HIV infection refers to people with a risk of acquiring HIV including:**

1. Anal or vaginal sexual contact without condoms with more than one partner in the past 6 months or
2. Recent history (in the last six (6) months) of any infection of

sexual transmission (STI) by laboratory tests or if you have received syndromic management of it, OR
3. You have used post-exposure prophylaxis (PEP) for sexual exposure in the last six (6) months, OR
4. You have had sex without using a condom with a person with HIV who is not on treatment or has detectable CV-

Exclusion criteria

1- Risk assessment for PEP-positive use within 72 hours

2. PrEP services.

The country believes that PrEP services should be integrated into existing services: HIV testing services, HIV treatment and related services for key population groups so we will start as follows:
PHASE I OF IMPLEMENTATION: It is proposed that the PrEP strategy can be carried out in a care service within the MSP-BS Network, where a considerable number of people go in treatment of HIV infection of the key population such as the Institute of Tropical Medicine in such a way to lower in this service the good practices of Phase I
PHASE II OF IMPLEMENTATION:> 1 year: After 1 year of implementation it is intended that other services within the MSP Network can offer PrEP as a Combined prevention strategy for HIV and carry out this strategy in Alto Paraná- In the Regional Hospital of Ciudad del Este, which corresponds to another HIV testing service and treatment of HIV infection)
PHASE III OF IMPLEMENTATION: determine feasibility that a community service previously enabled by the MSP can initiate the strategy, corresponding to a related service for key population groups.

3. Services prepared to offer PrEP

1. **Validation of clinical protocols and** standardized work procedures
2. **Human Resources Training.**

Health personnel will be trained in the relevant standard operating procedures before they are implemented. Training of human resources before the implementation of the strategy. Initial training for all health care workers can help sensitize staff to HIV prevention, present reasons for offering PrEP and supporting evidence, as well as the needs of some specific population groups, and cover aspects such as safety (including the use of PrEP in pregnancy), conducting the necessary tests before starting PrEP, monitoring PrEP users, counselling tools and approaches, etc. The training program would also include mentoring, support, supervision, and refresher courses.

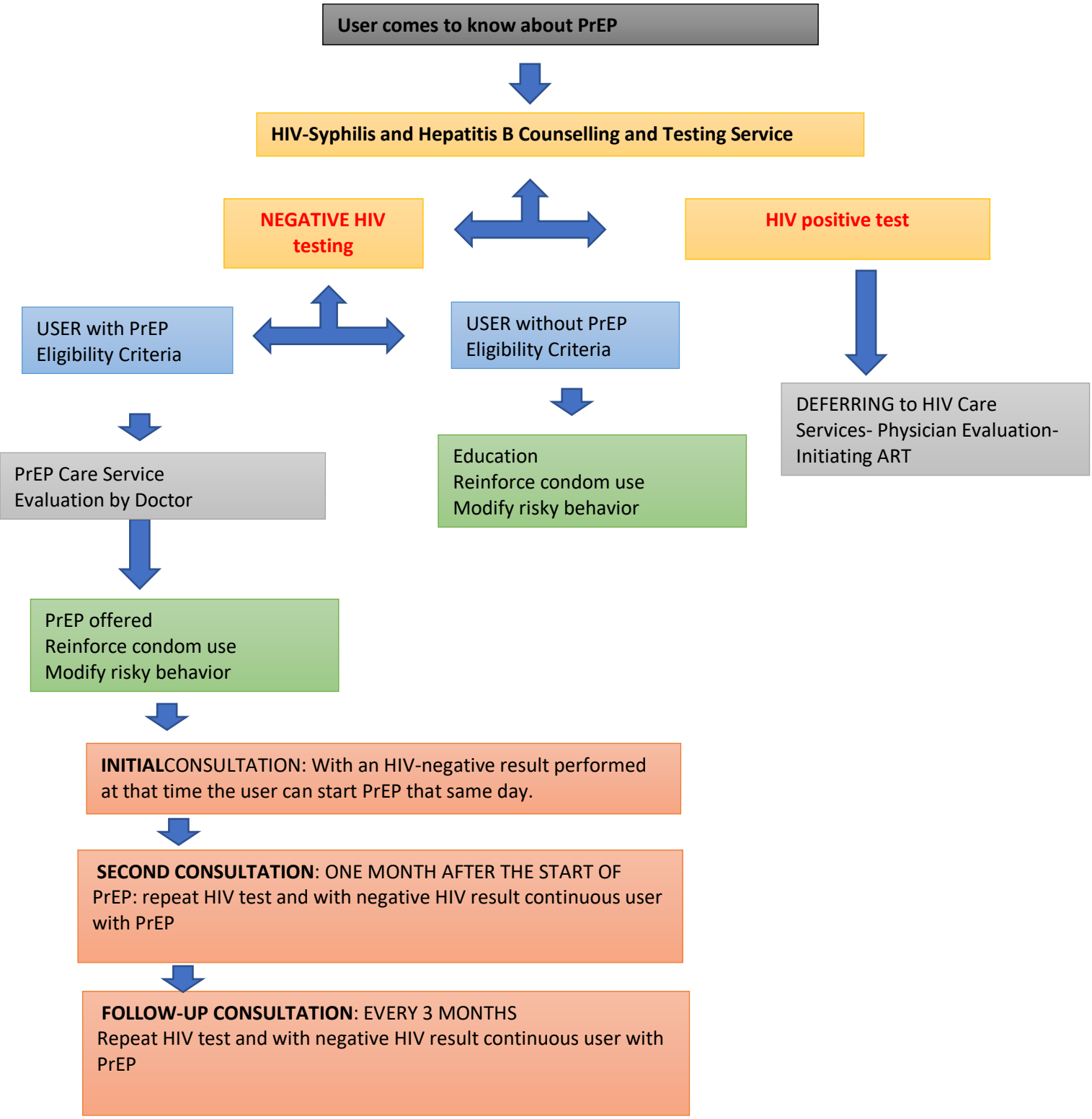
3. **Human resources:**

RESOURCES	**TASK**
Counsellors	They can offer PrEP to those at substantial risk of HIV infection from the key population who come to request HIV testing.

	The user can go directly looking for PrEP, the counselor will evaluate the substantial risk of the user for the start
Peer promoters	Support education programs that provide basic information about PrEP and other HIV prevention options, and how to recognize the risk of HIV infection. HIV. Support accession strategies.
Doctor	users of key population and with substantial risk will be evaluated by the Physician determining the risk calculation according to the type of population that has the eligibility criteria. It will be responsible for carrying out a structured history, which includes sexual habits, the history of use of drugs and medical history; complete the forms, request the laboratory tests specified in the clinical protocol, screen for infections of sexual transmission (STI). Also, provide advice on the use of PrEP and adherence to the Family planning and contraception, STIs and hepatitis B vaccination.

4. User Selection Algorithm to Deliver PrEP

The user of the key population who enters the counseling service to request an HIV test or is offered the test will be subjected to PrEP eligibility and if eligible will be offered such a strategy. In turn, a user who wishes to start will be subjected to the eligibility criteria and with the result of a negative HIV rapid TEST will be directed to the medical consultation in order to start PrEP.


User comes to know about PrEP
HIV-Syphilis and Hepatitis B Counselling and Testing Service
NEGATIVE HIV testing
HIV positive test
USER with PrEP Eligibility Criteria
USER without PrEP Eligibility Criteria
DEFERRING to HIV Care Services- Physician Evaluation- Initiating ART
PrEP Care Service Evaluation by Doctor
Education
Reinforce condom use
Modify risky behavior
PrEP offered
Reinforce condom use
Modify risky behavior
INITIALCONSULTATION: With an HIV-negative result performed at that time the user can start PrEP that same day.
SECOND CONSULTATION: ONE MONTH AFTER THE START OF PrEP: repeat HIV test and with negative HIV result continuous user with PrEP
FOLLOW-UP CONSULTATION: EVERY 3 MONTHS
Repeat HIV test and with negative HIV result continuous user with PrEP

Each consultation must be registered in the SEPRONASIDA system in order to have data on the strategy which must be completed by the doctor in each consultation. Psychological and social assistance follow-up will be carried out in order to reinforce adherence.
The Oral PrEP Schedule administered by the MSP-BS through PRONASIDA contains tenofovir disoproxil fumarate (TDF) associated with Emtricitavin (FTC) as an additional prevention option for people at significant risk of HIV infection, as part of a combined prevention approach

5. Monitoring to deliver PrEP

PrEP indicators

1. Percentage of eligible individuals who started oral antiretroviral PrEP in the past 12 months.
Numerator: The number of people who started oral PrEP in the past 12 months. Denominator Number of people who were recently offered PrEP in the past 12 months.
Breakdown • People who received PrEP for the first time in their lives • Age (15-19; 20-24; 25-49 and 50+ years) • Gender (Male, Female, Trans) • Population Type (MSM, TRANS, UD, PPL, Serodiscordant) • Health Regions

2. Percentage of PrEP users who continue with PrEP for 3 consecutive months after starting PrEP in the last 12 months-
Numerator: Number of people who continue with PrEP for 3 consecutive months after starting PrEP in the last 12 months Denominator: Number of people who started PrEP in the last 12 months.
Breakdown • People who received PrEP for the first time in their lives • Age (15-19; 20-24; 25-49 and 50+ years) • Gender (Male, Female, Trans) • Population Type (MSM, TRANS, UD, PPL, Serodiscordant) • Health Regions

3. Percentage of people who tested positive for HIV among people who received PrEP at least once in the past 12 months and had at least one follow-up HIV test
Numerator Number of people who had a positive HIV follow-up test among people who received oral PrEP at least once in the past 12 months. Denominator Number of people who received oral PrEP at least once in the past 12 months and who had at least one follow-up HIV test.
Breakdown • People who received PrEP for the first time in their lives • Age (15-19; 20-24; 25-49 and 50+ years) • Gender (Male, Female, Trans) • Population Type (MSM, TRANS, UD, PPL, Serodiscordant)

- Health Regions

SEPRONASIDA SYSTEM TEMPLATES TO COMPLETE TO PREP USER

01. First Consultation Form for PrEP

1. What**motivated you to seek PrEP care?** ○I was ed by a health professional/other service ○Own decision / internet / friend ○I received guidance from an NGO	**2. Have you used PrEP medications before?** ○ Not ○ YES	**2. a.** If so, for how long?_____months. **2.b. C** uando was the last dose: _____ day/month/year

Risk Assessment Criteria **for PrEP Use**

3. Have you**had any risk exposure to HIV in the past 72 hours? If yes, evaluate PEP.** ☐ No Yes, unprotected sexual intercourse Yes, for sexual violence ☐☐ ☐ Yes, when sharing a syringe and/or needle Yes, by piercing or cutting accident☐	**3. a** Howmany times have you used PEP in the**past 12**months? (Enter amount, inclusive if it is 0)

4. In**the last 6 months have you had sex with how many people? (Enter the amount in all fields, even if it is 0)**
( ) Men ( ) Women ( ) TRANS Person

5. In the past 6 months, have you had sex WITHOUT a condom in any of these **options? (Check all applicable)**

☐ Anal Insertive (penetrate the anus) Anal Receptive (being penetrated into the anus) ☐☐ Vaginal Insertive (penetrating the vagina)

6. How many times a week have you had sex:
○< 2 times and cans plan it (Consider Intermittent PrEP)
○< 2 times and can't plan for it (Consider Continuous PrEP)
○ >2 times (Indicate continuous PrEP).

7. In the last 6 months, have you had sex WITHOUT a condom with **an HIV+ person with detectable or untreated CV?**

8. In the last 6 months you have used for more than 25 days, or what is equivalent, one day per week or more drugs such as cocaine or crack, ecstasy or others other than marijuana? ○No Yes○

9. In the past 6 months, have you accepted money, valuables, drugs, or services in exchange for sex? ○No Yes○

10. In the past 6 months, have you had or have any symptoms or been diagnosed with any Sexually Transmitted Infections (STIs)? (Check applicable options) No) ☐☐Yes, syphilis ☐Yes, Gonorrhea ☐Si, Chlamydia

☐ Ulcers in the vagina / penis Ulcers in the anus ☐
☐Vaginal,anal, or urethral discharge of a different color, with a bad smell or itching
☐ Warts on the vagina / penis
☐ Verrugas in the anus

11. If you are a woman, ReproductivePlanning?	**12.** Are youpregnant? ○No Yes Not applicable○○

Potential exclusion criteria for PrEP use

13. In**the last 30 days have you had any episodes of fever, adenopathies, sore throat and rash?** (If so, consider not initiatingr PrEP and investigar acute viral infection with CV) ○No Yes○

14. Do you**have** a history of bone fracture unrelated to **the trauma?** ○No Yes ○○You don't know

15. Do you**have a history of kidney disease?** ○No Yes ○○You don't know

Eligibility Test	Date of analysis	Result of the Examination
16. Rapid HIV test **performed today** **17. Syphilis Rapid Test Performed Today** **18.HB Rapid Test Conducted Today**	**Automatic**	○ Reactive ○ Non-Reactive ○ Reactive ○ Non-Reactive ○ Reactive ○ Non-Reactive

19. Vaccination for Hepatitis B: ○Full application (3 doses recorded on the vaccine card) Aimed at vaccination Analysis is○○ requested

20. Conduct of the Attention Service:
○Start PrEP and request exams *(see list of exams* in the reverso)*
○ Start PEP

<table>
<tr><td colspan="3">O Suspected Acute Infection Wait CV
O Not eligible for PrEP</td></tr>
<tr><td>21. Prescription: TDF/FTC for 30 daysO
Prescription Date:
___/_____/_____
_____</td><td>22. Discuss PrEP Dosage Options:
OGo on
OIntermittent
ALARM Remember to bring bottles of medicine</td><td>23. Sign thePrEP Strategy Access InformedConsent. Attached-</td></tr>
</table>

02- File 2nd consultation 1st month – PrEP

POTENTIAL EXCLUSION CRITERIA FOR THE USE OF PREP		
1. **In the last 30 days have you had any episodes of fever, adenopathies, sore throat and rash?** (If so, investigar acute viral infection with CV) No ○Yes○		
PrEP-related ADVERSE EVENTS		
2. Since the last visit have you felt any discomfort or discomfort related to the use of PrEP? ☐No ☐Yes, diarrhea ☐Yes, nausea Yes, vomiting Yes, abdominal pain Yes, other ☐☐☐ specify.....		
SELF-REPORT OF ADHESION		
3. How many PrEP pills have you taken in the month? ( ) number of pills (0 to 30) If it is continuous and takes less than 21: Reinforce Adhesion. If you are on Flashing and take more than 20: Recommend moving to Continuous ALARM		
4. If you take intermittently, how many risky situations did you have without having taken the pill in the month? Number () Alarm If you have more than 1 reinforce adhesion		
5. What was the main reason you stopped taking PrEP pills? ☐I have not stopped taking ☐them Forgetfulness ☐Travel / Away from home The drug is ☐over Adverse ☐effects ☐Other:		
RESULT OF SCREENINGS		
TESTS	**Date of completion**	**RESULT OF THE EXAMINATION**
6. Elisa test for HIV		○Reactive ○ Non-Reactive
7. Was the diagnosis of Active Syphilis confirmed?		○No ○Yes
8. Chlamydia Identification		○No ○Yes ○Not realized/ No disisponible
9. Identification of Gonococo		○No ○Yes ○Not done/ Not available
10. Test for Hepatitis A (GI G)		○Non-Reactive ○Reagent ○ Not Performed
11. Quantitative Anti-HBs Sorology		○Equal to greater than 10 IU/mL○ No realized ○No detectable less than 10 IU/mL
12. Hepatitis C (Anti-HCV) Test		○Reactive ○Non-Reactive ○ Not realized
13. Presence of protein in plain urine		○Absence ○Presence ○Not Realized
14. Laboratory Routine (Blood Count and Hepatogram)		○Normal ○Changed In ○realized

15. Serum Creatinine From Screening		**Value**
16. HIV Viral Load Outcome		○Detectable ○Not realized ○Undetectable

Security Exams	**Date of analysis**	**Result of the Examination**
17. Today's RAPID HIV Test		○Reactive Non-Reactive ○
19. Weight (kg)		_____kg
20. *Estimated Creatinine *Clearence* calculation calculated automatically		○ < 60 ml/min ○ ≥ 60 ml/min

*Suggestion to calculate Creatinine = [((140 – Age) x Weight(kg)) / (Serum Creatinine x 72)]. If you are a woman, multiply by 0.85. If the creatinine *clearence* < 60ml/min, DO NOT indicate PrEP. .

21. Vaccination for Hepatitis B: ○1st dose ○2nd dose Full Application ○(3 doses recorded on the card) ○Not applied

FINAL CONDUCT

22. Will the user continue to use PrEP?
○Yes,continue continuously
○Yes, continue intermittently
○ No, due to reactive HIV test, request CV and resistance test, direct to treatment
○ No, due to Cl Cr < 60
○ No, due to low adherence to the drug
○ No, due to adverse events
○ No, by decision of the user
○ No, due to suspicion of acute viral infection, request CV

Reminder: Request for the next consultation: rapid HIV test - VDRL

23. Prescription for PrEP: TDF/FTC suitable for ○30 days (if low adherent) ○60 days

03 - MonitoringSheet(PrEP)

RISK ASSESSMENT ASSOCIATED WITH HIV INFECTION
1-**In the last 30 days have you had any episodes of fever, adenopathies, sore throat and rash?** (If so, investigate acute viral infection with CV) ○No Yes○
2-In the last 3 months, have you had or have any symptoms or been diagnosed with a Sexually Transmitted Infection (STI)? (Check applicable options) No) Yes, ☐☐ syphilis ☐Yes, Gonorrhea ☐Si, Chlamydia ☐ Ulcers in the vagina / penis Ulcers in the anus ☐ ☐ Vaginal or urethral discharge of a different color, with a bad smell or itching ☐ Warts on the vagina / on the penis ☐ Verrugas in the anus
3- In the last 3 months have you had sexual intercourse with how many people? (Enter the amount in all fields, even if it is 0) ( ) Men ( ) Women ( ) TRANS person ( )
4- In the last 3 months, have you had sex WITHOUT a condom in any of these **options? (Check all applicable)** ☐ Anal Insertive (penetrate the anus) Anal Receptive (being penetrated into the anus) ☐☐ Vaginal Insertive (penetrating the vagina) ☐ Receptive Vaginal (being penetrated into the vagina)
5. In the last 3 months you have used for more than **25 days, or what is equivalent, one day per week or more drugs such as cocaine or crack, ecstasy or others other than marijuana?** ○No Yes○
PrEP-related ADVERSE EVENTS
6-Since the last visit have you felt any discomfort or discomfort related to the use of PrEP? ☐No ☐Yes, diarrhea ☐Yes, nausea Yes, vomiting Yes, abdominal pain Yes, other ☐☐☐ specify.....
6-a. If so, do those sign(s) or symptom(s) persist at this visit? ○No Yes Not applicable○○
SELF-REPORT ABOUT ADHERENCE
7. How many PrEP pills have you taken in the month? ( ) number of pills (0 to 30) If it is continuous and takes less than 21: Reinforce Adhesion. If you are on Flashing and take more than 20: Recommend moving to Continuous ALARM
8- If you take intermittently, how many risk situations did you have without having taken the pill in the month? Number () Alarm If you have more than 1 reinforce adhesion
9. What was the main reason you stopped taking PrEP pills? ☐I have not stopped taking ☐them Forgetfulness ☐Travel / Away from home The drug is ☐over Adverse ☐effects ☐Other:

Follow-up exams	Date of collection	Results of the Quarterly Exams
10. Was the diagnosis of Active Syphilis confirmed?		○ No Yes○
11. Chlamydia Identification (quarterly)		○ No Yes ○○ Not Realized/Unavailable
12. Identification of Gonococo (quarterly)		○ No Yes ○○ Not Realized/Unavailable
13. Test for Hepatitis C (Anti-HCV) (1 time a year)		○ Non-Reactive Reagent○○ Not Performed

14. Proteins in plain urine (6 months)		○ Absence Presence ○○ Not Realized
15. Blood count and hepatogram (according to clinical criteria)		○ Normal Changed ○○ In realized
16. Creatinine (every 6 months)		Value
Security Exams		**Result of the Examination**
17. Today's Rapid HIV Test		
18. Weight (kg)		_____Kg
19. *Estimated Creatinine *Clearence* calculation: **automatic**		○ < 60 ml/min ○ ≥ 60 ml/min
*Suggestion to calculate CICr = [((140 – Age) x Weight(kg)) / (Serum Creatinine x 72)]. If you are a woman, multiply by 0.85. If the creatinine *clearence* ≤ 60ml/min, it is NOT elegivel for PrEP.		
20. Vaccination for Hepatitis B: 1st dose ○○2nd dose Full Application ○(3 doses recorded on the card) **○Not applied**		
FINAL CONDUCT		
21. Will the user continue to use PrEP? ○ Yes No, due to reactive HIV test No, due to change in other tests No, due to low○○○to adherence to the drug ○ No, due to adverse events No, by user decision No, due to suspicion of acute viral infection○○		
22. Prescription for PrEP: TDF/FTC suitable for ○**30 days 90 days**○		

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