STANDARD OPERATING PROCEDURES

Pre-Exposure Prophylaxis (PrEP) Facility Record

Purpose: Document and track clients initiated on PrEP

For whom: All clients initiated on PrEP

When to use: After completing the PrEP Screening for Substantial Risk and Eligibility form

Responsible staff: Healthcare worker who is initiating the client on PrEP

Source document: Completed with the client; PrEP Screening for Substantial Risk and Eligibility form

DESCRIPTION OF VARIABLES

The PrEP Facility Record is completed with the client. Consult the PrEP Screening for Substantial Risk and Eligibility form and client's medical record when indicated below.

- **Date:** Date this form is completed, day (dd), month (mm), and year (yyyy); e.g. 30/04/2018
- **Person Completing Form:** First and last name of the healthcare worker completing this form

A. FACILITY INFORMATION

- **Facility Name:** Name of the facility
- **District:** District where the facility is located
- **Date of Initial PrEP Client Screening Visit:** Date that the client was screened for PrEP eligibility, from the PrEP Screening for Substantial Risk and Eligibility form: day (dd), month (mm), and year (yyyy)
- **PrEP Client Number:** Unique number assigned to the client when he or she accepts PrEP. If no PrEP-specific number is assigned, leave this space blank.

B. CLIENT DEMOGRAPHICS

- **First/Given Name:** Client's first (given) name
- **Middle Name:** Client's middle name (if any)
- **Surname:** Client's surname or family name
- **Address:** Client's current address (where the client lives now)
- **Telephone:** Client's primary telephone number

- **Telephone (alternative):** Any other number (if any) that may be used to contact the client
- **Date of Birth:** Day (dd), month (mm), and year (yyyy)
- **Age** *(years)***:** Client's age at most recent birthday, in years
- **Client ID Number:** Number assigned to the client at clinic registration
- **Marital Status:** Ask the client and tick the box for the client's current legal status: Single, Married, Divorced, Widowed, Separated, or No response.

C. SEXUAL AND DRUG INJECTION CORE RISK CLASSIFICTION

- **1. Do you consider yourself: male, female, transgender, or other?** Client's current gender as self-identified by the client, regardless of the client's sex at birth. Consult the PrEP Screening for Substantial Risk an Eligibility form and tick the appropriate box. If Other, specify in the space provided.
- **2. What was your sex at birth?** Ask the client's sex at birth and tick Male, Female, Other (specify in the space provided), or No response.
- **3. Do you have sex with:** Ask the client and tick the appropriate box: Men only, Women only, Both men and women, or No response.
- **4. Have you exchanged sex as your main source of income in the last 6 months?** Ask the client if her or his main monetary or non-monetary source of income comes from sex work and tick the appropriate box: Yes, No, or No response.
- **5. In the last 6 months, have you injected illicit or illegal drugs?** Ask the client and tick the appropriate box: Yes, No, or No response.
- **6. Are you incarcerated?** Ask the client and tick the appropriate box, Yes, No, or No response.

D. KEY POPULATION CLASSIFICATION

- Use information from section C to determine the client's key population classification(s). For example, if the client answers "Male" to section C question 1, and answers "Men only" or "Both men and women" to section C question 3, categorize the client as "MSM." Then tick the right-hand box AND the box for MSM in the Final Classification column.
- Repeat this process for the transgender (TG), sex worker (SW), person who injects drugs (PWID, and person in prison (PP) classifications, ticking both the right-hand boxes AND the boxes under the Final Classification column.

E. IF FEMALE: PREGANCY AND BREASTFEEDING

- **Client currently pregnant?** Ask the client for the date of her last normal menstrual

period and do a pregnancy test if needed. Tick Yes or No.

- **Client currently breastfeeding?** Ask the client if she is currently breastfeeding and tick Yes or No.

F. BASELINE LABORATORY TESTS

Consult the client's medical record and/or PrEP Screening for Substantial Risk and Eligibility form for all baseline laboratory tests.

- **Date of last HIV test:** Date of the client's last HIV test; day (dd), month (mm), and year (yyyy)
- **Date of creatinine test:** Date the client's baseline serum creatinine test was performed; day (dd), month (mm), and year (yyyy). If the test not done, tick Not done.
- **Calculated creatinine clearance (CrCl):** Write the result. If the test was not done, tick Not done.
- **Date of creatinine clearance:** Date that the client's creatinine clearance was determined; day (dd), month (mm), and year (yyyy)

G. HEPATITIS B TESTING, VACCINATION, AND TREATMENT

Consult the client's medical record where appropriate.

- **Date of HBsAg test:** Day (dd), month (mm), and year (yyyy). If the facility does not offer hepatitis B testing, leave the test date blank.
- **Test result:** Tick Negative, Positive, or Not Done
- **If positive, is client on treatment?** Tick the appropriate box according to client's report. Yes = client is initiated on Hepatitis B treatment; No = client is not initiated on Hepatitis B treatment; Unknown = client does not know.
- **If negative, dates HBV vaccination provided** *(if available)***:** Record the 1st, 2nd, and 3rd dates of the client's HBV vaccinations, day (dd), month (mm), and year (yyyy). If vaccinations are not provided, tick Not done.

H. SEXUALLY TRANSMITTED INFECTIONS (STI)

Consult the client's medical record where appropriate.

- **STI symptom screen date:** Day, (dd), month (mm), and year (yyyy)
- **Result** *(see codes)***:** Write the appropriate codes: U = Urethral discharge; G = Genital ulcers or lesions; V = Vaginal discharge; I = Itching; L = Lower abdominal pain (women only); S = Scrotal swelling; B = Bubo in inguinal area; D = Dysuria (pain with urination); P = Pain with intercourse (women only); O = Other (specify in the space provided). If screening was not done, tick Not done.
- **If STI syndromic management, syndrome treated** *(see codes)***:** Write all codes that

apply: GUS = Genital ulcer syndrome; VDS = Vaginal discharge syndrome; LAP = Lower abdominal pain; MUS = Male urethritis syndrome; SSW = Scrotal swelling; O = Other (specify in the space provided).

- **STI treatment start date:** Day (dd), month (mm), and year (yyyy). If the client has not started STI treatment, tick Not started treatment.

I. INITIATION OF PrEP TREATMENT

- **PrEP start date: Date initiated:** Date the client was started on PrEP at the facility, day (dd), month (mm), and year (yyyy).
- **PrEP (ARVs) prescribed:** Tick the client's PrEP regimen or tick Other and specify the regimen prescribed in the space provided.
- **PrEP discontinued:** Complete this section if the facility clinician stops PrEP or is informed that the client has stopped PrEP. **Date discontinued:** Record the date that discontinuation was documented by the facility, day (dd), month (mm), and year (yyyy).
- **Reasons for stopping PrEP:** Ask the client and tick all reasons given: Tested HIV+; No longer at substantial risk; Side effects; Client preference; Abnormal creatinine result; and/or Other (specify in the space provided).
- **HIV status at time of discontinuation:** Tick Negative, Positive, or Unknown.

I. Continued: RE-START PrEP TREATMENT

Complete this section for clients who discontinued PrEP but have decided to re-initiate at a later date. When the client decides to re-initiate PrEP, another PrEP Screening for Substantial Risk and Eligibility form is completed.

- **PrEP re-start date:** Write the **Date re-started** on PrEP, day (dd), month (mm), and year (yyyy).
- **PrEP (ARVs) prescribed:** Tick the client's PrEP regimen or tick Other and specify the regimen prescribed in the space provided.
- **PrEP discontinued:** Complete this section if the facility clinician stops PrEP or is informed that the client has stopped PrEP. **Date discontinued:** Record the date that discontinuation was documented by the facility, day (dd), month (mm), and year (yyyy).
- **Reasons for stopping PrEP:** Ask the client and tick all reasons given: Tested HIV+; No longer at substantial risk; Side effects; Client preference; Abnormal creatinine result; and/or Other (specify in the space provided).
- **HIV status at time of discontinuation:** Tick Negative, Positive, or Unknown.

J. TRANSFER OUT, DEATH, AND LOSS TO FOLLOW-UP

Leave this section blank unless the client transfers out, is lost to follow-up, or dies. Consult the client's medical record where appropriate.

- If the client transfers out, tick **Transferred out (TO)**, write the **date TO,** day (dd), month (mm), and year (yyyy), e.g. 30/04/18. Write the **Name of facility transferred to** in the space provided.

- If the client dies, tick **Died** and write the **Date of death**, (dd), month (mm), and year (yyyy).

- Tick **Lost to follow-up (LTFU)** if the client is lost to follow up, i.e. the client has missed a PrEP follow-up appointment by more than 90 days. Write **Date confirmed LTFU,** day (dd), month (mm), and year (yyyy).

PrEP FOLLOW-UP VISITS

Clients started on PrEP will be followed at 3-month intervals after the 1st month on PrEP. Complete this section during each follow-up visit. Use one column for each follow-up visit. Use the Provider Checklist for Follow-Up PrEP Visits as a guide for conducting follow-up visits.

- **Date of visit (starting with screening visit):** Date the client attends the appointment, day (dd), month (mm), and year (yyyy)

- **HIV test:** Tick the HIV **Test result**, Negative or Positive or Inconclusive. Write the tests used in the spaces provided for First HIV test and Confirmatory test.

- **Signs and symptoms of acute HIV infection?** Assess for acute HIV infection and tick Yes or No.

- **Side effects:** Ask the client if he or she has experienced any side effects from the PrEP medication and write all codes (listed on the bottom of the form). If the client has no side effects, write a dash in the space. A = Abdominal pain; S = Skin rash; Nau = Nausea; V = Vomiting; D = Diarrhea; F = Fatigue; H = Headache; L = Enlarged lymph nodes; R = Fever; and O = Other (specify in the space provided).

- **CrCl calculation:** Record the client's serum creatinine and calculated creatine clearance (baseline and every six months).

- **Risk reduction counseling and commodities provided?** Tick box to indicate that risk reduction counseling and commodities have been provided.

- **PrEP prescription:** Tick the client's PrEP regimen or tick Other and specify the regime in the space provided.

- **Next scheduled visit date:** Date of the client's next appointment, day (dd), month (mm), and year (yyyy)

- **Additional notes**: Write any other lab investigations or clinical findings in the space provided.