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[Home](#) > [Resources](#) > [AIDSFree Guidance Database](#) > [HIV Post-Exposure Prophylaxis Guidance Database](#) >

Zimbabwe

The following provides a summary of specific guidelines from the country's national guidance strategy. Use the jump links in yellow to access details on criteria for starting PEP, evaluation of risk, recommended prophylaxis, and follow-up screening recommendations by patient population. This summary can be downloaded or e-mailed to yourself or a colleague. The original country guidance document can also be downloaded.

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Suggest Updates

- [Occupational Exposure](#)
- [Rape or Sexual Assault](#)
-  [Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe \(PDF / 3 MB\)](#)

Occupational Exposure

Year Issued:

2013

Criteria for Starting PEP:

The following types of exposures should be considered for post - exposure prophylaxis:

- Needle-stick injury or injury with a sharp object used on a patient
- Mucosal exposure of the mouth or eyes by splashing fluids
- Broken skin exposed to a small volume of blood or secretions such as may occur with sexual abuse
- Sexual assault (rape)

Evaluation of Risk:

Low risk:

- Solid, such as surgical needle, superficial exposure on intact skin
- Small volume (e.g., drops of blood) on mucous membranes or non intact skin
- Source patient asymptomatic or with VL less than 1,500 copies/ml

High risk:

- Large-bore needle, deep injury
- Large-volume splash on mucous membranes or non intact skin
- Source patient symptomatic or with high VL levels

If source patient is HIV-negative, no further post-exposure prophylaxis is necessary for the exposed health worker. There will be need to consider exposure to other infections such as hepatitis B.

If the exposed health worker is HIV-positive, no further post-exposure prophylaxis is necessary for the

health worker. The health worker should be referred for further counseling and the long-term management of his or her HIV infection, which would have occurred prior to the exposure.

If the health worker is HIV-negative and the source patient is HIV-positive, continue ARVs for a period of one month; repeat the health worker's HIV tests at three months and at six months after the initial test. If the health worker should seroconvert during this time, provide appropriate care and counseling and refer for expert opinion and long-term treatment.

If it is not possible to determine the HIV status of the source patient, then assume that the source is positive and proceed according to the guidelines.

Recommended Prophylaxis:

Wash the exposed area thoroughly with soap and water.

Rinse the eye or mouth with plenty of water if contaminated.

Adults: Zidovudine + Lamivudine +Atazanavir/ritonavir for one month.

Children

> 40 kg and/or > 6 yrs: TDF/3TC + ATV/r

< 40 kg and/or < 6 yrs: AZT/3TC + LPV/r

Special note

All health care workers on atazanavir/ritonavir should have a baseline liver function test and a repeat at two weeks. If there is any derangement in transaminases urgent advice must be sought. Please note that atazanavir causes hyperbilirubinaemia which is a normal part of treatment. Patients on atazanavir may develop a rash. If this happens urgent advice must be sought. If a health care worker is on Zidovudine, a baseline full blood count should be done. It should be repeated at two weeks.

Follow-up Screening Recommendations:

Repeat the health worker's HIV tests at three months and at six months after the initial test.

In Accordance with WHO 2014 PEP Recommendations?:

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Rape or Sexual Assault

Year Issued:

2013

Recommended Prophylaxis:

It is recommended that a victim of rape or sexual assault presenting within 72 hours of exposure be counseled and provided with the medicines recommended for post-occupational exposure prophylaxis. It is important to try to determine the HIV status of the perpetrator. If that is not possible, it may be assumed that the perpetrator is HIV – positive, and the victim is provided with the treatment as listed in the preceding section. Refer the client to the nearest support centre for sexual assault survivors.