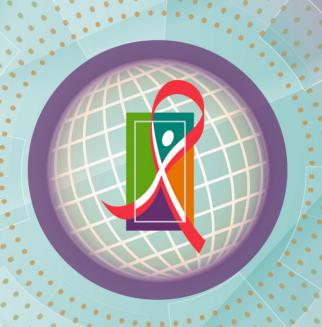
15th International Conference on HIV TREATMENT AND PREVENTION ADHERENCE

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Optimizing the PrEP Continuum: Solutions for Low PrEP Uptake

PrEP



UNAIDS Fast-Track Targets

What Model Assumed



90% key population covered



90% of AGYW (key locations)



>6bn condoms (SSA) per year



3m PrEP



5m VMMC per year



- Funding (additional \$6.5bn per year)
- Testing, treatment, virologic suppression in PLHIV worldwide: 90-90-90

What Was Implemented



47% for sex workers
33% for gay
men & other MSM
32% for PWID*



34% of AGYW in key locations covered**



<3bn condoms (SSA)*** per year



Approx 385,000 PrEP****



4.1m VMMC per year in 2018



- Flat funding
- Testing, treatment, virologic suppression in PLHIV worldwide: 79-78-86 with large disparities

Low PrEP Uptake



- Lack of awareness about PrEP
- HIV risk misperception
- Non adapted delivery models
- Accessibility (geographical, financial, ...)
- Myths, misconceptions and fears about potential side effects and risk of resistance
- Stigma and discrimination

Lack of awareness about PrEP

- From eligible individuals (key populations) and healthcare providers
- Lack or limited knowledge about PrEP
- PLHIV not aware of PrEP (partners)
- Prescribing rate of PrEP linked to awareness of PrEP for healthcare providers

HIV risk misperception



• Individuals:

- ✓ Underestimation of HIV acquisition risk documented in several studies
- ✓MSM, transgenders, women experiencing GBV, adolescents, mental health disorders

Health Care Providers:

- ✓Insufficient ascertainment of HIV risk
- ✓ Inconsistent knowledge about sexual orientation and sexual practices
- ✓ Personal biases and discomfort to openly discuss sexuality with clients

PrEP related stigma



- PrEP shaming: "Truvada whores", "PrEP whores"
- Confusion between PrEP for prevention and ARVs for treatment
- Fear of risk compensation and STIs surge by Health Care Workers
- Criminalization (MSM, sex work, drug use...)
- And "The usual suspects": stigma related to HIV, AIDS, homosexuality, sex work...

Non adapted delivery models

- Limitations of the conventional healthcare system model
 - ✓ Distrust
 - √ High burden of work
 - ✓ Non flexible operating hours
 - ✓ Lack of adequate training for HCP
 - √ Stigma
- Logistical barriers
- Financial accessibility

Client and Provider Education



- Wide diffusion of PrEP information
- PrEP promotion among potential users and Health Care providers (internet, dating apps, client advocates, peer navigators...)
- Providing adequate training for HCP
- Addressing Health Care Providers fears and misconceptions about PrEP
- Introduction of PrEP and combined prevention in medical/ paramedical studies
- Stigma-reduction activities

Improving accessibility



- Adopting the community model
- Extending access to PrEP
- Using old and innovative technology
- Improving integration of PrEP services with STI screening
- Addressing socio-economical vulnerabilities

Community mobilization



- Community initiation, dispensation and follow up of PrEP
- Community involvement in whole process (planning, design, service provision, evaluation...)
- Role models and leadership
- Involvement in research and research gaps filling

Impact of COVID-19



- Dramatic reduction of PrEP uptake* :
 - Behavioural change (reduction of sexual activity and partner numbers)
 - Mobility restrictions (lockdowns, travel restrictions...)
 - Concern about COVID-19

Risk of an upswing in HIV transmission

Impact of COVID-19



- Switching services to telemedicine or phone/WhatsApp services "TelePrEP"
- Alternative modes of PrEP drugs delivery (outreach, courier, by hand delivery...)
- Forgoing/delaying routine lab testing
- Re-organizing services (PPE, physical distancing, limitation of the number of clients...)

CONCLUSION

