

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

### What Was Implemented

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  - 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
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  - 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

