GGD
Amsterdam

STI incidence and program retention among priority populations in the National PrEP Pilot in Amsterdam, the Netherlands

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Disclosures

- None

Background

- National PrEP pilot (NPP): August 2019 –2024
- Capacity reached; prioritisation based on anticipated barriers to care

People under 25 years

Trans and gender diverse (TGD) persons

Sex workers

People without health insurance

People who migrated from a low- or middle-income country (LMIC)

Research questions

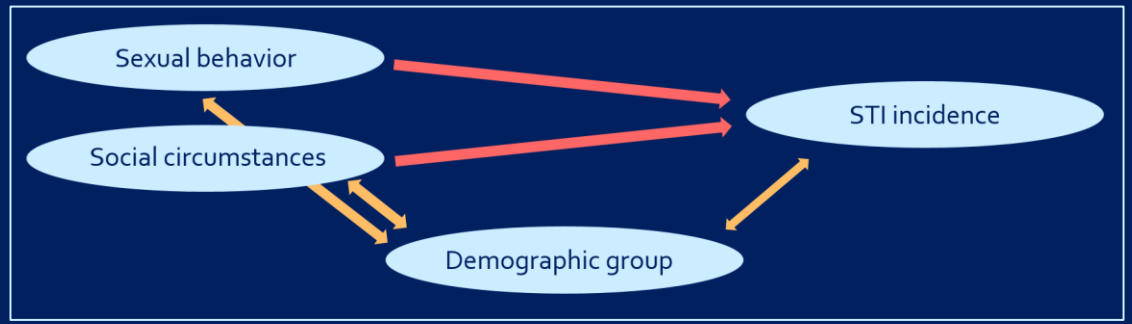
Among people with ≥1 PrEP visit in the National PrEP program in Amsterdam (July 2019-February 2023):

1) **How many people belong to these demographic priority populations?**

1) **Are there differences in STI incidence and program retention** between people who do and do not belong to demographic priority populations?

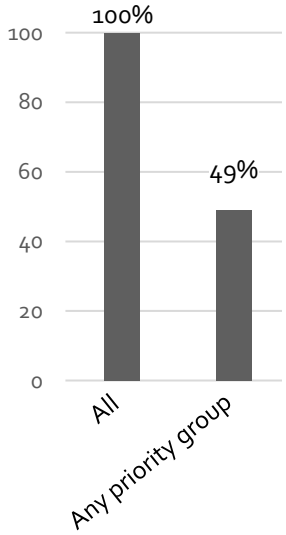
Disclaimer

- Identity is ***not a causal risk*** factor for STI incidence or retention!
- Sexual behavior and social circumstances (most likely) are
- Routine measures of behavior and social circumstances are imperfect
- Identity / demographic group can be a ***meaningful confounder*** to point out areas for further investigation



How many people belong to priority groups?

- N=4,061 people with ≥1 PrEP pilot visit in Amsterdam



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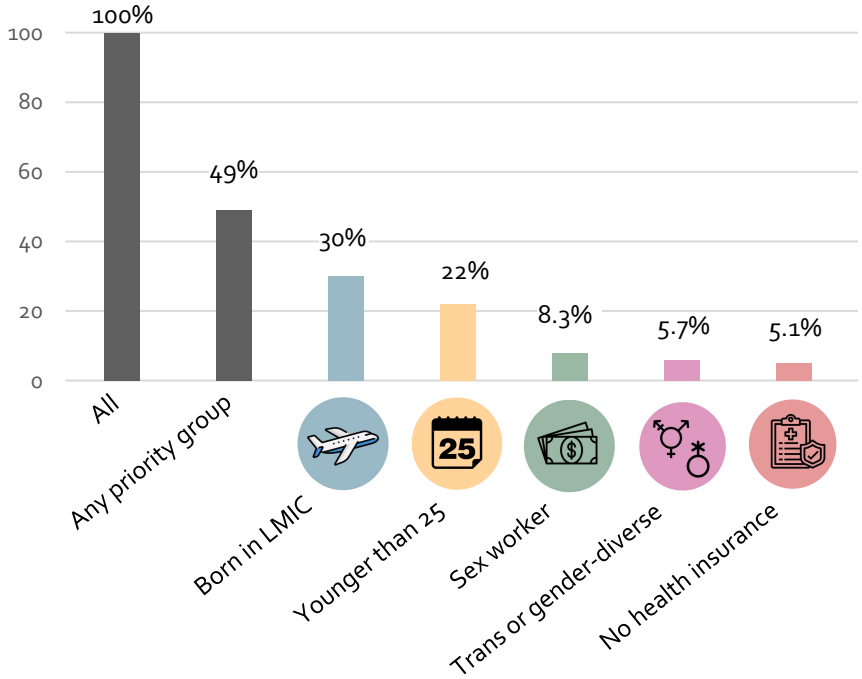

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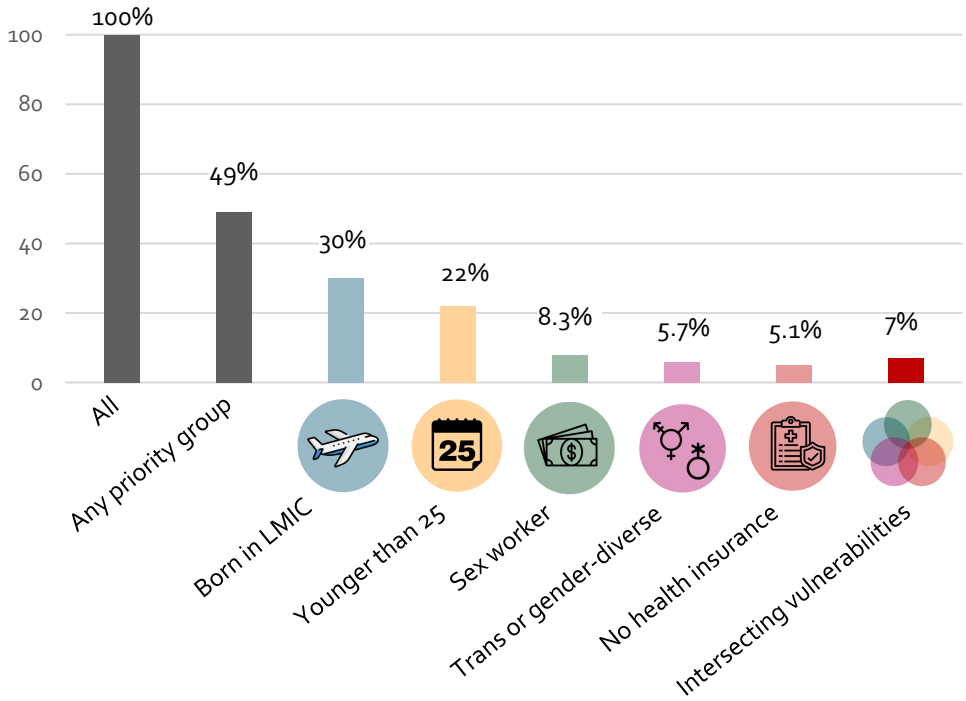

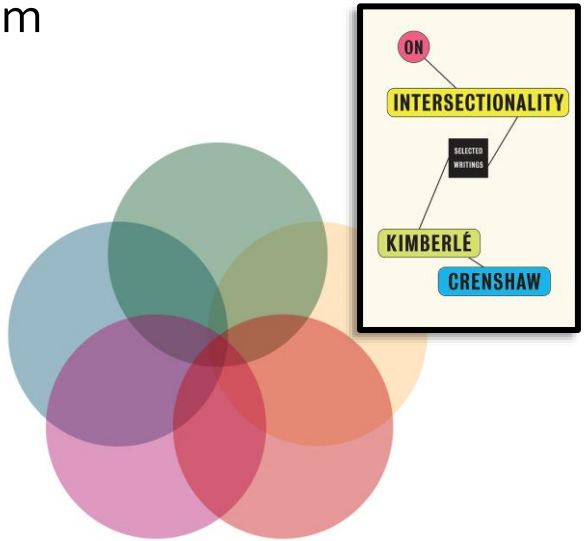

N=302 sex workers from LMIC
- Half are trans or gender-diverse
- Half have no health insurance

Incidence of sexually transmitted infections (STIs)

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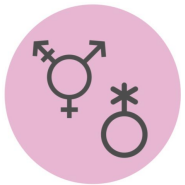
STI incidence

Incidence rate (IR) of any chlamydia, gonorrhoea and syphilis ('Any STI'):
85.6 [83.4-87.8] / 100 PY

IR ratio:	LMIC (n=1,209)	Young (n=875)	Sex worker (n=339)	TGD (n=232)	Uninsured (n=207)	Intersections (n=302)
						
Unadjusted	↑ 22%	↑ 20%	↑ 36%	↓ 19%	↑ 34%	↑ 43%
Adjusted*	↑ 12%	↑ 34%	similar	↓ 27%	similar	similar

PrEP pilot retention

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Retention

Early loss-to-follow-up: 369 individuals

- 1 NPP visit, but no follow-up

Later loss-to-follow-up: 727 individuals

- Client had >1 NPP visit, but final NPP visit was >6 months ago (and no exit visit)

Retention

Born in a LMIC country

(vs born in a high income country)

Early loss-to-follow-up

- n=149/1,165 (12.8%)
- Did not differ (aOR=1.07 [0.75-1.52])

Later loss-to-follow-up

- n=209/1,016 (20.6%)
- Less often (aHR=0.62 [0.50-0.77])

Retention

Younger than 25 years

(vs ≥25 years)

Early loss-to-follow-up

- n=129/847 (15.2%)
- More often (aOR=1.69 [1.13-2.53])

Later loss-to-follow-up

- n=191/718 (26.6%)
- More often (aHR=1.59 [1.24-2.03])

Retention

Engaged in sex work

(vs not engaged in sex work)

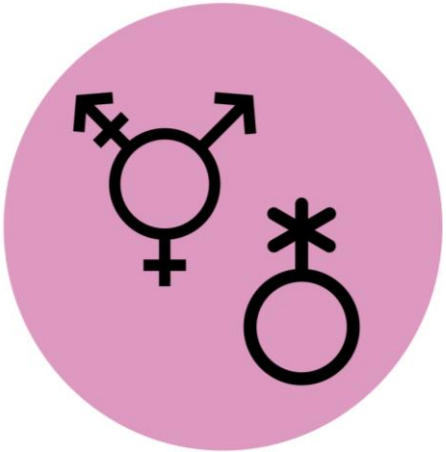
Early loss-to-follow-up

- N=97/367 (26.4%)
- More often (aOR=2.31 [1.40-1.82])

Later loss-to-follow-up

- n=101/270 (37.4%)
- More often (aHR=1.94 [1.39-2.70])

Retention



Trans or gender diverse

(vs cisgender)

Early loss-to-follow-up

- N=52/215 (24.2%)
- More often (aOR=1.82 [1.05-3.16])

Later loss-to-follow-up

- n=57/163 (35.0%)
- Did not differ (aHR=1.39 [0.92-2.01])

Retention

No health insurance

(vs health insurance)

Early loss-to-follow-up

- N=31/183 (16.9%)
- Did not differ (aOR=1.32 [0.77-2.25])

Later loss-to-follow-up

- n=33/152 (21.7%)
- Did not differ (aHR=1.04 [0.70-1.54])

Retention

Intersecting vulnerabilities

(vs people who do not belong to any priority group)

Early loss-to-follow-up

- N=78/301 (25.9%)
- More often (OR=5.89 [4.28-8.10])

Later loss-to-follow-up

- n=66/204 (32.4%)
- More often (HR=2.51 [1.94-3.25])

Summary of results

- Half of NPP participants in Amsterdam belong to a demographic priority population, and 7% meet a cluster of priority criteria

- STI incidence was high in all prioritized populations except TGD individuals
  - When corrected for available sexual behavior variables, STI incidence was higher in those younger than 25 and born in a LMIC

- Early loss-to-follow-up was higher in most prioritized populations, and especially high in those meeting multiple priority criteria (HR: 5.9 [4.3-8.1])

- Later loss-to-follow-up was more common among people younger than 25 or with a history of sex work, and less common among people born in a LMIC

Limitations

- No insight into the number of people from demographic priority populations *in need of PrEP* -> no conclusions on over / underrepresentation

- Unclear why STI incidence in migrants and people younger than 25 is higher after correction for sexual behavior variables (sexual behavior or sexual network related?)

- Unclear why priority populations are lost-to-follow-up more often: changes in HIV risk, continuing PrEP elsewhere, or missed opportunities for (tailored) PrEP care on our side?

Conclusions

Prioritizing populations with anticipated barriers to (PrEP) care is not antithetical to prioritizing populations vulnerable for STI and HIV

Program retention was lower among demographic priority populations. Interventions to improve PrEP retention among these populations are needed.

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Questions?