Pre-exposure prophylaxis (PrEP) in Poland 2017-2021

Lessons from a country with no national PrEP programme

Background

PrEP has been the primary of HIV prophylaxis in key populations in recent years, especially among MSM [1-3]. However, there are still countries (especially in CEE) with no national PrEP programmes, prevalent HIV and STI stigma as well as public officials and politicians sympathetic to PrEP and MSM health. This has led many individuals at risk of infection and to soaring HIV incidence. As medical professionals from Polish AIDS Societies we decided to develop PrEP guidelines in 2014 [4] as a tool to help build competence. PrEP clinics in Poland started to operate only when general TDF/FTC became available in October 2017 at $28 Eur or 50 tablets. Free and anonymous HIV testing was available in large cities only at voluntary counselling and testing sites (VCTs).

Results (see Table 1)

Half of the questioned infectious diseases/HIV specialists were ready to offer PrEP at their current place of work (see Fig. 1), especially younger ones, while 70% were ready to work at designated PrEP clinics (see Fig. 2). PrEP provision at HIV clinics has not worked out yet, however, due to staff and MDs being overworked. Forty percent of patients chose a doctor as their preferred venue while 24% chose either PrEP clinic or HIV testing site. However, most of the actually created PrEP venues turned out to be private with no reimbursement of medical care, testing (unless performed at VCTs) or medication. Only one large PrEP clinic offered free medical care and testing. There was a steady increase in PrEP patients in 2017-2021. The cumulative exposure to PrEP education and public campaigns started to increase PrEP as an additional prophylactic method. The demand PrEP use increased to 35% in the last year. Fifteen new HIV infections were confirmed during 2018-2019, increasing incidence of 0.19/100PY based on HIV incidence of 3.10/100PY among MSM at VCTs in Poland. The relative risk reduction in our cohort was 95% and NNT 27 (almost equal cost of PrEP compared to CART—cost effectiveness study going on).

Discussion

We have shown that a successful PrEP programme can be set-up fairly quickly without any public funding input, the only prerequisites being generic PrEP and motivated MDs. This set-up, however, created loneliness for MSM outside of large cities as well as those who cannot afford the cost or visits of PrEP clinics. Mostly younger ones. This may have led to selection bias as older, better educated and highly dedicated, hence more adherent patients came forward. Continuous monitoring is necessary, especially if access and reimbursement improve. With increasing numbers of younger, high-risk, chemsex users on PrEP poor adherence may become a real problem. In effect, incidence may increase as well as NNT and overall cost-effectiveness of the programme.

Conclusions

Despite no financial support from Ministry of Health and no reimbursement, almost 5000 patients received access to PrEP and sexually transmitted infections care. The programme was highly efficient with incidence similar to other PrEP projects with very adherent and dedicated patients [5-10]. Improvement in access is urgently needed, new clinics have to be set up all outside of large cities and universal reimbursement of medical care and medication implemented for good scalable and actual countrywide reduction in HIV incidence.

Materials and methods

During annual HIV conference in Poland questionnaires were taken among medical professionals to ascertain attitudes and readinesses to provide PrEP care. Dedicated questionnaires for patients were also available at PrEPedia webpage, an information exchange point for the whole country. 17 PrEP clinics run by single MDs, NGOs or joint ventures were systematically created in largest cities. The programme evaluation was based on actual prescriptions from Central Health Systems, wholesale volume to pharmacies and data from PrEP clinics. HIV prevalence and incidence among MSM in Poland were calculated based on VCT data, national registers and national reports for 2017-2021 [4].

Fig. 1 MDs readiness to do PrEP consultations at their current workplace.

Would it be possible to offer PrEP at your current clinic?

52% YES
9% NO, I do not have time
14% NO, I am not interested
25% NO, because I do not work at an out-patient clinic

Fig. 2 MDs readiness to work at PrEP clinics.

If there were PrEP clinics, would you be interested to work there as a doctor?

70% YES
21% NO, I do not have time
9% NO, I am not interested

Fig. 3 Preferred PrEP venues among patients.

Where would you want to access PrEP?

45% Any doctor
24% Testing sites
24% PrEP clinics
3% Somewhere else

Tab. 1. PrEP use characteristics and HIV incidence in Poland 2017-2021

<table>
<thead>
<tr>
<th>10-12-2017</th>
<th>2018</th>
<th>2019</th>
<th>2021</th>
<th>2022</th>
<th>2017-2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>PrEP users at dedicated PrEP clinics [n]</td>
<td>102</td>
<td>1108</td>
<td>1933</td>
<td>2684</td>
<td>3678</td>
</tr>
<tr>
<td>PrEP users outside of PrEP clinics [n]</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Total estimated PrEP users [n]</td>
<td>102</td>
<td>1108</td>
<td>2427</td>
<td>3220</td>
<td>4410</td>
</tr>
<tr>
<td>On-demand PrEP users [n]</td>
<td>2</td>
<td>15</td>
<td>20</td>
<td>17</td>
<td>33</td>
</tr>
<tr>
<td>HTX PrEP users [n]</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>MSM/PrEP users/PrEP users at VCTs in Poland</td>
<td>NA</td>
<td>NA</td>
<td>4.3</td>
<td>3.4</td>
<td>3.7</td>
</tr>
<tr>
<td>HIV Incidence among MSM at VCTs in Poland (1/100PY)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

NA = not applicable; VCT = voluntary counselling and testing site; HTX = heterosexual; MSM = men having sex with men

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