Partnering for Success: Patient Engagement and PrEP Adherence Strategies

CMEO Podcast Transcript

Florence Momplaisir, MD, MSHP, FACP:

Hello and welcome everyone. We're really excited to have you today. On behalf of CME Outfitters, I would like to welcome and thank you for joining us. This activity is titled, *Partnering for Success: Patient Engagement and PrEP Adherence Strategies*. And it really addresses global considerations by focusing on adaptable engagement principles rather than country-specific protocols so clinicians can apply them across diverse cultural and health system contexts. This program has been supported by an independent educational grant from Gilead Sciences.

So, I do have a few housekeeping slides to go through before we start this engaging and exciting conversation. So, today's activity may include discussions of products and devices that are not currently labeled for use by the U.S. Food and Drug Administration (FDA). And as a reminder, because this is a global program, indications and availability may vary by regulatory authority. So, clinicians should really consult local guidance when confirming approved pre-exposure prophylaxis (PrEP) options.

My name is Florence Momplaisir. I am an Associate Professor based in Philadelphia, Pennsylvania. I'm a physician scientist focusing on HIV, HIV prevention, particularly among women. And I'm really excited to be participating in this session with this esteem panel of experts. And we're going to start with introductions. I'm going to start with you, Dr. Barber. If you could tell us a little bit about you and where you're currently located.

Tristan J. Barber, MA, MD, FRCP:

Florence, thank you so much. It's a great delight to be here on this session with you. My name's Tristan Barber. I'm a sexual health and HIV physician working in London in the United Kingdom (UK). Also involved in research and really looking forward to our discussions today. Thanks.

Florence Momplaisir, MD, MSHP, FACP:

Wonderful. Dr. Solomon?

Sunil Suhas Solomon, MBBS, PhD, MPH:

Hi, everyone. I'm Dr. Sunil Solomon. I'm a Professor of Medicine and Epidemiology based at Johns Hopkins University School of Medicine in Baltimore. Most of my work focuses on access to medications, including PrEP to sexual gender minorities, people who inject drugs across the world.

Florence Momplaisir, MD, MSHP, FACP:

Wonderful. Thank you. And next, Dr. Bekker.

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

Thanks, Florence. A real pleasure to be part of this meeting this evening. And my name is Linda-Gail Bekker. I'm based in Cape Town, South Africa. I'm an Infectious Diseases Professor of Medicine, and I also run the Desmond Tutu Health Foundation and HIV Center, which is at the University of Cape Town. My work really is across the board, treatment, prevention, but of late, we've really focused in on young key populations (pops) and young

women and adolescent girls who could benefit most from pre-exposure prophylaxis. And that's where we've been putting the most of our energies of late.

Florence Momplaisir, MD, MSHP, FACP:

Wonderful. And moving forward, we can address each other by our first names, just to keep it more informal and conversational.

So, our learning objective for today is to really incorporate effective patient engagement strategies when thinking about PrEP and HIV prevention in general. We know that we have this amazing tool which is super effective at preventing HIV. However, use is really subpar in the U.S. and across the world. And so, most of our efforts today will really focus on using those effective patient engagement strategies, and we have a lot to discuss.

But first, I'm going to start with Tristan. When thinking about decisions that patients make regarding health prevention and PrEP in general, they don't make those decisions in a vacuum. They live in a social-political context. And Maslow's framework really talks about this. So, can you walk us through this a little bit?

Tristan J. Barber, MA, MD, FRCP:

Yeah, sure. I think it's sometimes good to take a step back, isn't it, and think about the context that a person is living in. And I think Maslow's hierarchy really reminds us that unmet basic safety or belonging needs can really limit a person's ability to prioritize prevention in their life, even when they understand the potential benefits.

Traditionally, I think care has followed a unidirectional clinician-driven model. We sometimes refer to this as being top-down or paternalistic in approach. And I think shared decision-making can really shift this to a bidirectional, person-centered approach that's built on education, empowerment, and partnership.

In pre-exposure prophylaxis care, this really helps us uncover any barriers that may not surface in a single visit and helps us to reframe adherence challenges as signals to reassess needs and adjust the plan according to the individual that's in front of us and the individual we're building a relationship with.

Florence Momplaisir, MD, MSHP, FACP:

You said it so well. Thank you so much. And when thinking about this and equity regarding PrEP and PrEP care, I don't know, Linda and Sunil, if you have anything else to add to what Tristan mentioned. Particularly in your context, Linda. I'm just thinking of your patients in South Africa, how do you think they prioritize health prevention and PrEP in their context?

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

Yeah, so thanks, Florence. And Tristan has said it really beautifully. I mean, I think in our experience, young people particularly are facing a range of constrained choices and health needs don't always move right to the top. So, I think we have to really think about how we reach them where they're at. And then very importantly, what we offer needs to be an easy choice, one that they can really adapt into their lives easily and make their own.

So, I think you started out by saying context matters, and I think as healthcare providers, this is absolutely key and critical for us to think about, particularly in the setting of prevention. Because people are going about their

busy lives, they don't necessarily have to come into our services. And so, we need to be sure that every point where we have access or where they make contact, that that is a meaningful contact that they can really use for their lives.

Florence Momplaisir, MD, MSHP, FACP:

Absolutely. And thank you so much for sharing that. That was really powerful. And Sunil, I know that you also do research in India. Do you encounter, for example, people facing a lot of social determinants where they really don't really think about HIV prevention as a priority?

Sunil Suhas Solomon, MBBS, PhD, MPH:

No, I completely agree with everything that both Linda-Gail and Tristan said earlier. I think to us as clinicians or providers, HIV is front and center in our mind. But if you're someone who is experiencing homelessness and living on the street and your access to your next meal is doubtful, you're probably not thinking about PrEP.

So, I think that's where the whole context and almost working with them or talking to them, sharing your knowledge, sharing their experiences and trying to work together in that whole process versus a unidirectional approach really makes a huge impact on them feeling that they're being heard. And then finding a solution that fits their lifestyle at the current point because people's lives evolve. And it doesn't mean what you do today is what you're going to be doing in 3 months or 6 months or 9 months, but maybe you do one option for PrEP today and your life evolves.

So, I think taking that context and people's conditions, and as Linda said, meeting them where they are currently is probably the best approach to take with PrEP.

Florence Momplaisir, MD, MSHP, FACP:

I love it. And I think that's a great segue to shared decision-making. And Tristan, going back to you, can you share with us what is shared decision-making? I mean, we think about that a lot in medicine, but practically, what does it look like?

Tristan J. Barber, MA, MD, FRCP:

It's a great question. I think we are really evolving beyond that paternalistic approach that I mentioned before, or at least we should be aspiring to move beyond it with every individual contact, as both Linda-Gail and Sunil have mentioned. We actively now invite people who are seeking care into the decision-making process.

And we know that PrEP is preference sensitive and that fit matters as much as efficacy. You can have a method of PrEP that's a hundred percent efficacious, but if someone's not going to use it appropriately, then it's not going to work. And we've seen this in clinical trials where a method of PrEP administration is more acceptable to certain groups, obviously the efficacy is maximized.

And so, really it's engagement over time that is the goal. It's understanding what someone's needs are, how PrEP is going to fit into their lifestyle, and making sure that they have access to the right form of PrEP for them, not only so that they can take it in the short term, but of course, so that they can also adhere to their PrEP regimen over the long term.

Florence Momplaisir, MD, MSHP, FACP:

Yeah. And I think that's a great transition to you, Linda-Gail, and really thinking about all the different PrEP modalities and how choice actually comes into play during the shared decision-making process.

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

Yeah, Florence, I think what Tristan and Sunil have been saying is we really want to make sure people have their preference met. And preference implies choice, so that there are actually going to be options for people. So, I think that's the first step. Now, I come from a part of the world where we, particularly in treatment, we followed a World Health Organization (WHO) public health approach where you had a schedule one or a first line of treatment, and then a second line with not a lot of option for choice.

I'm so pleased that we've evolved in 2026 in prevention where we are now saying choice really matters. And I like to think of it as the science of choice because we haven't as healthcare providers been really good about this in the past. So, we have to sharpen our skills now to be able to say, how do we offer people choice?

And the other way of thinking about this is really differentiated prevention delivery. So, we say, what is the product? What is the choice around that? Who gives the product to you? Who's the person who's got …. Which kind of PrEP would you like and who is the best person to deliver that to you? And in what kind of delivery system? So, that speaks to the health system.

So, I really like this slide because it sort of works through the fact that it isn't just the biomedical tool that we're talking about or the PrEP option, it's really about everything around it. How is it given to you? Who has that conversation with you? In what sort of health system is this delivered to you?

And this is a time when we are thinking about facility-based or clinic-based, as well as community-based options and this concept of de-medicalizing prevention so that again, people don't feel that they're being reduced to a patient who receives an instruction and they have to follow that instruction for their own good, which I think in 30 years has really not worked for us in the HIV prevention paradigm.

Florence Momplaisir, MD, MSHP, FACP:

Absolutely. Well said. And particularly, I think one of the goals of this session obviously is to really provide the providers, whether you're an infectious disease physician or a family practitioner or even outside of medicine, thinking of the practical tools that you can use when engaging people in HIV prevention.

So, Sunil, just thinking of the core principles of shared decision-making, can you just walk us through this so that we can really think about how we can apply this in our setting?

Sunil Suhas Solomon, MBBS, PhD, MPH:

Sure. I think when it comes to shared decision-making, the way we talk about PrEP matters just as much as which prevention option is selected. I think there are a couple of principles that you could really apply on how you discuss PrEP. And I think the first thing and probably the most important thing is just normalize the conversation, so the person sitting next to you feels like they're just talking to you, there's no judgment.

And try to be as simple as possible. Sometimes we like to be complicated and say complicated things because it makes the other person think that we're very knowledgeable. But I think it's important to break it down into

very simple language, no jargon. Tell them it's either one tablet once a day or one injection every 6 months in your abdomen. And be very specific in lay language and lay out what the different PrEP options are.

And I think the other point that's come up several times before is really exploring the life context where these people are saying, "Where do you live? What do you do for work? How far are you from this facility? Can we deliver medicines to your house? Can you come to the facility to receive injections?" Really understanding what their logistical barriers are, what their social context are is extremely important.

And once you have all that together, I think this is probably the most important part is really working with your client sitting across from you or on the phone or however you're doing it in whichever part of the world you are, deciding on what would be the best option for them at this particular point in time. And it's something that the two of you have to come to a realization together with, and it shouldn't be something that we as clinicians say, "You need to do this, you need to do that." It needs to be like that shared process.

I recognize in many settings outside the U.S. where options are limited, you may not have the ability to offer all the options. But I still think there are options and there needs to be that shared process in that decision making where you both arrive at the decision that yes, PrEP, this particular PrEP option is the best option for me at this point in time.

Florence Momplaisir, MD, MSHP, FACP:

Yes, and thank you so much for sharing that. And when thinking of all the tools that we can use as practitioners, motivational interviewing is one tool particularly that can be integrated in shared decision-making. So, I'd like to turn to you, Linda Gall, and if you can share a little bit how motivational interviewing can be conceptualized or even operationalized in clinical practice.

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

So, I think the first thing I would just say, Florence, is it implies some kind of relationship with this individual. And so, I think we have to work at that. And often in our busy practices, there isn't a lot of time for that. So, again, I think it's a skill we need to practice to get down to that point, as Sunil was saying, where you're on a level with an individual and they have a sense of rapport.

So, the first thing is really to open the conversation. And often that is an open-ended kind of, it's not that I know what's best for you and I'm going to tell you what needs to happen. It really needs to start with a, you tell me what you think and where are you at? And often it isn't actually about PrEP to start with, as Sunil has mentioned, it may be how are the kids? What are the difficulties you're dealing with at the moment? Where are you at? Because often even probing around individual's mental health may be a good place to start.

So, an open-ended start to the conversation, then hearing where and listening, this is such an important component of this, opening our ears and really listening to what people are telling us. And then maybe there may be a need for information or clarification. And so, that's really important. We do have a role to play in making sure that good, unambiguous, clear information is imparted to this individual, as said, in a very non-judgmental, non-prejudicial way. So, it is not in our place to decide whether somebody should be having more or less sex, how they should be having sex or whatever. I think it's a triumph if somebody's sharing with us what kind of sex they're having or what they perceive some of their risks may be.

And then we need to move to how then can we position the tools that are at our disposal to meet your need where you are? So, lay out the options. And then it really is about that individual saying, "This is where I think I need to go." There may need to be a little bit of guidance. I have a real problem with needles. Well, maybe then injectable PrEP isn't going to be your first option. Do you think you could manage daily PrEP or have you realized that we can use ice packs? So, really making sure that individuals get a full amount of information so that they can make their choices.

And then we need to validate that choice. And remember, one of the choices might be, I don't think I'm ready for PrEP. I don't think PrEP is my option. That is a valid preference, in which case we want to explore what other prevention methods that individual may be able to use. So, again, really working from the lead coming from our clients, the person sitting in front of us and making sure that we're responsive, we're bringing the good information and then validating any decision that that individual might want to make.

And then I think it was beautifully said just a moment ago, this is not set in stone. So, we need to revisit this, and be able to, with a lot of humility, be able to go back and say, "Okay, where were you? How did that go for you?" Perhaps I've changed my mind now. Maybe I want to switch my options. Well, I'm with you on this and I want to see how we can best meet your needs in order to get the best success.

Florence Momplaisir, MD, MSHP, FACP:

Yeah, and I love this framework because I think it shifts the dynamic away from the traditional system where now the patient is the expert and we're arming them and empowering them with information and trusting that they can make the best choice for themselves, which is great.

So, now let's talk a little bit and also a little bit more about language and the lens by which we offer, discuss PrEP and HIV prevention, and definitely reframing the goal from adherence to fit. I think fit is something that I heard multiple times in different ways since we started our conversation.

So, Tristan, I'm going to turn it back to you. And this slide really highlights a mindset shift and helps us explore how a motivational approach can possibly improve persistence by allowing patients to feel heard, respected, and valued. And can you walk us through this?

Tristan J. Barber, MA, MD, FRCP:

Sure, and I was just thinking of a couple of things while Linda-Gail was speaking. I think sometimes when people are in busy clinics, you can sum up a lot of those priorities or prioritization by asking a really simple question, which is just what's most important for you today. And often that will uncover things that you weren't anticipating because if you lead straight in with a top-down approach, you may be anticipating where the problems or barriers are going to be, but I found that particular question quite useful.

And also, maybe we can come to it later, but I'm aware that we all aim to use person-centered language, certainly in the HIV treatment space. And sometimes the word patient I think can be very acceptable in that space. But in a PrEP context, I'm really trying to avoid using the word patient because I don't see these people as someone presenting with an illness or something we need to think about treating. But of course, they're individuals who are just looking to protect themselves from HIV acquisition and probably talk about other sexually transmitted infection (STI) prevention as well. So, I want to normalize them as much as possible. So, maybe just some things for us to think about a little bit later on.

So, I think we're clearly moving from a compliance, adherence kind of conversation to collaboration, making sure that we're recognizing people's competing priorities and making people realize that there's no perfection when it comes to PrEP. There's a best option that has to fit in with their lives and meeting them where they are.

And I think when we follow people up, we need supportive check-ins. We're not monitoring them. We're not observing them, and we need to support them in terms of what's working well for them. Have they found any barriers that may be getting in the way of their PrEP usage? Are they talking to other people, friends and family about PrEP, or is it something they would prefer to keep private? Is there anything they need in terms of tools to help them with language to talk to partners about PrEP or is it something they feel they want to keep for themselves? They know they're taking the right action to protect their own sexual health.

So, I think using very inclusive, non-judgmental, holistic language, meeting people where they are, getting rid perhaps of some of our historical language that is about adherence, persistence, failure, terrible word, I hate the word failure, are words that we should avoid. And we should really think about our use of language very carefully to make sure people here feel that we understand where they are and that we're here to support them for however long they want to stay on their chosen method, or as we've alluded to already, if they want to switch it. So, really thinking about careful use of language to support people on their journey.

Florence Momplaisir, MD, MSHP, FACP:

And I also am reflecting on the word that we're using to characterize them and thinking maybe using client instead of patient. Do you think that's a little bit more appropriate?

Tristan J. Barber, MA, MD, FRCP:

I think it really depends on the healthcare setting. I know some community groups are very happy with the word client. Some people don't like the word client because they think it implies some kind of service or paid for service. So, I use personal people very commonly, but again, I think it depends on your own environment. And I think talking to communities and finding out what language is appropriate is the best way to go. Be guided by the people that we're serving and helping to treat.

Florence Momplaisir, MD, MSHP, FACP:

Okay. So, I definitely appreciate the fact that you all are experts in your context. You all come from different places where resource allocations are different. And so, now I'd like for us to talk a little bit together about how shared decision principles can be tailored globally for PrEP. Any thoughts?

Sunil Suhas Solomon, MBBS, PhD, MPH:

Sure, I can go first. I think Linda-Gail mentioned this before. Sometimes there's limited time that healthcare providers have to spend with the clients or the people sitting across from them. But I think the challenge is, we've mentioned this several times, there has to be the rapport built with these people who are on PrEP and ensure that there's that continued engagement.

So, in settings like India, the accredited social health activists (ASHA) workers who are lay health workers are someone who exist within the healthcare system. So, they're not doctors, but you could train them and they

could deliver the message and they could engage with the participants, work with the families to support, and the communities, and really get there.

The one thing I will mention about India, so we run this virtual PrEP platform across India, and we have about a couple of thousand people on PrEP. And so, we have a role called a virtual outreach worker who's a person who's sitting at home, but communicates with all these clients on PrEP, reminding them when their refills are, asking them how are they doing. Are you facing any adverse events? This is what you should do for your adverse events. Positive reinforcement, asking them, literally walking them through their entire PrEP journey over WhatsApp.

And from what we've figured out from many of these clients who are on PrEP, they said those virtual outreach workers are probably the reason that they're still engaged in PrEP. So, they're building this relationship with someone who is not a doctor, but again, a lay health worker who's able to maintain that engagement with them because I think that's the most important part of PrEP. Because starting PrEP is easy, keeping people on PrEP, that's the biggest challenge.

And so, thinking creatively in your particular situation, what is the best way to engage with these people as they're on PrEP and how do you support them through their journey?

Florence Momplaisir, MD, MSHP, FACP:

Love it. And also leveraging community resources and trusted messengers, right? So, Linda-Gail, I'll turn it over to you.

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

Yeah, thanks. The model in South Africa for the vast majority of PrEP users to date, and there's more than 3 million people now using oral PrEP at least in South Africa, and we're very much anticipating the addition of other kinds of PrEP in the near future. But the basis of our program is a nurse-led model, both treatment and prevention. So, nurses provide the full gambit, if you like. But Sunil is right. What we have found very, very useful in community is not only our wonderful lay healthcare workers, but peer navigators.

So, young people who are of a similar age, they often are on PrEP themselves, they're using it themselves, and they introduce the first conversations around choice and what works for them and what other services this young person might need. Often contraception is what brings them into our service or the need for sexual health treatment and screening. And that sort of starts the conversation.

And then as mentioned, often these young people are the best sources of good information to ensure that people leave with the right kind of information to keep them going and persisting on their PrEP choice. They also remove all that prejudice and all that anxiety.

But I will say there are still those PrEP users for whom discretion is the most important element. And they actually want to get into the clinic or into the mobile or into the service, and in fact, would prefer to have it couriered to their home if at all possible. So, we do offer those options in our programs, for instance. So, that is what I call the very discreet PrEP user who really doesn't want to hunt in packs, doesn't want to be seen with other people, really just wants to get their prevention and get home.

So, again, I think this is where we need to show flexibility, versatility, and roll with the punches, as it were, to make sure that we meet the needs of the people who require our services.

Florence Momplaisir, MD, MSHP, FACP:

Absolutely. And I think it connects well to what you said at the beginning about meeting people where they're at and giving them the choices that best fits their desires.

And so, Tristan, when thinking a little bit about building trust and leveraging community, particularly whether it's peer educators or community workers or even faith leaders, tell me a little bit about your thoughts, or I don't know if you have any examples that you can think of.

Tristan J. Barber, MA, MD, FRCP:

Thank you. Actually, I mean, I think I should really defer to Linda-Gail here because we have seen huge uptake of mainly oral PrEP in the UK in gay and bisexual men who have sex with men. We have a new HIV action plan in England to end new HIV transmissions by 2030, but we're way behind in leveraging up PrEP access to underserved communities, including women.

So, we have talked a lot recently about the use of peer navigators or peer educators and how to identify those people to really initiate those PrEP conversations in populations that have not been accessing PrEP or have low PrEP literacy. I think in addition, of course, to peer navigation, you touched on it, we could think about other trusted guides to PrEP. And I don't think these need to be people that are taking PrEP themselves. There may be people who've had a PrEP discussion, have decided for one reason or another that they're not going to take PrEP. I think those people can still be huge PrEP advocates. Of course, lived experience is really important, but with faith leaders, I think educators, community leaders, I think can also be really important.

So, we don't have a lot of practical experience of that yet in the UK, but it's clearly a direction of travel that we need to adopt because those with the best health literacy, those of better socioeconomic status, those who can really advocate for PrEP are the ones who are already there and receiving it, and that's not going to help us achieve the goals that we want to achieve. So, we really need to find better ways to get into other populations, particularly heterosexual younger women, but also of course heterosexual men and other underserved populations. So, I'm really here to learn rather than give true experience in our own country setting. Thanks.

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

The other group that is so important and I think growing in importance, and particularly Kenya and parts of the United States have shown this, are pharmacists. So, pharmacists in private pharmacies. And South Africa has just actually finally overcome a court ruling that stopped pharmacists doing this, which is a triumph because we have about 3,000 private pharmacies in the country, each of which can be a point of PrEP education, PrEP sharing, and of course PrEP dispensation. So, that's another important group that we shouldn't overlook.

Florence Momplaisir, MD, MSHP, FACP:

Absolutely. And I think that's a great transition to thinking of the global considerations when it comes to PrEP and particularly the context and how context matters. And particularly, you sort of alluded to that, Linda-Gail, about the policies, the workflow in different settings. There's migration issues, stigma may or may not be as prominent. So, can you all share a little bit, based on your context, how do you see PrEP delivery?

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

I love Sunil's Blue Shed model. Why didn't you share some of that, Sunil?

Sunil Suhas Solomon, MBBS, PhD, MPH:

Sure, given that you brought it up. I think this just goes back to what we've all been saying. I think the basis is to really meet people where they are. And so, we were working with people who inject drugs in New Delhi, we recognized that for them, their priority was getting access to showers, getting access to food and getting access to toilets because many of them were living on the street, they were homeless. And so, when I asked them about HIV PrEP and HIV testing and antiretroviral therapy (ART), they literally told me, "What's the point of us talking to me about ART and PrEP when I don't know when I'm going to eat or sleep next?"

And so, we actually built this, I guess it's a medical care facility where we married medical services with basic necessities. So, it provides … it has showers, it has toilets, it provides food, it gives people haircuts, but it also provides harm reduction services, HIV testing, antiretroviral therapy, all under one roof. And what we've seen is that a lot of people were coming there essentially to use the toilets and for the food, but when they were there and they were waiting, we asked them, "Hey, now that you're here, are you interested in getting screened for HIV? Are you interested in getting on PrEP?"

So, really using completely nonmedical services as the entryway into HIV care and HIV PrEP. And I think this is something we've done here, but this is something that has been seen across the world is all these non-HIV entry points into HIV care or post-exposure prophylaxis leading to pre-exposure prophylaxis.

So, I think to what Tristan and Linda-Gail have already said so eloquently before, I think we need to get a lot more people on PrEP, which essentially means we need to start thinking differently. What we can do has a limit. So, what can we do to go beyond that limit to get to millions of people? Because that's essentially our target if we want to really translate these efficacious tools into effective public health interventions.

Florence Momplaisir, MD, MSHP, FACP:

Yeah, and if I can have you weigh in a little bit about how trust is central to this process, because it feels like you had to establish a relationship with this population and really think about their needs and their priorities. And so, tell us a little bit more about how trust is really important when thinking of PrEP initiation and continuation.

Sunil Suhas Solomon, MBBS, PhD, MPH:

No, I think if there's one thing that you have to build with your client, it's trust. Without trust, nothing's going to work. And it takes multiple steps and multiple attempts to actually build that trust, build that rapport with the client. But I think probably the most important things is really showing that you're someone who knows what you're talking about, you are there for them and really listening to them when they talk to you. Many times they talk to us and we don't listen, we just tell them what we think they want to hear. But I think we need to stop, really listen to what they're saying.

They also need to know, there has to be a lot of clarity and transparency in any conversation you have with them. And I think the most important is when you come to that final decision of what particular regimen it is, it needs to be a shared decision that starts almost with the client. Actually, it should start with the client and you say, "Yes, what you have said is correct." So, that's when you know you've really built that trust.

It gets challenging because in some situations you don't have the entire toolbox. You may only have oral PrEP, you may only have emtricitabine (F)/tenofovir disoproxil fumarate (TDF). But I think even in those conditions, there's still 2-1-1, there's on-demand PrEP, there are still options. And so, working with them and arriving at that decision primarily from the client side versus the provider side is what really helps build that trust with the client.

Florence Momplaisir, MD, MSHP, FACP:

I love it. And you speak a lot about individual trust, which is very, very important, but there's also a role for community trust, right? And Tristan, I don't know if you can speak a little bit about that.

Tristan J. Barber, MA, MD, FRCP:

I think this slide really shows us how to build community trust, and discussion of why this matters, really by starting with people, by informing them, co-designing services, co-producing services. Again, we talked a lot to groups of women in London recently about how we could make PrEP more accessible. And many of them said that sexual health clinics HIV don't feel designed for me. They feel designed for gay and bisexual men who have sex with men.

So, I think getting people involved from the start is really, really important. Engaging people and constantly consulting with them, patient groups, advisory groups, making sure you involve people in decisions about how you provide your services, I think is tremendously important. And for too long, we've done this in reverse. We've designed the services first, and then we've wondered why people don't come to them. So, I think this is a really good approach to starting out well, starting out in the direction of travel you mean to go in and centering the people you most want to reach from the beginning.

Florence Momplaisir, MD, MSHP, FACP:

Wonderful. And Linda-Gail, I think you probably had a reaction from-

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

Yeah, no, no, Tristan really got my juices flowing on that. I think just the importance of going to the community before you even conceptualize your program. We have been right from the get-go, involving young persons in a thing we called our youth reference group, and we have about a hundred young people. And my team knows they do nothing without consulting that group of experts really. They are content experts. They know what will bring their peers into a space and what will be best for them in terms of programmatic needs.

And so, out of this grew our Fast PrEP concept, which is designed to be like fast food, so easy, accessible on every street corner, allowing choice, efficiency, non-judgmental. If you want to have Kentucky Fried or McDonald's, no one's going to judge you, whatever the case may be. And that really has caught on and created a real buzz around prevention.

And then we haven't been apologetic. We've been loud and out. Our vehicles are brightly colored. But the idea again is we understand, and I recognize our context is one of a high-burden HIV environment, so it is very much in everybody's purview, but our approach has been one of a zero neutral one. So, it doesn't matter whether you

think you're going to test positive, negative, or you really don't know, step in, there is something for everyone. Everyone leaves with something that is going to make their lives better, healthier, more in touch with their ...

And here we can bring a really sex-positive message that is going to create pleasure and enjoyment in their lives again, take the fear and the anxiety out of their lives. So, that can all be mixed in. And at the end of the day, again, those services are more likely to be taken up and adhered to in the long run.

Florence Momplaisir, MD, MSHP, FACP:

Yeah, and I'm taking all of this in and thinking of how Tristan talked about the fact that sometimes we put HIV separately in this corner, in this box. And particularly with your work, Linda-Gail, about positive sex and thinking of sexual health in general and how HIV prevention is and or should be integrated in all of this.

So, Sunil, we just want to get your thoughts. I think you were involved in a series of focus groups in Baltimore. And just help us understand based on what you learned, how to think of the best practices when engaging or at least thinking about sexual practices and PrEP.

Sunil Suhas Solomon, MBBS, PhD, MPH:

Sure. I think a couple of things. Probably the most important is having that non-judgmental attitude towards the person sitting across. Probably the most important to start off and you have someone sitting across from you is really ask them, how do you want to be addressed? Starting off with what are your pronouns is very important, especially in certain settings where people identify in different ways. And so, it's important for them to be seen, be heard, and be addressed how they want to be addressed versus how we think they want to be addressed.

But after that, I think really normalizing conversation. And echoing off what Linda-Gail said, whether they said McDonald's or Kentucky Fried Chicken, your face is going to be the same, do not judge them. And it's the same thing that goes to sex. Because I think for us, it's very easy to talk about, but I realize when I talk to my friends who are clinicians outside of HIV, unprotected anal intercourse is not something that comes up in daily practice for them.

And so, when you're having these conversations, especially as you go from specialists to primary care providers and other providers, to start trying to increase access to PrEP, it's very important that they're able to have a normal conversation regardless of what the terms are. Whether it's chemsex, whether it's group sex, whether it's unprotected anal intercourse, there cannot be any judgment because we really need to understand what the practices are because that plays a big role in what PrEP choices work for them.

The other thing is I think providers also need to be very well aware of what the different PrEP options are. So, this actually came up in our focus group where many of the people we worked with in Baltimore actually told us they knew more about injectable cabotegravir than the providers did. And so, they were almost educating their primary healthcare providers about what cabotegravir was. And in that case, you've already lost the trust. So, it's really hard to build anything from that point. So, that's another key element is ensuring that whoever is providing PrEP is aware of all the options and is knowledgeable.

And then obviously the most important thing is really centering around the patient values and the patient priorities. What really is the client sitting across from you really looking for? Is it a long-term solution? Is it a short-term solution? What is their lifestyle? How does this option fit into their lifestyle? How do the other options fit into their lifestyle? So, really centering the conversations around the person sitting across from you.

And I think those are probably the three most important practices I would say to try and engage people in sexual health and PrEP.

Florence Momplaisir, MD, MSHP, FACP:

I love it. Tristan, anything else to add?

Tristan J. Barber, MA, MD, FRCP:

I think I'm going to be stating things that we've already mentioned before, but I think we've gone through this really rigorously. We're offering choice, supporting informed decision-making, presenting options, addressing structural and contextual barriers, particularly things that may influence engagement and persistence. And we need to partner and engage with communities and community organizations. I mean, I think these are clear themes that have come through all of our discussion so far.

Florence Momplaisir, MD, MSHP, FACP:

Yeah, and Linda-Gail, we're going to turn it over to you. In this slide, we have two patient quotes actually from South Africa. So, I'm going to let the audience read for a minute and then we'll discuss.

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

Yeah. So, Florence, I think it really speaks to, I want to say the world I hope we're leaving behind, which is one where medicine is very hierarchical, it's very down, I know what's best for you, shut up and take your medicine, swallow your pills and don't darken my doorstep if you don't, kind of thing. And that was the language, failure, compliance, all the things we meant well, but they really do conjure up a very instructive, patriarchal approach, a paternalistic approach.

And any one of us who needs a prevention option or needs a service in our lives, we don't do well with that, right? If you're going to buy a new fridge in your home, the last thing you want is the salesperson to tell you what they think you need and to take the choice and leave with no sense of your own values.

So, let's put ourselves in the steps and the feet, the shoes of the people we're trying to help and recognize that those quotes are what I hear time and time again, "I don't want to go to the clinic. I'm going to be told that I was promiscuous. I'm going to pick up on discrimination. I'm going to pick up on stigma. I'm going to pick up on a tone that I'm in trouble and that I shouldn't be engaging in sex, I shouldn't be inquiring about prevention."

And I really want to turn that on its head and say when a young person comes into our services, that is something to be celebrated and encouraged and absolutely validated that that individual has been brave enough, has had the courage, has taken the step. And then the very least we can do is make sure that we hear them, we meet them where they are, and we hear what their particular needs are.

I mean, that's the other point here, and I think we've said it in different ways, PrEP may not be the most important thing this individual is looking for. In fact, often what we have found is what they're looking for is a shoulder to cry on, somebody to tell their heartache to, somebody to feel supported by, maybe to get some information, maybe some reassurance. And these are the things we can provide. If we meet those needs first, then our mission to provide good prevention can follow immediately after that.

So, I think those quotes, I'm hoping that as we move into this next era of very exciting prevention where I think we can bring this epidemic under control, then in that era, I hope we are not going to hear those kinds of quotes anymore. We're going to hear that people are being validated, they're having their needs met, and they're able to take and use the prevention to make themselves healthier and more resilient in the future.

Florence Momplaisir, MD, MSHP, FACP:

I love it. And I think from what you just shared, you identified specific barriers, but also strategies. We talked about stigma, isolation, but also having this approach where you understand the person's priorities. And so, Sunil and Tristan, can you speak a little bit about barriers and strategies that you've used with the people you engage in for PrEP?

Sunil Suhas Solomon, MBBS, PhD, MPH:

Sure. So, I think a lot of these barriers from stigma to economic barriers, competing priorities are very relevant in India and many other settings across the world. India especially because PrEP is paid out of pocket. It's not available for free from the government programs. Economic and paying for PrEP becomes a much bigger challenge because you take it for prolonged periods of time, as long as you're engaging in practices that place you at risk for HIV acquisition. So, what we've done there is that we've actually negotiated prices with pharmaceutical companies. We've done like bulk purchasing, so reduced the cost and made it a lot more affordable for people.

Stigma, fear of disclosure, again, a huge issue. And where we've really helped with that is using these virtual outreach workers and other support staff to have this conversation in a very non-judgmental way, making it clear to them that you can take PrEP. Even if you miss PrEP, there's nothing wrong with it. It's almost normalizing the behavior of missing a dose here or missing a dose there. Because many people, I think as Linda-Gail mentioned, are very afraid of telling a clinician that they missed a dose because they think they're going to be judged.

The mismatch between user preferences and available options is obviously huge because there are many people who are experiencing homelessness where storing oral medications is not easy on the side of a street, but unfortunately at this point in time, our only options are oral PrEP in India. So, I think that's something that is going to be more systemic and would have to change with policy and law and access to the long-acting formulations. But these challenges are pretty much standard across the world.

Florence Momplaisir, MD, MSHP, FACP:

Wonderful. Thank you so much for sharing. And I think that's a great transition to thinking about best practices for patient engagement, but also using the lens of the clinicians and the teams. Can you speak a little bit more about that, Sunil, the solutions and best practices that we can use?

Sunil Suhas Solomon, MBBS, PhD, MPH:

Sure. I think a lot of this has already been said before. I think probably the most important, again, is really having that non-judgmental conversation, almost being at the same level as the patient sitting across from you as a client and having that conversation with them. And integrating it into routine preventive services. When you

take a sexual history and something comes up that you think that could place them at risk for HIV acquisition is ask them, hey, have you ever considered PrEP? So, just bringing it up in normal conversation.

And also having a whole group of people, whether a counselor or the pharmacist, multiple people, all in part participating in this whole process from a multidisciplinary support perspective.

And also, really, I think everyone has said this before is really being very simple and plain. And I think these are things that we could incorporate into practice at the clinician or at the team level and it's systemic. I think what's important is anyone who is going to be prescribing PrEP, whether it's the nurse or the doctor or supporting system, pharmacists or healthcare workers have to be trained on culturally sensitive communication. But at the same time, they also have to be extremely aware of all the different PrEP options. So, as new options come up, there needs to be education and training for them so they're all aware of what the different options are in the system.

Developing systems is extremely critical. As I mentioned before, starting PrEP is probably the easiest thing you will do, keeping them on PrEP and having systems that track when is the next refill, have you sent the reminder out? And having staff whose roles are almost essentially to build that rapport and send messages. So, again, I keep going back to those virtual outreach workers because these are just people sitting at home.

And with a phone, even if it's daily oral PrEP, which needs to be refilled once a month or once every three months, they're able to reach multiple people just sitting from their home. And when you go to long-acting PrEP, which is every 2 months or every 6 months, that volume can go up a lot more. So, it actually ends up being a lot more cost savings if you move to low-income countries where cost of labor isn't as high.

So, just thinking about how do you build these different support systems into the existing infrastructure that you have to ensure that continuity is insured. I guess the key principle really is promoting PrEP as an empowering individual wellness choice, and it's not just a medication, but it's a choice that they're making about their own health.

Florence Momplaisir, MD, MSHP, FACP:

Absolutely, absolutely. And I love this next slide because it really talks about normalizing PrEP discussions and then providing frequent check-ins where the plan can be adjusted based on new priorities or a different context. Any additional thoughts about that, Linda-Gail and Tristan?

Tristan J. Barber, MA, MD, FRCP:

Just back to that piece about barriers a little bit where I was thinking about stigma as something that's overarching, but one of the things we often neglect is to think about opening hours of our services. I was talking recently to a group of commercial sex workers who of course work at night, clinics are open in the daytime. And how to really engage people and keep people engaged with conversation, but also with their follow-up and their visits, we really need to make sure we adjust appropriately to the people that we serve.

In terms of the best practices, I think we start with relationships, not necessarily information. We've mentioned that already, really, I think meeting people where they are. We know that being kind, being attentive to people's needs builds trust and that that strengthens the therapeutic alliance and it's that alliance that drives persistence.

And I guess just the one thing for me to close this section with is thinking about how we sometimes have to keep pushing ourselves because we only know what we see. So, we see the people in front of us, we work with them,

we build a relationship, we get them to a place we or they want to be in, in terms of their PrEP use. And we have to keep reminding ourselves that there are people out there that we're not seeing and that we're not engaging with and how we can continue to do that better, I think is one of the main challenges. Sorry, over to you, Linda-Gail.

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

No, beautiful, Tristan. I think that's so right. There were two things I wanted to say. The one is definitely preference can change. So, I think, again, no judgment on the fact that somebody may come back and go, "Well, no, really, I actually think I'd prefer to do this or that." And being able to accommodate that, I think that's really important.

And then I think also being able to say to people that come back if anything changes and accommodate if people are going away. So, again, these are flexibilities within our system that we need to take into consideration. So, that may mean that somebody has to go off from an injectable to an oral in order to facilitate that they're going to not be at a place where they can get the administration of an injection. So, again, fitting into people's lives, not making them have to fit their lives around a particular program, I think is going to win hearts and minds.

And then maybe the last thing I would just say, and it was triggered by Tristan saying, let's be kind. I was so humbled some years ago when we followed up with people coming into our service with a simple WhatsApp to just say, thank you so much for coming in today. It was lovely to see you. And people called us back to say, "That was the nicest thing anybody has said to me." And these were generated messages that we sent out in a generic fashion and it was so humbling for me.

If we as healthcare practitioners can just show some of that kindness and give people dignity, it will go so far in helping them stay engaged in the programs in which they find themselves. Too often, there are long queues and hard words and hardships and the dignity leaves. Those of us who travel these days know exactly what I'm talking about, those queues at the airports, the dignity has disappeared. Can we put that back into the health services that we provide for people? I think it would make all the difference in the world.

Florence Momplaisir, MD, MSHP, FACP:

I love it. And see people as people, not as numbers or a case, right? You give us a lot to think about and leave with. Thank you so much, Linda-Gail.

And as we are wrapping up, we are going to share with the audience this resource that is actually available in the CME website. These are a series of tools that you can peruse and choose to use in your practice if you feel like it's a good fit for you. And really, Tristan, I just wanted to pick your brain about do you have any thoughts around how to best use those educational tools in your practice?

Tristan J. Barber, MA, MD, FRCP:

Again, I think we're back to meeting people where we are and finding out what people's needs are, whether they prefer written or visual information? I wouldn't overly rely on digital. Some people digital is very good for. Some people want to take something away they can read in the privacy of their own space. So, I think, again, it's individualizing the use of patient education tools or person education tools to make sure they're appropriate for the individual that you're working with.

Florence Momplaisir, MD, MSHP, FACP:

Absolutely, and that the literacy level is also appropriate, etc.

Linda-Gail Bekker, MBChB, DTMH, DCH, FCP (SA), PhD:

One thing we found with young women is that we use both “I” language in terms of information, particularly written language, but also third-party type language. So, if she needs to give it to a partner or even a mom or an auntie or an older sister at home, that there's third party language so that you know your family member is using PrEP, this is what PrEP is. We found that that was quite useful so that they did not have to have the discussion themselves, but they could use written literature to try and share and disclose and get information across. So, I think that's really helpful.

And then one other thing we've really exploited, and here I'm going to appeal to teens and people who look after teenagers, particularly young women love to do these quizzes to work out what suits them better. Are they this kind of person or that kind of person? We've adapted a quiz so that people can go, "What PrEP suits me better?" And so, they sit in the waiting room and they sit down and do their quiz, and then they come into a room. So, one can also do that work beforehand to a certain extent. It doesn't all have to be in front of ... There's sort of pre-work that can be done. Or people can be sent home with literature to read and then come back. So, there are different ways we can use the tools that are at our disposal. So, those are just some things we've used with young people.

Florence Momplaisir, MD, MSHP, FACP:

Absolutely, and thank you so much for this additional insight. I know we discussed a lot today, and I hope that all of you will come out with very specific nuggets that you can actually apply to your setting. And now we're going to close the program with really an action step. We're going to have you think about how to use SMART goals in your settings. And SMART stands for specific, measurable, attainable, relevant, timely, inclusive, and equitable. So, it's SMARTIE actually, SMARTIE goals.

And what we would love for all of you to do, meaning the audience, is to really set a timeframe that fits within your work environment and is reasonable and really think about how you can improve having PrEP conversations and really support the people that you care for across the HIV, the PrEP care continuum.

So, the first is to incorporate at least one inclusive patient-centered engagement strategy, and we talked about shared decision-making, motivational interviewing, sexual health practices, into PrEP initiation conversations. And we want you to do this within the next 30 days.

The second is to implement a structured shared decision-making-based PrEP initiation process for oral or long-acting injectable based on your setting, of course. That includes discussions of expectations regarding adherence support, addressing potential barriers. And we discussed a lot of that about stigma, isolation, workflow, availability of products, etc., and really come up with individual strategies that can help support the people you care for in the next 60 days.

And then finally, develop and apply a patient engagement focused adherence support plan that includes follow-up touchpoints, reminder systems, but also as Linda-Gail mentioned, just readjusting based on priorities and things that come up. And we want you to do this in the next 60 to 90 days. So, you do have homework.

And we're going to really end here and really thank this esteemed panel for your wonderful insight and this rich conversation that we've had. I feel very privileged to be a part of this discussion. And we would also like to invite the audience to visit the CME Outfitters Infectious Disease Hub where there are additional resources and tools that you can use in your practice, particularly when thinking of using your SMARTIE goals.

And we also want to say that this series is not in a vacuum. There are other topics as part of the CME Snack HIV Prevention Program, and you can see the titles here. So, I hope that you can benefit from these resources and really think of how you can apply them in your setting.

And lastly, if you want to receive either CME or CE credit, just a reminder that you will need to complete the post-test and evaluation available online and that you'll be able to download and print the certificate after this.