

Introducing Oral PrEP in Zimbabwe: findings from community dialogues with potential users



National AIDS Council
Co-ordinating the multi-sectoral response to HIV and AIDS



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List of abbreviations

AGYW	Adolescent girls and young women
ABYM	Adolescent boys and young men
ART	Antiretroviral Therapy
DAACs	District AIDS Action Committees
DREAMS	Determined, Resilient, Empowered, AIDS- free, Mentored and Safe
FSWs	Female sex workers
HCWs	Health Care Workers
IEC	Information, Education, Communication
KPs	Key populations
MOHCC	Ministry of Health and Child Care
OPTIONS	Optimizing Prevention Technology Introduction on Schedule
PMDs	Provincial medical doctors
PMs	Provincial managers
PrEP	Pre-exposure prophylaxis
PZAT	Pangaea Zimbabwe AIDS Trust
TWG	Technical Working Group
VAACs	Village AIDS Action Committees
VHWs	Village health workers
VMMC	Voluntary Medical Male Circumcision
USAID	United States Agency for International Development
WAACs	Ward AIDS Action Committees

Executive summary

The World Health Organisation (WHO) issued global guidance on oral pre-exposure prophylaxis (PrEP) in 2015, which Zimbabwe adapted and subsequently launched as part of the ART consolidated guidelines in December 2016. With an HIV prevalence of 14.7% and an estimated HIV incidence of 0.47%, (1), Zimbabwe has a generalized HIV epidemic with some populations being at elevated risk of HIV compared to others. These populations include, adolescent girls and young women (AGYW), female sex workers (FSWs), men at risk and sero-discordant couples. These populations have been singled out in the Zimbabwean oral PrEP guidance as being prioritized for oral PrEP.

In an attempt to better understand how oral PrEP could be scaled up in Zimbabwe, a total of 21 community dialogues were conducted in five out of the ten provinces of Zimbabwe. Target populations included AGYW, adolescent boys and young men (ABYM), FSWs, men who have sex with men (MSM), transgender populations, adult men, adult women, pregnant and lactating women, influential leaders, students in tertiary institutions, internally displaced populations and people living with HIV.

Key findings were presented in three main categories namely: community perceptions of oral PrEP; facilitators and barriers to PrEP uptake and adherence; and preferred service delivery models and communication channels for PrEP.

On perceptions, complete awareness and understanding of oral PrEP was low, including evidence of misconceptions. Many community members confused oral PrEP with PEP, and many viewed PrEP as being an intervention for sex workers only. Others misunderstood that contraception, alcohol and/or hormonal therapy for transgender populations interfere with PrEP effectiveness. Both younger and older men had concerns about whether PrEP would affect their libido, while both younger and older women expressed fears of PrEP affecting fertility later in life.

When it came to facilitators and barriers to using oral PrEP, communities thought oral PrEP use might be a license for non-condom use with some raising concerns over government's capacity to meet the demand for oral PrEP considering that some districts are already experiencing ARV stock-outs for People Living with HIV (PLWHIV).

Communities expressed feeling anxious over the possible stigma and discrimination that might ultimately be associated with oral PrEP use, coupled with the fear of being labelled as promiscuous or being wrongly identified as a person living with HIV. The pill packaging also raised concerns around storage and how to be discrete about taking PrEP. Both the initial and subsequent regular HIV testing required in oral PrEP use posed as a potential challenge for those considering PrEP.

Several socio-cultural issues also came to the fore particularly associated with gender dynamics. Those consulted acknowledged it would be more acceptable for men to introduce PrEP in relationships compared to women. Some women felt they would rather be infected with HIV within the marriage context, rather than risk the social ramifications of being “found out” using PrEP without their partner’s knowledge and approval. Whether or not to disclose being on PrEP was a contentious issue. Some community members felt a need for users to disclose PrEP use rather than risk being “discovered,” while some felt it made better sense to conceal PrEP use as much as possible in order to foster the greatest level of protection.

Preferred service delivery modes differed by target groups. Older groups felt integrating PrEP into ART and or family planning services would be ideal, given their regular visits to other services. Younger groups on the whole preferred having discreet ways of accessing PrEP and tended to prefer more stand alone and specialized services. ABYM specifically wanted service providers to be mature enough so they are not physically attracted to them.

Lastly, communities emphasized the need for PrEP communication that goes beyond delivery of basic information; rather, they wanted communication that was effective enough to trigger individual action. Communication should speak to individual situations and elevate their risk perception which would ultimately make them realise how much they would benefit from oral PrEP as individuals.

Based on these findings, we make the following summary recommendations:

- 1: Promote favourable and accurate perceptions about and use of oral PrEP, by engaging with end users, supporting providers with training and supervision, and engaging with key

power players like men, community and political leaders that can potentially hinder successful uptake, retention and adherence to PrEP.

2: Engage in developing and disseminating communication messages through channels that promote understanding and demand for oral PrEP

3: Identify and invest in preferred oral PrEP service delivery models for various population groups representing potential end-users

1.0 Background

In 2016, there were an estimated 36.7 million people living with HIV globally and an estimated 2 million new infections every year. Although the global efforts to strengthen HIV prevention and treatment programs have led to a 16% decline in new HIV infections from 2010(2), the rate of decline is far too slow to reach the fast track target of 500,000 or fewer new infections per year. Populations at higher risk of new infections include young women aged 15-24 years, sex workers, people who inject drugs, men who have sex with men, prisoners and transgender people.

In Zimbabwe, there are an estimated 1.3 million people living with HIV, a national HIV prevalence of 14.7%, and incidence of 0.48% among adults aged 15-64 years(3). The country has made significant progress towards achieving the 90-90-90 fast track targets, achieving 74%, 87% and 86% respectively. Despite this progress, however, the country recorded 33,000 new HIV infections in 2016 and 44,000 HIV related deaths. Zimbabwe has pledged its commitment to achieving the vision of zero new infections, zero HIV related deaths, zero discrimination and ending AIDS by 2030.

In 2015, the World Health Organization (WHO) published guidance on antiretroviral therapy (ART) including oral pre-exposure prophylaxis (PrEP), recommending oral PrEP to be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention. PrEP is defined by WHO as the use of antiretroviral drugs before HIV exposure by people who are not infected with HIV in order to prevent the acquisition of HIV. WHO also defines substantial risk of HIV infection as HIV incidence around 3 per 100 person-years or higher in the absence of oral PrEP. This high level of HIV incidence has been identified among some groups of MSM, transgender women in many settings, sex workers and heterosexual men and women who have sexual partners with undiagnosed or untreated HIV infection.

Zimbabwe adapted the WHO guidance on oral PrEP, and HIV treatment for all infected with HIV, and launched the ***Consolidated Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe***, in December 2016. Zimbabwe has previous experience delivering oral PrEP prior to launching these guidelines. Research and demonstration projects on oral PrEP were implemented in the country as early as

2009 through a demonstration project among FSWs in selected sites in the country. This was followed by DREAMS – an initiative aimed at empowering AGYW and reducing HIV incidence in 6 districts namely Harare, Mutare, Bulawayo, Gweru, Mazowe and Makoni. In June 2017, Wilkins Infectious Diseases Hospital became the first public sector health facility to offer PrEP for MSM through the gender based violence (GBV) clinic. The national guidelines provide an opportunity for Zimbabwe to scale up oral PrEP beyond demonstration project status.

The guidelines identify individuals belonging to key population groups that may be at an increased risk of HIV infection compared to other groups, and thus, may be considered for oral PrEP. These groups include:

- Female and male sex workers;
- Sero-discordant couples (the HIV seronegative partner);
- Adolescent girls and young women;
- Pregnant women in relationships with men of unknown status;
- High-risk men (MSMs, prisoners, long distance truck drivers); and
- Transgender people.

Although Zimbabwe has identified these priority populations, the guidelines also ensure that PrEP will be accessible to all individuals who are at substantial risk for HIV infection and may benefit from oral PrEP, whether or not they belong to one or more of these groups.

Oral PrEP acceptability has been researched through studies among multiple populations, including women, sero-discordant couples, female sex workers, young women, people who inject drugs, transgender people and men who have sex with men (4). In addition, the provision of oral PrEP to diverse populations has proven feasible in multiple trial and demonstration project settings. In Zimbabwe, such projects include the provision of oral PrEP to sex workers and young women engaged in transactional sex under DREAMS, oral PrEP demonstration studies conducted by the centre for sexual health and HIV research among female sex workers, and research studies providing oral PrEP to adolescent girls and young women (HPTN 082, MTN 034).

However, there are significant gaps in oral PrEP implementation, and questions about how to scale-up oral PrEP on a national level in a way that ensures equitable access to PrEP. These include limitations in health system capacity; and stigma, legal and human rights concerns for key population groups; and the need for approaches to identifying individuals and populations at risk; and promoting efficient and effective use of oral PrEP, including prevention effective adherence.

In partnership with Ministry of Health and Child Care (MOHCC), the National AIDS Council (NAC) and with support from Optimising Prevention Technology Introduction on Schedule (OPTIONS)¹, Pangaea Zimbabwe AIDS Trust (PZAT) conducted community dialogues with potential oral PrEP users to gather evidence on the acceptability of, and current knowledge and key concerns about the delivery of oral PrEP, to inform its rollout in Zimbabwe. These dialogues were part of a larger effort on the part of MoHCC to align policies and resources and stimulate action and sustainability, help communities identify roles and responsibilities to support the service delivery of oral PrEP as well as build public consensus and commitment necessary for oral PrEP implementation.

2. Aims and Objectives

2.1 Aims of the oral PrEP Community Dialogues

The overarching aim of the oral PrEP community dialogues was to explore and understand community-level perceptions about oral PrEP, and identify potential facilitators and barriers to uptake and use of oral PrEP as a new HIV prevention intervention in Zimbabwe.

The purpose was to gather evidence to inform the development of the National Oral PrEP Implementation Plan, used to guide and operationalize the introduction and roll-out of oral PrEP through implementation of Zimbabwe's oral PrEP guidelines.

¹*The Optimizing Prevention Technology Introduction on Schedule (OPTIONS) consortium is one of five interlinked projects funded by the U.S. Agency for International Development (USAID), in partnership with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), to expedite and sustain access to antiretroviral-based HIV prevention products.

2.2 Objectives

The objective of the community dialogues was to gather information representing community perspectives on the following:

- Perceptions of the community about oral PrEP effectiveness and safety and identify potential beneficiaries
- The facilitators and barriers to oral PrEP uptake, utilization and adherence, including understanding of myths and misconceptions about oral PrEP

Preferred oral PrEP service delivery models for various population groups representing potential end-users

Acceptable and accessible communication messages and channels for promoting understanding and demand for oral PrEP

In addition to the stated objective, a secondary guiding principle was to use the dialogues as a platform to share basic information on oral PrEP with the community members and address emerging misconceptions.

3.0 Methods

In total 21 community dialogues were conducted in 8 provinces in Zimbabwe. A standardized discussion guide was used to ask participants about their perceptions of oral PrEP, and to identify potential facilitators and barriers of use, and to explore preferences in communication and service delivery models for oral PrEP. Table 1 highlights the geographic spread of locations where the dialogues were conducted, and the different population groups represented.

Table 1: Overview of populations groups and geographical locations of community dialogues

Population group	Number of dialogues	Province	District	Urban/Rural
Adolescent girls,	2	Harare	Harare	Urban
		Manicaland	Buhera	Rural
Adolescent boys,	2	Harare	Harare,	Urban
		Masvingo	Gutu	Rural
Young women	2	Mashonaland East	Marondera,	Urban
		Mashonaland East	Murehwa	Rural
Young men	2	Midlands	Gweru	Urban
		Midlands	Shurugwi	Rural
Students in tertiary institutions	2	Midlands	MSU	Rural
		Mashonaland West	Chinhoyi	Urban
Adult men	2	Matabeleland South	Beitbridge,	Urban
		Midlands	Lower Gweru	Rural
Adult women,	2	Matabeleland South	Beitbridge,	Urban
		Midlands	Lower Gweru	Rural

Population group	Number of dialogues	Province	District	Urban/Rural
Pregnant and lactating women	2	Bulawayo	Bulawayo	Urban
		Mashonaland East	Seke	Rural
Influential leaders in communities including traditional leaders, religious leaders, political leaders, educationists, traditional healers	1	Mashonaland East	Seke	Rural
Internally displaced populations	1	Harare	Hopely	Peri urban
Men who have sex with men (MSM)	2	Harare	Harare,	Urban
		Bulawayo	Bulawayo	Urban
People living with HIV	1	Manicaland	Mutare	Urban
Total	21			

3.1 Approach for selecting community groups

The team first identified 14 districts with high HIV prevalence by consulting the list generated by the hotspot mapping exercise conducted by the National AIDS Council in 2015. Districts were chosen to ensure inclusion of both urban and rural high-risk settings to align with the national guidelines. Additional considerations for the selection of districts included time, ease of geographic access and available resources.

Within selected districts, the team identified population groups shown in Table 1. Through the established NAC structures at local level, certain groups were then mobilised and invited to participate in the community dialogues. Participants were reimbursed for their time and transport. A total of 630 people participated in dialogues.

3.1.2 Participant profile

Individuals selected for participation in the dialogues met the following profile: 1) being aged 13 years and above and 2) being a member of at least one of the priority population groups in Table 1. All participants were informed that their participation was voluntary, and all included individuals expressed their willingness to participate. Parental or guardian permission was sought for the participants aged 13 to 15 while a few were emancipated minors² from rural communities who offered their own consent.

3.1.3 Mobilization of dialogue participants

Mobilization of community dialogue participants was conducted by The National AIDS Council, a government parastatal mandated to coordinate the national multi sectoral HIV response. NAC operates through established structures from national to the ward level put in place to aid the coordination of the HIV national response at all levels. NAC utilized its infrastructure at ward level to mobilize participants through the District AIDS Action Committees (DAACs) using NAC registers. Using the registers, the Village Action AIDS Committees (VAACs) and Ward Action AIDS Committees (WAACs) identified potential participants and conducted door-to-door mobilization prior to the community dialogues.

All community dialogues were held at a NAC-designated venue within selected communities, in settings where community members were assured of confidentiality.

3.2 Data collection

The oral PrEP community dialogues were guided by a standard tool (Annex 1) that explored the following themes:

- Knowledge of oral PrEP
- Preferred sources of health information
- Potential barriers to oral PrEP use
- Potential facilitators of oral PrEP use
- Preferred modes of service delivery

² Emancipated minors in Zimbabwe are defined as those below the age of legal consent and have assumed adult roles, some may be married or heading households

- Preferred health care providers
- Gender based violence/Intimate partner violence as an unintended social harm
- Disclosure of oral PrEP use
- Support needed to initiate and stay on PrEP during periods of risk

The community dialogue guide was developed through a consultative process including peer review by members of the National Oral PrEP Technical Working Group (TWG) and the OPTIONS Consortium.

Two teams conducted the field-based dialogues in August and September 2017. Each team comprised of a facilitator, note taker, one MoHCC and one NAC official.

Dialogues commenced with welcome remarks, introductions and stating the objectives. Participants expressed willingness to participate in the dialogue and for facilitators to record the proceedings. Ground rules for the dialogues were agreed among the group. The dialogues were audio recorded. At the end of each dialogue, the facilitator and note taker met to debrief and share issues that emerged which were then recorded on a daily report template. The note-taker would listen to the recorded dialogue whilst compiling detailed notes, and subsequently compile a daily report using the template provided (see Annex 2). In total, 21 daily reports and recordings were generated from the dialogues.

3.3 Analysis

To analyse the community dialogue reports, first 3 team members read the reports. The analysts recorded emerging themes and relevant quotations into a data analysis tool (Annex 3). Brainstorming sessions were held among the analysts and project leads to understand and summarize emerging themes. These themes were subsequently documented with relevant supporting quotations from the community dialogues.

Preliminary findings from early rounds of the analyses were presented to the oral PrEP technical working group (TWG) as part of the feedback process, and to inform the development of the implementation plan.

4. Findings

4.1 Demographic data

Table 2 presents the demographic characteristics of the 630 community members who participated in the 21 oral PrEP community dialogues across Zimbabwe by target group.

The population groups involved in the dialogues included AGYW, ABYM, students within tertiary institutions, pregnant and lactating women, MSM, transgender populations, female and male sex workers, adult women, adult men, people living with HIV (PLHIV) and influential leaders within communities.

Across all groups, participants had a mean age of 31 years and an age range of 13-75 years. The majority of the dialogue participants were females. Twelve of the 21 dialogues were conducted in urban settings, and eight were in rural settings, with one dialogue conducted in a peri-urban area.

Table 2. Demographic distribution of oral PrEP community dialogue participants by age and population group

Target population	Age range	Mean age	Number of participants	Number of Dialogues
AGYW	13 - 24	20	107	3
ABYM	16-23	23	55	2
FSWs	16-50	28	74	2
Young men (artisanal miners)	17-44	29	30	1
Adult women	17-50	36	51	2
Adult men	28 - 80	49	45	2
MSM and transgender	19 - 47	28	52	2
PLHIV (adult men, adult women, AGYW, ABYM)	17 - 57	34	33	1
Internally displaced populations	18 - 64	37	30	1
Pregnant and lactating women	18 - 51	26	63	2
Influential leaders	27 -75	52	29	1
Students in tertiary institutions	18 - 26	21	63	2
Total			630	21

4.2 Findings and emerging themes

The following sections highlight the findings from the community dialogues, including the key themes that emerged from the analysis organized by study objectives.

4.2.1: Perceptions of the community about oral PrEP and potential beneficiaries

4.2.1.1 Oral PrEP awareness

Oral PrEP awareness was generally low across all population groups in both urban and rural settings. Most people had learned about oral PrEP for the first time only during the community dialogues. However, some members of key population groups had exposure to oral PrEP through research or programs targeting their communities. For example, some AGYW and FSW staying in research communities where oral PrEP demonstration and or oral PrEP research studies had taken place* expressed previous knowledge about oral PrEP. Similarly, some representatives of the MSM and transgender communities were familiar with oral PrEP through Population Services International New Start Centres and Wilkin's Hospital's GBV clinic, which are currently delivering oral PrEP in Harare.

Other sources of information on PrEP were reported to come from peers during social gatherings (bars, clubs etc.) and civil society organisations working with prisoners.

4.2.1.2 Incomplete understanding, misconceptions and concerns about oral PrEP

Incomplete understanding and misconceptions were apparent given community members' relative new exposure to oral PrEP. Furthermore, there were a lot of concerns raised around oral PrEP use. For example, many community health care workers confused oral PrEP with post-exposure prophylaxis (PEP). At general community level, myths and misconceptions associated with oral PrEP included:

3.*CeSHHAR Zimbabwe sex work sites that were implementing PrEP demonstration studies. Chitungwiza had several PrEP studies

- **Oral PrEP will interfere with contraceptive effectiveness**

Many women in both urban and rural settings expressed concerns on hormonal contraceptive interaction with oral PrEP. For example, most women on the oral pill and

depo (DMPA) were worried and feared the possibility of falling pregnant whilst using oral PrEP.

“Can you use both PrEP and the contraceptive pill, will one not fall pregnant because of PrEP? (Pregnant women group)”

- **Oral PrEP will interfere with my hormonal treatment**

In dialogues conducted with transgender populations in Harare and Bulawayo, concerns were raised on possible hormonal interaction with oral PrEP. A few indicated they were on hormonal therapy and wanted to know if there was evidence showing efficacy of oral PrEP whilst one is on hormonal therapy. Fears were also expressed on whether oral PrEP would slow down their transition.

“Is there any drug interaction between hormonal treatment and PrEP (MSM and transgender group,)?”

- **Alcohol/ substance use will interfere with oral PrEP effectiveness**

Generally, there were concerns around substance/alcohol with PrEP use. This was mainly raised by FSWs, young men and MSM. They were concerned that alcohol was such a big part of their lifestyle and oral PrEP would potentially be less effective for them.

“So, some of us go to the bars, will PrEP work after I take my beer?” (FSW group)

- **Oral PrEP will affect my libido**

A major concern for adult men, younger men and women in both urban and rural areas was on oral PrEP potentially reducing their libido. This issue was discussed extensively because culturally, a man’s masculinity is associated with his libido. Men wanted to find out if oral PrEP would affect their sexual appetite.

“Will this pill not lower my sexual drive when I want to have sex with my wife?” – (Adult men, Lower Gweru)

- **Oral PrEP will affect my fertility later on in life**

Young women in urban, tertiary institutions and a few in rural areas expressed fears of infertility later in life after oral PrEP use.

“Will this pill not make the young ones infertile and unable to have children in future after continued use?”- (Adult men group)

- **Oral PrEP is for Female Sex Workers**

Most participants thought that oral PrEP was for FSWs given that the first demonstration project conducted in Zimbabwe was delivering oral PrEP among FSWs only.

- **Oral PrEP will result in non-condom use**

Both young and adult men in rural and urban settings believed that there would be no need to continue using condoms for those on oral PrEP. Adult men in one group specifically said they thought introducing oral PrEP would result in non-condom use amongst adolescent girls and boys. There was a general feeling from adult men that since oral PrEP protects from HIV acquisition, young people might throw caution to the wind.

“With PrEP, is there a need to continue using condoms?” (young man (artisanal miners))

“We were starting to think that this PrEP has come as a licence for people to stop using condoms.”- (Adult men)

“If my girlfriend finds out that I am on PrEP, she would want us to have unprotected sex.”- (ABYM)

A few MSM and transgender participants were under the impression that PrEP could be taken as just one pill before a sexual encounter and offer one full protection from HIV. This information was coming from their sexual partners.

“We were talking about unprotected sex at the bar, and one of the guys was saying there is a new pill that has been brought in from abroad. If you take it, you can’t catch AIDS, but the only boring part is that you have to take it every day for 5 days.” (MSM group)

“We heard that one can take PrEP there and there, just before sex and you will be ok.”
(MSM group)

- **Conspiracy theory**

A few students from tertiary institutions and adult men in some rural areas thought that the introduction of oral PrEP was one way that the Western world was planning to get rid of African populations.

“I think this (PrEP) is a way of trying to wipe us all out” (tertiary student group)

“Are they trying to sterilise us...will this not make us sterile?” (Adult men group)

- **Government’s capacity to provide oral PrEP**

Apart from individual concerns, most community members were not confident that the government would have the capacity to procure and sustain the delivery of PrEP given challenges experienced in procuring HIV treatment medicines and sustaining PLHIV on ART. It was reported that some districts are experiencing drug stock outs and government is unable to consistently supply ART and fully meet the needs of PLHIV.

4.2.1.3 Acceptability and perceived benefits of PrEP

After basic information on oral PrEP was shared (i.e. what it is, how it works, eligibility, national plans for rollout), participants across all communities generally viewed oral PrEP as a welcome additional HIV prevention option that will be added to the combination HIV prevention package.

In terms of potential benefits, young women talked about PrEP as potentially providing a prevention alternative that they could use without their partner’s or parent’s knowledge, thus offering a tool to potentially improve their agency and provide effective options within inequitable relationships to prevent HIV.

“The way one doesn’t disclose to their parents that they are using condoms should apply to PrEP.” (Student in tertiary institution, Chinhoyi)

The idea of using oral PrEP covertly was more prominent among young women in urban settings compared to those in rural settings. The general observation was that young women in rural areas were not as vocal as their counterparts in urban areas.

For young people living with HIV (who were part of the PLHIV group), PrEP offered hope that it would provide more options for them to date whomever they wanted, regardless of their HIV status, given that PrEP could potentially provide protection against HIV for their HIV negative partner/s. PrEP was viewed as a game changer among sero-discordant couples, especially where the HIV positive partner is not adhering well to treatment or for some other reason is not virally suppressed.

Participants described how the availability of PrEP theoretically offers more freedom to engage in relationships, fall in love with and have sex with partners, regardless of HIV status.

“There is no reason why people cannot love each other anymore regardless of your HIV status.” (ABYM group)

“With PrEP, I can date anyone, positive or negative. I will be taking my ART whilst they are taking their PrEP. I think that is fair.” (PLHIV group)

Among women across all communities, PrEP was seen as empowering for those who were unable to successfully negotiate for consistent condom use.

Older women felt that introducing oral PrEP in the home, would be a sign that one is HIV negative. This could be more acceptable and easier than bringing ART in the home.

“It’s easy to take PrEP because my spouse will be pleased to know I am HIV negative.”
(Adult women group)

4.2.2 Facilitators and barriers to oral PrEP uptake, utilization and adherence, including myths and misconceptions about oral PrEP

4.2.2.1 Potential Barriers

Communities highlighted potential barriers to PrEP uptake and effective utilization. These potential barriers ranged from the need for HIV testing as the entry point into PrEP services, stigma and discrimination, provider attitudes and packaging of the PrEP medicines.

Participants highlighted ongoing fears around HIV testing as a potential barrier to oral PrEP, given that an HIV negative test is required for one to be able to access PrEP, and the frequent HIV testing that is required once on PrEP.

“This HIV testing is a problem, why do I need to get tested.” (young men group (artisanal miner))

“HIV testing requires one to go to the clinic where we hardly go, so, that does not work.” (AGYW group)

“The testing issue is a problem, at times they have mobile services but, not all the time.” (Adult women group)

4.2.2.2 Stigma and discrimination

Community members were worried about the potential for stigma as PrEP drugs are antiretroviral drugs (ARVs), the same group of drugs used for the treatment of PLHIV. HIV negative participants echoed potential unwillingness to be associated with ART for HIV treatment. The concern was on how communities would tell an HIV positive person on ART apart from an HIV negative person on PrEP.

“People in the community gossip a lot, what more will they say when they see someone taking PrEP.” (PLWHIV group)

The current packaging for Truvada® appeared to be a potential barrier to uptake. There was stigma reportedly associated with the packaging of the pills which resembles that of ART drugs. The dialogues revealed fear of being seen with oral PrEP drugs that are associated with being HIV positive by the communities. From the dialogues held, AGYW, MSM and FSWs specifically singled this out as a potential barrier. The rattling sound the pills in the container make, the bulkiness of the packaging and the size of the pills were perceived as unfriendly. Some community members who had experience in using PrEP said the pill is too big and difficult to swallow at times.

“It is better for them to put PrEP in the little plastic packets, at least no one will notice you have some drugs.” (AGYW group)

PrEP packaging raised two main fears from the community perspective, namely, fear around PrEP users being mistaken to be living with HIV and fear of being labelled promiscuous or one who engages in inadvertent risky sexual behaviours. This mainly came out from the AG, YW, adult women, students in tertiary institutions, pregnant and lactating women.

“That pill container is too big. Where do you put it?” (FSW group)

Communities also raised concerns about stigma and discrimination against most high-risk groups, and about who and how one is determined to be in need of PrEP. Some participants were apprehensive about discrimination by health workers, which may result in people at substantial risk, such as sex workers and MSM, being denied access to PrEP due to their negative attitudes towards these populations. Service delivery models such as standalone clinics for PrEP for certain key population groups like FSW and MSM, as well as the use of tools such as the OI/ART Patient Booklet that easily identify clients as coming from key population groups, were perceived to be potentially discriminatory, and might deter people from accessing oral PrEP. Communities emphasized their disapproval of PrEP being delivered through the opportunistic infection clinics where ART is normally delivered. Being seen at the opportunistic infection clinic is reportedly associated with being HIV positive, and all the groups we spoke to agreed on this.

Communities thought it would be inappropriate for an HIV negative person to be seen accessing care from that clinic as it would bring about stigma.

“In our community, people on ART are given green files when they go to collect their pills. We don’t want the same system for PrEP.” - (AGYW group)

4.2.2.3 Socio-cultural norms/ Power dynamics

Power dynamics, which is the ability to influence or outright control the behaviour of people based on social structures, was highlighted as a potential barrier to PrEP uptake and utilization. It was highlighted that the context in which the communities exist is patriarchal, which largely excludes women from decision making processes. This results in women making some choices and trade-offs on sexual and reproductive health services. This was raised in several groups including AG, YW, adult women, MSM and influential leaders

Gender and relationship dynamics were highlighted as potentially having an effect on PrEP usage. For example, it is culturally acceptable for a man to have multiple sexual partners without being questioned by their wife or partner but, it is unacceptable for a woman to have other or multiple partners. Because of this, women felt it would be difficult for them to introduce PrEP in a marriage or relationship, without their partners feeling accused, or accusing them of having other partners, potentially causing problems in the relationship. With this cultural context, women felt it would be easier for men to introduce PrEP in the home.

“It is better to be counselled together, that way a man can initiate PrEP which is more acceptable.”- (Adult women group)

Whilst oral PrEP was viewed as acceptable, there were some strong views that brought out the value of notifying and negotiating with one’s partner before being initiated on oral PrEP. Some older women and pregnant and lactating women found it unacceptable to initiate PrEP without first discussing with their husbands prior to initiation. Even if a woman had a reason to believe her husband had secondary partners, having a discussion about oral PrEP was reportedly *“the right thing to do.”* If the husband is not agreeable, it would be prudent for the woman to comply.

It was a common sentiment among women that it is easier for men to engage in risky behaviour and use PrEP than for women because of the prevailing socio-cultural norms that are more tolerant towards men having more than one sexual partner than women. Women are expected to comply with men's sexual behaviour. For example, some women said that culturally, it would be unacceptable for them to use PrEP without disclosing it, and if they were to be "found out" using PrEP, they would risk being accused of being unfaithful, and even be subject to violence and or losing the relationship.

"If you are seen with the PrEP, you will be asked to go back to your parents' house, that marriage will be a thing of the past." (Pregnant and lactating women group)

Some of the older women and pregnant and lactating women felt if their husbands were not agreeable to them taking PrEP, the stakes would be too high for them to go against that decision. They felt their marriages were too important to risk over using PrEP. Some married women felt HIV infection within a marriage setting would be embraced with dignity than risk losing their marriage or social standing by being discovered on PrEP.

"It is better for you to contract HIV than be seen with the PrEP pills, you will be chased away from the house." (Pregnant and lactating women's group)

"It is better and more dignified for one to contract HIV in a marriage setting rather than go against your husband and take PrEP." (Pregnant and lactating women's group)

"He will kill you if he discovers you are taking PrEP without disclosing to him." (FSW group)

However, it would be assumed that if a man wanted to use oral PrEP, he would not be held to the same standard and would have the freedom to use PrEP without disclosing it. This was compared to the double standard that is often experienced by women in

relation to condom use, where men use condoms with secondary partners, but do not accept it when their female partners try to introduce condoms.

“Even if you see a condom in his trousers as proof that he uses condoms out there, if you try to introduce condoms in the home, he will refuse. You will be the one who is accused of infidelity.” (Adult women group)

This issue was underscored when we spoke to artisanal miners (unskilled miners) who generally spend long periods of time away from their families at the mining sites which are frequented by FSWs. It was reported that some would end up hiring the services of FSWs. Some artisanal miners reportedly use condoms, but this was not an issue that is discussed at home. The artisanal miners highlighted that the same way some of them use condoms whilst at the mining sites without informing their primary partners is the same way they would use PrEP.

“We cannot disclose to our wives that we are taking pills.” (artisanal miner)

“We will use PrEP in secret just like we have been using condoms with our secondary partners without our primary partner’s knowledge.” (Male Artisanal miner,)

Similar to heterosexual relationships, some same sex relationships were reported to have power dynamics as highlighted above. Among men who have sex with men (MSM) some of those who described themselves as representing the “female partner” in the relationship thought it would be important that PrEP messages reach the MSM “male partner” directly. There was an acknowledgement that they are hard to reach and most of the “male figure heads” would not want to be identified because they may also be married and in heterosexual relationships, have sex with other men without disclosing it to their wives, partners or families. The “female figures” in MSM relationships felt disempowered to introduce PrEP in their various relationships and reported hesitancy in initiating PrEP without the male figureheads’ knowledge.

“It is better for PrEP to be suggested by the man in the relationship because it is romantic and more acceptable.” (MSM group)

Some of the participants from “adult” groups discussed their feelings about PrEP as parents of young and/or adolescent women. Some parents expressed discomfort in discussing PrEP with their AGYW, some equated such discussions with encouraging young women to engage in pre-marital sex which they found culturally unacceptable.

‘It is culturally unacceptable to discuss issues to do with sex with our children....’ (Adult men group)

However, it was interesting to note that parents living with HIV had a different perspective to that raised by the general adult discussion groups. They embraced the idea of conversing with their children about PrEP. Their general feeling was that PrEP could potentially offer a level of protection from HIV to their children which they wish they could have used, had PrEP been available then. They viewed HIV as a threat and were able to conceptualise the benefits of prevention.

‘Now that we know about PrEP, we are going to inform our children when we get back home.’ (PLHIV group)

4.2.2.4 Disclosure

PrEP disclosure was raised as a big issue also linked to the power dynamics in relationships. There were anticipated fears associated with PrEP disclosure, especially AGYW and FSWs in urban settings. Fears were mostly centred around partners and clients having a “right” to unprotected sex once they hear one is on PrEP, thereby exposing themselves to sexually transmitted infections (STIs).

‘If I tell my boyfriend that I am taking PrEP, he may start saying that we should have unprotected sex since PrEP will protect us.’ (AGYW group)

Some AGYW felt unsure about disclosing PrEP use to their sexual partners for fear of being labelled as “lose girls.” They felt they were not empowered enough to explain why they felt PrEP was for them. It was reported that the initial perception in the community was that PrEP would be a good fit for FSWs given they are known to sell sex for a living.

This initial perception reportedly made it difficult for AGYW to disclose their PrEP use since it has some connotations of promiscuity. Further to that, fears of potential rejection after disclosure were expressed.

“If I ever find out that my girlfriend is on PrEP and she did not tell me, I would be very upset. I would even leave her!” (ABYM group)

Some of the fears among AGYW were around having parents and guardians discover through their PrEP use that they were sexually active. Some AGYW explicitly said that the same way they did not announce to their parents when they engaged in sex for the first time is the same way they would keep PrEP a secret.

“You will hide that PrEP just like you hide the \$40 that John (boyfriend) gave you, your mother should never get to know that you are on PrEP.” (AGYW group)

Indirectly linked to disclosure, for some AGYW, adult women and MSM, their fear was around justifying to their partners why they would need PrEP. For them, taking PrEP was an indirect way of acknowledging lack of trust between couples and this was reportedly not an easy conversation to have.

Some AGYW especially in urban settings felt that PrEP would complicate their lives even though they acknowledged its benefits. They were worried about keeping their PrEP use a secret and the potential risk of being discovered. Moreover, the monthly supply further complicated the situation as they felt that it would be difficult to conceal.

“Privacy does not work, I share a room with other people. It is bound to be exposed sooner or later and it may cause problems.” (AGYW group)

“I would rather hide the pills where I store my tea bags or inside a pillow.” (Young women,)

4.2.3. Preferred oral PrEP service delivery models for various population groups representing potential end-users

4.2.3.1 Provider attitudes

There were several concerns raised by specific populations on health service provider attitudes that might affect the uptake of PrEP. All community dialogue participants highlighted poor provider attitudes as a barrier to uptake of health services and health information. This barrier was seen as a major hindrance as it was said to hinder information and quality services from being offered.

“At the public hospital, they don’t give me time. They don’t ask me any questions. They just write a prescription without explaining anything.” (Adult women group)

MSM, FSWs and transgender individuals voiced concerns around how some key populations are generally made to feel unwelcome when they visit health facilities. Community members echoed the fact that there was some level of stigma associated with AGYW who would be seen accessing PrEP. It was also reported that information-giving sessions were not being done consistently by health care workers due to the high volumes of patients who will be waiting to be attended to.

“Some people are afraid of going to the hospitals due to the ill-treatment there.” (FSW group)

“When I go to the clinic to find out about PrEP, the nurse may start asking a lot of personal questions, and judging me for being in a sexual relationship.” - (AGYW group)

“Alice (not real name) here swings when he walks. As soon as he walks into the health facility, people may begin to jeer at him and even mock him. The health workers can even start giving him attitude.” (MSM group)

Participants raised the point that HCWs are community people before they become HCWs and they interact with the communities. With this, there were concerns on where HCWs have been seen to be judgemental when it comes to patients. HCWs were reported to have their own stereotypical person who is expected to come to the health facility seeking STI screening and treatment.

Communities highlighted the fact that although HCWs do not expect married women to be at risk of contracting HIV as they are viewed to be in “stable relationships,” there are some married women who are at substantial risk of contracting HIV due to their

partner's sexual behaviours. They felt that if some married women assess their risk and decide to be on PrEP, they should not be denied the opportunity to protect themselves from HIV.

"My child, should I suffer with an untreated STI because your father is a fool?" (Adult women)

MSM and transgender populations felt that HCWs are people who are used to seeing certain populations, and anything outside the normal confines of what they are used to raises their curiosity. They believed that no amount of training would change the attitudes of HCWs within a general public health facility. One of the participants reported that whenever they saw an MSM or a transgender person they would gather around and start discussing, making them feel uncomfortable and unwanted.

"Even if you train HCWs in a million years, their attitudes will never change." (MSM group)

4.2.3.2 Preferred service delivery models

Communities expressed preferences on how PrEP should be delivered in health facilities. These included:

- Having a *"one stop shop"* model where potential PrEP users will be tested for HIV, counselled and given PrEP in the same room and preferably by the same health worker. Participants, especially young women and FSWs, felt that referrals to other departments or health facilities would contribute to losing potential PrEP users along the PrEP cascade.
- Decentralization of PrEP to all levels of the health system, including community level, to improve access and ensure potential PrEP users do not have to walk for long distances in search of PrEP services. In addition, mobile services and outreaches should be offered, where possible, in hard to reach areas.
- Having dedicated spaces for PrEP in the health facilities so that potential users do not spend long periods of time in queues when all they need is to get tested for HIV and get PrEP if they meet the criteria. Dedicated spaces would eliminate the possibility of PrEP users being mistaken for people on ART.

- Dedicated spaces for specific groups like AGYW, MSM and transgender populations. However, some participants felt that this could potentially lead to stigmatization.

“It is better to have a place where I can freely go to as a young woman: where there is a nurse who is trained to serve young women only. Someone with a smiling face and who is relaxed.” (AGYW group)

“We want a central place where one does not have to walk very far to access services and the place should not be a clinic.” (MSM group)

- Some AGYW preferred a week’s supply of PrEP, as this would help reduce the risk of inadvertent disclosure to family members due to lack of private spaces to store PrEP drugs. However, this means more frequent visits to the health facility for supplies.

4.2.3.3 Preferred health worker characteristics

Participants highlighted some preferred characteristics of health workers who might deliver PrEP effectively to the different population groups at substantial risk. There was a general feeling that service providers have to be empathetic, compassionate and friendly to all populations and have the ability to respect privacy and confidentiality. FSWs felt that the service providers should not be from the same locality as them and that there should be a system of rotation such that the HCWs do not stay in one area for too long lest they become too familiar with the FSWs. ABYM felt that the service providers have to be mature enough so they cannot be attracted to them. AGYW preferred non-judgemental health workers who do not view them as too young to be engaging in sexual activity and possibly getting labelled as “lose” when they request for oral PrEP.

“The provider should not be too young such that one can potentially catch feelings with her.” (ABYM group)

“The service providers should not be from this area, like we have with the CeSHHAR staff who come once a week. They should also be rotated every so often so that they do not become too familiar.” (FSW group)

“When I go to the clinic to find out about PrEP, the nurse may start asking a lot of personal questions, and judging me for being in a sexual relationship.” – (AGYW, ABYM groups)

4.2.4 Acceptable and accessible communication messages and channels for promoting understanding and demand for oral PrEP

4.2.4.1 PrEP communication for action

Participants stressed that the way PrEP is communicated as an intervention is important, as it determines uptake, continued use and retention. They reported the need to go beyond awareness in order to trigger actual action. Participants wanted more than just basic information on PrEP, they wanted information that would prompt them to act. Another suggestion was the use of social media platform – including affordable platforms like bulk SMS for information to reach a wide range of people.

Communities pointed out that knowledge on PrEP does not necessarily result in PrEP uptake. The initial push for PrEP should be on building awareness. There was an acknowledgement that communication is a journey. Other HIV programs like VMMC were cited as examples where the communication journey was a long and tough one, with miscommunication in some cases but through that journey, with the good and bad now, most communities are aware of VMMC and most would like to be associated with one of the tag lines such as, “Live the boss life.”

It was recommended that PrEP messaging address the following:

- What PrEP is
- What does the pill look like?
- Pill size?

- Efficacy
- Who is it for?
- Where can one access it?

Some MSM had been hearing about PrEP but, they specifically wanted to know how PrEP could potentially benefit them. There was a call to have MSM PrEP champions who are actually using PrEP so that they share real life experiences. It was recommended that different media targeting the various population groups be employed so that everyone is reached with some form of PrEP messaging.

"This is my first time to hear about this (PrEP). I think it should be advertised a lot using all kinds of ways like fliers, adverts on television so that a lot of people get to know about it." - (AGYW group)

Communities felt it was important to get community-level support for PrEP, as this would help with uptake, adherence, retention, disclosure and support. Communities highlighted their desire to be involved in mobilization activities, PrEP-related dramas and road shows. This involvement would help mobilise people on PrEP and help them to stay on for as long as they perceive themselves to be at risk of HIV. The community was seen as an important player in the success of oral PrEP as people come from and engage in activities within communities.

"Leaving PrEP information at hospitals won't really work because we hardly visit health facilities except when we are sick. You can go for years without visiting a clinic." (ABYM group)

In the past, AGYW were given advice on dating and boy-girl relationships by their aunts. With the disintegration of the extended family, aunts are not as close to the AGYW as they used to be. As such some AGYW strongly felt they are closer to their mothers and would never contemplate using oral PrEP without discussing this with them. For these AGYW, social marketing campaigns targeting their mothers in order to reach them would be more effective in getting PrEP information to them. Given this dynamic, some AGYW were calling for some PrEP sensitization or campaigns targeting the mothers as a means to reach the AGYW.

"Do everything you can to inform our parents about PrEP."- (AGYW group)

PLHIV felt that through their lived experiences with ART, they had a role to play in PrEP delivery by offering adherence support. For those who have moved from first line, second line to third line ART, they could be better placed to talk about drug resistance. There could be a lot to learn from the other programs such as ART.

5. Discussion and recommendations

The community dialogues show that there are some social and structural issues that could prove an impediment to the roll-out of PrEP. As shown in studies elsewhere (5) gender inequality, power dynamics in sexual relations and women's lack of economic empowerment relate directly to patterns of poverty and are key factors in the spread of HIV/AIDS. Issues of mistrust and accusations of infidelity in relationships are a key issue whilst disclosure of risk behaviour and the use of PrEP may result in judgemental responses and harsh treatment of AGYW by parents, partners and service providers. There is need for MoHCC, partners, and donors to think through how to strategically engage communities and support them in successful uptake of oral PrEP while recognising the sensitivities around these dynamics.

Consistent with findings in other communities(6), external stigma was highlighted as a key issue. Potentially stigmatizing factors include being associated with the use of ARVs; being members of key populations such as sex workers and MSM; and using a product for people at substantial risk. Barriers related to stigma should be tackled in order to make headway in HIV prevention.

Some HCWs were not comfortable to offer oral PrEP due to limited oral PrEP information on their part. From literature, there is evidence that service providers can act as potential barriers to access when it comes to new products and interventions (7). Health care workers who are knowledgeable, with the required practical skills and the right attitude determine the uptake and utilization of services such as PrEP. Different population groups, such as adolescents and young people, prefer service providers who are respectful and responsive to their specific needs and can provide client-centred care. As such, provider comprehensive training and mentorship cannot be underestimated as this has direct implications on provider attitudes and whether potential PrEP users will be offered PrEP at the health facility. For AGYW, it is recommended that their vulnerability be highlighted as part of why they would be a potential group to benefit from PrEP. In order to effectively reach key populations, there is need to train HCWs appropriately, capture KP perspectives and identify approaches that are inclusive whilst minimising feelings of stigma and shame.

From the dialogues, it emerged that communities recommended communication that would go beyond information giving but one that would trigger action. Because Oral PrEP is a new intervention, there is need for a strong communication strategy that drives awareness and promotes a context in which PrEP uptake will be stimulated whilst ensuring retention for those at increased risk of HIV infection. Again as been documented in other studies and reviews, (8) new interventions and programs are likely accompanied by various myths and misconceptions. The community dialogues revealed some common misperceptions, such as PrEP is for sex workers, alcohol / substance use will interfere with oral PrEP and oral PrEP interaction with fertility and libido. It will be important to develop advocacy and awareness messages on PrEP and educational materials for demand generation and education on oral PrEP within communities.

There is a strong call to deliver clear non- stigmatizing education and correct messaging which is readily available to communities. In addition, roll-out should be accompanied by use of media that is not only accessible to people but is affordable such as bulk messages. In-order to ensure higher levels of acceptability, messaging has to clearly communicate ownership of the program by MoHCC ultimately being informed by consultations with end users. MoHCC is seen as a credible source of health-related information as such, information coming from MoHCC is usually well-taken. This will ensure there is a more complete understanding of what PrEP is and that the messaging is clear and not misinterpreted.

Communities have found some programs to work more than others. With this benefit of hindsight, communities have strongly recommended the use of campaigns informed by potential end-users and the use of ambassadors who champion PrEP within their own communities to reduce potential product and certain populations being stigmatized.

Given the similarities that exist between PrEP and ART, PLHIV could have a potential role to play in PrEP introduction, specifically in relation to uptake, continued use and adherence. Given that there are some effective strategies that have been employed, PrEP would be more effective if certain lessons are drawn from the national ART

program. Consistent with available literature, the dialogues revealed that many communities still have fears of HIV testing. More work therefore needs to be done to strengthen HTS in support of PrEP delivery.

5.1 Summary of recommendations

Below is a list of recommendations for consideration as MOHCC, partners and donors plan for programming and scale up of oral PrEP.

Recommendation 1a: Promote favourable and accurate perceptions about oral PrEP

1b: Invest in facilitators of oral PrEP uptake and accurate use, and in mitigating barriers

- a) Continue to engage with end users to understand their perceptions and context to inform oral PrEP roll out.
- b) Strengthen HTS to ensure that populations that need oral PrEP are identified and referred appropriately
- c) Sensitively tackle socio cultural dynamics through engagement of key power players like men, community and political leaders that can potentially hinder successful uptake, retention and adherence to PrEP

Recommendation 2: Engage in developing and disseminating communication messages and channels for promoting understanding and demand for oral PrEP

- Develop a comprehensive communication strategy on HIV prevention including PrEP, and target parents, general community members, as well as potential end-users
- Develop IEC materials for demand generation and education on oral PrEP using different channels and platforms based on the different target populations

Recommendation 3: Identify and invest in preferred oral PrEP service delivery models for various population groups representing potential end-users

- a) Integrate PrEP into existing systems and processes to ensure client-centred care that is delivered in a “one stop shop.”

- b) Decentralize services to different levels of the health delivery system and the community to improve access to PrEP
- c) Provide comprehensive training and mentorship for health service providers to ensure delivery of services that are respectful and responsive to the needs of the different population groups
- d) Learn from and adapt some of the effective strategies from other mature programs like ART and VMMC, including interventions to enhance uptake, adherence and retention and effective communication and demand creation
- e) Develop targeted strategies for AGYW to ensure uptake and retention and adherence to oral PrEP. This also applies to other specific groups like FSWs and MSM

6. Limitations

Some groups we conducted in the dialogues had larger numbers making it more complex to attain maximum participation from all participants.

These dialogues were conducted to inform programme planning in Zimbabwe. The approach was designed to identify issues potentially warranting attention and to generate ideas on ways to strengthen the PrEP implementation plan. The findings are not intended to be generalizable within or beyond Zimbabwe.”

7. Conclusions

Oral PrEP is an acceptable HIV prevention option that should be delivered to people at substantial risk, in combination with other known effective prevention methods such as condoms. However, a lot of effort should be put towards raising awareness and educating communities on oral PrEP and combination HIV prevention. In addition, there is need to address social and structural barriers to effective uptake and utilization of PrEP and other HIV prevention services such as stigma and discrimination, power dynamics in sexual relationships, health worker competence, availability and affordability of the services. Lessons on how to address some of the potential barriers to PrEP uptake can be drawn from other mature programmes such as ART and VMMC.

8. References

1. ZIMPHIA. Zimbabwe Population -based HIV impact assessment. Harare; 2016.
2. UNAIDS. Prevention GAP report [Internet]. 2016 [cited 2018 Jan 23]. Available from: http://www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf
3. ZIMPHIA. Zimbabwe population -based HIV impact assessment [Internet]. 2016 [cited 2018 Jan 23]. Available from: http://phia.icap.columbia.edu/wp-content/uploads/2017/11/ZIMPHIA_First_Report_FINAL.pdf
4. Fonner VA, Dalglish SL, Kennedy CE, Baggaley R, O'Reilly KR, Koechlin FM, et al. Effectiveness and safety of oral HIV preexposure prophylaxis for all populations. *AIDS* [Internet]. 2016 Jul 31 [cited 2017 Sep 15];30(12):1973–83. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/27149090>
5. RS S. To have and to hold. Womens property and inheritance rights in the context of HIV / AIDS in sub-Saharan Africa. [Internet]. Washington D.C. International Center for Research on Women [ICRW] 2004.; 2004 [cited 2017 Nov 21]. Available from: <https://www.popline.org/node/235698>
6. van der Straten A, Stadler J, Montgomery E, Hartmann M, Magazi B, Mathebula F, et al. Women's Experiences with Oral and Vaginal Pre-Exposure Prophylaxis: The VOICE-C Qualitative Study in Johannesburg, South Africa. Le Grand R, editor. *PLoS One* [Internet]. 2014 Feb 21 [cited 2018 Feb 12];9(2):e89118. Available from: <http://dx.plos.org/10.1371/journal.pone.0089118>
7. Hasson F, Keeney S, McKenna H. Research guidelines for the Delphi survey technique. *J Adv Nurs* [Internet]. 2000 Oct 1 [cited 2017 Jun 15];32(4):1008–15. Available from: <http://doi.wiley.com/10.1046/j.1365-2648.2000.t01-1-01567.x>
8. Delany-Moretlwe S, Cowan FM, Busza J, Bolton-Moore C, Kelley K, Fairlie L. Providing comprehensive health services for young key populations: Needs, barriers and gaps. *J Int AIDS Soc*. 2015;18(2):29–40.

Annex 1: Community dialogues tool

Community dialogue guide for adolescent girls and young women

Key themes to be explored

- Knowledge
- Where to access oral PrEP –related information
- Service delivery platforms
- Where to access oral PrEP
- Potential barriers to use oral PrEP
- Potential facilitators to use oral PrEP
- Support needed to help retain young women on PrEP
- Who would be the likely service providers
- Disclosure

Introduction

Hi everyone, my name is _____ and I am here with my colleague/s _____ . Today we are here to talk to you about oral PrEP. As you know Zimbabwe released guidance on oral PrEP in December 2016. The guidance says that oral PrEP will be given to all those who are at substantial risk of contracting HIV. In this case – substantial risk simply means/ refers to those people who feel they are at an increased risk or those who feel they could contract HIV due to their individual or partner’s sexual behaviours. The plan is to have oral PrEP delivered to those who need it starting January 2018. Currently, one is able to access oral PrEP from the PSI new start centres in Harare, Mutare, Chipinge, Gweru, Masvingo and Bulawayo. The aim of today’s consultation is to better understand from you as the potential PrEP end-users, what you feel must be done to ensure that when PrEP roll out happens, it happens in a way that meet the end-user needs. This information will be used to shape PrEP roll out, which will start sometime early 2018. The information will also help us identify the HCW’s training gaps, help design the PrEP training curriculum and also help us understand more about what needs to be done within communities before PrEP roll out starts, for uptake, adherence and retention to happen as expected.

Ice breaker questions

What does being healthy mean to you?

Why do we value our health so much?

Where do you see yourself in 5 years?

What would stop you from getting there?

Do you think your health matters at all in attaining your vision?

1. Knowledge questions

What do you know about oral PrEP?

Where did you get the information?

Do you think there are a lot of people who know about PrEP in this community?

Do a lot of people use PrEP?

What else would you like to know about oral PrEP?

2. Access to PrEP information

Where do you normally get health – related information?

How accessible is that information?

Where would you like to access PrEP – related information? Why?

Can you think of 3 places you would like to access PrEP – related information?

How accessible are these places?

What is the best way to disseminate information about PrEP?

In what form should this information be delivered? (Written, oral, visual?) Why?

Who should be targeted with information on PrEP? Where?

3. Preferred service delivery platforms and why

Where do you normally get prevention /health/ reproductive health services?

If you were going to access PrEP, Where would you like to access it?

Can you think of 2 service delivery platforms you would like to access PrEP from? And why?

4. Potential barriers to access PrEP

What are the potential barriers to access PrEP?

What do you think can be done to minimise obstacles to PrEP access?

What factors can make it difficult for a person to access PrEP? Why?

How can these challenges be addressed?

5. Potential facilitators to PrEP

What are the potential facilitators to PrEP?

What do you feel would help with PrEP?

What do you think would help people start on, take and stay on PrEP?

What do you think can be done to make PrEP more acceptable as a prevention method?

What do you think needs to be done to raise awareness of the benefits of PrEP?

As a person engaging in sex, what strategies do you use to minimize your chances of contracting HIV.

6. Support needed to start and stay on PrEP

What do you think potential PrEP users would need to start PrEP?

What do you think potential PrEP users would need to take their PrEP medication?

What do you think potential PrEP users would need to stay on PrEP?

What do you think are the things that can help a person to choose PrEP?

What kind of support can enable a person to take their PrEP medication effectively?

What kind of support is needed to enable a person to adhere to their PrEP medication?

7. Preferred service providers

Now let's discuss the type of provider that young women like you look for when accessing services like PrEP.

- What type of providers do young women prefer?
- Do young women prefer a woman or a man or does it not matter?
- What about the age of the provider?

8. Disclosure

Do you think it is important to disclose when you are taking PrEP?

If you were using PrEP, would you disclose to anyone?

Who would you disclose to? And why?

If you were married, would you disclose to your partner?

GBV

What are the risks of taking PrEP without disclosing to your partner?

In what ways would PrEP cause conflict within relationships

9. Is there anything else related to PrEP you would like to discuss that we did not discuss / cover.

Thank you so much for taking the time to come here and discuss this very important topic with us. We appreciate the time you have taken. If you feel you have more information for us, please contact our colleague xxx who is based here at xxxx

Annex 2: Daily report

Oral PrEP community dialogue daily report template

Date:

Venue:

Target group:

Facilitators:

Report compiled by:

Brief on logistics: challenges faced getting to the venue, mobilizing participants etc.

What went well?

What did not go well?

What can be improved in future?

Were the questions well understood? Do some questions need rephrasing going forward? If yes, which ones - suggestions

Group dynamics: How was the participation, did everyone feel comfortable to contribute, why, why not?

Key issues coming out of the main topic guides

Please write main issues discussed under each topic in bullet form and a summary paragraph

1. Knowledge questions
2. Access to PrEP information
3. Preferred service delivery platforms and why
4. Potential barriers to access to PrEP
5. Support needed to start and stay on PrEP
6. Preferred service providers
7. Disclosure
8. Anything else that came out

Annex 3: Reporting tool

Questions	Theme and sub-themes #1	Theme and sub-theme #2	Theme a
1. Knowledge Questions			
2. Health related information			
3. Preferred service delivery platform			
4. Potential barriers			
5. Potential facilitators			
6. Support needed			
7. Preferred service providers			
8. Disclosure			
9. Anything else?			