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Providers' Knowledge, Attitudes, and Practices about Oral Pre-Exposure Prophylaxis for Adolescent Girls and Young Women in Zimbabwe

Findings from Implementation Science Research

OPTIONS
OPTIMIZING PREVENTION TECHNOLOGY INTRODUCTION ON SCHEDULE

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KEY FINDINGS

- Despite few providers being trained on pre-exposure prophylaxis (PrEP), most had basic knowledge of PrEP.
- Some providers had misconceptions around PrEP eligibility and when PrEP can safely be stopped.
- Providers were least likely to think PrEP should be given to adolescent girls and young women (AGYW) who are married, have a much older partner, or have a sexually transmitted infection.
- Although many acknowledged that adolescent girls could benefit from PrEP, some providers had reservations about them being sexually active and whether they could successfully use PrEP.
- Providers with experience providing PrEP felt that AGYW needed enhanced support from providers, parents, or partners to use PrEP successfully.

BACKGROUND

Daily oral PrEP has demonstrated efficacy in prevention of HIV infection and serves as a revolutionary tool for HIV prevention packages worldwide. Since 2015, the World Health Organization has recommended PrEP for people at substantial risk of HIV infection.[1] Soon after, Zimbabwe's Ministry of Health and Child Care (MoHCC) provided guidance on oral PrEP use.[2] Rollout of PrEP began in 2016, using a phased approach that began with small demonstration projects offering PrEP to AGYW (ages 16–24), followed by provision to key populations including high-risk men and serodiscordant couples.

The phased introduction of oral PrEP in Zimbabwe provided the opportunity for the OPTIONS Consortium to investigate providers' knowledge, attitudes, and practices related to oral PrEP provision to AGYW. The study aimed to evaluate providers' knowledge of oral PrEP, learn about providers' attitudes and beliefs about providing PrEP to AGYW, and identify areas of training that need further support. Results were used to inform Zimbabwe's PrEP implementation plan (2018-2020)[3], identify training needs for PrEP delivery among health service providers, and inform oral PrEP demand-creation activities. This brief describes the key study findings and makes recommendations for provider training to improve PrEP delivery to AGYW.

From 2017 to 2018, OPTIONS conducted a cross-sectional, descriptive, mixed-methods study with health care providers in public and private health facilities in Zimbabwe. Data collectors administered a survey to 127 providers in five of the ten provinces in Zimbabwe, followed by 27 in-depth interviews (IDIs) with a subset of providers who took part in the survey. Nurses, counselors, clinicians, pharmacists, village health workers, and peer educators who were currently involved in oral PrEP provision (57%) or likely to be involved in the future (43%) participated in the survey.

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RESULTS

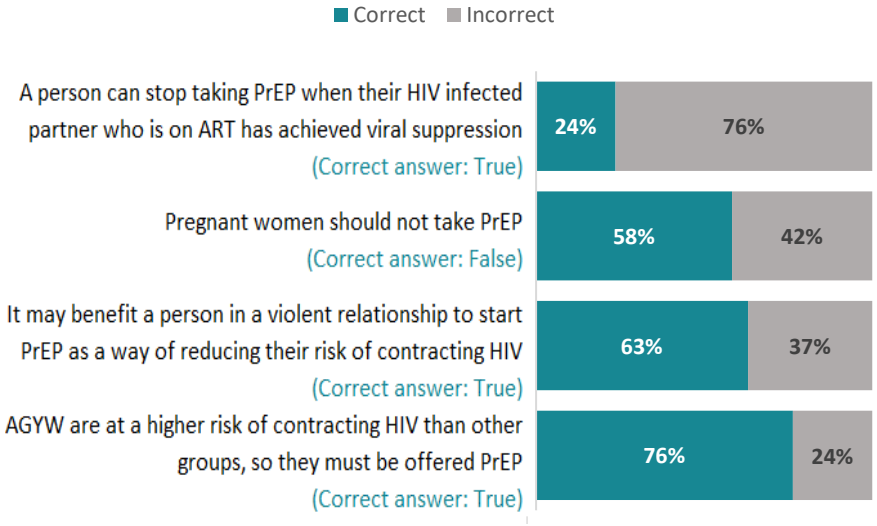
What did providers know about PrEP?

The majority of surveyed providers (77%) had heard of oral PrEP. Participants who said they had not heard of PrEP were given a brief description before continuing with the survey. Some questions were only asked of providers who had heard of PrEP prior to the survey. Only 24 providers had received training on oral PrEP, and they requested additional training in monitoring and evaluation, the risk of resistance, clinical monitoring, and counseling about effective use and adherence.

Despite few being trained, PrEP knowledge was high, as providers on average correctly answered 87% of the 25 knowledge questions. The most common knowledge question answered incorrectly was related to whether PrEP can be stopped if one's partner had achieved viral suppression; only 24% answered correctly (Figure 1). Other questions frequently answered incorrectly were about who should take or could benefit from PrEP—specifically, people in violent relationships, pregnant women, and AGYW.

In IDIs, a few providers expressed misconceptions around PrEP and pregnancy. For example, two participants recommended prevention of mother-to-child transmission services for pregnant women, potentially indicating a lack of knowledge about PrEP being for people who are HIV negative. Other misconceptions related to PrEP and pregnancy included thinking that PrEP prevents pregnancy, that PrEP reduced contraceptive effectiveness, and that PrEP would cause termination of a pregnancy.

Figure 1: PrEP knowledge questions most commonly answered incorrectly (n=127)

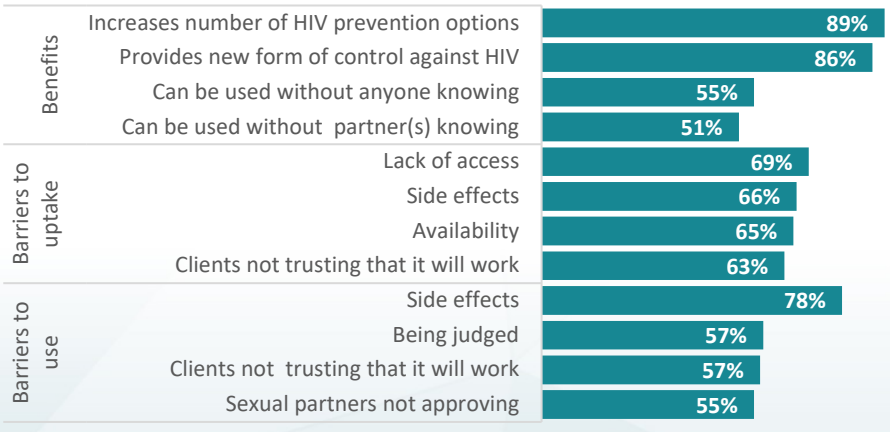


What are health care providers' perceptions and concerns about providing oral PrEP?

Overall, providers believed that PrEP should be provided to all at-risk groups. Most providers (87%) were confident that oral PrEP is effective if used correctly. Commonly mentioned benefits are shown in Figure 2.

Providers were also asked about perceived barriers (Figure 2). Side effects were a commonly mentioned barrier to both uptake and sustained use. This response was subsequently explored further in IDIs, where slightly more than half of providers said that they were not concerned about the side effects.

Figure 2. Commonly mentioned benefits and barriers to oral PrEP uptake and use (n=127)



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One PrEP-experienced provider said:

"They [side effects] are there, but they are minimal. I have also found out that within the first month when you are taking them, that's when you experience a little bit of side effects, but after that, clients will not be having a lot of side effects, so I am not very, very concerned."

– Female nurse, 52 years, PrEP-experienced

Among those who were concerned, the focus was primarily on long-term side effects such as renal and liver impairment. Only one provider mentioned concerns about side effects as affecting long-term adherence. In the survey, other concerns around uptake included lack of access and stock-outs. Potential PrEP candidates' lack of trust in PrEP's effectiveness also came up as a concern for both uptake and use.

How do health care providers feel about providing PrEP to AGYW?

Providers were accepting of providing oral PrEP to a wide range of people. When asked about whether oral PrEP should be provided to AGYW, fewer providers believed it should be provided to adolescent girls (74%) than to young women (89%). When asked about provision to AGYW in different situations (Figure 3), providers were least likely to think PrEP should be provided to AGYW who are married, have a considerably older partner, or have a sexually transmitted infection.

When probed further in IDIs, many providers indicated they understood the unique experiences of AGYW and were able to specify many situations in which married AGYW could be eligible for PrEP. These included if their partner had other partners, they themselves had other partners, or they could not negotiate condom use.

"…So, she will be at risk and will not be mature to refuse or discuss what they would have been told at the clinic and negotiating for a condom might be difficult because the male partner will refuse. So, they should be given [PrEP]. […] *some AGYW are married at a young age and are immature to engage in meaningful discussions about safe sex."*

– Female nurse, 25 years, PrEP-naïve

Similarly, most of the IDI respondents were of the opinion that an AGYW who has a partner who is considerably older should be given PrEP for a number of reasons, the main one being that the older partner may have other multiple sexual partners, followed by AGYW being unable to negotiate safer sex such as condom use in relationships with older partners due to unbalanced power relations.

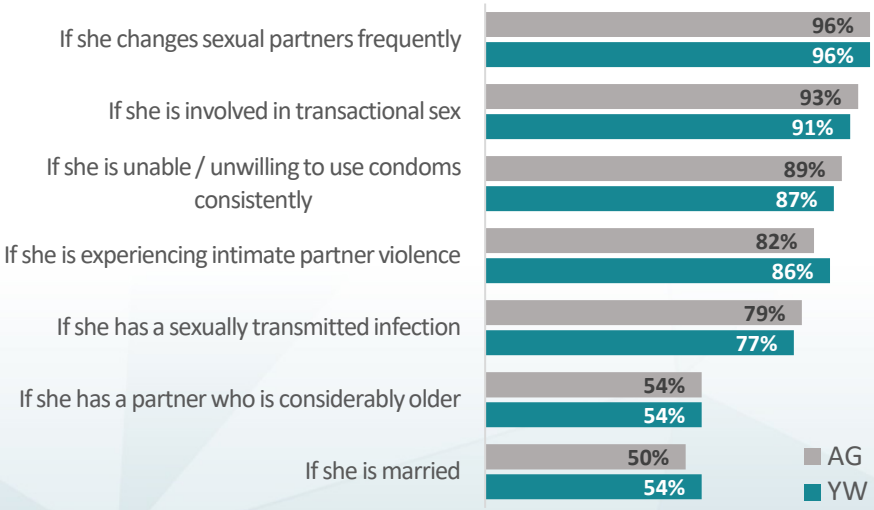
"…these ladies, they have their sexual practices and behaviors, are dependent on those men, so they really need oral PrEP because they cannot negotiate for safer sex."

– Female nurse, 34 years, PrEP-experienced

Generally in IDIs, many providers demonstrated a good understanding of what to consider when working with AGYW. They also noted the need to assess each person's risk, because not all AGYW who are married or have an older partner are at substantial risk.

In the survey, providers had concerns about the ramifications of providing PrEP to AGYW, including that PrEP provision to AGYW would result in a backlash from the community (AG: 69%, YW: 43%) and promote sexual promiscuity (AG: 50%, YW: 42%). Many felt it was better to tell sexually active unmarried AGYW to abstain from sex rather than give her PrEP (AG: 44%, YW: 31%). In IDIs, nearly all providers felt that ideally, adolescents would wait until they are at least 18 to have sex, but many also recognized that some adolescents have sex before age 18 and need HIV prevention education and options.

Figure 3. Percentage of providers agreeing with provision of PrEP to adolescent girls and young women in different situations (n=127)



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"We may discourage it, but adolescents are engaging in sex. We cannot deny that it is happening. Since it is already happening we need to focus on providing them with HIV prevention education."

– Male counselor, 51 years, PrEP-naïve

The issue of whether AGYW were responsible enough to adhere to PrEP was also addressed in the surveys. Surveyed providers were divided on whether adolescent girls are responsible enough to be able to use PrEP consistently (45%), but many more providers (74%) agreed that young women can adhere.

Experiences Providing PrEP to AGYW

Providers' experiences providing PrEP to AGYW were primarily explored in IDIs. Nearly all providers who had experience providing PrEP had provided it to AGYW. Some indicated that delivering services to young women was easier than to adolescent girls, because they are more "mature" and "focused," resulting in better PrEP continuation.

"[Young women] 20-24 years, I have seen that their retention rate is a little better in comparison to those below 20. Yes, I think they more focused, they know their problems, they know their risk and they are determined."

– Female nurse, 52 years, PrEP-experienced

PrEP-experienced providers noted that PrEP continuation and a lack of disclosure to parents and partners were the main challenges faced by AGYW; these were often noted as being a greater challenge for AG. Providers also noted that these challenges were inter-linked: AGYW who felt that they were unable to disclose their PrEP use to their parents would not only lack important social support, but they would also face challenges taking PrEP daily and returning to the clinic for refills when attempting to conceal use.

"In most cases you see they [adolescent girls] will be coming the 1st month, 2nd month, when we go to the 6th month we won't be seeing them. I think the challenge is mainly on disclosing why they are taking those tablets to those they are staying with, and maybe the association with the PrEP with ARVs…So people won't understand that it is medication for prevention and also that it is associated with some kind of mischievous behaviors..."

– Female nurse, 34 years, PrEP-experienced

For these reasons, providers recommended providing intensive counseling, support, and client follow-up to promote successful PrEP use.

RECOMMENDATIONS

The Zimbabwe MoHCC has responded to findings from this provider survey, along with other sources of information, to make the following changes:

- Training was modified to further reinforce PrEP eligibility criteria and situations in which PrEP can be stopped, as defined in the national PrEP guidelines.
- Values clarification exercises were added to the PrEP training curriculum to prepare providers to counsel adolescents effectively on PrEP even if they have personal concerns about adolescents being sexually active.

Based on the study findings, the following are additional modifications that could be made in Zimbabwe to strengthen PrEP services for AGYW:

- PrEP delivery to AGYW will require more time and support than services for other populations.
- Training should help providers feel comfortable working with adolescent girls and prepare them to provide a more intensive level of support.
- Services should be organized to permit adequate time for counseling tailored to the needs of AGYW.
- Resources should be allocated for follow-up of AGYW clients to encourage PrEP continuation.
- Efforts to engage communities around HIV prevention be intensified.

REFERENCES

1. World Health Organization. Guideline on when to start antiretroviral therapy and pre-exposure prophylaxis for HIV. Geneva: WHO; 2015.
2. National Medicines and Therapeutics Policy Advisory Committee, Ministry of Health and Child Care. Guidelines for antiretroviral therapy for the prevention and treatment of HIV in Zimbabwe 2016. Harare: Ministry of Health and Child Care; 2016.
3. Ministry of Health and Child Care. Implementation plan for HIV pre-exposure prophylaxis in Zimbabwe 2018-2020. Harare: Ministry of Health and Child Care; 2018.

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