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“This might be the only place for those kinds of needs”: a qualitative study of U.S. family planning providers’ attitudes towards PrEP for HIV prevention

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Background

- Sexually transmitted infection treatment and prevention are core components of family planning services as defined by the United States Quality Family Planning Recommendations[1]
- Family planning clinics are key access points for women to obtain HIV testing and prevention services
- A recent study demonstrated family planning providers in the United States have limited knowledge about pre-exposure prophylaxis (PrEP) for HIV prevention, and conflicting attitudes towards their roles in HIV prevention[2]
- It is unknown whether family planning providers see PrEP education and provision as within their scope of work

[1]Gavin, Moskosky, Carter et al. **Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of Population Affairs**. MMWR 2014;63(4).
[2] Seidman, Carlson, Weber, Witt, Kelly. **United States family planning providers' knowledge of and attitudes towards preexposure prophylaxis for HIV.** Contraception 2016;92(4).

Objective

To understand United States family planning providers’ attitudes towards integrating PrEP into family planning care

Methods

- Semi-structured topic guide developed
- Emergent design employed to follow new ideas introduced by participants during discussions and adjust the topic guide
- Participants recruited from a national family planning conference and family planning clinics in San Francisco, California and Kansas City, Missouri from November 2015 – February 2016
- Focus groups (45 – 90 minutes duration) conducted with family planning providers and counselors were taped and transcribed
- Open-coding independently performed by 2 investigators
- Codes grouped into themes, and thematic analysis performed

Results

- 5 focus groups (30 total participants)
- Informants included physicians, nurse practitioners, physicians assistants, health educators and counselors at family planning clinics in the United States
- Providers’ experience in family planning ranged from 2 months to 18 years
- 3 themes emerged
  - ***Tension between desire for efficient screening tools and need for in-depth risk assessment***
  - ***Discomfort with “high-risk” patients***
  - ***Commitment to providing PrEP at family planning clinics***

Themes

Tension between desire for efficient screening tools and need for in-depth risk assessment

“You expect me to spend 10 minutes talking to somebody about smoking cessation and using condoms like how the hell is a PrEP conversation going to fit in and based on the way it looks like it takes to prescribe this medication I’m going to have to spend 35 minutes even assessing their risk and talking about adherence…” (FG 1)

“Assessment of whether somebody needs a gonorrhea or chlamydia or HIV test is, a more superficial discussion in a way. You can kind of get to that without going in too deep. But you’re worried that, to go into PrEP, it requires a much deeper discussion that maybe required more rapport with the patient and more sensitivity and that, so you’re saying it’s more than just a few extra minutes.” (FG 2)

“It’s one of the reasons that I think it just needs, like, I think it needs more than just kind of a five-minute conversation because it’s so loaded.” (FG 2)

While providers expressed a need for screening tools to improve efficiency, they recognized risk assessments are “sensitive conversations” that take time and skill to facilitate. Working in reproductive health, they regularly navigate these conversations and know risk is not easily summarized in a checklist. Consequently, time was perceived as a significant barrier to PrEP implementation. While ideas like screening tools were proposed to improve efficiency, there was consensus that comprehensive assessment required in-depth conversations.

Discomfort with “high-risk” patients

“There’s a lot of HIV prevention education and there’s a lot of comfort around EC and chlamydia but when someone has a positive rapid . . . the provider freaked out.” (FG 1)
Note: EC - emergency contraception

“I think one of my concerns with the sensitivity of this conversation is making assumptions about patients related to their sexual behaviour and the potential for bias and – and there’s this tension between, like, we have objective criteria, we think you’re at risk, and patients’ subjective assessment of their own risks.” (FG 2)

“I don’t want to prescribe PrEP. I’m afraid.” (FG 2)

While most providers initially stated their clinic populations were “low risk” and would not qualify for PrEP, many clinicians had examples of female patients who would be eligible. Providers expressed a lack of familiarity with HIV and “high-risk” patients. Even when describing women who would meet “high-risk” criteria by most guidelines, providers were hesitant to label them as such. Reasons for this hesitation included not wanting to blame or stigmatize patients. Providers also identified systems barriers to caring for these patients.

Commitment to providing PrEP at family planning clinics

“I think it makes sense because I think people think about family planning clinics as sexual health clinics, you know, even if they’re not seeking contraception… So, I think that they’re thinking of it as where I go for my sexual health needs. And if that’s what they’re thinking about, then it seems like this would be an appropriate place to at least be able to give information, if not be able to give that to someone.” (FG 3)

“Women say that they like to see their practitioners, and we all have patients that we know that ask for us. And even the patients that we don’t know, I think that we're just taught how to kind of get to the point pretty quickly and make people feel comfortable and kind of disarming. And it's just our model of care, the nursing model. So, I think that this is very possible to do in a quick visit, and we would figure it out, how to talk with the patient. We can do it.” (FG 5)

“Most of them (our patients) are not going to primary care doctors, so this might be the only place that they’re going to for any of those kinds of needs.” (FG 3)

"But there was this whole thing around empowerment and choice which we would have never had before PrEP.” (FG 1)

Despite concerns about time and discomfort with labeling risk, focus group participants concluded PrEP should be provided at family planning clinics. Clinicians noted their patients often do not see other healthcare providers and family planning providers are uniquely equipped to navigate conversations about sensitive topics related to sexual and reproductive health. Finally, subjects expressed responsibility for providing women-centered care and concluded that PrEP, as an empowering choice for women, should be incorporated into family planning care.

Conclusions

- Family planning providers in the U.S. identified barriers to PrEP implementation including lack of time, need for tools to efficiently screen patients, and need for training on HIV and related risk
- Despite barriers, providers were committed to integrating PrEP into family planning care

Significance & implications

- To our knowledge, this is the first qualitative study exploring family planning providers’ attitudes towards PrEP for HIV prevention
- Family planning provider-specific training is needed on HIV and related risk allowing providers to more efficiently incorporate PrEP education and services into their practices

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