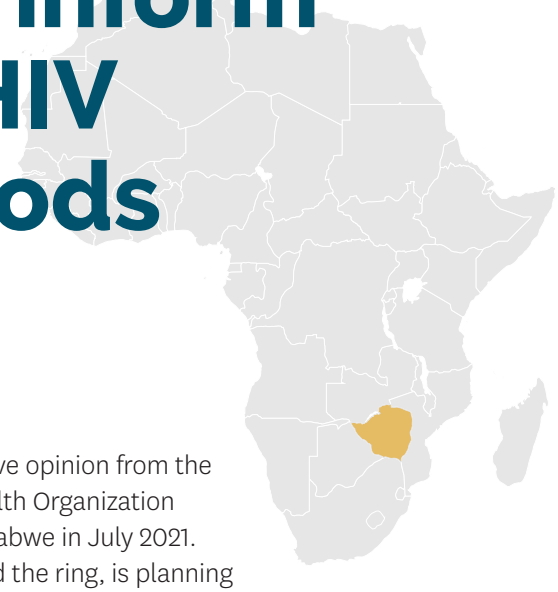
Stakeholder conversations to inform delivery of new HIV prevention methods in Zimbabwe



INTRODUCTION

The dapivirine vaginal ring (the "PrEP ring" or "ring") received a positive opinion from the European Medicines Agency in 2020, was endorsed by the World Health Organization (WHO) in 2021, and approved by Medicines Control Authority of Zimbabwe in July 2021. The International Partnership for Microbicides (IPM), which developed the ring, is planning to introduce it as an additional HIV prevention option for women when oral PrEP is not/cannot be used or is not available. Another form of pre-exposure prophylaxis (PrEP), injectable cabotegravir (CAB PrEP or CAB-LA) has recently shown great promise in clinical trials as an additional, highly effective, HIV prevention method that could be made available in the future. Experience has shown that multiple methods are necessary to meet the HIV prevention needs of women, especially adolescent girls and young women (AGYW), and that expanded method choice has the potential to increase uptake overall. However, little is known about what is needed for health care providers (HCPs) to ensure adequate counseling on method choice, referral mechanisms, and supportive follow-up with regards to multiple biomedical HIV prevention methods. The goal of these conversations with stakeholders,, implemented by the PROMISE and CHOICE Collaborations, was to gain input on implementation considerations from provider and potential end-user perspectives, as well as community-level considerations, to inform the introduction of the PrEP ring alongside oral PrEP and future inclusion of additional prevention methods for women.

METHODS

Six experienced qualitative researchers from Pangaea Zimbabwe AIDS Trust (PZAT), based in Zimbabwe, conducted in-person individual and group conversations in April 2021 using thematic discussion guides adapted for use with each stakeholder group and aligned with national priorities. PZAT was introduced to potential participants in six provinces (Bulawayo, Masvingo, Midlands, Harare, Manicaland, and Mashonaland Central) by the Ministry of Health and Child Care (MOHCC) as part of the team evaluating progress on the country's PrEP Implementation Plan. The goal was to purposively sample participants for the following participant types: oral PrEP and antiretroviral therapy (ART) providers (n=12), family planning (FP) providers (n=8), end users (n=51), and community members (n=20). The total number of participants was informed by standard qualitative research methods and budgetary limitations.

Sample composition

- **12** Oral PrEP providers
- **8** Family planning providers
- **51** PrEP end users
- **20** Community members

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Verbal permission was received from participants prior to the start of the conversations, which were audio-recorded to support fluid and interactive discussion. Detailed notes were also taken during the conversations, omitting any personally identifiable information. This activity was conducted following the COVID-19 prevention guidelines and precautions set by the Zimbabwe government and USAID mission. The activity was determined not to be research by FHI 360's Office of International Research Ethics (IRBNet ID: 1733984-1).

We used a rapid qualitative analysis method to analyze data from the conversations via a two-step process. First, PZAT researchers listened to recordings and referred to notes from each conversation to summarize data for each theme, entering relevant illustrative quotes in a structured table in Microsoft Excel. Next, FHI 360 staff consolidated the summaries from the table by participant type (i.e., provider, potential end user) to identify common occurring themes and to allow comparison across groups.

RESULTS

Whom did we consult during the conversations?

TABLE 1: PARTICIPANTS AND DATA COLLECTION

Potential end user	Data Collection	Total Number of People
End user	7 groups	51
Community member	3 groups	20
ART/PrEP provider	Individual interviews	12
FP provider	Individual interviews	8

Potential end users

Fifty-one potential end users participated across seven groups (see Table 1). Four groups were with AGYW end users the ages of 18–25, one of which was fully comprised of female sex workers (FSWs), and three groups were conducted with older women the ages of 26–29 years.

TABLE 2: PARTICIPANT CHARACTERISTICS: END USERS

Group	Age Range	Marital Status	Education	Use/d Oral PrEP
AGYW (n=24) *9 of these participants were FSWs; 3 were pregnant/breastfeeding*	18-25	Married (n=3) Partnered (n=9) Single (n=12)	Primary (n=0) Secondary (n=10) High school (n=5) Tertiary (n=8) Graduate program (n=1)	Currently using (n=13) Formerly used (n=2) Never used oral PrEP (n=9)
FSW (n=6) *1 of these participants was also pregnant/ breastfeeding*	22-24	Partnered (n=1) Single (n=5)	Secondary (n=5) Tertiary (n=1)	Currently using (n=4) Formerly used (n=2)
Women (n=21) *8 adult women participants were FSWs; 1 was pregnant/ breastfeeding*	26-49	Married (n=11) Partnered (n=1) Single (n=9)	Primary (n=2) Secondary (n=16) High school (n=1) Tertiary (n=2) Graduate program (n=0)	Currently using (n=11) Formerly used (n=5) Never used oral PrEP (n=5)

Community members

Twenty community members participated across three groups. Across groups, participants included HCPs, religious and political leaders, teachers and village workers. Many were also parents of AGYW.

TABLE 3: PARTICIPANT CHARACTERISTICS: COMMUNITY MEMBERS

Group	Age Range	Marital Status	Education	Use/d Oral PrEP
Community 1 (n=9)	30-48	Married (n=7) Single (n=1) Relationship(n=1)	Tertiary (n=2) Secondary (n=5) High school (n=1) Graduate/Doctoral (n=1)	Yes (n=2) No (n=7)
Community 2 (n=5)	30-66	Married (n=4) Single (n=1)	Secondary (n=2) Graduate/Doctoral (n=3)	Yes (n=0) No (n=5)
Community 3 (n=6)	23-56	Married (n=4) Single (n=1) Cohabitating (n=1)	Tertiary (n=2) Secondary (n=3) Primary(n=1)	Yes (n=0) No (n=6)

Providers

Twelve ART/PrEP providers and eight FP providers were interviewed individually. Ten of the ART/PrEP providers and five of the FP providers had been cross-trained for FP/oral PrEP services.

TABLE 4: PARTICIPANT CHARACTERISTICS: PROVIDERS

Provider type	Type of facility	Designation	Experience	Age Range	Use/d Oral PrEP
ART/PrEP provider (n=12)	Public (n=6) Private (n=4) Church-based (n=2)	General nurse (n=11) Primary counselor (n=1)	>6 years (n=3) ≤5 years (n=8) 1 missing	20-39 years (n=4) 40-59 years (n=7) 1 missing	Yes (n=1) No (n=11)
FP provider (n=8)	Public (n=1) Private (n=4) Pharmacy (n=2) Church-based (n=1)	General nurse (n=4) Pharmacist (n=2) Village health worker (n=1)	>6 years (n=6) ≤5 years (n=1) 1 missing	20-39 years (n=2) 40-59 years (n=4) 60+ years (n=1) 1 missing	1 Yes (n=1) No (n=7)

Similarly, about half of the FP provider participants were familiar with the new products: three out of eight had heard about the ring, and four had heard about the injectable.

What have stakeholders already heard about new PrEP products?

TABLE 5: KNOWLEDGE OF NEW PREP PRODUCTS

	Number who had heard of new PrEP products	
	PrEP Ring	CAB PrEP
End users (n=51)	2	2
Community members (n=20)	2	2
PrEP providers (n=12)	5	8
Family planning providers (n=8)	3	4

No community or AGYW end users had heard about the ring or injectable for preventing HIV. Within the FSW group, two participants each had heard about the PrEP ring and CAB PrEP, respectively. These participants had heard that the PrEP ring is inserted into the vagina and reduces the likelihood of HIV acquisition by more than 50%, and that CAB PrEP will also be available soon and prevents the chances of acquiring HIV by more that 99%. The FSWs received this information from their provider, a PZAT-run facility.

All end-user participants were familiar with condoms and oral PrEP for preventing HIV. Some AGYW participants in one group also mentioned abstinence and being faithful, and another group mentioned post-exposure prophylaxis.

Likewise, almost all community participants had not heard about the ring or injection to prevent HIV. Like end users, community participants had some knowledge about other HIV prevention methods. All community member participants were familiar with abstinence and condoms. Some were also familiar with oral PrEP. Participants in two communities discussed voluntary medical male circumcision (VMMC) and in one community mentioned limiting numbers of sexual partners and HIV testing.

About half of the ART/PrEP provider participants were familiar with the new products: five were familiar with the ring, and eight had heard of the injectable. Most participants with knowledge of the ring mentioned knowing it was an alternative to oral PrEP. Three participants noted they had heard the ring was for specific populations, including women, sex workers, or other populations with a higher likelihood of HIV exposure. Participants with knowledge of the injectable said it was a long-acting option to be added to the prevention method suite, with users one day choosing between the injectable or oral PrEP. Providers thought it either lasted for one or two months, and one provider had heard clients could be trained to self-inject it like insulin.

Similarly, about half of the FP provider participants were familiar with the new products: three out of eight had heard about the ring, and four had heard about the injectable. Only one FP provider had additional information about the ring. This participant said the ring is vaginally inserted and releases an antiretroviral drug that prevents HIV from entering the body. Participants who knew about the injectable said that it is a long-acting injection for HIV prevention, and clients will have to get injected every eight weeks.

> Almost all community participants had not heard about the ring or injection to prevent HIV.

What do stakeholders think about new PrEP products?

The PrEP Ring

Advantages

The most frequently mentioned advantages of the ring were convenience, discreetness—especially having control over ring disclosure to a partner—and lowered likelihood of side effects due to localized drug delivery, which were noted by end users, community members, and HCPs. Many participants thought women would use the ring because the ring is long acting compared to oral PrEP and clients will not be worried about forgetting to take daily pills or the pill size. ART/PrEP provider participants also thought that clients using the ring may have fewer clinic visits than those using oral PrEP. HCPs felt the long-acting feature of the ring would increase uptake and effective use and noted that the ring expands choice for women. **Participants said the ring should be offered to any women with a higher likelihood of HIV exposure, though most said the ring should specifically target AGYW, FSWs, users in serodifferent relationships, users who are highly mobile, and users with multiple partners.**

> *"I think everyone who is at risk of contracting HIV should be offered any of the two products (the ring and the injection). For the adolescents who want to prevent themselves from getting HIV without the knowledge of their parents, if they get an injection or the ring, they will not be seen carrying or taking pills for PrEP. Both the ring and the injectable can help in ensuring privacy."* Female private sector ART/PrEP provider

> *"Every woman at risk of contracting HIV should have access to both the ring and the injectable."* Female public sector FP provider

> *"I think people should be given all the information, then they make an informed decision as to which method they should use. But I am sure HIV negative women with HIV infected partners and women with multiple sexual partners should be offered the ring."* Male private sector FP provider

Disadvantages

The disadvantages of the ring most frequently mentioned by end users and community members were lower effectiveness, discomfort with a vaginally inserted product, remembering to switch the ring monthly, and concern that the ring may be noticed or dislodged during sex, resulting in involuntary disclosure. Some community members were also concerned about ring availability and frequent facility visits, noting the potential for increased transportation costs for women who want the ring changed at a health facility and possible discomfort if a male HCP assists with ring insertion.

Some FSW participants wondered if it would be possible to take oral PrEP and the ring at the same time to increase effectiveness, and one summed up her concerns related to effectiveness as follows:

> *"For a married woman, the ring is perfect and she may not be very much bothered with the 50% level of effectiveness. But for us FSWs, it is tricky because the level of effectiveness is very low."* FSW, group dialogue

ART/PrEP providers were concerned that the ring does not protect against other sexually transmitted infections (STIs) and felt that it may lead to a decrease in condom use. A PrEP and FP provider raised concerns about possible infections caused by the use of vaginal products, with the FP provider noting that vaginally inserted products were frequently associated with infection.

CAB PrEP

Advantages

The most frequently mentioned advantages of the injectable were its discreetness and convenience due to being long-lasting. Both were mentioned by all stakeholder groups. End user and community members also mentioned the high effectiveness of the injectable as an advantage. HCPs hoped it would improve uptake and effective use because it is long-acting and can reduce the burden of daily pill taking for clients who might forget or are unable to take a daily pill.

> *"The injectable is good. Also has some privacy because no one will know that you are using that. There is no forgetting as well unless maybe you miss the due date of getting another injection. The injectable is 99% effective, it's okay [acceptable]."* *Female public sector ART/PrEP provider.*

> *"The issue of daily dosing is a challenge. If we get the injectable, this will work for FSWs."* *Female private sector ART/PrEP provider*

HCPs also mentioned that the injectable will increase options for women. While most participants said the injectable should be offered to all women, FSWs and other key populations, including AGYW, were commonly mentioned, given the mobility and irregularity of partners for the former group and issues with effective use of oral PrEP for the latter.

Disadvantages

The most frequently mentioned disadvantages of the injectable expressed by end users and community members was that users may need to continue taking oral PrEP for up to a year if they stop the injection while still in need of HIV prevention.

End users and community members also raised concerns about juggling CAB PrEP and contraceptive (DMPA) injections, which are due every two and three months, respectively. These concerns were related to the potential for transport and time costs for multiple clinic visits, scheduling challenges, possible involuntary disclosure due to multiple clinic trips, or potential challenges to potential challenges tracking the timing for both injections. Some community members worried that the two-month duration for CAB PrEP would be confusing to health workers. This concern was not expressed by providers.

Participants in one community reported hearing rumors about CAB PrEP—specifically, that because they refused the COVID-19 vaccine, scientists decided to punish the community by injecting them with HIV disguised as CAB PrEP. Only one ART/PrEP provider offered a disadvantage of the injectable, stating that it does not protect against STIs and pregnancy. Likewise, one FP provider expressed concern about how clients will how clients will manage use of the injectable and DMPA, opt for the injectable and manage DMPA, explaining that this could lead to client fatigue and missed visits.

What PrEP method would end users choose if they had access to all three options (oral PrEP, PrEP ring, or CAB PrEP)?

End users were asked which PrEP method they would choose if they had all three options (oral PrEP, ring or CAB PrEP). The end-user participants selected different methods for a variety of reasons. Oral PrEP was "chosen" by most participants because end users felt it is less complicated, can be stopped at any time and, is more effective than the PrEP ring, and they perceived no issues around insertion. In addition, those currently using oral PrEP mentioned that they have not yet experienced challenges taking pills.

CAB PrEP was the next commonly "chosen" method because it is longer acting and discreet. In one group, older women explained that the injection would help them to not disclose PrEP use to their husbands. Five out of 51 end users (three AGYW, one FSW, and one older woman) said they would 'choose' the PrEP ring because it had fewer side effects and they did not like taking pills.

How will new PrEP products affect use and choice?

Many community members worried that users of new PrEP products will face potential stigma and discrimination. According to these community members, PrEP users will be thought of as promiscuous, and trust issues may develop with their partners. Some community members thought that it might be easier for a married woman or a female sex worker to use either a ring or an injectable than it would be for an adolescent girl due to expectations of abstinence before marriage.

> *"Having FP providers also offer PrEP would help, but right now the FP providers are separate. But, we also see a lot of clients, which may be a challenge."*
>
> *Male private sector FP provider*

Most ART/PrEP provider participants expressed concern about the burden new methods would place on clinics and provider workloads, especially the amount of time spent with clients. They anticipated client-provider communication to take longer with more methods to discuss and a with more methods to discuss and the potential addition of a demonstration of the ring.. **However, many ART/PrEP provider participants thought that communication would improve and become easier with more choices for clients.**

> *"Through counselling [we can help by] talking to patients, offering them the prevention methods that are available, especially being able to identify the high-risk groups without necessarily offending anyone."*
>
> *Male public sector FP provider*

Most HCPs further noted that offering choice will not be a new experience for some providers given the suite of FP methods already available. Both ART/PrEP and FP provider participants noted the lack of integrated services across facilities and the siloing of PrEP services, versus making them available across access points. One ART/PrEP provider said, "We are just hoping that these new innovations are going to be available everywhere—even the public sector—so that wherever clients are, they can get their doses" (female private sector ART/PrEP provider). **FP providers said with proper training and information, they would be helpful in supporting clients to learn about HIV prevention services because of their existing knowledge of client sexual health needs.** Providers said this could be accomplished through referrals from FP to PrEP services and through integrated services that would allow FP providers to provide PrEP. However, they expressed concerns about increased workload and the need for training on risk screening, as illustrated by the quotes from two FP providers shown on this page.

What is needed to support informed choice of PrEP products?

What information is needed, and who should deliver it?

End users said they want information about each PrEP product to make an informed choice, specifically requesting that providers give comprehensive counseling on the advantages, disadvantages, side effects, and how each method works. End users preferred that this information be delivered by nurses or HCPs in clinics and hospitals because they offer confidentiality and privacy and are trusted to give accurate information. In addition older end users felt information should be delivered by friendly staff who take their time to explain methods, and offer high-quality services with demonstrations, and provide IEC materials, such as pamphlets. **AGYW participants stated that providers should be trained to offer youth-friendly services and encourage young women to choose methods.**

Where should methods be delivered?

End users prefer to get new PrEP methods where they are already getting their PrEP or FP services. Participants said they currently obtain HIV prevention services at a clinic, hospital, or their general practitioner, such as CeSHHAR clinic and SHAZ! Hub. AGYW also said they access condoms at supermarkets and pharmacies or for free in hotel restrooms. FSW participants emphasized confidentiality and respect from providers as highly important to them. **The most common factors for location choice were accessibility, distance, convenience, privacy and confidentiality, and costs of transport and/or services.**

Most end users were not concerned about having to see another provider to obtain their PrEP method of choice as long as the other providers had positive and supportive attitudes, including providing youth-friendly services. However, participants in most groups did not feel comfortable traveling to another facility to receive their method of choice.

AGYW said it was not likely they would go to the other locations because the new providers may not be youth-friendly or have positive attitudes, and that further distance may be problematic due to transport costs. Older end users said it would probably be okay if the other location was not too far (incurring few or no transportation costs) and the services were welcoming. When asked what could be done to support referrals, most end-user respondents felt that moral support and encouragement would be needed.

What influences decision-making?

The majority of end users stated that their perceived level of personal risk or fear were factors in how they make decisions about protecting themselves from HIV and other STIs. Other decision-making factors included the accessibility, availability, and affordability of prevention methods. **AGYW said they look to health care providers for information and support in decision-making. Older end users said their ability to effectively use a method was also a factor.**

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Community members largely felt it would be difficult for women to use HIV prevention methods because of stigma and the need for their male partners to approve use. Lack of support from male partners could lead to participants experiencing intimate partner violence or not using prevention at all. **The following structures have strong influence on**

women's health decisions: health centers, churches, male partners, health worker volunteers, nongovernmental organizations (NGOs), and community support groups. Community members said influencers need to be provided with information, education, and communication (IEC) material and training so that they can confidentially talk about HIV prevention in general and increase awareness of new PrEP methods as they become available. **Participants suggested engaging community leaders such as village heads, chiefs, church leaders, councilors, and especially male partners, as well as conducting awareness campaigns and discussing PrEP in health talks and school curriculums.**

How can providers support informed decision-making?

All ART/PrEP provider participants said they discussed all currently available prevention options with clients, and most emphasized informed decision-making. When asked how they would decide which new prevention options to recommend to clients, most ART/PrEP providers said they would assess the circumstances of a client's life and counsel based on that, with special focus on counseling for user-controlled methods if the client is a member of a key population group. Some ART/PrEP providers noted that their perception of a client's ability "to effectively use some methods" (female private sector ART/PrEP provider) would affect their counseling approach. **Some ART/PrEP providers noted they would give full information on PrEP methods regardless of client age, while others said that younger clients may face adherence issues with PrEP or fear that pills will be discovered by parents, so that they would more likely offer the ring or injectables to this population.** In contrast, FP providers were more likely to stress the importance of treating all clients the same and prior to assessing client knowledge on prevention methods prior to initiating counseling.

ART/PrEP providers gave a variety of responses regarding counseling on the effectiveness of different prevention options: some ART/PrEP providers said that they would discuss the effectiveness of different prevention methods, while others said they would not discuss it much or at all. Some providers proposed recommending the method with the highest efficacy, with one provider stating they "dwell more on advantages" in their counseling (female public sector ART/PrEP provider). Other providers said they would give all available information and including effectiveness to let the user decide while emphasizing the need for adherence/dual prevention. The majority of **FP providers proposed an approach of giving clients adequate information to support understanding of the effectiveness of PrEP methods and discussing the importance of dual protection/back-up methods.**

> *"Maybe we can have the different methods displayed in the waiting areas so that they can read for themselves and already decide which method would best suit them even before the meeting with the health care provider."*
>
> *Female public sector ART/PrEP provider*

Most ART/PrEP providers said they use IEC materials or pelvic models and samples for demonstrations (usually for condom use) to convey information on available HIV prevention options, although the availability of IEC materials varies by clinic. **ART/PrEP providers felt they need the following to support clients' decision-making about multiple PrEP products: training on the products, samples of the products, IEC materials and job aids, and pelvic models for demonstration.** A common motivator for what materials providers requested was the ability for a client to use an information tool prior to the initial visit. One provider suggested, "maybe we can have the different methods displayed in the waiting areas so that they can read for themselves and already decide which method would best suit them even before the meeting with the health care provider."(Female, public sector ART/PrEP provider) Another reflected that "the most important thing is information giving, for someone to understand what you are talking about so that they can make an informed choice." (Female, private sector ART/PrEP provider) **FP providers recommended product demonstrations and reassurance that clients can return to the clinic and/or switch methods if there are any problems.**

What is needed to support continued use of PrEP products?

To learn what is needed to support end users' continued use of PrEP, the researchers asked 28 end users currently using oral PrEP were asked about their experiences. **Current users mentioned fear of HIV acquisition, support from friends, and continuous supply of the method as helping them continue oral PrEP use.** Current users also said that continued follow-up by providers, text messages, refill reminders, and a reduction in the pill size could help them to continue using oral PrEP. Nine end users had previously used oral PrEP but as of the date of the conversation were not current users. These participants stopped taking oral PrEP for a variety of reasons, including lack of availability of oral PrEP at their facility, the negative attitudes of nurses, and COVID restrictions and related clinic closures. Most FSWs who had stopped taking oral PrEP mentioned stigma—with oral PrEP being confused for antiretroviral treatment—as a barrier to continuation, although forgetting to take pills and side effects were also mentioned. Some AGYW mentioned forgetting to take doses as well as changing partners and no longer feeling that they may be exposed to HIV.

> *"I had some [oral PrEP charts] hung on the walls of my bedroom such that anyone who enters my room would see and read them. Many of my clients would ask, and I would explain to them the benefits of oral PrEP. Many would appreciate and ask how they can access it.*
>
> *FSW, group dialogue*

Interestingly, participants in the FSW group noted that disclosure of clients had not affected their continuation on oral PrEP. In fact, many indicated that disclosure of PrEP ring or CAB PrEP use to clients would not be a problem, describing methods for telling their clients about their oral PrEP use, including using IEC materials to support those conversations.

How can providers support continued use?

The majority of ART/PrEP providers said that clients need adequate information to support effective use, including information on benefits, side effects, method of choice, and any follow-up appointments. Some providers noted that encouragement as part of counseling is important to support continuation. For example, one ART/PrEP provider said, "A client should understand their risk at a personal level, and for this to happen they need a good relationship with their nurse. The nurse would need to send reminders and do follow-up on the client. The participant mentioned that if the nurse has a good relationship with the client, then it is easy to communicate with the client" (female private sector ART/PrEP provider). **Most ART/PrEP providers requested adequate materials for counseling and additional IEC materials to offer clients to support clients' effective use of chosen method.** FP providers also mentioned male involvement and counting pills to support clients' effective use of PrEP products. For example, one provider said, "Men discuss these things, and once there is no buy-in from the men, women will not be able to use the products" (Male private sector FP provider).

> *"PrEP-friendly clinics… where they will just walk in and get their chosen method—for example, PrEP—without having to join long queues."*
>
> *Female church-based ART/PrEP provider*

Many HCPs requested dedicated resources such as fuel to visit clients, phone airtime to call clients with reminders, and appointment diaries to support PrEP clients' follow-up. Other HCPs mentioned needing clients' contact details, removing service fees, forming support groups for users, and better tracking and tracing registers, like what exist for ART. One ART/PrEP provider said there is a need for "PrEP-friendly clinics." FP providers recommended counseling on adherence and what to do if clients are unable to meet on an appointment day would help to avoid missed visits.

What is needed to support switching and discontinuing PrEP?

The majority of end users said they need comprehensive counseling and adequate information on all available options, including user requirements and side effects, to change how they protect themselves from HIV. Overall, HCPs felt that knowing a client's adherence levels, the challenges they faced, and the reasons why a client wants to stop using a particular method were key to supporting client choice. One FP provider explained, "Understanding issues a client is having with a chosen PrEP method serves as a basis for supporting a client to switch PrEP methods" (Female private sector ART/PrEP provider). ART/PrEP providers also requested guidelines, lab tests, continuation, and available products, and availability of methods to support client choices messaging on switching,

> *"Understanding issues a client is having with a chosen PrEP method serves as a basis for supporting a client to switch PrEP methods."*
>
> *Female private sector ART/PrEP provider*

KEY FINDINGS & RECOMMENDATIONS

Conversations with end users, community members, and HCPs in Zimbabwe revealed that awareness and knowledge about the ring and injectable in these populations and their communities was low. Efforts are needed to disseminate information about these new PrEP products so that when they are introduced people, will already be familiar with them and misconceptions will not form in the absence of information. Notably, client age was a concern among community members due to expectations of abstinence prior to marriage innate among some HCPs who mentioned innate and systemic challenges to effective use of PrEP by younger individuals. **System-wide efforts, including with HCPs and communities, are needed to address the stigma and discrimination associated with PrEP use, especially for AGYW. In addition, opportunities to elevate PrEP users as experts should be explored,** potentially adapting methods described above by FSWs above.

End users were interested in receiving information and services related to PrEP methods at locations where they already accessed services, with younger participants placing special **emphasis on existing relationships of trust and friendliness** at these service points. Younger end users were also less likely to feel comfortable going to a second location to access a PrEP method than older respondents were—but all participants mentioned transport costs as a barrier to visiting a second location. FSWs prioritized **nonjudgmental, confidential services and expressed a preference for providers who believed they had a right to access HIV prevention.** These findings should be considered when designing **referral pathways and service integration to enhance PrEP access.**

Once new methods were explained, end users, community members and HCPs felt that **women would use the ring and injectable because they are long acting, which makes them discreet and convenient.** Another perceived advantage of the ring was its localized drug delivery, which may decrease the likelihood of side effects, whereas **participants found the high effectiveness and long duration of the injectable advantageous.** These product advantages should be highlighted in communication messages.

Concerns about the ring included lower relative effectiveness, discomfort with a vaginally inserted product, remembering to switch the ring monthly, and the ring may be noticed during sex. **Efforts should be made to support ring users with ring switching reminders, and clear messages should be developed for ring users and their communities about ring use during sex.** Concerns about the injectable included that users may need to continue taking oral PrEP for up to a year after the injection is discontinued if they may still be exposed to HIV and the need for multiple clinic visits for clients who receive CAB PrEP and DMPA injections. **Research should be conducted to see if the timing for these two injections can be adjusted to allow for fewer clinic visits.**

> Once new methods were explained, end users, community members and HCPs felt that women would use the ring and injectable because they are long acting, which makes them discreet and convenient.

While HCPs welcomed the new methods because they expand choice for women and will likely increase uptake of and adherence to PrEP, they expressed concern about the time investment needed to counsel clients on multiple methods. **FP providers expressed willingness to apply their skills, experience, and client relationships to enhance PrEP method uptake and use, presenting an opportunity for rollout of new PrEP methods.** End users requested thorough information about each PrEP product to make informed choices and HCPs called for training and materials to help them provide comprehensive counseling. In addition, the **accessibility, availability, and affordability of all prevention methods must be ensured.** Health systems will need to respond to HCP concerns and **plan for the additional human and other resources needed to offer new PrEP methods and to support informed choice** and effective use of PrEP, which includes switching and discontinuing PrEP.

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