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"Far More than Just a Prescription": Focus Groups With U.S. Family Planning Providers and Staff About Integrating PrEP for HIV Prevention Into Their Work

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ABSTRACT

Background: Cisgender women in the United States use pre-exposure prophylaxis (PrEP) for HIV prevention at lower rates relative to other groups. Advocacy groups and patients identify family planning clinics as the preferred sites to lead PrEP implementation for women in the United States. However, limited qualitative exploration exists of U.S. family planning practitioners' attitudes toward integrating PrEP into their work.
Methods: We conducted qualitative focus groups with a convenience sample of family planning clinicians, counselors, and clinic managers to explore barriers and facilitators to PrEP provision in U.S. family planning clinics.
Results: We conducted six focus groups (total participants = 37) with respondents who worked in family planning clinics in San Francisco, California; Kansas City, Missouri; and Philadelphia, Pennsylvania. Key themes emerged highlighting how PrEP at times runs contrary to other family planning agendas, including efficient clinic visits, condom promotion, and long-acting reversible contraception counseling. Throughout these discussions, participants expressed discomfort with HIV vulnerabilities rooted in social and structural determinants of health.
Conclusions: Findings suggest that those seeking to implement PrEP for U.S. cisgender women may benefit from exploring 1) how to integrate patient/provider conversations about the structural determinants of health and their relationship to HIV and other sexual and reproductive health outcomes and 2) how to foster person-centered prevention conversations in the context of busy family planning visits.

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Oral pre-exposure prophylaxis (PrEP) with tenofovir disoproxil fumarate and emtricitabine for HIV prevention is highly effective and safe, but use in cisgender women in the United States continues to lag significantly behind other groups (Fonner et al., 2016; Hill, Lightfoot, Riggins, & Golin, 2020). Although women comprise one in five new HIV diagnoses in the United States, men receive 93% of U.S. PrEP prescriptions (AIDSVu, 2016). To highlight these disparities, Siegler et al. (2020) reported PrEP-to-need ratios, defined as the number of PrEP users divided by

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new HIV diagnoses (lower ratios indicate greater unmet need). In 2018, PrEP-to-need ratios were 5.7 for men and 1.6 for women, demonstrating extreme unmet need for HIV prevention in U.S. women.

Multiple reasons for the low use of PrEP among U.S. cisgender women exist. First, screening and identifying U.S. women who may benefit from PrEP is particularly challenging, because there are no characteristics that reliably predict HIV acquisition in U.S. women (Seidman & Weber, 2016). Although the Centers for Disease Control and Prevention published clinical guidelines to identify eligible PrEP users, for cisgender women these guidelines predominantly rely on partner characteristics that are often unknown to women (Aaron et al., 2018). Furthermore, studies continue to demonstrate women's lack of knowledge of their risk as well as awareness of PrEP, and health care providers' lack of knowledge about PrEP (Aaron et al., 2018; Bradley & Hoover, 2019; Hirschhorn et al., 2020; Unger, Benedict, & Kohn, 2020). A mixed methods study including cisgender women in Chicago noted that more than 5 years after the U.S. Food and Drug Administration approval of PrEP, cisgender women still infrequently knew about PrEP; participants expressed anger and frustration that the health care system was withholding this important information from them (Hirschhorn et al., 2020).

Women at highest risk for acquiring HIV face layered obstacles to accessing PrEP. For example, in the context of a long history of structural racism, Black women in the United States are 15 times more likely to acquire HIV than White women (Centers for Disease Control and Prevention, 2019). Although PrEP could mitigate this inequity, providers are four times more likely to prescribe PrEP to White women in the United States than Black women (Bush, 2016). These disparities highlight the entrenched histories of structural racism, sexism, and other intersecting social and structural determinants of health. Furthermore, they make clear the continued gaps in PrEP education and use among clinicians and patients. Successful PrEP implementation, therefore, requires attention to these persistent structural determinants that place Black and other women of color at an increased risk of HIV and pose barriers to accessing PrEP.

Women identify family planning clinics as a preferred location to learn about PrEP (Auerbach, Kinsky, Brown, & Charles, 2015; Hirschhorn et al., 2020). A national survey of family planning providers in 2016 demonstrated high interest in offering PrEP, but few providers actually discussed PrEP with patients (Seidman, Carlson, Weber, Witt, & Kelly, 2016). Multiple groups call upon family planning clinicians to lead PrEP implementation for women (Seidman, Weber, Carlson, & Witt, 2018), and organizations including the American College of Obstetricians and Gynecologists and Planned Parenthood support PrEP provision (American College of Obstetricians and Gynecologists, 2014; Unger et al., 2020). Given the persistently low use and awareness of PrEP among women, research is needed to understand the challenges family planning providers face in integrating PrEP into their practice. We conducted focus groups with clinicians and staff in family planning clinics to explore barriers and facilitators to PrEP integration into family planning care to inform future efforts to improve PrEP provision.

Methods

Recruitment

We recruited a convenience sample of participants from family planning clinics in San Francisco, California; Kansas City, Missouri; and Philadelphia, Pennsylvania. These sites were included to reflect geographic diversity, as family planning providers' knowledge of PrEP has been found to vary by region (Seidman et al., 2016). We used announcements at clinic staff meetings to recruit participants in San Francisco and Kansas City. We recruited participants from Philadelphia at a family planning conference. Inclusion criteria included working at a clinic providing family planning services as a clinician, counselor, or manager. Two focus groups were conducted with participants from each city, and participants in each group generally (but not always) worked at the same clinical site. Participants verbally agreed to participate at the start of each focus group. The University of California, San Francisco, Institutional Review Board approved the study (#15–15737).

Data Collection

J.W., K.C., D.S., and S.W. (two of whom are family planning clinicians) developed an interview guide to explore barriers and facilitators to PrEP implementation in family planning settings. The guide began with introducing recent national survey results demonstrating family planning providers' limited knowledge of PrEP, belief in the importance of PrEP, and conflicting views around whether PrEP provision falls within the scope of family planning care (Seidman et al., 2016). Participants were asked to respond to these results, and then to discuss knowledge, attitudes, and capacities related to PrEP implementation (Appendix 1). A.R. led focus groups in 2015 and 2016. Although A.R. is not a clinician, she has extensive research and interview experience and has worked on family planning and women's health topics.

Data Analysis

Focus groups were audio recorded and professionally transcribed. N.R., A.R., and D.S. analyzed transcripts using a thematic, grounded theory-informed approach (Corbin & Strauss, 1990), to explore barriers and facilitators to PrEP implementation in the family planning setting. These investigators used open coding to independently code each transcript using Dedoose (Dedoose, 2018) and then met to resolve differences in coding. After establishing a shared codebook, NR recoded the transcripts, and we grouped codes into key themes.

Results

We conducted six focus groups (henceforth, FG1–6), each composed of approximately six participants (total $N = 37$) (Table 1). Groups lasted on average 60 minutes (range, 35–75 minutes). The majority of participants (73%) self-identified as

Table 1
Participants' Roles in Family Planning Clinics

Position	*N* (%)
Nurse practitioner	13 (35)
OB-GYN doctor	8 (22)
Health educator	4 (11)
Midwife	3 (8)
Clinic manager	2 (5)
Family medicine doctor	2 (5)
Medical assistant	2 (5)
Nurse	2 (5)
Physician assistant	1 (3)

Table 2
Exemplar Quotes Supporting Themes

PrEP Creates Tensions with Family Planning Priorities
PrEP discussions are challenging to integrate into efficient, low-touch, low-intensity family planning services
• I think it's also a question of, like, that trust and relationship, and, like, how much is a woman going to be able to reveal in a 15-minute appointment? Which is different from the prenatal patients, who we do really develop a relationship with. And the family planning, sure, there are some who we see again. But those are, like, really deep fears and issues to bring for a woman to be able to reveal, even when asked the specific question. That's a barrier. (FG1)
• But my question is, how do we kind of balance these competing priorities in a limited clinic visit? I definitely have not figured it out at all. (FG1)
• To do a quick… 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 requires more rapport with the patient and more sensitivity and that—so, you're saying it's more than just, like, a few extra minutes. (FG2)
• I think that's a much more in-depth conversation about people's sexual practices that are necessary to decide whether or not someone's eligible for PrEP. And especially given such economic and racial—the demographics of HIV infection in this country … what we know about health care disparities, I think that's a very sensitive conversation to have and to just apply kind of data criteria to in a very kind of, like, overly rote way I think it would be troublesome … it's one of the reasons that I think it just needs … more than just kind of a five-minute conversation because it's so loaded. (FG2)
• And, I mean, this is going to speak to what I think about health care, but I kind of want them to go to like an NP or a PA that's going to be able to really sit down with them and spend time with them because in my perception, physicians are, like, that we can't—we—we are constrained by time, and then also just our training is not such that we really sit with the patient for a long time. (FG2)
• I think as [clinic network] rolls out the protocol, this is very different than treating somebody for gonorrhea or chlamydia, though, in terms of talking about sexual practices and risk and those kind of things. This is a little bit different time commitment from a clinician standpoint. (FG4)
• And, so, I think that would be the harder thing is, like, okay, we have this information and then, like, who do we decide is, like, maybe because you're telling me that you are engaged in sex work, I might talk to you about PrEP or maybe you're telling me that you have multiple partners and some of them are men; like, you know, I think it would just be a difficult thing to, like, when would you provide that education to somebody in a short intake. (FG5)
• You know I think that what we've seen is like people just immediately throw up their hands and say I can't do it. I'm too afraid of the medication, I have no capacity like you already 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. (FG6)
PrEP disrupts STI prevention counseling
• I feel like the weight of my agenda goes toward family planning and preventing things like chlamydia, which we see much more of, versus HIV. I mean, I always encourage people to use condoms, obviously. (FG1)
• We already have the condom talk: You should use condoms even though you're using an IUD because the IUD doesn't protect you against so on and so forth. And then there will be some, oh, you mean I don't—I shouldn't use condom, I should take this pill instead? Oh, no, I don't mean that. Condoms are a lot cheaper and more effective if you use them. So, that's an additional complexity. (FG2)
• You know, to be perfectly honest, is when I first heard about it, I had the gut reaction of it being, well, that seems good, but I hope it doesn't make people decide that they still don't need to protect themselves. (FG3)
• A lot of times when we're doing a risk assessment for patients, we find that what they're much more likely at risk for are STIs like chlamydia and gonorrhea; you know, those are really common in the patients that we see, and HIV is not as common. So, what I'm usually more concerned with those patients are, you know, using barrier methods a lot of time makes more sense for them because that's what they're more at risk for, so that might be where I would guide the conversation for them if that's what makes sense. (FG5)
• But I agree with what you said that I don't think that it would make sense to, like, offer it at every single visit in the same way that we would—might talk about condoms at every visit because I don't think that that's the higher risk thing for a lot of people. (FG5)
• [S]ome clinicians… finally feel comfortable to be like "You do you. … Take your PrEP everyday like we don't need to talk about condoms. Like I'm going to still be here to talk about them cause [sic] you're still getting gonorrhea and so like that's a thing, but you know like what can we do to help you take PrEP every day?" Right. Which is really different than like you're going to get HIV if you don't use a condom. (FG6)
Daily oral PrEP challenges counseling on long-acting methods for contraception
• It's an interesting juxtaposition as family planning moves towards LARCs and then to re-introduce a pill once a day when we've been saying for so long that like women don't want one pill once a day options, they want LARCs. Ah, and then you know to like to re-frame that conversation when you're trying to like you know, counsel up the method, counsel up the method, and like constantly move up that method chart, um, to get folks to like the longest acting method and then dial back and say but you really have the strengths to take a pill daily. Which, you know, I think like it's, it's just an interesting juxtaposition in terms of provider education. Um, and re-framing if we've been hammering home people's inability to be adherent to oral contraceptive pills in family planning. (FG6)
• I feel like, you know, there is a really big movement to start counseling with the LARCs and then kind of move down to the less-effective [methods]. But I feel like that does some of our patients a disservice, because there are plenty of our patients who really, really like birth-control pills and do really well with them, never, ever miss them and really kind of, you know, like having regular periods, like a lot of the other benefits of the pills. (FG3)
• So, we have, you know, we have a proportion of our women who do really well on pills and are really organized and motivated. Those women would be fine, you know, taking PrEP, and lots of our patients would not. (FG3)

(*continued on next page*)

Abbreviations: IUD, intrauterine device; LARC, long-acting reversible contraceptive; NP, nurse practitioner PA, physician assistant; PrEP, pre-exposure prophylaxis; STI, sexually transmitted infection.

prescribers (advanced practice registered nurse, physician assistant, midwife, or physician). Respondents were affiliated with clinics at various phases of PrEP provision, including clinics that prescribed PrEP, clinics that offered PrEP education (but did not prescribe), and clinics that did not yet offer any PrEP services.

Participants raised several key themes around the challenges of implementing PrEP within family planning visits: tensions with other family planning visit priorities, including efficiency of visits; sexually transmitted infection (STI) prevention counseling; and long-acting reversible contraception (LARC) counseling (Table 2). Throughout these discussions, participants expressed discomfort with HIV vulnerabilities rooted in social and structural determinants of health—particularly how racism and poverty drive inequities in HIV diagnoses.

Tensions with Other Family Planning Priorities

PrEP discussions are challenging to integrate into efficient, low-touch, low-intensity family planning services

To remove barriers to contraceptive provision, the family planning field emphasizes minimizing unnecessary laboratory test, examinations, and visits, and clinicians often work within time-limited visits. Focus group participants worried about how to discuss PrEP in already brief visits with competing priorities

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such as contraception and STIs. One FG1 participant remarked, "My question is, how do we … balance these competing priorities in a limited clinic visit?"

Furthermore, participants described how PrEP required more in-depth discussion than other topics, challenging existing visit formats:

> To do a quick … 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 requires more rapport with the patient and more sensitivity and that—so, you're saying it's more than just, like, a few extra minutes. (FG2)

This participant suggests that PrEP and HIV prevention require more in-depth conversations than STI or even HIV testing. Although this participant did not explain why PrEP requires a more extensive conversation, other respondents expanded on this issue. Specifically, participants highlighted how social and structural determinants of health, and particularly racism, drive HIV acquisition.

> I think that's a much more in-depth conversation about people's sexual practices that are necessary to decide whether or not someone's eligible for PrEP. And especially given such economic and racial—the demographics of HIV infection in this country … what we know about health care disparities, I think that's a very sensitive conversation to have and to just apply kind of data criteria to in a very kind of, like, overly rote way I think it would be troublesome … it's one of the reasons that I think it just needs … more than just kind of a five-minute conversation because it's so loaded. (FG2)

Multiple participants alluded to PrEP as a uniquely sensitive topic. Specifically, this participant from FG2 identifies talking about sexual practices in the context of racial and economic inequities as "loaded"—requiring thoughtfulness, time, and perhaps acknowledgement of historical context and structural determinants that are otherwise infrequently addressed. This exceptional quality of HIV prevention discussions presented, according to respondents, a significant barrier to integrating PrEP into efficient family planning visits.

PrEP disrupts STI prevention counseling

Family planning providers expressed concern that PrEP might distract from other key family planning interventions, namely, condoms for STI prevention. As one FG3 provider explained: "When I first heard about [PrEP] I had the gut reaction of it being, 'Well, that seems good, but I hope it doesn't make people decide that they still don't need to protect themselves.'" PrEP offers the option of a different type of protection, but for many focus group respondents it disrupted their typical prevention agendas. A FG1 provider described, "The weight of my agenda goes toward family planning and preventing things like chlamydia, which we see much more of, versus HIV." Similarly, another provider described this tension between more common STIs and PrEP:

> A lot of times when we're doing a risk assessment for patients, we find that what they're much more likely at risk for STIs like chlamydia and gonorrhea; you know, those are really common in the patients that we see, and HIV is not as common. So, what I'm usually more concerned with those patients are, you know, using barrier methods a lot of time makes more sense for them because that's what they're more at risk for. (FG5)

Several respondents described guiding conversations to STI prevention rather than HIV prevention. Notably, this provider (and others) did not express a role for patient priorities in setting this agenda. Instead, the counseling around STIs and HIV prevention is directive, rather than using a shared-decision making approach.

In contrast, other participants discussed PrEP as an opportunity to provide options, and more person-centered sexual health care. One participant in FG6 stated:

> [S]ome clinicians… finally feel comfortable to be like "You do you … Take your PrEP everyday like we don't need to talk about condoms. Like I'm going to still be here to talk about them cause [sic] you're still getting gonorrhea and so like that's a thing, but you know like what can we do to help you take PrEP every day?" Right. Which is really different than like you're going to get HIV if you don't use a condom.

Daily oral PrEP challenges counseling on long-acting methods for contraception

Many respondents contextualized conversations about PrEP within a contraceptive counseling visit, and noted how they promote LARC to patients as a method that does not require daily adherence. Several interviewees questioned reintroducing a daily pill to women because it could confuse LARC messaging:

> It's an interesting juxtaposition as family planning moves towards LARCs and then to re-introduce a pill once a day when we've been saying for so long that like women don't want one pill once a day options, they want LARCs. Ah, and then you know to like to re-frame that conversation when you're trying to like you know, counsel up the method, counsel up the method, and like constantly move up that method chart, um, to get folks to like the longest acting method and then dial back and say but you really have the strengths to take a pill daily. Which, you know, I think like it's, it's just an interesting juxtaposition in terms of provider education. Um, and re-framing if we've been hammering home people's inability to be adherent to oral contraceptive pills in family planning. (FG6)

This participant highlights using tiered effectiveness counseling for contraceptives, promoting the most effective and patient-independent method because of patients' "inability to be adherent" to a daily pill. PrEP challenges narratives around tiered effectiveness, and the (false) assumption that (all) people are unable to take a daily pill. PrEP instead opens up the possibility for diversity of behaviors, experiences, and preferences in sexual health. This disruption is unsettling, in that it challenges both assumptions about patients and a widely used framework for counseling.

Discussion

In focus groups with U.S. family planning providers, barriers to PrEP implementation emerged as tensions with current family planning agendas, including efficient visits, condom promotion, and LARC counseling. Although the field of family planning

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celebrates choice, providers viewed the option of PrEP as potentially disruptive to their other prevention agendas. Moreover, although inequities pervade family planning metrics, PrEP seemed to strike a nerve with participants; they expressed how PrEP requires greater attention to inequities, making visits longer and more "loaded."

Although family planning providers are arguably more experienced at discussing sexual health than other providers, participants identified PrEP as uniquely sensitive, requiring "a much deeper discussion" than other STI prevention conversations. By using this presumption, aptly named HIV exceptionalism, participants may intend to increase sensitivity around a stigmatized topic (Bayer, 1991). However, they may inadvertently heighten stigma around HIV, making conversations overly loaded and removed from routine care. In drawing attention to the tension between efficiency and appropriately taking the time to address sensitive sexual health topics in the context of social and structural inequities, participants highlighted why PrEP integration feels more complex. However, similar challenges may also exist when addressing other STIs and contraception (as suggested by striking inequities in STIs and reproductive health outcomes), if clinicians and counselors chose to explore these dynamics during patient encounters.

Inequities riddle the fields of sexual and reproductive health (Eichelberger, Doll, Ekpo, & Zerden, 2016; U.S. Public Health Service, 2017), including STI diagnoses (Centers for Disease Control and Prevention, 2017), maternal mortality (American College of Obstetricians and Gynecologists, 2018), and experiences of racism in family planning care (Dehlendorf et al., 2011; Mengesha, 2017). Prather et al. (2018) highlight the importance of integrating knowledge of historical context, and specifically racism, into public health research and clinical care to address sexual and reproductive health inequities. Focus group participants alluded to this context and struggled with how to move from awareness to practical strategies to advance racial equity in the context of busy clinic visits. Development of trainings for family planning providers and staff to learn more deeply about historical context and applying that knowledge to clinical care may be critical to advancing health equity in HIV prevention, and in the broader family planning field.

The heightened focus on racism in institutions, including health care, provides an opportunity to think deeply about our complicity in perpetuating inequity. While structural competency and antiracism training in isolation is unlikely to advance PrEP implementation, community education campaigns about PrEP and universal PrEP education in clinics—offering PrEP education to everyone in relevant clinical settings to decrease barriers posed by screening and increase demand for PrEP—are equally critical (Calabrese, Krakower, Willie, Kershaw, & Mayer, 2019). Addressing providers' and counselors' concerns about uncomfortable conversations is important to advance equity, lest providers continue to shy away from universal PrEP counseling. In turn, inequities in PrEP provision may even be exacerbated, as patients less affected by structural determinants are deemed easier to counsel and engage, and thus are offered more information about PrEP.

Identified tensions around LARC and condoms highlighted respondents' commitment to pre-set agendas focused on decreasing STIs and promoting LARC. Although there has been growing concern around the potential for coercion with LARC promotion, the push toward tiered-effectiveness counseling remains dominant in many family planning settings (Brandi & Fuentes, 2020). Notably absent from these discussions were patients' participation in prioritization of agenda topics. A minority of participants described how PrEP provided options and opportunity to discuss something other than condoms, allowing providers to say to patients, "you do you." Experts in the field of family planning have promoted shared decision making as a best practice approach to contraceptive counseling (Dehlendorf, Krajewski, & Borrero, 2014), with the ultimate goal of providing person-centered family planning care (Gubrium et al., 2016); these focus groups suggest that providers do not apply the same concepts to STI and HIV prevention. With longer acting PrEP methods—vaginal rings, injectables, and implants—as well as multipurpose technologies, including PrEP combined with contraception, on the near horizon, family planning providers will likely continue to wrestle with tensions between method effectiveness and patient priorities. Consequently, the family planning community may benefit from explicitly including PrEP in discussions of person-centered family planning services.

Participants' discussions of condom use highlighted concerns for risk compensation with PrEP use—stopping using condoms in the setting of PrEP as effective HIV prevention (Ramchandani & Golden, 2019). Notably, oral contraception was also historically criticized due to concerns for risk compensation (Seidman et al., 2018). Nevertheless, family planning providers have learned to provide integrated counseling about pregnancy and STI prevention. The existing body of research on changes in condom use while using PrEP focuses on men who have sex with men (Giguère et al., 2019). Experts suggest that engagement in PrEP services increases STI diagnoses by engaging more people in sexual health care and frequent STI testing. Regular PrEP visits provide opportunities for scheduled laboratory tests and holistic discussions on patients' prevention priorities. In the present study, participants' discussions of condom counseling did not include assessment of patient priorities, abilities, or how PrEP may provide a prevention option to those who cannot, or chose not to, use condoms.

This study has several limitations. First, with a focus group design, generalizability is limited to included participants. We included family planning clinicians, counselors, and managers as all of these actors contribute to clinic culture. Second, while this study was conducted in 2015 and 2016, women's use and awareness of PrEP remains low (Raifman et al., 2019). As recently as 2020, two studies including cisgender women in the Southern United States (Hill et al., 2020) and in Chicago (Hirschhorn et al., 2020) demonstrated less than one-third of participants were aware of PrEP as an HIV prevention method. These finding highlight the continued importance of dissemination research to improve PrEP provision. Our study provides a lens into why family planning providers, a critical group of practitioners providing sexual and reproductive health care to cisgender women, struggle to integrate PrEP into their work.

Conclusions

This study highlights significant constraints that clinicians and staff experience in the context of providing efficient family planning care, and how these constraints impact PrEP provision in family planning visits. Offering skills trainings to incorporate knowledge of inequities into clinical care may be critical to improving patient–provider communication in family planning encounters and specifically PrEP services. Moreover,

acknowledging structural inequities may facilitate shifting conversations away from stigmatizing individual "risk" to the broader role systems and structures play in HIV acquisition. Finally, applying the same person-centered approach that has been promoted for reproductive health counseling to HIV prevention and sexual health in general may ease tensions with preexisting family planning prevention agendas and promote the provision of structurally informed, person-centered, integrated sexual and reproductive health care.

Implications for Practice and/or Policy

Family planning providers struggle to incorporate PrEP into their clinical work, despite family planning providers being identified by policy makers and patients as an important source of PrEP education and prescribing for cisgender women. This study highlights how PrEP implementation for U.S. cisgender women may benefit from providing training for providers in two main arenas: 1) structural determinants of health and their relationship to HIV and other sexual and reproductive health outcomes and 2) how to foster person-centered prevention conversations in the context of busy family planning visits. Skills-based trainings on these topics may address some of the key challenges faced by family planning clinics in offering PrEP to cisgender women in the United States.

Supplementary Data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.whi.2021.02.006.

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