



Do You PrEP? A Review of Primary Care Provider Knowledge of PrEP and Attitudes on Prescribing PrEP

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Oral preexposure prophylaxis (PrEP) has been proven to be a safe and effective means of preventing HIV. The purpose of our literature review was to examine primary care provider knowledge and attitudes about prescribing PrEP. PubMed, CINAHL, Web of Science, and Scopus were searched and additional articles were identified through other sources, yielding 11 articles that met inclusion criteria. Overall, there was high variability among providers regarding attitudes, knowledge, and prescriptive practices related to PrEP. PrEP continues to be an underutilized HIV prevention intervention and more research focusing on provider-specific factors is warranted.

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As of 2013, there were approximately 1.2 million HIV-infected individuals and an estimated 160,000 undiagnosed individuals living in the United States (Centers for Disease Control and Prevention [CDC], 2016b). In 2015 alone, 39,513 new cases of HIV were diagnosed in the United States (CDC, 2016b). Populations most affected by HIV in 2015 included men who have sex with men; heterosexual intravenous drug users; and African American, Hispanic, and Latino populations (CDC, 2016b). Although the

rate of HIV diagnoses decreased 19% from 2005 to 2014, HIV continues to burden these populations despite current HIV testing and prevention efforts (CDC, 2016a). There is, therefore, a need for additional HIV prevention methods.

In 2012, the U.S. Food and Drug Administration (FDA) approved the use of emtricitabine/tenofovir disoproxil fumarate (Truvada®; Gilead Sciences Inc., Foster City, CA) as the first once-daily drug indicated for antiretroviral preexposure prophylaxis (PrEP) (CDC, 2014). In 2014, the CDC released clinical practice guidelines for health care providers, with updates in 2015 and 2017, to aid in prescribing PrEP (CDC, 2014). The approval of PrEP by the FDA and the release of CDC guidelines occurred after the findings of several large clinical studies supported safety and efficacy among populations at risk for HIV infections. In fact, several large clinical studies have

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shown that the daily use of PrEP is 93% effective in preventing HIV transmission in high-risk populations (CDC, 2014). Not only have these studies provided evidence concerning the efficacy of PrEP, but several studies have also provided support for the safety of PrEP in these at-risk populations. Studies have found no statistically significant difference in adverse events associated with PrEP compared to placebo (Baeten et al., 2012; Choopanya et al., 2013; Grant et al., 2010; Grohskopf et al., 2013; Thigpen et al., 2012). A systematic review and meta-analysis found that the adverse events for PrEP versus placebo were similar when controlling for potential confounding variables such as adherence, drug regimen, sex, dosing, and age (Fonner et al., 2016). In addition, risk compensation has been addressed in various studies. Risk compensation is the belief that as disease-prevention strategies such as PrEP become available, people are more likely to engage in risk behaviors such as condomless sex (Grant et al., 2014). Most studies have found either no change or slight increases in condom use during receptive and insertive anal intercourse among PrEP users at follow-up and over time (CDC, 2014; Fonner et al., 2016; Grant et al., 2014; Liu et al., 2013; Marcus et al., 2013; Mugwanya et al., 2013). These large landmark studies, along with the approval of the FDA and CDC guidelines, support the use of PrEP in populations at risk.

Studies to describe factors associated with PrEP use have largely focused on patient-level factors, with only a small number of studies examining providers (Sowicz, Teitelman, Coleman, & Brawner, 2014). Provider-level factors that could influence the use and prescription of PrEP range from background factors such as age, years of clinical experience, and knowledge of PrEP, to behavioral factors such as attitudes surrounding the use of PrEP. A systematic review of studies that used health behavior theories to explain a variety of provider behaviors, including prescribing practices, found 78 studies that measured determinants of intentions, behaviors, or both. The most frequently used theories were the Theory of Reasoned Action, or its extension, the Theory of Planned Behavior (Godin, Belanger-Gravel, Eccles, & Grimshaw, 2008). The Theory of Planned Behavior has been shown to explain variance in provider behavior (Godin et al., 2008) supporting the use

of social-cognitive theories to predict health care provider intentions and behaviors, including prescriptive practices.

The Integrative Behavioral Model (IBM) expands on the Theory of Planned Behavior/Theory of Reasoned Action models by including additional factors and variables that affect intention and behavior (Fishbein & Ajzen, 2010). According to the IBM, intention to perform a particular behavior is the best predictor of behavior. In turn, attitudes, norms, and perceived control in relation to the behavior predict intention. Attitude is a general view about the outcome of a behavior (beneficial or harmful), norms are a perception of others' views of behaviors (approval or disapproval), and perceived control is whether the individual thinks it is easy or hard to perform the behavior. Underlying attitudes are specific behavioral beliefs about the behavior (e.g., prescribing PrEP to patients will lower the risk for acquiring HIV). Norms are influenced by normative beliefs (e.g., if one thinks his/her professional colleagues support the idea of prescribing PrEP). Perceived control is related to control beliefs (e.g., if a provider thinks insurance coverage will be a barrier). The IBM can be used to identify modifiable beliefs that can be targeted in interventions for behavior change (Fishbein & Ajzen, 2010). Given the limited body of existing literature focused on provider-level factors regarding PrEP, the constructs of the IBM can be used to describe relationships between provider knowledge, beliefs, attitudes, norms, perceived control, and intentions and behaviors in relation to the prescription of PrEP (see Figure 1).

The purpose of our review was to critically appraise and synthesize the current literature on provider-level factors that impact appropriate prescription of PrEP in the primary care setting. We specifically focused on knowledge and attitudes, as these are major constructs in the IBM. We defined knowledge as information, awareness, and/or skills acquired by a person through experience or education. We defined attitudes as relating to whether providers perceived PrEP as beneficial or harmful. Therefore, our initial research questions were (a) *what were provider knowledge and attitudes about the prescription of PrEP?* and (b) *what was the quality of evidence in the current body of research?*

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