
INTEREST Workshop
May 15, 2019
Methods

- Mixed methods study to understand healthcare providers’ attitudes and experiences delivering PrEP to AGYW to inform provider training and service delivery

Survey participants (n=609)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
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<tbody>
<tr>
<td>Kenya</td>
<td>290</td>
</tr>
<tr>
<td>South Africa</td>
<td>192</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>127</td>
</tr>
</tbody>
</table>

IDI participants (n=115)

<table>
<thead>
<tr>
<th>Country</th>
<th>Number</th>
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<tbody>
<tr>
<td>Kenya</td>
<td>40</td>
</tr>
<tr>
<td>South Africa</td>
<td>48</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>27</td>
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Experience with PrEP Delivery

- Yes, 335
- No, 274
Results: Providers had reservations about AGYW being sexually active, but acknowledged they need PrEP

- Survey: It’s better to tell sexually active unmarried girls/women to abstain from sex rather than give her PrEP.

- Interviews: Prefer that AG wait to have sex until they are 18, but acknowledged that many girls engage in sex before 18 and could benefit from PrEP.
Results – experiences delivering PrEP to AGYW

Interviews:

• Barriers to uptake, adherence, retention:
  • AGYW lack of PrEP knowledge
  • Lack of disclosure of PrEP use
  • HIV stigma
  • Low community awareness of PrEP

• Strategies to support AGYW:
  • Intensive adherence and relationship counseling
  • Phone follow-ups
  • Home visits
  • Peer counseling
  • Community awareness raising
Recommendations

• Include **values clarification** exercises in provider training.

• Provide **tailored technical support** to PrEP providers to deliver services that are responsive to the needs of AGYW.

• Build providers’ capacity to counsel AGYW on whether/how to **disclose PrEP use** to partners and parents.

• Conduct **community sensitization** about PrEP as a prevention option for AGYW.
Thank you
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OPTIONS Consortium Partners
Oral pre-exposure prophylaxis (PrEP) is a promising new HIV prevention option that is offered to populations at substantial HIV risk in Kenya, South Africa, and Zimbabwe, including adolescent girls (AG) ages 15-17 and young women (YW) ages 18-24. These countries differ in their strategy and scope of PrEP rollout (see Table 1). To inform provider training and PrEP service delivery, we conducted mixed methods implementation research with healthcare providers in 2017-2018 to examine providers' attitudes and experiences delivering PrEP to AGYW.

Table 1. PrEP rollout strategy by country

<table>
<thead>
<tr>
<th>Country</th>
<th>Type of rollout</th>
<th>Target populations</th>
<th>Number and types of facilities where PrEP is available</th>
<th>PrEP use by providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya</td>
<td>2017 - national rollout</td>
<td>AG, YW, younger ages 15+</td>
<td>2,840 facilities (public, NGO, faith-based organizations, and private facilities)</td>
<td>79% of providers agreed for AG, 63% for YW</td>
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<tr>
<td>South Africa</td>
<td>2016 - phased approach by target population</td>
<td>Women who use drugs, AGYW, sex-variant men, sex-disident individuals</td>
<td>72 sites (12 sex service sites, 58 facilities, 44 public facilities)</td>
<td>57% of providers agreed for AG, 53% for YW</td>
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<tr>
<td>Zimbabwe</td>
<td>2016 - phased approach starting with NGO clinics</td>
<td>Adolescent girls, high risk men, sex-disident individuals</td>
<td>70 sites including 5 NGO youth drop-in centers</td>
<td>82% of providers agreed for AG/YW</td>
</tr>
</tbody>
</table>

METHODS

We surveyed providers in Kenya, South Africa and Zimbabwe who worked at public, private, and non-governmental health facilities, including facilities offering oral PrEP during the study period and facilities that were likely to offer PrEP in the future. We used follow-up qualitative in-depth interviews (IDIs) with select survey participants were conducted to better understand key survey results. Survey data were descriptively analyzed in STATA 13. IDI data were coded and thematically analyzed in NVivo 12.

RESULTS

Participant characteristics

We surveyed 609 providers (Kenya=290, South Africa=192, Zimbabwe=127) and conducted 115 IDIs (Kenya=40, South Africa=48, Zimbabwe=27). The study included community-based workers (survey=154, IDIs=43), nurses (n=123, 33), pharmacy staff (n=91, 15), counselors (n=99, 25), clinicians (n=8, 19), and facility-in-charge (only in Kenya (n=18; 0). Participants included providers with experience delivering PrEP (335 survey, 67 IDIs) and without PrEP experience (24 survey, 35 IDIs).

Adherence and retention

More survey participants (75%) believed YW were responsible enough to take PrEP consistently compared to AG (49%) (see Figure 1). IDIs with PrEP experience confirmed that adherence and retention have been challenging, particularly for AG, because of clients’ lack of PrEP knowledge, daily pill burden, lack of disclosure and support, and association of PrEP with HIV treatment. IDIs also said that delivering services to YW is generally easier because they are “more mature” while some AG “don’t listen.”

“I think they [young women] are more focused. They know their problems, they know their risk and they are concerned”

– Female nurse with PrEP experience, age 52, Zimbabwe

Experienced PrEP providers shared strategies they used to help AGYW use PrEP successfully, including intensive adherence and relationship counseling, phone follow-ups, home visits, peer counseling, and community awareness-raising.

Behavioral disinhibition

Some providers in IDIs voiced concern about potential decreased use and increased risky behavior. Surveyed providers had mixed opinions on this topic, with 47% (AG)/40% (YW) agreeing or strongly agreeing that “providing PrEP to unmarried AG/YW would promote sexual promiscuity” (see Figure 1).

DISCLOSING TO PARENTS AND PARTNERS

Although PrEP delivery differs across countries, providers shared similar attitudes. Providers were generally supportive of PrEP for both age groups, but had more reservations about PrEP for AG. Hesitations about providing PrEP to AG seemed mostly related to negative attitudes about AG being sexually active and concern about the ability of AG to adhere, particularly if using PrEP without disclosing to parents and partners.

Recommendations & research utilization:

- Conduct values clarification training to help providers reflect on their personal views about AG being sexually active.
- Deliver tailored technical support to PrEP providers to help them deliver services that are responsive to the needs of AGYW.
- Assess which forms of provider support are most effective at increasing AGYW PrEP adherence and retention.
- Build providers’ capacity to counsel AGYW on whether/how to disclose PrEP use to parents and partners.
- Conduct community sensitization about PrEP as a prevention option for AGYW—particularly targeting parents/guardians and male partners—to make it easier for AGYW to use PrEP.

CONCLUSIONS

We surveyed providers in Kenya, South Africa and Zimbabwe who worked at public, private, and non-governmental health facilities, including facilities offering oral PrEP during the study period and facilities that were likely to offer PrEP in the future. We used follow-up qualitative in-depth interviews (IDIs) with select survey participants were conducted to better understand key survey results. Survey data were descriptively analyzed in STATA 13. IDI data were coded and thematically analyzed in NVivo 12.

BACKGROUND


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