RECOMMENDATIONS FOR INTRODUCING THE DAPIVIRINE RING TO HEALTHCARE WORKERS:

Findings from seven countries in Sub-Saharan Africa

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BACKGROUND

In Sub-Saharan Africa, women bear the brunt of the HIV/AIDS epidemic and urgently need new women-centred, self-initiated prevention products. To address this need, the International Partnership for Microbicides (IPM) has developed the monthly dapivirine (DPV) vaginal ring to provide women with a discreet, long-acting option they can use to protect themselves from HIV. The ring is currently under regulatory review.

Healthcare workers (HCWs) including healthcare providers (HCPs) (qualified professionals such as doctors, nurses and pharmacists) and community health workers (CHWs) play a critical role in ensuring the successful launch and sustainable uptake of new medical products. However, the attitudes, training and sensitisation of HCWs is often overlooked when introducing new products, which influences the prescription and use of these products.

AIMS & OBJECTIVES

To inform the DPV ring introduction strategy, if it is approved, we aimed to understand whether the ring would be acceptable to HCWs, what factors would support or hinder their prescription of the ring, and what training they would require.

THE OBJECTIVES OF THIS STUDY WERE TO:

1. Document **existing knowledge** of the DPV ring among policymakers, HCPs and CHWs;
2. Understand the training needs of HCPs in order to inform the development of **training and sensitisation materials**; and
3. Determine the **acceptability** of the DPV ring as an HIV prevention method among policymakers, HCPs and CHWs.

METHODS

We held key informant interviews (KIIs) with policymakers and HCPs and focus group discussions (FGDs) with CHWs in seven high HIV burden countries in east and southern Africa.

Kenya · Malawi · Rwanda · South Africa · Tanzania · Uganda · Zimbabwe

IN TOTAL, WE CONDUCTED:

- **12 KIIs** with **key policymakers**
- **101 KIIs** with **HCPs (doctors, pharmacists and nurses)**
- **20 FGDs** with **CHWs (n=127)**

Ethics approval was obtained from a national institutional review board in each country.

Data was analysed in line with a qualitative framework using thematic content analysis.

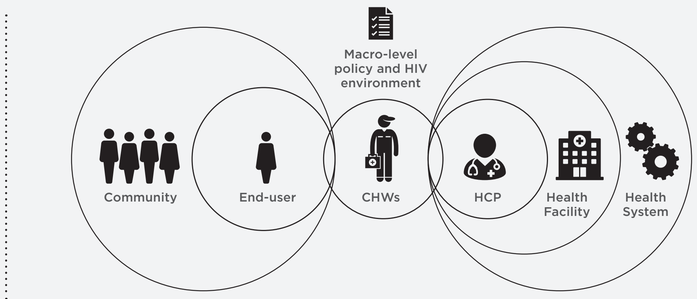

FIGURE 1: Qualitative Framework

RESULTS

KNOWLEDGE

In most countries, knowledge of the DPV ring was high among policymakers who had primarily heard of the ring through medical journals, conferences or in-country clinical trials. At the level of HCPs and CHWs, awareness of the ring was low, especially in countries where DPV ring clinical trials had not been conducted.

TRAINING AND SENSITISATION NEEDS

Across the countries, HCPs suggested that the training strategy follow a **top-down approach** that is largely based on the **training of trainers (TOT)** model.

Due to the shortage of doctors across the region, the health system is heavily reliant on **nurses, who are a key cadre to include in training**. Training for HCPs should include both a practical and theoretical component. It is important to provide **demonstrations of the insertion and removal process using anatomical models and role-playing** consultations with patients. Theory should focus on the **side effects, efficacy of the ring, and any relationship with other HIV prevention and family planning products**.

CHWs are trusted by the community members and often serve as a conduit to the healthcare system making them an important group to include. The focus of **CHW training should be to provide easy-to-understand factual information** to dispel myths and build confidence in the ring at the community level.

ACCEPTABILITY OF THE DPV RING

Acceptability differed across countries and HCW cadre. Doctors and policymakers were concerned about perceived modest efficacy, stating that "***the DPV ring would be valuable to women but a low efficacy might be an issue***" (policymaker, Kenya). Nurses and CHWs were more positive with one male CHW in Tanzania stating that he is so excited about the ring that he would wear a dress if he had to so he could promote the ring to women in the community.

Barriers preventing HCPs from prescribing the ring included: **lack of information on the ring** and concerns about **consistent availability**. In some countries, **possible religious and cultural issues** were identified as a barrier.

HCPs mentioned that they would prescribe the DPV ring if it were **free** and if they had **sufficient information about it themselves**. The fact that the ring is **female-controlled** and **discreet** is a key factor in obtaining support from HCWs.

RECOMMENDATIONS

1. Consistently communicate with key policymakers on the DPV ring using **personalised and salient communication** to address country-specific concerns and reinforce enablers.
2. **Support nurses** as the cadre responsible for assisting women with the **initial insertion and removal of the ring** and **CHWs** as the primary group responsible for **promoting the DPV ring at the community level**. Consider including **local leaders and religious leaders** who would be **good advocates for the ring**.
3. Use the **TOT model** to train HCPs and make use of **practical exercises to ensure HCPs have the confidence to prescribe and effectively administer the DPV ring**. It would be **beneficial to engage with non-profit organisations and non-governmental organisations** that currently specialise in HCP training.
4. Use **behavioural insights and interventions** such as **1) personal stories**, **2) "in my shoes" exercises** (used to help people see how any situation can have multiple perspectives and that feelings toward someone's situation can change when you "step into their shoes") and **3) framing** (how people often draw different conclusions to identical content depending on how it is presented) to address barriers and enablers to prescribing the ring.
5. Leverage existing **digital healthcare applications and medical associations as platforms** to continuously update HCPs on the ring.

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