Health Care Provider Training for New HIV Prevention Products

OVERVIEW AND CONSIDERATIONS

FHI 360, LVCT Health Kenya, PZAT Zimbabwe, Wits RHI South Africa

MAY 2021

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Introduction

This presentation was developed to inform the development of training curricula for new biomedical HIV prevention products. It provides summary insights from an analysis of provider training systems in Kenya, South Africa, and Zimbabwe developed for introduction of the dapivirine vaginal ring in 2020 – 2021.

The presentation includes four sections:

- **AUDIENCE**
- **STRUCTURE**
- **CONTENT**
- **PROCESS**

For the purposes of this document, the term *health care provider* (HCP) refers to members of the broader health workforce, including trainers, pharmacists, monitoring and evaluation (M&E)/data entry officers, supervisors/managers, village health volunteers, and community health workers (CHWs).

Audience Key Takeaways

- Training participants should be guided by the product's implementation plan and should include **providers** from all priority delivery channels, including HIV, family planning (FP), and community-based health care, and across public and private channels, if relevant.

- In addition, initial training on new HIV prevention products should also include **key stakeholders** at the national and subnational levels, including policymakers, supply chain and monitoring stakeholders, and implementing partners.

Details are on the following slides.

Key audiences for trainings

Public and private sector providers

The core audiences for introductory trainings are facility-based and community HCPs.

Providers can include doctors, nurses, community health workers (CHWs), clinical officers, health managers at all levels, pharmacists, and other private sector providers.

Policymakers and other key stakeholders

Introductory trainings can also include a range of stakeholders beyond providers to build understanding and awareness for the rollout of a new product.

Participants can include national and subnational stakeholders, including policymakers, regulators, and supply chain managers.

Suggested provider audiences for training

Facility-based providers	• Medical doctors • Facility managers • Pharmacy personnel • M&E personnel • Counselors • Nurses • Midwives • Personnel from adolescent-friendly or key population services • Private sector providers • Clinical officers
Community-based providers	• CHWs • Outreach workers/demand creation facilitators • Village health workers (VHWs) • Health promoters • Peer educators • Community-based organization (CBO) staff

Additional stakeholders to include in training

National government stakeholders	• Stakeholders from Ministries of Health (MoHs) and other policy bodies (e.g., national AIDS councils or associations) from relevant divisions, including HIV and sexual and reproductive health (SRH) or FP services • Commodity supply teams • M&E teams • Communication or health promotion teams • National trainers of trainers (TOT) • Program implementers/coordinators, including implementing partner (IP) program officers • National pharmacy stakeholders
Subnational government stakeholders	• Health program managers or officers (e.g., HIV officer, health management teams, HIV services coordinator, reproductive health (RH) coordinator, health management teams) • Focal persons for HIV, HIV prevention, or Pre-exposure prophylaxis (PrEP) • Focal persons for SRH/FP or HIV/FP/SRH integration • Procurement officers, coordinators, or managers • Health management information system (HMIS) officers, coordinators, or managers • Clinical and nursing officers, coordinators, or managers • Quality improvement (QI) officers, coordinators, managers, or focal persons • Health promotion or information officers, coordinators, or managers • Pharmacy officers, coordinators, or managers
Others	• Community representatives and civil society organizations • Other members of PrEP/HIV prevention technical working groups (TWGs) • Media • Community leaders

Structure Key Takeaways

- **There are three opportunities for training on new products**: Pre-service, in-service, and ongoing supervision and mentorship.
- Training on new HIV prevention products can be more easily **included into in-service training and supervision** for HIV prevention, oral PrEP, or FP; inclusion into pre-service training is a longer-term effort.
- Training design should consider what will be needed to scale the training, including a **cost-effective design** that is **replicable**.
- An **online module**, where possible and accompanied by practical follow-up, would meet training needs and avoid costly, challenging, multi-day trainings.

Details are on the following slides.

Three training opportunities

Pre-service training

Training that occurs before individuals begin to provide health care services (e.g., as part of nursing school or medical school curricula) or prior to the provision of a new service

While integrating new products into pre-service training takes time, it is beneficial to ensure widespread awareness and understanding of new products, especially in countries with significant staff rotation or turnover.

In-service training

Training of health care professionals who are already employed on new products or approaches that are being introduced in the country

This will likely be the first step for introducing new products to HCPs who are already practicing and can be aligned to other trainings or as a one-off training program.

Ongoing supervision and mentorship

Ongoing mentorship and supervision of HCPs, typically led by national or subnational public health authorities on a regular basis

This is an important consideration for introducing new products to health care providers, who benefit from follow-up and supervision to support high-quality care and problem-solving, especially on new technologies.

Pre-service training

- HCPs typically receive pre-service training as part of achieving an initial qualification or license necessary to register with professional bodies and initiate their practice.
- Pre-service training presents an opportunity to integrate new products into pre-service training for all HCPs.
- While pre-service training has a broad reach to a wide range of providers, it can be a complex and long process to integrate a new product into pre-service training. This is likely not the first option to integrate new products.
- Once products are included in guidelines, they can be incorporated into broader relevant modules – for example, the dapivirine ring should be incorporated into HIV prevention training and potentially also into broader SRH or FP training.
- Pre-service training is typically managed by training institutes that sit within MoH or education, for example:
  -  In Kenya, pre-service training is managed by the Kenya Institute of Curriculum Development within the MoH.
  -  In Zimbabwe, pre-service training is managed by the Ministry of Health and tertiary Education and the Ministry of Health and Child Care (MoHCC).
  -  In South Africa, pre-service training is managed by colleges (e.g., the College of Health Sciences) or organizations (e.g., the Nurses Council or the Demographic Nursing Organization of South Africa in South Africa).

In-service training

Clinic—based providers

- In-service trainings are targeted, one-time trainings for doctors, nurses, clinical officers, and other providers within healthcare facilities as part of initial rollout that are typically the first type of training introduced for new products; training for the dapivirine ring will likely be included in ongoing oral PrEP trainings.
- Trainings can include on-site or off-site trainings, multi-day workshops, or online training modules specific to the new product.
    - On-site trainings typically reach more providers but can be disruptive to service delivery and providers may not be able to dedicate their full attention to the training.
    - Off-site trainings are more expensive and reach fewer providers but offer a dedicated and focused opportunity to build understanding for new products.
- Trainings are typically conducted via a train-the-trainer model, wherein a small group of trainers are trained at the national level and then cascade trainings on new products through to the subnational and facility levels.
- Trainings are typically conducted with a standard national training curriculum developed by the MoH, in partnership with the TWG.
- Trainings for initial cohorts of trainers are often conducted by MoH trainers in partnership with implementing partners.
- There may be significant turnover among healthcare workers, so trainings need to be conducted at regular intervals.
- Trainings are typically monitored in a national system (e.g., Integrated Human Resources Information System in Uganda).
- Training completion can result in a certificate or other qualification; in some countries, participants can get “points” towards continuing medical education (CME) – for example, in Zimbabwe and South Africa, participants receive points that contribute to the renewal of the annual practicing certificates from regulatory bodies such as the Nurses Council of Zimbabwe or Continuing Professional Development (CPD) for South Africa.

In-service training

Community—based providers

- Community health workers and peer educators have separate training systems, typically managed and conducted at the subnational level, and based on national CHWs training curricula (e.g., at the sub-county or parish level in Uganda, at the sub-county level in Kenya) or by implementing partners (e.g., nongovernmental organizations [NGOs] and community-based organizations [CBOs] in South Africa).
- Training incorporates coaching, typically developed inline with CHW learning patterns – for example, the ***Sisi Kwa Sisi*** model (Swahili term meaning "for us by us") is used in some parts of East Africa. The *Sisi Kwa Sisi* coaching model is especially useful as most CHWs learn better from people to whom they can relate; this typically includes a combination approach, including participatory elements.
- In some countries with more formal CHW systems, some members of this cadre are included in the provider trainings.

Example: Kenya

In Kenya, sub-counties are the administrative units of county governments. Within Kenya's Community Health Strategy, the **sub-county health management teams coordinate community health services** and are organized around community units. A community unit consists of a specified number of households living in a specified location. There are **two cadres of health care worker (HCW): community health volunteers (CHVs) and community health extension workers (CHEWs)**. Each community unit is served by at least 10 CHVs and 1 CHEW.

In the context of HIV prevention, peer educators and mentors operate at the community level in roles similar to those of the CHVs. They may be supervised by CHEWs or outreach workers/field officers employed by NGO programs. CHEWs/outreach workers/field officers are usually trained in workshops along with facility-level staff and sub-county health managers. CHVs/peer educators/mentors are usually trained in their own workshops led by TOT, CHEWs, or facility-level staff and/or sub-county health managers and IPs.

Ongoing supervision and mentorship

- Providers across all countries go through refresher trainings and CME– this provides another opportunity to integrate training on new products. They can be included in refresher trainings for SRH, HIV prevention or oral PrEP, which are currently conducted across countries. In some countries, refresher trainings account for CME credits.
- In addition, providers in all countries receive ongoing supervision and mentorship. In some countries this is managed by national training centers and institutions, and for others by teams at the subnational levels (e.g., quality improvement teams, HIV or reproductive health focal persons, district health teams). In some countries, supervision is carried out at multiple levels and often with implementing partner support.
- In many countries, supervision happens via regular (e.g. quarterly,) visits to health facilities.
- In addition to formal supervision, informal communities of practice (e.g., via WhatsApp) led by a focal person at each facility or cluster of facilities can help providers connect with and provide ongoing support, advice, and mentorship to one another.

Example: Zimbabwe

- In Zimbabwe, support and supervision are conducted at three levels: national, provincial and district.
- Teams are composed of program managers and leadership at the provincial and district levels, such as the Provincial Medical Director, Provincial Nursing Officer, District Medical Officer, District Nursing Officer, pharmacy managers, and health information managers.
- Supervisory visit schedules are included in national, provincial, and district annual or quarterly plans. Standard checklists/tools are used. A standardized section on the dapivirine ring (DVR) can be developed and disseminated across all teams to ensure uniformity.
- National, provincial, and district multidisciplinary teams provide mentorship services. These are usually experts in clinical services (nurses and doctors), pharmacy, lab, and health information. The frequency of visits varies from monthly to quarterly, depending on the need and stage of mentorship.

Content Key Takeaways

- **Provider training should include a foundation of respect for client choice**, and values clarification activities should accompany training on HIV prevention methods.
- **Training content should include four product-specific components**: Target Population, Clinical Information, Utilization and Side Effects.
- **Additional content areas should be country-specific:** Counseling and Attitudinal Change, Supply Chain Management, and M&E.
- **A human-centered design approach should be used** to identify best practices and user needs, as well as explore health system realities with a focus on communities.
- **Training should be tailored** to the audience and granularity of information needed.

Details are on the following slides.

Trainings should cover four major topics

Product attributes	Training components with basic information on the core attributes of the product, including clinical background, target population, product use considerations, and side effects; training should also include essential information on all HIV prevention products available in the community, and referral pathways to support client choice.
Counseling	Training components on relevant client counseling, risks screening, and interpersonal communication, including guidance on supporting informed client choice and working with specific populations (e.g., adolescent girls and young women [AGYW]).
Supply chain management	Training components on facility-level supply chain considerations, such as ordering, inventory management, and reporting.
Monitoring & evaluation	Training components covering M&E activities, including registers, client tracking systems, and other monitoring and reporting requirements for providers.

Training on product attributes

Product attributes will be specific to individual products – below is an example of recommended content for the dapivirine ring.

Target Population Who can use the ring	**Clinical Information** The science behind the ring	**Utilization** How the ring is used	**Side Effects** Side effects of the ring
• Recognition of the ring as the first woman-centered, long-acting HIV prevention method • Ring use for clients of reproductive age • Ring use for pregnant and breastfeeding clients • Ring use for AGYW	• How the ring works • Ring effectiveness/ineffectiveness against the different routes of HIV acquisition (anal, vaginal, and oral sex and nonsexual transmission) • Level of protection offered by the ring, relative to other methods • Unique characteristics relative to other methods (e.g., no need for a daily pill, long-acting, discretion) • Use of combination prevention (e.g., how the ring can be used with other HIV prevention methods) • What the ring does *not* do (e.g., not a method of contraception, no prevention for sexually transmitted infection (STIs)	• Screening tests • Introduction to the ring and instructions for insertion, correct positioning, removal, and replacement • Information on how the ring will react when placed (e.g., will not retract into the uterus, unlikely to fall out of the vagina) • Information on use of the ring during menses • Information on ring disposal after use and environmental concerns	• Review of possible side effects of the ring, including changes to the genital environment caused by the ring (e.g., odor, amount of discharge) • Localized nature of drug absorption with the ring, which is thought to minimize side effects • Possible impact of the ring on sexual experiences (e.g., variety of responses from improved sex life to discomfort to no difference) • Possibility the ring is felt by a sexual partner

Research teams engaged in ring clinical trials emphasized the importance of pelvic models for use in training across all these areas.

Training on product attributes

Training should include information on anticipated myths and questions – below is an example of anticipated questions about the dapivirine ring.

FAQ

- For how long can one ring be used?
- Can the ring be used with other medication?
- Is it possible for the ring to fall out without the user knowing?
- Does the ring travel within the body?
- Is the ring safe to use with contraceptives?
- Can the ring be bought and used without a prescription?
- Can the ring prevent pregnancy?
- Does the ring cause one to lose their virginity?
- What tests need to be done before the ring can be used?
- How is the ring disposed of?
- Can the ring be used with condoms?
- How does the user know the ring is in the right position?
- What are common adherence challenges for the ring?
- How can adherence to the ring be best supported?
- Can the ring be used by a person living with HIV to prevent reinfection?

Lessons from experience with rollout of other products

- With oral PrEP, myths and misconceptions were learned through community dialogues before the national rollout (but after the development of the national guidelines) and incorporated into the training package.
- A major challenge in terms of communication about PrEP is explaining efficacy.

Training on product attributes

"Myth-busting" is an important role for providers - below is an example of how training can address myths about the dapivirine ring.

Myth	Addressing the myth
The ring can disappear in the body or fall out.	Use the pelvic model to explain ring insertion; education on female anatomy can be helpful.
The ring causes cancer, STIs, or infertility.	Explain how the ring works and share information on the safety of the ring from clinical trials.
The ring also acts as a contraceptive and/or may be confused with a contraceptive method (e.g., in Uganda, where the ring and intrauterine device (IUDs) have similar names.	Be explicit in communicating about the different tools and be sure to differentiate them.
The ring causes impotence or other harm to male partners.	Share clinical trial evidence showing safety for male partners and demonstrate the ring's flexibility, noting that partners rarely felt the ring in clinical trials.
Partners of ring users claim it is the ring causes STIs, not the sexual partners.	Explain the mechanism of action of the ring and STI transmission.
The ring shrinks or melts away with time as the product in the ring is used up like a suppository.	Explain the mechanism of action of the ring and use a demo ring to show it does not dissolve.
The ring is hard and rigid, and therefore difficult to use and may expand the vagina.	Use pelvic models and demo rings to explain how the ring fits and dispel fears that it is rigid.
The ring can be pushed into the uterus during sexual intercourse/disappear in the body.	Provide reassurance and demonstration using pelvic models.
The ring blocks menstrual flow.	Provide education on female anatomy and demonstrations using pelvic models.
Ring use promotes infidelity and exposes women to HIV infection.	Educate on gender roles and clinical trials showing HIV risk reduction from the ring.
Ring use is associated with Satanism.	Use demo rings and pelvic models to show that it is a clinical intervention.

Training on counseling approaches

All three of the countries in this analysis include training on provider – client engagement.

Kenya

- Kenyan guidelines and training curricula commonly refer to counseling as an essential package of care for those receiving SRH services.
- Most of the training manuals have components on counseling and communication with clients (e.g., the AIDS Package of Care has a section on communication and counseling for adolescents).
- A focus on attitudinal change is missing from trainings; however, there has been a push to include attitudinal change content in SRH and HIV manuals. For example, the oral PrEP curriculum was able to introduce attitudinal change.

South Africa

- Modules on communicating about oral PrEP, HIV risk, counseling and sensitization has been developed based on contraception and abortion care training – these are available in the South African HIV Clinicians Society training materials but are not universally used.
- Modules on values clarification and attitude change for providers have also been developed, with a focus on adolescent-friendly services.
- The MyPrEP website includes a full provider training platform and counseling tools for providers.

Zimbabwe

- Pre-service training includes modules on counseling, interpersonal communication, and attitudinal change.
- In-service training with the integrated HIV curriculum also includes sessions on counseling and communication.
- The focus is on specific areas, such as adherence to Antiretroviral therapy (ART). For this training package, expert patient trainers facilitate sessions on different scenarios across the HIV prevention, care, and treatment continuum of care. Other teaching methods include role plays, videos, group discussions, and demonstrations.

Training to support client choice

All three of the countries in this analysis have national FP counseling strategies which support client choice and can be drawn upon when training to support choice in HIV prevention methods.

Kenya

- The Balanced Counseling Strategy Plus (BCS Plus) is an interactive, client-friendly counseling strategy that seeks to simplify decision-making and respond more appropriately to the client's sexual and reproductive health needs and reproductive intentions.
- The BCS Plus has three main components: the algorithm, counseling cards, and method brochures. The counseling cards include information on HIV/STI prevention, HIV risk assessment, HIV testing, dual protection, adolescent counseling, and women support and safety to help clients create plans for HIV prevention.

South Africa

- The National Integrated SRH & Rights Policy (2019) is an overarching framework for all SRH service delivery. The policy explicitly addresses rights and choice in its overall goal – to promote, through informed choice, safer reproductive health practices by women, men, and youth, including use of quality and accessible reproductive health services.
- This is reflected in the Contraception Clinical Guidelines, which contains a dedicated section on informed decision making that emphasizes the importance of rights, choice, counseling, and the provision of sufficient information for a client to be able to select the right methods as appropriate to their fertility intentions, needs, preferences, and circumstances.

Zimbabwe

- A conversational approach to counseling is used, supplemented by a chart with all available FP methods (from short-term to long-acting methods) as a guide. Each method is discussed in depth, highlighting each method's pros and cons.
- All providers, including CHWs, are trained in all available FP methods, although only a few options are provided at the community level. CHWs are responsible for educating communities on all available FP methods so that women can seek their preferred methods at health facilities.

Addressing provider bias

Across countries, several practices help sensitize providers to the needs of diverse populations.

- Conduct values exploration/clarification activities to identify how personal views and values about HIV prevention and sexual behavior may impact how providers interact with and respond to different clients. These activities can help providers understand the importance of separating personal views and values from the provision of quality health care.
- Unpack and review what is included in acceptable, equitable, appropriate, and effective health services for all types of populations, including AGYW, transgender people, and same-gender loving individuals.
- Use a rights-based approach to discuss national policies with providers.
- Invite model providers providing non-discriminatory, non-stigmatizing services to trainings to share their values and service delivery approaches.
- Engage end users to share their experiences accessing HIV prevention services and how they want to engage with providers.
- Conduct community dialogues, “mystery client” reviews, and client surveys to gather feedback to share with health care providers.
- Co-design solutions with clients to address gaps and issues with service provision and provider bias.

Training on supply chain

All three of the countries in this analysis include training on supply chain considerations for new products.

Kenya

- For new products, a training module on supply chain considerations will be helpful for HIV and reproductive health supply chain personnel.
- It is also increasingly recognized that health care providers would also benefit from training on commodity management to avoid wastage and/or stock-outs.

South Africa

- All partners need to comply with pharmacy and drug management guidelines and be aligned with Good Pharmacy Practice, so this may require a job aid and a standard operation procedure (SOP) focused on supply chain logistics, depending on complexity for each new product.
- Complexity will depend on whether the supply chain is managed through partners or the National Department of Health (NDoH) – for oral PrEP, for example, the supply is streamlined and managed by NDoH, including for pharmacies and implementing partners.

Zimbabwe

- The MoH administers standard medicines management training across provinces, districts, and facilities, with post-training support from district pharmacy managers; this training covers all medicines based on the Essential Medicines List of Zimbabwe or ART guidelines (updated every 4 and 2 years, respectively, with addendums to add new evidence periodically).
- Shorter modules are included in in-service training on HIV prevention and HIV prevention and included supply chain and medicines management; the PrEP TWG includes representatives from the pharmacy and logistics department who are responsible for incorporating the necessary updates into the training package and developing SOPs/job aids.

Training on M&E

All three of the countries in this analysis include training on M&E for new products.

Kenya

- M&E is a distinct module of training curricula, including an overview of all national MoH data collection and reporting tools.
- Case studies and practical exercises are often included to familiarize trainees with how data should be recorded in these tools.
- National MoH data collection and reporting tools must be updated to include new products, which could have their own register(s) or be incorporated into existing oral PrEP registers, depending on the indicators for tracking.

South Africa

- Every training includes an M&E aspect.
- New products would need new M&E tools or would have to be incorporated into another M&E tool, depending on the programmatic indicators.

Zimbabwe

- Most training packages include a module on M&E that addresses the theory and practical aspects of M&E and practical aspects, covering in detail data collection, indicators, and reporting tools and processes.
- M&E modules are developed by the M&E task teams of the TWG.
- Additional sessions on data quality, verification processes, and data use for improvement are included.

Training materials

Training materials are relatively consistent across countries and include the following:

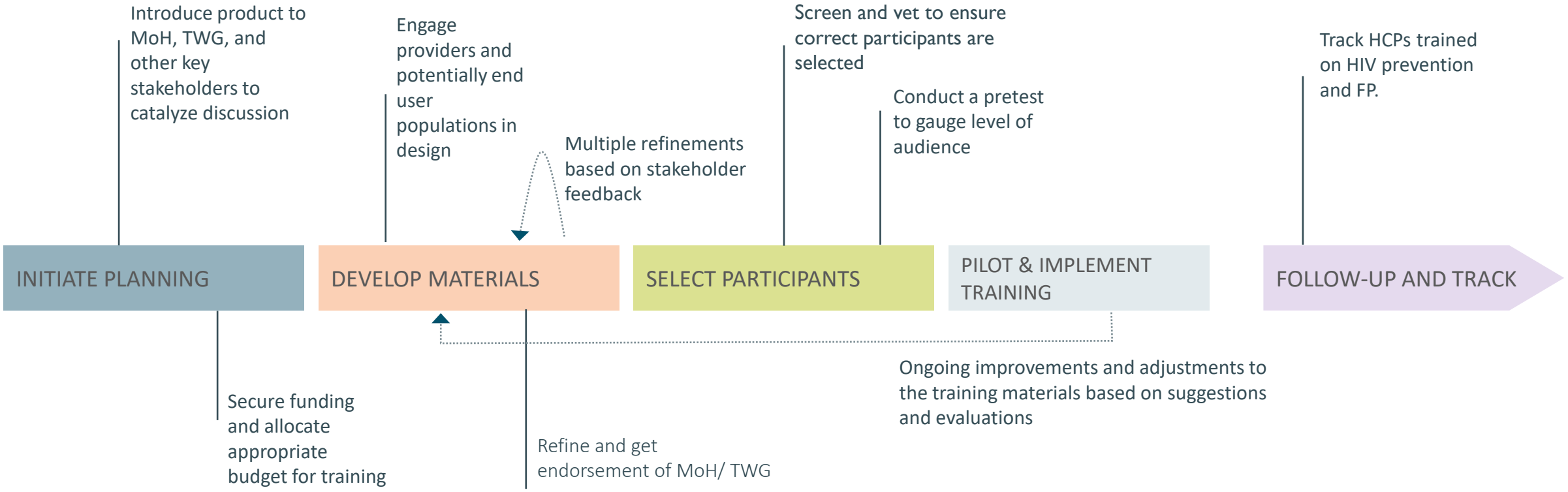
- Training materials include training manuals, videos, and other materials for interactive exercises.
- Trainings walk providers through ongoing reference materials, including guidelines, job aids, service flow charts, provider information packages, Q&A guides, and/or SOPs.
- Job aids can be in multiple formats, including posters for the wall, flip charts that can be kept on a clinic desk, palm cards, or a pocket booklet.
- Trainings should introduce providers to applicable demand creation campaigns to ensure they understand the background and messaging around the campaign. Providers should also receive materials including information, education and counseling (IEC) materials for clients, support and supervision checklists, and client survey tools.
- In addition, some countries have introduced online trainings or mobile applications with clinical guidelines that can be adapted to include new products.
- For the dapivirine ring, pelvic models will be helpful both for trainings and for provider use when providing services (e.g., for demonstration to end users); however, pelvic models are in short supply across many countries (e.g., in some countries they are available at central-level hospitals, in others they are held at the sub-county level and are made available to facilities upon request).

Process Key Takeaways

- **Ensure that key stakeholders – especially MoHs– are engaged** from the outset in the development of trainings on new products.
- **Consider a "process mapping" or "journey mapping" approach** by soliciting feedback from AGYW, target populations, and communities in the development of HCP training materials and curricula.
- **Make continuous improvements** and adjustments to training materials based on suggestions and evaluations.
- **Leverage existing trainings** where possible.
- **Invest in** learning forums and communities of learning, where possible.

Details are on the following slides.

Typical training development process



Considerations throughout the process

- MoH buy-in and engagement during the design, planning, implementation, and monitoring stages of training development
- Ongoing changes based on technical updates and changes in the national guidelines and protocols
- Engagement of AGYW, target populations, and communities in the development of HCP training materials and curricula
- Close coordination with FP, HIV, or other relevant MoHs focal people at the national or subnational level
- Inclusion of new products in ongoing and existing trainings

Training development considerations

INITIATE PLANNING

- Engage the **MoH and TWG** from the outset
- Embed into **existing trainings** where possible, although some new training will be needed
- **Delivery plan** should guide who joins (e.g., across different delivery channels)

DEVELOP MATERIALS

- Will require **iteration with key stakeholders** – led by TWG or a task force within TWG
- Materials/tools should be **pretested** with different audiences (e.g., across regions or provider types) with the aim of refining content, teaching methods, timing, and flow
- Materials should incorporate **end user perspectives**, for example via a community advisory board
- Trainings can often build on **existing materials** from clinical trials and demonstration projects

SELECT PARTICIPANTS

- **Participants** should be determined in-line with the rollout plan for the product – for example, training may be phased starting with high volume districts, HIV hotspots, or other relevant criteria
- Most countries use a **train-the-trainer** model to reach widespread audiences (e.g., train department leads who can cascade trainings to others in their facilities)

PILOT & IMPLEMENT TRAINING

- Ensure an adequate supply of **training materials**
- Use **training aids**, interactive exercises, and multiple modes of training delivery
- A self-taught, **online curriculum** that allows providers to register, receive training, take exams, and receive a certificate at the end can be highly effective
- **Learning forums** and communities of learning (e.g., via WhatsApp) can complement formal training

FOLLOW-UP AND TRACK

- Tracking will be required across different systems (e.g., professional associations that manage certifications, national MoH systems)
- **Track staff transfers/ turnover** to ensure consistency of trained HCWs
- **Evaluation reports from previous trainings** may shed light on gaps and areas for improvement

Acronyms

AGYW	Adolescent girls and young women
ART	Antiretroviral therapy
BCS Plus	Balanced Counseling Strategy Plus
CBO	Community-based organization
CHV	Community health volunteer
CHW	Community health worker
CME	Continuing medical education
CPD	Continuing professional development
DVR	Dapvirine vaginal ring
FP	Family planning
HCP	Health care provider
HMIS	Health management information system
IEC	Information, education and communication
IP	Implementing partner
M&E	Monitoring and evaluation
MoH	Ministry of Health
MoHCC	Ministry of Health and Child Care
NDoH	National Department of Health
NGO	Nongovernmental organization
PrEP	Pre-exposure prophylaxis
QI	Quality Improvement
RH	Reproductive health
SOP	Standard operating procedure
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TOT	Training of trainers
TWG	Technical working group
VHW	Village health worker

PROMISE HCP Training Working Group Members

Kenya

Patriciah Jeckonia
Maryline Mireku
Regeru Njoroge Regeru

Zimbabwe

Imelda Mahaka
Joseph Murungu
Definate Nhamo

USA

Manju Chatani
Jessica Rodrigues

USA

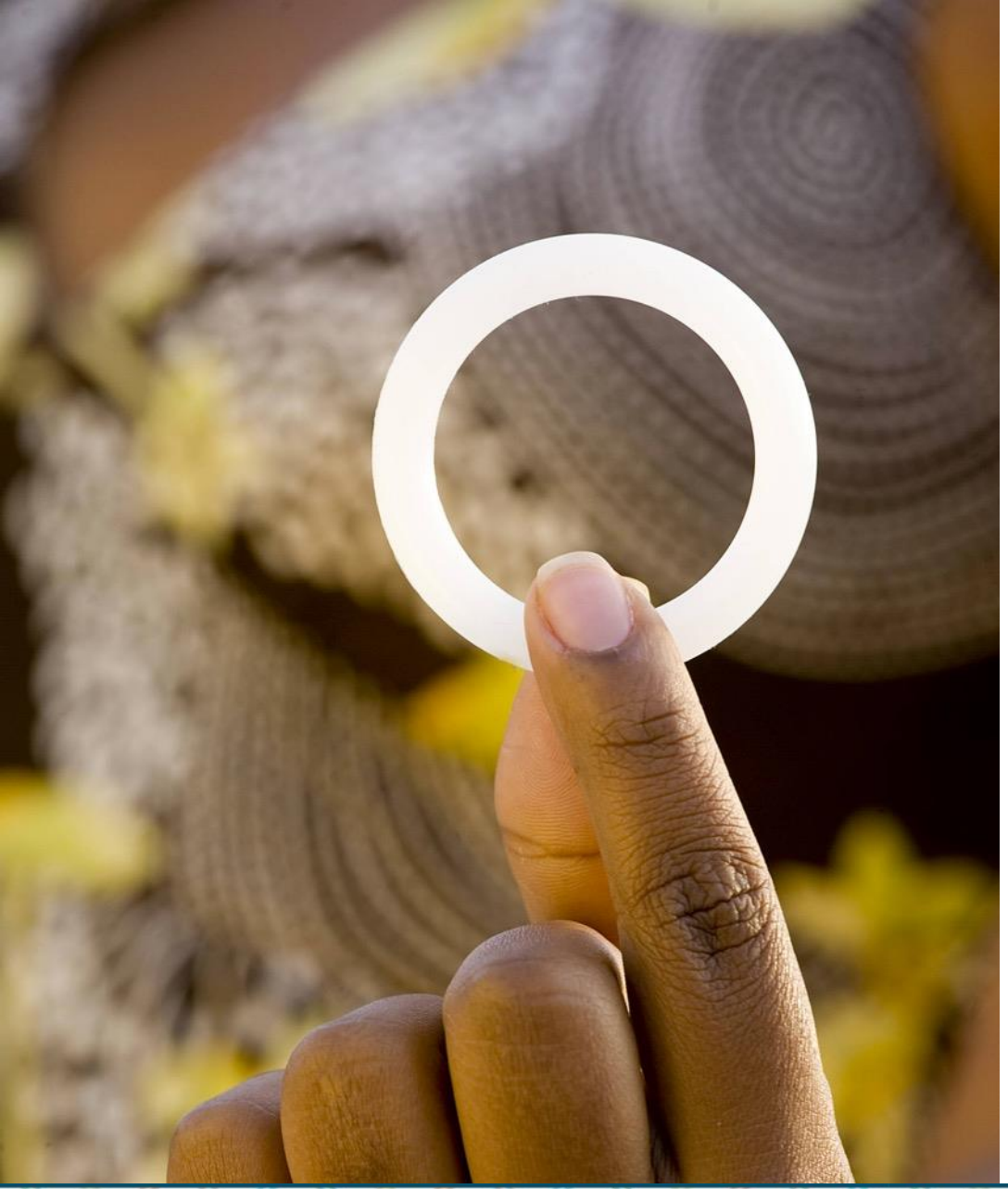
Holly Burke
Allison Cole
Susan Duberstein
Morgan Garcia
Brian Pedersen
Katie Schwartz
Lilian Tutegyereize

South Africa

Elmari Briedenhann
Saiqa Mullick
Diantha Pillay
Melanie Pleaner

USA

Neeraja Bhavaraju
Christina Scaduto



Thank You!

For more information, please visit:

- https://www.prepwatch.org/about-prep/dapivirine-ring/
- https://www.mtnstopshiv.org
- https://www.ipmglobal.org/our-work/our-products/dapivirine-ring

This document is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the terms of cooperative agreements 7200AA19CA00002, 7200AA19CA00003, and AID-OAA-A-15-00045. The contents are the responsibility of the EpiC project, the RISE project, and Envision FP and do not necessarily reflect the views of USAID, PEPFAR, or the U.S. Government.