CAB PrEP Compendium of End User Insights

Review of available published and gray literature on behavioral factors related to CAB PrEP and women

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Acronyms

AGYW	Adolescent Girls and Young Women
ART	Antiretroviral Therapy
BBC	Behavior Change Communication
DSD	Differentiated Service Delivery
FP	Family Planning
FSW	Female Sex Worker
HCW	Healthcare Worker
HIV	Human Immunodeficiency Virus
IPV	Intimate Partner Violence
PrEP	Pre-Exposure Prophylaxis
SBC	Social and Behavior Change
TDF	Theoretical Domains Framework
USAID	United States Agency for International Development

(1) INTRODUCTION AND BACKGROUND

Introduction and Context

As of the creation of this review, CAB PrEP has not yet been widely introduced in sub-Saharan Africa. Zimbabwe was the first sub-Saharan country to approve CAB PrEP in October 2022.[41] Since then, CAB PrEP has been approved in several African countries and has been submitted for approval in a number of others.

To date, CAB PrEP has been exclusively available in clinical trial and implementation study settings in sub-Saharan Africa with wider rollout expected in the future. As a result, data describing the behavioral factors of the use of CAB-PrEP among end users in Africa are limited and have been largely gathered in clinical trial settings. Additionally, data describing the behavioral factors of CAB PrEP use among women in Africa are limited.

At the time of this writing, there are no available data describing learnings derived from wider CAB PrEP rollout in African settings. Additional learnings on CAB PrEP are expected as implementation studies and rollout proceeds.

Objective

To help direct and inform CAB PrEP marketing and demand generation efforts by synthesizing relevant end-user insights about CAB PrEP and women from existing research.

Methodology

From September to November 2023, peer reviewed, published, and grey literature was reviewed to identify factors which may influence women's uptake and adherence to CAB PrEP across three major categories: capability, motivation, and opportunity.*

Inclusion criteria

Qualitative or quantitative studies on the use of CAB PrEP among women of any age in sub-Saharan Africa, including descriptive studies, human-centered design, and discrete choice experiments, published between 2015 and 2023. Due the limited available literature on this topic from sub-Saharan Africa, it is not possible to disaggregate the data by key population or age range.

Practical use

Understanding end users is a critical first step to establishing effective communication and informing program delivery. This document intends to help inform development and updating of national HIV prevention, combination prevention, and PrEP communication and demand generation strategies, campaigns and plans with CAB-specific insights.** It can also be shared with program implementers to inform communication and program delivery for CAB PrEP and method choice.

*Michie S, van Stralen M, and West R. (2011) The behavior change wheel: A new method for characterizing and designing behavior change interventions. Implementation Science 6:42. https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-6-42

**See Dapivirine Ring Compendium of End User Insights, OPTIONS, March 2020 for end user insights specific to the PrEP Ring. www.prepwatch.org/wp-content/uploads/2020/04/OPTIONS_DapRing_EndUser_Compendium_2Mar2020.pdf

Approach

The basis of this compendium is a desk review* of published and gray literature, including qualitative and quantitative studies on the use of CAB PrEP by women** in sub-Saharan Africa. This review includes clinical trials, implementation studies, descriptive studies, human-centered design research, discrete choice experiments, and other research methodologies. 41 references yielded relevant findings and are included in this review from the below literature screened and accessible in the references section of this report. This review did not follow PRISMA guidelines for a systematic review and should not be considered as such.

Peer-Reviewed Literature

We screened 120 peer-reviewed articles, largely on PubMed; 62 met the criteria for inclusion and were reviewed.

Inclusion criteria

- Sub-Saharan Africa
- Published between 2015-2023
- Key Search Terms:
  - Women OR adolescent girls OR young women
  - AND drivers OR factors OR facilitators OR barriers
  - AND Cabotegravir OR long-acting PrEP OR CAB PrEP or CAB LA

Gray Literature

We screened 8 project websites, including HIV conference sites, HIV Prevention sites, and SBC project sites.

Selection criteria

- Sub-Saharan Africa
- Published between 2015-2023
- Key Search Terms:
  - Women OR adolescent girls OR young women
  - AND drivers OR factors OR facilitators OR barriers
  - AND Cabotegravir OR long-acting PrEP OR CAB PrEP or CAB LA

*This review also includes input from several MOSAIC project stakeholders working in HIV Prevention and CAB PrEP. They were consulted to confirm findings from published literature and identify other potential sources of input.
**Due to the limited available literature on this topic from sub-Saharan Africa, it is not possible to disaggregate the data by key population, age range, or priority group.

Theoretical Framework

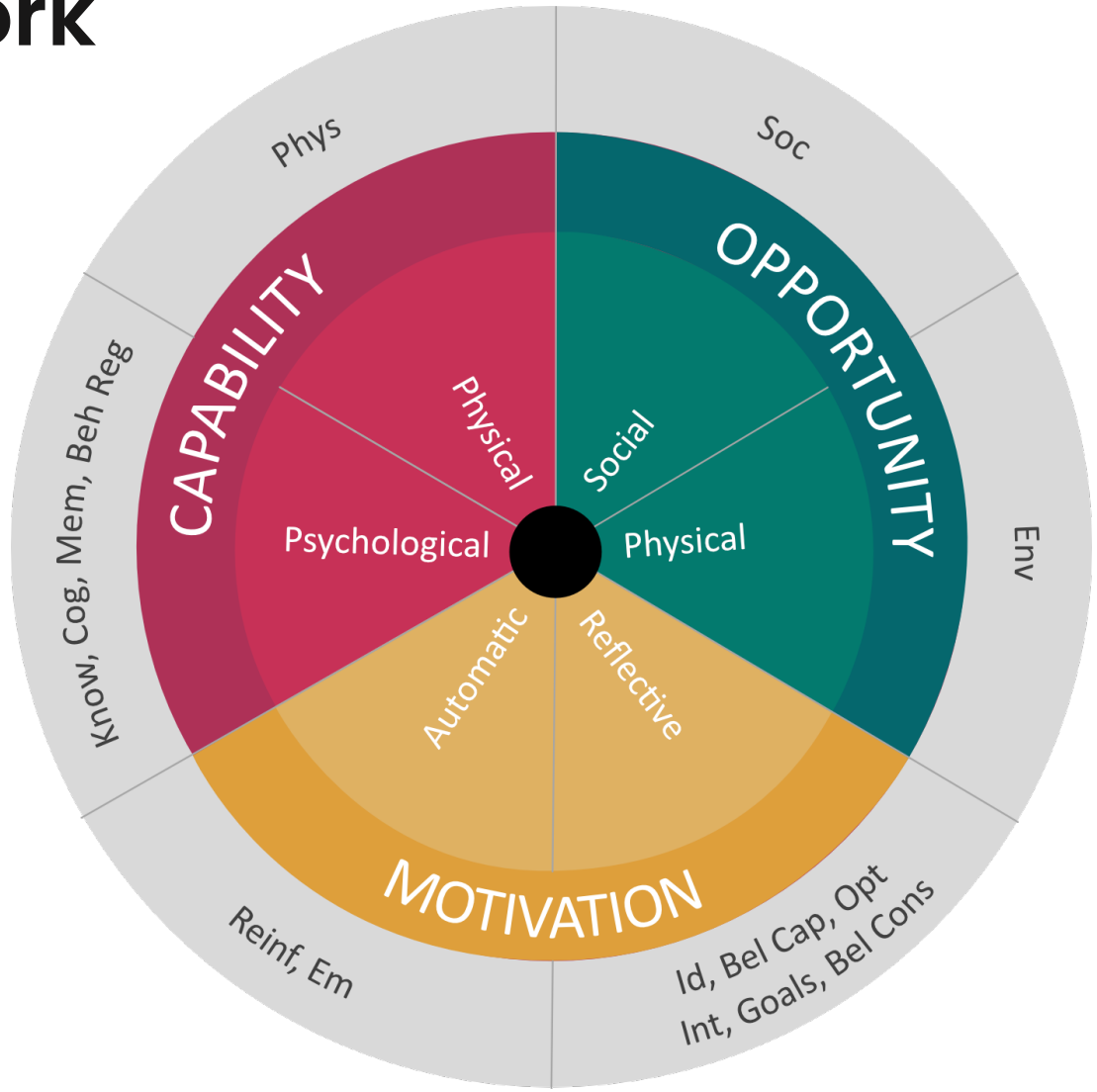
This review organizes behavioral factors along the **Theoretical Domains Framework (TDF)**. TDF was developed by a collaboration of behavioral scientists and implementation researchers who identified theories relevant to implementation and grouped constructs from these theories into large behavioral factor categories, or “domains”. It was originally published in 2005 and updated in 2012 after being validated. It updates and builds on the **COM-B framework**,* adding more up-to-date understanding of the drivers of behavioral factors.

One important note on the TDF and COM-B frameworks: Structural factors are represented in the frameworks as opportunity factors in COM-B (external factors that make execution of a behavior possible) and corresponding, environmental context/resources and social influences in TDF, and play a role as drivers of end user behavior in this framework. We have included both factors that are at the individual level and the structural factors (health system, influencers, etc.) to align to the framework of analysis and thus ensure a comprehensive review of behavioral drivers of CAB uptake and use.

*The COM-B Model for Behavior Change, The Decision Lab, https://thedecisionlab.com/reference-guide/organizational-behavior/the-com-b-model-for-behavior-change

Theoretical Domains Framework

Soc	Social influences
Env	Environmental context and resources
Id	Social/professional role and identity
Bel Cap	Beliefs about capabilities
Opt	Optimism
Int	Intentions
Goals	Goals
Bel Cons	Beliefs about consequences
Reinf	Reinforcement
Em	Emotion
Know	Knowledge
Cog	Cognitive and interpersonal skills
Mem	Memory, attention, and decision processes
Beh Reg	Behavioral regulation
Phys	Physical skills



Source: Atkins, L. Francis, J, Islam, R. et al. A guide to using the Theoretical Domains Framework of behavior change to investigate implementation problems. Implementation Sci 12, 77 (2017). Https://doi.org/10.1186/s13012-017-0605-9.

Definition of the TDF pillars

Each domain of the TDF framework is defined by a set of sub-factors, the table below defines all TDF sub-factors.

CAPABILITY	OPPORTUNITY	MOTIVATION
Knowledge: The extent to which an individual is aware of something leading to understanding of informed action.*	**Social influences:** Interpersonal processes that can cause a person to change their thoughts, feelings or behaviors. These influences may include injunctive and descriptive norms and tangible or emotional aid provided by one individual or group to an individual by members in one's social network or community.* **	**Beliefs about capability:** Acceptance of the truth about an ability, talent, or facility that a person can put to constructive use. Includes: self-efficacy, beliefs, and self-esteem.**
Physical, cognitive and interpersonal skills: An individual's ability or proficiency specific to a behavior.*	**Environmental context and resources:** Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence, and adaptive behavior.**	**Social/professional role and identity:** A coherent set of behaviors and displayed personal qualities of an individual in a social or work setting. Includes: self-confidence, professional confidence, and group identity.**
Memory, attention, and decision processes: The ability to retain information, focus selectively on aspects of the environment, and choose between two or more alternatives.*		**Optimism:** The confidence that things will happen for the best or that desired goals will be attained.**
Behavioral regulation: Anything aimed at managing or changing objectively observed or measured actions.*		**Beliefs about consequences:** Acceptance of the truth, reality, or validity about outcomes of a behavior in a given situation. Includes an individual's belief that positive or negative things will result if they perform a behavior. **
		Reinforcement: Punishment, consequences, or sanctions for performing an undesired behavior or not performing a desired behavior; and reinforcement and incentives for performing the desired behavior.**
		Intentions: A conscious decision to perform a behavior or a resolve to act in a certain way.**
		Goals: Desired outcomes or end states that an individual wants to achieve. For example, goal setting, action planning.**
		Emotion: A natural, instinctive state of mind resulting from one's circumstances, mood or relationship with others.**

* Michie S, van Stralen M, and West R. (2011). The behavior change wheel: A method for characterizing and designing behavior change interventions. Implementation Science 6:42

** Source of Definitions: Source: Atkins, L. Francis, J, Islam, R. et al. A guide to using the Theoretical Domains Framework of behavior change to investigate implementation problems. Implementation Sci 12, 77 (2017). Https://doi.org/10.1186/s13012-017-0605-9.

Definition of the TDF pillars as applied in this review

The table below describes all TDF sub-factors identified in the literature using *illustrative* examples.

CAPABILITY	OPPORTUNITY	MOTIVATION
Knowledge: The extent to which an individual is aware of CAB PrEP, how CAB PrEP is delivered, and/or HIV knowledge. **Memory, attention, decision processes:** The ability to remember and decide to take CAB PrEP.	**Social influences:** The way one's thoughts, feelings or behaviors concerning CAB PrEP respond to their environment. These influences may include norms and tangible or emotional support provided to an individual by members in one's social network or community. **Environmental context and resources:** Any circumstance of a person's situation or environment that discourages or encourages CAB PrEP use.	**Social/professional role and identity:** Aspects of CAB PrEP use that reinforce or contradict one's roles and/or the ways they identify socially or professionally (i.e., as a 'good/ethical provider'). **Beliefs about consequences:** The belief that CAB PrEP use will protect a user from HIV. **Emotion:** A natural, instinctive state of mind (e.g., fear, relief) resulting from one's use of CAB PrEP.

(2) EXECUTIVE SUMMARY

Categorization of Behavioral Factors

EVIDENCE SOURCE LIMITATIONS

Most of the available and relevant literature describes *hypothetical factors* of CAB PrEP uptake and/or consistent use and is derived from formative research conducted through studies and projects that do not include product use and/or prior to approval and rollout of CAB PrEP in market (i.e., findings are not based on actual experience with the product). The hypothetical factors relevant to demand generation and communication make up the bulk of the literature and thus are included in this compendium. *Confirmed* factors are those that are known from studies and projects that included product use (i.e., clinical trials).

As a result, findings in this compendium are organized into two categories:

- **Hypothetical Behavioral Factors:** Barriers and facilitators derived from formative research (descriptive studies, human-centered design projects, and discrete choice experiments) conducted without product use, including perspectives of those who do not have actual CAB PrEP experience and do not live in a setting where CAB PrEP has been made available and applicable learnings from oral PrEP rollout or the rollout of other medical interventions (i.e., family planning, etc.).

- ✓ **Confirmed Behavioral Factors:** Barriers and facilitators with documented confirmation derived from CAB PrEP clinical trial data or from research conducted among those with experience using CAB PrEP.

Key Insights Overview

	CAPABILITY	OPPORTUNITY	MOTIVATION
FACILITATORS	✓ **Prior familiarity with injections for other health services:** End users' familiarity with the mode of administration of CAB PrEP due to experience with injectable contraceptives. ✓ **Belief that regimen is simple to follow:** Belief that CAB PrEP simplifies the PrEP regimen compared to oral PrEP. It offers greater perceived ease in adherence and eliminates the need to remember a daily pill. ▪ **Awareness**: Behavior change communication (BCC) materials may facilitate awareness and use of CAB PrEP.	✓ **Privacy for the user:** The ability to use CAB PrEP more discreetly than oral PrEP reduces the risk of unintentional PrEP disclosure to others. ✓ **Buy-in or support for CAB PrEP use from an AGYW's parents/guardians.** ▪ **Availability in diverse service delivery settings:** CAB PrEP may be offered in a range of health service delivery settings, including outside of traditional health facilities. ▪ **Task sharing of injection delivery**: Injections may be administered by a range of healthcare cadres, not only facility-based providers. ▪ **Integration of CAB PrEP services with other SRH-related services.** ▪ **Provider training/capacity building** in injection administration and effective counseling on PrEP choice.	✓ **Perceived high efficacy of CAB PrEP in preventing HIV.** ✓ **CAB PrEP users appreciated that CAB PrEP is not potentially disruptive to sex,** like other HIV prevention methods. ✓ **High risk perception of acquiring HIV.** ✓ **Acceptance of the delivery modality and tolerable side effects of CAB PrEP.** ▪ **Administration of CAB PrEP by a healthcare professional** is believed to increase safety of PrEP use.
BARRIERS	▪ **Lack of knowledge or awareness** of CAB PrEP among clients and providers.	✓ **Negative attitudes or perceptions of CAB PrEP held by AGYW's parents/guardians and/or communities.** ▪ **Costs to clients** associated with acquiring CAB PrEP (e.g., HIV testing, travel to clinics, time commitment, etc.). ▪ **Lack of private spaces to administer injections.** ▪ **Potential shortage of providers** who can administer and counsel on CAB PrEP. ▪ **Potential supply chain issues** such as CAB PrEP stockouts, needle supply and disposal needs, and cold chain requirements.	✓ **Dislike or fear of needles/injections.** ✓ **Long-term and short-term side effects.** ✓ **Belief that CAB PrEP is not effective in preventing HIV.** ✓ **Safety and efficacy concerns for pregnant/ breastfeeding women.** ▪ **Concerns about the risk of drug-resistant HIV and stopping CAB PrEP use,** including concerns about "oral bridging" (intermittent use of oral PrEP when CAB PrEP injections are missed). ▪ **Perceived loss of control or independence** because CAB PrEP must be administered by a provider and can not be administered by oneself.

Key findings include those that are confirmed and most frequently mentioned in hypothetical literature. ✓denotes a confirmed finding and ■ denotes a hypothetical finding.

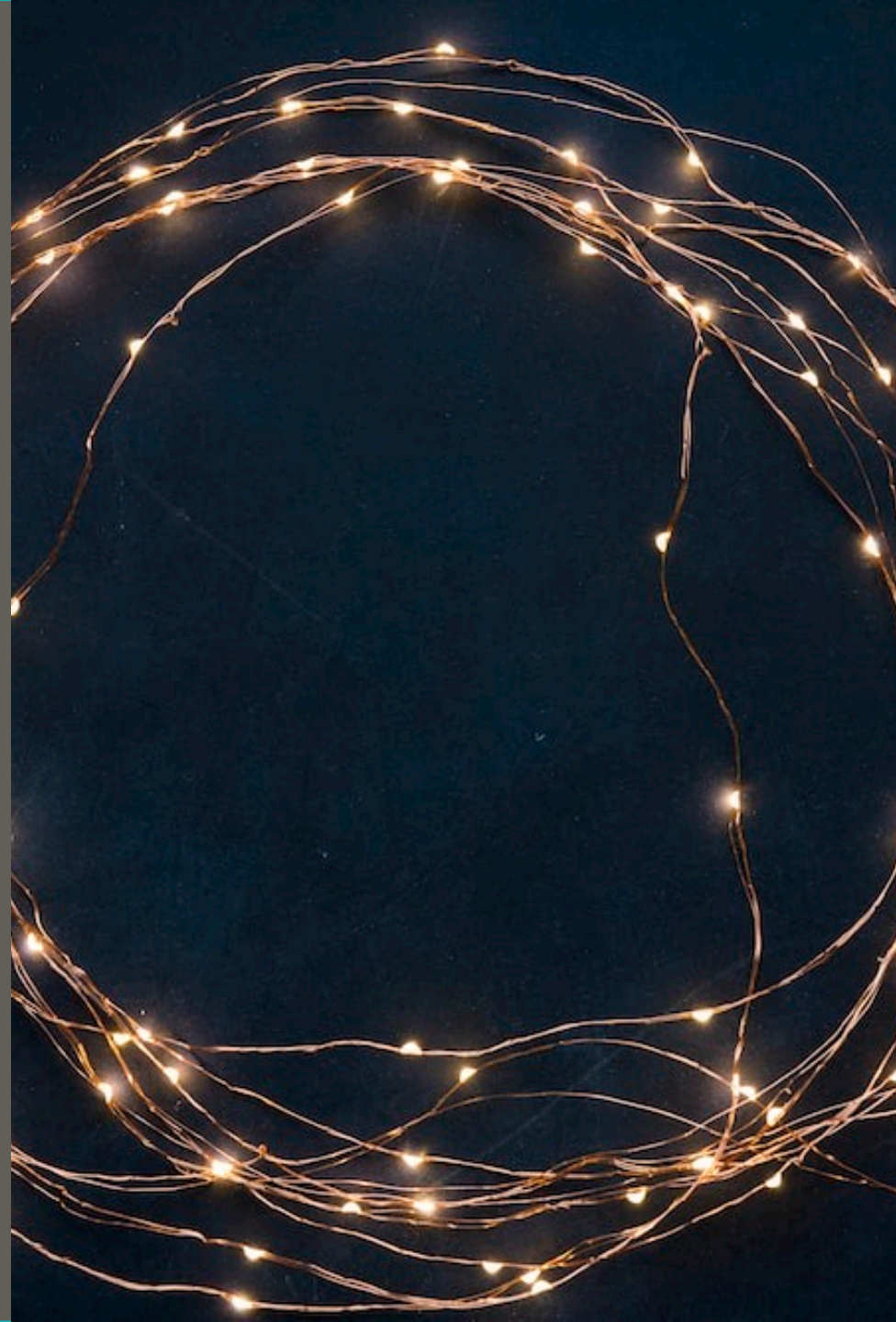
(3) INSIGHTS

Behavioral Factors

The following slides include a summary of insights on behavioral facilitators and barriers across studies for each component of the TDF framework for CAB PrEP.

Confirmed facilitators to women's CAB PrEP use include high efficacy of CAB PrEP, discretion of product use, ease of adherence, and prior or current use of injectable contraceptives. Confirmed barriers include include side effects and fear of injections.

Hypothetical facilitators to women's CAB PrEP use include behavior change communication, differentiated service delivery, and provider capacity building. Significant hypothetical barriers to women's CAB PrEP use include risk of developing drug-resistant HIV, potential CAB-related strain on the healthcare system (facilities and providers), client costs associated with CAB PrEP use, and potential supply chain issues.



Behavioral Facilitators and Barriers: Capability

✓ Confirmed ■ Hypothetical

CAPABILITY

FACILITATORS

✓ **FAMILIARITY WITH INJECTIONS**

End users' familiarity with the mode of administration of CAB PrEP due to experience with injectable contraceptives[8,9,18]

✓ **PERCEIVED SIMPLICITY OF REGIMEN**

CAB PrEP simplifies the PrEP regimen compared to oral PrEP. It offers greater perceived ease in adherence and eliminates the need to remember a daily pill.[7,8,17,23,35,36]

CAB PrEP complements an active lifestyle, especially for youth and those who travel who may forget to pack or take pills.[18,23]

■ **APPOINTMENT REMINDERS TO FACILITATE ADHERENCE**, a key learning from oral PrEP.[3,24]

■ **BEHAVIOR CHANGE COMMUNICATION (BCC) MATERIALS FACILITATE AWARENESS AND USE OF CAB PrEP**

Both client- and provider-facing materials that emphasize high-efficacy and convenience of CAB PrEP, provide information on various PrEP options in non-technical language for women, and answers FAQs to support providers; based on key learnings from oral PrEP rollout.[3]

BCC materials to facilitate community sensitization and greater acceptance among key influencer groups of CAB PrEP and correct myths and misinformation.[24, 27, 28, 29]

Materials dissemination through various channels – social media, billboards, interpersonal communication, etc.[24, 28]

BARRIERS

■ **LACK OF KNOWLEDGE OR AWARENESS** of CAB PrEP among clients and providers.[24,40]

Behavioral Facilitators and Barriers: Opportunity

✓ Confirmed ■ Hypothetical

OPPORTUNITY

FACILITATORS

✓ **USER DISCRETION**

End users report that CAB PrEP provides user discretion, preventing the negative social consequences of unintentional PrEP disclosure to others.[9,12,13,17,23,35]

In one study, South African youth saw long-acting PrEP methods as providing greater discretion compared to oral PrEP. Unlike oral PrEP, CAB PrEP does not need to be carried around, stored covertly in households, or used in settings with unsupportive family members. Also, CAB PrEP offered greater discretion for those who did not wish to disclose to partners.[23]

✓ **BUY-IN OR SUPPORT FOR CAB PrEP USE FROM AGYW'S PARENTS/GUARDIANS**[9]

■ **TASK SHARING OF INJECTION DELIVERY**

Injections may be administered by a range of healthcare cadres (including community, lay, and peer providers), not exclusively clinical physicians. This may result in less stigmatized services and reduce pressure on the health system.[7,11,24,40]

■ **DIVERSE SERVICE DELIVERY OPTIONS**

CAB PrEP may be offered in a range of settings, including those outside traditional health facilities (e.g., pharmacies, food banks, schools, and mobile health approaches). This may increase client reach, lower the travel burden to traditional health settings, and destigmatize services.[11,16,20,21,24,27,30,40]

■ **INTEGRATION OF CAB PrEP SERVICES WITH OTHER SRH-RELATED SERVICES**

To decrease the number of clinic visits, travel cost to the client, and pressure on health system.[3,20,22,24,28,29]

■ **CAB PrEP INJECTIONS OFFERED FREE OF COST**[39]

■ **PROVIDER TRAINING/CAPACITY BUILDING**

To ensure that providers correctly administer injections and knowledgeably counsel clients on multiple options, in a non-judgmental manner.[3,7,11,24,27,28,32]

Behavioral Facilitators and Barriers: Opportunity

✓ Confirmed ■ Hypothetical

OPPORTUNITY

BARRIERS

✓ **NEGATIVE ATTITUDES OR PERCEPTIONS OF CAB PrEP OF INFLUENCERS AND COMMUNITIES**

Negative attitude of AGYW's parents/guardians and/or communities.

In a Kampala-based study, parents of AGYW were asked their thoughts on CAB PrEP. Many reported concern and belief in myths about the harms of CAB PrEP including that it causes infertility, changes in DNA, and/or cancer.[25]

■ **COST TO CLIENTS ASSOCIATED WITH CAB PrEP-USE**

Cost of drug, HIV testing, travel to clinics, time commitment, etc.[6, 11, 16, 24, 40]

■ **LACK OF PRIVATE SPACES TO ADMINISTER INJECTIONS**

At healthcare facilities and limited private spaces elsewhere.[7,16,20,24,26,32,20,24]

■ **POTENTIAL SHORTAGE OF PROVIDERS** [11,22,24,28,30,40]

Shortage of providers who can administer CAB PrEP.
CAB PrEP may strain provider time due to drug administration and counseling demands and increase their workload.

■ **LOGISTICAL BURDEN ASSOCIATED WITH CLINIC VISITS**

Such as the need to remember appointments, distance and travel, long wait times, and inconvenient opening times at facilities. CAB PrEP shots are not on the same schedule as injectable contraceptives, which may lead to unintentional PrEP disclosure due to increased clinic visits or client fatigue and missed visits.[18,20,24,26,27,34,40]

■ **SUPPLY CHAIN ISSUES**

Such as potential CAB PrEP stock outs and issues with cold chain requirement; sufficient needles and needle disposal will be needed.[4,6,7,16,22,24,28,40]

■ **PROVIDERS' STIGMATIZING ATTITUDES TOWARDS CLIENTS INQUIRING ABOUT OR USING HIV PREVENTION**[11,20]

■ **DISCOMFORT WITH INJECTION LOCATION**, the buttocks, perceived as invasive.[18]

Behavioral Facilitators and Barriers: Motivation

✓ Confirmed Hypothetical

MOTIVATION

FACILITATORS

✓ **PERCEIVED HIGH-EFFICACY OF CAB PrEP IN PREVENTING HIV**[9,12,13,17,21,23,36]

One study including South African youth found that participants' top priority in any PrEP product was efficacy; and for some, this overrode other concerns such as fear of pain from injection.[23]

In the clinical study HPTN 084-01, when asked what they liked about CAB PrEP, most (55%) of African female adolescents reported that they liked that CAB PrEP offers prevention from HIV.[8]

Some end users perceive CAB PrEP as highly efficacious due to beliefs that injections are more effective than other forms of medication.[23]

Some women appreciate that CAB PrEP becomes effective quickly after administration.[1,6,18,28,31]

✓ **CAB USERS APPRECIATED THAT CAB PrEP IS NOT POTENTIALLY DISRUPTIVE TO SEX,** like other HIV prevention methods.[12,13,36]

✓ **HIGH RISK PERCEPTION**

The HPTN 084 open-label extension study found that those who chose CAB PrEP over oral PrEP appeared at higher risk for HIV: more likely to not live with partners, have experienced recent physical intimate partner violence, and to have been paid for sex.[5]

✓ **ACCEPTANCE OF DELIVERY MODALITY AND MANAGEABLE SIDE EFFECTS**

In the HPTN 084-01 study, needle size (1½ inch) and site of administration (gluteal muscle) were generally deemed acceptable by participants.[8]

During HPTN 084-01, CAB PrEP was found to be tolerable, with no discontinuations of product due to adverse events.[9]

BELIEF THAT CAB PrEP PREVENTS HIV FROM ALL TYPES OF SEXUAL EXPOSURES

Some women appreciate that CAB PrEP can reduce HIV risk not only through vaginal sex, but through other types of HIV exposures.[27,28]

ADMINISTRATION OF CAB PrEP BY A HEALTHCARE PROFESSIONAL is believed to increase safety of PrEP use and reduce chances of mistakes.[6,30]

Behavioral Facilitators and Barriers: Motivation

✓ Confirmed ■ Hypothetical

MOTIVATION

BARRIERS

✓ **DISLIKE OR FEAR OF NEEDLES/INJECTIONS**[8,18,35]

✓ **SIDE EFFECTS**

Including injection site pain, injection site reaction, nausea, headaches, dizziness, etc.[8,12,17,22,23,35,36,38]

The CAB PrEP injection is seen as irreversible. Unlike oral PrEP, if the user experiences unwanted consequences they cannot just stop taking it; concern that CAB PrEP stays in the system.[12,17,35]

✓ **CONCERNS ABOUT EFFICACY**

Some AGYW during clinical trials expressed concerns that CAB PrEP may not be effective in preventing HIV.[12]

✓ **CONCERNS FOR PREGNANT/BREASTFEEDING WOMEN**

Desire for pregnancy arose as one reason some may opt for oral PrEP instead of CAB PrEP. Some concern exists that since CAB PrEP is not yet approved for use by pregnant/breastfeeding women, the safety and efficacy profile for CAB PrEP use among this population is unknown.[38]

■ **CONCERNS ABOUT THE RISK OF DRUG-RESISTANT HIV, ORAL BRIDGING AND STOPPING CAB PrEP-USE**

Oral PrEP is to be taken for a period of time after stopping CAB PrEP. Additionally, oral PrEP is to be used between missed doses of CAB PrEP ("oral bridging"). Oral bridging may be difficult for those who already have adherence issues with oral PrEP.[4,6,11,16,27,28,30,33,40]

■ **PERCEIVED LOSS OF CONTROL OR INDEPENDENCE**

CAB PrEP must be administered by a provider and cannot be administered by oneself.[24,28,29,30]

(4) REMAINING GAPS

Select Key Remaining Gaps

As CAB PrEP research and implementation continues, it is expected that additional learnings on behavioral factors of CAB PrEP demand and use among women will emerge. The table below summarizes some of the relevant, key gaps identified through review of existing published and gray literature, and through input from a select group of stakeholders engaged with CAB PrEP research and implementation. While not an exhaustive list of gaps, these are **intended to provide prompts and stimuli to those working to understand end-user behavior of CAB PrEP among women**. Some of these gaps are filled by partial insights or anecdotal information while others remain full gaps in understanding.

CAPABILITY	• What types of **reminder techniques** work to facilitate consistent use of CAB PrEP? • What types of **communication messaging, strategies, and tools** best influence CAB PrEP demand and consistent use.? • What **knowledge gaps** need to be addressed? What types of **misinformation** persists about CAB PrEP (i.e.: effectiveness, drug resistance)? • What **messages and communication techniques** address knowledge and awareness of CAB PrEP? Which work best and with whom (clients, providers, community, etc.)? • Will CAB PrEP offer an opportunity for women to feel **more in control**? • How can **providers feel comfortable and confident** in recommending and supporting CAB PrEP use among clients? • What is the **emotional cost** of using CAB PrEP for women?
OPPORTUNITY	• How can **health systems adapt** to make CAB PrEP more available and accessible for women? • What is the extent to which **task sharing and differentiated service delivery** may be addressed by government and other key stakeholders to improve demand and access among AGYW? • What are the ways in which specific **influencers (peers, partners, parents) facilitate and/or limit CAB PrEP access and use** and which successful interventions can encourage their support? • In addition to training, what are the **types of interventions and techniques targeting providers** that work best to improve client-centered care for CAB PrEP?
MOTIVATION	• What are the **barriers and facilitators to oral bridging** and successful approaches to ensure adherence? • How do the **unique service delivery requirements** (i.e., administration in medical setting) of CAB PrEP affect women's uptake and continued use (i.e., capability to use) of the product? • Does hearing the **experiences of other women using CAB PrEP** affect uptake/use? What types of testimonials are most compelling (i.e., type of information, messaging used, type of interaction)?

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