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Views of policymakers, healthcare workers and NGOs on HIV pre-exposure prophylaxis (PrEP): a multinational qualitative study

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ABSTRACT

Objectives: To examine policymakers and providers' views on pre-exposure prophylaxis (PrEP) and their willingness to support its introduction, to inform policy and practice in this emerging field.

Design: Semistructured qualitative interview study.

Setting: Peru, Ukraine, India, Kenya, Uganda, Botswana and South Africa.

Participants: 35 policymakers, 35 healthcare workers and 21 non-governmental organisation representatives involved in HIV prevention.

Results: Six themes emerged from the data: (1) perceived HIV prevention landscape: prevention initiatives needed to be improved and expanded; (2) PrEP awareness: 50 of 91 participants had heard of PrEP; (3) benefits of PrEP: one component of the combination prevention arsenal that could help prioritise HIV prevention, empower key populations and result in economic gains; (4) challenges of PrEP: regimen complexity, cost and cost-effectiveness, risk compensation, efficacy and effectiveness, stigmatisation and criminalisation, information and training and healthcare system capacity; (5) programmatic considerations: user eligibility, communication strategy, cost, distribution, medication and HIV testing compliance and (6) early versus late implementation: participants were divided as to whether they would support an early introduction of PrEP in their country or would prefer to wait until it has been successfully implemented in other countries, with around half of those we spoke to supporting each option. Very few said they would not support PrEP at all.

Conclusions: Despite the multiple challenges identified, there was general willingness to support the introduction of PrEP. Yet, strengthening existing HIV prevention efforts was also deemed necessary. Our results suggest that an effective PrEP programme would be delivered in healthcare facilities and involve non-governmental organisations and the community and consider the needs of mobile populations. Comprehensive information packages and training for users and providers would be critical. The cost of PrEP would be affordable and possibly segmented. Extensive counselling and innovative monitoring measures ought to be considered.

ARTICLE SUMMARY

Article focus

- Understanding the attitudes, perceptions and preferences of key stakeholders towards PrEP to identify important programmatic aspects that may enhance or hinder its effectiveness.

Key messages

- Policymakers, healthcare workers and NGOs, particularly from Sub-Saharan Africa, would be willing to support PrEP if proven cost-effective.
- PrEP was envisaged as part of a combination prevention strategy deeply rooted in and driven by its beneficiaries.
- To effectively tackle the HIV epidemic, reducing stigmatisation against those at higher risk of infection and strengthening existing prevention programmes is as critical as introducing new ones.

Strengths and limitations of this study

- This is the first international study on key stakeholders’ preferences and concerns regarding PrEP and how best to address these at a policy and service level.
- The interview guides and local interviewers’ training were standardised, which facilitated data comparability.
- Relevant PrEP stakeholders were recruited.
- Limitations include the largely hypothetical nature of the addressed PrEP characteristics, potential social desirability bias and purposive recruitment—mainly in urban areas.

INTRODUCTION

HIV incidence is stabilising and beginning to decline in many countries with generalised epidemics. Further efforts should now focus on consolidating this trend.1 New prevention approaches are being considered that might, in combination with existing ones, help achieve this goal. Following both successful
and futile results in recent clinical trials, the use of antiretrovirals to prevent HIV transmission (treatment for prevention) or acquisition (pre-exposure prophylaxis (PrEP)) has become a focus of HIV/AIDS policy discussions. Although further clinical evidence will be needed to determine optimal regimens and delivery mechanisms, multi-disciplinary preparatory work needs to be undertaken to identify where existing and potential modalities may fit best within an integrated HIV prevention package.

Previous work on the implications of a future PrEP implementation has highlighted the importance of engaging relevant stakeholders in a consultation process designed to strengthen, legitimise and ultimately enhance its sustainability and effectiveness. Understanding the preferences and concerns of policymakers and providers towards PrEP, drawing on their experience in designing and delivering comparable programmes, is therefore paramount to the success of this prevention approach.

This article reports on qualitative research exploring policymakers, healthcare workers and non-governmental organisations’ (NGOs) perspectives on oral and parenteral PrEP in seven countries: Peru, Ukraine, India, Kenya, Uganda, Botswana and South Africa. The research presented here complements a study on attitudes and acceptance of PrEP among potential users reported elsewhere. The research presented here aims to inform priority setting, programme design, and implementation, should PrEP prove cost-effective, and complements a study on attitudes and acceptance of PrEP among potential users reported elsewhere.

METHODS
A qualitative approach is most appropriate in an exploratory in-depth study of this sort. Face-to-face individual interviews were therefore conducted between November 2010 and March 2011 with policymakers, healthcare workers and NGO representatives responsible for or involved in HIV prevention in major cities of seven countries with diverse HIV epidemics: Peru, Ukraine, India, Kenya, Uganda, Botswana and South Africa. Participants were purposively selected using a combination of criterion and snowball sampling.

Ipsos MORI, an international social and market research company, coordinated the data collection. Interviews were conducted by experienced local senior researchers. Interviewers were trained face-to-face by both our team and/or Ipsos MORI. They were also provided with a comprehensive interview manual, which contained background on PrEP research, frequently asked questions, information on participant eligibility, detailed interview instructions and a consent form in countries where local ethical approval required written consent. All participants provided verbal consent. Interviews took place in a private office at the participants’ work place and lasted between 45 and 60 min. Interview guides and materials were translated into Spanish (Peru) and Russian (Ukraine) by the local research team and checked in London by professional translators for consistency and quality. In India and Sub-Saharan African countries, interviews were conducted in English.

We used a semistructured and probing interview guide constructed through expert consultations and a literature review. Before commencing, participants were informed that their answers would be anonymised and treated with strict confidentiality. Participants were first asked about their role, involvement with HIV prevention, perceptions of their countries’ HIV prevention efforts and awareness of PrEP. To provide all participants with a minimum level of background knowledge, interviewers subsequently read a description of hypothetical and real PrEP attributes, including its ineffectiveness against other sexually transmitted diseases; its route of delivery as a daily and before-and-after-sex pill and eventually as a monthly and bimonthly injection; its mild temporary side effects including tiredness, headaches and gassiness; its partial protective efficacy against HIV, especially if not taken as directed, and the need for frequent HIV testing. It was stressed that PrEP was undergoing clinical trials and its characteristics remained uncertain. Participants were then asked to rank their concerns in order of importance. They were also asked to identify the benefits of PrEP, if any. Subsequently, they were asked to describe what an effective PrEP programme would look like in their countries. Participants were finally asked whether they would support PrEP being introduced at an early stage, a later stage or not at all.

All interviews were digitally recorded, transcribed and translated into English by professional translators where necessary and were analysed independently by AW, GBG and ABE to ascertain inter-rater coding reliability. Using thematic analysis, an initial categorising system was developed based on the study objectives and the interview guides. We identified new themes and sub-themes emerging from the data analysis, which were included when consensus was reached regarding their relevance. A final thematic index was produced to code all data.

RESULTS
We conducted a total of 91 interviews (13 per country) including 35 policymakers, 35 healthcare workers and 21 NGO representatives. Fifty-one participants were men and 42 were women. Participants’ eligibility criteria are described in table 1. We present our findings across countries and job roles, highlighting areas of convergence and divergence around six themes: perceived HIV prevention landscape, PrEP awareness, perceived benefits of PrEP, perceived challenges of PrEP, programmatic considerations and early versus late implementation.

Perceived HIV prevention landscape
Peruvian participants mentioned that their HIV epidemic had reached a plateau with a significant
A reduction in mortality. Men who have sex with men (MSM), especially transsexuals, were identified as the most affected group. Stigma, low self-esteem and substance abuse were frequently referred to as underlying determinants of high HIV incidence among MSM. Cultural and religious barriers, insufficient resources and the recent decentralisation of Peru’s healthcare system, which had led to inefficiencies in the provision of services, were raised as the main reasons behind the current HIV prevention deficiencies. A mismatch between treatment and prevention expenditure and the comparatively low HIV incidence among the beneficiaries of prevention programmes were mentioned as main causes for concern.

Most Ukrainian participants agreed that HIV prevention had recently become a priority on their government’s agenda. Nonetheless, they raised concerns regarding the accuracy of the official HIV incidence data and the pervasive criminalisation and stigmatisation of key populations (injecting drug users (IDUs), female sex workers and MSM), which in turn hindered their access to prevention programmes. Participants felt that reducing Ukraine’s dependency on international donors, increasing and optimising public resources for HIV prevention, as well as involving communities in the design of prevention programmes, strengthening advocacy work and raising awareness was urgently needed to increase the impact and sustainability of prevention efforts.

Similarly, Indian participants felt that their country’s HIV prevention efforts were insufficient and identified sex workers, MSM, truck drivers, serodiscordant couples and IDUs as populations at higher risk of infection. Key HIV prevention challenges included lack of access to condoms and difficulty negotiating condom use, stigmatisation—often from healthcare workers—and unknown HIV status. Like in Peru, most noted that investment in prevention programmes was often inversely proportional to the risk of the populations they targeted and some suggested that the available HIV incidence and prevalence figures were underreported.

The perceptions of participants from Sub-Saharan Africa were comparable. Most agreed that HIV incidence was highest among young people, especially women, and stable couples. However, MSM (including prisoners), female sex workers, fishermen and truck drivers were also mentioned among those at higher risk of infection. Participants acknowledged their countries’ efforts to reduce HIV incidence, yet they felt these remained suboptimal. Key prevention challenges included lack of resources and competing priorities, specifically HIV treatment; stigma and criminalisation of groups at higher risk, which frequently impeded their access to HIV services; inadequate communication strategies, often mono-lingual (English) and focused on certain groups; over-reliance on the ABC approach (abstinence, being faithful and using condoms); prevalence of multiple concurrent partnerships; women’s vulnerability

### Table 1  Participant eligibility criteria

<table>
<thead>
<tr>
<th>Job role</th>
<th>Eligibility criteria</th>
</tr>
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<tbody>
<tr>
<td>Policymakers (5 per country)</td>
<td></td>
</tr>
<tr>
<td>National policymakers (3)</td>
<td>▶ Senior officials</td>
</tr>
<tr>
<td>▶ Portfolio includes HIV prevention</td>
<td></td>
</tr>
<tr>
<td>Local policymakers (2)*</td>
<td>▶ Working in local authorities outside the capital city</td>
</tr>
<tr>
<td>▶ One local authority is at the forefront of HIV prevention</td>
<td></td>
</tr>
<tr>
<td>▶ Portfolio includes HIV prevention</td>
<td></td>
</tr>
<tr>
<td>Frontline healthcare workers (5 per country)†</td>
<td></td>
</tr>
<tr>
<td>Community health worker (1)</td>
<td>▶ Involved in HIV prevention</td>
</tr>
<tr>
<td>Healthcare professionals working in a reproductive health clinic (1)</td>
<td>▶ Doctor or registered nurse</td>
</tr>
<tr>
<td>▶ Involved in HIV prevention</td>
<td></td>
</tr>
<tr>
<td>Healthcare professionals working in an HIV clinic (2)</td>
<td>▶ At least one doctor</td>
</tr>
<tr>
<td>▶ Involved in HIV prevention</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS Voluntary Counselling and Testing (VCT) counsellor</td>
<td>▶ Lay counsellor, trained counsellor or registered nurse who is a counsellor</td>
</tr>
<tr>
<td>NGOs (3 per country)</td>
<td></td>
</tr>
<tr>
<td>Staff of supranational NGO (1)</td>
<td>▶ Senior staff</td>
</tr>
<tr>
<td>▶ Involved in HIV prevention</td>
<td></td>
</tr>
<tr>
<td>Staff of NGOs who work with vulnerable populations (2)</td>
<td>▶ Senior staff</td>
</tr>
<tr>
<td>▶ National or regional influence</td>
<td></td>
</tr>
<tr>
<td>▶ One is supportive of HIV prevention</td>
<td></td>
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</tbody>
</table>

*In Peru, we only interviewed national policymakers due to the centralised nature of its HIV policy-making process.

†Working in public, non-profit or private healthcare facilities.
and inability to negotiate the use of condoms and donors’ silo approach and often divergent agendas.

**PrEP awareness**

Participants’ degree of awareness about PrEP varied across countries and job role, as reported in Table 2. Fifty of ninety-one participants were aware of PrEP before the interview took place.

**Perceived benefits of PrEP**

There was general consensus across countries and job roles regarding the benefits of PrEP, as reported in Table 3 and illustrated in Box 1. Most participants emphasised that PrEP was an additional prevention tool for those most at risk of infection, which would complement and possibly enhance existing methods. They also felt that implementing PrEP as part of a combination prevention strategy could result in a much needed increase in public resources devoted to HIV prevention. PrEP was widely perceived as an empowering mechanism that could enhance users’ well-being, reduce the burden of the disease and have a positive impact on countries’ economies.

**Perceived challenges of PrEP**

The identified challenges of PrEP were largely comparable. Yet, there were differences in frequency and ranking order, particularly across countries, as reported in Table 4 and illustrated in Box 2.

Most participants pointed out that the PrEP regimen would be difficult to follow. Identified barriers to uptake included the following: side effects, particularly in Ukraine and Peru; adherence, predominantly in South Africa; and the emergence of resistance, mainly in Botswana, Kenya and Uganda. With the exception of India, the cost and cost-effectiveness of PrEP were also frequently mentioned as key concerns. An increase in risk behaviours (i.e., decrease in condom use, increase in sexual activity and number of different partners) was a relevant issue among Indian, South African and Batswana participants. With the exception of Kenya and Uganda, a high PrEP efficacy and/or effectiveness was generally deemed critical for making the case for allocating public funds to this initiative. In India, it was frequently stressed that effectiveness data should be generated by local clinical trials. Some participants felt that reaching key populations would pose significant challenges due to the stigmatisation and criminalisation of certain sexual practices, which could in turn have an impact on governments’ willingness to introduce PrEP. This held particularly true in Peru and to a lesser extent in Ukraine, India and Uganda. The provision of adequate information and training to healthcare providers and users was also deemed challenging, particularly in Ukraine, Uganda and South Africa. Some participants mentioned that their health systems were overloaded and raised concerns regarding their capacity to offer PrEP. Participants from Southern Africa felt that their healthcare workforce was already overstretched, whereas Indian participants’ concerns revolved around logistics and continuity of supply.

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**Table 2**

<table>
<thead>
<tr>
<th></th>
<th>Policymakers</th>
<th>Healthcare</th>
<th>NGOs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aware</td>
<td>Unaware</td>
<td>Aware</td>
</tr>
<tr>
<td>Peru</td>
<td>2 (Local)</td>
<td>3 (National)</td>
<td>1 (Local)</td>
</tr>
<tr>
<td>Ukraine</td>
<td>2 (Local)</td>
<td>3 (National)</td>
<td>1 (Local)</td>
</tr>
<tr>
<td>Kenya</td>
<td>2 (Local)</td>
<td>3 (National)</td>
<td>1 (Local)</td>
</tr>
<tr>
<td>Botswana</td>
<td>2 (Local)</td>
<td>3 (National)</td>
<td>1 (Local)</td>
</tr>
<tr>
<td>South Africa</td>
<td>2 (Local)</td>
<td>3 (National)</td>
<td>1 (Local)</td>
</tr>
</tbody>
</table>

NGO, non-governmental organisation (national and supranational); PrEP, pre-exposure prophylaxis.

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Programmatic considerations

There were many commonalities in participants’ views and recommendations on what an eventual PrEP programme should look like. An overview of key sub-themes is provided below.

User eligibility
Participants from countries with concentrated epidemics (Peru, Ukraine and India) felt that prioritising key populations would be a cost-effective approach. Yet, concerns were raised regarding the ability of IDUs and mobile populations to comply with a PrEP regimen. A confidential and tactful approach was perceived as critical to prevent further stigmatisation and avoid jeopardising demand among those at higher risk of HIV infection. Offering PrEP to sex workers’ clients was also suggested.

Most participants from countries with generalised epidemics (Sub-Saharan Africa) would offer PrEP to young people and serodiscordant couples first. Other priority populations included sex workers, MSM, truck drivers and fishermen. However, most felt that due to the characteristics of their epidemics, prioritisation would be challenging.

Communication strategy
An effective communication strategy would involve Ministries of Health, relevant HIV services and civil society. Peer educators, community leaders and social networks were regarded as crucial components of a PrEP communication campaign, albeit complemented with targeted mass media advertising, as they would provide access to and colloquial information exchange with key populations.

Participants noted that training PrEP providers and those involved in a communication campaign was critical. For example, a Ukrainian nurse working at an HIV clinic pointed out “We should teach our staff how to

<table>
<thead>
<tr>
<th>Table 3</th>
<th>PrEP benefits*</th>
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<tbody>
<tr>
<td>Policymakers</td>
<td>Healthcare workers</td>
</tr>
<tr>
<td>Peru</td>
<td>▶ Prevention tool for most at risk</td>
</tr>
<tr>
<td></td>
<td>▶ Additional prevention strategy</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Ukraine</td>
<td>▶ Additional prevention strategy</td>
</tr>
<tr>
<td></td>
<td>▶ Increased well-being</td>
</tr>
<tr>
<td></td>
<td>▶ Empowerment of most at risk</td>
</tr>
<tr>
<td>India</td>
<td>▶ Alternative prevention strategy for serodiscordant couples</td>
</tr>
<tr>
<td></td>
<td>▶ Not gender specific</td>
</tr>
<tr>
<td></td>
<td>▶ Alternative prevention strategy</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>▶ Potential economic gains</td>
</tr>
<tr>
<td></td>
<td>▶ May benefit most at risk</td>
</tr>
<tr>
<td></td>
<td>▶ Empowering most at risk</td>
</tr>
<tr>
<td>Uganda</td>
<td>▶ Reduce HIV incidence</td>
</tr>
<tr>
<td></td>
<td>▶ Potential economic gains</td>
</tr>
<tr>
<td></td>
<td>▶ May benefit most at risk</td>
</tr>
<tr>
<td></td>
<td>▶ For those who cannot negotiate condom use</td>
</tr>
<tr>
<td>Botswana</td>
<td>▶ Reduce HIV incidence</td>
</tr>
<tr>
<td></td>
<td>▶ Reduce cost of treatment and care</td>
</tr>
<tr>
<td></td>
<td>▶ HIV-free newborns</td>
</tr>
<tr>
<td></td>
<td>▶ Protect HWs</td>
</tr>
<tr>
<td></td>
<td>▶ May benefit most at risk</td>
</tr>
<tr>
<td></td>
<td>▶ For high-risk periods</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>▶ Reduce HIV incidence</td>
</tr>
<tr>
<td></td>
<td>▶ May help achieve Millennium Goals†</td>
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<tr>
<td></td>
<td>▶ For those who cannot negotiate condom use</td>
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<td></td>
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</tbody>
</table>

*In descending order from most recurrent.
†HIV related, maternal and child health and gender equality.
‡Associated with AIDS (ie, cervical cancer and tuberculosis).
HW, healthcare worker; NGO, non-governmental organisation; PrEP, pre-exposure prophylaxis.
approach people, how to present PrEP to them to prevent them from saying it’s non-sense and they don’t believe in it” (Uk08).

A PrEP communication campaign was also perceived as a potential vehicle of messages against stigma and prejudice, contributing to address these fundamental barriers. Some suggested that a consultation process would be essential to meet communities’ needs and tackle any concerns from the outset.

Cost

Most participants agreed that PrEP should be free or heavily subsidised. Some, however, felt that a cost-segmented strategy was a more sustainable approach. It was noted that asking users to pay an affordable amount for the medication and associated services could improve adherence, as illustrated by a Ukrainian national policymaker: “... people should pay at least for some percentage of the medicine cost ... If they pay this money they will naturally keep in mind the necessity to take this pill ... because they have bought it at their own expense. They had to work to buy PrEP ... I mean, the attitude is completely different in this case. It’s not a freebie” (Uk02).

Distribution

There was widely held support for PrEP to be managed by the Ministries of Health and distributed through existing public and NGO-based healthcare services. It was stressed that PrEP distribution channels had to comply with strict privacy and confidentiality codes of practice. For example, an Indian local policymaker stressed: “If everyone takes PrEP, then there will be no stigma. But if you will start with certain groups (there will be) ... so confidentiality has to be taken care of when you are giving such medicines” (I04).

Distributing PrEP in antiretroviral therapy (ART) centres was not favoured, as users may worry about being associated with HIV patients. Some participants felt that distributing PrEP through pharmacies would reduce transportation costs and facilitate uptake. Yet, most agreed that other essential PrEP services (ie, counselling, HIV testing) had to be delivered at a healthcare setting. Providing PrEP to highly mobile populations such as sex workers and truck drivers was raised as an important hurdle. This was illustrated by a Kenyan doctor working at an HIV clinic: “... we will have to force them to start going to a facility regularly, not just for the test but for the drug, for the test they can go anywhere but to get a drug ... you have to register somewhere and go there regularly ... I think that may discourage them because some of them are highly mobile groups” (K08).

Medication and HIV testing compliance

People’s willingness and ability to take long-term prophylactic medication and to frequently get tested for HIV was raised as a major challenge. Those who raised this considered offering tailored information and...
counselling, devising a contractual agreement between the provider and the user, subject to regimen compliance, and developing a tight monitoring system, including electronic reminders and frequent follow-up, to be fundamental in order to enhance compliance to treatment and testing. As suggested by a Voluntary Counselling and Testing counsellor in Botswana:

Participant: "... the individual can be told when to come for the next supply and when they come that’s when they get tested."

Interviewer: “Who would keep the card, is it the patient or would it remain at the clinic?”

Participant: “The patient would have to keep the card so that he can get it in any facilities so that you don’t restrict that person to one health facility. The patient will be free or would it remain at the clinic?”

Interviewer: "Who would keep the card, is it the patient to be fundamental in order to enhance compliance to the provider and the user, subject to regimen compliance, and developing a tight monitoring system, including electronic reminders and frequent follow-up, to be fundamental in order to enhance compliance to treatment and testing. As suggested by a Voluntary Counselling and Testing counsellor in Botswana:

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Interviewer: “Who would keep the card, is it the patient or would it remain at the clinic?”

Participant: “The patient would have to keep the card so that he can get it in any facilities so that you don’t restrict that person to one health facility. The patient will be free.
to go to Marina, to go to Tlokweng and get the treatment when it’s due” (B10).

Most agreed that the PrEP route of administration would play an important role on levels of adherence: an injection once or every 2 months was preferred over a daily or a before-and-after-sex pill, although a considerable minority felt that offering different modalities to match users’ needs would be a desirable option. For example, an Indian community health worker pointed out: “It depends on a person’s sexual interaction. If a person has sex once a month, then he can go for a before-and-after pill. Those who do it regularly would want to go for the injection” (I06).

Early versus late implementation

Forty-three participants would support PrEP being implemented early in their countries: three in Peru, five in Ukraine, three in India, seven in Kenya, six in Uganda, eight in Botswana and 11 in South Africa. A Ugandan doctor working in a reproductive health clinic illustrates this tendency: “... we needed PrEP yesterday... I would want the...” (P04, national policymaker).
after it is found to have worked, that would have been a missed opportunity” (Ug07). Forty-four participants, however, would only support the introduction of PrEP in their countries after proven safe and cost-effective elsewhere. A Ukrainian national policymaker exemplifies this position: “PrEP should pass all the clinical trials. If its effectiveness is proved, then why not?” (Uk03). Only two participants from India, one from Uganda and one from Botswana would not support PrEP at all.

**DISCUSSION**

This is the first study to explore policymakers and providers’ views on oral and parenteral PrEP. We found many commonalities between participants’ opinions on HIV prevention in general and PrEP in particular. Interestingly, participants’ views were not significantly influenced by their job role, yet policymakers and healthcare workers were better at detailing the benefits of PrEP than NGO representatives. Conversely, we observed local differences in both the perceived benefits and constraints of PrEP, a reflection of particular epidemiological, socioeconomic and political contexts. These differences should not be overlooked in the planning of an eventual PrEP implementation.

Most participants felt that HIV prevention needed to be enhanced to effectively tackle their epidemic. Introducing new HIV prevention modalities as part of a combination prevention strategy was deemed necessary to decrease HIV incidence and was also perceived as an opportunity to expand and strengthen existing prevention efforts.

Although most participants easily identified the benefits of PrEP, were able to envisage how it would fit into existing services and were supportive of introducing it in their countries, they also expressed numerous concerns. The complexity of implementing PrEP, its cost/cost-effectiveness, partial efficacy, the ability of key populations to access, understand and comply with it and potential perverse effects such as increased risk behaviours and sexually transmitted infections and the emergence of resistance were important challenges that deserved consideration.

**Strengths and limitations of this study**

Our research builds on previous qualitative work on topical PrEP, and our results are comparable to previous studies exploring attitudes of policymakers and implementers towards microbicide gels. Hoffman et al. compared data from the US and South Africa and found several commonalities across job roles and settings, and overall enthusiasm about this method, yet balanced with concerns analogous to those found in our study. Similarly, Orner et al. found that participants’ considerable support for microbicides was tempered by concerns regarding effectiveness, cost, increase in risk behaviour and challenges related to education and distribution. Our results also resonate with the views of Piot et al.,

who urge governments, communities and scientists to adopt HIV prevention as a national cause and ensure its funding, to work together to build demand for HIV prevention and to implement combination prevention programmes against HIV, including PrEP.

This research was conducted while PrEP attributes and effectiveness were still uncertain and only 55% of the interviewees were aware of PrEP. In light of recent trial results and the worldwide attention these have received, we expect that awareness relating to this technology might be higher. However, many of the opinions expressed here are based on previous experience and knowledge of the local epidemic.

Although interviews were conducted in an open and non-judgemental manner, and participants were made aware that all data would be anonymised once it had been analysed by our research team, given the sensitive nature of this study, participants may at times have felt compelled to give ‘desirable’ answers. Of similar importance, purposively recruiting participants may have an effect on the generalisability of our results. Nonetheless, the many commonalities in participants’ opinions are encouraging, suggesting that it may be possible to devise standardised PrEP programmes that could be subsequently shaped to meet local needs.

**Future research**

Qualitative research undertaken using purposive sampling enables a wide range of experiences and opinions to emerge, but further quantitative work, particularly among providers, is needed to determine the true prevalence of our findings. Moreover, as clinical trials continue to shed light on PrEP effectiveness among different key populations, research on policymakers and providers’ views on PrEP considering new findings, in other countries and rural settings, is likely to provide different accounts. Future research on the preferences and concerns of communities’ opinion leaders and peer educators towards PrEP would also be of considerable value.

**Impact on policy and practice**

The critical question from a policy perspective is whether countries are willing and prepared to introduce PrEP. We have learnt from our previous study that key populations would be willing to use PrEP. The work reported here demonstrates that, despite multiple concerns, policymakers and implementers, particularly from Sub-Saharan African countries, would also be willing to support PrEP once it proves cost-effective.

We found that the identified barriers to PrEP were largely comparable to the perceived HIV prevention challenges. This suggests that current prevention shortfalls may have a bigger impact on an eventual PrEP implementation than vice versa. Significantly reducing HIV incidence, therefore, would require countries to incorporate new prevention methods and to strengthen, redirect and integrate existing prevention programmes. The emergence of a Combination Prevention Secretariat,
a joint collaboration of the Bill and Melinda Gates Foundation, PEPFAR, UNAIDS and the World Bank, reflects the importance of this approach for donors. The sustainability of such integrated strategies, however, depends on the availability of international and local resources as much as it does on societal and political will.

Due to the significant challenges to implementing PrEP, including a desire to wait for PrEP programmes to be rolled out successfully in other countries, it may be advisable to identify early adopters to initiate feasibility and demonstration projects with PrEP as a component of combination prevention.

Because some key stakeholders are still unaware of PrEP, an important aspect of initial work will be to provide information about PrEP, including its rationale, benefits and drawbacks. Comprehensive training programmes for providers and users, and targeted communication strategies, which encompass wider issues related to stigma and the specific needs of those most at risk of HIV infection, ought to be developed and tested before introducing PrEP.

The results of this study have implications for PrEP feasibility and demonstration projects. Our data indicate that PrEP should be offered to key populations in the first instance, although reaching some of these groups and prioritising specific populations in settings with generalised epidemics, is likely to be challenging. PrEP should be coordinated by the Ministries of Health and involve relevant NGOs and community representatives. Effective and affordable information channels should include existing healthcare services, peer educators, community leaders, social networks and targeted mass media advertising. PrEP should mainly be offered in public and NGO-based healthcare services as part of a combination prevention package and be decoupled from specialised ART services to avoid stigmatisation. An integrated service that would allow mobile populations to access PrEP in different areas should be considered. The ongoing decentralisation of HIV services towards primary care, promoted by funders, is a step in the right direction. PrEP should be affordable and its price could be segmented. All available PrEP routes of administration should be offered, although parenteral PrEP, when and if becomes available, would be easier to adhere to. Counselling and frequent monitoring, as well as introducing innovative measures to increase regimen adherence, such as contractual agreements between providers and users, and the use of mobile technology, may limit the emergence of resistance to antiretrovirals and increase PrEP effectiveness.

More profound societal and legislative changes, aimed at tackling widespread stigma, may be necessary for new HIV prevention approaches in general, and particularly those directed at stigmatised populations, to be fully successful. The enthusiasm and debate surrounding scientific breakthroughs like PrEP have the potential to become a catalyst for change.

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Views of policymakers, healthcare workers and NGOs on PrEP


