How does Integration of Oral PrEP Affect Family Planning Service Delivery? An Exploratory Assessment in Kenya

DATA DOCUMENTATION

1. Introduction

Integration of oral pre-exposure prophylaxis (PrEP) services into reproductive health services is among the key objectives in Kenya's national strategy to scale-up holistic HIV prevention. One matter warranting examination is how family planning (FP) service operations are affected by the addition of PrEP services, considering the experiences of providers, managers, and clients. The study objectives are to assess expressed and potential demand for PrEP among FP clients; explore providers' and managers' experiences delivering PrEP within FP services; examine FP clients' reactions to PrEP services being offered within FP services; and estimate the cost of adding PrEP to FP services. The planned work comprising this observational study includes compilation and analysis of service statistics; client, provider, and service manager interviews; and inventory of resource requirements and costing of these inputs for service delivery. These activities were performed in 10 public sector health facilities in Nairobi, Kakamega, and Kitui Counties, Kenya. Study results include data on actual and potential demand for PrEP, data on FP clients who express satisfaction with integration of PrEP and FP services, data on providers' and managers' attitudes toward integration of PrEP and FP services, and information on resources and related financial costs of resources required for integrating PrEP into FP services. The study provides program managers, national policymakers, sub-national/district officials, health providers, and donors with evidence about how FP services are affected when oral PrEP is integrated into FP services. The significance of the results is that they are intended to guide decisions about the provision of PrEP services within public sector FP programs.

Objectives

The general objective of this study is to assess the effect of integrating oral PrEP with FP services in public health sector facilities. The research is designed to provide program managers, national policymakers, sub-national/district officials, health providers, and donors with evidence about how FP services are affected when oral PrEP is integrated into FP services. The results are intended to guide decisions about the provision of PrEP services within public sector FP programs. Specific objectives are listed below:

1. Assess expressed and potential demand for PrEP among FP clients.
2. Explore providers' and managers' experiences delivering PrEP within FP services, along with perceptions of any changes in FP service delivery with the addition of PrEP.
3. Examine FP clients' reactions to PrEP services being offered within FP services.
4. Measure the cost of adding PrEP to FP services.

2. Study design

This is a descriptive, observational study designed to examine existing, real-world models of integrated FP-PrEP services and identify factors supporting and impeding integrated service delivery. The research will combine the following data collection components:

- Compilation and analysis of service statistics.
- Structured exit interviews with FP clients to assess demand for service and seek reactions to the offer of integrated services.

- Semi-structured interviews with providers and service managers to explore perspectives on integrated services, considering advantages, challenges, and constraints.
- Inventory of resource requirements from the health system perspective and costing of those inputs for the addition of PrEP services within FP services.

Study population and sample size

The study was conducted between October-December 2022 at 11 public sector health facilities in Kakamega, Kitui, and Nairobi counties in Kenya. The three counties were selected in consultation with the National AIDS and STI Control Programme (NASCOP). Nairobi County was selected because it has the longest experience with integrated services; the USAID-funded CHOICE project supported FP-PrEP integration in three facilities beginning in 2020. NASCOP directed the study team to Kitui in the east of Kenya and Kakamega in the west to capture experiences in diverse geographic settings. Kitui and Kakamega will have approximately 9 months of experience with PrEP integrated into FP services when data will be collected. A variety of types of public facilities are included—dispensary, health center, sub-county hospital, and county hospital.

During the study preparation phase (before data collection), the research team contacted the health facility heads by phone to confirm that PrEP was currently being offered within FP services. *They were asked to make that determination based on whether a) the FP service manager reported at least 10% of FP clients in the past* **six months** *were screened for HIV risk, counseled on PrEP, or referred to the HIV unit for PrEP services; and b) the facility was equipped to offer PrEP services, meaning the health facility head reported at least one FP provider is trained to deliver PrEP services and the facility had PrEP drugs and other necessary supplies*. Facilities where PrEP services have not been offered to FP clients at all for the past six months due to factors such as staff shortages or stockouts of HIV test kits or PrEP drugs were not eligible to be involved in the study. For efficiency in data collection, facilities with, on average, fewer than 12 FP clients are served on the days when FP services are offered were excluded. 2 facilities originally intended to be in the study were excluded (1 had fewer than 12 FP clients per day and 1 had not offered PrEP services in the past 6 months).

Data collection method	Unit	Sample size
Service statistics abstraction	Facilities	11
FP Client exit survey	Participants	720
In-depth interviews with providers and service managers	Participants	22
Costing exercise	Facilities	11

Service statistics

Information reflecting provision of integrated services was extracted from existing facility paper registers for the 6 months prior to data collection.

Client exit interviews

Exit interviews were conducted with a convenience sample of FP clients (over age 18). As this study is descriptive in nature and has limited resources, the sample size was based on the number of FP clients who present during a one-week period at each facility. Research Associates (RAs) completed between 720 exit interviews across the 11 facilities.

IDIs with providers and service managers

Semi-structured interviews will be conducted with trained nurses who are current FP service providers and managers (all over age 18) supporting integration of PrEP into FP services in each facility. Participants must have had at least one month of experience delivering or supervising delivery of PrEP services to FP clients. Selection of managers and providers was purposive. Up to two FP providers and one FP service manager were allowed to be recruited to participate in interviews in each facility.

Service statistics

Research teams collected information on the costs of providing integrated services at their facility. Interviews were conducted with facility and county health office staff.

Data collection instruments

Research-related data was collected throughout this process. Here is a list of each data collection tool in the study:

Instrument name and description	Dataset included in Dataverse?	Dataset name
Service statistics abstraction to assess demand for PrEP among FP clients	No[1]	N/A
FP Client exit survey to assess demand for service and seek reactions to the offer of integrated services	Yes	Client Exit Survey
In-depth interviews with providers and service managers to explore perspectives on integrated services	Demographic survey data included, qualitative data not included	Provider survey data
Costing exercise to assess costs related to the provision of integrated PrEP/FP services	No	N/A

3. Data collection

Data collection was conducted between October-December 2022. The team compiled this information using an Excel-based file. Client exit interviews were administered in English and Kiswahili. They were administered using a form programmed using Kobo Collect. Interviews were conducted in English and audio-recorded.

4. Data management

Data from the client exit survey was downloaded from Kobo Collect and saved on the project SharePoint. Service statistics datasets were combined using Microsoft Excel Power Query and aggregated into a single file. Audio recordings of the IDIs were transcribed by the data collection firm. They uploaded the finalized transcripts to the project SharePoint. Audio recordings were then deleted. Data were cleaned in Stata version 17.

5. LIMITATIONS

[1] Only client exit interview and IDI demographic survey data will be shared on the Dataverse. Qualitative guides, codebook, and informed consent forms, and the service statistics abstraction form will be included in the Dataverse but no qualitative, service statistics, or costing data will be shared.

The selection of study sites is limited to three counties and does not necessarily represent situations that would be found elsewhere in Kenya. The FP clients participating in the exit interview comprise a convenience sample and do not necessarily represent the views of FP clients in general. Some women, such as those concealing contraceptive use or reluctant to discuss HIV risk, may also be more likely to decline participating in exit interviews. Questions related to HIV risk or willingness to consider PrEP use could be affected by social desirability bias. A possibility of recall bias also exists, whereby participants may inaccurately report what occurred in the FP consultation.

Adolescent girls are normally a priority population for PrEP services given their high HIV incidence. However, due to current political sensitivities associated with public sector facilities delivering FP services to minors, the population for client interviews is limited to adult women 18 years and older. Adolescent girls' use of FP and PrEP services will be examined through analysis of service statistics only. Additionally, interviews with providers and managers will explore their experiences offering integrated FP-PrEP services to clients of all ages, including adolescents.

The selection of providers and managers is purposive and may not fully represent the views of all providers responsible for FP-HIV services integration, including those with less FP service experience. Responses from providers and managers may also be affected by social desirability bias.

Finally, with this study's focus on how PrEP integration affects FP service operations, the research is not designed to assess the quality or effectiveness of PrEP service delivery. Despite all these limitations, we expect that the data will provide information about integrated services under real-world conditions that will be useful to guide decision making about FP-PrEP integration.