

***“You are your own driver”*: Factors Influencing the Decision to Initiate PrEP Among Adolescent Girls and Young Women within Routine Maternal Child Health and Family Planning Clinics in Western Kenya**

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Abstract

***“You are your own driver”*: Factors Influencing the Decision to Initiate PrEP Among Adolescent Girls and Young Women within Routine Maternal Child Health and Family Planning Clinics in Western Kenya**

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Objectives: To understand key influences on decisions to accept or decline pre-exposure prophylaxis (PrEP) for HIV prevention among Kenyan adolescent girls and young women (AGYW). **Design:** Qualitative interviews were conducted with two groups of HIV-uninfected AGYW aged 15-24 years: 1) those at-risk who declined PrEP (≥ 1 sexual partner of unknown HIV status) and 2) those not at-risk who initiated PrEP (reported single HIV-uninfected partner). **Methods:** Semi-structured interviews (IDIs) were conducted with 47 HIV-uninfected Kenyan AGYW who were offered PrEP through Maternal and Child Health (MCH) and Family Planning (FP) clinics at four facilities in Kisumu County. IDIs were audio-recorded, translated into English, and transcribed. A qualitative descriptive analysis using a combination of conventional (inductive) and directed (deductive) content analysis methods was performed to elucidate common themes influencing PrEP uptake. **Results:** AGYW’s decisions to initiate or decline PrEP were largely

influenced by three major themes: 1) relationships with partners shaped perceived risks and benefits of PrEP use, 2) having a role as a mother or caregiver provided a strong desire to protect their child's health and future, and 3) PrEP attitudes, awareness, and logistics (e.g., acquiring, storing, and swallowing pills) facilitated or challenged PrEP uptake. The complex interplay between these factors influenced each women's specific decision to uptake or decline PrEP. Other factors such as being offered PrEP while receiving MCH or FP services, knowing a current PrEP user, and health literacy also affected PrEP use decisions. **Conclusion:** Future PrEP scale-up for AGYW within MCH and FP clinics should consider priorities and concerns prioritized by AGYW. PrEP demand creation will require increased PrEP awareness and sensitization in the community, messaging that addresses misconceptions and reduces disease- and behavior-related stigma, through targeted messaging in both FP and MCH clinics and the community in general.

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Introduction

Adolescent girls and young women (AGYW) ages 15 to 24 in Sub-Saharan Africa have high HIV incidence.¹ Although they represent roughly 10% of the population living in Southern and Eastern Africa, they account for 26% of new HIV infections.² In Kenya, adolescent girls experience more than double the number of HIV infections when compared to male peers.¹ In Kisumu county, roughly 37% of all HIV infections were among residents under the age of 24 years old.³ The World Health Organization recommends that HIV-uninfected AGYW with substantial risk for HIV acquisition should be offered oral tenofovir-based pre-exposure prophylaxis (PrEP) for HIV prevention.⁴ In 2016, the Kenya Ministry of Health (MOH) guidelines on the provision of PrEP included AGYW in HIV high-burden areas as a priority population.⁵

In Kenya, PrEP delivery is scaling up through various public-sector facilities, including Maternal and Child Health (MCH) and Family Planning (FP) clinics.⁶ Demonstration projects in Kenya found that up to 22% of AGYW accepted PrEP when offered and uptake was higher among AGYW with known behavioral risk factors for HIV (e.g., having a partner known to be living with HIV).⁷⁻¹⁰ However, other studies among Kenyan AGYW in HIV high-burden settings report low PrEP uptake (<5%).¹¹ Only one-third of AGYW who initiated PrEP through routine MCH and FP clinics in Western Kenya continued use after one month.¹² As PrEP access expands, it is increasingly important to identify key influences on PrEP uptake for AGYW, in order to optimize PrEP delivery for this priority population. Understanding AGYW rationale and decision-making processes related to PrEP initiation could inform interventions to support effective PrEP uptake and use among AGYW most likely to benefit from this powerful HIV prevention tool.

Exploring the personal experiences of AGYW who are offered PrEP within routine care settings during early phase PrEP scale-up could inform future PrEP implementation initiatives. To date, there have been no qualitative evaluations regarding influences of PrEP initiation among AGYW

within routine MCH and FP settings in Western Kenya, a setting with high HIV burden. We report findings from a qualitative study designed to elicit personal narratives among AGYW who were offered PrEP within routine MCH and FP clinics in Western Kenya. Understanding key contextual factors influencing PrEP decision-making among these women can inform the development of PrEP implementation strategies tailored to encourage uptake among AGYW.

METHODS

Study Design and Population

From October to December 2018, we conducted individual interviews (IDIs) with AGYW ages 15 to 24 eligible for PrEP per national guidelines, who were participants in the PrEP Implementation for Young Women and Adolescents (PrIYA) Program and were offered PrEP through MCH and FP clinics at four facilities in Kisumu County. Kisumu is an urban county bordering Lake Victoria where Luo culture is prevalent. PrIYA is a previously described large demonstration program evaluating real-world programmatic delivery of PrEP via MCH and FP clinics in Kisumu County, Kenya.⁶ Facilities for this qualitative sub-study, conducted at the end of the PrIYA program, were selected based on whether they offered PrEP services within both MCH/FP clinics and were still active PrIYA sites.

Recruitment

A subset of AGYW who were counseled on PrEP during the PrIYA Program were purposively recruited to capture a range of perspectives on PrEP initiation. Specifically, the population recruited for this sub-study included AGYW with risk factors for HIV who declined PrEP and AGYW without risk factors for HIV who initiated PrEP. AGYW were invited to participate in IDIs if they either 1) declined PrEP yet had at least one sexual partner whose HIV status was unknown, or 2) initiated PrEP yet had a partner known to be HIV-uninfected. Potential AGYW were identified by routine clinic staff and referred to study staff if interested. The interview team included six

female Kenyan social scientists. IDIs were conducted on the same day as the AGYW's FP or MCH care appointments or scheduled for a later date depending on clinic flow or the participant's availability and preference. Before each IDI, the interviewer confirmed eligibility and conducted informed consent. Interviews were independent of the clinic's services provided and no clinic staff involved in the participants' routine care were present during the IDI.

Data collection

The interview guide was developed collaboratively by the study team based on literature reviews and prior PrEP research experience among Kenyan women. The guide was designed based on the Stages of Change Model (or Transtheoretical Model)¹³ to explore participant's experiences and decisions for PrEP uptake within the pre-/contemplation, preparation, and action stages and to assess knowledge, access, and beliefs informing these decisions. Questions centered on several interrelated domains, including where AGYW first heard about PrEP, what factors influenced initial decisions to accept/decline PrEP, descriptions of relationship dynamics with partner(s), and whether she would recommend PrEP to a friend.

Basic demographic information, including age, education, and relationship status, was collected for each participant prior to each IDI. IDIs averaged 20 minutes in length and were conducted in English, Dholuo, or Kiswahili based on participant preference. Each participant was offered 1000 Kenyan Shillings (KES) following the completion of the IDI as compensation for her time and travel costs. All interviews were recorded, transcribed verbatim, and translated into English as needed. Following each IDI, interviewers summarized their subjective impression of the interview and briefly captured the participants accounts related to key themes in a structured debrief report.

Data Analysis

Data was analyzed using a combination of conventional (inductive) and directed (deductive) content analysis methods.^{14,15} Directed content analysis, based on the Stages of Change Model, was used to capture the decision-making stages AGYW move through as they make decisions about PrEP.¹³ Our analysis was primarily focused on early phases within the Stages of Change Model including precontemplation (learning about PrEP for the first time), contemplation (considering whether to initiate PrEP), and preparation (deciding to accept PrEP pills when offered during MCH/FP services).

Conventional content analysis was used to capture the types of information motivating PrEP decisions.¹⁴ We used open coding to derive codes that captured key concepts from the data. A codebook organizing emerging codes was iteratively refined in phases. First, factors influencing PrEP decisions were compiled from the targeted debrief report summaries of each IDI. Identified factors were further refined and expanded after reviewing a subset of full-length transcripts. Additional transcripts were reviewed until no new factors influencing PrEP decisions were identified. Influencing factors were grouped into categories and subcategories, and the study team established and revised definitions for each category, subcategory, and code through a collaborative, iterative process of reviewing transcripts against the developing codebook and group discussion. Transcripts were imported into Dedoose software (version 7.0.23, Los Angeles, CA, USA: Sociocultural Research Consultants, LLC) for analysis.

All transcripts were independently coded using a final version of the codebook by one member of the study team. Code application was reviewed by another member of the team to ensure completeness, appropriateness, and consistency in application across transcripts. Disagreements in code application were noted, and all disagreements were resolved through group discussion until consensus was reached. Key themes were identified by running queries to compare and contrast key factors influencing PrEP uptake decisions between AGYW and

different stages of change. Thematic memos were drafted throughout the analysis process and used to identify similarities and differences in PrEP knowledge, access and risk perception across AGYW. Thematic network analysis was used to categorize individual themes into related networks, so overall motifs and patterns from basic to global, were visualized and their explicit rationalizations and implicit meanings derived.¹⁵ Representative quotations pertaining to each global theme were selected to summarize findings.

Ethical considerations

The PriYA program received approval from Kenyatta National Hospital-University of Nairobi Ethical Review Committee and University of Washington Institutional Review Board. In addition, approval was obtained from the Kisumu County, Department of Health and administrators in respective health facilities.

Results

Overall, 47 AGYW participated in IDIs, including 21 AGYW who initiated PrEP despite having known HIV-uninfected partners and 26 AGYW who declined PrEP but reported having at least one partner of unknown HIV status. The median age for all AGYW was 21 years. The majority of AGYW interviewed were unemployed (70%), 47% were currently in school and approximately half (53%) were married. Characteristics were similar across groups, except for educational attainment, and parity (Table 1).

Some AGYW were in the pre-contemplation stage (i.e., had not previously heard of PrEP or did not fully understand or consider it) prior to attending clinic for MCH or FP services the day they were offered PrEP and interviewed. AGYW identified factors they considered while contemplating the decision to either take action and initiate PrEP or decline PrEP. Three major themes emerged from the IDIs related to the decision to initiate or decline PrEP: 1) relationships with partners

shaped perceived risks and benefits of PrEP use, 2) having a role as a mother or caregiver provided a strong desire to protect their child's health and future, and 3) PrEP attitudes, awareness, and logistics (e.g., acquiring, storing, and swallowing pills) (Figure 1). The complex interplay between these factors influenced each women's specific decision to uptake or decline PrEP.

Relationships with partners shaped perceived risk and benefits of PrEP

While contemplating PrEP initiation, participants reported that their relationships with male partners heavily influenced their HIV risk perception, primarily due to either knowing or suspecting that male partners had other sexual partners. Participants often recognized the benefits of taking PrEP for HIV prevention due to their male partners' behaviors but weighed this against the risks of disrupting their relationship's harmony by introducing the potentially controversial topic of PrEP.

"If you have been with someone for long, you know them, you know if they are fishy, you know their characteristics...I have been with him the entire time, he has not been shady. I thought if I started taking the medicine [PrEP], he will think "this mama, what does she think of me?", or he will think that I don't trust him, or he will think like...I don't know, I just thought it will instigate a lot of issues. So, I thought to myself, I have been [HIV] negative all this while so probably he is not doing anything [e.g., cheating] that warrants me to go for PrEP." - MCH client who declined PrEP, partner HIV status unknown

Some women felt that the HIV prevention benefits from PrEP did not outweigh potential of social harms or violence that could occur as a result of taking PrEP.

"The reason why I don't want to take it [PrEP] because he could find it. Where I am going to store it? He can physically assault me if he finds them before I consult with him first.... He can even

send me away from my matrimonial home, so I am scared to carry PrEP at home with me.” - MCH client who declined PrEP, partner HIV status unknown

Other participants felt that PrEP would provide “peace of mind” since they were unsure of whether their male partners had other partners and knew that this increased their risk of acquiring HIV. Participants described how attempting to discuss infidelity with their male partners often led to discord, or even violence. PrEP was seen as a way of maintaining harmony by avoiding uncomfortable conversations about infidelity and HIV status while simultaneously affording women the protection they wanted from HIV.

“I liked it [PrEP] because it reduces my chances of getting HIV/AIDs...I may have one partner who may be having other girlfriends. So maybe they are having unprotected sex with those ladies, you know? So I thought, maybe if I use this PrEP I will be much safer than to keep asking, are you ok (HIV-uninfected)?” - MCH client who initiated PrEP, partner HIV-uninfected

Many participants described high levels of mistrust and suspected infidelity within their relationships. Conversations with peers often amplified suspicions of partner infidelity for AGYW and validated these feelings of mistrust.

“...[A] man is only yours when you are with him in the house,’ that is what my friends usually say... But when he is outside there, he belongs to many people. You cannot know how he is walking [i.e., having partners outside marriage].... Yes, that is why when I was told about PrEP then I agreed take it if it can help me.” - MCH client who initiated PrEP, partner HIV-uninfected

Many AGYW reported a strong sense of autonomy as a key influence behind their decision to take PrEP. For some, knowing they could exercise control and make a choice to protect their own

health by taking PrEP provided comfort when they could not control the behavior of their partners.

One participant said:

“For me, PrEP is the best because you protect yourself on your own, you have control over your own safety. You are your own driver... like this is your car and you manage it by yourself. Yes, and nobody will tell you, you are not supposed to take PrEP, you are on control over your body, so you take for your own protection.” –FP client who initiated PrEP, partner HIV-uninfected

Role of motherhood and concern for baby’s future influences PrEP uptake

For many AGYW, their role as a caregiver and/or mother was a central force in deciding whether or not to take PrEP. The role of motherhood served as both a positive and negative influence for PrEP uptake, depending on other coexisting values and understanding of PrEP safety. Most AGYW who were mothers felt that as primary caretakers of their family, they had an obligation to both protect the health and future of their child and believed that remaining healthy was central to fulfilling these responsibilities. Several AGYW who perceived HIV risk and had a strong sense-of-purpose instilled by motherhood were strongly motivated to preserve their well-being, and protect their child.

“I decided to take PrEP because of the pregnancy so that I can protect the child from getting infected [with HIV]. So that the life of the baby will be good, and my health too will be good....I was told that if I want to be safer, I should use PrEP so that me and the baby we should be safe because the trust is not there in our relationship.” - MCH client who initiated PrEP, partner HIV-uninfected

In contrast, a few pregnant women declined to take PrEP because they feared that it would negatively impact their unborn babies. They perceived that taking medication while pregnant

exposes the fetus to “chemicals” and causes harm. By declining PrEP, they felt they were making a decision to avoid exposing their baby to potential harm.

“I don’t want it [PrEP] now because let me say that ... we were told [by nurses] that if you are pregnant you are not supposed to take many medications [for the safety of the infant].” - MCH client who declined PrEP, partner HIV status unknown

For some AGYW, future plans for motherhood and concerns about interactions between FP and PrEP drove the decision not to initiate PrEP. A few AGYW expressed that they thought PrEP would either interfere with their contraception rendering it ineffective or that PrEP may affect their ability to conceive later when they wanted to become pregnant.

“[T]he fact that I still don’t have a baby, I just have fears that it [PrEP] might [negatively] affect my fertility.” - FP client who declined PrEP, partner HIV status unknown

PrEP attitudes, awareness, and logistics influence PrEP initiation

AGYW reported that a previous bad experience with taking medication, a strong dislike or perceived inability to take and adhere to medications led them to decline PrEP. Additionally, the ability to process and understand health information or distinguish PrEP from other medications while contemplating PrEP influenced whether participants decided to initiate or decline. Similar to the mothers concerned about exposing their babies to chemicals, some participants expressed the fear of exposure to “chemicals” or unfamiliar medication in general and the unknown experiences of using PrEP outweighed the potential benefits.

“.... I thought this medication [PrEP] may contain some chemicals which I may not need because I had never heard about it [before clinic today]. It was my first time [to hear about it], so I felt I may

decide to start using it and maybe it might have negative effects on me.” - MCH client who declined PrEP, partner HIV status unknown

Another AGYW shared that in addition to fearing the side effects PrEP would have on her body, she also feared the actual PrEP medication itself.

“I just have fears that it (PrEP) may interfere with my kidneys. There is a point when I asked that can it affect my body and stuff and then the health provider told me that it is always washed out from the body through the kidneys. So, I like the idea, but I just feel like it might tamper with my kidneys if I use it. And I also fear the size, yeah, I feel that it is going to stick into my throat and something of that sort. Those are the things that have made me not to take it.” - FP client who declined PrEP, partner HIV status unknown

Other AGYW reported that conversations with peers who had PrEP knowledge or experience influenced their understanding of PrEP and decision to initiate. Learning from other PrEP users helped AGYW feel less intimidated by taking an unknown drug. Familiar PrEP users (typically friends or family members) helped AGYW learn about positive PrEP experiences and provided evidence that PrEP was safe. Peer support helped normalize PrEP use and reduce stigma.

“When I first came [to get PrEP], I was hiding because there were many people in the queue who may know me and I was so worried that they would go and share with other people [that I was taking PrEP], but I gathered courage because even them, they were coming for the drugs [PrEP]. So, I asked one if she has been using for a long time and she told me that it has helped her, so I got encouraged” - FP client who initiated PrEP, partner HIV-uninfected

Practical logistics such as obtaining pills, taking them daily, and finding a place to store them also influence AGYW's decisions about whether to initiate PrEP. For some, the availability of PrEP at either their FP or MCH clinic made it more convenient to initiate, especially if they had already considered PrEP prior to attending clinic.

"Today I brought the baby for immunization, but I also had a plan that once I am done with that I was going to ask about PrEP." - MCH client who initiated PrEP, partner HIV-uninfected

For others, the practicalities of taking PrEP were too difficult to overcome. Lack of a private storage area at home or needing to take a daily pill were major barriers. Others shared that the instability of poverty and lack of resources eliminated PrEP as an option. Some AGYW shared that they did not have basic essentials such as enough food to eat each week or money to take monthly trips to the clinic for medication refills, so they declined PrEP because these needs posed bigger challenges than the risk of HIV.

"[T]he doctor told me that a bottle has like 30 pills when I was having a discussion with her, and that means that I must keep on coming back for my PrEP refill after every one month and I am someone with a low source of income. Yes, I may not afford fare to use for coming here at Ahero every month for PrEP." - MCH client who declined PrEP, partner HIV status unknown

"I think young girls outside here [not within the city] not all of them have the knowledge of PrEP...Very few have the knowledge and very few have the facilities and very few also have the money to reach the hospital so that they can acquire these medical things....I don't think they know about this [PrEP] because for some even getting sanitary towels is hard. So, I think this knowledge [of PrEP] should also reach any person not only females, [but also] males and kids." - FP client who declined PrEP, partner HIV status unknown

In addition the logistics of frequent refills and daily medication were overwhelming to some pregnant AGYW, especially in the context of being a new mother. One pregnant participant shared that the additional logistical burden of traveling to the clinic every month to obtain pills and needing to take medications every day, lead her to defer PrEP until after her pregnancy.

“I fear taking medication, taking medication every day can be a very big challenge to me as well especially if I am not sick.... [with PrEP] I cannot forget to take it if I start taking it.... I will take [PrEP] next time once I am done with pregnancy.” - MCH client who declined PrEP, partner HIV status unknown

Discussion

This qualitative study identified key influences on decisions to initiate PrEP among AGYW offered PrEP within routine MCH and FP clinics in a high HIV burden setting in Kenya. By understanding personal experiences during PrEP offer, we outline a series of potentially modifiable barriers to PrEP initiation among AGYW. Similar to prior studies from African settings, HIV risk perception, peer influence, practical logistics, and the desire to preserve relationships influenced PrEP use among AGYW in our study.^{16–23} However, our study adds new data unique to PrEP delivery within routine MCH and FP clinics, including how caretaker roles and desires for healthy children can influence PrEP decision-making among pregnant AGYW. Our study also identifies how gaps in knowledge of interactions between PrEP, fertility and contraception can negatively influence PrEP uptake. Results from this study demonstrate the importance of acknowledging concerns related to relationship climate and developing strategies to safely and discreetly use PrEP when necessary. As programs consider integrating PrEP services into MCH and FP settings to reach AGYW within high HIV burden settings, implementation science studies that explore strategies to

enhance PrEP uptake through messaging that is tailored to AGYW within the context of MCH/FP will be critical.

While many AGYW in our study felt that PrEP could be a helpful tool for protecting themselves against HIV, they worried about the reactions of their partners and prioritized preserving their relationship or avoiding uncomfortable or unsafe situations over taking PrEP for HIV prevention. Unemployment and financial dependence on a partner may further influence an AGYW's motivation to maintain peace in her relationship, especially during pregnancy and postpartum when resources are acutely needed. Studies have shown that financial independence also influences uptake of health promoting behaviors in other populations (e.g., antiretroviral therapy adherence among pregnant women living with HIV).²⁴

Prior studies among mutually disclosed HIV-serodiscordant couples found that PrEP was a desirable option for preserving relationships without fear of HIV transmission.²⁵ Similarly, we found that some AGYW chose to initiate PrEP to eliminate their fear of HIV acquisition due to known or suspected infidelity. However, many AGYW in our study were not in mutually disclosed relationships and declined PrEP because they feared possible negative partner reactions from PrEP discussions or a partner finding out about PrEP use. These findings support the importance of involving male partners in PrEP messaging in addition to providing AGYW with skills for talking with their partners about PrEP and using PrEP discreetly, when necessary. These results also underscore the need for additional PrEP modalities for AGYW beyond daily pills (e.g., long acting injectables) which pose challenges when partners are unsupportive of PrEP or PrEP use could potentially cause social harms

We also found that an AGYW's role as a mother or caregiver influenced PrEP decisions. The responsibility of caring for a child and providing a future for them was a strong motivating factor

for staying healthy and HIV-free among participants in our study. However, when AGYW had an incomplete understanding of PrEP or fear of medication use during pregnancy generally, the motivation to protect the child's health led some mothers to decline PrEP. Ensuring that AGYW correctly understand the risks and benefits of PrEP, including interactions with FP, and dispelling myths and misconceptions about PrEP safety will be critical for promoting appropriate PrEP uptake among AGYW.

Peers are known to have greater influence over adolescent decisions, than peers often have in other stages of life. Knowing someone who used PrEP while pregnant or having personal knowledge of peer's PrEP use quelled fears about PrEP among our participants. To date, there have not been evaluations of peer-support strategies to improve PrEP uptake among AGYW MCH clients, although this approach has been successful for AGYW living with HIV within the context of prevention of mother-to-child transmission (PMTCT) programs.^{26,27} As PrEP delivery expands within AGYW populations, more intervention studies are needed that test implementation strategies for supporting PrEP use within this context.

Practical considerations, including acquiring, storing, and taking PrEP pills, influenced the decision to initiate PrEP among AGYW in our study. In some cases, AGYW did not grasp all aspects of PrEP fully, despite receiving recent counseling and opportunities to ask health providers questions. Diversification of PrEP messaging and counselling strategies, as well as providing messages that specifically target factors related to AGYW PrEP uptake decisions, may be helpful to help move AGYW from pre-contemplation to contemplation, especially if they are only hearing PrEP messaging for the first time. Importantly, our findings support previously reported findings that AGYW want options and convenience when it comes to HIV prevention.^{19,20,28} Our findings also support that is important that women have discrete HIV prevention options that they have autonomy to employ and use privately.

Our study has limitations. We sought to specifically describe reasons for declining PrEP among AGYW with partners of unknown HIV status (i.e., eligible for PrEP per national guidelines) and reasons for initiating PrEP among woman with HIV-uninfected partners. Thus, the experiences and decision-making influences described may not reflect perspectives outside of these groups. However, this study utilizes personal narratives to gather rich information regarding the experiences, perspectives, and beliefs around PrEP uptake among AGYW offered PrEP within MCH and FP and the themes we identified are likely applicable to other groups of AGYW offered PrEP in these clinical settings. PriYA research coordinators did not perceive any potential power dynamics influencing interviews and information collected from participants. Additionally, our study included only women seeking MCH and FP services who may have more social agency than AGYW at-large in settings with high HIV burden.

Future PrEP scale-up for AGYW within MCH and FP clinics should consider of the priorities and concerns of AGYW. PrEP demand creation will require increased PrEP messaging that addresses misconceptions and reduces disease- and behavior-related stigma. Meanwhile, alternative delivery approaches in health facilities and pharmacies in the community can increase PrEP accessibility and acceptability. As AGYW continue to be at high risk for HIV acquisition, their roles as mother/caregiver and relationship dynamics should be incorporated into PrEP education and messaging, as these factors will be critical for developing effective implementation strategies to increase PrEP uptake.

Table 1. Demographic Characteristics of AGYW Participants

Characteristic	Total n (%) or Median (IQR) N=47	Low risk, PrEP n (%) or Median (IQR) n = 21	High risk, no PrEP n (%) or Median (IQR) n = 26
Age (years)	21 (20 – 23)	22 (20 – 23)	20 (20 – 22)
Highest level of education at enrollment			
Primary	14 (29.8)	8 (38.1)	6 (30)
Secondary	22 (46.8)	10 (47.6)	12 (46.2)
University	11 (23.4)	3 (14.3)	8 (30.8)
Currently attending school	22 (46.8)	8 (38.1)	14 (53.8)
Employment status			
Unemployed	33 (70.2)	15 (71.4)	18 (69.2)
Salaried	4 (8.5)	2 (9.5)	2 (7.7)
Regular hourly	2 (4.3)	2 (9.5)	0 (0)
Irregular hourly	5 (10.6)	1 (4.8)	4 (15.4)
Other	3 (6.4)	1 (4.8)	2 (7.7)
Receives financial support from partner	33 (70.2)	14 (66.7)	19 (73.1)
Relationship status			
Single	2 (4.3)	2 (9.5)	0 (0)
Steady boyfriend	20 (42.6)	8 (38.1)	12 (46.2)
Married	25 (53.2)	11 (52.4)	14 (53.9)
HIV infected partner			
No	25 (55.6)	18 (94.7)	7 (26.9)
Yes	1 (2.22)	0 (0)	1 (3.9)
Don't know	19 (42.2)	1 (5.3)	18 (69.2)
Currently has live children			
No	19 (40.4)	6 (28.6)	13 (50.0)
Yes	28 (59.6)	15 (71.4)	13 (50.0)
Parity			
1	21 (75.0)	10 (66.7)	11 (84.6)
2	5 (17.9)	1 (20.0)	2 (15.4)
3	2 (7.1)	2 (13.3)	0 (0)
Clinic Type			
MCH	33 (70.2)	14 (66.7)	19 (38.5)
FP	14(29.8)	7 (33.3)	7 (26.9)
Knows PrEP user			
No	27 (57.5)	14 (66.7)	13 (50.0)
Yes	20 (42.6)	7 (33.3)	13 (50.0)

Figure 1. Key themes and influencers of PrEP uptake among AGYW within MCH/FP

Theme	Relationships with partners shaped perceived risks and benefits of PrEP	Role as a mother/caregiver provided a strong desire to protect their child	PrEP attitudes, awareness, and logistics
Influencers of PrEP uptake among AGYW MCH and FP attendees	Positive <ul style="list-style-type: none"> • Suspicion/knowledge of partner infidelity • Exercising autonomy for HIV prevention • Ability to use discretely at home 	<ul style="list-style-type: none"> • Desire to protect child’s future and health • Motivation to remain healthy to fulfill provider role 	<ul style="list-style-type: none"> • Having prior PrEP knowledge before offer at clinic • Peers discussing factors affecting HIV risk • Knowing current PrEP users
	Negative <ul style="list-style-type: none"> • Risk of disrupting harmony of relationship • Fearing partner retaliation/harm • Financial dependency on partner for livelihood • Lacking private or secure pill storage 	<ul style="list-style-type: none"> • Fearing taking medication will negatively affect baby • Not wanting additional responsibility while new mother • Fearing interference with fertility or family planning 	<ul style="list-style-type: none"> • Stigma from peers/community • Perceived inability/dislike of medications • Fear unknown chemicals/medicines • Lacking resources to take daily pill • PrEP pill burden • Fearing side effects

Figure 1: Key influencers of PrEP Uptake Among AGYW attending MCH and FP. PrEP- Pre-exposure Prophylaxis; AGYW – Adolescent Girls and Young Women; MCH - Maternal and Child Health; FP - Family Planning

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