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Acceptability of pre-exposure prophylaxis as an HIV prevention strategy: barriers and facilitators to pre-exposure prophylaxis uptake among at-risk Peruvian populations

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Summary: This study examined pre-exposure prophylaxis (PrEP) acceptability among female sex workers, male-to-female transgendered persons and men who have sex with men in Lima, Peru. Focus groups explored social issues associated with PrEP acceptability and conjoint analysis assessed preferences among eight hypothetical PrEP scenarios with varying attribute profiles and their relative impact on acceptability. Conjunct analysis revealed that PrEP acceptability ranged from 19.8 to 82.5 out of a possible score of 100 across the eight hypothetical PrEP scenarios. Out-of-pocket cost had the greatest impact on PrEP acceptability (25.2, P < 0.001), followed by efficacy (21.4, P < 0.001) and potential side-effects (14.7, P < 0.001). Focus group data supported these findings, and also revealed that potential sexual risk disinhibition, stigma and discrimination associated with PrEP use, and mistrust of health-care professionals were also concerns. These issues will require careful attention when planning for PrEP roll-out.

Keywords: pre-exposure prophylaxis (PrEP), South America, HIV, MSM, FSW, acceptability

INTRODUCTION

The HIV prevention field continues to seek both behavioural and biomedical interventions to reduce the transmission of HIV.1 Behavioural interventions have not been able to contain the pandemic2 and recent biomedical approaches such as the use of the topical vaginal microbicides have had disappointing results.3 Pre-exposure prophylaxis (PrEP) is a biomedical approach generating considerable interest, and could be an important additional HIV prevention tool.2, 4–8 PrEP involves taking antiretroviral medications (ARVs) before potential HIV exposure to prevent infection in contrast to post-exposure prophylaxis (PEP), the use of ARVs after exposure to prevent infection. In practice, PrEP becomes PEP once exposure occurs; however, for convenience we use the term ‘PrEP’ to encompass the regular use of ARVs by seronegative individuals to prevent HIV infection independent of potential exposure. Currently, ARVs are used to prevent mother-to-child transmission of HIV during childbirth9,10 but the efficacy of their daily use among HIV-uninfected individuals to prevent HIV infection during sexual intercourse is not yet known and is the subject of multiple international studies, including Botswana (young adults), Thailand (injection drug users), and Ecuador, Peru, Brazil and USA (men who have sex with men [MSM]).2,8,11–13 In the Peru study, a daily dose of the ARVs emtricitabine and tenofovir disoproxil fumarate, coformulated into one pill that is marketed as Truvada, is being tested.

As the clinical trials work to establish PrEP clinical efficacy, a parallel body of research is investigating its acceptability among potential users. For example, studies among MSM in California and New York found that overall knowledge of PrEP was modest, with concerns related to potential side-effects and degree of effectiveness.8,14,15 There are no published studies of which we are aware that examine PrEP acceptability among non-USA populations, who account for 96% of adults and children living with HIV globally.16

The purpose of this pilot study was to examine PrEP acceptability among female sex workers (FSW), male-to-female transgendered persons and men who have sex with men in Lima, Peru. These groups, when compared with the general population (HIV prevalence <1%), are at elevated risk for HIV infection with HIV prevalences of 1.6%17 and potentially high as 4.7%18 among FSW and 18–22% among MSM/TG.16 Since PrEP clinical trials are underway in Peru, data regarding its acceptability and potential impact on HIV risk behaviours are needed in order to plan for roll-out should the strategy prove efficacious. To address this, we conducted focus groups and conjoint analyses with the above three at-risk populations; implications of our findings on future PrEP dissemination strategies in Peru are discussed.
MATERIALS AND METHODS

Participants

Recruitment was based on convenience sampling, and was conducted by community Peer Outreach Workers who went to venues such as parks, beauty salons, volleyball courts and certain community-based organizations in Lima where FSW, TG and MSM were known to frequent. The Peer Outreach Workers explained the study to potential participants and referred those interested to the study staff. Participants were compensated 15 Nuevos Soles (approximately US$5.00) for transportation. Institutional Review Boards at the University of California, Los Angeles and the Universidad Peruana Cayetano Heredia reviewed and approved the study prior to implementation.

Procedures

Seven groups of four to eight individuals (total n = 45) were formed (3 FSW, 2 TG and 2 MSM). Each group met once for approximately two hours when focus groups and conjoint analyses were conducted. The focus groups were conducted prior to the conjoint analysis exercise as these allowed for participants to freely discuss their understanding and knowledge of PrEP and gave the facilitators the chance to correct any erroneous information about PrEP before the conjoint analysis exercise so that all participants were completing the exercise with the same, correct information. Both procedures were conducted in Spanish by two, female, bilingual (Spanish-English) masters-level facilitators who have extensive experience working with our target population.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Probes</th>
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<tr>
<td>1 PrEP in general</td>
<td>Examples, analogies</td>
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<tr>
<td>What have you heard about antiretroviral medication used for HIV prevention (PrEP)?</td>
<td>• Like malaria prophylaxis</td>
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<tr>
<td>2 What do you know about PrEP or about how it works?</td>
<td>• Like contraception</td>
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<tr>
<td>3 How would you feel about taking a medication everyday to prevent HIV infection?</td>
<td>• Understand that PrEP is before you are exposed, like a vaccine, different from PEP, that you take after you are exposed, like the morning after pill.</td>
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<td>4 Receptiveness to PrEP and explanation</td>
<td>Possible issues:</td>
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<td>Would you or your close friends be willing to take PrEP?</td>
<td>• Remembering to take it</td>
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<tr>
<td>5 What would be the reasons you or your close friends would want to take PrEP?</td>
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</tr>
<tr>
<td>6 What would be the reasons you or your close friends would NOT want to take PrEP?</td>
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<tr>
<td>7 Social and community concerns</td>
<td>• People seeing you take it</td>
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<tr>
<td>What are possible social concerns that may discourage you or your close friends from taking PrEP?</td>
<td>• Do you think your friends would be (very likely, somewhat likely, somewhat unlikely or not likely) to take PrEP?</td>
</tr>
<tr>
<td>8 Health-care provider concerns</td>
<td>• To protect against getting ill from HIV?</td>
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<tr>
<td>What are possible concerns about health-care providers that may discourage you or your close friends from taking PrEP?</td>
<td>• So you or your close friends could have unprotected sex?</td>
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<td>9 PrEP characteristics</td>
<td>• Fears, worries, barriers</td>
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<td>• Side-effects</td>
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<td>• Places (where) of dissemination</td>
<td>• Discrimination</td>
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<tr>
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<td>• Disclosure</td>
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<td>• Duration of taking PrEP</td>
<td>• What would your family think?</td>
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<td>• Efficacy</td>
<td>• What would your acquaintances think?</td>
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<tr>
<td>• Frequency of administration (QD versus before sex acts)</td>
<td>• What would your sexual partners think?</td>
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<tr>
<td>• Cost</td>
<td>• Any other possible social or community concerns?</td>
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<td>10 Behavioural change after PrEP</td>
<td>• People recognizing you when you get the medication</td>
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<tr>
<td>• How would having PrEP available change your or your friends’ sexual behaviours?</td>
<td>• Provider judging you</td>
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<tr>
<td>• How would taking PrEP change your or your close friends’ use of condoms?</td>
<td>• Difficulty accessing it</td>
</tr>
<tr>
<td>• How much might they change their behaviours? (A little? A lot? Not at all?)</td>
<td>• Difficulty getting information</td>
</tr>
<tr>
<td>• How would taking PrEP or having it available change your or your close friends’ use of condoms? (A little? A lot? Not at all?)</td>
<td>• Being embarrassed to ask for it from providers</td>
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</table>

PrEP = pre-exposure prophylaxis
for the treatment of HIV. Participants were asked to discuss both their own opinions of PrEP as well as their perceptions of the opinions and attitudes of their peers. Basic demographic information was collected at the conclusion of the discussion.

Focus groups were recorded, transcribed and translated into English for the USA-based research team. The English transcript was then back-translated to Spanish by a second, blind translator and compared with the original Spanish transcript in order to confirm its fidelity. To increase reliability, two investigators (one from Lima and one from Los Angeles) independently coded the transcripts and reviewed the codes with a third investigator. After several iterations, 20 codes in six ‘families’ (key themes) were created using ATLAS.ti 5.0. Analysis was further refined by identifying the most frequently occurring themes for each of the three target populations.

**Conjoint analysis**

We used conjoint analysis to assess the acceptability of hypothetical PrEP scenarios and to quantify the impact of various PrEP attributes on acceptability. Conjoint analysis is often used to elicit consumer preferences and has been widely applied in economics and market research and is gaining popularity in the health domain for assessing consumer acceptability of health-care services and pharmaceuticals. In this study, conjoint analysis was used to describe PrEP as a ‘bundle’ of attributes. Participants rated composite hypothetical PrEP scenarios, thus requiring decisions regarding the relative importance of different PrEP attributes, which more closely approximates real-world decision-making than a series of disparate single-item questions. Our group has successfully used conjoint analysis to assess HIV vaccine acceptability and willingness to participate in HIV vaccine trials. Seven PrEP attributes were identified by integrating input from PrEP experts, PrEP acceptability research and the need to present meaningful alternatives from a consumer perspective.

PrEP attributes were out-of-pocket cost per month (US$10 versus US$250), efficacy (75% versus 95%), side-effects (none versus nausea/dizziness), duration of use (1 year versus 10 years), dosing frequency (before sex versus every day), dispensing venue (general clinic versus HIV clinic) and person dispensing (pharmacist versus doctor/nurse). The range of cost was chosen to be sufficient to produce an impact on acceptability. We selected 75% versus 95% efficacy because the literature suggests that our target population expects PrEP to be completely efficacious; thus our objective was to determine the effect of partial efficacy (75%) versus almost complete efficacy (95%) on acceptability. The one year versus 10 years administration of duration was selected to assess preferences regarding short-term use of PrEP (1 year) versus long-term use (10 years).

A full factorial design for eight PrEP scenarios, each with seven dichotomous attributes, would yield 128 different PrEP scenarios. We applied a fractional factorial orthogonal design to reduce the number to eight hypothetical PrEP scenarios. Following the focus groups, the hypothetical PrEP scenarios were presented simultaneously to each individual participant on laminated cards. Participants rated their likelihood of accepting each PrEP scenario on a 5-point Likert-type scale ranging from ‘definitely would accept’ to ‘definitely would not accept’. Ratings were transformed into a 0 to 100 scale, whereby ‘definitely would accept’ = 100 and ‘definitely would not accept’ = 0. We derived the acceptability of each hypothetical scenario by averaging individual PrEP acceptability ratings across respondents. Next, a one-way analysis of variance (ANOVA) model was applied to fit each respondent’s acceptability ratings across the eight PrEP scenarios. The seven PrEP attributes served as independent variables in the model. The effect for each PrEP attribute from the ANOVA model is the impact score of the attribute on PrEP acceptability for the individual respondent. We then averaged individual impact scores across respondents for each attribute to compute its impact on overall PrEP acceptability. A one-sample t-test was used to determine the statistical significance of the impact of each attribute on PrEP acceptability.

**RESULTS**

**Demographics**

We recruited 45 participants comprising 15 FSW in three groups, 13 TG in two groups and 17 MSM in two groups. The mean age of participants was 40 (FSW), 28 (TG) and 33 years (MSM).

**Focus groups**

Six key themes were identified regarding PrEP: knowledge/awareness; attitudes/expectations; social/community concerns; concerns regarding health-care professionals; ideal characteristics and behavioural changes. Results are organized by theme; see Table 2 for representative quotes.

**PrEP knowledge/awareness**

All three populations reported little or no knowledge/awareness of PrEP, although one transgendered participant had heard of preparations for a PrEP study in Peru (Quote 1).

**PrEP attitudes/expectations**

All three populations were generally supportive of using PrEP; however, there were concerns regarding the need for a daily regimen and remembering to take the pills (Quotes 2, 3) or the necessity to take the pills daily if not regularly having sexual relations (Quote 4). Side-effects were a concern among FSW and TG participants, particularly with regards to other concomitant health conditions (Quotes 5, 6). MSM suggested that lifestyle issues such as going to a party and alcohol use could interfere with taking PrEP (Quote 7). All three populations expressed high expectations for PrEP as a method of self-care (Quote 8), as backup protection when condoms are forgotten or break (Quote 9), or for casual sex (Quote 10).

**Social and community concerns regarding PrEP use**

All groups were supportive of selective disclosure of PrEP use within their specific social networks, for example to other sex workers (Quote 11) or friends (Quotes 12, 13), while disclosure of use to clients or one-night stands was not supported (Quotes 14, 15). In particular, MSM reported disclosure to family as unlikely due to fear of rejection or being seen as ‘promiscuous’ (Quote 16).

**Concerns about health-care professionals**

While FSW and TG participants spoke of the potential lack of sensitivity on the part of health-care professionals dispensing
PrEP, they also mentioned that the Peruvian Ministry Of Health was conducting sensitivity workshops for all health-care staff to improve communication and trust with patients of diverse sexual orientations and risk behaviours (Quotes 17, 18).

**PrEP’s ideal characteristics**

Accessibility: all three populations preferred PrEP being available in health-care centres as opposed to pharmacies, citing higher costs (Quote 19), increased potential for patient misuse...
(Quote 20) and privacy risks (Quote 21) if the drugs were dispensed in neighbourhood pharmacies.

Cost: TG and FSW thought that PrEP should be free like contraception pills given out at health centres (Quote 22). Conversely, MSM felt that PrEP should cost something, citing a risk for habituating the population to something free which eventually may be charged for (Quote 23), or that paying for PrEP is part of investing in one’s own health (Quote 24).

Duration of use: acceptability views ranged from taking PrEP as a time-limited activity dependent on the duration of being a sex worker (Quote 25), to a lifetime commitment by MSM (Quote 26).

Effectiveness: 100% effectiveness was desired by all three populations (Quotes 27, 28).

Frequency of dosing: daily dosing was endorsed by FSW who saw it as commensurate with their type of work (Quote 29), but not by TG or MSM who viewed daily dosing as impractical or incompatible with a lifestyle where most people ‘live in the moment’ (Quotes 30, 31, 32).

Provider: all groups agreed that PrEP should be delivered by health-care professionals, as these were seen as people who already were interacting with the population, could handle other health concerns (Quotes 33, 34) and offered the most privacy (Quote 35).

Behavioural changes after PrEP

Only FSW participants felt that PrEP would not change sexual risk-taking behaviours since it would only protect against HIV and not other sexually transmitted infections (STIs) (Quote 36). TG and MSM participants, however, felt that condom use would decrease as a result of PrEP (Quotes 37, 38, 39).

Conjoint analysis

PrEP acceptability ranged from 19.8 to 82.5 on the 0–100 point scale, with a mean acceptability of 53.4 out of 100 across the eight hypothetical PrEP scenarios. The scenario with the highest acceptability (scenario 1) had the following attributes: US$10 per month, 95% efficacy, no side-effects, 10 years duration of administration, use before sex and dispensed at an HIV clinic by a doctor/nurse. Table 3 shows the acceptability of all eight PrEP scenarios and their attribute profiles.

Table 4 shows the impact of each of the seven PrEP attributes on PrEP acceptability, and acceptability with the preferred versus the non-preferred value of each attribute. Cost had the single greatest impact on acceptability across the seven PrEP attributes, controlling for all other PrEP attributes. Participants reported significantly higher PrEP acceptability with a cost of US$10 (acceptability = 62.0), compared with a cost of US$250 (acceptability = 36.8), yielding a net impact score of 25.2 (P < 0.001). Efficacy had the second greatest impact on PrEP acceptability. Participants reported significantly higher PrEP acceptability with a 95% efficacious PrEP (acceptability = 60.0 out of 100), compared with PrEP with a 75% efficacy (acceptability = 38.7 out of 100), yielding a net impact score of 21.4 (P < 0.001). In addition, side-effects had a significant impact on PrEP acceptability. The acceptability of PrEP with no side-effects was 56.7 on the 0–100 point scale, in contrast to the mean score of 42.0 (P < 0.001) for PrEP with minor side-effects of nausea and dizziness. While not statistically significant, there was a notable preference for PrEP being dispensed by a health-care professional (versus pharmacist).

DISCUSSION

In this convenience sample of FSW, TG and MSM in Peru, we found a wide range of attitudes and opinions regarding PrEP acceptability. Important potential barriers to PrEP found in both the focus group and conjoint analysis data included high out-of-pocket cost, partial efficacy and fear of side-effects. Stigma and discrimination associated with PrEP use, mistrust of health-care professionals and a belief that PrEP would result in a decrease in condom use were concerns for MSM and TG. These potential barriers will require careful attention when planning for PrEP dissemination.

Acceptability of the best possible PrEP scenario (82.5 out of 100) suggests the potential for widespread use in our target population with an optimal product. Nevertheless, the average acceptability of 53.4 on the 0–100 scale across the eight hypothetical PrEP scenarios may be a more realistic estimate of its probable uptake and indicates that the eventual degree of acceptability of PrEP is likely to be influenced by its specific characteristics.

Both conjoint analysis and focus group data revealed concerns regarding PrEP use. Cost had the single greatest impact on PrEP acceptability in the conjoint analysis; participants were significantly more likely to indicate acceptance of PrEP with a low out-of-pocket cost. Focus group data supported this finding.
with some participants expecting PrEP to be free or low-cost (like contraception pills) while others feared that if PrEP was initially free but then later charged for use would decrease. Efficacy had the second greatest impact on PrEP acceptability in the conjoint analysis. Participants were significantly more likely to indicate acceptance of PrEP with a 95% efficacy than a 75% efficacy. Focus group findings revealed that 100% efficacy (understandably) was desired by all three study populations; however, even an optimistic estimate of potential PrEP efficacy places it at 90%, thus participant expectations may be unrealistically high. Side-effects such as nausea and dizziness had a significant impact on PrEP acceptability in the conjoint analysis. Focus group data supported this finding, with all three populations expressing concerns about the potential side-effects of PrEP particularly with regard to existing health conditions. While not statistically significant, there was a notable preference for PrEP being dispensed by a health-care professional (versus pharmacist) in the conjoint analysis. Focus group findings also showed a preference for PrEP being dispensed by health-care professionals (versus pharmacists). While all groups voiced concerns about health-care professionals that might discourage them from using PrEP, such fear of being mistreated, lack of sensitivity, and stigma and discrimination regarding sexual orientation (MSM and TG) and lifestyle (FSW), they maintained that health-care professionals would be better qualified than pharmacists to dispense PrEP.

Focus groups revealed some information regarding PrEP characteristics not identified in the conjoint analysis. For example, all three populations preferred PrEP being dispensed in health-care clinics (versus pharmacies). In Peru, neighborhood drugstores are numerous and many are family-operated, thus making privacy a potential issue if PrEP were dispensed at such establishments. We also found that daily use of PrEP would not be acceptable to MSM and TG, while FSW seemed more willing to accept PrEP on a daily basis comparing it to a contraception pill also taken daily.

Information regarding social barriers related to the disclosure of PrEP use emerged in the focus group data. All three populations reported being hesitant to disclose PrEP use with anyone outside of their social networks, with fears stemming from the potential of stigma and discrimination that could be associated with their lifestyles or behaviours by parents, friends or clients. Similar findings have been shown in previous studies. It is unknown how social barriers will impact the acceptability of PrEP, but the very fact that it is a relatively ‘invisible’ prevention method compared with condoms, and could be used without others’ knowledge may in fact be considered an important potential strength of PrEP as an HIV prevention strategy.

One issue we hoped to assess in this study was the possible impact of PrEP on behavioural risk disinhibition. Concerns regarding risk disinhibition hypothesize that new HIV prevention technologies like PrEP may foster an overly optimistic sense of protection among users and lead to increased risk behaviours (e.g. by reduced condom use; feelings of ‘immunity’ to HIV, etc.). The data for MSM and TG in our study suggest that this was, in fact, a concern but interestingly not for FSW. While this discrepancy requires further exploration, it is possible that FSW may view PrEP specifically as added security against the occupational hazards of their work.

There were limitations to our study. First, we chose focus groups as one of our methods to explore PrEP acceptability. This methodology facilitates in-depth discussion of individual perspectives within the context of a larger group but may overrepresent specific participant contributions; therefore, aggregate group data may not reflect equally the specific concerns of every group participant. Second, the small sample size (n = 45), convenience sampling and selection bias limits the ability to generalize our results to others. The purpose of this study was to elicit and explore reactions to hypothetical PrEP among select consumers at potential risk for HIV rather than to generalize our findings to all persons at risk. Third, the variables modelled in the conjoint analysis included physical characteristics of PrEP. We consulted PrEP experts in creating seven of the most critical characteristics of PrEP, which was based on current knowledge at the time the study was conducted. Social issues (e.g. perception of HIV risk, HIV testing practices, relationship issues, trust in providers, stigma/discrimination) were not included in the model, and may also impact PrEP acceptability. Further investigation of the impact of social issues on PrEP acceptability using conjoint analysis is warranted. Finally, it is important to note that conjoint analysis need not reflect the exact characteristics of a future PrEP to yield meaningful data. Rather, the purpose is to present a meaningful range to consumers within each PrEP attribute in order to estimate the likely impact of PrEP attributes on product acceptability.

PrEP studies are underway, and within the next few years efficacy data will continue to emerge. With hope and scientific data mounting, it is essential to prepare for the possible roll-out of PrEP should it be shown to be efficacious. Our study demonstrated that clear differences were observed between groups, particularly the FSW versus the TG and MSM, pointing to the necessity of much deeper exploration of the intended target

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<tr>
<td>Cost per month^</td>
<td>US$10 versus US$250</td>
<td>61.92</td>
<td>36.77</td>
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<tr>
<td>Efficacy^</td>
<td>95% versus 75%</td>
<td>60.03</td>
<td>38.66</td>
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<tr>
<td>Side-effects^</td>
<td>None versus nausea/dizziness</td>
<td>56.69</td>
<td>42.01</td>
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<tr>
<td>Duration of administration</td>
<td>1 year versus 10 years</td>
<td>48.55</td>
<td>50.15</td>
</tr>
<tr>
<td>Frequency</td>
<td>Before sex versus every day</td>
<td>48.55</td>
<td>50.15</td>
</tr>
<tr>
<td>Location PrEP is dispensed</td>
<td>General clinic versus HIV clinic</td>
<td>48.40</td>
<td>50.29</td>
</tr>
<tr>
<td>Person dispensing PrEP</td>
<td>Pharmacist versus doctor/nurse</td>
<td>47.67</td>
<td>51.02</td>
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SD = standard deviation

^P < 0.001 for one sample t-tests
groups in each environment – or microenvironments – where PrEP is introduced.

ACKNOWLEDGEMENTS

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