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Community PrEP delivery preferences among pregnant and breastfeeding women using oral PrEP in South Africa and Kenya

Running head: Community PrEP preferences in pregnancy

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Running Head: Community PrEP delivery during pregnancy

Abstract

Objective: We evaluated preferences for differentiated service delivery of oral pre-exposure prophylaxis (PrEP) versus clinic pick-up among oral PrEP-experienced pregnant and breastfeeding women (PBFW) in South Africa and Kenya.

Design and Methods: From September 2021 to February 2022, we surveyed PBFW in oral PrEP studies in South Africa and Kenya. We asked participants about their PrEP delivery preferences and used logistic regression models adjusted for age and country to identify predictors of preferring community over clinic-based PrEP delivery.

Results: We surveyed 394 South African and Kenyan PBFW (73% postpartum, median age 28 years). Overall, 59.5% of South African participants (n=113) and 24.5% of Kenyan participants (n=50 , $p<0.01$) were interested in community PrEP delivery, most frequently due to convenience (n=80, 49.1%) and lower transportation costs (n=78, 47.9%). Participants preferred clinic PrEP pick-up due to privacy (n=174, 75.3%) and desire to see a healthcare provider (n=83, 35.9%). Preference for community PrEP delivery was positively associated with South African participants (aOR=4.32, 95% CI=2.80-6.67), PrEP stigma (aOR=2.59, 95% CI=1.58-4.23), completing secondary school or higher (aOR=1.84, 95% CI=1.17-2.92), and transportation cost to clinic (aOR=1.39, 95% CI=1.10-1.75). Preference of community PrEP delivery was negatively associated with age (aOR=0.68 per 10-year increase, 95% CI=0.49-0.95) and having one or more sexual partners versus no sexual partners (aOR=0.34, 95% CI=0.12-0.95).

Conclusions: Oral PrEP-experienced PBFW in South Africa and Kenya described varied preferences for community PrEP delivery. Associations with community-based PrEP delivery preference identified in this analysis may be useful in the development of context-specific DSD interventions targeting PBFW.

Key Words: PrEP, differentiated service delivery, community delivery, pregnancy, breastfeeding, South Africa, Kenya

Introduction

Pregnant and breastfeeding women (PBFW) continue to be at increased risk of HIV acquisition in sub-Saharan Africa [1]. Oral pre-exposure prophylaxis (PrEP) has been implemented throughout African countries with high HIV burden, with greatest uptake in South Africa and Kenya [6-9]. However, despite high rates of PrEP initiation, adherence, and persistence (e.g., PrEP continuation over time) remain low among women in Kenya and South Africa [6-8]. PBFW describe logistical barriers to consistent PrEP access (e.g., transportation cost to clinic, lack of childcare, difficulty continuing PrEP in non-antenatal clinics) [9,10]. It is important to address modifiable barriers to PrEP access among PBFW.

Several strategies to improve PrEP adherence and persistence are being evaluated in African countries, including long-acting PrEP modalities, interventions to support HIV risk self-evaluation and PrEP decision-making, and differentiated service delivery (DSD) of PrEP, in which PrEP and other HIV prevention services are offered in community locations [11-13]. DSD (in the form of community- and pharmacy-based delivery) has been shown to improve PrEP uptake and continuation among adolescent girls and young women in South Africa and Kenya [14,15]. In these contexts, DSD models have been shown to decrease the frequency of clinic-based visits through decentralized care delivery, leading to improved convenience for patients seeking care (e.g., decreased wait times) and decreased burden for high-volume clinic settings, leading to the addition of DSD into World Health Organization guidelines on PrEP delivery [16,17]. However, DSD models are not currently part of the standard-of-care in the delivery of PrEP services among PBFW in South Africa and Kenya. A recent discrete choice

experiment among PBFW on oral PrEP in South Africa and PrEP-naïve PBFW in Botswana demonstrated that choice of PrEP method, less frequent prescription collection (6-monthly), and delivery choice (clinic and community) were key preferences [18]. Additionally, injectable PrEP was commonly preferred in PBFW in South Africa, where contraceptive methods are commonly injectable [19].

Given ongoing challenges with PrEP persistence among PBFW, implementation of PrEP DSD strategies, such as delivery of PrEP in community settings, may address the logistical barriers faced by this important population. In this study, we evaluated preferences for PrEP pick-up in clinic versus PrEP pick-up in community-based settings, as well as predictors of community PrEP preference, among PBFW with a history of oral PrEP use in South Africa and Kenya.

Methods

Study participants: We conducted surveys with oral PrEP-experienced participants in two studies in South Africa and Kenya. The PrEP in pregnancy and postpartum (PrEP-PP) study enrolled pregnant cisgender women without HIV in Cape Town, South Africa, offered HIV prevention counselling and oral PrEP, and were followed through 12-months postpartum [6]. The PrEP Implementation for Mothers in Antenatal Care study extension (PRIMA-X) study was an observational extension cohort of a cluster randomized trial offering daily oral PrEP among PBFW in western Kenya [7]. Eligibility criteria and participant study visits within PrEP-PP and PrIMA-X have been previously described [20]. Eligibility criteria for this sub-study included: current or previous oral PrEP use; currently pregnant or up to 12-months postpartum; and concurrent enrolment in PrEP-PP or PrIMA-X.

Data collection: Data collection methods for this sub-study have previously been described [20]. Briefly, between September 2021 and February 2022, trained study staff screened participants attending PrEP-PP or PrIMA-X follow-up visits for study eligibility and obtained written informed consent in English or the participant's local language (isiXhosa, Kiswahili, or Luo). Study staff administered a 30-40 minute survey to eligible and consenting participants, and recorded responses electronically on REDCap [21,22]. Survey measures included basic demographic data, including: age in years, pregnant or postpartum status, education level (categorized as last grade completed: secondary school or higher vs. primary school or some secondary school), employment (categorized as any reported formal or informal employment vs. none), sexual partner (categorized as none versus one or more), HIV risk perception (categorized as: no risk at all, small chance, moderate or great chance), and current alcohol use from the Alcohol Use Disorders Identification Test. We ascertained self-reported days on oral PrEP, any oral PrEP use in the last month (categorized as any vs none), and perceived PrEP stigma using a seven-item scale derived from existing literature (Supplemental Table 1, <http://links.lww.com/QAD/D859>) [23-26]. Participants were also asked about their transportation method, total travel time to and from the clinic where they received PrEP, and estimated total transportation cost to and from clinic. We described existing models of DSD (e.g., community, private pharmacy or home PrEP delivery) and asked participants whether they would prefer clinic pick-up or any PrEP DSD, if available. We then asked participants about the reasons for their preference, and asked participants interested in potential PrEP DSD about where they would be interested in receiving

their PrEP (e.g., community halls, private pharmacy, churches, taxi ranks, home delivery, a different location provided by the participant, etc).

Statistical analyses: We report participant responses descriptively (median, interquartile range [IQR], frequency) and used Chi-square, Fischer's Exact, and Wilcoxon rank sum tests to compare responses between participants who preferred clinic versus community PrEP delivery. We used univariable and multivariable logistic regression models to identify predictors of selecting community PrEP delivery over clinic pick-up. Variables that were statistically significant (defined as $p < 0.05$) in univariable logistic regression models were included in a multivariable logistic regression model. We used two-tailed tests to evaluate significance for regression models, with a significance threshold of $p < 0.05$. Statistical analyses were conducted with STATA v.17 [27].

Ethics: PrEP-PP was approved by the Human Research Ethics Committee of the University of Cape Town Faculty of Health Sciences (#297/2018) and the University of California, Los Angeles Institutional Review Board (IRB#18-001622). PrIMA-X was approved by the Kenyatta National Hospital-University of Nairobi Ethics and Research Committee (P921/11/2019) and by the University of Washington Human Subjects Division (STUDY00008710).

Results

Participant characteristics

Overall, 394 PBFW were enrolled in the study: 190 PBFW (out of 220 eligible participants approached; 86.4%) in South Africa from PrEP-PP (N=1201) and 204 (none declined, 100.0%) in Kenya from PrIMA-X (N=1300). In all, 72.4% women were postpartum, median age was 28 years (IQR 24-32), and median time on PrEP was 335 days (IQR 168-420).

Participant characteristics by PrEP delivery preference are reported in **Table 1**. Overall, 163 participants (41.4%) preferred community PrEP delivery, while the remainder preferred clinic pick-up (n=231, 58.6%) (**Table 2**). Preferences for PrEP pick-up differed by country: 59.5% of South African participants preferred community PrEP delivery (n=113/190); in comparison, 75.5% of Kenyan participants preferred clinic PrEP pick-up (n=154/204, $p < 0.001$) (**Table 3**). Participants who preferred community PrEP delivery were younger (median age 27 vs 29 years, $p = 0.018$) (**Table 2**). Among participants who preferred community PrEP delivery, 32.5% (n=53) were pregnant, compared to 22.5% of participants preferring clinic pick-up (n=52, $p = 0.027$). Participants who chose community PrEP delivery reported more time using oral PrEP compared to those who chose clinic pick-up (median 336 versus 327 days, $p = 0.018$). Regarding education status, 44.2% of individuals preferring community PrEP delivery completed secondary school or higher education (n=72/163), compared to 25.1% of those preferring clinic pick-up (n=58/231, $p < 0.001$). Regarding sexual history, 97.4% of participants who chose clinic pick-up reported at least one sexual partner, compared to 90.8% of those who chose community PrEP delivery ($p = 0.004$). Overall, 41.7% of participants preferring community PrEP delivery agreed with at least one statement regarding perceived PrEP stigma (n=65/156), compared to 28.6% of participants preferring clinic pick-up (n=64/224, $p = 0.008$). Median clinic travel time (including return) was 30 minutes among those preferring community PrEP delivery (IQR 20-50).

and 45 minutes among those preferring clinic pick-up (IQR 30-60, $p<0.001$). Despite both groups having the same median transportation costs (\$USD 1.29), there was a wider inter-quartile range among clinic pick-up participants and a significant difference between groups using Wilcoxon rank sum ($p=0.007$). In both groups, most participants were unemployed (80.4% vs 78.7%, $p=0.925$), described no current alcohol use (95.5% in both groups, $p=0.992$), reported any PrEP use over the previous 30 days (75.5% vs 74.0%, $p=0.747$), and most frequently described a “small chance” of acquiring HIV in the next year when asked about HIV risk perception (41.7% vs 35.7%, $p=0.073$).

Reasons for PrEP Pick-up Preferences

The most common reasons for preferring community PrEP delivery included convenience ($n=80/163$, 49.1%), lower transportation costs ($n=78/163$, 47.9%), and the belief that community PrEP delivery would increase community awareness of PrEP ($n=61/163$, 37.4%) (**Table 3**). More South African participants described convenience as a reason for community PrEP delivery preference (54.0% vs 38.0%, $p=0.060$), while significantly more Kenyan participants described less anticipated PrEP stigma in the community (38.0% vs 1.8%, $p<0.001$) and privacy (12.0% vs 0.9%, $p=0.004$) as reasons for preferring community PrEP delivery. When asked about preferable locations for community PrEP delivery, most replied that they wanted home delivery ($n=117$, 71.8%) community halls ($n=80$, 49.1%), or retail pharmacies ($n=43$, 26.4%). The most common reasons for preferring clinic PrEP pick-up were privacy ($n=174/231$, 75.3%) and desire to see their healthcare provider at the clinic during PrEP refill visits ($n=83/231$, 35.9%), particularly among Kenyan participants (41.6% vs 24.7%, $p=0.012$). Additionally, more South African participants described concerns regarding anticipated stigma due to community PrEP delivery (23.4% vs 1.3%, $p<0.001$).

Predictors of Community PrEP Delivery Preference

In univariable analysis, predictors of community PrEP delivery included being in South Africa (vs. Kenya) (OR=4.52, 95% CI=2.94, 6.95, $p<0.001$), secondary or higher education (vs. primary or some secondary school, OR=2.36, 95% CI=1.54, 3.62), and endorsed PrEP stigma (OR=1.79, 95% CI=1.16, 2.75, $p=0.008$). Maternal age (OR=0.60, 95% CI=0.44, 0.82, $p=0.001$), time to clinic (OR=0.98, 95% CI=0.97, 0.99, $p<0.001$), relationship status (sex partner vs. none, OR=0.26, 95% CI=0.10, 0.69, $p=0.007$), and moderate or great HIV risk perception (vs. no risk at all: OR=0.58, 95% CI=0.31, 0.90, $p=0.19$) were inversely associated with community PrEP preference.

In the multivariable model, preference for community PrEP delivery was positively associated with being in the South African group (aOR=4.07, 95% CI=2.32-7.14, $p<0.001$), completing secondary school or higher education versus completing some secondary school or less (aOR 1.82, 95% CI=1.12-2.97, $p=0.017$), and agreement with at least one statement about PrEP stigma (aOR 2.66, 95% CI=1.60-4.41, $p<0.001$) (**Table 4**). Community PrEP delivery preference was negatively associated with having one or more sexual partner(s) (aOR 0.27, 95% CI=0.09-0.83, $p=0.023$).

Discussion

Oral PrEP-experienced South African PBFW reported preferences for community PrEP delivery over clinic pick-up, while oral PrEP-experienced PBFW in Kenya more frequently preferred clinic pick-up, highlighting the necessity for context-specific strategies to improve adherence and persistence on PrEP among PBFW, as well as the importance of choice in how one accesses HIV prevention services. In South Africa, community delivery has been scaled nationally for HIV antiretroviral treatment (ART) delivery among non-pregnant individuals, and ongoing randomized control trials are evaluating feasibility, acceptability, and effectiveness of community-based PrEP delivery for populations including adolescent girls and young women as well as PBFW [14,28-30]. Our study emphasizes the acceptability among PBFW of utilizing DSD strategies to access PrEP, supporting the inclusion of PBFW in future national scale-up of DSD services for PrEP delivery. In Kenya, very few (5%) people living with HIV (PLWH) are engaged in community ART delivery compared to PLWH using community ART pick-up in South Africa (up to 40%) – it is possible that this may contribute to decreased familiarity with community-based PrEP delivery among Kenyan PBFW [31-32]. However, in Kenya, studies show acceptability and improved PrEP continuation through community pharmacy-based models of PrEP delivery, where seeing a pharmacist may address concerns regarding wanting to see a healthcare provider when collecting their PrEP [33-34]. Further research is necessary to evaluate whether scaling pharmacy-based PrEP delivery models in Kenya addresses potential concerns relayed by Kenyan PBFW in our study, such as potential lack of privacy and desire to see a healthcare provider. The strong association between South African participants and preference for community PrEP delivery may support the utilization of differentiated PrEP delivery among pregnant or breastfeeding adolescent girls and young women (AGYW) in South Africa, a key population for HIV prevention [35-36].

Community PrEP delivery preference was also associated completion of secondary school education or higher adds to existing evidence on associations between education and reducing HIV transmission among AGYW in African countries, while emphasizing the continued need for targeted services to support PrEP use among PBFW of all education levels [37-38]. Women who report having a current sex partner also preferred clinic pick-up, compared to those without current sex partners. Shorter distance to the clinic was also associated with clinic pick-up preference, while higher cost of travel to clinic was associated with community PrEP delivery preferences, in line with a recent discrete choice experiment among pregnant women in Kenya [39].

Our study also highlights the varied experiences PBFW have with PrEP stigma, particularly as it relates to their desire for discreet medication pick-up in clinic or community settings. Community PrEP delivery preference was associated with experienced PrEP stigma, which highlights the potential role of community PrEP delivery in addressing existing stigma with accessing clinic-based HIV services [40]. Further, many participants chose community PrEP delivery to increase community knowledge regarding PrEP, indicating that community PrEP delivery may be a useful form of PrEP education to normalize PrEP use. However, some participants preferred clinic pick-up for increased privacy, reflecting a potential concern that community PrEP delivery may lead to less privacy or worsened PrEP stigma. Studies have explored the multidimensional roots of PrEP stigma and describe the importance of widespread PrEP integration into healthcare as a way of reducing PrEP stigma [41].

PrEP stigma may be further addressed by integrating discreet long-acting PrEP modalities (e.g., injectable cabotegravir and lenacapavir) into community PrEP delivery models [42]. The variety of experiences with PrEP stigma and its relationship with PrEP delivery preference in our study emphasize the importance of offering choice in PrEP delivery methods to PBFW.

Limitations

Our study surveyed PBFW returning for in-clinic PrEP follow-up, so our study findings may not be generalizable to PrEP-naïve PBFW or those already experiencing difficulty with clinic-based PrEP delivery. Our study findings also may not be generalizable to settings outside of South Africa and Kenya. PrEP DSD is not yet available at scale to PBFW in South Africa and Kenya, so responses may differ during actual implementation. In addition, our analysis relied on data from ongoing cohort studies that did not include additional variables on income, marital status, gestational age and weeks postpartum at time of survey completion, and partner's HIV status. However, given the lack of existing community PrEP delivery programs available to PBFW, these findings may vitally inform the development and implementation of community PrEP delivery strategies.

Conclusion

Our study demonstrates country-specific preferences in community PrEP delivery among Kenyan and South African PBFW, reinforcing the importance of context and choice in PrEP delivery. Additionally, we identified characteristics associated with community PrEP delivery preference among PBFW such as younger age, reporting PrEP stigma, completing secondary school education or higher, and reporting barriers to clinic travel. Community PrEP delivery models may benefit from considering these factors in implementation, in order to effectively mitigate barriers to PrEP access among PBFW in South Africa and Kenya.

Declarations

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Table 1: Participant characteristics among oral PrEP-experienced pregnant and breastfeeding women (PBFW) in South Africa and Kenya, September 2021 – February 2022 (N=394 participants)

	Overall N=394 (%)
Maternal age (years, median, IQR)	28 [24-32]
Country	
South Africa	190 (48.2)
Kenya	204 (51.8)
Pregnancy status	
Pregnant	105 (26.6)
Postpartum	289 (72.4)
Days on oral PrEP (median, IQR)	335 [168-420]
Last grade completed (n, %)	
Primary or some secondary school	264 (67.0)
Secondary school or higher	130 (33.0)
Currently employed, formally or informally (n, %)	
No	313 (79.4)
Yes	80 (20.3)
Prefer not to answer	1 (0.3)
Currently have at least one sexual partner (n, %)	
No	21 (5.3)
Yes	373 (94.7)
PrEP stigma ¹ (n, %)	
Endorsed 0 stigma statements	251/380 (66.1)
Endorsed ≥1 stigma statement	129/380 (33.9)
HIV Risk Perception ^b (n, %)	
No risk at all	121/380 (31.8)
Small chance	145/380 (38.2)
Moderate or great chance	112/380 (29.5)
Prefer not to answer	2/380 (0.5)
Current alcohol use (n, %)	
No	363/380 (95.5)
Yes ^c	17/380 (4.5)
Any PrEP use over past 30 days (n, %)	
No	100 (25.4)
Yes	294 (74.6)
Total travel time to clinic and return (minutes, median, IQR)	40 [30-60]
Cost to travel to clinic and return (USD, median, IQR)	1.32 [1.31 -1.74]

^aParticipants were asked to respond on a 5-point Likert scale from “Strongly Disagree” to “Strongly Agree” to 7 statements on potential stigma experienced regarding PrEP use (i.e. “I feel ashamed of

using PrEP,” “I feel embarrassed about using PrEP”). Items found in Supplemental Table 1, <http://links.lww.com/QAD/D859>.

^bParticipants were asked “How would you describe your chances of getting HIV in the next year?” with the option to select “No risk at all,” “Small chance,” “Moderate chance,” “Great chance,” or “Prefer not to answer.”

^cSynthesized categories: “Once a month or less, 2-4 times a month, 2-3 times a week, 4 or more times a week”

Table 2: Participant characteristics, stratified by community PrEP delivery preference, among oral PrEP-experienced PBFW (N=394 participants)

	Prefers community PrEP delivery n=163 (%)	Prefers clinic pick-up n=231 (%)	p-value
Maternal age (years, median, IQR)	27 [23-32]	29 [25-33]	0.018
Country			
South Africa	113 (69.3)	77 (33.3)	<0.001
Kenya	50 (30.7)	154 (66.7)	
Pregnancy status			
Pregnant	53 (32.5)	52 (22.5)	0.027
Postpartum	110 (67.5)	179 (77.5)	
Days on oral PrEP (median, IQR)	336 [168-420]	327 [178-420]	0.018
Last grade completed (n, %)			
Primary or some secondary school	91 (55.8)	173 (74.9)	<0.001
Secondary school or higher	72 (44.2)	58 (25.1)	
Currently employed, formally or informally (n, %)			
No	131 (80.4)	182 (78.7)	0.925
Yes	32 (19.6)	48 (20.8)	
Prefer not to answer	0 (0)	1 (0.4)	
Currently have at least one sexual partner (n, %)			
No	15 (9.2)	6 (2.6)	0.004
Yes	148 (90.8)	225 (97.4)	
PrEP stigma ^a (n, %)			
Endorsed 0 stigma statements	91/156 (58.3)	160/224 (71.4)	0.008
Endorsed ≥1 stigma statement	65/156 (41.7)	64/224 (28.6)	
HIV Risk Perception ^b (n, %)			
No risk at all	56/156 (35.9)	65/224 (29.0)	0.073
Small chance	65/156 (41.7)	80/224 (35.7)	

Moderate or great chance Prefer not to answer	35/156 (22.4) 0/156 (0)	77/224 (34.4) 2/224 (0.9)	
Current alcohol use (n, %)			
No	149/156 (95.5)	214/224 (95.5)	0.992
Yes ^c	7/156 (4.5)	10/224 (4.5)	
Any PrEP use over past 30 days (n, %)			
No	40 (24.5)	60 (26.0)	0.747
Yes	123 (75.5)	171 (74.0)	
Total travel time to clinic and return (minutes, median, IQR)	30 [20-50]	45 [30-60]	<0.001
Cost to travel to clinic and return (USD, median, IQR)	1.29 [1.29 -1.29]	1.29 [0.86 - 1.71]	<0.001

^aParticipants were asked to respond on a 5-point Likert scale from “Strongly Disagree” to “Strongly Agree” to 7 statements on potential stigma experienced regarding PrEP use (i.e. “I feel ashamed of using PrEP,” “I feel embarrassed about using PrEP”). Items found in Supplemental Table 1, <http://links.lww.com/QAD/D859>.

^bParticipants were asked “How would you describe your chances of getting HIV in the next year?” with the option to select “No risk at all,” “Small chance,” “Moderate chance,” “Great chance,” or “Prefer not to answer.”

^cSynthesized categories: “Once a month or less, 2-4 times a month, 2-3 times a week, 4 or more times a week”

Table 3: Preferences for community PrEP delivery versus clinic pick-up and reasons for preferences among oral PrEP-experienced PBFW (N=394)

PrEP Pick-up Preference	Overall N=394 (%)	South Africa n=190 (%)	Kenya n=204 (%)	p- value
Clinic PrEP pick-up	231 (58.6)	77 (40.5)	154 (75.5)	<0.001
Community PrEP delivery	163 (41.4)	113 (59.5)	50 (24.5)	
<i>For those who selected community PrEP delivery: Why would you be interested in accessing HIV prevention through community delivery?*</i>	<i>Overall n=163 (%)</i>	<i>South Africa n=113 (%)</i>	<i>Kenya n=50 (%)</i>	<i>p- value</i>
Convenience (e.g. close to home/work)	80 (49.1)	61 (54.0)	19 (38.0)	0.060
Lower cost of transport	78 (47.9)	58 (51.3)	20 (40.0)	0.182

Increase community awareness of PrEP	61 (37.4)	47 (41.6)	14 (28.0)	0.098
Less time spent seeking care	46 (28.2)	32 (28.3)	14 (28.0)	0.966
Less HIV/PrEP stigma	21 (12.9)	2 (1.8)	19 (38.0)	<0.001
More private	7 (4.3)	1 (0.9)	6 (12.0)	0.004
<i>For those who selected community PrEP delivery: If you could access your HIV prevention product(s) through community delivery, where would you access it?*</i>	<i>Overall n=163 (%)</i>	<i>South Africa n=113 (%)</i>	<i>Kenya n=50 (%)</i>	<i>p- value</i>
Home delivery	117 (71.8)	82 (72.6)	35 (70.0)	0.737
Community hall	80 (49.1)	61 (54.0)	19 (38.0)	0.060
Retail pharmacy	43 (26.4)	30 (26.5)	13 (26.0)	0.941
Supermarket/shops	25 (15.3)	23 (20.4)	2 (4.0)	0.999
Church	23 (14.1)	20 (17.7)	3 (6.0)	0.991
Taxi rank	12 (7.4)	11 (9.7)	1 (2.0)	0.99
Garage	11 (6.7)	10 (8.8)	1 (2.0)	0.985
Other (e.g., schools, library)	6 (3.7)	5 (4.4)	1 (2.0)	0.894
<i>For those who selected “clinic delivery” or “unsure”: Why do you prefer clinic delivery?*</i>	<i>Overall n=231 (%)</i>	<i>South Africa n=77 (%)</i>	<i>Kenya n=154 (%)</i>	<i>p-value</i>
Clinic is more private	174 (75.3)	58 (75.3)	116 (75.3)	1
Want to see healthcare provider	83 (35.9)	19 (24.7)	64 (41.6)	0.012
Stigma of delivery in the community	20 (8.7)	18 (23.4)	2 (1.3)	<0.001
Less convenient (e.g. clinic is closer to home/work)	13 (5.6)	7 (9.1)	6 (3.9)	0.106
More overall time spent seeking care	12 (5.2)	4 (5.2)	8 (5.2)	0.634
I pick up other medications at the facility	9 (3.9)	0 (0)	9 (5.8)	0.024
Mistrust of community delivery	8 (3.5)	2 (2.6)	6 (3.9)	0.466
Higher cost of HIV prevention product	4 (1.7)	0 (0)	4 (2.6)	0.195
Higher cost of transport to get to community pickup as well as clinic	2 (0.9)	1 (1.3)	1 (0.6)	0.890
Other (e.g. adequate supply in clinic)	1 (0.4)	0 (0)	1 (0.6)	0.667

* More than one response was allowed

Table 4: Factors associated with preference for community PrEP delivery versus clinic pick-up among PBFW with experience taking oral PrEP in South Africa and Kenya (N=394)

	Unadjusted OR (95% CI)	p-value	Adjusted OR* (95% CI)	p- value
Maternal age** (years)	0.60 (0.44, 0.82)	0.001	0.82 (0.58, 1.19)	0.26
Country South Africa Kenya	4.52 (2.94, 6.95)	<0.001	4.07 (2.32, 7.14)	<0.001
Pregnancy status Postpartum Pregnant	1.66 (1.06, 2.60)	0.028	1.23 (0.71, 2.11)	0.33
Days on oral PrEP	1.00 (1.00, 1.00)	0.555	--	--
Last grade completed Secondary school or higher Primary or some secondary school	2.36 (1.54, 3.62)	<0.001	1.82 (1.12, 2.97)	0.017
Currently employed (formally or informally) Yes No	0.93 (0.56, 1.53)	0.764	--	--
Currently have at least one sexual partner Yes No	0.26 (0.10, 0.69)	0.007	0.27 (0.09, 0.83)	0.023
PrEP stigma ¹ Endorsed ≥1 stigma statement Endorsed 0 stigma statements	1.79 (1.16, 2.75)	0.008	2.66 (1.60, 4.41)	<0.001
HIV Risk Perception ² No risk at all Small chance Moderate or great chance	<i>ref</i> 0.94 (0.58, 1.53) 0.58 (0.31, 0.90)	- 0.813 0.019	<i>ref</i> 1.49 (0.83, 2.67) 0.98 (0.52, 1.85)	0.18 0.96
Current alcohol use Yes No ¹	1.01 (0.37, 2.70)	0.992	--	--
PrEP adherence over past 30 days Yes No	1.08 (0.68, 1.71)	0.747	--	--

Total travel time to clinic and return (minutes)	0.98 (0.97, 0.99)	<0.001	0.99 (0.98, 1.00)	0.098
Cost to travel to clinic and return (USD)	1.05 (0.86, 1.28)	0.663	--	--

**Per 10-year increase

Bold $p < 0.05$

Participants were asked to respond on a 5-point Likert scale from “Strongly Disagree” to “Strongly Agree” to 7 statements on potential stigma experienced regarding PrEP use (i.e. “I feel ashamed of using PrEP,” “I feel embarrassed about using PrEP”). Items found in Supplemental Table 1, <http://links.lww.com/QAD/D859>.

Participants were asked “How would you describe your chances of getting HIV in the next year?” with the option to select “No risk at all,” “Small chance,” “Moderate chance,” “Great chance,” or “Prefer not to answer.”