

MPT Acceptability in Uganda, Nigeria and South Africa

Live Webinar -12 November 2014

Participant Questions with Answers

Q1. Are there plans to expand the market research study on MPTs to other African countries like Kenya?

We believe that this work showed how important it is to conduct similar work in other countries: the situation for women in South Africa is quite different to those in Uganda and Nigeria (and vice versa) – women in Africa (and the world) do not lead the same lives and have different and dynamic influencing factors around them which, need to be understood in order to make sure that product introduction is done in the right way, using the right platforms. Kenya would be a great country to do this work, considering its different epidemiology, society, healthcare system and high prevalence of HIV/AIDs.

Q2. What are the reasons why more women are getting tested in Uganda and South Africa than my country, Nigeria? How can this attitude be improved on? Which cities were chosen for the research in Nigeria?

Important reasons from this work that may explain why women in Nigeria are not getting tested as much as their counterparts in Uganda and South Africa are that:

- 1) There is a lower level of awareness around the importance of testing
- 2) Interaction with the healthcare professionals is more limited in Nigeria – fewer women are using contraceptives which require healthcare administration and fewer women are seeking advice about contraceptives and HIV from healthcare professionals compared to women in South Africa and Uganda
- 3) There is a sense of denial/fate with regard to acquiring HIV – mainly from the qualitative phase ... in the sense that women either didn't think they could get it, or that it was not in their hands
- 4) There is also somewhat of a stigma with regards to testing – even being seen to be getting a test, some may assume the woman has HIV
- 5) Trust in healthcare facilities seems low – some women do not believe they would get correct results

Some ways of improving this situation include:

- 1) Education – creating platforms for community members to learn and inform each other on the importance of testing & efforts to reduce stigma of testing
 - May require outreach programmes
 - School programmes
- 2) Opening up a wider discourse on HIV in civil society
- 3) Increase availability of access of testing – illustrating also reliability of testing process to population
- 4) Improve perception of healthcare facilities via strengthening of their services

Q3. Can you speak to the relative importance of the attributes of contraceptive vs. HIV prevention?

Overall, the combining of both HIV and Pregnancy prevention was overwhelmingly demanded by the vast majority of women. However, with regard to relative importance, the contraceptive attributes of the implant (5 years duration) create a high level of interest from women. In essence, the longer the duration, the more appealing (except for those women who would prefer an on-demand option). Other attributes such as administration, storage and so on was shared by both the HIV and contraceptive parts of the MPT – so acceptability of these was the same. Where the MPTs differed was side effects and duration (only for the Implant), however what we learnt was that with regard to the side effects two in particular (one from contraceptive and the other from anti-viral drug) were equally unacceptable.

Q4. Why is it that there is no full acceptance of any one MPT even though there is great demand and acceptability of the products?

There is universal acceptance of the concept of an MPT, however when we showed the 4 profiles it is clear that there needs to be options as no one profile was demanded universally. It shows that women need options – as not one profile does not fit all women's lifestyles/stages.

Q5. Did suppliers assume that ring would need cold chain storage, like the contraceptive ring?

We described the rings (and the film) as needing to be stored at room temperature. They shouldn't be kept in the sun but don't need to be in a refrigerator either: minimal temperature of 15°C to maximum temperature of 30°C.

Q6. Was there any feedback / comments on women regarding the additional cost of HIV testing?

There was no feedback on this actually – only that for some women being tested every 3 months was laborious and that some women assumed that they would receive the test for free (in particular women in South Africa).

Q7. Was there any discussion about other STIs?

In the qualitative phase STIs did come up, where some women asked if the MPT could protect against STIs, if it did, many women felt it would be even more appealing. When we discussed STIs, many women had never had an STI. Furthermore, many women felt that it is easier to deal with an STI and could get medication. Importantly, women were most aware of: gonorrhoea, syphilis, and candida. Overall, awareness was quite low for STIs – in particular more detailed understanding other than: they existed, some names of STIs and how generally you acquire them.

Q8. With regard to current practice what did you learn about women’s beliefs with regard to protection against pregnancy and avoiding HIV infection through current practice? Correlated? Impact on choice of protection?

We measured satisfaction and recommendation of current methods can speak about their beliefs regarding protection – our findings are below:

For contraceptives:

- Women are satisfied with the contraceptive they are using. Generally, if women are satisfied, they will recommend.
- However, there are some methods which are recommended less: The injection, withdrawal, OCPs and abstinence.
- Fewer women in Uganda are satisfied with the timing method and ECPs which affects recommendation.
- Fewer women in Nigeria are satisfied with withdrawal (one of their main methods)

Top 2 Box %	South Africa		Uganda		Nigeria	
	Satisfied	Recommend	Satisfied	Recommend	Satisfied	Recommend
Fully & somewhat satisfied						
Male condoms	94% (n=335)	94% (n=332)	87% (n=146)	86% (n=144)	94% (n=298)	95% (n=301)
Contraceptive injection	96% (n=241)	94% (n=236)	90% (n=154)	79% (n=136)		
OCPs	90% (n=52)	78% (n=45)	83% (n=40)	73% (n=35)	84% (n=26)	84% (n=26)
Withdrawal			83% (n=52)	57% (n=36)	77% (n=74)	70% (n=67)
Timing/ Safe Days/Calendar			76% (n=28)		91% (n=61)	93% (n=62)
ECPs					88% (n=58)	85% (n=56)
Abstinence			83% (n=49)	75% (n=44)		
Contraceptive implant			85% (n=40)	85% (n=40)		

● High level ● Medium level ● Low level

For HIV: Women are satisfied with the contraceptive they are using. Generally, if women are satisfied will recommend their method to a friend

Top 2 Box % Fully & somewhat	South Africa		Uganda		Nigeria	
	Satisfied	Recommend	Satisfied	Recommend	Satisfied	Recommend
Male Condoms	94% (n=387)	94% (n=386)	89% (n=203)	88% (n=201)	96% (n=308)	96% (n=309)
Female condom			85% (n=29)	91% (n=31)		
Abstinence	87% (n=26)	93% (n=28)	92% (n=88)	88% (n=84)	97% (n=33)	97% (n=33)
Faithfulness/ Monogamy	97% (n=93)	98% (n=94)	97% (n=299)	94% (n=291)	90% (n=178)	90% (n=179)
Male circumcision	88% (n=29)	94% (n=31)				

Note: only methods with n≥20 are included

Another part of this story is the findings we shared on risk perception – there is a proportion of women who believe they are at some degree of risk. Furthermore, with the high level of inconsistent condom use women are at risk. What is more, many women are practicing faithfulness as a method of protection against HIV (in particular Uganda) alongside a very low level of trust for the partner's faithfulness. We believe this could impact choice of product (especially taking into account what they are currently using).

Q9. Do you think the low demand for IVR can be overcome by education to increase familiarity?

We found that women's understanding of their own bodies definitely impacted their ability to understand how to use the IVR. However, the best way to find out how to increase familiarity would be to engage and talk to women themselves to truly understand what is needed to improve their familiarity with the way the IVR works.

What they see are the needs for information [what are the misconceptions, barriers, details needed], and how this information would be disseminated and presented to them. Commercial executives are doing this already – finding out what women know, what they think about their products and how they would use them, and from this knowledge then establishing educational campaigns to remove misconceptions on the product itself and how it should be used via community-led education campaigns and interventions. They are having some success with this approach which means education is a critical part of improving acceptability and proper use.

Q10. How by using sales to the more affluent group of people would help the less affluent?

This would be a very interesting solution to offer women in less affluent groups' options. We learnt that women in higher socio-economic groups both were more aware and paid for their contraceptives. These were women who were more likely to understand how to use more modern forms of contraceptive as well as feminine products such as the tampon, and therefore would be an important group to initiate use. Their purchasing could offset somewhat cost for women who couldn't afford the product [not taking into account the large educational campaign that would be needed for women in less affluent groups].

Q11. I did not see sterilization as an option- is it used?

Women were allowed to be aware of sterilization as an option of pregnancy prevention, however they were screened out of the study because we wanted to discuss the MPTs with women who may need to use them, therefore they had to be able to become pregnant. From DHS data in South Africa (2008) sterilization made up 14.4% of women's contraceptive method. With regard to Uganda and Nigeria – it was not a main method of contraceptive method

Q12. Public Health education in these countries. How does a village woman get information if she doesn't trust what she is hearing from a partner or family, or can't ask?

Precisely, we would therefore need to know who she trusts and how to implement a solution getting those people she can trust to talk to her.