

Applying Lessons from Family Planning to HIV Prevention Product Introduction

Learnings from family planning service delivery and products to inform introduction of existing and pipeline HIV prevention products

October 2018

HIV Prevention
Market Manager

Accelerating Product Introduction
Informing Product Development
Reducing Time to Impact



Supported by the Bill & Melinda Gates Foundation

Applying Lessons from Family Planning to HIV Prevention Product Introduction

The icon consists of the letters 'FP' in a bold, black, sans-serif font, centered within a light blue circular background.

FP

Executive Summary



Lessons from existing oral PrEP and family planning integration projects & pilots



Family planning product attribute analysis



Family planning use trends among AGYW across East and Southern Africa

FP Executive Summary



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Family planning product attribute analysis



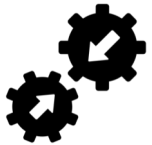
Family planning use trends among AGYW across East and Southern Africa

PMM conducted an initial analysis of family planning services in East and Southern Africa for Adolescent Girls & Young Women (AGYW), age 15-30

Objective

Use lessons and data from family planning to better inform HIV prevention product introduction and integration of HIV prevention into family planning settings

Scope



Oral PrEP & family planning integration lessons

Qualitative analysis of 4 pilots/projects across 12 sites currently providing PrEP alongside family planning products



Family planning product attribute analysis

Literature review of consumer and provider preferences for family planning products



FP use among AGYW across East and Southern Africa

Quantitative analysis of available data on family planning need and usage



Top Insights—Oral PrEP & family planning integration



PROVIDER INSIGHTS

The interest of FP providers in incorporating oral PrEP into the family planning services they provide is critical to getting PrEP uptake in family planning settings. Training/re-training, identifying ways to minimize additional workload and reporting, and identifying one provider at each clinic who acts as a mentor to other providers all play a role.



MESSAGING INSIGHTS

Providers can use explanations from contraceptives, which AGYW are familiar with, to explain PrEP. For example, relating the initial side effects of PrEP to initial contraceptive side effects, which many AGYW have experienced. *NOTE: PMM also uncovered insight on FP messaging from the South Africa research that will be combined with this analysis.*



CONSUMER INSIGHTS

AGYW often attribute *all* side effects to oral PrEP when taking both PrEP and contraceptives and/or STI treatments. Even when the side effects are known to be those of contraceptives or STI treatment, AGYW tended to attribute them to PrEP. Additionally, adolescents have been negotiating “seasons of use” for contraception for a long time—something we will likely see with HIV prevention as well.



INTEGRATION INSIGHTS

Pairing oral PrEP and contraceptive visits improves continuation. Seeing the same provider at each visit and getting on a schedule with oral PrEP that matches the contraceptive schedule were identified as ways to increase continuation.

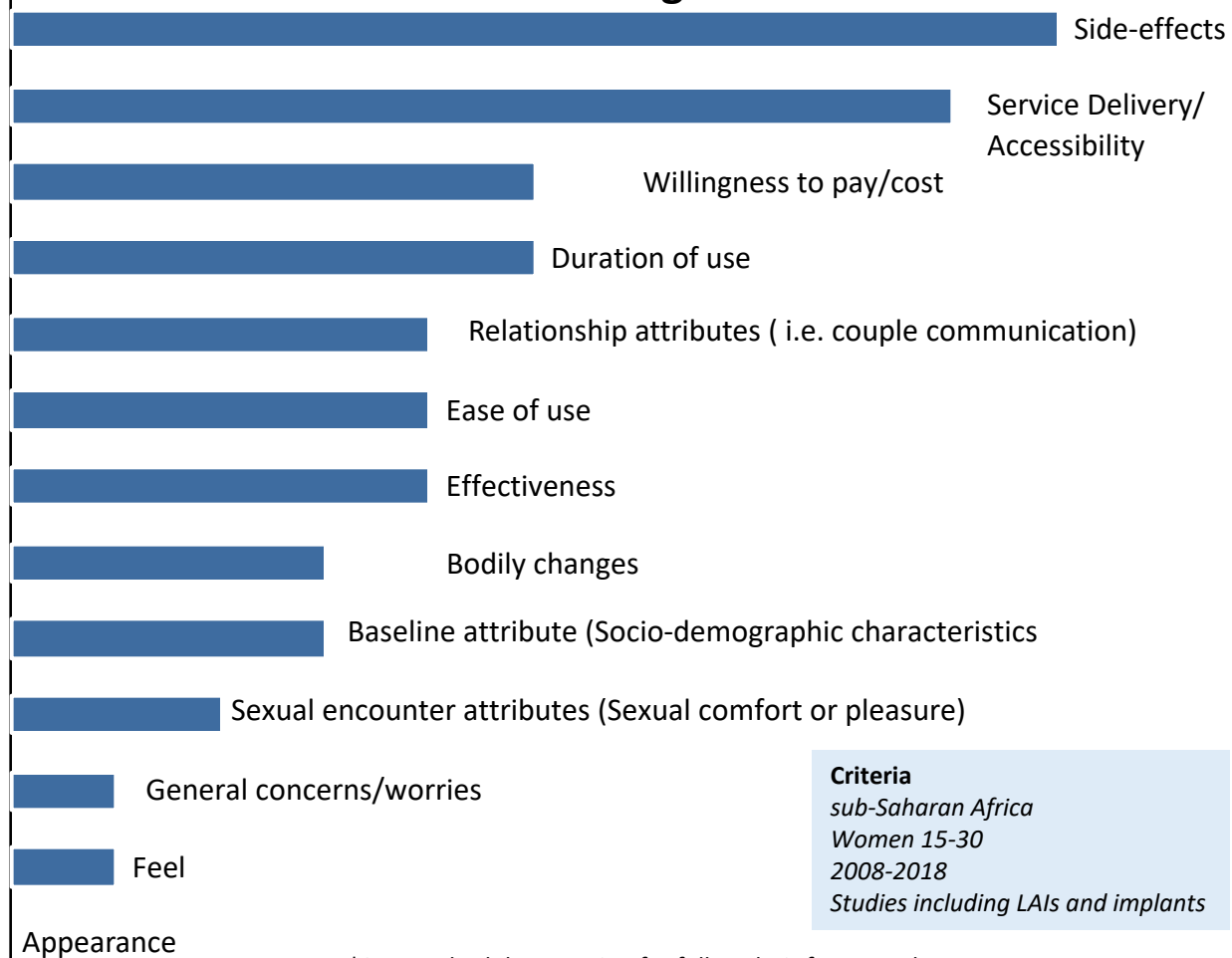


Top Insights—Family planning product attribute analysis

Literature review of consumer and provider family planning preferences helped to identify which family product attributes are most important. As with initial oral PrEP research, side effects were identified as a major concern impacting uptake and continued use.

- **Side effects** were the most frequently referenced attribute by both consumers and providers across products for not taking up a product and discontinuing use
- **Cost/willingness to pay** came up often as a consumer and provider concern for LARCs
- The ability to **discontinue a method without having to see a provider** was frequently referenced by consumers
- **Privacy** also surfaced frequently as a concern among consumers
- **Inadequately trained healthcare workers** to implement LARC methods or lack of the appropriate facilities to implement LARCs was referenced by consumers and providers
- **Service delivery** issues, rather than attributes related directly to the products, came up frequently as factors affecting uptake and continued use (i.e., staffing levels and lack of facilities needed to implement methods)

Most Common Attribute Ranking



Criteria
 sub-Saharan Africa
 Women 15-30
 2008-2018
 Studies including LAIs and implants

*See methodology section for full analysis framework

Top Insights—Existing FP use among AGYW Across East and Southern Africa



While there is momentum around integration of oral PrEP into existing FP services in order to reach AGYW, we analyzed current uptake and unmet need of FP among this cohort to understand opportunities and challenges

Unmet need for FP among AGYW, who are also at risk of HIV

Self-reported unmet demand for FP among unmarried, sexually active AGYW is significant. It is markedly higher among women ages 15-19 than 20-24. Thus, **specialized outreach for both PrEP and contraception methods are needed for AGYW, particularly women aged 15-19**. The integration of FP and HIV Px services may only be a starting point for increasing use of both.

Product Preference

Contraception product use mix varies across countries and age groups. **Among unmarried, sexuality active AGYW LARCs are relatively low usage**. It is unclear whether LARC usage is low due to lack of access or preference for other modern contraceptives. Among sexually active AGYW who do use LARCs the implant and injectable are the most popular. These preferences should be taken into account when and if we are planning roll out for CAB-LA and implantable.

Service Delivery Points

FP users tend to go to public facilities. However, for non-LARC methods, private facilities and dispensaries/pharmacies play a larger role, which can often provide additional confidentiality and/or anonymity for young women. **Generally, the higher the cost of the contraception the more likely it is being accessed at a public facility.**

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Methodology—Oral PrEP & FP Integration Lessons

A qualitative analysis of family planning projects and programs currently providing oral PrEP was conducted. Semi-structured, in-depth interviews were conducted with projects and programs in Kenya, South Africa, Eswatini and Zimbabwe. The 12 sites in these countries are a mix of public and private, urban and rural, dedicated family planning facilities and general youth-friendly service delivery settings. Insights are drawn entirely from qualitative interviews with ongoing projects that had not yet published, but provided early findings to PMM in advance of data availability.

LINKAGES, through FHI, is implementing oral PrEP for women at two family planning sites in Eswatini, and expanding to five sites. Oral PrEP is being provided to women 18+ with a target enrollment of 1,300 across all family planning sites.

CHAI conducted a study to oral PrEP at two learning sites in Zimbabwe. One facility was in Harare—a larger facility, with a strong family planning focus, that also provides HIV testing and VMMC. The other facility was in Chimanimani, a rural area in Eastern Zimbabwe that provides family planning, HIV testing and social activities. The total target enrollment was 538.

POWER is delivering oral PrEP at family planning facilities and in clinics with family planning services for AGYW 16-25 in Kenya and South Africa, with a target enrollment of up to 3,000 AGYW. In Cape Town, they are providing PrEP from a mobile clinic, integrated with family planning and testing that serves AGYW 16-25. In Johannesburg, the clinic is a DoH-supported, adolescent, youth-friendly facility. In Kisumu, there are two sites at family planning clinics—a private clinic and a public clinic within a government hospital.

DREAMS sites in Kiambu, Homa Bay, Migori and Nairobi, implemented by LVCT, are delivering oral PrEP with a package of services, including family planning, to AGYW 18+.

1. What is working/not working to integrate oral PrEP at a family planning site and with family planning services?



PROVIDER INSIGHTS

Provider training/re-training is key to patient buy-in. LINKAGES saw a marked increase in patients interested in oral PrEP coming from the family planning unit after they conducted a training with nurses. After one nurse took the training and became a PrEP champion, other nurses at the LINKAGES sites asked their matrons if they could also take the training. There are not unlimited spots in the trainings, so LINKAGES had to open up more spots.

Nurse mentors/champions are key to the buy-in of other nurses. During start up/rolling out phase of LINKAGES, they trained nurses to be “nurse mentors,” one at each clinic. Each clinic identifies an oral PrEP focal person—those who are initially trained—those clinicians have a WhatsApp group, and other physicians are paired with nurse mentors at each site. Providers WhatsApp their questions or ask the nurse mentor. They also have access to an MoH point person.

Provider feedback sessions/provider-driven solutions can ameliorate challenges. LINKAGES conducts monthly feedback sessions with staff. The POWER site staff have one-on-one conversations with nurses to get them to think outside of the box with oral PrEP and come up with solutions to common challenges. For example, POWER had issues with provider stigma at their sites, and held discussions with providers to get their views on how to work through stigma issues with their colleagues.

Understand the motivations of site staff when adding a new service/option. LINKAGES presents the study as an MoH study, not an FHI study, and this motivates the staff to want to participate in providing oral PrEP.

Age of provider matters. POWER is finding older nurses are more judgmental, they feel they should not be promoting PrEP which they equate with promiscuity. Older nurses were discouraging young women from using oral PrEP, so they had a meeting and explained that the risk that the AGYW population has right now is the same that the nurses had at that age.

The interest of the nurse [in PrEP] is so important—if she buys in [to providing PrEP], she'll sell it.

LINKAGES

1. What is working/not working to integrate oral PrEP at a family planning site and with family planning services?



CONSUMER INSIGHTS

Family planning as a point of entry for oral PrEP. Thus far, the main point of entry for oral PrEP for AGYW in Eswatini is family planning, followed by HTS. LINKAGES sites are also seeing a higher level of retention at month one with AGYW in serodiscordant relationships (57%).

Acceptability differs by family planning product type. POWER is finding that the contraceptive injection is more acceptable than oral contraceptives—AGYW are more tolerant of the side effects from the injection than the pill. *Although they might have prevention seeking behaviors, they don't have pill taking behaviors.*

Attributing all side effects to oral PrEP. POWER found that even though some of the side effects AGYW are experiencing are known to be due to contraceptives or STI treatments clients may be on, all side effects they experience AGYW often attribute to oral PrEP. Thus, they are more likely to discontinue oral PrEP than contraceptives or STI treatments. POWER theorizes this is because oral PrEP is new, and there is much discussion in the community of the side effects of PrEP.

Forethought about decision to go on oral PrEP. One early finding from LINKAGES is that the AGYW at their sites have a lot of forethought about why they want to go on PrEP (i.e., “my boyfriend is going away and I don't know what's going to happen when he's gone; I want to break up with my boyfriend so I want to go on PrEP”).

AGYW want to pair family planning and oral PrEP visits. Patients in POWER want to pair their visits and get refills for both contraceptives and oral PrEP at the same time.

AGYW are asking if there's one injection they can get for both HIV and pregnancy prevention. Several projects said that AGYW had asked if there is one injection they can get for both HIV and pregnancy prevention.

1b. What does oral PrEP provision in a family planning clinic look like (i.e., who/how counsels, refers, prescribes, refills)?



INTEGRATION INSIGHTS

Where a patient is counselled and prescribed oral PrEP differs by setting type (mobile, private, public, etc.). In CHAI's Zimbabwe clinics, nurses can prescribe oral PrEP in the same room where they provide IEC materials and testing. If a client is eligible for oral PrEP, she can be initiated and PrEP is dispensed in this room. POWER has several different clinic flows depending on the clinic type. At the mobile site in Cape Town, counsellors introduce oral PrEP and family planning and a nurse prescribes both oral PrEP and family planning at the same time. However, in POWER's private clinic in Kisumu, they are referred for oral PrEP from HIV testing services (HTS), then see a nurse who prescribes, and then get PrEP at a pharmacy on site. In the public facility in Kisumu, the-client comes directly to the clinic for family planning, where she sees a family planning nurse who talks about oral PrEP, prescribes it and issues it in the same room. LVCT in Kenya has "master safe spaces" where an AGYW can get all services.

All sites are different in terms of who can prescribe oral PrEP, and there are challenges when prescribers are limited to only a few. LINKAGES in Eswatini does not train all providers at their sites to initiate on PrEP; they train all providers to assess eligibility. If the initiation trained nurse is on vacation, it means the site cannot initiate anyone at the clinic on oral PrEP that day. CHAI in Zimbabwe trained all providers to assess risk and prescribe in both learning clinics. In South Africa, most nurses are trained on prescribing family planning, but have not gone through the more intensive training to prescribe oral PrEP.

Seeing the same provider at each visit for refills and pairing oral PrEP and family planning refill visits. In POWER, AGYW see the same provider for both family planning and oral PrEP refills. Many AGYW in POWER want to pair their family planning and oral PrEP visits. While at LVCT's DREAMS "master safe spaces" an AGYW might see a different counsellor each time, most see the same service provider when they come back to ensure continuation to the extent possible. Some DREAMS clinicians are also trained as counsellors.

Integrating oral PrEP into the workload of all providers at a site. POWER is trying *not* to have a dedicated "PrEP nurse" at the sites, where all tasks related to PrEP shift to one nurse in a clinic, and instead to fully integrate PrEP into their workload.

At some sites, the providers can work with patients to time refill visits of oral PrEP and contraceptives together. At some POWER sites, nurses have no set schedule of monitoring and can work with the patient to better match their refill timing. This makes it easier for the nurse to personalize care to the patient.

1b. How are sites incorporating oral PrEP messaging with family planning messaging around uptake and adherence?



MESSAGING INSIGHTS

Presenting oral PrEP in the context of a combination of options. At the CHAI learning sites in Zimbabwe, providers at sites are comfortable delivering a combination of options for family planning, so they are comfortable incorporating another option and discussing the pros/cons of each option with patients. They apply the same approach they use to go through family planning options to the package of prevention options and oral PrEP. POWER is integrating oral PrEP and family planning messaging in both sites in Kisumu (public and private), and find it a lot easier to get the AGYW to come back when integrating messaging. If incorrect messaging is being used, POWER has the nurses come together to discuss the issues and find collective solutions.

Messaging oral PrEP for women the same way VMMC is messaged for men. For women seeking family planning products, oral PrEP is messaged as an additional tool. While there are clearly big differences with each option, this is similar to how VMMC and oral PrEP are counseled in a package offered to men. This messaging is also used to train providers on how to incorporate another option into the package they offer.

Most sites not training providers specifically in integrated messaging, relying on providers to understand how to integrate. POWER is not using any formal training in terms of messaging, the nurses at their sites are very experienced.

Negotiating seasons of risk (of pregnancy) with contraceptives. Some AGYW have already been negotiating intermittent use of contraceptives for a long time. With girls in varsity setting, they go home to rural settings and go off contraceptives, but return to school and go back on family planning. POWER found that a successful messaging strategy is explaining that oral PrEP, like contraceptives, is not something that you have to take forever, but is connected to risk.

Relate oral PrEP back to family planning. POWER uses the messaging around family planning and how to use that as a way to explain PrEP to a young woman – often they relate it back to family planning methods. For example, explaining that it is not like emergency contraception. For side effects, providers will explain that just like contraceptives, when you use PrEP your body is still not used to the new drug so you may have 1-2 weeks of side effects when you first start using it. Most AGYW have gone through contraceptive side effects, so relate to this explanation.

FP

Executive Summary



Lessons from existing oral PrEP and family planning integration pilots



Family planning product attribute analysis



Family planning use trends among AGYW across East and Southern Africa



Methodology—Family Planning Product Attribute Analysis

Review of existing literature on family planning product consumer and provider preferences, including injectables and implants, was conducted. Categorization of product attributes along a theoretical framework from Kestelyn et al. (adapted from Van der Straten et al.) was used for analysis.

CRITERIA

Geography | sub-Saharan Africa

Population | AGYW 15-24

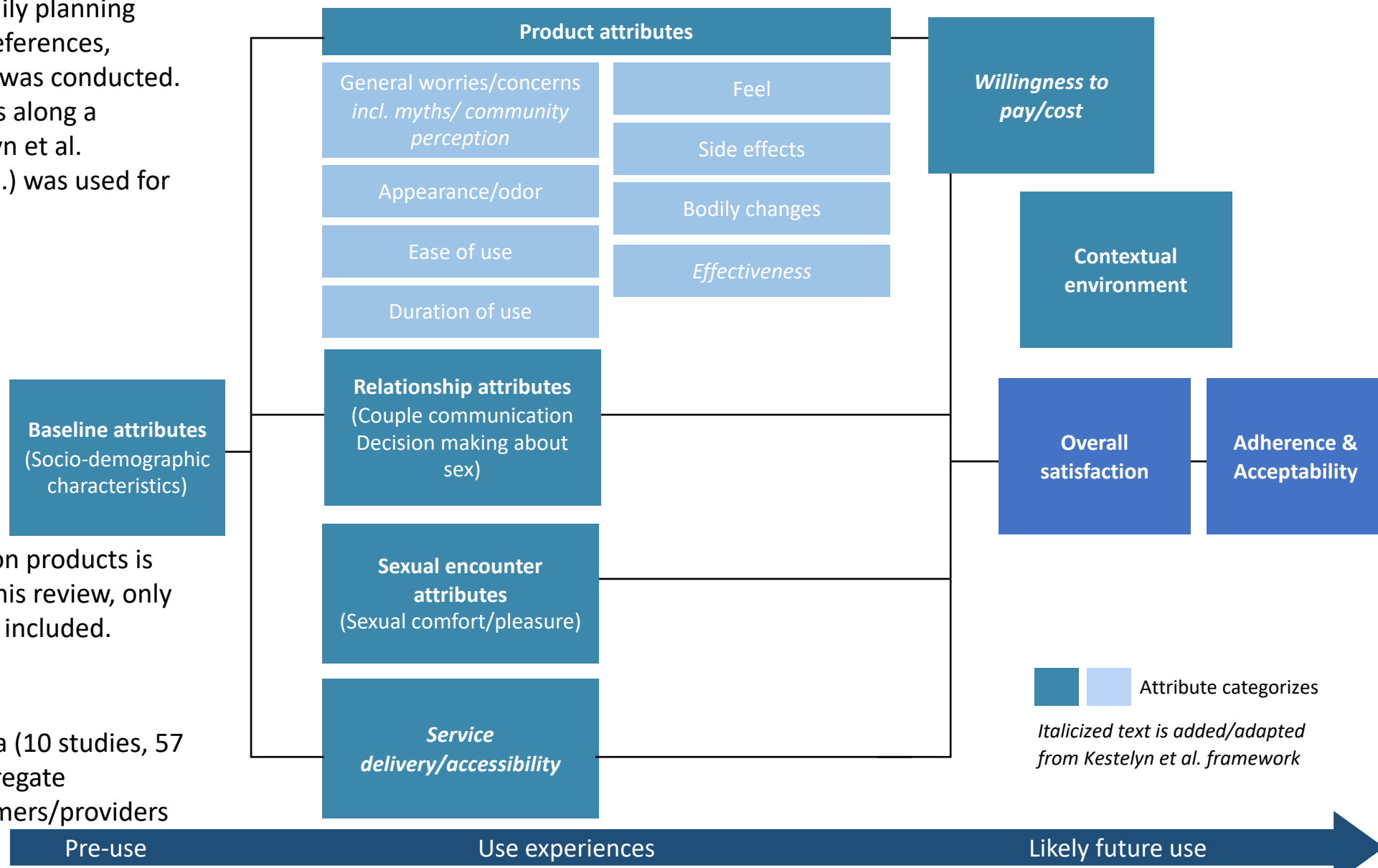
Date range | 2008-2018

EXCLUSION CRITERIA

Literature focused on HIV prevention products is not included. For the purposes of this review, only existing contraceptive products are included.

LIMITATIONS

Limited studies meeting this criteria (10 studies, 57 factors categorized), and often aggregate preference data across both consumers/providers and across LARC methods.





PROVIDER VIEWS

- Providers lacked confidence in providing FP implant services effectively, particularly **removals**, which they ascribed to the inadequate training received.
- Providers also received limited training on how to **counsel** women about the method
- Providers held negative views towards the method **due to side effects**. Noted the need for clear/standardized guidelines on how to deal with side-effects and training on how to counsel women through side effects
- Providers said **inadequate training** directly affected the quality of the services they provided
- Providers also preferred sticking to a **known method** (pill/injection)

I have been threatened many times by clients because they want to get it removed immediately and we have had cases where clients are removing it themselves because of side-effects, especially bleeding

Provider in South Africa

Key Country Context

Despite these challenges, there has been rapid uptake of FP implants in LMIC markets among AGYW.

However, in 2014 following initial high uptake in South Africa when the government rolled out Implanon (long-acting subdermal contraceptive implant), use declined considerably amid reports of early removals and frequent side-effects. This has not necessarily been the case in other settings, for example in Zimbabwe, where the majority of AGYW on LARCs are using implants.



CONSUMER VIEWS

- Few women said they received **counseling on implant effectiveness or side-effects** before insertion. Only about half of all users/removers reported having received information on side effects at the time of insertion.
- Almost all discontinuers identified **side-effects as the primary reason for stopping use**, particularly bleeding and headaches.
- **Convenience (duration/lack of need for daily adherence/reduction in clinic visits)** was cited as the motive for uptake more in those who ended up discontinuing use. Women who identified **contraceptive effectiveness** as the primary motive for use were more likely to continue. However, little information was given to women on the implant's effectiveness, and some were concerned about the efficacy.
- Some users also identified **not being satisfied with other methods** due to their side effects (long-acting injectable, the pill) as the reason for use.
- **Myths/rumors** were reported that exaggerate the frequency and severity of side-effects. Rumors/myths contributed to some removals, while **positive attitudes of partners, family and friends** towards the implant affected uptake and continued use.
- Many women said the implant affected their **sexual relationships**, mostly due to prolonged bleeding. Some women also reported that the implant negatively affected their libido and caused vaginal dryness.

'I don't have to worry about coming to the clinic to collect pills,' and 'I don't have to stress about being in long queues waiting to get prevention pills, so I only come once and be stress-free for 3 years.'

Implanon User, South Africa

[The] perception is that most, or the large majority of women experience side-effects, even women who had not had any side-effects had the perception that most women had them.

South Africa Implanon study



PROVIDER VIEWS

- Providers had strong preferences for an injectable delivered in 1 injection, prepackaged, could be disposed of after one use and associated these attributes with less pain for injectable users, higher safety & efficacy
- Providers held **misconceptions** about menstrual side effects & fertility of injectables, additionally, some providers conflated the long contraceptive tail with an extended period of effectiveness
- Appreciated the **potential for a lighter workload** due to fewer follow-up visits for an injectable, but concerned that fewer visits would decrease their ability to help women **manage side effects**
- Some providers allow women the full **grace period** in which to return for reinjection, other providers intentionally advise women that the grace period is much shorter than what it really is or do not mention a grace period at all to try to ensure that women return on time
- There is variation in provider views on **who should receive** which contraceptive method by country, for example far more South African providers considered the FP injectable appropriate for women at high-risk of HIV and HIV positive women than clinicians in Zimbabwe
- Providers (and consumers), especially in Kenya, preferred a method with a **predictable return to fertility**

Country context

In eastern and southern Africa, injectables are the most commonly used contraceptive method.

Increases in total contraceptive use have followed increases in injectable use. The injectable has not only substituted for the use of pre-existing methods, but studies show it has also given a net increase to total use.



CONSUMER VIEWS

- **Women are less concerned about family planning injectable side effects than providers.** Some women in one study in Kenya and Rwanda suggested that side effects were related less to the product than to their own body chemistry, and that side effects were acceptable as long as they did not last a long time or disrupt daily activities.
- **Long-term side effects** of LAIs were mentioned by women in Uganda, especially a return to fertility. Women in Kenya preferred a method with a **predictable return to fertility**.
- Many Kenyan, but few Rwandan, participants appeared **willing to pay for an LAI**, with some assuming cost savings from reduced menstruation and less frequent clinic visits.
- Women had a higher likelihood of using an LAI rather than the pill if there were **more community health workers** in an area and more facility nurses who had received HIV **training**.

Most people use Depo-Provera because it is readily available and it is also more private. Most mothers tell us that they are hiding from their spouses, since they do not want them to use any family planning methods.

Uganda, Provider

Even the injections cause loss of periods while you are using them; I am afraid that if I use a long-term method like the Implant, I might never bleed again.

Uganda, Consumer

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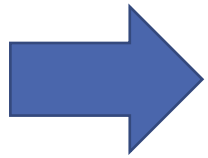
DHS Data: Background and Limitations

- Data in this presentation was extracted from the **DHS STATcompiler** funded by USAID, which allows users to make custom tables based on thousands of demographic and health indicators
- The relative year and data source per country is shown on the table below. Due to the outdated data from **Botswana and South Africa** (from 1988 and 1998 respectively), they **were left out of the current analysis** (we will look for alternative data for SA)
- STATcompiler and FP 2020 are both sponsored by USAID. **The DHS and AIS surveys inform FP2020 stats**, though they are **not the only source**. *For overview on FP2020 stats, see appendix.*

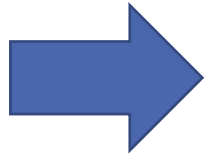
Country	Survey
Botswana	●
Kenya	●
Lesotho	●
Malawi	●
Mozambique	●
Namibia	●
South Africa	●
Swaziland	●
Tanzania	●
Uganda	●
Zambia	●
Zimbabwe	●

Legend	
●	2014 or later
●	2005-2013
●	2004 or earlier

DHS data on family planning need and usage are based on self-reported responses to household surveys



Demographic and Health Surveys (DHS) are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition that utilize questionnaires, biomarkers, and geographic information. *See appendix for further details.*



Within PMM areas of interest on family planning and modern contraception that are analyzed in this presentation, outcomes are entirely questionnaire-based. **Thus, results discussed herein are dependent on self-identification.**

Disaggregation

DHS disaggregates FP data across women ages 15-49, all self identified, with the following denominators:

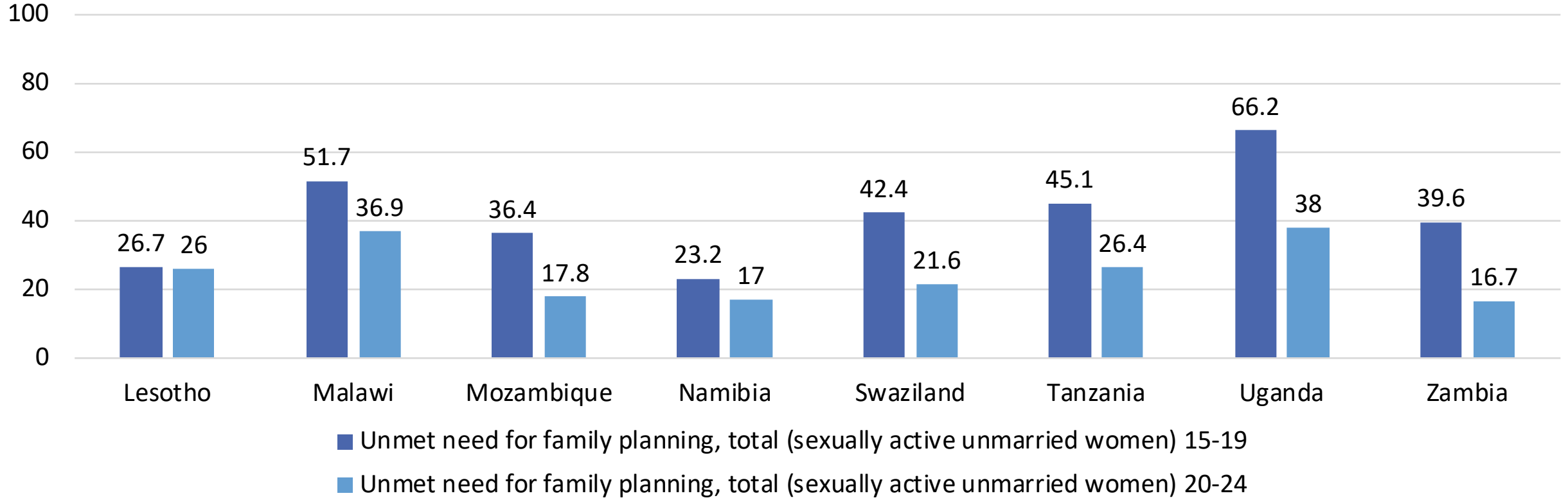
- “All Women”: includes any woman, regardless of current sexually active or marital status
- “Unmarried Sexually Active Women” : women whose marital status is single and are sexually active
- “Married Women”: married or in-union women

This analysis focuses on unmarried sexually active women, due to the relatively small percentages of married AGYW in focus countries represented in the data

Unmet need for family planning across *unmarried, sexually active* AGYW is significant across S/E Africa, highlighting gaps in current FP service delivery



Unmet need for family planning among sexually active unmarried women

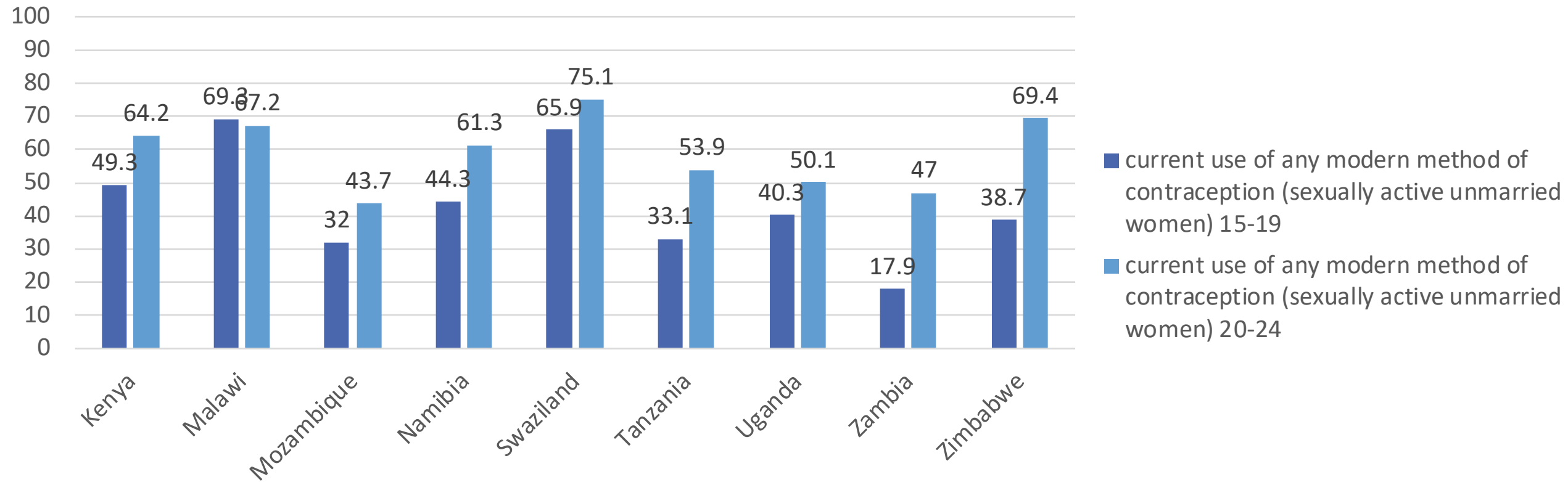


Indicator	Unmet need for family planning
Measure	Percent
Definition	Percentage of sexually active unmarried women with an unmet need for family planning
Denominator	Sexually active unmarried women

Usage of modern contraception among unmarried, sexually active AGYW varies by country; usage among 15-19s is consistently lower than 20-24s



Current use of any modern method of contraception across unmarried, sexually active AGYW



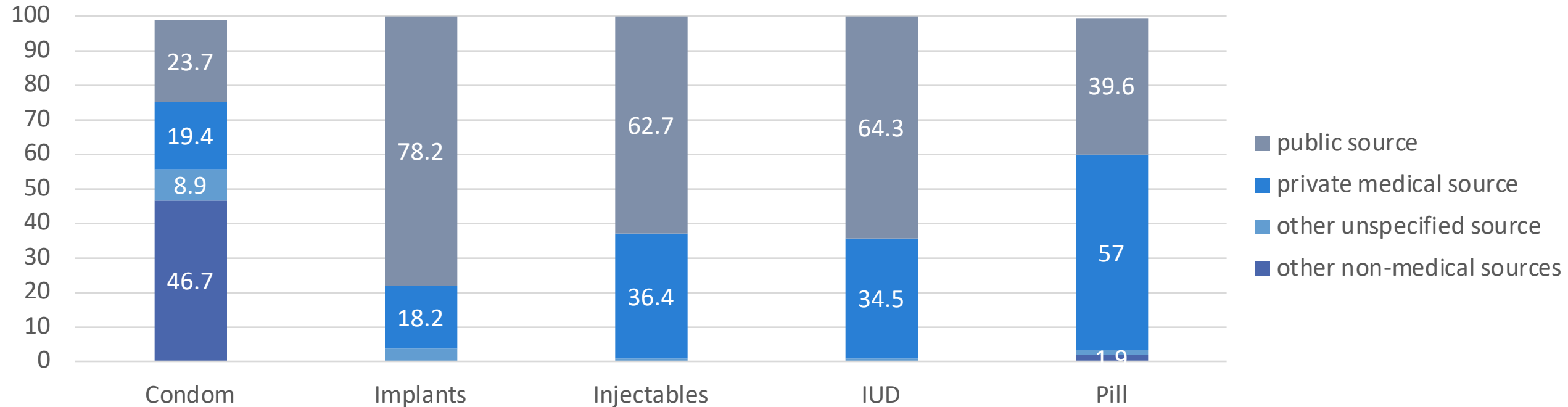
Indicator	Current use of any modern method of contraception \
Measure	Percent
Definition	Percentage of sexually active unmarried women currently using any modern method of contraception
Denominator	Sexually active unmarried women

AGYW access FP services from a mix of public *and* private sources; qual data shows a perception that private sources offer more confidentiality



- DHS data from Kenya shows women tend to access LARCs at public facilities and a mix of public and private facilities for condoms and OCPs

Source for most recent supply of LARCS, OCP and condom in Kenya

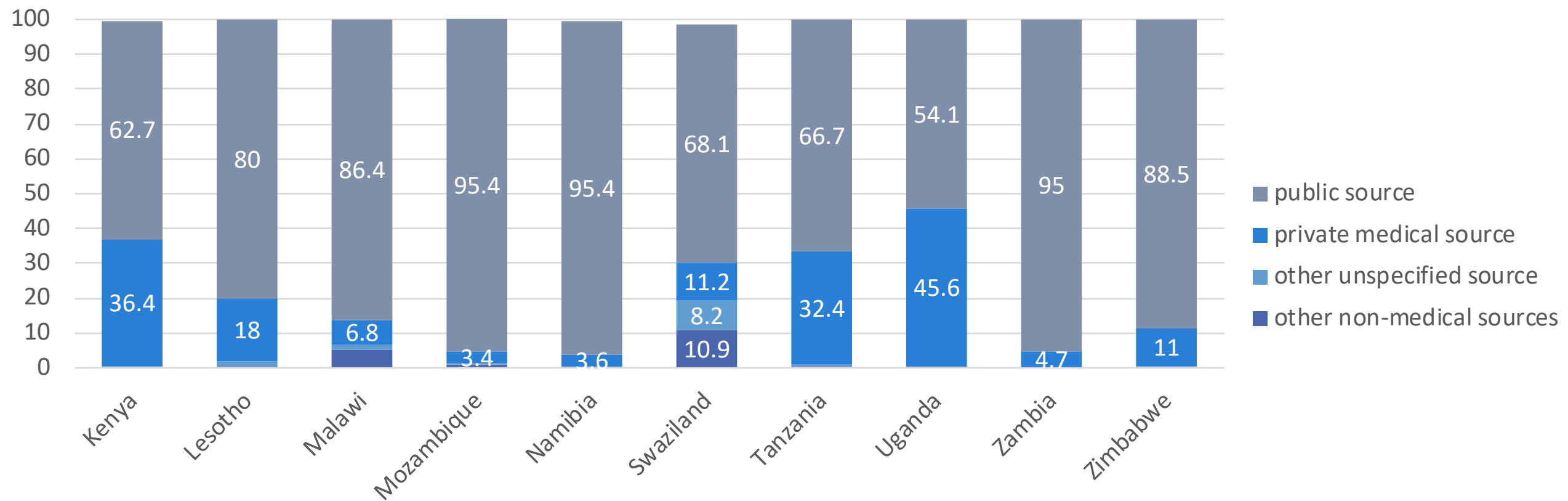


Indicator	Current users most recent supply or information from a public source
Measure	Percent
Definition	Percentage of women currently using modern contraceptive methods who received their most recent supply or info from a public source
Denominator	Users of modern contraceptive methods



Spotlight on Injectable FP: The vast majority of injectable contraception users receive their most recent supply or information from a public source

Current users source or information for most recent supply of injectable contraception



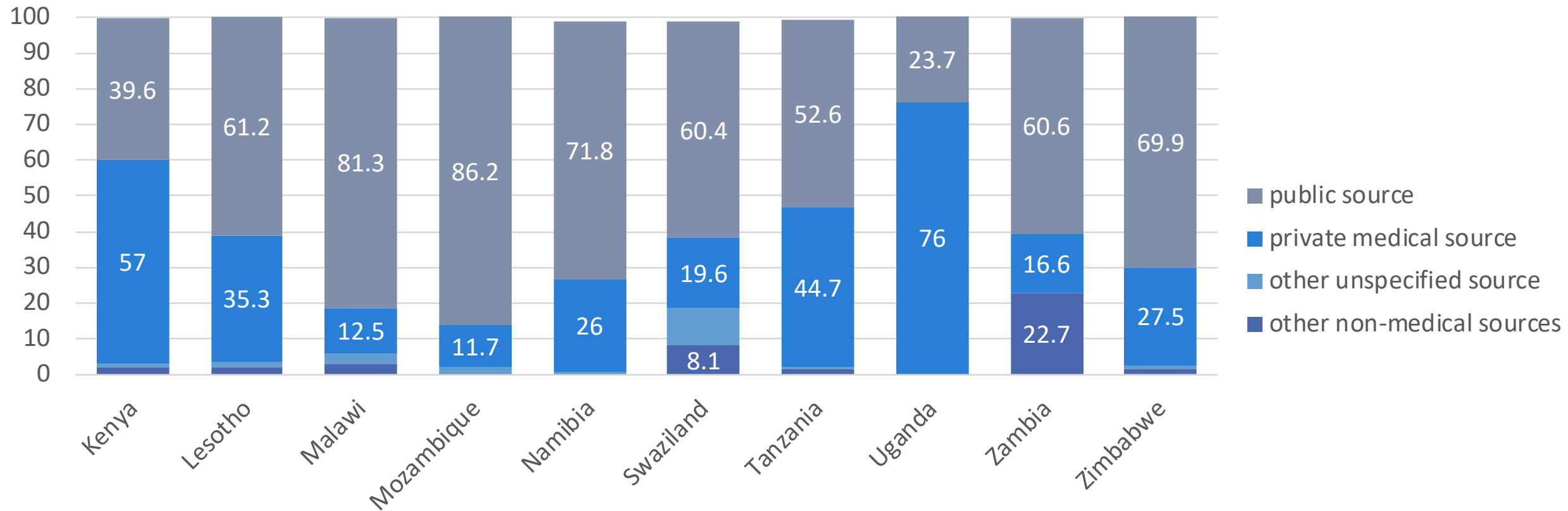
Indicator	Current users most recent supply or information for injectables from a public, private, unspecified or non medical sources
Measure	Percent
Definition	Percentage of women currently using modern contraceptive methods who received their most recent supply or information for injectables from a public, private, unspecified or non medical source
Denominator	Users of modern contraceptive methods

NOTE: Kenya, Uganda and Tanzania all have high private sector FP provision

Spotlight on OCP: Private medical sources play a larger and more significant portion of the most recent supply for current users



Current users supply or information for most recent supply of OCPs

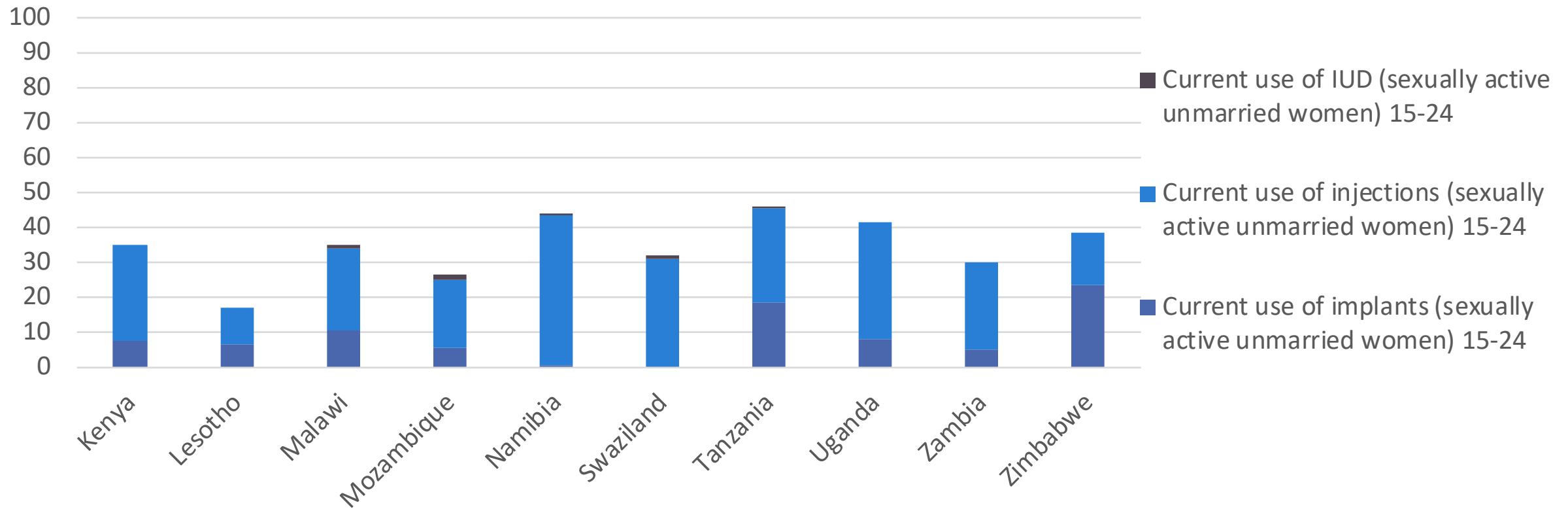


Indicator	Current users most recent supply or information from a public source
Measure	Percent
Definition	Percentage of women currently using modern contraceptive methods who received their most recent supply or information from a public source
Denominator	Users of modern contraceptive methods

Usage of LARCs has been growing at a global level, but these tools still have limited uptake among unmarried, sexually active AGYW



Current Use of LARCs among unmarried sexually active AGYW (15-24)

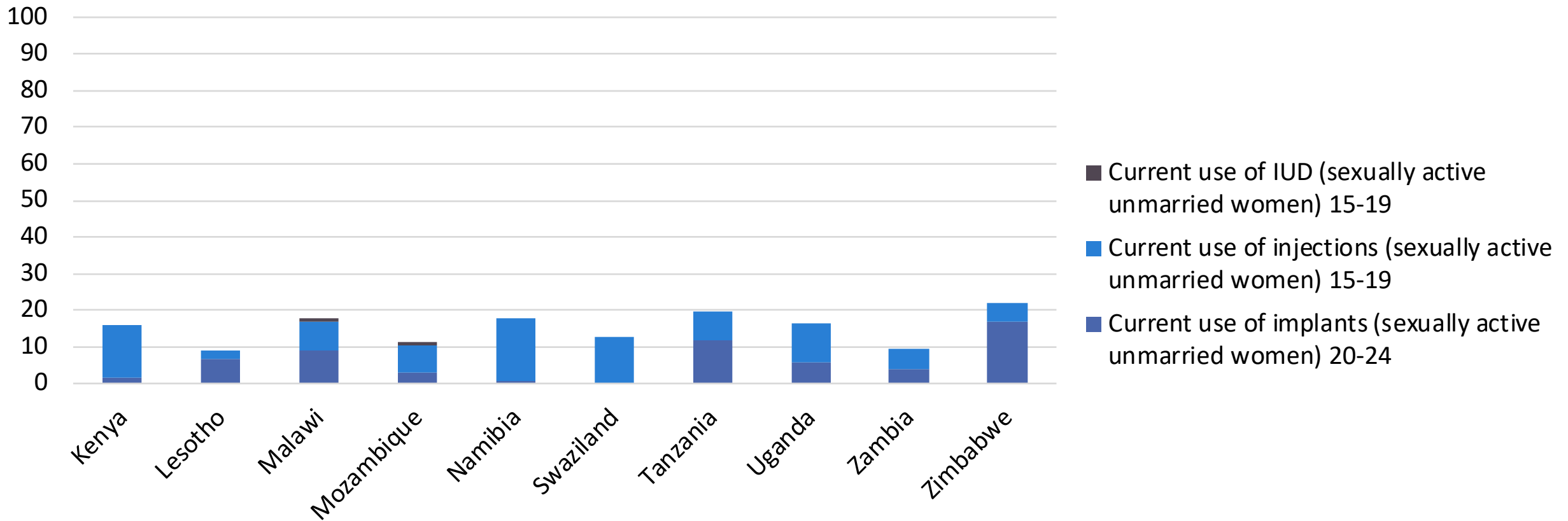


Indicator	Current use of LARCs (sexually active unmarried women)
Measure	Percent
Definition	Percentage of sexually active unmarried women currently using LARCs
Denominator	Sexually active unmarried women



Spotlight: LARC usage among unmarried, sexually active 15-19 year olds

Current Use of LARCS among unmarried, sexually active AGYW aged 15-19

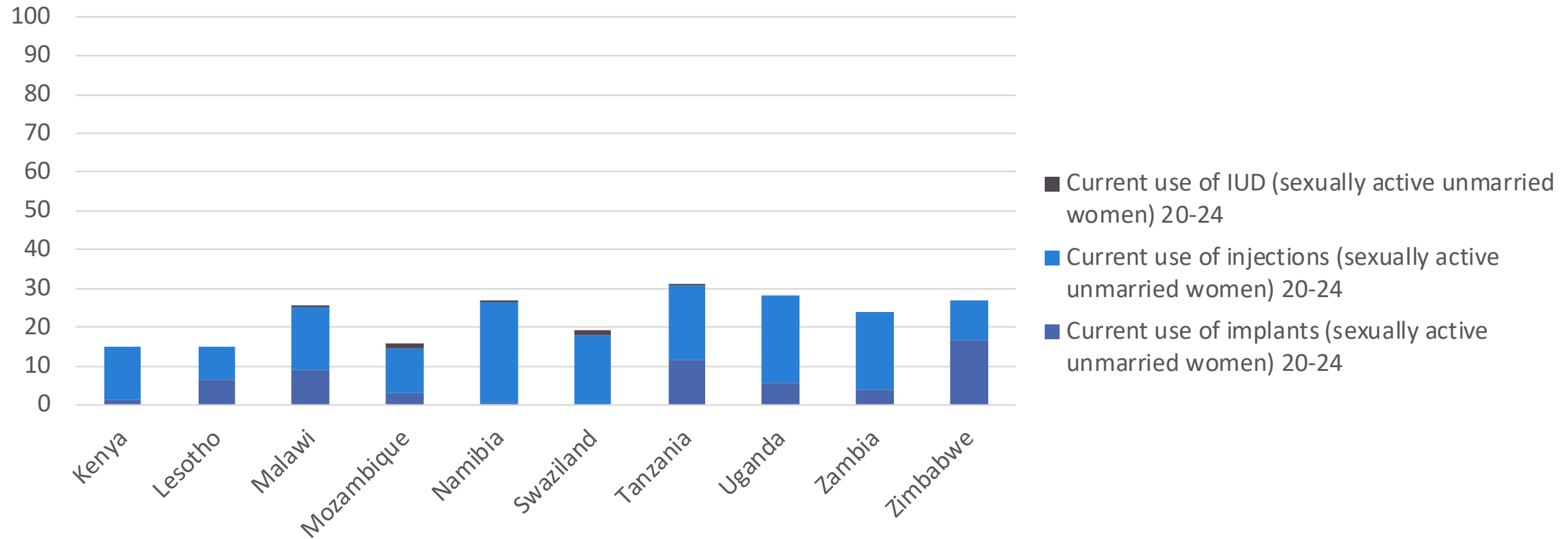


Indicator	Current use of LARCs (sexually active unmarried women)
Measure	Percent
Definition	Percentage of sexually active unmarried women currently using LARCs
Denominator	Sexually active unmarried women



Spotlight: LARC usage among unmarried, sexually active 20-24 year olds

Current use of LARCs among sexually active unmarried women aged 20-24

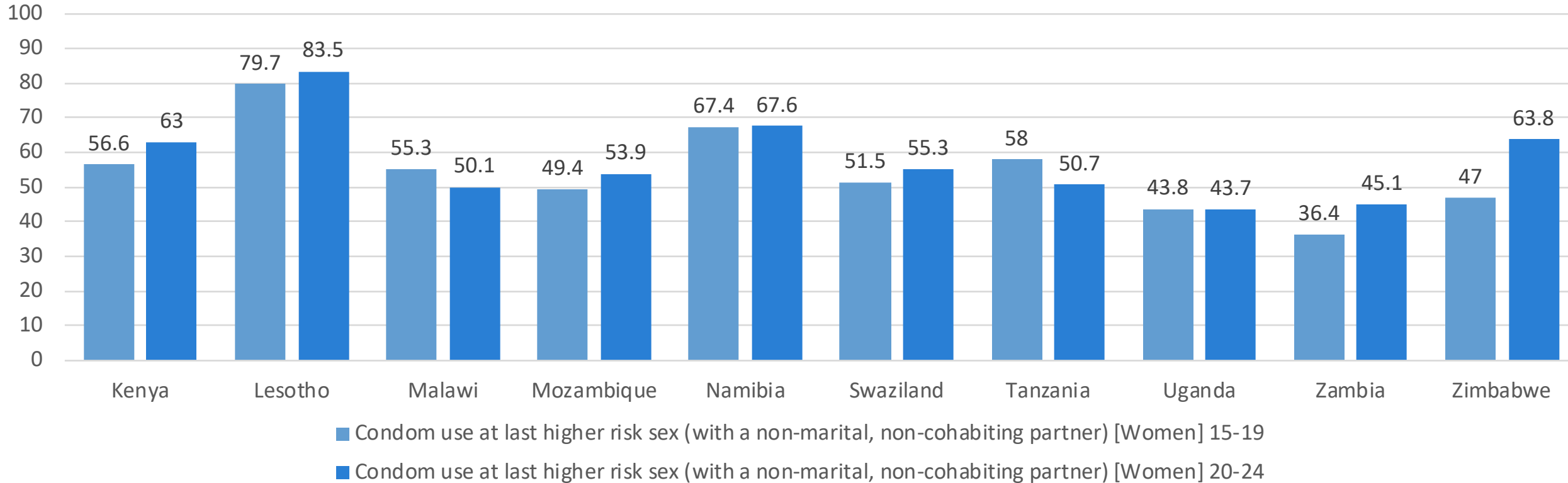


Indicator	Current use of LARCs
Measure	Percent
Definition	Percentage of sexually active unmarried women currently using LARCs
Denominator	Sexually active unmarried women

AGYW's self reported condom use at last higher-risk sex is reported at ~50% on average, underscoring the HIV risk potential in this population



Condom Use at Last Higher-Risk Sex with a non marital, non cohabiting partner

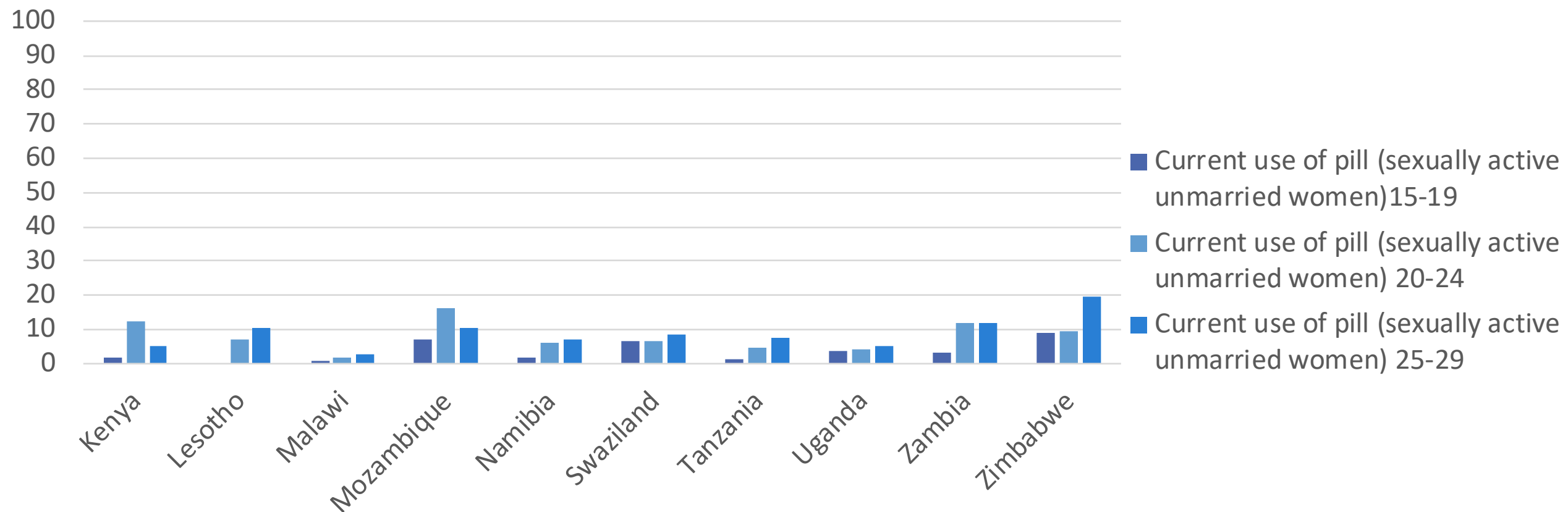


Indicator	Current Condom use at last higher risk sex (with a non-marital, non-cohabiting partner)
Measure	Percent
Definition	Percentage of women who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months
Denominator	Women who had sex with a non-marital, non-cohabiting partner in the last 12 months

Less than 10% of sexually active unmarried AGYW use OCPs in most countries, but this proportion increases with age in some settings



Current use of pill (sexually active unmarried women)



Indicator	Current use of oral pill among sexual active unmarried women
Measure	Percent
Definition	Percentage of sexually active unmarried women currently using the pill
Denominator	Sexually active unmarried women

Appendix



Survey Instruments

A mix of survey tools are used to conduct DHS Surveys:

Questionnaires

There are four Model Questionnaires in DHS-7 surveys: A Household Questionnaire, a Woman's Questionnaire, a Man's Questionnaire, and a Biomarker Questionnaire. There are also several standardized Questionnaire Modules for countries with interest in those topics.

Biomarkers

DHS surveys collect biomarker data relating to a wide range of conditions including infectious and sexually transmitted diseases, chronic illnesses such as diabetes, micronutrient deficiencies, and exposure to environmental toxins. Most surveys now include testing for HIV infection in their survey design.

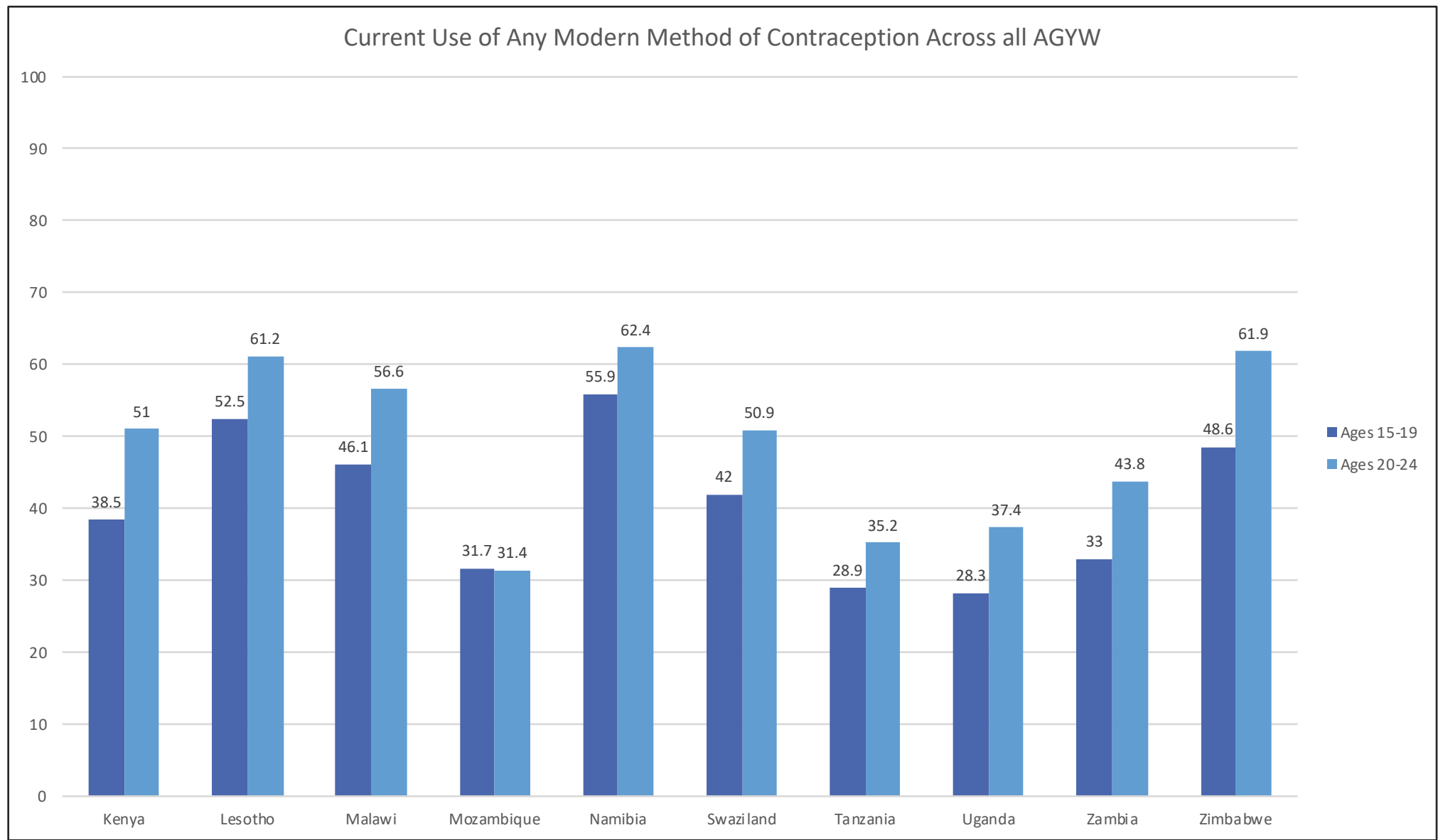
Geographic Information

DHS surveys routinely collect geographic information in all surveyed countries. All survey data is presented both nationally and by sub-national reporting area. These reporting areas are often, but not always, provinces or groups of provinces, and are included in all recoded data files.

Modern Contraception Usage Among AGYW across S/E Africa (self-reported sexually active and unactive) *



*unable to draw conclusions about unsatisfied demand

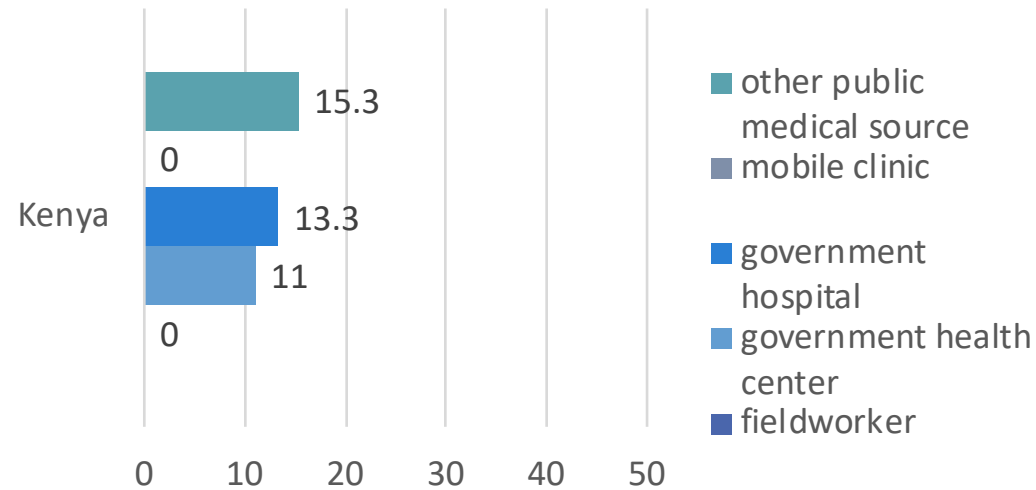


Indicator	Current use of any modern method of contraception (all women)
Measure	Percent
Definition	Percentage of women currently using any modern method of contraception
Denominator	All women, regardless of marriage status, and sexually active status
Note	Self identified

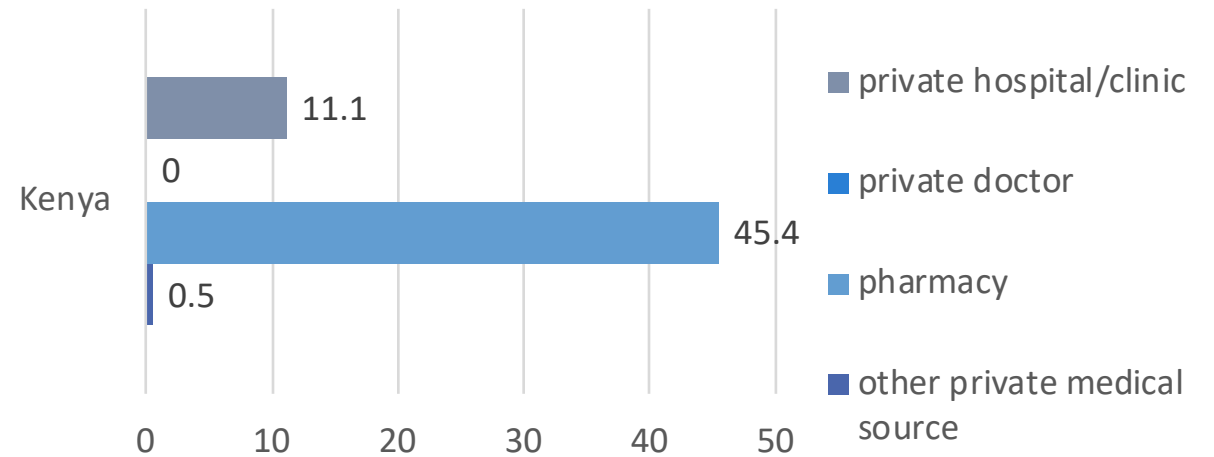
Service Delivery Detail: What types of facilities are preferred within public, private, non-medical and unspecified?



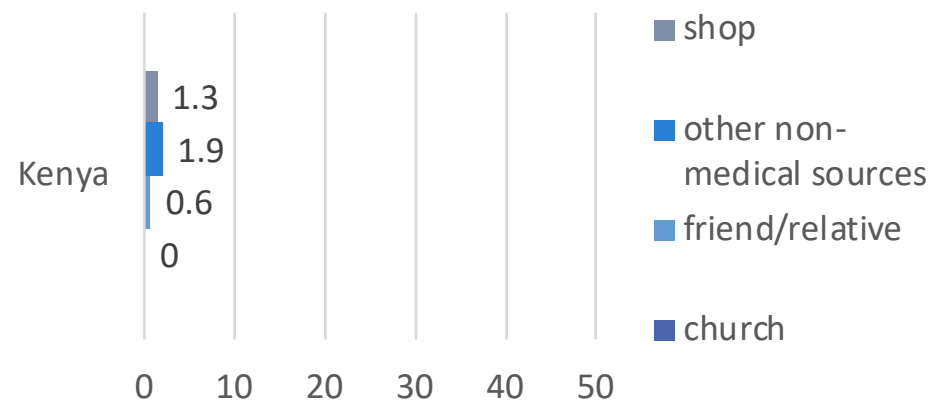
Public supply sources for OCP in Kenya



Private medical supply sources for OCP in Kenya



Non-medical supply sources for OCP in Kenya



Unspecified sources for OCP in Kenya

