Adolescent PrEP delivery: Opportunities and Challenges

Linda-Gail Bekker

The Desmond Tutu HIV Centre,
University of Cape Town, RSA

International AIDS Society
This evening....

• Why we need comprehensive prevention in SA adolescents.
• How PrEP is part of comprehensive prevention.
• The unanswered questions: Who? Where? How?
• Some imminent research/demos to fill some of these gaps....
State of the HIV epidemic ......

• 28 000 people were newly infected in SSA with HIV this week

• 2000 were young women in South Africa

UNAIDS Gap Report 2015
HIV+
HIV-

Vicious HIV Cycle

12-24 years.

24-40 years

24-35 years.

12-24 years.

HIV+ Apologies to D’Oliviera T et al. AIDS2016, CAPRISA and The Simpsons
HIV+ Unemployment
GBV Limited Agency?
Services not ideal
STIs Hormonal contraception?
12-24 years.

Difficult to test, link and suppress "invisible"
Services ill-designed....

HIV-ve

24-35 years.

Uncircumcised Reluctant to test

12-24 years.

Couples testing rare
Belief of positivity

HIV+

Vicious HIV Cycle

HIV+
Accessible, layered, integrated.
TAILORED, Client-Centred Prevention Packages
PrEP as part of a comprehensive package

- Information
- Education
- Access to SRH services
- Empowerment
- Social protection
- Self and Couples HIV testing
- PMTCT
- Safer conception
- Choices for contraception
Need a tailored approach:
Behaviour
Structural
Biomedical

Security
PrEP
Resilience
Empowerment

Seek, Test, Treat and Suppress

Oral PrEP
Treat and Suppress

Information
MMC and Condoms

Universal Testing
Couples Testing
Self Testing
Community testing

PMTCT
PrEP works........

BUT has to be on board when HIV attacks!!!
The “Who” of PrEP?

- Do we “profile” within a risk group?
- Is there a valid risk score we can apply?
- Will adolescents “self-identify” correctly
## Systematic review results

<table>
<thead>
<tr>
<th>Analysis</th>
<th>No. of studies</th>
<th>Sample Size (N)</th>
<th>Risk Ratio (95% CI)</th>
<th>p-value</th>
<th>I²</th>
<th>P-value (meta-regression)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RCTs comparing PrEP to placebo</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>10</td>
<td>17424</td>
<td>0.49 (0.33-0.73)</td>
<td>0.001</td>
<td>70.9</td>
<td>--</td>
</tr>
<tr>
<td><strong>Adherence</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>High (&gt;70%)</td>
<td>3</td>
<td>6150</td>
<td>0.30 (0.21-0.45)</td>
<td>&lt;0.0001</td>
<td>0.0</td>
<td>&lt;0.0001</td>
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<tr>
<td>Moderate (41-70%)</td>
<td>2</td>
<td>4912</td>
<td>0.55 (0.39-0.76)</td>
<td>&lt;0.0001</td>
<td>0.0</td>
<td>0.009 ref</td>
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<tr>
<td>Low (≤40%)</td>
<td>2</td>
<td>5033</td>
<td>0.95 (0.74-1.23)</td>
<td>0.70</td>
<td>0.0</td>
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<tr>
<td><strong>Mode of Acquisition</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal</td>
<td>4</td>
<td>3167</td>
<td>0.34 (0.15-0.80)</td>
<td>0.01</td>
<td>0.36</td>
<td></td>
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<tr>
<td>Vaginal/penile</td>
<td>6</td>
<td>14252</td>
<td>0.54 (0.32-0.90)</td>
<td>0.0</td>
<td></td>
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</tr>
<tr>
<td><strong>Biological sex</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>7</td>
<td>8706</td>
<td>0.38 (0.25-0.60)</td>
<td>&lt;0.0001</td>
<td>0.0</td>
<td>0.19</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>8716</td>
<td>0.57 (0.34-0.94)</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 to 24 years</td>
<td>3</td>
<td>2997</td>
<td>0.71 (0.47-1.06)</td>
<td>0.09</td>
<td>20.5</td>
<td>0.29</td>
</tr>
<tr>
<td>≥25 years</td>
<td>3</td>
<td>5129</td>
<td>0.45 (0.22-0.91)</td>
<td>0.03</td>
<td>72.4</td>
<td></td>
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<tr>
<td><strong>Drug Regimen</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TDF</td>
<td>5</td>
<td>4303 active</td>
<td>0.49 (0.28-0.86)</td>
<td>0.001</td>
<td>63.9</td>
<td>0.88</td>
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<tr>
<td>FTC/TDF</td>
<td>7</td>
<td>5693 active</td>
<td>0.51 (0.31-0.83)</td>
<td>0.007</td>
<td>77.2</td>
<td></td>
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<tr>
<td><strong>Drug Dosing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily</td>
<td>8</td>
<td>17024</td>
<td>0.54 (0.36-0.81)</td>
<td>0.003</td>
<td>73.6</td>
<td>0.14</td>
</tr>
<tr>
<td>Intermittent</td>
<td>1</td>
<td>400</td>
<td>0.14 (0.03-0.63)</td>
<td>0.01</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td><strong>RCTs comparing PrEP to no PrEP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>2</td>
<td>720</td>
<td>0.15 (0.05-0.46)</td>
<td>0.001</td>
<td>0.0</td>
<td>NA</td>
</tr>
</tbody>
</table>

1. The iPrEx trial included 313 (13%) transgender women.  
2. Includes only studies that stratified age by <25 and ≥25.
**Recommendation**

Oral PrEP containing TDF should be offered as an additional prevention choice for people at substantial risk of HIV infection as part of combination HIV prevention approaches (strong recommendation, high-quality evidence).

>3 per 100 person years
PrEP for Young Women?

ADAPT HTVN 067: An open label of oral PrEP use by 179 women in Cape Town, South Africa.

- Majority of women took oral PrEP when made available, with no difference in drug levels between older and younger (<25 years) women.

- Daily dosing resulted in good adherence (higher drug levels) & better coverage of sex acts, compared to intermittent use.

- Daily dosing may foster better habit formation and provide the most forgiveness for missed doses at observed adherence levels.

32 FTC/TDF PrEP Demonstration Projects
Seroconversion Rates By Sex/Gender

<table>
<thead>
<tr>
<th>Sex/Gender</th>
<th>Men n=7002</th>
<th>Women n=1388</th>
<th>Transgender Women* n=76</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total exposure, p-y</td>
<td>6214</td>
<td>788</td>
<td>48</td>
</tr>
<tr>
<td>Number of HIV-1 seroconversions</td>
<td>64</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Rate/100 p-y (95% CI)</td>
<td>1.03 (0.80-1.32)</td>
<td>0.25 (0.03-0.92)</td>
<td>2.07 (0.05-11.52)</td>
</tr>
</tbody>
</table>

*Includes genderqueer, androgynous designations. McCallister, ASM Microbe 2016, Abs 371LB.
High rates of unplanned, **teenage pregnancy** (SA performed 70,000 TOPs in 2014)

High rates of **Non consensual sex/GBV**

High rates of **asymptomatic STIs** (70% of a cohort of 17 year-olds girls had 1/more STIs)

Inconsistent use of hormonal **contraception** (Preferred method 3 monthly DMPA)

Inconsistent **condom** use.

**Under use** health facilities (Numerous barriers)

**Young and Vulnerable**

15-19 years: **8x** higher than male peers

19-24 years: **4x** higher than male peers

20-34 year old females have the highest incidence rate

15-19, 20-29, 30-39, 40-49, 50+

**HSRC Household Survey 2014**

**Middelkoop K, et al 2008**

**Pettifor, Karim, Jewkes, Bekker, Delaney-Moretiwa**
Incidence in AGYW.

Figure 2: HIV Incidence (%) in South Africa – 2012
Some similarities: Teenage pregnancy
Unintended Pregnancy Is a Particular Concern in Adolescents Worldwide¹

- Around the world, about 16 million girls and women aged 15 to 19 years give birth each year.
  - Most of these pregnancies are unintended.

94,000 SA school girls: 2011
77,000 Terminations: 2011

Unintended Pregnancy May Result From Incorrect or Inconsistent Use of Contraceptives

Failures Within First 12 Months of Use (United States)\(^1\)

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**Rate per 100 Women**

- **Perfect use**
- **Typical use**

<table>
<thead>
<tr>
<th>Contraceptive</th>
<th>Rate per 100 Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single-Rod Implant</td>
<td>0.05</td>
</tr>
<tr>
<td>Levonorgestrel IUS</td>
<td>0.2</td>
</tr>
<tr>
<td>Copper T IUD</td>
<td>0.6</td>
</tr>
<tr>
<td>Injection</td>
<td>0.8</td>
</tr>
<tr>
<td>OCs</td>
<td>0.2</td>
</tr>
<tr>
<td>Patch</td>
<td>0.3</td>
</tr>
<tr>
<td>Ring</td>
<td>0.3</td>
</tr>
</tbody>
</table>

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*IUS= intrauterine system; IUD= intrauterine device; OC= oral contraceptive (progestin-only and combined pills).*

Adolescent Risk Behaviour: Tutu Teen Truck

- Transactional sex: 0.2%
- Intravenous drug use: 0.4%
- Intergenerational sex: 1.2%
- Symptomatic STI (prev 6 month): 3.0%
- Multiple partners (prev 6 months): 14.6%
- Inconsistent condom use: 42.6%
- Unknown partner status: 56.2%

Self-reported sexual risk behaviour
Pluspills cohort: 150 (15-19 yo)

- “Self Selection” – adolescents who see themselves at risk
- STI rates – 52% tested positive for at least 1 STI at screening
- 9% pregnant at screen
- 2% HIV infected at screen
- 44% reported condomless sex
- 27% concurrent partners
- 20% Intergenerational sex

Adolescence is a Developmental Transition: Dynamic biological and behavioral vulnerabilities

- Pre-adolescence: 10-13 years
- Middle Adolescence: 14-16 years
- Late Adolescence: 17-20 years
- Emerging Adulthood: 21-25 years
Force of infection tips the balance
PrEP’d for safer conception- key pops?

Significant exposure in utero occurs: but no review has found any specific adverse effects on pregnancy outcome or infant growth.

- No difference in low birth weights
- No increase in reported birth defects
- No difference in infant growth
- No impact on maternal health
- Safe in breast feeding

Swiss study of 46 discordant couples using timed intercourse with PrEP

- 75% of couples achieved natural conception
- None of the female partners seroconverted for HIV.

(Vernazza et al., 2011, AIDS)

Challenge: considered SAFE, but limited studies in HIV-uninfected women + low adherence in PrEP studies

Source: Mofenson, 2016

WHO: “PrEP may be offered and continued during pregnancy in women at substantial risk of HIV acquisition”
Offer PrEP in Southern Africa

A location-Gender-Age approach.....

HIV infections averted per 100 person years of PrEP
The “Where” of PrEP?

• Which public health platform?
• Which cadre of health staff?
• Can we de-medicalise and move away from health facilities entirely?
• If so, where and how?
What do adolescents want?

Specific adolescent preferences for health, sexual and reproductive health services....

Adolescent Friendly Services
- Appropriate tailored info and services tailored to them
- Confidentiality and privacy

Flexibility:
Opening times that suit them, is close to them & adapts around their school obligations

Comprehensive services ONE STOP SHOP
- Counselling & education
- Contraceptives
- Link to effective services

Source: Smith et al., Unpublished
Community based YC vs Health Facility

- Family Planning visits AG: 4 x more likely
- HIV testing among Adolescent Boys: 4 x more likely
- HIV testing Adolescents: 2 x more likely

Why?
- EASY
- QUICK
- IMMEDIATE
- PRIVATE
- DIRECTED
- RELEVANT
Accessible  
Efficient  
Friendly  
Tailored  
Funky  
Comprehensive  
One STOP Shopping

Contraception  
HIV, STI, Preg screening  
Mental health screens  
Basic primary care  
CD4, VL  
ART, PrEP  
BMI, Blood sugar  
CV writing, ID books  
Hairbraiding, manicures  
Music  
WIFI

Philip, Elzette
The “How” of PrEP?

- **UPTAKE /INITIATION**
  - Demand Creation Identification
  - Referral/linkage
  - Self selection
  - Presentation

- **PERSISTENCE**
  - Minimise monitoring
  - Efficiency
  - Ease of delivery
  - Demedicalise
  - Convenience
  - Non-stigmatised

- **EFFECTIVE USE**
  - Adopt and Adapt
  - Hassle-free
  - Improves Quality of Life
  - Fold into daily living

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Adolescents now are not the adolescents of old:

• **Instant communication** is not exciting, it's a **basic right**

• **Transparency** in the system – political, corporate, organisational – is **expected**

• **Collaboration** and **VOICE** is expected and **obvious**

• **Web-based self-learning approach**: for school, for recipes, for work, for anything.

• **Comfortable within a diverse society**

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Why The Next Generation After Millennials Will Be 'Builders', Not 'Founders' - Forbes
Health Care is different for iGen:

1. Instant Health Readouts
2. App prescriptions & medical social media
3. Increased familiarity of disease prevention – a more pro-active generation
4. Personal relationship’s with their health care provider and stronger call for personalized treatment
Engage – How?

• Gain-and loss-framed messages are differently persuasive.
• If a behavior leads to a certain outcome, gain-framed messages work well.
• If a behavior leads to a more uncertain outcome, then loss-framed messages more effective.
• Gain-framed messages can be more persuasive than loss-framed messages
• We’re more sensitive to minor losses than to minor gains.
• In general, we prefer certain alternatives to uncertain alternatives.

Rothman and Salovey, 1997; 2006
3P Demand creation campaign.....

GAIN FRAMING.......... NOT LOSS FRAMING

McCann Advertising funded by BMGF
Correlates of low adherence in oral PrEP trials

- Younger age (Partners PrEP, VOICE)
- Not partnered (VOICE, FEM-PrEP)
- Low perception of risk? Stigma? (FEM-PrEP, others?)
- Less sex (Partners PrEP, iPrEx)
- Alcohol use (Partners PrEP)
- Not attending appointments (Partners PrEP, VOICE, others?)

Key factors diminish adherence to daily preventative therapy (or to optimal clinical trial participation).
Adherence to chronic medication in adolescence: not just an HIV problem!!

Insulin adherence in adolescents with **Diabetes**:
- Adolescents have poorer glycaemic control and higher rates of acute complications than adults. *Snyder*, 2014
- Recommendations incl. positive psychological interventions

Adherence to and continuum of **hormonal contraceptives**:
- Breakdown social stigmas - 11% of all births worldwide come from adolescent girls. *WHO*, 2016
- Enhanced counselling & intensive reminder systems, including phone call follow up and daily text messages *Halpern et al.*, 2014
Most important ingredients of young woman engagement.....

• **Relationships** are key – peers, trusted adults, staff
• **Support** from home or intimate partner helps a lot
• **Accessibility**, speed
• **Ease of use** – no time wasting, no PT,
• **Tailored**, relevant information with trusted guidance on choices
• **Choice**- but presented with clarity
• **Fun** and Innovation
• **No stigma** or bad feeling .....leading to suspicion
• **Gain**-framed messages are great - if accompanied with good experience

Many great colleagues! 2016
Pluspills Study

• An Open Label Study to Assess the
• Acceptability
• Use
• Safety

of Truvada PrEP in Healthy, HIV neg, 15-19yrs

75 adolescents in Masi/ Cape Town
75 Adolescents in Soweto/ Joburg
Basic Package: HCT, MMC, PEP, condoms
Female condoms

Choice of daily, weekly or no SMSs

Adherence clubs

Screen, enroll. Package + PrEP

DBS + real time FB vs none

DBS + real time FB vs none

DBS + real time FB vs none

DBS + real time FB vs none

CHOICE: package +/- PrEP
Acceptability
Reasons for choice

CHOICE: package +/- PrEP
Acceptability
Reasons for choice

CHOICE: package +/- PrEP
Acceptability
Reasons for choice

Final Visit

DBS + real time FB vs none

DBS + real time FB vs none

DBS + real time FB vs none
PrEP Demonstrations: Pluspills

- 293 screened, **150 enrolled (15-19 yo)**. 2% HIV+, 9% Pregnant, 52% STI.
- Sexual debut 15 years, 27% concurrency, 9% transgenerational sex.

For the first time in my life, oral Prep allows me to own my sexuality

Sinazo Peters 22 yrs, Former “Future Fighter” Desmond Tutu HIV Foundation
Opt Out at week 12

• 10% of cohort chose to opt out at week 12
• 10% of girls and 10% of boys
• Reasons
  Tired/ Bored/ Wanted a break/ Lost interest
  Side effects
  Want to focus on school work/ Hard to swallow/ no risk
• 6 have opted back in (all because of risk perception)
• Demand for post trial access
Side effects/ Toxicities

• Similar profile to adults
• GIT side effects/ headaches and dizziness
• Side effects frequently quoted as a reason for opting out
Pluspills: Preliminary Adherence

>10 ng/ml

% of cohort with detectable drug levels

Preliminary data Oct 2016
Sexually Transmitted Infections: Pluspills

<table>
<thead>
<tr>
<th>STI</th>
<th>SCREENING</th>
<th>WK 12</th>
<th>WK 48</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSV</td>
<td>16%</td>
<td>20%</td>
<td>22%</td>
</tr>
<tr>
<td>CT</td>
<td>30%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>NG</td>
<td>5%</td>
<td>6%</td>
<td>14%</td>
</tr>
</tbody>
</table>

85% of infection were new infections.

Preliminary (incomplete) data OCT 2016
HIV Incidence: Pluspills

No HIV infections in 113 adolescent years of follow up.

Preliminary Data Oct 2016

HIV Incidence: 7.4 per 100 person years (95% CI: 4.3-12.8)

3 Ps for Prevention: Partners, PrEP and Payment.

WHAT ARE THE FACILITATORS AND BARRIERS TO PREVENTION UPTAKE?

WHAT SHOULD DEMAND CREATION LOOK LIKE?

WHAT DOES THE PREVENTION CASCADE LOOK LIKE?

CAN A SHORT TERM CCT IMPROVE EARLY ADHERENCE?

- Formative work on risk, partners, narratives
- Behaviour-centred ethnographic work
- PrEP + SOP + CCT
- PrEP + SOP
- 2 Best
- 12 months follow-up

Approach 1000 selected women 16-26 years
Enrol, randomise 200 women to PrEP +/- CCT

Bekker/Cellum: Funding: NIMH, BMGF
Barriers to PrEP adherence

- Side effects – stopped taking oral PrEP, either temporarily or permanently
- Size of the pill – difficult to swallow, improved with time
- PrEP – forgetting due to changes in routine, i.e. weekends, travelling, etc
- Stigma of taking ARVs – ??HIV pos
- Community perceptions of PrEP – ?? safety of the PILLs, trust in clinic
- Inadequate information regarding pill use –
- Low perception of risk – trusting partner
- Unsupportive partners or family members

3P Formative Data: Hartmann M, Bennie T, 2016
Facilitators of Adherence

• Pill-taking with a daily activity
• Buddy system – a family member / friend or a staff member – appreciated staff dedication in sending reminders or calling
• Adherence clubs – sharing pill-taking strategies, learning how to deal with side effects and how others deal with other challenges
• Using alarm clocks as reminders (phone reminders not so great – sharing, battery dying)
• Knowing / believing that the pill works to protect against HIV
• Receiving drug levels feedback was useful – motivated – to get a better result next time
• Supportive family members / partners – reminder
Target Enrollment

- Uninfected women, 16-25, southern Africa
- 400 women who accept PrEP at enrollment
- Up to 200 women who decline PrEP at enrollment

Follow-up duration: 12 months

Evaluation of daily oral PrEP as a primary prevention strategy for young African women: A Vanguard Study

Primary objective: Assess PrEP initiation, adherence, acceptability, and continuation among young women in three sites in southern Africa offered open label oral PrEP.
EMPOWER Research Design

Can clinical enquiry for GBV and linkage-to-care be integrated into HCT for AGW?

EMPOWER Clubs
4 structured empowerment sessions + ongoing adherence support

Will adherence clubs improve PrEP adherence?

Randomise

SoC (SMS, counselling)

HIV positive and/or immediate risk of harm

Referral +/- peer navigator and brief counselling

EMPOWER Clubs
Quarterly visits for HCT + social harms enquiry over 12 months
Adherence assessment and PrEP re-supply in acceptors
PREP offer and initiation in previous decliners (first 6 months)
Assessment of study outcomes including adherence

HIV negative

Assess HIV risk and
Provide information on HIV risk and prevention options
Assess interest in and eligibility for PrEP
Offer PrEP as part of package

HIV positive and/or immediate risk of harm

Assess HIV risk and
Provide information on HIV risk and prevention options
Assess interest in and eligibility for PrEP
Offer PrEP as part of package

SoC (SMS, counselling)

Empowerment clubs + SoC (SMS, counselling)
Effectiveness, acceptability, efficiency of 3 models of PrEP provision:

- Family Planning Services (Kenya)
- Adolescent Friendly clinics (Johannesburg)
- Mobile services (Cape Town)

- 1000 AGYW in each centre – number taking up PrEP and persisting
Unicef funded by UNITAID

- 8 000-10 000 young people 15-19 years
- Oral PrEP from public sector clinics for 5 years
- Cape Town, Africa Centre, Soweto
- Feasibility, acceptability, effectiveness.

Bridge to Scale Project.
PrEP is easy !!!

Is it for me?  
Eligibility and Desire

Get started  
USE DAILY  
Cover for 3 weeks

You are on your way!  
USE DAILY  
Test 3 monthly

AS LONG AS YOU TAKE A PILL A DAY - THE VIRUS WILL STAY AWAY!!!
We have procured new coloured and scented condoms to increase condom use among young people. They provide the four maximums: maximum pleasure, maximum protection, maximum quality and maximum number of young people making use of them.

AARON MOTSOALEDI

SHE CONQUERS” YWAG Campaign RSA 2016

Deputy President Cyril Ramaphosa SA Parliament 2016

South Africa’s Prevention Revolution
Target: <100,000 infections by 2022
SA promises PrEP for 3000 sex workers

- Launched with Test n Treat in 2015
- 150 000 SWs –prevalence 40-72%
- 300 Sex workers on PrEP in 11 sites
- Periodic Presumptive STI treatment ??
- Decriminalization ??

Combo prevention for SA Sex Workers
The SA Prevention Revolution will:

• Layer prevention where **force of infection** is high
  - Hot spot mapping, ANC prevalence survey

• Move prevention **out of health facilities** into communities
  - Mobiles, community based organisations

• Test in homes (self test), mobiles, libraries and provide **Point of Testing Prevention and Treatment services.**
  - Double helix of prevention and treatment (Bekker, HoseK JIAS 2015)

• Create **demand with gain-frame** messaging using social media
  - i-Generation demands this!

• Provide **tailored, relevant** information and services
  - Adolescents and key populations deserve this!
Effective Adolescent Friendly Services
Reaching the millions, getting to the last 10%.....

- Innovation and creativity
- Move out of facilities
  - Mobile health
- Engage communities
- Integrate and go beyond to health and wellbeing
- Tailor services
  - Confidential
  - Efficient
  - Relevant
  - Respectful
  - Client centred
In summary

• AGYW remain at the heart of the epidemic in SA
• Engagement with young women critical for success of programs
• Young women will take PrEP

Let’s make it work!
Thanks

• Carey
• Katherine, Sybil and CHAMPS team
• Miriam, Thola, Laura and Jabu
• Connie, Jared, Ariane, Maggie and 3P team
• Elzette, Phil and TTT team
• Rebecca and Andrea
• McCann Advertising
• Funders : BMGF, NIH, NIMH, USAID, UNICEF, UNITAID, DTHF, ViiV, Gilead, MSD.
• DTHF Youth Centre and CAB

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