Adolescent Girls and Young Women Profile

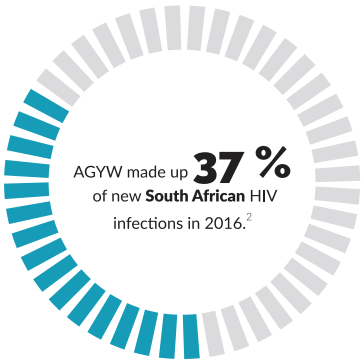
Who They Are (and in the Context of HIV)

In a snapshot: They are caught between finding their own way and fitting in.

Adolescent girls and young women (AGYW) in sub-Saharan Africa struggle with many of the pressures familiar to young adults all over the world: parental oversight and scrutiny, the need for financial stability, and the desire for freedom—which is often associated with money and influenced by an aspirational lifestyle seen online. While AGYW care about the expectations of their family, elders, schools, and religious leaders, they most importantly value the opinions of their peers and their own social status. They want to fit in with their friends, even as they are testing out new rules and standards for their emerging adulthood.

AGYW are disproportionately affected by HIV. In some countries, their risk is nearly four times higher than it is for young men.[1]

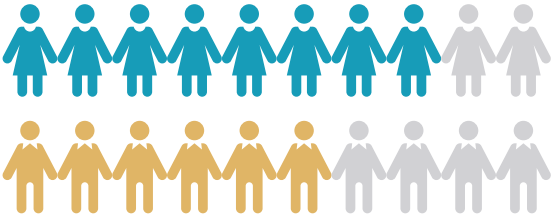
While a young woman's risk of infection varies with different demographic and socioeconomic factors, this group is majorly affected by the HIV epidemic, as shown by recent country-specific studies:



HIV prevalence was **4X** higher among AGYW in **Uganda** than it was among young men in 2016.[5]

AGYW represented 21% of new **Kenyan** HIV cases in 2012—nearly **2X** the rate for young men of the same age.[1]

HIV prevalence in **Zimbabwe** among young women in 2012 was, more than twice the rate of young men.[3]



More than **25,000** **Tanzanian** young women acquired HIV infections in 2016, compared to about 20,000 young men.[2]

Economic and cultural vulnerabilities put AGYW at high risk of infection.

Young women are highly vulnerable to HIV due to a complex web of cultural and economic factors that inhibit their sexual and health agency. A 2017 study involving AGYW in South Africa confirmed that conditions such as scarce employment and financial strain limit their ability to be financially independent while increasing their dependence on families and partners.[6] Girls whose economic situations are the most precarious are often at the greatest risk, such as those who live in slums or informal settlements, are orphaned, or live on the street.[7] Unprecedented unemployment rates in some areas make it difficult for AGYW to prioritize tomorrow ahead of today. AGYW, especially those with limited or no schooling, worry about issues like finishing their education, finding work, moving to a better place, or having enough money.[8]

A young woman's ability to attend school, as well as the overall HIV incidence rates in her area, influences her risk. Drug and alcohol abuse are known to exacerbate that risk, and some ethnic tribal practices, including female genital mutilation (FGM) and wife inheritance, are also thought to increase it, although the direct association between HIV and FGM remains unconfirmed.[9]

Beyond these social determinants, sexual power dynamics play a major role in HIV infection among AGYW. For example, an earlier sexual debut has been shown to increase risk.[10] And at any age, women are vulnerable whenever they are in a relationship with an uneven balance of power. These include relationships with men who are eight (or more) years older[11], men who practice polygamy, and/or relationships characterized by violence.[12] They also include exchange-based sexual relationships, which are prevalent across sub-Saharan Africa.[13]

Priorities, Worries, Dreams, Aspirations

When designing a communications program, it is vital to understand the complexity of audience members' lives. This section explores AGYW's priorities (not specifically related to HIV) including education, health, family, and working for a brighter future.

AGYW are a heterogeneous group. Lifestyle, attitudes and demographic factors—such as age and where they live—affect their behaviors and risks, so these factors should be taken into account when building any communications strategy and plan.[7]

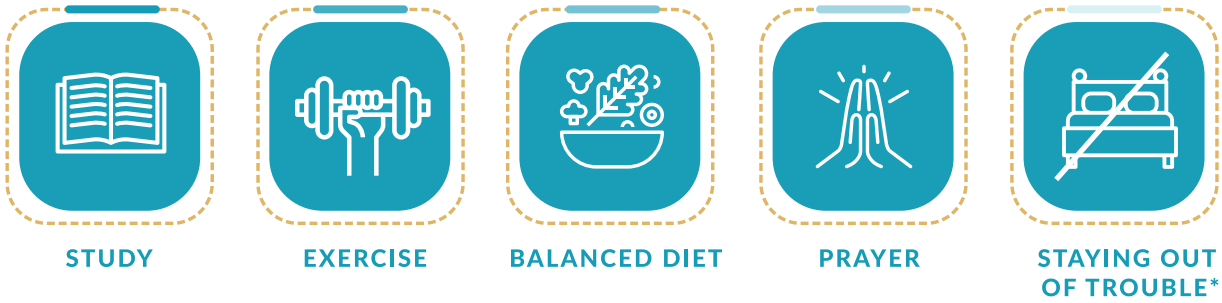
Research with AGYW shows that opportunities and barriers differ between them.[14] For example, in Kenya, urban AGYW are more likely than rural AGYW to own a mobile phone and have access to a television.[7] Similarly, UNESCO reports that Kenyan girls who live in rural (as opposed to urban) settings are less likely to attend school, and those living in slums will likely have few to no opportunities to generate income.[15]

Age is also an important factor. There may be significant variations in behavior, perspective, and risk between older (ages 18-25) and younger (ages 15-17) AGYW, as found in a quantitative study in Kenya described below.

Younger AGYW (ages 15-17) prioritize and focus on their education.[16]

According to research conducted in 2017 in Kenya by the OPTIONS Consortium[16], younger AGYW have a singular focus on getting good grades and completing their studies. One in three girls in this age bracket aspires to leave the country, potentially fearing Kenya's increased rate of unemployment.

When adolescent girls ages 15-17 were asked how they planned to achieve their dreams, the most common answers were[16]



*by which they meant abstaining from sex to avoid HIV and pregnancy[4]

Older AGYW (ages 18-25) place greater priority on health and family.[16]

As AGYW transition into adulthood, their priorities shift. Older respondents in the OPTIONS study cared about their health, getting married, and starting their own businesses—in that order. Some respondents also reported a desire to complete their studies.

A study in South Africa found that HIV-positive AGYW with a mean age of 18 had acquired HIV from men about eight years older than themselves.[11] Later, when these young women are in their mid20-s, they may transmit the virus to male partners of similar age—who continue the cycle when they engage in sex with younger girls.[11]

Challenges

People's risk factors for HIV acquisition are closely tied to the challenges they face. For AGYW, the predominate risk factors are economic and financial vulnerability, tied to patriarchal social norms, which often influences AGYW's decisions and leads them to risky behavior.

AGYW face pressure to have sex but are also stigmatized for being sexually active.

In the 2017 OPTIONS market research, one in five AGYW surveyed in Kenya said they perceived themselves as stigmatized or victimized. Stigma was most commonly described as being gossiped about for having sex.[16]

Similarly, study respondents reported experiencing pressure to have sex. Those who did experience pressure said that it came from either a partner/spouse (73 percent) or friends (23 percent), and the most common form of pressure to have sex was when they were "not in the mood."[16]

AGYW generally lack personal agency in the face of pressure to have sex. One in four study respondents reported "giving in" to pressure because "there's nothing (they) can do."[16]

A lack of personal agency is a hallmark of AGYW's sexual lives and health.[17]

Low access to education, and specifically a lack of information about sexual and reproductive health, can seriously impede AGYW's control over their own lives. Lack of information is likely the norm. In Kenya, for example:

- Twenty percent of adolescent girls never attend school.
- Only 57 percent of girls complete their primary education.
- While HIV/AIDS is part of the curriculum, condom use is not taught in schools.
- Sex is a taboo topic for both parents and teachers.[18]
- One-third of Kenyans believe that teaching about contraception is immoral.[19]

In a separate POWER study conducted in 71 ,2018 percent of AGYW reported that their partner provided financial support, which also limits their personal agency to some extent.[20]

Early sex, marriage, and childbearing — which often reduce personal agency — are common.

In the 2009 Demographic and Health Survey in Kenya, about 11.5 percent of AGYW reported having sex before their 15th birthday.[21] According to the 2009 Kenyan Modes Of Transmission Analysis Report, by age 18, nearly half of(out-of-school) young girls have had sex.[22]

AGYW also get married—and have children—early. In Kenya, the median age at first marriage is 20.2 years for women ages 25-49, and nearly half of women age 20 have given birth.[23]

The prevalence of intimate partner violence also inhibits personal agency and contributes to AGYW's vulnerability to HIV.

Intimate partner violence (IPV) is extremely common in sub-Saharan Africa. In a 2009 South African study, 86 percent of young, peri-urban women surveyed had experienced IPV in the past 12 months.[24] In Kenya, 47 percent of ever-married women ages 15-49 have experienced intimate partner violence.[25] Because of its prevalence, intimate partner violence is sometimes viewed as normal.

> **"A woman must be beaten somehow, because it is a practice that has been there even before we were born."[25]** — Adult woman in rural Kenya

Women reported being abused in response to perceived infidelities, or for transgressing gender norms. Men may also abuse partners who do not consult them on health-related decisions, such as HIV testing.

Because it inhibits women's health and personal agency, intimate partner violence increases a woman's vulnerability to HIV.[25] In some regions of Kenya, for example, women who are exposed to IPV are 50 percent more likely to acquire HIV than those who are not.[26] Similarly, intimate partner violence was associated with about a 1.3 times increased risk for HIV positive status in Zimbabwe.[17]

Patriarchal society has far-reaching effects on AGYW's relationships and health.

The violence, sexual pressure, and lack of personal agency that AGYW experience are all tied to broader patriarchal attitudes prevalent in sub-Saharan Africa, which influence the lives of women and girls.

- AGYW often have no power to negotiate condom use. In Kenya, 28 percent of men ages 15-49 believe that a woman has no right to request that a man use a condom.[17]
- AGYW are more likely to be subject to sexual violence. About 33 percent of girls in Kenya are raped by the time they turn 22; 18 percent of girls ages 15-19 report that their first sexual intercourse was forced.[27] In Zimbabwe, 25 percent of all women have experienced sexual violence, and 21 percent report that their first sexual intercourse was forced.[28]
- Economic and sexual sovereignty are closely intertwined. For many AGYW, a lack of economic empowerment pushes AGYW to make sexual compromises.[29]

> **"Most of my work has been on sexual and reproductive health, and we haven't seen ourselves as experts on economic empowerment. But I've realized it's intertwined. For a woman to be able to exercise her reproductive health, she needs to be economically empowered. If she's relying on a man, she's not able to make her own decisions and will not realize her rights."[29]** — Youth advocate in Kenya

Like any adult, some AGYW are concerned about their health while others are not.

According to the 2017 OPTIONS research, as many as one in two younger AGYW (age 15-17) in Kenya are not at all concerned about their health—not necessarily surprising, given their youth. For older AGYW, the figure decreases slightly: About 40 percent of AGYW age 18-25 are not concerned about their health, whereas 49 percent are very concerned.[16]

When asked about their peers, AGYW report that they are slightly more worried about developing cancer (63 percent) than HIV (60 percent).[16]

The 2017 Routes2Results qualitative research found that health was of importance to some AGYW in South Africa and that connecting overall health with sexual health (which is not a connection that is always consciously made) may resonate with AGYW.[6]

Top preventative health practices do not include safe sex practices, especially if those practices limit her ability to preserve the stability of her sexual relationships.

Using condoms, staying faithful, and other safe sex practices do not seem to be considered "preventative measures" for this group, as found by the 2017 OPTIONS research.[16] Instead, AGYW consider eating healthy, exercising, sleeping under a mosquito net, and good personal hygiene to be effective methods of maintaining their general health. Further, more than 50 percent rely on the power of prayer to stay healthy, and one in five rely on herbal or traditional medicines.

Interestingly, HIV Prevention Market Manager research conducted in 2018 found that AGYW are more inclined to adopt healthy sexual behaviors if doing so will not risk the preservation of her sexual relationships in any way.[56]

AGYW in Kenya may go to a private clinic but are more likely to visit a government hospital.[16]

The majority of AGYW (76 percent) in the OPTIONS study reported receiving health care at government hospitals. Another one in three reported visiting a private clinic, and one in four visited a private hospital.

While AGYW in general will most likely seek health care alone, about half of those under 17 years old will go with their parents, confirming that parents of young girls can be significant influencers of the decisions AGYW make regarding their sexual health.[16]

Relationship to and Engagement in High-Risk Activities

In this section we specifically look at the behaviors and social norms that commonly put AGYW at most risk of HIV acquisition. For AGYW, these activities are: exchange-based sexual relationships, intergenerational sex, and sexual peer pressure, as discussed below.

Relationships are often intertwined with the quest for financial stability.[30]

In sub-Saharan Africa, many nonmarital, noncommercial sexual relationships involve the exchange of money or gifts; importantly, neither party considers this sex work, as reported by BMC Public Health in 2017. Romantic relationships are often organized around exchange, either in the form of transactional sex or sponsor relationships.

In transactional sexual relationships, both parties expect the male partner to dictate sexual conditions.

A 2017 qualitative study conducted as part of the DREAMS initiative with the nonprofit health organization Jhpiego in Lesotho, for example, found that sex is often transactional in nature:

The 2017 DREAMS study showed that young women in Lesotho feel agency when choosing a partner; however, that agency weakens within transactional relationships, which may lead to increased risk. In these exchanges, there is an unspoken understanding that spending money on a young woman gives a man the right to set the sexual conditions, usually meaning no protection during sex.[31]

Sponsor relationships also create an imbalance of power in favor of the male partner, increasing the younger female partner's risk.

There is a "sponsor" trend in sub-Saharan Africa of older men, sometimes called "sugar daddies" or "blessers," offering to fund a lavish lifestyle for a girl or young woman in exchange for sex. In Tanzania, studies report that the "sugar daddy" culture is widespread, with women often accepting the sexual advances of older men in order to obtain money, affection, and social advancement.[32]

Other research shows examples from Kenya and Lesotho:

> **"Having a sponsor for university girls is 'the talk of the day'…if you don't have a sponsor you are outdated."[7]**
> — Researcher in Kenya

> **"When an unemployed guy approaches me, I look at him from head to toe and ask myself, 'Is he serious?!' There is no point in dating him because he can't even afford to buy my cosmetics! But a guy who has a job will buy my cosmetics, sleep with me, and go—because that's all he wants from me. The unemployed guy is just a waste of my time."[31]** — AGYW in Lesotho

A researcher in South Africa explains that the trend reflects the pressure on women to improve their socioeconomic status:

> **"While the need to survive (or attain 'bare life') is often the main driving force toward taking risks, there is also a post-apartheid desire to consume. Consumption is related to prestige and a 'better life,' as opposed to a 'bare life.'"[32]** — Researcher in South Africa

Some of the pressure to engage in intergenerational "sponsor" relationships can come from families:

> **"The answer also depends on where the girls/women live. In the rural areas our parents encourage us to have love affairs and get married to well-to-do stock farmers who get good checks after the sheep-shearing season."[31]** — AGYW in Lesotho

Intergenerational sex contributes to new HIV infections.[33]

A 2017 quantitative study in Zimbabwe found that intergenerational sex contributes to the rate of HIV infections among young women, as older partners are more likely to expose a young person to unsafe sexual behaviors, such as low condom use. The study shows a strong link between low education levels and intergenerational relationships, but with little difference between urban and rural areas.

Peer pressure also contributes to AGYW's sexually risky behaviors.

In Kenya, it is common for girls to place a high value on abstinence before marriage—possibly due to the influence of the church.[34] Yet that mandate becomes more difficult to comply with when AGYW are surrounded by social pressure. Respondents in multiple studies in Kenya, Lesotho, and South Africa described how sexually risky behaviors may be inspired by peer pressure.[36, 35]

> **"All-white parties are where as many as 20 students come together, and it's a free for all. Everyone has sexual relations with everyone, could be for the whole weekend. No rules. Lots of drinking and drugs. Anyone for everyone."[7]** — Mercy Kamau, stakeholder interview

> **"In order to fit in, I often do what my peers claim to do in relationships so that I can feel like part of the pack even without my friends putting pressure on me."[31]** — AGYW in Lesotho

Finally, the common practice of having multiple partners contributes to AGYW's risk.

While AGYW often do not report having multiple concurrent partners, in a number of studies they have attributed this practice to their peers—suggesting that discomfort, or social desirability bias, is influencing their reporting on their own practices. In South Africa, for example, most respondents in a 2017 report to USAID did not report multiple partners for themselves, but said it was the norm among their friends.[37]

> **"I have a friend who says she has about five sexual partners. When she counts them I sometimes notice the number going as high as eight."[38]** — AGYW in Lesotho

There may be some differences in average number of partners between older and younger AGYW. A Clinton Health Access Initiative (CHAI) survey in Lesotho, for example, found that AGYW between the ages of 24 are more likely to have more than one sexual partner compared to AGYW age 15-18.[38] However, this age division is not necessarily universal.

AGYW may also be at the whim of their partners› risky sexual behavior. In the POWER study conducted in South Africa and Kenya in 2018, almost half of the AGYW interviewed (49 percent) did not know whether their partners had other sexual partners.[20]

Relationship to Sexual and Reproductive Health and HIV Testing, Prevention, and/or Treatment

This section examines AGYW's access to and habits regarding important preventive practices specifically related to HIV. For many in this group, such habits are uncommon; this is because they have a low consideration of their own risks, too little information and education about sexual health, and patriarchal relationship pressure that discourages them from seeking care without their partners' permission.

Despite a number of high-risk behaviors, AGYW can have a low perceived risk of HIV.

It is difficult to generalize findings amongst this heterogeneous audience; it is important to look at multiple research findings to see that risk perception is varied across AGYW.

2018 HIV Prevention Market Manager research revealed that AGYW use subjective probabilities to distance themselves from risk and/or overestimate their ability to evaluate their HIV risk.[56]

The 2017 OPTIONS research conducted in Kenya, for example, found that younger girls perceive less risk. This is true even though young women reported that the subject of HIV often comes up in conversation with her peers. AGYW may believe that their peers are at far higher risk of contracting the disease as they themselves are. The OPTIONS study found that for AGYW ages 18-24, only about 24 percent consider themselves at personal risk while 56 percent consider their peers at risk.

For those older AGYW who do consider themselves at personal risk, the primary reasons reported in the OPTIONS study included inconsistent condom use (56 percent) and not knowing whether their partners are faithful (50 percent).[16]

Similarly, in a 2017 study of risk and prevention behaviors among young women in South Africa, over 50 percent of participants underestimated or were unsure of their HIV risk.[14]

The risks and rewards of safe sex are evaluated emotionally and in a reactive manner, rather than cognitively prior to any risky behavior.

The 2018 HIV Prevention Market Manager research found that AGYW may experience transitory instances of feeling at risk. However this doesn't have the desired effect because the rewards of safe sex (e.g., not getting HIV) are too distant, while the costs (e.g., conflict if requesting a condom) are certain and immediate.[56]

Awareness of risk does not necessarily translate to an understanding or avoidance of risky behaviors.

Interestingly, of AGYW who do not consider themselves at risk, only 42 percent reported they "always" use a condom in the 2017 OPTIONS Kenya study; only 40 percent said they knew their partner's status, and 42 percent said they had only one sexual partner. These high numbers indicate these AGYW were either unaware of the risks in their behavior (and perhaps unaware of how HIV spreads), or that they were heavily influenced by their present bias.[16]

Alternatively, the reason may be less about understanding risk, and more about taking on risk willingly, in order for an AGYW to prove that she trusts her partner. Two-thirds of AGYW in the OPTIONS study reported using a condom at first sex, but abandoning condom use over the course of a sexual relationship, even with a partner of unknown status.[16]

Ultimately, risk may not always have the same effect on AGYW. They may feel resigned to HIV risk because they do not see a means of protecting themselves; alternatively risk can be motivating when they think about their future, their family, and their relationships.[14]

When the disease hits "closer to home", AGYW can be moved to action:

> **"My sister got HIV, and I saw her get sick and see her get her treatment. I don't want HIV."[14]** — AGYW in Kwadukuza, South Africa

Other studies have found that some AGYW do understand their risk.

Again, it is difficult to generalize, but multiple pieces of research have found that there are AGYW subgroups that do consider themselves at risk for HIV.[39] For example, the LVCT Health PrEP Demo Project in Kenya classified three groups of AGYW based on varied risk perception, comprised of those who:

1. Very clearly understand their risk and are early PrEP adopters.
2. Know their risk and need counseling and information on PrEP.
3. Absolutely do not perceive their risk and do not think they need PrEP.

Similarly, in the CHAI research of AGYW in Lesotho, 43 percent of AGYW self-identified as being at risk for contracting HIV. (Note, 51 percent of respondents had reached or were finishing secondary education; 32 percent were pursuing or completed tertiary education; only 2 percent had no formal education at all).[38]

- **Reasons for perceived high risk:** Those who consider themselves at a higher risk mention reasons like drugs and alcohol abuse, peer pressure to engage in sexual activities, multiple partners, unprotected sex, not knowing their partners› HIV status, living with and taking care of sick people who may potentially be HIV positive, and, in some cases, sexual assaults by older men.
- **Reasons for perceived low risk:** Those who consider themselves "low risk" most frequently mentioned reasons like having adequate information about HIV transmission and prevention, being exposed to trainings and workshops around HIV topics, and having support and advice from friends and family.

In general however, AGYW have far too little access to the information they need to protect themselves.

In Kenya, a 2016 study suggested that many AGYW receive conflicting and inadequate messages and information from their peers, elders, teachers, and church.[35]

> **"I viewed my body through layers of complicated misconceptions that the world told me and which, in turn, I told myself repeatedly until it became my truth."[40]** — AGYW in Kenya

Similarly, in Zimbabwe, some people hold the belief that promoting condoms to young people encourages them Similarly, in Zimbabwe, some people hold the belief that promoting condoms to young people encourages them to experiment with sex at an early age. More than half of adult respondents in a 2011–2010 Demographic and Health Survey felt that it is inappropriate to teach young people aged 14–12 about condoms.[41]

> **"You do not talk about these things with parents. It is just not done…Teachers cannot teach about sexual and reproductive health themselves because they are also not comfortable, they are parents themselves."[7]** — Mercy Kamau, stakeholder interview

This kind of reluctance to discuss sexual health with young people may contribute to a lack of understanding about HIV. For example, in Uganda, a 2014 progress report found that only 38.5 percent of young women and men aged 15-24 could correctly identify ways of preventing sexual transmission of HIV.[42] Similarly in Kenya, many AGYW cannot identify how HIV is transmitted; in a 2014 Demographic and Health Survey in Kenya, only 54 percent of young women correctly identified ways to prevent sexual transmission of HIV, compared to 64 percent of young men.[23]

Stakeholder interviews for the 2016 OPTIONS landscape analysis revealed that AGYW have several misinformed beliefs about sexual and reproductive health.[7] Examples of misinformation include:

- Having sex with a virgin will cure you of the HIV virus.
- If you wash your vagina with Coca-Cola after having sex, you will not become infected with HIV.
- Sex during ovulation is better because there is less risk of transmitting HIV (because the vagina is wetter).
- Condoms are spreading HIV/AIDS.
- If you have sex standing up, you will not become pregnant.
- Boys have "safe days" when they cannot make a girl pregnant.

Within their relationships, AGYW are also unable to speak openly about sexual health issues.

In the Lesotho DREAMS study, the majority of AGYW (52 percent) had never discussed sexual and reproductive health with their main sexual partner, and an even larger portion (68 percent) had never discussed it with other (secondary) sexual partners.[31]

The absence of open dialogue on these topics is definitely an urgent issue for HIV prevention and treatment efforts, and one that may need to be dealt with in tandem with educating and creating demand for PrEP.

> **"Men are reluctant to talk about HIV infection, especially if a man knows that he is HIV positive. We never discuss STIs and HIV because if we do, they threaten to leave us and they tell us that there are many fish in the pond!"[31]** — AGYW in Lesotho

Preferences for HIV prevention methods are not static.

In the 2017 OPTIONS research in Kenya, the majority of AGYW respondents had tested for HIV at some point in their lives and knew their status: 70 percent of younger AGYW (ages 15-17) and 90 percent of older AGYW (ages 18-25). Respondents were most likely to seek testing at government hospitals (54 percent) or private clinics (35 percent).[16]

The majority of AGYW respondents had tested for HIV at some point in their lives and knew their status.[16]

For older AGYW, approximately one in three tests every two to three months, and one in four tests every four to six months. At least 45 percent test irregularly, or only about once a year.[16]

A 2016 cross-sectional study of demographic surveys of youth (ages 15-24) across sub-Saharan Africa showed that young women were slightly more likely to have tested for HIV than men, although an individual's likelihood of HIV testing was based not only on sex but also on age, age at sexual debut, economic status, education, history of STIs, and other factors. Overall, young men had a testing prevalence of 23.1 percent, while women overall had a testing prevalence of 40.3 percent.[43]

Testing prevalence varies by country, as recent Demographic and Health Survey (DHS) rates show for youth age 15-19. Rates for women in these countries fall between 46 and 54 percent:

- In Uganda, a 2016 DHS showed that approximately 53.6 percent of women and 44.1 percent of men ages 15-19 had ever been tested for HIV.[44]
- In Zimbabwe, a 2015 DHS showed that approximately 46 percent of women and 35 percent of men ages 15-19 had ever been tested for HIV.[4]
- In Malawi, a 2015-2016 DHS showed that approximately 47.7 percent of women and 33.3 percent of men ages 15-19 had ever been tested for HIV.[46]
- In Zambia, a 2014 DHS showed that approximately 47.5 percent of women and 28.5 percent of men ages 15-19 have ever been tested for HIV.[47]

Research in South Africa of a wider age range showed slightly higher rates: 2013 research on the determinants of HIV testing among young people ages 18-24 showed 60.1 percent of women and 39.9 percent of men in that wider age group had ever tested for HIV.[48]

While some AGYW seem openly committed to regular testing so as to know their status, many have reported to require an excuse or an additional benefit in order to go through with it. For AGYW, with limited or no schooling, who don't like to admit they are at risk for HIV, they find a different reason to tell their friends and partners why they went to the clinic. In the South African context, for instance, the reason can be for "Discovery Vitality points" (health insurance bonus points) or because "I was already (at the clinic)."[8]

For AGYW, a negative HIV test can bring a wave of relief (and, in fact, may inadvertently encourage future risky behaviors[56]), which is why any communication of a negative result that doesn't message around ways of staying HIV free, may be a missed opportunity. Communication campaigns can leverage this critical moment by framing PrEP as a sure way to maintain the relief that a negative HIV test can provide.

Condom use and other safe sex practices are somewhat irregular.

Condoms, abstinence, and regular HIV testing are generally the HIV prevention methods young women promote most. In Kenya, according to the 2017 OPTIONS study[16]:

- **The most common reasons for using condoms:** avoiding pregnancy, fear of acquiring HIV and fear of acquiring a STI.
- **The primary reason for not using a condom:** "My sexual partner does not like condoms."

Condom use also seems to vary between AGYW's primary and secondary partners. In Lesotho, for example, AGYW have been found to use condoms more regularly with secondary partners (although use is still low). In the Lesotho DREAMS study, AGYW reported using condoms at last sex with secondary partners at a rate of 67 percent, and using condoms with main sexual partners 54 percent.[31]

Improved HIV treatments may be reducing the urgency of prevention.

Thanks to treatment advances, people with HIV can and do live long, productive lives. This, together with the destigmatization of HIV in some countries, has resulted in AGYW potentially overestimating their ability to live with the disease or to carry the constant responsibility of ART.

CASE STUDY

Engaging Men to Support Women's Health Care and Prevention

Due to gender power dynamics and social norms, men may play a vital role in PrEP uptake and adherence.

Women are interested in engaging men in their health care. For many AGYW, relationships are highly valued and play an important role in self-actualization and self-esteem.[98] AGYW seek symbols of loyalty and commitment, even in casual relationships—and in certain dynamics, PrEP (similarly to condoms) can be seen as a symbol of distrust.[14]

When preparing to roll out oral PrEP in Zimbabwe in 2017, the Pangea Zimbabwe AIDS Trust (PZAT) conducted a series of community dialogues; reports from conversations showed that in some heterosexual relationships, it would be more acceptable if the men were to introduce PrEP. This opinion, voiced by AGYW and adult women, is because PrEP is associated with extramarital relationships—a woman who introduced PrEP would be seen as unfaithful (while a man is generally allowed more freedom).[49]

Relatedly, a 2014 study in South Africa, Kenya, and Tanzania found that women prefer to have a steady partner's agreement to use microbicides.[50]

However, women in that study faced challenges in involving a male partner, due to a number of patriarchal stigmas and biases.[50] When deciding whether to engage their male partner, the decision was based on:

- The nature of their relationship.
- The partner's temperament.

- Their evaluation of how the partner might react if told in advance (versus finding out the product had been used without his knowledge).

Respondents in that study reported the following motivations for engaging men in their treatment:

- Promoting an open, trusting relationship.
- Preventing a disagreement or breakup.
- Gaining the partner's support in case the women later experience side effects or other problems.
- Feeling it was "the right thing to do" because their partners would also be exposed to an experimental product.
- Difficulty in explaining the sudden need to use condoms, frequent visits to the clinics, and/or the change in using lubrication during sex.
- Potential challenges hiding the applicators and inserting the gel.

In the same 2014 study, among men who were aware of their partner's microbicide use, involvement ranged from opposition, to agreement/non-interference, to active support. The study found that male partners often "need" to maintain a public appearance of authority/dominance; however, they were in many cases willing to participate in female-centric HIV interventions as long as their social standing isn't damaged by doing so.[50]

Women who decided to involve their male partners used a number of strategies to obtain partner approval, including using the product for a while before telling their partner, giving men information gradually, and continuing to bring up microbicides until resistant partners acquiesced. Note that in general, it was found that couples were more likely to discuss HIV risk, get tested, and use condoms at the beginning of a relationship.[50]

However, when engaging men in their female partners' health care, their own set of barriers must be addressed.

A growing number of studies across sub-Saharan Africa have highlighted that men are significantly less likely to get tested for HIV, or to enroll and adhere to antiretroviral therapy (ART) services.[51]

A 2014 study in South Africa, Kenya, and Tanzania found that men's attitudes toward health care and prevention create barriers to participating in their female partners' microbicide use.[50] A number of other studies in Zimbabwe, Kenya, South Africa, and Tanzania have specified some of these barriers:

- Being a patient is not considered masculine. Hospitals and clinics are perceived as female spaces, and the need to make appointments and show up on time is reportedly difficult for men, who feel that doing so conflicts with their masculinity.[51]
- Fear of HIV can lead to denial.[51] Grounded in a fear of HIV, many men appear to be in denial regarding the seriousness of HIV and AIDS, preventing them from accessing HIV-preventative information and seeking HIV services. In fact, men will actively avoid spaces where AIDS is being discussed. There are also lingering beliefs about HIV being "a death sentence," and a lack of messages about the ability to live a long and healthy life on ART.
- Avoiding testing is common. Men refused to receive HIV tests even when feeling unwell or when a partner was HIV positive. They want to "test by proxy," meaning they will determine their HIV status based on their partner's status.[51]

- Low awareness of treatment. The old ideas about ART—that it is only for those who are very ill, as it used to be—still remain in some areas. Many people are also not aware of the developments in ART and believe that ART is still a complicated multi-pill regimen; fear of outdated side effects (such as disfigurement) also persist.[50]

For these reasons, many experts suggest that strategies to engage men in their female partners' HIV interventions and treatments are important.[50] Both men and women expressed a desire for men to have access to information about microbicides. Some women and men said that it would be helpful if male partners could talk with a healthcare provider about microbicides. However, men rarely went to the clinics during the trials because of their work schedules, fear of HIV testing, and stigma.[37]

Health-related interventions are more effective and sustainable when they are gender transformative, engaging men in new ways.

Providing safe spaces where men can reflect on their current attitudes and behaviors and what it means to be a man, internalize messages, and try new, more gender-equitable behaviors is vital. Some studies have suggested that health facilities create separate spaces where men can feel more comfortable, and that more male healthcare workers be available for confidential conversations.[55]

Relationship to PrEP

When thinking about how best to influence an audience's behavior and encourage PrEP uptake, it is important to consider five factors: 1) awareness, 2) understanding, 3) benefits, 4) interest, and 5) barriers. This section looks at how AGYW currently understand and consider PrEP across these five dimensions:

1) Awareness is low.

2) Understanding is low.

3) Benefits for this audience (perceived) include freedom, autonomy, and an extra layer of protection.

4) Interest is strong (once understanding is established).

5) Barriers to uptake include fear of side effects, as well as the stigma (e.g., PrEP is associated with promiscuity).

Research shows awareness of PrEP is generally low among this group.

Awareness is low across sub-Saharan Africa. A 2017 report to USAID on South Africa confirmed that few women, even among those working in HIV-related fields, were knowledgeable about PrEP.[37] Almost one-third of those interviewed reported they had never heard of PrEP; some who reported having heard of PrEP had actually mistaken it for PEP or ARV medication.

Similarly, research in Zimbabwe revealed that awareness of PrEP among AGYW was low (except when they learned of it through past or ongoing research).[49]

In Kenya, nearly seven in 10 AGYW surveyed for the 2017 OPTIONS study were unaware of PrEP. For those who had heard about it, the most common methods of communication were either word of mouth or advertising; interestingly, only 15 percent of older AGYW (ages 18-25) had heard about PrEP through a medical professional.[16] This underscores the need for training to address common concerns and misconceptions around PrEP and improve healthcare provider and stakeholder knowledge.

In addition to greater awareness, there is very much a need for greater understanding.

Even those who are aware of PrEP are not necessarily confident in its effectiveness. In Kenya in 2017, OPTIONS found that few (13 percent of AGYW ages 18-25) consider PrEP to be an effective means of prevention.[16]

This highlights the need for education, as well as more opportunities for this group to become familiar with the product and how PrEP works. It's also essential to provide an understanding what PrEP can do for them beyond just reducing their HIV risk.

Understanding how PrEP works and fits into their lives is important for optimal adherence.

In the 2017 report to USAID, South African respondents read a short description of PrEP and how to take it, which included a very short communication about PrEP's mechanism. Many young women did not understand how PrEP would accumulate over time in the bloodstream, and therefore assumed there was a one-to-one relationship between taking the pill each day and being protected for that day.[37] Language that creates assumptions like these could lead to poor adherence patterns, or tip the scales of a cost-benefit analysis against PrEP.

It›s essential to keep in mind that not only is she being introduced to a new product, but she needs to figure out how to integrate it into her life and routines, which, at her life stage, may be in constant flux.[14]

There is interest in trying PrEP.

The 2017 OPTIONS research found that in Kenya, only 41 percent of older AGYW, ages 18-25, are interested in trying PrEP, the lowest rate out of all of the groups surveyed. Another 28 percent of AGYW said they were "unsure," however, this should be considered an opportunity.[16]

On the other hand, a couple of studies reveal that AGYW may, in fact, be more open to trying PrEP. The POWER study, for instance, conducted in Kenya and South Africa in 2018, reported that an average of 89 percent of AGYW initiated PrEP the same day as their clinic visit. It is, however, important to balance this knowledge with the fact that openness to PrEP initially is no guarantee for adherence. As was shown in the same study, the drop off rate was significant with 43 percent of AGYW persisting after one month.[20]

There are important emotional benefits to PrEP that resonate with AGYW.

- Security and feeling in control. In terms of "perceived benefits," over half of the respondents in the 2017 report to USAID on South Africa seemed to prioritize their "feeling secure and in control with PrEP." Feelings of "control" may be expressed in different ways. Women may feel empowered by the protection PrEP offers or they may interpret PrEP as a tool to ward off uncertainty[37]:

> **"I would have total control, oh ja, that would be a good feeling… Ja, ‹cause I can't get [HIV]! There is no way, it's protecting me as much as a condom…these pills will save my life. I am getting it, never mind."[37]** — AGYW in Johannesburg

> **"I would not know when I would get raped or have unprotected sex so I would rather be on the safe side."[37]** — AGYW in Cape Town

- Freedom from worry. The 2017 OPTIONS research in Kenya showed older AGYW (ages 18-25) found the idea appealing that they would not have to worry when the condom burst, and could live happier lives not having to worry about HIV.[16]
- Avoid stigma. In a qualitative study in South Africa and Kenya, adolescent girls found PrEP appealing because they could avoid the stigma associated with collecting condoms from a clinic.[52]
- Additional layer of protection. While this question hasn't, as far as we're aware, been asked of AGYW, it's

noteworthy that research has found that many serodiscordant couples felt safer when using PrEP. It can be seen as a backup to protect them either when their partner refuses to wear condoms or in cases of condom breakages.[53]

In addition to the emotional benefits mentioned above, the 2017 report to USAID on South Africa revealed that the following factors were predictive of a stronger interest to try PrEP[37]:

- A woman's personal assessment of her one-year HIV risk.
- The belief that one would be good at taking PrEP almost daily.
- Her expectation that she will use condoms less if she takes PrEP.

In the survey, the average woman rated the benefits of taking PrEP (in terms of feelings of safety and individual and community empowerment) as more influential on their decision to try it than the costs (in terms of side effects, clinic visits, and daily effort).

The expectation that condom use will reduce appeared in the 2017 OPTIONS research as well; close to one in three AGYW thought that PrEP would make condoms no longer necessary. This is a concerning misperception, and something that should be taken into account when educating this audience group about PrEP.[16]

Regardless of the benefit that resonates with a local target population, a finding of qualitative and quantitative research with AGYW in South Africa revealed that communicating about the emotional value of PrEP (e.g., safety, protection, health) before educating about PrEP's attributes and side effects (which can cause immediate concern) could be essential in catching AGYW's attention and interest and keeping it.[6]

AGYW's decision to try PrEP is influenced heavily by present bias.

In contrast to the public health perspective, which is focused on health, for young women, the value of trying PrEP is influenced heavily by present bias, which is the common tendency to value the costs and benefits right now over those of the future.

For instance, the 2017 report to USAID on South Africa shared responses of young women who, upon first learning about PrEP, were excited at the prospect of being able to have condomless sex without worry. This was cited as a primary motivator for some, followed by disappointment upon realizing that PrEP will not protect them against STIs.[37]

Some AGYW may need to "try" PrEP a couple of times before being able to fully commit to it.

The POWER study conducted in South Africa and Kenya in 2018 found there to be considerable drop-off of AGYW enrolled on oral PrEP after one month (about half did not persist) potentially revealing that the first month on oral PrEP is the most critical in terms of providing support and reassurance.[20] Furthermore, after three months, the drop-off number increased to eight in 10—in other words, only 20 percent of AGYW had persisted.

When asked why these AGYW decided to discontinue oral PrEP, the following reasons were given:

- No perceived risk (30 percent)
- Side effects (13 percent)
- Daily use difficult (13 percent)
- Abstinent (12 percent)

Interestingly, an average of 17 percent of these AGYW decided to restart oral PrEP after three months, indicating that, for some, it may take a couple of tries before being able fully commit to PrEP.[20]

For those AGYW who did persist after one month, while there was still some drop-off, adherence rates were far better. Forty-eight percent of AGYW continued to persist after three months and 40 percent continued to persist after five months.[20]

Communicating or framing PrEP in a way that is relevant to AGYW is critical.

> **"Facts are irrelevant. What matters is what the consumer believes."** — Seth Godin

A communication campaign about a new product (PrEP, in this case) needs to inform how it can meet a need of the target audience. For example, if a young woman desires safety in her relationships and wants to feel good about herself, an effective campaign can show if and how PrEP meets that need.[14]

To that point, making AGYW aware of PrEP requires more than merely promoting or raising awareness about it. It is about meeting AGYW in the right moments and dovetailing with her motivations. If PrEP is not framed in a way that is relevant to her life, HIV prevention will remain secondary to other, more pressing priorities such as, for instance, preventing pregnancy. Put another way, if PrEP is in contradiction with what motivates or inspires her and/or if it doesn't fulfill a relevant need, it will be ignored in favor of whatever is considered more important or desirable at the time.[14]

With an audience-specific introduction and explanation, a young woman can better understand PrEP and how PrEP fits into her life. In addition, empathizing with and addressing her concerns and perceptions not only helps her make a confident choice but also helps her communicate that choice to others.[14]

There are, in fact, three components (in addition to price and community acceptance considerations) that may prove critical when rolling out PrEP locally:

Emotional communications (goal: generate desire for PrEP) + rational communications (goal: address fears and concerns) + support (goal: deepen the understanding of how and when to take PrEP; provide emotional support to women to help them 1) navigate when PrEP is right for them and 2) stay adherent) = rollout set up for success.[6]

There are still barriers to be overcome, especially as PrEP is such a new concept for so many.

As PrEP is a new concept, young women harbor many questions and incorrect beliefs about the "dark side"[6] of PrEP, in other words, how it works and how they should use it.

Research-surfaced issues in the 2017 report to USAID in South Africa include: whether PrEP can be taken concurrently with other medications, whether it can be taken on an empty stomach, and whether one should continue taking it when they become sick or experience side effects, since it is seen as a medication that impacts the immune system.[37]

To this point, it will be important to invest in informational and educational communications that clear up

uncertainties and misconceptions (about side effects, for example), so that questions and concerns about PrEP now do not end up becoming barriers later.[14] However this educational component should, ideally, not occur before the emotional benefit of PrEP has been communicated, as was mentioned earlier.

Other common barriers expressed include:

- Side effects. Young women in South Africa (as reported to USAID) were very concerned about side effects, often proclaiming that side effects were a dealbreaker. However, once the short-term and manageable nature of side effects were emphasized, many felt they could persevere.[37]

> **"There are side effects with all medicines, and this pill has side effects that can make you vomit, have diarrhea, feel dizzy, and have some kidney problems. But after one month these get better. The pill is safe and won't harm your baby if you get pregnant."[6]** — AGYW, South Africa

- Fear and stigma. Fear of being judged and/or ostracized may prevent women from seeking information about their sexual health.[14] This is a major roadblock to overcome. As with many HIV interventions, being assumed to have HIV is a major barrier to uptake. This negative association overshadows for many that PrEP lowers HIV transmission. In the 2017 OPTIONS research in Kenya, AGYW said they were worried about PrEP being mistaken for ARVs.[16] Because AGYW definitely prioritize social acceptance, informational/educational materials that straightforwardly communicate how PrEP is not an ARV and how it's different from ARVs may be beneficial.
- Appearance of promiscuity. AGYW in Kenya and South Africa also face a barrier in terms of worrying that others will assume they are promiscuous. In the 2017 OPTIONS research, many said they consider it necessary to keep their PrEP use a secret as a result. (Note, AGYW in that study were also commonly worried about PrEP increasing the rate of unwanted pregnancies and prostitution.[16]) This was found to be true in South Africa as well.[6]
- Adherence challenges: AGYW may worry about what will happen if they cannot adhere to PrEP. At this stage of life, their lives can be in constant flux. New circumstances and influences that disrupt sustained PrEP use can, and may, arise frequently. A woman's discomfort or lack of knowledge in these circumstances can lead to a lapse in use, or can prevent her from starting PrEP in the first place. It may be beneficial to help AGYW anticipate new or difficult life circumstances and provide support to prepare them so they can continue using PrEP through or after these changes.[14]
- Support and reassurance is of paramount importance. Research of AGYW in South Africa found that support and reassurance from the appropriate people in the appropriate settings (e.g., a health care professional or an experienced user of PrEP) is essential to encourage uptake and adherence.[6] Support may be especially critical in the first month of initiation onto PrEP when AGYW have many questions.[20]

How to Reach and Connect with AGYW: Best Channels to Connect

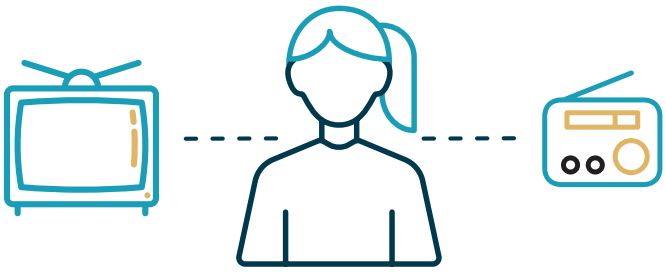
The following details reflect the findings of the 2017 OPTIONS study, conducted in Kenya. Except where otherwise noted, the insights listed below are specific to AGYW in Kenya; like all insights in this document, these are only a starting point for further investigation focused on a specific audience and context.

In Kenya, AGYW's main interests include:[16]

Singing, watching TV, watching movies, listening to music, going to church, and socializing with friends.

Across Kenya, radio and TV are the best way to reach AGYW on mass media.[16]

88% of AGYW own a TV set and/or a radio[16]



The internet may also be effective, especially as it is already used for facilitating other sexual behavior.

The internet is widely available—91 percent of individuals have access to a cellphone; of these, 79 percent have access to a smartphone and 86 percent have their own cellphone. Thirty-one percent own a computer.[16] This has opened new channels for pursuing transactional sex; for example, "sugar daddy" and "blesser finder" websites are increasingly accessible for AGYW to find older men for sponsor or transactional sex. Examples of "blesser-finder" websites include blesser360-.co.za and blesser.club.

Urban AGYW can source a great deal of their information on sexual health from their online networks, whereas rural AGYW need to go offline to source theirs.[16]

In a stakeholder interview conducted by OPTIONS in 2016, experts said urban AGYW primarily rely on information found on the internet and social media, while rural AGYW get information from their aunts, extended relatives, or friends.[7] Other sources of information include seminars, talks at school, peer educators, and guidance counseling groups.[16]

AGYW are more receptive, and give more credibility, to the following sources[16]:

- TV
- Radio
- Health care centers/hospitals
- Talks at school/campus
- Social media

Note, just because a recommendation comes from a medical professional does not mean it is the most credible source, especially for this audience.[37]

AGYW themselves offer a wide range of ideas for communicating about PrEP.

For the 2017 report to USAID on South Africa, AGYW were asked about the best methods to relay PrEP promotion and educational messages effectively to young women like them. Participants in three different studies proposed[37]:

- Peer educators/counselors.
- Health centers.
- Community healthcare workers of matched age (when possible).
- Support groups.
- Seminars.
- Talks at schools, campuses, and churches.
- The internet[6] and social media (including videos and chat groups) .
- Radio and television.
- PrEP ambassadors.
- Social events where AGYW can connect with one another about unrelated topics, e.g., beauty, fashion etc.

The Routes2Results research in South Africa confirmed that AGYW are most likely to try PrEP as a result of recommendations from healthcare professionals, followed by the government and female influencers.[6]

How to Reach and Connect with AGYW: Best Tactics to Connect

Condom dispensaries may serve as key touchpoints for communication.[38]

As reported in the 2017 CHAI study in Lesotho, women may get birth control pills and condoms from a range of locations, depending on their preferences and level of comfort (note, many AGYW are afraid to get or buy condoms for fear of being judged).[38] Existing dispensary locations to consider include:

- Pharmacies, clinics, hospitals, schools and specifically adolescent/youth corners at hospitals.
- Service organizations.
- Youth centers.
- Supermarkets, bathrooms in malls and bars, and other public places.

Explore cultural and youth-focused channels online.

As can be seen all around us, AGYW are highly influenced by global youth culture through social media and online. The influence of social media on sexual behavior and risk has been increasingly researched and understood—there are opportunities to deliver prevention messages through these influential media.

> **"It's very possible that blessers were always around, but it's just now—because of the highly narcissistic quality of Instagram—we get this insight into how these people are living."[54]** — Anthropologist quoted on PRI.org

Connect through AGYW's influencers.[37]

A 2016 stakeholder interviews for the OPTIONS Kenya landscape analysis suggest that, because AGYW are in a self-discovery phase, their behavior is usually driven by peers, especially those in urban areas.[7] AGYW's trusted advisors and confidants may be a mix of friends, family, or local role models, but if PrEP is also new and unfamiliar to them they may not be able to offer much support.[14]

A mother is a key influencer in a young woman's life and often can be the primary driver of the adoption of PrEP. Parents need to understand the importance of PrEP as an HIV-prevention option so they can support their children.[8]

Additionally, role models—who can include from parents, teachers, and celebrities—influence their behavior. In some parts of rural Kenya, the influence of aunts and grandmothers is also heavy. Larger social circles are influential, but when AGYW face intimate challenges, direct personal support is sought from a select few.[14]

Research in South Africa has also revealed that AGYW find experienced female users and older women to be more influential in their decision to choose a specific HIV prevention intervention.[6]

For consideration is the fact that matriarchs (mothers, grandmothers, aunts), nurses and community health workers have different, potentially complementary strengths when it comes to positively influencing AGYW. Currently these influencers operate in silos but an interesting question to explore locally may be how opportunities can be created for communication and collaboration between them (while still respecting AGYW's need for confidentiality) for a more effective outcome.[56]

For a campaign that targets AGYW's influencers, these connections may be considered a useful starting point. In fact, local experts in the Lesotho DREAMS study suggested targeting messages to these groups as an important component of encouraging young women's uptake and adherence to PrEP.[31]

Support better adherence rates.

In terms of supporting AGYW with the goal of adherence, the following tactics were used in the POWER study in Kenya and South Africa in 2018 with some measure of success[20]:

- WhatsApp to send SMS/texts about follow-up appointments
- Monthly peer-led adherence clubs where those AGYW using PrEP could address questions and concerns
- Adolescent and youth-friendly services i.e. homework clubs at the clinic
- Combination of services (e.g., family planning, psycho-social care etc.)
- Helping AGYW figure out the best way to disclose that they are using PrEP

To Keep in Mind for Engagement in Sexual and Reproductive Health and HIV Testing, Prevention, Treatment

Accessibility and approachability of HIV testing and PrEP services is critical.

Interviews in the 2017 report to USAID on South Africa highlighted concerns about the accessibility and convenience of HIV testing and PrEP services for young women, especially due to staff biases against sexually active young women.[37] Young women were especially enthusiastic about mobile clinics and HIV testing services.

To address accessibility needs, women encouraged private services be offered in close proximity to where young women live and spend time, with well-advertised, consistent schedules. Service staff should be approachable; they should be able to relate to young women, and should provide private, professional, and nonjudgmental health services.[6]

Approachability of health professionals is important because their biases may be discouraging to women who discontinue or face adherence challenges. AGYW crave safe, judgment-free opportunities to talk about sexual and reproductive health issues and get information, but some younger women may be afraid to ask sensitive questions.[14] There is an opportunity for healthcare providers to create a safe space during visits where AGYW can talk about PrEP.

> **"As much as [healthcare providers] are educating us, they should not preach. They must not force the information."[6]** — AGYW in Urban Western Cape, South Africa

The appropriate context for advice and support is critical.

70 to 90 percent of AGYW agree that access and advice should be personal and nonjudgmental, from educated/professional persons, experienced users, or older women. It should also be offered in private spaces and through the internet and multimedia platforms.[6]

To Keep in Mind for Engagement in Sexual and Reproductive Health and HIV Testing, Prevention, Treatment

Emphasize that PrEP does not replace condoms for STIs and pregnancy.

Research in South Africa found general enthusiasm for the idea that PrEP could be used instead of condoms.[37] There is a need to emphasize that PrEP will not protect against STIs or pregnancy, and that condoms and/or family planning methods are still needed.

In informational and educational materials, descriptions of PrEP must be comprehensive but still simple enough to be well understood.

The research in South Africa also found that descriptions of PrEP should be kept simple—but that it may also encourage adherence (and help users feel more protected in times of missing a pill) if clinics provide patients with a clear description of how PrEP works.[37]

Such a description should include PrEP's HIV-specific role in the immune system, how long it takes to be optimally protective in the body, and how long it takes to leave the bloodstream. User instructions could explicitly address PrEP's effectiveness at four or more pills per week, the safety of taking concurrent medications (including over-the-counter medications for flu and cold), and why experiencing side effects is not a sign of long-term harm in the body.

Give AGYW a reason to care.

When introducing PrEP to AGYW, leverage moments and relatable stories that make risks feel real in her life, especially in situations when she is considering her health proactively or feels at risk (like when she goes in for health tests or following a health scare).[14]

PrEP can also be connected to AGYW›s values. In South Africa, for example, this could mean linking the brand to the concept of female empowerment—individually or in terms of the collective—or positioning the product in the self-care or beauty categories, e.g., makeup or skincare.[8]

A PrEP campaign needs to stand out from any HIV prevention campaign that has come before it.

In some countries there may be high saturation of HIV messaging, and the word "HIV" can act as a cue for disengagement. If this applies to your local context, your strategy will need to adapt accordingly.

The experienced users can play a useful role.

Experienced users of PrEP have an important role to play as ambassadors of the prophylactic. Product anxieties are a significant barrier to PrEP uptake, therefore, leveraging experienced users to allay any fears about PrEP can drive improvement in the perception of the pill.[6]

HIV-prevention products can be instruments for social change.

Due to lack of knowledge and stigma around HIV and sex, AGYW may not consider their communities as sources of information, making this critical influencer a barrier or a disabler of behavior change. Existing negative community stances on HIV and sex causes concern to AGYW and discourages them from using HIV prevention. There is a need to inform and educate the communities in which AGYW live about PrEP in order to ensure acceptability of the pill.[6]

The research for the AGYW profile was based largely on six resources including a study of consumer preferences (Routes to Results 2017), a stakeholder interview (OPTIONS 2016), a product design guide for the dapivirine ring which include human centered design (USAID 2017), a market intelligence report (OPTIONS 2018), a study of male sexual partners of AGYW (Jhpiego 2017), and a formative work report (POWER Study Team 2017). The resources included respondents from South Africa, Uganda, Kenya, and Lesotho. Respondents ranged in age with a focus on AGYW between 15 to 24 years old, and men ages 18-65. The sample size ranged from one stakeholder to several hundred respondents, and included sexually active men and women, AGYW, health providers, community leaders, and a program implementer. Most of the data were gathered in 2016 and 2017.

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