



EMPOwHER CHOICE

Meaningful HIV Prevention Choice for Adolescent Girls and Young Women

Baseline findings • Evidence and advocacy brief • Programme action

Selected communities across Gauteng Province

Including Soweto, Soshanguve and surrounding communities | South Africa 2026

Executive Summary



EmpowHER CHOICE Ambassadors, South Africa Y+ Global, 2026

1. Context and implementation question

The HIV prevention landscape is changing rapidly. The expansion of pre-exposure prophylaxis (PrEP) options, including long-acting injectable technologies, creates opportunities to address barriers associated with daily or more frequent use of prevention. In July 2025, the World Health Organization recommended twice-yearly injectable lenacapavir (LEN) as an additional option within combination HIV prevention.



Implementation question: To what extent do the current HIV prevention landscape and service environment enable AGYW to understand, consider and access options that fit their needs and circumstances?

2. Aim

The EmpowHER CHOICE baseline assessment generated evidence on HIV prevention knowledge, information sources, preferences, service access and decision-making among AGYW in and around Soweto to inform implementation, adaptation and advocacy.



Design boundary: This was an implementation-learning assessment, not a population prevalence study or causal evaluation.

3. Methods

Design and data sources

A mixed-methods implementation-learning assessment combined an electronic self-administered survey with a focus group discussion and key informant interviews. The survey measured prevention awareness, knowledge, information sources, preferences, service experience and decision-making; qualitative data provided contextual and experiential insight.

Analysis

Survey data were summarised using frequencies and percentages; qualitative data were analysed thematically.

Integration:

Quantitative and qualitative findings were analysed separately and integrated interpretively; they were not statistically pooled.

Sample

Purposive implementation-learning sample:

Data source	n
Survey	14
FGD: AGYW aged 17 years	3
Key informants	3
Total	20

Evidence boundary:



Results describe a small purposive sample and should not be interpreted as population-level estimates, causal evidence, or evidence of future behaviour.

Analytic denominator:

Principal quantitative findings use 12 substantive survey responses unless otherwise stated.

4. Results at a glance

Awareness and knowledge

- ▶ 12/12 (100%) had heard of HIV prevention methods.
- ▶ Awareness varied across male condoms (12/12; 100%).
- ▶ Oral PrEP (9/12; 75%).
- ▶ Female condoms (8/12; 67%).
- ▶ HIV testing services (8/12; 67%).
- ▶ Injectable PrEP (7/12; 58%) and PEP (7/12; 58%).

Interpretation: General awareness was high, but knowledge varied across specific options. Accessible, comprehensive information is needed to support informed choice, including around long-acting technologies.

Provider interaction and counselling

- ▶ 9/12 (75%) valued healthcare workers' advice.
- ▶ Only 4/12 (33%) said providers always or often listened, while 7/12 (58%) had avoided questions for fear of judgement.

Interpretation: Product availability alone may not enable informed choice, uptake or sustained use. Respectful, non-judgemental and choice-enabling counselling is essential.

Prevention preference and choice

- ▶ 10/12 (83%) selected long-acting injectable PrEP as their preferred option if available.
- ▶ 9/12 (75%) would consider an alternative if their preferred option was unavailable.

Interpretation: The findings signal programme-level interest in long-acting prevention and support a choice-based approach. They are not population estimates or evidence of preference for LEN specifically.

Autonomy, decision-making and support

- ▶ 12/12 (100%) retained the final decision about prevention use.
- ▶ 4/12 (33%) had experienced pressure not to use prevention, while 5/12 (42%) needed advice when making decisions.

Interpretation: Autonomy can coexist with a need for trusted advice. Programming should strengthen informed, voluntary choice and protect young people from judgement, misinformation and undue pressure.

5. Central programme proposition

Core implementation message



Expanding HIV prevention options will create public-health value only when AGYW also have the information, autonomy, supportive services and practical access required to choose meaningfully among them.

6. Priority programme actions

- | | | | |
|---|--------------------------------|---|--|
| 1 | Strengthen prevention literacy | → | Explain prevention methods, benefits, limitations and follow-up requirements clearly and accessibly. |
| 2 | Deliver balanced counselling | → | Present available options impartially, without directing AGYW towards a preferred product. |
| 3 | Improve service quality | → | Ensure every interaction is confidential, respectful, youth-responsive and non-judgemental. |
| 4 | Offer meaningful choice | → | Provide appropriate alternatives and clear referral pathways when a preferred method is unavailable. |
| 5 | Support access and continuity | → | Reduce practical barriers and enable initiation, continuation and switching as needs and circumstances change. |

7. The HIV prevention landscape and implementation context

Policy and programme

A new era of HIV prevention requires a new approach to choice

HIV prevention programming has traditionally prioritised awareness, commodity availability and service coverage. These remain essential, but the landscape is changing rapidly as biomedical options expand across different dosing schedules, routes of administration, durations of protection and service-delivery requirements (World Health Organization [WHO], 2022, 2025).

Scientific and policy context

WHO recommends multiple pre-exposure prophylaxis (PrEP) options, including oral and long-acting injectable PrEP. In July 2025, WHO recommended twice-yearly injectable lenacapavir (LEN) as an additional HIV prevention choice for people at risk of HIV infection, alongside existing PrEP options (WHO, 2025).

The PURPOSE 1 phase 3 trial evaluated twice-yearly subcutaneous LEN among adolescent girls and young women aged 16–25 years in South Africa and Uganda. No HIV infections occurred among participants assigned to LEN during the trial, demonstrating 100% efficacy against HIV acquisition in the trial population (Bekker et al., 2024). This provided important evidence for LEN as a highly effective long-acting prevention option.

South Africa has moved from evidence generation to implementation. The national rollout of twice-yearly injectable LEN was launched in June 2026, reinforcing the need for programmes serving AGYW to consider not only how new technologies are introduced, but also how they are understood and accessed (WHO, 2026).

Programme significance

A broader prevention portfolio can respond to differences in preferences, convenience, perceived stigma, privacy, adherence considerations, and service access needs. Its significance, therefore, extends beyond introducing another product: it creates a responsibility to ensure that prevention choices are informed, voluntary, appropriate, and equitable.

“ New prevention technologies must be introduced within systems that enable informed, voluntary and equitable choice. ”

Conditions for meaningful choice

For AGYW, prevention programming must consider not only which products are available, but whether the following conditions are in place:

Condition	What it requires
Awareness	AGYW know which prevention options are available.
Understanding	They understand how the options work and how they differ.
Preference expression	They can communicate their preferences, questions and concerns.
Respectful counselling	Providers listen, respect preferences and support informed decision-making.
Confidentiality	Services protect privacy and personal information.
Practical access	Appropriate options are realistically accessible through acceptable service pathways.
Continuity and adaptation	AGYW can continue, switch or modify prevention as their needs and circumstances change.

Together, these conditions reflect a person-centred approach to HIV prevention: the availability of technologies must be matched by the information, services and enabling environment people need to make and act on informed decisions (WHO, 2022, 2025).

8. The knowledge gap

The missing element is not simply another prevention product

Expanding the range of HIV prevention technologies does not, by itself, resolve the implementation barriers that shape whether AGYW can understand, consider and access options suited to their needs and circumstances.

HIV prevention research shows that uptake and sustained use depend on more than biomedical efficacy. They are also shaped by knowledge, acceptability, perceived risk, stigma, social and interpersonal influences, provider interactions, and the accessibility and responsiveness of services (WHO, 2022; UNAIDS, 2025).

The EmpowHER CHOICE baseline therefore examined the conditions that enable meaningful prevention choice, rather than product availability alone. It considered AGYW's knowledge and awareness, information sources, preferences, decision-making, service access and use, experiences of care, barriers and facilitators, and the wider community and health-system context for implementation.

Assessment questions

The baseline examined six closely related dimensions of meaningful prevention choice:

1	Knowledge	→	What do AGYW know about HIV prevention?
2	Information	→	Where do they obtain prevention information?
3	Preference	→	Which prevention options do they prefer?
4	Influence	→	What shapes those preferences?
5	Service experience	→	How do they experience prevention-related services?
6	Decision-making	→	Which individual, interpersonal and service factors shape their prevention decisions?

Together, these questions provide a programme-level view of the prevention landscape and the contextual conditions likely to shape implementation.



Evidence boundary: The findings establish a programme-level baseline for future implementation learning and adaptation. They are not population-level estimates of AGYW knowledge, preferences or prevention uptake.

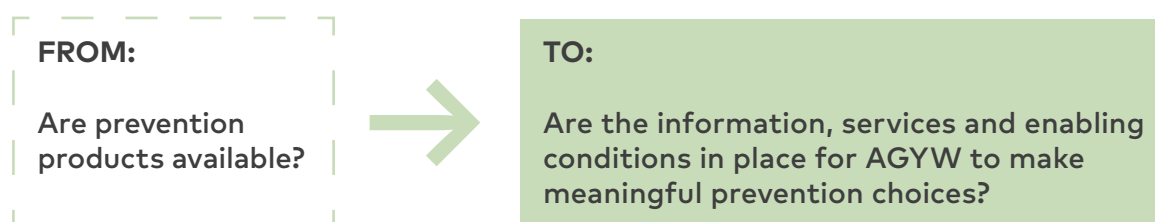
Central implementation question



To what extent do the current HIV prevention landscape and service environment enable adolescent girls and young women (AGYW) to understand, consider and access prevention options that fit their needs and circumstances?

This question connects the baseline evidence to the advocacy purpose of EmpowHER CHOICE by widening the focus from product availability to the conditions required for informed, voluntary and practical choice.

Strategic shift



9. Why meaningful choice matters as prevention options expand

Finding 1: Awareness was high, but knowledge of specific prevention options varied

Evidence snapshot

Among 12 survey respondents:

Indicator	n/N	%
Heard of HIV prevention	12/12	100%
Heard of PrEP	12/12	100%
Heard of PEP	10/12	83%
Recognised oral PrEP	9/12	75%
Recognised injectable PrEP	7/12	58%
Rated prevention knowledge 4–5/5	11/12	92%

- ▶ Respondents used healthcare facilities, community outreach, social media and educational settings for prevention information.
- ▶ All 12 had mobile-phone access, and 10/12 (83%) reported daily internet access, supporting a multichannel communication approach.

Interpretation and programme implication

General awareness was high, but recognition of specific prevention options was uneven. Hearing about HIV prevention does not necessarily equip AGYW to compare methods or identify an appropriate option. The programme priority is therefore to move from information **exposure to practical prevention literacy**.



Advocacy position: Every new prevention option requires informed users, not only informed programmes.

Programme pathway



Priority actions

- ▶ Build practical prevention literacy so AGYW can compare available options.
- ▶ Explain each option clearly, including use, benefits, limitations, follow-up and potential side effects.
- ▶ Use healthcare, community, education and digital channels to reinforce consistent information.
- ▶ Present options impartially, without promoting one product over another.



Accountability question: Can AGYW explain the available prevention options well enough to make an informed and voluntary decision?

Finding 2: Long-acting injectable prevention generated strong interest in this sample

Evidence snapshot

Among 12 survey respondents:

Indicator	n/N	%
Preferred long-acting injectable PrEP	10/12	83%
Preferred daily oral PrEP	2/12	17%
Would consider an alternative if preferred option was unavailable	9/12	75%

- ▶ Preferences were associated with ease of use, convenience, perceived effectiveness, trust and ease of access.

Interpretation and programme implication

10/12 (83%) is a programme-level signal of interest in long-acting injectable prevention, not a population estimate or evidence of preference for LEN specifically. The defensible conclusion is that long-acting prevention may appeal to some AGYW and that convenience, effectiveness, trust and access should inform implementation.



Advocacy position: Investment in new prevention technologies should be matched by investment in the systems that enable meaningful choice.

Priority actions

- ▶ Prepare providers to explain oral and long-acting options accurately and impartially.
- ▶ Create space for questions, preferences and voluntary decisions.
- ▶ Establish referral pathways when a preferred option is unavailable.
- ▶ Monitor initiation, continuation, switching and discontinuation separately.



Accountability question: Are we introducing LEN as another product, or building a system in which AGYW can make informed choices across appropriate prevention options?

Finding 3: Healthcare workers are influential, but interactions do not consistently enable choice

Evidence snapshot

Indicator	n/N	%
Preferred face-to-face counselling	10/12	83%
Discussed prevention with a healthcare worker	9/12	75%
Considered healthcare-worker advice extremely important	9/12	75%
Providers always/often listened to opinions	4/12	33%
Avoided questions because of fear of judgement	7/12	58%

Interpretation and programme implication

Healthcare workers were influential, but advice alone did not ensure that AGYW felt heard or able to ask questions. As prevention options expand, programmes need better counselling (not only more commodities) with listening, balanced explanation, confidentiality and voluntary decision-making treated as core quality standards.

Priority actions

- ▶ **Listen:** Elicit preferences and concerns.
- ▶ **Explain:** Provide accurate, balanced information.
- ▶ **Respect and protect:** Use non-judgemental communication and safeguard confidentiality.
- ▶ **Support:** Allow time for questions and voluntary decisions.



Advocacy position: Provider readiness is a prerequisite for meaningful prevention choice.



Accountability question: Do providers support AGYW to choose, or do service interactions unintentionally narrow their options?

Finding 4: Service access extends beyond whether a clinic exists

Evidence snapshot

The focus group discussion identified several barriers affecting prevention-related service experiences:

Reported barrier	n/N	%
Fear of judgement; lack of privacy; negative provider attitudes; need for caregiver support/permission	10/10	100%
Shyness or embarrassment; fear of being seen; school commitments	7/10	70%
Not knowing where to go	6/10	60%

Evidence boundary:



These qualitative-response counts describe the assessment sample and the nature of reported barriers; they are not population estimates.

Interpretation and programme implication

Clinical effectiveness and service availability do not guarantee practical access. Judgement, limited privacy, inconvenient service arrangements and weak navigation can prevent AGYW from using services safely and confidently.



Advocacy position: Access means being able to use prevention services safely, privately, conveniently and respectfully, not simply having a clinic nearby.

Priority actions

- ▶ Protect privacy and confidentiality through youth-responsive service design.
- ▶ Reduce waiting and offer convenient service times.
- ▶ Improve navigation, referral and community or peer-supported access.
- ▶ Monitor service experience alongside utilisation.



Accountability question: Can AGYW use prevention services safely, privately and conveniently when they need them?

Finding 5: Autonomy is reported, but choice exists within a social environment

Evidence snapshot

Indicator	n/N	%
Would make the final prevention decision themselves	12/12	100%
Reported high decision-making confidence	11/12	92%
Experienced pressure not to use prevention	4/12	33%
Needed advice before deciding	5/12	42%

Interpretation and programme implication

Seeking advice does not necessarily reduce autonomy. AGYW may consult trusted people while retaining ownership of the final decision. Programmes must therefore ensure that social and service influences support informed, voluntary choice rather than create undue pressure.



Advocacy position: Autonomy requires more than the final say; it requires conditions that allow choice to be exercised freely and meaningfully.

Programme conditions for autonomy

- ▶ Accurate information and appropriate options.
- ▶ Trusted providers, privacy and confidentiality.
- ▶ Supportive relationships and freedom from judgement.
- ▶ Protection from undue pressure.



Accountability question: Do programme and service conditions enable AGYW to make prevention decisions freely, with support but without pressure?

Finding 6: The evidence points to a choice-enabling system

Cross-cutting interpretation

Across the findings, five interconnected implementation conditions emerge:

1	Prevention literacy	→	AGYW understand the available prevention options.
2	Meaningful choice	→	Appropriate options are offered rather than a single default.
3	Supportive providers	→	Providers listen, explain and respect preferences.
4	Enabling services	→	Services provide privacy, confidentiality, convenience and practical access.
5	Continuity	→	AGYW can continue, switch or modify prevention as circumstances change.



Central implementation proposition: New prevention technologies expand what is possible; choice-enabling systems determine whether that potential is realised.

Implementation takeaway

“ The key question is not only whether LEN will be available, but whether AGYW will have the knowledge, autonomy, supportive services and practical access needed to decide whether LEN—or another appropriate prevention option—is right for them. ”



Evidence boundary: The baseline did not specifically measure preference for LEN. It supports future testing of a choice-enabling implementation model as long-acting prevention options become available.

10. The EmpowHER CHOICE advocacy framework

Translate expanded HIV prevention options, including long-acting technologies, into informed choice, uptake and sustained use through seven programme commitments.

Commitment	Programme standard
Inform	Ensure AGYW understand the prevention options available to them.
Offer choice	Provide appropriate options without directing AGYW towards one product.
Listen	Hear and respect AGYW preferences, questions and concerns.
Protect	Safeguard privacy, confidentiality and voluntary decision-making.
Facilitate access	Reduce practical, social and service barriers.
Support continuity	Enable continuation, switching and adaptation as needs change.
Measure what matters	Assess whether services create meaningful choice, not only commodity delivery.

11. Priority implementation questions for LEN and other long-acting options

As LEN enters the prevention landscape, implementation learning should address five questions:

1	Understanding	→	Do AGYW understand what LEN is, how it is administered and how it differs from other PrEP options?
2	Preference	→	What shapes consideration of LEN, oral PrEP or other available options?
3	Provider readiness	→	Can providers explain multiple options accurately and without directing choice?
4	Access and continuity	→	Can AGYW obtain LEN when appropriate and return for follow-up visits?
5	Switching and choice	→	Can AGYW move between options as circumstances, preferences or needs change?



Evidence boundary: These are implementation questions for the future, not findings from the current baseline.

12. Discussion

The central lesson: choice requires an ecosystem

The baseline does not indicate that any prevention product will be preferred or adopted by AGYW at the population level. Its value lies in showing that prevention choice sits within an interconnected ecosystem of *knowledge, preferences, providers, services, social influence, and access*.

Implementation gap	Likely consequence
New product without adequate information	Confusion and weak informed choice.
Information without appropriate options	Unmet expectations.
Options without respectful providers	Constrained meaningful choice.
Services without privacy	Reduced engagement.
Effective method without continuity systems	Interrupted prevention use.

The scientific and programmatic implications are clear: biomedical efficacy is only one component of public health impact. Implementation must also enable people to understand, access, choose, initiate and continue prevention in real-world conditions.

For LEN and other long-acting approaches, public health value will depend on appropriate HIV testing, clinical follow-up, service readiness, equitable access, and sustained engagement.

13 Conclusion

Meaningful choice turns prevention options into prevention opportunities

The baseline was conducted as HIV prevention options were expanding. Awareness was high, but knowledge of specific options varied. Most respondents preferred long-acting injectable PrEP if available, while many would consider an alternative. These programme-level findings do not establish population preference or preference for LEN specifically.

The qualitative evidence shows why product availability alone is insufficient: judgement, limited privacy, provider attitudes and practical barriers shape service experience. The strategic opportunity is therefore to build a **choice-enabling HIV prevention system**.

System capability	What AGYW should be able to do
Understand	Know which options are available and how they differ.
Consider	Assess which options fit their circumstances.
Choose	Decide freely and voluntarily.
Access	Obtain the option they choose.
Continue	Remain engaged in prevention over time.
Adapt	Switch or modify prevention when needs change.

Investment in technologies such as LEN should be matched by investment in the people, information, services and systems that make meaningful choice possible.

Final advocacy message



“AGYW need more than additional HIV prevention products. They need meaningful choices they can understand, access, trust and use on their own terms.”

14 References

- ▶ Bekker, L.-G., Das, M., Abdool Karim, Q., et al. (2024). Twice-yearly lenacapavir or daily F/TAF for HIV prevention in cisgender women. *New England Journal of Medicine*, 391, 1179–1192. <https://doi.org/10.1056/NEJMoa2407001>
- ▶ Delany-Moretlwe, S., Hughes, J. P., Bock, P., et al. (2022). Cabotegravir for the prevention of HIV-1 in women: Results from HPTN 084, a phase 3, randomised clinical trial. *The Lancet*, 399 (10337), 1779–1789.
- ▶ World Health Organization. (2025). *Guidelines on lenacapavir for HIV prevention and testing strategies for long-acting injectable pre-exposure prophylaxis*. Geneva: World Health Organization.
- ▶ World Health Organization. (2025, July 14). *WHO recommends injectable lenacapavir for HIV prevention*.
- ▶ World Health Organization. (2024). *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: Recommendations for a public health approach*. Geneva: World Health Organization.
- ▶ World Health Organization. (2026, June 15). *WHO applauds South Africa's leadership in advancing HIV prevention through lenacapavir rollout*. [WHO rollout update](#)
- ▶ UNAIDS. (2024). *HIV and adolescent girls and young women: Thematic briefing note—2024 Global AIDS Update*. [UNAIDS thematic briefing note](#)

