Service Delivery Modality	Author (Year) and study setting	Publication type and objectives	Study population and Sample	Intervention description	Detailed Description of Findings
Studies among AGYW					
Health facility[a]	Maseko et al. (2020)[39] Malawi	Research article To understand knowledge of, interest in, concerns about, and delivery preferences for PrEP among AGYW enrolled in the Girl Power study.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Sample size (total – N):*** 40 ***Gender distribution:*** Female: 100% ***Age distribution:*** 15-19yrs: 21; 20-24yrs: 19	***Nature of Intervention:*** Four models of service-delivery were compared in four separate clinics: Model 1) standard of care (SoC), Model 2) Integrated youth-friendly health services; Model 3) Model 2 plus a small-group behavioural intervention on; and Model 4) Model 3 plus a cash transfer ($5.50/month). An explanation of PrEP was provided to 40 participants prior to IDI ***Intervention components:*** HIV testing, syndromic management of STIs, family planning, and condom distribution. **NB:** PrEP was not provided in this study, nor was it available in government clinics at the time of the study.	• Interest in PrEP based on a belief that their HIV risk exposure was due to factors that were out of their control, including partners having concurrent relationships, challenges with condom negotiation/use, and rape. • Disinterest in PrEP included: perception of low risk because of abstinence or having a single partner, use of PrEP implying infidelity among married AGYW, taking pills daily implying HIV infection. • Interest in initiating PrEP depends upon: - ease of accessing PrEP (confidential), - packaging attributes (discrete, cartons, packets, or bottles that would give the appearance of medications for common ailments preferred - delivery context (available in locations frequented by youth such as schools or youth friendly spaces because of ease of access and comfort in the absence of adult patients and family members).

Health facility[b]	Mugwanya et al. (2019)[31] Kenya	Research article To demonstrate the feasibility of integrating PrEP delivery within routine family planning clinics to reach at-risk AGYW for PrEP in HIV high burden settings.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 1271 ***Gender distribution:*** Female: 100% ***Age distribution:*** Median: 25 (22-29) <20: 105 20-24: 522 25-29: 356 30-34: 172 ≥35: 116	***Nature of Intervention:*** PrEP-dedicated nurse-led integrated delivery of PrEP in family planning clinics ***Intervention components:*** Newly hired nurses were trained on HIV risk assessment, counselling, and PrEP provision. These nurses performed only these duties at the FP clinic. Women attending FP clinics completed other services were then referred to the PrEP-dedicated nurse. This nurse counselled and assessed willingness to consider PrEP (guided by a national guidelines and HIV risk assessment screening tool). Interested and medically eligible women were provided same-day PrEP initiation.	• Of 1,271 women screened, 22% initiated PrEP, and 41% returned for at least one refill. • PrEP uptake was independently associated with reported male-partner HIV status ($p < 0.001$) and marital status ($p = 0.04$). • More women >24 years (26%) initiated PrEP compared to young women <24 years (16%). • For women >24 years, the likelihood of initiating PrEP increased by about 3% for each additional year of a woman's age ($p < 0.001$). • FP clinics can be an effective platform to efficiently reach HIV at-risk women who may benefit from PrEP. • Integration of PrEP delivery in FP clinics, makes this a potential "one-stop" location for FP and PrEP. • Although FP visits are busy, efficient implementation strategies such as less frequent PrEP visits and expanding the pool of providers who might be able to screen and provide PrEP beyond the few clinicians and nurses (e.g., training and empowering HIV testing counsellors and community health workers or peer educators) can be built into existing routine services.
Health facility[b]	Pintye et al. (2018)[33] Kenya	Research article To define approaches for integrating PrEP into routine	**Study population:** Offered to use PrEP services **Sample**	***Nature of Intervention:*** Nurse-led teams worked with maternal and child health (MCH) staff at 16 public, faith-based, and	• Clinics developed two approaches for integrating PrEP delivery within ANC/PNC: 1) co-delivery: ANC/PNC and

		antenatal and post-natal care (ANC/PNC) using PrIYA Program as a case study.	***Sample size (total – N):*** 16 Health facilities; 40 program-supported nurses ***Gender distribution:*** Female 100% ***Age distribution:*** not described	private facilities to determine optimal clinic flow for PrEP integration into antenatal (ANC) and postnatal (PNC) care. A program-dedicated nurse facilitated integration. ***Intervention components:*** All ANC/PNC clients received assessment for behavioural risk (completion of a questionnaire and willingness to consider PrEP, general informational counselling on PrEP depending on the client's awareness and interest in PrEP. Among clients who were willing to initiate PrEP, PrEP counselling also included information on how to use PrEP and adherence as well as medication dispensation.	PrEP services delivered by same MCH nurse or 2) sequential services: PrEP services after ANC/PNC by a PrEP-specialized nurse. • 86 ANC/PNC visits were observed. • Clients who initiated PrEP took a median of 18 minutes (IQR 15-26) for PrEP-related activities (risk assessment, PrEP counselling, creatinine testing, dispensation, and documentation) in addition to other routine ANC/PNC activities. • For clients who declined PrEP, an additional 13 minutes (IQR 7-15) was spent on PrEP-related risk assessment and counselling. • PrEP-specific activities took <20 minutes per client, the moderate additional time burden for PrEP initiation in MCH would likely decline with community awareness and innovations such as group/peer counselling or expedited dispensing.
Health facility	Kinuthia et al. (2020)[32] Kenya	Research article We implemented and evaluated a novel programme to provide PrEP in maternal and child health clinics in Kenya	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 9376 women ***Gender distribution:*** Female:100% ***Age distribution:*** <24: 5033 Median age: 24 years (IQR: 21-28)	***Nature of Intervention:*** Integration of PrEP into existing structures at 16 maternal and child health clinics (public, faith-based, and private sector) At each facility, they offered sensitisation sessions to introduce the programme, educate facility staff on PrEP, and seek advice on the best way to integrate PrEP delivery at the facility.	• PrEP initiation: 2030 (21·7%) women-initiated PrEP: 79·3% women with partners living with HIV, 37·2% with partners of unknown HIV status, and 11·6% women with HIV-negative partners. • 999 (49·2%) women who initiated PrEP were younger than 24 years • Reasons for initiating PrEP: having a partner living with HIV

				Intervention components: Programme nurses approached all eligible women provided PrEP counselling as part of routine maternal and child health clinic processes. Risk was assessed using a using a risk assessment tool Women who did not know the HIV status of their partners were offered HIV self-testing kits, if they were willing to test with their partners at home. All women (regardless of risk factors) were informed that PrEP was available if they perceived they were at risk for HIV.	or of unknown HIV status and feeling at risk for acquiring HIV. Reasons for declining PrEP: need to consult partner and low perceived HIV risk Factors associated with initiation: being younger than 24 years, having a partner living with HIV or of unknown HIV status, gestational age less than 26 weeks among pregnant women, having experienced intimate partner violence in the previous 6 months, or sharing needles while engaging in injection drug use, diagnosed or treated for an STI, forced to have sex, and had recurrently used PEP. • PrEP continuation: 38.7% of 2030 women returned for PrEP refill at least 1 month after initiation • Factors associated with continuation: women with HIV-positive partners. • Reasons for discontinuation: side effects, no longer perceiving HIV risk, and partner known to be HIV-negative. • PrEP refills: 21.7% of women who initiated PrEP at least 3 months before this evaluation returned for PrEP refill. Of these 242 (54.9%) were younger than 24 years and 199 (45.1%) were aged 24 years or older (p=0·05).
Health facility	Pintye et al. (2019)[29] Kenya	Conference abstract To understand motivations for early PrEP discontinuation	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):***	***Nature of Intervention:*** The PrIYA Program provides real world evidence on delivering PrEP to AGYW	• Interest in initiating PrEP was heavily influenced by one-on-one interactions with a close

		among AGYW and Adolescents (PrIYA) Program	69 AGYW 69 in-depth interviews: 21 AGYW received, but never used PrEP • 24 discontinued PrEP within 1 month • 24 discontinued PrEP within 3 months ***Gender distribution:*** Females: 100% ***Age distribution:*** Age (years) 22 (20-23)	seeking routine ANC, PNC and family planning (FP) services within 16 MCH clinics in Kisumu County, Kenya ***Intervention components:*** **N/A** AGYW were identified by program nurses and purposively sampled based on 3 categories	friend, relative, or teacher/professor • Early PrEP discontinuation patterns were influenced by side effects (feared or experienced) and important life eventsAGYW frequently stopped PrEP after childbirth and found it challenging to remember to take PrEP during the complex transition to motherhood • AGYW reported that pre-initiation counselling focused on adherence; many were unaware that they could restart PrEP after stopping • Messaging on stopping/restarting PrEP tailored to life events common among AGYW, such as childbirth and periods away from partners, could promote appropriate PrEP use
Health facility[a]	Hill et al (2020)[38] Malawi	Research article To understand the level of interest in PrEP among AGYW at highest HIV risk, and the potential role of perceived risk in motivating PrEP interest.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Sample size (total – N):*** 825 ***Gender distribution:*** Female: 100% ***Age distribution:*** Median: 20 [18 to 22] (range: 15 to 27)	***Nature of Intervention:*** AGYW rated their potential interest in using PrEP after receiving this explanation: "PrEP is a medicine that can be used to prevent HIV for people who are HIV-negative. To be protected with PrEP, a pill is taken every day. These pills contain some of the same medicine used to treat people who already have HIV. PrEP is not currently available in Malawi." ***Intervention components:*** participants were enrolled and followed for one year.	• Epidemiologic risk scores were positively associated with PrEP interest, high numbers of AGYW both above and below the high-risk cut-off were very interested in PrEP (68% vs. 63%). • Perceived risk partially explained the relationship between HIV risk and PrEP interest; greater epidemiologic HIV risk was associated with high perceived risk, which was in turn associated with PrEP interest. • Many more high-risk AGYW were interested in PrEP (68%)

				NB: PrEP was not provided in this study, nor was it available in government clinics at the time of the study.	than expressed a high level of perceived HIV risk (26%). • High number of participants with risk scores below the high-risk cut-off who both expressed high perceived risk and interest in PrEP suggesting that demand for PrEP among AGYW may not be well aligned with epidemiologic risk
Mobile clinic/health facility[c]	Travill et al. (2018)[30] Kenya and South Africa	Conference abstract To assess PrEP uptake and sexual behaviour in the POWER cohort.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 330 ***Gender distribution:*** Female: 100% ***Age distribution:*** Median age: 20.5 years (IQR:19-22)	***Nature of Intervention:*** PrEP was integrated with reproductive health services at family planning clinics (Kisumu, Kenya), an adolescent and youth-friendly clinic (Johannesburg, South Africa [SA]) and a mobile van for reproductive health services for youth (Cape Town, SA) ***Intervention components:*** PrEP for AGYW	• PrEP uptake at the initial visit was 90% across all sites. • Two-thirds (68%) did not know their partners' HIV status and only 4% were in a known sero-discordant relationship. • Main reasons for declining PrEP were fears of HIV stigma or partner reactions • AGYW had evidence of high HIV risk using a risk score, indicating that women initiating PrEP would benefit from it. • AGYW had high willingness to initiate PrEP when delivered in these youth-friendly settings.
Hybrid (community-health facility)[c]	Ong'wen et al. (2018)[28] Kenya	Conference abstract To know more about adolescent girls accessing routine PrEP services in the context of national scale-up programs.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 1851 ***Gender distribution:*** Females: 100% ***Age distribution:*** 15-19 years	***Nature of Intervention:*** PrEP integration through drop-in centres (DICEs), public and private clinics ***Intervention components:*** The adolescents received either static or outreach services from 93 Jilinde supported clinics	• Among 28,268 clients initiating PrEP, 1851 (6.5%) were adolescent girls • DICEs, clinics designed primarily for sex workers, were the preferred PrEP outlet for adolescent girls, with 66% accessing services in DICEs, 25% accessed PrEP services in public clinics and 9% in private clinics. • Entry to PrEP was through peer educators and networks (50%);

					community outreaches (20%); and within health facilities (30%) • Efforts to make PrEP accessible to AGYW at risk of HIV acquisition should include restructuring the service delivery model
Mobile clinic[c]	Rousseau et al. (2019)[29] South Africa	Conference abstract Hypothesized that contraceptive use was associated with PrEP uptake and continuation in young women accessing sexual and reproductive health services	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 1096 ***Gender distribution:*** Female: 100% ***Age distribution:*** 16-25	***Nature of Intervention:*** Contraceptive use associated with PrEP uptake and continuation in AGYW accessing sexual and reproductive health services (SRHS) from a mobile clinic ***Intervention components:*** Sexual reproductive health service including HIV testing, contraception (oral, injectable and implant), and PrEP	• Among 1096 AGYW who accessed SRHS 31% initiated PrEP on the same day. • AGYW who were using contraception were significantly more likely to initiate PrEP on the same day compared to those who declined PrEP (76% vs 66% on contraception at that visit; p=0.001). • PrEP initiation was also significantly associated with contraception initiation; contraception was initiated by 44% of AGYW on the same day as PrEP initiation compared to 30% contraception starts in AGYW who declined PrEP (p=0.003). • AGYWs contraception use facilitated PrEP initiation and continuation, PrEP initiation also encouraged young women to initiate contraception use supporting the integration of SRHS with the provision of PrEP for AGYW.
Research site	Delany-Moretlwe et al. (2018)[36] South Africa & Tanzania	Conference abstract To evaluate whether empowerment clubs increase PrEP uptake and continuation among AGYW.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** ***Gender distribution:*** Female:100%	***Nature of Intervention:*** Participants were randomised to standard of care (SoC), which included comprehensive sexual and reproductive health care, with counselling and SMS	• 431 AGYW enrolled and 213 randomised to clubs • 97% initiated PrEP • PrEP continuation did not vary significantly by study arm (p-value =0.31)

			Age distribution: Not mentioned	reminders for PrEP users, or to empowerment clubs plus SOC. ***Intervention components:*** Facilitators-led small group sessions and clinic follow-up visits for sexually active AGYW on PrEP	• PrEP continuation was 73% at month 1, 61% at month 3 and 34% at month 6. • While PrEP uptake was high in this at-risk population, use diminished with time. Empowerment club participation was low and did not enhance PrEP continuation, contrary to experiences in the HIV treatment field.
Research Site	Donnell et al. (2021)[37] South Africa	Research article To assess the effect of on-site access to PrEP on HIV incidence.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 2121 ***Gender distribution:*** Female:100% ***Age distribution:*** 16-35 years; median age: 23 years (IQR 20-27)	***Nature of Intervention:*** On-site PrEP access at nine trial sites provided by research staff ***Intervention components:*** Research nurse provided PrEP	• After on-site PrEP access began 543 (26%) out of 2124 reported PrEP use. • HIV incidence was 2.16% after on-site PrEP access, compared with 4·65% before PrEP access (p=0·0085). • Future studies of HIV prevention should incorporate PrEP as part of the standard of prevention
Hybrid (community-Health facility)	Were et al (2020)[35] Kenya	Research article To describe the programmatic application of an oral PrEP cascade; to quantify progression across each step of the cascade for female sex workers (FSW), MSM and AGYW and, to identify missed opportunities.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 299,798 ***Gender distribution:*** FSW: 211,927, MSM: 47,533 MSM and AGYW: 40,338 A***ge distribution:*** AGYW: 15-24; FSW >15 years; MSM:>15 years	***Nature of Intervention:*** Scaling up oral PrEP through integration into routine health services in drop-in centres (DICEs), public and private health facilities ***Intervention components:*** Individuals enter the PrEP pathway through community mobilization. Individuals who are interested in PrEP are referred to facilities providing PrEP, where they undergo HIV testing services. Clients who screen positive for substantial behavioural risk, or who request PrEP, are referred to an	**Quantitative:** • Among PrEP-eligible individuals, 2,900 (11%) AGYW, were initiated on PrEP. Of these clients, whereas 55% of AGYW were between 20 and 24 years. • Majority (81%) of clients-initiated PrEP through DICEs, whereas 14% and 5% were initiated through public and private facilities respectively. • PrEP cascade for AGYW aged 15-19 years: HIV- negative (99%), screened (22%), eligible (36%), initiation (95%), month 1 follow-up

				onsite clinician who conducts a clinical assessment and provides PrEP to clients who are eligible and opt-in. Clients are followed-up visit at the same facility one month following initiation and monthly thereafter.	(31%), month 3 follow up (5%) • PrEP cascade for AGYW aged 20-24 years: HIV- negative (98%), screened (23%), eligible (34%), initiation (91%), month 1 follow-up (32%), month 3 follow up (5%) • AGYW had higher missed opportunities for screening (78%). Among those screened, a substantially higher proportion of AGYW (65%) were ineligible for PrEP. • Missed opportunities for PrEP initiation was 8% among AGYW. • Majority of AGYW did not persist on PrEP use at month-1 (68%) and month-3 (94%) follow-ups. **Qualitative** • Eligibility for PrEP: Poor rapport between AGYW and providers inhibits disclosure of risk behaviours. Peer mobilization and referral of low-risk individuals coupled with inadequate client education on PrEP. • Initiation of PrEP: Myths and misconceptions about PrEP and low risk perception among FSW, MSM and AGYW. Co-location of both PrEP and HIV services in comprehensive care centres (HIV clinics) resulted in PrEP clients feeling stigmatized as HIV positive.

					Stigma-related discouragement from peers, family and friends for eligible users. Providers reluctance to prescribe PrEP associated with reluctance to increase provider workload; provider belief that client will not adhere to PrEP. Insensitive referral and access pathways in public and private health facilities.
Studies among Men					
Not specified	Bell et al. (2019)[25] South Africa	Conference abstract To understand perceptions of PrEP, and barriers and enablers of uptake among young South African men.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Sample size (total – N):*** 2077 (Quantitative: 2019; Qualitative: 58) ***Gender distribution:*** Male: 100% ***Age distribution:*** 20-34	***Nature of Intervention:*** Perceptions of PrEP use and barriers and enablers of uptake. 58 IDIs ***Intervention components:*** N/A	• **Enablers to PrEP use:** - Maintain an HIV-negative status - Avoid conflict and turmoil that HIV diagnosis would bring - High degree of enthusiasm towards the concept • **Barriers to PrEP use:** - Practical: remembering to take the pill daily, side effects and access to clinics. - Knowledge: Had basic information, confused PrEP with PEP - Psychological: perceived as "only for women" and health seeking behaviour is not the norm for men. - Social: Being seen at clinics by community members, as people will assume that they are HIV positive. - Interpersonal: Keep PrEP use a secret from their partners, friends and family.
Studies among AGYW and Men					

Hybrid (research site-health facility)[e]	Heffron et al. (2018)[52] Kenya and Uganda	Research article To explore fertility intentions, pregnancy, and evaluated the use of PrEP and ART as peri-conception HIV risk reduction strategies.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 1013 ***Gender distribution:*** HIV-infected females: 455; HIV-uninfected males: 224; HIV infected males: 110; HIV-uninfected females: 224 ***Age distribution:*** HIV-infected females: 26 (22-30); HIV-uninfected males: 30 (26-37); HIV-uninfected females: 29 (24-35); HIV-infected males: 35 (30-42)	***Nature of Intervention:*** The PrEP delivery model integrated PrEP into HIV treatment services. PrEP discontinuation was encouraged once the HIV-infected partner had used ART for at least 6 months (time to achieve HIV viral suppression). ***Intervention components:*** Couples-based HIV prevention counselling; safer conception counselling or contraceptives; counselling and HIV testing for HIV-uninfected partner; PrEP initiation/prescription and adherence counselling; referral of HIV infected partner for ART	• Uptake and adherence to integrated PrEP and ART strategy was high with an estimated 96% reduction in HIV incidence. • During the 6 months preceding pregnancy, 82.9% of couples used PrEP or ART and there were no HIV seroconversions, 14.5% used some ART and/or PrEP and 2.6% used neither PrEP nor ART. • Among the 81 couples who were using ART only (61 couples with HIV-infected women and 20 with HIV-infected men), 91.2% of the HIV-uninfected partners had discontinued PrEP due to sustained (i.e., [6 months) ART use by their HIV infected partner. • Integrated PrEP and ART was readily used by HIV serodiscordant couples. • Widespread scale-up of safer conception counselling and services is warranted to respond to strong desires for pregnancy among HIV-affected men and women.
Hybrid (research site-health facility)[e]	Ngure et al. (2016)[45] Kenya	Research article To gather insights into couples' decision-making, motivations for PrEP uptake, and experiences soon after PrEP initiation.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 40 ***Gender distribution:*** Female: 20; Male:20 ***Age distribution:*** Females: 29.1 (20-43), Males: 36.6 (27-57)	***Nature of Intervention:*** The PrEP delivery model integrated PrEP into HIV treatment services. PrEP discontinuation was encouraged once the HIV-infected partner had used ART for at least 6 months (time to achieve HIV viral suppression).	• PrEP offered couples an additional strategy to reduce the risk of HIV transmission, meet their fertility desires, and cope with HIV serodiscordance. • Remaining HIV-negative at follow-up visits reinforced couples' decisions and

				Intervention components: At the time of interview: time since initiating PrEP was 6.3 months and time since initiating ART was 5.6 months	motivated continued adherence to PrEP. Daily PrEP use supported the HIV-infected partners adherence to ART. • A positive clinical encounter (provider's advice and client-friendly services) motivated initiation and continuation of PrEP
Hybrid (community-health facility)[d]	Koss et al. (2018)[41] Kenya and Uganda	Research article To report on "early adopters" of PrEP in the Sustainable East Africa Research in Community Health (SEARCH) study in rural Uganda and Kenya. intervention.	**Study population:** Offered to use PrEP services **Sample** ***Population:*** AGYW Men ***Sample size (total – N):*** 4064 ***Gender distribution:*** 1934 females 2130 males 48% females 52% males ***Age distribution:***	***Nature of Intervention:*** PrEP education and discussions occurred on arrival at the health campaign, with HIV counsellors and clinicians. During home-based testing, 1 staff member conducted HIV testing and counselling and provided info about PrEP. ***Intervention components:*** 1-month community mobilization and sensitization activities on PrEP. PrEP risk score or was administered. Hybrid HIV and multi-disease testing was conducted (health campaigns & home-based) with counselling and health education discussions on PrEP.	• Of 21 212 HIV-uninfected adults, 4064 were identified for PrEP (2991 by empiric risk score, 1073 by self-identified risk). • 739 individuals started PrEP within 30 days; 77% on the same day. • Among adults identified by risk score, predictors of early adoption included male sex (adjusted odds ratio 1.53; 95% confidence interval, 1.09-2.15), polygamy (1.92; 1.27-2.90), serodiscordant spouse (3.89; 1.18-12.76), self-perceived HIV risk (1.66; 1.28-2.14), and testing at health campaign versus home (5.24; 3.33-8.26). • Among individuals who self-identified for PrEP, predictors of early adoption included older age (2.30; 1.29-4.08) and serodiscordance (2.61; 1.01-6.76).
Hybrid (community-	Koss et al. (2020)[43]	Research article To assess PrEP uptake and engagement after population-	**Study population:** Offered to use PrEP services **Sample**	***Nature of Intervention:*** Population-level HIV and multi-disease testing using a hybrid mobile testing approach	• In 12935 (10% serodifferent partnership, 54% risk score, 36% self-identified risk) people

health facility)[d]	Kenya and Uganda	level HIV testing and universal PrEP access to characterise gaps in the PrEP cascade	***Sample size (total – N):*** 12935 (HIV-negative with elevated risk) ***Gender distribution:*** Female: 6459; Male: 6476 ***Age distribution:*** 15-24: 4800; 25-34: 4712; 35-44: 1927; 45-54: 991; ≥55: 505	at community health fairs, home-based testing or facilities. PrEP initiation at health fairs or at local clinic. ***Intervention components:*** *Community:* community sensitisation, HIV testing, PrEP counselling to HIV- negative people at elevated risk (serodifferent partnership, risk score, or self-identified risk); on-site PrEP start at health fairs or same-day PrEP initiation at local clinics. *Home*: home-based testing and PrEP counselling, offer of PrEP through local clinics. *Local clinic:* Patients with HIV were asked to bring their HIV-negative or partners with unknown HIV status to the clinic for HIV testing and the offer of PrEP initiation. *Follow up*: visits included supportive delivery system with options for visits at clinic, home, or community locations. Follow up visits included: HCT, PrEP refill blood tests and adherence measurements	at elevated risk, 27% initiated PrEP. • 82% initiated PrEP on the same day as HIV testing, 50% of whom were men • 19% of AGYW (15-24 years) initiated PrEP • PrEP uptake was lower among individuals aged 15-24 years and mobile individuals. • At week 4, 64% were engaged in the programme, 49% received medication refills, and 40% self-reported adherence. • At week 72, 56% were engaged, 33% received a refill, and 27% self-reported adherence. • Inclusive risk assessment (combining serodifferent partnership, an empirical risk score, and self-identification of HIV risk) was feasible and identified individuals who could benefit from PrEP. • The biggest gap in the PrEP cascade was PrEP uptake, particularly for young and mobile individuals. •
Hybrid (community-health facility)[d]	Mayer et al. (2019)[42] Uganda	Research article To estimate the association between distance to clinic and other transportation-related barriers on PrEP uptake and initial clinic visit	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 701 ***Gender distribution:*** Female: 300; Male: 401 ***Age distribution:*** 15-24: 339; 25-34: 242;	***Nature of Intervention:*** PrEP was given using a hybrid model and initiation was dependent on participant choice. PrEP could be initiated same day on-site at community health fairs or at local clinic). For those tested at home PrEP was offered within one to six months following the	• Of the 701 PrEP-eligible participants, 39% started PrEP within four weeks; of these, 17% were retained at four weeks. • Participants with a distance to clinic of ≥2 km were less likely to start PrEP (p = 0.012) and

			35-44:77; 45-54: 991; ≥45: 43	community campaign through local clinics. ***Intervention components:*** Meetings with community stakeholders to sensitise them on PrEP, at community health campaigns (CHCs), eligible HIV-negative participants at elevated risk (serodifferent partnership, risk score, or self-identified risk) were directed to a PrEP education station where they were informed about how PrEP works, interested participants were offered referral to a linkage station to make an appointment at clinic for PrEP enrolment or same-day PrEP start or a clinic appointment at a later date.	less likely to be retained on PrEP once initiated (p = 0.024) • Eligible participants (from home-based testing) who did not have the option of same-day PrEP initiation were also less likely to initiate PrEP (p < 0.001). • Barriers to PrEP use: daily use of PrEP, "low/no risk of getting HIV, transportation-related barriers (clinic is too far away and travel away from home).
Hybrid (community-health facility) [d]	Camlin et al. (2020)[44] Kenya and Uganda	Research article To explore understandings of PrEP, elucidate factors influential of demand, decisions around PrEP uptake or non-initiation, and adherence and discontinuation in population subgroups at elevated HIV risk.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 111 ***Gender distribution:*** Females: 65; Males: 46 ***Age distribution:*** 15-35, median age: 24 (range 17-35)	***Nature of Intervention:*** Same day PrEP initiation on-site at community health campaigns or at health facilities. 8 FGDs (4 male, 4 female groups) each with 8-12 participants; 13 IDIs with PrEP initiators and 10 IDIs with PrEP decliners ***Intervention components:*** As per SEARCH study: Same day initiation of PrEP on-site at community health campaigns or health facilities. Transport to clinics for the PrEP initiation visit. Follow-up visits which occurred at local health facilities, participants' homes, or other community-based	• Gendered motivations for PrEP: young men viewed PrEP as a means to safely pursue multiple partners, while young women saw PrEP as a means to control risks in terms of engagement in transactional sex and difficulty in negotiating condom use and partner testing. • Uptake was hindered by HIV/ART-related stigma (colour of pill same as ART, accessing PrEP at the same facility where HIV care was provided), the need for partners permission, distance to facilities, mixed messaging on the dosing of PrEP, taking daily medications, living with

				locations of the participant's choice.	parents or were attending school, moral prohibitions against sex among young people, desire for "proof" of efficacy by peers • Uptake was motivated by high perceived HIV risk, and beliefs that PrEP use supported life goals (completing schooling or having a family). • Discontinuation of PrEP was due to dissolution of partnerships/changing risk, unsupportive partners/peers, or early side effects/pill burden.
Hybrid (community-health facility) [d]	Koss et al. (2017)[26] Kenya and Uganda	Conference abstract To evaluate barriers to the uptake of open-label PrEP offered in a population-based context in high HIV prevalence settings.	**Study population:** Offered to use PrEP services (nested in SEARCH Trial) **Sample** ***Population:*** Men. Women and youth ***Sample size (total – N):*** 63 Community members: 40% men; 35% women; 25% youth 42 Clients who did not initiate PrEP: 38% women; 45% at risk for HIV by empiric score ***Gender distribution:*** 16-53 years, median age of 28 years ***Age distribution:*** 40% men, 35% women, 25% youth	***Nature of Intervention:*** This is a cross sectional study based on SEARCH trial ***Intervention components:*** **n/a** ***Intervention delivery setting:*** n/a	- In communities that were offered targeted PrEP in this population-based study, multi-level barriers to the uptake of PrEP were identified. - In addition to barriers identified in prior studies of targeted populations, such as aspects of pill-taking, concerns about effectiveness, and partner and household---level influence, concerns about access to PrEP via health facilities or at school, opportunity costs, mobility, and misconceptions about PrEP as barriers to uptake in SEARCH communities. • Strategies are needed to address these barriers, such as community sensitization, expanded provision of information on PrEP, and community---based delivery mechanisms to facilitate access to PrEP.

Hybrid (community-health facility)	Gombe et al. (2020)[46] Zimbabwe	Research article To understand the factors that motivate clients to accept, decline, continue, or discontinue PrEP.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 60 ***Gender distribution:*** Female: 46; Male: 14 ***Age distribution:*** 16-25: 20%; 26-40: 60%; >41: 20%	***Nature of Intervention:*** PrEP was integrated at two family planning clinics. 54 IDIs with PrEP acceptors and 6 IDIs with PrEP decliners ***Intervention components:*** HIV testing; screening for PrEP eligibility according to a tool; same day initiation of PrEP (one-month supply); follow-up visit at month 1 (three-month supply)	• Motivators to accept PrEP: High HIV risk perception, preference for PrEP over other HIV prevention methods, perceived severity of living with HIV, confidence in PrEP • Barriers to accepting PrEP: fear of pill burden or impact of pills, wanting partners consent or fearing partner reaction to PrEP, feeling satisfied with current method of HIV prevention • Motivators to continue PrEP: focus on original motivation, establishing daily pill routine, accessible PrEP pill storage, planning ahead before travelling out of town, partner or facility support - Barriers to continuing PrEP: being unaccustomed to taking pills, religious issues, travel out of town, clinic schedule/hours, lack of transport funds, misunderstanding dosing guidance, side effects
Health facility	Sack et al (2020)[55] Mozambique	Research article To explore the perspectives, attitudes, and experiences of HIV serodiscordant partners taking PrEP and develop a messaging campaign to improve PrEP uptake in rural Mozambique to reduce HIV transmission among serodiscordant partners.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 20 ***Gender distribution:*** Female: 11; Male: 9 ***Age distribution:*** Median age 35, interquartile range 26.5-37.5). Female: median age 32, interquartile range 25.5-36; male: median age 36, interquartile range 31-38.	***Nature of Intervention:*** Stories will be presented to discordant couples to try to improve PrEP uptake and reduce incident HIV infections. ***Intervention components:*** Three oral stories designed to educate, empower, and normalize PrEP use.	• Individual factors influencing PrEP uptake and adherence: love for one's partner, knowledge about PrEP and the belief it is effective, fear of HIV and PrEP stigma • Interpersonal factors affecting PrEP uptake: desire to protect family, partner support and relationship strength, overcoming the fear of stigma

					to seek support from family and friends
Community	Bassett et al. (2018)[48] South Africa	Research article To assess the acceptability and feasibility of offering family planning and HIV prevention services at salons.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Population:*** 17 hair salons, 92 stylists, 326 clients ***Sample size (total – N):*** Salons (N = 17), Owners (N = 17), Stylists (N = 92), Female clients (N = 326) ***Gender distribution:*** 100% of salon clients were female 82% of stylists were female 65% of owners were female ***Age distribution:*** Median age (IQR): Salon clients: 28 (IQR 24 to 33); Stylists: 29 (26-32) Owners: 36 (33-43)	***Nature of Intervention:*** n/a ***Intervention components:*** n/a ***Intervention delivery setting:*** n/a	• Overall, most owners, stylists, and clients were willing to receive contraception and PrEP from a nurse in hair salons in and around Umlazi Township. • Frequent client visits and willingness of stylists to offer health education suggest that a stylist initiated, nurse-supported health intervention could be feasible in the salon setting. • Hair salons represent a promising venue for reaching young women in sub-Saharan Africa at risk of unintended pregnancy and HIV infection.
Community	Bassett et al. (2019)[47] South Africa	Research article To assess the acceptability of nurse-offered contraceptive and PrEP services at hair salons in Durban, South Africa.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Population:*** Clients of hair salons-Females, mean age 27 years, hair salon owners, hair stylists ***Sample size (total – N):*** Clients=42 (all female) Stylists=43 (40 female; 3 male) Salon owners=10 (8 female; 2 male) ***Gender distribution:*** Clients: 42 Females Stylists: 40 Females; 3 Males Owners: 8 Females; 2 Males ***Age distribution:*** Clients: M=27.1; SD=6.3 Stylists: M-29.6; SD=5.1 Owners: M=40.3; SD; 7.6	***Nature of Intervention:*** n/a ***Intervention components:*** n/a ***Intervention delivery setting:*** n/a	• Participants felt that incentives would be beneficial to program enrolment, if not necessary, to garner interest among clients. One client noted that incentives have become an expected part of research • Overall, participants liked the idea of receiving personal SMS messages and having WhatsApp groups as adherence supports. Clients preferred SMS messages for direct adherence motivation because they are more private. • One client felt that an SMS could also serve as an automated daily reminder for women on PrEP to take their

					medication. A few participants also noted that SMS would be more accessible than WhatsApp given data constraints. • Overall, participants were enthusiastic about the program. Convenience and a conducive environment were noted as facilitators to receiving health services in the hair salon; attention will have to be directed to establishing privacy and program legitimacy. • Hair salons represent an innovative venue for reaching young women at high-risk for unintended pregnancy and HIV infection.
Community	Lubwama et al. (2019)[49] Uganda	Conference abstract A review of PrEP data from PEPFAR Data for Transparency Impact Monitoring (DATIM) for July 2017 to June 2018	**Study population:** Offered to use PrEP services **Sample** ***Population:*** Key populations including sex workers (SW), men who have sex with men (MSM), transgender persons (TG) and other high-risk groups (fisher folk [FF], discordant couples [DC], truckers, adolescent girls and young women [AGYW] and people who inject drugs). ***Sample size (total – N):*** Initiated PrEP (6 sites) 3,846 PrEP clients (1 community): 1538 ***Gender distribution:*** Not mentioned ***Age distribution:*** Not mentioned	***Intervention components:*** Drop-in centres (DINCs), Community based outreach centres	• 3,846 individuals-initiated PrEP; 2,568 (67.2%) SW, 327 (8.5%) MSM, 15 (0.4%) TG, and 918 (23.8%) other high-risk groups • One community had 1538 PrEP clients: 58.1% SW, 25.4% FF, 7.4% DC and 0.5% MSM. • Return rates for PrEP were higher among DC (3 months:56.9%, 6 months:46.8%) and low among SW (3 months 37.5%, 6 months 26.3%) and FF (3months 16.4%, 6months 14.2%). • The majority (69.2%, 1064/1538) were reached through outreach models versus fixed public health facilities • More SW than other KP and high-risk groups were reached with PrEP. Retention at 3 and 6

					months was low for sex workers and fisherfolk, somewhat higher for discordant couples. • Outreach approaches should be scaled up to reach more KP clients with PrEP. Retention strategies should be strengthened, especially for sex workers and fisherfolk, who may be highly mobile.
Community	Morton et al (2020)[53] South Africa	Research article To understand how to effectively create awareness, stimulate interest, and increase uptake of PrEP.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Sample size (total – N):*** 385 Quantitative: 320 Qualitative: 28 key stakeholders; 11 PrEP-naïve young, 10 PrEP-experienced women, five older women living with HIV, four men, seven key informants ***Gender distribution:*** Female 100% in household surveys ***Age distribution:*** Quantitative: 20 (18, 23) Qualitative: PrEP-naïve young women (aged 16-25), PrEP-experienced women (aged 16-29), older women living with HIV (aged 26-32), men (aged 25-35)	***Nature of Intervention:*** Young women were shown a 90-second PrEP demand creation video and two informational brochures and then asked to self-administer a short survey that included questions on demographics, sexual relationships, risk taking, HIV risk perception, PrEP interest and knowledge, and their opinions about the video.. ***Intervention components:*** Research staff visited houses up to three times, requesting to speak with the young woman household resident. Young women who agreed to participate were shown the video and then asked to self-administer a short survey.	**Quantitative** • Most reported interest in learning more about PrEP (67.7% 'definitely interested' and 9.4% 'somewhat interested') and taking PrEP (56.4% 'definitely interested' and 12.5% 'somewhat interested'). • Factors significantly associated with interest in taking PrEP were having a primary partner with whom they regularly have sex (80.0% vs. 65.2% without a primary partner; adjusted odds ratio (AOR)=3.1, 95% CI: 1.3, 7.0) and being in a sexual partnership for <6 months (86.8% vs. 68.5% for >12 months; AOR=3.0, 95% CI: 1.2, 7.3).
Research site	Heffron et al. (2018)[40] East Africa	Research article To present estimates of effectiveness and patterns of PrEP use within a two-year demonstration project of PrEP for HIV- negative members of heterosexual HIV	**Study population:** Offered to use PrEP services **Sample** ***Population:*** Serodiscordant couples ***Sample size (total – N):*** 1010 couples ***Gender distribution:***	***Nature of Intervention:*** PrEP was offered at enrolment at research site to all HIV-negative participants as PrEP with a daily dosing schedule; participants electing not to initiate PrEP at enrolment were	• 97% of HIV-negative partners-initiated PrEP. • Median duration of PrEP use was 12 months (IQR 6-18) • Adherence: 71% of HIV-negative participants took ≥80% of expected doses

		serodiscordant couples in East Africa.	Males: 1010 Females 1010 ***Age distribution:*** HIV-: Age, years 30 (26, 36) HIV+: Age, years 28 (23, 35)	offered PrEP initiation at subsequent visits ***Intervention components:*** **N/A** ***Intervention delivery setting:*** Research site	• 95% reduction (95% CI 86-98%, p<0.0001) in HIV incidence, relative to estimated HIV incidence for the population in the absence of PrEP integrated into HIV treatment services.
Research site[e]	Ware et al. (2018)[54] Uganda	Research article To evaluate the integrated strategy of delivering PrEP & ART to find out why it was successful.	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N):*** 93 couples ***Gender distribution:*** Female HIV-uninfected partner: (46%) ***Age distribution:*** HIV uninfected partner: 31 (26 to 37) HIV infected partner 31 (25 to 37)	***Nature of Intervention:*** The integrated strategy offered time-limited PrEP to uninfected partners as a "bridge" to long-term ART in the infected partner. Uninfected partners were offered PrEP at baseline and encouraged to discontinue once infected partners had used ART for six months. ***Intervention components:*** PrEP was integrated with ART	• Couples viewed in services as hope for staying together, attending joint follow up appointments together increased mutual support, and travelling and waiting room time provided an opportunity for discussion, reflection and joint decision making. • Concern for partner wellbeing was a reason for initiating ART whilst the simultaneous use of ARVs turned management of HIV into a shared experience • Couples devised joint strategies for adhering to PrEP and ART such as mutual reminders and emotional and material support for adherence.
Research site	Atujuna et al. (2018)[27] South Africa	Research article To explore acceptability and preferences for New biomedical prevention technologies (NPTs) among key and other vulnerable populations in two South African townships.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Sample size (total – N)*** Adolescents=14 ***Gender distribution:*** Heterosexual women=10 Heterosexual men=9	***Nature of Intervention:*** n/a ***Intervention components:*** n/a ***Intervention delivery setting:*** n/a	• Different product preferences and motivations emerged by population based on similarity to existing practices and contexts of vulnerability. • Adult women and female adolescents preferred a vaginal ring and HIV vaccine, motivated by longer duration of protection to mitigate feared repercussions from male partners, including threats to their marriage and

					safety, and a context of ubiquitous rape. • Male adolescents preferred an HIV vaccine, seen as protection in serodiscordant relationships and convenient in obviating the HIV stigma and cost involved in buying condoms. • Adult men preferred PrEP, given familiarity with oral medications and mistrust of injections, seen as enabling serodiscordant couples to have a child.
Research site[e]	Baeten et al. (2016)[50] Kenya and Uganda	Research article To understand the delivery feasibility and uptake of, as well as adherence to, an integrated package of ART and PrEP among high-risk heterosexual HIV-1-serodiscordant couples	**Study population:** Offered to use PrEP services **Sample** ***Sample size (total – N)*** 1013 serodiscordant couples ***Gender distribution:*** HIV-1-uninfected partner Male: 679 (67%) ***Age distribution:*** HIV-1-uninfected partner Age <25 y=207 (20%), HIV-1-infected partner Age <25 y= 317 (31%)	***Nature of Intervention:*** HIV- partners were offered PrEP which was provided at the study sites, as PrEP was not available otherwise in Kenya and Uganda during the study period. ART was offered at the study site or by referral to another HIV-1 care center of their choice ***Intervention components:*** - Couples were offered antiretroviral medications - Counselled on HIV-1 prevention benefits PrEP discontinued 6 months after the infected partner initiated antiretroviral treatment	• ART was initiated by 789 (78%) HIV-1-infected partners. • 960/1 013 (95%) HIV-uninfected partners-initiated PrEP at enrolment, and 2% initiated PrEP at a later visit. • Among those initiating PrEP at enrolment and attending the month 1 and 3 visits, 840 (97%) and 792 (94%) continued to receive PrEP. • Adherence to PrEP measured by pill counts of returned, unused pills, indicated that 95% of dispensed pills had been taken as expected and 88% of periods between study visits had adherence >80%. • 14 initially HIV-1-seronegative partners seroconverted during follow-up (12 were infected at the time of study enrolment).

Research site	Heffron et al. (2019)[51] Kenya	Research article To determine uptake, use and effectiveness of a comprehensive safer conception intervention among HIV-serodiscordant couples with immediate fertility desires.	**Study population:** Offered to use PrEP services **Sample** ***Population:*** Serodiscordant couples ***Sample size (total – N):*** 74 ***Gender distribution:*** HIV-negative females/HIV positive males= 54%	***Nature of Intervention:*** Couples attended monthly visits at the study clinic prior to pregnancy and quarterly visits during pregnancy. Couples were followed for 12 months or until the end of pregnancy. During all visits, couples received counselling about HIV prevention, information about how to track women's menstrual cycles and identify peak fertility days and how to conduct vaginal self-insemination ***Intervention components:*** The intervention package included antiretroviral therapy (ART) for HIV-positive partners, oral pre-exposure prophylaxis (PrEP) for HIV-negative partners, daily fertility and sexual behaviour tracking via short message service (SMS) surveys, counselling on self-insemination, and referrals for voluntary medical male circumcision and fertility care.	• Of the 74 enrolled couples, 54% were HIV-negative female/HIV-positive male couples. • Prior to pregnancy, 100% of partners living with HIV used ART and 100% of HIV-negative partners-initiated PrEP. • One-month preceding pregnancy, 80.9% of HIV-positive partners were virally suppressed and 81.4% of HIV-negative partners were highly adherent to PrEP. • 42.6% pregnancies were protected using all four strategies i.e., men were circumcised, high adherence to PrEP, ART and timed condomless sex. • In addition to male circumcision, seven pregnancies (14.9%) were also protected by high adherence to PrEP and ART, 5 (10.6%) were protected by PrEP and timed condomless sex. • 0 HIV seroconversions (95% CI 0.0 to 6.0 per 100-person years) were observed indicating a 100% reduction in HIV risk (p = 0.04).
Research Site	Minnis et al (2020)[56] South Africa	Research article Examined youths' preferences for key attributes of long-acting PrEP, with a focus on characteristics pertinent to product delivery alongside key modifiable product attributes.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Sample size (total – N):*** 807 ***Gender distribution:*** Female: 401 (50%); Men who have sex with women only (MSW): 216 (27%).	***Nature of Intervention:*** Participants were asked to choose between two hypothetical PrEP products composed of five attributes product form (injection, implant); dosing frequency (two, six or twelve months); where to obtain the product (clinic, pharmacy, community	• All three subgroups had strong preference for a product with a one-year duration over two months ($p < 0.001$). • MSW placed the most importance on dosing frequency, with it being five times more important than any other attribute.

			Men who have sex with men MSM): 190 (23%) ***Age distribution:*** Median age (IQR): Female: 21 (19 to 22); men who have sex with women only: 21 (19 to 22) men who have sex with men: 20 (19 to 22)	distribution, mobile clinic - all models for current HIV prevention and contraceptive service delivery); pain involved with injection or insertion (mild, moderate) and delivery location on the body (arm, buttock, thigh). ***Intervention components:*** Participants completed interviews on a tablet computer. The survey first introduced each attribute individually with both visual and narrative descriptions. Participants were then presented with nine DCE choice questions, each one a unique choice **NB:** PrEP was not provided in this study.	• Females had greater preference for a single injection over an implant compared to MSW ($p \leq 0.004$). • Females and MSW expressed more preference for two injections compared with implants ($p \leq 0.009$). • Females preferred using a product that was offered at a health clinic over accessing it at a pharmacy ($p < 0.001$). • All youth preferred product insertion in the arm ($p < 0.001$). • Females disliked insertion in the thigh and both MSW and MSM disliked insertion on the buttocks ($p = 0.01$). • Youth indicated strong preferences for longer duration products. Each attribute nonetheless influenced preferences, offering insight into trade-offs that inform long-acting PrEP development.
Other					
Not described	Jani et al. (2018)[59] Tanzania	Conference abstract To describe support for PrEP use among male partners of AGYW in Tanzania via a qualitative comparative analysis of AGYW's and male partners of AGYW's views	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Sample size (total – N):*** not described ***Gender distribution:*** not described ***Age distribution:*** not described	***Nature of Intervention:*** Prior to IDIs and FGDs participants were acquainted with PrEP, by sharing a visual, standardized script of PrEP information with them. 24 IDIs and 4 FGDs with AGYW; 16 IDIs with men ***Intervention components:*** PrEP for AGYW	• AGYW and male partners agreed that most male partners would be willing to support PrEP use by AGYW. • However, male partner support might be contingent on their early involvement in the decision-making process regarding PrEP. • Early inclusion was perceived to remove suspicion of infidelity and alleviate negative consequences associated with

					late or inadvertent disclosure of PrEP use. • AGYW suggested potential social harms (relationship dissolution, loss of financial support, and verbal and physical violence) if male partners are not involved whilst male partners denied such potential extreme consequences. • Male participants recommended strategies on gaining men's support of PrEP including providing education to men on PrEP, equipping AGYW with skills to educate their partners, couples counselling by providers, provision of PrEP for men, and community education and sensitization. • Educating male partners about PrEP and engaging them in implementation activities should be part of PrEP roll-out strategies for AGYW.
Not described	Makyao et al. (2018)[60] Tanzania	Conference abstract To explore how social norms and gendered parenting roles might influence parental support of AGYW"s PrEP use.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Sample size (total – N):*** 55 ***Gender distribution:*** Female parents: 28; Male parents: 27 ***Age distribution:*** not described	***Nature of Intervention:*** Prior to IDIs and FGDs participants were acquainted with PrEP, by sharing a visual, standardized script of PrEP information with them. 4 FGDs with male parents and 4 FGDs with female parents ***Intervention components:*** PrEP for AGYW	• Parents supported PrEP availability recognizing AGYW"s high risk of HIV due to limited power to negotiate preventative behaviours and frequent violence in sexual relationships. • Differential parenting roles influenced the type of support. Men noted shame and embarrassment in communicating with their

					daughters about relationships and sex. • Social norms around adolescent sexuality influenced parental support. Parents were wary of being viewed as condoning pre-marital sexual activity, while they worried that AGYW could be stigmatized as promiscuous. • Parents recommended strategies for supporting their daughters PrEP use included: creating a supportive environment for PrEP use (e.g., ensuring good diet) while male parents described offering logistical and material support (e.g., providing transport to health centres).
n/a Modelling	Cremin et al. (2015)[57] Mozambique	Research article The aim of this paper is to estimate the prevention impact and the cost effectiveness of providing time-limited PrEP to partners of migrant miners in Gaza, Mozambique.	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Population:*** adult heterosexual ***Sample size (total – N):*** Note mentioned (modelling) ***Gender distribution:*** N/A ***Age distribution:*** N/A	***Nature of Intervention:*** n/a ***Intervention components:*** n/a ***Intervention delivery setting:*** n/a	• Providing time-limited PrEP to partners of migrant miners in Gaza Province during periods of increased exposure would be a novel strategy for providing PrEP. This strategy would allow for a better prioritized intervention, with the potential to improve the efficiency of a PrEP intervention considerably, as well as providing important reproductive health benefits
n/a Modelling	Irungu et al. (2019)[58] Kenya	Research article To provide estimates of the cost of delivering antiretroviral-based HIV prevention to HIV serodiscordant couples in	**Study population:** Never been offered to use PrEP services (hypothetical opinions related to PrEP) **Sample** ***Population:*** Heterosexual couples ***Sample size (total – N):*** N/A	***Nature of Intervention:*** n/a ***Intervention components:*** n/a	• Time-limited provision of PrEP to the HIV uninfected partner within HIV serodiscordant couples can be an affordable delivery model implemented in HIV care programs in Kenya and similar settings. These

		public health facilities in Kenya and the incremental cost of providing PrEP as a component of this strategy.	***Gender distribution:*** none provided ***Age distribution:*** No age disaggregation		costs can be used for budgetary planning and cost effectiveness analyses.
n/a Modelling[e]	Ngure et al. (2020)[34] Kenya and Uganda	Research article To estimate the associations between effective contraceptive use and 1) PrEP dispensation 2) high effective PrEP use	**Study population:** Offered to use PrEP services **Sample** ***Population:*** ***Sample size (total – N):*** 311 ***Gender distribution:*** Female: 100% ***Age distribution:*** Median age: 29 years ([IQR] 24.0-35.0)	***Nature of Intervention:*** HIV-uninfected women were provided with both PrEP and effective contraception ***Intervention components:*** PrEP was integrated with ART	• PrEP dispensation was more frequent among those concurrently using effective contraception, (adjusted relative risk [aRR]=1.19; 95% confidence interval [CI]=1.08-1.32) and contraceptive use was more common among those on PrEP (aRR=1.63; 95% CI=1.18-2.25). • Healthcare delivery models that integrate the provision of family planning and PrEP may successfully promote both preventive products, especially long-acting contraception

a. Conducted in the context of the Girl Power study b. Conducted in the context of the PrEP Implementation in Young Women and Adolescents (PrIYA) study c. Conducted in the context of the Prevention Option for Women Evaluation Research (POWER) project d. Conducted in the context of the Sustainable East Africa *Research* in Community Health (SEARCH) study e. Implemented within The Partners Demonstration Project