Improving the Quality of PrEP Implementation for Adolescent Girls and Young Women in Eastern and Southern Africa

A Regional Think Tank

4th March 2021
Aims and Objectives

The aim of the regional think tank and webinar series is to inform quality implementation and scale-up of PrEP Programming for AGYW in the ESA region as part of combination HIV prevention interventions.

Engage and convene diverse stakeholders

Generate implementation considerations

Document and disseminate key considerations

Share best practice, evidence, and lessons learned from implementation
What We Heard Last Session: Healthcare system Considerations

Integration with family planning and SRH services

An integrated package which incorporates the spectrum of SRH and FP services required by AGYW and supports diverse delivery platforms, including community based, online, postal/courier and tele-health is important to cater to the needs of AGYW.

What is the minimum package?

PrEP provision should be integrated into existing AYFS models and based on global standards for quality health care services for adolescents. This includes ensuring technically competent providers and facility features that enhance accessibility i.e. one stop shop, fast track lines.

Risk Assessment

Risk assessment/screening tools should be implemented as part of a prevention package to support a holistic approach to HIV prevention. It is important that risk assessment is used as a means to reach and identify those that are at risk and not as an exclusionary tool.

Capacity building for providers

It is important to recognize that capacity building of providers extends beyond training of providers. There should be systems for mentorship, supervision, coaching and continued learning. It is also important to anticipate workforce changes and plan accordingly to maintain service continuity.

Integration with family planning and SRH services

What is the minimum package?

Risk Assessment

Capacity building for providers

An integrated package which incorporates the spectrum of SRH and FP services required by AGYW and supports diverse delivery platforms, including community based, online, postal/courier and tele-health is important to cater to the needs of AGYW.

PrEP provision should be integrated into existing AYFS models and based on global standards for quality health care services for adolescents. This includes ensuring technically competent providers and facility features that enhance accessibility i.e. one stop shop, fast track lines.

Risk assessment/screening tools should be implemented as part of a prevention package to support a holistic approach to HIV prevention. It is important that risk assessment is used as a means to reach and identify those that are at risk and not as an exclusionary tool.

It is important to recognize that capacity building of providers extends beyond training of providers. There should be systems for mentorship, supervision, coaching and continued learning. It is also important to anticipate workforce changes and plan accordingly to maintain service continuity.
Session 2: Service Delivery Platforms and COVID-19 Implications

Dear Colleagues,

Thank you for your contributions during session 2 breakout groups. Please review the implementation considerations below, and submit a response to each, you can either 'endorse' or 'reject' each implementation consideration. Where relevant please place any additions, suggested changes or comments in the 'other' box.

Please reach out with any questions.

Many Thanks,
Organising Committee

https://forms.gle/h4VJb49vxZDmSDrn6
## Google Drive

<table>
<thead>
<tr>
<th>Name</th>
<th>Owner</th>
<th>Last modified</th>
<th>File size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session 1</td>
<td>me</td>
<td>Feb 18, 2021 me</td>
<td></td>
</tr>
<tr>
<td>Session 2</td>
<td>me</td>
<td>Feb 18, 2021 me</td>
<td></td>
</tr>
<tr>
<td>Session 3</td>
<td>me</td>
<td>Feb 18, 2021 me</td>
<td></td>
</tr>
<tr>
<td>Session 4</td>
<td>me</td>
<td>Feb 18, 2021 me</td>
<td></td>
</tr>
<tr>
<td>Session 5</td>
<td>me</td>
<td>Feb 18, 2021 me</td>
<td></td>
</tr>
<tr>
<td>Supplementary Material</td>
<td>me</td>
<td>12:54 PM me</td>
<td></td>
</tr>
</tbody>
</table>

## Agenda

### Research Car Park

### Literature Compendium

[https://docs.google.com/document/d/1fTKiCVmzbQK9JHspO8NzHz8fCpCtnRQ3m0bH2L9-wA/edit?usp=sharing](https://docs.google.com/document/d/1fTKiCVmzbQK9JHspO8NzHz8fCpCtnRQ3m0bH2L9-wA/edit?usp=sharing)
Today's Agenda

Session 4: Emerging Areas of Interest

10:00 – 10:15
Welcome and Introductions

10:15 – 10:50
Presentations and Q&A

10:50 – 11:25
Consensus Building via Jam Board

11:25 – 11:30
Next Steps and Close
Jam Board Introduction

Access the Jam Board using the link in the chat or below:

Add implementation considerations using the Sticky Notes:

https://cutt.ly/vl4PUrs

Note: If you cannot access the Jam Board use the Teams meeting chat.
Presentations: Emerging Areas of Interest

**PrEP for Pregnant and Breastfeeding AGYW**
Daya Moodley, The University of KwaZulu-Natal

**New Biomedical Delivery Modalities**
Sinead Delany-Moretlewe, Wits Reproductive Health Institute
PrEP for Pregnant and Breastfeeding Adolescent Girls and Young Women

Daya Moodley, PhD
Associate Professor, Dept of Obstetrics and Gynaecology
School of Clinical Medicine
Research Associate, CAPRISA
University of KwaZulu-Natal

Improving the Quality of PrEP Implementation for Adolescent Girls and Young Women in Eastern and Southern Africa
From Research and Demonstration Projects to Quality Implementation at Scale

4 March 2021
Agenda

• HIV Incidence and Identifying PBFW for PreP
• Safety of PrEP in PBFW
• WHO PrEP Implementation Framework for PBFW
• Implementation Experience in ESA
  – PrEP Uptake, Adherence and Persistence
• Key Considerations
### HIV incidence during pregnancy and breastfeeding

#### HIV incidence in meta analysis of 37 cohorts – 100 758 PY followup:
- **Pregnancy** = 3.4/100 PY
- **Breastfeeding** = 3.1/100 PY
- **Combined** = 4.6/100 PY
- Pre-2010 = 4.1/100py (1.1-12.2)
- Post-2014 = 2.1/100py (0.7-6.5)

Source: Graybill, AIDS, 2020

---

**Figure S1. Forest plot of HIV incidence rates among pregnant and breastfeeding women, by mid-year of study follow-up.**

<table>
<thead>
<tr>
<th>Study</th>
<th>Events</th>
<th>PY</th>
<th>Incidence Rate per 100 PY</th>
<th>Rate [95% CI]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van de Perre et al.</td>
<td>18</td>
<td>473.7</td>
<td>3.8 [2.4; 6.0]</td>
<td></td>
</tr>
<tr>
<td>Leroy et al. 1994</td>
<td>17</td>
<td>390.0</td>
<td>4.4 [2.7; 7.0]</td>
<td></td>
</tr>
<tr>
<td>Motti et al. 1994</td>
<td>43</td>
<td>998.0</td>
<td>4.2 [3.2; 5.9]</td>
<td></td>
</tr>
<tr>
<td>Tah et al. 1998</td>
<td>97</td>
<td>2302.0</td>
<td>4.2 [3.5; 5.1]</td>
<td></td>
</tr>
<tr>
<td>Molzow et al. 2001</td>
<td>66</td>
<td>1375.0</td>
<td>4.8 [3.8; 6.1]</td>
<td></td>
</tr>
<tr>
<td>Gray et al. 2005</td>
<td>63</td>
<td>4940.0</td>
<td>4.6 [3.8; 5.5]</td>
<td></td>
</tr>
<tr>
<td>John et al. 2016</td>
<td>116</td>
<td>2565.2</td>
<td>3.5 [3.1; 3.9]</td>
<td></td>
</tr>
<tr>
<td>Humphrey et al. 2006</td>
<td>299</td>
<td>7783.0</td>
<td>2.1 [1.6; 2.6]</td>
<td></td>
</tr>
<tr>
<td>Morrison et al. 2007</td>
<td>63</td>
<td>3086.0</td>
<td>3.1 [2.4; 3.8]</td>
<td></td>
</tr>
<tr>
<td>Menston et al. 2013</td>
<td>767</td>
<td>57240.0</td>
<td>1.3 [1.2; 1.4]</td>
<td></td>
</tr>
<tr>
<td>Metham et al. 2009</td>
<td>36</td>
<td>717.0</td>
<td>3.5 [3.0; 4.0]</td>
<td></td>
</tr>
<tr>
<td>Teasdale et al. 2018</td>
<td>16</td>
<td>417.0</td>
<td>3.5 [2.4; 6.3]</td>
<td></td>
</tr>
<tr>
<td>Munjom et al. 2010</td>
<td>73</td>
<td>79.0</td>
<td>5.5 [4.7; 6.3]</td>
<td></td>
</tr>
<tr>
<td>Kruithof et al. 2010</td>
<td>53</td>
<td>779.0</td>
<td>3.8 [3.0; 5.0]</td>
<td></td>
</tr>
<tr>
<td>Reid et al. 2010</td>
<td>72</td>
<td>1758.0</td>
<td>4.1 [3.3; 5.2]</td>
<td></td>
</tr>
<tr>
<td>Moodley et al. 2011</td>
<td>48</td>
<td>1946.0</td>
<td>3.7 [3.2; 3.6]</td>
<td></td>
</tr>
<tr>
<td>Moodley et al. 2009</td>
<td>72</td>
<td>679.0</td>
<td>3.6 [2.8; 4.6]</td>
<td></td>
</tr>
<tr>
<td>Braunstein et al. 2011</td>
<td>17</td>
<td>625.0</td>
<td>2.9 [1.7; 4.4]</td>
<td></td>
</tr>
<tr>
<td>Kieffer et al. 2011</td>
<td>56</td>
<td>388.0</td>
<td>3.6 [2.7; 4.7]</td>
<td></td>
</tr>
<tr>
<td>Thomson et al. 2018</td>
<td>24</td>
<td>447.0</td>
<td>2.8 [2.3; 3.5]</td>
<td></td>
</tr>
<tr>
<td>Keating et al. 2012</td>
<td>11</td>
<td>275.0</td>
<td>2.1 [1.4; 3.0]</td>
<td></td>
</tr>
<tr>
<td>Moodley et al. 2015</td>
<td>6</td>
<td>109.3</td>
<td>3.5 [2.5; 12.2]</td>
<td></td>
</tr>
<tr>
<td>De Schacht et al. 2014</td>
<td>14</td>
<td>328.0</td>
<td>5.5 [2.5; 7.1]</td>
<td></td>
</tr>
<tr>
<td>De Schacht et al. 2014</td>
<td>41</td>
<td>1278.0</td>
<td>3.2 [2.4; 4.4]</td>
<td></td>
</tr>
<tr>
<td>Tracey et al. 2012</td>
<td>0</td>
<td>126.0</td>
<td>3.0 [0.7; 17.0]</td>
<td></td>
</tr>
<tr>
<td>Egie et al. 2016</td>
<td>9</td>
<td>147.2</td>
<td>3.4 [3.1; 7.9]</td>
<td></td>
</tr>
<tr>
<td>Imade et al. 2013</td>
<td>4</td>
<td>238.0</td>
<td>3.8 [2.6; 5.4]</td>
<td></td>
</tr>
<tr>
<td>Kruithof et al. 2015</td>
<td>26</td>
<td>1278.0</td>
<td>3.5 [2.0; 5.1]</td>
<td></td>
</tr>
<tr>
<td>Tabu et al. 2013</td>
<td>5</td>
<td>311.0</td>
<td>3.0 [1.9; 5.6]</td>
<td></td>
</tr>
<tr>
<td>Chetty et al. 2017</td>
<td>66</td>
<td>1857.3</td>
<td>3.2 [2.4; 4.4]</td>
<td></td>
</tr>
<tr>
<td>Rogers et al. 2017</td>
<td>4</td>
<td>45.4</td>
<td>3.4 [1.1; 7.4]</td>
<td></td>
</tr>
<tr>
<td>Fathi et al. 2017</td>
<td>11</td>
<td>826.0</td>
<td>3.0 [1.3; 7.9]</td>
<td></td>
</tr>
<tr>
<td>Phip et al. 2016</td>
<td>83</td>
<td>4884.1</td>
<td>3.4 [3.2; 3.6]</td>
<td></td>
</tr>
<tr>
<td>Nitzu et al. 2017</td>
<td>33</td>
<td>406.0</td>
<td>3.4 [1.3; 7.8]</td>
<td></td>
</tr>
</tbody>
</table>

Random effects model: \( \hat{\tau}^2 = 0.10, \hat{\tau} = 0.32, p < 0.001 \)

Prediction interval: [1.2; 11.1]
Algorithm for Combination HIV Prevention Strategy for Moderate to High Risk Population within the PMTCT Programme

Antenatal Registration
Provider Initiated Counselling and Testing

HIV Seronegative
Primary HIV Prevention

1. Risk Assessment
2. Clinical and Laboratory Assessments if at Substantial Risk
3. Risk Reduction Counselling
4. STI Screening and Treatment (Syndromic and syphilis)
5. Condom Promotion
6. Partner Invitation for HCT

Partner Accepts Invitation
1. Client Initiated Counselling and Testing or Couple Counselling

Partner HIV Negative
8. Condom Promotion
9. Risk Reduction Counselling
10. Referral for VMMC

Partner HIV Positive
1. Condom Promotion
2. Referral for ART

Partner HIV Positive
1. Offer PrEP and adherence counselling
2. Emphasise importance of followup visits and repeat HIV Testing

HIV Seropositive
PMTCT, Treatment, Support

HIV Unexposed Woman
6. Reassess HIV Risk 6 monthly
7. Continue Risk Reduction Counselling

HIV Exposed Woman
1. Offer PrEP and adherence counselling
2. Emphasise importance of followup visits and repeat HIV Testing
Safety of PrEP in Pregnancy

- There is significant exposure *in utero* as TDF in amniotic fluid and cord blood.

- Studies of TDF use in HIV-uninfected pregnant women are limited.

- Evidence of safety is reassuring.

- However, it will be important to continue surveillance of maternal, pregnancy and infant outcomes to confirm the safety that reviews to date suggest.
Using a Risk Assessment Tool to Identify PBW for PrEP

- 50% of the antenatal population could likely be identified at high risk vs 3% actual infection rate
- Sensitivity: This tool could accurately identify 75% of women who subsequently acquired HIV infection during pregnancy or postpartum and could benefit from PrEP.
- Specificity: The poor specificity (59%) however, would mean that up to 40% of antenatal attendees and their unborn babies may be unnecessarily exposed to PrEP.

Using a Risk Assessment Tool to Identify PBW for PrEP

<table>
<thead>
<tr>
<th>HIV RISK ASSESSMENT TOOL</th>
<th>Initial: _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How old are you?</td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>2</td>
</tr>
<tr>
<td>≥25</td>
<td>0</td>
</tr>
<tr>
<td>2. Are you married or living with your partner?</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>2</td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>3. How old is your current partner?</td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>1</td>
</tr>
<tr>
<td>≥25</td>
<td>0</td>
</tr>
<tr>
<td>4. Does your partner have other girlfriends?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>I do not know</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>5. Does your partner provide you with financial support?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>6. Have you had any alcohol in the last 3 months?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>7. Have you had a STI in the last 3 months?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td><strong>Final Score</strong></td>
<td></td>
</tr>
<tr>
<td>High Risk</td>
<td>≥5</td>
</tr>
<tr>
<td>Moderate or Low Risk</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>
Overall, we enroll ~50 pregnant women/month of whom >90% of women initiate PrEP at baseline.
PrEP persistence declines significantly across women in sub-Saharan Africa

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Persistence rates (M=month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>POWER²</td>
<td>Kenya, South Africa</td>
<td>43% (M1) 20% (M3)</td>
</tr>
<tr>
<td>PrIYA³,⁴</td>
<td>Kenya</td>
<td><strong>MCH clinic</strong>: 39% (M1); 12% (M6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>FP clinic</strong>: 41% (M1); 24% (M3); 15% (M6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pregnant women reported <em>side effects</em> more frequently than non-pregnant women &amp; 36% of women discontinued PrEP</td>
</tr>
<tr>
<td>EMPOWER¹</td>
<td>South Africa, Tanzania</td>
<td>73% (M1) 61% (M3) 34% (M6)</td>
</tr>
</tbody>
</table>

Source:
**PrEP persistence**

- Persistence defined as returning for repeat PrEP prescription after baseline initiation

- PrEP continuation drops precipitously after COVID lockdown and after postpartum period

- **To improve persistence:** phone interviews & adherence counseling, weekend visits and after hours to accommodate women and COVID risk
PrEP Adherence

TFV-DP in DBS for pregnant/postpartum adolescent and young women on PrEP in Africa

Peter L. Anderson, Lynda Stranix-Chibanda, Sharon Huang, Sybil Hoesek, Deborah Kacana, Tselel Botlhe, Frank Taulo, Violet Kondoro, Clemencia Nakavita, Masekole Masenya, Kathryn Lypen, Nahida Chakhoura, Hans M. Solocelli, Benjamin H. Chi, on behalf of the IMPAACT 2009 team

Adherence benchmarks using TFV-DP in DBS were established for pregnant/postpartum African adolescents and young women.

TFV-DP in DBS was 31%-37% lower in pregnancy compared with postpartum, in line with expectations. Strict adherence to PrEP is recommended during pregnancy.

<table>
<thead>
<tr>
<th>Interpretation</th>
<th>Pregnant</th>
<th>Post-partum</th>
</tr>
</thead>
<tbody>
<tr>
<td>~7 doses/wk</td>
<td>&gt;650</td>
<td>&gt;950</td>
</tr>
<tr>
<td>2–6 doses/wk</td>
<td>200–649</td>
<td>250–949</td>
</tr>
<tr>
<td>&lt;2 doses/wk</td>
<td>&lt;200</td>
<td>&lt;250</td>
</tr>
</tbody>
</table>
PrEP Persistence and Adherence

Detectable TFV-DP in Pregnant Women prior to SAE or Delivery

PrEP in Pregnancy RCT

<table>
<thead>
<tr>
<th>Doses per week</th>
<th>TFV-DP (fmol/punch)</th>
<th>Number (%)</th>
<th>95%CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 doses/wk</td>
<td>&gt;650</td>
<td>41</td>
<td>(23.6%; 17.5-30.6)</td>
</tr>
<tr>
<td>2-6 doses/wk</td>
<td>200-649</td>
<td>84</td>
<td>(48.3%; 40.7-71.8)</td>
</tr>
<tr>
<td>&lt;2 doses/wk</td>
<td>&lt;200</td>
<td>49</td>
<td>(28.2%; 21.6-35.5)</td>
</tr>
</tbody>
</table>
Key Considerations

• Approaches to Offering PrEP to PBFW
  – Universal vs Targetted vs Demand
• Using Risk Assessment to Identifying PB AGYW for PrEP
• Adherence Monitoring and Support
• Monitoring Safety through Surveillance
• Optimizing PrEP Persistence and Retention
Novel PrEP delivery strategies

Sinead Delany-Moretlwe, MBBCh PhD DTM&H
UNAIDS ESA PrEP in AGYW
February 2021
Overview

• Why do we need a range of PrEP options?
• What new options are likely to be available?
• What does this mean for implementation?
Tracking global oral PrEP access

By Q4 2020, **928,750** people on PrEP worldwide

...And 1/3 new initiations discontinue within one month
Higher rates of discontinuation in AGYW

**Goal:** 3 million on PrEP by 2020

Reasons for oral PrEP discontinuation

Much like contraception, we need a range of PrEP options that can overcome these barriers across the life course

- **Drug**
  - Side effects
  - Pill burden or size
  - Habit formation

- **Health system**
  - Cost
  - Access
  - Visit burden

- **Context**
  - Stigma
  - Judgement and/or discrimination
  - IPV

Zarwell, AIDS Behav 2020; Bargnighausen, Culture Health Sex 2020; Pillay, PLoS One, 2020; Rutstein, Lancet HIV, 2020;
Monthly dapivirine ring

- Flexible silicone vaginal ring developed by IPM
  - Self-inserted monthly
  - Dapirivine released over 30 days
- Low systemic absorption
- Two Ph 3 trials showed well-tolerated and reduced HIV risk in women by ~30%
- Open-label extension studies showed greater use with estimated ~50% risk reduction
- Favourable side effect profile
- Favourable EMA opinion, July 2020
  - Recommended when women cannot use oral PrEP

Nel, NEJM 2016; Baeten, NEJM 2016; Baeten, IAS 2019; Nel, SA AIDS 2019
Monthly dapivirine ring – next steps

• WHO prequalification of DVR, Nov 2020
  o Included in guidelines, Feb 2021

• Paves the way for country-level approvals and implementation

• Additional studies
  o adolescents
  o Resistance in seroconverters
  o pregnant and breastfeeding women

• Future:
  o 90-day ring, dapivirine-contraceptive ring
  o 2 phase I studies using DPV
Long-acting injectable Cabotegravir

• Integrase inhibitor

• LA formulation is low solubility crystalline drug suspended in aqueous vehicle for intramuscular injection

• HIV treatment studies (with rilpivirine) demonstrate potent anti-HIV activity and high resistance barrier

• Developed for both HIV treatment and prevention

Source: Andrews, 2014; Radzio, 2015; Andrews, 2015; Andrews, 2017; Dobard, 2018
Long-acting injectable cabotegravir is safe and effective for PrEP

- N= 4566 cisgender men and transgender women
- Pooled incidence 0.81 (95%CI 0.61-1.07) per 100 PY

Landovitz RJ et al. AIDS 2020, #OAXLB0101
Long-acting injectable cabotegravir is safe and effective for PrEP

HIV incidence – ITT population

- N= 3224 cisgender women
- Pooled incidence 1.03 (0.73, 1.4) per 100 person-years
- Grade 2+ ISR CAB>TDF/FTC

HR: 0.11 (0.01, 0.31)
P=0.000027
Cabotegravir - 4 incident HIV Infections
Long acting injectable cabotegravir – next steps

- Blinded portion of studies stopped
- Additional HIV, PK and resistance testing of HIV infections ongoing
- Open-label extension with offer of CAB LA
  - Optional oral lead-in
- Additional studies in adolescents, pregnant and breastfeeding women
- The tail?

- MPT:
  - alignment with contraceptive visits, coadministration or coformulation?
  - Future use in implants or micro-array patches
PrEP 2.0 – future long-acting products

- Monthly oral pill or implant – Islatravir
- 6-month sub-cutaneous injection – Lencapavir
- Phase III trial results expected 2024
Implications for implementation - opportunities

• Supporting product choice
  o Demand from men as well as women
  o Cost-effectiveness vs. affordability considerations
  o Health system – offer all or to those that fail oral PrEP
  o Provider training and support tools
    • Client preferences vs. product efficacy and safety profile

• Integration within sexual health services
  o Visit alignment
  o Multi-purpose products
  o Opportunities to increase uptake of range of services in a broad range of populations
Implications for implementation – more data needed

• Adapting to long-acting products
  o Delayed dosing and implications for resistance?
  o Implications for HIV diagnosis and rapid testing platforms?
  o Linkage to treatment
  o Provider skills and training
  o Messaging and decision support

• Strengthened surveillance
  • Strengthened pharmacovigilance for rare events in pregnancy
  • Resistance
Acknowledgements

Participants and communities taking part in these trials
Trial staff, sponsors and funders
Next Steps

1. Complete the Delphi Survey
   Consensus Building Exercise
   You will receive a Delphi Survey via e-mail.
   Please complete the survey by Monday 8th March

2. Join us for Session 5
   Session 5: Monitoring, Research Agenda and Finalisation
   Tuesday 9th March
   10:00 am – 11:45 am SAT