HERSTORY 2 STUDY

Process evaluation of the combination HIV prevention intervention for adolescent girls and young women (AGYW), Global Fund grant period 2019 to 2022

REPORT 3/5: QUALITATIVE EVALUATION

HERStory 2

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Qualitative Study Component Report

FINAL REPORT
9th June 2021

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CONTENTS

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Acknowledgements

EXECUTIVE SUMMARY

The Global Fund (GF) funded AGYW Programme (2019-2022) offers an age-tailored combination HIV prevention programme for Adolescent Girls and Young Women (AGYW) aged 15-24 in 12 districts in South Africa. The HERStory 2 study, comprised of several sub-studies, is a process evaluation of the AGYW combination intervention conducted by the South African Medical Research Council (SAMRC) and partners. This report describes the Qualitative study component, which aimed to 1) assess the **acceptability of the intervention** to AGYW and key stakeholders in schools and communities, explore the intervention from the perspective of intervention beneficiaries, describe participants' views of the intervention; 2) examine the **context of the intervention**, assess the extent to which the context is conducive to intervention implementation, the extent to which key gatekeepers in the intervention context are supportive of implementation, and examine the broader social/community culture into which the intervention is introduced, and how it may have influenced and interacted with the acceptability of the intervention, and its delivery; and 3) examine the extent to which the **Theory of Change (ToC)** was appropriately specified to achieve the intervention goals, and assess the extent to which it is being implemented as theorized.

The qualitative sample was drawn from 6 of the 12 districts in which the intervention is being implemented, comprising two districts per Principal Recipient (PR), as follows: Klipfontein, Cape Town (Western Cape), King Cetshwayo (KwaZulu Natal), Ehlanzeni (Mpumalanga), Bojanala (North West), Nelson Mandela Bay (Eastern Cape), and Thabo Mofutsanyana/Dihlabeng (Free State). Interviews were conducted in the period from November 2020 and March 2021, with a total of 100 respondents, comprising AGYW, intervention implementers, health workers, social workers, and other community stakeholders. Analysis followed a thematic approach by a collaborative analyst team.

Section 1 (part A) documents **implementation experiences** of the Core and Layered services of the intervention from the perspective of implementers. The Core Service consists of three main activities: demand creation, a risk and vulnerability assessment and a follow-up journey / service plan for each AGYW. Observations on recruitment included reports that recruitment events were more successful and safer for implementing teams than recruiting AGYW on the street, door-to-door or at key entry points. Providing incentives at recruitment events such as catering and branded items improved enrolment, although not all SRs were providing these. Several SRs stated late or non-delivery of diaries/journals intended for the service plans. Respondents in two districts noted that previous programmes offering Cash Transfers created expectations for cash incentives. A commonly cited challenge was that AGYW provided incorrect contact numbers when recruited and thus could not be contacted for further services or re-enrolment. The ToC programme model assumes an inherent value to the programme components, and that AGYW would naturally want to participate if offered the opportunity to do so. However, the common experience of having to convince AGYW of the value of the programme, undermined this inherent assumption.

Implementers stated that the Risk Assessment is too long. Moreover, forms had not been tailored or adapted to the different implementation districts; some questions refer to services that are not offered and therefore create expectations for services that cannot be provided. Respondents also reported that staff conducting the assessments had not been trained adequately, and that the sensitive nature of the questions required counselling training, which Peer Group Trainers (PGTs) did not have; it was stated that this lack of training has negatively impacted the quality of data captured.

Another critical finding was that Risk Assessment tools have not been translated into local site languages; as a consequence terminology is not standardised and questions may be open to multiple interpretations.

The findings from this evaluation indicate that the quality of **Core services** appears to have been compromised by a number of challenges during implementation. Thus, the ToC model holds true in that the actions took place as planned, but the quality of delivery was more of an implicit assumption that did not always hold true in practice. The intention to recruit from multiple sources in the ToC model was a success, as findings revealed that some settings are easier to recruit from than others, for example through events and at schools as opposed to public spaces. However, a host of difficulties reported by the implementers suggest that in reality, the dynamics of recruitment are more nuanced than the model allows for. Findings revealed how difficulties or negative experiences of recruitment may negatively impact on the effectiveness of other steps in the ToC model, for example not being able to offer all the services promised during recruitment, resulting in a breach of trust, which resulted in poor retention. The ToC model assumes that all that is required is that the steps happen, without consideration for *how* they happen.

The next section of the report reports on **Behavioural, Biomedical and Structural services** in the form of **Layered services**. It captures implementer experiences of **Biomedical Services**. Respondents described the comprehensive sexual and reproductive health (SRH) services offered through the programme, comprising a 'one-stop-shop' SRH health care to AGYW. SRs stated that the rollout of PrEP was slow due to challenges in supply of PrEP through the National Department of Health, which affected AGYW participation. In addition, several challenges associated with PrEP uptake, adherence and acceptability were described. Implementers reported considerable challenges related to PrEP retention, noting that although a high number of AGYW were initiated onto PrEP, few were successfully retained. Respondents felt there was insufficient follow-up, ART adherence support and monitoring for AGYW who test positive for HIV, and described challenges in keeping track of ART for those AGYW testing positive whose records are transferred to government clinics. A key barrier to implementer acceptability of biomedical services was the perceived pressure to meet targets compromising the quality of care and service provision.

Implementer experiences of delivering **Behavioural Services** such as the Teen Parenting Programme, Psychosocial Support, Peer Education, Comprehensive Sexuality Education (CSE) were described. The intervention was perceived to have improved access to 'youth friendly' psychosocial services and improved AGYW SRH knowledge. Peer Education programmes were considered successful; AGYW were able to engage with peers in supportive group settings, and related well to younger PGTs, facilitating relationship building and a positive mentorship dynamic. Social workers stated that their ability to provide 'proper' comprehensive, sensitive social work services was compromised by pressure to meet targets, and the high burden of administrative work. Additionally, social workers were expected to perform a wide range of duties, including facilitating self-defence classes, grant and document applications, and homework support, which many did not feel suitably qualified to provide. As a result, social workers felt overburdened and unable to provide "proper social work support" to AGYW in need. There were challenges in Comprehensive Sexuality Education (CSE) provision due to staff delivering CSE being inadequately trained and lacking sensitisation, as well as resistance to CSE content from school principals. Critical challenges undermining the implementation of these services included the assumption that implementing staff would able to successfully put aside personal beliefs relating to sex, to provide CSE.

The report discusses implementer experiences of **Structural Services**, including the Self-Defence Programme, Men's Dialogues, access to work opportunities and academic scholarships, academic support and career guidance, return to school support and provision of dignity packs. There was high demand among AGYW for dignity packs, work opportunities, career guidance and access to identity documents and social grants, however these elements of the programme delivery experienced most challenges. Implementers stated that the self-defence programme was popular among beneficiaries, and thus regarded by implementers as potentially the most successful structural programme. Several challenges regarding consistent and sufficient supply of dignity packs were noted. Implementers were frustrated that they had created expectations among beneficiaries for structural services that did not materialise timeously. Several implementers concluded that services offered under the structural layer were the weakest aspect of the programme, and that non-delivery of certain components in various districts had negatively impacted on acceptability.

While a number of challenges with layered services were reported, there was overwhelming support for the psychosocial benefits of the programme. Implementers emphasised that AGYW participation in psychosocial behavioural services allowed for relationship building, yielding disclosures around risks and vulnerabilities not always uncovered during Risk Assessments. However, the importance of this aspect of relationship building is not explicitly stated in the ToC model. The layered services provided significant benefits, but not necessarily as a direct result of the Risk Assessment, as per the ToC model assumption. This suggests that the Risk Assessment may not be a necessary condition for effective uptake of layered services.

Section 1 (part B) of the report focuses on **implementation relationships and referral mechanisms**. A central principle of the AGYW Programme is that the various service components would be provided through a referral system between Global Fund funded programmes, services provided by government entities, other NGOs and private service providers. While some SRs stated that service mapping and referral databases were comprehensive, in certain districts they were described as inaccurate or outdated. SRs reported a number of challenges regarding relationships and referrals with government service providers. The nature of pre-existing relationships that SRs had with government stakeholders prior to the AGYW programme strongly influenced the success of referrals. Reportedly, Memoranda of Understandings (MOUs) assist in establishing referral systems but do not on their own ensure effective referrals; particularly if held by PRs at national level and not at district level. A common challenge was lack of buy-in or recognition of the intervention among government stakeholders. For example, DoH clinic staff not recognising or acknowledging the referral forms. While implementers reported conducive relationships with local clinics, many acknowledged that clinic staff were overburdened and lacking capacity to deal with referrals.

Section 1 (part C) discusses **intervention delivery settings and spaces**. The programme intended for both core and layered services to be delivered by SRs in schools, TVET colleges, dedicated Safe Spaces and mobile clinics. Several implementers described delays in setting up Safe Spaces, negatively impacting the delivery of services and activities. Common challenges included safety concerns, barriers to accessibility (location and opening times), under-resourced and understaffed facilities, under-utilisation of Safe Spaces by AGYW, and underservicing of rural areas. Challenges providing services through clinics, TVETs and schools were related to lack of dedicated spaces for intervention staff. SRs made use of community venues to bring services closer to AGYW, however challenges were noted where local councillors and municipal staff acted as gatekeepers to facilities, or there was competition for use of venues with other organisations.

Section 1 (part D) documents **implementer experiences of implementation management and logistics**, and discusses experiences with set-up and planning, delays in starting the programme, staffing and training, resource management, monitoring and evaluation, reporting requirements, data management and the My Hope System. Implementers indicated that at the start of implementation, field staff did not fully understand their roles and responsibilities due to insufficient or delayed training. Some programme components, such as grief counselling and teen parenting, require highly trained personnel; several SRs noted that training to facilitate these courses was delayed, disrupting delivery and negatively impacting beneficiary acceptability. Respondents reported that further technical training was required, particularly on GBV and substance use. A commonly recurring theme was that PGTs were undervalued and underpaid for their tasks and level of responsibility. Some SRs stated that the funding that they received from PRs was sufficient, while others commented they had insufficient funds to cover costs such as hosting demand creation events, transport for participants, resourcing Safe Spaces and providing incentives to participants and field staff.

An external service provider was contracted to develop My Hope, a biometric-based information management system for the monitoring and evaluation of the AGYW intervention, designed to allow for programmatic and performance management at SR and PR level through a cloud and mobile based management system. Implementation experiences with the My Hope System were overwhelmingly negative. Implementers described the system's negative impacts on data quality by duplicating or deleting entries, compounding invalid/inaccurate data entry by requiring that all fields are entered before accepting a form. Another common complaint among SR respondents was the failure to implement mobile data capture devices; field staff had to use paper-based Risk Assessment forms, resulting in added data entry burden. Implementers stated that reporting systems may not be facilitating effective implementation, prioritising targets and numbers of AGYW engaged and events hosted, over provision of quality services.

Section 1 (part E) discusses **contextual factors** impacting the implementation of the intervention, such as safety concerns and the COVID-19 pandemic. Implementers described various ways in which COVID-19 had limited the ability of PRs and SRs to implement as planned and meet targets. SRs had acquired permits to operate during lockdown and attempted to continue offering some services to AGYW door-to-door. However AGYW and their families were wary of inviting fieldworkers into their homes during this time. Staff were also reluctant to conduct outreach activities due to both potential COVID infection and safety concerns. School closures also negatively affected implementation; in-person group activities were halted, as were services provided in schools and TVETs during lockdown. Even after schools reopened, school staff were hesitant to allocate class time for programme activities due to teaching time that had been lost. Various attempts were made to adapt services to this context, for example by setting up WhatsApp groups and providing online/remote services. SRs assisted local clinics and schools to screen for COVID-19 and used this opportunity to recruit AGYW into the programme. However, overall COVID-19 negatively affected both recruitment and retention. AGYW beneficiary access to biomedical services was disrupted, particularly contraceptives, HTS and PrEP; AGYW were hesitant to go to clinics due to COVID-19 infection fears. Conducting Risk Assessments or providing telephonic counselling was described as problematic and inappropriate due to the sensitive nature of discussions. COVID-19 heightened issues around community acceptability and particularly highlighted the inadequate engagement with parents, as many parents only discovered that their daughters were participating in the programme when fieldworkers visited their homes. AGYW respondents described feeling isolated during lockdown, exacerbated by programme activities being halted and being unable to receive psycho-social support, meet in groups or attend events. One

positive aspect narrated by AGYW beneficiaries, was that in some cases, AGYW were able to continue accessing Safe Spaces, where they could study and get academic support.

Section 2 (part A) of this report discusses **acceptability and perceived benefits of the intervention from implementers' perspectives**. Implementers described a number of benefits of the intervention for AGYW including a reduction in teenage pregnancy and HIV incidence, improved AGYW access to 'youth friendly' SRH services, improved SRH knowledge and access to psycho-social support, improved mental health, empowerment and personal development, positive behavioural change, improved parenting skills and support for AGYW with children, reduction in school drop-out and increased school returns, improved educational support and educational attainment, and improved career opportunities and skills. While implementers perceived many benefits, they also articulated criticism relating to the lack of pre-implementation piloting of programmes, insufficient consultation of communities prior to implementation, and in some cases components or services that were not being delivered as planned and promised. Fieldworkers and other frontline staff tended to receive the backlash from communities for failure to deliver on promises.

Section 2 (part B) presents findings on **AGYW beneficiary acceptability and experiences of Core and Layered services**. According to AGYW respondents, the main motivating factors to join the programme were assistance with education; psycho-social support and guidance; opportunities for connecting with peers; self-defence classes; and access to health services and SRH information and education. Key barriers to AGYW participation included lack of transport and distance to venues, lack of interest, childcare responsibilities, and resistance from parents/caregivers. The report documents varied AGYW experiences and acceptability of Risk Assessments; several AGYW respondents stated that assessments were invasive and embarrassing, and some expressed concern about the confidentiality of their answers or the lack of privacy at venues. In general, AGYW beneficiaries shared positive views around the Safe Spaces.

AGYW experiences and acceptability of various biomedical services are discussed, including HIV Testing Services, PrEP and SRH. AGYW expressed a preference for the services provided by Global Fund PRs and SRs, over those offered at government health facilities, as they were more efficient, more personalised, less judgemental, and more comprehensive. Hesitancy related to PrEP uptake was reported, linked to fear of side effects, intermittent supply, and a preference for the dual-prevention afforded by condoms. A key perceived benefit of behavioural and structural services were the supportive peer networks fostered through activities and groups. AGYW also reported that the intervention had improved their ability to communicate and access psychosocial support. AGYW perspectives on the benefits of the intervention included empowerment, improved hopes and future aspirations, peer support and the feeling that 'someone cares'. Some AGYW expressed that the programme had not delivered on what they had been promised when they were recruited into the intervention; AGYW acceptability of the intervention was negatively impacted by apparent misunderstandings relating to the supply of dignity packs, and the non-delivery of journals/diaries.

Section 2 (part C) describes **community acceptability of the intervention**. Communities were generally welcoming of the programme, and particularly appreciated the social workers. Community stakeholders' perceptions of positive behavioural changes among participating AGYW also engendered acceptability for the programme. SRs that ensured engagement with communities observed how this had a positive impact on acceptability. SRs who did not engage parents or seek their approval before enrolling AGYW into the programme experienced hostility from some parents and caregivers, especially where AGYW had been enrolled on PrEP or contraceptives without parental

consent. Parental acceptability created a conducive environment for implementation as parents/caregivers encouraged AGYW to keep attending services and advocated for the programme among other stakeholders.

Some SR respondents described cases of community resistance to specific components of the programme, such as PrEP, contraceptives and self-defence. Respondents described community perceptions of AGYW HIV-prevention focused programmes being limited in scope, through excluding other groups also needing assistance, notably adolescent boys and young men (ABYM) and AGYW outside the 15-24 age group. Other contextual challenges were also perceived as more important in the views of community stakeholders, such as poverty-alleviation and job creation. SRs who provided men's dialogues were viewed favourably, whereas failure to ABYM tended to impact negatively on community acceptability. Community members questioned why SRs only targeted AGYW when decision-making around sexual health and strategies to address GBV need to ABYM. Participants also stated that solely empowering AGYW could have unanticipated consequences, through causing ABYM to feel threatened, and inadvertently increasing GBV.

SRs had diverse responses regarding relationships with community gatekeepers such as Ward Councillors and traditional leaders. SRs stated ensuring access to communities required engaging with community leaders. In some cases, ward councillors assisted in recruiting AGYW, and SRs were working with traditional leaders as an advocacy strategy. Building relationships with Ward Councillors enhanced the safety of field/outreach teams. In cases where ward councillors and traditional leaders were not supportive of the programme, implementation was negatively impacted. The programme was viewed by some traditional leaders as conflicting with traditional gender and cultural norms. Some SRs also stated political interference from Ward Councillors, who threatened to prevent implementation in their ward, unless they received financial rewards or preferential access to job opportunities for their kin and political constituents. Some SRs motivated for a top-down approach to reaching communities, whereby communities would be accessed through local gatekeepers like Ward Councillors and traditional leaders. While others emphasised the importance of reaching beneficiaries directly and avoiding political interference from gatekeepers.

Section 2 (part D) examines **community acceptability of the intervention through the lens of the Theory of Change critique**. It is evident that discourses of acceptability rely strongly on observed or perceived positive behavioural change. However, the literature on adolescent sexuality confirms that public health interventions aimed at behaviour change often neglect the influence of important socio-economic factors. The ways in which AGYW negotiate their sexual and social relationships are more complex than the ToC model allows for. The model assumes that exposure to services is all that is required to bring about the desired change. Respondent narratives revealed deeply complex processes and factors within AGYW social contexts that influence health outcomes. AGYW described the pressures of surviving the effects of poverty, violence, gendered social norms, political, cultural and class dynamics, poor familial support and many other challenging factors in these contexts. These broader social and contextual factors may be inadequately accounted for by theoretical logic models such as the ToC. It is imperative to find ways to incorporate these learnings into Theories of Change more effectively.

Section 2 (part E) presents **Implementer, Beneficiary, and Community Stakeholder views on how the intervention could be improved**, with regards to services and components, systems, relationships, settings, and engagement efforts. Respondents shared views and perspectives of the various ways in which they believed the intervention could be improved to enhance its effectiveness, accessibility, appropriateness, and acceptability, as well as various ways in which existing challenges with

implementation could be addressed. **Section 2 (part F)** discusses **the broader context of AGYW lives and** communities, although in-depth data on this thematic area are not included in this report.

Section 2 (part G) captures **respondents' views on the sustainability of the intervention**. Concerns regarding sustainability were raised by implementers, community stakeholders and AGYW beneficiaries. Implementers expressed concerns regarding 'letting down' beneficiaries, who would expect to keep receiving services beyond the funding period. Since 'youth friendly' programme services were far more attractive to AGYW than those offered in clinics, it was felt that AGYW were unlikely to return to clinics for biomedical services when SRs stop providing them. There were concerns that gains made in improving psychosocial support would not be sustained after the grant period. Some respondents noted that the more subtle 'perceived impacts' of the project, related to AGYW behavioural changes and some structural impacts, were more likely to be sustained, for example AGYW empowerment, or links to economic opportunities and training. However, it is unclear that AGYW would be able to maintain these changes without the continued support of the programme. Implementers did not appear to have sustainability plans in place and thus have not been able to provide responses to community and beneficiary concerns regarding sustainability. The ToC model assumes that improved health outcomes will result from exposure to the core and layered services but does not necessarily speak to how these may be sustained post the grant period. There is an assumption that what has happened during the grant period (exposure to core and layered services), will be enough to sustain the changes. However, the assumption that change will be sustained after the intervention is not well supported by the findings.

List of Acronyms

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
ART	Antiretroviral Therapy
CSE	Comprehensive Sexuality Education
DBE	Department of Basic Education
DCoG	Department of Cooperative Governance
DoH	Department of Health
DOL	Department of Labour
DSD	Department for Social Development
EC	Eastern Cape province
ECD	Early Development Centre
FS	Free State province
GBV	Gender-based Violence
GF	Global Fund
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IDI	In-depth Interview
IPV	Intimate Partner Violence
KZN	KwaZulu Natal
LSA	Learner Support Agent
MOU	Memorandum of Understanding
MPU	Mpumalanga
NACOSA	Networking HIV/AIDS Community of South Africa
NEET	Not in Education, Employment or Training
NGO	Non-Governmental Organisation
NW	North West province
PGT	Peer Group Trainer
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
SAMRC	South African Medical Research Council
SAPS	South African Police Service
SASSA	South African Social Security Agency
SAW	Social Auxiliary Worker
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SR	Sub-Recipient
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
ToC	Theory of Change
TVET	Technical Vocational Education and Training
WC	Western Cape province

BACKGROUND TO THE INTERVENTION

The AGYW Programme (2019-2022) offers an age-tailored combination prevention programme for AGYW aged 15-24. The programme targets AGYW, in and out of school, but will not decline service provision to other populations who are engaged by the programme (i.e. ABYM in-school, members of the broader community). All PRs were to conduct a situational analysis and service mapping exercise for each sub-district to assist with placement of Safe Spaces and establishing a reliable referrals directory.

According to the programme design, an adolescent girl or young women can be introduced to the programme through a number of entry points from where she would be receiving services via two main service components called the Core Service and Layered Services. She would first receive the Core Service and then follow a path of receiving additional services layered over time as required. The layered services are not necessarily provided in specific order but dependent on the needs of the beneficiary.

Importantly, a central principle of the AGYW Programme is to ensure that there is collaboration and interaction with the other GF funded programmes and cross referrals and information flows at all levels, from programme management at PR level, to providing comprehensive and integrated services to AGYW in community across all 12 sub-districts

The AGYW Programme 2019-2022 has the following key objectives:
- Increase retention in school
- Decrease HIV incidence
- Decrease teenage pregnancy
- Decrease gender-based violence
- Increase economic opportunities

The intervention is in line with South Africa's National Strategic Plan (NSP) for HIV, TB and STIs: 2017–2022. The specific NSP goals addressed by this programme are:

GOAL 1: Accelerate prevention to reduce new HIV and TB infections and STIs.
GOAL 3: Reach all key and vulnerable populations with customised and targeted interventions.
GOAL 4: Address the social and structural drivers of HIV, TB and STIs, and link these efforts to the National Development Plan (NDP)

AGYW are introduced to the intervention through a number of entry points and referred to receive services via two main service components called the Core Service (which are received first) and Layered Services (which are additional services depending on the needs of the beneficiary, which are to be received over time). Core and layered services are delivered by funded SRs in schools, TVET colleges, dedicated Safe Spaces in communities, and mobile clinics that deliver clinical HIV and SRH related services. Layered services are categorised into biomedical, behavioural and structural services. In addition to delivery of layered services by SRs, some layered services are delivered by unfunded external service providers such as government health, education or social development providers, in their own settings via referrals from the funded SRs. The approach of the AGYW programme is to leverage these existing services rather than set up parallel and less sustainable services.

The Theory of Change Model

The AGYW intervention was designed and conceptualized according to a theory of change model (Figure 1). The theory of change is built on the assumption that IF adolescent girls and young women are identified through various entry points (in schools, communities through NGOs, churches, public spaces and higher education institution through TVET colleges) and have their risks and vulnerabilities assessed and, IF AGYW are linked to biomedical, behavioural and structural HIV prevention interventions, THEN that may lead to positive health and behavioural outcomes, that, in turn should lead to reductions in new HIV infection among this group, IF programmatic, financial and political assumptions hold true (NACOSA et al., 2020, AGYW Programme Description).
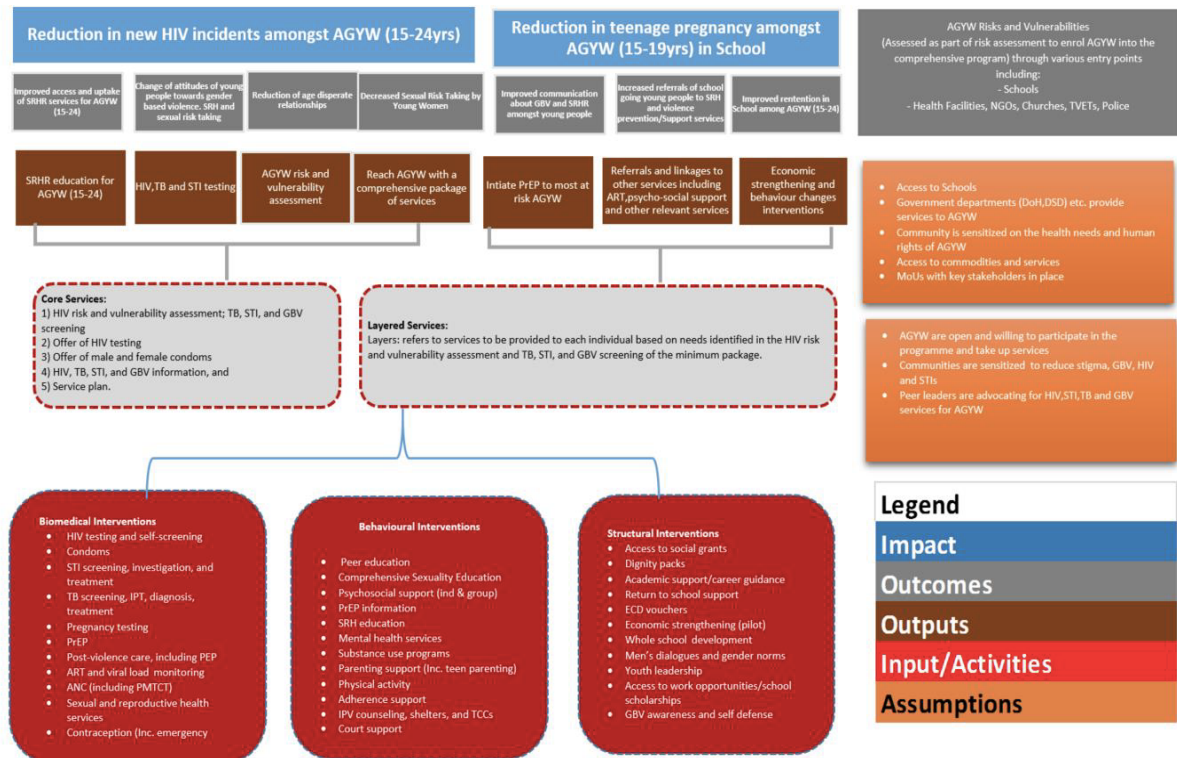

Figure 1: AGYW Programme Theory of Change

The HERStory 2 Process Evaluation

Informed by the Medical Research Council guidance on process evaluation of complex interventions, and by the guidance on evaluating service coverage cascades, the HERStory 2 study was a process evaluation of the AGYW combination intervention delivered between 2019 and 2022. The HERStory 2 process evaluation comprised several sub-components or sub-studies. This report describes the Qualitative Component. The other sub-studies are described in associated reports, and are available at: https://www.samrc.ac.za/intramural-research-units/healthsystems-herstory

Process evaluations of complex interventions

Process evaluations investigate how and why an intervention works or does not work in the context of a trial or outcome evaluation (Cheng et al., 2018). Complex interventions such as the AGYW intervention, have several interacting components and target multiple organizational levels, and they are usually difficult to implement (Moore et al., 2015). Process evaluations of complex interventions can be used to "assess fidelity and quality of implementation, clarify causal mechanisms and identify contextual factors associated with variation in outcomes" (Moore et al., 2015).

It is important to base process evaluations on the explicit causal assumptions about how the intervention in question will work. These causal assumptions are usually described in a theory of change or a logic model, such as the theory of change for the AGYW's intervention (Figure 1). Process evaluations will usually assess fidelity (whether the intervention was implemented as intended). Because complex interventions are often tailored during implementation, it is important to capture what happens in practice, with reference to the theorized model. Process evaluations also commonly investigate the why intended beneficiaries participated or decline to participate) (Moore et al., 2015). The context in which the intervention is delivered may undermine or promote implementation and intervention effects, and thus studying the context is an important part of a process evaluation of a complex intervention.

Process evaluations can help explain why interventions do not work. For example, the underlying theory of change may be sound, but the intervention may not have been delivered as planned, that is, the delivery had poor fidelity. Process evaluations can also aid understanding of why the intervention works for some population groups, in some contexts, but not others. These are important findings which can contribute to better-designed interventions and studies in the future.

The Medical Research Council guidance (Moore et al., 2015) recommends that, for a process evaluation, the causal assumptions represented by the intervention and the key uncertainties are identified up front, and are used to inform the research questions and study design. It is recommended that the research questions are developed collaboratively with key stakeholders. This is the approach we have taken in this study.

Aim of the HERStory2 Process Evaluation

The aim of this process evaluation is to assess whether the selected health and educational interventions for AGYW, based on the theory of change, are being implemented as planned and whether the implementers are on a trajectory to achieve the desired outcomes.

Purpose

The purpose of the evaluation is to provide recommendations to the intervention implementers during the current grant period 2019-2022, to enable them to correct the course of implementation and to better align intervention implementation to the theory of change and best practice, so that they are on a trajectory to achieve the outcomes specified in the theory of change. The evaluation recommends the changes and improvements that might correct the trajectory to better align it to the theory of change or best practice. The focus was on selected inputs, processes and activities, identified by the researchers together with other key stakeholders including the Principal Recipients, SANAC representatives, and the Global Fund. These include interventions to promote high school completion, HIV prevention interventions such as condoms and PrEP, HIV care interventions and sexual and reproductive health interventions such as contraception.

Research Questions relevant to the Qualitative Process Evaluation study

The mid-term qualitative process evaluation aimed to answer the following research questions:

a) To what extent is the intervention **acceptable** to AGYW and key stakeholders in schools and communities, and why do they participate in it, or decline to participate in aspects of the intervention?

b) To what extent is the **context** of the intervention conducive to intervention implementation, and to what extent are key gatekeepers in the intervention context supportive of implementation? The context of the COVID-19 pandemic was considered here. What role has the context played in shaping the theory of change, and how the programme works in practice?

c) To what extent is the **theory of change appropriately specified** to achieve the intervention goals and to what extent is it being implemented as theorized?

Evaluating Acceptability

In assessing the acceptability of an intervention, it is critical to clearly define the concept of acceptability. Acceptability has been defined as the perception among intervention beneficiaries and implementation stakeholders that a given intervention and its activities are agreeable or satisfactory (Proctor et al, 2011). Acceptability is not simply an attribute of an intervention but is rather a subjective evaluation made by individuals who experience (or expect to experience) or deliver (or expect to deliver) an intervention (Sekhon et al., 2017). Acceptability should be assessed based on stakeholders' knowledge of or direct experience with various dimensions of the intervention – acceptability can be prospective or retrospective, depending on whether the assessment occurs before, during and after intervention delivery (Proctor et al, 2011; Sekhon et al., 2017). Importantly, levels of acceptability are likely to vary at different time points, and throughout various stages of implementation, and different temporal perspectives change the purpose of the acceptability assessment and may change the evaluation (Proctor et al, 2011; Sekhon et al., 2017). The acceptability of an HIV prevention intervention or service is one of the factors influences AGYW motivation to take it up or use it, and therefore is one of the underlying concepts influencing the steps in the HIV prevention cascade or in any coverage cascade. Hand in hand with acceptability is the notion of appropriateness, which refers to the perceived fit, relevance, or compatibility of the innovation or

evidence based practice for a given practice setting, provider, or consumer; and/or perceived fit of the innovation to address a particular issue or problem (Proctor et al, 2011). The acceptability of interventions to beneficiaries/recipients, community stakeholders, and intervention implementers is an important issue to consider in the development, evaluation and implementation phases of interventions (Sekhon et al., 2017). The insights about acceptability from process evaluations can help to inform the interpretation of the gaps in the HIV prevention cascade or other coverage cascades, and in intervention outcomes (Sekhon et al., 2017). Qualitative methods are useful to assess experienced acceptability of the intervention for recipients and implementers (Sekhon et al., 2017), and we have included such methods in this process evaluation.

Theory of Change

Early implementation science has been criticized for being empirically driven and ignoring the theoretical basis for interventions. When conducting process evaluations, especially of complex interventions, the absence of strong theoretical underpinnings makes it difficult to understand and to explain how and why an intervention fails or succeeds, and limits the understanding of unintended research outcomes (Eccles et al., 2005; James, 2011; Kleinman, 2010; Nilsen, 2015; Rapport et al., 2018). Theoretical clarity in terms of the outcomes could assist researchers to identify factors that influence the likelihood of success, and thus inform improved strategies for success in ongoing and future interventions. In response to this criticism, there has been an increased effort to integrate theoretical foundations that implicitly inform Public Health interventions aimed at initiating behaviour change of individuals, with the Theory of Change (ToC) being perhaps most notable (Care, 2012; Ebenso et al., 2019; Nilsen, 2015).

The Theory of Change model was first published by Weiss in 1995 and as much as it has gained increased popularity recently, it appears that little is known about the extent to which it has been used to design and evaluate Public Health interventions aimed at behaviour change. ToC has been framed as an answer to the dilemma of both poor theoretical grounding and inadequate causal explanations by making the theoretical assumptions between inputs and outcomes clear in the research design (Care, 2012; Ebenso et al., 2019; Nilsen, 2015) In earlier versions, ToC was most often viewed as a tool that delivers a logical framework that maps a sequence of events from input to outcome known as logic models (LMs), but more recently there have been calls that ToCs should offer a more in-depth reflexive process that facilitates reflection amongst stakeholders on values, worldviews, and philosophies, thereby unearthing role players' assumptions about how and why change occurs (Vogel, 2010).

Theory of Change models have been criticised for explaining *what* happens but failing to explain *how* it happens (Breuer et al., 2016; Care, 2012). ToC should include discussions around relative elements such as social, political and environmental conditions, a consideration of other actors that may influence change and a description of how long-term changes are envisioned and will continue to be supported in future. A systematic review of the use of ToC in Public Health interventions however found that the papers reviewed rarely explained how the theory was integrated into the analysis (Breuer et al., 2016; Care, 2012; Nilsen, 2015). In practice, many ToCs fail to account for the complexity of systemic change within social systems because they focus on individual behaviour change with too little consideration for the influence of the contextual complexities inherent in social change processes (Coryn et al., 2011; Cullen et al., 2016; Kessi & Howarth, 2015; Leclerc-Madlala, 2011; Reeler & Van Blerk, 2017; Vogel, 2010).

Qualitative study objectives

Of the overall HERStory2 process evaluation objectives, the following are relevant to the Qualitative study component.

Objective d

Assess the **acceptability of the intervention** to AGYW and key stakeholders in schools and communities, and reasons for why AGYW participated or declined to participate in aspects of the intervention. Explore the intervention from the perspective of intervention beneficiaries and describe participants' views of the intervention (including intervention acceptance).

Objective e

Examine the **context** of the intervention, and assess the extent to which it is conducive to intervention implementation. Assess the extent to which key gatekeepers in the intervention context are supportive of implementation. Assess the extent to which context has shaped the theory of change, and how the programme works in practice. We examined the broader social/community culture into which the intervention is introduced, and how it may have influenced and interacted with the acceptability of the intervention, and its delivery.

Objective f

Examine the extent to which the **theory of change** was appropriately specified to achieve the intervention goals, and assess the extent to which it is being implemented as theorized. We explored the implementation processes and how the intervention works in practice.

Assessing Theory of Change in the AGYW intervention

The tension between the need to simplify social change processes into manageable frameworks that explain change through cause and effect (LMs) with reasonable ease, versus the need to account for the immense complexity of the social systems that interventions operate within is evident in literature (Blue et al., 2016; James, 2011; Reeler & Van Blerk, 2017; Valters, 2015). The HERStory study has been tasked with investigating how well the ToC model was specified for this intervention. The report offers brief analyses on the use of ToC at the end of each of the relevant sections. The framework adopts Weiss' perspective of trying to highlight both the explicit and implicit assumptions about change, and also attempt to explain both *what* and *how* change did or did not happen.

The key assumptions embodied in the theory of change that we investigated are described below.

Key assumptions embodied in the theory of change

- AGYW will be identified through various entry points (in schools, communities through NGOs, churches, public spaces and higher education institution through TVET colleges), and will have their risks and vulnerabilities assessed

- AGYW identified in the implementation areas through demand creation activities will be willing and able to participate in the AGYW Programme

- The AGYW's personal journey plan describes her own life goals and the things that will help her to fulfil those goals and become the person she aspires to be

- AGYW who participate in the core services and who are identified as in need of a layered service will be willing and able to participate in, or take up the layered service

- AGYW can access commodities and services

- Communities are sensitised on the health needs and human rights of AGYW

- External service providers, including Government Departments (Department of Education, Department of Health, Department of Social Development, Department of Justice) and community-based organisations, will provide behavioural, structural and biomedical services to which AGYW can be referred. Implicit in this is the assumption that AGYW will have access to such services and find them acceptable and of high quality.

    - These partners will collaborate with the AGYW Programme by signing partnership agreements, supporting access to commodities, access to facilities and schools and/or providing layered services to AGYW.

Qualitative methods

The qualitative component of the HERStory2 Process Evaluation used individual in-depth interviews conducted remotely/telephonically to collect data from a range of respondents. Key informant interviews were conducted in the period from November 2020 and March 2021, with a total of 100 respondents, comprising AGYW, intervention implementers, health workers, social workers, and other community stakeholders. See the section on Study Limitations for comments on methodological limitations of a process evaluation capturing data at a specific time-point in the implementation of an intervention.

Methodological Rationale

Qualitative methods are interpretive, seeking to contextualise the social phenomena being researched. Qualitative research methodologies, which encompass a diverse collection of approaches to inquiry, intend to explore and explain the subjective experiences of individual actors in society, generating knowledge grounded in human experience (Power, 2002). By providing rich, in-depth observations and 'thick descriptions' (Geertz, 1973), qualitative enquiry unpacks the meaning of behaviours, attempting to understand them from the subject's own frame of reference, and situate them within the context in which they occur. Qualitative research methods such as in-depth interviews (IDIs) are well suited to the task of unpacking meanings, lived experiences, perceptions and the socio-cultural factors and contexts that influence decision-making processes and behaviour (Villanueva, 1997; Strauss, 1990).

Qualitative research methods can also be used to examine social processes and structures by examining in fine detail the lived experiences of individuals situated within those contexts (Hermanowicz, 2013). By conducting interviews and hearing the views, opinions and experiences of research participants, and by examining the decision-making processes that result in risk behaviours

or intervention uptake, one can begin to understand how these behaviours and decisions are conceptualised and experienced in the real-life setting.

The qualitative study component employed predominantly single one-time in-depth interviews (IDIs). Individual in-depth interviews (IDIs) allow a researcher to delve in considerable detail into the life experiences and views of selected individual respondents, in order to gain an understanding of the contexts in which behaviours occur, using respondents' own perceptions and explanations of the factors influencing their behaviour (Power, 2002). IDIs provide greater depth and detail of information than possible in group discussions, and being more private, create an enabling environment for the individual respondent to express their views and share their experiences. IDIs conducted in this evaluation study followed an interviewer-led, semi-structured approach, which enabled the discovery of unexpected themes, which highly structured interviewing approaches do not allow for. Although in the semi-structured approach the general sequence of the questions and topics is predetermined, interviewers use probes, which are helpful to delve deeper into the subtleties of a participant's responses, and attain more expansive answers (Power, 2002). Qualitative interviews take the 'actor's point of view' of experiences that they have had, and help the researcher to develop an understanding of the context of those experiences.

Qualitative sample

As with the AGYW survey sample, we drew the qualitative sample from 6 of the 12 districts in which the intervention is being implemented (Table 1), with two districts per Principal Recipient. We used the My Hope database to draw the sample. Within each of the six districts, we randomly selected 4 schools and 4 community settings per district.

Figure 2: HERStory 2 Study research site map, South Africa

Table 1: Qualitative study research sites and predominant languages of the AGYW population

District Research Sites	Provinces	Language/s spoken
Klipfontein, Cape Town	Western Cape	isiXhosa, Afrikaans, English
King Cetshwayo	KwaZulu-Natal	isiZulu
Ehlanzeni	Mpumalanga	siSwati, English
Bojanala	North West	seTswana, seSotho, Zulu, English
Nelson Mandela Bay	Eastern Cape	isiXhosa, Afrikaans, English
Thabo Mofutsanyana (Dihlabeng)	Free State	seSotho

Sample category 1: AGYW Intervention Recipients

A sample of AGYW including, AGYW intervention recipients aged 15-19 in-school and out of school, and AGYW intervention recipients aged 20-24 in-school or tertiary education, and out of school, who were enrolled in the intervention were invited to participate in individual, telephonic IDIs. The sample was purposively selected to represent a range of those who received or did not receive core / layered interventions, and range of those who adhered to referrals and other actions recommended by implementers, and those who did not. IDIs were used to explore acceptability of services, and assess how the intervention fits into the AGYW social context and the practical reality of AGYW daily life. IDIs provided participants with the opportunity to articulate their intervention experience, perceptions of the intervention, and their views on what worked or did not work. IDIs provided a deeper understanding of participant views and experiences, and barriers or facilitators to participation.

Sample category 2: Intervention Implementation key informants

IDIs were also conducted with intervention implementers and facilitators to explore barriers and facilitators for implementation. Emphasis was placed on all aspects of intervention delivery, feasibility and acceptance. We also examined contextual issues (such as timing, availability of resources, or facilities) that may have shaped the delivery of the intervention.

Sample category 3: Context / Community key informants

In addition, key informant interviews were conducted with various stakeholder and gate-keepers of the communities, to assess and understand the dimension of context. Community stakeholders sampled included male sexual partners and male peers of AGYW aged 18 years and older, school teachers and principals, community / religious leaders, parents of AGYW intervention recipients, health care workers and social workers. We requested assistance from the PRs or SRs to identify the key informants.

The AGYW who consented for male sexual partners or male peers to be contacted, provided phone numbers and contact details of the male partner/peer who was then contacted and invited to participate.

Final study sample

The final qualitative study sample included a total of 100 respondents, comprising 50 AGYW between the ages of 15 and 24 years, 27 intervention implementers, 4 health workers, 7 social workers, and 12 other community stakeholders (including male peers and partners, and community leaders). Interviews were conducted in the period from November 2020 and March 2021.

Table 2: Qualitative Study Sample IDI Respondents

Sample Group	Western Cape	KwaZulu-Natal	Free State	Mpumalanga	North West	Eastern Cape	Survey Follow-Up	Total
AGYW 15-19 years – Core intervention recipients		5	1	4	5	2		17
AGYW 15-19 years – Biomedical intervention recipients		1			2			3
AGYW 20-24 years – Core intervention recipients	1	6	2	5	6	2		22
AGYW 20-24 years – Biomedical intervention recipients	1	4	2		1			8
AGYW Total	**2**	**16**	**5**	**9**	**14**	**4**		**50**
Intervention implementers & facilitators	4	5	4	1	2	1	10	27
Health workers	1		2			1		4
Social workers	2	1	1	2	1	0		7
Male Peer and Partners		4	1		3	1		9
School Teachers and Principals								0
Parents of AGYW 15-24 years								0
Community Leaders	1		1	1				3
Total participants	**10**	**26**	**14**	**13**	**20**	**7**	**10**	**100**

Participant eligibility

Inclusion criteria

- Females aged 15-24 years who have been direct recipients of the AGYW intervention
- Parents, guardians or caregivers of females aged 15-24 years who have been direct recipients of the AGYW intervention
- Teachers in schools in which intervention activities have been implemented

- Intervention activity facilitators
- Health care worker or social worker in communities in which intervention has been implemented
- Community/faith/opinion leader in communities in which intervention has been implemented
- Willing to provide written informed consent
- Willing to participate in this study

Exclusion criteria

- Cognitive or mental challenges (based on the assessment of the participant's ability to comprehend the study information provided)
- Unable to speak or hear
- Unable to speak English, IsiZulu, isiXhosa, Sesotho, Setswana, siSwati, Afrikaans
- Not available for participation between 8 a.m. and 9 p.m.
- Participants who have been living in the district for less than 6 months

Ethical Considerations

Research ethical approval to conduct this study was granted by the SAMRC Research Ethics Committee (REC). Permission to interview teachers was sought from the Department of Basic Education in the relevant provinces.

Informed consent

The overriding principle in all scenarios related to the informed consent process was be that any decision should be in the best interests of the child. Each potentially eligible study participant was informed about the study using the English or local language consent form prior to enrolment, in accordance with 21 CFR Part 50 and ICH GCP guidelines. The term consent is used for children less than 18 years as per local ethics committee regulations. Informed consent was obtained from all participants older than 18 years. Parent/guardian/foster parent/caregiver consent together with consent from the adolescent was obtained (if the adolescent is younger than 18 years of age). The consent forms were designed to be easy to understand and appropriate to the participants' education level. The consent forms for the qualitative study component included:

- Individual IDI consent form for participation of AGYW (18 years and older)
- Individual IDI consent form for participation of AGYW (15-17 years of age)
    - Parental/guardian consent for IDI participation of the minor (15-17 years)
- Individual IDI consent form for participation of implementer key informant
- Individual IDI consent form for participation of community key informant
- Individual IDI consent form for male sexual partners (18 years and older)

Ethical implications of male partner involvement: To mitigate one possible source of social harms, the study team worked with those AGYW participants who gave permission to us to contact their male partners to carefully explain the potential consequences of allowing their male partners to be contacted for participation (e.g., disclosure of study involvement and/or intervention participation) prior to contacting the male partners.

Qualitative research tools

Semi-structured interview guides were used to frame discussions, outlining key topics for discussion in the form of open-ended questions, with suggested probes for potential additional issues, allowing for iteration, probing and digression on relevant themes.

Analysis of qualitative data

Audio recordings of IDIs were directly translated from their original language into English. Translated transcripts were reviewed by the interviewer/s for accuracy. Qualitative data were coded using thematic analysis.

Analysis of the qualitative data sought to transform the raw data (transcripts) by searching, evaluating, recognising, coding, mapping, exploring and describing patterns, trends, themes and categories, in order to interpret them and provide their underlying meaning (Patton, 2002). We used a Thematic analysis approach, following an integrated and cyclical process using a set of pre-determined deductive code types based on the topics included in the interview guides, which were built upon through the inductive development and refinement of code. Transcripts were analysed first through identification of emergent key themes and topics in initial readings. The analysis process evolved iteratively through a deductive and inductive process reflecting the study's key objectives and topics that emerged through reading the data. During the early stages of data collection, a set of preliminary themes and topic areas were defined based on the key research questions. The analysis structure reflected the topics/themes covered in the interview guides.

After the initial interviews were completed, and transcripts completed, preliminary analysis involved multiple readings of transcripts by analysts, using this initial set of thematic areas, identifying sub-themes that emerge from the data. During preliminary analysis, definitions of thematic areas were expanded, modified and refined as necessary. Additional thematic areas were identified through an iterative process of reading the textual data and identifying emergent themes. In addition to descriptive themes, pattern themes, which achieve a greater level of abstraction, were used to start linking themes and topics together in order to explore relationships in the data.

Analysis involved collaborative interpretation in which research team members engaged in data immersion and familiarisation, including repeated readings of the data in an active way searching for meanings and patterns. The thematic analysis approach did not follow a linear structure, but was an iterative process in which the analysts re-examined the data at different stages in the process. Team members documented theoretical and reflective thoughts that developed through immersion in the data, sharing growing insights about the research topic during regular team discussions. As concepts and themes emerged, the team collaboratively reviewed them, returning to the raw data, and refining themes through team consensus.

Beyond allocating sections of text under thematic areas, analysis involved a continuing and iterative process. Throughout this process the analysts recorded their thoughts and reflections. Through memo-ing, data exploration was enhanced, continuity of conception and contemplation was enabled and communication was facilitated (Birks et al., 2008). The use of analytic memos created an important extra level of narrative: an interface between the participants' data, the researchers' interpretations and wider theory. Memos also formed part of the summary process, in which analysts articulated interpretations of the data in a more concise format.

The Collaborative Analysis Methodology

Collaborative data analysis enables integration of the perspectives provided by multiple researchers, incorporating diverse perspectives and counteracting individual biases, which combine to enhance rigour, quality and trustworthiness of data interpretation (Patton, 2015; Richards & Hemphill, 2017; Olson, McAllister, Grinnell, Walters, & Appunn, 2016). Team analysis allows for a plurality of interpretations, and peer-checking of assumptions and interpretations.

The Collaborative Qualitative Analysis (CQA) process is grounded in thematic analysis, which is a process for identifying, analysing, and reporting patterns in qualitative data (Boyatzis, 1998). Typically, thematic analysis culminates with a set of themes that describe the most prominent patterns in the data. These themes can be identified using inductive approaches, whereby the researcher seeks patterns in the data themselves and without any pre-existing frame of reference, or through deductive approaches in which a theoretical or conceptual framework provides a guiding structure (Braun & Clarke, 2006; Taylor, Bogdan, & DeVault, 2016). Alternatively, thematic analysis can include a combination of inductive and deductive analysis. In such an approach, the research topic, questions, and methods may be informed by a particular theory, and that theory may also guide the initial analysis of data. Researchers are then intentional in seeking new ideas that challenge or extend the theoretical perspectives adopted, which makes the process simultaneously inductive (Patton, 2015; Richards & Hemphill, 2017).

Researcher triangulation involved when using multiple analysts can increase validity in qualitative research (Richards & Hemphill, 2017). Analyst agreement, which enhances trustworthiness and credibility, is attained through dialogue and consensus on data. Teamwork in the analysis of qualitative data, comprising an active and circular process of discussion and reconciliation with constant comparisons, encourages critical questioning and constructive criticism, allowing for divergent viewpoints (Milford et al., 2017). Analysts continuously make notes in related to problems with the generative themes, interesting patterns in the data, reflecting on insights developed during analysis, and discussing these during weekly research meetings (Richards & Hemphill, 2017).

FINDINGS

Findings are presented in key thematic areas relating to the research aims and questions. Quotations presented in indented italic text are respondents' words (verbatim in English, or translated into English), followed by details of the respondent's site and sample group.

Section 1: Intervention Implementation

In this section we present data pertaining to the implementation of the intervention, from the perspectives of implementer respondents. The section is divided into Core and Layered Services, and aspects related to implementation logistics.

Section 1 part A:

Implementation Experiences Intervention Components

Core Services

The Core Service consists of three main activities: demand creation, a risk and vulnerability assessment conducted between a programme implementer and the AGYW, and a follow-up journey plan or service plan for each AGYW over time. In the design of the intervention it was intended that this plan would guide the selection of layered services according to the needs identified in the risk and vulnerability assessment. The plan describes the personal journey of each AGYW including her own life goals and the things that will help her to fulfil those goals and become the person she aspires to be. It was intended that each beneficiary would receive an AGYW Programme Journal in which her goals and journey plan were to be documented. Also, part of the core services are HIV, TB and gender-based violence (GBV) screening, the offer of HIV testing and male and female condoms, and HIV, TB, STI, and GBV information.

The AGYW programme uses the 'My Hope system' to track the provision of services across the core and layered services for each individual AGYW beneficiary during the grant period. SRs use the system to enrol, provide the core package of services and monitor individual AGYW across the intervention areas (biomedical, structural and behavioural) with paper-based back-up data collection tools to use at the source i.e. all AGYW entry points.
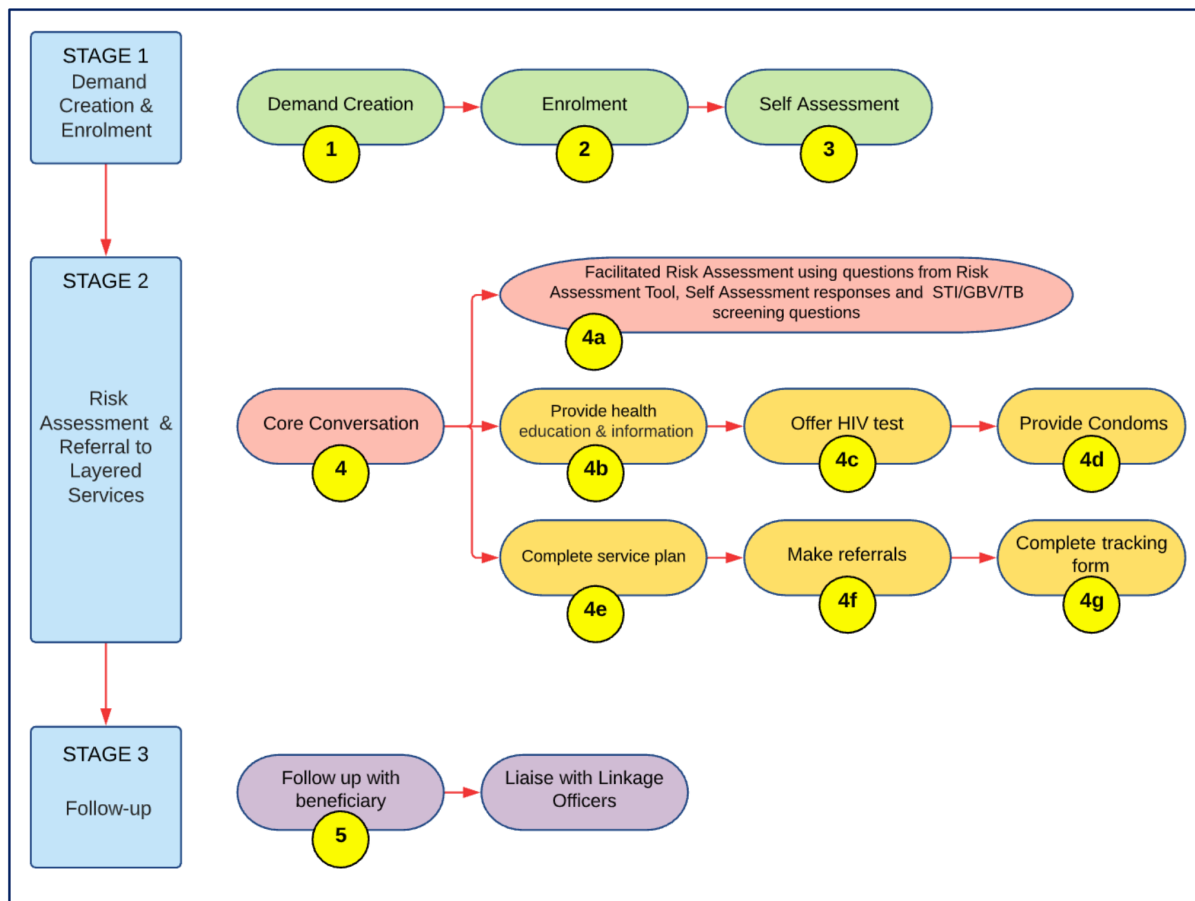
Figure 3: Stages and Steps of the Core Service

Recruitment and Enrolment of AGYW Beneficiaries

In the design and planning of the intervention it was anticipated that SRs would use a variety of strategies to recruit AGYW into the programme. Recruitment strategies for school-based and TVET-based AGYW were to include career jamborees and community dialogues, and PGT outreach activities. Recruitment strategies for community-based AGYW were to include outreach activities in communities, shopping complexes, homes and during health calendar events. Entry points that were identified as places where AGYW can be reached included community GBV dialogues hosted by other GF funded programmes, door-to-door AGYW mobilization, DoH clinics especially Antenatal and SRH clients, sporting events, SASSA pay points, Department of Home Affairs, TCCs, War Rooms, DSD, career jamborees, youth hangout hotspots.

Implementer Experiences with Recruitment, Enrolment & Demand Creation

SRs noted that recruiting community-based AGYW compared to school-based and TVET-based AGYW has proven to be more challenging. The latter can easily be approached at schools and on campus whereas the former need to be recruited through community outreach activities, which is more logistically challenging and time-consuming, especially in the context of COVID-19. Additionally, those AGYW who are not studying, may be working or have other commitments which make them less accessible.

> *Those AGYW that are out of school are the ones that are giving a challenge, because they are like: "no I am working", or "no I am busy." (KZN, Implementer)*

Respondents noted the difficulty experienced in finding appropriate times to provide community-based AGYW with core services or to recruit them for group events and programmes. SRs who had good relationships with clinics were able to get assistance from nurses to recruit AGYW into the programme. As noted in more detail in Section One (Part E), during COVID-19, SRs who were helping clinics screen for the coronavirus were also using the opportunity to enrol AGYW into the programme.

> *Normally what we do with the PGTs, as they are the ones that work more in the field, they would leave our attendance register in the clinic, then if the AGYW comes for services they will write down their names if they are not in the programmes. Then the following day we can take the list and contact the girls. (Free State, Implementer)*

Events involving other SRs and partner organisations outside of the program, were noted to be more efficient and successful than recruiting AGYW individually on the street and at key entry points. Some SRs noted that AGYW were influenced by their peers to not join the programme and therefore recruiting AGYW in groups on the street was often not very effective. Crime and safety concerns also made recruiting AGYW on the streets and through door-to-door activities challenging or even unfeasible in certain areas. Some SRs found it useful to get enrolled AGYW to assist with recruitment, for example, 'bring a friend' events.

Issues related to beneficiaries being enrolled despite being the wrong age were cited by some implementers. Reportedly in some cases this was due to outreach teams enrolling ineligible AGYW just to meet targets (see section on Data Falsification). In addition, some respondents noted that AGYW who do not fit the 15-24 age group, lie about their age to be eligible to join the programme and receive services. Younger AGYW may lie about their age because they are in need of family planning and frightened to go to clinics. AGYW over 24 may also prefer to access the more youth-friendly services of the programme.

> *Most AGYWs lie about their age because they are avoiding to go to the clinic. For example, if I am 14 years of age, and in need of family planning, the nurses won't understand why I need family planning at the age of 14. (Mpumalanga, Implementer)*

Implementers noted that they do not verify AGYW data against identity documents. Although this may impact on reaching programme targets, one would not want to compromise the current rights-based recruitment approach. Moreover, It would not be advisable to make personal data verification a condition of participating in the programme due to the fact that so many AGYW are undocumented in South Africa and struggle to receive birth certificates and ID documents from Home Affairs.

One suggestion was that recruitment could be improved if data sharing agreements could be established between government, particularly the Department of Basic Education (DBE), and AGYW programme implementers. SRs noted that it would assist the programme to have access to the DBE database to be able to more efficiently target AGYW for their programmes.

> *Approximately 60% of the AGYW that this grant targets are in school… so, if you have an effective mechanism to tap into the state's administration capabilities… there's an alignment with the data that the school has got to have on them, and that the programme wishes to have on them. That kind of data sharing agreement and kind of enrolment process would be a huge administrative win. (Gauteng, Implementer)*

The department could allow us to at least access the database of the girls up until matric, to see… which girls could be approached for our services into the AGYW program… maybe what they could do is put in some rules as to how we use the database... to make sure that the data is not used in negative ways. (Gauteng, Implementer)

Experiences and Views on the Use of Incentives for Recruitment

Providing incentives at recruitment events like food/catering, and branded items (t-shirts, stationery, caps and hand sanitizer), assisted SRs in attracting AGYW to events and improving the likelihood of enrolment. Although some SRs complained that parents and other community members attend recruitment events primarily to access food, especially in poorer areas, their participation ultimately assists towards raising community awareness of the programme and ensuring acceptability from AGYW parents and other gatekeepers.

The only situation is that the entire community wants to attend the event, so you may think you have reached the target but when you screen them you find some are over-age and some are underage… they just want to come to events… they know that after the event there are refreshments… It doesn't affect us that much because the information is for everybody. (Free State, Health worker)

Not all SRs agreed that the lack of incentives acted as a barrier to successful recruitment, noting how the lack of incentives promoted intrinsic motivation to participate in the programme.

What has made the programme harder but also better is the lack of incentives, because there haven't been many incentives until more recently… nobody is getting money for participating in our sessions, which has happened before[1]. (Western Cape, Implementer)

However, there were more SR respondents that noted that the lack of incentives provided for as part of the grant, acted as a barrier to successful recruitment. Previous 'Cash Plus Care' programmes[1], which have been implemented in some of the same districts at the AGYW Programme, have created expectations for incentives, and in areas where these programmes are still running, SRs struggled to recruit AGYW into their programmes.

There was a programme before this one... 'Cash Plus Care'. This programme used to give incentives to young girls, they used to get R300. So now, they are getting into this (AGYW) programme where they don't get any money. For them the previous programme was better because each and every month they used to get this R300. With us, we are not providing them with money, what we do is we provide them with services that will be helpful for them... that is the reason why some don't come back, they realise, "eish, if I can get the services at the clinic what is the reason for coming back?" (KZN, Implementer)

Retention of AGYW Beneficiaries

The intervention programme documents outline that strategies for retaining AGYW beneficiaries in the intervention include the provision of incentives, service/activity reminders through WhatsApp

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[1] Respondent is referring to Cash Transfer interventions such as the 'Cash Plus Care' programme. See for example Stoner et al. (2021)

groups, constant invitations to programme events, linkage to care and follow-ups, home visits/face-to-face visits, and youth events.

Implementers' Experiences with Retention and Re-Enrolment of AGYW in the Programme

Several respondents suggested that follow-up of enrolled beneficiaries has been insufficient, and emphasised that strategies for encouraging AGYW to re-enrol in the programme after 6-months needed to be reassessed. In some cases AGYW parents or other gatekeepers may resist AGYW reenrolment (and enrolment). SR programme implementers providing services in schools noted that they sometimes struggled to get buy-in from principals and teachers to allow Grade 11 and 12 students to participate, since this is considered a crucial time for schooling. The limited services being offered by some SRs, were noted as a possible deterrence to AGYW continued participation.

> *If you are only offering one service then you are unable to really bring in more girls into our organisation, because they know what we got, it is not like everyday people want to test (for HIV)… you get fed up of always being tested and the same services every day… So, if sometimes you come and we are able to offer more services then they will come. (Free State, Health worker)*

Some implementers noted that AGYW did not have their own cell phones or that their phone numbers changed frequently, making it difficult to follow up with them. This could be regarded as an inherent flaw in the design of the recruitment and retention process that, which relied on beneficiaries being reliably contactable via cell phone. In communities and contexts where AGYW may not own their own phone, or even have access to a cell phone, this strategy may be inappropriate. A related theme noted by several respondents was that AGYW gave the wrong contact numbers and thus could not be contacted for further services or reenrolment. Respondents noted that this could in some cases simply be a data capture issue but could also be a result of PGTs not explaining adequately the purpose of the programme and why they need the AGYW contact number for re-enrolment after 6-months and for layered services.

> *Some of the girls don't have phones and some of the girls are refusing to provide the phone numbers… that is the only response that I got regarding the missing information… the reason that they might refuse to give their phone numbers to the team is only because they do not understand why they are being enrolled into the programme, maybe they (PGTs) don't actually explain enough, why am I enrolling you into the programme (Eastern Cape, Implementer)*

Implementers also noted that AGYW felt nervous about implementers recording all of their data and contact information and were concerned about confidentiality, which may explain why in some cases false information was given. Additionally, as discussed in more detail in relation to the contexts of safety in communities, AGYW may have been uncomfortable giving their phone number to a stranger. This concern led some implementers to suggest that the process of recruitment should be rethought, for example though ensuring that more time is taken to build trust with AGYW before undertaking the Risk Assessment.

> *It's something new to them, even though we assure them about confidentiality, but still (they think) "these people are taking all our information, and we don't even know who they are"... I think that way is just to protect themselves (North West, Social worker)*

In the views of some of the implementation respondents, the failure to deliver promised services and material support to AGYW beneficiaries, also negatively affected AGYW perceptions and trust of the programme and the implementing organisation, and therefore negatively impacted success in re-enrolment of beneficiaries.

> *We get the challenge when we go back to the kids for re-enrolment. They run away from us saying our programme does not give them what they need… you know how we black people are, if you come to me and promise to help me and then next thing you come to me forever preaching without giving me what you promised, next time I run away from you [laughter]. (Free State, Implementer)*

In some cases, AGYW may not perceive the inherent value of the programme and do not want to participate. The ToC programme model assumes an inherent value and that AGYW would naturally want to participate if offered the opportunity to do so. However, this common experience of PGTs having to convince AGYW of the value of the programme, perceivably undermines this assumption (see ToC critique below for more on this).

SRs whose Safe Spaces offered varied and engaging activities, beyond the core services, or who could successfully refer to other service providers were more likely to ensure AGYW re-enrol into the programme. It was also noted that there had been some confusion among SRs regarding whether re-enrolment of AGYW counted towards reaching targets, which may also account for low levels of re-enrolments.

Background to Risk Assessments

In the design and planning of the intervention it was anticipated that the specific risks and needs of each AGYW beneficiary would be identified through: 1) a Self-Assessment form, a standardised tool to assess HIV/TB/STI and GBV risk, which AGYW would complete on their own; and 2) a Risk Assessment and screening process, using a standardised Risk Assessment tool, facilitated by a programme implementer. It was anticipated that the Risk Assessment process should take approximately 60 mins and be conducted as a private conversation between the AGYW and the implementer. A person-centred counselling approach was proposed as the theoretical framework for engagement with the beneficiary; establishing a relationship by allowing a two-way conversation would make the content of the Risk Assessment more acceptable. This must occur before services are offered. Information offered must be on all key programme elements and programme implementers are urged to avoid information overload and to be concise. (NACOSA et al., 2020 c).

Implementer Experiences of Risk Assessments

Respondents noted that the Risk Assessment tool, and the entire screening process, is too long and AGYW generally do not have the time or patience to complete it, which negatively impacts on successful enrolment.

> *The girls refuse to join the programme. They say they don't want to enrol because firstly the documents are too long… we stand in the heat for too long... that is the problem… our enrolment papers are too long. (Free State, Implementer)*

Added to AGYW frustrations at the length of the Risk Assessment process, SRs hurry through the forms, not completing them properly, and feeling under pressure to meet enrolment targets.

> *If you look at the targets that we have to reach... you look at the number of pages we have to complete... the form is just too long. It takes too much time and the girls don't have that time. (KZN, Implementer)*

Moreover, because the forms have not been adjusted to various districts, some questions refer to services that are not offered and are thus both irrelevant and create expectations for services that cannot be provided, which impacts negatively on beneficiaries' trust of the intervention. Respondents also noted that implementers conducting the assessments had not been trained adequately to know which questions are asked to assess certain needs in order to refer AGYW to specific services[2].

> *One of the assumptions that's made in that design is that there will be this referral process. The referral process would be a cornerstone kind of key part of the Risk Assessment, so that every question that's asked actually does refer to a service that's actually available. But that's not existent. In a lot of senses that referral pathway is not what it was assumed to be. And so, asking those very, very personal questions almost doesn't have a justification. (Gauteng, Implementer)*

One key issue highlighted was that Risk Assessment tools were not translated into local site languages, and site staff were only provided with English versions of tools. The PGTs administering the Risk Assessments have to translate the questions as they go. The implications of this are that translations/terms/questions are not standardised. Additionally, there is a risk of meaning of the questions being open to multiple interpretations, as well as compromising the standardised framing of the questions and appropriate use of language, particularly for sensitive questions. This compromises quality of data being collected. It also creates additional work burden for PGTs, who have to translate the questions as they go.

> *Some of the wording (in the Risk Assessment forms) becomes extremely long. Also, it is in English and most of our girls are Xhosa speaking; that is their home language. Most times, they don't understand it, then you try to translate it but it loses its meaning in the translation… There are no translated versions of that Risk Assessment, we only have the English version one… it is a bad thing, especially for the first line responders who are our PGTs because we are expecting them to do the bulk of the work. (Western Cape, Implementer)*

The staff conducting the Risk Assessments, PGTs, LSAs, SAWs and occasionally Social Workers, feel under pressure to meet daily targets, since the assessments are so time-consuming. This may, in certain cases, undermine the sensitivity and manner in which the assessments are delivered. Several respondents noted that the questions are 'very sensitive' and 'personal' and that PGTs are not adequately trained to deliver them. This raises ethical concerns and also impacts on the quality of data that is collected; ultimately affecting the service plan that is delivered, which should accurately reflect

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[2] There is an initial 2-day training provided on how to use the data collection tools and how to ask the questions contained in the Risk Assessment. (NACOSA, 2020, Risk Assessment Tool Feedback Presentation to Technical Working Group) The ToC model assumes that all aspects of the intervention will be acceptable and will be experienced as of a high quality by role-players. The most relevant explicit assumptions here would be: Assumption that communities are sensitized on the health needs and human rights of AGYW

and respond to the individual AGYW's particular risks and vulnerabilities. Staff delivering the assessments also noted that they felt unprepared to deliver certain parts of the Risk Assessment, for example, questions regarding gender based violence or substance use. In certain cases, PRs have then asked SRs to omit these questions. However, SRs feel that they are then not providing a full service to AGYW.

> *Before the programme starts, you should train us more in gender-based violence, so that when you go and ask the child, "Have you experienced gender based violence?"... you need to explain to a child what gender-based violence is. (Free State, Implementer)*

> *We haven't had training for how to deal with cases of substance abuse. We have been asked [by the PR] not to ask those questions that relate to substance abuse… I see a lot of substance abuse happening. So it is dangerous when you then say: "don't ask those questions". Because then how do we help the girl? She comes into the Safe Space, she looks intoxicated and I can't chase her away because she has come for a service. But then, if I am not to ask her about her substance usage, then how can I help her? (Western Cape, Implementer)*

Respondents noted that the design of the assessment does not ease the AGYW in, because 'intrusive questions' are asked too early on in the process, which is not conducive to building rapport and trust, for example questions regarding anal sex or transactional sex.

> *The Risk Assessment… it's a strange design. It goes from… meeting someone for the very first time, to asking her really, really personal questions very, very quickly. (Gauteng, Implementer)*

> *There is a question that asks about money for sex… "do you have sex with someone because you want goods, you want something in return like money or goods?" You can't ask a girl such a question… in front of her friends... It is difficult, you need to find a way. You need… to make them comfortable so that you can get the truth (KZN, Implementer)*

When analysing the actual assessment form the structure does allow for questions to first be asked about the AGYW dreams and goals, it then moves onto demographic information and household context, before discussing her relationship context and sexual behaviour and health. However, suggestions have been made that AGYW rather be invited to a second session where more sensitive questions could be asked after trust and rapport have been established (NACOSA et al., 2020, AGYW Programme Description).

Some respondents, especially social workers, social auxiliary workers and health workers did illustrate sensitivity and professionality when describing how they went about delivering the Risk Assessment; making effort to build trust with AGYW and putting them at ease. Some staff described methods they used for building rapport.

> *To ask a girl if they are sexually active or not, is a very sensitive question… they just stare at you [laughing]. So, I have to simplify or break the ice! ...so when I ask that question, "are you sexually active?" They should not see me as a mother, they should see me as their peer. So, I developed a strategy to break the ice. (Free State, Health worker)*

However, social workers and other respondents noted that due to the very sensitive nature of the questions, they require counselling training to deliver appropriately. PGTs or LSAs delivering the assessment do not have counselling experience and would therefore not have these types of nuanced skills. Management staff noted that the qualification requirement for someone to deliver the

assessments (Grade 12) is too low. Some respondents therefore suggested that Social workers and SAWs should primarily be responsible for delivering these assessments rather than PGTs and LSAs.

> *The sections that are covered are actually very private and they require some level… of basic counselling… The criteria for someone to be a LSA (learner support agent) is just someone who has matric. So at some point we are not getting what we should be getting from the Risk Assessment… if you can take the social worker or auxiliary and you give them that assessment they will probably facilitate differently to how someone without basic counselling would do it. (North West, Implementer)*

Monitoring and Evaluation (M&E) Managers noted that the lack of PGT training impacts negatively on the quality of data (see section on Data Falsification). Another explanation regarding why PGTs skip certain sensitive questions, is that PGTs do not have confidence in the referral pathway. If they know that a certain service cannot be offered to the AGYW, they choose to avoid that question to not create an expectation that the need will be addressed by the programme. Several PGTs noted that they felt they were the ones receiving the backlash when AGYW needs could not be met by the programme. PGTs themselves expressed frustration that they could not, for example, assist AGYW from very poor households by referring them for socioeconomic assistance, and therefore did not feel comfortable probing about their household finances.

> *There is this one question that bothers me so much in this Risk Assessment. You ask the girl: 'financially, are you guys coping at home?' And then she says: 'no we are not coping'. And then you know that you don't have a place that you can send the girl for help or for food… you find that the girl is struggling. (Western Cape, Implementer)*

In some cases, PGTs were unable to notice where an AGYW was giving conflicting answers and probe further during the interview. The problematic nature of the data is then only recognised much later, upon further review and analysis by Monitoring and Evaluation (M&E) managers, after a service plan has already been designed. The other way in which the very 'intrusive' nature of the Risk Assessment forms influence data quality, is that there is a tendency that AGYW provide staff conducting the assessments with the answers that they think they want to hear or at times they also refuse to answer certain questions.

> *On those 11 pages there are… intrusive questions about her sexual relationships, her current sexual relationships, her previous sexual relationships. This is a girl that I have just meet two minutes ago and I am already asking her if she has had anal sex, if she is sleeping with older men, if she is having five sexual partners at the same time. This is a girl that I don't know, I met her five minutes ago, and I am asking her those questions. It is tricky [laughing]… the girls will just give you the responses that she thinks you want to hear, so that you get out of her face! (Western Cape, Implementer)*

Given the well-known challenges of collecting accurate data on sexual behaviour among adolescents, the nature of the interaction between interviewer and respondents is critical. Although various methods for administering questions have been explored, to solve the issue of 'social desirability bias', challenges remain in ensuring the accuracy of reporting (Mensch et al., 2008).

AGYW Service Plans, Journey Plans and Journals

The assessment and screenings are planned to result in a Service Plan for the sub-recipient which forms part of an agreed journey that each AGYW plans for her future. The service plan provides the overall guide for the integrated and layered services tailored and responsive to the needs of the girl/young woman. The goal of the personal journey is for the AGYW to identify her life goals and what will help her to fulfil those goals and become the person she aspires to be. The implementer also identifies potential services that may benefit the AGYW on her journey. After completing the facilitated Risk Assessment, the implementer prepares the individualized service plan, discuss the services available to the beneficiary on offer through the grant SRs or through other service providers in the sub-district and jointly agreeing on which of these would be first priority and which are relevant for the longer term. The implementer recommends/refers/directs the young person to the most relevant services from the services directory, whom provides the relevant service to the beneficiary. As part of the Risk Assessment, beneficiaries are screened for GBV and intimate partner violence (IPV) in line with the WHO (2013) clinical and policy guidelines for responding to IPV and sexual violence against women. Beneficiaries affected by GBV / IPV are provided with psychosocial support in the form of individual or group counselling.

When the service plan is completed with the beneficiary, the AGYW is supposed to receive a journal in which she can document her journey. The AGYW Programme Journal is a tool designed to enable girls to document their goals and track their own journey through the programme; show the services available to girls in the community (demand creation); provide key health and wellness information, as well as risk reduction techniques; incentivise and support treatment adherence and engagement with services; and empower them to identify their goals, barriers to achieving these goals and make plans for achieving these goals.

Implementer experiences with Service/Journey Plans

Limited experiences relating to the journey plans and the use of the journal were shared overall. This is likely a result of the journals not being issued timeously. Implementers reported being trained on the importance of the journals, but they were not available at the time of the initial demand creation activities. The journals arrived later in the programme but there seemed to be confusion around which AGYW beneficiaries were to receive them, which led to inconsistent practice regarding the use and distribution of the journals.

> *The journals only came out this year… that was supposed to be something we gave to everyone. When the journals were introduced, they said only the girls coming back into the program, returning to core, could get them. But that wasn't the initial offer… Then in the meeting that we had last week they said: "Ok just hand them out because we can't find 'return to core'", and so that part of the programme is not working as planned. (Western Cape, Implementer)*

> *They had given us journals, but they were not enough and we just gave a few beneficiaries (Free State, Implementer)*

We were told to start giving journals to those (AGYW) that are new as well, before that we were just giving to those returning. (Western Cape, Implementer)

One implementer spoke about how journaling is not a familiar or well-known activity amongst AGYW in these communities, which may speak to the acceptability of the tool. The respondent did however relate that once they became more familiar with it, it did help AGYW to open up.

AGYW like them (journals)… we don't have a culture of diarizing our daily lives as girls. So, this has been interesting because the social worker has taken them through what they should do, how they should… diarize everything that is happening within their lives in the diaries, their hopes, their dreams… It is encouraging the girls to open up. From what the social worker tells us, when we have our monthly debriefing meetings, is that these girls who would have come as broken girls… at the beginning, but once they start documenting their daily lives in their diaries, they start opening up more. Our social worker also offers individual and group counselling and she says that these girls are starting to open up more. (Western Cape, Implementer)

Theory of Change Critique on Core Services: Recruitment/Demand Creation, Risk Assessments and Service /Journey plans

The following is an excerpt from the AGYW programme description document for the 2019 to 2022 period, outlining the way that the ToC was envisioned to work:

Critical to the theory of change is a set of assumed pre-conditions. In order for the Programme outcomes to be achievable, it is assumed that AGYW identified in the implementation areas through demand creation activities will be willing and able to participate in the AGYW Programme. External service providers, including Government Departments and Community Based Organisations, will provide behavioural, structural and biomedical services to which AGYW can be referred. These partners will collaborate with the AGYW Programme by signing partnership agreements, supporting access to commodities, access to facilities and schools and/or providing layered services to AGYW. The realisation of the pre-conditions and assumptions will ensure a conducive environment for the Programme to be implemented as planned. This will result in AGYW being reached with defined core and layered services and interventions that identify and address their HIV, TB and STI risk as part of a cascade of care. (NACOSA et al., 2020, AGYW Programme Description)

Theory of Change relating to Demand Creation and Risk Assessment

As per the description above, the explicit assumptions upon which the ToC design is based are critical to the success of the model. Recruitment/ Demand Creation and the Risk Assessment are the first two components of the Core Service package, and also the first two steps in the ToC model.

The model's explicit assumptions that relate to these two activities are:

- AGYW will be identified through various entry points (in schools, communities through NGOs, churches, public spaces and higher education institution through TVET colleges), and will have their risks and vulnerabilities assessed
- AGYW identified in the implementation areas through demand creation activities will be willing and able to participate in the AGYW Programme

These statements do not necessarily reflect any standard of delivery, but rather assume *that* these activities must take place. What has been evidenced in the analysis above however is that the quality of delivery of these activities appears to have been compromised by a number of challenges during actual implementation. Thus the model holds true in that the actions took place as was planned, but perhaps the quality of delivery was more of an implicit assumption, and one that did not always hold true in practice. An exploration of the more implicit assumptions of the model may yield a richer understanding of how well the model was specified.

Looking at the first bullet point, it seems that the intention to recruit from multiple sources was a success as the findings revealed that some settings are easier to recruit from than others. Thus the inclusion of multiple sources for recruitment improved the chances for recruitment. This item of the ToC model thus seems to have been well specified for this context.

The explicit assumption regarding recruitment is *that* they will be identified, but the model does not make allowances for explaining the *how* involved in this identification process. The findings revealed how negative experiences of recruitment may negatively impact on the effectiveness of steps further down the line. This was exemplified through the finding that all services were not offered unilaterally across locations. This resulted in a breach of trust, which may then have resulted in poor retention later on. The implicit assumption here is that the planned recruitment strategies were acceptable to all the role-players and free from hindrances that may negatively impact on the subsequent steps of the ToC model to follow, but this was not evidenced in practice.

The second part of the first bullet point speaks about having their risks and vulnerabilities assessed, but again, does not offer much more than the assumption *that* this will occur. Again it can be argued that the ToC model, stated in this manner, may reveal an implicit assumption about the acceptability of the Risk Assessment, which also did not hold true in practice. As was revealed in the section relating to the Risk Assessment, there were a host of challenges related to *how* the Risk Assessment was implemented. Based on the feedback from implementers, the experience of conducting the Risk Assessments was fraught and may even have had the opposite of its intended effect in some instances. While data extraction may have been the stated goal according to the ToC model, it seems that unintended negative emotional experiences of the AGYW receiving it, as well as the implementers conducting it, resulted in the tool not being used as specified, and also having a negative impact on participants.

The next step in the ToC model speaks to the explicit assumption that AGYW identified will be willing and able to take up the service plan offered to them. Again, this assumption presumes *that* the programme will be found to be acceptable, but leaves little room for a consideration for *how* and *why* it may or may not be. Based on the findings presented in sections above, the *how* involved in the first two activities (the recruitment and Risk Assessment) has a significant impact on the next step; being able and willing. Where AGYWs find the Risk Assessment questions to be too imposing for example, they may not be willing to participate further.

Thus, in cases where all the assumptions hold true, and the end result is an able and willing participant, it can be argued that the ToC model is well specified. However, in cases where the result is a

participant that is not willing and able the model in its current form cannot adequately account for, or propose adaptations to address this.

The findings of these sections reveal that the way in which the steps of the ToC are carried out are experienced in far more nuanced ways than the model presumes. The assumption that all that is required is *that* the steps happen, without consideration for *how* they happen, may lead researchers to fall prey to the commonly cited failing of ToC, which is that the models often present an explanation for *what* changes do/do not happen, but not an explanation of *how* or *why* (Breuer et al., 2016; Care, 2012) . As can be seen above, it is in investigating the how, that the inherent flaws in the assumptions are revealed and it is precisely this information that is most valuable for understanding what may in fact be impeding the desired changes that the model aims to promote.

Theory of Change relating to Service / Journey plans

The explicit Theory of Change assumption that relates to the service plans is:

- The AGYW's personal journey plan describes her own life goals and the things that will help her to fulfil those goals and become the person she aspires to be

The journey plan is materialised through the use of the journal, which was designed to focus on the personal experience and also the life goals and aspirations of the AGWY. If it has been used as planned it is reasonable to believe that this would have improved the perceived benefit and also the acceptability of the programme. In the absence of this step, the programme was aimed only at Risk Assessment and service provision, with no attention being paid to the personal experience of the AGYW. A reflection on the overall impact of this is included in the ToC critique of implementation after Section 1B.

Layered Services

Based on the risks and needs identified during the core services, the AGYW Programme planned to tailor a set of behavioural, biomedical and structural services for each AGYW beneficiary in the form of layered services. The intention of this programme design was to ensure each AGYW would receive services that are responsive to her specific risks and needs.

The Layered Services were intended as an additional programmatic service that would be on offer, on a needs basis only. Not all AGYW need to access layered services, which should rather be reserved for AGYW who are vulnerable to a number of risks. In the design of the intervention, it was intended that Layered Services could either be provided directly by SRs, using GF funds (internal referral), or could alternatively be provided by non-GF entities (e.g. ART initiation by public clinic or career guidance provided by an external service provider). In the latter case, the AGYW beneficiary would be linked to an existing service, and a follow-up should be made by SR linkage officers to ensure the success of the referral.

Possible linkages would be determined through the services mapping – undertaken at the start of the programme by PRs and would be updated regularly. If the quality of these services was deemed to be

inadequate, the PR should invest in quality improvements as the service provider and conduct supportive monitoring to ensure effectiveness (NACOSA et al., 2020 c).

Biomedical Services

Biomedical services included in the intervention comprise the following:

- HIV testing or self-screening
- Condom provision
- STI screening, investigation, and treatment
- TB screening, IPT, diagnosis, treatment
- Pregnancy testing
- PrEP
- Post-violence care, including PEP
- ART and viral load monitoring
- ANC (including PMTCT)
- Termination of pregnancy and post- abortion care
- Contraception (including emergency contraception)

Implementer Experiences of Biomedical Services

A number of SRs are working within clinics, in collaboration with clinic staff, to deliver these services, or are referring AGYW to local clinics to access certain services. Other services can be provided directly by SRs in mobile clinics or Safe Spaces. Therefore relationships and effective referral systems with local clinics and DoH were integral to successful implementation, which is discussed further in the following section.

Contraceptives and Condoms

According to the programme description, contraception is promoted and a contraceptive method mix is available to AGYW beneficiaries, with a focus on increasing access to long-acting reversible contraceptives and increasing dual method protection. This includes training healthcare providers in adolescent-friendly service promotion and service delivery and ensure that providers are comfortable providing a wide range of contraceptive methods including emergency contraceptives. As a layered service in the programme, contraception is primarily offered via the Department of Health facilities (external layered services) with limited operating times and often long queues. Where SRs negotiate access to commodities the services are implemented as internal layered services. All contraception is offered by Registered Nurses, following the National SRH guidelines promoting the use of dual methods of contraception; with injectables being the most preferred/ adopted method nationally (South Africa Family Planning 2020).

The programme supports the implementation of a comprehensive condom distribution programming by ensuring that all sexually active persons at risk of HIV/STIs are offered and motivated to use condoms, have easy access to quality condoms, and can use them consistently and correctly. The programme promotes increased condom use, and aims to create and sustain the environment so that

there is increased availability, accessibility, and acceptability of condom use and to implement Condom Distribution Programmes (CDP) as part of a larger HIV prevention strategy.

Implementer respondents described the comprehensive sexual and reproductive health services and family planning offered through the programme, inclusive of contraceptives, and referrals for termination of pregnancies or antenatal care.

> *They (AGYW beneficiaries) do family planning… and for those who get pregnant, and not willing to… not wanting to keep the baby… we also refer them for TOPs and then we follow them up. We inform them after they have done everything to come and give us feedback. We also have other sub-recipients… other stakeholders that we can send them to for further counselling… for those who want to keep pregnancies, we send them for antenatal care. (Western Cape, Health worker)*

The comprehensive services provided by the intervention comprise a one-stop-shop SRH health care to AGYW. When a AGYW beneficiary comes in for one service, for example an HIV test or contraceptives, she is offered a whole range of other biomedical services, including PrEP.

> *While the AGYW is there… they get a one stop shop. They get everything, if they were going in the facility for family planning, we give them family planning, we also offer HIV testing, then the bonus is that they get PrEP, that they were not even aware of. (Western Cape, Health worker)*

<table>
<tr><td>PrEP</td></tr>
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In line with South Africa's National Strategic Plan for HIV, AIDS and TB, 2017-2022, which prioritizes AGYW age 15-24 for pre-exposure prophylaxis (PrEP), and coinciding with the National Department of Health (DOH) scale up and roll out plans for AGYW, the AGYW intervention included PrEP demand creation and provision as a biomedical component. Clinic and outreach services within the hub and spoke model were intended to be equipped to initiate PrEP for beneficiaries who test HIV negative at these sites.

In the evaluation interviews, several SRs noted that the rollout of the PrEP programme was slow, and that at the beginning of the programme there were challenges regarding adequate supply of PrEP, which was sourced through DoH. According to respondents, DoH was not sufficiently prepared to roll out PrEP when the programme began. Sourcing PrEP procured by PRs via district DoH was described by SRs as a complex process. The limited availability of PrEP affected the participation of some AGYW, who had initially agreed to participate in the PrEP programme, but when they could not be initiated onto PrEP, subsequently lost interest.

> *We offer these young girls PrEP… (but) right now we honestly don't have them (PrEP). So, it becomes hard for me to do my job because I am promising these young girls… "we have this that can prevent it (HIV)"... but the next time they come to collect, we don't have them… it makes my job difficult. (North West, Implementer)*

SRs noted challenges with PrEP adherence, with AGYW not taking PrEP as prescribed. Considerable discrepancies were noted between the number of AGYW originally initiated onto PrEP and the number of follow ups conducted, indicating that AGYW were not continuing to take PrEP over time. SRs did note that linkage officers would follow up to find out the reasons why AGYW were not returning for refills. Implementers noted that AGYW discontinued PrEP due to short supply at clinics, unsupportive

parents and community, COVID-19 regulations or occasionally when experiencing negative side-effects or hearing about such experiences from peers. Some implementers noted that AGYW may just be attracted by incentives, for example caps (hats), received once initiated on PrEP. However, it is unclear whether PrEP adherence and the reasons for discontinuation are being effectively monitored between the linkage officers and DoH.

> *PrEP is very challenging because even when you explained about PrEP to a person, how it is taken… they (AGYW) do not take it… The number of initiations and the number of follow ups is not the same... Young people are just taking it for fun. A person would just show up and say "I heard there are pills"… We were giving them caps (hats) after taking PrEP. So one would take PrEP because they want a cap… it is affecting us because they don't come back for a follow-up, they just take the PrEP and never use it. (KZN, Implementer)*

Implementers' views on AGYW acceptability of PrEP were varied. Some noted that AGYW were enthusiastic about enrolling, while others noted AGYW were sceptical and hesitant to enrol. The reasons for the latter included prevalent misinformation about PrEP in the community, stigma around taking PrEP, often regarded as the same as ART, unsupportive parents and fear about negative side-effects.

> *They (AGYW) would come up with excuses like, "I am not sexually active"... Others would say they were told that PrEP is like ARVs, which is due to lack of information about PrEP. Others would say, they want to first ask permission from their mothers. Others, like I once had a case, this girl was willing to take PrEP, but it was not good for her (she experienced side effects). Then she stopped taking it… She told me that her entire body got swollen. (KZN, Implementer)*

Implementers also expressed the view that since AGYW are accustomed to and familiar with contraceptive injections already, they believed AGYW would be more willing to have an injectable HIV prevention product rather than take daily oral tablets.

> *The PrEP injection… caused a buzz (excitement)… girls were asking us about the injection and we told them no their injection is still under investigation… (AGYW) are willing to take injection for 3 months… because they are already coming for family planning injection. So, maybe it seen as if it will be convenient to get an injection every 3 months… They say taking medication every day is not on. (Western Cape, Health worker)*

Implementers used various strategies for improving acceptability and uptake of PrEP amongst AGYW, including PrEP awareness events and campaigns, and the use of PrEP ambassadors, who were AGYW peers already initiated on PrEP, who would provide encouragement to other AGYW.

> *We were struggling to get girls to be on PrEP, so what we have decided to do is to use their own peers that are on PrEP already to say you are PrEP ambassadors, go and recruit your own peers to be initiated on PrEP. We've seen that the turn-up of girls who are interested in PrEP is amazing because of their peers… it's a very nice opportunity. (Mpumalanga, Implementer)*

In some cases, good SR relationships with DoH clinics facilitated demand creation and uptake of PrEP, where nurses would refer AGYW to the PrEP programme.

> *The minute you tell them about PrEP they are keen to take it and keen to protect themselves more… Even in the clinic, they tell us, 'we have got four clients for you'. (Free State, Implementer)*

ART and Viral Load Monitoring

The lack of follow-up, adherence support and monitoring for AGYW who test positive for HIV was cited as an issue.

> *Test and treat… is not working… they (AGYW) do take them (ARVs), but we are not sure if they adhere… they do initiation… but according to the statistics, there are many defaulters… I meet AGYW… who say "the treatment is not good for me", so they prefer to stop taking them… who does a follow up for those young girls？…there are no longer classes in the clinics like before, no support groups. (KZN, Implementer)*

SRs discussed linkage to care for the HIV cascade. SR health workers explained that they themselves do not dispense ART, so if an AGYW beneficiary tests positive for HIV, they have to refer her to the clinic to receive ART. One challenge that was mentioned by the SR Health Workers is that they struggle to keep track of AGYW treatment for those who test positive and whose records are transferred to local clinics, and subsequently get lost in the system.

> *Let's say that AGYW tests positive, as a professional nurse I have to initiate her. If I met that AGYW in the Safe Space... her records should be transferred to the clinic…. But then she just disappears. They are nowhere to be found, that alone to us is frustrating. (KZN, Implementer)*

HIV Testing

HIV testing was offered to AGYW beneficiaries as part of the Core service layer, included in the initial Risk Assessment process. As narrated in evaluation interviews, implementers explained how the intervention provided comprehensive HIV testing services, inclusive of linkage to social workers for psycho-social and emotional support in case of a positive diagnosis.

> *The programmes are structured such that all (SR) organisations involved should have HTS and have facilitators and Social workers… so that there's a total package for a young girl. So that if she wants to do testing, she can, if she has received results that will affect her emotionally, she will be linked to a Social worker. And for any other problem this girl might have… so it is a total package for this young girl. (KZN, Implementer)*

Several of the social worker respondents described situations in which AGYW who had been infected with HIV through vertical transmission, had never been informed by their parents, and required counselling from social workers when testing positive for the first time.

> *The child has tested positive and has never had sex, then we (social workers) will have to intervene, as the child needs counselling. We need to even get through to her parents… We get involved… and help her accept her status. (Free State, Social worker)*

One challenge cited in HTS service provision related to AGYW beneficiaries being resistant to getting tested, and refusing.

> *We do test the girls… most of them would refuse the test, they have their own reasons, but we don't force them to. We try to make them see the importance of testing your status, that can be a little bit of a challenge… it makes my job difficult. (KZN, Implementer)*

According to implementer respondents, some AGYW are reluctant to get tested for HIV due to a fear that their parents will think they are sexually active.

> *Some of the girls don't want to test. They say "my mother will think that I am having a boyfriend, so I can't do HIV testing". (Eastern Cape, Implementer)*

An additional challenge related to inaccurate biomedical history being collected due to AGYW beneficiaries withholding information of lying about their HIV status and testing history.

> *In the data tools for HIV testing they will be asked: "Have you ever tested before?", and the person will say, "I never tested"…. (but) you find that she is a known positive and… (has maybe) defaulted treatment… but that person said to you it is the first time. They come up with stories. (Eastern Cape, Implementer)*

One of the key issues relating to implementer acceptability of the biomedical services was the sentiment that the pressure to meet targets meant that the quality of care and service provision was compromised. In situations where AGYW test positive for HIV for example, she needs sensitive support, and not to be pressured into initiating treatment before she feels emotionally ready to do so.

> *If she's saying she's not ready to start ARVs, and then there's demands… (that) you are not linking your AGYW… It (starting treatment) doesn't happen within a week, or within a month. Some of these things take time, you know. A social worker will start developing that relationship… counselling this girl and then maybe only after six months, the girl will start saying, now we can talk about my status… But then the way the programme is structured is I test positive today, you need to link me, if you don't link me, then the numbers will flare to say, so many girls are not linked, you get me… so that does not accommodate the quality component. (Mpumalanga, Implementer)*

Health workers also expressed dissatisfaction with the test and treat policy, feeling that it lacks attention to the psycho-social aspects of HIV care, and the necessary counselling, adherence support and follow up care.

> *I don't understand 'test and treat' because it means you are saying to me, I must test now, and while she is still… trying to heal… we will encourage her to take the treatment…. if she does take the treatment at home that is another challenge altogether… She will come on another return date and collect the treatment… She will come for the sake of ticking the box… (but) she is not ready. We don't want a person to come and collect treatment just for adherence sake… Not for me to tick a box but we want them to adhere to treatment. So, the test and treat for me personally is not working, because the girl has not healed… she still needs an additional counselling. (KZN, Implementer)*

Behavioural Services

The key behavioural drivers of the HIV epidemic among AGYW in South Africa have been identified as comprising multiple and concurrent sexual partnerships, age disparate sexual relationships, transactional sex, early sexual debut, low levels or inconsistent condom use, high alcohol consumption, recreational drugs and abuse, and self-perceived risk of HIV infection (Genesis Analytics,

2020). In response to this, the combination intervention included a range of behavioural programmes and services.

The Behavioural Services included in the intervention are the following:

- Peer education
- Comprehensive Sexuality Education
- Psychosocial support (individual and group)
- PrEP information
- SRH education
- Mental health services
- Substance use programmes
- Parenting support (including teen parenting)
- Physical activity
- Adherence support
- Intimate Partner Violence (IPV) counselling, shelters, and Thuthuzela Care Centres (TCCs)
- Court support

Implementer Experiences of Behavioural Services

Parenting support / Teen Parenting Programme

Implementers spoke highly of the Teen Parenting programme and noted its various benefits (see section on Implementer Perceived Benefits of Behavioural Services). The only challenge that was noted related to the limited capacity among SRs to meet the high demand; one SR noted that a maximum of 15 AGYW could be included in a Teen Parenting programme every 8 weeks.

> *The teen-parenting... also receive praises as it continues. The only problem is that they can only take 15 people at a time, every 8 weeks… But I think that one will also match the standards that have been set by the self-defence classes. (Western Cape, Implementer)*

> *We do sessions with teenage mothers... They include challenges that teenagers face as young mothers. We offer our support to them. We formed a club for them to be able to unwind, and talk about the challenges they meet… we also give them an opportunity to form relationships with other teenage mothers, so they can support each other on this journey. (Free State, Implementer)*

Psychosocial Support

Implementers noted that having Social Workers and SAWs on the programme staff improved the acceptability of the programme among both AGYW and the community. Waiting times were reduced and AGYW were able to meet with social workers in a welcoming, youth-friendly space. Having social workers on the team, in the Safe Spaces, clinics or in the field has improved AGYW demand for and access to psychosocial support. One issue that implementers noted was that AGYW may not feel uncomfortable when social workers from DSD are referred to do home visits. However, being able to access psychosocial support at Safe Spaces and outside the home, rendered these services more accessible and youth friendly. Implementers noted that where AGYW were referred to DSD social

workers, waiting times may be long and the once-off individual counselling provided was often not effective for AGYW that required ongoing counselling, to deal with GBV for example.

> *I do not know to what extent these social workers operate but I feel that our kids do not need to be seen only once, and then they would only come again after a month or three months. I meet a lot of children who are exposed to many types of abuses… I see a lot of gender-based violence and the child is not able to speak out… it takes a lot of time before they (social workers) can see the child. If the child was attended to this week, at least the following week the child should be seen again… The girls don't talk to you when you first meet, it is only after you meet them for a few times that they will open up about their challenges. (Free State, Implementer)*

Social workers expressed the sentiment that their ability to provide 'proper' comprehensive, sensitive social work services, as they were trained to do, was compromised by pressure to meet targets. Respondents also noted that social workers' high burden of administrative and management work was compromising the delivery of psycho-social services. The manner in which the intervention is designed means social workers are expected to perform a wide range of duties that fall under the umbrella of 'psycho-social services'. Social workers are thus overburdened and unable to offer proper support in line with their skill set and training.

> *Social workers treat a case in a certain way. We know how cases should be treated as social workers. [SR] is more focused on numbers more than the quality of services. The way we work as social workers is time consuming. We work according to the pace of a child as we were taught at (training) institutions. (Free State, Social worker)*

Amongst the services classified as psycho-social support to be delivered by social workers include self-defence classes, grant and document applications, and homework support, which many social workers do not feel suitably qualified to provide. Meanwhile, they are unable to provide satisfactory social support to those who need it.

> *Something like self-defence… that is not a service that requires me, but it falls under the psycho-social services… Similarly, the homework support, it is also part of psycho-social… How do I tell my supervisor that I am busy helping a child with homework, while there are other serious cases that need my attention?… Under the psycho-social, we also help girls with birth certificates, the grants and back to school. (Free State, Social worker)*

Peer Education

Implementers noted that an attractive aspect of the programme for AGYW was the opportunity to be able to engage with other AGYW, particularly in a supportive group setting. Facilitators in schools spoke favourably about the supportive dynamics created among AGYW in peer education groups. The fact that many PGTs are also young and close to the age of the participating AGYW, facilitated relationship building and a positive mentorship dynamic.

> *We have our groups that we called "Mentor me Chommy"… we are saying, teach the other one, and the same one must teach the others, mentor me chommy! (Free State, Implementer)*

One challenge with the peer group approach is that AGYW peers or PGTs themselves may reinforce problematic views and stigmas. This is one of the reasons that the efficacy of peer education as an HIV-prevention strategy has been questioned, and some literature asserts limited efficacy in changing SRH health knowledge, attitudes, beliefs, and behaviours (Chandra-Mouli et al., 2015; Simoni et al.,

2011; Sun et al., 2018; Tolli, 2012). The quote below explaining an 'HIV champ' title given in a peer education group, although probably well intentioned from a PGT, encourages 'judgement' of behaviour, because if you 'fail' (are HIV-positive or pregnant) then you are not deemed to be a 'champ'. The inherent assumption underlying the idea is also that HIV status and teenage pregnancy is dependent on being a 'well-behaved girl child', which ignores the structural factors and could reinforce stigma around HIV.

> *We would love to have a girl that we would be able to refer to as our champ this year. This girl that is referred to as our champ, she comes to our activities, she will always be there and she has not yet been HIV positive and she has not been pregnant. We give that girl the medal that she is `HIV champ something `, because we have our groups that we called `Mentor me Chommy`... If it's mine for this year, then it must be for somebody next year, if it happens that it stays mine the following year, so it's because I am a well-behaved child. (Free State, Implementer) .*

Despite the many challenges of peer to peer educational approaches, evidence shows that support from peer relationships can serve as protective factors for physical and mental health, and should continue to be considered for inclusion into combination interventions for AGYW (Colarossi, 2001; Duby et al., 2021b). Structured interventions and group programmes designed to foster social and emotional bonds between peers, and provide nurturing environments, have the potential to significantly improve subjective well-being (Lampropoulou, 2018; Mundell et al., 2011). AGYW benefit from facilitated social support networks and Safe Spaces in which they can share their feelings, discuss with peers, and seek advice from trained facilitators (Duby et al., 2021b). Interventions for AGYW that comprise of group-based interventions for improving AGYW SRH and reducing HIV risk by providing access to safe social spaces where participants are able to develop and strengthen their peer networks, receive curriculum-based education on SRH and gender can improve self-esteem and social networks, as well as improve SRH knowledge and promote safer sexual decision making (Plourde et al., 2017). Peer-group models can be challenging to implement but, when applied successfully, the supportive peer networks provided in small facilitated peer-groups can help to protect AGYW from the negative effects of stressors and promote more positive mental health outcomes, and in turn lead to a reduction in sexual risk taking and early pregnancies (Cheng et al., 2014; Clacherty et al., 2019; Duby et al., 2021b). In order to mitigate some of the challenges of the peer education approach and the peer-group club context mentioned by respondents in this evaluation study, strategies for ensuring confidentiality need to be prioritised, as well as the provision of on-going values clarification engagements and self-reflection activities designed to address some of the problematic and prejudicial attitudes described above.

Comprehensive Sexuality Education (CSE) / SRH Education

Overall, the SRH education delivered through the programme was regarded positively. One challenge noted with SRH education delivered in school settings however, was that facilitators sometimes felt that they could not talk freely about certain topics, such as PrEP and PEP, due to the restrictive environment.

> *Since I'm at school, I feel there are things that you cannot talk about inside the school... so I have never had a situation where I can tell a girl about PEP or PrEP. (KZN, Implementer)*

The programme was designed to deliver Comprehensive Sexuality Education (CSE), however from the narratives of some of the implementing staff, it appears that some of the implementers providing SRH education may have included topics such as abstinence instead. One challenge with the provision of CSE is that it requires training and support in order to equip educators with the skills to provide the information in a moral-free and non-judgemental manner, putting aside personal beliefs and moralising attitudes relating to sex and sexuality. It appears that this may not have been the case amongst all programme staff providing SRH education. One inherent assumption in this respect is that implementing staff can and will be able to successfully put aside personal beliefs relating to sex, in order to provide high-quality CSE.

> *What we usually encourage most to those (AGYW) who are still young is to abstain. But to those who are already sexually active, we teach them about the different forms of contraceptives. (KZN, Implementer)*

> *I am responsible to train the kids especially when it comes to sexual activities and education… when it comes to the issues of teenage pregnancy… I teach them to stay away from the boys… because they are still young ladies… that they can be HIV free also. So the information that we are giving them is to say "just stay away from boys" (Free State, Implementer)*

Another challenge implementers have experienced in providing Comprehensive Sexuality Education relates to the resistance of school principals towards the delivery of CSE content, fearing that teaching about safe sex would promote sexual activity amongst young people. This is a commonly held perception amongst both parents and educators in South Africa.

> *We went to the matrics… and they (school management) were very negative saying that we are telling the young women to have sex. They were saying, "so you are telling them that you must wear a condom and that there is this pill that prevents HIV", so you are basically telling our children to go and have sex… and then they said: "no we don't need this kind of a service". (North West, Implementer)*

The successful provision of CSE in schools is also based on an inherent assumption that the environment is conducive, and that educators, principals and parents will accept it. Although the South African Department of Education offers what is designed to be comprehensive sex education in the form of Life Orientation, research has demonstrated that, far from adequately addressing gender and its relation to sexuality, Life Orientation classroom practice has avoided these issues or even reinforced heteronormative assumptions (DePalma et al, 2014). Available evidence suggests that sexuality education offered through Life Orientation (LO) classes all too often fails to meet the needs of young people, often because educators delivering the classes are themselves ill-equipped with the skills and attitudes required to deliver the content in a satisfactory manner (Francis 2017; Shefer and Macleod 2015). The skills and competence of teachers are central to the successful delivery of CSE (UNESCO, 2015; Wekesah et al., 2019).

Structural Services

Key structural drivers of the HIV epidemic among AGYW that have been identified include: Legal and policy barriers, Poverty, Being out of school, Gender-based violence, Stigma and discrimination, Limited economic opportunities and Gender inequality and norms (Genesis Analytics, 2020). In response to these, the intervention's structural services component includes the following:

- Access to social grants
- Dignity packs
- Academic support/career guidance
- Return to school support
- ECD vouchers
- Economic strengthening (pilot)
- CSE through whole school development approach
- Men's dialogues and gender norms
- Youth leadership
- Access to work opportunities/school scholarships
- GBV awareness and self defence (IMPower / "No Means No")

Implementer Experiences of Structural Services

Regarding overall delivery of the structural layered services, many key informants, especially PGTs and social workers, were frustrated by the fact that they had created expectations among the participants for structural services that never materialised. In particular, there was high demand among AGYW for dignity packs, work opportunities, career guidance and access to Identity Documents and social grants, however these elements of the programme delivery experienced the most challenges. Therefore several respondents concluded that the structural layered service component was the weakest aspect of the programme.

> *Most of the services, we don't have them… livelihoods, opportunities for education, bursaries, livelihood skills… there are a lot of programmes that are in the service plan that are not able to be implemented… It is so hard that you promise a girl… you will be doing this and this and that, but then as time goes on you are seeing that you are not able to do the services. (KZN, Implementer)*

The lack of resources and limited ability to provide material assistance to AGYW who had been identified as being in need was felt as a deep frustration by social workers who were only able to provide emotional support and counselling.

> *It is difficult… because the social worker will attend the family, they will just give the family support without any resources, just verbal support… nothing tangible will be left with the family... This thing is a very traumatic situation. When you identify a child and you start to interview about her family… she thinks now that she has mentioned her problem this social worker is going to assist her to overcome the problem but nothing… only the support and the advice. They can't even meet the family or the child halfway. Because when you say a person must go to Home Affairs, but to go to home affairs that person needs transport. She is going to say: I didn't go to Home Affairs because I didn't have transport to go to Home Affairs. So, they find it not useful or helpful for them. (Free State, Health worker)*

The failure to deliver promised programme components sometimes meant PGTs and other staff members were personally assisting AGYW with their own resources and providing assistance beyond the scope of what the programme itself was offering.

> *We have received a lot of stories from the field; people thanking the fieldworkers for all of the assistance that they have provided. But in most cases it is usually when the fieldworker goes beyond the call of duty. Sometimes they have even had to provide funds to these young girls*

because they were touched. If you are sitting with another human being and they are sharing their story with you, you are bound to get touched and then you go beyond the call of duty… if they need money, you provide it or if they need food you assist them. So, in most cases it wasn't necessarily the program, it was the fieldworker that went beyond the call of duty to make sure a human being was assisted. (Western Cape, Implementer)

Implementers noted that structural services, particularly to out of school/ community-based AGYW are likely the most essential component for combination HIV-prevention for this target group, but currently SRs are unable to sufficiently address these needs. The ability to provide a comprehensive service also differs across the districts, since the 'Economic Strengthening and Livelihoods' component is not being piloted in all districts.

When you look at out of school beneficiaries… they require those economic strengthening activities, whereby you assist them with the application of jobs, access to internships and employment and helping them with maybe compiling CVs, preparing them for job interviews and stuff like that. If that element can be strengthened… even when we do some sort of a cascade, HIV cascade, to check for the positivity rate, where is it coming from in terms of the yield? The main contributor is the out of school (AGYW) because remember they are unemployed, they are doing nothing, they are not really engaged on a daily basis actively. So, for them that element or intervention can strengthen the implementation, if all the SRs had the resources to implement it. (Free State, Implementer)

Self-defence programme

While respondents highlighted some success with the structural service components, the self-defence course (IMpower / "No Means No") received the most apparent praise. The self-defence course is considered to be so successful because it is addressing an urgent need, due to the high rates of GBV and IPV across South Africa.

I have heard a lot of people praise the self-defence classes… in most of the areas that we implement the program… young women tend not to feel safe. But after they have participated in the self-defence class, you then start seeing that they are more confident …it is addressing a need that has long been there in the community. If you look at the crime rates or the GBV rates that have been reported on national news, young women are more at risk now and the situation just keeps on getting worse… some of the skills that they are taught, even in those classes, they are effective, they really are effective. (Western Cape, Implementer)

The focus on self-defence naturally brought up various traumas for participants and disclosures of GBV, after which AGYW could be referred on to a grief counselling course or to a social worker. Some SRs initially did not anticipate that so many AGYW would disclose that they had been victims of GBV, and so the trainings were initially managed by PGTs. However, noting the high number of AGYW disclosing abuse, SRs subsequently ensured that SWs and SAWs were included in the programme to provide counselling support.

The self-defence classes assisted a lot because a lot of kids disclosed there. It is managed by peer group trainers, they are trained for the self-defence classes… then we discovered there were a lot of disclosures. We then suggested that one Social Worker must be present in a training, or SAW... Because these instructors (PGTs) are not trained in counselling. When there

are disclosures, at times they don't know how to deal with such cases, because the training content itself triggers those emotions. (Western Cape, Social worker)

The programme was also considered to be successful at providing a gateway into other programme components. Due to its engaging nature, it allowed SR staff to build trust with AGYW in a relatively relaxed environment and encouraged them to sign up to further programmes.

Our entire self-defence programme... is sort of our gateway programme... it is available to any young woman... it is actually quite hectic… because you are dealing with how you defend yourself, what comes up quite quickly is disclosures about what has happened… a lot of young women have been actually attacked, and so all of this starts to be disclosed in the sessions with the participants...it is just a first point of connection... "ok now I can trust you with this information, you know this about me, and you still welcome me back, so it must be safe enough to try something else". (Western Cape, Implementer)

The only negative outcome associated with the self-defence course is that some implementers noted that some men felt threatened by the fact that AGYW were receiving self-defence training. AGYW expressed that they were frightened of being targeted as a result of their participation or had experienced hostility from male partners. This hostility from men in the communities may also reflect the fact that the programme did not adequately engage and ensure buy-in from men in the implementing districts. Moreover, SRs are not ensuring parents and AGYW household members are informed about the programme, leaving it up to AGYW to explain the programme to them.

They (AGYW) had a fear of being targeted in the community… they would be expected to put the skills they learnt into practice because they have done self-defence classes… one participant… shared that she got into an argument with her boyfriend… (and) there was pressure to show… what she had learnt in these self-defence classes. (Western Cape, Social worker)

<div style="background-color: pink; text-align: center;">Men's dialogues and gender norms</div>

In the programme design, the stated aim was that partnering organisations would conduct demand creation dialogues and educational talks with men in various entry points in order to encourage men to take up health screening as well as to discuss cultural and social issues which perpetuate GBV. In the evaluation interviews, some of the respondents described the ways in which SRs have engaged ABYM in their programmes through hosting men's dialogues in schools and Safe Spaces, and through contracting SSR services.

This is a forum for men… we come up with discussions through our advocacy SSRs to say, as men, what role can you play to protect adolescent girls from abuse, from gender-based violence? ...those are the kinds of platforms that are available for our advocacy SSRs to raise issues and address them and it's working very well. (Mpumalanga, Implementer)

For those that are in school, I usually go to school and talk to the principal… and get one period (class slot)… to talk to the girls. But I am not dealing with the girls only, I do talk to the boys because they are also involved in our lives… when it comes to getting involved in sexual intercourse, they are also there. We should get both sides, not just one side with the girls. (KZN, Implementer)

Respondents noted that one of the factors that explains why men are not being engaged in the programme, is that the funding and targets are not conducive to involving ABYM and older partners in forums and dialogues, even though this component is meant to form part of the structural services.

> *We can focus more on girls, but let us at least have that 10% of boys. For now, we cannot even try to include the boys because we are working on targets. Even if you see a need for them (boys) to be included, it will be like you are wasting the organisational resources because you will be doing something that is not based on the organisation you are working for… the creators of the problems are boys… those who are creating problems like teenage pregnancy etc, are left behind… The programme was going to run hundred percent if that was to be implemented… there's not much for a boy child, but we can have focus groups. At the moment we only distribute condoms to them. (Mpumalanga, Social worker)*

The lack of engagement of ABYM and men in the community has negatively impacted community acceptability of the programme. Implementers were also concerned that empowering young women could be a catalyst for increased GBV if ABYM and older men were not involved in the process.

Economic Strengthening and Livelihood Programme

An Economic Strengthening and Livelihood (ESL) pilot programme is being implemented in selected sub-districts. The ESL programme's primary objective is to provide socio-economic development support and opportunities to AGYW, with the aim of enabling young women to become economically active. The ESL Programme was only piloted in certain districts and was supposed to be implemented as a layered service in AGYW Safe Spaces. The three components of the ESL Programme are:

1) Livelihood skills for school leavers and young women: Work readiness programmes i.e. Drafting a professional CV; preparing for interviews etc.
2) Livelihood opportunity for AGYW who are not in any form of education, employment or training (NEETs): Safe Spaces to identify local partners and develop partnerships for short term opportunities, employ AGYW as Interns, youth skills training and placement; and youth entrepreneurship.
3) Livelihood Support: Safe Spaces to support interventions and incentives e.g. transport assistance and Early Childhood Development (ECD) vouchers that would assist young unemployed AGYW to overcome their burden of care challenges. AGYW were to be provided with skills training for Savings Clubs.

A separate evaluation is being conducted focusing on The Economic Strengthening Livelihood (ESL) Programme, so this evaluation did not seek to assess this component in depth. However we have included some of the data that came up in interviews pertaining to this component.

Feedback from respondents on the ESL programme was mixed. Some SRs noted that one of the PRs had contracted a service provider (Ikhumiseng) to provide ESL services to AGYW. Respondents from these districts noted that the programme was comprehensive and was providing tangible benefits to participating AGYW. This programme was targeting unemployed, out of school AGYW with capacity building, computer skills, developing CVs, starting savings groups and encouraging them to start their own businesses.

> *There's a service provider that is contracted by [PR] to implement the economic and livelihood programme… We recruit them and provide services and refer successfully to the ESL*

programme for them to be capacitated, to come up with business ideas, and some of them will be linked to economic opportunities, some will get jobs… it's very comprehensive and it benefits our girls a lot. (Mpumalanga, Implementer)

The Economic Strengthening Programme is implemented by Ikhumiseng which is one of our SSRs. The AGYW who are receiving Economic Strengthening are not working or studying… We teach them how to draft a CV… We also help them with basic computer skills, even though it is only for 7 days, but they are taught the basic skills… They are also taught about how to save money with the different savings plans in the course. After that, they are given a certificate and they can look for jobs. Some realize that they can have businesses opportunities like opening a salon, so they will be provided with all the equipment a salon needs, then they will be mentored and funded for the business to be successful. (Mpumalanga, Social worker)

Some challenges were noted, especially relating to beneficiary attrition, and ensuring regular AGYW attendance of the full course. However, this challenge was noted in relation to several of the group courses and therefore is unlikely to be specific to the ESL programme.

Access to work opportunities/academic scholarships

The aspect of the programme focused on supporting AGYW to find work opportunities and enrol for further education opportunities was considered to be in high demand from AGYW and an important component of the programme that improved community acceptability. Unfortunately, it is also the programme component that implementers often noted was either not available in certain districts or not being delivered as promised or originally planned. Some SRs were assisting community-based/ out-of-school AGYW to compile CVs, search and apply for jobs, prepare for interviews and apply for funding to start their own businesses. Safe spaces offered access to the internet for job searching and mentorship from SR staff. Some of the access to work opportunities was being delivered though the ESL programme in pilot sites by SSRs.

Firstly, it is about employability. We teach them on how to construct a CV and how to conduct themselves when you are going to an interview. Because we have girls who are ready to go to the workforce or work place. (KZN, Implementer)

The one thing that we don't do is we don't promise them jobs, because we are not the ones creating jobs. We let them know that we can assist you to apply and what not… (but) it is not us that is making the decisions... If you get the job, then it is a good job that we did, and we will be thankful that it went well. (Free State, Implementer)

There were successful cases reported where SR support resulted in AGYW finding jobs. Although some SRs noted that this had occurred due to PGTs and other programme staff going above and beyond the call of duty to assist individual AGYW, rather than being a result of a funded programme component. Certain organisations were taking it upon themselves to provide services like linking AGYW to recruitment agencies and providing university application information. However, these activities fall outside the scope of the defined programme and are being done on the basis of the 'good-will' of fieldworkers.

In most cases… all of the other things that we wanted to do, like providing information about… universities for example and linking them to recruiting agencies, that has been fieldworkers taking it upon themselves to help these young girls, because they were touched by the stories

that they encountered in the field, and so they took it upon themselves to do it. It wasn't necessarily the programme. (Western Cape, Implementer)

Academic support / career guidance

SRs with programmes based in secondary schools, were assisting AGYW with homework support. Implementers spoke favourably about the perceived impacts of this programme. Respondents emphasised that especially for AGYW from particularly poor households, being able to come to the Safe Space and access the internet and receive help from PGTs to complete homework, was having a positive impact on school performance. Offering assistance with homework was also a means to provide SRH education while interacting with AGYW and to potentially attract AGYW into other programme services; especially for Grade 11 and 12 learners who are very busy with the school curriculum and otherwise difficult to access.

> *If you are in school and you do not have internet at home, we have a Safe Space where these young girls can come and do their homework etc… even if they are crowded at home, they can come to the Safe Space and do their homework and things like that. So, this girl has a safety net… she can know "I have people that can assist me". (KZN, Implementer)*

In cases where PGTs were well equipped to assist AGYW with homework, the provision of homework support also allowed for relationship building and informal discussions around SRH with Grade 11s and 12s, who were otherwise difficult to reach due to their schooling obligations. However, some respondents such as social workers, did not feel that their specific skill set was well aligned to provide the 'homework assistance' component of the programme, even though the programme expected them to.

Return to school support

SRs operating in schools were assisting schools to track absenteeism, uncovering the reasons for absenteeism and then assisting AGYW where possible, for example where there was a need for dignity packs or child-headed households needing support from the Department for Social Development (DSD). SRs reported that they believed that programmes conducted in schools were helping AGYW to remain in school.

> *In the schools that we are based in, the principals are happy with our services because we are assisting a lot. Every Monday we go to the community with a list from the school to check the absenteeism. Sometimes when you get to the house you find that the child is not absent because she is sick or something, the child is absent because there are no parents there. There is no one to take care of the child. Sometimes it is a situation of menstrual periods, because the child doesn't have a sanitary pad and what not so she can't go to school. So, we are assisting in those terms. (Free State, Implementer)*

SRs noted that they received positive feedback from principals and teachers who were noticing positive changes in girls involved in the programmes. There were also a number of successful experiences reported where SRs had encouraged teen mothers to return to school. Others noted that assisting AGYW to access ID documents through Home Affairs was also helping them to return to school to finish Grade 12.

We also have 'return to school' for girls who want to go back to school, who dropped out because of certain reasons… We try to communicate with nearby schools so that they can go back to school. Those who do not have IDs, we help, it depends on the needs of the girl. (KZN, Implementer)

There are a few girls… that during the time that we met they were pregnant already. But when you check with them, they are still young, some 14 turning 15 or some 19. They were having thoughts like: "I can't go back to school, because some girls are going to be talking about me"… But that is not the end of life, if you encourage them, they will be ok, they can do well. What is nice is that even the principal and some teachers can see the change in some girls. Their perception, how they see things is different. (Free State, Implementer)

Respondents from SRs across three districts noted that they were not able to provide return to school support or to refer AGYW to other SRs who could in their districts. Challenges were noted, for example, in Thabo Mofutsanyana (Dihlabeng) in the Free State, with providing support to teenage mothers who wanted to return to school. Other SR respondents in King Cetshwayo, KwaZulu-Natal, for example, noted that they could not address the various structural barriers that prevent AGYW from returning to school such as access to transport money, dignity packs and uniforms.

There is no other way because the girls would be fighting with you, they will be saying, you promised us this and this and this and that. You know we are supposed to be helping girls to return back to school, what are their needs, so that they can return back to school? The girl needs a uniform, she needs transport money… that programme is not implemented in our district. (KZN, Implementer)

Dignity Packs

As outlined in the programme description documents, "Menstrual Dignity Packs" comprising sanitary pads for menstrual management, were to be procured for schools where this was identified as a need amongst female learners, in line with the Department of Women's Sanitary Dignity Framework. Female learners identified as indigent, within Quintile 1-3 schools, were to be provided with Dignity Packs as part of the structural services component. As already noted above, a number of challenges were reported regarding the supply of dignity packs for AGYW, which were often not available. This was highlighted as particularly problematic in the Free State.

Since the introduction of this programme, there's no single child who got a dignity pack and the programme is coming to an end next year. (Free State, Implementer)

Some SRs were able to provide dignity packs later into the programme, however, challenges with maintaining a sufficient supply to meet demand were reported. PGTs also reported that they had promised AGYW dignity packs when they signed up and then subsequently could not provide them. This contributed to a loss of trust between SRs and AGYW and difficulties in registering AGYW into the programme again at the 6-monthly visits. Sometimes PGTs ended up giving AGYW money to buy sanitary products and SRs also noted that they had found other channels to procure dignity packs from outside of the programme.

It would be much better if they can give us a lot of dignity packs… you would have promised a child that we can provide dignity packs… and after 6 months when you go back to that child…It is sad that the child would tell you that you promised me the dignity pack… it is also difficult for you to re-register her because they lose trust in us saying 'you have since promised to help

me with a dignity pack'… we meet AGYW who are in dire need to such an extent that sometimes we take money from our own pockets because this person keeps coming to you for help. (Free State, Implementer)

Theory of Change critique of core and layered services

The explicit assumptions that relate to these activities are:
- AGYW who participate in the core services and who are identified as in need of a layered service will be willing and able to participate in, or take up the layered service
- AGYW can access commodities and services

While there were also a number of challenges with delivery of layered services, the feedback provided overwhelming support for the psychosocial benefits that were derived from participation in these services. Of interest to note is that despite significant challenges with both willingness to participate and accessing services (the explicit assumptions noted above), implementers still reported successes that related to the psychosocial benefits inherent in participation of these services - benefits which are more implicit assumptions of the model. Many reports from implementers indicate that participation in these services allowed for relationship building which yielded disclosures around risks and vulnerabilities that were not always uncovered during the official Risk Assessment phase. These elements that allow for deeper relational connections between implementers and AGYW may be a critical feature of success of the programme, especially as it improves acceptability and therefore retention and uptake of services.

The importance of this aspect of relationship building is not explicitly stated in the ToC model. According to these reports, the layered services provided significant benefits, but not necessarily as a direct result of the Risk Assessment, which is what the model dictates. The feedback here points to a possibility that the Risk Assessment may not be a necessary condition for effective uptake of layered services, but that perhaps a focus on the provision of psychosocial support services initially, followed by a Risk Assessment at a later stage, once a relationship has been established may have been more effective. The Journey plan and journal would then be used as a tool to explore the personal values and aspirations of young girls and to integrate these into their decisions regarding uptake of services, which could bolster the acceptability and willingness of AGWY to participate.

Further to this the model states *that* AGYW should be willing and able to participate and be able to access services, but does not speak to the quality of interactions that are necessary to facilitate and support such participation; essentially the *how* involved in uptake of the core and layered services, which according to the reports from the implementers, may be a more important aspect to consider in terms of improving acceptability. This will be discussed in more detail in the ToC critique of Implementer experiences after Section 1B.

Implementation Relationships and Referral Mechanisms

A central principle of the AGYW Programme is that the various service components would be provided to AGYW through a referral system between Global Fund funded programmes (internal referral) as well as to services outside the GF programme (government entities, other NGOs and private service providers). A process of services mapping was planned to be undertaken by PRs and updated regularly. This mapping would identify possible referrals in each district. The various roles and responsibilities of the PRs and SRs in this process are described in the AGYW Programme Description document as follows:

> PRs are responsible for ensuring that a full package of services is available to AGYW in their allocated sub-districts. The PRs shall aim to create sustainable referrals to existing services and infrastructure, or capacitate local partners, rather than design and create dependence on new service delivery mechanisms owned by this programme. (NACOSA et al., 2020, AGYW Programme Description, P.22)

> SRs must ensure good relationships and collaboration with programme managers of available service providers as identified through the service mapping exercise (NACOSA et al., 2020, AGYW Programme Description, P.27)

Referrals are achieved by issuing a referral letter to the beneficiary following the Risk Assessment or testing service. The beneficiary takes the letter to the allocated service provider. If possible, the SR provides transport for the AGYW, or accompanies her to the referral services (referred to as the handshake approach). Linkage officers are responsible for linkage to care and tracking successful referrals by making regular telephonic contacts with the AGYW or checking routine public health service registers such as Tier.Net.

Implementation Roles and Relationships

between Principal Recipients (PRs) and Sub-Recipients (SRs)

In the programme description the PRs' roles and responsibilities in implementation were to include: overall grant management, programme design, sub-recipient (SR) oversight and capacity building, system strengthening, networking and coordination. SRs' roles and responsibilities primarily relate to service delivery and making referrals to services for AGYW beneficiaries. Linkage officers are responsible for linkage to care and tracking successful referrals by making regular telephonic contacts. Linkage is done by issuing a referral letter/slip to the beneficiary following the risk assessment or testing service. The beneficiary takes the letter to the allocated service provider - transport to the service point is provided if possible. The handshake approach, when the client is accompanied by the linkage officer to the facility, is a preferred method.

In the qualitative evaluation interviews, implementers shared their views and experiences relating to the dynamics of the working relationships and referral systems. The majority of SRs noted that they feel sufficiently supported by their PR. Effective channels of communication have been established to resolve arising issues, for example through WhatsApp groups, regular meetings and direct channels

of communication between managers. Some SRs praised their PRs for being open minded and encouraging SRs to develop innovative approaches to improve programme components.

> *I really like our PR! They are not necessarily prescriptive… they are mainly interested in terms of how are we achieving the outputs but also they are very open-minded in terms of us coming up with innovative approaches which then can also necessarily assist us in terms of achieving the desired outputs. (Free State, Implementer)*

> *One of the things (that has worked well) is the WhatsApp groups… we have this easy communication between the SRs and PRs. We can contact them at any time via email or WhatsApp and they usually respond. (Gauteng, Implementer)*

> *I have a very good relationship with the team from (PR)... if I have any queries, I can ask… and the feedback is quite good usually. (Western Cape, Implementer)*

Some SRs expressed frustration over their lack of decision making influence, noting that they did not feel that they had the power to suggest changes to the implementation approach or programme design where concerns are raised regarding the appropriateness of the intervention design for the context. SRs suggested that there should have been more consultation with implementers and beneficiaries to assess programme design prior to implementation.

> *Everything goes through the PR… we basically just get told... the information just cascades down saying this is how you need to implement it… The design of the programme is in such a way that… it comes designed already and we have to follow how it's designed instead of getting input from the people on the ground. (KZN, Implementer)*

Implementers remarked on the slow and non-responsive processes for providing feedback or suggestions for changes in implementation. Any changes would have to be filtered through the PR, steering committees, and the donor, which did not allow for an iterative and flexible approach to implementation.

> *From the onset we identified things that wouldn't work in the community… we actually had a meeting with the PRs and we voiced our concerns but nothing was really done… after a while we realised that even if you raise those concerns… it is not something that gets addressed immediately, it usually takes a while. There is a long process of the PR coming together with other PRs and then the information going to… a steering committee, and then that information going to Global Fund; so, that process is very long and discouraging. Then you also have some things that they tell you immediately, that this thing cannot be changed. (Western Cape, Implementer)*

The various roles and responsibilities between SRs and PRs are not clearly understood by all, in terms of establishing and ensuring the effective functioning of the referral system. Some SRs noted that the service mapping referral list was comprehensive.

> *They (PR) did a community mapping of the area for all the stakeholders and the facilities, up to so far, it is well structured. (Mpumalanga, Social worker)*

However in certain districts it appears that the original service mapping process undertaken by PRs was not entirely successful. SRs in some districts, noted that the referral registry includes organisations and services that no longer exist or that do not have the capacity to provide the required services.

57

One of the difficulties is with this idea of referring… who do you refer to and how do you know that, that place has the capacity to offer the service? …That's been an issue… when we started the mapping process, we got a massive spreadsheet full of organizations who apparently were offering XYZ. But then… probably 80% of those were non-existent anymore, and those that were existing, didn't really have capacity to deliver on, what on paper they said that they could. (Gauteng, Implementer)

As outlined in the Programme Description document, and the Linkages SOP, following up on referrals made, is the responsibility of the SR and is implemented through linkage officers.

There are linkage officers… they trace and try to call and check if the girl did come for her next visit. They contact her and check if maybe the clinic is far from where she is or it for whatever reason. If that is the case, they go and fetch her to the clinic so that she can access the services. (KZN, Implementer)

While some SRs noted that their linkage officers were able to follow up successfully, others did not seem to have the linkage to care process established. A challenge with this system, is that it relies on the linkage officer following up directly with the AGYW, as implementers noted that several government departments do not acknowledge or agree to sign the referral slips.

We are just identifying the child, taking their stats and writing the referral, and then it is done. Now reporting to our managers that we have met that child… and no follow up or a proper follow up is being done. Until such time as you meet that child and the child reminds you: "I have been waiting for you for so long, that you are going to call me or send me that person that is going to assist me"… we end up being liars! (Free State, Health worker)

The system could be strengthened by ensuring better coordination between SRs and government departments and buy-in to the system from the latter.

Relationships and Referrals between SRs (and SSRs)

The part of the referral system that is reportedly working most smoothly are referrals between SRs. Within a specific district SRs provide different services and can simply link AGYW to the services that they may not personally provide. An aspect particularly highlighted by several respondents was the improved access to psychosocial support as a result of SRs being able to refer to other SRs who have social workers (as opposed to referring to DSD). Linkage offers are also able to easily follow up to ensure that AGYW received the required service.

They (AGYW) don't have to wait for a long time because we work with (SR) and they do have social workers… when we have such cases, we have our own linkage officers, we just take them to our linkage officers on the same day and we ask them if they agree to meet with the social workers… they will get help almost immediately. (North West, Implementer)

Respondents from SRs noted that they collaborated well together and had created various formal and informal mechanisms to communicate effectively and provide each other with support, through monthly meetings, and using communication platforms such as WhatsApp groups to quickly resolve issues. SRs were also sharing their broader networks and assisting fellow SRs to connect with various stakeholders and other organisations in implementing districts, which strengthened the referral system.

If you need help, here and there, the other partners are able to assist in a formal environment… having meetings every month… we also have a WhatsApp group, so if you need a solution very quickly, you can post on the WhatsApp group and get an immediate response… it was that comradeship, understanding that we are facing the same challenges, which actually brought us together… if someone from one SR has a good relationship with an NGO, in a certain area or a partner, then they are able to introduce you as well. (Western Cape, Implementer)

Some minor challenges were noted regarding SR relationships, in particular logistical issues relating to find suitable times where all stakeholders could meet. There were also challenges in identifying common areas of collaboration between SRs working with in-school AGYW as opposed to community-based AGYW, or among SRs working in different implementing spaces (clinics, schools, TVETs, Safe Spaces). Some respondents also noted that delays in providing certain services or lack of resources (e.g. testing kits and PrEP) also affected successful referrals between SRs or between SRs and SSRs. However, overall there were no serious relationship and referral challenges noted between SRs by key respondents.

There were SSR respondents in the evaluation interviews that did, however, note some challenges and conflicts between SRs and SSRs related to not coordinating their activities effectively, SRs not delivering payments and services timely and ineffective referrals linked to the programme not delivering as promised to AGYW. SSRs who had been contracted to assist with demand creation and advocacy noted that this strategy was not working effectively since beneficiaries were getting lost in the referral process to SRs for core services. They suggested that it might have worked better if SSRs doing door-to-door demand creation had also been trained to provide services such as HTS.

Being mobilisers only I think affects our programme in terms of meeting our targets… It is very difficult to work with the [SR], to be honest, we are not motivated at all… they are no longer sticking to their promises like being on time, providing us with services… It also becomes difficult for girls to approach the [SR] for the services they want, because they are always in a hurry… if we are doing a door-to-door campaign and I get an AGYW who wants an HTS, I was going to test and record her. But if I had to tell her to come maybe on Thursday, what if it is not convenient for her. If we can be trained on HTS, we can avoid it. (Mpumalanga, Implementer)

Relationships and Referrals

Between Implementers and Government Departments and Entities

The AGYW Programme Description document outlines the key role that PRs are meant to play in engaging government departments in the programme and facilitating access and collaborative relationships: With guidance from the Country Coordinating Mechanism (CCM), Technical Advisors and SANAC-convened technical working groups (TWGs), PRs should work closely with the Department of Health (DOH), Department of Basic Education (DBE), Department of Social Department (DSD) and Department of Women at national, provincial and district-levels, district support partners, local sub-recipients and existing CBOs and FBOs, to engage and target and reach AGYW by operationalising this programme. (NACOSA et al., 2020, AGYW Programme Description, p. 22)

SRs, as the implementing organisations in various districts, noted a number of challenges regarding relationships and referrals with government departments and entities. It was clear from the interviews

that successful implementation, as well as local government acceptability of the programme was strongly influenced by the nature of pre-existing relationships and networks that SRs had with government stakeholders prior to the AGYW programme.

> *It works better because as an organization that has been existing and working with the government departments... when we went to introduce that we have been appointed as one of the implementing partners for this programme, it just basically enhanced the relationship. We didn't have any challenges because they already knew who we are. They already know us working in the community… we have built a reputation… they could trust us. (KZN, Implementer)*

> *We have been lucky in that before we started implementing this Global Fund AGYW program, we had already been running the Safe Space before, so we had existing relationships with some government departments and some health facilities, actually… we had existing MoUs with 5 clinics… So, to us it was actually an added advantage and we don't have any challenges working with the government departments. (Western Cape, Implementer)*

> *You are trying to link the girls to the services… But there aren't many services for us to link the girls to, you know!... the services are available, but... we don't have the relationships with such people… when you refer someone… it would be really nice if you can refer that person to a particular person that you know and you tell that person whatever information that they need to know, so that when the girls actually goes to them for help then they don't actually have to repeat their story again. (Western Cape, Implementer)*

According to respondents, MoUs do assist in establishing referral systems, however they do not on their own ensure effective referrals, especially when these are held by the PR and not the SR implementing on the ground, which is mostly the case. MoUs (even those held by PRs) do however assist with ensuring initial access to clinics and schools and go some way in ensuring acceptability of the intervention by these stakeholders who may otherwise refuse to cooperate.

Some SRs noted that they are not taken seriously by government departments unless they get the PR to directly intervene on their behalf to get things done or when participating in multi-stakeholder meetings/forums. SRs also sometimes need to escalate challenges with district government officials to the provincial level for resolution, which is effective because the AGYW programme is considered 'a national priority program'.

The degree to which SRs were able to gain access to and cooperation from district government departments also depends on their ability to successfully advocate for the programme and navigate the local bureaucracy. The lack of a stable advocacy officer in one district was noted as a barrier in this regard. However, some SRs described the way in which they leave relationship building to PRs, while other SRs persevere and seem more politically astute and able to build the kind of relationships needed to succeed. However, undoubtedly there are varying contexts across districts and governance challenges do exist which could make implementation more challenging in certain districts.

Respondents also noted that there is misalignment between some of the programme targets and government policies, for example on policies relating to the frequency of HIV testing in high risk populations. This may put strain on relationships with government and hamper referrals if the programme is not viewed as aligning with government policies or contributing directly to their targets.

> *With the guidelines, if the funders or the organisation can be inline also with the guidelines of the Department of Health because we are doing the same thing. If I can make an example, if*

we are saying we are dealing with a high risk population like the AGYW… the HIV testing needs to be done every six weeks… we need to be on the same page. Not to say now, we need to test for the girl to be counted maybe after six months… If we can work together, so that we also don't confuse the intervention to say the funder wants this but the Department of Health wants this. (Western Cape, Implementer)

For SRs who were working out of the clinic space, having strong relationships with DoH clearly assisted implementation. These SRs were more easily able to refer AGYW for biomedical services not covered by SR professional nurses, for example in GBV cases, termination of pregnancy and initiation of ART, and to source biomedical resources from clinics such as PrEP and testing kits. SRs who managed to get strong buy-in from clinic staff were also able to recruit more AGYW into the programme with the help of clinic nurses and contribute to a more youth-friendly dynamic at clinics. Clinic nurses would also refer AGYW patients to SRs for psychosocial support.

The other thing that works really, really well is that we have built a solid relationship with the Department of Health… we work in the clinic most of the time, there is an office allocated to us. Even though the clinic is small, because of the relationship that we have built with the clinic we have a space where we work, where we counsel the kids… Even if I am not there, the people in the clinic, the nurses, they make sure that we are getting our people and we are assisting each other and meeting each other halfway and assisting the community to be a better place for everyone. So, when coming to biomedical and even psychosocial, everything is flowing nicely. (Free State, Implementer)

If we can have a GBV case, we refer that case to SAPS… if the case needs the attention of the hospital, the professional nurse will refer the girl to hospital because at our Safe Space, we only provide HTS and contraceptives only. If there is something more that needs medical attention then we refer our children, the hospital takes over… we have a very good working relationship with them. (Mpumalanga, Social worker)

Most of the cases we find in the community, they depend on government departments for solutions. We'll speak of the issue of the teenage pregnancies when the young girls want to terminate, we need to refer them to the clinics… to the nearest, friendliest, safest clinics. (Eastern Cape, Implementer)

The way in which the programme was reportedly viewed by DoH clinics varied across districts; some SRs reporting strong working relationships with clinics, but many SRs also reporting challenges in building relationships and effective referrals. A common challenge was that clinic staff felt that the programme was adding to their already heavy work burden and they felt they did not have the capacity to deal with referrals.

I will just recall one incident where we actually referred a young girl to a clinic for contraceptives and when they got there, the sister at the clinic said: "you know we are already overworked, why do these programmes now come and refer more girls to us, when we are already overworked?". So, I mean, really, they were not for it! …even if you go to the facilities to try and build a relationship… they don't even make time for you. (Western Cape, Implementer)

Some clinics felt that having SR nurses providing services to AGYW might assist them in sharing the burden of work. However, not all clinics viewed the programme this way, especially those working with SRs that do not provide any biomedical services. Respondents also noted that it was up to individuals working for the SR to cultivate positive working relationships with clinics and ensure the programme was understood and acceptable to clinic staff.

> *To work at the clinic is challenging sometimes… it depends with you as an individual, how you relate with the health staff. How you approach them… if you don't explain yourself properly and your intentions, if you don't explain the programme well, they will not be able to understand. They would not understand that you are going to use their medication. They will not even understand that you are there to support them… It requires you to be humble and explain the programme to the operational manager or the person in charge. (KZN, Implementer)*

A key challenge is creating demand for clinic services from AGYW who have become used to poor treatment at clinics and who are generally fearful of accessing SRH services for fear of being stigmatised. SRs also noted that unless a staff member accompanied an AGYW to the local clinic, it was unlikely that the AGYW would attend the clinic by herself. SR nurses working in clinics also complained that when they were not present their AGYW patients may be turned away by clinic staff even though their files remained in the clinic.

> *I'm not very confident (with referrals to clinics) unless we accompany them (AGYW)… they are not very user-friendly… when the girls go there, instead of giving them the service that they deserve, people start by discriminating and judging them... calling them all sorts of things instead of just providing a service. The fact that, for instance… a seventeen-year-old would like to terminate a pregnancy... I don't think it's up to any nurse to try and mother them… So, they (AGYW) are more confident when we accompany them because if we don't accompany them, they just end up not going. If we give them a referral note, they just don't go. (KZN, Implementer)*

Another challenge was that some clinics did not recognise the referral slip and therefore would not sign it, which made following up on referrals challenging. In these cases, it was essential to have a good linkage officer that could follow up on the referrals and ensure that the AGYW received the service. Some SRs noted that the referral system was much easier to implement with other NGOs, as compared to clinics and government departments that often refused to sign and return referral slips.

> *Mostly with NGOs it is (easy), because when we call them and we say: "we have got the referral form, please return the form to us". It really works out, ok. With government departments it's really difficult. Even if you have a contact person in the clinic that you can refer to, the chances of you getting your referrals slip back is non-existent. (North West, Implementer)*

> *For those who tested positive [for HIV] we have linkage officers. They link them to care, in fact for those services that we refer, we always try to link the client and then find out the feedback what has happened, whether it's TB, whether it's HIV, whether it's STI or anything… if ever they get referred we need to find out what has happened. (Western Cape, Health worker)*

Relationships and Referrals with Department of Basic Education and Schools

SRs emphasised the importance of having strong relationships and MoUs in place with the schools in which programme activities are being implemented, as well as with provincial and district DBE. This was especially critical since some of the programme activities are conducted during school hours, and if not scheduled sensitively and carefully, could be viewed as disrupting the school curriculum. Schools can also assist in creating awareness of the programme among parents and help secure acceptability, for example some SRs were invited to present the programme at parent meetings.

> *What has worked well for us is… maintaining relationships has always been important for us… relationships from provincial department and district as well as the local schools… so that we get time to do our work, because our programme is supposed to be run during school hours but again it should not replace academics… When the school has a buy-in they also arrange when you get the time to see AGYW. (North West, Implementer)*

SRs who had strong relationships in place with the district DBE noted being able to run their programmes more smoothly as the department assisted in ensuring access to schools and mediating in any challenges that may arise.

> *We have relationships with the Department of Education from this district… we are working hand in hand with them, whatever challenge that we get we contact them and then they speak to schools on our behalf. (North West, Social worker)*

If good relationships are not in place and stakeholders in schools are not accepting of the programme, (and in cases where MoUs have not been signed), SRs reported that principals and teachers tend to act as gatekeepers and even refuse access to the school campus and to students, particularly where educators and principals are resistant to the idea of AGYW receiving Comprehensive Sexuality Education.

> *The challenges most of the time are principals, like the school I was working in, we were not allowed to get into the school premises… when we were supposed to go to that school he (the principal) told us that he needs a letter, he doesn't know the organization and we cannot come into the school when the SGB (School Governing Body) doesn't know about us… Other people have problems of being ill-treated by teachers, the teacher would refuse to give you access to the children, telling you that you are disturbing the school's programme. (Free State, Implementer)*

SRs also noted that getting the school's permission to work with AGYW in Grades 11 and 12 was difficult since they are preparing for Matric examinations. Therefore there is an implementation gap in some cases where SRs are not able to reach this critical target group of AGYW.

> *Some schools do allow us a bit to use Grade 10, but otherwise Grade 11 and 12, we are not allowed to touch because it's a crucial time for schooling. (KZN, Implementer)*

Learner Support Agents (LSAs) noted that a successful strategy for ensuring access to AGYW was to develop strong relationships with Life Orientation (LO) teachers, since SRs can motivate that there is an alignment between the content of the programme and that of the regular LO curriculum. Some respondents also noted that teachers were supportive of the programme because LSAs and social workers were able to provide psychosocial support to AGYW, which also reduced teacher stress.

You have to be in good relations with the LO teacher. Because what we are doing touches a bit on LO, so I get very close to the LO teacher... we work very well, and the support is great. They don't leave you alone, but they walk with you and support you. (KZN, Implementer)

Teachers, they're very, very supportive... they also have challenges with these kids, they don't know how to deal with them so for them they receive support from us because now if the child is problematic you send her to the Learner Support Agent (LSA)... Call the social worker to deal with her, and then in a way we reduce their stress. (North West, Social worker)

Respondents who noted that they had established a conducive work relationship with schools noted that acceptability depends on the ability of SRs to effectively demonstrate how the AGYW programme will benefit stakeholders in schools. In other words, effective relationships with schools can be built on emphasizing a common understanding that programmes can help to deal with issues such as drug and alcohol use, teenage pregnancy, school retention and return and improved adolescent behaviour and academic performance.

They've got issues of... drug use... high teenage pregnancy... they've got a lot of issues. So, when we go to them and say this is what we can help you with, then they get excited and... they support our programme. (North West, Implementer)

Relationships and Referrals with Department of Social Development and SASSA

The evaluation narratives of referrals between SRs and DSD and South African Social Security Agency (SASSA) were mixed, pointing to definite regional variations in regards to the effective functioning of district offices. It is evident from this evaluation research that the working relationships between implementers and DSD appear to be particularly weak in many settings, and referrals to DSD are often fruitless. This finding highlights the importance of the intervention's own embedded social workers and SAWs. However this solve the issue of referrals to SASSA for social grants.

In some of the intervention districts, SRs operating in Ehlanzeni in Mpumalanga, noted having an effective referral system in place with DSD. They reported successful referrals of vulnerable AGYW for support, including access to comprehensive assistance to remain in school and follow-up on cases where statutory rape needed to be reported.

The stakeholders that we are working with are also supportive especially when we refer children who are vulnerable, they support us... the Department of Social Development, when we tell about the vulnerable children, they support us... Because we don't do (deal with) statutory rapes in the Safe Space, we then refer our cases to the Department of Social Development, and they help us with the social relief of distress. (Mpumalanga, Social worker)

We also work very well with the Department of Social Development and Home Affairs because our layers (layered services) are attached to them, so we'll have to refer AGYW to these different departments... our relationship with them is very smooth. (Mpumalanga, Implementer)

In sharp contrast, other SRs (for example, Thabo Mofutsanyana, Free State) complained about ineffective referrals. For example, cases were noted where AGYW were referred for home visits with DSD social workers and 6-months afterwards had still not been visited. The system for following up on referrals was also noted to be ineffective in some cases. SR linkage officers could only confirm

successful linkage to care by following up directly with AGYW, as they would not receive feedback from DSD.

> *If we refer a child to social workers for a home visit, they should go because there are certain kids that we meet that will tell you "I want to go back to school but I don't know the correct channels"… we were also told that social workers can help… (But) you will find that you have referred the child for home visit and you have stated that the child wants to go back to school, and if you go back to the child after 6 months she hasn't met the social worker, the social worker hasn't visited the home. (Free State, Implementer)*

Relationships and Referrals with Home Affairs

The importance of strong relationships and referral mechanisms is reflected in the experience of SRs referring to the Department of Home Affairs. The vast majority of SRs complained that referring to Home Affairs was pointless as the referral failed to improve the service delivery experience of AGYW because they are not prioritised by virtue of being part of the programme. Very few SRs have established relationships with Home Affairs that could ensure better service, to improve demand for these services among AGYW. Respondents' comments also indicated that effective referrals to deliver the service plans assume the effective functioning of government departments, which is often not the case with Home Affairs branches. Moreover, service delivery challenges have been exacerbated due to COVID-19.

> *It's honestly meaningless to give someone a referral form to Home Affairs. To say that we've referred you… it doesn't really mean anything… we've had one successful social grant referral, one!… what could have been really helpful, would be if those pathways were established as part of a programming stream. But it was just kind of left to, kind of left to the SRs to establish those pathways. (Gauteng, Implementer)*

> *If you refer a young girl for an ID or for a birth certificate, they are expected to join the same queue, which has resulted in almost all of our refers to the Department of Home Affairs, being unsuccessful. Because they don't want to build relationships with us, they are overworked! (Western Cape, Implementer)*

Although many other SRs complained that referring to Home Affairs was pointless and that they struggled to establish relationships with them, one SR operating in Klipfontein District in the Western Cape was able to get Home Affairs officials to come to their Safe Space and issue ID documents. As mentioned above, this illustrates the positive impact that strong working relationships preceding the grant period can have on implementation. The respondent also emphasized that besides the strong relationship, the organisation also had direct MoUs in place (i.e. not via the PR) with Home Affairs and various clinics from pre-existing programmes. Therefore it was a lot easier to implement the programme, since the groundwork had already been laid in the district. This could be an important future consideration regarding selecting grant recipients for short-term grants.

> *They can then say "ok we will give you a day in a particular month and then get all of the girls that you know that are wanting IDs". So, last year we were able to get IDs for our girls that are going to Grade 12 and didn't have IDs. Home Affairs came to the Safe Space and gave out IDs for those girls that qualified, specifically for the girls that were writing Grade 12s… We have that relationship to be able to say, "we have got these activities and we have got these girls and they are wanting these services; are you available on such and such a day for your*

department to come to us so we can offer those services to the girls?". Instead of us saying to the girls, "go to Home Affairs" and then they queue for the whole day but don't get served. (Western Cape, Implementer)

SRs who were referring AGYW mothers to Home Affairs to apply for birth certificates for their children and to access child support grants, noted that AGYW are often stigmatised by Home Affairs staff.

With regards to Home Affairs... when a young woman going to the facility is saying, 'I've got a baby and I need to come apply for a birth certificate'... the stigma starts by saying... 'oh you are applying for the birth certificate because you want to go get a social grant'... they don't think about the welfare of a child, the staff there just think about being nasty to the girls. (KZN, Implementer)

SRs also struggle to assist undocumented migrant AGYW who are not being accepted back into schools without ID documents. This challenge was especially noted by SRs operating in Thabo Mofutsanyana (Dihlabeng), Free State, in the context of undocumented migrant AGYW from Lesotho. SRs are unfortunately only able to support them with biomedical services.

This side of the Free State we are coming across people who come from Lesotho because we are close to Lesotho. Some of the AGYW don't even have an ID and then we can't enrol them because you can't enrol someone from another nation unless they are South African. But when coming to biomedical services, we give them services. But with services, like maybe a child is out of school AGYW, she is only 16 and a drop-out, we can't continue to assist and take the child back to school... It is painful because some of the kids are keen to go back to school, they want to but they can't because they don't have the right documents.... they (Home Affairs) said they have nothing to do if the child is from Lesotho... There are those ones that commit suicide because of the situation at home. You get there and they say she is no longer here because of what not. It is saddening when you are working with those kids and you can't assist. (Free State, Implementer)

Relationships and Referrals with SAPS and Department of Justice

SRs noted that they did not have firmly established relationships with SAPS and the Department of Justice to be able to effectively resolve GBV cases. Challenges in dealing with GBV cases were also linked to a lack of cooperation between SAPS / local police stations where cases are reported, and the local clinics and department of social development.

If we can have a GBV case, we refer that case to SAPS... if I need help from SAPS they will send me from pillar to post. (Mpumalanga, Social worker)

From all the stakeholders that we have this side, most of them... maybe 90% of them are involved. The ones that are not really involved, that we are not working hand in hand with, are the Department of Justice. (Free State, Implementer)

MoUs / SLAs

Various MoUs and Service Level Agreements (SLAs) are in place between PRs and government departments, as well as with other service providers. As already noted above, there are also rare cases where MoUs are in place between government departments and SRs, which is facilitating effective programme implementation. However overall, an implementation gap has arisen since most often PRs are the ones signing MoUs, however, SRs and SSRs are the ones implementing on the ground. Respondents noted that having MoUs in place with government departments is particularly important due to high staff turnover rates in government departments.

> *When it comes to government, people are always changed. They are always deployed, redeployed, all those things… It makes us safe to have that MoU and that letter of support. So even if the official is changed, be it DG [Director-General] or that person responsible and the area manager, if we do have that MoU, they can see that it's been a long relationship, that we have worked with them. (Eastern Cape, Implementer)*

A challenge that was emphasised was that MoUs held with national or provincial levels of government are not necessarily recognised at the district level. Other SRs noted that MoUs can be helpful in some cases to initially gain access but that they do not necessarily facilitate work on the ground or ensure service delivery.

> *The MoUs are not necessarily helpful to carry out the work on the ground but they are useful when you approach local structures. So, for example, if you meet with someone from the Department of Education, and then they ask: "who are you, have you spoken to anyone from the department?" You are able then to provide something, the MoU as evidence, that you have in fact spoken to their superiors. (Western Cape, Implementer)*

> *(The PR) has those MoUs at national level. But the filtering down into districts… one of the things with government is that everyone needs to be consulted, and because it's a massively bloated state, some of those consultations might have been taken for granted. But when it comes to practically implementing things, they can just put a stop to things until the relevant person has been consulted. (Gauteng, Implementer)*

SRs and SSRs also noted that they are not involved in compiling the terms of the MoU, to ensure they are conducive to service delivery. Some SRs and SSRs were not even aware of the contents of MoU or SLAs to comment on whether the relevant parties are adhering to the terms or not.

> *We don't have (MoUs) because for instance at the moment we are an implementing partner so we are an SSR… the contract in place is with the PR… we don't have our own… We're the implementing partners, we were not even asked for input into the MOU, but also even the signed MOU that's in place, I'm not sure who even looks at them when we provide the service. Then are we actually adhering to the MOU in place? (KZN, Implementer)*

In absence of an MoUs, SRs are using a 'programme presentation letter' or 'letter of support' to ensure cooperation from government departments. In many cases SRs lack the established relationships or 'legal' clout to ensure effective referrals. Some SRs noted that they often need to get PRs to intervene to ensure government access to government departments and that MoU terms are met.

> *It hasn't been that easy to connect with government officials… even from previous trainings we had recently… when advice was being given, to get them to actually do what you want or what you are asking for… they might need to see (the PR) there and (the SR) may not be taken seriously. You may need to send someone with a higher role, you know, within an organization, in order for them to assist. (Gauteng, Implementer)*

67

The programme description document describes the intention for implementers to engage with local formal and informal leadership structures. The implementation plan details how SRs should participate in Local Aids Councils and District Aids Councils, meeting with Ward Councillors and actively participate in joint stakeholder initiatives.

Relationships with District/ Local Aids Councils

In the evaluation interviews, several respondents noted that District/Local Aids Councils were in many cases not functioning effectively. However, in the few cases where they were, for example in Ehlanzeni District, SRs noted that sitting on the council assisted with building networks with government and civil society stakeholders to strengthen implementation.

> *I was part of the local AIDS council… I was part of all of the structures that were there… Currently it (AIDS Council) is fading away, there are only a few people remaining. (North West, Implementer)*

> *The way that, for example, the multi-sectoral AIDS management units, which is a body that sits within municipalities… that's kind of supposed to have people from all different sectors, and those meetings, I really tried my best. I attended… and each of them …would cost you half a day…(but) it was just not of any use. (Gauteng, Implementer)*

> *We sit in the District AIDS Council… in Mbombela, or in Ehlanzeni, there is a technical working group that sits on a monthly and on a quarterly basis… we form part of that… it's different departments, different government departments, different organisations… we sit in those meetings and account as well and report… Our stakeholder relations are very good, because we are able to work very well with all the different stakeholders in Mbombela sub-district as well as in Ehlanzeni District. (Mpumalanga, Implementer)*

Relationships and Referrals

with Civil Society Organisations and Multi-Stakeholder Forums

According to the evaluation respondents, SRs that have strong relationships and networks in place with other organisations outside of the GF programme, or who sit on local multi-stakeholder forums, were able to draw on these networks to help with demand creation for the AGYW programme as well as strengthen their referral system and linkage to care. Respondents also noted that in cases where SRs were not collaborating sufficiently with multi-stakeholder forums, for example Operation Sakuma Sakhe/ War Rooms in KZN, they may experience challenges ensuring community acceptability of the programme and lack buy-in from community leaders.

> *I have noticed that if relations are not good with the stakeholders… if the programme has been introduced well in the War Room, it is more likely that things will go smooth because the people who are in the War Room and who are leaders, will be the ones who will tell the community*

about the programme... The mistake with an intervention is that, if you don't include the leadership of that community, they will also make sure that your programme is rejected. So, it is very important that you make very good stakeholder relations from the district. (KZN, Implementer)

We have working groups, our sexual and reproductive working groups, that are ongoing and are not part of the AGYW programme but they feed into the AGYW programme. As well as domestic violence working groups, that comprise of other NGOs, that are not the sub-recipients for the Global Fund, as well as Department of Justice, as I mentioned, and SAPs and other community organisations… they help us in doing our demand creation for the AGYW programme within our Safe Space. (Western Cape, Implementer)

We work with the other NGOs also to strengthen the linkage to care because there are those who are working in facility… we are not in facility, so they also assist us in the linkage to care… and also when we have the clients that are not staying in your area, they come for the services and then you've got this special NGO in the other area where the client lives… you can refer your client so that there is continuity of care. (Western Cape, Implementer)

Another successful strategy that was noted, were cases where SRs were collaborating with clinic committees to address demand barriers for SRH services.

Each facility has a clinic committee… they will have a meeting with these girls, with support from advocacy SSRs, they will then go to that facility and say, we have issues around the facility... Maybe there's issues of prioritising AGYW for services in that facility… the clinical committee will take those issues and you know, implement them to ensure that that facility is providing proper services. (Mpumalanga, Implementer)

Some SRs did note that there was competition and overlap between their mandate and that of other civil society organisations operating within implementation districts. In these cases, SRs noted ways in which they were able to complement each other's work.

We discovered that there is a programme that offers the same services as ours… we had a problem with that but that did not stop us… we just decided to alternate days… for us the TVET programme was for a short period, when the learners started writing exams, we stopped and went back to the clinics. (KZN, Implementer)

However, as already noted in this report, SRs also struggled to create demand for their services in areas where 'Cash Plus Care' programmes were running. Some SRs also noted a general lack of collaboration with community stakeholders and organisations. This appeared to especially be the case with SRs that did not have a history of working in their assigned district and therefore did not have established networks in the communities they were implementing in.

There were challenges when we were starting. It was about getting people used to the program, having a proper introduction, having a proper introduction to the community and having a proper introduction to all of the structures that are needed for us to be introduced. We were not properly introduced to all of the structures. (Free State, Health worker)

With the partners we have been collaborating since day one… the other AGYW implementing SRs. With other community stakeholders or youth centres… there hasn't been much involvement there. (Gauteng, Implementer)

Section 1 part C: Intervention Delivery Settings / Spaces

The intervention intended for both core and layered services to be delivered by funded sub-recipients in three tailored and targeted settings: schools, TVETs and dedicated Safe Spaces in communities. A fourth entry point is the mobile clinic that delivers clinical HIV and SRH related services at different points in the community within or nearby schools, TVETs and Safe Spaces. The situational analysis and service mapping exercise conducted by PRs for each sub-district was also intended to assist with placement of Safe Spaces, along with establishing a reliable referrals directory. Layered services may also be delivered by unfunded external service providers identified in the mapping exercise, in their own settings via referrals from the funded SRs.

The programme planned on using the 'hub-and-spokes model' to conduct HIV prevention interventions and services to out-of-school AGYW. SRs implementing services for out-of-school AGYW, including activities for school-going girls after school hours, were mandated to establish a hub from where their services can be organised and offered. They would also offer their programmes to AGYW who are geographically further away using satellites. The central hub was intended to be a permanent space with each hub of the spoke being a permanent or mobile service that in turn provides a combination of outreach services. One Safe Space and up to four satellite sites per sub-district would serve as settings for integrated, community-based and demand-responsive service delivery.

The rationale for establishing the hub-and-spokes model was to increase access to services through a number of decentralised but linked points that offer a range of adolescent prevention programmes throughout the year. The idea is to leverage on local infrastructure such as Thusong Centres that are DSD managed multi-purpose community care centres serving youth and vulnerable children, multipurpose community centres, and community halls to act as a space where young people can 'drop in', access resources and access individual and group services. The hub is envisioned as a physical Safe Space situated at a community centre in an area that is accessible (walkable &/or via public transport) to AGYW during safe and appropriate times, and well-equipped to deliver both core and layered services to beneficiaries.

Ideally, the selected centres should be close to a high-volume health facility and the Safe Space acts as a hub, offering a range of core and layered services under one roof, with outreach offered through satellite spaces. These spaces should be staffed by professional staff such as social workers, social auxiliary workers and nurses, as well as trained peers (PGTs). (NACOSA et al, 2020, p. 47)

Setting	Potential layered services to complement Core services in this setting
Schools	MTV Shuga, After School support or prevention programmes like IMpower rape prevention, substance abuse support groups; Containment, referral to services and linkage follow up
Community Safe Spaces	Support groups and talks, grief support groups, rape prevention groups or substance abuse awareness talks; Professional individual and group counselling services; Containment, referral to services and linkage follow up; Provision of menstrual dignity packs for girls in need; Recreational activities
TVETs	Referral to mobile clinic services available on a set rotational basis. HIV prevention services, Comprehensive SRH, HTS, TB, GBV and STI screening; Containment and referral to services

Mobile Clinics	Biomedical services; Containment, referral to services and linkage follow up

Implementer Experiences of Safe Spaces

Several respondents stated that a major challenge experienced in the implementation of the intervention related to the delays in establishing and setting up Safe Spaces. Numerous respondents noted that in some districts, Safe Spaces had still not been established, and SRs were having to operate out of clinics, schools, TVETs or hired venues, while the Safe Space was still in planning. Negative impacts on implementation were noted, with respondents emphasising that some services and activities have been interrupted, for example in cases where biomedical services cannot be offered at schools. Due to lack of Safe Spaces, social workers were conducting home-visits to reach AGYW. However this approach was noted to be problematic due to confidentiality concerns, and the fact that AGYW may not feel comfortable talking in front of parents. Some social workers had even resorted to conducting consultations with AGYW in cars. An additional issue was that the presence of a social worker at the house may result in AGYW being stigmatised by their neighbours or community members.

They are busy working on the issue of the Safe Spaces because you would find that we were forced to go to these children's homes… it's not all the children who would be able to talk about their problems in front of their parents… not all the children who would love their neighbours to see that social workers are at their houses… Like now when I am going to interview them inside the car, it is really not a good thing and most of these children would cry when I talk to them. (Free State, Social worker)

Some SRs noted that they struggled navigating bureaucratic red tape to get approval from councillors to establish Safe Spaces. Implementers in the Klipfontein sub-district in Cape Town observed the sentiment that the area is saturated with NGOs and programmes, and so all of the appropriately located areas were already allocated. Other reasons noted for delays in establishing Safe Spaces included safety concerns in certain neighbourhoods, finding a large enough space that could host group sessions, limited resources and accessibility concerns.

Finding a safe enough space in a safe enough area, with access to a hall and office space, that was quite a long process. So, we eventually started just begging churches to let us in. (Western Cape, Implementer)

We struggle for space in other areas, because you have to ask, especially with things involving councillors… You are told you have to speak to so and so, in order for you to access the area… even though you have spoken about the matter you will find that the issue of getting a space becomes difficult. (Western Cape, Social worker)

Implementers noted that the issue of delays in setting up Safe Space pointed to a programme design challenge, namely that setting up the Safe Spaces should have preceded implementation, rather than being an activity that ran alongside recruitment of AGYW into the programme. This created challenges when AGYW could not be referred to Safe Spaces to ensure they were retained in the programme and actively engaged in ongoing activities

The issue of the Safe Spaces and satellite… that should have been started with, not only when the implementation has already started. Because as we are enrolling these girls it should be

71

able to refer them and say the Safe Space which is near you is this one, this is where you will come and access the services. (Free State, Implementer)

If we could have the Safe Spaces operating from the day that I got here, it would have been easy because they would know I come here and there is a room for biomedical, a room for psychosocial and a room for activities and what not, there is an open place where we can do our CVs and what not… that would work better. (Free State, Implementer)

For SRs that had successfully managed to establish Safe Spaces, the common challenges noted by respondents included safety concerns, accessibility concerns (location and opening times), under resourced and under staffed facilities, and AGYW not utilising Safe Spaces as expected. Experiences across districts did however differ, as some respondents noted that their Safe Spaces and chosen venues were accessible and appropriate to meet the needs of the context. In particular, it was noted that while rural areas had been difficult to reach, the programme was accessible to AGYW living in townships and Safe Spaces were well located. In other cases, where Safe Spaces and satellites were reported to not be conveniently located for AGYW, SRs needed to frequently hire community venues to ensure greater uptake of their services.

The Safe Space is very far for most of them, so I usually alternate the place, using a hall nearby, a place where people usually go… the community hall… or a school or the church that might open itself. (KZN, Implementer)

You don't need money for transport and other things. You just go there because it is in the centre of the location… anybody can access it from around the location… it's a people centred approach... Some are remote and are not accessible but they do go there. They take the programme or the service to the people. (Mpumalanga, Social worker)

Some respondents felt that the resources allocated to Safe Spaces were not sufficient. This resulted in Safe Spaces being under resourced without all the required facilities, such as computers and WIFI for AGYW to use, with implementers noting that they may not be attractive to AGYW without these.

Safety issues were cited as a barrier to accessing Safe Spaces. This concern was most notable in the Klipfontein district in Cape Town, Western Cape. SRs were concerned that their Safe Spaces are not 'safe' for AGYW and their staff due to gang violence. Some SRs did not feel that it was safe to ask AGYW to come to the established venues, while others were unable to establish Safe Spaces due to these safety concerns. In these areas, implementers noted that it was particularly important to have strong relationships with local community members who could advise SRs regarding safety concerns and protocols. Some SRs noted that they were considering a strategy of implementing flexible Safe Spaces in these areas, rather than having established Safe Spaces that some AGYW ca not access.

The issue of shootings in Manenberg and Hanover Park, that has made going to these areas very hard; there are areas that we did not go to at all because of these shootings… There are places where we had relationships with stakeholders, as a result they would tell us not to come, not to enter certain areas at certain times because there was a shooting. (Western Cape, Social worker)

If I just reflect on Manenberg as an example, our Safe Space that we identified, is located in one area of Manenberg, and obviously there is opposing gang turf… There are girls from one sector of Manenberg that can't access our Safe Space because they can't cross turf and they are known from a different part… so that is why we are looking to change from the established Safe Space to something that is more flexible so that we can actually then go into the different

areas and access the young women in the different areas… our Safe Space is next to a shop where most of the gang leaders of the area hang out, and we didn't know that initially… we had one of our staff members stuck at a traffic light with gangs shooting around her, hiding behind a car… so like lots of trauma! (Western Cape, Implementer)

Community venues

SRs noted making use of community venues to bring services closer to AGYW, in cases where Safe Spaces were either not accessible, convenient or had not been established yet. Using conveniently located community venues also enabled SRs to avoid arranging transport for AGYW or encountering challenges with transport reimbursement, which was not budgeted for.

We try to find venues closer to where they reside instead of doing this up and down of transport… we find a venue there so that it can be within walking distance. (Western Cape, Social worker)

SRs noted that it was challenging to book community venues in implementation districts where communities were saturated with programmes and there tends to be a lot of competition for the use of community halls or church halls, for example. Local councillors and municipal staff also acted as gatekeepers to municipal facilities. Some SRs noted that Ward Councillors assisted them to locate and book suitable venues, however, those who did not have good relationships with local leadership would struggle to make use of these spaces.

Most open spaces and halls are taken up by other programmes… communities are quite programme heavy. (Western Cape, Implementer)

Educational Institutions (schools / TVETs)

Some SRs operating at schools and on TVET campuses noted that they often are not provided with a dedicated room or office space where facilitators could base themselves. This makes it challenging for AGYW to seek out services or to be received in an appropriately confidential space for psychosocial support. Social workers noted that AGYW do not like being seen with them at school due to fear of being stigmatised by their peers. Some LSA/PGT staff noted that they were working out of staff rooms but that AGYW would not feel comfortable coming to the staff room to talk to them.

(We need) a space where the facilitator can be found in case if a young girl needs something, they will know where to go and find her. Instead of looking for me amongst the teachers, you see. Because others might be afraid to come to me because she is afraid to come to the staffroom where there is all the teachers. (KZN, Implementer)

SRs who were working within schools but did not have additional Safe Spaces established, lamented that they could not offer AGYW more comprehensive services, for example access to computers and WIFI, homework support, and assisting AGYW to apply for learnerships and to universities.

We are based in schools and based out of schools… we don't have that space where a person can stay for an hour or even two with you assisting them and guiding them and helping them

to apply for the learnerships and internships, especially those who have finished matric. (Free State, Implementer)

When I go meet with her at school I will not divulge the reason for my visit, I will talk to the principal or teacher and inform them that there is a case of a learner that I'm attending but the fact that a child will be seen with me at school or leaving school with me is one of the things that make them uncomfortable sometimes. (Free State, Social worker)

Clinics and Health Facilities

Several respondents noted challenges operating out of clinics due to lack of a dedicated space to receive AGYW. Clinic staff are also overworked and may perceive the presence of programme staff as an added burden in the work space. Some SRs did report having a conducive relationship with clinic staff and were even assigned a dedicated room for counselling. However, clinic staff were allegedly less accommodating of SRs who did not have biomedical teams on staff, questioning their added contribution to the clinic.

We seem to not be in clinics as often because they question why are community organisations actually working within a clinic structure… we have gone via the biomedical teams at points because they get access… then they'd know that we are affiliated and then we sort of had more of a right to be in the space because we're with a biomedical organization or team. (Western Cape, Implementer)

We were working in the clinic, but if the clinic is full there is nowhere to work. (Free State, Implementer)

Section 1 part D:

Implementer Experiences of Implementation Management and

Logistics

Each PR is responsible for overall grant management, programme design, sub-recipient (SR) oversight and capacity building, system strengthening, networking and coordination. PRs ensure effective implementation by managing and overseeing arrangements inclusive of resources, data and information and commodity flows, as well as reporting lines and collaborative relationships between partners. SR ensure service delivery to AGYW beneficiaries, and are responsible for their own sub-district level implementation and coordination.

Set up and Planning

Delays in setting up the programme created disillusionment among beneficiaries who were being recruited for services that did not yet exist.

(If the services had been in place) I believe that youth would be buying into this program, we wouldn't have to be going around chasing after the youth. The youth would be coming to us. (Free State, Health worker)

Delays were caused by challenges in establishing Safe Spaces and securing access to other implementation spaces, which has already been discussed in the previous section. Some of these delays were linked to establishing MoUs and SLAs with government departments. Agreements signed at a national level by PRs did not facilitate implementation at district level. The tendering process was also noted to create delays, since SRs had to rely on PRs to provide certain resources like mobile units and medical equipment.

There were some delays in that the SLAs… they had been signed at a national level but hadn't really trickled down into local district… MoUs… there were some delays on that. (Gauteng, Implementer)

When we started, the AGYW were being told that they were going to receive a service but then the service only came months later and that was quite challenging. You are trying to recruit someone for something that is not there. (Gauteng, Implementer)

The tender process that [PR] has to follow, does delay a lot of things… with the mobile units, we're only getting them this month. And any resources for COVID… we couldn't open our sites because we hadn't received thermometers from [PR] for 2 or 3 months. (Western Cape, Implementer)

SRs also noted that the complexity of the programme contributed to the delays in setting up. SR staff had to be capacitated around programme design and aims, reporting requirements and the referral system, which took time.

We went out there without knowing… there was lots of paperwork that we had to do and… submit to at the end of the day. But we got the hang of it… The programme started in March… then around… September, that is when we got the hang of it. Understanding what the donor wanted and what we were supposed to do with the young girls, with our referrals. (North West, Implementer)

Staffing and Training

Several respondents noted that they felt that the process of staff training and orientation was rushed. The key implementers were not appropriately informed, capacitated and trained around the programme goals, processes and relevant staff roles. Delays in providing staff training and insufficient training for SR and SSR staff meant that field staff did not understand their roles or what was expected of them.

At first we didn't work well! …the programme was not well introduced to us so we did not know what was expected of us. (Free State, Social worker)

I don't really think that it was set up properly… There was a little bit of rush… I normally invite the key implementers, engage with them, so that I can assess their knowledge in terms of whether there is understanding of the implementation of the plan, of the programme. Because when I hold them accountable, my approach should be based on the level of understanding,

so that I should be able to say… I need to provide them with capacity, so that they can meet a certain standard and so forth. (Free State, Implementer)

I expected that for some of the programmes they would come and train us and then we would hit the ground running afterwards… but we just had to implement on our own, with our own experiences, from other companies that we come from. (KZN, Implementer)

Some of the programme components, like grief counselling and teen parenting, require highly trained personnel with a specific skill set. According to several SR respondents this training to facilitate group courses was only provided late into the programme by the PR. SRs noted that there were not enough trained staff to meet the demand for these group courses. SRs also noted that staff were not adequately trained to address cases of GBV or substance dependency, despite these being described as common challenges faced by AGYW in the implementation districts. Therefore, further training opportunities should focus on these elements.

With Abangani, the grief support, you need to be trained to do the group sessions and at the moment there are only two people who are trained… Klipfontein is such a big area, so that is putting strain on the two social auxiliary workers that are currently doing Abangani… those services were not running smoothly. (Western Cape, Implementer)

One of the things that we have stopped doing is education on gender-based violence. That was because the LSAs didn't have adequate training on how are they going to respond if AGYW is saying I experience GBV… because of the high GBV in the country we have said they should be trained on how they respond as the first responder. (North West, Implementer)

Some SRs, who are accessing 'public health' related grants for the first time, did not have staff with skills to deliver various intervention components. One particular organisation was not offering any services for the first year of the programme. Staff noted that they felt they were mobilising beneficiaries for services that did not yet exist. The delays in conducting training affected the ability of SRs to recruit AGYW into the programme and to build the necessary trust to retain them in the programme and it also negatively affected staff morale.

Initially the feedback we got was we didn't have any services to offer… our team had not been trained in IMPOWER, they'd not been trained in Abangani [grief counselling]... so we couldn't offer that yet. We couldn't offer HTS [HIV testing services]… it's a year into the programme almost... that negatively affects the programme but also our name… We've had staff actually just challenge us and say you've been lying to the participants because there's actually nothing here to give them… if my staff were all trained in the teen parenting and the Abangani from the start, we'd have some services even if the biomedical resources were not there. (Western Cape, Implementer)

When we started in July 2019, we didn't have trained staff members to run these programmes… we started recruiting AGYW when there were not any staff to run these programmes… we did other things in this time like running testing campaigns, providing AGYW with PrEP, condom promotion as well as one on one counselling… but we didn't have groups that were running at this time… So, when we started now with staff being trained… in 2020, with the groups.… they [AGYW] were not encouraged, they didn't know when the classes or groups will finally take place. (Western Cape, Social worker)

Another challenge mentioned by SRs was staff shortage and high staff turnover. Incomplete implementation teams compromise the ability to provide certain services as intended. Several

respondents noted a lack of social workers, social auxiliary workers and professional nurses. Respondents also noted that there was a lack of data capturers and M&E staff. This was also a result of the failure to go 'digital' with the My Hope System. Since the programme had originally intended for data to be captured on mobile devices, the programme budget had not anticipated the need for data capturers. As a result, social workers, SAWs and PGTs had to play the role of data capturers in several SRs, which created some discontent as staff felt overburdened with the extra work of capturing data.

> *You have social auxiliary workers who have to work in the field and then also come to the office and carry out duties that were supposed to be undertaken by a data-capturer, because we don't have a data-capturer... because they were supposed to use the tablets and then there would be no need for capture. (Western Cape, Implementer)*

> *I don't think we are planning properly just to meet all of the areas that need to be reached. Maybe it is just due to a shortage of the staff because in our team, our biomedical team, since I have arrived into the program, we have never been a completed team… if four resign, they hire just two. So, we are running short of staff all of the time. We are never a completed team to cover all of the areas we are supposed to cover. (Free State, Health worker)*

> *This is the vast remote rural area… it means that they were not able to capture all the information that is required… we need to have more staff when it comes to monitoring and evaluation, so that the data can be captured and be sent to the relevant people. (Eastern Cape, Implementer)*

High staff turnover results in a lack of continuity of staff that have been trained to deliver various programme components. Due to the short grant period, of three years, staff tend to look for more permanent positions, especially in the last year of the programme. In some districts, managers noted that there is competition among different organisations for staff and particularly for professional nurses and social workers.

> *We have quite a high staff turnover… it feels like I do HR most of the time [laughing]… because it is a three-year program, at this stage of the programme… people start to look for more permanent positions… they become upskilled in being in such a programme and then they get snapped-up by people… we have had six or seven social workers from the start of the programme and only one of my social workers remained throughout. (Western Cape, Implementer)*

Nurses are allegedly choosing to leave the AGYW programme due to the comparatively unattractive salary package and heavy workload.

> *When we look at our staff components, people that you will lose a lot are your professional nurses. And you know, the competition is very high…. they are at liberty to move from us to go to others if they feel like the pressure is too much, because there's a lot of pressure with this programme… the package of the salaries that people get… they are low. (Mpumalanga, Implementer)*

Absence of a stable Advocacy Officer in the Klipfontein district has undermined programmes in that district, according to key informants. The AGYW programme description document explains the role envisioned for the advocacy coordinator as follows: focus on establishing and maintaining partnerships with local fora like the local coordinating forum on health and or AIDS; and representing the AGYW programme at those fora. This role is also ideally placed to manage and update the sub-

district based services directory for easy service plan referrals. The lack of a stable advocacy coordinator may also have contributed to the difficulties experienced with the referrals, which was emphasised by key informants from the Klipfontein district.

> *In our particular district, we've had three different advocacy officers and we've just gotten a new one started and they're meant to be responsible for the development of the MOU's [Memorandum Of Understanding]... what delayed our processes, that we haven't had any traction, is our advocacy officer's focusing on that across the entire district, so we keep having to restart the relationships with the new person. (Western Cape, Implementer)*

> *In Klipfontein sub-district specifically, there was an advocacy officer whose main role was to approach stakeholders, including government departments and formalise those relationships. But that role has been occupied by a number of people, so there was no continuity. (Western Cape, Implementer)*

Certain tensions were apparent between staff members on the team, related to the relative salary packages offered for different categories of workers. Social workers, for example, complained that they are valued less than nurses/biomedical staff, which creates tension among the staff.

> *We feel that the programme is more bio-medical and that an auxiliary nurse has a better salary than that of a qualified social worker. That makes me feel belittled in so many ways. An auxiliary nurse has a better salary, but I have trained for 4 years at school and she has gone for 2 years at school. (Free State, Social worker)*

A commonly recurring theme was that PGTs feel undervalued and underpaid for their respective level of responsibility in the programme. The source of much of the dissatisfaction appears to be linked to how their roles and responsibilities in the programme are very similar to a social auxiliary worker however, the pay is much less. The PGT role is crucial for implementation success and therefore addressing job satisfaction amongst this cadre should be prioritised.

> *We're currently in the process of putting in a debriefing, a monthly debriefing for the PGTs… the salary bracket for them is very low so they tend to compare that the work and the level of effort required from them is almost similar to that of the social auxiliary workers, except that the social auxiliary workers are doing sessions… because of the disparity in salary, they feel like they're actually just being used and, and we, most of the staff agree because it's too low for that level of responsibility. (Western Cape, Implementer)*

> *If you look at the level of effort required to conduct the activities in the field, it is almost exactly the same for a PGT and a social auxiliary worker… they are doing more or less the same thing. So, the outcry from the PGTs was: "if we are doing exactly the same thing, then how come there is a huge difference in our salaries?"… that discouraged them! In the beginning we thought that the social auxiliary workers would be doing something completely different but it turns out that they are doing exactly the same as the PGTs. (Western Cape, Implementer)*

It was felt that PGTs are also left out of important meetings and important training sessions. PGTs also expressed that they do not feel their challenges are taken seriously by management. SR Managers also noted that unresolved suggestions and complaints were creating discontent among PGTs; especially regarding work processes, unreasonable daily targets and concerns raised around the content and delivery of the Risk Assessment forms.

They are not understanding situations, that we have challenges… The management… now they gave us a target of 10, that we should reach 10 beneficiaries on a daily basis… they make it seem like we're coming up with excuses when we don't reach targets, they should be more supportive. (Free State, Implementer)

PGTs feel that they receive all of the frustrations and discontent from beneficiaries, regarding the failure of the programme to deliver as promised. However, PGTs noted that they have no power to make the necessary changes to improve implementation. Some SR managers noted that making these kinds of design changes to the programme, was beyond their control and required the PR's consent. Some PGTs did seem to understand that their managers were constrained by funding requirements and the programme management hierarchy.

Some of the things they cannot do to us is not their call, the way I have seen it, and the way they explain it, is that if something doesn't happen it's not because they don't want to do it, it comes from the top. Then it affects us because we're the ones approaching the kids and it affects us, you see. (Free State, Implementer)

Due to the emotionally challenging nature of the work that PGTs do, when engaging AGYW in the Risk Assessments, a key aspect that may have been overlooked by some SRs was the need for an adequate counselling and support system for PGTs. SAWs and social workers would have more experience with managing the particular pressures of the work environment. However, respondents noted that in some instances, PGTs were struggling with the emotional burden of the work. Other organisations did note that they had adequate counselling and support systems set up for the field team.

It does take its toll on the team that is on the ground, and I don't think that we have addressed this well enough or addressed it as much as we should have. Some have broken down emotionally in the field… and there was actually no plan for us, to provide counselling or things like that… the emotional part has been overlooked and we may need to look at it because we depend on these implementers in the field implementing the programme for us to reach our targets. (Western Cape, Implementer)

I have a tendency of carrying their (AGYW) burden too much, I don't separate work and personal stuff. That is why I end up too attached to that young girl, and I feel like I can always check on her even after work because of the things she has told me, you see. That is quite depressing, I must say… this is something I have to learn… the ability to separate work and personal staff. (KZN, Implementer)

I didn't have much difficulties, because as we are having our sisters that we report to, so whenever I was having a bad day, I was able to go and say to them: 'my day didn't go well and this is what happened'. And then they would be able to counsel me as well. (Western Cape, Implementer)

Resources and Funding

SRs receive funding to cover the cost associated with programme delivery, to enable the implementation of all the various components of the comprehensive programme at district level. In the evaluation interviews, some SRs expressed satisfaction with the resource allocation and commented that in their view, the funding that they received from PRs is sufficient for their needs.

I'm not sure how the other PRs are, but this is the first time I'm working with NACOSA and I feel that they really are supported financially… all of our budget lines; I feel have got sufficient funds. (Gauteng, Implementer)

However, other SRs described challenges regarding the slow turnaround time in responding to funding requests, which hampers responsiveness to meet programme targets and deadlines.

When we make requests for resources… with the turnaround time there is a little bit of a delay… this is a funded programme which has got time frames so it requires people to be very quick in responses. (Free State, Implementer)

Other SRs noted that there was not enough funding for various programme components. For example, SRs hosting self-defence / "No Means No" courses emphasised the huge demand among AGYW to participate, and that there was not enough funding to run the number of courses required to meet growing demand.

We should actually get more funding for 'No Means nNo' because we are only supposed to do one group per month but I am noticing a rising interest in that programme. If we could get extra funding then at least we could do two or three groups per month because they girls are more interested in that. They want the self-defence classes. (Western Cape, Implementer)

Other line items that were noted to be insufficiently funded included hosting demand creation events, catering and entertainment for events and group courses, transport for participants (transport reimbursement), resourcing and furnishing Safe Spaces, providing monetary and non-monetary incentives to participants and field staff, providing Dignity Packs to AGYW beneficiaries, and the budget to engage the services of advocacy SSRs. In some cases field staff were using their own money to provide incentives to AGYW and to help AGYW who were in need.

When it comes to sessions, HTS services, individual counselling we are able to render those services. But a child that is in need who will say I need stationery, food, then it stops there, we cannot help any further. We as the field workers decided that to make sure that we work well with the community and make them to trust us again, that each of us who is capable should buy stuff like Vaseline, pads, toothpaste and everything that you can then we put them in a box at our Safe Space… Others say no, we're not supposed to do that because the organisation has funds. (Free State, Implementer)

With activities, the most challenging thing for activities is food and music… we are being given R500 for 40 kids, oh and then they have increased the number from 40 kids to 70 kids. And we had to donate from our poor pockets on the minute salaries to see to it that these kids get enough food… if there is no entertainment, if there is no music, you know the youth, they cannot sit for 3 hours in a hall listening. (Free State, Implementer)

Monitoring, Evaluation and Data Management

According to the intervention description documents, the main goal of the AGYW Programme M&E system is to allow for programme data to be collected, processed and transformed into strategic information that will enable informed decision-making at all levels. All programme staff and work streams, including at PR and SR level, were to ensure that monitoring, evaluation and reporting form an integral part of the achievement of the objectives of the programme. In order to effectively monitor

the multi-dimensional AGYW programme, a comprehensive M&E system supported by robust use of appropriate information management systems (including biometrics) was identified as a key requirement. The PRs identified the need to develop a comprehensive M&E system that will be implemented across all sites and by all partners in order to track programme beneficiaries across all interventions offered by the programme. The integrated approach in managing data was intended top enhance effectiveness of programme M&E and improve the ability of stakeholders to use the data to boost programme performance and impact.

An external service provider was contracted to develop My Hope, a comprehensive biometric-based information management system (IMS) for the monitoring and evaluation of the AGYW Programme. The biometric system was designed to allow for programmatic and performance management at SR and PR level through a cloud and mobile based IMS, built on Microsoft and Android Technology, and the use of Bio Rugged BF30 biometric devices. The intention was that the AGYW programme implementers would use the My Hope system to track the provision of services across the core and layered services for each individual AGYW beneficiary during the grant period. SRs were to use the system to enrol, provide the core package of services and monitor individual AGYW across the intervention areas (biomedical, structural and behavioural) with paper-based back-up data collection tools to use at the source i.e. all AGYW entry points (NACOSA et al., 2020, AGYW Programme Description, p.69-70).

Implementer Experiences with M&E Systems and Reporting Requirements

The reporting system and programme targets and objectives were described as confusing and unclear by implementation staff. From the responses of key informants, it appears that the established reporting systems may not be facilitating effective implementation and are viewed as an impediment to meeting the needs of AGYW by implementers working in the field.

> *They should understand how their programme works, its objectives. What they want to get from the community, if it is about helping people or the numbers. Because as a worker, if you have no direction and you don't know what is expected from you, it becomes difficult to work. (KZN, Implementer)*

Social workers, for example, noted that it was a big transition for them to get used to the reporting system. Trained social workers felt that their mode of working, according to the protocols of their profession, was not adequately integrated into and recognised by the M&E system. PGTs and other staff also felt that the targets for daily Risk Assessments are too high, which means that the quality of services that can be provided to AGYW is compromised.

> *The reason I am saying the relationship was not right is that when we report monthly or quarterly, based on what we reported it is like we didn't work at all. Yet according to our observation and the way we work, we have done a great amount of work. We work according to the rules that we know as social workers. We know how we are supposed to work… but at the end of the day it looked like the team providing psycho-social doesn't work. (Free State, Social worker)*

Several respondents noted that the M&E system was creating the wrong incentives for staff, in that numbers of AGYW engaged and events hosted are rewarded over providing quality services to AGYW. This may not be particular to the programme itself but rather represents a status quo in the

development sector (enforced by funding models and accepted M&E systems), whereby success is measured by easily quantifiable indicators rather than more meaningful, albeit less tangible and measurable indicators like impact on AGYW lives and epidemic control.

> *Funded programmes… they are giving a bit of a problem because at some point people are pushing numbers and we are not really investing in ABYM or AGYW… instead of you saying I am focusing on one person and I am making sure that this one person actually receives services and is informed… I do five Risk Assessments in a day… it impacts on the quality of the services. (North West, Implementer)*

> *On the one hand, the kind of status quo of the sector is that interventions are measured by or via events… there is the kind of paradigm shift that you kind of want to walk people along. To say… let's continue to do events, but that's not a measure of success… events are not development. But… getting epidemic control, you know that will be development, because then HIV money can be put into economic strengthening. (Gauteng, Implementer)*

Number chasing rather than providing high-quality services for AGYW is demoralizing for PGTs and other field staff conducting Risk Assessments, who are receiving backlash from the community for failing to deliver. SR biomedical teams also expressed that they feel they are chasing numbers rather than providing a quality service. There is a general sense that the burden of reporting and the M&E systems of the programme hinder implementers' ability to prioritise comprehensive and quality services and support for AGYW. Delays in providing various programme components has also exacerbated this. Field staff feel they are under pressure to mobilise AGYW to reach their monthly targets, however staff feel uneasy with mobilising AGYW for services that they are not yet able to provide.

> *Staff members feel like they are only chasing numbers and they are not providing a high-quality service to members in their community… They blame management because before the programme was introduced all of these gaps should have been identified, before they were brought in to then make these empty promises and then also take the backlash from the community. (Western Cape, Implementer)*

Implementation Experiences with Data Management and the My Hope System

Implementation experiences were overwhelmingly negative with the My Hope System. Field and management staff expressed resistance to the My Hope System and on the whole were not accepting of the system. Respondents noted that the My Hope System does not add any value to the programme and is rather seen as time-consuming and a hindrance to effective implementation. Implementers noted that the My Hope System should have been piloted before implementation began. Into the second year of implementation, there were still several technical glitches that needed to be resolved to ensure that the My Hope System worked more effectively.

> *Zero value add! I would even put it in the minus. The amount of administration time that's required by it, for zero use value, it's a hindrance to the programme!… it's an inappropriate technology and it's anti-developmental… post this grant, when we need to create systems for people to use data for decision making… this My Hope System doesn't fulfil any of that. (Gauteng, Implementer)*

I don't really see it as a dependable system per se… we are approaching… our second year, we should be having a system that is up and running… they still need to do more with the My Hope System. (Free State, Implementer)

There's lots of papers!… number one we are supposed to be using the biometric system. To date it's still not yet implemented. (Mpumalanga, Implementer)

Limitations of the My Hope System highlighted by respondents included its inability to capture important information such as the ward in which the AGYW beneficiary resides, which in turn undermines analysis. Due to the fact that the My Hope System cannot capture certain important data fields, M&E managers felt that they could not use the system to analyse data to inform implementation and reporting. Since some of the data can not be captured into My Hope, this is imputed into a separate spreadsheet. Respondents noted that capturing on two different systems is too complex and burdensome.

My Hope… the system does not capture the HTS, we only capture the reach. So, the HTS is done on a spreadsheet which has got an element of human error… capturing on two different systems is just too complicated. With regards to the My Hope system, I wish we would be able to drill down information and analyse it… it doesn't capture what ward the girl lives in. So, if we capture these girls on the system and now I want to check how many of these girls come from ward number 18, for instance, I'm not able to. I have to now check on the names of the PGT to see if these girls maybe live in that area. (KZN, Implementer)

A key emergent theme related to the way in which the My Hope System negatively impacts data quality. Respondents noted that the system tended to duplicate entries, delete data entries and made the process of data cleaning very laborious. There was also the issue of duplication of data across different SRs due to challenges with the My Hope System, related to the cross-referrals of AGYW.

We have the 'My Hope' system that we use to capture our data. I am not 100% happy with it because it has a lot of challenges by itself; from duplicating entries to losing people that we have captured… You get to a particular stage like… filling in the service plan, and it kicks you out!… At the end of the day when you are doing your analysis you have duplicates… it becomes a nightmare when you are doing data cleaning… I am not 100% happy with the M&E system. (Western Cape, Implementer)

I flagged the fact that they hadn't been communicating across SR's or comparing data across SR's, because they couldn't see if (SR A) was duplicating (SR B's) people or not… now some people are sitting with a thousand duplicates... this should have been done from the start... it's disappointing and it's quite challenging that we can't use much from the system… the analytics of the data is also going to be incorrect (Western Cape, Implementer)

As noted in section one on the Risk Assessments, and in the Data Falsification section below, My Hope system requirement that all fields are entered before accepting a form, created issues with data entry and accuracy.

With some of the consent forms, you find that the information is not fully filled in the consent form. So then for us, it is very difficult to capture, because you cannot capture a consent form when there is not full information. (Western Cape, Implementer)

Another common complaint among SR respondents was the failure to implement mobile data capture devices/ tablets. As a result, field staff are still using paper-based Risk Assessment forms. Some SRs

noted that they had tried to pilot them however several technical challenges emerged and the Risk Assessment forms were also apparently structured differently on the devices and so the use of mobile devices was then abandoned.

> *Initially when we started, we had the tablets… We were enrolling the girls on the tablets but then we changed to paper… the questions that we ask in the tablet were not the same as the ones on the paper. They were the same idea but not the way in which they were structured on the form… the challenge is that the BioRugged devices, they are always being worked on, they are being updated... so you cannot fully use it alone. They were saying that you have to use the paper as well as the devices, until everything is analysed. (KZN, Implementer)*

At the time of interviews, procured biometric devices were still not being used, which was noted to be a waste of programme resources. This has resulted in much more paperwork for SRs. Field staff also have the added burden of data entry post- Risk Assessment interview. This has created a backlog of data entry and is also undermining data analysis to inform programme management. Allegedly, there were plans to begin using the mobile devices again. However, it was noted that 'double data capturing' would be required i.e. one PGT capturing on the device and one capturing on paper forms, as a precautionary measure.

> *The biometric devices are not usable yet… halfway through the programme, we've ended up with at least five to six forms per beneficiary that need to be updated in the six month period... and the online management system is still not giving us accurate data… what's going to have to happen, as the rollout happens, is that one staff member has to work with the device and another one is to sit next to them while they do the interview with the form… So if the biometric device doesn't work, we still have the information captured on paper. (Western Cape, Implementer)*

> *When we started the programme there was a rollout of mobile devices that the PGTs were supposed to use to capture the data together with the paper-based system, so that eventually we would phase out these 11 pages of the Risk Assessment. But up until now, the tablets are still kicking us out of the system. (Western Cape, Implementer)*

There were a few respondents that questioned the appropriateness of the mobile devices in certain contexts, particularly highlighting safety issues in areas with high crime rates. A second issue that was raised, was around network challenges in certain areas where the programme is being implemented. This would affect the functioning of the mobile devices, which rely on access to a secure network to upload data.

Several respondents noted that the programme is very 'paper-heavy'. PGTs and other field staff feel that the amount of paperwork required takes time away from being in the field actually implementing programmes and engaging with AGYW. Paperwork and the 'double data capturing' system (paper and electronic) is negatively affecting staff job satisfaction and is viewed as being inefficient and pointless.

> *The only thing that I wish can make my work easy is to stop using the paper-based (system). If we stop using the forms and move to the actual technology… I would be happy, I'd be a happy person. (Eastern Cape, Implementer)*

> *With the forms… it should be electronically. They should get rid of the paper-based collection of data! Let's just get rid of the paper-based and do things electronically. (KZN, Implementer)*

The level of paperwork, the paper heaviness of the programme, if that could change then that would be great. If more things could be updated faster, then the team could be engaging in the field more… there is a lot of paperwork that takes your time away from engaging with the young people… that is one of the things I raised with [PR]. Because it is currently so paper heavy, my team is not given time. (Western Cape, Implementer)

Verification of enrolment, yoh!… That thing can make you resign! The verification log is too much, it is tiresome and draining… I resent paperwork since I deal with a lot of paperwork here at work… Our enrolment has about 30-40 pages, that's an enrolment for one child… and then I have 7 PGTs which I supervise. If one PGT has enrolled 5 beneficiaries… This means I must verify information for 35 people, imagine! (Free State, Implementer)

Several respondents questioned the competency of the service providers of the My Hope System. They were concerned that they do not have the capacity to resolve the technical issues before the end of the programme. As a result some respondents were suggesting that the programme shift to a trusted and widely available system like Google Forms, which could also ensure sustainability after the grant period.

I have had problems with the system ever since it was introduced, and we even have problems with it today… I don't foresee the current service provider resolving these issues. I don't think they have the capacity to resolve these issues… they have bitten off more than they can chew. (Western Cape, Implementer)

With the 'My Hope' tool… as an IT service provider… they need to know our problems before we even know them, and they haven't done that… There have just been a lot of bugs… It needs to run at least 100% faster. (Gauteng, Implementer)

We've had four or five trainings with the company in software, to deliver on how this device is going to be used. But every time we try to implement, then they pull and say something's not working, let's not use it. (Western Cape, Implementer)

The acceptability of the M&E system among implementers has up until now been negatively affected by the sentiment amongst implementers that capturing data in the My Hope System was pointless since the data could not be analysed. However, one respondent reported positively about the appointment of a service provider, 'Zenesis', to resolve this issue. Zenesis is assisting with data analysis and providing guidance around how data from My Hope System can be analysed to inform implementation.

Zenesis has taken all of the information that we have been capturing and they have a platform that can analyse all of the information and we find it very useful. We had a workshop last year in December… it is only now that we are going to start to use the information that we captured. But no, up until now, we have never used the information that we have captured. (Western Cape, Implementer)

Implementer Reports of Data Falsification

Issues relating to data falsification were reported by a number of implementer respondents in discussions on recruitment, Risk Assessments, and data capturing. As noted in the section on recruitment experiences, there were reports from some implementation respondents that in some cases, outreach teams may have been falsifying the age of AGYW in order to reach recruitment targets.

It is not clear if this may be happening widely as several respondents did note that PGTs falsify 'data' on Risk Assessment forms (as discussed below in more detail).

> *Most AGYWs lie about their age because they are avoiding to go to the clinic. For example, if I am 14 years of age, and in need of family planning, the nurses won't understand why I need family planning at the age of 14… I have to supervise if the outreach teams are doing their jobs because there's a tendency of falsifying information… because they want to recruit more girls, they also recruit those who are 14 years of age, which is not allowed, and even go to an extent of convincing them to lie about their age. (Mpumalanga, Implementer)*

M&E Managers also noted that the lack of PGT training impacts negatively on the quality of data. PGTs may side-step very sensitive questions and capture fabricated data, since assessment forms have to be fully completed to be uploaded into the My Hope System. Some managers even believed that PGTs were fabricating entire Risk Assessment forms and AGYW were never interviewed.

> *The questions are a little 'too much' for them. This results in the PGT sometimes just fabricating answers to that part of the Risk Assessment… When these answers are being fabricated, we are getting false data which makes it hard to make decisions from this data. It's a little too sensitive… for a person who just finished matric, to go and ask people these questions… People will tell you… that they reached 20 AGYW, only to find out that there are 10 of them that are real and the other 10 are fabricated. (Gauteng, Implementer)*

As discussed in the Risk Assessment section, since the system requires that all fields are entered before accepting a form, this compounded the issue of false data entry by PGTs and other field workers. It was also noted that data capturers sometimes had to 'tweak' the data to get the system to accept it, which adds to the problem of false data entry.

> *We have the 'My Hope System', which is being developed since the beginning of the programme, but there are still bugs that are impacting… little details which also makes it hard to really see what is the truth… with the Risk Assessments, the people who are asking those questions, they don't always get us the full information or the right information… one is the system but also, we have implementers giving us false data… tweaking things around so it can be accepted by the system. (Gauteng, Implementer)*

Section 1 part E:

Implementation Context

Context is critical to the successful implementation of any intervention. In the qualitative component of the process evaluation, we sought to understand the extent to which the context of the intervention has been conducive to implementation. The context of the COVID-19 pandemic was considered here.

Contextual Factors Affecting Implementation of Intervention

In the process evaluation interviews, respondents described various contextual factors that had impacted on implementation. The two main emergent themes related to safety and the COVID-19 pandemic context.

Safety and Implementation

Safety was noted as a key concern across that was affecting implementation across implementation sites. SRs were concerned for both the safety of AGYW beneficiaries while reaching service sites and for the safety of staff. The extent to which safety disrupted implementation did however differ across the districts. For example, certain areas of Cape Town's Klipfontein district (Western Cape) were considered 'no go zones' due to gang wars, most notably Manenberg and Nyanga. Gangsterism was also noted to create heightened safety issues in Ehlanzeni district of Mpumalanga. In these areas, SRs struggled to set up Safe Spaces (as discussed in section 1C), programmes may be disrupted and in extreme cases, SR managers felt that they could not, in good conscience, ask staff to operate in these areas.

> *Safety is a factor… if staff want to walk around, we have to make sure that they are in groups that are large enough... some of the areas are just 'no go zones'... they have weapons, so they are not particularly phased by the size of the group… we can't ask them (staff) to do things that we are not willing to do ourselves, in my opinion. So that does leave a bit of a gap in terms of reach, for the people that are most in need. (Western Cape, Implementer)*

> *Like if I can mention places like Athlone, Hanover park, there's always gangsterism and shootings in those areas (Western Cape, Implementer)*

> *Here we have gangsters. They will shoot and kill you. If they don't like you they will come with a gun and say this is what we want you to do. It was tense from October until January but they are now working freely… they know that this one is from social development... We fear but we go to work because they haven't started to trouble us. (Mpumalanga, Social worker)*

Strategies for working around safety issues included asking other community stakeholders to bring AGYW beneficiaries to the services venues.

> *With the Manenberg area it is not easy for us to go in because there is always shooting going on, so it is really, really dangerous for us to go in… what we have tried, is to make relationships with other stakeholders within Manenberg community, so that they can try and bring girls to us ...But it hasn't been working so well. (Western Cape, Implementer)*

SRs also noted that safety in implementing areas impacted on the ability to retain AGYW into programmes. In areas where it is dangerous for AGYW to access venues and Safe Spaces, they may not be able to attend group courses frequently, for example.

> *It's very difficult for us at times to retain them in the programme... Because if you're starting a session… even if it's IMPOWER (self-defence), Teen Parenting or Grief (counselling). They will drop out! Reason being at times the areas where they are living it's very dangerous… even for us if we have to go to the community at times, it's difficult there's a shooting, the area is vulnerable, the area you can't walk in… you would find that our offices are in an area where they cannot go that side because the gangs are that side. (Western Cape, Social worker)*

Female staff members also noted safety concerns, as home visits put them at increased risk of GBV. In certain contexts, this was the reason provided for SRs conducting the repeat Risk Assessment telephonically.

> *I don't feel comfortable because you will be alone… when I knock, I don't know who is inside… I might be meeting a man in that house, when I am alone and something may happen to me, so it's too risky. I have fear, I have fear… If we do the repeat core, it's better if we call before we go to the house. (Free State, Implementer)*

Intervention Implementation in COVID-19 Context

All respondents noted various ways in which COVID-19 had limited the ability of PRs and SRs to implement as planned. During Stage 5 lockdown, although SRs made noticeable efforts to remain in contact with enrolled AGYW and to provide some limited services remotely via WhatsApp groups and phone, COVID-19 severely limited which services could be provided. SRs who had acquired permits to operate during lockdown, also attempted to continue offering some services to AGYW door-to-door. However, AGYW and their family members were also wary of inviting fieldworkers into their homes due to fear of being infected by implementers, which limited the effectiveness of door-to-door visits. Therefore COVID-19 had a significant impact on both the ability of SRs to continue providing services to existing beneficiaries, as well as SR's ability to recruit new AGYW.

> *Then we went back… we were given the permits and then it was hard you know, working with the permit and going door-to-door to people's houses. Some people were really worried about COVID but we were also going around with COVID tools (Free State, Health worker)*

> *We couldn't do home visits because we were afraid of getting COVID-19 and the people we were supposed to visit, were also afraid that we will infect them with COVID-19… We were afraid of one another. (Mpumalanga, Social worker)*

> *Recruiting becomes very difficult… I go to a family because there are girls, but they refuse to let me in. When it comes to recruiting the girls, it had a huge effect. After recruiting them, you refer them to the clinic. They will be lazy to go because, firstly, the clinic does not operate normally like before, they follow the COVID-19 protocols. And secondly, the queues are too long. (KZN, Implementer)*

> *You go to a place and knock looking for the child, they think that you are bringing COVID to their homes. They did not trust us at all, to such an extent that it was rumoured in other places that we are the ones that bring it to their homes. (Free State, Social worker)*

Staff themselves were also reluctant to conduct these outreach activities. Fieldworkers were concerned about contracting COVID-19 during outreach activities from co-workers or from AGYW and the community. Although efforts were made to continue providing some services to AGYW through a door-to-door approach, this did not seem to be very effective, especially during the height of the first and second waves of COVID-19. Responses from implementers indicated that COVID-19 negatively affected the rapport between programme implementers, AGYW beneficiaries, and the wider community, and therefore programme acceptability.

We were doing door-to-door, but they were chasing us. We tried to make some rapport and make some friendships so that they would trust us… the previous months, it was so tense! Everyone was scared of everybody, even the co-workers… But later, it became easy… until this second wave… The lack of trust between the community and us- that they think we are the carriers of the COVID to them. (Free State, Health worker)

Effects of COVID-19 on Core Services and Risk Assessments

Implementers noted that conducting Risk Assessments over the phone during COVID was problematic and inappropriate due to the sensitive nature of the questions. Interviewers felt that they could not build rapport over the phone and provide the necessary support if AGYW were triggered by the questions being asked. AGYW also could not speak freely and answer openly in front of their parents, when being interviewed telephonically while at home during lockdown.

Most of our Risk Assessments are being done over the phone but obviously that has impacted on the quality of our work... you can't see someone's non-verbal communication and some of our beneficiaries live with parents, and they can't be on the phone and talk about the contents of the Risk Assessment while they are sitting with their parents. (North West, Implementer)

Conducting Risk Assessments and the 6-monthly repeat Risk Assessment through door-to-door visits during COVID-19 lockdowns, also encountered challenges. Conducting the Risk Assessment in the presence of other household members presented confidentiality issues. Many parents were not aware that their children were participating in the programme as they had not been informed or given their consent. This created conflict between the SR team and parents, and also between AGYW and their parents. Therefore COVID-19 also heightened issues around community acceptability and particularly highlighted how SRs in many cases had not involved parents adequately in the programme.

You will meet with parents with problems, who will ask you how did you allow her kid to enrol without his or her consent?, and that they don't want their children enrolled in the programme… If you're going to ask her sexuality questions and about boyfriends, they can't be free because of the presence of the parents. And if you ask to be excused with the child, the parent refuses and asks "what is it that you are going to discuss with the child in secret, that I cannot hear?" (Free State, Implementer)

Effects of COVID-19 on Recruitment and Retention

Recruitment events, community campaigns and career jamborees were all cancelled due to the pandemic. Respondents noted that the timing of COVID, soon after implementation began, meant that the programmes were not adequately introduced into the communities. This made it hard to sustain the gains that had been made and to meet monthly recruitment targets. The pandemic also caused a shift of attention, whereby local communities and government were more concerned about COVID than HIV prevention. This could also have a potentially negative long term effect.

We couldn't find more kids on the streets because the instruction was that they should stay at home… We just go to the clinic or we walk down the streets looking for those kids that we can enrol or conduct repeat core (services)... it's like we're selling policies and I don't like it. (Free State, Implementer)

HERStory2 Process Evaluation – Qualitative Study Component

Those mass activities which require, like community campaigns… school jamborees, mass events, of course they were not implemented. (Free State, Implementer)

Usually every year we have to have a Career Jamboree for young girls. When you hold the Jamboree, you invite all the stakeholders and you even invite the varsities and what not… but during this last year we didn't have one because of COVID. (Free State, Implementer)

Implementers noted that lockdown negatively affected the retention of AGYW in the programme since the 6-month repeat call was affected and the limited programmes on offer deterred continued participation. Many AGYW were not willing to do the 'repeat call' over the phone due to the sensitivity of the content. Moreover SRs noted that many AGYW did not re-enrol in the programme even after emerging out of Level-5 lockdown. In some cases, this was just due to a loss of momentum with AGYW losing interest. However, there were also cases where AGYW could not be reached due to incorrect contact details and also cases where migrant households had moved back to their original homestead in another district or province, possibly due to job losses or general economic shocks and stresses.

The challenge that we faced was that we then had girls who were then supposed to come back for their 6-month repeat call… we were then told to do these repeat calls telephonically, but the girls would tell you straight out: "I am not comfortable talking about my sex life over the phone"… So, when we eventually opened after the lockdown… Most of them showed lack of interest, they no longer wanted to be part of the AGYW program… Most of the girls, from what they have said, have moved back to the Eastern Cape and they are no longer in Cape Town, which I understand. But those that are in Cape Town, the majority have been refusing to come back. (Western Cape, Implementer)

Effects of School-Closures on Implementation

School closures affected implementation of the various components being offered at schools by some SRs. Some SRs reported that even after schools began to reopen, they were not able to access the schools to provide services for in-school AGYW. Schools had communicated with SRs that they were not allowed to accept 'visitors' due to COVID regulations. Even SRs with previously good relationships with schools had to halt their programmes. Variations were reported between districts, with some SRs noting that they were able to return to certain schools from June 2020, in other schools activities were halted between March and October 2020, after which most schools fully reopened. However, in other cases, SRs only returned to schools in 2021 or had not yet been given permission to recommence their activities.

When they re-opened in June there was a change… some grades will come this week and other grades will come the following week… There were also some schools which didn't allow us back to their schools because they are saying, there is a circular which is from the district office which says we must not allow any visitors… when they were back fully in schools, they did allow us to go back to schools… they minimised the interaction between our team and them because of COVID regulations… There were six schools which didn't allow us back. (Eastern Cape, Implementer)

During the height of first and second waves, only core services were being provided, there were no activities at schools, dialogues, in-person peer education groups and other group activities.

90

From COVID-19, as 'Mentor Me Chommy', we did have a plan of activities and to go to another town… to do public speaking and debate with girls from other towns. But we couldn't do it because of COVID-19 and the kids were excited, so the schools were closed. (Free State, Implementer)

Implementers who had returned to schools, noted that staff were more hesitant to schedule time for programme activities due to the teaching time that had been lost during lockdown. The rotational schedule of students attending school on different days and times, has also affected implementation. SRs were also assisting schools with COVID-screening however some noted that they were not able to run any of their regular programmes and so they decided to stop because they were not able to reach their AGYW programme targets. The closure of schools also affected community acceptability, and particularly parental acceptability, since the regular means through which SRs engaged with parents through schools were not available.

Since we usually meet with the young women only without their parents… when we want to meet with them on a certain day and listen to their point of views, we sometimes would call them with their parents in one session. But due to COVID-19 and the fact that we cannot bring people together, it is something that has not happened. (KZN, Implementer)

Effects of COVID-19 on Biomedical Services

Respondents emphasised how access to biomedical services by AGYW was disrupted, particularly family planning, HTS and PrEP. At the start of the COVID-19 pandemic services were halted, while SRs and PRs were figuring out a strategy to adjust programmes to the changing context and to apply for permits to keep offering services. Later on, some SRs continued to offer biomedical services in mobile clinics, however, they struggled to reach AGYW. Allegedly some AGYW thought that the truck was for COVID testing and were afraid to approach it. AGYW were also hesitant to go to clinics, due to both fear of infection and increased waiting times due to COVID-19 protocols. This particularly affected service provision from those SRs who were based in clinics. SRs also noted that AGYW struggled to get to clinics due to how the restrictions affected public transport systems.

If they have to test for HIV they are scared to go there… Because remember if you go to these health facilities you might get COVID-19… the reason at times they don't want to come access the services is because they would say they are scared to be infected. (Western Cape, Social worker)

During the first lockdown, we all stopped like other people. Then a go ahead was given later on, and we continued with the programme… It did have an impact because the turn up was not as usual. Because even when schools were open young people were busy at school… others were even afraid of the truck, thinking it is there for COVID test. They do not even want to pass near it. (KZN, Implementer)

Implementers noted a number of negative effects resulting from how COVID-19 had disrupted biomedical services. Some AGYW were not receiving PrEP and regular family planning services as a result of COVID-19 restrictions and there were fears that this might increase teenage pregnancy and HIV and STI infections.

COVID disturbed everything… when the COVID started we were not allowed to do the community testing… we were only allowed to go to the clinics and then do the main core, so

> *we were not able to reach the girls in the community… The girls couldn't have a chance now to come to us because of the limitations… and as a result we got a lot of girls that were defaulting now on their appointment days for the family planning (Western Cape, Implementer)*

To address this, some SRs were providing PrEP, family planning and counselling services door-to-door. However, as noted above implementers experienced challenges with this outreach approach. There were also cases reported where staff had contracted COVID-19 or had contact with COVID-19 patients and therefore needed to self-quarantine, which disrupted biomedical service delivery to AGYW. SRs also had challenges recruiting new AGYW for biomedical services since SRs and SSRs were not holding advocacy events and events involving mass testing, which were cancelled due to COVID-19.

> *We usually do events for the girls, for massive testing and some sort of dialogue… They had to postpone that until further notice, until the lockdown would be lifted. (Eastern Cape, Implementer)*

> *During COVID because we were staying home, after having some contacts (with COVID patients), some of the children missed their days because we were not there. Some went to the clinics and they chased them away. Some didn't even attempt to go to the clinics when it was their day, especially for family planning. (Free State, Health worker)*

> *From March, some of the activities, we were not able to do them… some of the AGYW were struggling to come and receive these services, so we were doing door-to-door… Especially for the ones that are on PrEP, that they received follow-up medication… we were doing door-to-door testing… and then we did one-on-one counselling. (Western Cape, Implementer)*

Effects of COVID-19 on Behavioural Services

Respondents noted that many of the behavioural services components were halted due to COVID-19, especially the group training programmes which could not be conducted due to regulations on numbers of people that could gather during different levels of lockdown.

> *Our trainings were affected because there were limitations in terms of the number of people required in any gatherings. So most of our trainings were put on hold. (Free State, Implementer)*

It was also noted that once lockdown regulations were eased and group sessions were allowed to go forward, the limited numbers of AGYW allowed per group activity deterred AGYW from enrolling into some programmes.

> *We would say we have drama clubs and drama groups, but it is limited to 15 [laughing]… and then the girls lose interest. (Western Cape, Implementer)*

Implementers noted that during lockdown it was challenging to continue to offer psycho-social support over the phone. AGYW may not feel comfortable to talk over the phone or if they are suffering from abuse in their homes, they may not be safe to talk over the phone.

> *They can't give psychosocial support on the phone. It's easier when you see somebody because then you see the body language and the expression. They are at home, they are uncomfortable*

speaking… I mean can you imagine if the uncle of the dad is abusing this girl at home and now she has to talk on the phone in front of everybody about the issue. (KZN, Implementer)

In terms of counselling… it's difficult to have a session with a child on the phone because you can't give that support to them... They're not comfortable to talk infront of their families especially the kid which is being abused at home. We can't talk to the child… she doesn't want parents to know, so it has affected us in a very negative way because now we are unable to provide AGYW with the support that they need. (North West, Social worker)

Effects of COVID-19 on Structural Services

Many of the structural services that involved group training and in-person sessions were halted at some point during the COVID lockdown. Since the easing of restrictions these groups have begun to be offered again in reduced numbers, for example the self-defence course or ESL trainings. The requirements of social distancing have also meant that certain aspects of programmes involving physical contact could not be delivered at all.

We were also not focusing on groups at that time. Our groups, when we started, when we were on Level 2 or Level 1, they were about 10 (people). For an example, for the self-defence classes, we had 20 and more, and now they had to be cut down to 10 per group. And they could not even practice some skills, because in self-defence classes they practice, but they could not demonstrate (physically) what they needed to do. (Western Cape, Social worker)

Effects of COVID-19 on referrals to government services

Referrals to government departments to deliver various services to AGYW have been negatively affected since the COVID-19 pandemic began. As already noted, AGYW were hesitant to go to clinics, due fear of infection and increased waiting times due to COVID-19 protocols. Respondents also particularly noted how referrals to the Department of Home Affairs and DSD were negatively impacted. Some respondents noted that service delivery at every level of government and elsewhere, became very inefficient during COVID-19, and the pandemic became an excuse for non-delivery.

COVID also became a blanket term to paper over very systemic inefficiencies everywhere, with schools, with clinics, with police stations, with funders, with every person, every structure that you engage with. COVID became… a convenience. (Gauteng, Implementer)

Failures to refer to Home Affairs impacted AGYW livelihoods since accessing social grants would have been affected. The AGYW programmes 'back to school' component was affected by difficulties in accessing the necessary documents for AGYW to be accepted back into schools once they reopened. SRs also noted that they have been unable to work effectively with DSD due to COVID-19. Implementers described the way in which DSD staff were affected by the pandemic, and how meetings with SRs were postponed or cancelled.

It's only now that we are starting to collaborate with the department of social development… They had a lot of people who had passed away due to COVID and many times our meetings were postponed… Even now we haven't got a date… They have lost I think about thirteen staff members in their department. (Eastern Cape, Implementer)

DSD... they said that they'll provide support but it hasn't materialised... COVID has impacted how we can engage more fully and the offices are not as open to the public as it maybe could have been in the past... I can't say that we have a relationship that's working as yet. (Western Cape, Implementer)

Experiences with COVID safety protocols during in-person and group sessions

Respondents noted that once the lockdown was eased, SRs still struggled to host group sessions because some AGYW were resistant to follow COVID safety procedures for in-person services. AGYW were reluctant to wear masks and some refused to. Respondents explained that knowledge about the pandemic tended to be poor and that views were frequently affected by false news and conspiracy theories.

The majority of these girls don't want to wear a mask. To wear a mask, you have to provide them with a mask and then they don't know or understand the significance of wearing a mask. Or sanitizing... when you sanitize them, they will laugh at you... They think that COVID it was for those who were staying in Gauteng, not here (Free State, Health worker)

They don't understand COVID-19 at all... I'm talking about when we were still in Level 5- they were not wearing masks ...they don't take COVID-19 seriously. They think it doesn't exist. (Eastern Cape, Health worker)

The main problem is that everyone in the community does not wear masks. (Western Cape, Implementer)

Effects of COVID-19 on meeting targets

Several respondents across all of the implementation districts noted that they struggled or were unable to meet the original targets due to COVID-19. PGTs enrolling AGYW into the programme and staff offering biomedical services especially struggled to meet their targets. Staff morale was also affected since they felt they had to work much harder to try and meet targets, however, no incentives were offered despite the difficult and often dangerous working conditions caused by contexts of crime and risk of COVID infection.

The staff had to work twice as hard to meet targets because... you cannot meet in big groups anymore... People don't want them in their homes because nobody's safe... if you don't look after your staff, chances of abuse and not implementing to the best of their ability are there. (KZN, Implementer)

Our target was difficult to reach... if the target needs you to reach 20 girls and PrEP needs 8 per day, it became so difficult to reach the target. Instead of getting 8, you maybe get 3... The target for lay counsellors is 15 but they can't reach that number, maybe it will be 3 or 5 young women who will be tested a day... At least the psychosocial team has no target but the PrEP and HTS has a target. (Mpumalanga, Social worker)

COVID-19 destroyed our lives!... We went to work in April after that very strict lockdown... We were struggling to reach stats because the children are not in the streets, we were not allowed

94

to go to school because the schools are closed… Our PGTs were stressed because they couldn't find the children… a lot of staff contracted COVID-19… (the community) told others that those people will bring us COVID-19. (Free State, Implementer)

Despite the difficult circumstances, most SRs noted that they felt supported by their PRs, which provide support, information and Personal Protective Equipment to SRs during COVID.

In terms of procuring the PPE [Personal Protective Equipment] and also in making sure that our team was supported psychosocially… we were getting the proper support during that time because they (PR) were available on call, they were giving us information about COVID. (Eastern Cape, Implementer)

A number of respondents noted that programme funding was not flexible enough to allow implementers to adapt the programme to the COVID context. Funding streams were not flexible enough and funds could not be reallocated to programmes and line items that could be more responsive to the pandemic environment, for example providing data to AGYW, investments to offer programmes virtually, relief packages for AGYW households or other incentives for both AGYW and field staff. Staff were concerned that original targets could not be met but there was equally a sense of pointlessness to the mechanisms through which SRs were trying to drive numbers upwards for reporting purposes.

Logistics and staff management and morale during COVID-19

Respondents noted that logistics and supporting staff to keep implementing during COVID was challenging. Transport logistics for field teams were complicated and prohibitive during lockdown, since regulations limited the number of people who could travel in a vehicle.

Previously, we were sharing the car but then our manager said, 'only 3 people in a car'. So, it was not easy, we had to travel with 3 people to a side and then come back with the car, to come back and fetch another 3 people, because we are more than 3 in our team. So, it was just consuming time and consuming petrol. Then it started to be an easier point when we were 5 in the car. (Free State, Health worker)

Managers explained that it was difficult to keep staff motivated during lockdown, since the working environment had become challenging and in some contexts unsafe. Staff were worried about catching COVID during outreach activities and in-person services. Staff felt under pressure to meet the targets that seemed unreasonable given the pandemic context.

We were all worried about getting COVID, but we all need food on the table, so we went out to do what we have to do. (Free State, Health worker)

It was quite hard to keep staff motivated to do phones and WhatsApp calls to the young women because a lot of the numbers are wrong, we couldn't find the girls and that did affect staff morale quite a bit. But then coming back we had to push really hard to then catch up on target, because the quarter over COVID… our total reach was maybe 29 or 30%. (Western Cape, Implementer)

There were also instances in which staff themselves fell ill, their families were affected or they had been in contact with COVID-19. Therefore implementation was challenging, given that teams were not always complete.

> *It affects our stats because we have to stay home for a while when we are having some contacts… This week someone is ill and then the next week someone is ill, so we were not a complete team. So, the stats were a little bit low due to COVID. (Free State, Health worker)*

Some staff who had COVID-19 or were affected by it, felt that they were not supported and that reaching targets was the primary concern of the SR managers.

> *I was one of the people who was diagnosed with COVID 19… it was very emotional, I'm originally from Gauteng… So here I am working and I am staying alone… I was very sick dealing with the symptoms of COVID but I would be called regularly. They would ask for stats, you understand, they would ask for reports, they wouldn't ask me how I am and how am I coping and such stuff… so support was not there, 0%. There was no support at all. (Free State, Implementer)*

Mid-stream adaptations to the Intervention during COVID

SRs described several ways that they attempted to adapt to the pandemic context, such as offering services remotely, over the phone and through social media platforms such as WhatsApp. Respondents also noted that some mid-stream adaptations were made to the recruitment strategy and intervention design to be able to respond to the challenges of the COVID-19 context. Instead of large recruitment events, SR teams were recruiting AGYW during COVID-screening activities in clinics, schools and with DoH outreach teams. Some SRs had replaced recruitment drives and large career jamboree events with user-friendly information booklets that encouraged AGYW to sign up to the programme and also to distribute vital SRH and career information.

> *With the career jamboree, we have to change from the original jamboree. We have developed a jamboree booklet instead to say if we can't have executives coming to the school and showing the different careers that one can follow or displaying the courses that maybe the college is offering, we put all of that information and we print it in a user friendly booklet so that they can have that information regardless of COVID-19 happening. (North West, Implementer)*

> *For COVID we had to now move from physical sessions to telephonic interventions… We were supposed to have groups, career jamborees… we had to try and shift them and try and redo them in a different manner. (North West, Implementer)*

Another successful recruitment strategy created in response to COVID allegedly involved recruiting in vehicles inside communities and making use of a loud hailer to minimise personal contact.

> *What we did in the last few months last year, we took the company car… We went into the community… we had a loud hailer, we calling them on that loud hailer… we will play the music, then we get them in that manner. Otherwise, if you are sitting there, just waiting for them to come, it's not going to work. (Western Cape, Social worker)*

In response to school closures, some SRs continued to run activities with school-based AGYW over WhatsApp groups, through door-to-door activities and by conducting group activities in smaller numbers off school grounds, once lockdown regulations loosened. School based PGTs, were therefore either operating from Safe Spaces or recruiting AGYWs on the streets during COVID.

> *During the pandemic… ever since Corona started, we didn't have access to go to the schools… usually we were working in the community to enrol the kids and doing door-to-door. (Free State, Implementer)*

> *We couldn't go to the schools, schools were closed, schools took time to open. So now we asked other organizations, which have been used to accommodate us… so far each group must be of 15 learners, but we couldn't go that far because of the regulations, we had to take 10 to reduce the number. (North West, Social worker)*

Experiences offering remote services during COVID-19 lockdowns

During Level 5 lockdown, several SRs were unable to deliver their full programme of activities and were only offering one-on-one telephonic support and support via WhatsApp groups and Zoom (in limited cases) for sending AGYW information on SRH. Some respondents, such as social workers, noted that although this approach is challenging, at least they could continue being in contact with AGYW and offer psycho-social support.

> *It made our job simple when they (SR management) started providing us with airtime to call the children and set appointments with them, especially if the case is sensitive and needs to be attended at quick then you call them. (Free State, Social worker)*

> *It's still a challenge but we are making it work …What I usually do, I tell the parents that I'm the social worker based in schools… and we teach them about social challenges that they face… I'm calling just to check up on them… and then that's how I get them. (North West, Social worker)*

> *The best thing was that we opened a WhatsApp group engaging with these learners and getting them in the community, even though they were not allowed to be in the streets… even those who didn't have cell phones they were using from their parents; for those who understood about the programme. (Free State, Implementer)*

However, several implementers noted that the virtual space was inappropriate because fieldworkers were not able to provide the requisite support. They did not respond well to this new medium of communication and were either unable to participate or unwilling to participate in online or WhatsApp groups or to receive psychosocial support over the phone. Many AGYW preferred to participate in in-person services. Therefore some SRs arranged to continue to provide face-to-face psychosocial support when this was possible, even though group sessions were halted.

> *They had to stop going out to the community when the lockdown started in level 5. So what the implementers were doing, they were only calling the girls to check up on them and find out if they're okay and stuff like that, and sending them information like for sexual reproductive health… they're also sending things via WhatsApp instead of taking to them like personally. (Eastern Cape, Implementer)*

The feedback from the AGYW has been that they don't want to talk over the phone. They actually want the contact face-to-face contact. So the minute we were able to set up the counselling, I think it was level three, we did face-to-face psychosocial support. (Western Cape, Implementer)

In some instances, reaching AGYW at home also created conflict with parents and other household members, who were not aware that the AGYW were enrolled in the programme. Some SRs felt that contacting AGYW via phone felt like 'chasing numbers' for M&E purposes because the AGYW couldn't be referred to the services and programmes that they needed.

To be honest, even though we did our best, I do not think that we did justice, we did not provide a high-quality service to our beneficiaries. They also did not access the services; none of the services were available during that time. Especially on level 5, there were no services available; so, it was just chasing numbers to be honest… We contacted the young girls and we said we would refer you, but we never did. (Western Cape, Implementer)

Some of the challenges that had been experienced during recruitment (and documented in section 1A of this report), regarding AGYW providing the wrong contact number, also meant that these beneficiaries could not be contacted during lockdown. Another commonly noted challenge of this virtual mode of engaging with AGYW was that some AGYW beneficiaries did not have either a personal phone or more commonly, access to sufficient data. It seems that in most cases SRs were not able to buy data for AGYW to enable them to participate in WhatsApp or other online groups.

Some don't have cell phones, the ones that have phones don't have airtime to make a call and ask for help or support with a certain issue. (Western Cape, Social worker)

They (AGYW) don't always have data access, so even WhatsApp, some of them couldn't read it... because they couldn't get to the free sites for network access, it didn't actually work continuously and we weren't allowed to give data to any of the participants either. (Western Cape, Implementer)

Some of them (AGYW) had a challenge with data because they say that we don't have enough data to be always chatting to you on a daily basis. (Eastern Cape, Implementer)

WhatsApp does not work. Facebook very few of them are on Facebook and some of them say- 'Hey, you want to reach me on WhatsApp but you don't buy me data and I don't have Wi-Fi at home'… You form WhatsApp groups with 20 people in it and before you know it you only left with five. (KZN, Implementer)

One positive adaptation cited was the way in which the COVID work context meant an improvement in staff use of and familiarity with online systems for data management and reporting. These changes have lasted beyond lockdown, and have helped improve some of the SR work processes.

The positive is that we innovated as a team, we moved all our work online. People had to quickly adjust to how to operate on google drive and how to edit work online… now everything we learnt during COVID is stuck into our work process and has helped us to better manage our data… right now I can tell you what is happening in our data because of those… processes and innovations… for me it is exciting because that is where the world is moving… google meetings and zoom meetings. (Gauteng, Implementer)

98

A number of SR respondents explained that they tried to be responsive to the increased economic pressure that COVID-19 was placing AGYW households under, by providing relief to poor households. Some SRs were directly arranging for food parcels and vouchers to be delivered to AGYW households during lockdown. Other respondents noted that they were making referrals to social workers and DSD so that AGYW could receive food parcels and psychosocial support.

> *We tried to get food parcels, the food vouchers sent to their phones where possible, via other networks… because we're a Community Development organization that's sort of our usual, so we could also do other things to supplement the programme, which was helpful. (Western Cape, Implementer)*

> *We as the centre, we were giving them food parcels during COVID… I see who has those challenges, that need serious attention and refer them to a social worker, and they will get a food parcel. (KZN, Implementer)*

> *The situation in their homes was not the same. So, we engaged with the Department of Social Development, where they can assist with those kids. Even though we didn't have the capacity to give them the food parcel and what not, but at least we had other stakeholders that are working hand in hand with us, so that they can assist those girls. (Free State, Implementer)*

Respondents in every implementing district noted that SRs were assisting local clinics and schools to screen for COVID-19. Some SRs were also working with the community action networks (CANs) that were formed during COVID-19 to support local communities. Fieldworkers would use this opportunity to recruit AGYW into the programme. SRs were also teaching AGYW and their families how to protect themselves against COVID-19 infection.

> *Normally what we do, especially now during the pandemic, is that we partnered with the Department of Health, so that we can be in the community and help with screening. During screening we enrol the kids into our programmes. (Free State, Implementer)*

> *It was a really difficult time when we didn't work through the first lockdown. Only a few of us like myself, was called to go into the clinics and help with the screening for COVID-19. (North West, Implementer)*

> *We were teaching them how to wear a mask, how to wash their hands and we told them about all of the regulations that we should follow for COVID-19. (KZN, Implementer)*

> *Some of our team has been working with the community action networks that were formed during COVID and so they have been sourcing the young women, they provide the food and we do the recruitment and engagement and sharing ideas. (Western Cape, Implementer)*

Effects of COVID on AGYW Intervention Experiences

In terms of the ways in which the COVID pandemic context impacted on the experiences of AGYW beneficiaries, most of the narratives related to negative impacts. Many of the AGYW respondents described feeling isolated during lockdown which was exacerbated by the fact that programme activities were halted and they could not meet in groups or attend events.

99

> *Lockdown has made things difficult, because we couldn't meet and we were not holding any events…the people I liked to talk to… when I'm going through something and I needed to talk… I couldn't because we couldn't meet… we communicated over the phone through WhatsApp, they formed a WhatsApp group… but there was no one-on-one meeting. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Core)*

> *COVID affected us badly because they were helping us girls… Some kids are unable to sit down and discuss issues with their parents especially their mothers… So if you know that you will meet them (peers)… you will feel free because you know that next to you there is a friend. It has affected it badly because they assisted us in informing us about a lot of things as girls. (Ehlanzeni, MPU, AGYW 20-24 years, Core)*

Many of the AGYW beneficiaries explained that they had become accustomed to receiving psycho-social support regularly through the programmes, so found it especially hard during lockdown, when this support structure was suddenly taken away.

> *When lockdown began that affected me a lot because we did not have our sessions where we spoke about everything… there were times when I felt like I needed to open up, but I couldn't, because you were used to talking to your group… as a result, you end up keeping whatever was bothering you to yourself, so it affected us a lot. (Nelson Mandela Bay, EC, AGYW 15-19 years, Core)*

In addition, AGYW respondents remarked on how difficult it was to access biomedical services and health care during lockdown.

> *Before, they used to go from location to location and put some stretch tents and welcome young people in, get to talk with them… Last time it was easy for us, because you found a couple of tents around or else if you are unable you go to that Safe Space and you will always find them, but now it's so scarce. Clinics are not offering that much help, because it's always full. (Ehlanzeni, MPU, AGYW 15-19 years, Core)*

One positive aspect narrated by AGYW respondents was that when schools were closed, some beneficiaries were able to access Safe Spaces, where they could study, and get academic support and assistance with homework from the programme staff.

> *It was not normal that you study at home through WhatsApp and you don't get to see teachers when they are explaining. Because for some of us… if you want to understand something a teacher must be in front for you to understand. But, for me it was not that hard because the programme was there for me at the Safe Space. If there were homework and assignments, I could go there get help and everything. (Ehlanzeni, MPU, AGYW 15-19 years, Core)*

Section 1 part F:

Implementation Experiences through the Theory of Change lens

The Assumptions of the Theory of Change model that relate to this section of the report are:

- Assumption that external service providers, including Government Departments (Department of Education, Department of Health, Department of Social Development, Department of Justice) and community-based organisations, will provide behavioural, structural and biomedical services to which AGYW can be referred. Implicit in this is the assumption that AGYW will have access to such services and find them acceptable and of high quality.
- Assumption that these partners will collaborate with the AGYW Programme by signing partnership agreements, supporting access to commodities, access to facilities and schools and/or providing layered services to AGYW.

Implementer Perceptions of Intervention Goals/Objectives

Most implementers had a holistic view of what changes the programmes aimed at bringing about including all the biomedical, structural and behavioural components. Many respondents also noted the importance of assisting with other psychosocial support services such as getting ID documents and poverty alleviation. Finally, they also mentioned how important psychosocial support is for improving self-esteem, supporting girls in developing positive life goals and also providing assistance with social challenges such as GBV.

> *When I first was introduced to the program, it seemed to me that the main change was to identify the main vulnerabilities… all of the things that make young girls vulnerable to participate in… for example, unprotected sex or to be more vulnerable to engage in a sexual relationship, in exchange for financial favours or things like that. So, I thought that the programme was then coming in to identify all of these gaps that the programme identified. Not just the HIV prevention components, like providing condoms or testing for HIV but also other things on the side like making sure they have a birth certificate and an ID… that is a requirement and the more you have all of these things, the more you feel like you are a decent human being so you are not prone to making bad decisions. Because you feel like there is someone who cares for you; you are a South African citizen; you have documentation; if you need help with your homework there is someone to help you; if you feel unsafe, you are referred to the self-defence classes… all of these things that they really needed, or things that are likely to lead them to the wrong path; if you are able to address them then they could feel valuable and then that also changes their mindset. (Western Cape, Implementer)*

Implementers also noted that a significant component of change requires AGYW to engage in behaviour change. Behaviour change was often described as mitigating against risk.

> *It starts with them identifying this type of behaviour and then knowing the risks that go with that behaviour because if you are a AGYW who has multiple partners you first need to identify that, ok I have multiple sexual partners and what are my risks you know in relation to that. (North West, Implementer)*

Another important component of behaviour change is centred around the programme fostering empowerment, and shifting unequal gendered power dynamics.

> *It is designed to change the attitude of a young woman… When you are growing up, you learn from your parents that as a woman you should not speak against the man. So, anything that a man in the house says, it must go! So, now we are teaching the girls, that even you, you have a voice!… If you are in an abusive relationship, don't stay in that relationship for the sake of*

> *it… you are capable of getting a job yourself… and don't depend on the man. (Western Cape, Implementer)*

Empowerment was described as a combination of improving girl's knowledge through information sharing, but also shifting mindsets, which should then lead to behaviour change as girls are then more capable of making informed choices.

> *Some of them (AGYW) don't even understand what HIV is… so the knowledge also that we are providing them… is also kind of opening the young girls' minds on some of the things that they did not understand or that they did not know so… we are bringing more informative services to them… the aim is to bring change to them. (Eastern Cape, Implementer)*

> *The information affects the choices, because the more you know, the more likely you are to make an informed decision. So, I am not sure whether or not behaviour itself will change but I definitely think that mindsets will begin to shift. (Western Cape, Implementer)*

Finally, implementers mentioned the importance of reducing the stigma of HIV and offering emotional support to girls as part of the process of change.

> *If we have to tell that young girl that she is (HIV) positive, she will be so devastated and we will need to counsel her and try to help her understand, and make her understand that whatever is happening in her life, it is not her fault. (North West, Implementer)*

When asked what they thought the programme was designed to change, implementers did not focus heavily on the importance of M&E system priorities such as data collection or even Risk Assessment as an important factor for bringing about change. The responses above lean more toward respect for the personal experiences of AGYW and also how the programme can help them to navigate change impetus within their social context. Implementers felt that what was required to change behaviour was empowerment, which involved dissemination of knowledge and information sharing, as well as providing emotional support and stigma reduction, which would then shift mindsets, and ultimately facilitate different behaviour choices. Over and above all this the programme also needed to address a host of social issues that AGYW face, while providing all the services that the ToC outlines.

When comparing these responses to the steps of the ToC model which really outlines the M&E priorities of Risk Assessment and referral for services, it appears evident that the priorities for change that implementers noted, may be more implicit assumptions of the model. These implicit assumptions may look more like   :

> IF AGYW are empowered and assisted with psychosocial support services, and IF they receive emotional support through the process, THEN they may shift their mindsets and make different behaviour choices which can then be supported by the provision of the services that the programme offers.

Important to note here is the order of the steps in the model, as the implementer responses may imply that a few steps are required before all the current steps in the model.

> *I wish there was some kind of event or engagement before recruitment happened… more information sharing, about the actual program, because often our first point of contact is: 'can I do the interview with you?' ...sometimes you don't get access because they are going: 'why should we do this with you?'. (Western Cape, Implementer)*

Importance of relationship building

As per the findings from Section 1 of the report, there have been many challenges with implementation, from lack of training, to services being delivered late or not at all, to COVID-19 limitations. Some of the negative effects mentioned have been a lack of trust between implementers and their PR's and SR's as well as between AGYW, community and the implementers. Despite all the challenges noted in the previous sections, there were still reports of high morale amongst implementers as well as perceptions of the programme being effective and bringing about the change that it aimed to.

> *It's challenging at the same time is interesting…Because I love very much to work with them… And when I see them being helped and getting what they need, so I become so excited like to help more people (Western Cape, Implementer)*

Despite all the challenges noted with structural and biomedical services, there was a lot of positive feedback regarding the behavioural services that provide psychosocial support, such as the mental health support groups and the self-defence programmes. Findings indicate that these programmes provide a gateway to AGYW returning or using other services because of a trust relationship that is fostered through them.

> *It is like, "ok now I can trust you with this information, you know this about me, and you still welcome me back, so it must be safe enough to try something else" (Western Cape, Implementer)*

Further to this, implementers noted that the programmes allowed for the time and opportunity for relationship building and that the true impact is achieved when they were able to engage in relationship building with AGYW. They also noted that youth friendly clinic services were more effective in terms of building trust with AGYW.

> *The connection is where the shift happens… because they are not just running a program, they are also developing those relationships (Western Cape, Implementer)*

Many implementers also reported the challenge of balancing the requirements of meeting targets and paperwork, versus relationship building or providing good quality services.

> *At some point people are pushing numbers and we are not really investing in… AGYW… now it becomes about instead of you saying I am focusing on one person and I am making sure that this one person actually receives services and informed….As soon as I do the Risk Assessment because now they need the office target. They want me to bring five….So I think you know to reach a target I know it's impossible to not do the work and not be judged on how you do the work but also it impacts on the quality of the services. (North West, Implementer)*

There were reports that the paperwork and M&E requirements may even be hindering the objectives of the programme, rather than expediting them, because it detracts from relationship building, which is where it seems that the positive impact is most often felt by implementers.

> *If we had said to people, show me the impact that we have made on AGYW it would have been better…To keep them focus that's the goal actually; not the data and not that stuff. (North West, Implementer)*

An important element of relationship building is a sense that implementers took time to understand the personal and social context in which girls engage in the behaviours that the programme is trying to change.

> *When they got tested a lot of things came out… with our services it is not just about the testing alone, it goes with the counselling, to get to know the girl more, to know more about what is happening in her life (KZN, Implementer)*

> *What I enjoy the most is interacting with young women, because as much as we think we know what is going on with them, we are now hearing it from them, they are teaching us new things, that we didn't know that young people experience… interacting with the girls and actually making an impact on their lives. (KZN, Implementer)*

. . .

What these findings relating to relationship building and personal context possibly point to, is that despite significant challenges with implementation and a host of areas where the programme activities could not be executed as planned, it is the element of building relationship with AGWY that produced positive impact, mostly in terms of empowerment as defined by the implementers. The importance of relationship building and understanding the personal context are not explicitly stated in the ToC model, but is likely more of an implicit assumption. In terms of the implicit assumption that the services that girls receive should be of a high quality, it appears that 'high quality' may not be as dependent on perfect operational implementation, but more on the quality of relationship that is formed with the implementers. While the ToC model does not clearly incorporate this element of relationship building, it may be a significant thread that has considerably enhanced the model in practice, when operational assumptions have failed. The journey plan/diary is the one component of the programme that was specifically aimed at relationship building and understanding the personal context of AGYW, but according to the findings, it was not implemented until recently.

Section 2: Intervention Acceptability

In this section we present data on the acceptability of the intervention from the perspective of implementers, AGYW beneficiaries, and community stakeholders. Acceptability of the intervention is based on respondents' direct experience with the intervention, views on the appropriateness of the intervention for AGYW needs and context.

The data below comes from evaluation interviews with implementer respondents, and includes data on the acceptability of the intervention from implementer perspectives, and implementers' perceptions of the benefits of the intervention.

Implementers' General Acceptability of Intervention

Overall, implementer respondents appeared to be accepting of the programme. Respondents noted that the programme focus was holistic and comprehensive. It was felt that the combination prevention approach of the programme had the potential to make a positive impact on AGYW lives, that it was well aligned to address pertinent needs, and that the activities were suitable for achieving the programme goals. Some implementers felt that the programme design was appropriate and that affecting positive change depended on SR's ability to facilitate programme components skilfully.

> *The programme setup worked well… everything that is needed for a girl child is there… it is a comprehensive package. They get everything in one place, in the Safe Space and it is safe, they will go out satisfied… I have already seen young women in the community who are happy about the programme, some are employed or we increase their employability, some are tested, some are on PrEP, some are initiated, they are protected… you can see change. (Mpumalanga, Social worker)*

> *There is encouragement from schools, accepting that girls have to go back to school even if you fall pregnant early. They support them with a start-up for their businesses… The transition from being a single parent or young parent to be a stable business person. They offer them those programmes on how to start a business… By means of just looking at the programme, and the holistic approach of the programme, it's about the people and for the people. (Mpumalanga, Social worker)*

Implementers were encouraged by the positive changes they observed among participating AGYW, which had a positive impact on job satisfaction and reinforced acceptability of the programme among the SR teams**.** Several implementers noted that they felt that the programme was creating a necessary support system for participants and that fieldworkers were able to help AGYW and change their lives positively. Respondents commented that they had received positive feedback from AGYW about their programme experience, indicating an improved sense of wellbeing and behavioural change.

> *The part that I find enjoyable… it is nice when you get to somebody's life and then when you leave, it has changed… I have been here since 2019, there are a lot of lives that have been changed. It is not a matter of you giving them something, but by talking to them daily and encouraging them. It is exciting that one day someone sends you a random text saying: "I am happy that I met you in my life, I have changed my perception… doing things differently". (Free State, Implementer)*

> *We have our beneficiaries, and when you ask them how the programme is going for them, you get positive feedback and then you can even see positive feedback, even from our angles… you*

can see they were broken and now, a young girl will come up to you: "...this programme has helped me a lot with this and this"... it is very, very nice. (North West, Implementer)

Some implementers felt that the design was acceptable and appropriate however the challenges lay in implementation and grant and programme management; particularly the fact that not all layers of the proposed programme had been implemented as planned.

The programme is designed, with all of these branches and layers... this programme has a lot of layers. If we can be able to implement all of the layers for this program, and make sure that all of the layers are currently working, then I believe... I am 100% sure that this programme was going to empower these young girls in a very, very positive way... I don't even know why they are not there because if I do talk to them, they will say it is a funders issue... I don't think it is my place to really say... because it depends on managerial issues. (Free State, Health worker)

Other implementers were, however, critical of the design of the programme, and the failure to deliver as promised (see section on Implementer perceptions of whether the intervention was delivered as promised). Noting that it did not take varying contexts into consideration, for example local governance challenges, political dynamics or government capacity to deliver on referrals. Additionally, some respondents felt that the intervention had not been properly piloted, and communities had not been sufficiently consulted prior to implementation.

They did get adolescent girls and young women inputs on how the programme should be and what the programme should include and how it should be formed. But in terms of the actual pilot to say now we've got a programme... we (should) then go to the school and say if we do Risk Assessment with five AGYW, what is gonna be the output of that? ...We don't do that. We get a programme and then we give it to implementers and implementers must implement. But also the challenge that comes from me for if we have done a pilot we could have picked up challenges and we could have tried to rectify. (North West, Implementer)

Community engagement was not done... if there were engagements... they would have done things much better... that's where we get a platform to meet young people... the youth that we are working with, as well as the children's parents. (Western Cape, Health worker)

Respondents also felt that the intervention was not adequately addressing structural barriers, for example in the inclusion of men and adolescent boys and young men (ABYM) in dialogues and programmes, or addressing other important social determinants of health. Several respondents stated that more needs to be done to include ABYM and older male partners of AGYW in the programme, and that more needed to be done to engage older men and the community at large, rather than just focusing services on AGYW. The failure to adequately involve ABYM and men in the programme had a negative impact on implementer, AGYW and community acceptability of the programme. This area of contention was mentioned by several respondents.

They did very well when it comes to the setup, besides the issue of the boy child because we also need the boys. There was not much practice of how the implementation will look if you are working on a programme with just AGYW. (Mpumalanga, Social worker)

Another common challenge noted by respondents was that the programme did not have sufficient reach in rural areas and did not have the resources or capacity to deliver to AGYW in these areas. This negatively impacted on implementer, AGYW and community acceptability of the programme.

Our problems are in the farms. Since we started our programme, kids from the farming areas have not received their things from us at all and this thing pains me a lot and they tell us…`Sister Angie, since you told us that you would bring the services in our farming area you never did that and you always keep telling us that you will come visit us but you do not bring the services to our farms… We are not able to reach out to them because the vehicles that are rented by [SR] are small, they cannot be used in the farms. (Free State, Implementer)

Several respondents remarked that staffing for the programme was inappropriate and had not been well thought through, for example PGTs lacked sufficient skills to deliver Risk Assessments, no data capturers had been budgeted for, social workers are overburdened with administrative and management tasks and the wide array of services defined as psycho-social. Expecting staff to perform duties which are outside the scope of their skillset and profession is a cause for dissatisfaction among implementers, which is negatively affecting both implementation and programme acceptability.

Psycho-social support has a lot of work… this programme should review and eliminate things that are not good, things that are not important here. Like this self-defence, it's not important… Similarly, the homework support, it is also part of psycho-social, and I ask myself how am I going to teach this child homework... The current syllabus is different from the one that was used when I was attending school… I only take the child and refer them to the PGTs… those that have the ability and the knowledge in the subject where the child needs assistance. (Free State, Social worker)

AGYW acceptability of the programme was also influenced by various aspects of the staffing on SR teams. Although implementers had described several challenges around the role of PGTs in the programme, one often noted positive aspect was that having younger PGTs on the team improved AGYW acceptability of the programme. Implementers explained that AGYW found it easier to open up to younger female PGTs and other fieldworkers that make up the SR team, allowing staff to build trust with participants. Younger PGTs and other field staff act as role models for AGYW and were positively influencing their behaviour and encouraging a 'mindset change'.

We know that parents prefer that AGYW should engage in sex after marriage… it becomes difficult (to discuss) but because in our organisation we are a team of young people, and most facilitators are young, so it becomes easy to come to someone who is the same age as yours and talk to her about your mistake. (KZN, Implementer)

Our programme entails staff members that are mostly young people; some are the same age as them. So they do not feel judged… they can speak freely and all those things and this encourages them… in the AGYW programme… having staff that is around the same age as the recipients of the programme [AGYW] is good… For them [AGYW] to come and find someone in the office that is around their age is one of the things that works about the programme. (Western Cape, Social worker)

Respondents noted that older staff members and male PGTs, nurses, social workers and social auxiliary workers found it difficult to gain the trust of AGYW. Male PGTs found that during recruitment and outreach activities, AGYW would be frightened and unwilling to talk to them, unless they were in a group with other female PGTs. Conducting a Risk Assessment as a male PGT may also compromise the validity of AGYW responses to sensitive questions.

For me, as a male it is a bit difficult… as a male to be honest, there are times when I meet girls and I am trying to really tell them the services and they just walk away… personally I don't go

> *there by myself, I go there with a team. So, when I am with someone that is a member of a team, at least the girls will give me attention... I even go around and then find them as a group and then just go there and greet them. (Free State, Health worker)*

One very concerning response was received, where male PGTs were accused of having or proposing sexual relations with AGYW beneficiaries, as illustrated in the quote below.

> *We're working with gents and they're full of eyes... they were supposed to be taught that here we work with girls... there should be a policy that states that if you do this and this, these are the repercussions for you as a male. Because they can propose to all the beneficiaries and what is going to happen, we don't know if a PGT can propose a beneficiary, whether it is right or wrong. And if the beneficiary can fall pregnant when with us; whilst we're fighting pregnancy... if it happens that a girl be impregnated by the PGT or the CSC whilst on our programme, it means it will have a bad ending for the programme and it will be blamed, that we encourage beneficiaries to sleep with men. (Free State, Implementer)*

Implementers described some programme management and coordination challenges that were impacting negatively on programme acceptability. A common theme which was highlighted in responses was that inappropriate scheduling of programmes and group courses was reducing AGYW participation and making the programme inaccessible. Respondents noted that some AGYW could not access the programmes easily because they finished school late, for example Matric students with afternoon classes. Clinics and SRs tended to stop offering services in the late afternoon or to close Safe Spaces too early for these AGYW to participate. SRs also had difficulty reaching community-based AGYW and aligning programmes for those who were working, as well as unemployed. Most SRs did not run programmes on the weekend, however, some had started to once this barrier to access was acknowledged. Therefore respondents noted that better alignment was needed in terms of scheduling programmes at convenient times for AGYW .

> *If they're in school, the grade 12's... by the time they come... the NGO that is providing those services is no longer available... they mostly come around three o'clock, some even come at four o'clock, after four and our clinic closes at four... the time that the adolescent is out of school... from afternoon classes, when they're out, the services are not available for them. (Eastern Cape, Health worker)*

> *These young people who are not working and attending school wake up late around 12:00 pm. That's another issue, because they have nothing to do ...while you are busy recruiting, they are still in their pjs (pyjamas) and gowns (nightgowns), they just woke up. (Western Cape, Social worker)*

Some respondents suggested that participation in the group courses was low due to the unrealistic time commitment required. The scheduling was described to be particularly problematic and a barrier to access for AGYW with childcare responsibilities. This was being addressed by some SRs by providing incentives and child caring services, while AGYW were participating in group courses.

> *The teen parenting one, they have to complete up to 23 sessions and that kind of commitment... we're really struggling to retain... we're trying to have benefits... like incentives. They get a care-pack for the child and then for themselves twice in the course of the course... the commitment of such a long amount of time is harder to motivate for... if it was slightly shorter, there'd have been more buy-in... Our self-defence course is 5 two-hour sessions, which is more doable. (Western Cape, Implementer)*

108

In implementers' views, the other key factors affecting AGYW access to and acceptability of the programme were the lack of incentives (already discussed in Section 1A of this report) and the cost of transport to reach services, which the programme failed to budget for and to address adequately. However, other SRs noted that although transport was initially considered to be a barrier to access, even when it was provided, AGYW still did not attend. It was not until a wider array of services were offered, that there was more buy-in to the programme. Therefore some respondents asserted that although transport was an important element in certain contexts, demand for programmes was more strongly determined by the attractiveness of the programming and providing incentives and refreshments at events.

> *The transport (was a barrier) because these children have to walk for 4 or 5 kilometres because they don't have that transport fee... we don't have the transport fee for them, so they have to just walk. When they arrive here, they are tired, they need something to eat but we didn't prepare something... Our budget doesn't accommodate transport for them. (Free State, Health worker)*

Implementers' Views on Perceived Benefits of the Intervention

In general, despite the various logistical challenges to implementation, implementer respondents were mostly positive about the intervention, and felt that it has thus far been very beneficial.

> *When they (AGYW) are with us, they no longer just get the service that they wanted, they go home having a lot of information... that is the best part of the job... we are educators as well as change agents in the community... we go to bed saying "we have done something". (KZN, Implementer)*

Benefits for AGYW Sexual and Reproductive Health

Reducing Teenage Pregnancy

Across the implementation districts, SR respondents shared their views that the various programme components were reducing the incidence of teenage pregnancy. A number of respondents anticipated that the programme was well placed to contribute to reducing teenage pregnancy or noted that they were already observing changes. Some respondents were however concerned that COVID-19 may have undermined these gains.

> *We've got the feedback... in some schools you might find 20 pregnant children at the same time but this has reduced... last year we got the report... to say teenage pregnancy has reduced; unless now after this COVID, maybe we are back to the same challenge again but it was... It has reduced (North West, Social worker)*

> *The children we started with are not pregnant by now and are not HIV positive, I think the programme is working. It's working very well and the schools appreciate the programme. (Free State, Implementer)*

They get education about such services… they get educated when it comes to family planning… it reduces the number of teenage pregnancies. (Eastern Cape, Health worker)

Reducing HIV Incidence

Implementers perceived a positive impact of the combination prevention approach on reducing the number of new cases of HIV infection. PrEP was especially hailed as an effective component of this approach, as it protects AGYW even where there is no behavioural change. Improved SRH knowledge and how the programme was rendering biomedical services more youth-friendly and accessible, were also noted as important factors.

The ones that come also come for their follow-up dates and they return on their specific date… some take PrEP when they see there is a need, there is a difference. Even the number of people who test positive are not as high as before, so it means they listen to these educational programmes. (Western Cape, Social worker)

The view was also expressed that the provision of Comprehensive SRH education to AGYW beneficiaries contributed to lowering HIV risk and subsequent infection.

They get educated when it comes to STIs and HIV, which also limits the numbers (lowers prevalence) because the community that I am working with, has got very high rates of these problems (Eastern Cape, Health worker)

Improved AGYW access to SRH services

Implementers generally felt that the intervention has been successful in improving AGYW access to health services, SRH in particular.

AGYW are afraid to go to the clinics because of the long queues and they feel like they are discriminated… they prefer to get help from us because we are fast… we help them immediately. (KZN, Implementer)

Reducing the burden on public health care facilities was regarded as one of the key benefits of the Biomedical layered services.

It also reduces the burden on the clinics because we are the community based mobile clinics, so we work in the community… we are reaching the girls in and out of the school because of the flexi hours we work, so it reduces the burden from the clinic... it also gives the AGYW confidence now to come to us because… most of them they are scared to go to the clinic... (our services are) youth friendly. (Western Cape, Implementer)

Where implementers have worked to strengthen health service provision and work within clinics, they have enabled waiting times to be reduced, and increased capacity for youth specific services, which has improved demand for the services, and reduced barriers to access.

They (AGYW) are fast tracked. There's no need for them to wait any longer, they know… they'll get quick service… now we can see that there's a lot of teenagers, young girls, adolescents, that are coming for such services because now they're not even embarrassed because they know that they have their own room. They don't have to meet with the adults. (Eastern Cape, Health worker)

110

Making health services more appealing to AGYW has helped to increase the use and uptake of services amongst this population, who are often reluctant to seek health care at a public facility, particularly for SRH and accessing contraceptives.

> *Young people don't like going to the clinic… they complain about being shouted at and they don't like waiting… and spending the whole day there… so (this programme) makes things somewhat easy for young people to receive these services. (Western Cape, Social worker)*

> *The programme is approached by a lot of AGYWs who come and say we have heard from our friends that we can come here for testing, and family planning and some will say we don't want to go to the clinic because the nurses are shouting at us, saying we are too young for family planning… this programme is comfortable for them to express their challenges and what they face compared to the clinic setup. (Mpumalanga, Implementer)*

Additional factors that have contributed to improving AGYW access to SRH services relate to youth-friendly services provision offered by the intervention.

> *I find this programme very essential for the young girls; they love it! …compared with services that they get from most of the clinics around here, our services are very, very user-friendly… the girls can… talk about all the things they can't talk about with the clinics… They started to trust us very well… we are having… some very convenient appointments for them. (Free State, Health worker)*

SRs providing SRH services exclusively to AGYW in clinics has improved demand for these services, which are offered in a youth-friendly and non-judgemental way, compared to nurses who are often criticised for being harsh with youth.

> *Girls do not want to go the clinics because they are afraid of being stigmatised, so, they choose to come to us and they are free to come here. We test them and they go home knowing their statuses, so we are getting there in reaching the 90-90-90 strategy. We are reaching it. (Mpumalanga, Social worker)*

> *We are able to create that friendly environment since it is evident that when the kids go to clinics they don't find the anticipated services because people at the clinic will be shouting at them. The nurse will be asking them why they are sexually active at such a young age and such things… we wanted to create that safe environment that is youth friendly (Free State, Implementer)*

The personalised attention provided by the programme also allows SRs to detect other issues and identify cases when AGYW need to be referred for psycho-social support.

> *I have seen some changes… now we having a high, a high, a high influx of adolescents coming to the clinic and… willingly without having to be coerced or being pushed… talking about issues that previously they couldn't talk about… They get more attention… which means it's now becoming more comprehensive… you are able to pick up some of the things like your social issues… identify social psychological issues… now they're willing to talk about sexuality without feeling a sense of judgment. (Eastern Cape, Health worker)*

Providing clinic services after-school hours increases access to health care for those AGYW in school, for whom normal clinic opening hours are not convenient.

> *Help is accessible, we are there for them... most of the clinics knock off at half past four… We are there at 6 o'clock… our services are accessible… even if they were there at school for afternoon classes, even if they were travelling from a school that is further away… they know that they will find us open. (Western Cape, Health worker)*

Implementers also felt that improving AGYW access to HIV testing was a key benefit of the programme. Assisting with the first HIV diagnoses for HIV positive AGYW would enable them to protect their future sexual partners from infection, and in turn contribute to reducing HIV prevalence in South Africa.

> *Some of the teenagers don't even know… they are HIV positive. They were born with HIV… (but) the parents didn't even tell them. So now because we do HIV screening… they get to know that. (Eastern Cape, Health worker)*

Improved access to PrEP

Despite challenges cited by implementers in PrEP roll out, generally SRs noted that the PrEP programme is now running more smoothly. Most implementers were very positive about the PrEP programme and its potential impacts. Implementers expressed their sense of excitement at being involved in the roll-out of this important new biomedical prevention product.

> *Our main programme entails offering or preparing PrEP to HIV negative girls….I think what came into mind was excitement of the fact that now they have a chance of being the future generation of HIV negative… doing something about it and bringing the services to their own level I think that was the best part of it… Even though we are working in such conditions… It was really kind of exciting. (Western Cape, Health worker)*

Respondents emphasised how critical PrEP was in protecting AGYW from HIV-infection, even in the absence of behavioural and structural changes.

> *PrEP is assisting us because if a young woman has initiated PrEP… HIV will decrease, even though she can have blessers, but she will not be infected with HIV. So, we are getting there, what will follow will be an HIV free generation. (Mpumalanga, Social worker)*

> *My wish is that all of them can be a part of PrEP, because it is a part of the prevention of HIV… Especially now that the topics now are about rape and killing of AGYW most of the time. So, if they can be part of PrEP, we will know that we can be able to fight (Western Cape, Implementer)*

Improved SRH Knowledge

As already noted, some professional nurses felt that improved SRH knowledge among AGYW was contributing to lowering rates of HIV and STI-infections. SRH education and the positive behavioural changes associated with various programme components, was also perceived to improve uptake of biomedical services. Implementers noted that they felt that SRH education programmes were contributing to increased awareness of SRH among AGYW was also perceived to improve uptake of biomedical services. Another more indirect benefit of the SRH education groups was that AGYW felt

112

supported and cared for by the facilitators and that they have a space that they can openly talk about SRH. Some professional nurses felt that the SRH education being provided would contribute to lowering rates of HIV and STI-infections.

> *Most of the girls are actually unaware of services that are provided, but once we get into the community, they are getting interested. They are actually showing interest in what we do and saying that it is helping them. (KZN, Implementer)*

Benefits for AGYW Mental Health and Well-Being

Improved Access to Psycho-Social Support

Several respondents noted that a positive benefit of the programme was how it was improving access to psycho-social support and individual counselling through social workers on SR teams. AGYW and the community especially appreciated that social workers and SAWs were on the implementing team, which contributed to programme acceptability. According to respondents, AGYW often feel uncomfortable being referred to DSD social workers for home visits. Therefore having social workers on the team, who can be accessed through the Safe Spaces and elsewhere, has improved AGYW demand for and access to psychosocial support. Having social workers and SAW on staff has made psychosocial support more easily accessible and convenient to access for AGYW, who might otherwise have been perturbed by long waiting times.

> *We also refer those who have psycho-social problems, because on the other domain, we are having a social worker, so we refer them. We make some appointments for them… some very convenient appointments for them. (Free State, Health worker)*

> *With those girls… that I've had time to sit down with and had a conversation with… their lives have been positively impacted… the programme is helpful in terms of allowing girls to stage the problems they have been sitting with for years… it is shaped, is so designed, such that when they answer these questions, those who are brave enough, they come out… this is the way we reach them. (KZN, Social worker)*

Social worker respondents remarked on the programme's benefits for AGYW accessing psychosocial support to deal with various traumas, including GBV. The visibility of the programme in communities, along with AGYW access to a trusted psychosocial support system, encouraged the reporting of rape cases that had gone unreported and ensured that AGYW received the necessary counselling.

> *In our Risk Assessment there's a part there that asks: "is there anything that you would like to share with us?"… then we will schedule an appointment for counselling… you would find that this person has been raped twice or thrice, but has never, never got counselling… In five girls you will find two girls have been raped and not once, but twice, thrice. (Western Cape, Social worker)*

> *We had a lot of rape cases that had never been reported, they had never spoken to anyone, they were scared… Now that we were visible in the community, they were able to access those services… the majority needed counselling, some cases were reported but there was never*

counselling, the focus was on getting the perpetrator arrested. For the victim there was no counselling, nothing happened. So, we played a big role. (Western Cape, Social worker)

Programme social workers observed an increase in reporting of cases of GBV and perceived this to be a result of improved access to psychosocial support for AGYW. Access to psychosocial support was also perceived to be providing the necessary support to AGYW who struggle with alcohol and drug abuse.

We also have a problem of GBV. Before they were not reporting the cases but now because we engage with them and when we refer them, they are able to talk about their challenges and they get assistance. (Mpumalanga, Social worker)

Improved Mental Health

Although delivery of the diaries/journals to AGYW beneficiaries was limited, implementers noted that the activity of journaling had beneficial effects on AGYW mental health, enabling AGYW to open up and talk about sexual abuse and other traumas to the programme social workers, and therefore access the support they need.

These girls who would have come as broken girls… at the beginning… once they start documenting their daily lives in their diaries, they start opening up… a lot of these girls have been violated one way or the other and these diaries are helping them talk about it because they are writing it down, and then in their next counselling session with the social worker, they will discuss it. It is helping the girls talk more about what is happening in their lives. (Western Cape, Implementer)

Implementers reported that grief counselling groups/courses had received positive feedback and believed this programme component to be beneficial. The perception was shared that the service was supporting AGYW mental health, helping to process grief and restore hope to AGYW who had experienced trauma and loss. There were a number of successful case studies reported, which indicate positive benefits from the grief counselling course and the other elements of psychosocial support of the programme.

With the grief counselling course, one girl said that her father had died… (it helped her) just around processing and letting go of her father… being able to do that work and to move on with life with some vision and hope. (Western Cape, Implementer)

We have just had one of our grief counselling courses end, and got them to write personalized stories of their… participation in the programme and the course… an amazing wealth of information came from that… The level at which they can share is then much deeper, because now they have dealt with their grief, and then often after dealing with your grief, hope is restored. (Western Cape, Implementer)

Respondents also noted that grief counselling was supporting AGYW who had lost friends and family due to the COVID-19 pandemic.

We have the grief counselling… Most of them have lost people in this COVID-19… the grief counselling helps them to talk about their loss and share their experiences about their loss. (Western Cape, Social worker)

114

Another mental health benefit of the programme was a result of the peer support received. Particularly for community-based AGYW, who were unemployed and not enrolled in studies, peer education groups provide the opportunity to connect with peer mentors and other AGYW, helping to reduce feelings of isolation and enabling AGYW to feel empowered.

> *What I am hearing from the young women is that it has definitely decreased isolation… mindsets will begin to shift because they are seeing quite empowered young women sharing… most of the staff are young and hip… the peer aspect of it is very good… the staff share a lot of their own journeys, and a lot of their own journeys have not been easy. So, there is definitely a connection, and the connection is where the shift happens. (Western Cape, Implementer)*

AGYW Empowerment

One of the United Nations' Sustainable Development Goals relates to the achievement of gender equality and empowerment of all women and girls. The concept of empowerment for AGYW is understood to include aspects in the economic domain, such as opportunities for employment; in the social and interpersonal domain, including freedom from sexual and domestic violence and shifts away from cultural norms that place women subservient to men; in the health domain, including aspects such as reproductive choices, and the ability to exercise those choices, control over their own bodies and access to SRH services; and in the psychological domain, including feelings of self-worth and happiness, and sense if agency and self-efficacy in decision making.

Several implementers believe that the programme is contributing to AGYW empowerment by addressing gender inequality, challenging harmful and disempowering gender norms, addressing GBV, encouraging healthy behavioural change among AGYW and the community and providing AGYW with multi-faceted support to facilitate economic independence.

> *The programme asks the AGYW what you want to be when you grow up, it makes a young woman think that, I might be coming from rural areas, and from a bad background, but I can still dream to be a policewoman… every six months the same question will be asked, so it will keep on reminding her that she said she wanted to be that particular someone. (KZN, Implementer)*

> *What is good about the programme is not only about the Biomedical services, it's also about empowering the girls… we empower them with a lot of information… there's a lot to empower them to become better people and better women. (Western Cape, Implementer)*

Implementers also perceived empowerment of AGYW beneficiaries to be a result of the successes of the self-defence programme

> *This programme has a great impact on the teenage girls and young women… especially the, the IMPOWER… young girls are being killed, are being raped… some of the girls didn't know how to defend themselves… didn't know about GBV stuff… I remember the last session that we had one participant said… that she is now a different person, she knows better now how to defend herself. (Western Cape, Social Worker)*

In terms of how 'empowerment' happens, the views expressed, perhaps rely too strongly on individual agency and 'mindset' or behavioural change of AGYW to be enough to ensure empowerment. This is

why other implementer respondents emphasised that not enough is being done to ensure the structural barriers to AGYW health and empowerment are addressed.

Improved Parenting Skills and Support for AGYW with children

Implementers spoke highly of the teen parenting programme. They noted that AGYW were not only benefiting from parenting information and skills but implementers also noted positive behavioural changes and personal growth among graduates. Teen parents often experience isolation and so implementers perceived that bringing AGYW together in a group programme had positive impacts on teen parents' mental health.

> *It is a very good class for teenage mothers, they are also being taught a lot of things, also about themselves, not just parenting. (Western Cape, Implementer)*

> *In the teen-parenting we found that the companionship and the less isolated behaviour gets shifted… they all come together with their children into the sessions and we have someone looking after the children, while the moms do the sessions, so it is a different level of support. (Western Cape, Implementer)*

Implementers noted that the teen parenting programme was reducing isolation of teen mothers and therefore improving their mental health and social support system. The wider support received on this programme resulted in certain cases where teen mothers found jobs, improving their economic independence. The positive behavioural changes and mental health arising from improved access to psychosocial support had renewed AGYW motivation to seek employment or enrol in further educational opportunities.

> *With the programme that we had of teen parenting… in that training, we also have a session there that has to do with work… how do they spend their money and what not… there are those AGYW that… were sitting at home (before)… after they joined our programme… some of the girls managed to get some jobs. (Western Cape, Social worker)*

Benefits for AGYW Education

AGYW Returning to School

Implementers noted that the programme had successfully supported a number of AGYW to return to school through referrals and assisting AGYW with applications for required documents, provision of psychosocial support, referrals to DSD and encouraging teen-mothers to return to school. There was also the perception that the programme was helping to keep AGYW in school, through the comprehensive layers of the programme. SRs were assisting schools to track absenteeism and provide necessary support where needed.

> *This programme is very good for the young girls… There have been positive impacts… in our service plan we also have a clause there, where if a teenage girl perhaps has dropped out of school, then we meet this young girl, then we enrol her, we explain the programme… there*

were those that dropped out of school and want to go back to school… we help them in that aspect, so that they can go back to school and re-register at school. (Western Cape, Social worker)

We also focus on the ones that are not at school and make sure they return to school… [SR] then makes sure that they stay in school especially when they have returned… There is also what you call homework support… you would find that one is studying and they are not able to do their homework, they are not able to do their schoolwork because there are a lot of people at home and they are not able to concentrate which in turn affects their performance in school. (Western Cape, Social worker)

Improved Educational Support

Homework support was another element where positive benefits were noted. Having access to a Safe Space, where AGYW could access the internet and do homework, also assisted AGYW who came from under resourced households. Career Guidance provided to Matrics and community-based AGYW also assisted AGYW to make successful applications and enrolments for tertiary education.

I work with the matrics only… I help them with their school work. I got good grades in matric, so I was able to help them with their studies… with their school work, that's how I had the opportunity of working with the matrics, but it is not easy to get the matrics because they are very busy. (KZN, Implementer)

They needed to apply for Tertiary, so I did apply for them... then I would teach one person who is going to teach all of them how to do the application online. (KZN, Implementer)

Implementers noted that support provided to AGYW through the structural services component, especially ESL, had resulted in improved knowledge on compiling CVs, making job applications and interviewing. Some successful cases of AGYW finding internships and jobs were also reported. However, this differed across the districts, depending on what structural services were available, as is detailed in Section 1A of this report. Employment opportunities and successful linkage to social grants were allowing AGYW to become more economic independence. Implementers perceived that a possible impact of ensuring AGYW economic independence, along with educational components, could be tackling the issue of transactional sex with older men/ 'blessers'.

Some get jobs as a result and become independent… the youth nowadays, some of them depend on their boyfriends… They end up getting 'blessers', not because they want to do that or they are enjoying it, but because there is nothing at home… the programme assisted by educating on such issues, they were also taught independence and not to depend on a blesser, to also access the Wi-Fi so they apply for jobs, internships and bursaries. (Western Cape, Social worker)

117

Implementers perceived that there would be future positive benefits arising from the Economic Strengthening and Livelihoods (ESL) programme, since AGYW are being encouraged to start their own businesses. Other perceived impacts were improved business skills, empowerment,

> *The ESL program is a life changing opportunity for these adolescent girls and young women… it's empowering… it's very exciting. So, it's a very good programme to report about as well… it has good successes! (Mpumalanga, Implementer)*

> *AGYW can even start their own business because you will find that some are gifted when it comes to doing hair… but they are not doing anything about that… they needed motivation, a person that will encourage them and say "you are good with hair, you can start your own thing". The programme assisted in making sure they put their skills to good use. (Western Cape, Social worker)*

Respondents also noted that there were some success stories in increasing access to work opportunities and linking AGYW with employment. This was regarded as a really important aspect of empowering AGYW to aspire to more in life than marriage and motherhood, to be financially independent, and not rely on male partners for support.

> *A lot of them (AGYW) were losing hope. In this area, what is important to the girls is getting married and having kids. (Free State, Implementer)*

> *Some (AGYW) get jobs as a result and become independent, because the youth nowadays, some of them depend on their boyfriends. (Western Cape, Social worker)*

Implementer Perspectives on Whether Intervention Delivered as Promised

There were several implementer respondents who were critical of the programme, noting that it was not being delivered as planned and promised to AGYW beneficiaries. Fieldworkers and other frontline staff who interact more closely with AGYW and are therefore receiving the backlash for failure to deliver, tended to be more critical. Staff dissatisfaction also varied across the districts, with notably more challenges around implementer acceptability in Thabo Mofutsanyana (Dihlabeng), Free State.

SRs noted that failure to provide AGYW with promised incentives such as diaries/journals has caused enrolled participants to lose trust in the programme.

> *We didn't offer any incentives… that's not part of the programme… we were supposed to be able to offer the journals to them, but they only got printed this year. (Western Cape, Implementer)*

Allegedly, in certain communities, the failure to provide promised components gives the programme a negative reputation, which in turn adds to retention challenges, and deters other AGYW from joining the programme.

> *The issue of dignity packs… does not give us a good reputation… because you would have promised there is a dignity pack, and you can help with different services. If you go back to the beneficiary after 6 months they are no longer interested in the programme because all we do*

118

is give them empty promises, we don't deliver… The management don't understand the challenges we meet on the streets because people are losing trust. So it is difficult to approach a new beneficiary on the streets because she has already heard that the organization makes promises but they don't deliver. (Free State, Implementer)

Documented experience with the failure to provide these structural services such as scholarships and other work or skills development opportunities tends to erode community and AGYW acceptability of the programme. SR staff noted that the structural services layer in particular, failed to materialise in some districts. Initial promises of what the programme would provide as part of service plans were not fulfilled (components like help with job searching, CVs, providing an internet cafe, information on and connection to learnerships). Several SRs noted that this created mistrust among AGYW.

The promises that we are not fulfilling… when we were introducing initially the programmes, we were saying that we were going to provide them with the internet café where they can do some homework, and there would be a person that could assist them with their homework. We would be their first line, for those who have passed the matric, the information for learnership programmes or some jobs that need young women with grade 10, 11 or 12… for those who didn't pass matric… We promised them initially, but then in our facility where we are working, we haven't implemented it… the learnership information... We are only providing them with the HIV testing... We usually enrol them after each six months again into the programme. Then when they come back, they say, 'no you are liars! (Free State, Health worker)

Most of the services we don't have them, we just have to find a way. Services like your livelihoods, your opportunities for education, your bursaries, your livelihood skills… there are a lot of programmes that are in the service plan that are not able to be implemented within the period we have started. It is so hard that you promise a girl… "you will be doing this and this and that", but then as time goes on you are seeing that you are not able to do the services. (KZN, Implementer)

One specific example of failure to deliver structural services as promised came from Thabo Mofutsanyana (Dihlabeng) in the Free State. The SR had originally promised teenage mothers that the programme would arrange and pay for their children to attend a crèche, so that mothers could return to school. However, this assistance never materialised and thus created frustration and disillusionment among AGYW beneficiaries who could not return to school without child care assistance.

We haven't done anything for these kids to assist them to stay in school… except that we are giving them family planning… Those that had unwanted or teenage pregnancies, we were promising them as they entered the programme that we are just going to take their kids to creche, and we would pay for the creche and they were so happy… Then the social worker should have made some arrangements about the kids… That is our promise initially to them, but that thing didn't happen... It just dies a natural death because we didn't know whom to contact when there was a child that wanted to go back to school and a baby that needed to go to creche. (Free State, Health worker)

One respondent noted that this support should have been provided to AGYW mothers through the ECD (Early Childhood Development) vouchers. ECD vouchers were meant to be a component of the ESL Programme to 'assist young unemployed AGYW to overcome their burden of care challenges' (NACOSA et al., 2020, AGYW Programme Description). However this element of support did not materialise in some of the pilot sites.

119

Things like ECD vouchers… when it comes to the referral, you will find that the child has been referred for something that I cannot offer… for example there is a 15 years old child who has a baby and is no longer able to going to school. She might feel she wants to go to school but if only someone could help with paying for the little one's crèche… Even this ECD voucher… I wish that it could be made that, each service that is rendered here, must be rendered. (Free State, Social worker)

Many of the PGT respondents expressed the sentiment that they are the ones who bear the brunt of the anger, frustrations and discontent from communities and beneficiaries, regarding the failure of the programme to deliver as promised.

If you go to the community you are insulted, as we meet different people they will be swearing saying you are wasting their time, they don't want to hear anything… we end up telling them (management) that from henceforth we're no longer involved with issues of events, you should go and invite those people for yourself because you make us appear as bad people, who are selling empty promises. (Free State, Implementer)

Section 2 part B:

AGYW Beneficiary Intervention Acceptability and Experiences

One of the objectives of this evaluation study was to assess the acceptability of the intervention to AGYW beneficiaries. In this section we present the perspectives of AGYW intervention beneficiaries and describe their experiences, views and acceptability of the intervention components.

AGYW Experiences and Acceptability of

Recruitment, Enrolment and Demand Creation

AGYW beneficiaries shared their experiences of being recruited into the intervention, listing various ways there were contacted initially and recruited. Some AGYW were contacted through telephone calls, suggesting that their phone numbers were listed in a database, possibly from a prior intervention. Each quotation is followed by the AGYW respondent's site, age group, and whether she received Core or Biomedical Layered services (as determined by the My Hope database).

I was recruited by phone. They called me… and explained to me that they got my number from the organisation I was attending in the community… it dawned to me that it was the Cash Plus Care, because they had all our contact details… that's how they got my details. They explained everything to me and made it clear that they are not forcing me to be part of them, but if I would like to be part, I will let them know, then they will call me for some questions. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

AGYW also recounted their experiences of having been approached by programme staff on the street, who introduced the programme to them and invited them to participate.

I first heard about them on my way back from church… we met these ladies… and they approached us and they told us what they do… they told us that the organisation they are working for deals with changing people's lives… I first registered my names there and also gave all my details. ...I then started attending and became a member. (Nelson Mandela Bay, EC, AGYW 15-19 years, Core)

Being approached by strangers and recruited on the street was described as frightening for some AGYW; indicating that on-street recruitment may not be an appropriate strategy in communities were safety is an issue.

It is better to have someone who you can come and talk to you at your house because it is scary to talk to people that you meet on the street and join a programme. (King Cetshwayo, KZN, AGYW 15-19 years, Core)

Other beneficiaries explained that they were recruited when accessing health services at the clinic, such as HTS.

When I first joined the program… I was actually testing for HIV… that's when I got further information, the nurse told me okay this is what's gonna happen, we are going to keep in contact with you… everything is confidential. (Bojanala, NW, AGYW 15-19 years, Core)

Several AGYW respondents recounted that they first heard about the programme at school or college, either from teachers, or from programme staff who came to speak to them.

The teachers asked us if we would be interested in the programme, so that is how I found out about it… I felt that I would really like to take part in something like this, so I went during break to sign up… they spoke more about… girl's empowerment… for us women to build up our self-image and all that… I felt that there was something that I actually needed at that moment, especially with my environment which I find myself in… I felt that it would be good for me… it came at the right time and I felt like that was the support I needed and that was what could maybe help me so I'm going to take part in this programme... The teacher didn't have to explain a lot about the programme and when she finished asking us, it was; Where can we sign up for it? (Nelson Mandela Bay, EC, AGYW 15-19 years, Core)

They came to school and asked for girls of a certain age, then we discussed with my friends that let's join maybe we will get help, you know the peer pressure thing. Then we registered our names, contact numbers and we joined the group. They told us how we are going to do it and how we were going to meet. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

Some AGYW explained that having heard about the programme at school, and having received sanitary pads, they did not think that there would be any further follow up, despite having registered and provided their phone numbers.

They came to register us at school and they gave us sanitary towels… our friends were going, and we all went there… they told us that they are helping girls… they said they will assist us with our needs like giving us food parcels and toiletries and to find out if we are not abused at home… they are able to assist… (At first) we didn't take them serious. We thought they are just registering people and they are just leaving…. I thought they are just dishing out pads because they didn't ask us our personal stuff… I thought they are just passing through, that they came and gave us pads and that was all to it. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

121

Many of the AGYW respondents described how they had been recruited through door-to-door visits at their homes.

> *The woman who registered us was doing a door to door campaign. She then recruited me to join the programme, but she said it was up to me if I am willing and I agreed. She then asked me some questions and I answered them… She then took my details and after that she told me that she would call us into a meeting (King Cetshwayo, KZN, AGYW 15-19 years, Core)*

Some AGYW expressed disappointment that after being recruited and registered, they had never received any follow up or further communication about the programme activities.

> *There were people who came to my house who were recruiting… they asked me if I wanted to join… I said "yes okay, you can register me"…. They told me that… we will be required to attend meetings… but it has never happened like that. (Bojanala, NW, AGYW 15-19 years, Core)*

AGYW were also recruited through community events, ward committees and local Ward Councillors.

> *It was announced in the community that there would be such and such a programme for girls… they said those who are interested can come and join… They informed the councillors and the councillors informed the ward committees that they must announce in the community that there is such a programme. That's how we knew about it… we were told to bring our documents together with our details. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)*

According to the narratives of some of the AGYW beneficiaries interviewed, some were not aware that they were being recruited into a programme when they initially gave their details. Hence some of the AGYW were surprised to be contacted later on, having not understood the implications of having provided their phone numbers.

> *I remember that there were people who came to school… the ones that took my numbers... the ones who tested for HIV… I didn't think it will be like this big you see… they came to school like to test, they came to provide us with condoms... I didn't even remember giving them my details… so I was super surprised… when they called me… I remember going to test but I don't remember giving you my numbers… we just filled in (forms) because we want to test you see… I didn't take it that seriously… I was like "what the hell… what have I done?" (Bojanala, NW, AGYW 20-24 years, Core)*

As part of demand creation and recruitment, AGYW who are active in the programme were encouraged to become champions and ambassadors of the programme, and to recruit their peers.

> *The only thing that they wanted me to do was to tell young people and bring them there for help… I was like a superhero saving the world. It was nice because I was getting to help other young people like me… I was able to help them, to tell them about the programme, what they are offering and what service they can get there. (Ehlanzeni, MPU, AGYW 15-19 years, Core)*

AGYW motivation to join the programme

AGYW beneficiaries listed the various factors that motivated them to enrol and join the programmes offered in their communities. AGYW described the ways in which they believed that participating in the programmes may be able to benefit them.

122

I really wanted to be part of that organisation, because there are not a lot of opportunities like that for girls in the community… you can get tested for free or you can get birth control… or you can also get counselling there. Or if they cannot help you, they refer you to other NGOs… and you get assisted in that manner... it definitely made me want to be part of organisations like theirs…. the programmes were all about female empowerment, and I strongly believe in female empowerment… everything they spoke about was something I believe in, and it excited me to be definitely be a part of it. (Nelson Mandela Bay, EC, AGYW 20-24 years, Core)

The main motivation for some AGYW was the offer of assistance with education, including support with staying in, or returning to school, applying for tertiary education, and other types of educational support.

The main reason that made me to become part of the programme is that they told me that they are able to help people to carry on with their lives and help them to go back to school if they want to. (King Cetshwayo, KZN, AGYW 15-19 years, Core)

For other AGYW, the psycho-social support and guidance offered by the programme was the key motivation for joining.

It is not easy as a teenager to grow alone. You need some assistance from people like Social Workers. So, when I heard about that, I tried to be part of that group… some of us might have problems… you cannot not handle on their own…. if you are abused at home… they will be responsible and help you in everything or maybe if you have a problem at school…. any personal problem that you might have as a girl… what made me to decide to participate was because I realised that I also need some advice… I saw it as an opportunity to get help. (King Cetshwayo, KZN, AGYW 15-19 years, Core)

Many of the AGYW interviewed explained that they had been motivated by the prospect of connecting with peers, and having a space to meet with other AGYW. Being provided with a space to connect and speak with peers was particularly attractive for AGYW in the 20-24 age group, many of whom were out of school and unemployed.

I was very happy (when I heard about the programme) because nowadays we don't have time to sit, come together as girls and talk, and help each other… I was happy that I will have time to stay with other people and talk about matters relating to life… thinking about that opportunity of discussing with my other peers. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

The self-defence classes offered by the programme was also a motivation for AGYW who are concerned about their personal safety or live in communities where they feel unsafe.

At that time there was many cases of gender based violence… also not feeling safe in the community that I lived in… girls were beaten up… so I decided to attend (the self-defence classes) so that I can be able to defend myself. (Bojanala, NW, AGYW 15-19 years, Core)

Other AGYW were motivated by the health services offered as part of the intervention, in particular support, information and education regarding their sexual and reproductive health.

What interested me was sexual health… we needed something like that, people who would talk to us about our problems and what we're going through… problems you get as a female... pregnancy, contraception, infections, termination of pregnancies… sometimes you need someone you can be there for you, so people of (organisation/programme) they act as friends around us... (they) make (these things) fun to talk about... I was a bit scared (at first) but at

the same time I felt free you know that can talk about things that I'm going through, my sexual being and myself as an individual. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Core)

AGYW perspectives on incentives

Some of the AGYW respondents openly admitted that they had only been motivated to join the programme due to the incentives offered. Although AGYW also expressed the view that incentives were a form of bribery to persuade them to enrol, and that incentives brough no real change or value to AGYW.

They took our ID numbers, and initials. Then they bribed us with pads and lilettes (tampons)... and take-aways with seven (quarter leg chicken piece) and a mini loaf, and that's when we gathered to register as girls…. We as the youth of (name of community), are requesting that when there is a new programme introduced, it must bring change but not to give us pads and take-aways only… so that you can help us. Instead of helping us, you bribe us with pads then you leave… bribe the poor people with take ways and brown bread and taking their IDs and initials as if I have done something… an organisation with an aim of helping girls, and that's what they say, but they don't help us… The only thing I have is a pink t-shirt… A take away and lilettes...They bribed us with that, but we need jobs, we need money and opportunities in life. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

Interestingly, some AGYW who had previously participated in Cash Plus Care programmes, were not interested in joining a programme that did not provide cash / monetary incentives, as they had become accustomed to cash transfer programmes.

AGYW perspectives on confidentiality

AGYW beneficiaries expressed positive views on the anonymity and confidentiality afforded by being issued with a UID (Unique Identification Number) instead of using names. They felt this afforded a greater sense of privacy and freedom to share.

What I like about this programme is that even when… I come with my story, maybe about my state of health or help with regards to health, my relationship or problems I have at home… my name will not be published, but they use a certain number instead of my name… my name has not been disclosed... it meant that I will have freedom to share… I am at liberty to talk… so the use of a number has made me to be free in talking all that I know and all that is happening around me. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

They just take your ID (Identity document) and make a copy… from there they don't call you by your name anymore, they create a number for you… you become that number (you are called/ referred to by that number)… they don't share everything with other people, that is why they call/ refer to you by a number. (Bojanala, NW, AGYW 20-24 years, Core)

Barriers to AGYW participation

A few AGYW respondents mentioned barriers to their participation in the programmes; key barriers included lack of transport and distance to venues, lack of interest, childcare responsibilities, and resistance from their own parents.

> *What affected my participation was my daughter... I am at home and I am a single parent. I have to take care of her... I couldn't focus because she was with me in the classes. I tried my best to focus with her by my side but was a bit of a hassle having her there. (Klipfontein, WC, AGYW 20-24 years, Core)*

> *My mother was saying that she doesn't trust these programmes, because it might be a scam or associated with human trafficking... So, if there was a meeting with the group, sometimes it wouldn't be easy for me to go and attend. (King Cetshwayo, KZN, AGYW 15-19 years, Core)*

Some of the AGYW interviewed, despite being listed on the beneficiary database, said that they were not aware of any programmes for AGYW in their communities.

> *I don't see many activities happening for young women... I don't think there are any programmes in the community... That is the problem, there aren't programmes (for AGYW)... The majority of the things happening in the community are always about boys, it is not much focused on girls. (Nelson Mandela Bay, EC, AGYW 20-24 years, Core)*

AGYW Experiences and Acceptability of Risk Assessments and Self-Assessments

In interviews with AGYW beneficiaries, interviewers probed on AGYW experiences and perspectives on the Risk Assessment process. In most of the interviews it was unclear whether respondents were describing or referring to the Risk Assessment questionnaires, that were designed to be administered by a member of intervention staff, or the Self-Assessments, which were intended for AGYW were to complete themselves before the facilitated Risk Assessment process.

> *They requested that we sit in pairs. They then gave us the forms to complete... They clarified what was expected of us. The second time they came... we also completed those forms. they were dealing with one person at a time and we had to write in ourselves. The second time they will ask you and they will fill in the information. (Ehlanzeni, MPU, AGYW 15-19 years, Core)*

The data presented below provides an overview of AGYW views on these assessment questions and processes. The respondent below described a process in which the AGYW were seated in groups and given forms to complete themselves under the instruction of a member of staff. She also recounts that some of the other AGYW left questions they felt were too invasive unanswered.

> *We were in tents... They just grouped us. There was a person who told us where to tick and advised us what to do. They just go on with the instruction and your task was to read and ask where it is not clear... I didn't see the other girls because some of the questions were too personal for them and I just thought that they didn't like it. It was as if they are invading their privacy. There was this one who told me she didn't answer the HIV question and under the sex one. (Ehlanzeni, MPU, AGYW 15-19 years, Core)*

> *Under the tree we were given papers to fill information in… I filled it (the form) in under the tree… what I didn't know was left blank… They also clarified on how and what to fill in… There was someone on the side who was asking questions… and has told us on how to respond to the questions asked. (Ehlanzeni, MPU, AGYW 20-24 years, Core)*

The sentiment that some of the questions in the assessments were quite invasive and embarrassing was expressed by several respondents.

> *The questions they ask you there at enrolment… they are heavy…. how many times do you have sex, do you use a condom… are you being abused by your partner or anyone, your HIV status and such stuff…. I felt insecure but I became relaxed when my friend started to explain that don't be afraid these are the questions that you're going to have to answer if… but if you don't want to answer them, it's cool, but it's part of the enrolment. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Core)*

Some AGYW expressed concern about the confidentiality of their answers in the assessments, and were thus reluctant to disclose experiences such as sexual abuse.

> *There's a form I once filled… I told them everything, how I live… it was saying if you have ever been raped you must… write yes or no… and also how I live, my partner is he making trouble for me when I don't want to have sex with him or what… I filled those forms. And those of rape I did not say this one I'm not going to tell her… I don't want people from this house to know that I was raped… you know they read it (the form)... they said they were coming from what-what there they were sent by what-what there, they were doing door to door… the lady who brought that form… she told me that she won't tell anyone. (Bojanala, NW, AGYW 20-24 years, Core)*

Another concern that some AGYW had relating to the assessment process was the lack of privacy at the venues where the assessments were conducted, which was problematic given the sensitivity of the questions being asked.

> *There were questions there which made me feel uncomfortable... Like those of who broke your virginity? ...Are you still a virgin?… I was around people you see, then when I told them that no I'm still a virgin then other people started saying "Aye you are lying, as old as you are"… So those were the things which made me hesitant to answer… when we were answering those questions it was six or five of us at the table, and then after we answered those questions, it was then you will enter alone where they were going to test you… but each and every one was holding their question paper… there was a lot of us around the table and then when you complete then you go alone to the room where they test you. (Bojanala, NW, AGYW 15-19 years, Core)*

> *The questions they were too much deep… we were sitting on chairs while queuing… there was no privacy. (Bojanala, NW, AGYW 20-24 years, Biomedical)*

Some of the AGYW felt that the staff administering the assessment questionnaires were too old, which made the AGYW reluctant to disclose their behaviours due to a fear of being judged.

> *They just ask us about life… if we have HIV, STIs also to find out if our boyfriends are not troubling us... things like that… I felt embarrassed because it's old people who were asking those questions. They ask you about a boyfriend and if you have slept with a boy… It's a person*

of my mom's age and she is asking me such questions. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

There appeared to be a lack of understanding on behalf of some of the AGYW beneficiaries about the purpose of the assessments, indicating that in some cases, explanations of the process to AGYW beneficiaries may have been insufficient.

You fill in your personal information and the person assisting will write name, surname, your ID and your residential address. I was shocked at first… I didn't know the implications of filling it in. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

There were groups of people who came (to our school)... they came with forms.. that form it was asking about me… about my life… whether I'm being abused… do I have a boyfriend, if me and him are active (sexually)... they gave us the form and we were just sitting… I also wanted a little bit more info (Information)… I thought maybe it will be more of a study for about like maybe they will call other people for us where they will say we get in there privately then we talk about something that we needed to talk about, and we get help with what we need after but it just ended there with the form. (Bojanala, NW, AGYW 15-19 years, Biomedical)

According to accounts from some AGYW, assessments were conducted over the phone; some AGYW were reluctant to answer such sensitive questions over the phone, particularly if the phone number they were called by was not one that they recognised.

I was like "what is this number?" (phone number calling), I answered it… this woman told me that she is calling from school… she asked if I'm available to answer those questions… questions were like 'am I sexually active'… 'have I been abused before', 'have I been in a relationship where I've experienced abuse', and 'sometimes do I ever feel like I want to commit suicide' those kind of questions. (Bojanala, NW, AGYW 20-24 years, Core)

AGYW emotional reactions to the assessment process were varied. Some found the questions easy to answer honestly, whilst others found the questions too invasive and were too uncomfortable to answer them truthfully. Discomfort around the questions meant that some AGYW chose not disclose their behaviours, and chose to give false answers.

Those questions… they were too deep, they were too deep, they were too personal. (Bojanala, NW, AGYW 20-24 years, Biomedical)

Some AGYW who had been reluctant to take part in the lengthy and tedious assessment process and answer the questions were persuaded to do so by the incentives provided.

There were questions there which were embarrassing to answer …if you have a boyfriend, does he have other affairs or is it you only… they gave us forms to fill them, it was huge form so most of us we did not want to fill them then they said you get a chocolate lunch bar if… you fill it… So we went then they gave us the chocolate [Laughing]... (Bojanala, NW, AGYW 15-19 years, Biomedical)

AGYW Experiences and Acceptability of Diaries / Journals

Very few AGYW respondents spoke about the diaries/journals provided by the intervention, which may have been due to the fact that for most SRs, the diaries arrived late, if at all. Those AGYW that did share their views on the journals spoke positively of them, and how the activity of journaling provided emotional release and stress relief.

> *They gave me a diary… for me to write my feelings, everything that happens in my life… it's useful because I'm able to express my feelings, then after that I'm able to see… what is right and what is wrong, I'm able to be okay after I wrote in it… I write about everything that stressed me out, after I wrote about that and look at what I wrote I realize that I'm relieved… Because I don't have anyone I can talk to so my problems I write them on that diary… and other things that I don't like that are happening I just write them on my diary. (Bojanala, NW, AGYW 20-24 years, Core)*

> *We were also given diaries so that we can write things that did not sit well with us, to write our wishes and goals. (King Cetshwayo, KZN, AGYW 20-24 years, Core)*

AGYW Experiences and Acceptability of Safe Spaces

In general, AGYW beneficiaries shared positive views of the Safe Spaces provided by the intervention. Perceived benefits of the Safe Spaces included access to computers, a safe and quiet environment conducive to studying, access to homework support, assistance with applications, and a space in which to connect with peers.

> *They helped us when we got there… there were documents we had to type… they were able to assist with their machine and laptops and everything and give us information… We were able to go there and study because it was a safe environment. It was quiet environment and for us it was a good place for study. And by the time I was supposed to apply for varsity bursaries, again they are ones who helped me. I just went there and gave them my documents, reports, and everything for the application. They did everything for me. (Ehlanzeni, MPU, AGYW 15-19 years, Core)*

Some AGYW liked to use the Safe Spaces as a place to chill and relax, hang out with peers, and get support.

> *We just go there (to the Safe Space)... most of the time I just sit down and chill. Sometimes I go with my books, my novels. I will just be reading them or study… If I find others I just go there and talk about what affect us as women at this age. So we find resolutions and everything. (Ehlanzeni, MPU, AGYW 15-19 years, Core)*

AGYW Experiences, Acceptability and Perceived Benefits of Biomedical Services

Many of the AGYW beneficiaries described positive experiences of the HIV testing services provided by the intervention, including the pre- and post-test counselling and support offered to AGYW who tested positive.

> *I was scared (of testing) …before they can test you they counsel you… They talk to you very well, they say "if you find out that you have AIDS, I know you will want to kill yourself, you will want to do whatever… I'm going to give you counselling till you understand… and accept"… They give you counselling and then tell you that if you are injected… that it will not be the end of your life. What is important for you is to get treatment you should drink… When you get out from there you have already accepted, and when find that you're negative, your heart will still be beating fast. (Bojanala, NW, AGYW 20-24 years, Core)*

> *We were testing for HIV… they were not forcing us, it was a voluntary thing… every time we attended, I would check (my status)... they will ask you if you are willing to test… if you have tested positive, they will counsel you by saying this is now your life, but we can help you by giving you treatment so that you can be fine. (King Cetshwayo, KZN, AGYW 15-19 years, Biomedical)*

Negative views of the HIV testing services mostly related to the lack of privacy that some AGYW experienced in the mobile testing sites. Where testing was conducted in mobile containers, or testing tents and gazebos erected by the intervention staff, AGYW felt that confidentiality was compromised, and thus expressed a preference for clinic-based testing services.

> *Testing from the container is not that ok because there's no privacy. When you are busy testing, others are queuing outside… when the results are out, maybe they will hear what is being said… A lot of people prefer not to go there… It is much better to go to the clinic… they should get a place which can be better than a container, something like a building… where you will know that you are enter in the room alone and they will close the door. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)*

> *I was afraid of testing there [laughing]... I felt it is much better to go to the clinic… It is scary there, it is much better to go the clinic and be alone rather than with everyone there, even though they cannot see your results, but I prefer doing it in the clinic. (King Cetshwayo, KZN, AGYW 15-19 years, Core)*

However other AGYW expressed a preference for the mobile testing services provided by the intervention, rather than clinic-based services.

> *I prefer testing at the mobile clinic, rather than at the clinics, because at the clinic people keep on looking at you, especially when you go to the counselling room, people will always think maybe you are sick… a mobile clinic is much better because mostly there are people who are your peers… But at the clinic, there are places that are known that once you get in, it means you are going for counselling to check your status, and that makes one to be shy. Even when you are done and the results are negative, to the people who are looking at you, it will seem as if you are positive…. clinics are always full… you also bump into people you know… if you are a young person it better at the mobile clinic. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)*

AGYW beneficiaries shared their experiences of being offered PrEP while accessing other biomedical intervention services, such as HIV testing.

> *When I first joined the program… I was actually testing for HIV… that's when I got further information, the nurse told me... there's also this prevention thing, HIV prevention thing (PrEP) in the program… If you wanna take it… you basically drink pills every day… that's part of the program… But you're not forced to take them… It's your choice. (Bojanala, NW, AGYW 15-19 years, Core)*

Those AGYW who declined to take PrEP explained the reasons for their decision not to. Some felt that since PrEP would still have to be used alongside a contraceptive methods, it was better to use condoms that at least offered dual protection from HIV, STIs and pregnancy.

> *I don't see the point of taking those… prevention pills (PrEP)... you're not solving other problems, you're just solving one problem (HIV)… I felt like okay there's a condom, a condom does both… it does more good than any of these preventions. (Bojanala, NW, AGYW 15-19 years, Core)*

Several AGYW expressed concern and fear about potential side effects that may be experienced when taking PrEP; in addition, a few AGYW were scared of developing a resistance to ARVs. Some AGYW stated that they had heard about side effects from friends or health care providers, others explained that they had personal experience of the side effects.

> *They told us about HIV prevention pills (PrEP)... and I took them… But then eish the side effects were not nice for me… So I stopped… when I take them… on my head I feel like iyoo!… you know eh…a rush… I feel weird on my face… it was like itchy… like numbness… that feeling wasn't nice at all.. my face was just itching… I can't carry on taking them, I can't… Right now I'm just condomizing (using condoms) and I'm at peace (Bojanala, NW, AGYW 15-19 years, Core)*

AGYW also described various beliefs and rumours that were circulating about PrEP which fuelled fear and a reluctance to initiate on PrEP.

> *I refused them, I was afraid of them… we heard the rumours that those pills after you've taken them you get HIV… I got afraid of them [Laughing]... they said "no they made it (PrEP) so that we can be infected by AIDS" (Bojanala, NW, AGYW 20-24 years, Core)*

An additional barrier to uptake of PrEP amongst AGYW beneficiaries related to the intermittent supply and stock outs of PrEP in some facilities.

> *After testing we were informed about the PREP… and informed that we would be told as to when we should return when they have tablets for PREP, because at that time they did not have any to distribute. So, they just took our contact details and were told that we would be contacted telephonically when they get what they need. (Nelson Mandela Bay, EC, AGYW 20-24 years, Core)*

In the views of AGYW beneficiaries, the biomedical layered component of the intervention provided AGYW with comprehensive SRH support and services.

If you have never tested (for HIV) in your life, they can say go and test if you want… if you don't want to be pregnant you can go for an injection, to test for AIDS, to get PrEP… Injection for pregnancy prevention. You also test for AIDS… there are sanitary towels and toiletries. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

Narratives from AGYW beneficiaries who believed that the intervention had improved their ability to access SRH services included the sentiment that the services offered through the intervention were preferable to those offered at government health facilities, being more efficient, more personalised, less judgemental, and more comprehensive.

They offer counselling, support group… hand out condoms, pregnancy test and contraception… I received condoms… HIV testing, and counselling when I have problems… they calm me down and give me emotional support… the way they treat people is proper, it is the correct way… the clinic is very different from (programme) people... especially public clinics, they don't take you seriously… there are a lot of people, so (the programme) give you special treatment as an individual, giving you the necessary attention… if you need help… they will take time to help you… At the clinic eish it's just a mess… eish the clinic depresses me [laughter] yhooo! (Thabo Mofutsanyana, FS, AGYW 20-24 years, Core)

Their health services are good… They give you their time unlike at the clinic where they are always in hurry and there are too many people. If you go there seeking for assistance they give you all the information that you need. They explain everything well. (Ehlanzeni, MPU, AGYW 20-24 years, Core)

They treat us well… with no attitude and are approachable... I would choose the programme (over the clinic) because it is not full like the clinic, the service is so quick. (Ehlanzeni, MPU, AGYW 20-24 years, Core)

AGYW also felt that the health services provided through the intervention afforded more privacy than those received at the clinic.

At the clinic there are many eyes. They all are looking at you… On the other side (programme), it's private and it's only girls. It's a one-on-one consultation… and there is no one seeing you. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

Those AGYW that accessed health services provided on their TVET college campuses enjoyed the convenience and accessibility of these services.

The programme on campus... that is the only one that I use in terms of family planning and all that stuff… When you pass by you can grab a pamphlet and a packet of condoms or anything of that nature that you need or want... you can access it without any worries… It is way different to what I have experienced in community clinics… in community clinics they really don't care… (whereas) the services on campus… every time you go and get something you get some information, you learn something new… I took full advantage of what was happening on the campus… I am hungry for information. (Klipfontein, WC, AGYW 20-24 years, Biomedical)

The narratives shared by AGYW intervention beneficiaries demonstrated their increased awareness of their sexual and health rights.

> *What made it easier for me to actually go to a clinic and ask… (we were told) that you should not be ashamed as a young woman, it is ok to be able to go forward, it is your right to ask. (Klipfontein, WC, AGYW 20-24 years, Core)*

AGYW felt that they had been made more aware of the importance of testing for HIV regularly, and of communicating with sexual and romantic partners about HIV testing. AGYW also expressed a sense of increased assertiveness in relation to looking after their own health.

> *(Talking about HIV testing with your boyfriend)... it seems that I am growing, since I am in the programme, I discovered that these questions are actually really important to have in a relationship… Boys actually tend to run away from questions around HIV and all of that. I have actually made a decision… he will have to know that we are going to have an HIV test every three months and if he is not up to that, then he is not for me... if he doesn't agree… then it is a deal breaker. (Klipfontein, WC, AGYW 20-24 years, Biomedical)*

For those AGYW who were HIV positive but had not yet initiated ART, the programme encouraged and supported them to access treatment.

> *They have encouraged me to be able to go to the clinic to get the treatment (ARVs)… because I knew something was wrong with me… I am HIV positive, that is the treatment I am talking about… They helped me with a lot of things… they treated me well. They talk nicely with you. You feel comfortable even to talk about your secret. (Ehlanzeni, MPU, AGYW 15-19 years, Core)*

AGYW Experiences, Acceptability and Perceived Benefits of Behavioural Services

One of the key benefits of the intervention as described by AGYW beneficiaries related to the ways in which supportive peer networks and friendships were fostered through the peer engagement and peer education activities.

> *We have developed a solid friendship as adolescent girls, there was no discrimination… we managed to create friendship, such that I can even ask anything from them when in need. (King Cetshwayo, KZN, AGYW 20-24 years, Core)*

> *That opportunity of discussing with my peers. Sharing information and hearing new things from them. Oh, I was very happy. (King Cetshwayo, KZN, AGYW 20-24 years, Core)*

> *(In the group you can) meet with other girls, hear their views and understand how others think… you are able to speak out and not bottle things inside... when something bothers you, you can speak out… It was fun, so exciting to get to know what other people go through in life… I learnt that you have to speak out when there is something that is bothering you. Something that doesn't sit well with you. (Ehlanzeni, MPU, AGYW 20-24 years, Core)*

> *We were taught… to be able to share with confidence with other women who are like us. About things that are troubling us. (King Cetshwayo, KZN, AGYW 20-24 years, Core)*

AGYW beneficiaries described their perception that due to their participation in the intervention, they felt they had an improved ability to communicate and access psycho-social support

(Being part of the programme is) really exciting and it gives you a sense of purpose, knowing that there are actually people who are there for us… there were people that I could relate to. Many people were opening up and it made me feel so comfortable… I was shy at the start... (In the groups) there was laughing, there was healing, there was help, it made us open up and some of us cried; mostly me… it helped us a lot! It helped us to open up to ourselves… it helped my health a lot, really! Especially my mental health as well as my emotional health. (Klipfontein, WC, AGYW 20-24 years, Core)

I have learned that if there is something bothering you… You must talk about it, and get a person who you can talk to, because being silent will make things worse. Talking about it is so helpful because, it makes it to go away and clears your mind so that you can be able to do other things that are new… even though it was not something big. But, sometimes we are not aware, you end up seeing yourself being troubled whereby it is not a big problem… The problem was with me because I would bottle up and not talk about it. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)

AGYW explained that they felt comfortable to open up and seek support around issues that they were not able to speak with parents or family members about, such as relationships and SRH.

I was benefiting a lot of things… when you're in a relationship, it's not often you will talk to parents about such things… (with the programme) you're able to talk properly, be open and talk about everything with them. (Bojanala, NW, AGYW 20-24 years, Core)

Being provided with an opportunity to connect with their peers, AGYW beneficiaries expressed a sense of comradery, identifying with others experiencing the same challenges in life, which helped them to gained strength to cope with their circumstances.

It has actually helped me to know that there are actually other girls out there too, who are going through the same, because we are going through the same stuff and we love each other and to build each other up, and that everything in the future ahead can get better. (Nelson Mandela Bay, EC, AGYW 15-19 years, Core)

AGYW felt that by discussing their problems and challenges with others, they were able to find solutions to their problems, and seek advice and support.

We would discuss things that we face as adolescent girls and young women… about how we can get help… I was able to be open and talk with other people about whatever that I am facing and they would come up with solutions or advice… that helped me a lot… when you talk, you can get advice and find a way to deal with it… and realise that it was not something big. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)

In addition to support gained from peers in peer-group environments, AGYW beneficiaries described how they were also provided with counselling and emotional support from the programme staff.

We received love, we were taught how to open up when we have a problem… there are nurses, counsellors and we open up and tell them about our problems. (Nelson Mandela Bay, EC, AGYW 15-19 years, Core)

With improved skills for emotional communication, AGYW felt that they were now able to reach out to their own parents for help, support and advice.

Afterwards I felt that it is important to talk to parents… if there is something that bothers you, you shouldn't be scared… go to someone you trust to talk to about such situation… (Now) I can share everything with them (parents)… I'm not scared to talk them anymore... Yoo… at the beginning ey I was scared, maybe they'd say this child is young and is too forward with things that are way too grown up for her… but now… I can... It changed after I joined the programme, I could see that no, talking to your parents is good. (Bojanala, NW, AGYW 15-19 years, Core)

Through the parenting support programme, those AGYW who had children of their own felt that they had learned parenting skills, self-belief and coping skills.

I am able to handle my child as a single parent. I didn't know how to before, and that has been really great. I feel like I am a better parent and a better person. I feel like I can protect myself… without hurting anybody else. I used to be very angry at everyone and at myself and I have learnt to control that. So, I am really grateful (Klipfontein, WC, AGYW 20-24 years, Core)

They are teaching us that even if you get pregnant as a teenager, what are the ways that can help you to carry on and trust yourself that you can still carry on, whatever people say to you. (King Cetshwayo, KZN, AGYW 15-19 years, Core)

General psychosocial support and guidance offered by the behavioural layered intervention components was regarded as making a big difference to AGYW lives.

They create an environment for… kids to feel free to talk about things that they don't normally talk about… to be referred to professional help… some kids at their homes… they have parental neglect… they are not well taken care of… Some are in abusive households… those type of things… it's more like a platform… they give more information to say if this is what you're going through then this is the right step to do… guidance… they are trying to help the youth… in their current situation that they are faced with… they are basically giving them guidance of how to you know how to overcome these situations… the things that happening… in our daily lives (Bojanala, NW, AGYW 15-19 years, Core)

Comprehensive sexuality and SRH education was also included as a behavioural layered service. AGYW articulated improved SRH knowledge, and enjoyed the girls-only environment for learning about SRH, unlike the Life Orientation classes offered at school.

When we are taught (about sex) in school, it becomes awkward and learners laugh about it… when we are alone as girls, with no boys amongst us… it is better... we become free. (King Cetshwayo, KZN, AGYW 15-19 years, Core)

The grief counselling support groups component offered by the programme was also described as beneficial by AGYW beneficiaries.

We did a lot of activities that were really great, especially the grief classes, that was amazing! ... I have dealt with a lot of losses in my life… it has really been hard for me. So those classes have really given my life a sense of meaning, it helped me a lot by moving on… even though I didn't believe that such a thing was possible… they helped me to get through the pain and to heal me. (Klipfontein, WC, AGYW 20-24 years, Core)

One aspect of the behavioural layered services related to encouraging physical activity amongst AGYW. Beneficiaries remarked on the benefits of engaging in sports and physical activities.

There were the netball games… if you are willing to participate, you join the team, and if not, you are not forced to participate… It does help because it keeps us busy and keep us away from things that can be an obstacle in having a bright future… because when I play my mind tells me to focus on the game and at school only, then all will be well. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)

AGYW Experiences, Acceptability and Perceived Benefits of Structural Services

Career guidance

One of the components of the structural layered services related to the provision of career guidance, and support with writing CVs and preparing for job interviews. AGYW beneficiaries who attended the sessions would 'graduate' and be given certificates, which gave them a sense of achievement and pride.

They were providing us with booklets… Some of the topics… were telling us about how to apply for a job… how to dress when going for an interview, how to write a CV… the do's and don'ts when going for an interview… when you complete the sessions, you were given an opportunity to graduate… We were given a certificate, we celebrated and happy for each other. They also gave us medals, it was a very nice experience. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

They educate us… we get certificates… They taught us on how to be independent as girls… People normally choose careers for girls, and go on saying as a girl you can't have this career, even if you feel you want it. They educate us about banks, computers and other things… it's helpful. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

Support and advice on career planning was also provided to AGYW, alongside assistance with filling in applications for scholarships and funding.

They were very helpful, they also assisted us when we wanted to do applications. Last year there was a workshop that helped us to choose careers, they will sit us down and help us with a lot of things concerning careers… they will help you in choosing the right subjects. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)

They want to know if you have completed schooling, or you want to further your studies... they are able to advise on what to do and which courses to take in order to be what you want to be. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Biomedical)

Academic support

Academic support provided by the intervention included support with homework, studying, and guidance and assistance to help AGYW return to, or complete school and get Matric. AGYW who needed additional support with school work and homework were able to get assistance.

The fact that at school you are struggling to pass… when you are academically struggling unlike other children… they will give you maybe those tips that you can try so that you can improve in your schoolwork... They also tell us that we can ask at home so that they can find

135

us tutors if we are struggling at school academically and it is still hard to understand, maybe you can try books that can help you. (King Cetshwayo, KZN, AGYW 15-19 years, Core)

Those AGYW beneficiaries who had dropped out of school were given academic, material and financial support by the programme to enable them to return to school to complete their education.

They were teaching us a lot of things… if there are dropouts, they will help them to go back to school. (Ehlanzeni, MPU, AGYW 20-24 years, Core)

if you want to go back to school or when you are behind with your schoolwork, they were very helpful.

If you go there and tell them that you haven't completed your studies and you ask for assistance to go back to school. Let's say you left school in Grade 11. They assist by buying you uniforms, school bags and they even give money to carry at school. If you are using transport to school, they even pay for that. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

GBV awareness and self-defence

As part of the structural layered services, the intervention also offered gender-based violence (GBV) awareness, and self-defence classes and training; AGYW beneficiaries described the benefits of these components.

They talk of women abuse and they make girls aware of the social harassment that is being done to women and how they should care and protect themselves… they tell you where you can go report such things, that you can go to the police station, and if the victim is too emotional where you can go to find someone who can take care of her and be able to talk to her… a counsellor. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Biomedical)

They came to teach us about self-defence… it taught us a lot… like when someone approaches you wanting to beat you or wanting to rape you how to protect yourself… we were training on how to do it… what we did it was something important… we have to protect ourselves… because most of girls we are being raped… abused so if I know that when a person attacks me… I will be able to protect myself. (Bojanala, NW, AGYW 20-24 years, Core)

Menstrual management products / Dignity Packs

Included as a structural layered services was also the provision of menstrual management products (sanitary pads), or dignity packs to those AGYW identified as in need. As noted above, there were many implementation challenges in the provision of dignity packs; however those AGYW beneficiaries who did receive them expressed their appreciation.

I was attending a programme… they will give us our parcels…. (inside there were) sanitary pads… when you are in your periods as a girl you do not know what to do and sometimes you are even scared to ask for pads from others. What if they will gossip about you… you end up not knowing what to do. So, they were helping us a lot. (King Cetshwayo, KZN, AGYW 15-19 years, Biomedical)

For those AGYW from resource-constrained settings, or families living in poverty, the provision of sanitary pads and other toiletries was regarded as very beneficial.

136

They register the impoverished children and give them food and sanitary towels… toiletries… You are assisted if there are no sanitary towels at your home and you can't afford them. They are assisting you. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

However, in line with the narratives of implementation respondents, many of the AGYW beneficiaries complained that the supply of sanitary pads was inconsistent and insufficient to meet demands. At times, AGYW would just be given one or two pads each.

The number of sanitary towels was not enough for all of us. Some did not get at all… they were not all satisfied and the pads were not enough for everyone or the person who needed them mostly did not get them. Others got one and we each got two each… They were not enough… there was a shortage. (Ehlanzeni, MPU, AGYW 20-24 years, Core)

Overall AGYW Acceptability and Perceived Impact of Intervention

AGYW Perspectives on the Benefits and Value of the Intervention

Empowerment

There was a general sense of AGYW giving positive feedback about the programme, and the impact it had on their lives. AGYW beneficiaries interviewed in this evaluation study described their perspectives on how participating in the programme had fostered a sense of empowerment.

We would meet as girls, and talk as girls, empowering ourselves as women, and how to take care of yourself as a woman. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

(This programme) is designed to empower young women and make them realise that they can do more by themselves. They can get education, there is still time to go back to school. They can stand up for themselves… They get self-esteem, for those who don't have self-esteem, they can get empowered to know, I can stand up for myself and this is what I don't want, and this is what I want… So, it is all about empowering young girls. (Bojanala, NW, AGYW 20-24 years, Biomedical)

We spoke about a lot of things, to build up one's self-image more and empowerment and how we get raised in our community… it did help. (Nelson Mandela Bay, EC, AGYW 15-19 years, Core)

Part of this sense of empowerment gained from intervention participation included AGYW feeling that their self-respect and sense of self-worth had been improved.

They explained that you should respect yourself before going out throughout the world… I was happy when I was told to love my self more… Irrespective of what I have, I am unique… that made me happy… I had issues in accepting myself… I did not have peace for a long time… So, the programme about loving yourself, helped me a lot in founding, respecting myself and moving on from that situation and not being able to accept… I gave myself time to figure myself out… That I am worthy of being loved. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

A key aspect of improved self-worth and a sense of empowerment was due to increased self-esteem that many of the AGYW experienced.

> *There were things I was learning… The more we talk, the more I gained... For a young girl who wants to be ok in the future… being part of this group, I can see that it has made a difference… it has brought back my self-esteem. (King Cetshwayo, KZN, AGYW 15-19 years, Core)*

Several of the AGYW respondents shared their perceptions of how participating in the intervention has enabled positive behaviour change.

> *What was changed was that I learned that we should treat other people well, I was this kind of a person who did not have patience with other people, I would shout and scold at people… (they taught) that we should talk to people nicely, that I should communicate with others in a good manner, and that I should learn to accept that if someone asks for forgiveness. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Biomedical)*

> *Before I was a person who does not care. I took things lightly, but when I began attending the programme I saw that I needed to take some things more seriously… me taking part in these programmes has changed a lot of things in my life… I have learnt which direction to take and the consequences involved with whatever decision I take… whatever I do now I do with caution. (Nelson Mandela Bay, EC, AGYW 15-19 years, Core)*

AGYW beneficiaries also felt that participating in the intervention had helped them to gain self-belief and confidence, and in doing so had improved their sense of hope and aspirations for the future.

> *The programme basically built me up… so that I can tell myself that I will reach my goals… you don't have to depend on other people… you can do it yourself… it built me up to be more confident. (Nelson Mandela Bay, EC, AGYW 15-19 years, Core)*

> *The change in my life has been that… now I have hope... it has given me hope that there is a chance when I believed that there was no chance. (Klipfontein, WC, AGYW 20-24 years, Core)*

> *It was helping me by encouraging and motiving me so that I can see a bright future even though I had problems. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)*

For some AGYW beneficiaries, the fact that there is an intervention focused on meeting their needs makes them feel as if someone cares about them, giving them hope.

> *I appreciate that there are people who are concerned about us and the programmes that are taking place in our community... to know how things are going regarding adolescent girls. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)*

AGYW Perspectives on whether the Intervention Delivered what was Promised

Some of the AGYW respondents explained that in their view, the intervention did manage to deliver what was promised, in some cases even surpassing expectations.

> *For me, I see them really doing what they have promised… they came to encourage me on the issue of schooling because my only plea was that I want to go back to school, so they would*

ask me how I left school and what happened so I would explain to them. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Biomedical)

I did not expect much (from the programme), but I was (pleasantly) surprised. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

Others felt that the programmes had not managed to deliver on what had been promised to AGYW beneficiaries when they were recruited into the intervention. Some AGYW described their frustration at not getting the help and support they needed, even after requesting it from the intervention staff.

When I joined, my intention was to benefit and get help, and sometimes I had the privilege of meeting the team members of the organisation as individuals because it is not one person, and I would express my frustrations to every one of them… I would explain the same story to each one of them. When I am in the clinic, I would meet them, and they would give me pads and other things… (But) when I don't see results of what they have promised, I would continue to talk to different people and maybe now I have talked to 4-5 of them, without feedback. (King Cetshwayo, KZN, AGYW 15-19 years, Core)

Some AGYW respondents felt that the help and support they received was very limited, for example they had only been provided with sanitary pads, and nothing more.

One of my neighbours came and recruited me, and I told her that I am already a member and I told her that maybe I have already joined 5 times… I told her that when I register, I only get pads, so I don't see any difference… When you register they will tell you that as a young woman, you will get help. (King Cetshwayo, KZN, AGYW 15-19 years, Core)

One AGYW shared her perspective that the intervention had promised to make communities safe for AGYW, and to support them, but from what she saw, this did not happen.

They said they would protect the girls in our township… but after that something happened… in our community… not even the police took it that seriously that case ended up nowhere… they promised to protect the girls, neh! …So this thing that they say they protect the girls did not happen. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Biomedical)

Some AGYW beneficiaries had understood that support and assistance with finding employment would be provided, and that this did not materialise.

We graduated and received the certificate so that when you complete that you go and work… when we completed they said we should compile a CV, so we did… and then they said they will send them out and they will call us to tell us how it went… (but) they have never called us. (Bojanala, NW, AGYW 20-24 years, Core)

Section 2 part C:

Community Acceptability of Intervention

The findings represented here have certain limitations due to the small sample group of community leaders. Only three 'community leaders' could be interviewed as part of this research. One community leader in Klipfontein, Cape Town (Western Cape), one in Thabo Mofutsanyana (Free State), and one in Ehlanzeni (Mpumalanga). Despite efforts to do so, it was not possible to conduct interviews with community leaders in King Cetshwayo (KwaZulu-Natal), Bojanala (North West) or Nelson Mandela Bay (Eastern Cape). Ten male peers and partners were interviewed from four of the six research sites. It was not possible to interview any parents/caregivers of AGYW, due to the fact that no AGYW respondents gave permission for the research team to contact their parents. Due to the small size of the sample group for community members, the views expressed may not be representative of community views at large.

In qualitative data collection it is not necessary to have a statistically representative sample. However, it is useful to at least be able to 'sample to redundancy', until it becomes clear that with each interview undertaken, similar themes and issues keep emerging and therefore dominant dynamics begin to emerge. At this point, no new insights can be gained by continuing to increase the sample. Most of the data presented here on community acceptability is from the perspective of implementers. It was at least reassuring to observe that dominant themes and dynamics around community acceptability emerged among this sample group and that they shared some views around acceptability with the small community leader sample.

General Programme Acceptability Among Communities in Implementing Districts

Respondents from various sample groups, including community leaders, implementers, social workers and health workers, shared views that communities are welcoming of the programme. It was felt that in general, communities recognise that young people in their area need help and support, and therefore welcome the intervention, which is perceived as being responsive to AGYW needs.

I would say about 70-80% of the community are supporting the programme. (Free State, Health worker)

The community have welcomed it well… we haven't had any challenges or strikes, or people complaining about it. People need services… We are doing everything… you find that there is a waiting list… I haven't heard anyone or anybody saying no because here… if they don't like something they go and stop it. (Mpumalanga, Social worker)

In the community most people take the programme in a positive manner as they see that we're helping the beneficiaries… we're advising them, they are happy that there is such a programme. (Free State, Implementer)

140

Those SRs that ensured that they sufficiently engaged with the community, with other community structures and multi-stakeholder forums, to promote awareness about the programme, described how this had a positive impact on community acceptability.

> *We always have a community meeting and I will be there… to address the family or the parents and girls who are also there… I say we are still having the program, come and be in the programme and get excited... if they plan anything in the community, they also invite us to be there. (KZN, Implementer)*

> *I know most of the people, so it was not that hard for me…. from the community meetings that are being held, that is where it all starts, you go there to attend the meetings, to introduce who you are, and where you are working, and what are you delivering. From there they will be able to invite you to the next meetings. (Western Cape, Implementer)*

Implementation respondents shared details of the strategies they had used to enhance community acceptability and buy-in. Where SRs have staff that are from the areas in which the intervention is being implemented, community trust and acceptance is facilitated. The strategy of employing locals also reassures community members that employment opportunities are not being taken by outsiders, which also engenders acceptance for the programmes and implementing organisations.

> *I grew up here, so that helps… I have insider knowledge (Western Cape, Implementer)*

> *When we go in (to the community), we find someone that we refer to as a 'peace person'... someone who knows the community and is known by the community and they will go with us initially so that we get a feel for what is ok and what is not ok. (Western Cape, Implementer)*

> *It also gives the community the sense like these people are not coming to take our jobs because that's the talk that the people are saying. (Western Cape, Implementer)*

A common theme that came up in the interviews with implementers, was that community trust and acceptability enables implementation. Having staff on the team who came from the areas and communities in which services are being provided, helped to gain trust in the community. An important aspect of this was job creation. In cases where PGTs or other staff members were hired from the community this improved acceptability. However, on the other hand, if the programme didn't live up to expectations, these implementers also tended to receive the backlash from their community.

> *It helps a lot (to have staff from the community)… It helps a lot …they know him and she also knows the areas that are no go areas… 'you can go in this area, and there's a lot of girls here'… And it also gives the community, like the sense like, these people are not coming to take our jobs. Because that's the talk that the people are saying: 'You bring people to work in our area but we are not benefiting from them'. So it gives them that hope that they (SR) are not only bringing the service but they are also employing our own people. (Western Cape, Implementer)*

The following responses from community leaders, emphasise community acceptability of the intervention. These narratives also highlight the role that these community leaders had in convincing parents and household members to allow AGYW to participate. Community leaders felt that the programme was giving AGYW 'something to do' and keeping AGYW safe and 'off the streets'. Poorer households were attracted by the 'structural aspects of services', even if it meant that AGYW would get something to eat from attending events and programmes.

It just gives a positive impact… most of them (AGYW) they don't have anything to do. Some of them have families that are looking to get something… they don't have anything to eat at the end of the day. Such programmes, they are making a huge difference because they know the child is with the programme and she is safe there and at the end of the day you get something out of nothing. (Klipfontein, Western Cape, Community Leader)

The community loves it! …there are also parents who are working for EPWP (The Extended Public Works Programme), they also love it. I explained to them about the programme and told them it is for the benefit of our girls. So they now understand and let their daughters attend. I explained that we should not ruin things for our girls. (Ehlanzeni, Mpumalanga, Community Leader)

So far, there haven't been people who have a problem with the programme. (Thabo Mofutsanyana/Dihlabeng, Free State, Community Leader)

A common theme that came up was that the community members were appreciative of the fact that the programme has social workers. Social worker respondents commented that the positive behavioural changes that parents and community members observed in participating AGYW engendered acceptability for the programme. It was noted that parents and the community are struggling to address the challenges that AGYW are facing, particularly related to teenage pregnancies and school dropouts, and so they are thankful for the assistance that the programme provides.

When a child gets help it's easier for them to see when their parent needs help. I need to help at home more with 1,2,3. So, I think they help the community, we are not only assisting young people we are also assisting the community. (Western Cape, Social worker)

In all the communities that we are working in, in fact, the community is very excited about the programme. Because a lot of these communities are struggling with children or with teens; and young women that are sitting at home doing nothing, that are dropping out of school because of pregnancy. (Western Cape, Social worker)

Implementers also noted that community members and leaders were assisting the programme, through either providing key information to support implementation, advising on safety of teams in various neighbourhoods, locating appropriate venues or even volunteering the use of their spaces, for example yards, churches, halls, and schools.

Without community support we wouldn't do this… there is a little bit of negativity but most of them are positive because sometimes when we work in the area, they are the ones that will tell us: 'no we don't think you should work here, it's not safe, you better move', or sometimes there are parents that even provide their space like in their yards and say 'no it's fine you can put your tents here, you can work from here'. (Western Cape, Implementer)

Most of the people in the community are willing to work with us… sometimes we use the church building or the school… we receive positive energy from them… I usually hear from the managers that they do get assistance from the church leaders they also do get assistance from the principles and the schools that we are implementing in. (Eastern Cape, Implementer)

However, 'communities' are not homogenous and unified entities, and respondents also noted that there were certain individuals or groups within communities that were not approving of the programme. In particular, some community members disapproved of the aspects of the programme

142

related to sexual behaviour and sexuality, in the belief that learning about safe sex would encourage sexual activity amongst AGYW.

> *Some in the community are negative and are questioning why we are asking about the sexuality of the children, we're introducing them to such life, any are we talking about such stuff. (Free State, Implementer)*

> *Especially the elderly men… they don't view it as a programme that helps children. The elderly do not think sex can be part of education. To them, sex is something that must be confidential, something that is not supposed to be spoken to children about, but for adults only. (Mpumalanga, Implementer)*

Even when there may be some level of community resistance towards the provision of SRH services and education to AGYW, in general communities were grateful for the broader psycho-social support offered, which made them more accepting of the overall programme.

> *The community have really accepted it… the one thing that they like the most is that we have social workers… when we say we have social workers then it means that we are saying that whatever challenges that we gonna pick up at the school they will be addressed... they don't like their children testing for HIV. But if we say we've got social workers and this is what we can offer. We want to decrease teenage pregnancy, then it's better and they really appreciate that. (North West, Implementer)*

Community Resistance and Mistrust

Not all of the SRs noted that the programme had been welcomed by the communities in which activities were being implemented. Some respondents noted that certain individuals/groups/factions in the community were against the programme as a whole, or against certain components of the programme (which will be discussed below). There was a perception among some community members, that the number of AGYW enrolled or reached is not enough compared to the need and that SRs should increase their intake.

> *If we can get more of programmes like these ones I believe that South Africa can be safe, because… If we only have 30 girls and then out of 100 of girls… there are those who want to be part and parcel of the programme but they are not due to the capacity of restrictions and all that. (Klipfontein, Western Cape, Community Leader)*

> *There are some community members that are very supportive... but they are few and far in-between. They are very few… there are very few that you can say, "this one I can count on". (Free State, Health worker)*

Some community members felt that the programme was not responsive to AGYW needs. As already discussed in Section 1 of this report, the failure to adequately deliver some of the structural services component, contributed to this lack of community acceptability in some contexts. Respondents also noted that community members felt that AGYW HIV-prevention focused programmes are limited in scope and that there are other challenges that are viewed as more important, such as poverty-alleviation and job creation. There is a high demand for programmes that can create employment opportunities for young people.

> *I don't think it was ever viewed in a bad way… But the community… they think that we should be doing more… We are explaining to them that the girls are getting testing and they get*

143

excited but then now they are asking the question: "what else are you going to do for us?"... Because the youth are not working, so what are we doing to get them jobs?... they are expecting that we are going to get the youth jobs. (KZN, Implementer)

You have some people who after a while say that: "you have been here for quite some time and we don't see the difference"... Even though this is an HIV prevention program, there are other challenges that they are dealing with; you've got unemployment... and quite a lot of other issues that they are dealing with as community members and yet you are only providing a solution to one. (Western Cape, Implementer)

Barriers to community acceptability of the intervention also related to communities wanting programmes to be open to everyone, not just AGYW aged 15-24. The fact that SRs have had to turn away AGYW which do not fit the age group 15-24 years, has negatively impacted acceptability.

The community do enjoy this program, but the challenge is since we don't go above 24, so some of the people we don't test because they are not qualifying for our programme. So, we are just referring them to the other clinics, where they can go and be tested there. (Western Cape, Implementer)

The majority of the community, the parents, fathers and mothers, sisters and brothers... according to my view or evaluation, they are even jealous of us, why are we only choosing 15-24 and not including them as part of the programmes? They would love to be part of the programmes. (Free State, Health worker)

There's always this comment – "Why girls? Why specifically to this age group?" It feels as if it's not fair to the rest of the community. But we have to specify, we have to explain to them why the government saw it fit to concentrate on this age group. (Western Cape, Health worker)

Respondents also noted that many AGYW tend to be sexually active before the age of 15, and therefore the perception was that younger AGYW should also be included in the programme, from the age of 12 or 13 years.

Number one is the age group that we work with. In my experience of working with the youth, age fifteen is a bit too late to reach the girl. By age fifteen, the girls are sexually active already... adolescents start at about age 12, 13... we need to consider looking at that. (KZN, Implementer)

Concurring with community perceptions of AGYW below the age of 15 years needing sexual and reproductive health interventions and services, were the findings from the HERStory 1 survey, in which 9% of AGYW reported that their first sex occurred before the age of 15 (SAMRC, 2020).

Another reason cited for community resistance was a sense of 'programme fatigue' in those communities, such as Klipfontein in Cape Town, that community members feel to be 'saturated with programmes' from NGOs and government. There were comments pertaining to the way in which some communities have become disillusioned and apathetic about the potential of these short-term programmes to resolve their challenges. In instances where previous programmes have failed to deliver, communities may be distrusting of outsiders trying to introduce a similar programme. Moreover, community expectations may be linked to previous programmes, for example 'Cash Plus Care' programmes, which may negatively affect the acceptability of the AGYW Programme.

If I make an example with the Nyanga community, they have other services in the community. So, when you come to girls, they come to you with the intention that maybe this programme is the same as the one that they once had in the community. (Western Cape, Implementer)

One barrier to community acceptability related to a lack of awareness and understanding about the intervention among community members. From respondents' narratives it was evident that there was a lack of clear understanding regarding what the intervention programmes offer, and how these are differentiated from normal services offered at clinics. There was also a lack of clarity around the division of labour between clinic staff and SR health workers for those SRs embedded in the clinic space.

Anything you do in the community, as long as the people who are bringing services they are not informing, it's not as if something is definitely going to fail but with time when people learn, hear through word of mouth... I believe we could have better results… in as much as I have tried to have a stakeholder engagement to inform… I have never been invited by the people I requested to invite me. (Western Cape, Health worker)

Our organization, neh! When they started working here in Free State… did not look at the issue of the community, that there should be a community meeting. They should go to the community and say, 'here we are and this and that, and we're going to work at such and such a place'…. And another thing is the issue of parents' meeting, it was going to play a very important role! Because when the parent knows about the programmed, she will be able to inform the pastor, and the church congregation. (Free State, Implementer)

Lack of community trust was noted by some respondents, and this highlighted the failure of SRs to adequately introduce the programme. A number of responses highlighted that the community was poorly informed about the intervention. As a result, false rumours spread around about the SRs which negatively affected acceptability. Failure to engage communities was linked to several factors including resistant community gatekeepers, SRs' lack of effective advocacy strategies, SRs that did not have existing networks in districts and COVID-19 limiting advocacy and recruitment events.

They are afraid to go to the centre because there's a lot of stories that are said about the programme, some say they do abortions to girls, so that makes them to be scared. So if they (SR) can come to them in the community and sit the girls down and explain to them. (Ehlanzeni, Mpumalanga, Community Leader)

The transport that we are using, the name plate is not written Free State… the names of our cars are Eastern Cape. So, some of the parents and some of the kids they are afraid of us. They say, no this guy is going to hijack us, or what do you say… trafficking us. They are afraid of us at times. (Free State, Health worker)

Class and racial dynamics also influenced community acceptability. A theme which emerged in the research was that 'multiracial' communities and AGYW from 'middle class households' do not want programmes.

The multiracial schools, they don't want our services. We are relying on the informal settlements kids. Those that are attending in the towns, they don't need our services. They just tell us: 'no, I will do it at my doctor', or 'the family planning we usually do it at Clicks'. We are relying on these informal settlement kids. (Free State, Health worker)

In communities like Athlone, you come to girls and they tell you: 'no, I don't need this! I have got this, and I have got that!' Then you walk around the community and you see that actually the girls are in need of this programme, but they are not willing to come to you… you find them sitting around the corners of the street, in their nightgowns in mid-day… and they don't want to come to you and listen to you about what services you bring. If they do come then they will tell you: 'I don't need this, I have got a medical aid!' So, it differs, with the areas within the Klipfontein district. (Western Cape, Implementer)

Acceptability of Intervention from Parents of AGYW

The responses regarding parental acceptance of the programme from implementers and community leaders was varied. Much seemed to depend on how closely the SR had engaged and involved parents, and whether they had been successful in demonstrating the value of the programme. However, various social and cultural norms also impacted on whether parents would be accepting of the programme or not.

My experience that I have with the community is that the parents love the programme and they love to see their girls being part of the programme, you see. Especially if you get the chance to explain to a parent about how we work, what we do, what we aim for and what we really want… they fall in love with it, it then becomes simple for a parent to allow her to be part of the programme. (KZN, Implementer)

I see them (parents) appreciating our programme because what they don't want is their children to be HIV positive and to get pregnant, what they want is for their children to be able to stand for themselves, go to school and stop drinking and having boyfriends. (Free State, Implementer)

Parents view it positively because we can sit down with their children and advise them. It is not about introducing them to family planning only, or about the HTS, but we talk about school-related issues… they feel like it is an environment where their children can get advice and be supported which is something they are failing to give to them. (Mpumalanga, Implementer)

Respondents suggested that some parents were welcoming of the programme because they felt overwhelmed by the various challenges facing AGYW and were unsure about how to navigate the negative influences of the social context in communities and of social media.

You can tell your child (how to behave) and hopefully raise a child in a proper manner but the reality is the outside world is always playing a huge role, but when you've got programmes like these ones, the outside world doesn't have a chance… It's an advantage for us parents and the community entirely for us to benefit… the next generation it's not an easy task especially with the current situation where social media took over …The parents they will even like fight for the space for their kids. (Klipfontein, Western Cape, Community Leader)

My mother was positive because she had that understanding that us as today's generation need such programmes, and because adolescent girls like me do not listen. Such groups are needed because they are helpful in discussing, and the fact that we are of the same age (King Cetshwayo, KZN, AGYW 20-24 years, Core)

Ensuring parents' acceptability of the programme also had the positive impact of ensuring AGYW were retained in the programme and attended services like family planning and PrEP regularly. Considering that retention emerged as a challenge in the evaluation, and that this was linked to implementers not being able to contact AGYW for repeat calls or to follow up to offer them layered services, parental involvement assisted in this regard.

> *We also get now parents that come and bring their kids for the family planning, when we also phone them like when we are doing the return to call, some of the AGYWs they give their parents the contact details, so we call the parents when we want the girls, and then the parent pick up the phone… we get a positive feedback from the client. (Western Cape, Implementer)*

It was also noted that in some instances, the community was accepting of the programme and the parents would encourage AGYW to participate, however resistance and lack of acceptability was felt on the part of AGYW who did not want to participate.

> *The community is very happy about the programme but… the problem is that even them, they cannot force them to come to the services… you would hear the views of the parents saying that "it's good, we will bring them… it's good for them, at least they will have something to do". But again, it all boils down to them (AGYW). If they don't want to come, then there's nothing that we can do. (Western Cape, Social worker)*

Some parents placed their hopes in the programme to enable positive behaviour change in situations where relationships with their daughters were challenging, or where daughters were 'troublesome'.

> *Dealing with AGYWs can be stressful, because sometimes a parent will recommend that we must come and talk to the AGYW because she is troublesome… convincing an AGYW to see your point of view can be stressful because sometimes they don't see the point you are trying to drive at. Some will be rebellious and when that happens, the parent feels like we have let them down because we were their only hope and… the parents feel disappointed. (Mpumalanga, Implementer)*

A challenge that was commonly cited regarding lack of parent acceptability of the programme, was that SRs did not engage parents or seek their approval before enrolling AGYW into the programme. Programmes need to be carefully introduced into the communities. Parental acceptability of the programme also depended on the space in which SRs were implementing, for example in schools, parents could be engaged through parents' meetings. In instances were PGTs were recruiting AGYW 'on the street' without parents and other community stakeholders being informed about the programme aims, this could potentially create resistance. Some organisations even admitted to relying on AGYW to give feedback to their parents, which does not seem to have been effective.

> *Most of the time, because we will be getting the young girls from the community… they (AGYW) wouldn't explain to their parents, this is the programme that I am with, and this is how it works. So, when we get there the parent is angry and doesn't understand… we just have to take time with the parents to explain what [SR] is offering to his or her child. Most of the time, the parents will say: "ok now I understand your program, so you may talk to her and give her your service". (North West, Implementer)*

> *They just see us with their kids and seeing them with the field-based teams, sometimes they are not wearing uniform… So, there were minor challenges around that… The challenging thing is just with the parents. (Free State, Health worker)*

In cases where AGYW had been enrolled on PrEP or contraceptives without parental consent, this tended to create hostility from parents. This particularly came to light when AGYW were contacted at home during COVID-19 lockdown for repeat services, and parents found out about their participation for the first time, without their knowledge or consent.

Clearly one of the motives behind SRs offering services directly to AGYW and not consulting parents was also to avoid situations in which parents would act as gatekeepers. However, responses indicated that on the whole, not involving parents, negatively impacted on community acceptability and on AGYW retention in the programme. Responses also indicated that parents who were informed about the programme and had very high expectations about what the programme would deliver would refuse to allow their daughters to continue when these expectations were not met or when SRs did not deliver what they had promised.

> *I will give you an example that one time our PGT reported that she was nearly burnt with hot water… The parent was angry and the PGT visited and wanted to enrol the child as a repeat. The parent was holding a container of hot water saying 'you people, what you do is just to let our children fill up the forms and you don't help them with anything so please leave'. (Free State, Implementer)*

Acceptability of the Intervention from Male Partners and Peers

Several interviews indicated that male peers and partners are resistant to contraceptives and that AGYW often do not have the decision-making power regarding contraceptive or condom use. This finding emphasizes the importance of engaging male peers and partners directly to promote contraceptive acceptability. Since AGYW feel they cannot discuss contraceptive use with male partners, some end up taking contraceptives secretly to avoid falling pregnant. In the quote below, a male partner interviewed also notes that the condoms provided by the programme are 'bad quality'.

> *I only use my own condoms, I buy mine. I didn't take their condoms… I think that those that they provide, they're so soft you know… I don't trust them… I once used them and they blasted (burst). (Bojanala, North West, Male peer/partner)*

> *In my community, if you're mine, you're mine. Either we're in a relationship or we're not, we either use a condom or we don't… I hear from people that there are those girls who use the injection, who take a morning after pill after sex… They use them without telling you… I think she is selfish, why can't she tell me in the first place… why is it that she's taking them without notifying me? What if as a guy, I want to have a baby… I will tell her what I want right, but she's secretive and keeps on taking those pills or getting the injection. (Thabo Mofutsanyana/Dihlabeng, Free State, Male peer/partner)*

Additional resistance to the provision of contraceptives to AGYW among their male peers and partners are influenced by factors related to gendered power dynamics. Decisions around conception, also seemed to rest with men, from the responses provided by male partners. This may be another reason why contraceptive use is not discussed openly between AGYW and their partners and AGYW opt to take contraceptives secretly. Negative rumours and beliefs regarding contraception, including that using contraceptive pills leads to infertility, also contributed to male partner/peer lack of acceptance of AGYW being provided with contraceptives in the programme.

To use contraceptives in adolescent girls is not a good thing and it paints a bad image because what if the person that you are dating would like to have a family with you?... To use contraceptives is also caused by not behaving well and rushing into things too early as a girl.... But in the long run, it will have a negative effect because you will be affecting your fertility and at the end you won't be able to have children. (KZN, Male peer/partner)

Responses from some male partners indicated that they viewed teenage pregnancy and HIV infection among AGYW as being caused by AGYW 'not behaving well', not being raised well or girls not looking after themselves. While, male sexual behaviour and resistance to wearing condoms is often not viewed as an important factor in HIV prevalence and teenage pregnancy, in spite of research suggesting otherwise.

HIV is caused by how the adolescent girl is raised and how the girl behaves. If she is behaving well, she won't be in that position whereby they will end up having diseases like HIV, but if she is not behaving well, she is likely to get sick... So, the way in which girls behave and handle themselves at the end of the day determines if they will get these diseases or not... if a girl becomes pregnant, that will mean that the girl is not taking care of herself. (KZN, Male peer/partner)

Some implementers noted that men (brothers/ partners) had tried to discourage AGYW from participating because they do not understand the programme's objectives or do not agree with it.

The challenge that I once had was going to a house that I see that there are brothers that are trying to tell their sisters... but at the same time they don't understand the programme that we are saying to the girls... what is it that we are giving the girls? What are the services that we provide to them? (KZN, Implementer)

However, not all male partners and peers were resistant to the programme. Some responses indicated that male partners were accepting of the programme because they acknowledged that AGYW needed support. They appreciated how the programme offered SRH education and services and psycho-social support to AGYW, especially in light of the high levels of GBV in South Africa.

I see the need for programmes like this in my community... that teach about such things as abstinence, about sexual protection, pregnancy protection... about using contraceptives... From my community I don't think there are enough actual programmes that support women who had suffered from emotional distress and physical... there should be more programmes like that... if we can have that then we could have a better society. (Bojanala, North West, Male peer/partner)

Some responses, like the one below, reflect acceptability of the programme, however, it simultaneously reflects some potentially harmful views which perpetuate the idea that challenges faced by AGYW, along with challenges in their relationships with men, are all a result of 'AGYW misbehaviour'. This was a common theme that emerged among community and especially male partners. It demonstrates that more needs to be done to change dynamics of gender equality through programmes such as these, in order to fully support AGYW health and wellbeing. Focusing programmes solely on AGYW, while not engaging men, can potentially reinforce these kinds of harmful views.

The programme has helped a lot because when you look at today's generation, it is not easy for them to get married because of the way they behave... the programme has played a role in helping girls to get married and getting jobs... When boys are growing up, they dream of

149

getting married one day, but when you look at today's generation, it is not possible because if the girl did not attend the programme and get the advice, it won't be possible for a boy to marry that kind of girl. (KZN, Male peer/partner)

Community Acceptability of Intervention Components

Community Acceptability of PrEP

Community views on PrEP provision to AGYW were mixed. There were some responses that indicated a level of acceptance of the PrEP programme among communities and parents of AGYW. There were even cases reported in which AGYW parents had brought their daughters to be enrolled on PrEP. Responses that emphasised community acceptability of PrEP noted that the community appreciated how PrEP could protect AGYW even in the absence of behavioural change around contraceptive use among AGYW and their partners.

> *There was one parent who, they came in our office and told us that the child changed drastically… the child is now educating the mother about the PrEP, about preventing yourself, taking care of your health and about everything… the mother was really, really happy… it was really a nice feedback to hear. (Free State, Implementer)*

> *They are very supportive because the parents are the ones who bring the young women to us. They are excited about PrEP because they know that it will keep the girls safe even if they engage in sexual activities. (Mpumalanga, Social worker)*

> *They like this thing about PrEP. They know that a lot of young people will sleep around without using a condom, you know. (North West, Implementer)*

However, numerous implementer respondents highlighted the challenges that they had faced in gaining community acceptability of this particular component of the programme. According to implementers, some community members and parents disapprove of PrEP due to the belief that it encourages AGYW to take risks, be sexually active and promiscuous.

> *People were saying that PrEP is condoning the kids to live recklessly. (Free State, Implementer)*

It was also noted that in communities with a strong religious presence, there tended to be resistance to PrEP from church leaders, who asserted that promoting PrEP was counter to their religious values. In some communities, the views of religious leaders have the potential to derail the PrEP programme. However, there were also cases reported where church leaders were supportive of the programme and were allowing SRs to operate out of church facilities, for example in Klipfontein district.

> *Such people preach and preach… they do spend most of their time in their churches, so they make a big effect. When you offer PrEP to a young girl, they go around saying at the church "no, no, no those things are bad… ARVs, you must not take them". And you know there are all of these myths around HIV, so these people are making it difficult for us to convince our young girls who are really sexually active and not taking care of themselves, to have a little bit of protection… they are making it really hard for us to reach our young girls. (North West, Implementer)*

Implementer responses emphasized that the community are often misinformed about PrEP. There are several myths that are perpetuated around PrEP, such as that it causes infertility, termination of pregnancy or results in HIV-infection. This is linked both to accessing inaccurate information online and also some negative experiences with side effects that have created mistrust around PrEP. A few cases in which people contracted HIV whilst being on PrEP, has also negatively affected community acceptability of PrEP. Information regarding whether these people were taking PrEP consistently and correctly was often not discussed alongside these unfortunate cases, when community speak among themselves.

> *The ones that are in the township know, but you find that they have the wrong information. For example, for PrEP, they will be saying, oh if you are eating PrEP you end up getting HIV. And then now you have to elaborate, to explain why some people use PrEP but they end up getting HIV positive, then you have to explain for them. (KZN, Implementer)*

> *Some side-effects, you know, people do talk among each other. Some would say that they get a rash, some would say that they can't sleep… most of them will say, "no I don't want it because this is what happened to my friend, so I don't want it". (North West, Implementer)*

> *They were saying that we give their children PrEP so that they will abort… it's a lack of information… they assumed we teach their children about sex and how to do abortion. (Free State, Implementer)*

A common explanation provided by implementers and health care workers, for the lack of community acceptability of PrEP, was that the community failed to differentiate between PrEP and ARVs/ART.

> *They think PrEP is the same like ART. They think that we are giving the girls ART while they are still negative, because they don't get much information about what PrEP is. They just take the information from the kids or whatever they just hear it. They have that negative view of the PrEP. (Free State, Health worker)*

> *Especially the ones that they don't want to take PrEP. They were saying that "PrEP is ARVs and why are we giving ARVs?"… And they will not give you the chance to explain what is PrEP… I just tell them that they mustn't believe everything that is being posted on Google. (Western Cape, Implementer)*

AGYW parents who were on ARVs themselves, were sometimes hesitant about having their daughters initiate on PrEP, given the misinformation about it.

> *The challenge was because PrEP is an ARV medication, and some of the parents had that medication at their home. So, they thought that we are giving their kids ARVs. We had to do a lot of explanation to make them understand, how do these things work... Some parents they still don't allow us… But through more engagement, parents are more understanding and some parents are even calling us to initiate PrEP for their kids. (Free State, Health worker)*

Parents were also accusing AGYW of not disclosing that they were HIV-positive when they found them taking PrEP, because parents were not informed about PrEP and were not consulted before AGYW were enrolled on it. The negative experiences that parents had with ARVs, also contributed to a lack of acceptability of PrEP and in some cases to parents telling AGYW that they could not take it.

> *Some of the kids that stop taking PrEP it's because of the information they got from their parents. ...and a parent's voice is the most powerful than any other person- it's the final word.*

151

> *So how do you change mother's mentality if ever the mother was not informed, and people don't know that… we've got better ARVs than ever… They don't even make anyone sick. (Western Cape, Health worker)*

> *There was a gap when it comes to PrEP. And you would initiate girls on PrEP, and then when they go home, the parents would be like, "what drugs are these? You are lying you're HIV infected; you are lying". (Mpumalanga, Implementer)*

A common theme that emerged to explain why the community and AGYW parents were not very accepting of PrEP, was that SRs are generally not seeking parent's approval when initiating AGYW on it. This presented an ethical and legal dilemma for implementers and health workers.

> *Some of them also say "how can you give my child ARVs without even my consent?"… those are like those ethical dilemmas where now, it's culture versus the medical field… some of them (AGYW)… they are 15 coming for family planning and the mother will come and fight you: "Why are you giving my child an injection without my consent?" (Eastern Cape, Health worker)*

Since parents are often not properly engaged in the programme, they tend to not be well-informed about PrEP. Information about PrEP and the programme is left to AGYW to explain to their parents, which is a strategy that does not seem to have been very successful. Some SRs were planning to initiate awareness campaigns around PrEP, to close knowledge gaps and address PrEP acceptability.

> *The challenge also becomes that some, they (AGYW) will be willing maybe to take PrEP or maybe other services but they haven't really disclosed to the parents… Hence as a trouble shooting or as a mitigation we are also inviting parents in the dialogue, whereby we are selling the programme so that they can also have a deep understanding of the programme implementation as well. (Free State, Implementer)*

> *We work with our advocacy SSRs to say, this is an issue, can you please go back to the community and educate them about PREP, so that we close the gap, because surely there's a gap between the parents and the girls. Because the girls know what PrEP is, however, the parents don't. (Mpumalanga, Implementer)*

Some healthcare workers and implementers noted that resistance to PrEP is caused by failure on the part of programme implementers to properly explain what PrEP is to AGYW, their parents and the community at large. Implementers noted that when the community and parents are better informed about PrEP through closer engagement, acceptability tends to improve and some parents are even approaching SRs to initiate their children onto PrEP.

> *They are not getting in-depth education about, that's the only problem area that I noticed, with the PrEP… there are some things that they don't even understand. That it's ARVs- actually the drug that they're using… That's something that we need to iron out and explain- this is an ARV… they (AGYW) go home and the mother knows- 'oh, this is ARV'. She probably reads the second line or whatsoever, and now it becomes a problem. 'Why are you taking HIV medications?' (Eastern Cape, Health worker)*

A number of respondents, across sample groups, highlighted the need to involve Adolescent Boys and Young Men (ABYM) and older male partners of AGYW more in the intervention. Despite the intention to engage ABYM in service delivery, it appears that this was limited. SRs that were providing men's dialogues were viewed favourably, whereas failure to involve men in the services provided tended to impact negatively on community acceptability.

> *The community have responded very well. Especially now that we have included the component of the men's dialogues and we have been including the boys; the community is happy. There was a time that the community would say: "but what are you doing for us as well?" (Western Cape, Implementer)*

> *She (mother of AGYW) was even asking, why can we not take boys because she has more boys than girls and why are we only focusing on girls… Their concern mostly is, why can't you involve boys? We can't just keep motivating the girls, what about the boys? (Free State, Implementer)*

Community members highlighted how ABYM were also struggling in the communities and needed support and mentorship. Community members also did not see the sense in only targeting AGYW when decision-making and behaviour around sexual health also involves men.

> *The other question that will come up is why boys are not included of the same age group because it's not as if girls, they are sleeping alone, they are having sex alone. They are having sex with somebody. (Western Cape, Health worker)*

Parents, community members, and implementers expressed the view that reducing teenage pregnancy and HIV amongst AGYW would only be successful if ABYM were reached by the intervention, and targeted for behaviour change.

> *The only thing that they want is for the boys to be included, that's what the parents say. They ask why don't we include the boys when we involve girls… They say we should include boys for testing and explain to them about PrEP as it is not for ladies only. And also to mentor their boy children… Girls fall pregnant because boys approach them, girls don't approach boys. (Free State, Implementer)*

> *Maybe if we include the other gender… the males… You find that these adolescents… she tested negative but to find that now, the partner who's a male is forcing to continue having unprotected sex, knowing very well that he is HIV positive… She's married, but the husband is saying, I'm married to you, so it doesn't matter because I'm sick now. I can have sex with you without a condom… those are the negative events that I've picked up. (Eastern Cape, Health worker)*

Implementers also noted that empowering AGYW may have the unexpected side effect of increasing GBV as the quotes below suggest. Respondents noted that men feel threatened when you empower young women. Some AGYW got beaten up by their male partners when they told them they were doing the self-defence course, for example. Staff then told AGYW to tell their partners they were doing 'life skills' to avoid this. These types of experiences suggest that there is a need to involve male

partners more in the programme so that they understand its objectives and so that the root causes of GBV can be addressed.

> *We need to be aware that when you strengthen the women you also need to work with the men so that there is a balance… because we had girls being empowered and they were telling their partners that they were doing a self-defence course, and as a result two or three of our participants never came back because they actually got beaten up by their partners for it. (Western Cape, Implementer)*

Respondents noted that it was not only the ABYM and older male partners that should be involved, but also men in general. Many men (fathers, brothers, uncles, community leaders) in the implementation sites were found to be resistant to the programme, particularly older men. Men were found to hold values about the social roles and relative autonomy of women in society, that could be viewed as undermining women's human rights. Men therefore need to be convinced about the value of the programme and engaged in dialogues that interrogate these harmful gender norms that perpetuate gender inequality in South Africa.

Community Stakeholder/ Gatekeeper Relationships and Impact on Intervention Acceptability: Ward Councillors and Traditional Leaders

There was diversity in responses from SRs regarding relationships with Ward Councillors. A number of SRs emphasised the necessity of working closely with Ward Councillors and the positive benefits this had on programme implementation. Securing acceptability among Ward Councillors and traditional leaders, ensured that these community leadership figures did not resist programme implementation. In some cases Ward Councillors and Ward committee members assisted SRs to recruit AGYW. Some SRs were also working with traditional leaders as an advocacy strategy. SRs also noted that building relationships with Ward Councillors enhances the safety of the programme implementing team in the field, especially in districts where safety is a concern.

> *We feel like we are also protected because in other areas they even organise people that will be going around just to see if you are safe. So, working with the councillors helps… sometimes they even provide the community halls for us to work on and then they also organise the youth to come and get the services… by informing them and updating them. (Western Cape, Implementer)*

> *I am in the ward committee of our ward… when they (SR) need these young girls, they will call me, and I will assist by sending the young girls to them. (Ehlanzeni, Mpumalanga, Community Leader)*

> *We have built in that community engagement, in terms of making sure that our work is recognized through the traditional leader sub-structures… there's what is called: Iya wesi imbumbaya makoskaz' lakho m'khulu [go to your great-great grandmother]… the women who are married to chiefs… we make use of that touch. (Eastern Cape, Implementer)*

A number of respondents noted that gatekeepers, like Ward Councillors and traditional leaders, were not supportive of the programme, which negatively impacted upon implementation. Ward councillors, in particular, act as gatekeepers to AGYW and the community and impact SR ability to access implementation spaces and venues such as community halls, churches and schools. SRs and

154

ward committee members themselves, noted that Ward Councillors should be informed and give permission for every event or programme that takes place. When SRs have an uneasy relationship with councillors they can undermine the successful functioning of the programme.

> *They don't involve the councillor and I am very sure about it, because I once shouted at someone… and told them that I am speaking as the ward committee and as a secretary. I told them that it is not the right thing that the councillor will hear of activities that are happening from people, but when this thing started, they promised to involve the councillor. (Ehlanzeni, Mpumalanga, Community Leader)*

> *In this programme there are so many people that are involved as gatekeepers… you find your chiefs that are involved, your councillors that are involved, your OSS [Operation Sukuma Sakhe]… they are all involved… it is quite a challenge. (KZN, Implementer)*

> *The councillor should know all of the things that I want to run in the community, like loud hailing... usually I am checking things and taking it back to the councillor so we can work together… if I want to plan an event... I should always talk to the councillor… working closely with the ward councillor will make this programme in our ward to be a success. (KZN, Implementer)*

Some respondents noted that traditional leaders were resistant to the programme. The programme was viewed by traditional leaders as being against traditional and cultural norms. This was particularly the case in rural areas were the institution of traditional leadership has a stronger presence. Traditional views on a young woman's role in society sit uncomfortably with the programme's emphasis on AGYW sexual health and rights, for example the ongoing practice of 'virginity testing' in some areas.

> *There are cultural factors because we are staying in a rural area and under the rulership of a traditional council… there are girls that are still going for virginity testing. So, some leaders, like the traditional headmen, are against our programme because they feel like we are introducing the virgin girls into sex… So that makes it difficult for us to do our job especially when we come to a place which is under the leadership of a traditional headman, we are turned back… If I'm being honest, I don't think they will accept topics that deal with sex. Because it is against their culture, their beliefs and they think it is western culture. (Mpumalanga, Implementer)*

Some SRs also noted political interference from Ward Councillors, who threatened to prevent SRs from implementing in their ward, unless they agree to give financial rewards or preferential access to job opportunities for their kin and political constituents through the programme. This is not a unique challenge and is a commonly reported dynamic in the South African context.

> *When we started we had to sit in one of the constituency offices of the ANC somewhere in a hall whereby we were asked questions: "Who are you? How many millions are you bringing?"… Because there you will find a ward councillor whose interest will be to benefit from the programme. So one ward councillor would say: "you hire my wife or create a good position for my wife, otherwise, you won't implement in my ward"… It's all about politics. Now we are going to elections, they look at organisations like us to say, "how many people are you going to employ in my ward?" (Mpumalanga, Implementer)*

The Ward Councillors and the municipality, they said that for any programme or activity that will take place we should first start with them… they just wanted to be the first priority in the programmes, before the target group… I find it very selfish of them. (Free State, Health worker)

There seems to be disagreement among SRs as to the best approach to engage with community gatekeepers and ensure access to beneficiaries. Some SRs motivated for a top-down approach, whereby they access communities through local gatekeepers like Ward Councillors and traditional leaders. While others emphasise the importance of reaching beneficiaries directly and avoiding political interference in the programme. It seems that SRs require more guidance regarding what approach is considered appropriate by the programme. The former top-down approach chosen by a number of SRs, does not seem to have been adequately problematised by the organisations involved, as an approach that is widely criticised in development literature.

The mistake with an intervention is that, if you don't include the leadership of that community. They will also make sure that your programme is rejected… I usually say it should be an up down process. The district should introduce the programme to the locals and the locals should introduce it to the people on the ground. (KZN, Implementer)

One challenge that we've experienced... the interference of… political and your civil society… I wish we implemented differently… (like in the) PEPFAR approach, you work directly with the stakeholders. You don't start from the ground, because here for you to implement, you have to go to the ward councillor. (Mpumalanga, Implementer)

SRs need to be aware of the political dynamics in the communities in which they are implementing and avoid affiliating the programme to potential political interests. The role that Ward Councillors and traditional leaders play as gatekeepers is a common challenge noted in development programmes in South Africa. Another important dynamic that needs to be navigated is the friction between traditional leaders and Ward Councillors, linked to confusion and conflict over the roles of traditional governance, as opposed to political governance systems, in a democratic South Africa (Claassens, 2013/2015). These tensions may be more pronounced in certain districts. If not carefully navigated, this could very easily create a rift in communities if specific organisations appear to align strongly with certain political or traditional figures.

Community Stakeholder and Gatekeeper Views on Perceived Impacts of the Intervention

Taking AGYW 'Off the Streets' and Encouraging Personal Development

A number of respondents made use of the notion that the programme 'takes AGYW off the streets', giving them something productive to do with their time. Parents and communities were happy that girls were being 'taken care of' by the programme because of the safety concerns for AGYW in implementing districts. High levels of unemployment and GBV have created a sense of hopelessness; respondents appreciated the way in which the intervention was positively engaging AGYW, giving them hope and encouraging them to think positively about their futures. The less tangible 'impacts' of creating hope, encouraging a positive mindset and being a catalyst for personal growth and development, were appreciated by community members.

The programmes take them out of the streets, not only does it take them out the streets but it also helps them participate in something that helps them with their personal development... it helps them to increase their networks with people who can also help them grow on their journey, so I think it has a positive impact. (Nelson Mandela Bay, Eastern Cape, Male peer/partner)

Reducing Teenage Pregnancy

The quotes below from community leaders and a male peer/partner respondent indicate a perception that the programme is contributing to reducing teenage pregnancy, particularly through the behavioural layered services. The emphasis on 'behaviour of AGYW', as a key factor driving high teenage pregnancy rates in South Africa, apportions blame on 'badly behaved' AGYW, and fails to reflect the more complex and layered underlying factors, including structural. However, it does demonstrate the acceptability of behavioural services in communities and also illustrates something about the 'theory of change' from the perspective of certain stakeholders in the community.

Previously in our community young girls they normally used to get pregnant early between 17 and 20 but currently, ever since we introduced or enrolled for such programmes, that kind of challenge has been cut we…the numbers have decreased. (Klipfontein, Western Cape, Community Leader)

There are now less of them (AGYW) who are pregnant. (Thabo Mofutsanyana/Dihlabeng, Free State, Community Leader)

If you can look at the generation that we have, the girls give birth at the age of 14, and that does not give them a good reputation... It also reflects badly on the household where they are coming from, as if the parents are not doing the right thing, so, these programmes help a lot in teaching the girls how to behave. (KZN, Male peer/partner)

Positive Behavioural Change

As already captured above, acceptability of the programme was positively impacted by the perception that it was encouraging a positive behavioural change in AGYW that were participating. This change was noticed both in the space of AGYW households and in schools. Positive behavioural changes were further linked to encouraging outcomes such as school retention and returns, improved motivation to find employment and reduction in teenage pregnancy. These various challenges are thus rationalized, from the perspective of male partners and other community members, as being driven primarily by AGYW behaviour. Although behaviour may reflect one contributing factor, it does not necessarily reflect the more complex 'reality'. This could be an indicator for programme implementers that more needs to be done to engage communities (particularly men) around the structural drivers that undermine AGYW health and wellbeing.

Respondents noted that the programme was having a positive influence on educational attainment and encouraging AGYW to return to school, to avoid dropping out and encouraging older AGYW to enrol in further education and training opportunities. This change was again linked to positive behavioural change and also to the mentorship provided by programme staff, in particular from social workers. The reduced numbers of AGYW dropping out was also noted to be connected to a decrease in teenage pregnancy, linked to the programme.

> *The impact that I have seen is that there are now less drop-outs, there are now less people who are pregnant… it helped many people to be able to go back to school again and go to the colleges… it has improved a lot because they (AGYW) were roaming around, they did not take care of themselves because there was no one who gave them guidance… they would just date and end up having children and there were cases where older men would have sex with the AGYW… It created space for them to meet with the Social workers. (Thabo Mofutsanyana/Dihlabeng, Free State, Community Leader)*

> *The programme has had a positive impact in some girls because some of them are able to finish school and become something. Some are behaving well, and they still are. (KZN, Male peer/partner)*

Empowerment

A number of community members noted that a positive outcome of the programme was that AGYW were more aware of their rights and had received the support they needed to become more confident, positive and empowered women. This perceived impact was also noted by implementers, who had received this feedback from community members and beneficiaries.

> *It helped them because they know their rights… it has given them their rights in order to see what is it that they can do. (Thabo Mofutsanyana/Dihlabeng, Free State, Community Leader)*

> *The system is doing a great job of women empowerment… as they continue speaking, the more they are able to speak… most girls can't speak of abuse but this programme helps them so that they can talk… Like my sister, I see her being a free person, she embraces herself, she doesn't keep things in… (before) she was always on her own, locked up and not talking to anyone, now she's cool, I can talk to her… I see her smiling and being just herself, I have not seen her sad, I have not seen her negative. I've just seen her being positive and being okay. (Thabo Mofutsanyana/Dihlabeng, Free State, Male peer/partner)*

Improved Access to Psychosocial Support

A number of respondents noted that the programme had improved access to psychosocial support for AGYW. The presence of social workers on the SR teams had improved acceptability of the programme in general. Improved access to psychosocial support was credited with helping AGYW to report cases of GBV and to receive the support that they needed to deal with trauma.

They help those who have problems at home but are afraid to speak… they avail themselves so that they help those who have problems but are scared to come out. They also offer counselling… when they are not at home, they are free to express how they are treated at home to someone who is an outsider or who is not part of the family and ask for help. (Ehlanzeni, Mpumalanga, Community Leader)

Improved Access to Health Services

Respondents noted that the programme has made services more youth friendly, which has positively impacted on community acceptability. It was noted by all sample groups that AGYW are often not treated well by health workers in clinics and especially younger AGYW feel ashamed to access SRH services. Therefore, being able to access mobile clinics and health services offered in Safe Spaces was particularly highly appreciated.

It's hard for them because first they don't get pleasant treatment from those nurses, because the first question to a child at 13, the first question is from those nurses is "what do you want here at your age? What's wrong with you?"… in the township it gives a support to have let's say mobile clinics that are dealing with girls, young girls only. (Klipfontein, Western Cape, Community Leader)

Section 2 part D:

Theory of Change critique: Intervention Acceptability

From the implementer responses it is evident that the design of the programme was deemed acceptable, but that there were some failings with implementation. Despite numerous operational challenges with implementation, the sentiment from implementers, AGYW and community members is largely positive in terms of acceptability. This positive sentiment seems to be the result of the programme being a combination intervention, in that even if there are some components that are not delivered as planned, there are always other aspects of the programme that are experienced in a positive way, highlighting the true benefit of a combination interventions.

The most relevant explicit assumptions here would be:
- Assumption that AGYW who participate in the core services and who are identified as in need of a "layered" service will be willing and able to participate in, or take up the layered service
- Assumption that AGYW can access commodities and services
- Assumption that the AGYW's personal journey plan describes her own life goals and the things that will help her to fulfil those goals and become the person she aspires to be
- Assumption that communities are sensitized on the health needs and human rights of AGYW

There is an implicit assumption in the ToC model that all aspects of the intervention will be acceptable and will be experienced as of a high quality by all role-players.

Implementer Perceptions of whether Intervention achieved objectives / aims

As per the findings above, there is a sense from many implementers that the intervention is succeeding in its objectives:

> *Most definitely, a lot of things have been achieved, a lot of girls are changing. Slowly but surely, we are getting there, they are changing. You know when the change is good, the person tells another person: "wena, this is what they did for me". Normally you invite another person to come to this change, so there is really a lot of change in the young girls. (Free State, Implementer)*

There seems to be general consensus that objectives such as teenage pregnancy reduction have occurred, but that perhaps other components such as economic strengthening have not been as effective. Many implementers linked the general positive sentiment to the benefits of the psychosocial support that AGYW have received, and the positive impact that this has had on their personal and emotional wellbeing. Despite operational challenges with actual service delivery, AGYW benefited from the interaction with the staff who provided emotional support.

AGYW perceived value of the intervention

Most of the feedback in terms of the way in which AGYW perceived the value of the intervention was largely positive. While the practical benefits that the services rendered are mentioned, there was also an overwhelming sentiment around the perceived psychosocial benefits and improved aspirations for their futures. For some AGYW beneficiaries, the fact that there is an intervention focused on meeting their needs makes them feel as if someone cares about them, giving them hope.

> *I appreciate that there are people who are concerned about us and the programmes that are taking place in our community... to know how things are going regarding adolescent girls. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)*

Forming trusting relationships with the staff was also a commonly noted perceived benefit, with many speaking about how the staff felt like friends to them, again, emphasising the importance of relationship building. AGYW also felt that the programme provided an opportunity to get the information and help that they needed to cope with the challenges they face.

> *I saw it as an opportunity to get information maybe that I was not going to get at home and it won't be enough because they are dealing specifically with that… I saw it as an opportunity to get help. (King Cetshwayo, KZN, AGYW 15-19 years, Core)*

One view expressed by AGYW was that the intervention, and the data collected therein, will enable a better understanding of the needs of AGYW, and the realities of their lives, which will help to make programmes more responsive.

> *When the organisation collects data, it becomes easy for them to see the kind of problems that are faced by the youth because they will check the most common factors that were brought by different girls, and in that way, they will know that young women and adolescent girls from a certain age, experience such problems during a certain period because they are common and they will know that this is a common factor to abuse (King Cetshwayo, KZN, AGYW 20-24 years, Core)*

Overall, perceptions of the changes that the programme was supposed to bring about were positive and inspired hope for a better a future for AGYW.

Community Acceptability

While there were mixed reports about community acceptability, the criticism of the programme centred around a sense that it "did not do enough" to address the vast range of social problems. The philosophy of combination intervention designs of course aims to do just this. The fact that implementation may not have happened as planned in all cases, and also the overwhelming need in most of the study sites may have been the reason for this perception of poor acceptability, rather than a problem with the programme itself. Based on this area of feedback, what can be concluded is that the Theory of Change model design was acceptable, but implementation was not in cases when it did not happen as planned. Over and above the challenges of implementation, the overwhelming need in the intervention sites may also have impacted on the negative perceptions regarding the effectiveness of the programme.

The final explicit statement of the Theory of Change model states that planned outcomes will occur: "IF programmatic, financial and political assumptions hold true". Much of the feedback in the preceding sections point to many instances where these assumptions were compromised by implementation challenges, but that despite these, the overall perception of whether the intervention did indeed achieve the changes that it planned to, were largely positive. Much of the positive sentiment centred around the relationship building and psychosocial benefits that were afforded to AGYW.

Section 2 part E:

Implementer, Beneficiary, and Community Stakeholder views on how the intervention could be improved

Views on how the Intervention set-up period could be improved

Both community and implementation respondents felt that future interventions would benefit from comprehensive formative background research, including feasibility studies and mapping processes, highlighting context specific dynamics in each implementation district.

> *Do a feasibility study before you actually say, this is the content, how we want the programme to be implemented. (KZN, Implementer)*

> *They have to do mapping to check the problems that are experienced by young girls… In short, they must first look at the living conditions of girls in that place. (Ehlanzeni, Mpumalanga, Community Leader)*

Implementer respondents articulated views relating to the importance of pre-implementation piloting to test feasibility of programme design and to get feedback from implementation teams and beneficiaries.

> *I would consider a five-year grant rather than a three year. And have the first year spent on setting up everything that needs to happen… looking at how best to situate a Safe Space. How best to optimize processes, how best to record data. (Gauteng, Implementer)*

> *With these kinds of programmes they don't have pilots… We get a programme and then we give it to implementers and implementers must implement… if we had done a pilot we could have picked up challenges and we could have tried to rectify. (North West, Implementer)*

Implementer respondents described the way in which training of staff in the current grant period had taken place alongside recruitment of AGYW into the programme. Recruitment of beneficiaries commenced before staff were properly trained and before the services were properly set up. This seems to have negatively impacted recruitment and retention of AGYW.

> *What would also be great… is to have a lot of the training at the outset. So if we actually in the first months had no targets, in terms of reach, but focus on getting the entire staff trained, up and running, so before we start accessing the girls we have something to offer and people are ready to take it on. I think this negatively impacted the programme at the start because they [AGYW] said: we actually don't have anything to offer them so why should they bother. (Western Cape, Implementer)*

Views on how staffing and training could be improved

Respondents felt that there were insufficient numbers of trained staff to deliver various group courses, such as teen parenting and grief counselling. It was also noted that these trainings were delivered very late into the programme (some SRs only received training a year into the programme). Respondents noted that field staff require further training to be able to effectively deliver various technical components. Training on GBV and substance abuse were particularly mentioned as urgent requirements.

> *We need more training… training for HIV testing and other services offered by the HTS… Training for the GBV cases… things like those will help us if they can bring them to us so that we can provide the necessary services for the AGYW. (Free State, Social worker)*

In order to address issues relating to staff feeling poorly informed about the intervention processes and objectives, on-going / refresher trainings would boost staff confidence and motivation.

> *The implementers kind of need a refresher course, like a refresher training to reinforce what the programme is about so that maybe they can understand better why they are on the ground and why are they collecting that information. (Eastern Cape, Implementer)*

Respondents noted the need for the provision of adequate counselling and support for PGTs, SAWs and social workers, and any staff who may be dealing with emotional cases of trauma, abuse, GBV etc.

Several respondents felt that providing either monetary or other incentives to field staff, particularly PGTs who feel undervalued, could assist with staff morale, encourage innovation and improve implementation.

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Views on how Recruitment, Enrolment and Demand Creation could be improved

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Implementation respondents felt that providing non-monetary incentives that are responsive to the needs of AGYW like catering at recruitment events, reimbursement for transport costs, food parcels, access to dignity packs and certain branded items, could improve the success of the recruitment process.

> *The participants… should get incentives, but not cash incentives. It should be something that is… that is sustainable… something that would make a difference in their lives. (KZN, Implementer)*

Respondents, particularly social worker respondents, felt that incentives should be more responsive to contexts of poverty and hunger in which AGYW live.

> *There is a lot of poverty here so when there is a programme there needs to be catering (food provided) because when inviting her for a programme the first question she's going to ask is: "Is there any catering?"... There should sanitary pads or some presents (gifts) of different things that are going to be useful to them. (Free State, Social worker)*

AGYW beneficiaries also outlined their recommendations for how incentives could be more appropriate and responsive to their needs. The provision of food was cited by AGYW as a means not only of attracting more AGYW, but of enhancing the benefit of the sessions, as those who attend hungry will be unable to focus.

> *As youth if there's some nice food, you'll go… just because of food, and sometimes you learn something you will never know, when you get there what are you going to learn (Bojanala, NW, AGYW 15-19 years, Biomedical)*

> *Some girls are coming with empty stomach, and you will hear them complaining… we came here to learn but they don't give us food, and we have not eaten at home. If they can try to provide us with food. (Ehlanzeni, MPU, AGYW 20-24 years, Core)*

Respondents suggested that in order to attract AGYW to be recruited, as well as to meet the needs of AGYW from impoverished families, the provision of both food and menstrual management products would encourage AGYW to attend on a regular basis.

> *To encourage girls to come to the programme they can give them free pads… That can make girls come in numbers. (King Cetshwayo, KZN, AGYW 15-19 years, Core)*

Some SRs felt that they would benefit from increased budget for recruitment events to allow for sufficient catering and entertainment to improve the appeal of the programme among AGYW.

> *They don't give these kids food, AGYW would be there at the event from 8.00 until 14.00 and will only get a drink, biscuits and sweets. So these kids tell us never to call them anymore, "I*

163

don't want anything to do with that programme, I had enough of it!". When they host events, they should give these kids something that is tangible, like a shirt at least so that they know that next time I attend such an event I come back satisfied. (Free State, Implementer)

SRs suggested that having a designated budget that would allow for branded items to be provided to AGYW at recruitment like t-shirts, caps, pens, wrist bands, writing pads could assist in promoting the programme. Some SRs have already begun to provide these incentives and reported favourably about them. Respondents also noted that being able to assure AGYW of preferential access to government services could also potentially incentivise participation, for example access to the Department of Home Affairs for ID documents. The necessity of having reliable access to incentives such as diaries/journals as a recruitment tool was emphasised by most respondents. Failure to deliver promised incentives was reported to impact negatively on trust and confidence in the programme.

AGYW beneficiaries suggested that one strategy for encouraging young people to test for HIV regularly would be to provide a small incentive each and every time they get tested. Recommended incentives included water bottles, T-shirts, caps, and snacks.

If they can offer things… every time when they get tested they should get a bit of a present (incentive) (Bojanala, NW, AGYW 20-24 years, Core)

One suggestion that came from implementers, community stakeholders and AGYW beneficiaries was the idea of engaging AGYW in relaxed environments in order to build trust and create demand for services. Due to the programme's focus being potentially intimidating to AGYW, respondents suggested that recruitment events try to create a relaxed atmosphere as the first point of engagement with AGYW. For example, it was suggested that sporting events, poetry days or debating competitions, offering prizes, should be arranged in collaboration with community leaders and other local organisations, and can include an awareness talk about the programme to recruit AGYW. COVID-19 restrictions have obviously limited the ability of SRs to offer recruitment events and career jamborees, as discussed in this report.

Most of the girls are afraid to go directly to the centre. One way to recruit them I think, is for the people who are running the programme to come and erect gazebos and organize tournaments in our sections… whilst they are busy playing, they can then come and talk to them, and explain to them by encouraging them that they must not be afraid to come and be part of the programme. (Ehlanzeni, Mpumalanga, Community Leader)

AGYW beneficiary respondents detailed various recommendations for ways in which AGYW could be recruited into the programmes. One suggestion was the use of social media channels in a creative and interesting way.

A way to make it more attractive is… maybe a group on WhatsApp… a more interesting group…. us as the young generation we are more interested in our phones and all that… (you) can screen people or maybe ask questions about HIV and all that…. screen people and make it more attractive for them to actually want to go and take an HIV test and to want to participate in our programmes. (Klipfontein, WC, AGYW 20-24 years, Biomedical)

In addition, AGYW suggested that awareness campaigns could be conducted in order to engage AGYW in the communities, and to build trust for the intervention. AGYW respondents suggested that organised sporting events, community outreach, putting up posters and handing out flyers around the community, and general efforts to foster a sense of familiarity with the community.

They should do more campaigning… going out like sponsoring netball, sponsoring ladies soccer… Be more involved with us… get out there and know us more. Publicise themselves. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

(To get more AGYW to come to their programmes they should) make posters... move around the community… to make girls aware (Bojanala, NW, AGYW 15-19 years, Biomedical)

AGYW suggested that one way to build trust in the community and thus recruit more AGYW to the programme would be to employ young people from that community, and those who had experience with the programme themselves.

The ones that have participated like us girls who were there and experienced, we should share the information… share experiences. (Nelson Mandela Bay, EC, AGYW 15-19 years, Core)

They should employ more people of our age, people who will know and understand our situations and know them, unlike a person who doesn't know our situation, who is not from the same place… who cannot know our challenges… the challenges of that place… It will be much easier if we know him and in turn it will be easier for people to open up. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

Views on how Retention could be improved

Implementer respondents commented on the lack of regular follow-up of enrolled beneficiaries, which negatively impacted on success in re-enrolment; suggestions were made to improve follow-up and retention.

There should be a few more steps of engagement because at the moment it is: enrol, provide services and check in on them a bit later on and ensure the re-enrol a bit later on, five or six months down the line… the steps between that would be something we can work on… big events regularly in the communities, to show them that we are still present… so they know we are still available… that is something that is missing. (Western Cape, Implementer)

AGYW beneficiaries interviewed also offered suggestions for ways in which retention could be improved. It was stated that regular home visits for AGYW who had been enrolled would ensure that they were not lost to follow up, and ensure that their needs were met, particularly for the most vulnerable AGYW.

They must... visit... the people who have enrolled… and check if they need help. Because sometimes I'm unable to state all of my problems… let's say I'm being abused at home …but I can't talk about it… I am not talking about it and I go to a meeting and they don't notice that things are like that at home. At least if you are coming to my place you can notice that something is wrong here …and you can see on the side that this is what is happening in your household so I am asking you to open up and talk to me. That is the only thing they can do in order to improve… they should come and check the households of the people they are servicing. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Core)

For those AGYW beneficiaries who had tested positive for HIV, it was stated that there is a need for better psycho-social support and counselling.

Some girls after they tested positive, they stay home and not go to the clinics because they say, they are afraid... they end up staying at home. If we can have people that we know and that we can be able to talk to. People like social workers... if my results are positive, I can be able to talk to them, so that I can be able to get the treatment, so that I can continue to live and be ok. (King Cetshwayo, KZN, AGYW 15-19 years, Biomedical)

Additional support for those AGYW who have dropped out of school was also stated as a need.

They have to focus more on education... there are more dropouts... they could help those that have dropped out... motivate them, inspire them to carry on with their studies or to help them where they can for them to further their studies. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

Views on how Risk Assessments could be improved

Implementer respondents suggested that questions in the Risk Assessments which create expectations for services that cannot be provided by SRs or where referrals cannot be made should be removed. This would entail having 'district specific' Risk Assessment forms that speak more closely to the service mapping process undertaken in various districts. SR respondents interviewed commented on the the need to establish more effective feedback loops between SRs and PRs, regarding revising Risk Assessment forms to respond to emerging insights from the field. Some SR managers felt that the issues and proposals that they were raising are not being resolved.

We (SR managers) have been told that there are some questions that need to be changed. However, that is not a process that we are responsible for. We collate all of the information and send it to the PR, who should after a while be able to review and change the Risk Assessment... for them, (PGTs) if they ask a particular question again and again, and then they also give you feedback to programme management, that this question needs to change, and then it doesn't happen... eventually they will just give up. They will just say: 'what is the point of even giving you feedback, if you are not even going to change the tools?' (Western Cape, Implementer)

Both implementing staff and AGYW beneficiaries commented on the issues relating to discomfort and embarrassment in the Risk Assessment process, given the sensitivity of some of the questions. One suggestion that respondents made for overcoming reporting bias was that Risk Assessments could be self-administered.

You won't be comfortable to look at the person, one on one... to ask you those question and be able to answer them... you will feel that the question is too much and then you won't answer it... you won't tell the truth, so I think to fill the form... it's much better... writing on a form (yourself) rather than a person asking you one on one... (Bojanala, NW, AGYW 20-24 years, Biomedical)

I wish it was something we could say "let us put it on your phone", and a girl can just complete it and send it... like a google form that you complete on the phone, because some questions are a bit personal and girls don't feel comfortable. (KZN, Implementer)

However it should be noted that this suggestion could act as a barrier to access for AGYW who lack the required technical and literacy skills. Self-administered assessments would also need to be carefully facilitated to ensure accurate data is collected.

166

Commenting on the drive to meet targets, some SRs felt that reducing core service targets would help to ensure quality services are provided and Risk Assessments are not rushed.

> *If the targets can be reduced and focus more on quality. I know we try to provide quality services, however, if we are pressed with targets, somewhere down the line, certain services are compromised… It is a very comprehensive package of services that we are providing. However, the targets sometimes are out of this world! (Mpumalanga, Implementer)*

Views on how the M&E and Data Management Systems could be improved

Implementer respondents described various experiences related to technical challenges using the My Hope System, articulating the sentiment that the system hampers effective implementation and compromises the ability to ensure evidence-based programme management and monitoring. SRs also raised sustainability concerns because respondents feel that the system is not setting them up to continue with the programme after the grant period.

> *We need to create systems for people to use data for decision making… this My Hope System doesn't fulfil any of that… Google Forms is a very good developmental tool… It would motivate people that data is important, and it's not just collected for reporting purposes… it matters that your data is actually accurate. Whereas at the moment it doesn't matter at all because it's just empty, you know there's no use value from the data and so people are disenchanted. (Gauteng, Implementer)*

Some of the SRs felt that just reporting on the numbers of events hosted and the number of AGYW engaged are not sufficient indicators of programme success. Respondents' voiced frustration with the futility of counting the number of AGYW reached when these 'beneficiaries' are not receiving quality services. Some respondents shared views that M&E has just become a 'funding requirement' which serves no programmatic purpose to help improve the implementation and services to AGYW.

> *People are pushing numbers and we are not really investing in AGYW… if we had said to people, show me the impact that we have made on AGYW it would have been better. To keep them focused on the goal actually not the data and not the staff. The goal is the goal… The goal is to show me what you have done for this particular AGYW. (North West, Implementer)*

Views on how Relationships and Referrals could be improved

Some of the implementation respondents described experiences of clinic staff and other government staff not accepting the referral process or not acknowledging referral forms, and felt that more effort should be made to ensure buy-in from government employees. Respondents suggested that clinic staff could be engaged to assist with SRH promotion and education in local schools, to ensure that these services are sustained. There were examples noted, where this was already happening, and it was noted to also create demand for clinic services by AGYW. Some respondents also felt that strengthening relationships with government departments would also enable data sharing between DBE and implementers, which could assist in identifying and recruiting school-based AGYW.

Views on how Layered Services could be improved

Views on how Biomedical Services could be improved

Some of the AGYW respondents felt that the contraceptive options offered to them were limited, and expressed the desire to be given access to a greater range of choices.

> *They should include other ways for preventing, other than condoms, and pills… they should help so we can access those things… they should teach about more prevention stuff, excluding condoms and pills, they should teach about others, and also they should help us in making them available… I want to find more information about what do them call it? They call it IUD (Intrauterine device). (Bojanala, NW, AGYW 15-19 years, Biomedical)*

Some of the implementer respondents commented on the need to improve follow-up, on-going support, monitoring and adherence counselling for AGYW who test positive for HIV.

> *We can improve in strengthening the pre and post HIV testing… also strengthen on the readiness of an HIV positive AGYW to take medication (KZN, Implementer)*

Some of the implementers also felt that engagement of parents/caregivers throughout the HIV care cascade would benefit HIV positive AGYW; particularly in cases where AGYW has HIV through vertical transmission. Parents need to be supported and equipped with skills to disclose and discuss HIV.

> *There are parents who know that their children are HIV positive, they were born with the virus but the parent has not yet disclosed to the child. So if the programme starts with the parents, they will be prepared… the parent has not told the child since she's afraid, but if the programme starts with the parent, involve them, then they will understand the importance of telling the child the truth… At times you can tell that the parent would never be ready to tell the child that she is HIV positive… So the programme should also include the parents. (Mpumalanga, Social Worker)*

Implementers also felt that the acceptability and uptake of PrEP could be improved through increased efforts to engage parents in PrEP promotion and education.

> *Some kids they are keen to take PrEP but the parents don't know anything about it. So, it is better to involve the parents… let them understand. (Free State, Implementer)*

Views on how Behavioural Services could be improved

Regarding AGYW beneficiary recommendations for improving behavioural layered services, respondents suggested that confidentiality in group sessions could be enhanced. Some AGYW felt unwilling to discuss their personal behaviour in the group setting, and shared instances of confidentiality being breached by other group members.

> *Some girls are afraid… we sometimes meet as girls… when they ask questions, you can tell that others are afraid... there must be a policy that says, whatever information shared must remain confidential, and when you are found to have taken confidential information that has been discussed in the groups, something must be done to the one who has taken the information*

168

and spread it. Because we have instances where other girls hate others, and they decide to go and tell their friends about what was discussed in the groups, and it hurts a lot when you hear your story being shared in the streets. (Ehlanzeni, MPU, AGYW 20-24 years, Core)

AGYW beneficiary respondents also expressed the desire for more opportunities of receiving one-on-one counselling.

If there are things that you don't want to say in front of the entire group, we must be given a chance to have privacy. They can even use the woman who was registering us to talk to us privately… to be able to have a one on one conversation so that if there's something I want to confide, I can talk with her. (King Cetshwayo, KZN, AGYW 15-19 years, Core)

Views on how Structural Services could be improved

AGYW respondents expressed frustration about the lack of sufficient and consistent supplies of sanitary pads, and stated that the provision of pads and toiletries needed to be more regular.

I would like them to… donate sanitary pads to us… some of us do not have that money to buy sanitary pads. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Core)

They should provide us with sanitary towels because some girls don't have and they don't afford them… on a monthly basis… If they can supply us with toiletries… soap, bath towel, roll-on, tooth brush.. on a monthly basis. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

Both implementer and community stakeholder respondents felt that ensuring better health outcomes for AGYW requires the participation of ABYM and older male partners, and expressed view that currently the intervention is not doing so satisfactorily. Very few of the SRs said that they had been offering the planned men's dialogues. Respondents argued that there is a real need for more programmes for ABYM with a mentoring focus, as a means to contribute to better health outcomes for both ABYM and AGYW in the future and to address GBV in South Africa.

It is not helping the young women only while boys are the ones creating the problems… they have checked the stats and it showed that it was the young women who needed help, but the reason is caused by the boys, because you will find a boy having relationships with 3 young women… it's like we are doing a futile exercise that will not yield results. If the boys can be part of the programme and grow with the program, be groomed by it… the blessers we call today started from an early age… they were not well groomed when they were growing up, that's why they are blessers today, and when the young women see money, they are attracted, especially the age that we are talking about. (Mpumalanga, Social worker)

The ABYM are not given enough attention, the boys… if we teach a young boy how to treat a young girl… to say "no means no"… Gender-based violence will reduce… rape will reduce, because these children are not being given that kind of information… we only have six ABYM and they rotate and the girls have LSAs full time at school but for them they do not have that full time. (North West, Social worker)

AGYW beneficiary respondents also shared the view that ABYM should be included in programmes and activities, particularly in order to address IPV and GBV.

169

Even if we are focusing more on girls, let's not exclude boys… more focus should also be directed towards them that we must just groom them at the age of 10… from 10 years we must start building men, men who are strong, men who would know that they don't have to beat women. Men who know that if they are not satisfied by something, they don't resort to beating up a woman. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Core)

In order to reduce barriers to school attendance and completion, some AGYW respondents highlighted the need for financial assistance with covering the costs of education.

I have problems with money so that I can go to school… Maybe they can assist with money so that I can go to school. (Bojanala, NW, AGYW 15-19 years, Core)

Respondents felt that skills based training, including computer literacy classes would increase employment potential and income generating opportunities for AGYW.

AGYW should be taught how to use a computer… computer classes… so that they can get jobs. And learn something that you can do with your hands… so that they can at least do something… if they cannot go back to school… so that they can generate income for themselves…. have money at the end of the day because these girls have children, small children. They are young themselves, but they have children. (Western Cape, Social Worker)

The suggestion was made by respondents that the programme should reach out to those young people most vulnerable, those living on the streets, and those engaging in sex work.

The programme should be for children who are suffering… those who are telling themselves that their lives will never be okay and they end up living off the streets… that's the people that I wished could have been included… there should classes that would be attended so that they can end up knowing that they are not just useless people but they are people they are alive… life has challenges… if you're like struggling... there must be something that you can do other than going out and selling your body... suffering out there. (Bojanala, NW, AGYW 20-24 years, Core)

Views on how Accessibility of Intervention Services and Spaces could be improved

AGYW beneficiaries suggested that offering more comprehensive SRH services at school would enable better access for both AGYW and ABYM, especially for those who are reluctant to go to the clinic.

There are other people who do not want to go to the clinic… so doing it (offering services) at school is good… they should come and do tests for everything, not only to come and do the HIV test only… They should come and do other tests such as those STIs… they should offer the medication because a lot of kids are unable to go to clinics. It's not like they're unable, they don't want to go to the clinic. (Bojanala, NW, AGYW 20-24 years, Core)

AGYW beneficiaries also felt that providing more services and group programmes on college and TVET campuses could improve the accessibility of the programme for AGYW.

The issue is to be off campus and go for a long distance to attend… So, if they can have it inside the campus, it can help because there's a lot of girls who need this programme. (Ehlanzeni, MPU, AGYW 20-24 years, Core)

Implementer respondents described the need to ensure that programmes take place in hours and locations that are accessible for AGYW. It was stated that SRs should consider the school and college hours of AGYW and the other work and life commitments of community-based AGYW, when planning programmes.

Accessibility is a problem… because it's only from 7:30am to 4 o'clock… what's going to happen to those that are at work or at school? (Eastern Cape, Health worker)

It was also suggested by AGYW that offering services over the weekend and after-school would enable more AGYW to access them.

The time is not enough… when you come after school and wanted to attend, sometimes you will find them gone… they must maximise in working on Saturdays and Sundays… Because a lot of people are not busy on weekends, unlike during the week where people are working, other are studying… they don't even have a chance to go for a simple test. (King Cetshwayo, KZN, AGYW 20-24 years, Biomedical)

Why don't we meet on meet on Saturdays… on a Saturday we would have time. (King Cetshwayo, KZN, AGYW 20-24 years, Core)

AGYW beneficiaries, particularly those in the older age group 20-24 years, felt that they would benefit from toll-free helplines and data-free online support

They must have a landline that is free… for kids from small areas like ours, airtime becomes a problem when they want assistance… they must form WhatsApp groups since everyone has the phones, they should have WhatsApp groups where they will be helping one another. (Thabo Mofutsanyana, FS, AGYW 20-24 years, Core)

They should use social media platforms because we like social media very much… We follow social media a lot especially Facebook… if we can see the page we will want to go to it and view the content. If we view it we will want to follow it and to be part of it. (Ehlanzeni, MPU, AGYW 20-24 years, Core)

AGYW beneficiaries also felt that the provision of transport, or at least transport costs to AGYW would improve accessibility.

If you are attending their classes… they give you a bus fare… when you are attending their classes they should give you money for transport so that you can be able to reach the place. (Ehlanzeni, MPU, AGYW 15-19 years, Core)

If they can try to provide transport that will come and fetch us, because others are staying far. (Ehlanzeni, MPU, AGYW 20-24 years, Core)

AGYW beneficiaries also felt that barriers to participation for those AGYW with babies and children could be addressed through the provision of childcare facilities.

They could help with my child, like getting her a creche. (Ehlanzeni, MPU, AGYW 20-24 years, Core)

171

Various implementer and community stakeholder respondents felt that rural communities remain underserviced, and that the intervention needs to provide services to rural communities in their localities. It was noted that most AGYW only receive these services when they travel to towns, however, transport costs represent a barrier to access, which should be addressed. One community leader suggested that programmes need to be adapted to the rural context with a focus on SRH education and services, school return for teenage mothers and supporting rural livelihoods.

> *(This programme) has to expand and reach out to the farms… Because in most instances, people from the farming communities get the services when they come to the townships… So, they need to reach out to the farms… it can help them, maybe it can improve their livelihoods… they do not have information… It can also help them with information, they fall pregnant… and have children unnecessarily while they are on the farms… some become drop-outs on the farms. (Thabo Mofutsanyana/Dihlabeng, Free State, Community Leader)*

Implementers and community respondents felt that the programme needs to be more accessible for AGYW living in remote rural areas. Implementers noted the need for extra funding to account for the transport needs for AGYW to reach Safe Spaces/ other venues or access to appropriate vehicles for implementers to conduct outreach activities and host events in rural locations. Staff shortages are also affecting the ability to reach AGYW in these areas, which should be addressed.

> *If you do spend quite a lot of time in one space, you find that space becomes quite saturated, so we are actually looking at having Safe Spaces that move, like satellites… so that we actually get more access to girls that we are not currently able to reach in the current spaces. (Western Cape, Implementer)*

> *They need more workers and transport so that they can go to remote areas and have those programmes. Even if it's not a branch but they can have a mobile trailer… it's a very good sustainable programme, it just needs to expand. (Mpumalanga, Social Worker)*

Views on how Intervention Settings and Spaces could be improved

Respondents expressed views that Safe spaces should provide WIFI and access to computers for AGYW, since this was a frequently noted demand and a source of disillusionment among AGYW beneficiaries in cases where this was promised but then not delivered. SRs suggested that Safe Spaces should provide incentives like refreshments and meals to AGYW. Absence of resources in households contributes to school drop-outs, therefore this could assist in keeping AGYW in school.

> *Even just (giving AGYW) simple soup… when it is very cold… (when they are) getting their homework assistance… we are also addressing some of those indicators whereby we are addressing the school dropout… if we can have fully set up Safe Spaces and satellites this can really contribute massively in terms of changing the life situation of these beneficiaries. (Free State, Implementer)*

Respondents suggested that there should be fewer Safe Spaces and satellites but they should be well resourced, rather than having a high number of poorly resourced Safe Spaces.

> *The money allocated to the Safe Spaces is limited… we could only sort of afford an office space linked to a hall… maybe (we should) not have so many Safe Spaces and satellites, but have one or two, invest a lot more into it. (Western Cape, Implementer)*

172

Views on how programme implementation during COVID-19 could be improved

Some SR respondents felt that they would benefit from having more flexible funding in order to best respond to the changing context and bring some programme components online

> *The budget also doesn't allow for some of the things that we would like to do; so, a bit of flexibility with the budget so that we can move some of these things online… this programme is very rigid! There is no room for flexibility… In one of the meetings with the PR, I actually said, there is a saying that goes: "I adapt or die". But in this case, it is the programme that is not adapting and it is the girls that are dying. (Western Cape, Implementer)*

Implementers described the ways in which online platforms could better be utilised to deliver and provide psycho-social support that do not involve costs or data expenditure for beneficiaries.

> *We need to get a way of communicating with them (girls) maybe via skype but in such a way that they don't get charged on their phones. (Free State, Social worker)*

In contexts where AGYW homes are not safe or confidentiality cannot be assured, it was felt that services are best provided outside of the home if COVID restrictions allow and if safety protocols can be followed.

> *For the services to continue, you should remember that for some kids, the problems are right at home, the abuse is at home where she lives. But if ever we can find a way of continuing with the services despite COVID, that would be good… when COVID subsides there will be more problems, even the child that was better will be in more deep pain. (Free State, Social worker)*

Implementers described the need to be sufficiently prepared and aware of how programmes can be adapted and what measures can be put in place at different levels of COVID lockdown, to avoid being caught off guard.

> *We have to look at what elements of the programme can be done online and what is the best way to go about it. And then we also have to look at the different levels of lockdown and how we are going to respond to it. So, if you are at level 1, this is how you need to implement and if you are at level 3, this is how you need to further escalate, and then if you go into full lockdown, which is level 5, this is what you are able to do and this is how you should do it. (Western Cape, Implementer)*

Views on how Acceptability of the Intervention could be improved

Views on how Parents' Acceptability of the Intervention could be improved

In several cases it was found that SRs are not engaging with the parents of AGYW, which has negatively affected acceptability and the participation of AGYW in the intervention. In particular, it was found that parents/ guardians need to be engaged more closely around PrEP, HIV testing and HIV care cascade, GBV and sexual abuse in homes. To address GBV and sexual abuse in home and school

environments, it was suggested that mothers/female caregivers could be engaged and equipped with skills to mitigate and report violence. Rather, it is suggested that 'all parents/guardians' (including men) should be engaged, so that the root causes of GBV in communities can be addressed. In cases where SRs have made efforts to involve parents and ensure they are aware of the intervention's aims this improved acceptability and parents became proponents of the intervention; assisting programme implementers with AGYW retention, availing venues for programme activities, and engendering general community acceptability. SRs should ensure that they present the programme to parents at school parents' meetings and in community meetings, as in cases where parents are not consulted, acceptability is negatively impacted, and ultimately affects continuity of care for AGYW. However consultation should not be a once-off event but rather SRs should ensure continuous opportunities for engagement.

> *If the programme can be opened and be broad and include parents, especially mothers, it would be simple for us to get these kids... The issue of gender based violence... a lot of children have been seriously violated at home... sometimes the mother is aware that the father is abusing the child physically or sexually, however because the mother is worried about who is going to buy food or what is going to happen, she ends up accepting it... if the parents, especially mothers, can be included in the programme... The mother is the one who will tell the child to go to the Safe Space. (Free State, Social worker)*

Use platform of school parents' meetings to build trust amongst parents for the programme.

> *It's now that they have requested the parents meetings dates for each school so that we can go and attend all those meetings and we get slot whereby we introduce the programme so that they can know that we are working hand in hand with the school and also we have psychosocial team that is going to help their children... with parents knowing the programme that it also include HIV testing... if there are meetings which are being held at school... we really want to be part of those meetings... that will make a difference. (Eastern Cape, Implementer)*

Engaging parents would also improve AGYW uptake of HIV testing and other SRH services.

> *We needed to work more on that... to give the parents more information, why the AGYW needs to be tested, why is it important, because not all the parents are so open to AGYW being tested, given family planning, so they needed like lot of information and education. (Western Cape, Implementer)*

The evaluation found that AGYW are not able to talk to their parents about the challenges that they face. Programmes that aim to improve the dialogue between AGYW and their parents/ guardians and build capacity for AGYW to speak to and seek support from parents around SRH would be of benefit.

> *Let them (AGYW) know and let them build a relationship with their parents, like those group support where the mother and the child become friends. If they can get to that level that they talk about everything it becomes easier for us to work with them... And remember that it is not easy to change someone's mindset about certain things, so you need to take them step by step. (Free State, Implementer)*

Respondents noted that implementers should engage the community more around the design of the intervention and create opportunities for co-evaluation of needs and co-creation of programme design. Responses emphasized that project design and implementation was too top-down and that insufficient community consultation had occurred. Community acceptability could be improved by integrating a more participatory approach.

> *Go to the people, live with the people, talk to the people… if you want to work with the community, you should go to the people and find out what is it that they want and what are their needs. Find out what's the best way to meet those needs… let's say I am from Gauteng, I cannot come up with my dream idea and say this will work in Limpopo… if your target is the youth… hear from them what their challenges are and what is it that they need… Don't come with the information you got on google and think it will work. No, we should learn to hear what people say. (Free State, Implementer)*

Respondents highlighted community demand for the intervention to involve ABYM, older male partners and men. Community members felt that ABYM needed mentoring to address the drivers of HIV. It was noted that empowering AGYW left men in the community feeling threatened, and some cases of GBV had been recorded as a result, for example against AGYW who had attended the self-defence course. Community members also felt that it did not make sense to only focus on AGYW when sexual health closely involved their partners. Interviews with men and other respondents, also noted that men are the ones that generally make decisions around contraception use. SRs that were providing men's dialogues were viewed favourably, whereas failure to involve men in the services provided tended to impact negatively on community acceptability.

Several respondents noted that communities are poorly informed around PrEP and this has contributed to resistance to PrEP rollout. Several SRs are not engaging the community and parents and leaving it up to AGYW to inform their communities.

It was noted that when it was possible to host events against (in regard to COVID-19 regulations), that more attention should be focused on making these events engaging for communities. Respondents suggested creating a more relaxed atmosphere in which to discuss the topic of HIV by using sports, music and the arts, as well as providing context-relevant incentives. In the meantime, awareness campaigns can be initiated that draw on music and the arts to engage communities around difficult topics, such as PrEP.

> *A really helpful and a relevant thing for young people is kind of music and the arts…. it's got that kind of, got universal validity… there are really amazing organizations that have been doing that kind of work for many, many years. The one that we're working with… has added such value to our programme and expanding on that has got huge potential. (Gauteng, Implementer)*

175

Section 2 part F:

Broader Context

One of the aims of this qualitative evaluation was to examine the context of the intervention, exploring the ways in which the context affected intervention implementation, and how the programmes work in practice. We also examined the broader social and community cultures into which the intervention has been introduced, and how these may have influenced and interacted with the acceptability of the intervention, and its delivery.

Context of AGYW lives and communities

During the qualitative interviews, we collected data on the perspectives of community stakeholders, intervention implementers, and AGYW themselves on the social, cultural, educational and economic contexts of AGYW lives, and the communities in which they live. Data was also gathered relating to the perspectives of respondents on how COVID and lockdown had impacted on AGYW health, education, safety and risk, as well as views on broader impacts of COVID on the communities in which AGYW live. For the purposes of this evaluation report, we have briefly outlined the thematic areas that emerged in the analysis of this data set, and included them as an appendix (see Appendix 1). Due to the volume and richness of the descriptive data around context, and for the sake of brevity of this process evaluation report, we have elected to not present the detailed analysis and respondent quotations illustrating these themes, but shall develop manuscripts at a later stage in which these themes and findings shall be unpacked and explored further.

Theory of Change: Broader Context

Research on the sustained high incidence of HIV in adolescent girls and young women has suggested that interventions may not sufficiently address and account for the complex social forces that are located within the personal realities and contexts of role players. These social forces may be instrumental in bringing about or impeding the social change processes that most interventions are aiming to effect. Literature on adolescent sexuality confirms that public health interventions aimed at behaviour change in this group also tend to neglect the influence of these important social forces. As such, problems of interest are often positioned within narrow frames of reference which have been critiqued for being too linear and too dependent on rationality of the individual. The dominant public health discourse around adolescent sexuality also tends to frame it in moralising and negative terms that adopt a singular view of sexual relationship dynamics, reducing them to a sum of individual behaviours and practices. These behaviours and practices are located within a paradigm of risk, thereby eliding all the multi-layered and nuanced factors present in the individual's social contexts, including more positive elements of sexuality such as romanticism and pleasure, that also influence and shape the outcomes of interest. Hence the way in which young women negotiate their sexual and social relationships, may play out in far more complex ways than the Theory of Change model allows for.

Some of the respondents in the evaluation research spoke of a need to respect the local knowledge systems upon which girls negotiate their sexuality.

> *These girls tell us a lot of things about why they date different kinds of men. There are different slangs they use that we don't know, so that is when we get educated… There is a lot that we learn from them… they talk about how they negotiate sex. They talk about how they keep a man waiting. It is very interesting, because for us we have gotten old now, we have gone past that stage of negotiating (sex). For them, as much as they love the partner, they know that… maybe it is sex that they have to perform in order to keep that partner. But now they have that strategy to keep him waiting… those are the kind of things we hear. We hear that they sleep with other men because they have been given alcohol, so now they are obliged to sleep with them. But we can't judge them… because we don't know what happens down there in the community. (KZN, Implementer)*

The model assumes that exposure to the core and layered services is all that is required to bring about the desired change. The contextual data however reveals that there are deeply complex processes and factors within AGYW social context that also influence behaviour. The respondents speak of the pressures of surviving the effects of poverty, violence, powerful gender norms, poor familial support and many other precarities of life in these contexts. As much as the Theory of Change model allows for the inclusion of a wide range of behavioural interventions, it is always difficult to incorporate findings that relate the personal and social contexts to processes of change, within a logic model framework. These social phenomena may not be adequately accounted for using a Logic Model such as the ToC model here does. So much of the *how* of the change processes may be explained by the information revealed in this section. It is imperative to find ways to incorporate these learnings into Theories of Change more effectively.

Section 2 part G:

Ensuring the Sustainability of Intervention Services

and Perceived Impacts

Concerns regarding sustainability have been raised by community stakeholders and AGYW beneficiaries. Implementers did not seem to have sustainability plans in place and thus have not been able to provide responses to these concerns. Implementers themselves appeared to be concerned about sustainability and whether their organisations would be able to continue to support beneficiaries when the grant period comes to an end.

> *There was a great need because a lot of young girls needed help in a lot of things. If I had my way, this programme would continue because a lot of girls are getting help, although some of them are not yet part of the programme, but as time goes on, they will be part. (Ehlanzeni, Mpumalanga, Community Leader)*

They are so happy to have something like this but their only worry is how soon is it going to end… we don't have answers for that one. So, we just tell them that we don't know, we have been hired and this is what we do and if you need more information go to [SR]. (Free State, Implementer)

The latest concern was… when the project funding ends, what is going to happen to all of these young girls… we haven't had a response to that one. (Western Cape, Implementer)

SR respondents demonstrated an interest in continuing to implement the intervention, if the grant would be extended or alternative funding could be sourced. However, there were concerns regarding whether other funding sources could be found beyond the grant period. Implementers expressed their concerns regarding 'letting down' the beneficiaries, who would expect to keep receiving the services.

Of course the major concern becomes the ongoing funding. Because remember, ourselves we don't have control. Sometimes when you provide a programme, in an area which is very, very needy and only to find that you don't receive or get the continuous funding. Of course that has a detrimental effect on the beneficiaries and the community at large… they get used to the service, they expect the service to be provided, to be ongoing. So, that becomes a concern because we don't have control in terms of the continuity or whether we will be funded on the next round. (Free State, Implementer)

SRs were also concerned, in general for the sustainably of their organisations, in light of the COVID-19 pandemic. Some respondents noted that the Global Fund grant was keeping their organisations afloat and that they were concerned about the organisations' viability in general, beyond the grant period. Some SRs had lost their other funding sources and grants in general are scarce, especially for 'upper middle-income' countries like South Africa.

We have also tried to apply for further funding… if a similar programme were to be run in the future, we should definitely apply for funding because… the scope in terms of impacting young women is great… I am all for that. But in terms of the programme itself… if funding were to end in March 2022… organizationally we will have to reassess where we are at because we have also taken strain as a result of COVID. Because the churches can't fund as much as they used to, and we are a church organization… So in terms of our sustainability I am not sure, because we have been challenged this year and this programme is keeping us going. (Western Cape, Implementer)

Sustainability of Safe Spaces

Several implementers, AGYW and community members noted concerns regarding the sustainability of Safe Spaces beyond the grant period. One SR respondent described the steps they were taking to ensure sustainability of Safe Spaces; an important mechanism for ensuring the sustainability of the project beyond the grant period included ensuring a sustainable referral system and the independence of data management, for example through transitioning towards accessible software such as Google forms and Excel, and moving away from the My Hope System.

I'm trying my absolute best to create a Safe Space that will continue to be a Safe Space and operational, with service delivery routes into the community that are established and data management processes etc… one really important part of that would be data management

independence, you want to be transitioning to Excel and Google, that don't belong to you. (Gauteng, Implementer)

Concerns were raised regarding the sustainability of biomedical services. Respondents noted that the aspect of the intervention focused on biomedical reach, is unlikely to be sustained, especially PrEP adherence. SRs who have been operating in clinics during the grant period, have helped to transform the approach to working with AGYW and made the services more 'youth friendly'. However, there are concerns regarding the sustainability of this improved access to services beyond the grant period finishes. Respondents felt that clinics and the health system are unprepared to take over the 'youth-friendly' approach to biomedical services for AGYW, after the end of the grant period.

> *I have girls calling me asking: 'are you at the clinic? I need to come'… I am not sure that they will feel comfortable to come when you are not there. There is also this… about the nurses… the girls feel that when they go to the clinic, the nurses are rude towards them… now they feel that when you are there at the clinic and they come, the treatment will be different. So, whether they will use the services when we are not on the ground anymore… yo! That is a big question! (Western Cape, Implementer)*

> *They don't want that, for instance, now you have introduced PrEP to the child and the child no longer wants to go to the clinic. Now if the project comes to an end, what is going to happen to that child? That's the main problem. (Free State, Implementer)*

> *I don't think sustainability will be maintained… these youth are not going to go back to the clinic, they are going to stop. I don't think that clinics are ready to take over after we leave… for PrEP programmes, the facilities are not ready to take charge… I don't think that young girls like clinics, they are not going to go to the clinic to test. So, if we stop, some of the positive changes that we are making are just going to go… Yo! I feel like they will feel like we let them (AGYW) down! (Free State, Health worker)*

Respondents feared that the youth are unlikely to return to clinics for these services if the SRs stop providing them. This aspect of the short grant period, was noted as having a negative impact on community acceptability in general, because communities are tired of NGOs only supporting them for a short period and then leaving without a plan to ensure sustainability of the services provided.

> *I'm just worried about the continuity… if we can just leave the people hanging… For example, when we are giving the PrEP pill, not all of the facilities in the Klipfontein area are giving PrEP. So, now I'm worried if we are not there one day, the AGYW from that specific area, where will they get these services?… That is the other thing that the community will always say, that 'no we know that you always come with these wonderful services, and then, two to three years down the line you just disappear. (Western Cape, Implementer)*

Some respondents felt that AGYW needed to receive continuous support and encouragement to ensure that the positive outcomes of the programme were sustained. While other respondents noted that sustainability and continuity of care would differ based on the motivation and agency of individual AGYW. In this latter view, respondents felt that where AGYW were sufficiently convinced of the value of continuing HTS and PrEP, for example, they would likely continue to seek out these services in the

public health system. From this perspective, individual agency is viewed as critical, while structural barriers are not considered as determining continued access. To a certain degree, individual agency would be an important determinant of sustainability, but research also indicates that several structural drivers undermine AGYW health and their agency in various sociocultural contexts.

> *It will depend on the girl whether they want to continue from where we've left off… because as much as you can give skills and supports to someone it's kind of forever. As soon as the programme ends, they need to make sure that they continue, from where we left off and try and achieve those goals that they're wanting to achieve. (Eastern Cape, Implementer)*

> *We do worry, but there will be nothing that we can do because even us, we will be out of jobs by then… the sustainability part of it will carry on. Because these girls, we've made an impact in their lives, and before they even begin PrEP, they know the reason why they begin the PrEP… So, I think it will be sustainable… it would be very good if this programme continued because some of them, eish, they are very stubborn, very stubborn!… I really hope that Global Fund reconsiders the programme continuing because, these young girls [laughing], they change… the one day they are willing, the next day they are not willing, so eish… it is like that. I really hope that we can continue. (KZN, Implementer)*

Another aspect highlighted in the quote above, is the concern among implementers regarding the sustainability of their own employment and livelihoods. This also highlights a concern regarding how to ensure the community and the health system at large, continues to benefit from the skills that these implementers have gained over the course of the grant and to sustain their value in the health system, if they cannot be absorbed in other organisations or projects.

Sustainability of behavioural and structural services and their perceived impacts

Respondents noted that the more subtle 'perceived impacts' of the project, related to AGYW behavioural changes and the structural impacts, are more likely to be sustained, for example through empowerment programmes, or having linked AGYW to economic opportunities and further training. Respondents expressed greater concern with the sustainability of biomedical services, since it was noted that AGYW may not continue to access these once SRs were no longer providing them. However, given that so many respondents noted how the programme improved access to psychosocial support, it is also a concern that this important aspect would not be sustained after the grant period.

> *If we do what we do well enough I think the AGYW would have had enough input to be able to engage going forward… whether it is in jobs or economic opportunities, if we have linked them to further training. So, I think the impact is not going to end when the programme ends. (Western Cape, Implementer)*

One suggestion to improve and ensure the sustainability of the programmes and their benefits was to extend, or have longer grant periods for future interventions. Due to the fact that so much time and effort goes into setting up programmes, building trust and relationships with community and other stakeholders, it was felt that it was a waste to have such short grant periods.

> *We're starting to gain traction… with the team that we have in place… one of my recommendations would be an extension of the grant… once you gain traction in the*

community, the program's going to end… we will defeat (the purpose)… even if it's just slightly (extended), but to have some kind of momentum that builds it would be great. (Western Cape, Implementer)

Sustainability of Intervention from Theory of Change Perspective

One of the commonly cited critiques of the Theory of Change model is that such theoretical models do not pay sufficient attention to the indigenous change processes that were already active before the intervention began ,or how these change processes will continue and/or be mitigated by the intervention's actions; and how change may continue in the future, with or without continued intervention activities. In this case, the change agents that were previously active before the intervention could be seen as the SRs and NGOs that the Fund partnered with for implementation. These services were bolstered by the inputs from the Fund, but ideas about sustainability were not stated as explicit assumptions in the ToC model. The model assumes that improved health outcomes will result from exposure to all the core and layered services, but does not necessarily speak to how these may be sustained post the grant period. As has been shown, despite a host of operational challenges in delivery of the planned core and layered services, there is a sense that the programme has yielded enormously positive benefits for AGYW and the community. Much of this benefit has been described to be derived from building trusting relationships with health care providers, with the youth friendly services, Safe Spaces and psychosocial support being key drivers for this.

AGYW and implementers emphasised how the youth friendly services were far more attractive than the services and care that were offered in clinics before the programme began. If these services were not sustained post the grant period, implementers reported worries that AGWY would not revert back to the previous services, and that positive outcomes may then be attenuated. As has been shown above, there is the tenuous assumption that *what* has happened during the grant period (exposure to core and layered services), will be enough to sustain the changes, even in the absence of these services post grant period. While it is clear that there are many cases where girls have been empowered with knowledge which has resulted in behaviour change, it is not clear that they would be able to maintain these changes without the continued support of the programme services. Further to this sustainability (or lack thereof) impacts negatively on acceptability as communities develop mistrust in programmes once they have terminated, which may render them less likely to want to use further services that may be offered.

The current ToC model it seems, did not clearly state assumptions about how changes can be maintained in the absence of the intervention services post the grant period. As previously mentioned, a commonly cited critique of ToC, is that models often explain *what* changes happen, but not *how* they do. Based on the current model and both its explicit and implicit assumptions, it is the exposure to the core and layered services that should bring about change. As has been shown however, the model does not make adequate provision for explaining *how* these changes come about. If this were better understood, it may be easier to then strategize around which elements of the programme are needed to sustain current and ongoing change, and which changes could last without continued intervention. The results of these interviews indicate that a large part of the *how* was forming a trusting relationship with health care providers and psychosocial support services, as these appear to have been key aspects of facilitating effective AGYW engagement in the programmes, and the assumed positive changes.

As the data on context illustrates, there are multiple structural barriers and precarities within the lived context in which AGYW are embedded, that complicate sexual decision-making for AGYW, rendering it much more than a series of simple behaviour choices. It therefore would seem imperative to gain a deeper understanding of the social context and the impact that this had on change, in order to predict the impact that it will have on sustainability. The assumption that change will be sustained post the intervention is thus not well supported by the findings.

Study Limitations

Sample limitations: A limited number of community stakeholders were interviewed, with some intended sample groups not represented. Despite attempts to contact and interview parents of AGYW, and teachers at schools in which the intervention was implemented, we were unable to interview any parents or teachers.

Social desirability and reporting bias: Positive reports on the impacts of the intervention may have in part be due to social desirability bias. Although the research team was independent from the intervention, it is possible that participants viewed the interviewers as connected to the implementers, and therefore shared positive opinions. Additionally, data was collected at one time point, which means that the narratives of intervention recipients may be prone to recall bias.

Process Evaluation data capture time-point: Important to note is that since data collection was conducted at one time-point in the implementation of the intervention, as per the design of process evaluation studies, the data is limited to this particular time-point. In some cases, PRs and SRs may have been aware of issues with implementation highlighted in the report findings, and may have already been implementing mid-stream adaptations that were not captured during this specific period of data collection. To address this limitation in the evaluation, the implementers were provided with the opportunity to provide feedback on the evaluation report and the recommendations made by the evaluation team, and to furnish details on any mid-stream adaptations or modifications that may have already been underway. These details are captured in the accompanying HERStory 2 Process Evaluation Overview and Recommendations document.

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APPENDICES

Appendix 1:

Thematic Areas relating to Broader AGYW Life and Community Context

AGYW Health Context

AGYW Sexual and Reproductive Health

- AGYW Contraceptive Use
- AGYW SRH knowledge, decision making, and behaviour
    - Beliefs about Contraceptives
- Teen pregnancies and Teen parenting
    - Community stakeholder perspectives on Teenage Pregnancy
    - AGYW Perspectives on and Experiences of Teenage Pregnancy
- Illegal / Unsafe Termination of Pregnancy
- AGYW HIV and HIV in AGYW Community contexts
    - HIV Stigma
    - HIV testing
- Condom Use

AGYW Health Care Access

- Barriers to AGYW access to SRH
    - Community Stakeholders' Perspectives on Barriers to AGYW SRH access
    - AGYW Perspectives on and Experiences of Barriers to AGYW SRH access

AGYW Mental Health and Well-being

- Suicidality and Depression amongst AGYW
- Psycho-social support
    - AGYW emotional and psycho-social support context

AGYW Socio-Cultural and Economic Context

Economic context of AGYW lives

- Community Stakeholders' Perspectives on AGYW Socio-Economic Context
- AGYW Perspectives on and Experiences of Socio-economic Context
- Employment and Job Opportunities for AGYW

- Menstrual poverty
- Child-headed households & connected vulnerabilities
- Undocumented AGYW

Safety of AGYW in Communities

- Implementer views on AGYW Safety in Communities
- Community stakeholder views on AGYW Safety in Communities
- AGYW Perspectives on Safety in their Communities
- Gender-based violence
    - Sexual Violence and Rape experiences

Socio-cultural context of AGYW lives

- Gendered expectations for AGYW
- Cultural and Religious Norms for AGYW

AGYW Interpersonal Relationships Context

Family environments

- AGYW-Parent Relationships
- Absent Fathers
- Communication barriers between AGYW and parents / caregivers
- Family support for AGYW Education
- Sexual and domestic violence in households/families

AGYW Sexual and Romantic Relationship Context

- Gendered power dynamics and Decision making in relationships
    - AGYW Perspectives on Decision Making in Relationships
    - Community / Male Peer Perspectives on Decision Making in Relationships

    - Condom Use and Decision Making in Relationships
    - HIV testing behaviour in relationships
    - First Sex Experiences
    - AGYW views on multiple partnerships

AGYW Education Context

- Support for AGYW education
- Barriers to AGYW Education
- Bullying at School
- School Attendance
- Poverty and Education
- AGYW Educational Aspirations

- Funding for AGYW Education
- Educational concerns / challenges

AGYW Risk Behaviour

- Multiple Partnerships
- Transactional sex
    - Age-Disparate Transactional Relationships
- Alcohol and Substance Use

Effects of COVID on AGYW lives and communities

Economic Impacts of COVID

- COVID and Unemployment
- COVID, Poverty and Hunger
- COVID and Access to Social Grants

Health Impacts of COVID

- COVID and Mental Health
- COVID and Access to Health Care
    - COVID and AGYW Access to Contraceptives
    - COVID and AGYW HIV testing

Education Impacts of COVID

- COVID effects on AGYW Education
- AGYW Educational Resilience during COVID

COVID Impacts on AGYW Safety and Risk

- COVID and AGYW Risk & Behaviour
- COVID Impact on AGYW Safety
- GBV, IPV and Domestic Violence during COVID

Appendix 2: Interview guides and Participant Consent Forms

Interview guides and participant consent forms can be provided on request. Please contact the corresponding author via email.