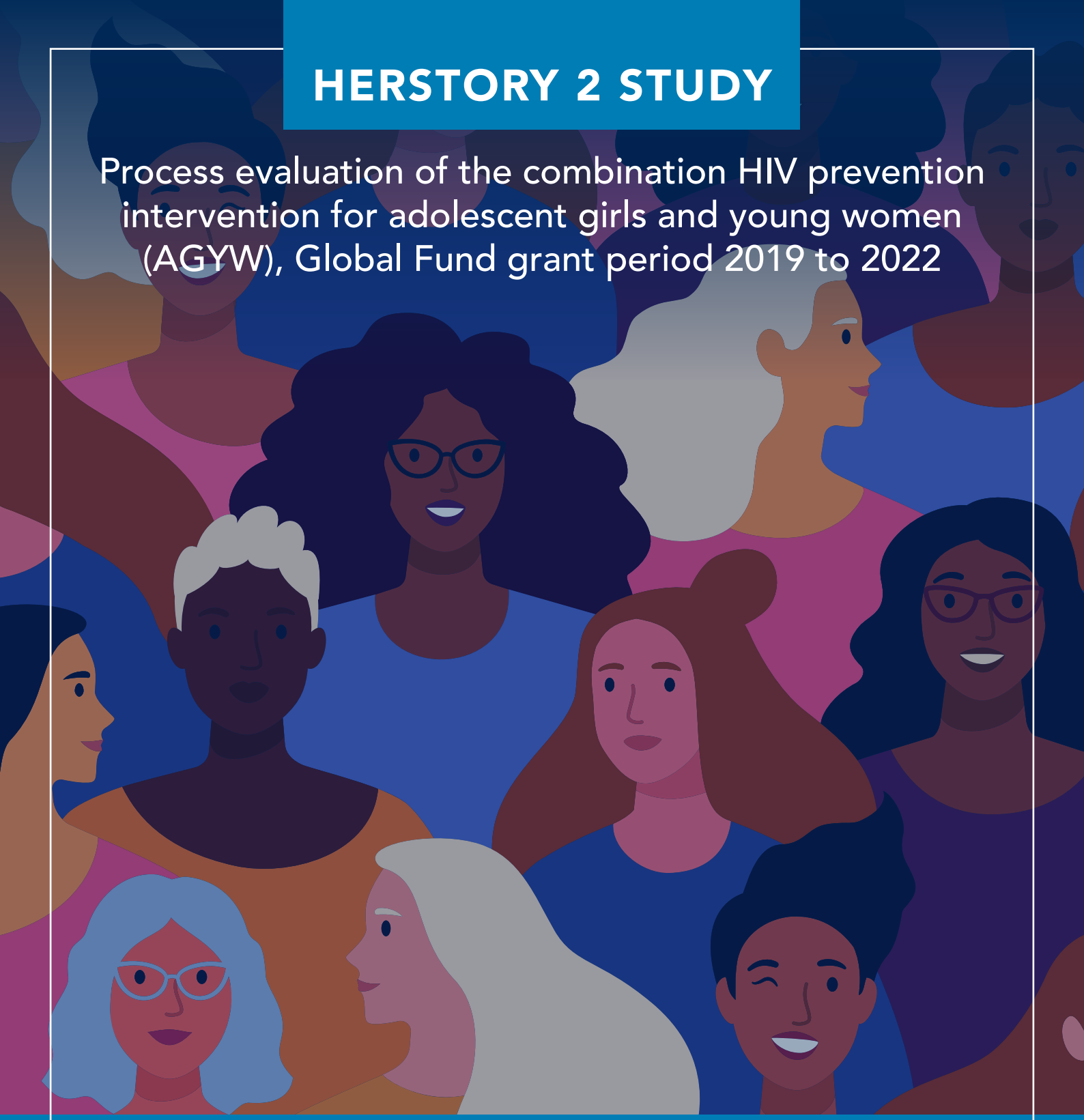
HERSTORY 2 STUDY

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



REPORT 1/5: OVERVIEW OF FINDINGS AND COMBINED RECOMMENDATIONS

2. AGYW SURVEY | 3. QUALITATIVE EVALUATION | 4. LEADERSHIP AND MANAGEMENT EVALUATION | 5. RECORD REVIEW

HERStory 2

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Overview and Recommendations

July 2021

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Funding Statement

The AGYW intervention was funded by the Global Fund to Fight AIDS, TB and Malaria. The combination HIV prevention interventions were implemented in 12 districts in South Africa by a range of civil society organisations that were appointed by the organisations responsible for the management of the AGYW programme: the Networking HIV and AIDS Community of Southern Africa (NACOSA); the AIDS Foundation of South Africa (AFSA) and Beyond Zero. The programme is aligned with the She Conquers campaign and is implemented with support from the South African National AIDS Council (SANAC) through the Country Coordinating Mechanism (CCM) and the CCM Secretariat. This research has been supported by NACOSA.

CONTENTS

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

Overview

From 2016 to the present day, the Global Fund to Fight AIDS, TB and Malaria (the Global Fund) has invested in a combination intervention for adolescent girls and young women (AGYW) in South Africa, with the aim of reducing HIV incidence, teenage pregnancy, and gender-based violence and increasing retention in school and access to economic opportunities. Combination HIV prevention interventions, which merge effective biomedical, behavioural and structural interventions for combined delivery, are one of the key strategies for reaching the 90-90-90 targets and achieving the Sustainable Development Goal (SDG) of ending the HIV epidemic by 2030 (UNAIDS, 2014).

The South African Medical Research Council conducted a process evaluation of the AGYW combination intervention being implemented during the 2019 to 2022 Global Fund grant period. During this grant period, the combination HIV prevention intervention for AGYW aged 15 to 24 years was being implemented in 12 South African districts.

The aim of this process evaluation was to assess whether the intervention was being **implemented as planned** and whether the implementers were on a trajectory to achieve the outcomes, with reference to the theory of change (logic model) for the intervention being delivered in the grant period 2019 to 2022. The focus was on interventions to promote high school completion, HIV prevention interventions such as condoms and PrEP, and sexual and reproductive health interventions such as contraception, and HIV care.

The process evaluation objectives included evaluating whether the **coverage** of the intervention was aligned to the targets and to the theory of change. We constructed "coverage cascades" and coverage measures for HIV prevention and care interventions and for pregnancy prevention interventions. We described barriers to coverage and factors associated with gaps in the cascades, relating to motivation, access and adherence. We investigated coverage gaps related to the COVID-19 pandemic. We disaggregated coverage by age group (15-19 years and 20-24 years), socioeconomic status, district, and sexual behaviour. We investigated the extent to which the intervention was **acceptable** to AGYW and key stakeholders in schools and communities, and why they participated in it, or declined to participate in aspects of the intervention. We investigated the extent to which the **context** of the intervention was conducive to intervention implementation, and to what extent key gatekeepers in the intervention context were supportive of implementation. Lastly, we investigated whether the **theory of change was appropriately specified** to achieve the intervention goals.

We undertook a **mixed-method (quantitative and qualitative)** study comprising various methods. These included a survey of a random sample of AGYW beneficiaries in selected districts to investigate the intervention coverage (**sub-study 1: AGYW Survey**); in-depth interviews with AGYW, implementers, key gatekeepers and stakeholders to investigate the acceptability of the intervention and to describe the intervention context (**sub-study 2: Qualitative Evaluation**); an online survey of, and in-depth interviews with implementers to investigate the implementation processes (**sub-study 3: Leadership and Management Evaluation**), a record review comprising a quantitative analysis of routine programme monitoring data (**sub-study 4: Record Review**). Given that this study was taking

place during a time when there was a surge in COVID-19 infections, we adapted data collection procedures to enable the use of "remote" approaches including a telephone survey, telephone interviews and an online survey. This study was conducted between September 2020 and April 2021. Data collection began in November 2020 and was completed in March 2021.

We produced five reports, one for each of the process evaluation sub-studies, and this overview report that summarises each of the sub-study components and presents a summary of the recommendations emanating from the process evaluation.

Introduction

Combination HIV prevention interventions, which merge effective biomedical, behavioural and structural interventions for combined delivery, are one of the key strategies for reaching the 90-90-90 targets and achieving the Sustainable Development Goal (SDG) of ending the HIV epidemic by 2030 (UNAIDS, 2014). In 2020-2021, the South African Medical Research Council conducted the **HERStory 2 Study**, a process evaluation of the combination HIV prevention intervention for AGYW aged 15 to 24 years funded by the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria, and implemented in 12 South African districts during the 2019-2022 Global Fund Grant period.

HIV risk among AGYW in South Africa

In 2017 HIV prevalence amongst young people aged 15–24 years in South Africa was reported to be 8%, with 11% prevalence amongst females aged 15–24 years, compared to 5% amongst males aged 15–24 years (Simbayi, 2019). The disproportionate burden of HIV amongst AGYW in South Africa is evident, both in the 15–19 age group (4.7% amongst males, versus 5.8% amongst females), and even more pronounced in the 20–24 age group (4.8% amongst males versus 15.6% amongst females) (Simbayi, 2019). In the 2017 South African National HIV Prevalence, Incidence and Behaviour and Communication Survey, rates of HIV incidence in South Africa were highest amongst AGYW aged 15–24 years (1.5% compared to 0.5% amongst young males of the same age) (Simbayi, 2019). In the HERStory 2017-2018 survey, the HIV prevalence among the AGYW aged 15-24 years was 12.4% and the annual HIV incidence was 1.45%, similar to the national estimate among women 15 to 24 years from national survey (Simbayi, 2019). AGYW's risk for HIV is exacerbated by factors including having multiple sexual partners, age-disparate sexual partners (Maughan-Brown et al., 2018), stigma when attending health services (Geary et al., 2014, Schriver et al., 2014), adolescent pregnancy (Stoner et al., 2019), substance use (Probst et al., 2017), and low levels of educational attainment (Wils et al., 2019, Stoner et al., 2017). The structural factors that influence HIV risk and HIV risk behaviour among AGYW in South Africa include poverty, poor quality learning at school (Wils et al., 2019, Stoner et al., 2017), a lack of educational and economic opportunities, poor access to sexual and reproductive health interventions and services, gender inequalities and violence against AGYW, and the stigmatization of HIV and aspects of AGYW's sexuality (Harrison et al., 2015, Psaros et al., 2018).

AGYW combination intervention implemented in the Global Fund grant period 2019 to 2022

The AGYW programme funded by the Global Fund during 2019 to 2022 aimed to increase retention in school, decrease HIV incidence, decrease teenage pregnancy, decrease gender-based violence and increase economic opportunities. The implementation of the programme was the responsibility of three Principal Recipients (PRs): AIDS Foundation of South Africa (AFSA), Beyond Zero, and Networking AIDS Community of Southern Africa (NACOSA). These PRs sub-contracted sub-recipients (SRs) to implement the intervention components.

AGYW were 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 were received first) and *Layered Services*, additional services depending on the needs of the beneficiary, and which were received over time. Services were delivered by funded SRs in schools, TVET colleges, dedicated safe spaces in communities, and mobile clinics that delivered clinical HIV and SRH-related services. Layered services were categorised into biomedical, behavioural and structural services. In addition to delivery of layered services by SRs, some layered services were 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 was to leverage these existing services rather than set up parallel and less sustainable services. The core and layered services are described in Figure 1.

The **Core Service** consisted 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. This plan guided the selection of layered services according to the needs identified in the risk and vulnerability assessment, and described the AGYW's personal journey including her own life goals and the things that would help her to fulfil those goals and "become the person she aspires to be". Also, part of the core services were 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 core service was delivered in schools, TVET colleges and community safe spaces, and provided to each AGYW every six months. Demand creation techniques were school-based (for example, presentations at schools), community-based (for example, door-to-door, SASSA pay-points, places where youth congregate), based in TVET colleges, or health service-based (for example, at HIV testing service (HTS) events or among AGYW users of the mobile clinic SRH services) and they included AGYW champions and ambassadors.

Based on identified risks and needs, the AGYW Programme tailored a set of behavioural, biomedical and structural services in the form of **layered services**, to ensure each AGYW received services that were responsive to their specific risks and needs. **Layered Services** included: 1) Comprehensive **Biomedical Services** from mobile or fixed clinics in/near schools and in communities; 2) **Behavioural Services** delivered at safe spaces and other settings in communities; and 3) **Structural Services** delivered at safe spaces and other settings in communities focused on AGYW but also on changing norms and raising awareness of GBV among men, boys, parents and caregivers. An Economic

Strengthening pilot programme was implemented in selected sub-districts but was not included in this process evaluation because it was being evaluated separately.

The intervention was designed and conceptualized according to a theory of change model (Figure 1). The theory of change was 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" (extracted from AGYW Programme Description).

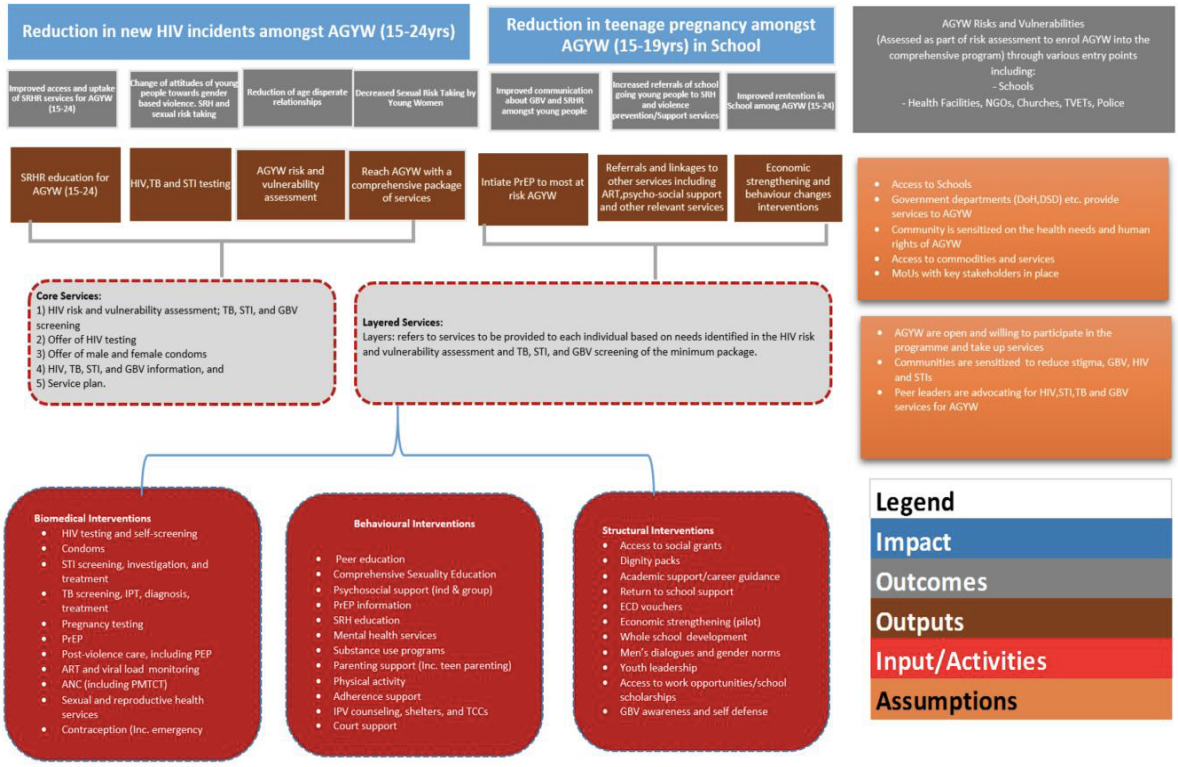

Figure 1: AGYW Programme Theory of Change

Evaluating progress towards effective coverage

We used the Effective Coverage framework developed by WHO and UNICEF expert group. The framework describes effective coverage as the proportion of a population in need of a service that has a positive health outcome from the service (Marsh et al., 2020). This framework identifies seven steps that focus on progressively examining the proportion of a population in need of services (such as AGYW in need of HIV prevention and care services), who accesses such services, which services meet quality of care standards, who is able to adhere to the services received, and who experience the desired outcome. Effective coverage can be measured using health service coverage cascades

applied to a clearly defined target population, for example those with a specific health need (Marsh et al., 2020).

HIV prevention cascades, one form of Effective Coverage cascades, have been proposed as a tool for measuring progress towards HIV prevention among people at risk of HIV (Hargreaves et al., 2020; Auerbach et al., 2020; Schaefer et al., 2019). However, HIV prevention cascades are much more complex than HIV care cascades because the denominator, the population in need or the "at risk" population, is not as clearly defined as in an HIV care cascade because people move in and out of risk over time, and because people in the population engage in a variety of risk behaviours with varying levels of risk. Furthermore, people at risk of HIV have several HIV prevention technologies and services available to them, and these are usually offered in combined packages (Fearon et al., 2019). Despite the complexity of HIV prevention cascades, there is an emerging consensus on the key constructs in such cascades (Auerbach et al., 2020).

Evaluating Acceptability

Acceptability of an intervention 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 deliver an intervention (Sekhon et al., 2017). Acceptability should be assessed based on stakeholders' knowledge of or direct experience with 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). The acceptability of an HIV prevention intervention or service is one of the factors that will influence AGYW's 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. The acceptability of interventions to beneficiaries, community stakeholders, and implementers is an important issue to consider in the development, evaluation and implementation phases (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 perceptions, experiences, and acceptability of the intervention (Sekhon et al., 2017); we included such methods in this process evaluation.

Adolescent well-being

Achieving effective coverage of HIV and pregnancy prevention and care interventions will not automatically eliminate other challenges that compromise AGYW's health-related quality of life and well-being. Therefore, it is important to investigate whether interventions to improve coverage are associated with improvements in well-being. In the HIV policy evaluation field, there is now increased

recognition of the importance of going beyond narrow disease measures in the HIV care cascade, and examining the impact of multi-sectoral programmes on people's quality of life using proxy measures such as well-being (Grønlie & Dageid, 2017; Reis et al., 2013; Lazarus et al., 2016). The AGYW programme that is the focus on this evaluation, included interventions to promote key dimensions of young people's well-being (i.e. improving access to support services, promoting positive coping and self-worth, stigma). Employing qualitative methods to capture the voices and experiences of young people might help to build an understanding of how interventions impact happiness, life satisfaction and positive peer relationships (Govindasamy et al., 2020).

The COVID-19 pandemic

In South Africa, in response to the COVID-19 pandemic, there have been several different levels of lockdown since March 2020. People whose human rights are least protected, such as women and adolescents (and marginalized groups) are likely to be disproportionately affected by the devastating economic and social consequences of the COVID-19 pandemic (Hall et al., 2020). The COVID-19 pandemic is likely to have had an adverse effect on AGYW's access to health and other services, and access to education and employment. Past humanitarian crises have led to reduced access to family planning, abortion, antenatal, HIV, gender-based violence, and mental health care services, and it is expected that the COVID-19 epidemic adversely affected AGYW's access to sexual and reproductive health (SRH) services (Hall et al., 2020) including HIV and STI care (Alpalhao et al., 2020).

Evaluating implementation of complex interventions

Over the past five years there have been considerable international investments to help curb the rising HIV incidence among AGYW in sub-Saharan Africa (Chimbindi et al., 2018; Gourlay et al., 2019; Subedar et al., 2018; Saul et al., 2018). Several evaluations of donor-funded programmes in South Africa and Kenya suggest that these initiatives have been effective in reducing HIV incidence and have had a favourable impact on the lives and livelihoods of AGYW. However, there is a gap in knowledge about the contextual conditions that contribute to successful implementation, particularly on best practices to facilitate scale-up and sustainability in various geographic settings. If we can understand the organisational and operational dynamics that affect the implementation process, then we can inform strategies to scale-up the AGYW combination HIV prevention intervention in South Africa. In this process evaluation, we included an assessment of the implementation processes, guided by the Consolidated Framework For Implementation Research (CFIR) (Damschroder, 2009).

The HERStory Process Evaluation

The **aim** of the HERStory process evaluation was to assess whether the AGYW combination intervention was being implemented as planned and whether the implementers were on a trajectory to achieve the desired outcomes.

The **purpose** of the evaluation was to provide recommendations to the intervention implementers during the current grant period 2019-2022, to enable them to correct the course of implementation so that it was on a trajectory to achieve the outcomes specified in the theory of change.

HERStory 2 Objectives

This process evaluation had the following key objectives:

1) To describe the **coverage** of interventions using coverage cascades stratified by age and sexual behaviour, and to investigate the reasons for gaps in coverage

2) To investigate the knowledge, perceptions, and **acceptability** of the interventions among AGYW beneficiaries, implementers, and key stakeholders in schools and communities;

3) To assess the extent to which the **context** of the intervention, (including the organisational leadership and management, and programme governance context) was conducive to intervention implementation, and the extent to which key gatekeepers in the intervention context were supportive of implementation;

4) To assess the extent to which the **theory of change was appropriately specified** to achieve the intervention goals and the extent to which it was being implemented as theorized.

Study design and overview of methods

We conducted a mixed-method (quantitative and qualitative) study comprising the following methods:

1. A survey of a random sample of AGYW beneficiaries to investigate the coverage of the core package and relevant layered services

2. Qualitative research comprising in-depth interviews with AGYW beneficiaries, programme implementers, and community stakeholders to assess acceptability, perceived benefits, and experiences of the intervention, and to describe the intervention context

3. An online survey of, and in-depth interviews with implementers (SRs) to investigate the implementation processes, successes and challenges

4. A record review of the routine programme monitoring data of the AGYW programme

We have provided detailed description of the methods for each of the study components in five separate reports described below. Detailed information on the analyses, ethical considerations, and informed consent procedures for each study component are provided in the relevant report.

Research Ethics Approval: The SAMRC Research Ethics Committee approved the study (reference number EC036-9/2020). Further details on Ethical Considerations can be found in each of the separate sub-study reports.

Findings of the HERStory 2 Process Evaluation

Detailed findings from the various study components are reported in separate reports:

- Report 1: Record Review
- Report 2: AGYW Survey
- Report 3: Qualitative sub-study combined with the theory of change critique
- Report 4: Implementer survey and interviews
- Report 5: Overview of findings and recommendations

These reports can be accessed at:

https://www.samrc.ac.za/intramural-research-units/healthsystems-herstory

Summary of the HERStory 2 Process Evaluation Findings

Summary of Findings from the AGYW Survey component

Aims and objectives

The aim of the AGYW survey was to evaluate the coverage of the intervention and whether it was aligned to the theory of change. The objectives were to 1) describe the coverage of the HIV and sexual and reproductive health interventions according to age group, socioeconomic status, HIV risk and district; 2) assess whether the coverage of HIV and sexual and reproductive health interventions was aligned to the theory of change using coverage cascades; 3) investigate barriers to, and reasons for gaps in coverage; and 4) describe the effect of the COVID-19 pandemic and lockdowns on coverage of HIV and sexual and reproductive health interventions.

Methods

Between 1 December 2020 and 28 February 2021, we conducted a cross-sectional telephone survey with a random sample of AGYW beneficiaries of the AGYW programme who had been enrolled at least one year before. We randomly selected 360 AGYW beneficiaries from each of six of the districts in which the AGYW programme was being implemented, using as a sampling frame a de-identified version of the My Hope programme monitoring database, which included a comprehensive list of every participating AGYW. We provided the Principal Recipients with the list of sampled AGYW beneficiaries' unique numbers. The Principal Recipient provided brief details about the study to the sampled beneficiaries using a script, and asked the AGYW if they would be willing to be contacted by a HERStory study team member to be invited to the study. A HERStory study team member contacted each of the AGYW telephonically to invite her to participate in the study and administered the consent process with her telephonically. For AGYW under 18 years of age, we first obtained parental consent telephonically before conducting the consent process with the AGYW. We invited consenting AGYW to complete a phone survey in the AGYW's language of choice, administered by a HERStory interviewer. Each participant received R100 reimbursement after completing the survey.

Coverage cascades were conducted overall, and stratified by age group, socio-economic status (SES) group and by factors that put AGYW at risk of HIV: multiple sexual partners, age-disparate sex partnerships, transactional sex, fear of sexual partner, and alcohol use. We explored the relationship between factors that may act as barriers to motivation, access and use of PrEP, condoms, and family planning services. To do this we calculated the frequencies (n), proportions (%), and 95% CIs for participants on each factor, by the coverage indicator. We also conducted chi-squared tests to compare the proportions, and risk differences. Sample weights were used in the calculations of proportions, confidence intervals and risk differences.

Results

The proportion of the sampled beneficiaries that the SR was unable to contact varied by district as follows from 32.7% to 74.6%. The sample realization varied by district from 16.1% to 35.0% with an overall sample realization of 23.8%. Those who were not contactable by phone are likely to be different to those who were contactable, and this may have introduced a bias in the study findings. A consequence of the sample realization of 23.8% was a lower precision of the estimates, particularly for subgroups, such as those living with HIV.

Description of the participants: Almost all the 515 survey participants were born in South Africa (97.9%), and were unmarried (97.8%). Most (73.9%) reported that they had ever had sex, and among those, 93.7% had had sex during the 12 months before the survey. Approximately one third of participants (30.1%) reported that they had ever been pregnant, and 23.5% reported they had one or more living children. Most participants (78.1%) reported that they had been enrolled in an educational institution at the beginning of 2020, with participants in the younger age group being significantly more likely to report this. In October 2020, 75.0% were enrolled in an educational institution, and 6.8% reported that they had dropped out of an educational institution during the year.

Participation in components of the AGYW Programme funded by the Global Fund

Nearly a third (27.6%) of all beneficiaries knew of an NGO in her community which provided "a safe space for young women to hang out and receive support", 23.6% spent time at a safe space in their community in the past year, and 14.7% had received the "My Journey" diary. Almost half (47.6%) of AGYW who used the safe space reported having an HIV test at the safe space, 66.2% reported that condoms were available at the safe space and 79.5% reported that information about health services for young women were available at the safe space. Furthermore, 86.4% of beneficiaries who had utilised a safe space said that it was a comfortable space to be in which suggests that going to the safe space was a positive experience for AGYW and a safe environment in which to receive HIV prevention services.

In the month before the survey, 23.7% of beneficiaries reported having received HIV testing from an NGO in their community, and 9.0% reported receiving family planning from an NGO in her community in the past month.

HIV testing uptake

Participants reported very high levels of HIV testing, with 87.5% having ever been tested and 80.3% having been tested in the year before the survey. It is not known whether the tests were provided through the AGYW programme, though it is noteworthy that more than a quarter of the most recent HIV tests (27.6%) were obtained at school or community sites, suggesting the AGYW programme played an important role in HIV testing coverage. The factors associated with having had an HIV test in the year before the survey were being in the older age group, having a living mother or father, fulfilling the study definition of being not in education, employment, or training (NEET), having ever had sex, ever having been pregnant, and ever having used contraception. When asked to report on

quality of care criteria at their last HIV test, 85.3% reported the waiting time was reasonably short; 97.0% reported being treated in a friendly manner by the person who tested them; 96.5% reported the person who tested them was respectful of their needs; 87.5% reported that all other staff at the testing facility were friendly and respectful; 90.2% believed that their test result and other information they had shared would be kept confidential; and 96.5% reported that the health information they had received was clear and understandable.

Coverage of PrEP interventions and services among AGYW at risk of HIV infection

We constructed an HIV prevention cascade for PrEP, in which we defined the population in need of PrEP as all beneficiaries who had sex within the 12 months before the survey and did not identify as HIV-positive. The percentage of AGYW who were motivated to use PrEP (62.9%) and had access to PrEP (43.8%) was substantially higher than the percentage of AGYW who had ever used PrEP (8.3%, not shown in the cascade), who were using PrEP at the time of the survey (3.7%) and effectively using PrEP (3.0%) at the time of the survey (Figure A). Our evaluation occurred before the widespread implementation of PrEP among beneficiaries, and at a time when it was difficult for the programme to procure the necessary continuous supply of PrEP through the National Department of Health.

We found that there were no significant differences in motivation, access, use and effective use of PrEP between groups of beneficiaries reporting HIV risk factors such as multiple partners, age disparate partners, and groups of beneficiaries not reporting such risk factors.

The factors associated with gaps in motivation for PrEP among AGYW in the study population included inadequate knowledge about the effects of PrEP on HIV incidence, lack of confidence about taking PrEP every day and after a meal, lack of confidence about taking PrEP if friends, parents, or family members disapproved, and lack of confidence about taking PrEP if others think the AGYW has HIV.

The factors associated with gaps in access to PrEP include never having been offered PrEP (75.9% reported they had never been offered PrEP) and never having received education and counselling about PrEP. Being in the younger age group was also associated with lack of access to PrEP.

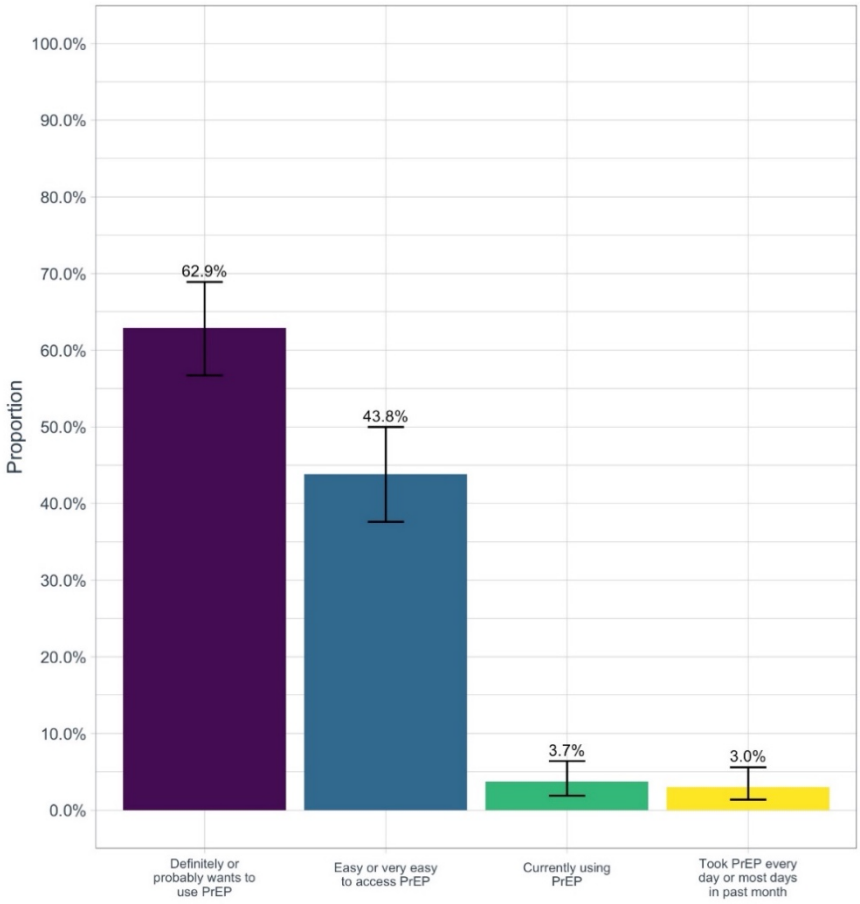

Figure A: Motivation to use, access to, use and effective use of PrEP by AGYW who had had sex within the 12 months before the survey and who were not HIV-positive (n = 351)

Coverage of condoms among AGYW at risk of HIV infection

We constructed HIV prevention cascades for male condoms among AGYW in need of HIV prevention, defined as those who had had sex within the 12 months before the survey and did not identify as HIV-positive. The overall cascade (Figure B) demonstrates very high levels of motivation to use condoms (89.1%), access to condoms (82.7%), and use of condoms (89.7%), suggesting the potential for positive outcomes related to HIV prevention. The level of effective use of condoms was low (22.3%). AGYW who had more than one male sex partner in the six months before the survey were less likely to effectively use condoms (7.8%) compared to those who did not have more than one partner (26.2%).

Most AGYW were motivated to use condoms with their partners, and our analyses did not identify any factors associated with gaps in motivation to use male condoms with partners. Our analyses found that the factors associated with gaps in access to male condoms included: being in the younger age group; and reporting that it was difficult to get male condoms for unspecified reasons.

We found several factors related to “demand-side” issues were associated with gaps in the effective use of male or female condoms: AGYW not having condoms to use; AGYW reporting dislike of

condoms; AGYW believing they were not at risk of getting HIV; AGYW's concerns about what their sexual partner would think if they asked to use condoms; believing that their partner opposed the use of condoms; and having one partner who they trusted. On the "supply-side" we found that the AGYW having experienced stock-outs of condoms was associated with gaps in effective use of condoms.

Female condom coverage

Less than half of all beneficiaries (39.0%) of the AGYW programme believed that it would be easy or very easy to access condoms, 30.2% of AGYW had received counselling and instructions on how to use female condoms and only 1.7% of AGYW had used a female condom in the past six months.

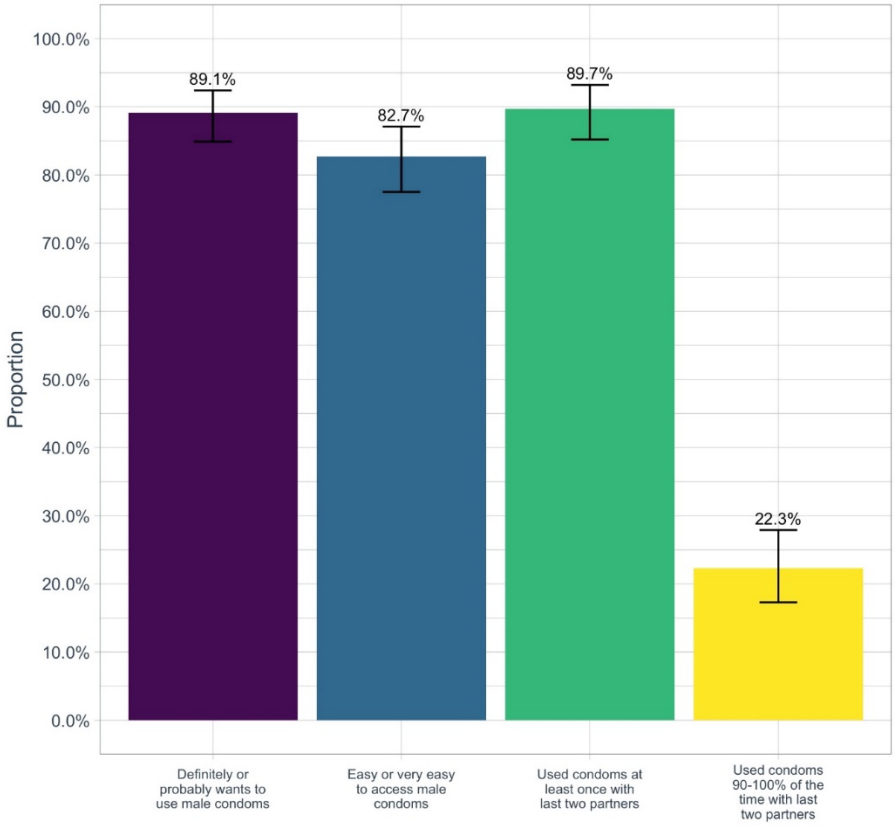

Figure B: Motivation to use, and access to male condoms, and use and effective use of condoms (not specified whether male or female condoms) by AGYW who had had sex within the 12 months before the survey and who were not HIV-positive (n = 351)

Coverage of HIV care interventions among AGYW living with HIV

Our assessment of the coverage of HIV treatment and care services was limited by the small number of participants who reported they were living with HIV (15 participants). Our findings demonstrate good access to and coverage of HIV treatment and care services. All beneficiaries who reported that

they were living with HIV were taking ART and almost all (96.0%) had had their viral load test within a year before the survey. Most AGYW (90.0%) said they started taking ARVs within three months of diagnosis. When asked whether, at their last viral load test, their viral load was suppressed, 9.2% reported that it had been suppressed, 33.8% reported unsuppressed, 50.9% reported that they had not been told, and 6.2% reported that they did not know. All participants living with HIV reported that at their last clinic appointment for HIV treatment, healthcare workers had treated them in a friendly manner and had been respectful towards them. Encouragingly, all AGYW living with HIV reported they had had no problems accessing their ART during COVID-19 or the lockdown. However, they gave somewhat contradictory reports about this, because 16.5% reported they had missed one or more appointments for collecting their ART because of COVID-19 and the lockdown, and 24.7% said they missed taking their ART pills because of COVID-19 and the lockdown. Only 12 of the 15 participants living with HIV reported that they had ever had sex. Among those who had ever had sex, 50.4% reported that they had used a condom 90-100% of the times when they had sex with their last male partner.

While we have shown that there were high levels of access to HIV treatment, participants reported suboptimal levels of adherence to the ART regimen. For example, only 61.6% beneficiaries living with HIV reported they had taken their ART medication 90-100% of the time and only 57.2% said they did a “very good or excellent” job of taking their ART in the way they are supposed to.

Coverage of pregnancy prevention interventions and services among AGYW at risk of pregnancy

Among beneficiaries who reported they had had sex in the year before the survey, motivation to use contraception (72.3%) and ease of access to contraceptive services (80.0%) were high (Figure C). Beneficiaries also reported a relatively high level of contraceptive use: most (65.5%) reported that they had used contraceptives during the six months before the survey. Fewer beneficiaries (28.1%) reported using contraceptives effectively, defined in this study as 90%-100% of the time in the six months before the survey (Figure C). It is possible that our estimates of the effective use of contraceptives reflected the time in which the survey was conducted. Participants reported that they had had fewer sexual partners and less sex as a result of the lockdown, and this might have resulted in lower than usual uptake and use of contraceptives.

The factors associated with gaps in motivation to use contraceptives were: being in the younger age group; beliefs that the contraceptive injection was not a good pregnancy prevention method for young women and that it made the body change in unpleasant ways; and beliefs that the contraceptive injection, implant and pill were not safe for young women.

The factors associated with gaps in access to contraception were: being in the younger age group; never having been offered contraception; believing that it was difficult to access contraceptives; believing that it would cost too much to get contraceptives; and believing that it was far to go to the contraception services.

The factors associated with gaps in the effective use of contraceptives among AGYW who had ever used contraceptives were: being in the younger age group; not being sexually active at the time of the survey; disliking the side effects of contraceptives; AGYW reporting that they had run out of contraceptives; perceiving the service opening hours to be inconvenient; having experienced a stock-out of contraceptives at the service; and reporting COVID-19 or the lockdown as a barrier to getting contraceptives. Various indicators of poor family planning service quality were also associated with gaps in effective use of contraceptives: AGYW reporting they had been steered or pushed towards a specific contraceptive method; reporting they had not received the contraceptive method of their choice; and believing that the information they shared at the contraceptive service would not be kept confidential.

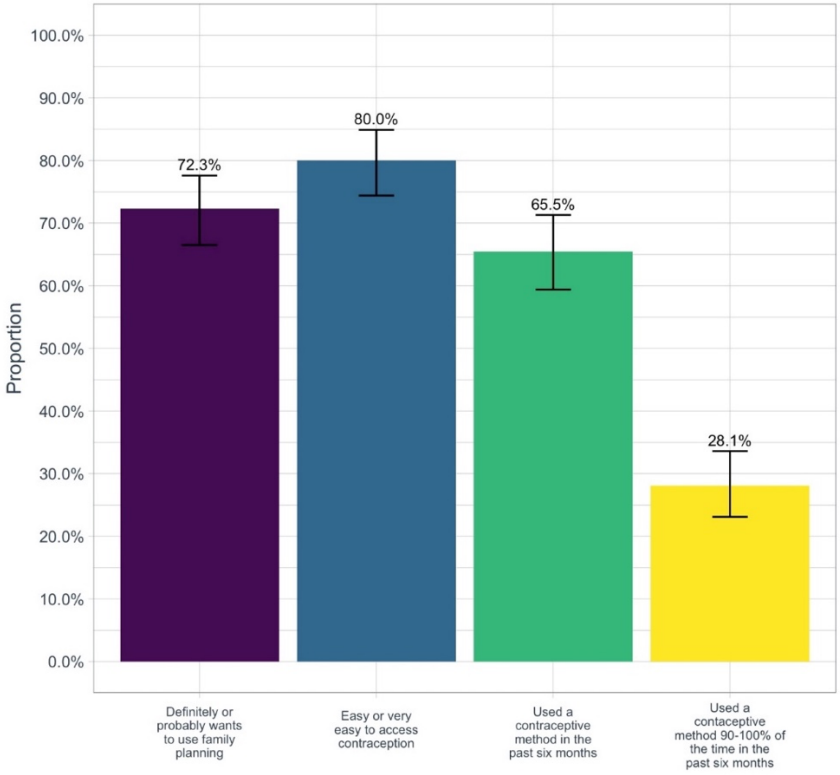

Figure C: Motivation to use, access to, use and effective use of family planning by AGYW who had had sex within the 12 months before the survey (n = 360)

The impact of COVID-19 and the lockdown

By AGYW's own accounts, the COVID-19 pandemic and the lockdown had a devastating effect on their lives, health, and access to health care based on their responses to the survey questions. Regarding access to health care, 22.5% of participants were unable to go to a clinic or doctor when they needed, 34.9% said they were unable to get the medicines they needed, 22.5% said they were unable to get the contraceptives they needed, and 21.0% reported challenges accessing condoms because of COVID-19 and the lockdown.

Regarding livelihoods, 69.8% of the participants reported that she or a family member experienced financial problems during COVID-19 and the lockdown, 73.4% reported concerns about food running out, and 24.0% said they had gone a day and night without food due to lack of money during COVID-19 and the lockdown. Regarding education, almost half (44.5%) of the participants reported they had been unable to continue with their studies because of COVID-19 and the lockdown. Regarding health and well-being, 67.1% reported they had become more distressed and anxious during COVID-19 and the lockdown and 49.6% reported they had found it harder to get to the emotional support they needed during COVID-19 and the lockdown. Some participants reported that since the pandemic and the lockdown, there was more violence in their home (14.1%), and that they were more worried about being physically abused (12.1%) emotionally abused (22.1%) or sexually abused (6.6%). It is important to note that the participants of this study have reported potentially less HIV risk behaviour (fewer sexual partners and fewer incidences of sex) during the pandemic and lockdown, but greater concerns about being victims of violence. These concerns reflect a need for interventions to protect AGYW from violence especially during situations in which their access to the usual social protection resources are undermined, such as the lockdown.

Summary of Findings from the Qualitative Evaluation and the Theory of Change Critique

Background

The Qualitative study component of the HERStory2 process evaluation, 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.

Methods

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.

Findings

Implementation Experiences – Core Services

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. Implementer respondents' 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.

Implementation Experiences – Layered Services (Behavioural, Biomedical and Structural)

Implementer experiences of Biomedical Layered Services

Implementation 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 Behavioural Layered Services

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.

Implementer experiences of Structural Layered Services

Implementation respondents described their 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.

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.

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.

Implementation Management and Logistics

Implementer respondents described their experiences of **implementation management and logistics**, including intervention 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.

Implementation Context

Various **contextual factors** impacted 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.

Implementer acceptability and perceived benefits of the intervention

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.

AGYW beneficiary acceptability and experiences of the intervention

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 layered services

AGYW respondents described their experiences and acceptability of various **biomedical services**, 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.

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.

Acceptability of the intervention from the Theory of Change perspective

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.

Perspectives on how the intervention could be improved

Implementer, Beneficiary, and Community Stakeholder respondents shared their **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.

Perspectives 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.

Summary of Findings from the Leadership and Management component

Background

Leadership and management are regarded as key building blocks of a responsive and resilient health systems. Strengthening of community-delivered HIV prevention programmes is regarded as central to achieving HIV epidemic control and in turn supporting universal health coverage initiatives. If we can understand the organisational dynamics that affect the implementation process, then we can better inform strategies to integrate and scale-up these programmes within the wider health system, and as part of universal healthcare coverage. This study explored the implementation of a large-scale comprehensive HIV prevention programme funded by the Global Fund from the perspectives of top- and middle-management levels.

Methods

A mixed-method study was conducted between December 2020 and February 2021, using the Consolidated Framework for Implementation Research (CFIR) which focuses on organisational inner settings (structure, culture, networks and communication, implementation climate, readiness for implementation). It entailed an online REDCap survey with top- and middle-managers of implementing organisations who were conveniently sampled. This was followed by qualitative online in-depth interviews with a purposive sample of survey participants. Descriptive statistics such as proportions and means were used to analyse the survey data. In-depth interviews were audio-recorded and transcribed verbatim. Qualitative data were analysed drawing on a rapid framework analysis approach. Data collection tools and analyses were mapped on the CFIR.

Results

Of the 129 potentially eligible managers emailed, 126 (98%) agreed to participate in the online survey. However, only 55 (44%) completed the survey, and most participants were at the middle-management level. In-depth interviews were successfully conducted with 10 of these managers. Our quantitative findings revealed that internal network and communication channels were strong, with approximately 60% of managers indicating they met weekly with frontline teams to discuss the programme and targets. Most participants reported challenges with establishing partnerships with key government departments and noted the role PRs could play in facilitating these links. Almost 85% of participants indicated that meeting programme targets was a key stressor during the COVID-19 pandemic. In order to implement the programme, several managers highlighted how they had to adapt processes and ways of working such as reallocating resources towards safety and protection of staff, adjusting platforms to reach AGYW and partnering with other stakeholders to access and refer AGYW. Whilst 91% of participants reported being supported by PRs and SRs, implementers described a lack of decision-making power on key aspects to the programme such as M&E systems, risk assessments,

budget planning. Overall, we identified three strongly distinguishing themes that influenced implementation: networks and communication, autonomy, adaptative leadership during COVID-19.

Conclusions

Our findings underscore the need for funders and governance structures of community-based HIV prevention programmes to actively assist programmes with establishing partnerships with stakeholders, ensure implementers are involved in the decision-making process of key programme elements, and to integrate regular leadership and management training into the programme to increase the ability of managers to effectively respond to shocks.

Summary of Findings from the Record Review component

Aims and objectives

The aim of the record review was to evaluate routine programme monitoring data from the My Hope system for all beneficiaries of the AGYW programme to determine whether coverage of the intervention was aligned to programme targets and to the theory of change. The objectives were to 1) determine whether **coverage** of the intervention was aligned to the targets for programmatic coverage, according to age and geography; 2) determine whether **coverage** of the intervention was aligned to the theory of change, focusing on selected indicators of service; and 3) describe intervention **coverage** by age, occupation, sexual behaviour (as an indicator of HIV risk), district and time (before and after COVID-19).

Methods

A team of consultants at Zenysis were contracted by NACOSA to compile the programme records on their platform, in a format that complied to specifications given by NACOSA. The SAMRC investigators were given access to this platform to conduct a record review using all the available programme monitoring data captured by the My Hope system. We used this data to describe coverage of core and layered services in the first two years of the programme (01 April 2019 – 31 March 2021).

Results

Coverage of core services by time, age, district, occupation, school status and gender

In Year 1 (Y1) of the programme (01 April 2019 – 31 March 2020), a total of 80 321 AGYW were reached with core services and 68% of the target was met (Figure A). In Year 2 (Y2) of the programme (01 April 2020 – 31 March 2021), a total of 201 812 AGYW were reached and 86% of the target was met (Figure B). Most districts (10 out of 11) met at least 60% of their target in Y1 of the programme. In Y2, 9 out of 11 districts met 60% or more of their target, with 6 of these districts meeting 90% or more of their target and 4 districts exceeding their target. Because interventions were still being set up in the first year of the programme and implementation only began in September 2019, it is not surprising that coverage was lower in Year 1. A higher percentage of coverage targets were met in Y2 of the programme despite higher targets in the second year and challenges imposed by the COIVD-19 pandemic. These results are promising for year three of the programme

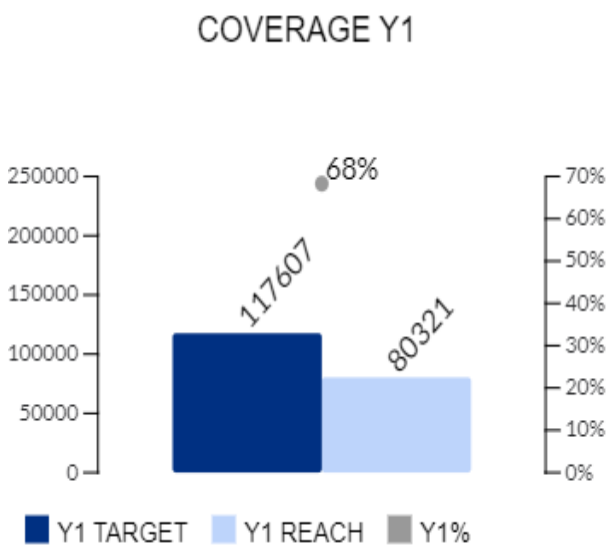

Figure 2: Number of AGYW reached with core services in Year 1 (Y1) compared to annual targets

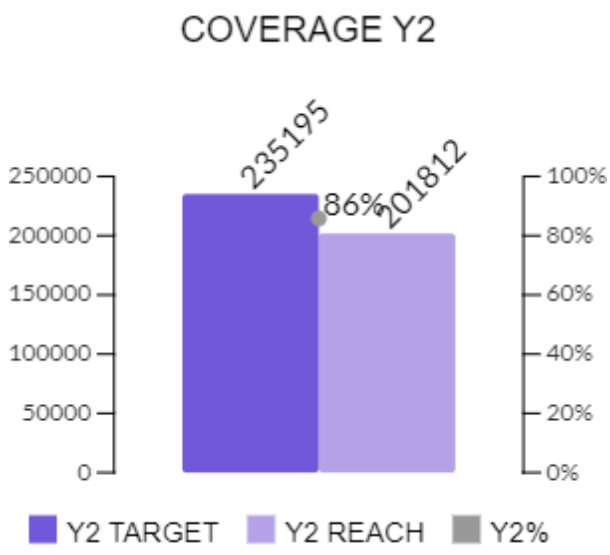

Figure 3: Number of AGYW reached with core services in Year 2 (Y2) compared to annual targets

Among all AGYW in the 15 to 24 year age range, 71% (Y1) to 59% (Y2) were in the 15 to 19 year age group and 29% (Y1) to 41% (Y2) were in the 20 to 24 year age group. Similarly, 71% (Y1) to 57% (Y2) of AGYW were reached in school versus 26% (Y1) to 42% (Y2) reached out of school. The high proportion of AGYW reached in the younger age group and in school may be because schools were willing to work with sub-recipients (SRs) of the programme to facilitate the programme. However, the qualitative report of this process evaluation highlighted challenges in reaching AGYW in school due to school closures during the COVID-19 lockdown and prioritisation of schoolwork over extra-curricular programmes when schools resumed, which may explain the decrease in the percentage of AGYW reached in school from Y1 to Y2.

For the first two years of the programme, the most common occupation of AGYW reached in the younger age group was to be in school (Y1: 50 891 AGYW; Y2: 104 486 AGYW) compared to the second most common occupation which was “not in education, employment, or training” (NEET) (Y1: 2622 AGYW; Y2: 10 850 AGYW). The most common occupation in the older age group was NEET (Y1: 7275 AGYW; Y2: 39 748 AGYW). These findings suggest that the programme was reaching individuals most in need of HIV-prevention services. Women in the NEET category may be at a higher risk of HIV infection because they may have less agency in sexual partnerships and when negotiating condom use as they are in an unfavourable economic position due to unemployment.

With regards to the impact of the COVID-19 lockdown on the intervention, the number of AGYW reached was higher in the three months preceding the lockdown (January to March 2020: 40 267 AGYW) compared to the three months after the start of the lockdown (April to June 2020: 24 525 AGYW). From July 2020 to

March 2021, the number of AGYW reached per quarter (≥ 55 005 AGYW) began to increase to numbers higher than before the lockdown. Nevertheless, this does not mean that the pandemic did not continue to impact the programme. During the lockdowns, SRs had difficulties in reaching beneficiaries and AGYW faced challenges in accessing biomedical services such as HIV testing, ART and PrEP, as described in the other study components.

Coverage of key biomedical services

Biomedical data was not available for all beneficiaries reached by the programme. Thus, this section only includes information on AGYW who received biomedical services, including HIV testing. The number of AGYW who were tested for HIV through biomedical services increased substantially from Y1 (75 989 AGYW) to Y2 (179 117 AGYW) of the programme. The percentage of AGYW tested for HIV who were newly diagnosed with HIV was 1% in Y1 (415 AGYW) and 1% in Y2 (1888 AGYW). Linkage to care targets were based on a 5% positivity yield assumption for new diagnoses. This suggests the programme implementers had difficulties in finding HIV-positive AGYW. However, the total number of HIV-positive AGYW reached with biomedical services increased from 1% to 2% from Y1 to Y2. In the AGYW survey, 4% of participants were HIV-positive and all of them reported that they were on ART at the time of the survey.

Unfortunately, we did not have access to reliable data from the record review to show the proportion of HIV-positive AGYW who were referred for ART and linked to care because AGYW often failed to report back to SRs on whether they received the services for which they were referred. However, we can see that the number of HIV-positive AGYW who were already on ART increased from 72 AGYW in Y1 (14%) to 1093 AGYW (43%) in Y2 of the programme. This could be because referral pathways for ART were not fully implemented in the first year of the programme. Challenges from the COVID-19 pandemic, described in both the AGYW survey and the qualitative report, affected access to medications in the second year of the programme.

New HIV-positive diagnoses were most common among AGYW who were NEET (Y1: 160 AGYW; Y2: 246 AGYW) or had an unknown occupation (Y1: 131; Y2: 346) for Y1 and Y2 of the programme. This reinforces the notion that AGYW who are NEET are at a higher risk for HIV, thus it is positive that most of the AGYW reached by core services in the older age group, were NEET.

In terms of PrEP coverage, 603 AGYW were newly initiated on PrEP in the first year of the programme and 21 AGYW were already using PrEP while 12 733 AGYW were newly initiated on PrEP in the second year of the programme and 1330 were already using PrEP. While we do not have reliable data on the number of AGYW who were retained on PrEP due to suboptimal health information system functionality, we can see that the programme had the potential to meet 30% of the target for PrEP use in Y1, based on the number of AGYW newly initiated on PrEP and already using PrEP, and 140% of the target set for PrEP use in Y2 of the programme. The low coverage of PrEP initiation in Y1 may be because PrEP had not been fully implemented in the first year of the programme and there were medication stock-outs. There may also have been challenges in adhering to PrEP in Y2 of the programme due to the COVID-19 lockdown which

were highlighted in the AGYW survey and qualitative reports. The number of AGYW already using PrEP was higher in the older age group, suggesting that the programme should place special attention on the effective use of PrEP among adolescent girls.

Coverage of core services by sexual behaviour and HIV risk

Sex between men and women is the primary vector for HIV transmission in South Africa (Kharsany et al., 2016). Furthermore, intergenerational / age-disparate relationships between AGYW and older men known as "blessers", who provide AGYWs with money or goods, increase infection among this vulnerable group (Evan et al., 2016). Having multiple sexual partners, relationships with older men or engaging in transactional sex can increase AGYW's risk of HIV infection if condoms are not used effectively or if the behaviour puts AGYW in a position where it is difficult to negotiate condom use. This section will report on sexual behaviours among sexually active AGYW, meaning AGYW who reported having ever had sex, who were reached by core services. Information about AGYW's sexual behaviour was self-reported during the risk assessment component of the core services.

Of all the AGYW reached by core services, most AGYW reported that they had ever had sex in Y1 (53%) and Y2 (62%) of the programme. Of the AGYW who had ever had sex, 20% of AGYW had a partner 5 or more years older in Y1 and Y2 of the programme, 5% (Y1) to 3% (Y2) received money or goods for sex (transactional sex), 18% (Y1) to 14% (Y2) had more than one sexual partner in the past year and 7% (Y1) to 1% (Y2) had experienced violence from their partner in the past year. The record review found a slightly lower prevalence of these risk behaviours compared to the AGYW survey which conducted telephonic interviews with a sample of beneficiaries. This could be because information about sexual behaviour from the record review was derived from the risk assessment component of the core package of services. We have highlighted in our qualitative study component that AGYW felt uncomfortable during the risk assessment because some of the questions were of a very personal and sensitive nature. In addition, fieldworkers conducting the assessments in many cases were not adequately trained to ask such questions and did not have the opportunity to develop a rapport with AGYW before asking these questions. Thus, the record review may reflect a process of data collection that was prone to social desirability reporting bias. However, it should be noted that the AGYW survey respondents may not have been representative of the population of programme beneficiaries, given the sample realization challenges in the survey.

In terms of effective use of condoms, we found that there was a lower percentage of sexually active AGYW who reported that they used condoms every time they had sex for Y1 (52%) and Y2 (58%) of the programme in the 20 to 24 year age group compared to AGYW in the 15 to 19 year age group (Y1: 61%; Y2: 64%). Findings from the AGYW survey found that effective use of condoms was much lower than the record review estimates; 23% in the younger age group and 20% in the older age group. The discrepancy in results may again be because AGYW did not feel comfortable to disclose their condom use during the

risk assessment, because the criterion for effective condom use was more stringent in the AGYW survey, or due to selection bias in the AGYW survey.

The percentage of AGYW who reported that they used condoms every time they had sex was lower among AGYW who engaged in transactional sex compared to the broader population of AGYW who were sexually active, which may include AGYW who engaged in transactional sex or did not. These findings are similar to those of the AGYW survey which found that fewer AGYW who engaged in transactional sex were effectively using condoms compared to those who did not report transactional sex. Both these findings suggest that AGYW who engage in transactional sex are a priority group for interventions to promote effective condom use.

In terms of pregnancy and childbirth, 22% of the 249 786 AGYW reached over the first two years of the programme had ever been pregnant. Of the 55 451 AGYW who had ever been pregnant, 88% now had children. This implies that 12% of pregnancies among AGYW beneficiaries of the programme ended in miscarriage, neonatal mortality, terminated pregnancy or infant mortality.

Record Review strengths and limitations

The record review was designed to evaluate implementation over time from the beginning of the grant period, and it has the potential to show the impact of lockdown on implementation and coverage. However, in the first year of the programme, implementation only began in September 2019 and some of the layered services were not yet available and therefore the first year also does not reflect the true potential of the intervention.

Another major limitation was data capturing. Due to challenges with biometric verification on the “My Hope” system, many SRs had to capture data on paper and manually enter the data into the system, leaving significant room for human error, misplaced hard copies and a large backlog of data. Information about layered services was only available for AGYW referred for biomedical services such as HIV testing, ART and PrEP due to issues with the service plan indicators and even then, the information was limited. Key biomedical indicators such as linkage to ART and retention on PrEP were not available for this report because results were unreliable, as beneficiaries did not always report back to SRs if they had successfully received these services for the information to be captured on the system.

The strengths of the record review are that it provides useful insights on coverage of the programme with core services as well as the age, gender, occupation, school status and sexual behaviours of the beneficiaries reached. While we can infer information from the sample of AGYW who participated in the AGYW survey and qualitative interviews, the record review provides information on all beneficiaries of the programme and is not subject to selection bias.

Overall study strengths and limitations

A key limitation of conducting the study in the context of the COVID-19 pandemic is that the results do not reflect the true potential of the intervention. The efficient delivery and coverage of the package of relevant interventions and services has likely been undermined by the lockdown.

The results of the AGYW survey and the qualitative research reflect coverage predominantly during the early phase of the grant period, when not all the intervention components were being widely implemented. There had been a staged roll-out of various services and interventions, and our study was conducted among beneficiaries who had been enrolled when some of the services were not yet fully implemented. A limitation of conducting the study among beneficiaries who were enrolled in the early period is that the findings do not reflect the full potential of the intervention when all components were effectively implemented. This limitation affected our estimates of intervention coverage.

One of the important limitations of the study design is that the success of the sampling strategy for the AGYW phone survey and IDIs was dependent on the AGYW beneficiaries being contactable by the SRs, predominantly by phone. A large proportion of sampled AGYW beneficiaries were not contactable. Those who were not contactable by phone are likely to be different to, and possibly more vulnerable than those who had working phones and who were contactable, and this is likely to have introduced a bias in the study findings.

There were several advantages to our approach of “remote” interviewing over the phone, and the online survey including the potential for increased disclosure of sensitive or socially undesirable behaviour (reduced social desirability bias) and reduced costs and risk of COVID-19. There were also disadvantages to the remote interviewing approach including possible barriers to building rapport with research participants, circumstances in the participant’s home affecting their participation, and technological problems. The SAMRC team did their best to overcome these barriers, using the expertise they had from previous studies in which they had successfully conducted phone interviews and phone counselling on sensitive topics (Kalichman et al., 2019).

Recommendations from the HERStory2 Process Evaluation

Background and Methodology to Recommendations

Important to note is that data collection for the process evaluation took place at a specific time point in the intervention implementation period, therefore:

- The AGYW participants in the evaluation survey and interviews were intervention beneficiaries who had been enrolled in the intervention for one year or more, before the survey and qualitative research were conducted. Therefore, it should be noted that these beneficiaries were enrolled in the early phase of the intervention implementation.
- 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 PRs 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, and that had not necessarily been captured during the evaluation process.

Important to note is that interviews conducted in the qualitative evaluation included the “implementer” sample group; this sample group comprised sub-recipients (SRs), who provided narratives of their perspectives and experiences of implementing the intervention. In developing these recommendations, the evaluation team provided an opportunity to the three Principal Recipients (PRs) of the Global Fund grant: AIDS Foundation of South Africa (AFSA), Beyond Zero, and Networking AIDS Community of Southern Africa (NACOSA) to contribute to the recommendations. Therefore, the recommendations emanate both from the evaluation and from consultations between the evaluation team and the PRs.

In this document, recommendations from the process evaluation research are presented, alongside information on how PRs were aware of, or already responding to these needs. Where possible the evaluation team have attempted to provide practical steps of how each recommendation can be implemented. Some of the recommendations are relevant to future intervention design and planning, and others are applicable to modifications and adaptations for the current intervention. The evaluation team did not make suggestions for which of the recommendations are likely to have the biggest impact, as we feel that it is not possible for us to predict the impact of each recommendation without evidence.

Summary Table of Recommendations

Focus Area		Timeframe where applicable
Pre-Implementation		
Research and Engagement	- Pre-implementation formative research - Community participation and engagement - AGYW participation, engagement and co-design - Piloting of programmes ahead of implementation	- Future grant cycles - Design and planning of future interventions - New funding cycle
Appointment of Partnering Organisations	- Involve managers of implementing organisations at early stages of planning process with funders and other governing institutions - Notification of appointment of implementing partner needs to be done timeously to ensure sufficient time to prepare for implementation	
Programme design based on Theory of Change models	- Make explicit assumptions about *how* change happens - Include aspects such as relationship building into the Theory of Change in addition to exposure to programme elements - Make provisions for the personal and social context of AGYW in the Theory of Change - Use participatory action research activities to get feedback on programme design from intervention beneficiaries	
Sustainability	- Incorporate detail on *how* to achieve sustainability into the Theory of Change model - Consider how changes might be sustained after the current funding period of the AGYW programme - Ensure continuity of services across grant periods - Have a sustainability plan in place from the outset - Jointly develop transition plans with multiple stakeholders - Fostering strong relationships with government, and jointly create phase out plan for each donor-funded activity - Align with country context and policy frameworks, both at national and sub-national levels - Coordination with local organisations	

Staffing and Human Resources		
Staff Training and Capacity	- Ensure a sufficient amount of staff training before starting programme activities - Additional training and support required around technical components of services - Increase intake of social workers and social auxiliary workers - Employ more highly trained and qualified staff - Provide leadership and management training that focuses on management strategies for maintaining programme functioning during shocks - Strengthen counselling and psycho-social support to staff	- 2nd grant cycle - Future grants and interventions - Refresher trainings and capacity building can be implemented in current grant cycle - Hiring additional auxiliary staff to assist social workers could occur in current grant cycle, however would require sufficient training
Recruitment, Enrolment, Demand Creation and Retention		
Incentives for beneficiaries	- Provide non-monetary, context-appropriate incentives to AGYW - Provide incentives that are relevant to intervention objectives	
Recruitment	- Recruitment efforts need to be responsive to context, community setting, and target beneficiary needs - Peer-to-peer recruitment - Improving confidentiality and privacy of Risk Assessments venues to improve recruitment	
Retention	- Tracking and follow up of enrolled beneficiaries - Ensuring AGYW trust and perceived value in enrolling and being retained - Offer services / engagement activities between 6-monthly visits	
M&E, Data Management, Indicators and Targets		
Data system considerations	- Electronic mobile app for data collection - System with off-line data capture functionality	

	- Set up data management systems prior to implementation	
Indicators and Targets	- Include quality indicators - Re-consider target assignments - Build in user-satisfaction data collection - Include quality assessment tools for provision of services and minimum standard requirements - Standardise M&E indicators and monitoring and tracking process at SR level	
Relationships and Referral Systems		
Referrals and Relationships	- Update and improve service mapping and referral lists - Strengthen buy-in for referrals from government service providers - Strengthen referral pathways - Set up MoUs/ SLAs between SRs and service providers to strengthen referrals - Improve tracking of referrals - Strengthen relationships with other implementing partners - Strengthen feedback loops between SRs and PRs	
Core Services		
Risk Assessment Questionnaires	- Shorten Risk Assessment or conduct over multiple sessions - Add 'not comfortable to answer' field - Conduct Risk Assessment over multiple sessions to enable rapport building, and re-consider whether Risk Assessment process is necessary/appropriate as first interaction - Accurate and standardized translation of questions/tools into local languages - Align assessments with services available in each district/area - Consider self-administered Risk Assessments - Strengthen Staff Skills for Implementing Risk Assessments	

Layered Services - Biomedical		
Contraceptives	- Expand contraceptive information and educational interventions - A person-centred, youth engaged, adolescent-responsive approach to service provision - Address issues in supply and procurement of contraceptives - Ensure an on-going supply of a range of contraceptive methods for AGYW - Offer AGYW the choice of a range of contraceptive options - Expand number/type of spaces and venues to make contraceptives and condoms more accessible to AGYW, and increase service operating hours to accommodate needs and preferences of AGYW - Address multi-level structural and contextual barriers to AGYW contraceptive access/use - Efforts to specifically target adolescent girls in all interventions to promote contraception	
Condoms	- Increase the accessibility of condoms - Offer risk-reduction counselling - Empower AGYW to choose their sexual partners and negotiate condom usage through economic and gender empowerment interventions - Engage men and boys in condom programming - Efforts to specifically target adolescent girls in all interventions to promote condoms	
PrEP	- Increase the availability of PrEP for AGYW - Address issues in supply and procurement of PrEP - Expand number/type of spaces and venues to make PrEP more accessible to AGYW, and increase service operating hours to accommodate needs and preferences of AGYW - Expand PrEP information and educational interventions - Improve support and follow-up for PrEP retention - Improve understanding of youth user preferences through innovative engagement methods - Assess PrEP coverage in the last part of the grant period - Strengthen tracking and monitoring PrEP adherence	

HIV Testing and Treatment	- Strengthen engagement of ABYM / older partners in HTS - Engage parents of AGYW to improve AGYW uptake of HIV testing - Strengthen HIV Treatment Cascade through counselling and support groups to improve adherence to ART for HIV positive AGYW - Engage parents/caregivers throughout the HIV care cascade - Strengthen and increase access to interventions to promote adherence to ART regimens	
Behavioural Services		
Psychosocial support	- Offer facilitated social support networks and safe spaces - Offer group-based peer interventions - Expand access to individual counselling	
Comprehensive Sexuality Education (CSE)	- Provide on-going values clarification engagements and self-reflection activities for staff - Provide additional staff training to provide CSE - Address issues relating to staff resistance to delivering CSE - Address issues of resistance to CSE amongst principals/teachers	
Structural services		
Dignity Packs	- Use dignity packs as an incentive for enrolment - Provide dignity packs to every AGYW beneficiary, not only those identified as “indigent”. - Opt for more sustainable menstrual management products - Support schools to increase availability and quality of sanitation facilities	- Next funding cycle to include ESL in all districts - Grant revisions for Year 3

Gender Based Violence (GBV)	- Strengthen participation and engagement of ABYM and older male partners - Include programme components that encourage AGYW and ABYM to critically reflect on gender identity, social norms and values that underpin gendered expectations - Involve men and boys in discussions around sexual consent and gendered power - Include programmes that provide a space for males to reflect on their own values and belief systems, community norms and cultural practices that reinforce gender inequality and male dominance over women - Programmes that promote healthy relationships and foster healthy models of masculinity - Offer 'peer-based groups' to allow men space to develop alternatives to traditional male gender role expectations and norms - Gender transformative interventions to critically address gendered expectations, masculinity and concept of control of women in heterosexual relationships	
Education and Employment Opportunities	- Expand provision of scholarships and funding for education for AGYW still in education - Offer computer literacy classes and job training for AGYW out of school - Address AGYW migrants' lack of access to education by resolving challenges with school enrolment for AGYW migrants with Home Affairs and DBE	
Intervention Delivery, Spaces and Services		
Accessibility of intervention services	- Offer expanded services at educational facilities - Provide transport/ transport reimbursement - Extend service hours - Provide childcare facilities to AGYW beneficiaries - Expand services in rural areas - Include AGYW from age 12 upwards - Offer toll-free helplines and data-free online support - Expand access for most vulnerable adolescents and young people, such as the homeless and migrants	

Safe Spaces	- Establish and set-up Safe Spaces before programme implementation begins - Ensure Safe Spaces are fully resourced to provide promised services - Address privacy and safety concerns - Expand Safe Space intervention	
Implementation in context of COVID-19	- Flexible funding to be responsive to needs and context - Online platforms to provide support and information during COVID-19 - COVID-19 context responsive incentives and support - On-going provision of one-on-one / individual services where possible - Utilise Safe Spaces to ensure continued access to services and interventions where possible - Maintaining coverage during COVID - Increase accessibility to HIV treatment during COVID-19 pandemic / lockdowns	
Acceptability of Intervention		
Parental Acceptability	- Enhance meaningful engagement of parents/caregivers of AGYW - Introduce programme elements to improve relationships and communication between AGYW and parents/guardians - Improve dialogue between AGYW and their parents/ guardians - Build capacity amongst AGYW and parents to facilitate better communication and support around SRH	
Community Acceptability	- Engage with communities in order to assess needs and co-create programmes - Reflexive approach of adapting the programme to more closely fit the intervention context in specific districts - Raise community awareness around PrEP, targeting AGYW, parents and community gatekeepers - PRs and Global Fund to provide guidance to SRs regarding the preferred process for engaging communities and ensuring community acceptability	
AGYW Acceptability	- Engage AGYW in the process of identifying and redesigning programmes and retention strategies	

Recommendations Context and Evidence

Pre-implementation phase

The Medical Research Council's guidance for the development and evaluation of complex interventions provides a four-phase framework comprising: development, feasibility and piloting, evaluation and implementation. The first phase involves the development of an intervention's theoretical rationale, inputs, processes and mechanisms of change; identifying underpinning 'active ingredients' and how intervention components are expected to interact with each other and the context of delivery to generate outcomes (Craig et al., 2008). Formative research can help in increasing understanding of the socioecological context, exploring potential intervention delivery and hypothesising mechanisms of action; formative research can help to provide information on the acceptability of intervention components, theorise the mechanisms of change and how implementation and causal pathways may vary by context (Young et al., 2019).

A comprehensive formative research approach is integral to intervention design; formative research can yield greater understanding of key factors impacting AGYW lives, health and behaviours, as well as potential barriers to the proposed intervention, or its facilitators, all of which are crucial for successful intervention development (Bellows et al., 2018). As illustrated by the qualitative evaluation findings on community acceptability of the programme, and resistance to specific components, it was evident that in some cases communities felt poorly informed about the programme and its activities and services. With regards to specific community concerns and resistance towards contraceptives and PrEP, as well as CSE, formative research should include aspects of contextualisation. Allowing for genuine and meaningful community participation and consultation to feedback into the programme design could improve community buy-in and acceptability from the outset. Formative research involving community participation is a mechanism to facilitate the development of context appropriate interventions.

Community participation in the development of interventions and implementation strategies improves their adoption and sustainability. The process of ensuring buy-in from stakeholders is an on-going activity and is likely to always present challenges; there will always be resistance from some quarters. However, it is important that communities feel engaged, involved and consulted as far as possible, to ensure success of interventions implemented in any community setting. Community engagement throughout the processes of intervention design through to monitoring and evaluation are essential for facilitating successful intervention implementation (Galvaan et al., 2014). Both intervention implementers (SRs) and community leaders interviewed in the evaluation identified the need for community engagement throughout the intervention process including the designing phase. Evidence suggests that involving community stakeholders in the design phase of an intervention can guide the intervention to be more relevant and appropriate for the community (Galvaan et al., 2014). Iterative community engagement can allow for refinement and adjustments to meet the needs of the community instead of a pre-designed

intervention which may be irrelevant (Galvaan et al., 2014). The practical strategies that have been identified to facilitate community access and intervention buy-in include involving the community throughout the intervention including the designing of the intervention, identifying all the key stakeholders and planning enough time for regular engagement, promoting relationship building and creating clear communication pathways between stakeholders. The use of participatory approaches and participation may help to foster community support to facilitate successful intervention implementation; without community engagement and participation throughout the design and implementation, the sustainability and success of community based interventions may be impeded (Galvaan et al., 2014).

Notably, challenges in "Community Engagement" in the implementation of interventions include the fact that there are often poorly articulated instrumental and intrinsic goals for Community Engagement. Defining "communities" to engage with is a complex activity because people are members of multiple communities, membership of communities changes over time, and communities can be defined differently by different people such as researchers and 'community' members themselves. Additionally, issues of representation can be problematic: who is representing whom, in what way, and with what intention and outcome? Given the complexities and sensitivities of defining communities and selecting representatives, planning of these activities should begin as early as possible, and respond to unfolding realities. Ethical issues in Community Engagement include who represents diverse needs and realities, and particularly the priorities and concerns of those who are least vocal and visible (Molyneux et al., 2016).

Formative research looks at the community in which an organization is implementing or plans to implement program activities, and helps the organization to understand the interests, characteristics, and needs of different populations and groups in their community. Formative research helps to inform program planning and design, ensure that programme activities are contextually appropriate, and aids in developing partnerships with community members. Through formative research activities, implementers can begin dialogue between community, implementers and researchers, promoting community engagement and buy-in. This in turn will increase the possibility that effective, acceptable and sustainable interventions are developed.

Formative research can occur before a program is designed and implemented, or while a program is being implemented to help "form" or modify a program. Formative research can be done at various stages of implementation: pre-implementation, during the implementation phase, tracking of goal-related progress, and interpretation of process and outcome data to help clarify the meaning of success, or failure of implementation. *Pre-intervention* formative research helps in developing/contextualizing implementation interventions in partnership with local communities and service providers, ad is a critical part of delivering a multi-site intervention (Curran et al., 2008). Formative research should be an integral part of developing programs or adapting programs, and should be used to help refine and improve program activities.

In feedback sessions, **Beyond Zero** remarked that recommendations for the pre-implementation design phase are welcomed and will be very relevant for the second grant cycle. It was stated that as the AGYW

programme has been 'work in progress', there were no ready-made tools by the time the current grant cycle started, including the AGYW programme description. **NACOSA** also indicated support of the recommendation to delay the commencement of the programme until background research, programme description, programme branding, relevant M&E tools, training, pilot framework, MOUs and consultations with key stakeholders are concluded. This could imply no/reduced targets for the first 6 months of the new cycle to ensure sufficient time to conduct preparation and pre-implementation activities. In response to the recommendation for formative research, **AFSA** stated their agreement that formative research is critical and something that is currently not actively included in the programme. **AFSA** clarified that while it is important and useful to standardise implementation, considerations for context specific intervention/activities including stakeholder engagement would be useful for the programme. **AFSA** added that although the PRs are implementing the same programmes, community engagements tailored to specific context are critical in creating an enabling environment for implementation to run smoothly. **AFSA** also made the suggestion that intervention activities could be more context specific and appropriate if each PR was able to choose from list of services in the service plan to tailor the intervention to each community setting. **AFSA** proposed that this flexibility to choose specific services would enable programme implementation to best align with the specific needs of each context / district.

For the future grant, it is critical that from the Country Team level, processes are initiated timely allowing each step to unfold at all levels. The newly implemented programme components should be adequately piloted before being rolled out to all implementing areas (for example MTV Shuga and Economic Strengthening Livelihood (ESL) programme). **AFSA** suggested that improvements can be made in documenting lessons from the piloting phase and ensuring that when implementation is rolled out, capacitation is done adequately, and programme modifications and improvements are informed by the pilot.

NACOSA clarified that for the current grant, a rapid community mapping process was conducted at the beginning of the grant cycle, with the aim of understanding where to place Safe spaces, and locate hotspots. This was the only community engagement activity conducted prior to implementation. **NACOSA** indicated that the Technical Support Unit (TSU) was not well formulated at the start of the current grant, but is increasingly cohesive. For this current grant cycle, there were many more consultations, so these processes can inform the development, design, and planning of the next phases, more in line with the idea of "co-designing" / community assessment. **NACOSA** recommends involving the TSU in this process going forward. **NACOSA** also added the need for sustained and continued community engagement, not only pre-implementation. Additionally, **AFSA** remarked that getting buy-in can also be a tedious process requiring time.

Appointment of Partnering Organisations

The leadership and management findings in the HERStory 2 study found that strong relational ties, autonomy in key elements of the programme and adaptive leadership skills are critical for effective delivery and scale-up of this programme. Findings highlighted the importance of involving managers of implementing organisations at the early stages of planning process with funders and other governing institutions. This will allow for bottom-up input into key decision-making processes. As South Africa moves towards various community-based models to achieve Universal Health Coverage (UHC), the importance of early engagement with implementing partners and development of adaptative leadership skills (i.e. adjusting processes and ways of working to maintain programme functioning) to manage future health shocks will be critical.

AFSA agreed with the validity of these recommendations, and acknowledged that it may be useful to keep the same implementers in the new funding cycle, as the same PRs will continue implementing for continuity and minimizing start-up delays. PRs will be providing ongoing capacity to existing SRs, to address gaps where there are challenges. **AFSA** remarked that the process of SR recruitment is a long and drawn out process. **AFSA** confirmed that in the future, each implementer should be reviewed, and termination should be considered where there are issues with non-compliance.

Beyond Zero stated that there were various steps that were supposed to happen prior to implementation of their programmes, that were not possible to carry out, as there was insufficient time or opportunity to have a clear setup process due to the programme activities already commencing. **Beyond Zero** acknowledged these recommendations for the pre-implementation phase, and commented that going forward, PRs need to consider recommendations for the selection of SRs and SSRs, and sufficient time to set up clear processes should be budgeted for.

NACOSA clarified that in the current grant cycle, PRs will not be appointing new SRs. It is still unclear as to what the next step looks like, and if same sub-districts and SRs will be kept in the next grant period. Of note, is that **NACOSA** have a different model to BZ and AFSA in that they do not use SSRs. **NACOSA** added the point that there are currently issues with the model in which some SRs are selected by PRs at a sub-district level, but that national SRs are assigned to PRs. For example, Higher Health were assigned nationally, and **NACOSA** is responsible for managing TVET work. The appointment of national SRs raises challenges in that different PRs are managing SRs at national level. In addition, this causes issues with access to data by PRs. For example, for the ESL pilot programme, NACOSA is responsible, although intervention is implemented in various provinces and managed by different PRs. This means that **NACOSA** does not have access to data on AGYW, due to practical issues around sharing databases and access to information. A possible solution put forward was that if there is a national SR, each PR should manage that SR's work in their sub-district, which would make access to data more straight forward. An example of this is the current contractual agreement with MIET in Tshwane, which works well.

Programme design based on Theory of Change models

As was highlighted in the Qualitative report, more attention should be paid to *how* change is assumed to happen through intervention activities, and not only *what* needs to happen to facilitate change. In stating the Theory of Change and Logical Framework on which programmes are based, we recommend explicitly stating some of the more implicit assumptions about how change happens. When looking at the Risk Assessments used in the AGYW programme for example, there was an implicit assumption about the acceptability of the Risk Assessment, and an assumption related to the skills of the staff administering it. An example of making implicit assumptions explicit is the following: "AGYW have their risks and vulnerabilities assessed in a manner that allows them to build trust and rapport with their assessors". In making explicit the implicit assumption about building rapport with AGYW and the implicit assumption about the acceptability of the intervention to AGYW, attention can be drawn to the how (relationship building) as well as the *what*. In this way consideration of the personal experience of participants may be foregrounded in the planning.

Another recommendation relates to finding ways of incorporating a greater understanding of the personal and social contexts in which AGYW are situated, and how these impact on processes of change. The use of participatory action research activities that are designed to elicit feedback from AGYW on their experiences of the programme design and invite feedback on what changes and adaptations to the programme they may deem appropriate could facilitate this. This may or may not be explicitly added to the model, but could improve outcomes around the assumptions of acceptability.

In feedback from PRs, **AFSA** commented that the recommendations from the Theory of Change perspective are taken into consideration, but stated that there is a need for more evaluation studies that will determine how change happens. **AFSA** remarked that the PRs will focus on detail in this aspect when reviewing what has worked and critically look at the Theory of Change.

Sustainability Planning

The Theory of Change model specified in the programme design could incorporate more detail on how changes might be sustained after the current funding period of the AGYW programme, although it is acknowledged that this is challenging given the nature of funding cycles. It is important to note that in the literature, there is no consensus on a definition of sustainability. The donor community have often equated sustainability with financial capacity, however it has been suggested that although consistent financial support is a key component of sustainability, this definition needs refinement. There is little evidence about what works to sustain programmes in a complex health system. However it is recognised that efforts should be made to ensure long-lasting effects of donor funds, and nurture the continuation of effective program benefits, especially after donors leave. Ensuring the continuity of services across grant periods would enhance the sustainability of the intervention benefits.

Research examining the factors that enable the continuation of externally-funded programmes after the initial project ends, suggests the following: 1) designing and implementing the intervention with an explicit sustainability plan; 2) identifying champions with a strong commitment to the programme who could be supported beyond the life of the project with skills in advocacy and problem solving; 3) seeking financing options for a sustainable long-term source of revenue (involve donors and donor-recipient governments in the planning for sustainability) (Moucheraud et al, 2020).

Recommendations for strategies for transitioning the responsibility of the programme as funding is phased out include jointly developing transition roadmaps with multiple stakeholders, including AGYW. It is important to align with country context and policy frameworks, both at national and sub-national levels (Zakumumpa et al., 2021). Donors and local government need to jointly create a sustainability or a phase out plan for every donor-funded activity (Chiliza et al., 2021).

Strong relationships with government enables building of trust and results in more sustainable outcomes. Joint planning between donors and government at every level of government, down to district and health facility levels, throughout the life of the donor funded programme would enhance sustainability (Chiliza et al., 2021). In order to ensure sustained infrastructure, resources and improved donor coordination, donor/grantee partnerships need to be maintained (Chiliza et al., 2021). In addition, plans to transition posts from donor to government, can lead to greater number of skilled staff in the local health system (Chiliza et al., 2021). Evidence suggests that sustainability requires joint donor coordination with experienced local organizations with strong managers before during and after program implementation (Chiliza et al., 2021).

Staff Training and Capacity

For future interventions, we recommend allowing more time for staff training before start of programme and delaying recruitment of beneficiaries until initial staff training is complete and services are set up. During the feedback process, **NACOSA** indicated that they found themselves 'building the programme' from the second quarter, before all the layered services had been formalised, and before staff had been fully trained. This resulted in participants receiving Core services without referrals to internal layered services. **NACOSA** indicated that they support PR and SR staff training in the initial set-up phase of the programme, to ensure continuity of service to participants when it is rolled out.

We recommend further training and support required around technical components, specifically the delivery of content and group sessions on issues such as gender-based violence (GBV), grief counselling, substance use, and comprehensive sexuality education (CSE). Building current staff capacity and confidence to deliver existing services has the potential to strengthen provision of services, enhance staff job satisfaction and morale, and improve quality of services received by beneficiaries.

During the feedback process with PRs, **Beyond Zero** indicated that increases in staff capacity have already been incorporated in the current funding cycle, and that more recruitments are expected in Year 3 across PRs. **NACOSA** also stated that recommendations around building staff capacity will be addressed in Year 3 via the programme revision budget, including the in-school services. **AFSA** commented that they have made provision for staff capacity and recruitment in Y3, aligned to the increase in scope and targets. These changes will be implemented at both PR and SR levels**. NACOSA** explained that year 3 of the grant cycle came with programme revisions and additional budget to increase programme coverage and staff capacity. For example there have been efforts to improve saturation in Rustenberg, and a new sub-district, Mitchells Plain, has been added. There have also been increases in budget for incentives, a new boys programme, and a new ESL programme. NACOSA have hired new staff for these new programmes.

NACOSA clarified that capacity gaps in programme teams have been identified, for example psychosocial support services and counselling skills. In response, NACOSA have set up counselling training for all PGTs and SAWs. Additional staff training needs were identified and as a result, various trainings have been conducted including self-esteem training, COVID safety, linkage to care for biomedical teams (HIV, STI, TB adherence trainings). In summary, all the new staff have been trained, and existing staff have been provided additional training and capacity building. While NACOSA acknowledges that at programme set up, training of staff may not have been sufficient or timeous, now that the programme is set up, gaps are being assessed and steps being made to address these gaps and improve quality of services.

On the clinical side, training has also been challenging. **NACOSA** stated that gaps in training needs were identified, as SRs need to comply with Global Fund needs and requirements. Examples include procurement and supply management training, linkage to care, and HTS and finger prick training (counsellors & testers training needs to be updated every 2 years). It is challenging to meet these needs and ensure staff skills are updated, and that staff capacity meets strict standards. PRs are working to build capacity of SRs, and support them in service delivery.

We recommend increasing the intake of social workers for required training to deliver group courses, or alternatively hiring and training additional auxiliary staff so that social workers can focus on the core aspects of their work. Social workers were one aspect of the programme that communities were vocally appreciative of, so increasing the number of social workers might enhance community acceptability. However, the alternative of hiring additional auxiliary staff to take on some of the programme activities that social workers currently have to perform, that do not require social work skills, such as homework support, self-defence classes etc, would also be a strategy to ensure that social workers feel less overburdened, and enjoy greater job satisfaction when able to perform high quality social work and support, in line with their professional training. Supporting social workers with additional auxiliary staff has the potential to improve the quality of service delivery by social workers, including counselling and psychosocial support for the most vulnerable AGYW. It would also improve morale and job satisfaction among social work staff, enabling them to deliver high quality social work services.

High staff turnover at SRs poses an additional challenge to training. As result training needs to be on-going. For some SRs, the staff leaving tended to be professional staff, such as nurses. These nurses had received training through the programme, and have been benefiting from capacity building, gaining qualifications through programme training. With their new skills and qualifications, it is then easier for them to be appointed elsewhere. The situation is the same with social workers, whose capacity is built through the programme, they gain professional experience, and then they get fulltime post elsewhere, like DSD or DoE. One suggestion for dealing with this issue came from **NACOSA**, who proposed that SRs should request certification, prior experience and training when recruiting professional staff such as nurses and social workers. This would mean that staff are already more qualified and have already been trained, and are ready to provide services, instead of requiring extensive training staff from scratch.

AFSA made the additional suggestion that by recruiting trained community care workers/ youth care workers, who have already been trained in the same field by DSD or the National Association of Child Care Workers (NACCW), whose experience includes cohort management, and dealing with context specific youth issues as they come from the same communities, some of these challenges would be addressed. It was also noted that this could benefit both the retention of intervention beneficiaries, and PGTs. However, **AFSA** added that there can be challenges where community gatekeepers interfere with staffing issues and there is always high staff turnover at implementation level due to unequal salary scales at NGO levels. This requires promptness in filling vacant positions and continuous training and refresher courses**.**

With regards to staff training specifically for M&E and data management, **NACOSA** stated that the current training of trainers (ToT) approach is not working. SRs are already overburdened trying to reach targets and requirements, and on top of this, trained staff members are expected to train colleagues, but in reality do not have the time to do so, and may not have the personal skills needed to train colleagues. The suggestion was made that PRs need to enhance their support of SRs in this respect, and perhaps there should be a supervisor or coordinator, responsible for training and provision of support. Given that a huge number of staff need to be trained, some kind of ToT model is the only feasible model to meet training needs.

Additional challenges to trainings have been experienced in the COVID context. It has been challenging adapting to virtual training. For example counselling training for SAWs was face to face / in person with small groups. But with new COVID restrictions, PRs are having to adapt trainings to an on-line format. However many staff do not have access to computers and internet, which makes remote trainings challenging. It is also difficult to ensure the quality of training when delivered remotely. Some aspects of clinical training need to be practical and in person. Overall, PRs agree that staff training needs are complex and on-going, with implementers having to adapt to programmatic modifications and changing context, and high staff attrition.

Due to the emotionally burdensome work that many of the programme staff engage in during their work with AGYW and communities, the study findings highlighted the need to provide staff with adequate counselling and support systems, particularly for Peer Group Trainers (PGTs) and staff that are not

specifically trained to deal with processing emotions from the workplace. During the feedback process with PRs, **Beyond Zero** stated that the provision of support to staff is already taking place with increased efforts and human resource to focus on the effects of the COVID-19 pandemic. **NACOSA** also indicated that this recommendation has been addressed from mid-2020 and continues to be expanded. NACOSA explained that bi-monthly Community of Practice meetings are held as a learning platform with the Social Workers to ensure compliance to legislation and continued support for the staff.

Recruitment, Enrolment, Demand Creation and Retention

Incentives for beneficiaries

In the qualitative evaluation, SR respondents shared views that providing non-monetary incentives that are responsive to the needs of AGYW, such as catering at recruitment events, reimbursement for transport costs, food parcels, access to menstrual management products / dignity packs and branded items, could improve the success of the recruitment process. SR respondents in the qualitative evaluation, particularly social worker respondents, felt that incentives should be more responsive to contexts of poverty and hunger in which AGYW live. AGYW beneficiary respondents 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. Both SR and AGYW beneficiary 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. Some SRs felt that they would benefit from increased budget for recruitment events to allow catering and the provision of food and other context-responsive incentives, particularly in the context of COVID.

Evidence demonstrates that outside of material or monetary benefits of participating in programmes, AGYW simply appreciate the opportunity to talk with someone they trust, who is responsive to their needs and situations, and from whom they can get appropriate support with the issues that they need help with. AGYW beneficiaries spoke with pride of the certificates they received when completing programme components; incentives like these for participation should be further explored and utilised.

Incentives provided to beneficiaries should be closely aligned to the goals of the programmes, for example those that will support AGYW educational and health aspirations. Prioritising enrolled AGYW for scholarships and other work or skills development opportunities could also act as incentives to enrol. Importantly, these types of structural services should only be offered as incentives in cases where SRs are certain they can deliver these or that successful referrals can be made. In summary, the use of incentives should be thought through carefully, to ensure the programme attracts AGYW who want to participate and who are attracted by the merits of the programme rather than only material incentives.

During the feedback process with PRs, **NACOSA** explained that many lessons have been learned from the first 2 years of implementation. **NACOSA** highlighted the Economic Strengthening and Livelihoods (ESL) component of the programme and the scholarships and skills development opportunities available through this programme, bringing to attention the link between the ESL programme and the provision of an incentive for enrolment, since this is already work being undertaken. **NACOSA** also explained that the ESL programme has a full version, and a "lite" version. **AFSA** added that lessons have been drawn from the previous Global Fund cycle of Cash plus Care as well as the current grant GLO (ESL) program. It was explained that the issue of monetary incentives has been discussed at length at program design (PR, SANAC Technical Support Unit and Local Fund Agent) level. **AFSA** also indicated that standardizing incentives according to the needs of the program beneficiaries has recently been implemented.

Both **AFSA** and **NACOSA** acknowledged that in some sub-districts there are competing programmes that are demanding AGYW attention, and various organisations are offering different incentives, so AGYW choose programmes based on what incentives are provided. In order to enhance the incentives package and improve retention, **NACOSA** are providing incentives to AGYW to meet needs, for example health packs, food vouchers, dignity packs (to all AGYW), and journals. **AFSA** also added that using incentives has benefited recruitment and retention.

Recruitment

One of the key challenges identified in the findings pertaining to the recruitment of AGYW beneficiaries into the programme related to AGYW lack of trust in the programme, the staff, or the way in which they were recruited. Efforts to enhance the trust of communities for the programme, and increase visibility and awareness about the intervention, could allay some of these issues. Concerns about the confidentiality of AGYW contact details need to be addressed in order to ensure that AGYW provide the correct phone numbers at recruitment. Another method of ensuring trust could be to enhance the use of AGYW peers and people from the community to create awareness and recruit. Recruitment campaigns should be creative and attractive to young women. AGYW beneficiary respondents suggested the use of social media channels in a creative and interesting way, recruitment and awareness campaigns such as 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.

NACOSA outlined the different methods of recruitment used depending on the entry point, including through social media, door to door, in-school etc. **AFSA** explained that based on their experiences, peer-to-peer recruitment is one of the most effective strategies and should be expanded. Linked to suggestions for improving the risk assessment process by addressing issues related to confidentiality and privacy at venues, **AFSA** stated that challenges in the 'field environment' negatively impact on AGYW interest in enrolling. For example it is challenging to maintain privacy and confidentiality in gazebos when conducting

risk assessments and offering biomedical services. In response to these recommendations on demand creation initiatives, **AFSA** commented that these recommendations have been taken and are now being implemented.

Retention

The incentive and motivation for AGYW beneficiaries to enrol and remain in the programmes relies on their perception that there is some value to being enrolled as a beneficiary, their trust that the intervention will deliver on promises, and will treat their issues with appropriate sensitivity and confidentiality. A common finding reported among SR respondents was that AGYW contact details were either being captured incorrectly by fieldworkers or that AGYW were providing false contact details, which prevented follow up and undermined retention. The survey finding that a high proportion of enrolled beneficiaries was uncontactable for the research suggests that the programme implementers would also be unable to successfully retain and stay in contact with the majority of beneficiaries over time to ensure their needs are met through the programme. This finding suggests the importance of exploring ways to successfully retain beneficiaries in the programme over time.

We recommend re-designing the enrolment session or the session in which AGYW first has contact with the programme. If AGYW have a positive experience of the first session and if they perceive potential benefits of the programme, it might be easier for SR implementers to maintain contact with them over time. In order to ensure that the beneficiary database is accurate and useful, AGYW beneficiary contact details should be confirmed at several time-points: at initial recruitment, and also at each subsequent contact with the programme. This needs to be done in a sensitive, ethical and appropriate way, acknowledging that some beneficiaries may not want to, or may not be able to, provide contact details for various reasons. Implementation staff need to also make the AGYW feel free to say that she does not want to share her contact details. In situations like this, it is important for AGYW to be able to contact the programme at a place or to have a person they can contact.

SRs should put systems in place to verify contact details in a sensitive way that acknowledges the AGYW might not want to provide contact details. Further training is also required for PGTs to make sure that they are introducing the programme appropriately and making sure that beneficiary confidentiality concerns are adequately addressed to avoid false information being provided. Strategies to create demand need to include clear communication about the nature and potential benefits of participating in the intervention, and the inclusion of incentives which will be valued by participants (McClinton Appollis et al., 2021).

AFSA suggested that since the contact time in between provision of repeat core is an interval period of six months contacts, in order to keep beneficiaries interested in the programme, additional interactions should be offered by SRs, and used as an indicator to measure retention. **AFSA** suggested that identifying at least one key service per quarter to count toward retention would be a helpful strategy. **AFSA** stated

that the tracking of retention needs to be improved, and gave one suggestion of achieve this, through offering some in-between services to ensure that AGYW are kept active on the programme. **AFSA** suggested that AGYW should be reassessed after 6 months to assess behaviour change and success of referrals. **AFSA** recommended additional cohort management to improve retention, and said that it would be beneficial to offer programme activities for AGYW to attend before reassessment, like Stepping Stones. Related to this, **NACOSA** added that they were aware of the fact that if Safe Spaces were providing more activities to attract and retain AGYW, then AGYW they would be more incentivised to come back.

NACOSA added that challenges in retention have been identified in the Risk Assessment process, where implementers are promising services which were not yet available. **NACOSA** said that they had been making efforts to enhance their retention strategies, for example through running advocacy campaigns for PrEP uptake, by addressing parental concerns, debunking myths and responding to challenges.

M&E, Data Management, Indicators and Targets

Data system considerations

The 'My Hope system' currently used to track and monitor the provision of services across core and layered services for each individual AGYW beneficiary, was designed to be backed up with paper-based data collection tools to use at the source i.e. all AGYW entry points. SR respondents in the qualitative evaluation noted that the dual paper and data entry system discourages fieldworkers who feel overburdened. A reliable single electronic system would eliminate the need for duplicating through paper-based forms. This would allow fieldworkers to spend more time in the field implementing and could improve overall staff morale. Respondents noted that network challenges in certain areas where the programme is being implemented, affected data entry into mobile devices, which rely on access to a secure network to upload data. The evaluation highlighted that issues with the data capture system need to be addressed, for example, technological issues that prevent assessment forms from being uploaded into the My Hope System if they are not fully completed.

Another major challenge to data management and M&E was due to the failure to implement mobile data capture devices. As a consequence, field staff had to use paper-based Risk Assessment forms, resulting in added data entry burden. At the time of interviews, procured biometric devices were still not being used. 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. Respondents described plans to begin using the mobile devices again, however noting 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.

During the feedback process, **NACOSA** pointed out that while the recommendation to shift towards electronic capturing systems is noted, there are reasons why paper-based data collection tools are still being used (i.e. availability of smartphones or tablets [budget limitations], safety of using electronic data capturing devices in some sites). **NACOSA** indicated that since the replacement of the existing data capturing system is unlikely in the current grant period, there need to be other ways of addressing connectivity issues in the field while continuing to use the current system, for example overcoming network challenges through the use of dongles or other devices, or modifying the existing system with offline data capturing features. In addition, **Beyond Zero** suggested adapting the current My Hope System with in-field data capturing or off-line functionality, highlighting that it is neither practical nor cost-effective to change the entire system at this stage of grant implementation (Year 3 of implementation). The costs involved and the amount of relearning/re-training required might not be worth the effort. **NACOSA** indicated that there has already been significant investment into the development of the My Hope system, however acknowledged that parts of the My Hope system need improvement in order to resolve technical challenges, facilitate effective and sustainable implementation and evidence-based programme management and monitoring.

AFSA clarified that the My Hope system already has an offline functionality, and that the data entry challenges have been due to the slow roll-out of biometric devices, which created a huge gap and major challenges for data quality in the programme. **AFSA** added that SRs are experiencing backlogs in data capture due to capacity limitations with large numbers of paper-based forms that require manual capturing into the web-based platform. AFSA pointed out that considerations for data clerks were not made at the start of the programme as the assumption then was that implementers would be using the biometrics devices to capture data in the field. Due to pressure to report and meet deadlines, temporary data capture clerks have been hired, but do not have sufficient training and familiarity with programme, which has contributed to poor data quality.

NACOSA further explained that the whole programme was designed on the basis that staff would be using mobile device for starting point at first interaction, to capture beneficiaries' fingerprints and information. However this did not happen, and the intended devices are still not available. As a consequence, data capture has been negatively affected, and SRs do not have capacity or HR resources to capture data. SRs are having to hire temporary data capturers, who are not properly trained and not incentivised to do quality work. As a result there are numerous issues with data quality, which in turn negatively impacts on SR morale and frustration. Although this situation was not planned for, PRs have been responsive to these systematic challenges and the delays faced in setting up data management systems.

Mobile apps can validate data upon entry to ensure higher accuracy. They can incorporate complex mobile form features, such as skip logic, to help collect data more efficiently. Updates and programmatic changes can be deployed to the field, and frontline workers can reference support and information built into the mobile app to advise them through particularly challenging assessments as they speak with beneficiaries. Managers and supervisors can securely access relevant data, even doing so instantly when the fieldworker

has a mobile connection. As far as possible, a single electronic data capturing system should be used, optimally one that does not require in-field connectivity. There are several in-field data capturing solutions which do not require access to the internet and where data can be uploaded to 'the cloud' once a reliable connection can be sourced; solutions such as these should be considered. Off-line platforms will allow you to record data on the device and upload when connectivity returns. Some even allow for offline case management, meaning you can store data from prior visits on the device to access and update even without an internet connection.

Best practice/example tools for in-field data collection and programme M&E include:

- https://www.dimagi.com/commcare/monitoring-evaluation/
- https://www.teamscopeapp.com/features/case-management

AFSA made the suggestion that data management systems should be set up early on in the implementation period to ensure smooth running. **AFSA** noted that in the current grant cycle, a lot of changes and updates to data management system are being made during implementation, creating issues with reporting. **AFSA** shared that one of the system issues they have faced related to the challenges in updating successful referrals on My Hope system. System functionality was limited at the time of reporting, which means that successful referrals are not always counted/tracked.

NACOSA pointed out that a data management system of this type has not been developed before; the system has so many different layers and requirements, given the complexity of the intervention. This is a novel model for M&E, and there have been significant challenges, however it is a process of learning, and the PRs are working through the issues faced with developing a new system.

NACOSA also highlighted that regarding Zenysis and the Record review, the example of PrEP cascades and reported uptake, the records are not a true reflection, as either the data doesn't exist or the system was not functional at time of capture. There are system level issues with South Africa's national recording system for tracking retention on PrEP. Additional data challenges are due to the complexity of needing to track cycling on/off PrEP, and different time periods. **NACOSA** clarified that the My Hope system would be able to capture this (cycling on and off PrEP), given that information is captured.

Indicators and Targets

We recommend reviewing existing indicators to ensure measurements of quality service provision are included (i.e. hybrid approach of coverage/reach and quality). Targets and chosen indicators of success should promote quality service provision for AGYW; numerical target indicators should be supplemented with quality indicators.

NACOSA highlighted that since indicators and targets are set by the Global Fund at a global level, PRs are not at liberty to change reporting requirements, indicators and targets. Recommendations relating to intervention targets are challenging to implement since reach is a core indicator for PRs set by GF which is unlikely to change. **Beyond Zero** acknowledged the recommendation to incorporate quality metrics in the reporting system to monitor program quality. In addition, there was a need to implement routine client feedback systems, to monitor quality standards and use the data to design quality improvement interventions as needed. **AFSA** stated their agreement with recommendations by BZ and NACOSA, and concurred that the inclusion of outcome level indicators would be useful for the next grant cycle.

NACOSA commented that at times, there is competition for participants between PRs. There should be more consideration of community versus school bases services. For example AGYW could access services at either community or school, which has implications for recording reach and targets. There should be more consideration of how targets are assigned, and these should be linked to data management systems, which should support programme implementation. **NACOSA** clarified that the issue is not so much around sub-district level targets, but rather with the allocation of targets for SRs. For example, is the SR has enrolled a specific AGYW, this is only SR that can provide core service package. Which does not account for cases in which an AGYW moves from school to out of school. Targets are set for in-school SRs, but some AGYW access community-based services. Therefore the system of target setting between SRs, does not currently take into consideration movement of AGYW, for example leaving school within the same grant period.

One suggestion made by **AFSA** was the idea of using some kind of user-satisfaction survey. Another idea was conducting better training evaluations, comprising pre- and post-assessments. AFSA commented that it would be helpful to capture lessons learned for programme improvement, and potentially build in user-satisfaction data collection.

NACOSA suggested that there should be standards set for offering core services. For example space requirements for offering services that include quality measures, and standards for PGT skills requirements. **NACOSA** commented that they are trying to develop these assessment tools to measure and assess quality so that managers can ensure quality standards of services.

NACOSA clarified that indicators and targets are national and set by the Global Fund, but there can be challenges on the ground due to issues with indicator definitions. This is specifically an issue with PrEP indicators, where counts are made for AGYW who are initiated and retained on PrEP. If the AGYW comes back numerous times for PrEP, she is only counted only once, whereas for HTS she gets counted more than once.

Relationships and Referral Systems

Referrals and Relationships with government entities

In order to improve the referrals system, the referral lists/ service mapping process should be updated and improved. The community mapping process needs to be updated in implementation districts where referral lists were noted to be outdated, inaccurate and include services that do not exist or organisations that do not have the capacity to deliver. **AFSA** responded to this recommendation saying that one of the problems is that service mapping gets outdated quickly, as there are many changes with organisations and service providers. **AFSA** agreed that the service mapping database needs to be regularly updated. In response to these recommendations, **NACOSA** indicated that ongoing work has been done with Zenysis from year 1 on the service mapping process. Printed maps of the sub-districts have been shared with the SRs.

Buy-in for the referral process needs to be ensured. 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 the Department of Basic Education (DBE) and implementers, which could assist in identifying and recruiting school based AGYW. It is important to ensure school (DBE) and clinic (Department of Health (DoH)) stakeholders are properly informed and engaged and that negotiations about records/data sharing between implementers and government and started.

We recommend developing or strengthening pathways for referrals for psychosocial support/counselling, and livelihood opportunities, and strengthening referrals with the Department of Social Development (DSD). We recommend strengthening relationships and coordination with government departments via Memoranda of Understanding (MOUs). Relationships between PRs and higher-level structures would facilitate relationship-building at local levels. Currently most of the MoUs/service-level agreements (SLAs) that are in place are between PRs and service providers, including government departments, at national or provincial levels. However, these are often not recognised at district level and do not always facilitate implementation for SRs. In contexts where SRs need to work out of school and clinic spaces, it is especially critical that these stakeholders are properly informed and engaged. Better buy-in could be achieved if stakeholders are engaged in dialogues that discuss how the programme can be structured to ensure that it contributes to common aims, rather than adding an extra burden to clinic staff or disrupting school programmes.

NACOSA indicated that efforts to improve relationships and referral systems is an ongoing activity. SRs have some MOUs in place but find it very difficult to get MOUs signed with the government stakeholders (e.g.) Home Affairs, for the SASSA grants. PRs have battled to ensure all Provincial MOUs are in place (e.g.) DoH. **AFSA** commented that MOUs are set up with critical stakeholders like DOH, DOE and DSD to harmonise processes for needs of the program beneficiaries. However, they might not always have names for sub- sub-recipients as these do get changed in the middle of the grant at times. **AFSA** added that implementers are always encouraged to keep track of the services taking place around implementation sites and to forge relationships with all to ensure successful referrals and buy-in. It was also highlighted by **AFSA** that referrals especially for the DSD grants are effectively done whereby the implementers through Care and Support Champions. The MOUs are set up with critical stakeholders like DOH, DOE and DSD to harmonise processes for needs of the program beneficiaries; AFSA noted that the working relationship with higher levels for all the critical stakeholders is going well with no challenges. In addition, **AFSA** remarked that in terms of engagements with stakeholders, particularly those to which referrals are directed, the issue of ensuring buy-in is critical for improving successful referrals. **Beyond Zero** stated that establishing MOUs between the PRs, service providers, and SRs, might create confusion on the ground when there are multiple MOUs of the same grant.

Providing a comprehensive package of biomedical, behavioural and structural services to AGYW requires the effective coordination and cooperative governance of various government departments. The Department of Cooperative Governance (DCoG) should be engaged to see where various departmental processes and services to AGYW can be strengthened and aligned. SR respondents noted, for example, that dealing with GBV cases is severely hampered by ineffective relationships and disparate processes and protocols among DSD, DoH, local clinics, the Department of Justice and the South African Police Service (SAPs). The core priority of keeping AGYW in school and helping AGYW return to school is also being undermined by varying policies and disagreements over the constitutional obligations of different departments to ensure the right to education for all AGYW, particularly DBE, DSD and The Department of Home Affairs.

The HERStory2 Record Review indicated that the tracking of referrals to DoH and DSD is problematic. It appears that the issue is that government departments do not have robust and efficient monitoring and evaluation systems . **AFSA** explained the process in which AGYW are provided with referral slips, and service providers are asked to scan the referral slip, but implementers rely on AGYW self-reports and feedback to track referrals. **AFSA** also shared that access to data from government facilities is also a challenge. They have now incorporated self-reporting for services like ART initiation. Using forms provided by the programme, AGYW self-report on services they receive, which assists in updating referral records.

One of the recommendations that emerged from the PR engagement process came from **AFSA** who emphasised that engagements with stakeholders, particularly those to whom referrals are directed are critical for improving the success of referrals. Where there are implementing partners working in the same

districts, who may provide services that the PR/SR do not provide, strong relationships would enable collaboration and referrals.

In general, the relationship between PRs and SRs were reported to be good. However, feedback loops between SRs and PRs could be strengthened to ensure SRs feel their voice counts. Where SSRs are contracted, we recommend strengthening relationships and communication between SRs and SSRs (with regards to budget planning, adaptation of programme). In order to reflexively revise the programme and continually improve on the referral system, stronger feedback loops are required between PRs and SRs. There is also a need to clarify the relative roles of PRs and SRs regarding establishing and maintaining the referral system.

NACOSA indicated that quarterly face to face meetings are held with all SR Project Managers and M&E teams. Monthly / bi-monthly meetings are held with all SR role-specific teams, for example with Higher Health, ESL, Social Workers, In-school SRs, Biomedical SRs. This ensures ongoing communication and discussion between the team members, the opportunity to identify challenges early and the best practice approach to shared learning. In addition, **AFSA** clarified that feedback loops between PRs and SRs-SRs are being improved with regular feedback meetings that are conducted. Whenever there are communication issues or bottlenecks this get addressed immediately at the PR level, and budget expenditure meetings are held at the beginning of each grant year cycle to ensure that SRs and PRs are on the same page with budgeting and program implementation.

Core Services

Risk Assessment Questionnaires

We recommend assessing how the Risk Assessment forms could be shortened, or split over multiple sessions since many AGYW and SR implementer respondents noted that the 11 pages is too lengthy. This would imply re-evaluating Risk Assessment targets. **NACOSA** suggested that the Risk Assessment may not need to be over multiple sessions if shortened; as the RA tool may be a maximum of 4 pages, in contrast to the previous 12. **NACOSA** confirmed that edits have now been made to Risk Assessment tool, and the new “lighter” version is being rolled out. **AFSA** also commented that when the tool is revised for the next grant the aim is to shorten it. In response to the recommendations relating to the length of the questionnaire, or the RA process being split over multiple sessions, **AFSA** explained that these have been questions discussed from the inception of the program. **AFSA** indicated that guidance was received was that the tool needed to be aligned with what is piloted nationally and there were questions that had to be incorporated even though not seen relevant.

We recommend including ‘not comfortable to answer’ or ‘prefer not to answer’ fields in order to prevent AGYW from providing incorrect information in response to certain questions in the risk assessment they

may not wish to respond to. The issue of false data entry can also be addressed by including additional fields into the assessment form, for example 'not comfortable responding' or 'prefer not to answer' (NACOSA, 2020b). During the feedback process, **AFSA** commented that the Risk assessment tools have been discussed from the inception of the program, and that the PRs are continuously working together to review the tools and make them acquire what the program needs**. AFSA** stated that the revision of the tool is underway to eliminate certain questions and acknowledged that the inclusion of a 'prefers not to answer' field may help to mitigate data entry issues.

Given the 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). One strategy for improving reporting would be enabling staff to build rapport with AGYW before conducting Risk Assessments, by conducting them over multiple sessions.

Based on the finding that AGYW require more rapport building before having the Risk Assessment conducted, perhaps the step after them being identified through demand creation should incorporate activities that allow for this. Once more rapport has been established, then step 3 should be to have their "risks and vulnerabilities assessed". The most invasive and sensitive questions, pertaining to sexual behaviour, substance use, and GBV, could be reserved for a second interview session, or asked later on in the programme, once trust has been established and rapport has been built with the AGYW. This is likely to yield more accurate reporting.

AFSA was responsive to the recommendation related to building rapport with AGYW before conducting Risk Assessments, or conducting over multiple sessions, however stated that one possible barrier to this would be in situations when the commencement of the grant is delayed, where implementers 'chase targets' making it difficult to make multiple sessions before actual enrolment. **Beyond Zero** added that in light of reporting back from the ESL component, the suggestion of building rapport with AGYW over time to improve reporting in risk assessments makes sense. Feedback received from the ESL pilot was that after AGYW have undergone a training or engaged in group activities that feel recreational, then AGYW feel more comfortable and are more open to provide information they would be unlikely to share in an initial encounter.

NACOSA described how the programme is supposed to work, in which based on initial Risk Assessment (RA), a service plan is developed with each AGYW beneficiary. However they acknowledged that in reality, this did not happen as planned. Instead the RA process became the entry point, and services were offered at the outset without going back to the risk assessment. For example the iMpower (self-defence) programme was offered to all AGYW regardless of whether a GBV risk was identified for specific AGYW. The same was the case with grief counselling; even if AGYW did not disclose a need for grief counselling, they were offered services. This calls into question whether or not the RA process to determine a service plan is an appropriate and necessary step as the first interaction with AGYW. Another point raising

questions about the utility of the RA process is that once the RA is done, the intervention process needs to be implemented, for example clinical services such as PrEP, SRH, TB screening, ARVs and offered as per need. However, once you assess her needs and link the AGYW to a DoH clinic that is not youth friendly, she will revert to her previous situation, in which she's referred to a clinic that she doesn't want to go to.

Attention to language is crucial in the design of Risk Assessment tools. Selection of words and terms, as well as phrasing of questions, affects participants' comprehension, interpretation, and responses, and also impacts on how much or how little participants choose to disclose (Frith, 2000). To increase accuracy and consistency in interpretations, questions and terminology should be as clear, comprehensible, and unambiguous as possible (Duby et al., 2015). It is absolutely critical to have all assessment tools carefully translated into the local languages of each of the implementation districts. The accurate and reliable collection of sexual risk data is challenging in multilingual research settings, such as South Africa. We recommend first, creating an enabling environment in which participants feel comfortable enough to openly and honestly report their sexual behaviour; second, using methods that encourage the participant to report accurately and truthfully; and third, using terms that are precise, unambiguous, easy to understand, and are likely to be interpreted as researchers intend (Frith, 2000). The phrasing of research questions and the manner in which research participants understand and interpret terms are critical for the collection of valid and reliable data on sexual behaviour. Moreover, precise assessment of risk informs the design of effective and relevant HIV interventions (Schroder, Carey, & Vanable, 2003). Accurate translation is particularly important, and difficult, in multisite studies, exacerbated by the lack of a standardized process requiring researchers to retranslate terms for each study (Cleland, Boerma, Carael, & Weir, 2004; Ramirez, Mack & Friedland, 2013; Duby et al., 2015).

Risk Assessments should be revised to be more aligned with services available and ready to be delivered, to avoid creating false expectations. Regarding translation of Risk Assessment tools into local languages, **NACOSA** explained that as a result of the Year 3 programme revision, the ESL programme and services will be expanded to other sub-districts (beyond those it was piloted in). However, it was acknowledged that tools need to be tailored to sub-district specific services. **NACOSA** indicated that the initial Self-Assessment and RA tool suggested by the TWG has been implemented for Year 1 and Year 2. This tool has since been revised with feedback received by SANAC Technical Support Unit (TSU) and Local Fund Agent (LFA); SRs will be trained on the reduced tool.

One option that could be considered for self-administered risk assessments is Audio Computer-Assisted Self-Interview (ACASI). In ACASI, questions are pre-recorded in the local language, and respondents are asked to select their answer by touching the corresponding button on the screen of the device (e.g., a smartphone, computer or tablet) that they are provided with (Dunkley et al., 2021). ACASI provides respondents with privacy and confidentiality, and is widely regarded as a useful tool in reducing social desirability bias in responses to sensitive questions (Punjabi et al, 2021). While evidence shows that audio computer-assisted self- interviewing (ACASI) provides greater privacy than a standard face to face interviews (FTFI), and encourages markedly higher reporting of sexual behaviours and risk behaviours,

even self-interviewing with a computer does not lead to full disclosure (Mensch et al., 2011). Eliciting accurate information from participants is a challenging task. ACASI appears to encourage greater honesty than conventional FTF interviews, but is not without limitations. Electronic data capture introduces further complexities, including the need for sufficient redundancy in file-backup and data storage to prevent data loss, and additional time and cost for setting up the computerized interview program, training staff and participants on how to use the system, and designing and implementing a process for dealing with technological problems (Mensch et al., 2011). However, while self-administered questionnaires provide greater privacy than face to face methods, evidence shows that even self-interviewing with a computer does not lead to full disclosure, and may not fully overcome participants' reluctance to reveal 'socially undesirable behaviours' (Mensch et al., 2011).

We recommend improving training of staff on Risk Assessment, including counselling skills. Several respondents noted that PGTs and Learner Support Agents (LSAs) were unable to effectively deliver Risk Assessments due to low job requirements (Grade 12), no counselling experience and insufficient training on the tool. Consider more intensive training for PGTs/ LSAs, including on basic counselling skills and on technical topics covered in the tool (e.g. HIV, STIs, TB, contraception, pregnancy). Training should ensure that implementers are clear on the referral system and on which questions relate to different services offered by the programme. In light of the invasive and sensitive nature of some of the Risk Assessment questions, staff conducting the Risk Assessments need to be adequately trained and prepared. Implementer respondents suggested that trained Social Auxiliary Workers (SAWs) and Social Workers (SWs) should conduct the Risk Assessments, or at least be responsible for the follow-up interviews in which more sensitive questions are asked, in order to ensure more accurate responses, and to facilitate the provision of counselling where necessary.

PRs could provide frequent refresher training for SR staff on the assessment tool, where issues arising in the field can also be discussed and resolved directly with fieldworkers, rather than through SR managers. Provide on the job training for PGTs and LSAs through closer mentoring and supervision from SAWs and SWs. As already noted, more SAWs and SWs could be involved in facilitating the assessments, especially the more sensitive questions proposed for a second meeting with AGYW.

During the PR feedback process, **NACOSA** raised the concern that the claim of false data is a serious one and requires extensive further investigation. In response, the evaluation team clarified that the claims were made by respondents in the qualitative interviews and in order to be verified would require further substantiation by PRs. The evaluation team also clarified the differentiation between different categories of false/fabricated data and the reasons for this. For example, in cases where AGYW beneficiaries were providing an incorrect contact number due to privacy concerns, it was clarified that wrong contact numbers do not mean the dataset is fabricated or has been falsified. Additionally, in cases where AGYW may be choosing to provide incorrect/untruthful answers to sensitive questions they did not feel comfortable answering honestly in the Risk Assessment; it was clarified that evasive answers do not mean that the data is purposely or fraudulently falsified. In situations where PGTs are either leaving out (i.e.

missing data) or making up an AGYW beneficiary's responses on the risk assessment, there is a need for specific recommendations on how to address this, as simply adding a 'prefer not to answer' field does not address the gravity of the claim that information is fabricated by some PGTs in risk assessments. It was clarified that missing data does not equate to falsified data; instances in where suggestions of fabricated data are made, or questions of data integrity are raised need to be qualified/triangulated with other data sources. In response to this, the evaluation team ensured the findings were clearly framed as respondent narratives and perspectives.

Layered Services

Biomedical Services

Contraceptives and Condoms

Based on the barriers to motivation to use contraceptives, we recommend information and educational interventions to generate demand for contraception services including awareness campaigns about different contraceptive methods and their efficacy and safety for AGYW. Policies that support age-appropriate pregnancy prevention interventions and sex education in schools could help improve coverage among younger AGYW.

Various indicators of poor family planning service quality were associated with gaps in effective use of contraceptives including AGYW reporting that they had been steered or pushed towards a specific contraceptive method; reporting they had not received the contraceptive method of their choice; and believing that the information they shared at the contraceptive service would not be kept confidential. These are indicators of an approach to service provision that is not-person centred and not responsive to the needs of adolescents and young people. Where AGYW had procured contraception through the AGYW programme, it is possible that structural barriers related to procurement from DoH meant that the AGYW programme was not in a position to offer a range of contraceptive options the than the oral daily pill from the DoH. We recommend a person-centred approach to contraceptive services which places AGYW at the centre of contraception services. AGYW should be informed about all available methods of contraception, and be provided with comprehensive contraception counselling to enable them to make informed decisions about the contraceptive method that best suits their needs and reproductive intentions. We recommend interventions to improve adherence to contraceptive use such as behavioural counselling.

We recommend policies to ensure an adequate, accessible supply of a range of contraceptive methods for AGYW. Service providers should offer AGYW a range of contraceptive methods, listen to their needs and concerns, and work with them to find the contraceptive method of choice. Where AGYW do not receive the contraceptive methods of their choice, this is a barrier to effective use of contraceptives. We

recommend placing AGYW at the centre of contraception services, in which they have the opportunity to discuss all available methods of contraception, and are provided with comprehensive contraception counselling to enable them to make informed decision about a contraceptive method that will best suits each young woman's needs and reproductive desires. This will improve overall quality of contraception services. We recommend service providers listen to and acknowledge AGYW's beliefs and concerns about the side effects of contraceptive methods. We recommend including comprehensive contraception education and counselling during all family planning visits.

During the PR feedback process, **NACOSA** clarified that 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). **Beyond Zero** also added the clarification that contraception is mainly offered in health facilities and the relationships established by SRs with districts on the ground enables access by SRs to contraception to be offered in the community spaces where the SR operates. Extension of hours for services is dependent also on DOH as they are the key custodians of programmes, but in mitigation the grant can include support of health facilities to be youth friendly so that there is specific hours /unit for AGYW to access services.

AFSA clarified that SRs are provided with contraceptive commodities by the DoH. In most cases they do not have injections, but only have contraceptive pills. AFSA agreed that it would be better if SRs could provide a range of contraceptives, but added that it might be an issue with staff capacity/trained health workers to provide options such as injectables.

Improved access to and use of contraception services enables AGYW to control their fertility, maximize educational and economic opportunities, and enhances their SRH and wellbeing. To improve access to contraceptives, we recommend expanding the provision of contraception services in accessible spaces including schools, safe spaces, community halls and other platforms where young women congregate. At policy level, we recommend interventions to engage schools to eliminate barriers to provision of pregnancy prevention services in the school premises, and interventions to extend provision to the private sector, such as retail pharmacies.

Being an adolescent was one of the main barriers associated with access to, and effective use of contraception and condoms. We recommend specifically targeting adolescent girls in all interventions to promote contraception and condoms.

We recommend interventions to improve parental/care-giver and partner support for the use of contraception services by AGYW. Future interventions should incorporate multi-level approaches in addressing structural and contextual barriers to access and use of contraception services to gain maximum effect. At the individual level, efforts to improve AGYW knowledge and information about contraception

services should be strengthened; this can be done through comprehensive sexuality education inside and outside the classroom. Resources containing SRH information, such as myth busters and contraceptive method-specific information pamphlets and posters should be freely available and displayed in major youth-friendly zones, this way AGYW have the information at their disposal and can access it when necessary. Community gatherings, church or other religious activities, and sports and recreational facilities and activities should be used to offer educational interventions and promote the use of contraceptives by AGYW. Future interventions should address community norms and the myths around contraceptive use and the perceived future fertility decrease, as well as highlight the impact of unintended and unwanted pregnancy during adolescence with parents. Addressing health services level barriers requires health systems transformation inclusive of addressing providers' attitudes and enhancing competency for youth-friendly provision, ensuring responsive and time sensitive services, and prioritising effective implementation of SRH policies for adolescents and young people (Jonas et al., 2020).

NACOSA stated that PRs will workshop the risk-reduction counselling approaches with the biomedical SRs during the Mentoring and Support visits to expand their strategies. **Beyond Zero** added that the contraception recommendations will be included in the SRH refresher training. **AFSA** acknowledged the on-going challenges related to stock-outs of certain contraceptives at health facilities, where at times, a specific contraceptive method may not be available for several months. Going forward, perhaps it would be advisable that a budget exists to procure these in case of stock-out from facilities. Addressing AGYW concerns about contraceptives, including contraceptives side effects and safety is also noted. Implementing teams provide the contraceptives in Safe Spaces and Mobile Clinics which are accessible to the program beneficiaries.

Condoms

To address barriers to physically accessing condoms, structural interventions which increase the availability of condoms and the number of settings in which AGYW can access condoms, for example at settings including schools, clinics, community centres and safe spaces, could improve access

Given the barriers to the use of condoms, we recommend risk-reduction counselling delivered by healthcare workers or peer-counsellors to promote the effective use of condoms among AGYW.

Gender empowerment interventions need to engage young men and women in discussions about gender which critique existing ideas of manhood and womanhood and encourage more positive forms of masculinity and equal power dynamics in relationships where both partners can negotiate condom usage (Duby et al., 2021; Mantell et al., 2011). While AGYW may benefit from communication and negotiation training, interventions may also consider focusing on programmes for men and boys which foster gender-equitable beliefs, behaviours, and actions (Closson et al., 2018). With regards to economic empowerment,

strengthening livelihood interventions within the AGYW programme will also be important in enabling AGYW to choose their own sexual partners and negotiate condom usage

There has been some success with 'gender-transformative interventions' in shifting harmful gender norms and roles through integrated community-based programming, and in doing so, achieving an improvement in structural and individual-level risk behaviours and sexual outcomes (Closson et al., 2018). Additionally, since condom use is influenced by both individual and interpersonal level factors, there may be some value in targeting partner-level influences on condom use through interventions which include communication and negotiation skills training components, in order to empower AGYW to translate their safer-sex intentions into actual behaviour. It is also important that interventions recognise the bidirectional influence that sexual partners have on each other; couple-based HIV prevention interventions based on a model of healthy intimate relationships may be an effective means of addressing relationship level barriers to condom use. Engaging men and boys in SRH interventions, rather than leaving condom use negotiation to women, should be a key focus for future efforts. In order to enable sustained and consistent use of condoms, men's engagement and involvement is critical (Montgomery et al., 2008).

Within the framing of an integrated definition of sexual and reproductive health, comprising positive approaches to sexuality and reproduction, recognising the role of pleasure, trust, and communication in the promotion of self-esteem and overall wellbeing in sexual relationships, there is a need for contextually relevant education and messaging around relationship dynamics and gender, including exploration of the concepts of trust and construction of expectations within heterosexual relationships, socio-cultural norms around sexuality and pleasure (including female pleasure) and consent (Duby et al., 2021; Starrs et al, 2018). The importance of recognising pleasure as a central motivator for sex in the design of sexual health interventions is critical. Condoms remain an important HIV prevention method, in addition to an important tool for preventing the spread of STIs and unintentional pregnancies; programmes targeting SRH among adolescents and young people need to include condoms as one option amongst other prevention technologies, and provide on-going education and messaging around the importance of dual-protection, encouraging AGYW who use hormonal contraceptives to also use an HIV prevention method (Duby et al., 2021). In order to improve condom use amongst adolescents and young people in South Africa, the complex multilevel barriers to their use need to be addressed through innovative interventions inclusive of individual, interpersonal and socio-cultural level components (Duby et al., 2021).

AFSA indicated that the strengthening of engagement and provision of services to ABYM has just been incorporated in the current grant Year 3.

PrEP

Given that the factors associated with access to PrEP in the AGYW survey included ever being offered PrEP and receiving instructions or counselling on how to use PrEP, we recommend increasing the number or type of spaces and venues where PrEP is available to improve access to PrEP especially for adolescent girls (15-19 years old) and AGYW who are most at risk of HIV infection. These venues need to ensure a reliable supply of PrEP and reliable procurement processes need to be established.

NACOSA clarified that via the Year 3 programme revision, they have increased PrEP sites to ensure full coverage per sub-district. **AFSA** added that expanding the type of spaces and venues where PrEP is available to improve access to PrEP for most at risk AGYW is acknowledged, however, DOH guidance was on first ensuring adequate implementation of PrEP program in phases for all the clinics before the program gets implemented out of health facilities for sustainability purposes.

In the evaluation interviews, several SRs noted that the rollout of the PrEP programme was slow, and that there have been challenges regarding adequate supply of PrEP. 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. Implementers noted that AGYW discontinued PrEP due to short supply at clinics.

AFSA explained that restrictions and processes of procuring have been challenging. Procurement of PrEP is done by the provincial depot, and there are often stockouts, insufficient supplies, or facilities refuse to provide PrEP. **AFSA** highlighted that these issues need to be attended to, and that the procurement of PrEP should be standardized.

NACOSA indicated that the initial roll-out of PrEP stock was a challenge for all PRs during the period Oct - Dec 2020. S. Buys has been contracted as a Service Provider from Dec 2020; from Jan 2021 PRs and SRs have seen a consistent supply of PrEP medication being delivered with no stock outs - this has addressed the access to PrEP.

In addition, **Beyond Zero** commented that PrEP supply has been addressed through service provider contracted by PRs. Barriers to accessing PrEP also needs to be addressed through the structures of SANAC and country team in provinces like Limpopo for sustainability of the programme. Different strategies are employed to address challenges with linkage including collaborations with small grants CSOs, refresher trainings for linkage officers within the current grant funding**.**

Based on the barriers in motivation to use PrEP, we recommend community campaigns to promote PrEP uptake and address resistance, misconceptions, and problematic social attitudes towards PrEP. Interventions to shift social norms and views towards PrEP may be delivered in schools, healthcare settings, community centres and through the media by peers and existing social networks (Hargreaves et al., 2016; http://strive.lshtm.ac.uk/resources/hiv-prevention-cascade). Engaging parents and family

elders will be an important part of this intervention. Work is being done by the DoH to ensure promotion of PrEP. **NACOSA** proposed that PRs should consider engaging with the Advocacy teams to host a campaign to dispel myths and problematic social perceptions of PrEP, in order to address barriers to PrEP acceptability and uptake. In response to the recommendation for engaging parents in PrEP promotion, **AFSA** indicated that this has already started, although this was seen as a gap when certain parents came to enquire or request PrEP for their children. The intensification of parents and community campaigns to improve uptake of PrEP and to address misconceptions, resistance and problematic social attitudes towards PrEP is considered. **AFSA** added that one successful strategy has been using peer-to-peer recruitment/ambassadors for PrEP, who are able to encourage their peers to use PrEP.

Given AGYW survey findings which show that at the time or the evaluation, PrEP coverage of beneficiaries of the Global-Funded AGYW programme was low, as the evaluation occurred before the widespread implementation of PrEP and at a time when it was difficult for the programme to procure the necessary supplies, we recommend a follow-up assessment to assess PrEP coverage in the last part of grant periods. This could be achieved through a review of routine programme records.

The WHO PrEP M&E guidelines suggest a core indicator of 'Continuation on PrEP', defined as the 'Percentage of PrEP users who continued on oral PrEP for three consecutive months after having initiated PrEP in the last 12 months'. The decision to limit this indicator to 3 months was justified based on early data from demonstration projects suggesting that many users who discontinue oral PrEP do so during the first few months. However more recent evidence suggests that discontinuation is common even after month 3 (Stankevitz et al., 2020). The PEPFAR oral PrEP indicators also do not promote longitudinal monitoring, rather they parallel existing treatment indicators, which give a snapshot of changes in the total number in care over time, rather than allowing for an understanding of duration of continuation (Stankevitz et al., 2020).

Evidence suggests that high discontinuation at month 1 indicates a large percentage of PrEP clients are not returning for the first follow-up visit and has important implications for PrEP effectiveness. Although discontinuation at subsequent time points could be due to periods of low risk, discontinuation at 1 month likely indicates other reasons for stopping. When assessing whether a client should initiate PrEP, attention should be paid to not only PrEP eligibility, but also the client's readiness to take PrEP consistently over time. Initiations are costly, and no prevention impact can be assumed without at least one return visit. The number of PrEP initiations may not be a very useful indicator in estimating PrEP effectiveness. Recent studies show that side effects, stigma, influence of partners, difficulty accessing services and reduced HIV-risk perception have contributed to discontinuation in some PrEP users. Discontinuation due to lack of risk is an important concept for continuation measurement (Stankevitz et al., 2020). PrEP initiations may not be a good measure of effectiveness; longitudinal monitoring of continuation may be important for understanding long-term use patterns (Stankevitz et al., 2020).

We recommend improved support and follow-up to address challenges with PrEP retention. Additionally, we recommend efforts to improve understanding of youth PrEP user preferences through innovative

engagement methods, such as discrete choice experiments (Dietrich et al., 2021). **AFSA** highlighted issues with retention on PrEP, and explained that they have looked at coming to agreement with facilities that they provide first 3 months of PrEP supply. Currently **AFSA** only initiate PrEP, but it is hard to track retention.

HIV Testing and Treatment

Aspects of the HIV testing services offered by the intervention could be improved through strengthening the engagement of adolescent boys and young men (ABYM) / older partners in testing drives, potentially through couples testing. Engaging parents of AGYW could also improve AGYW uptake of HIV testing. The HIV Treatment Cascade could be strengthened through counselling and support groups to improve adherence to ART for HIV positive AGYW. The engagement of parents/caregivers throughout the HIV care cascade would benefit HIV positive AGYW; particularly in cases where AGYW has HIV through vertical transmission. While we have shown that there were high levels of access to HIV treatment, the participants living with HIV reported suboptimal levels of adherence to the ART regimen. We recommend strengthening and increasing access to interventions to promote adherence to ART regimens.

During the PR feedback process, **NACOSA** explained that Year 1 and 2 saw the focus of the male HTS done via the AFSA Male Sexual Partners Programme with ABYM <24 years receiving ad hoc services only. From Year 3 we are expanding the ABYM services and will create spaces for them to actively engage the programme for enrolment, core, layered services including HTS. Regarding adherence, **NACOSA** explained that Year 2 saw the ad hoc services of Adherence Clubs to promote consistent use of ART. For Year 3, **NACOSA** stated that they are formalising the Girls Clubs focused on a variety of youth engagement, including adherence to ART. The idea is that they understand that being HIV positive is not all there is to them.

AFSA commented that lessons will be taken further to the next grant cycle, and that the recommendation of the adherence clubs is noted for both ART and PrEP among AGYW. In relation to linkage to ART, **AFSA** highlighted the challenge that AGYW need to be taken to facilities for ART. These are the same facilities that AGYW do not want to attend; this negatively affects AGYW access to ART. AFSA pointed out that they do have staff capacity / nurses available on programme, who have capacity to provide ART, but that the implementers were under restrictions from DoH to provide full services relating to ART.

Behavioural Services

Psychosocial support

Evidence shows that 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. Interventions for AGYW that consist 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). Importantly, strategies for ensuring that confidentiality is maintained in the peer-group club context need to be included (Duby et al., 2021); we recommend improving the confidentiality of group sessions. In addition, we recommend increasing AGYW access to individual one-on-one counselling services. Interventions to improve emotional wellbeing and coping mechanisms for AGYW are needed in order to improve sexual and reproductive health outcomes (Duby et al., 2020).

NACOSA confirmed that confidentiality of group sessions will be encouraged during the RA Tool retraining. Individual counselling services have been improved with the addition of the Social Workers. **AFSA** added that the issue of psychosocial support increased even more during COVID-19 pandemic. The PRs took note to ensure adequate staffing for psychosocial support which will also improve confidentiality of group sessions and increase access to individual counselling services.

Comprehensive Sexuality Education (CSE)

The findings indicated that the assumption that implementing staff will be able to successfully put aside their personal beliefs relating to sex, to provide Comprehensive Sexuality Education, was not always evident in practice. Given that the skills and competence of educators are central to the successful delivery of CSE, further training should be provided to staff to address this issue; in order to prevent problematic or prejudicial views being espoused in the peer education setting, the provision of on-going values clarification engagements and self-reflection activities should be considered (UNESCO, 2015; Wekesah et al., 2019). The provision of CSE could be improved through providing additional staff training to provide CSE, and addressing issues relating to staff resistance to delivering CSE. An additional necessary activity would involve addressing issues of resistance to CSE amongst principals/teachers. Guidelines for

responding to school teachers, principals and educators' concerns about CSE are available from UNESCO, the UN's Education Sector, and from the African Population and Health Research Center (APHRC).

During the feedback process with PRs, **NACOSA** responded saying that they noted the political challenges with CSE nationally in year 1 and 2. DBE TSU has commenced training with the PRs and SRs in May 2021 for the Advocacy component of the CSE programme. Training of the SMTs, SGBs and Parents to be cascaded from Jun - Sept 2021. DBE is mandated to conduct Educator training on the Scripted Lesson Plans for implementation in term 3/ 4 in 2021. **Beyond Zero** led the selection of the printed SLP and Advocacy material; the vendor is due to deliver it in June/July 2021. PRs have complied with the processes as this unfolded. **AFSA** added that the implementation of Comprehensive Sexuality Education (CSE) got delayed from National DBE. The roll out has just started and PRs will ensure that all the support required to address issues relating to staff resistance to delivering CSE is done. This also entails addressing issues of resistance to CSE amongst principals and teachers.

Structural services

Dignity Packs

As the qualitative findings show, dignity packs were very popular among AGYW beneficiaries, and were seen to meet a great need for menstrual management products. 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. However there appears to have been a misunderstanding amongst AGYW beneficiaries and community members regarding the supply of dignity packs, therefore creating expectations that were not met. Given the popularity of, demand and need for menstrual management products, these could be used as an incentive for enrolment. In addition, to avoid issues of misunderstandings and unmet expectations, it would be worth considering providing dignity packs to every AGYW beneficiary, not only those identified as "indigent".

The provision of Dignity Packs could be improved through opting for more sustainable menstrual management products which could be provided once-off, such as menstrual cups and re-usable/washable pads, instead of disposable sanitary pads. One recommendation that would offer a potential solution to this would be the provision of more sustainable menstrual management products, such as reusable menstrual cups and/or washable cloth pads. As the on-going, consistent supply of a sufficient number of disposable sanitary pads to each and every AGYW beneficiary is not feasible, a once-off donation of a re-usable product would be more sustainable. Evidence from research conducted in South Africa shows that

a context-appropriate, well-designed, consistent and sustainable formal school-based sanitary product distribution programme is crucial.

In May 2020, the South African Bureau of Standards (SABS) passed the first reusable sanitary standard for the manufacture of Washable, Reusable Sanitary Towels (SANS 1812). The publication of this standard is one of the first standards for washable sanitary pads in Southern Africa and is leading the way for other African countries to follow. The Department of Women, Youth and Persons with Disabilities (DWYPD) offered support and guidance through the standards process1, as part of the department's Sanitary Dignity Implementation Framework, agreeing that reusable menstrual products such as the washable reusable menstrual pad offer women and girls an option that is affordable and longer lasting than a single use pad. The South African Coalition for Menstrual Health and Management (SACMHM) Products, Standards and Supply Chain Task Committee, part of the Washable Task Committee, alongside the Director of Social Empowerment and Participation in the department of Women, are working to broaden product choice in line with the sanitary dignity implementation framework.

Examples of organisations working towards the provision of sustainable menstrual products to AGYW in South Africa include:

- subzpads.co.za
- www.dignitydreams.com

NACOSA clarified that Dignity packs were planned as a layered service for participants based on the need identified, in line with the products issued by the Department of Women, Youth and People with Disabilities. This will need to be revisited if amendments to the type, quality and frequency is to be offered to all participants. In addition, **Beyond Zero** highlighted that the current criteria for distributing Dignity Packs does not include everyone and dignity packs are not intended as an incentive. Beyond Zero stated that they had incorporated the request to include out of school AGYW in Y3 in the distribution of AGYW. **Beyond Zero** also added that there had been discussions with DoH about feasibility of menstrual cups and other menstrual management solutions in the early stages of planning, and that PRs would follow national DoH directives and policies on products to provide. **AFSA** commented that ensuring uninterrupted supply of dignity packs has always been the priority. For reliable supply of menstrual products, PRs have centralised the procurement to ensure that the suppliers provide adequate stock that will cover lengthy periods to prevent interrupted supply. PRs agreed that sustainable menstrual management products can be looked at in the next funding cycle in consultation with AGYW themselves and Dept of Women.

Importantly, this programme must be situated within a high quality and consistently applied SRH educational programme that addresses the myriad of reproductive health challenges that AGYW face

1 http://www.women.gov.za/images/articles/20200528-Int-Menstrual-Hygiene-Day-Statement-V2.pdf

including and following menarche. Further, schools need to be supported to increase the availability and quality of sanitation facilities to ensure AGYW are enabled to properly manage their menses without the risks relating to poor hygiene, social ridicule or negative environmental impact (Crankshaw et al., 2020). Concerns have been raised regarding the acceptability of washable sanitary pads and menstrual cups, both of which offer sustainable, cost effective, and safe options. There have been promising efforts in South Africa to introduce washable pads and menstrual cups in school; these efforts needs to be coupled with work done amongst educators in increasing their reproductive health knowledge, including gender sensitization and values clarification, ensuring that school sanitation facilities are hygienic, private and safe (Crankshaw et al., 2020). In both the school and higher education learning environment, student support services should provide support for students to manage menstruation within the education environment, including material resources, education in self-care strategies and information to normalise the menstruation experience (Padmanabhanunni & Fennie, 2017).

Gender Based Violence (GBV)

More focus should be given to ensuring programme acceptability among men, to address some of the concerns raised by respondents regarding how empowering AGYW may lead to unforeseen increases of GBV. The key challenge of transactional sex and relationships between AGYW and 'blessers'/ older male partners, contributing to high HIV-infection rates among AGYW, could be addressed by involving men and ABYM in dialogues (Duby et al., 2021a). This should be reflected in the programme targets and monitoring and evaluation framework, to encourage SRs to include men in their programme.

Respondents in the qualitative evaluations articulated the sentiment that the engagement of ABYM, as well as older men, in dialogues and programmes was insufficient. We recommend the inclusion of programme components that encourage AGYW and ABYM to critically reflect on gender identity, social norms and values that underpin gendered expectations. Men and boys need to be involved in discussions around sexual consent and gendered power; efforts to "empower" young women can have unintended consequences. We recommend the inclusion of programmes that provide a space for males to reflect on their own values and belief systems, community norms and cultural practices that reinforce gender inequality and male dominance over women. Programmes that promote healthy relationships and foster healthy models of masculinity, have been shown to be critical and should be the foundations on which gender transformative interventions are based (de Villiers et al., 2021). Through dialogue and discussion, boys and men can be challenged to start thinking more critically about sexual violence, for example, men's personal values and belief systems, and how these are influenced by societal pressures for men's behaviour. Reflexivity enables men to engage in their own construction of manhood, intimate relations and sexual violence. Conscientization, an important pathway to change, can lead to change in men's behaviour in their personal lives and social roles, and men taking ownership of their own behaviour towards women and wanting to change (de Villiers et al., 2021).

Evidence suggests that programmes using the 'peer-based group format' appear to be more successful in allowing men the space to develop alternatives to traditional male gender role expectations and norms (Stewart et al., 2021). Studies suggest that feeling part of the process, being equipped with the information and skills, and having peer engagement, support and leadership/modelling, are all components that support the engagement of men and boys not only as allies but as participants, partners and agents of change when it comes to addressing gender inequality and the associated negative outcomes. Interventions have a greater chance of success of engaging men when using peer-based learning in education programs, involving participants in the design and development, and the use of peer delivery and leadership (Stewart et al., 2021).

Young men and women need to be encouraged to reflect on relationship and sexual values, and gendered expectations (Duby et al., 2021). 'Gender transformative interventions' that aim to critically address shared societal expectations that women should have sex with men in return for their material/financial support, and work to challenge provider norms, masculinity and the concept of control of women in heterosexual relationships, should also be combined with economic empowerment interventions for AGYW that may help to reduce the extent to which AGYW need to rely on male providers (Magni et al., 2020; Stoebenau et al., 2019). Another important aspect to include in interventions relates to age-disparate partnerships; efforts should be made to engage AGYW and older men in order to build skills in critical reflection on the short-, medium- and longer-term benefits and costs of engaging in age-disparate sexual relationships (Wamoyi et al., 2018).

NACOSA responded with the clarification that GBV discussions with males are included in the Men's Dialogues. In addition, **AFSA** indicated that strengthening engagement of older male partners to address GBV has been ongoing through Men's Dialogues that are implemented. There will be incorporation of more engagements for the ABYM since there will be specific targets towards that in the current year 3. **NACOSA** indicated that they plan to contract Azali Health Care (SANAC Men's Sector secretariat) to implement national men's dialogues, addressing gender norms and stereotypes. More work to be done in this area in Year 3. **AFSA** explained that for the first two years of the program, AFSA has been implementing older men program interventions. Men younger than 24 years were also allowed to access the program although they were counted in the targets. Going forward in Year 3, a closer engagement of ABYM is started in the current grant year, and this has been incorporated with the MSP program to engage older male partners of AGYW and men in general.

Education and Employment Opportunities

We recommend providing or expanding the provision of scholarships and funding for education for AGYW still in education, and computer literacy classes and job training for AGYW out of school. We further recommend addressing AGYW migrants' lack of access to education by resolving challenges with school enrolment for AGYW migrants with Home Affairs and DBE. We recommend addressing barriers to school

enrolment for AGYW migrants by working with Home Affairs and DBE to enable them to access the required documentation.

NACOSA clarified that Scholarships, funding for education, computer literacy is offered in one sub-district offered ESL Pilot programme only. Supporting migrant learners with enrolment in school and an ID at Home Affairs is a lengthy process. PRs will need guidance on this process and possible MOUs with these departments. **Beyond Zero** added that the next funding cycle can include ESL programme for all AGYW implementing subdistrict-now currently taking place in ESL pilot sub districts and soon to be in grant revision districts in Y3. Similarly, **AFSA** also added that the grant revision activities for ESL Pilot and ESL Light will address some of the concerns on the livelihood AGYW needs pertaining scholarships, provision of computer literacy classes and job training for AGYW out of school. However, the issue of funding for education for AGYW still in education might need to be considered especially for the next grant.

Accessibility of Intervention and Services

In order to improve the accessibility of intervention services, we recommend offering expanded services at educational facilities including schools, and on tertiary/college campuses. In the qualitative evaluation, 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 clinics. 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. PRs noted that limitations exist with in-school and TVET components as they are limited by the School/ Campus management and because many learners/ students commute to school/ campus. **AFSA** clarified that offering expanded services at schools, colleges, on campus is being implemented through Safe Spaces that are accessed by AGYW when coming back from school or campus. **AFSA** highlighted the need to consider flexibility hours which might still exist as a bottleneck in certain areas.

In the qualitative evaluation, AGYW beneficiaries suggested that the provision of transport, or at least covering transport costs to enable AGYW to attend services and programme activities would improve accessibility. We recommend that extending service hours would improve accessibility of services. In the qualitative evaluation, implementer respondents suggested that more attention needs to be paid to the hours and locations that are most accessible for AGYW. It was also suggested by AGYW respondents that offering services over the weekend and after-school would enable more AGYW to access them. **NACOSA** noted the recommendations for provision of transport or transport reimbursement. **NACOSA** indicated that MTV Shuga (virtual peer education) will be extended to the other sub-districts not covered by the pilot programme to the in-school SRs. **NACOSA** indicated that service hours are extended via the (1) biomedical services working Saturdays as needed (2) community-based SRs offering weekend dialogues and advocacy events.

In light of AGYW respondent narratives relating to childcare responsibilities acting as a barrier to attending activities and accessing services offered by the programme, we recommend addressing barriers to access for AGYW with children by providing childcare/creche facilities, enabling young mothers to attend programmes. **NACOSA** indicated that ECD vouchers have been extended to the ESL Pilot participants to enable them to continue accessing services or skills and while they seek employment. **NACOSA** clarified that the current ESL pilot does implement ECD Vouchers to address barriers to access for AGYW with children by providing childcare or creche facilities, this will be looked at further.

Various implementer and community stakeholder respondents in the qualitative evaluation felt that rural communities remain underserved, and that the intervention needs to provide services to rural communities in their localities. We recommend addressing barriers to access for AGYW in remote/rural areas, and unsafe areas by implementing programmes in rural communities, and consider using roaming / mobile services / Safe Spaces/ satellites. Given the context of restrictions imposed by COVID-19 regulations, the need for remote support has increased. One key barrier to accessing remote support is the requirement of paying for data/airtime. Providing toll-free phone helplines and data-free websites would enable free and easy access to important accurate information about SRH, education, health and programme activities to those who need it. **AFSA** responded with the clarification that addressing barriers to access for AGYW in remote areas is also incorporated into the program as there are satellite safe spaces that get identified and operated as the AGYW enrol into the program. In addition, **Beyond Zero** indicated that this recommendation is currently being implemented with extension of satellite safe spaces in Y3. During the feedback process, **NACOSA** indicated that via the TCC programme, NACOSA supports the toll-free counselling hotlines. Via the C19RM budget, NACOSA have deployed a reverse billing USSD support service covering the following topics:

- COVID-19 and the community response
- Adherence to medication (for HIV, TB, STIs and non-communicable diseases)
- GBV and accessing post-violence care services
    - Promoting safer sex and harm reduction practices

Community acceptability of the intervention was negatively impacted by the perception that the age range of the AGYW programme excludes AGYW under 15 years of age, many of whom are already sexually active. Community stakeholders felt that girls from the age of 12 should be included. The HERStory 1 survey found that 9% of AGYW reported that their first sex occurred before the age of 15 (SAMRC, 2020).

One recommendation that was cited by intervention beneficiaries was the need to include the most vulnerable adolescents and young people in the intervention communities, for example, homeless youth, sex worker youth, and young migrants – who are most in need of support and services. Access to these vulnerable adolescents and young people may be possible though shelters, community-based organizations, drop-in centres, and through DSD. Improving access to interventions and services for homeless youth is critical, as they are vulnerable to engage in a range of risk behaviours directed at survival with detrimental consequences to their health and wellbeing (Oppong et al, 2016). Development

of health promotion interventions which address the cumulative effects of multiple risk behaviours should be emphasised (Oppong et al, 2016). It may be possible for interventions to access street children and homeless youth though shelters, community-based organizations, drop-in centres, and through DSD. Vulnerable and most at risk youth should be supported by skills development and social support for the practice of health enhancing behaviours, and the development of coping skills. Milburn et al. (2012) recommend that innovative approaches for engaging parents of high-risk adolescents and youth need to be developed. Interventions should directly target parents, normalize potential sources of parent/adolescent conflict (e.g., adolescents' need for autonomy), and do not blame parents or adolescents for family conflict. There should be a priority in identifying youth who are newly homeless and targeting their families to prevent high risk behaviour patterns developing.

Safe Spaces

Given the popularity and acceptability of the Safe Spaces component, we recommend expanding this aspect of the programme. In addition, we recommend expanding the type of services and activities available at Safe Spaces. Importantly, Safe Spaces should be established before programme implementation begins, and should be fully resourced to provide promised services. Addressing privacy and safety concerns will improve Safe Space acceptability. Ensuring that Safe Spaces and satellite service centres are set up and ready to operate before enrolling beneficiaries would assist with retention of AGYW in the programme by offering ongoing services and a space to informally engage AGYW.

NACOSA explained that Safe space and 4 satellite spaces were selected based on available, accessible venues in the community. The challenge arose due to the vast distances of the sub-districts making the safe spaces accessible. **NACOSA** clarified that in year 3 the plan is to expand to decentralised spaces to support the existing structures. SRs to assess the feasibility of this model for the next cycle. In addition, **AFSA** commented that Safe Spaces identification needed to be mapped and be aligned with the future program beneficiaries. This can be adequately set when the program is already up and running since this follows engagement of stakeholders that assist in identification of the spaces taking in consideration buy-in of the program which should already be up and running not before. **Beyond Zero** also added that project initiation delays resulted in parallel planning and implementation as deliverables were due by the time grant was initiated, recommendations will be included for next funding cycle planning.

Programme implementation in context of COVID-19

SR implementer respondents noted that programme funding was not flexible enough to allow SRs 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.

In the qualitative evaluation, respondents from across sample groups suggested that the use of online platforms to provide support and information during the COVID-19 pandemic was a critical means of ensuring continuity of support. However alongside offering programmes online, AGYW need to be provided with airtime and data to ensure these costs do not need to be absorbed by struggling households.

Incentives that are responsive to the challenges that AGYW and their households are facing during COVID-19 should be provided. Respondents in the qualitative evaluation spoke about issues of food insecurity and hunger during COVID lockdowns, combined with loss of income for families.

It is important to develop innovative ways to ensure AGYW's access to health, social protection and educational interventions during situations like the pandemic. We recommend increasing support for civil society organisations, such as those implementing the AGYW programme, as they have first-hand knowledge of the needs of the communities in which they operate and the impact of the pandemic therein. They can also hold governments accountable to ensure that resources are distributed in an unbiased and equitable manner, and can support AGYW and youth to monitor the access and availability of commodities. SRs can also continue offering one-on-one individual services, support and counselling in Safe Spaces when group activities are not possible.

In the AGYW survey, there was somewhat contradictory evidence about the effect of COVID-19 on coverage of HIV treatment. We recommend special interventions to increase the accessibility of HIV treatment during crises such as the COVID-19 pandemic, for example, providing these services at Safe Spaces.

Acceptability of Intervention

In order to improve acceptability of the intervention amongst the parents of AGYW beneficiaries, there needs to be more meaningful engagement of parents/caregivers of AGYW. Additionally, the introduction of programme elements that improve relationships and communication between AGYW and parents/guardians would be of benefit. 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 beneficial.

NACOSA responded with the statement that the request for more parental involvement has been supported by the DBE via the in-school programmes. SRs are invited to brief parents at the Teachers meetings. More work needs to be done in this area for the community-based programmes. **Beyond Zero** also added that Parents' involvement will be initiated now as the CSE programme is being implemented and SRs are working with school principals to be invited when there are parents' school meetings to orientate them about the AGYW programme .

We recommend that future interventions work to engage with communities in order to assess needs and co-create programmes. Ideally this should be done before implementation begins, however, it could also be part of a reflexive approach of adapting the programme to more closely fit the intervention context in specific districts. During the design phase, intervention planners should clarify the approach to involving community gatekeepers in the programme. Community acceptability for services and programme components is likely to be enhanced through efforts to raise community awareness around PrEP, targeting AGYW, parents and community gatekeepers. In addition, emphasising the most 'acceptable' aspects of the intervention, for example the psychosocial support element, can help to foster community support and buy-in.

The question of how to involve Ward Councillors and traditional leaders in the programme is a complex dynamic that SRs need to navigate carefully to protect the integrity of the programme. In doing so, SRs should keep in mind that Ward Councillors are politically aligned figures and not all households are in good relations with traditional authorities or accepting of the role of traditional leadership. SRs should ideally maintain neutrality to ensure equal access to the programme among all AGYW households, irrespective of their political affiliation. Community acceptability and willingness to participate in the programme will be impacted by the strategies SRs take to recruit AGYW and the extent to which Ward Councillors are involved in recruitment and sanctioning project activities. PRs and the Global Fund should provide guidance to SRs regarding the preferred process for engaging communities and ensuring community acceptability.

Many respondents did note that having social workers on SR teams was a factor that strongly promoted community acceptability of the intervention. However, some respondents spoke of the huge demand for psychosocial support in both school and community settings that is not being met. Increasing the supply of these services and making these services more visible and accessible would improve community acceptability. SRs also need to ensure adaptations are in place to keep offering these services during COVID lockdowns, as telephonic services were noted to be inappropriate.

The findings illustrated how communities tended to be more resistant to the SRH components of the programme, however the benefits derived from improved access to psychosocial support were noted to increase acceptability. Therefore, especially when first introducing the programme into communities,

instead of highlighting SRH components, SRs could focus on the psychosocial support element. It was also noted that communities appreciate that SRs have social workers and SAWs on staff, so this can be emphasised to promote community acceptability.

Differing views were expressed by SRs regarding whether community engagement should follow a top-down approach, whereby communities would be accessed through local gatekeepers like Ward Councillors and traditional leaders, or if engagement should be made directly with community members and beneficiaries, therefore avoiding political interference from gatekeepers. It seems that SRs require more guidance regarding what approach is considered appropriate by the programme and the GF, to ensure equal access among all AGYW households, irrespective of their political and cultural affiliations.

During the feedback process **NACOSA** explained that the first 18 months on the grant have been dedicated to programme development (core and layered services), contracting SRs and vendors, M&E development, training, stakeholder engagement and planning the implementation (building the bridge while walking on it). Community involvement has been integrated in the latter half of year 2. **NACOSA** also clarified that awareness campaigns have been rolled out in 2021 inviting community leaders and stakeholders. Topics included Bullying, Gender-based violence, COVID-19 vaccinations. This will continue for the duration of the grant. A request will be made to the Advocacy Officers to focus on the PrEP awareness via the Advocacy Campaigns. **Beyond Zero** added that Community activities were affected by Covid lockdown level regulations for about a year and implementation is starting slowly and still dependent on the Covid regulations for community gathering. In addition, **AFSA** commented that better community consultation and engagement with parents has been seen as a gap especially when the AGYW need to be tracked for the program. This is being strengthened for parents to also support attendance of children.

In addition to changes recommended to specific services already mentioned, we recommend involving AGYW in co-creating interventions for them; AGYW should be engaged in the process of identifying and redesigning programmes and retention strategies. **AFSA** responded to this recommendation with the clarification that AGYW have been engaged through a mapping process that was done during the inception of the program. The AGYW dialogues that also take place on a daily basis in the Safe Spaces assist in getting feedback in the process of identifying and redesigning programmes and retention strategies.

NACOSA explained that while more needs to be done in incorporating the AGYW voices in programme designs, NACOSA have involved AGYW in the programme in:

- Focus Group Discussions: for the Community mapping & Safes spaces services
- My Journey Journal: Online feedback via Survey Monkey
- Influencers programme: engaging a diverse group of adolescents to ensure co-creation, and inclusion of AGYW voices in the programmes
- Mental Health Literacy Programme: testing the online screening tool, and focus groups
- National SANAC Consultations
- ESL Programme: co-creation consultation sessions

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