HERStory 3

IMPACT EVALUATION OF A COMBINATION HIV PREVENTION INTERVENTION FOR ADOLESCENT GIRLS AND YOUNG WOMEN IN SOUTH AFRICA:
A NON-RANDOMISED CONTROLLED CLUSTER TRIAL

THE HERSTORY 3 STUDY
FINAL REPORT | OCTOBER 2025

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Conflict of interest: None declared.

Commissioning and Ownership of this Evaluation

The SAMRC was commissioned to carry out an impact evaluation of the adolescent girls and young women (AGYW) programme (the My Journey Programme) by the Global Fund's Principal Recipients (PRs): NACOSA, Beyond Zero, and AIDS Foundation of South Africa (AFSA). The ownership of this evaluation report rests jointly with the Global Fund's PRs, including NACOSA, and the SAMRC.

Abbreviations

Abbreviations	
AGYW	Adolescent girls and young women
ANC	Antenatal clinic
ART	Antiretroviral therapy
ARV	Antiretroviral
CBOs	Community-based organisations
CDC	Centers for Disease Control and Prevention
CPD	Continuing Professional Development
DBS	Dried blood spot
DoH	Department of Health
EIA	Enzyme immunoassay
ELISA	Enzyme-linked immunosorbent assay
FBOs	Faith-based organisations
GBV	Gender-based violence
GCP	Good Clinical Practice
GLP	Good laboratory practice
GPS	Global Positioning System
GRT	Genotype resistance test
GTI	Geo Terra Image

HCT	HIV Counselling and Testing
HPLC	High-performance liquid chromatography
HSP	Human Subjects Protection
HSRU	Health Systems Research Unit
HSV-2	Herpes-Simplex Virus 2
HTS	HIV testing services
IgG	Immunoglobulin G
IPV	Intimate partner violence
LAg Assay	HIV-1 Limiting Antigen Avidity Assay
LIMS	Laboratory information management systems
MOP	Manual of procedures
MDRI	Mean duration of recent infection
NGOs	Non-governmental organisations
NICD	National Institute for Communicable Diseases
NRCCT	Non-Randomised Controlled Cluster Trial
OVC	Orphans and vulnerable children
PDA	Personal Data Assistant
PEP	Post-exposure prophylaxis
PHRP	Protecting Human subject Research Participants
PI	Protease inhibitor

PID	Process Identification Number
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
PrEP	Pre-Exposure Prophylaxis
PEP	Post-Exposure Prophylaxis
PHC	Primary healthcare clinics
QA	Quality assurance
QC	Quality control
RITA	Recent Infection Testing Algorithms
RNA	Ribonucleic acid
RPR	Rapid Plasma Reagin
SA	South Africa
SAL	Small Area Layer
SAMRC	South African Medical Research Council
SANAS	South African National Accreditation System
SAPS	South African Police Service
SAWs	Social Auxiliary Workers
SDGs	Sustainable Development Goals
SGB	School Governing Bodies
SNOC	Schools as Nodes of Care training

SOPs	Standard operating procedures
SRH	Sexual and reproductive health
SRH&R	Sexual and reproductive health and rights
SR	Sub-Recipient
SSA	South African Social Services Agency
STIs	Sexually transmitted infections
TB	Tuberculosis
TFV-DP	Tenofovir-Diphosphate
TPHA	Treponema pallidum haemagglutination
TRI	Test for Recent infection
TVET	Technical Vocational Education and Training
UCT	University of Cape Town

Contents

ABSTRACT

Impact evaluation of a combination HIV prevention intervention for adolescent girls and young women in South Africa: A non-randomised controlled cluster trial (The HERStory 3 Study)

Background: Adolescent girls and young women (AGYW) in South Africa are at high risk of HIV infection. A combination HIV prevention intervention for AGYW, the My Journey Programme, funded by the Global Fund, was implemented in 12 South African subdistricts from 2016 to the present by non-governmental organizations (NGOs). The Programme aims to reduce HIV incidence, teenage pregnancy, and GBV, and to increase retention in school and access to economic opportunities.

Objective: To determine the impact of the My Journey Programme on HIV prevalence (primary outcome), knowledge of HIV status, coverage of HIV prevention and care and pregnancy prevention services, and school dropout among AGYW.

Methods: We conducted a non-randomised controlled cluster trial (NRCCT) constituting a "post-intervention" household survey in 12 intervention subdistricts, and 12 comparison subdistricts with equivalent demographics and equivalent HIV prevalences before the intervention, across 8 provinces in South Africa. Two sites were purposefully selected within each intervention and comparison area, generating 48 sites. In each site, we conducted a representative household survey of 100 AGYW aged 15-24 years (n=4,800). The study was powered to detect a decrease in HIV prevalence from 12% to 6%. Dried blood spot specimens were collected, and participants self-completed an electronic questionnaire. Frequencies and percentages for each outcome were presented for intervention and comparison arms. Using a random effects logistic model, accounting for clustering at three levels and potential confounders (age, sexual debut, maternal orphanhood, socio-economic status, and educational enrolment), the odds ratio for the intervention was determined. In addition, we conducted a per protocol analysis of key outcomes comparing AGYW in the intervention arm who were exposed to the My Journey Programme (reported being enrolled into the My Journey Programme or spending time at a Safe Space in the year before the survey) to an equivalent subgroup in the comparison arm. We also conducted a substudy comprising a pre- post-intervention analysis of the change over time in six intervention districts with available baseline survey data. We compared pre-intervention survey data from the HERStory 1 baseline evaluation (2017/2018) to post-intervention survey data from the HERStory 3 impact evaluation (2024).

Results: Across study arms, 37,714 households were visited, 22,263 were screened, 5,150 AGYW were invited and 5025 participated. HIV prevalence was 9.5% in the intervention and 10.4% in the comparison arm (OR: 0.88; 95% CI: 0.46–1.70, p=0.703). In the per protocol analysis, HIV prevalence was 8.8% (95% CI: 5.6–11.9) among AGYW exposed the intervention compared to 9.8% (95% CI: 7.6–11.9) among those not exposed. In the pre- post-substudy, five of the six subdistricts showed a decline

in HIV prevalence over time of between 1.0% and 5.2% (absolute change), but in one subdistrict, there was an increase in HIV prevalence from 16.6% to 34.8%. In the NRCCT, knowledge of HIV status was 84.7% in the intervention and 80.5% in the comparison arm (OR: 1.46; 95% CI: 1.05–2.03, p=0.024). In the intervention arm, there were substantially fewer participants who did not know what PrEP was (28.2% vs 35.0%; p=0.03) and substantially more participants who had ever used PrEP (26.4% vs 13.0%; p=0.03). In the pre- post-substudy, 1.9% of participants reported that they had ever taken PrEP, and this increased significantly to 17.3% in 2024, risk difference=15.8% (95%CI: 7.3%–24.4%; p=0.003). In the NRCCT, among participants aged 15-19 years, school dropout before completion of Grade 12 was reported by 10.7% of participants in the intervention arm and 12.7% in the comparison arm (OR=0.80; 95% CI: 0.56–1.15, p=0.226). There was no difference between arms in male condom use, but some of the perceived barriers to condom access were less prevalent in the intervention arm. There was no difference in HIV care coverage between arms, and viral suppression was under 75% in both arms. There was very little suggestion of an intervention impact on contraception use in the NRCCT, but some of the perceived barriers to access were less prevalent in the intervention arm. However, the substudy found a substantial and statistically significant increase in contraception use over time among AGYW aged 20-24 years, from 39.5% in 2017/8 to 60.2% in 2024, risk difference=1.54 (95% CI: 1.14–1.95, p=0.003), but no difference between arms among adolescent girls aged 15-19 years. In the NRCCT, across subdistricts, between 20.5% and 72.5% of participants reported that they had been invited to participate in the Programme, and between 27.9% and 59.7% reported that they had been enrolled in the Programme. AGYW reported very high acceptability related to their My Journey Programme participation, with the overwhelming majority (over 78% in all subdistricts) reporting "good" or "wonderful" experiences with the Programme and with between 0% and 4.6% across subdistricts reporting bad or very bad experiences.

Conclusion: The findings of the NRCCT, per protocol analysis and pre- post-intervention substudy have provided evidence to suggest that the My Journey Programme made a small positive impact on HIV prevalence and school dropout, but the study was not powered to detect such small intervention effects. The evaluation produced strong evidence that the My Journey Programme had a positive impact on knowledge of HIV status, and on PrEP coverage, doubling the uptake of PrEP compared with the comparison arm. However, this finding also highlights the importance of sustaining high levels of uptake through interventions to promote continuation of PrEP where appropriate. This study shows that the My Journey Programme reached a very large proportion of participants in the targeted program sites within the intervention subdistricts, and it was highly acceptable. These findings demonstrate the potential and value of combination HIV prevention for AGYW. Globally, to our knowledge, there are few published evaluations of the impact of combination HIV prevention programmes on HIV prevalence, and none that have shown an impact on PrEP uptake at a community level.

Executive summary

Introduction

In South Africa, adolescent girls and young women (AGYW) are at high risk of HIV infection, and there has been insufficient progress in preventing HIV infection among this population. Multiple factors intersect to increase AGYW's risk of HIV, these include, but are not limited to gender inequalities, age-disparate relationships, gender- based violence (GBV), low levels of education, lack of access to adequate sexual and reproductive health (SRH) services and stigma and discrimination. These factors serve as barriers to young women's ability to protect themselves from HIV or to effectively treat HIV. To alleviate the HIV burden among AGYW, the Global Fund to Fight AIDS, TB and Malaria has invested in a combination HIV prevention intervention for AGYW, now called the My Journey Programme. This programme was implemented in South Africa from 2016 through to 2024, the time of writing this report. Combination HIV prevention interventions, which merge effective biomedical, behavioural and structural interventions for combined delivery, are one of the key strategies for reaching the 95-95-95 targets and achieving the Sustainable Development Goals (SDGs) of ending the HIV epidemic by 2030.

The Programme was implemented by three Principal Recipients (PRs): AIDS Foundation of South Africa (AFSA), Beyond Zero, and Networking HIV/AIDS Community of Southern Africa (NACOSA). The PRs contracted sub-recipients (SRs) to implement the intervention components. The aim of the combination intervention is to accelerate prevention efforts to reduce new HIV, STIs and TB infections among AGYW with specific objectives to reduce HIV incidence, teenage pregnancy, and GBV, and to increase retention in school and access to economic opportunities. AGYW were introduced to the Programme through several entry points and referred for services via two main components called the "Core Service" (which was usually but not always received first) and "Layered Services", which were additional services that were provided based on the needs of the beneficiary and were received over time. Core and layered 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, while core services included enrolment and consent, HIV risk and vulnerability assessment, and a service plan.

The South African Medical Research Council was contracted to evaluate the impact of the My Journey Programme. It is worth noting that it is rare to evaluate combination HIV prevention interventions on such a large scale and this evaluation is one of the few that have been conducted. Such large-scale evaluations are critical as they provide vital information on how well the combination HIV prevention intervention strategies might work for countries with large HIV

epidemics and persistent trends in key populations that are hard to tackle using any single method of intervention.

Aims and objectives

Evaluation Aim

The aim of the HERStory 3 Study was to evaluate the impact of the My Journey Programme.

Evaluation Objectives

Primary objective

To determine the impact of the My Journey Programme on HIV prevalence by comparing AGYW aged 15-24 years living in the intervention and comparison subdistricts: a non-randomised controlled cluster trial (NRCCT).

Other objectives

The other objectives included assessing the intervention impact on:

- HIV incidence
- Knowledge of HIV status
- HIV prevention and care coverage
- Behaviours that increase or decrease the risk of HIV and unplanned pregnancy including abstinence and the effective use of condoms, PrEP, and contraception
- Teenage pregnancy
- Pregnancy prevention coverage
- GBV
- Cognitions and social environments of AGYW
- School drop-out among 15-19 year olds
- Access to economic opportunities
- Wellbeing and health-related quality of life

We also sought to describe the acceptability of the intervention and the self-reported impact of the intervention on health and wellbeing and access to economic opportunities among AGYW who participated in it.

Methods

Evaluation Design

The main evaluation design comprised quantitative methods, however a nested qualitative study was also conducted and is reported separately. The quantitative component of the evaluation was a NRCCT and consisted of a cross-sectional "post-intervention" survey in the intervention and equivalent comparison areas. Two sites were purposefully selected within each of the 12 subdistricts of the intervention and comparison arms, generating a total of 48 intervention and comparison sites. Each site comprised a cluster of small area layers (SALs): a geographical unit made up of one or more enumeration areas with a general population of less than 500. Conducting a representative household survey, a target of 100 eligible AGYW (aged 15-24 years) was enrolled, generating a planned total sample of 4,800 AGYW. The sampling continued until the quota for the SAL was met.

Dried blood spot (DBS) specimens were collected from all study participants to measure the primary outcome, HIV status, as well as other biological outcomes. These included exposure to antiretroviral therapy (ART) and viral load among participants living with HIV, and exposure to pre-exposure prophylaxis (PrEP) among participants not living with HIV who self-reported that they were on PrEP at the time of the survey and a random sample of participants who did not self-report being on PrEP. ART exposure testing included Tenofovir, Efavirenz, Dolutegravir, Lopinavir, Atazanavir and Darunavir; and this made up a six-analyte panel screen for first- and second-line ART. PrEP exposure testing included Tenofovir-Diphosphate (TFV-DP) only.

Participants completed a questionnaire covering their demographics, knowledge and utilization of programmes and services, pregnancy and children, relationships, condoms, contraception and family planning, HIV testing and status, HIV treatment, pre-exposure prophylaxis, sexually transmitted diseases, wellbeing, alcohol use and My Journey Programme acceptability.

The quantitative analysis also included a per protocol analysis to compare key outcomes between AGYW in the intervention arm who were exposed to the My Journey Programme (reported being enrolled into the My Journey Programme or spending time at a Safe Space in the year before the survey) to an equivalent subgroup in the comparison arm.

Finally, we conducted a substudy in which a pre- post-intervention analysis was performed, comparing the pre-intervention survey data from the HERStory 1 baseline evaluation (2017/2018) to post-intervention survey data from the HERStory 3 impact evaluation (2024).

Study subdistricts

The subdistricts and nested sites where the My Journey Programme was implemented, as well as the comparison subdistricts and sites are shown in Table A below.

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Table A. List of subdistricts for My Journey Programme intervention arm (n=12) and comparison arm (n=12) with nested sites (n=2) indicated.

Provinces	Intervention			Comparison		
	Subdistrict	Site		Province	Subdistrict	Site
KwaZulu-Natal	Abaqulusi	Coronation, Nkongolwane		KwaZulu-Natal	Umhlabuyalingana	Madonela
		Vryheid				Madonela A
	City of UMhlathuze	Empangeni			Hlabisa	Hlabisa
		Esikhaweni H				Hlabisa A
Mpumalanga	Mbombela	Phola		Mpumalanga	Metsimaholo (FS)	Zamdela
		Matsulu				Zamdela A
	Govan Mbeki	Embalenhle			Umzimkhulu (KZN)	Nkqozana
		Embalenhle				Mfundweni
Eastern Cape	Nelson Mandela C	Malabar		Eastern Cape	Nelson Mandela B	Uitenhage
						Uitenhage
	Nyandeni	Maurbeni			Ubuhlebezwe (KZN)	Lufafa
		Nkanga				Hlokozi
Free State	Dihlabeng	Fateng Tse Ntsho		Free State	Kopanong	Itumeleng
		Kgubetswana / Mashaeng				Lephoi
	Setsoto	Moemaneng			Letsemeng	Ratanang
		Meqheleng				Koffiefontein
Limpopo	Fetakgomo Tubatse	Mpahanama		Limpopo	Ephraim Mogale	Uitvlugt*
		Praktesseer				Manapsane
Gauteng	Tshwane 1	Soshanguve**		Gauteng	Mogale City	Kagiso
		Garankuwe				Kagiso
North West	Rustenburg	Boitekong		Free State	Bloemfontein	J B Mafora***
		Boitekong				Botshabelo/ Thabanchu***
Western Cape	Klipfontein	Athlone		Western Cape	Bitou	Kwanokuthula
		Hanover Park				New Horizons
Total	12	24			12	24

* = Site was expanded to make up for potential respondents lost in site 2.

** = Data collection stopped in GP – Soshanguve, no access granted by community stakeholders (resampled Garankuwa).

*** = Data collection temporarily suspended in FS – JB Mafora, reapplication of ethics from the University of Free State requested by the Department of Health, and approval was re-instated in August 2024.

Study population

Adolescent girls and young women aged 15-24 years living in the 24 intervention and comparison subdistricts.

Sample size

Using a total of 48 geographical sites (clusters) with 100 AGYW per site, provided 90% power to detect a 6% difference in HIV prevalence, expecting an HIV prevalence of 6% in the intervention sites and 12% in the comparison sites, based on the HERStory 1 baseline survey prevalences. It also provided the power to detect a 10% absolute difference in knowledge of HIV status among AGYW who had ever had sex; a 15% absolute difference in AGYW's use of contraceptives at last sex (among the subset who had ever had sex); and an absolute difference of 5% in school dropout among AGYW aged 15-19 years, from 8% down to 3%.

Study Duration

The fieldworker training and pilot study were conducted in January 2024. Data collection for the post-intervention survey began in February 2024 and was completed in May 2024. GeoSpace International (Pty) Ltd was contracted by the SAMRC to setup the details and location of the sites as well as conduct and manage the survey related fieldwork of the study.

Results

The study design for the HERStory 3 study comprised a household survey in 24 subdistricts (12 intervention and 12 comparison subdistricts) and 48 sites (two sites per subdistrict). We planned to conduct 100 surveys in each site to generate a total sample of 4,800. A total of 37,714 dwellings were visited (20,614 in the intervention arm and 17,100 in the comparison arm) and, in 22,263 households, contact with residents was made for assessing eligibility (11,628 in the intervention arm and 10,635 in the comparison arm). We screened 5,154 AGYW aged 15-24 years living in the households (2,710 in the intervention arm and 2,444 in the comparison arm), 5,150 participants were invited to participate (2,708 in the intervention arm and 2,442 in the comparison arm) and 5025 participated (2,638 in the intervention arm and 2,387 in the comparison arm) with 4,932 successful DBS results (2,604 in the intervention arm and 2,328 in the comparison arm). Of the AGYW invited, 97.5% participated (97.3% in the intervention arm and 97.7% in the comparison arm).

Description of participants

When considering the demographic characteristics of participants, the intervention and comparison arms were similar with some marginal differences, for example, fewer participants planning to become pregnant in the year following the survey in the intervention arm, compared with the comparison arm. The rates of maternal orphanhood were high in both arms (over 15%) and the rates of paternal orphanhood were even higher (over 24%). Approximately one third of all participants reported that they had ever been pregnant. Among adolescent participants (under the age of 20 years), 16.9% in the intervention arm and 14.8% in the comparison arm had ever been pregnant. The levels of orphanhood and teenage pregnancy among the adolescent age group are signs of vulnerability in this population. The relative balance in demographic characteristics between the arms can be considered roughly equivalent to what would have been achieved through randomisation of subdistricts at the start of the Programme. This does not obviate the need to adjust for the differences that were observed between arms in factors associated with HIV prevalence.

NRCCT Impact of My Journey Programme on HIV Prevention

Primary outcome: HIV prevalence

HIV status as confirmed by testing of the biological DBS sample was the primary outcome for the HERStory 3 Impact Evaluation. We describe the observed HIV prevalence, and the marginal predicted HIV prevalence by intervention and comparison arm overall and within each age group. Adjusting for imbalances in age, socio-economic status, education, maternal orphanhood, and sexual debut across the study arms of this NRCCT, the marginal predicted HIV prevalence was 9.5% in the intervention arm and 10.4% in the comparison arm with a risk difference of 0.9% and an odds ratio of 0.88 (95% CI: 0.46–1.70). The intervention effect was not statistically significant (p=0.703).

In the 15-19 year age group, HIV prevalence was 6.0% in the intervention arm and 7.1% in the comparison arm, with a difference of 1.1% and an odds ratio of 0.81 (95% CI: 0.36–1.78), which was not statistically significant (p=0.593). In the 20-24 year age group, HIV prevalence was 15.2% in the intervention arm and 15.0% in the comparison arm, with a difference of -0.2% and odds ratio of 1.02 (95% CI: 0.50–2.11), which was also not statistically significant (p=0.949). The intervention effect estimates of the age groups did not differ, p=0.911.

Across the 12 intervention subdistricts, the observed HIV prevalences varied substantially. This study was powered to detect a decrease in HIV prevalence from 12% to 6%. Four subdistricts met or exceeded the expected 6% difference in HIV prevalence target (Klipfontein, Dihlabeng, Fetakgomo Tubatse and Rustenburg), five showed a decrease from the expected baseline

prevalence of 12% but not reaching 6% (Abaqulusi, Govan Mbeki, Setsoto, Tshwane 1 and City of UMhlathuze) and three showed no positive intervention effect.

The per protocol analysis found that HIV prevalence was 8.8% (95% CI: 5.6%–11.9%) in the intervention arm among exposed participants compared to the 9.8% (95% CI: 7.6%–11.9%) among similar participants in the comparison arm, but the difference was not statistically significant.

The pre- post-intervention substudy found HIV prevalence was 12.4% in 2017/8 and 12.8% in 2024, risk ratio 0.95 (95%CI: 0.22–1.69; p=0.825). However, it should be noted that in five of the six subdistricts, there was a decline in HIV prevalence over time of between 1.0% and 5.2% (absolute change). In one subdistrict (Mbombela subdistrict), there was an increase in HIV prevalence from 16.6% to 34.8%, and this is an outlier which has a substantial effect on the overall intervention effect.

Secondary outcomes

HIV incidence

The population at risk for HIV infection is HIV negative participants at a time point six months prior to DBS testing. Following the Recent Infection Testing Algorithm version 1 (RITA1 Algorithm), Limiting Antigen Avidity Enzyme Immunoassay (LAg assay) information and viral load data were used to identify 10 recent HIV infections that occurred within the six months before the survey (4 in the intervention arm and 6 in the comparison arm). The total number of persons at risk was the sum of the DBS HIV negative participants plus the DBS based recent infection participants. The incidence is calculated assuming that each participant contributed one person year of risk. The incidence rate was 1.71 cases per 1000 person years in the intervention arm and 2.85 in the comparison arm. The incidence rate ratio is 0.60, indicating a 40% reduction in HIV incidence in the intervention arm compared to the comparison arm, although this estimate is not statistically significant (p=0.449).

Knowledge of HIV status

This study demonstrated a statistically significant increase in knowledge of HIV status in participants in the intervention sites. We found that 84.7% of participants in the intervention arm compared to 80.5% in the comparison arm knew their HIV status (OR: 1.46; 95% CI: 1.05–2.03; p=0.024). Among participants aged 15-19 years, 82.8% in the intervention arm compared to 76.5% in the comparison arm had knowledge of their HIV status (OR=1.61; 95% CI: 1.16–2.24; p=0.005), demonstrating a significant intervention effect. Among participants aged 20-24 years, 89.4% in the intervention arm compared to 88.1% in the comparison arm had knowledge of their HIV status (OR=1.16; 95% CI: 0.74–1.82; p=0.510), showing a small increase in knowledge. This effect was not statistically significant. In addition, the per protocol analysis showed that AGYW in

the intervention arm who were exposed to the My Journey Programme were more likely to report knowledge of their HIV status at 85.9% (95% CI: 83.4%–88.4%) compared to 79.6% (95% CI: 76.5%–82.8%) in the comparison arm (Table 66).

Aligned with the finding on this secondary outcome, the study also produced several other findings on the uptake of HIV testing which confirmed the effect of the My Journey Programme on knowledge of HIV status. For example, HIV testing ever, past year, past six months and HIV self-testing ever were higher in the intervention arm compared with the comparison arm. Furthermore, the pre- post-substudy found that the difference in reporting past year HIV testing over time in the six subdistricts was statistically significant. In 2017/8, 62.7% AGYW reported that they had had an HIV test in the past year, and this increased to 67.5% in 2024, risk ratio 1.09 (95% CI: 0.98–1.19; p=0.037). This evidence indicates that the combination prevention intervention was successful at reaching AGYW, especially adolescents, and increasing the coverage of HIV testing. This meant that AGYW could be referred for HIV prevention or HIV treatment interventions as appropriate.

School dropout among AGYW aged 15-19 years

The study found that among adolescent girls (15-19 years of age), 10.7% in the intervention arm and 12.7% in the comparison arm had dropped out of school before they completed Grade 12 (OR=0.80; 95% CI: 0.56–1.15, p=0.226). This difference was not statistically significant, however the direction of the difference observed was in favour of the intervention arm. The study was only powered to detect a much larger absolute difference of 5%. The pre- post-substudy found that among AGYW aged 20-24 years, there was no significant difference in having completed Grade 12 over time in the six subdistricts. In 2018/19, 62.7% of young women reported that they had completed Grade 12, and in 2024, 61.6% reported this, risk ratio 0.96 (95% CI: 0.86–1.06; p=0.824).

Coverage of PrEP

This study produced strong evidence that the My Journey Programme had a positive NRCCT impact on PrEP coverage. The HIV prevention cascades for PrEP showed substantial and statistically significant differences in favour of the intervention arm among both participants eligible for PrEP (DBS-confirmed HIV negative) and among participants at high risk of acquiring HIV (DBS-confirmed HIV negative and self-reported having sex in the past six months), and within both age groups. All cascades are provided in the main body or the report, but the findings among those who were DBS-confirmed HIV negative and self-reported having sex in the past six months are reported below as sexual activity is an important factor in PrEP uptake and adherence.

In the 15-19 year age group, there were substantial and significant differences in favour of the

intervention in the first three bars of the cascade: 48.2% in the intervention arm and 32.8% in the comparison arm knew what PrEP was; 36.2% in the intervention arm and 16.0% in the comparison arm had ever been offered PrEP; and 22.2% of participants in the intervention arm and 9.6% in the comparison arm had ever used PrEP. In terms of continuation on PrEP, 7.1% of participants in the intervention arm and 6.1% in the comparison arm self-reported currently using PrEP, but there was no statistically significant difference between the intervention and comparison arm for this bar. Additionally, 0.6% in the intervention arm and 1.2% in the comparison arm had detectable levels of TFV-DP (the PrEP drug) in their DBS sample among participants who self-reported being on PrEP, although the study was not powered to show statistically significant differences in DBS-confirmed PrEP drug levels by study arm for either age group. This finding highlights the importance of sustaining high levels of uptake through interventions to promote continuation of PrEP where appropriate.

In the 20-24 year age group, there were substantial and statistically significant differences in favour of the intervention arm in all the bars except for the final bar (DBS-confirmed PrEP drug levels): 57.6% of participants in the intervention arm and 45.8% of participants in the comparison arm knew what PrEP was; 42.7% in the intervention arm and 23.9% in the comparison arm had ever been offered PrEP; 26.2% in the intervention arm and 13.5% in the comparison arm had ever used PrEP; and 10.5% in the intervention arm and 4.4% in the comparison arm reported that they were currently on PrEP. In the final bar, 1.4% of participants in the intervention and 2.5% in the comparison arm had detectable levels of TFV-DP (the PrEP drug) in their DBS sample among participants who self-reported being on PrEP, but the study was not powered to show statistically significant differences in DBS-confirmed PrEP drug levels by study arm.

This study also produced evidence that knowledge about PrEP, social norms supporting PrEP, beliefs about access to PrEP, and confidence about using PrEP were significantly higher in the intervention arm compared with the comparison arm.

In terms of the biological PrEP results, we report results among participants who were not living with HIV and: 1) self-reported being on PrEP and 2) a random sample who did not self-report being on PrEP at the time of the survey from both study arms. Among the 209 participants who self-reported being on PrEP (152 in the intervention arm and 57 in the comparison), 23% (95% CI: 18%–30%) had detectable TFV-DP metabolite levels (the PrEP drug) in their DBS sample (24% in the intervention arm and 23% in the comparison arm). In the 15-19 age group, 21% in the intervention and 11% in the comparison arm had positive concentrations of the TFV-DP drug in their DBS sample. In the 20-24 age group, 26% in the intervention and 33% in the comparison arm had positive concentrations of TFV-DP. Among the randomly sampled participants who were not living with HIV and did not report using PrEP at the time of the survey (n=150: 73 intervention,

77 comparison), only 1 participant in the intervention arm had a detectable level of TFV-DP, 0.7% (95% CI: 0.1%–3.7%). The observed proportions of TFV-DP levels in the participants' DBS samples from the two PrEP strata validates the reliability of the self-reported PrEP data by AGYW. This strengthens the reliability of our cross-sectional survey findings which showed that the My Journey Programme increased PrEP uptake among participants in the intervention arm.

The pre- post-substudy also showed a substantial increase in PrEP uptake. In 2017/8, 1.9% AGYW reported that they had ever taken PrEP, and this increased substantially to 17.3% in 2024, risk difference=15.8% (95% CI: 7.3%–24.4%; p=0.003).

Coverage of condoms

This study provides evidence that the My Journey Programme had no impact on extending coverage of male or female condoms. There was no intervention effect on motivation to use, access to, and effective use of condoms among participants who were at risk of transmitting HIV to their sexual partners (self-reported living with HIV, had sex in the past six months, and did not have plans to become pregnant). There was also no intervention effect on motivation to use, access to and effective use of condoms among participants who were at risk of HIV infection (self-reported not living with HIV, had sex in the past six months, and did not have plans to become pregnant). Among AGYW aged 15-19 years, in the intervention and comparison arm respectively, motivation to use condoms was reported by 56.6% and 62.9%, easy or very easy access was reported by 67.2% and 67.1%, use at last sex by 40.8% and 40.0%, and effective use (used condoms 100% of the time in the past six months) by 12.6% and 18.6%. Among AGYW aged 20-24 years, in the intervention and comparison arm respectively, motivation to use condoms was reported by 60.8%% and 69.7% (a statistically significant difference in favour of the comparison arm), easy or very access was reported by 77.8% and 74.7%, use at last sex by 42.1% and 42.9%, and effective use by 14.3% and 12.4%. This highlights the importance of continuing to find ways to increase condom coverage and acceptability among young people. There were however some significant differences in the prevalence of potential facilitators or barriers that favoured the intervention arm, and none that favoured the comparison arm, suggesting that the My Journey Programme reached AGYW with information and counselling about condoms and made it easier for them to access condoms.

NRCCT Impact of My Journey Programme on HIV Treatment and Care

HIV care coverage

The HIV treatment cascades for participants with DBS-confirmed HIV positive status show that in both age groups there were no statistically significant differences between arms in self-reporting knowledge of an HIV positive status, being biologically confirmed currently on ART and virally

suppressed (<1000 copies/ml). There were substantial gaps in each of the cascade bars, with under 50% of participants in both arms knowing their HIV status, and under 60% in both bars being confirmed on ART at the time of the survey. It is of concern that under 75% of participants in both arms were virally suppressed, demonstrating the need to explore innovative ways to reach AGYW living with HIV and offer HIV testing and referral to treatment services, including services to promote adherence to ART. The DBS results related to ART uptake and viral suppression provide reliable estimates showing that the My Journey Programme did not impact HIV care coverage among participants who had a DBS-confirmed HIV positive status.

The pre- post-substudy found that 62.1% of participants were virally suppressed in 2017/8 and 58.9% were virally suppressed in 2024, risk ratio=1.21 (95% CI: 0.69–1.74; p=0.179).

NRCCT Impact of My Journey Programme of Pregnancy Prevention

This study produced evidence to suggest that the My Journey Programme probably only had a small effect on the coverage of contraception. We found no intervention effect on use of modern contraception other than condoms among participants who had ever had sex in the total sample or within the different age groups. Overall, the marginal predicted use of modern contraceptives was 51.9% in both study arms (OR=1.00; 95% CI: 0.81–1.23; p=0.988). The absence of an intervention impact is reinforced by the pregnancy prevention cascades, which show that there were no statistically significant differences in motivation to use, access to, use, and effective use of family planning methods by study arm. Of all the variables assessing use of modern contraceptives, we only found one in which there was a favourable intervention effect: among participants in all age groups who had sex in the past six months, those in the intervention arm were more likely to report having effectively used modern contraceptives (always used them during sex) (17.4%) compared with 11.9% in the comparison arm (OR=1.94; 95% CI: 1.23–3.05; p=0.0093). In the older age group, significantly more participants always used family planning during sex in the intervention arm (19.6%) compared to 12.8% in the comparison arm (OR=2.24; 95% CI: 1.25–4.01, p=0.0128). In the younger group, the estimates were higher (14.4%) in the intervention arm compared with 10.5% in the comparison arm, but this difference was not statistically significant. There was also evidence that the My Journey Programme had a positive impact by reducing some (but not all) of the perceived access barriers to contraception.

The pre- post-substudy found that among AGYW aged 15-24 years, the difference in last sex contraceptive use over time in the six subdistricts was not statistically significant. In 2017/8, 35.9% of AGYW used contraceptives at last sex, and in 2024, 41.3% used them, risk ratio=1.19 (95% CI: 0.69–1.68; p=0.192). The age disaggregated findings showed that there was no change over time among AGYW aged 15-19 years. However, among AGYW aged 20-24 years, the difference in last sex contraceptive use over time in the six subdistricts was substantial and

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statistically significant. In 2017/8, 39.5% used contraceptives at last sex, and in 2024, 60.2% used them, risk ratio 1.54 (95% CI: 1.14–1.95; p=0.003).

My Journey Programme reach, acceptability and quality of care

This study shows that the My Journey Programme reached a very large proportion of participants in the targeted sites in the intervention subdistricts. Across subdistricts, between 20.5% and 72.5% of participants reported that they had been invited to participate in the Programme, and between 27.9% and 59.7% reported that they had been enrolled in the Programme. Of note is that in three intervention subdistricts over 50% of participants reported that they had been invited to participate in the Programme, and in three subdistricts over 40% of participants reported that they had been enrolled in the Programme.

AGYW reported very high acceptability related to their My Journey Programme participation, with a very large majority (over 78% in all subdistricts) reporting "good" or "wonderful" experiences with the Programme and with between 0% and 4.6% across subdistricts reporting bad or very bad experiences.

Participants who had ever received contraceptives, HIV testing, PrEP, or HIV treatment services from the My Journey Programme were asked questions to assess the quality of care at their last visit for these services. Their reports indicated that most participants had received good quality service, were treated in a friendly and respectful manner, waited no longer than one hour, and were provided a confidential and comprehensive service. However, their responses indicate that there is some room to ensure that a greater proportion of consultations take a comprehensive focus, covering all relevant topics as per accepted guidelines for high quality of care, such as those endorsed by the World Health Organization or the South African Department of Health. The finding that some participants felt judged by the health worker who provided the service indicates that the Programme implementers could consider ways to actively and explicitly counter this feeling during consultations with young people.

Strengths and limitations

This study compares HIV prevalence by age in the intervention areas with the HIV prevalence by age in the comparison areas. The differences in intervention effect estimates are the indication of the impact of the My Journey Programme under the NRCCT design. To ensure a sufficient proportion of AGYW had been adequately exposed to the intervention, in each intervention area we specifically targeted the sub-areas indicated to us by the Programme implementers to optimise coverage. A substantial strength of this study is that the realised sample represents the actual population of AGYW living in the selected study sites and is not biased by non-

participation: our response rate among AGYW was extremely high.

Features of the NRCCT study design follow the recommendations of the NICE real-world evidence framework such as: a) The NRCCT design prevented exposure misclassification because we knew which sites were intervention and comparison sites. b) The objective and quality controlled biological measure used for HIV status as well as extensive fieldworker training prevented outcome misclassification. c) We explored results within different age subgroups and exposure groups. d) We controlled for confounding by adjusting for known risk factors for HIV, identified during the HERStory 1 baseline survey. e) There was limited missing data due to the high inclusion rate of AGYW within households and proportion of survey participants with good quality biological samples. Thus, the missing component was very small and similar between study arms. f) Finally, models were prespecified in the statistical analysis plan based on the NRCCT design. Clusters were weighted equally and the intention-to treat principle was applied.

There are several limitations in this study: a) Subdistricts included in this study could not be allocated randomly to the intervention or comparison arm and therefore we are not able to completely account for factors outside of the My Journey Programme. b) For each intervention subdistrict, we attempted to find a similar comparison subdistrict in the same district without a large donor-funded intervention, but in some instances, we had to select comparison subdistricts outside of these metros that were similar especially in terms of HIV prevalence using the 2017 antenatal surveys. The comparison subdistricts are therefore more generalised, but we believe this adds validity to the comparisons we performed, and the selection of comparison sites was adequate. c) Parts of the intervention were designed to impact AGYW indirectly through promoting supportive communities, and AGYW might not have been aware of these components. d) Some intervention components were not branded, and even when components were branded with the My Journey Programme, awareness of the brand was not high. Therefore, AGYW's reports of participation in the Programme are likely to be an underestimate.

Conclusion

 The HERStory 3 evaluation found that the My Journey Programme had a small NRCCT impact in reducing HIV prevalence. HIV prevalence was 9.5% in the intervention arm and 10.4% in the comparison arm with a risk difference of 0.9%, after adjusting for age, socio-economic status, education enrolment, sexual debut, and maternal orphanhood. The study was not powered for small effects as observed in the evaluation. The results of the per protocol analysis and pre- post-evaluation substudy are aligned with those of the NRCCT, showing a 1% difference in HIV prevalence in favour of AGYW exposed to the My Journey Programme and a decrease over time in HIV prevalence (absolute declines from between 1.0% to 5.2%) in five of the six intervention

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subdistricts, respectively. The sixth subdistrict was an outlier, showing a large increase in HIV prevalence from 16.6% in 2017/8 to 34.8% in 2024, which had a substantial effect on the overall measure of intervention impact.

The results of the evaluation show that the My Journey Programme had a statistically significant NRCCT impact on increasing knowledge of HIV status, with 84.7% of AGYW in the intervention arm and 80.5% in the comparison arm knowing their HIV status. Aligned with this, AGYW's reports of HIV testing ever, in the past year, in the past six months and HIV self-testing ever were higher in the intervention arm compared with the comparison arm. Furthermore, the results of the pre-post-intervention study also show that there was a statistically significant increase in HIV testing over time in six of the intervention subdistricts. Together, these findings provide reliable evidence of an intervention effect on the uptake of HIV testing and knowledge of HIV status. Thus, the My Journey Programme created the conditions for a greater number of AGYW with knowledge of their HIV status to be referred for HIV prevention or HIV treatment interventions as appropriate.

The HERStory 3 study produced strong evidence that the My Journey Programme substantially increased the coverage of PrEP among AGYW who were not living with HIV, doubling the uptake of PrEP compared with the comparison arm. The HIV prevention cascades for PrEP show substantial and statistically significant differences in favour of the intervention arm in knowing what PrEP is, ever having been offered PrEP, and ever having used PrEP. Furthermore, social norms supporting PrEP, receiving instruction or counselling about PrEP and confidence about using PrEP were significantly more prevalent in the intervention arm compared with the comparison arm. The results of the pre- post-intervention study also show that there was a statistically significant and substantial increase in reports of ever having used PrEP over time in six of the intervention subdistricts. To our knowledge, this is the first evaluation of a combination HIV prevention programme which demonstrates an impact on PrEP coverage at a community level. The HERStory 3 study has highlighted the importance of sustaining high levels of uptake through interventions to promote continuation of PrEP where appropriate in a context where discontinuation is common. Until long-acting injectable formulations of PrEP are available at affordable prices, these findings suggest that the My Journey Programme needs to explore more effective strategies to promote continuation on PrEP.

The literature shows that AGYW who attend school more often and/or have higher grade attainment are at a lower risk of incident HIV and have a lower risk of sexual behaviours linked to HIV transmission. The My Journey Programme had a small NRCCT impact on preventing school dropout among adolescents. In the intervention arm 10.7% of adolescent participants dropped out of school before they completed Grade 12 compared with 12.7% in the comparison arm. This difference was not statistically significant because the study was only powered to detect a much

larger absolute difference of 5%. The pre- post-intervention substudy compared completion of Grade 12 among participants aged 20-24 years and found no significant difference over time from 2017/8 to 2024. This could suggest that the My Journey Programme has only begun to reduce school dropout in the more recent years, only affecting the younger AGYW participants.

The HERStory 3 evaluation produced no evidence to suggest that the My Journey Programme impacted HIV care coverage. There are substantial gaps in the HIV care cascades in the first bar, knowledge of HIV status, and second bar, DBS- confirmed on ART. This possibly suggests that the My Journey Programme's HIV testing initiatives, despite reaching a large proportion of AGYW in the intervention communities, are not adequately reaching AGYW living with HIV. However, it is also possible that AGYW were reluctant to disclose in the survey that they were living with HIV, reflected in the finding that there were more participants who were DBS-confirmed on ART than had knowledge of their HIV positive status. It is of concern that under 75% of AGYW in both arms were virally suppressed. The results of the pre- post-intervention substudy showed that viral suppression decreased over time in three of the six intervention subdistricts. Maintaining an undetectable viral load is of great health benefit to AGYW living with HIV and is one of the most effective options for preventing onward HIV transmission and thus has potential to contribute to the My Journey Programme HIV treatment and prevention goals. These findings can inform My Journey Programme strategies to ensure better HIV care coverage among AGYW living with HIV.

The evaluation produced no evidence to show that the My Journey Programme impacted the coverage of condoms. The HIV prevention cascades for male condoms for AGYW who self-reported living with HIV and who self-reported not living with HIV show no intervention impact on motivation to use, access to, and effective use of male condoms. To the contrary, among participants aged 20-24 years, motivation to use condoms was lower among AGYW in the intervention arm, compared with the comparison arm. However, the My Journey Programme results suggest a positive intervention impact on some of the perceived access barriers to condoms and AGYW in the intervention arm were more likely to have accessed information and counselling about condoms. Promoting condom use in the context of increasing uptake of PrEP is important because PrEP does not prevent against the acquisition of STIs. Therefore, the My Journey Programme needs to strengthen strategies to increase condom coverage.

The HERStory 3 evaluation produced evidence to suggest that the My Journey Programme probably only had a small impact on the coverage of contraception. The pregnancy prevention cascades showed that there were no significant differences in motivation to use, access to, use, and effective use of pregnancy prevention interventions by study arm. Of all the variables in the NRCCT assessing use of modern contraceptives, there was only a favourable intervention effect on one: among participants in all age groups who had sex in the past six months, those in the

intervention arm were more likely to report having effectively used modern contraceptives compared with the comparison arm. There was evidence to suggest that the My Journey Programme had a positive impact by reducing some (but not all) of the perceived access barriers to contraception. The pre- post-intervention substudy suggests a substantial and statistically significant intervention impact over time on contraception use among AGYW aged 20-24 years, but no difference over time among adolescent AGYW. The NRCCT findings show that under a quarter of participants in both arms reported that at last sex they used both condoms and another contraceptive method, and under 15% of participants in both arms reported that they had used a contraceptive method 100% of the time. These findings show the importance of continuing to promote access to and effective use of contraceptives including dual protection among AGYW.

The HERStory 3 evaluation findings on HIV prevalence, knowledge of HIV status, coverage of PrEP interventions, and school dropout demonstrate that the My Journey Programme is partially successfully meeting key HIV prevention goals and making progress towards preventing HIV among AGYW in South Africa. The next My Journey Programme grant cycle needs to strengthen the efforts to focus on HIV care coverage among AGYW as this evaluation showed concerningly low impact on HIV treatment coverage. This study provides valuable evidence which can inform the My Journey Programme implementers' strategy, such as to tailor their interventions to accomplish all their HIV prevention and care and pregnancy prevention goals and to ensure higher levels of coverage among AGYW in South Africa.

Key Words

HIV prevalence, HIV prevention, pregnancy prevention, sexually transmitted infections, adolescent girls and young women, combination intervention

Introduction

Background

Globally, there were 1.3 million new infections worldwide in 2022 (UNAIDS, 2022). Adolescent girls and young women (AGYW) aged 15-24 years bear a disproportionate burden of HIV infection with 4000 new infections occurring among this population each week (UNAIDS, 2023). South Africa has the largest HIV epidemic in the world, with 7.6 million people living with HIV (Simbayi, 2023; UNAIDS, 2023). AGYW aged 15-24 years are three times more likely to become infected with HIV than their male counterparts (https://hsrc.ac.za/special-projects/sabssm-survey-series/sabssmvi-media-pack-november-2023/). Multiple factors intersect to increase AGYWs risk of HIV, these include, but are not limited to gender inequalities, age-disparate relationships, gender-based violence (GBV), low levels of education, inadequate access to sexual and reproductive health (SRH) services and stigma and discrimination (Andrews et al., 2020; Glynn et al., 2018; Thomson et al., 2018; UNAIDS, 2023). Despite condoms having the potential to protect from HIV infections, condom use among AGYW remains low (Jonas, 2021; Shamu et al., 2021). Social norms promoting gender inequality make it hard for AGYW to negotiate condom use (Shamu et al., 2021). Condomless sex not only exposes AGYW to higher risks of HIV but also to other STIs and unintended pregnancies, which in turn increases the risk of HIV for the AGYW and her child (Assefa & Gilks, 2020; Awopegba et al., 2020; Hoque et al., 2021; Woldesenbet et al., 2020; Woldesenbet et al., 2021).

The UNAIDS advocates for a combination prevention approach which includes behavioural, biomedical, and structural interventions in order to protect young women from HIV infection. Combination prevention is one of the approaches recommended to reach the 95-95-95 target (UNAIDS, 2020, 2023), which aims to reduce new HIV infections to 200,000 or fewer by 2030, by ensuring 95% of people living with HIV know their status, 95% of those diagnosed with HIV are on antiretroviral treatment and 95% of those receiving antiretroviral treatment are virally suppressed (UNAIDS, 2015, 2022, 2023).

South African AGYW combination HIV prevention intervention implemented in the Global Fund grant period 2016 to 2019 and 2019 to 2022

To alleviate the HIV burden among AGYW, the Global Fund to Fight AIDS, TB and Malaria has invested in a combination HIV prevention intervention for AGYW in South Africa, now called the My Journey Programme. It has been implemented from 2016 through to 2024 and will continue to be implemented after 2024. The aim of the combination intervention is to accelerate

prevention efforts to reduce new HIV, STIs and TB infections among AGYW with specific objectives to reduce HIV incidence, teenage pregnancy, and GBV, and to increase retention in school and access to economic opportunities. In addition to the support for combination HIV prevention from the UNAIDS, the My Journey combination HIV prevention intervention was aligned with the She Conquers Campaign (Mathews et al., 2020), and the South African National Strategic Plan for HIV, STI's and TB 2017-2022 and 2023-2028 recommending a "comprehensive package of high-impact, context-tailored and carefully targeted combination prevention interventions … in all subdistricts" for AGYW.

The My Journey Programme provided a comprehensive package of health, education, and support services to AGYW aged 10-24 in- and out-of-school. The Programme was initially (2016 to 2019) implemented in 10 South African subdistricts in which AGYW were at high risk of HIV incidence. It comprised multiple components, and included biomedical, socio-behavioural, and structural interventions, targeted at AGYW of different ages, and included interventions for boys aged 10-14 years (Figure 1). The intervention was implemented by various South African governmental and non-governmental organisations.

BIOMEDICAL	BEHAVIOURAL	STRUCTURAL
Intervention components with clinical and medical methods	Intervention components that promote healthy behaviours	Intervention components that create an enabling environment
+ HIV testing + TB, STI and GBV screening + Linkage and referral to health and other services	+ Build self-efficacy and resilience + Caregiving and peer support + Education and counselling + Home visits to encourage school attendance + Homework support + Parenting education + Sexual and reproductive health education	+ Birth registrations + Career guidance and opportunities + Community activism + Economic strengthening + Promote access to social grants + Promote an environment for ongoing learning + Promote a supportive social environment + Reduce gender-based violence + Social cohesion

Figure 1: Combination Intervention Approach of AGYW's Intervention during the Global Fund Grant Period 2016 to 2019

During the next two Global Fund Grant periods (2019 to 2022, and 2022 to 2025), the combination intervention was expanded and was implemented in 12 South African subdistricts in which AGYW were at high risk of HIV incidence. The 12 subdistricts, which included the 10 from the previous grant cycle were AbaQulusi and City of UMhlathuze (KwaZulu Natal), Mbombela and Govan Mbeki (Mpumalanga), Nelson Mandela Bay and Nyandeni (Eastern Cape), Dihlabeng and Setsoto (Free State), Fetakgomo Tubatse (Limpopo), Tshwane 1 (Gauteng), Rustenburg (North West), Klipfontein (Western Cape). Like the previous grant cycle, the AGYW programme in this grant cycle aimed to decrease HIV incidence, increase school retention, decrease teenage

pregnancy, decrease gender-based violence and increase economic opportunities. The Programme was implemented by three Principal Recipients (PRs): AIDS Foundation of South Africa (AFSA), Beyond Zero, and Networking HIV/AIDS Community of Southern Africa (NACOSA). The PRs contracted sub-recipients (SRs) to implement the intervention components.

AGYW were introduced to the Programme through several entry points and referred for services via two main components called the Core Service (which was usually but not always received first) and Layered Services (which were additional services that were provided based on the needs of the beneficiary and were received over time). Core services included enrolment and consent, HIV risk and vulnerability assessment; offer of HIV testing (if negative or unknown status); TB and STI screening; pregnancy screening (AGYW only); provision of condom education; offer of female/male condoms and lubricant; provision of HIV, TB, STI and gender-based violence (GBV) IEC materials; and a service plan. Core and layered 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, 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 core and layered services are described in Figure 2, and are further described in **Annexure I**.
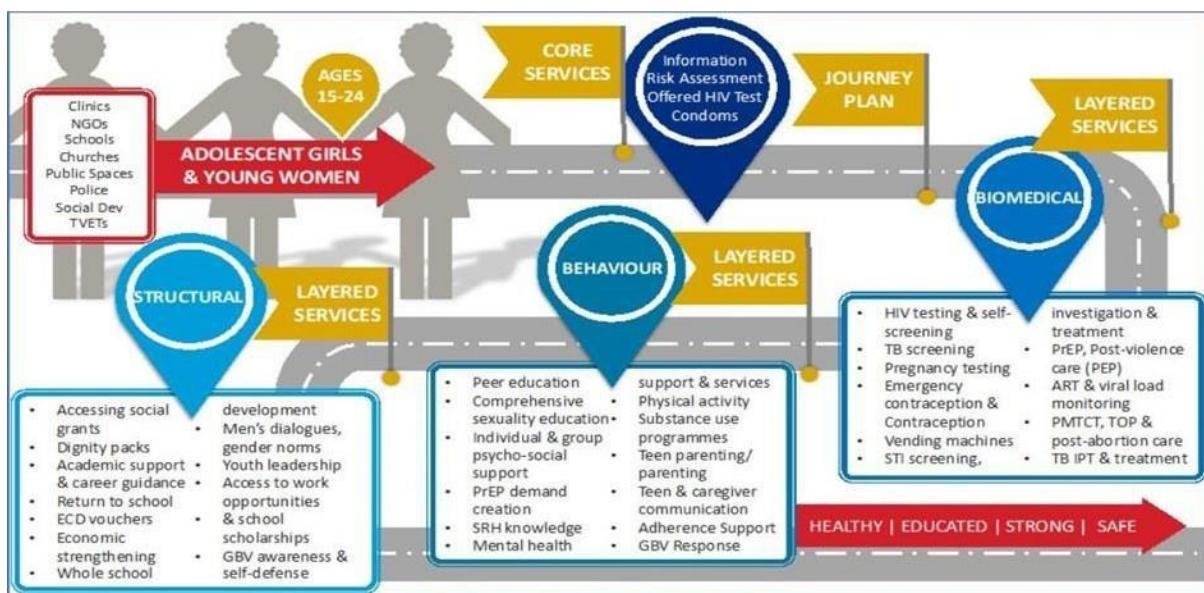
Figure 2: Core and layered services along the journey path of an AGYW beneficiary

The My Journey Programme intervention was designed and conceptualised according to a theory of change model. 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 heath and behavioural outcomes, that, in turn should lead to reductions in new HIV infections among this group, IF programmatic, financial and political assumptions hold true" (extract from AGYW Programme Description).

HERStory evaluations of the combination HIV prevention intervention implemented in the Global Fund grant period 2016 to 2019 and 2019 to 2022

Two evaluations of the My Journey Programme, coined the "HERStory Study evaluations", have been conducted between 2016-2019 and 2019-2022 over two cycles of the Global Fund grant by the South African Medical Research Council (SAMRC) and partners. The first HERStory study (HERStory 1 Study), conducted in 2017-18, comprised the first of two planned consecutive cross-sectional household surveys, as part of an evaluation designed to detect changes over time in HIV incidence (South African Medical Research Council, 2016). Building on HERStory 1, a mid-term, mixed methods process evaluation (HERStory 2 Study) was conducted between 2020 and 2021 during the second grant cycle (Jonas et al., 2021). The study reports are available on the project webpage: https://www.samrc.ac.za/intramural-research-units/HealthSystems-HERStory.

The HERStory 3 Study

In conceiving the present study, the concept of "effective coverage" was applied, which refers to the proportion of a population in need of a service that experience a positive health outcome from the service (Marsh et al., 2020; Tanahashi, 1978). To achieve effective coverage of the AGYW combination intervention, AGYW who need the relevant service or intervention component should obtain it in a timely manner and at a level of quality necessary to achieving the desired effect and potential health gains (Tanahashi, 1978). Effective coverage can be measured using health service coverage cascades applied to a clearly defined target population, for example AGYW with a specific health need, and include successive measures of contact with the health service/intervention, readiness of health service/intervention to deliver the service, receipt of appropriate and timely care, user-adherence, user-experience of care, disease control or prevention, wellbeing, health, and survival (Tanahashi, 1978). This impact evaluation has compared effective coverage of key HIV and pregnancy interventions across intervention and comparison areas, to assess whether AGYW in the intervention areas exhibit higher levels of coverage than AGYW in comparison areas.

The health service coverage cascades used in this study include HIV prevention and treatment cascades and pregnancy prevention cascades (Schaefer et al., 2019). These cascades have been

used to measure whether "appropriate programmes are being delivered with high quality and sufficient intensity and scale and are then taken up by the people who most need and want them in order to have both individual and public health impact" (Auerbach et al., 2020). The evaluation assesses whether AGYW living in areas in which the My Journey Programme was implemented exhibited higher levels of coverage compared with AGYW living in similar comparison areas without the intervention or other similar interventions. For several reasons, HIV prevention cascades are more complex than HIV treatment cascades, however there is an emerging consensus on the key constructs in such cascades which has guided the cascades in this report (Schaefer et al., 2019).

The acceptability of an HIV prevention intervention or other health 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 any health service coverage cascade. Hand in hand with acceptability is the notion of "appropriateness", which refers to "the perceived fit, relevance, or compatibility of the innovation or evidence-based practice for a given practice setting, provider, or consumer; and/or perceived fit of the innovation to address a particular issue or problem" (Sekhon et al., 2017). This study included both quantitative and qualitative measures of the acceptability and appropriateness of the My Journey Programme to beneficiaries/recipients to help inform the interpretation of the gaps in the intervention coverage cascades and intervention outcomes (Clark et al., 2020).

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 wellbeing. The My Journey Programme provides a combination of interventions to address a range of challenges that AGYW face beyond health-related challenges including the need for schooling, labour force participation, and social protection. This approach is aligned with the WHO's Council on the Economics of Health for All which promotes "a vision that every person can flourish physically, mentally and emotionally, and that all people are endowed with the capabilities to lead a life of dignity, opportunity and community, as part of a healthy living planet" (Grønlie & Dageid, 2017; WHO, 2023). In the HIV policy evaluation field, there is now increased recognition of the importance of going beyond narrow disease measures and health care and disease prevention coverage cascades, and to examine the impact of multi-sectoral programmes on people's quality of life using proxy measures such as wellbeing (Greeff et al., 2010; Lazarus et al., 2016; Reis et al., 2013). Therefore, in this study we evaluated the Programme's impact on AGYW's wellbeing, employing quantitative and qualitative methods.

Aims and Objectives

Evaluation Aim

The aim of HERStory 3 Study was to evaluate the impact of The My Journey Programme on AGYW during the whole grant cycle from 2016 to 2022.

Evaluation Objectives

The primary objective of the HERStory 3 Study was to determine the intervention impact on HIV prevalence by age among AGYW aged 15-24 years. HIV incidence was not considered a logistically feasible primary outcome since having adequate statistical power to show a difference in incidence between intervention and comparison arms (i.e., a 33% reduction in incidence in intervention arm), required a sample of approximately 48,000 AGYW. Therefore, the comparison of HIV prevalence in AGYW from 15-24 years was selected as the primary objective and served as crude proxy of HIV incidence which is also an objective biological measure.

The other objectives included assessing the intervention impact on:

- HIV incidence
- Knowledge of HIV status
- HIV prevention and care coverage
- Behaviours that increase or decrease the risk of HIV and unplanned pregnancy including abstinence and the effective use of condoms and PrEP
- Pregnancy prevention (contraception other than condoms) coverage at last sex among AGYW who had ever had sex
- Teenage pregnancy
- School drop-out among AGYW aged 15-19 years
- GBV
- Cognitions and social environments of AGYW
- Wellbeing and health-related quality of life
- Access to economic opportunities

The evaluation also sought to describe the acceptability of the intervention and the self-reported impact of the intervention on health and wellbeing and access to economic opportunities among AGYW who participated in it.

Methods

Evaluation Design

The main evaluation design comprised quantitative methods, however a nested qualitative component was also conducted.

As the HERStory 3 impact evaluation was designed and conducted after the implementation of the My Journey Programme, the intervention subdistricts were already selected. This meant that the intervention and comparison conditions could not be randomly allocated, and thus a randomised controlled trial was not possible. Hence, the quantitative component of the evaluation was a non-randomised controlled cluster trial (NRCCT) and consisted of a cross-sectional "post-intervention" survey in 48 sites (clusters) in the intervention and equivalent comparison areas (Health & Excellence, 2022; Sarri et al., 2022).

Intervention areas were defined as designated areas/communities in which the My Journey Programme was implemented. The comparison areas were defined as designated areas/communities where the intervention or similar programmes were not being implemented at the time of the My Journey Programme. The comparison areas were approximately matched to the intervention areas, in that they were selected to be comparable in terms of demographic characteristics and HIV prevalence in 2015/16, before the intervention was implemented. There were two sites in the intervention arm purposefully selected within each of the 12 subdistricts in which the intervention was implemented, generating a total of 24 sites in the intervention arm. Each geographical site comprised a cluster of small area layers (SALs): a geographical unit made up of one or more enumeration areas with a population of less than 500. The same procedure was used in the comparison areas. This allowed for a non-randomised comparison between 24 sites in the intervention arm and 24 sites in the comparison arm for the selected outcomes. In each of the 48 sites, we conducted a targeted representative household survey of 100 AGYW, which aimed to generate a total sample of 4,800 AGYW.

The study design incorporated biological sample collection to measure the primary outcome, HIV prevalence, as well as other biological outcomes, as listed below. Dried blood spot (DBS) specimens were collected from each participant to enable laboratory tests to determine:

1. HIV prevalence
2. Viral load measurement among those who tested HIV positive
3. Estimate of HIV incidence using a Limiting Antigen Avidity Immunoassay (LAg) to distinguish recent infection
4. ART exposure among those who tested HIV positive

5. PrEP drug exposure among a proportion of those who tested HIV negative

In addition to the quantitative research, we conducted qualitative research focusing on selected questions and topic areas of key interest. We aimed to examine key questions which we had not previously explored in the previous HERStory studies, or those that were highlighted as warranting deeper investigation. These questions included AGYW's motivation for, access to and effective use of PrEP and other questions which were determined by the study team in conjunction with the steering committee and partners and which are described in a separate report for the qualitative component.

Study setting

The setting of the My Journey Programme impact evaluation was the intervention subdistricts, and comparable subdistricts with standard of care as provided by programmes from the Departments of Education, Social Development and Health.

The 2015 antenatal survey was used for the HIV prevalence rates and the 2016 census data for the demographic characteristics to select the comparison arm approximately matching the intervention arm (Woldesenbet et al., 2020; Woldesenbet et al., 2021). The demographic characteristics used to select comparison areas included HIV prevalence, age, population group, and socio-economic status of the areas as they relate to the intervention areas. The intervention arm and comparison arm sites, with HIV prevalence (as it is the main outcome of this study) are described in Table 1.

Table 1: Provinces, subdistricts for My Journey Programme intervention and comparison sites

Province	District	Subdistricts, wards or areas for intervention (Intervention sites)	HIV prevalence	Principal Recipient of Global Funding	Sub-Recipient/s		Comparison sites	HIV prevalence in the Comparison sites
KwaZulu-Natal	Zululand	Abaqulusi	37.4%	AFSA	MIET Africa Higher Health (TVETs)		Hlabisa LM	41.4%
	King Cetshwayo	City of UMhlathuze	37.1%	AFSA	Consortium for Strategic Analytics (Strategic Analytics & Management) Higher Health (TVETs)		UMhlabuyalingana	34.4%
Mpumalanga	Ehlanzeni	Mbombela	27.9%	AFSA	Institute of Health Programmes and Systems (IHPS) Higher Health (TVETs)		Metsimaholo	28.8%

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	Gert Sibande	Govan Mbeki	30.9%	AFSA	Institute of Health Programmes and Systems (IHPS) Higher Health (TVETs)	uMzimkhulu	27.5%
Eastern Cape	Nelson Mandela Bay Metro	Nelson Mandela C	9.8%	Beyond Zero	MIET Africa Higher Health (TVETs)	Nelson Mandela B	15.1%
	Oliver Tambo	Nyandeni	19.8%	Beyond Zero	Social Change Higher Health (TVETs)	Ubuhlebezwe	20.5%
Free State	Thabo Mofutsanyana	Dihlabeng	25.8%	Beyond Zero	Institute of Health Programmes and Systems (IHPS) Higher Health (TVETs)	Kopanong	32.0%
		Setsoto	12.5%	Beyond Zero	Institute of Health Programmes and Systems (IHPS) Higher Health	Letsemeng	11.5%

					(TVETs)			
Limpopo	Greater Sekhukhune	Fetakgomo Tubatse	7.8%	Beyond Zero	Institute of Health Programmes and Systems (IHPS) Higher Health (TVETs)		Ephraim Mogale	12.5%
Gauteng	Tshwane	Tshwane 1	13.3%	NACOSA	Zakheni Training & Development Centre (Biomedical + Schools) - MIET Africa (Biomedical) - Childline Gauteng (Community) Higher Health (TVETs)		Mogale City	15.7%
North West	Bojanala	Rustenburg	19.1%	NACOSA	Lifeline Rustenburg (Biomedical) - Show me your		Bloemfontein SD	21.0%

					Number (Schools) - Childline SA for Childline North West (Community) Higher Health (TVETs)		
Western Cape	City of Cape Town	Klipfontein	15.5%	NACOSA	TBHIV Care (Biomedical) - Partners in Sexual Health (Schools) - Amandla Community Education Development (Community) - HOPE Africa (Community) Higher Health (TVETs)	Bitou LM	19.0%

Study population

The study population comprised AGYW aged 15-24 years, living in the 12 intervention and 12 comparison subdistricts.

Sample Size Calculations and Sampling

The study design included 48 geographical sites (24 intervention and 24 comparison sites) as described above. Since the number of sites was fixed, we calculated the statistical power of the comparison for a realistic and feasible number of participants in each site. The following indicators were used:

1. HIV incidence among AGYW aged 15-24 years
2. HIV prevalence by age
2. Knowledge of HIV status among AGYW aged 15-24 years who had ever had sex (defined as having had an HIV test in the past year and having received the test results)
3. AGYW's use of modern contraception (other than condoms) at last sex among AGYW aged 15-24 years who had ever had sex
4. Dropout of high school before completing Grade 12 among AGYW aged 15-19 years

With a sample of 4,800 AGYW in 48 geographical sites, the study had the power to detect a difference in the mean HIV prevalence assuming a prevalence of 5% or 6% in the intervention arm and 12% in the comparison arm. The study also had the power to detect a 10% absolute difference in knowledge of HIV status among AGYW who had ever had sex. The study had the power to detect a 15% absolute difference in AGYW's use of contraceptives at last sex (among the subset who had ever had sex). Likewise, the study had the power to detect a similar difference in condom use at last sex (estimates not shown); and the power to detect a similar difference in experience of any form of IPV in the past year (estimates not shown). Further, the study had the power to detect a large absolute difference (5%) in school dropout among AGYW aged 15-19 years (from 8% down to 3%) but it did not have the power to detect a smaller and more realistic difference. The prevalences in the intervention arm were based on the HERStory 1 baseline data (2018/19). Further details of the sample size calculations can be found in the study protocol in the supplementary material.

Sampling

For sampling of the 100 AGYW within the selected geographical sites, the 2016 census information of the SALs within the site was used to select the sampling fraction of dwellings and the number of SALs to be sampled.

The SAL sampling frames were cross-checked with other sources and mapped with aerial photography to make sure that they were accurate and up to date. The sampling frame was

further adjusted to the latest Geo Terra Image (GTI) counts, other subdistrict council estimates, and Stats-SA's most current midyear estimates of population numbers per province, according to the province boundaries, population group, five-year age groups and gender. (The SALs had information about the number of households, and number of individuals by gender, population group and age.)

Once the intervention and comparison arms had been identified, we estimated the total number of SALs in each using available census data, and the total number of households and individuals living in each study area. According to Stats SA Census data it was assumed there were AGYW in 50% of the households. Therefore, we estimated that to sample 4,800 AGYW, approximately 11,520 households split 50/50 between intervention and comparison sites would need to be visited, taking into account eligibility criteria and an expected 20% non-response rate.

GeoSpace, the service provider contracted to collect data, was provided with the intervention and comparison arms that had been sampled. Under the supervision of two SAMRC investigators (Prof Carl Lombard, a senior epidemiologist and biostatistician, and Dr Natashia Morris, a Spatial epidemiologist and GIS expert) the GeoSpace team assessed all SALs within each site for suitability of sampling using the updated Stats-SA GIF, up-to-date digital aerial photography, and available spatial data. All SALs were geospatially assessed to remove all non-residential (industrial, recreational, commercial etc.) areas from the sample. The resultant SALs were assessed using the latest Stats-SA population figures (specifically population group, age, gender, employment) to determine potential SAL cluster sizes.

Geospace customised the existing MappEnterprise data collection case management system to implement the field methodology and survey activities. The base data used for field data collection was the StatsSA Geographic Information Frame. Further details of the sampling methods applied can be found in **Appendix B.** The "geofence" quality assurance tool is described in **Appendix C.**

Participant eligibility

Residents of the identified study areas were eligible for inclusion in this study if they met all the criteria described below.

Inclusion criteria survey:

- Female household resident aged 15-24 years
- Female household resident <18 years of age who had consented and whose parent, guardian, caregiver, or household representative had consented
- Residing in the selected household
- Willing to provide written informed consent

- Willing to participate in the study

- Willing to undergo study procedures

- Willing to provide biological sample

Exclusion Criteria for survey:

- Cognitive or mental challenges (based on the assessment of the participant's ability to comprehend the study information provided)

- Deaf or mute

- Unable to speak English, IsiZulu, isiXhosa, Sesotho, Setswana, Xitsonga, siSwati, Sepedi, Afrikaans, isiNdebele

- Not available for participation between 8 a.m. and 9 p.m.

Data Collection Methods

Quantitative and qualitative methods were used to collect data for this evaluation. A schematic diagram of data collection flow is provided in the Study Operating Procedures in **Appendix D**.

Questionnaire

Participants were invited to complete a respondent-administered, audio-assisted electronic questionnaire (**Annexure II**) using a tablet and headphones. The questionnaire was programmed to skip or reveal questions as appropriate, depending on respondent's prior answers. The questionnaire, adapted from previous HERStory questionnaires, comprised demographic, psychosocial and behavioural questions, and participants were asked about their participation in educational, behavioural and/or biomedical prevention, treatment, and psychosocial support programmes for HIV, SRH and mental health including those provided by the My Journey Programme. The protocol (**Annexure I**) describes the key measures included in the questionnaire, their source, and sample items. Programming of the questionnaire software ensured that the questions about the My Journey Programme were only asked of participants in the intervention arm. The questionnaire was translated from English into nine of South Africa's 11 official languages spoken in the study areas. Participants had the option to read and/or listen to each question in a language of their choice while they self-completed the questionnaire. The questionnaire was completed in a space in which the participant had privacy, to prevent interruptions from others in her environment, and to ensure she could hear the audio-recordings well. The electronic questionnaire could be completed with no internet connection and uploaded at a time when the data collectors had network connection.

Blood sample collection and biomarkers

Trained fieldworkers collected dry blood spot (DBS) specimens spotted on two cards (five spots (70 ul) per card) via finger prick method from consenting AGYW. Approximately 750µl – 800µl of blood was collected into an EDTA microtainer. The blood sample was spotted onto Whatman Grade 903 cards using a graded Pasteur pipette. Ten circles (2 cards with approximately 70µL of blood per circle) were filled per participant. DBS was the chosen method because it is ideal for the conditions in household surveys where immediate sample transportation to the laboratory is not feasible. The DBS cards were placed on drying racks and stored in a plastic container. These cards were left to dry overnight (otherwise a minimum period of 4 hours was allowed for drying), before packaging for courier to the laboratory. The DBS cards were individually packaged in gas impermeable bags with desiccant packs and humidity indicator cards.

All samples were tested with two 4th generation HIV tests (2 enzyme immunoassays (EIAs) (A1 and A2). The first EIA (A1), the Biorad Genscreen Ultra HIV-Ag-Ab, was a screening test and the second EIA (A2), Diasorin Murex HIV Ag/Ab Combination, was a confirmatory test among those who tested positive on A1. Specimens that had discrepant HIV results were retested as above and if they remained discrepant, they were tested by HIV-1 Western blot. HIV viral load testing was carried out on all confirmed HIV positive specimens using the Abbott m2000RT VL testing platform that has been validated and is being routinely used by the laboratory for viral load testing.

HIV incidence was measured using a Recent Infection Testing Algorithm version 1 (RITA1 algorithm) for HIV based on a LAg assy in combination with additional information on ART exposure and HIV viral load in HIV positive samples. The LAg assay measures the strength of the bond between HIV antibodies and antigens to identify recent infections, as this bond is weaker during early (recent) infection. In the incidence testing algorithm for specimens with an ODn <0.4 on the LAg assay, the HIV status was re-confirmed by HIV Serology.

ARV testing on HIV positive specimens was performed by means of High-Performance Liquid Chromatography (HPLC) coupled to Tandem Mass Spectrometry. ART exposure testing included Tenofovir, Efavirenz, Dolutegravir, Lopinavir, Atazanavir and Darunavir. This made up a six-analyte panel screen for first- and second-line ART.

Among participants who were DBS-confirmed HIV negative and: 1) all participants who self-reported being on PrEP and 2) a random sample of 78 participants in the intervention arm, and 77 participants in the comparison arm who self-reported that they were not on PrEP at the time of the survey were selected and tested for PrEP exposure. (Not all DBS-confirmed HIV negative participants could be tested for PrEP exposure due to budget constraints.) PrEP exposure testing

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included Tenofovir-Diphosphate (TFV-DP) only, using the DBS spots remaining after HIV testing. For the TFV-DP (PrEP drug) testing, the DBS samples with insufficient/small spots were not included in the analysis (n=7).

Study Procedures

Recruitment

Prior to going to the community, political and traditional leadership buy-in was obtained, to ensure that entrance to the study communities had been negotiated. Details of community, political and other traditional leaders' buy-in are documented in **Appendix E**. Study staff approached households included in the sample and made appropriate introductions, explained the objectives of the study and the confidentiality of the household and individual information, and identified the head of household or designee. All individuals in the household who meet the eligibility criteria and were available were invited to participate in the study. Those who declined were thanked for their time and if they volunteered information about their reason for declining, this was recorded. Those who agreed to participate were asked to identify a relatively private location either inside or outside their home where the remainder of activities could be conducted with as much privacy as possible.

Detailed study procedures are documented in the Study Operating Procedure (**Appendix D**).

Each participant was assigned a unique study number (based on the geolocation household number and the laboratory package barcode) that was linked to the structured questionnaire and their blood sample. No personal identifiers were documented on any study related data collection instruments. Trained field staff collected the required two microtainers of whole blood for DBS specimens using finger pricks. Trained staff then showed the participant how to self-administer the audio-assisted electronic questionnaire using a handheld tablet. Apart from the first questionnaire items capturing geographical information and the unique barcode, the participant self-completed all questions with the option of listening to each question in English or their home language.

A flow diagram of the recruitment, consent, sample collection, questionnaire administration processes can be found in the Study Operating Procedure in **Appendix D.**

After specimens had been collected for testing at the laboratory and the questionnaire had been completed, participants were offered rapid HIV testing (**Appendix F**). If they accepted, they were given their rapid HIV test results immediately and privately and if they tested positive, they were referred to their nearest clinic or, in intervention areas, to the relevant SR for onward treatment and care. Field staff had been trained to conduct HIV testing according to the National Department of Health guidelines, including providing lay counselling services. This included

managing distress and minor psychosocial issues. They were equipped with information for further referrals, including for psychosocial issues.

For each referral, we actively followed up with the participant and the service provider to ensure that the participant received the support she needed. We kept records of individuals who were referred. Linkage of participants to support services was done in collaboration with the participant and in a manner that was in her best interest.

All participants were given a "HERStory Contact Card" (**Appendix G**), which listed the cell numbers of the principal investigator, the project manager, and study coordinators and the languages they spoke. This card encouraged participants to ask for help and provided participants with the means to ask for help, to find out any information they needed about how to redeem their reimbursement vouchers or where to find health care and/or social support services. It also enabled them to raise concerns or lay complaints related to the study. The people who were listed on the contact card responded to all messages, calls, and missed calls within 24 hours, and logged all calls received using a log template (**Appendix H**). The completed log forms were submitted to the principal investigator on a weekly basis, and she reviewed these to determine whether further action was required.

Enrolment of the study population

The number of sites and AGYW at each stage of the survey was summarised using a CONSORT diagram relevant to a cluster design. This included, in each arm, the number of eligible households found, the number with eligible AGYW, the number of AGYW who gave consent, and the number of AGYW who completed the survey and biological sampling.

Monitoring and evaluation of study performance

The team of investigators and collaborators consisting of the principal investigators, co-investigators, NACOSA, SANAC TSU, AFSA, Beyond Zero and the LFA formed an Evaluation Steering Committee to monitor and ensure that the study implementation was scientifically sound, ethical, and of high quality. The members of the Steering Committee made recommendations on the study procedures and the questionnaire design and administration. They reviewed study progress and documents. They assisted to resolve problems that were experienced during data collection. The committee met bi-weekly or as needed either in face-to-face or virtual meetings.

Investigator team meetings were held weekly with GeoSpace and NICD to monitor progress and to resolve any operational challenges.

The study was monitored by a Study Quality Assurance Team consisting of between 16 and 18

monitors. The monitoring was undertaken according to the Study Quality Assurance Plan and consisted of on-going monitoring of study progress and safety of study participants in accordance with Protecting Human Subject Research Participants (PHRP) and Good Clinical Practice (GCP) guidelines. Eighteen study monitors were trained for this role, and they also attended the training of the data collectors. Monitoring commenced during the pilot study and continued until study completion. During data collection, two monitors resigned, leaving 16 monitors. Any issues or findings related to participants' safety or non-adherence to the protocol by data collectors were reported immediately to the PI and taken up and resolved with the data collection service provider, GeoSpace.

Data Management

The use of Tablets allowed for data collection and real time data entry in the field, as well as real time data monitoring and quality control. The collected data was saved on the system's server and password-protected by a secret PIN. Each sampled household within the cluster was assigned a code defined by the Stats-SA enumeration area, and another unique code assigned by the research team for the study. The Stats-SA code and unique number were the household identifiers. Once in the household, each time a participant was enrolled, a unique barcode was assigned to that participant by the research team, using pre-prepared barcode packs. This barcode was the unique participant identifier, which linked the participant's questionnaire to the DBS samples. Each questionnaire had the unique household identifier and the unique participant barcode identifier which were used as the main identifiers in the dataset. In addition, each survey submission was allocated a system generated submission ID for each household and enumerated participant.

Quality assessment of household identification and recruitment, enrolment, informed consent, data collection, data handling, forms processing, data management and other study operations was on- going and conducted by Geospace. The study team reviewed the key indicators for each of the procedures on a weekly basis. Following this, any areas of concern were defined, assessed and the improvements put into place.

Data Storage and disposition

All data was transferred from the Tablet and web back-end of the software used for data collection. It was encrypted using appropriate encryption via cellular data networks or Wi-Fi. All data was password protected with access permissions. At the database level, row-level security was enforced restricting row-level access based on user's identity, role, and context. Participant data on devices could also be remote wiped in the case of hardware being lost or stolen.

Tablets were password protected, and Norton's security application was used to password secure all files and folders where data was stored on the tablet. The Kobocollect app itself is configured

in such a way that the files that are successfully uploaded are automatically deleted from the tablet. Therefore, only current data was ever on the tablet. Locational and field case management data was uploaded to the MappEnterprise server. The MappEnterprise server was located at Geospace.

Data was downloaded onto the service provider's servers daily. Identifying information such as name, GPS location was stored separately from the questionnaire data and was password protected thereby protecting the participant's privacy. This information was stored on a separate database linked with a barcode on the same cloud. Thereafter, data was transferred to the SAMRC server via the secure encryption process described above.

All biological laboratory data was captured into the NHLS/NICD TrakCare Laboratory Information Management System (LIMS). TrakCare is password protected and only accessible to authorised personnel. The data was extracted from TrakCare LIMS and exported into a dedicated excel spreadsheet designed to reduce the manual entry of data. The data in Excel was stored on the NICD server and was backed-up daily. All laboratory results were merged in the main questionnaire database using the participant unique identifying number. The data downloads were stored on a secure server in a data management centre at the service provider location and shared securely with the SAMRC. The data centre provided excellent security and reliability including physical access control and online protection through a firewall to protect against hacking and viruses. The data was backed up every four to five hours.

The data is co-owned by SAMRC and NACOSA, AFSA, Beyond Zero, and the SANAC TSU. The name of the participant and the responses to the questionnaire were linked by a barcode and stored in separate database to protect participant's privacy. Backup of the datasets excluding the identifying information was archived and the identifying information deleted from the server of the service provider. Electronic documentation will be retained for 10 years by SAMRC on Amazon Cloud.

With respect to making data available, SAMRC will adhere to the SAMRC's and NACOSA, AFSA, Beyond Zero, and the SANAC TSU policies for making data available to the public. This includes making papers accessible at time of publication of the paper and having the final version of the anonymised data set made accessible within 30 months after the end of data collection.

Data analysis

Analysis of data from this evaluation will follow an integrated mixed methods approach, guided by triangulation protocol (Jong et al., 2018). Data from the quantitative and qualitative components were analysed and reported separately. However, the findings of these components will be integrated in an appropriate manner as determined by the SAMRC together with the

Evaluation Steering Committee.

For this report, all survey questions were used, and a complete case analysis was performed for the primary and secondary outcomes and the study cascades.

For coverage variables, such as HIV services and commodities (e.g. ART, condoms, PrEP), as well as contraceptives, treatment and prevention, cascades were produced. For HIV prevention cascades, we aligned our analyses to the consensus around the steps in the cascades described by Moorhouse and colleagues, as was done in HERStory 2 (Jonas, 2021; Moorhouse et al., 2019). For other services such as contraceptives, we adopted a similar approach to the HIV prevention cascades, starting with the population at risk and in need of the service.

Laboratory analyses of the DBS cards were conducted as follows: one card was used for HIV serology screening and confirmation EIA and HIV-1 Limiting Antigen (LAg) assays, and the second card was used for HIV-1 viral load testing and ARV qualitative screening. Where DBS material was limited, the following key assays were performed in order of priority: HIV serology screen and then confirmatory, HIV viral load, HIV LAg and ARV exposure.

Comparative analyses

AGYW were analysed in the arms in which they were sampled regardless of intervention received. The comparison arm was used as the reference group in all analyses. For all outcomes of the post-intervention survey, the primary analysis was based on all available outcome data (i.e., a complete-case-analysis), with no imputation.

The impact analysis of the My Journey Programme followed that of a cluster randomised trial (Wilson et al., 2016). Since the study was a non-randomised design, the two groups (intervention and comparison) were compared for similarity with respect to demographic features to ensure that there were no inherent biases.

Primary analyses

For binary outcomes, the number and percentage with the outcome were presented by intervention versus comparison group, and the odds ratio (plus 95% confidence interval) was estimated using a logistic mixed effect model, adjusting for age in years, sexual debut, maternal orphanhood, whether the household had a tap in the home, whether the household owned a car (as an indicator of socioeconomic status), and whether the participant was enrolled in an educational institution. The analysis followed the principle of intent-to-treat and all sites and participants were included in the analysis producing non-randomised controlled effect estimates. For the outcomes listed in the statistical analysis plan, the marginal predicted prevalence as balanced on the covariates was estimated for each arm. The unit of sampling was a geospatial cluster; however, outcomes were collected at the individual level and therefore the unit of

analysis was the individual participant. There was also an additional level of clustering at the household level. To account for the correlation of outcomes within geospatial and household clusters, geospatial cluster household identifiers were fitted as random effects with random intercepts only. The intra-class correlation coefficients for geospatial cluster and household were estimated from the final model for the primary outcomes.

Since this was a non-randomised study, confounding had to be considered if the characteristics of the two arms differed. For the primary outcome HIV status, the primary analysis was adjusted for age, sexual debut, currently enrolled in school, college or university full-time, maternal orphan, and socio-economic status indicated by drinking water from a tap in the home or yard or whether the household owned a car or not.

Outcomes that were collected as part of the post-intervention survey but not specified as the main primary and secondary outcomes for the evaluation were analysed following the principles outlined for the primary outcomes.

Stata18 and R were used for the analyses of the data.

Pre-specified subgroup analysis

The consistency of the intervention effect on the primary outcome was assessed across specific subgroups using the statistical test of interaction. Effect estimates and 95% confidence intervals were presented for each subgroup, plus the interaction p-value. The subgroups included age groups 15-19 years and 20-24 years.

Prevalence of PrEP exposure based on the presence of Tenofovir-Diphosphate (TFV-DP) was estimated among the self- reported PrEP users and non-users by arm and age group and reported with 95%CI.

Per protocol analysis

The aim of the sensitivity analysis was to do a per protocol analysis. Participants exposed to the My Journey Programme as defined in the protocol were compared with equivalent participants from the comparison arm. This constituted the per protocol analysis sample.

Selection of participants exposed to the My Journey Programme

For participants in the intervention arm to be considered as "exposed" to the My Journey Programme, they had to have reported that they had been enrolled into the My Journey Programme (i.e., someone from the list of named SRs working in their community had asked them to participate in a programme for young women and girls, they had agreed, and they might have been asked for their fingerprints), or that they had spent time at a Safe Space in their

community in the past year (a place where young people can go to get services, interact with other young people and participate in activities). There were 1,605 participants exposed to the My Journey Programme in the intervention arm based on these two indicators.

Selection of participants with potential exposure to the My Journey Programme

It would be biased to compare the subgroup with the My Journey Programme exposure with the full comparison arm. Thus, to select an equivalent subgroup from the comparison arm, the following steps were followed:

Firstly, a prediction model for participation in the My Journey Progamme was established using only the intervention arm. Prediction variables used were age, tap in the house, maternal orphan status, ever had sex, have a car in the household, have a smartphone, flush toilet in the house, never hunger in the past month, like hip-hop/rap music, not studying further. The prediction of My Journey Programme exposure status using these variables was modest and had 61% sensitivity and specificity.

The second step in the selection process used the prediction variables for imputation of participants with a missing My Journey Programme exposure status in the comparison arm. The full dataset was used for the imputation and 60 multiple imputations were performed using a logistic regression model. The My Journey Programme subgroup in the intervention arm is thus fixed but the My Journey Programme subgroup in the comparison arm is variable based on the imputation model. The size of the subgroup selected in the comparison arm was proportionally similar to the subgroup distribution in the intervention arm.

Comparison of the My Journey Programme subgroups between intervention and comparison arms

The full imputed datasets were used for the imputation-based analysis and the estimates were stratified by the My Journey Programme and intervention-comparison status for obtaining the means and percentages and for estimating the intervention effect. Further stratification by age group was performed for some of the study outcomes. This imputation-based analysis accounts for the uncertainty of selecting the potential exposure of participants in the control arm using the demographic predictors from the questionnaire.

Pre-Post Comparison of the My Journey Programme

Pre-intervention data

General household survey in a subdistrict. The response rate was 60%.

Post-intervention data

Program targeted sampling of households with a 97% response rate.

Statistical Analysis

The information available from the two cross-sectional surveys was compared as is. The pre-intervention survey was a general household survey in each subdistrict compared to targeted household sampling in the post-intervention survey. The pre-intervention survey can therefore be considered as a generalised population against which the Programme populations is compared in six of the 12 subdistricts. Since the six subdistricts only represent 50% of the study population the results should be interpreted for the subdistricts included in the pre-post analysis only and not as results for the Programme in general.

The data of each subdistrict at each time point was summarised at a district level and a paired analysis was performed. The risk ratio and 95% confidence intervals were estimated when appropriate. For the PrEP comparison, risk differences were estimated with 95% confidence intervals since the change in prevalence was extensive and from a very low baseline.

Ethical Considerations

Research ethical approval to conduct this evaluation was gained from the SAMRC Research Ethics Committee (EC027-8/2023). Permission to conduct the study was also obtained from the Provincial Departments of Health in the relevant provinces, and followed by District approvals where relevant (see **Appendix E**). All amendments to study procedures and instruments were conducted in full compliance with the SAMRC Research Ethics Committee prior to implementation.

Each potentially eligible study participant was informed about the study and completed the English or local language consent form prior to enrolment. If the adolescent was younger than 18 years of age, consent from the parent/guardian/foster parent/caregiver was first obtained. If the minor was the caregiver in a child-headed household with no supervisory adult, a trusted adult nominated by the minor, including but not limited to the social worker, community worker or teacher, provided consent. The consent forms are included in **Appendix I**. The participant was reimbursed for study participation in the form of a voucher to a grocery store such as Shoprite, or electricity, or cell phone data (depending on the choice of the participant) to the value of R200, and reimbursement to the value of R50 was given to the parent/guardian/caregiver with the same choice of format.

Results of the HERStory 3 Impact Evaluation

Sampling flow and response rate

The HERStory 3 study consisted of four hierarchical levels of design and sampling. At the first level, 24 subdistricts (12 intervention and 12 comparison subdistricts) were assigned and selected, followed by the second level of targeted sites consisting of small area layers (SAL) with two sites selected per subdistrict. At the third level, dwellings/households were sequentially selected from the randomised list of dwellings in a SAL to determine if any AGYW lived there. At the final and fourth level, eligible participants were consented and interviewed across the targeted SALs of a site, with a sample size target of 100 participants generating a planned total sample of 4,800. The sample flow is described in Figure 1.

A total of 37,714 dwellings were visited across all study sites (20,614 in the intervention arm and 17,100 in the comparison arm). Overall, 22,263 households were screened (11,628 in the intervention arm and 10,635 in the comparison arm), meaning that the dwelling was an eligible household with residents present and data collectors were able to enquire about eligible residents in the household. There was a total of 5,154 AGYW aged 15-24 years living across the households screened (2,710 in the intervention arm and 2,444 in the comparison arm). Of these AGYW, four were excluded from the study because they had reduced physical or mental capacity (two in each study arm).

Therefore, a total of 5,150 participants were invited to participate in the study (2,708 in the intervention arm and 2,442 in the comparison arm). A further 125 participants refused to participate in the study (70 in the intervention arm and 55 in the comparison arm) because a family member other than their parent or caregiver would not let them participate, they had a fear of needles, they were sick or unwell, they were busy, or the reason was not specified.

A total of 5,025 participants completed the study questionnaire (2,638 in the intervention arm and 2,387 in the comparison arm) and the self-reported section of this report contains the results.

Among participants who completed the questionnaire, 93 did not have any DBS results (34 in the intervention sites and 59 in the comparison sites). The missing DBS results were due to incidents in the comparison sites in the Free State and Limpopo where community members insisted that the blood samples be destroyed, more than one blood spot present in the circle on the DBS card rendering the sample unusable (double spotting), insufficient sample on the DBS card, ethanol on the DBS card, or participants from whom not enough blood could be drawn for the DBS sample. The above incidents where study procedures were temporarily suspended, and where it was stopped completely (in Limpopo) did not affect the results in anyway. Thus, a total of 4,932 DBS results were available for analysis of the primary outcome (2,604 in the intervention arm and 2,328 in the comparison arm). This

subsample of participants was included in all analyses in the results section that included biological measures.

Table 2 provides a breakdown of household and participant screening, enrolment, and response rate by study site. Overall, the study had a 97.5% response rate (97.3% in the intervention arm and 97.7% in the comparison arm). Please note that the refusals in Table 2 include the four participants who were excluded from the study due to reduced mental and physical capacity.

```
┌─────────────────────────────────────────┐
│      Subdistricts assigned (n=24)        │
│  Intervention arm (n=12) with 2 sites each│
│  Comparison arm (n=12) with 2 sites each │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│      Dwellings visited (n=37,714)        │
│   From intervention site (n=20,614)      │
│    From comparison site (n=17,100)       │
└─────────────────────────────────────────┘

                Screening
                    │
                    ▼
┌─────────────────────────────────────────┐
│    Households screened (n=22,263)        │
│   From intervention site (n=11,628)      │
│    From comparison site (n=10,635)       │
└─────────────────────────────────────────┘
                    │
                    ▼
┌─────────────────────────────────────────┐
│    Assessed for eligibility (n=5,154)    │
│   From intervention site (n=2,710)       │
│    From comparison site (n=2,444)        │
└─────────────────────────────────────────┘
```

Excluded (n=4)
From intervention site (n=2)
From comparison site (n=2)
(Reduced mental or physical capacity)

Enrolment

Invited to participate (n=5,150)
From intervention site (n=2,708)
From comparison site (n=2,442)

Refused (n=125)
From intervention site (n=70)
From comparison site (n=55)
(Family member refused, fear of needles, sick, busy)

Completed survey for analysis (n=5,025)
From intervention site (n=2,638)
From comparison site (n=2,387)

No DBS result (n=93)
From intervention site (n=34)
From comparison site (n=59)
(Community insisted DBS be destroyed, DBS double spotted, blood could not be drawn from participant)

Analysis

DBS results for analysis (n=4,932)
From intervention site (n=2,604)
From comparison site (n=2,328)

Figure 1: CONSORT diagram for the HERStory 3 impact evaluation

Table 2: Response rate of the HERStory 3 impact evaluation among all study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Province	Subdistrict	Site	Dwellings visited	Households screened	Respondent eligible	Respondent refused	Respondent completed survey	Sample realisation (complete/ eligible) (%)
Intervention sites								
KwaZulu-Natal	Abaqulusi	Coronation, Nkongolwane, etc	410	258	107	0	107	100.0
		Vryheid	819	495	109	0	109	100.0
KwaZulu-Natal	City of UMhlathuze	Empangeni	398	268	116	4	112	96.6
		Esikhawini H	1099	590	112	4	108	96.4
Mpumalanga	Mbombela	Phola	405	253	117	8	109	93.2
		Matsulu	539	337	119	1	118	99.2
Mpumalanga	Govan Mbeki	Embalenhle	1541	848	113	4	109	96.5
		Embalenhle	857	516	109	5	104	95.4
Eastern Cape	Nelson Mandela C	Malabar	523	271	103	2	101	98.1
		Malabar	523	270	106	2	104	98.1
Eastern Cape	Nyandeni	Marubeni	546	289	115	1	114	99.1
		Nkanga	579	300	103	1	102	99.0
Free State	Dihlabeng	Fateng Tse Ntsho	812	478	111	2	109	98.2
		Kgubetswana/Mashaeng	726	493	102	0	102	100.0
Free State	Setsoto	Moemaneng	1571	954	119	9	110	92.4
		Meqheleng	1045	605	110	2	108	98.2
Limpopo	Fetakgomo Tubatse	Mpahanama	399	185	109	2	107	98.2
		Prakteseer	1062	690	107	1	106	99.1
Gauteng	Tshwane 1	Soshanguve/Garankuwa	1450	670	154	11	143	92.9
		Garankuwa	1400	643	126	2	124	98.4
North West	Rustenburg	Boitekong	919	535	107	3	104	97.2
		Boitekong	721	394	103	1	102	99.0

Western Cape	Klipfontein	Athlone	1618	866	114	5	109	95.6
		Hanover Park	652	420	119	2	117	98.3
Sub-total			*20614*	*11628*	*2710*	*72*	*2638*	*97.3*
Comparison sites								
KwaZulu-Natal	Umhlabuyalingana	Madonela	246	182	109	6	103	94.5
		Madonela A	245	182	109	0	109	100.0
KwaZulu-Natal	Hlabisa	Hlabisa	447	294	110	0	110	100.0
		Hlabisa A	447	294	107	0	107	100.0
Free State	Metsimaholo	Zamdela	661	658	103	2	101	98.1
		Zamdela A	725	719	112	1	111	99.1
KwaZulu-Natal	Umzimkhulu	Nkqozana	411	258	108	1	107	99.1
		Mfundweni	775	475	111	4	107	96.4
Eastern Cape	Nelson Mandela B	Uitenhage	846	525	110	5	105	95.5
		Uitenhage	845	524	108	5	103	95.4
KwaZulu-Natal	Ubuhlebezwe	Lufafa	290	190	108	1	107	99.1
		Hlokozi	516	341	109	5	104	95.4
Free State	Kopanong	Itumeleng/Ipopeng	1415	732	114	2	112	98.3
		Lephoi	1031	511	110	0	110	100.0
Free State	Letsemeng	Ratanang	652	337	110	0	110	100.0
		Koffiefontein	862	444	117	0	117	100.0
Limpopo	Ephraim Mogale	Uitvlugt	603	374	93	3	90	96.8
		Manapsane	103	45	13	0	13	100.0
Gauteng	Mogale City	Kagiso	1432	930	114	6	108	94.7
		Kagiso	1547	964	120	7	113	94.2
Free State	Bloemfontein	J B Mafora	529	205	44	3	41	93.2
		Botshabelo/Thabanchu	822	504	80	3	77	96.3
Western Cape	Bitou	KwaNokuthula	695	427	109	1	108	99.1
		New Horizons	955	520	116	2	114	98.3
Sub-total			*17100*	*10635*	*2444*	*57*	*2387*	*97.7*
Grand Total			**37714**	**22263**	**5154**	**129**	**5025**	**97.5**

Description of Participants

Demographic information

Table 3 describes the demographic characteristics of participants, showing that the participants in each study arm were very similar in the overall estimates and within age groups. The mean age was 19.1 years in the intervention arm and 18.8 years in the comparison arm. and there was no statistically significant difference in age between study arms. When disaggregated by age group, there were also no statistically significant differences in age within age groups (Table 3).

Almost all participants in both arms had been born in South Africa, and the percentages were similar across study arms: 97.1% in the intervention arm and 97.6% in the comparison arm (p=.553).

Over a third of participants (69.6% in each arm) had lived in the study site for five years or longer, and there were no statistically significant differences between arms overall or within age groups (Table 3).

In the intervention arm, 15.3% of participants reported being a maternal orphan and 26.6% a paternal orphan, compared with 17.1% and 24.3% in the comparison arm. There were no statistically significant differences between arms overall or within age groups (Table 3).

Almost all participants possessed a birth certificate (intervention arm: 96.4%; comparison arm: 96.2%) but fewer possessed a South African ID book or card (intervention arm: 73.4%; comparison arm: 69.1%). There were no statistically significant differences between arms overall or within age groups for these variables (Table 3).

In the intervention arm, 15.9% of participants had worked more than a few hours to earn money in the past month, compared with 15.7% in the comparison arm. There were no statistically significant differences between arms overall or within age groups (Table 3).

Ever having been pregnant was reported by 34.4% in the intervention arm compared with 33.2% in the comparison arm. Among adolescent participants (under the age of 20 years), 16.9% in the intervention arm and 14.8% in the comparison arm had ever been pregnant. There were no statistically significant differences between arms overall or within age groups (Table 3).

Ever having given birth to a child was reported by 29.3% in the intervention arm compared with 29.2% in the comparison arm. There were no statistically significant differences between arms overall or within age groups (Table 3).

In the intervention arm, statistically significantly fewer participants (2.8%) reported that they planned to become pregnant within the next year, compared with 3.6% in the comparison arm. In the younger adolescent age group, statistically significantly fewer participants in the intervention arm (1.8%)

reported that they planned to become pregnant within the next year, compared with 2.5% in the comparison arm. In the older age group, there was no statistically significant differences in plans to become pregnant within the next year (Table 3).

Table 3: Demographic characteristics of all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Descriptive statistics				Effect estimates*		
	Comparison		Intervention				
Variable	Freq/N		Freq/N		β/OR	95% CI	p-value
Age in years: mean (SD), range							
	Mean (sd)		Mean (sd)				
Total	18.8 (2.8)		19.1 (2.88)		0.19	-0.09 - 0.48	0.2014
Age group							
15-19	16.8 (1.4)		17.1 (1.4)		0.13	-0.00 - 0.27	0.0666
20-24	21.9 (1.4)		21.9 (1.4)		0.04	-0.09 - 0.16	0.5668
	Freq/N	%	Freq/N	%			
Born in South Africa							
Total	2329/2387	97.6	2562/2638	97.1	0.84	0.44 – 1.62	0.611
15-19	1411/1447	97.5	1481/1514	97.8	1.21	0.57 - 2.59	0.6278
20-24	918/940	97.7	1081/1124	96.2	0.66#	0.29 - 1.50	0.3311
Lived in study site for 5 years or longer							
Total	1662/2387	69.6	1837/2638	69.6	0.99	0.76 - 1.28	0.9285
15-19	1002/1447	69.2	1025/1514	67.7	0.93	0.71 - 1.22	0.6167
20-24	660/940	70.2	812/1124	72.2	1.09	0.76 - 1.56	0.6504
Maternal orphan							
Total	407/2387	17.1	403/2638	15.3	0.80	0.52 - 1.24	0.3315
15-19	191/1447	13.2	174/1514	11.5	0.84	0.53 - 1.34	0.4736
20-24	216/940	23.0	229/1124	20.4	0.79	0.46 - 1.36	0.4086
Paternal orphan							
Total	581/2387	24.3	703/2638	26.6	1.12	0.89 - 1.42	0.3441
15-19	283/1447	19.6	329/1514	21.7	1.18	0.88 - 1.59	0.2824
20-24	298/940	31.7	374/1124	33.3	1.14	0.80 - 1.61	0.4785
Possess a birth certificate							
Total	2297/2387	96.2	2544/2638	96.4	1.13	0.73 - 1.74	0.6000
15-19	1395/1447	96.4	1467/1514	96.9	1.28	0.70 - 2.33	0.4279
20-24	902/940	96.0	1077/1124	95.8	0.86	0.43 - 1.71	0.6650
Possess a South African ID book or card							
Total	1650/2387	69.1	1935/2638	73.4	1.07	0.87 - 1.31	0.5326
15-19	778/1447	53.8	903/1514	59.6	1.14	0.83 - 1.57	0.4328
20-24	872/940	92.8	1032/1124	91.8	0.84	0.37 - 1.93	0.6937

	Descriptive statistics			Effect estimates*		
	Comparison		Intervention			
Variable	Freq/N		Freq/N		β/OR	95% CI	p-value
Worked more than a few hours in the past month to earn money						
Total	375/2387	15.7	419/2638	15.9	0.92	0.56 - 1.52	0.7495
15-19	157/1447	10.9	167/1514	11.0	0.94	0.54 - 1.62	0.8152
20-24	218/940	23.2	252/1124	22.4	0.87	0.45 - 1.69	0.6825
Ever been pregnant						
Total	793/2387	33.2	907/2638	34.4	0.94	0.69 - 1.28	0.6803
15-19	214/1447	14.8	256/1514	16.9	1.20	0.72 - 1.98	0.4956
20-24	579/940	61.6	651/1124	57.9	0.84	0.62 - 1.16	0.3069
Ever given birth to a child						
Total	698/2387	29.2	772/2638	29.3	0.86	0.62 - 1.19	0.3597
15-19	170/1447	11.7	192/1514	12.7	1.05	0.58 - 1.92	0.8638
20-24	528/940	56.2	580/1124	51.6	0.81	0.59 - 1.12	0.2130
Planning to become pregnant within the next year						
Total	85/2387	3.6	73/2638	2.8	0.67	0.50 - 0.91	0.0164
15-19	36/1447	2.5	27/1514	1.8	0.66	0.50 - 0.88	0.0090
20-24	49/940	5.2	46/1124	4.1	0.61	0.29 - 1.29	0.2059

results based on model with site nested within subdistrict random effect (excluding household effect)

Socio-economic status

Table 4 describes the socio-economic characteristics of all participants. Participants in the intervention arm reported that they had their own money (18.3%), owed money to someone (15.6%) and saved money (57.7%) compared with 18.9%, 13.1% and 56.7% respectively in the comparison arm. There were no statistically significant differences between arms overall or within age groups for these variables (Table 4).

In the intervention arm, 76.5% of participants possessed a cell phone compared with 68.9% in the comparison arm. There were no statistically significant differences between arms overall or within age groups for these variables (Table 4).

The participants in the intervention and comparison arms were very similar in terms of reporting that they lived in a home with drinking water supplied by a tap in the house or yard, a flush toilet, electricity in working order, a refrigerator, a stove, a TV, a radio, and a computer or laptop. However, participants in the intervention arm were somewhat more likely to report that they lived in a home with a car (22.7%) compared with 16.8% in the comparison arm and this difference was also reflected within age groups. Also, participants in the intervention arm were somewhat more likely to report that they lived

in a home with internet compared with the comparison arm and this difference was also reflected within age groups (Table 4).

In the intervention arm, 41.2% of participants reported that in the past month, either they or another member of their household had gone a whole day and night without eating once or more times because of lack of food, compared with 42.7% in the comparison arm (Table 4).

Table 4: Socioeconomic characteristics of all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Has own money							
Total	452/2387	18.9	484/2638	18.3	0.91	0.63 - 1.32	0.6329
15-19	265/1447	18.3	258/1514	17.0	0.91	0.62 - 1.33	0.6140
20-24	187/940	19.9	226/1124	20.1	0.98	0.56 - 1.74	0.9582
Owes money to someone							
Total	312/2387	13.1	411/2638	15.6	1.22	0.90 - 1.66	0.2037
15-19	145/1447	10.0	191/1514	12.6	1.49	0.96 - 2.33	0.0896
20-24	167/940	17.8	220/1124	19.6	1.15	0.80 - 1.64	0.4643
Saves money							
Total	1353/2387	56.7	1521/2638	57.7	1.05	0.81 - 1.36	0.7220
15-19	850/1447	58.7	944/1514	62.4	1.18	0.92 - 1.53	0.2109
20-24	503/940	53.5	577/1124	51.3	0.90	0.67 - 1.21	0.4973
Possesses own cell phone							
Total	1644/2387	68.9	2018/2638	76.5	1.41	0.95 - 2.09	0.1017
15-19	882/1447	61.0	1034/1514	68.3	1.24	0.83 - 1.83	0.3019
20-24	762/940	81.1	984/1124	87.5	1.79	0.76 - 4.21	0.1959
Lives in home with drinking water supplied through tap in house or yard							
Total	1668/2387	69.9	2084/2638	79.0	0.99[+]	0.26 - 3.69	0.9862
15-19	991/1447	68.5	1188/1514	78.5	0.92[+]	0.24 - 3.55	0.9047
20-24	677/940	72.0	896/1124	79.7	1.06[+]	0.22 - 5.01	0.9443
Lives in home with own flush toilet							
Total	1233/2387	51.7	1628/2638	61.7	1.62[+]	0.57 - 4.67	0.3775
15-19	694/1447	48.0	911/1514	60.2	1.83[+]	0.63 - 5.30	0.2781
20-24	539/940	57.3	717/1124	63.8	1.39[+]	0.46 - 4.19	0.5685
Lives in home with electricity in working order							
Total	2067/2387	86.6	2333/2638	88.4	1.23	0.80 - 1.91	0.3585
15-19	1241/1447	85.8	1323/1514	87.4	1.24	0.71 - 2.15	0.4608
20-24	826/940	87.9	1010/1124	89.9	1.37	0.78 - 2.44	0.2880
Lives in home with car							
Total	400/2387	16.8	600/2638	22.7	1.92	1.14 - 3.22	0.0223

Table 4: Socioeconomic characteristics of all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
15-19	278/1447	19.2	361/1514	23.8	1.57	0.91 - 2.73	0.1223
20-24	122/940	13.0	239/1124	21.3	2.59	1.37 - 4.90	0.0078
Lives in home with computer or laptop							
Total	331/2387	13.9	516/2638	19.6	1.78	0.80 - 3.96	0.1692
15-19	186/1447	12.9	273/1514	18.0	1.72	0.74 - 4.02	0.2210
20-24	145/940	15.4	243/1124	21.6	1.41#	0.82 - 2.44	0.2307
Lives in home with internet							
Total	385/2387	16.1	644/2638	24.4	2.24	1.04 - 4.84	0.0523
15-19	241/1447	16.7	379/1514	25.0	2.03	0.89 - 4.65	0.1085
20-24	144/940	15.3	265/1124	23.6	1.86#	1.05 - 3.28	0.0439
Lives in home with refrigerator							
Total	1554/2387	65.1	1857/2638	70.4	1.34	0.96 - 1.88	0.1005
15-19	947/1447	65.4	1054/1514	69.6	1.37	0.90 - 2.09	0.1582
20-24	607/940	64.6	803/1124	71.4	1.45	1.02 - 2.05	0.0519
Lives in home with stove							
Total	1672/2387	70.0	1956/2638	74.1	1.32	0.87 - 1.99	0.2050
15-19	1017/1447	70.3	1114/1514	73.6	1.33	0.80 - 2.20	0.2829
20-24	655/940	69.7	842/1124	74.9	1.42	0.87 - 2.33	0.1738
Lives in home with TV							
Total	1571/2387	65.8	1834/2638	69.5	1.22	0.81 - 1.83	0.3470
15-19	952/1447	65.8	1048/1514	69.2	1.23	0.78 - 1.95	0.3826
20-24	619/940	65.9	786/1124	69.9	1.27	0.78 - 2.06	0.3457
Lives in home with radio							
Total	915/2387	38.3	1132/2638	42.9	1.19	0.88 - 1.62	0.2648
15-19	545/1447	37.7	622/1514	41.1	1.15	0.81 - 1.62	0.4448
20-24	370/940	39.4	510/1124	45.4	1.24	0.93 - 1.66	0.1594
In past month, participant or another household member went a whole day and night without eating because of lack of food once or more times							
Total	1020/2387	42.7	1087/2638	41.2	0.94	0.73 - 1.19	0.5940
15-19	578/1447	39.9	608/1514	40.2	0.98	0.73 - 1.31	0.8791
20-24	442/940	47.0	479/1124	42.6	0.85	0.65 - 1.10	0.2326

results based on model with site nested within subdistrict random effect (excluding household effect)

+ results based on model with subdistrict random effect only (excluding household and site effect)

Child support grant

Among participants who reported that they had ever given birth to a child, 79.0% in the intervention arm and 80.7% in the comparison arm had ever applied for the child support grant for their child/children; 77.7% in the intervention arm and 79.1% in the comparison arm were receiving the child support grant for their child/children; and 37.4% in the intervention arm and 41.4% in the comparison arm were receiving another child grant (foster or child dependency grants). The magnitude of these differences was very small (Table 5).

Table 5: Access to and receipt of child support grants among HERStory 3 study participants who had ever given birth to a child from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant has applied for the child support grant for her child or children							
Total	563/698	80.7	610/772	79.0	0.82	0.46 - 1.46	0.5005
15-19	115/170	67.6	124/192	64.6	0.73	0.37 - 1.44	0.3711
20-24	448/528	84.8	486/580	83.8	0.85	0.40 - 1.78	0.6632
Participant receives the child support grant for her child or children							
Total	552/698	79.1	600/772	77.7	0.80	0.46 - 1.39	0.4316
15-19	109/170	64.1	122/192	63.5	0.87	0.46 - 1.64	0.6641
20-24	443/528	83.9	478/580	82.4	0.71	0.31 - 1.65	0.4356
Participant receives another child grant - foster or child dependency grant							
Total	289/698	41.4	289/772	37.4	0.83	0.62 - 1.12	0.2406
15-19	71/170	41.8	67/192	34.9	0.77	0.49 - 1.19	0.2477
20-24	218/528	41.3	222/580	38.3	0.82	0.53 - 1.28	0.3888

Education

Table 6 describes the educational status of all participants. Full-time enrolment in school, college, or university was reported by 61.5% of participants in the intervention arm and 64.8% in the comparison arm. In the intervention arm, 41.8% of participants reported that they had completed Grade 12 at school, compared with 36.8% in the comparison arm. There were no statistically significant differences in these variables overall or within age groups (Table 6).

In the intervention arm, 13.9% of participants reported that they had completed further studies at a university, college or other training institution compared with 12.6% in the comparison arm. In the younger adolescent age group, 7.6% had completed further studies at a university, college or other training institution in the intervention arm compared with 9.7% in the comparison arm. In the older

age group, 22.3% had completed further studies at a university, college or other training institution in the intervention arm compared with 17.0% the comparison arm (Table 6).

We asked participants who were in primary or high school about absenteeism (Table 7). Among participants who were in primary or high school at the time of the survey, 32.9% in the intervention arm and 28.2% in the comparison arm reported being absent from school one or two times a month or more in the past year; and 18.0% in the intervention arm and 18.2% in the comparison arm reported being absent from school for more than a week at one time in the past year. There were no statistically significant differences in these variables overall or within age groups (Table 7).

Participants who reported being absent from school for more than a week at a time in the past year were asked the reason for their absence (Table 8). The most reported reason was being sick (62.7% in the intervention arm versus 53.1% in the comparison arm). The next most reported reason was feeling unsafe going to school (6.9% in the intervention arm versus 7.5% in the comparison arm). Overall, participants in the intervention arm were slightly less likely to report being absent from school for more than a week in the past year because they had completed exams (1.8%), compared with the comparison arm (4.4%).

Table 9 describes participants' reasons for leaving school among participants who reported that they were no longer in school (primary or high school). The most common reason was that they had completed Grade 12 (69.8% in the intervention arm and 64.0% in the comparison arm). There were very small differences by arm in this variable overall and in the older age group, however in the younger adolescent group, participants in the intervention arm were slightly more likely to report that they left school because they had completed Grade 12 (77.4%) compared with the comparison arm (64.4%) (Table 9). Participants in the intervention arm were slightly less likely to report that they had left school because they had been bullied or treated badly by learners or teachers at school (0.6%) compared with the comparison arm (2.0%) and this difference was also observed in the older age group where 0.5% of participants in the intervention arm versus 2.1% in the comparison arm reported that they had left school because they had been bullied or treated badly by learners or teachers at school (Table 9).

Table 6: Educational status of all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant is currently enrolled in school, college or university full-time							
Total	1546/2387	64.8	1623/2638	61.5	1.08	0.73 - 1.58	0.7058
15-19	1154/1447	79.8	1150/1514	76.0	1.17	0.69 - 1.99	0.5729
20-24	392/940	41.7	473/1124	42.1	1.01	0.43 - 2.35	0.9826
Highest grade completed at school is grade 12							
Total	878/2387	36.8	1103/2638	41.8	1.16	0.89 - 1.53	0.2883
15-19	313/1447	21.6	394/1514	26.0	1.02	0.65 - 1.61	0.9241
20-24	565/940	60.1	709/1124	63.1	1.13	0.78 - 1.63	0.5224
Participant has completed further studies at a university, TVET college or another training institution							
Total	301/2387	12.6	366/2638	13.9	1.08	0.76 - 1.52	0.6844
15-19	141/1447	9.7	115/1514	7.6	0.59	0.36 - 0.95	0.0421
20-24	160/940	17.0	251/1124	22.3	1.73	1.06 - 2.83	0.0397

Table 7: Absenteeism among HERStory 3 study participants who were in primary or high school at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
In the past year, participant was absent from school 1 or 2 times a month or more							
Total	353/1251	28.2	397/1207	32.9	1.30	0.88 - 1.93	0.1945
15-19	300/1057	28.4	341/1024	33.3	1.35	0.86 - 2.12	0.2055
20-24	53/194	27.3	56/183	30.6	1.17	0.75 - 1.84	0.4980
In the past year, participant was absent from school for more than a week at one time							
Total	228/1251	18.2	217/1207	18.0	0.95	0.67 - 1.34	0.7711
15-19	175/1057	16.6	171/1024	16.7	0.95	0.65 - 1.39	0.8049
20-24	53/194	27.3	46/183	25.1	0.88[#]	0.53 - 1.46	0.6249

results based on model with site nested within subdistrict random effect (excluding household effect)

Table 8: Participant's reasons for being absent from school among HERStory 3 study participants who reported being absent from school for more than a week at one time in the past year from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean			
	Comparison		**Intervention**	
Variable	**Freq/N**	**%**	**Freq/N**	**%**
Participant was sick				
Total	121/228	53.1	136/217	62.7
15-19	94/175	53.7	110/171	64.3
20-24	27/53	50.9	26/46	56.5
Participant doesn't feel safe going to school				
Total	17/228	7.5	15/217	6.9
15-19	12/175	6.9	11/171	6.4
20-24	5/53	9.4	4/46	8.7
Participant doesn't feel safe while in school				
Total	1/228	0.4	5/217	2.3
15-19	1/175	0.6	4/171	2.3
20-24	0/53	0.0	1/46	2.2
Participant is bullied or treated badly by learners or teachers at school				
Total	7/228	3.1	8/217	3.7
15-19	6/175	3.4	8/171	4.7
20-24	1/53	1.9	0/46	0.0
Participant doesn't like school				
Total	4/228	1.8	9/217	4.1
15-19	3/175	1.7	7/171	4.1
20-24	1/53	1.9	2/46	4.3
Participant has to look after people at home				
Total	5/228	2.2	7/217	3.2
15-19	4/175	2.3	5/171	2.9
20-24	1/53	1.9	2/46	4.3
There is not enough money to send her to school every day				
Total	10/228	4.4	9/217	4.1
15-19	7/175	4.0	8/171	4.7
20-24	3/53	5.7	1/46	2.2
School is too far away				
Total	11/228	4.8	5/217	2.3
15-19	7/175	4.0	4/171	2.3
20-24	4/53	7.5	1/46	2.2
Participant has to work				
Total	3/228	1.3	2/217	0.9

Table 8: Participant's reasons for being absent from school among HERStory 3 study participants who reported being absent from school for more than a week at one time in the past year from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean			
	Comparison		**Intervention**	
Variable	**Freq/N**	**%**	**Freq/N**	**%**
15-19	1/175	0.6	1/171	0.6
20-24	2/53	3.8	1/46	2.2
Participant missed school because of her period (menstruation)				
Total	11/228	4.8	11/217	5.1
15-19	8/175	4.6	11/171	6.4
20-24	3/53	5.7	0/46	0.0
Exams are done				
Total	10/228	4.4	4/217	1.8
15-19	8/175	4.6	3/171	1.8
20-24	2/53	3.8	1/46	2.2
Participant is pregnant, has a baby or has a child				
Total	19/228	8.3	16/217	7.4
15-19	13/175	7.4	8/171	4.7
20-24	6/53	11.3	8/46	17.4
Other reason				
Total	19/228	8.3	15/217	6.9
15-19	16/175	9.1	13/171	7.6
20-24	3/53	5.7	2/46	4.3
Prefer not to answer				
Total	12/228	5.3	5/217	2.3
15-19	11/175	6.3	3/171	1.8
20-24	1/53	1.9	2/46	4.3

Table 9: Participant's reasons for leaving school among HERStory 3 study participants who reported that they were no longer in school from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant completed grade 12							
Total	515/805	64.0	762/1091	69.8	1.49	0.98 - 2.27	0.0753
15-19	145/225	64.4	263/340	77.4	1.80[#]	1.06 - 3.05	0.0409
20-24	370/580	63.8	499/751	66.4	1.19	0.78 - 1.82	0.4205
Participant was bullied or treated badly by learners or teachers at school							
Total	16/805	2.0	7/1091	0.6	0.36	0.28 - 0.46	<.0001
15-19	4/225	1.8	3/340	0.9	1.38	0.92 - 2.08	0.1332
20-24	12/580	2.1	4/751	0.5	0.24[+]	0.08 - 0.78	0.0270
Participant was pregnant or had a child							
Total	72/805	8.9	81/1091	7.4	0.92	0.60 - 1.41	0.7152
15-19	15/225	6.7	17/340	5.0	0.57[#]	0.24 - 1.35	0.2172
20-24	57/580	9.8	64/751	8.5	0.99[#]	0.58 - 1.69	0.9686
Participant did not have money for school							
Total	32/805	4.0	61/1091	5.6	1.50[#]	0.86 - 2.62	0.1654
15-19	8/225	3.6	13/340	3.8	1.00[+]	0.39 - 2.59	0.9989
20-24	24/580	4.1	48/751	6.4	1.64[#]	0.90 - 2.98	0.1222
Participant needed a job							
Total	42/805	5.2	39/1091	3.6	0.65	0.41 - 1.03	0.0780
15-19	7/225	3.1	5/340	1.5	0.49[+]	0.15 - 1.62	0.2534
20-24	35/580	6.0	34/751	4.5	0.71[+]	0.40 - 1.25	0.2480
Participant needed to look after people at home							
Total	12/805	1.5	18/1091	1.6	1.14	0.51 - 2.52	0.7587
15-19	4/225	1.8	2/340	0.6	0.33[+]	0.07 - 1.71	0.2017
20-24	8/580	1.4	16/751	2.1	1.56[+]	0.62 - 3.91	0.3572
Participant was not learning much at school							
Total	6/805	0.7	14/1091	1.3	1.77[+]	0.66 - 4.71	0.2672
15-19	2/225	0.9	5/340	1.5	2.15[α]	-	-
20-24	4/580	0.7	9/751	1.2	1.84[α]	-	-
Participant's school did not have good teachers							
Total	4/805	0.5	3/1091	0.3	0.44[α]	-	-
15-19	1/225	0.4	3/340	0.9	-	-	-
20-24	3/580	0.5	0/751	0.0	-	-	-
Participant has special education needs, and her school was not meeting them							
Total	3/805	0.4	7/1091	0.6	1.55[α]	-	-
15-19	1/225	0.4	3/340	0.9	-	-	-

Table 9: Participant's reasons for leaving school among HERStory 3 study participants who reported that they were no longer in school from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
20-24	2/580	0.3	4/751	0.5	1.87^{α}	-	-
Participant refused to repeat a grade							
Total	18/805	2.2	30/1091	2.7	1.17^{+}	0.60 - 2.26	0.6553
15-19	6/225	2.7	5/340	1.5	0.53^{+}	0.14 - 1.97	0.3552
20-24	12/580	2.1	25/751	3.3	1.52$^{\#}$	0.71 - 3.23	0.2900
Participant could not cope at school because she was sad, distressed or depressed							
Total	23/805	2.9	23/1091	2.1	0.88	0.39 - 1.97	0.7590
15-19	4/225	1.8	4/340	1.2	0.67^{+}	0.17 - 2.58	0.5621
20-24	19/580	3.3	19/751	2.5	0.91	0.43 - 1.90	0.7986
Participant could not cope at school because of physical challenges, illness or sickness							
Total	7/805	0.9	19/1091	1.7	2.28	1.56 - 3.32	0.0003
15-19	2/225	0.9	3/340	0.9	1.20^{α}	-	-
20-24	5/580	0.9	16/751	2.1	2.62^{α}	-	-
Participant was expelled							
Total	5/805	0.6	5/1091	0.5	0.62^{α}	-	-
15-19	2/225	0.9	2/340	0.6	0.67^{α}	-	-
20-24	3/580	0.5	3/751	0.4	0.14 ^{α}	-	-
Participant left school for other reasons							
Total	64/805	8.0	75/1091	6.9	0.82	0.60 - 1.12	0.2348
15-19	18/225	8.0	21/340	6.2	0.70$^{\#}$	0.36 - 1.36	0.3053
20-24	46/580	7.9	54/751	7.2	0.91$^{\#}$	0.57 - 1.47	0.7057
Participant preferred not to answer							
Total	40/805	5.0	40/1091	3.7	0.69	0.52 - 0.91	0.0161
15-19	16/225	7.1	11/340	3.2	1.00	0.51 - 1.98	0.9949
20-24	24/580	4.1	29/751	3.9	0.88$^{\#}$	0.50 - 1.54	0.6592

\# results based on model with site nested within subdistrict random effect (excluding household effect)

+ results based on model with subdistrict random effect only (excluding household and site effect)

α/- frequency or sample size too low to obtain a reliable estimate

Sexuality, relationship status and sexual behaviour

Table 10 describes sexuality and sexual behaviour among participants and shows that there were only very small (and statistically non-significant) differences between participants in the intervention and comparison arms. Among all participants, 41.8% were single and 48.1% were dating in the intervention arm, compared with 42.9% and 43.1% in the comparison arm, respectively (Table 10).

Overall, 66.0% in the intervention arm and 58.9% in the comparison arm had ever had sex. In the intervention arm, 24.5% of participants had more than one male sexual partner in the past year compared to 22.5% of participants in the comparison arm (Table 10).

Among all participants, 13.0% in the intervention arm and 12.2% in the comparison arm had a female sexual partner or girlfriend in the past year (Table 10).

Table 11 describes sexual behaviour among participants who had ever had sex. Again, this table shows that there were only very small (and statistically non-significant) differences between study arms. Among all participants, 8.5% in the intervention arm and 7.5% in the comparison reported having their first sexual debut below the age of 15 years. In the intervention arm, 41.4% and 21.0% last had sex less than a month ago and between one month and three months ago, respectively, compared with 39.2% and 20.5% in the comparison arm (Table 11).

Among all participants, 34.2% in the intervention arm and 34.1% in the comparison arm had more than one male sexual partner in the past year (Table 11).

In the six months before the survey, 27.9% of participants in the intervention arm and 27.3% in the comparison arm had sex with a man who was five or more years older than them. Among all participants, 5.3% in the intervention arm and 4.6% in the comparison arm reported that the last boy or man they had sex with was 10 or more years older than her (Table 11).

In the past six months, 32.2%, 13.1% and 18.5% of participants in the intervention arm reported that they had stayed in a relationship with a boy or man so that she could receive help with money or goods, they had sex (oral, anal and vaginal) to pay for the things she needed, and had sex because they expected to get money or goods, compared with 33.9%, 12.9% and 19.7% in the comparison arm, respectively (Table 11).

Among participants who had ever had sex, 8.6% of participants in the intervention arm were in a relationship with a blesser in the past six months compared to 7.0% in the comparison arm. When disaggregated by age groups, in the 15-19 year age group in the intervention arm slightly more participants (10.6%) were in a relationship with a blesser in the past six months compared to 6.4% in the comparison arm. In the older age group, there was very little difference between arms (Table 11).

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Overall, in the intervention arm, 19.8% and 3.7% of participants thought that their male partner had sex with other women or men and knew that their male partner was living with HIV; respectively, compared to 21.4% and 4.1% in the comparison arm (Table 11).

Table 12 describes the goods or items reported by participants as the reasons they started or stayed in a relationship with a boy or man in the past six months among those who had ever had sex. Overall, in the intervention arm, participants started or stayed in a relationship with a boy or man in the past six months for the following: money (19.9%), transport (3.7%), food (10.2), clothes or shoes (8.2%), shelter (2.2%), school fees or uniforms (2.1%), airtime (11.5%), cell phones (4.9%), items for children or family (2.9%), cosmetics (6.8%), and other things (2.4%), compared to participants in the comparison arm (19.8%, 4.1%, 11.1%, 6.3%, 2.2%, 2.3%, 10.4%, 4.1%, 2.9%, 6.2%, and 2.8%; respectively) (Table 12).

Table 13 describes the goods or items reported by participants as the reasons they had sex in the past six months among those who had ever had sex. Overall, in the intervention arm, participants had sex in the past six for the following: money (10.8%), transport (1.9%), food (4.9%), clothes or shoes (4.4%), shelter (0.6%), school fees or uniforms (1.7%), airtime (3.6%), cell phones (2.2%), items for children or family (1.4%), cosmetics (2.6%), and other things (1.3%), compared to participants in the comparison arm (10.6%, 2.9%, 6.2%, 3.3%, 1.1%, 1.2%, 3.8%, 2.1%, 1.2%, 2.6%, and 1.8%; respectively) (Table 13).

Table 14 describes the goods or items participants received from their "blesser" among those who had ever been in a relationship with a blesser. More participants in the intervention arm who received airtime from their blesser (21.0%), compared to 10.7% in the comparison arm. Overall, in the intervention arm, participants received: money (54.5%), transport (8.4%), food (30.5%), clothes or shoes (20.4%), shelter (2.4%), school fees or uniforms (6.0%), cell phones (13.2%), items for children or family (7.2%), cosmetics (12.0%), and other things (7.2%), compared to participants in the comparison arm (47.5%, 5.7%, 25.4%, 12.3%, 0.8%, 4.9%, 5.7%, 3.3%, 5.7%, and 4.9%; respectively).

Table 10: Sexuality and sexual behaviour among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Relationship status							
Total							
Single	1024/2387	42.9	1102/2638	41.8	1		
Dating	1028/2387	43.1	1269/2638	48.1	1.11[+]	0.84-1.47	0.4538
Living together, not married	97/2387	4.1	76/2638	2.9	0.64[+]	0.37-1.12	0.1177
Living together, married	24/2387	1.0	31/2638	1.2	1.04[+]	0.52-2.08	0.9119
Married, not living together	2/2387	0.1	8/2638	0.3	3.23[+]	0.64-16.2	0.1542
Divorced	9/2387	0.4	8/2638	0.3	0.84[+]	0.30-2.38	0.7419
Other	42/2387	1.8	31/2638	1.2	0.73[+]	0.39-1.36	0.3256
15-19							
Single	699/1447	48.3	715/1514	47.2	1		
Dating	548/1447	37.9	675/1514	44.6	1.17[$]	1.00-1.37	0.0551
Living together, not married	30/1447	2.1	14/1514	0.9	0.40[$]	0.21-0.76	0.0056
Living together, married	8/1447	0.6	7/1514	0.5	0.79[$]	0.28-2.21	0.6470
Married, not living together	1/1447	0.1	2/1514	0.1	2.28[$]	0.20-25.46	0.5042
Divorced	7/1447	0.5	6/1514	0.4	0.86[$]	0.29-2.59	0.7885
Other	31/1447	2.1	23/1514	1.5	0.78[$]	0.45-1.35	0.3753
20-24							
Single	325/940	34.6	387/1124	34.4	1		
Dating	480/940	51.1	594/1124	52.8	1.05[$]	0.86-1.27	0.6472
Living together, not married	67/940	7.1	62/1124	5.5	0.78[$]	0.53-1.13	0.1919
Living together, married	16/940	1.7	24/1124	2.1	1.25[$]	0.65-2.40	0.5075
Married, not living together	1/940	0.1	6/1124	0.5	4.59[$]	0.55-38.59	0.1611
Divorced	2/940	0.2	2/1124	0.2	0.83[$]	0.11-6.24	0.8594
Other	11/940	1.2	8/1124	0.7	1.05[$]	0.23-1.49	0.2624
Participant has ever had sex							
Total	1406/2387	58.9	1740/2638	66.0	1.26	0.91 - 1.75	0.1767
15-19	576/1447	39.8	745/1514	49.2	1.38	0.88 - 2.16	0.1740
20-24	830/940	88.3	995/1124	88.5	0.97	0.48 - 1.94	0.9218
Participant had more than one male sexual partner in the past year							
Total	536/2387	22.5	646/2638	24.5	1.07	0.79 - 1.47	0.6589
15-19	248/1447	17.1	288/1514	19.0	1.05	0.67 - 1.64	0.8440

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
20-24	288/940	30.6	358/1124	31.9	1.08	0.77 - 1.53	0.6533
Participant had a sexual partner that identified as a girl or woman in the past year							
Total	291/2387	12.2	343/2638	13.0	1.06	0.77 - 1.46	0.7287
15-19	143/1447	9.9	157/1514	10.4	1.05	0.64 - 1.73	0.8431
20-24	148/940	15.7	186/1124	16.5	1.02	0.71 - 1.47	0.9234

+ results based on model with subdistrict random effect only (excluding household and site effect)

$ results based on model with no random effects

Table 11: Sexuality and sexual behaviour among HERStory 3 study participants who had ever had sex from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Age of first sex was below 15 years of age							
Total	105/1406	7.5	148/1740	8.5	1.16	0.82 - 1.64	0.4022
15-19	61/576	10.6	87/745	11.7	1.33	0.55 - 3.19	0.5354
20-24	44/830	5.3	61/995	6.1	1.21	0.66 - 2.21	0.5447
Participant last had sex:							
Total							
Less than a month ago	551/1406	39.2	720/1740	41.4	1		
Between one and three months ago	288/1406	20.5	365/1740	21.0	0.95[+]	0.70-1.29	0.7566
Between three and six months ago	148/1406	10.5	167/1740	9.6	0.86[+]	0.62-1.20	0.3816
Between six and 12 months ago	112/1406	8.0	155/1740	8.9	1.08[+]	0.78-1.50	0.6501
Over a year ago	156/1406	11.1	198/1740	11.4	1.00[+]	0.74-1.35	0.9895
15-19							
Less than a month ago	199/576	34.5	287/745	38.5	1		
Between one and three months ago	123/576	21.4	166/745	22.3	0.92[$]	0.68-1.24	0.5933
Between three and six months ago	59/576	10.2	81/745	10.9	0.95[$]	0.65-1.40	0.8076
Between six and 12 months ago	51/576	8.9	67/745	9.0	0.93[$]	0.61-1.39	0.7084
Over a year ago	73/576	12.7	86/745	11.5	0.82[$]	0.57-1.17	0.2755
20-24							
Less than a month ago	352/830	42.4	433/995	43.5	1		
Between one and three months ago	165/830	19.9	199/995	20.0	1.02[$]	0.79-1.31	0.8962
Between three and six months ago	89/830	10.7	86/995	8.6	0.81[$]	0.58-1.13	0.2151
Between six and 12 months ago	61/830	7.3	88/995	8.8	1.19[$]	0.84-1.71	0.3298
Over a year ago	83/830	10.0	112/995	11.3	1.11[$]	0.81-1.53	0.5201
Participant had more than one male sexual partner in the past year							
Total	479/1406	34.1	595/1740	34.2	1.00	0.77 - 1.30	0.9901
15-19	196/576	34.0	248/745	33.3	0.98	0.70 - 1.37	0.8953
20-24	283/830	34.1	347/995	34.9	1.06	0.76 - 1.46	0.7419
In the past six months, participant had sex with a man who was five or more years older than her							
Total	384/1406	27.3	485/1740	27.9	1.03	0.79 - 1.36	0.8094
15-19	123/576	21.4	158/745	21.2	0.94	0.56 - 1.58	0.8147

Variable	Comparison Freq/N	%	Intervention Freq/N	%	β/OR	95% CI	p-value
	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
20-24	261/830	31.4	327/995	32.9	1.11	0.82 - 1.50	0.5209
The last boy or man that the participant had sex with was 10 or more years older than her							
Total	64/1406	4.6	92/1740	5.3	1.26	0.76 - 2.10	0.3840
15-19	15/576	2.6	31/745	4.2	1.60#	0.76 - 3.35	0.2261
20-24	49/830	5.9	61/995	6.1	1.16	0.60 - 2.26	0.6608
In the past six months, participant started or stayed in a relationship with a boy or man so that she could get help with money or goods							
Total	476/1406	33.9	561/1740	32.2	0.88	0.65 - 1.19	0.4137
15-19	202/576	35.1	234/745	31.4	0.82	0.55 - 1.22	0.3290
20-24	274/830	33.0	327/995	32.9	0.97	0.71 - 1.34	0.8698
In the past six months, participant had sex (oral, anal or vaginal) to pay for the things she needed							
Total	182/1406	12.9	228/1740	13.1	1.02	0.70 - 1.47	0.9344
15-19	72/576	12.5	92/745	12.3	1.01	0.73 - 1.41	0.9518
20-24	110/830	13.3	136/995	13.7	1.02	0.59 - 1.76	0.9474
In the past six months, participant had sex (oral, anal or vaginal) because she expected to get money or goods							
Total	277/1406	19.7	322/1740	18.5	0.84	0.53 - 1.33	0.4555
15-19	115/576	20.0	132/745	17.7	0.83	0.41 - 1.69	0.6096
20-24	162/830	19.5	190/995	19.1	0.93	0.54 - 1.60	0.7873
In the past six months, participant was in a relationship with a blesser							
Total	99/1406	7.0	149/1740	8.6	1.20	0.67 - 2.14	0.5422
15-19	37/576	6.4	79/745	10.6	2.13	1.02 - 4.46	0.0579
20-24	62/830	7.5	70/995	7.0	0.85	0.54 - 1.34	0.4912
Participant thinks that her male partner has sex with other women or men							
Total	301/1406	21.4	344/1740	19.8	0.83	0.61 - 1.14	0.2590
15-19	130/576	22.6	176/745	23.6	1.05	0.71 - 1.57	0.8007
20-24	171/830	20.6	168/995	16.9	0.70	0.46 - 1.08	0.1197
Participant knows that her male partner is living with HIV							
Total	57/1406	4.1	64/1740	3.7	0.89	0.64 - 1.24	0.5030
15-19	19/576	3.3	30/745	4.0	1.27	0.71 - 2.29	0.4281
20-24	38/830	4.6	34/995	3.4	0.71#	0.40 - 1.28	0.2655

results based on model with site nested within subdistrict random effect (excluding household effect)
+ results based on model with subdistrict random effect only (excluding household and site effect)
$ results based on model with no random effects

Table 12: Participant started or stayed in a relationship with a boy or man in the past six months to get help with money or goods among HERStory 3 study participants who had ever had sex from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Money							
Total	279/1406	19.8	347/1740	19.9	0.96	0.66 - 1.39	0.8148
15-19	114/576	19.8	143/745	19.2	0.94	0.59 - 1.48	0.7883
20-24	165/830	19.9	204/995	20.5	1.07	0.69 - 1.67	0.7585
Transport							
Total	57/1406	4.1	64/1740	3.7	0.90	0.60 - 1.34	0.6118
15-19	13/576	2.3	23/745	3.1	1.26	0.82 - 1.94	0.3011
20-24	44/830	5.3	41/995	4.1	0.68	0.31 - 1.49	0.3510
Food							
Total	156/1406	11.1	177/1740	10.2	0.87	0.60 - 1.26	0.4616
15-19	62/576	10.8	72/745	9.7	0.89	0.47 - 1.67	0.7224
20-24	94/830	11.3	105/995	10.6	0.88	0.50 - 1.56	0.6643
Clothes or shoes							
Total	89/1406	6.3	143/1740	8.2	1.43	0.87 - 2.37	0.1758
15-19	32/576	5.6	51/745	6.8	1.24	0.59 - 2.62	0.5733
20-24	57/830	6.9	92/995	9.2	1.79	0.98 - 3.27	0.0711
Shelter							
Total	31/1406	2.2	39/1740	2.2	1.23	0.99 - 1.53	0.0705
15-19	9/576	1.6	16/745	2.1	1.45[+]	0.57 - 3.66	0.4452
20-24	22/830	2.7	23/995	2.3	0.91	0.50 - 1.65	0.7472
School fees or uniforms							
Total	32/1406	2.3	36/1740	2.1	0.94	0.49 - 1.79	0.8458
15-19	17/576	3.0	17/745	2.3	0.76[#]	0.37 - 1.54	0.4512
20-24	15/830	1.8	19/995	1.9	1.06	0.84 - 1.33	0.6271
Airtime							
Total	146/1406	10.4	200/1740	11.5	1.14	0.72 - 1.82	0.5732
15-19	75/576	13.0	94/745	12.6	0.91	0.48 - 1.71	0.7744
20-24	71/830	8.6	106/995	10.7	1.54	0.83 - 2.89	0.1874
Cell phones							
Total	57/1406	4.1	86/1740	4.9	1.20	0.86 - 1.68	0.3006
15-19	25/576	4.3	31/745	4.2	0.97[#]	0.55 - 1.71	0.9178
20-24	32/830	3.9	55/995	5.5	1.41	1.01 - 1.98	0.0556
Items for children or family							
Total	41/1406	2.9	50/1740	2.9	1.05	0.47 - 2.35	0.9108
15-19	11/576	1.9	15/745	2.0	1.05	0.48 - 2.31	0.8997
20-24	30/830	3.6	35/995	3.5	0.93[#]	0.48 - 1.82	0.8418
Cosmetics							
Total	87/1406	6.2	119/1740	6.8	1.14	0.58 - 2.24	0.7019
15-19	26/576	4.5	42/745	5.6	1.40	0.68 - 2.89	0.3664
20-24	61/830	7.3	77/995	7.7	1.00	0.46 - 2.18	0.9942

Table 12: Participant started or stayed in a relationship with a boy or man in the past six months to get help with money or goods among HERStory 3 study participants who had ever had sex from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Other things							
Total	40/1406	2.8	41/1740	2.4	0.85	0.48 - 1.51	0.5939
15-19	15/576	2.6	15/745	2.0	0.83	0.43 - 1.59	0.5791
20-24	25/830	3.0	26/995	2.6	0.88	0.59 - 1.31	0.5320
Participant has not done this							
Total	742/1406	52.8	984/1740	56.6	1.20	0.91 - 1.58	0.2022
15-19	306/576	53.1	425/745	57.0	1.21	0.88 - 1.66	0.2605
20-24	436/830	52.5	559/995	56.2	1.18	0.86 - 1.61	0.3231
Prefer not to answer							
Total	188/1406	13.4	195/1740	11.2	0.75	0.48 - 1.17	0.2210
15-19	68/576	11.8	86/745	11.5	0.86	0.45 - 1.64	0.6563
20-24	120/830	14.5	109/995	11.0	0.61	0.33 - 1.10	0.1150

\# results based on model with site nested within subdistrict random effect (excluding household effect)
+ results based on model with subdistrict random effect only (excluding household and site effect)

Table 13: Participant had sex (oral, anal or vaginal) in the past six months because she expected to get money or goods among HERStory 3 study participants who had ever had sex from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Money							
Total	149/1406	10.6	188/1740	10.8	0.92	0.56 - 1.52	0.7574
15-19	55/576	9.5	72/745	9.7	1.00	0.56 - 1.78	0.9992
20-24	94/830	11.3	116/995	11.7	0.99	0.56 - 1.78	0.9826
Transport							
Total	41/1406	2.9	33/1740	1.9	0.57	0.31 - 1.06	0.0879
15-19	18/576	3.1	16/745	2.1	0.68	0.39 - 1.18	0.1859
20-24	23/830	2.8	17/995	1.7	0.27	0.14 - 0.52	0.0007
Food							
Total	87/1406	6.2	86/1740	4.9	0.72	0.43 - 1.20	0.2192
15-19	38/576	6.6	35/745	4.7	0.58	0.24 - 1.38	0.2319
20-24	49/830	5.9	51/995	5.1	0.87	0.43 - 1.79	0.7139
Clothes or shoes							
Total	46/1406	3.3	76/1740	4.4	1.34	0.71 - 2.56	0.3763
15-19	17/576	3.0	32/745	4.3	1.56#	0.81 - 2.99	0.1964
20-24	29/830	3.5	44/995	4.4	1.28#	0.76 - 2.16	0.3649
Shelter							
Total	16/1406	1.1	11/1740	0.6	0.59#	0.27 - 1.29	0.1982
15-19	4/576	0.7	4/745	0.5	0.77+	0.19 - 3.15	0.7165
20-24	12/830	1.4	7/995	0.7	0.50+	0.18 - 1.37	0.1903
School fees or uniforms							
Total	17/1406	1.2	30/1740	1.7	0.81	0.72 - 0.90	0.0008
15-19	9/576	1.6	15/745	2.0	1.35+	0.61 - 2.97	0.4647
20-24	8/830	1.0	15/995	1.5	1.68+	0.72 - 3.93	0.2404
Airtime							
Total	54/1406	3.8	63/1740	3.6	0.87	0.40 - 1.89	0.7257
15-19	26/576	4.5	34/745	4.6	1.04	0.65 - 1.68	0.8663
20-24	28/830	3.4	29/995	2.9	0.90#	0.53 - 1.53	0.7043
Cell phones							
Total	30/1406	2.1	38/1740	2.2	0.96	0.68 - 1.36	0.8399
15-19	10/576	1.7	17/745	2.3	1.37+	0.48 - 3.92	0.5651
20-24	20/830	2.4	21/995	2.1	0.83	0.40 - 1.72	0.6152
Items for children or family							
Total	17/1406	1.2	24/1740	1.4	0.97#	0.43 - 2.22	0.9470
15-19	4/576	0.7	11/745	1.5	1.81	0.91 - 3.62	0.1051
20-24	13/830	1.6	13/995	1.3	0.80	0.54 - 1.20	0.2995
Cosmetics							
Total	36/1406	2.6	46/1740	2.6	1.22	0.52 - 2.87	0.6560
15-19	11/576	1.9	14/745	1.9	0.99+	0.40 - 2.44	0.9887
20-24	25/830	3.0	32/995	3.2	1.11	0.77 - 1.61	0.5684

Table 13: Participant had sex (oral, anal or vaginal) in the past six months because she expected to get money or goods among HERStory 3 study participants who had ever had sex from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Other things							
Total	26/1406	1.8	22/1740	1.3	0.70	0.39 - 1.26	0.2493
15-19	9/576	1.6	5/745	0.7	0.42+	0.14 - 1.28	0.1411
20-24	17/830	2.0	17/995	1.7	0.87	0.44 - 1.74	0.7004
Participant has not done this							
Total	930/1406	66.1	1205/1740	69.3	1.26	0.82 - 1.95	0.3088
15-19	389/576	67.5	516/745	69.3	1.16	0.64 - 2.11	0.6364
20-24	541/830	65.2	689/995	69.2	1.37	0.81 - 2.34	0.2554
Prefer not to answer							
Total	199/1406	14.2	213/1740	12.2	0.80	0.46 - 1.38	0.4261
15-19	72/576	12.5	97/745	13.0	0.99	0.47 - 2.10	0.9852
20-24	127/830	15.3	116/995	11.7	0.63	0.32 - 1.24	0.1961

\# results based on model with site nested within subdistrict random effect (excluding household effect)
+ results based on model with subdistrict random effect only (excluding household and site effect)

Table 14: Participant's blesser helped her or her family with money or goods among HERStory 3 study participants who had ever been in a relationship with a blesser from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean			
	Comparison		Intervention	
Variable	Freq/N	%	Freq/N	%
Money				
Total	58/122	47.5	91/167	54.5
15-19	27/59	45.8	47/95	49.5
20-24	31/63	49.2	44/72	61.1
Transport				
Total	7/122	5.7	14/167	8.4
15-19	2/59	3.4	8/95	8.4
20-24	5/63	7.9	6/72	8.3
Food				
Total	31/122	25.4	51/167	30.5
15-19	9/59	15.3	26/95	27.4
20-24	22/63	34.9	25/72	34.7
Clothes or shoes				
Total	15/122	12.3	34/167	20.4
15-19	3/59	5.1	17/95	17.9
20-24	12/63	19.0	17/72	23.6
Shelter				
Total	1/122	0.8	4/167	2.4
15-19	0/59	0.0	2/95	2.1
20-24	1/63	1.6	2/72	2.8
School fees or uniforms				
Total	6/122	4.9	10/167	6.0
15-19	3/59	5.1	6/95	6.3
20-24	3/63	4.8	4/72	5.6
Airtime				
Total	13/122	10.7	35/167	21.0
15-19	5/59	8.5	21/95	22.1
20-24	8/63	12.7	14/72	19.4
Cell phones				
Total	7/122	5.7	22/167	13.2
15-19	1/59	1.7	11/95	11.6
20-24	6/63	9.5	11/72	15.3
Items for children or family				
Total	4/122	3.3	12/167	7.2
15-19	2/59	3.4	7/95	7.4
20-24	2/63	3.2	5/72	6.9

Table 14: Participant's blesser helped her or her family with money or goods among HERStory 3 study participants who had ever been in a relationship with a blesser from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean			
	Comparison		Intervention	
Variable	Freq/N	%	Freq/N	%
Cosmetics				
Total	7/122	5.7	20/167	12.0
15-19	1/59	1.7	11/95	11.6
20-24	6/63	9.5	9/72	12.5
Other things				
Total	6/122	4.9	12/167	7.2
15-19	4/59	6.8	6/95	6.3
20-24	2/63	3.2	6/72	8.3
Participant has not done this				
Total	16/122	13.1	15/167	9.0
15-19	11/59	18.6	10/95	10.5
20-24	5/63	7.9	5/72	6.9
Prefer not to answer				
Total	9/122	7.4	10/167	6.0
15-19	7/59	11.9	5/95	5.3
20-24	2/63	3.2	5/72	6.9
Participant's blesser was 10 or more years older than her				
Total	40/122	32.8	48/167	28.7
15-19	14/59	23.7	25/95	26.3
20-24	26/63	41.3	23/72	31.9

Sexual relationship power

Table 15 describes sexual relationships power among all participants, and it shows that the differences between intervention and comparison arms were almost all small or very small. Overall, participants in the intervention arm agreed or strongly agreed with the statements that: when her partner wants sex, he expects me to agree (26.5%), if she asked him to use a condom, he would get angry (22.6%), he won't let her wear certain things (18.1%), compared with 23.3%, 21.9%, and 17.8% in the comparison arm, and the differences between arms were small (Table 15).

Among all participants, 30.6% and 15.5% in the intervention arm agreed with the statements that "he wants to know where I am all of the time" and "he lets me know I am not the only partner he could have", compared to 29.0% and 15.8% in the comparison arm, respectively (Table 15).

Among all participants, 19.7% in the intervention arm and 20.2% in the comparison arm agreed with the statement that "he has more to say than I do about important decisions that affect us". When disaggregated by age group, there was very little difference in the younger age group, but in the older age group, 21.2% agreed with the statement in the intervention arm compared to 26.1% in the comparison arm (Table 15).

Further, 14.6% in the intervention arm and 16.1% in the comparison arm agreed with the statement that "he tells me who I can spend time with", and there was very little difference between arms overall or in the younger age group, but in the older age group in the intervention arm fewer participants agreed (15.1%), compared to 19.6% in the comparison arm (Table 15).

Table 15: Sexual relationship power among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant agreed or strongly agreed with the following statements:							
When he wants sex, he expects me to agree							
Total	555/2387	23.3	700/2638	26.5	1.14	0.87 - 1.49	0.3559
15-19	224/1447	15.5	292/1514	19.3	1.19	0.73 - 1.96	0.4934
20-24	331/940	35.2	408/1124	36.3	1.05	0.86 - 1.29	0.6422
If I asked him to use a condom, he would get angry							
Total	523/2387	21.9	597/2638	22.6	0.97	0.72 - 1.32	0.8684
15-19	246/1447	17.0	298/1514	19.7	1.11	0.68 - 1.83	0.6764
20-24	277/940	29.5	299/1124	26.6	0.82	0.60 - 1.13	0.2468
He won't let me wear certain things							
Total	426/2387	17.8	477/2638	18.1	0.99	0.74 - 1.33	0.9314
15-19	203/1447	14.0	241/1514	15.9	1.05	0.66 - 1.69	0.8290
20-24	223/940	23.7	236/1124	21.0	0.84	0.61 - 1.14	0.2674
He has more to say than I do about important decisions that affect us							
Total	481/2387	20.2	519/2638	19.7	0.95	0.76 - 1.18	0.6268
15-19	236/1447	16.3	281/1514	18.6	1.14	0.81 - 1.61	0.4539
20-24	245/940	26.1	238/1124	21.2	0.78	0.64 - 0.96	0.0300
He tells me who I can spend time with							
Total	384/2387	16.1	385/2638	14.6	0.79	0.57 - 1.09	0.1658
15-19	200/1447	13.8	215/1514	14.2	0.92	0.57 - 1.46	0.7163
20-24	184/940	19.6	170/1124	15.1	0.61	0.41 - 0.91	0.0230
When I wear things to make me look beautiful, he thinks I may be trying to attract other men							
Total	418/2387	17.5	452/2638	17.1	0.90	0.67 - 1.20	0.4908
15-19	219/1447	15.1	240/1514	15.9	0.97	0.68 - 1.39	0.8829
20-24	199/940	21.2	212/1124	18.9	0.90	0.71 - 1.14	0.3778
He wants to know where I am all of the time							
Total	693/2387	29.0	806/2638	30.6	1.04	0.86 - 1.26	0.6834
15-19	346/1447	23.9	409/1514	27.0	1.11	0.84 - 1.46	0.4689
20-24	347/940	36.9	397/1124	35.3	0.95	0.77 - 1.18	0.6679
He lets me know I am not the only partner he could have							
Total	377/2387	15.8	409/2638	15.5	0.92	0.69 - 1.22	0.5650
15-19	208/1447	14.4	215/1514	14.2	0.89	0.60 - 1.32	0.5651
20-24	169/940	18.0	194/1124	17.3	0.86	0.61 - 1.23	0.4318

Alcohol use

Table 16 describes alcohol use among all participants, showing only very small differences between study arms. Among all participants, 18.0% in the intervention arm and 15.9% in the comparison arm reported binge drinking; and 42.1% in the intervention arm and 37.2% in the comparison arm were at risk of hazardous drinking, according to the AUDIT-C scale.

Table 16: Alcohol use among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Drank alcohol 2 or more times a month							
Total	393/2094	18.8	447/2271	19.7	1.07	0.58 - 1.96	0.8350
15-19	177/1276	13.9	220/1305	16.9	1.27	0.66 - 2.42	0.4785
20-24	216/818	26.4	227/966	23.5	0.89	0.43 - 1.84	0.7498
Drank 3 or more drinks on a typical day							
Total	493/2094	23.5	636/2271	28.0	1.48	0.72 - 3.03	0.2972
15-19	212/1276	16.6	291/1305	22.3	1.68	0.77 - 3.66	0.2072
20-24	281/818	34.4	345/966	35.7	1.27	0.56 - 2.88	0.5806
Binge drinking (6 or more drinks on one occasion) on a monthly or more frequent occurrence							
Total	333/2094	15.9	408/2271	18.0	1.40	0.63 - 3.07	0.4150
15-19	128/1276	10.0	186/1305	14.3	1.79	0.82 - 3.94	0.1598
20-24	205/818	25.1	222/966	23.0	1.00[#]	0.55 - 1.83	0.9882
Median (IQR) and 95% CI for the median of Audit-C Score							
Total	0 (3)	0 - 0	0 (3)	0 - 0	0.12[+]	-0.46 - 0.71	0.6797
15-19	0 (2)	0 - 0	0 (3)	0 - 0	0.31[+]	-0.19 - 0.80	0.2376
20-24	0 (3)	1 - 2	0 (3)	1 - 2	-0.12	-0.89 - 0.64	0.7561
At risk of hazardous drinking							
Total	780/2094	37.2	956/2271	42.1	1.27	0.67 - 2.41	0.4668
15-19	356/1276	27.9	463/1305	35.5	1.48	0.75 - 2.90	0.2705
20-24	424/818	51.8	493/966	51.0	1.05	0.49 - 2.27	0.8948

Denominator for Total and each age group differ from full sample due to excluding those who preferred not to answer any of the questions

\# results based on model with site nested within subdistrict random effect (excluding household effect)

\+ results based on model with subdistrict random effect only (excluding household and site effect)

NRCCT Impact of My Journey Programme on HIV Prevalence and Secondary Outcomes

HIV prevalence

The biologically determined HIV status using DBS sampling is the primary outcome for the HERStory 3 Impact Evaluation. For this outcome, the study was designed to emulate a randomised controlled trial comparing HIV prevalence in 12 intervention subdistricts to 12 comparison subdistricts using two sites per subdistrict. Since the subdistricts were non-randomised, adjustments were made in the analysis to account for underlying differences in age distribution, socio-economic status, education, maternal orphanhood, and sexual behaviour between the two arms to ensure a fair comparison. The intervention programme effect is estimated as the odds ratio for the probability of an HIV positive status in the intervention arm compared to the comparison arm. From the regression model, the predicted HIV status, based on the adjustments, can be estimated for each participant, and averaged over the participants of each arm. These are called the marginal predicted HIV prevalence estimates. The study was powered to show a 6% difference in HIV prevalence overall with an expected 6% prevalence in the intervention arm compared to a 12% prevalence in the comparison arm. This difference equates to an odds ratio of 0.50. We had 78% power to show a 5% difference in HIV prevalence. These findings describe the DBS results of 98% of the 5025 study participants, as these participants had viable DBS results.

Table 17 describes the observed HIV prevalence, and the marginal predicted HIV prevalence by intervention and comparison arm overall and within each age group. Overall, the observed HIV prevalence was 10.5% in the intervention arm and 9.7% in the comparison arm. Adjusting for age, socio-economic status, education, maternal orphanhood and sexual behaviour, the marginal predicted HIV prevalence was 9.5% in the intervention arm and 10.4% in the comparison arm. The difference in marginal predicted HIV prevalence by study arm is 0.9% and the odds ratio is 0.88 (95% CI: 0.46–1.70), with a non-significant intervention programme effect (p=0.703). The adjusted difference in HIV prevalence is small (0.9 % versus the expected 6%) and the odds ratio of 0.88 (close to 1) versus the expected 0.5, suggesting a minimal intervention programme impact which the study was not powered to detect (Table 17).

In the 15-19 year age group, the observed HIV prevalence was 6.2% in both study arms. The marginal predicted HIV prevalence was 6.0% in the intervention arm and 7.1% in the comparison arm. This is a difference of 1.1% and the corresponding odds ratio (OR=0.81) was not statistically significant (p=0.593) (Table 17).

In the 20-24 year age group, the observed HIV prevalence was 16.2% in the intervention arm and 15.0% in the comparison arm. The marginal predicted HIV prevalence is 15.2% in the intervention arm and 15.0% in the comparison arm. This is a difference of -0.2% and the corresponding odds ratio (OR=1.02) was not statistically significant (p=0.949) (Table 17).

Additionally, the intervention effect estimates of the age groups (OR=0.81 for the 15-19 year age group, OR=1.02 for the 20-24 year age group) did not differ, p=0.911. This can also be seen from the overlap of the confidence intervals of the odds ratio for each age group. Thus, age did not modify the intervention effect which aligns with the assumption we made at the planning stage of the study.

Table 17: Observed frequencies, denominators, HIV prevalence, marginal predicted HIV prevalence and odds ratios for the comparison of the intervention and comparison arms overall and by age strata, (n=4932)

Population	DBS confirmed HIV status				Effect estimate*		
	Comparison		Intervention				
	Freq/N	% (marginal predicted)@	Freq/N	% (marginal predicted)	Odds ratio	95% CI: lower - upper	p-value
Total	225/2328	9.7 (10.4)	272/2604	10.5 (9.5)	0.88	0.46-1.70	0.703
Age group (years)							
15-19	87/1410	6.2 (7.1)	92/1491	6.2 (6.0)	0.81	0.36-1.78	0.593
20-24	138/918	15.0 (15.0)	180/1113	16.2 (15.2)	1.02	0.50-2.11	0.949

* Effect estimates adjusted for age in years, whether the participant had ever had sex, was in school, had piped water in their house, household had a car and were maternal orphans.

@ Marginal predicted HIV prevalence from the random effects logistic regression model for estimating the intervention effect.

In Figure 2, the marginal predicted HIV prevalence is shown for each age by study arm. Comparison of the marginal predicted HIV prevalence profiles shows inconsistent effects across ages. The cross-over pattern of the HIV prevalence profiles is evidence of random fluctuations around the same increasing HIV prevalence profile over age.
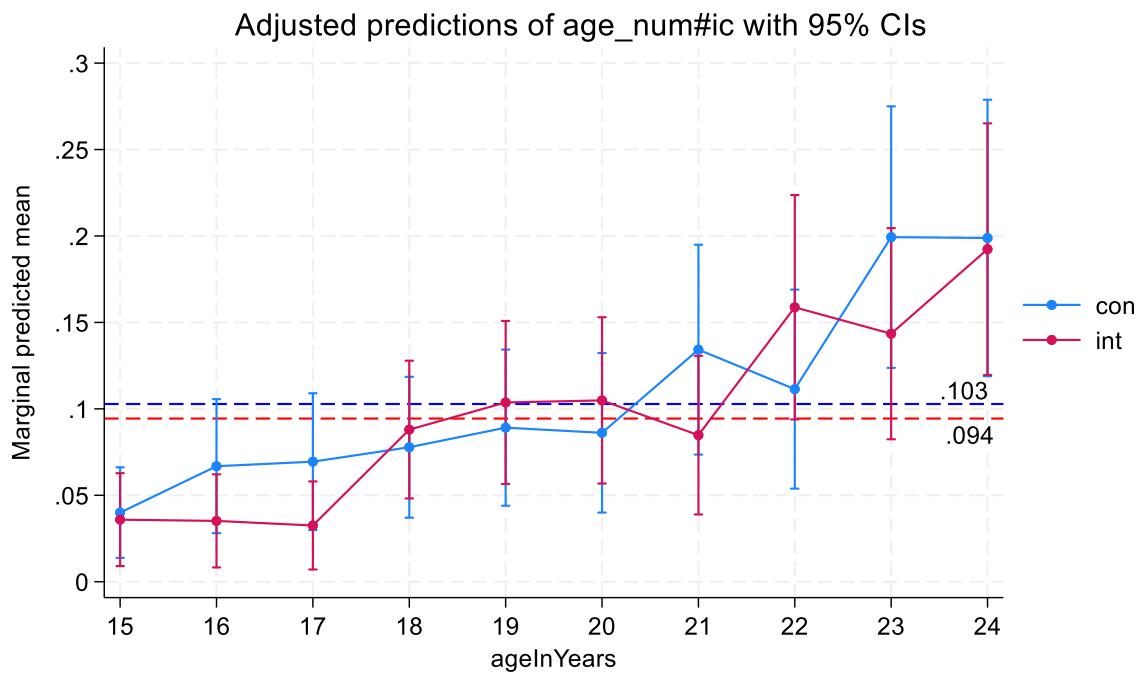
Figure 2. Predictive margins of HIV prevalence for each age by study arm

Figure 3a and 3b show the HIV prevalence in each subdistrict in the intervention and comparison arms, respectively. There was large variability in HIV prevalence by intervention subdistrict from 2.7% prevalence in Fetakgomo Tubatse to 35% in Mbombela (Figure 3a). In the comparison subdistricts, HIV prevalence ranged from 4% in Ephraim Mogale to 15% in Nelson Mandela B (Figure 3b). The high HIV prevalence in Mbombela affects the intervention effect on HIV prevalence.
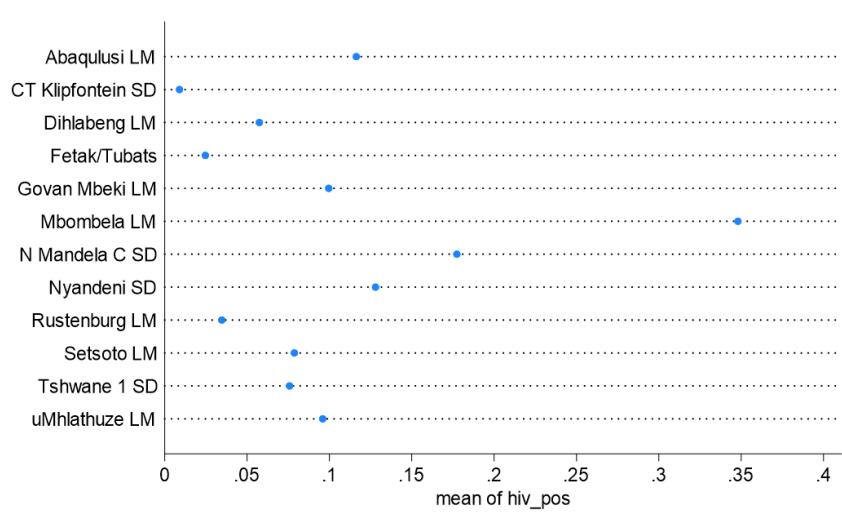
Figure 3a: HIV prevalence in in the intervention subdistricts
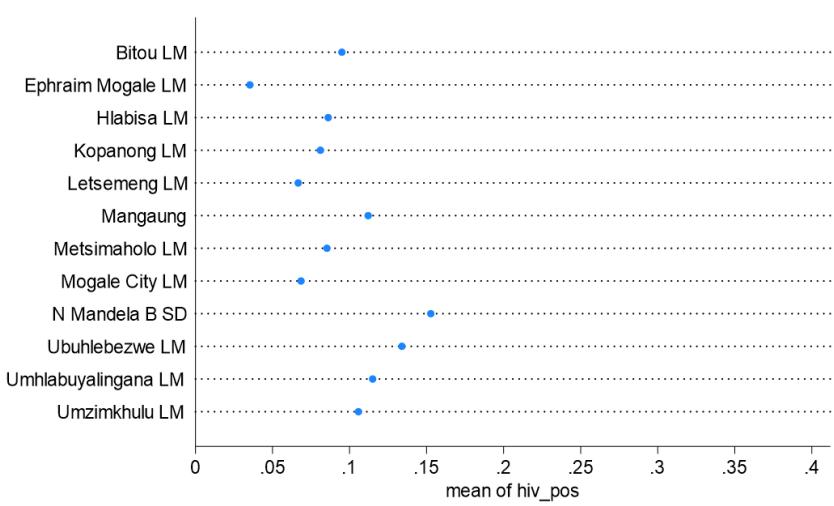
Figure 3b: HIV prevalence in in the comparison subdistricts

There was some over and under sampling in the subdistricts. We considered a weighted analysis where the weights ensured that each subdistrict contributed the information of 200 participants to the analysis for a weighted total of 2,400 participants in each arm. The weighted HIV prevalence was 10.38% (10.45% unweighted) in the intervention arm and 9.61% (9.66% unweighted) in the comparison arm. The intervention effect and marginal estimates only differed in the second decimal point and hence we decided to report the unweighted analysis in Table 17.

Further details of analysis of the primary results are described in **Appendix J**.

In the per protocol analysis, HIV prevalence was 8.8% (95% CI: 5.6%–11.9%) among participants in the intervention arm who were exposed to the My Journey Programme, compared to 9.8% (95% CI: 7.6%–11.9%) among similar participants in the comparison arm. In the 15-19 year age group, HIV prevalence was 5.2% (95% CI: 3.1%–7.3%) among exposed participants in the intervention arm compared to 6.3% (95% CI: 4.5%–8.1%) among similar participants in the comparison arm. In the 20-24 year age group, the estimated HIV prevalence was 14.1% (95%CI: 9.3%–18.9%) among exposed participants in the intervention compared to 15.4% (95% CI: 10.8%–20.0%) in the comparison arm. There were no statistically significant differences in HIV prevalence between exposed participants in the intervention arm and similar participants in the comparison arm overall, or within each age group.

HIV incidence

It was not feasible to compare HIV incidence between the intervention and comparison arms due to the large sample size requirement. We have however tested the DBS positive participants for the recency of their HIV infection. A recent HIV infection is defined as an HIV infection in the past six months during which time HIV antibodies become detectable. The algorithm for recent HIV infections

uses data on participant's recent infection from a LAg assay of participants with viral load ≥1000 copies/mL as well as biological information on ART levels in the blood. While LAg assay information and viral load was available at the time of this report, the effect of the biological ART data on recent infection was still being analysed, thus this report uses the RITA1 Algorithm which does not utilise ARV detection or reporting. Following the LAg testing protocol, there were 10 recent HIV infections, 4 in the intervention arm and 6 in the comparison arm.

The population at risk for HIV infection is HIV negative participants at a time point six months prior to DBS testing. The total number of persons at risk was the sum of the DBS HIV negative participants plus the DBS based recent infection participants. The incidence is calculated assuming that each participant contributed one person year of risk. The incidence rate was 1.71 cases per 1000 person years in the intervention arm and 2.85 in the comparison arm. The incidence rate ratio is 0.60, indicating a 40% reduction in HIV incidence in the intervention arm compared to comparison arm, although this estimate is not statistically significant (p=0.449) (Table 18a). The risk difference is -1.1 per 1000 person years but is also not statistically significant as the 95% CI of the risk difference spans 0 (95% CI: -4.0-1.7).

In the 15-19 year age group, HIV incidence was 0 cases per 1000 person years in the intervention arm compared to 0.76 in the comparison arm. The incidence rate ratio is undefined since we had 0 infections in the intervention arm (Table 18a). However, the risk difference is -0.8 per 1000 person years, but the difference is not statistically significant (p=.486).

In the 20-24 age group, the HIV incidence rate was 4.27 cases per 1000 person years in the intervention arm and 6.37 in the comparison arm. The incidence rate ratio was 0.67, indicating a 33% reduction in incidence in the intervention arm compared to the comparison arm, although this was not statistically significant (p=0.568) (Table 18a).

Although the LAg assay found 10 recent HIV infections, we cannot be certain that these are all recent infections until we have the final biological ART data. Of these 10 participants who were all DBS-confirmed HIV positive, 4 self-reported that they were not living with HIV and did not report on use of ART, suggesting that they are likely recent infections. The remaining 6 participants all self-reported living with HIV with 5 self-reporting that they had an HIV test in the past six months and a different set of 5 self-reporting that they were on ART, thus further information is needed to confirm these 6 participants as recent infections.

Table 18a: Observed frequencies, denominators and HIV incidence rates for the study arms overall and stratified by age group.

Population	Recent HIV infection				Effect estimates*		
	Comparison		Intervention		Incidence rate ratio	95% CI	p-value
	Cases/ person years	Incidence rate/1000 person years	Cases/ person years	Incidence rate/1000 person years			
HIV incidence							
Total	4/2336	1.71	6/2109	2.85	0.60	0.12-2.54	0.449
Age group(years)							
15-19	0/1399	0	1/1324	0.76	-	-	-
20-24	4/937	4.27	5/785	6.37	0.67	0.13-3.11	0.568

* Effect estimates adjusted for age in years, whether the participant had ever had sex, was in school, had piped water in their house, household had a car and were maternal orphans. Being in school was not included in the model for school dropout as this was the outcome variable.

Knowledge of HIV status

Knowledge of HIV status was defined as having an HIV test in the past year and knowing whether you are HIV positive or negative. We powered the study to show an 8% absolute difference in knowledge of HIV status between intervention and comparison arms. The crude unadjusted prevalence of knowledge of HIV status was 85.5% in the intervention arm and 79.6% in the comparison arm. After adjusting for imbalances in age, socio-economic status, education, maternal orphanhood and sexual behaviour, the marginal predicted estimates were 84.7% in the intervention arm and 80.5% in the comparison arm. These estimates lead to a difference of 4.2% in prevalence with an odds ratio of 1.46 and p=0.024, a significant intervention programme effect (Table 18b). Among all age groups, having ever had sex was strongly associated with increased knowledge of HIV status, unsurprisingly, with an odds ratio of 2.61 and p<0.0001.

When disaggregated by age group, the positive intervention effect of knowledge of HIV status was only observed in the 15-19 year age group (OR=1.61, p=0.005) and not the 20-24 year age group (OR=1.16; p=0.510) (Table 18b). However, the intervention effect estimates (odds ratios) of the age groups did not differ, p=0.141. Nevertheless, ever having sex was associated with increased knowledge of HIV status (OR=3.50, p<0.0001) as well as not being in school (OR=1.50, p=0.004).

In Figure 4, the marginal predicted estimates of knowledge of HIV status are shown for each age group by study arm. The findings suggest a clear positive impact of the intervention on knowledge of HIV status among participants aged 15-20 years old, but no evidence in ages 21 years and older.

Table 18b. Observed frequencies, denominators and prevalence of other outcomes: knowledge of HIV status in both arms overall and by age group.

Population	Comparison		Intervention		Odds ratio	95% CI	p-value
	Freq/N	% (marginal predicted)@	Freq/N	% (marginal predicted)			
Knowledge of HIV status							
Total	1708/2146	79.6 (80.5)	2012/2354	85.5 (84.7)	1.46	1.05-2.03	0.024
Age group (years							
15-19	923/1292	71.2 (76.5)	1081/1349	80.1 (82.8)	1..61	1.16-2.24	0.005
20-24	785/854	91.9 (88.1)	931/1005	92.6 (89.4)	1.16	0.74-1.82	0.510

* Effect estimates adjusted for age in years, whether the participant had ever had sex, was in school, had piped water in their house, household had a car and were maternal orphans. Being in school was not included in the model for school dropout as this was the outcome variable.

@ Marginal predicted HIV prevalence from the random effects logistic regression model for estimating the intervention effect.
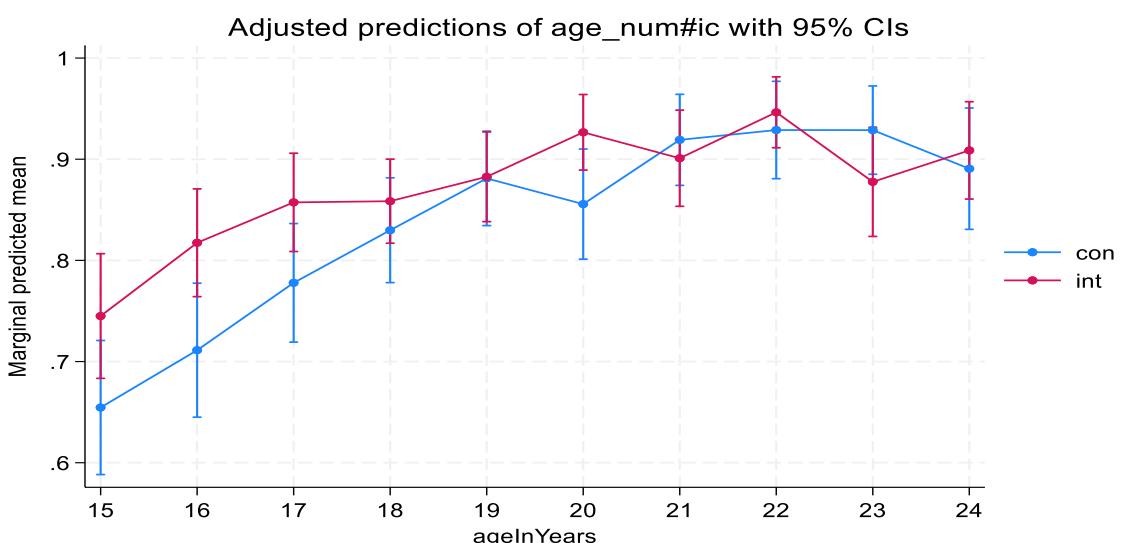
Figure 4. Predictive margins of Knowledge of HIV status for each age by study arm

HIV testing, HIV status and sexually transmitted infections

Table 19 describes self-reported HIV testing, HIV status and STI symptoms among all participants. Overall, reports of ever having an HIV test were higher in the intervention arm (78.6%) compared to the comparison arm (70.3%), (and this difference was statistically significant). In the younger age group, ever having an HIV test was also higher in the intervention arm (71.2%) compared to the comparison arm (59.4%). In the older age group, there was only a very small difference between study arms in this variable (Table 19).

Participants in the intervention arm were more likely to have reported having had an HIV test in the past year overall (69.4% in the intervention versus 59.6% in the comparison arm, a statistically significant difference). In the younger age group, HIV testing in the past year was also more prevalent in the intervention arm (59.9% in the intervention versus 46.5% in the comparison arm). In the older age group, there was only a very small difference between study arms in this variable (Table 19).

More participants in the intervention arm who reported having had an HIV test in the past six months compared to the comparison arm overall (57.6% in the intervention versus 48.6% in the comparison arm) and in the younger age group (45.6% in the intervention versus 35.0% in the comparison arm) and these differences were statistically significant. In the older age group, there was only a very small difference between study arms in this variable (Table 19).

Overall, participants in the intervention arm were more likely to have ever tested themselves for HIV using a self-test (32.1%) compared with the comparison arm (22.1%) and this was also the case in the older age group (40.8% in the intervention compared to 31.4% in the comparison arm), and the younger age group (25.7% in the intervention arm compared with 16.0% in the comparison arm). The overall and older age group differences were statistically significant (Table 19).

There were only small differences in the timing of last HIV self-test by study arm overall or in the younger age group. However, in the older age group, participants in the intervention arm were more likely to have performed an HIV self-test in the past month, three months, six months and past year (17.9%, 10.6%, 5.4% and 3.9% respectively) compared to the comparison arm (13.6%, 6.4%, 3.7% and 2.1% respectively) and these differences were statistically significant.

There were very small differences in self-reported living with HIV between study arms overall (6.8% in the intervention arm compared with 7.7% in the comparison arm) and within age groups. There were also very small differences by study arm in reports of ever having had an STI diagnosis from a doctor or nurse (16.6% in the intervention arm and 15.7% in the comparison arm) and in reports of having experienced STI symptoms in the past year (29.7% in the intervention arm and 29.1% in the comparison arm) (Table 19).

Table 20 describes the location of HIV testing services at last HIV test among participants from intervention sites who have ever had an HIV test. Most participants had their last HIV test at a clinic or hospital in total (65.7%), in the younger age group (55.8%) and in the older age group (76.3%). In the younger age group, 15.7% of participants had their last HIV test at school compared to 3.0% in the older age group (Table 20).

Table 21 describes the quality of HIV testing services at last HIV test among participants who have ever received HIV testing from the My Journey Programme. Overall, most participants reported that their waiting time was short (69.6%) and that they waited one hour or less (89.3%). More than 90% of participants reported that the person who tested them treated them in a friendly manner (92.7%) and were respectful of their needs (93.5%); 83.2% of participants reported that the other people at the testing sites (receptionist, cleaners, security guards etc.) treated them in a friendly and respectful way. More than 80% of participants believed that the information they shared would be kept confidential (84.2%) and that the information they received was clear and that they understood it well (89.7%). There were statistically significantly less participants in the younger age group who believed that their information would be kept confidential (80.1%) and that the information provided was clear (85.9%) compared to 87.7% and 93.0% in the older age group respectively (Table 21).

Table 19: Self-reported HIV testing, HIV status and sexually transmitted infection (STI) symptoms among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Ever had an HIV test							
Total	1679/2387	70.3	2073/2638	78.6	1.64	1.13 - 2.40	0.0169
15-19	860/1447	59.4	1078/1514	71.2	1.74	1.11 - 2.74	0.0239
20-24	819/940	87.1	995/1124	88.5	1.43	0.82 - 2.48	0.2188
Had an HIV test in the past year							
Total	1422/2387	59.6	1830/2638	69.4	1.65	1.16 - 2.35	0.0110
15-19	673/1447	46.5	907/1514	59.9	1.73	1.19 - 2.51	0.0088
20-24	749/940	79.7	923/1124	82.1	1.52	0.89 - 2.60	0.1434
Had an HIV test in the past six months							
Total	1161/2387	48.6	1520/2638	57.6	1.49	1.05 - 2.12	0.0375
15-19	506/1447	35.0	691/1514	45.6	1.56	1.05 - 2.32	0.0394
20-24	655/940	69.7	829/1124	73.8	1.55	0.95 - 2.55	0.0943
Participant has ever tested HERSELF for HIV (self-test)							
Total	527/2387	22.1	848/2638	32.1	1.69	1.05 - 2.73	0.0430
15-19	232/1447	16.0	389/1514	25.7	2.03	0.98 - 4.21	0.0711
20-24	295/940	31.4	459/1124	40.8	1.54	1.08 - 2.21	0.0272
Self-reported living with HIV							
Total	184/2387	7.7	179/2638	6.8	0.81	0.49 - 1.34	0.4171
15-19	84/1447	5.8	77/1514	5.1	0.87#	0.61 - 1.25	0.4687
20-24	100/940	10.6	102/1124	9.1	0.69	0.30 - 1.59	0.3880
Ever received an STI diagnosis from a doctor or nurse							
Total	374/2387	15.7	437/2638	16.6	1.05	0.76 - 1.45	0.7567
15-19	170/1447	11.7	183/1514	12.1	1.01	0.67 - 1.52	0.9661
20-24	204/940	21.7	254/1124	22.6	1.11	0.77 - 1.60	0.5742
In past year, experienced STI symptoms (itching, lumps, warts, rash, redness, smelly discharge, pain or burning upon urination)							
Total	695/2387	29.1	784/2638	29.7	1.01	0.78 - 1.31	0.9255
15-19	356/1447	24.6	418/1514	27.6	1.14	0.83 - 1.55	0.4265
20-24	339/940	36.1	366/1124	32.6	0.85	0.64 - 1.14	0.2933

results based on model with site nested within subdistrict random effect (excluding household effect)

Table 20: Location of HIV testing services at last HIV test among HERStory 3 study participants who have ever had an HIV test from 24 intervention sites across 8 provinces in South Africa, 2024

Variable	Freq/N	%	95% CI
Total			
Clinic or hospital	1361/2073	65.7	63.7 - 67.7
School	199/2073	9.6	8.3 - 10.9
Mobile clinic or van near school	129/2073	6.2	5.2 - 7.2
Mobile clinic or van in my community	127/2073	6.1	5.1 - 7.1
At work	9/2073	0.4	0.1 - 0.7
At home	138/2073	6.7	5.6 - 7.8
Private doctor	34/2073	1.6	1.1 - 2.1
Other	46/2073	2.2	1.6 - 2.8
Prefer not to answer	30/2073	1.4	0.9 - 1.9
15-19			
Clinic or hospital	602/1078	55.8	52.8 - 58.8
School	169/1078	15.7	13.5 - 17.9
Mobile clinic or van near school	84/1078	7.8	6.2 - 9.4
Mobile clinic or van in my community	68/1078	6.3	4.8 - 7.8
At work	0/1078	0.0	-
At home	89/1078	8.3	6.7 - 9.9
Private doctor	13/1078	1.2	0.5 - 1.9
Other	32/1078	3.0	2.0 - 4.0
Prefer not to answer	21/1078	1.9	1.1 - 2.7
20-24			
Clinic or hospital	759/995	76.3	73.7 - 78.9
School	30/995	3.0	1.9 - 4.1
Mobile clinic or van near school	45/995	4.5	3.2 - 5.8
Mobile clinic or van in my community	59/995	5.9	4.4 - 7.4
At work	9/995	0.9	0.3 - 1.5
At home	49/995	4.9	3.6 - 6.2
Private doctor	21/995	2.1	1.2 - 3.0
Other	14/995	1.4	0.7 - 2.1
Prefer not to answer	9/995	0.9	0.3 - 1.5

Table 21: Quality of HIV testing services at last HIV test among HERStory 3 study participants who have ever received HIV testing from the My Journey Programme from 24 intervention sites across 8 provinces in South Africa, 2024

Variable	Freq/N	%	95% CI
Waiting time was reasonably short			
Total	609/875	69.6	66.6 - 72.6
15-19	268/403	66.5	61.9 - 71.1
20-24	341/472	72.2	68.2 - 76.3
Waiting time was one hour or less			
Total	781/875	89.3	87.2 - 91.3
15-19	352/403	87.3	84.1 - 90.6
20-24	429/472	90.9	88.3 - 93.5
Person who tested participant treated her in a friendly manner			
Total	811/875	92.7	91.0 - 94.4
15-19	369/403	91.6	88.8 - 94.3
20-24	442/472	93.6	91.4 - 95.8
Person who tested participant was respectful of her needs			
Total	818/875	93.5	91.9 - 95.1
15-19	370/403	91.8	89.1 - 94.5
20-24	448/472	94.9	92.9 - 96.9
All the other people at the testing site (receptionist, cleaners, security guards etc.) treated participant in a friendly and respectful way			
Total	728/875	83.2	80.7 - 85.7
15-19	321/403	79.7	75.7 - 83.6
20-24	407/472	86.2	83.1 - 89.3
Participant believed her test result and other information she shared would be kept confidential			
Total	737/875	84.2	81.8 - 86.6
15-19	323/403	80.1	76.3 - 84.0
20-24	414/472	87.7	84.8 - 90.7
Participant reported that the health information provided during HIV testing was clear and she understood it			
Total	785/875	89.7	87.7 - 91.7
15-19	346/403	85.9	82.5 - 89.3
20-24	439/472	93.0	90.7 - 95.3

Coverage of male condoms among participants

At risk of HIV transmission

Participants were considered at risk of HIV transmission if they had sex in the past six months and reported living with HIV. Participants who had plans to become pregnant at the time of the survey were excluded from this group as they would not be using condoms.

Table 22 describes motivation to use, access to, and effective use of male condoms as well as one key barrier to effective use of male condoms among participants at risk of HIV transmission. Regarding motivation, 65.4% of participants in the intervention arm and 67.7% in the comparison arm definitely wanted to use male condoms when having sex.

In terms of access, 77.6% of participants in the intervention arm and 72.0% in the comparison arm found it easy or very easy to access male condoms overall (Table 22).

Concerning effective use, 15.0% of participants in the intervention arm and 11.8% in the comparison arm reported using male or female condoms 100% of the time when having sex in the past six months overall (Table 22).

Disclosure of a positive HIV status to a partner is a key barrier to effective use of male condoms. However, more than 60% of participants in the intervention (62.6%) and comparison (65.6%) arm had told their partner that they were living with HIV (Table 22).

At risk of HIV infection

Participants were considered at risk of HIV infection if they had sex in the past six months, did not report living with HIV and did not have plans to become pregnant at the time of the survey.

Motivation to use male condoms

Indicators of motivation:

Table 23 describes motivation to use male condoms with partners and potential barriers to and facilitators of motivation among participants at risk of HIV infection. Of these participants, 63.1% in the intervention arm and 66.0% in the comparison arm wanted to use male condoms when having sex. The differences between study arms were small and not statistically significant overall or within age groups for this variable (Table 23).

There were more participants in the comparison arm (67.2%) who reported that they *definitely* wanted to use male condoms when having sex compared to the intervention arm (59.0%), and this was statistically significant. In the younger age group, more participants in the comparison arm (62.9%) definitely wanted to use male condoms compared to the intervention arm (56.6%%) and this

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difference was not statistically significant. In the older age group, more participants in the comparison arm (69.7%) definitely wanted to use male condoms compared to the intervention arm (60.7%) and this difference was statistically significant (Table 23).

There were very small differences by study arm overall or within each age group among participants who planned to use condoms the next time they had sex (66.4% in the intervention arm and 68.1% in the comparison arm) and these differences were not statistically significant (Table 23).

<u>Potential barriers and facilitators of motivation to use male condoms:</u>

Knowledge of male condoms:

In terms of knowledge about condoms, there were fewer participants in the intervention arm (46.2%) who did not think that condoms reduce the risk of an HIV infection by 70% of more when they have sex with someone who has HIV compared to the comparison arm (54.3%) (a statistically significant difference). While there was a small and non-statistically significant difference favouring the intervention arm in the younger age group, there was a larger, statistically significant difference between the intervention (42.9%) and comparison (52.5%) arm in the older age group (Table 23).

Just over half of participants had spoken to a parent or caregiver about condoms in the intervention (58.0%) and comparison (58.5%) arm (Table 23).

HIV risk perception:

Regarding HIV risk perception, 67.4% in the intervention arm and 64.8% in the comparison arm thought that there was a small to no chance that they would become infected with HIV. Similarly, 45.8% in the intervention arm and 40.9% in the comparison arm never or rarely worry about becoming infected with HIV. A small proportion of participants in the intervention (21.8%) and comparison (22.6 %) arms had one faithful partner that they trust. The small differences by study arm in these variables were not statistically significant (Table 23).

Consequences of use and attitudes:

Negative attitudes towards condoms were very low and there were very small (non-statistically significant) differences between arms with 11.2% of participants in the intervention arm reporting that they do not want to use condoms compared to 7.7% in the comparison arm; 8.6% of participants reported that they don't like condoms in the intervention arm compared to 7.7% in the comparison arm (Table 23).

Social norms:

Overall, a very similar proportion of participants in each arm (17.2% in the intervention arm and 18.0% in the comparison arm) thought that their friends used condoms when they have sex (Table 23).

Access to male condoms

Indicators of access:

Table 24 describes access to male condoms and potential barriers to and facilitators of access among participants at risk of HIV infection. Of these participants, a slightly great proportion (71.6%) in the intervention arm knew a place where someone like them could get male condoms compared to 68.2% in the comparison arm. While there was almost no difference by study arm in the younger age group, but in the older age group more participants who knew a place where they could easily get male condoms in the intervention arm (76.5%) compared to the comparison arm (70.3%) and this difference was statistically significant (Table 24).

More than two thirds of participants found it easy or very easy to get male condoms in the intervention arm (73.5%) and the comparison arm (71.9%), with a very small difference by study arm (Table 24).

Potential barriers and facilitators of access to male condoms:

Availability:

In terms of the availability of condoms, there were very small differences between study arms: 24.5% of participants in the intervention arm and 27.8% in the comparison arm reported that they sometimes did not have any condoms while 3.0% in the intervention arm and 4.3% in the comparison arm reported that the health facility sometimes did not have any condoms (stockouts) (Table 24).

Accessibility:

Regarding accessibility, there were very small differences between study arms: 5.4% of participants in the intervention arm and 5.1% in the comparison arm reported that male condoms were not available at school (Table 24).

Overall, fewer participants in the intervention (3.9%) and comparison (7.0%) arm reported that the place where they could get male condoms was not open when they had time to go (with a statistically significant difference in favour of the intervention arm). There were also small differences favouring the intervention arm in each of the age groups (Table 24).

Similarly, 7.1% of participants in the intervention arm and 10.2% in the comparison arm reported that it was far to travel to get male condoms, and there were also small differences favouring the intervention arm in each of the age groups (Table 24).

Almost no participants reported that COVID-19 and lockdowns made it difficult to get male condoms in the intervention arm (1.1%) and comparison arm (1.0%) (Table 24).

Acceptability:

The intervention and comparison arms were very similar regarding aspects of acceptability of condom coverage overall or within each age group. Overall, only 3.2% of participants in the intervention arm and 3.4% of participants in the comparison arm reported that condoms were not available in youth-friendly places; 11.5% in the intervention arm and 11.9% in the comparison arm were worried someone would see them while getting condoms; 31% in the intervention arm and 32.8% in the comparison arm reported a lack of privacy and confidentiality when getting male condoms; and 6.2% in the intervention arm and 8.1% in the comparison arm reported that negative health worker attitudes made it difficult to get male condoms (Table 24).

Affordability:

Only 2.5% of participants in the intervention arm and 4.3% of participants in the comparison arm reported that it is too expensive to get to a place where male condoms are available (Table 24).

Locations where participants accessed male condoms:

Table 25 describes the locations or people from which participants got condoms in the past six months among participants who were at risk of HIV infection. Most participants in the intervention arm got male condoms from a clinic or hospital (54.9%) followed by a mobile clinic, a boyfriend, school, a pharmacy, a safe space in the community, a friend, an NGO in the community, another place, or their workplace (16.6%, 12.5%, 8.4%, 7.2%, 5.5%, 5.4%, 2.3%, 1.7% and 1.6% respectively). This was also the case for the comparison arm, and the differences between arms were very small (Table 25).

Effective use of male condoms

Indicators of effective use:

Table 26 describes effective use of male condoms among participants at risk of HIV infection. Overall, a similar proportion of participants in each arm (13.6% the intervention arm and 14.7% in the comparison arm) reported using male or female condoms 100% of the time when having sex in the past six month. In the younger age group, more participants in the comparison arm (18.6%) reported using condoms 100% of the time in the past six months compared to the intervention arm (12.6%),

and this was statistically significant. However, in the older age group there was only a small difference between arms (Table 26).

Overall, a similar proportion of participants in each arm (23.7% in the intervention arm and 23.8% in the comparison arm) reported that they had always used condoms when having sex in the past six months (Table 26).

Potential barriers and facilitators of effective use of condoms:

Skills:

In terms of skills around condom use, there was almost no difference between arms in reporting having ever had instructions or counselling on how to use condoms (50.4% of participants in the intervention arm and 49.3% in the comparison arm). In the younger age group, there a small difference between arms, while in the older age group, the was a larger difference in favour of the intervention: 58.1% of participants in the intervention arm and 51.0% in the comparison arm had ever received counselling or instructions on how to use male condoms, and this was statistically significant (Table 43).

There was a very small difference in reporting forgetting to use condoms: in the intervention arm, 16.3% of participants reported that they forget to use condoms when having sex compared to 14.3% in the comparison arm (Table 26).

Self-efficacy:

Regarding self-efficacy to use condoms, the differences between study arms were small: 4.8% of participants in the intervention arm and 4.9% in the comparison arm reported that they were not confident they could get their sexual partner to use condoms with them while 2.5% in the intervention arm and 3.7% in the comparison arm reported that they were not confident they knew how to use male condoms (Table 26).

Partner influence and refusals:

Concerning partner influence over condom use, there were very small differences between study arms: 30.3% of participants in the intervention arm and 33.2% in the comparison arm reported that there partner would get angry if they asked them to use condoms when having sex with them; 4.8% in the intervention arm and 5.9% in the comparison arm reported that they were worried what their partner would think if they asked to use condoms; and 4.4% in the intervention arm and 4.7% in the comparison arm reported that their partner refused to use condoms when having sex with them (Table 26).

Table 22: Coverage of male condoms among HERStory 3 study participants who had sex in the past six months, reported living with HIV and did not have plans to become pregnant at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | |
| | Comparison | | Intervention | |
Variable	Freq/N	%	Freq/N	%
Indicators of motivation to use, access to and effective use of male condoms:				
If condoms were freely available to her, participant would definitely want to use them				
Total	63/93	67.7	70/107	65.4
15-19	18/31	58.1	22/38	57.9
20-24	45/62	72.6	48/69	69.6
If participant wants to get male condoms, it would be easy or very easy for her to get them				
Total	67/93	72.0	83/107	77.6
15-19	17/31	54.8	26/38	68.4
20-24	50/62	80.6	57/69	82.6
Participant used male or female condoms 100% of the time when having sex with a boy or man in the past six months				
Total	11/93	11.8	16/107	15.0
15-19	4/31	12.9	7/38	18.4
20-24	7/62	11.3	9/69	13.0
Potential barrier to condom use:				
Participant has not told her boyfriend or partner that she is living with HIV				
Total	61/93	65.6	67/107	62.6
15-19	23/31	74.2	22/38	57.9
20-24	38/62	61.3	45/69	65.2

Table 23: Motivation to use male condoms with partners and potential barriers to and facilitators of motivation among HERStory 3 study participants who had sex in the past six months, did not report living with HIV and did not have plans to become pregnant at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Indicators of motivation:							
Participant wants to use male condoms when having sex							
Total	503/762	66.0	628/995	63.1	0.82	0.55 - 1.21	0.3175
15-19	176/280	62.9	242/412	58.7	0.76	0.40 - 1.45	0.4193
20-24	327/482	67.8	386/583	66.2	0.87	0.54 - 1.40	0.5687
If condoms were freely available to her, participant would definitely want to use them							
Total	512/762	67.2	587/995	59.0	0.64	0.42 - 0.95	0.0387
15-19	176/280	62.9	233/412	56.6	0.71	0.46 - 1.11	0.1461
20-24	336/482	69.7	354/583	60.7	0.57	0.36 - 0.90	0.0238
Participant plans to use male condoms the next time she has sex							
Total	519/762	68.1	661/995	66.4	0.88	0.64 - 1.21	0.4449
15-19	183/280	65.4	264/412	64.1	0.89	0.56 - 1.42	0.6266
20-24	336/482	69.7	397/583	68.1	0.93	0.69 - 1.26	0.6602
Potential motivation barriers and facilitators:							
<u>*Knowledge*</u>							
Participant did not think that male condoms reduce an HIV-negative person's risk of getting HIV by 70% or more when they have sex with someone who has HIV							
Total	414/762	54.3	460/995	46.2	0.71	0.56 - 0.89	0.0084
15-19	161/280	57.5	210/412	51.0	0.75	0.55 - 1.03	0.0934
20-24	253/482	52.5	250/583	42.9	0.67	0.50 - 0.89	0.0126
Participant's mother or father or caregiver has spoken to her about using condoms							
Total	446/762	58.5	577/995	58.0	0.96	0.69 - 1.34	0.8029
15-19	169/280	60.4	238/412	57.8	0.88	0.61 - 1.27	0.5036
20-24	277/482	57.5	339/583	58.1	1.03	0.69 - 1.53	0.8931
<u>*HIV risk perception*</u>							
Participant thinks that there is a small to no chance that she will become infected with HIV in the next 12 months							
Total	494/762	64.8	671/995	67.4	1.16	0.89 - 1.52	0.2754
15-19	181/280	64.6	255/412	61.9	0.88	0.62 - 1.24	0.4693
20-24	313/482	64.9	416/583	71.4	1.39	1.00 - 1.93	0.0619
Participant never or rarely worries about getting HIV or being HIV-positive							
Total	312/762	40.9	456/995	45.8	1.21	0.93 - 1.57	0.1749
15-19	109/280	38.9	182/412	44.2	1.20	0.81 - 1.78	0.3789
20-24	203/482	42.1	274/583	47.0	1.22	0.91 - 1.64	0.1930
Participant has one faithful partner who she trusts							
Total	172/762	22.6	217/995	21.8	0.98	0.66 - 1.44	0.9037

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
15-19	59/280	21.1	94/412	22.8	1.25	0.66 - 2.35	0.5034
20-24	113/482	23.4	123/583	21.1	0.88	0.50 - 1.55	0.6596

Consequences of use/attitudes

Participant does not want to use condoms

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	59/762	7.7	111/995	11.2	1.75	0.90 - 3.40	0.1113
15-19	27/280	9.6	55/412	13.3	1.41[#]	0.81 - 2.46	0.2340
20-24	32/482	6.6	56/583	9.6	2.15	0.92 - 4.99	0.0905

Participant does not like using condoms

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	59/762	7.7	86/995	8.6	1.13[#]	0.69 - 1.86	0.6297
15-19	25/280	8.9	36/412	8.7	0.96	0.61 - 1.49	0.8441
20-24	34/482	7.1	50/583	8.6	1.27[#]	0.76 - 2.15	0.3734

Social norms

Participant thinks her friends use condoms when they had sex

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	137/762	18.0	171/995	17.2	0.93	0.69 - 1.27	0.6675
15-19	53/280	18.9	60/412	14.6	0.60	0.26 - 1.37	0.2408
20-24	84/482	17.4	111/583	19.0	1.17	0.62 - 2.19	0.6370

results based on model with site nested within subdistrict random effect (excluding household effect)

Table 24: Access to male condoms and potential barriers to and facilitators of access among HERStory 3 study participants who had sex in the past six months, did not report living with HIV and did not have plans to become pregnant at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Indicators of access:							
If/when participant wants to use male condoms, she knows a place where someone like her can easily get them							
Total	520/762	68.2	712/995	71.6	1.25	0.92 - 1.69	0.1682
15-19	181/280	64.6	266/412	64.6	1.10	0.68 - 1.78	0.7039
20-24	339/482	70.3	446/583	76.5	1.34	1.02 - 1.77	0.0490
If participant wants to get male condoms, it would be easy or very easy for her to get them							
Total	548/762	71.9	731/995	73.5	1.14	0.76 - 1.72	0.5280
15-19	188/280	67.1	277/412	67.2	1.07	0.65 - 1.78	0.7822
20-24	360/482	74.7	454/583	77.9	1.22	0.62 - 2.38	0.5694
Potential access barriers and facilitators:							
<u>*Availability*</u>							
Participant sometimes did not have condoms							
Total	212/762	27.8	244/995	24.5	0.79	0.58 - 1.08	0.1544
15-19	66/280	23.6	98/412	23.8	1.01	0.71 - 1.45	0.9412
20-24	146/482	30.3	146/583	25.0	0.66	0.42 - 1.06	0.0972
The health facility sometimes did not have any male condoms (condom stock-outs)							
Total	33/762	4.3	30/995	3.0	0.58	0.30 - 1.14	0.1306
15-19	10/280	3.6	9/412	2.2	0.60+	0.24 - 1.50	0.2862
20-24	23/482	4.8	21/583	3.6	0.73	0.40 - 1.35	0.3272
<u>*Accessibility*</u>							
Male condoms were not available in school							
Total	39/762	5.1	54/995	5.4	1.02#	0.61 - 1.69	0.9429
15-19	22/280	7.9	34/412	8.3	1.06#	0.57 - 1.95	0.8608
20-24	17/482	3.5	20/583	3.4	1.01#	0.51 - 1.98	0.9825
The place where participant could get male condoms was not open when she had time to go							
Total	53/762	7.0	39/995	3.9	0.54	0.35 - 0.83	0.0107
15-19	20/280	7.1	17/412	4.1	0.54#	0.26 - 1.15	0.1248
20-24	33/482	6.8	22/583	3.8	0.51	0.29 - 0.90	0.0305
It was far for participant to travel to get male condoms							
Total	78/762	10.2	71/995	7.1	0.63#	0.35 - 1.13	0.1336
15-19	38/280	13.6	36/412	8.7	0.58	0.34 - 0.99	0.0561
20-24	40/482	8.3	35/583	6.0	0.72#	0.37 - 1.40	0.3443
COVID-19 and lockdowns made it difficult to get condoms							
Total	8/762	1.0	11/995	1.1	1.24	0.89 - 1.74	0.2152
15-19	4/280	1.4	6/412	1.5	1.03+	0.28 - 3.77	0.9643
20-24	4/482	0.8	5/583	0.9	0.98+	0.30 - 3.23	0.9687
<u>*Acceptability*</u>							
Male condoms were not available in youth-friendly places in the community							

Variable	Comparison		Intervention		β/OR	95% CI	p-value
	Freq/N	**%**	**Freq/N**	**%**			
Total	26/762	3.4	32/995	3.2	0.97#	0.53 - 1.78	0.9183
15-19	8/280	2.9	14/412	3.4	1.17+	0.48 - 2.86	0.7275
20-24	18/482	3.7	18/583	3.1	0.80+	0.32 - 2.01	0.6448
Participant worries someone will see her getting male condoms							
Total	91/762	11.9	114/995	11.5	1.00	0.58 - 1.72	0.9958
15-19	30/280	10.7	56/412	13.6	1.28	0.76 - 2.13	0.3617
20-24	61/482	12.7	58/583	9.9	0.67	0.31 - 1.45	0.3219
There is a lack of privacy and confidentiality when getting male condoms							
Total	250/762	32.8	308/995	31.0	0.90	0.66 - 1.21	0.4814
15-19	97/280	34.6	137/412	33.3	0.95	0.66 - 1.36	0.7791
20-24	153/482	31.7	171/583	29.3	0.83	0.54 - 1.29	0.4263
The negative attitude of health workers make it difficult to get male condoms							
Total	62/762	8.1	62/995	6.2	0.75	0.33 - 1.72	0.5029
15-19	23/280	8.2	32/412	7.8	0.93	0.52 - 1.64	0.7949
20-24	39/482	8.1	30/583	5.1	0.61#	0.33 - 1.13	0.1293
Affordability							
It was too expensive to get to a place where male condoms were available							
Total	33/762	4.3	25/995	2.5	0.55#	0.25 - 1.21	0.1492
15-19	12/280	4.3	8/412	1.9	0.44+	0.17 - 1.12	0.1003
20-24	21/482	4.4	17/583	2.9	0.61#	0.26 - 1.45	0.2757

Header (spanning): **Prevalence/Mean** over Comparison and Intervention columns; **Effect estimates*** over β/OR, 95% CI, p-value.

\# results based on model with site nested within subdistrict random effect (excluding household effect)

+ results based on model with subdistrict random effect only (excluding household and site effect)

Table 25: Participant got condoms from these locations or people in the past six months among HERStory 3 study participants who had sex in the past six months, did not report living with HIV and did not have plans to become pregnant at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total							
Clinic or hospital	417/762	54.7	546/995	54.9	1.02	0.81 - 1.29	0.8620
Mobile clinic	116/762	15.2	165/995	16.6	1.19	0.72 - 1.97	0.5084
School	65/762	8.5	84/995	8.4	0.95#	0.60 - 1.51	0.8432
Workplace	17/762	2.2	16/995	1.6	0.71#	0.35 - 1.42	0.3404
Safe space in community	32/762	4.2	55/995	5.5	1.24#	0.70 - 2.22	0.4698
Pharmacy	55/762	7.2	72/995	7.2	0.94	0.50 - 1.75	0.8393
NGO in community	13/762	1.7	23/995	2.3	0.60	0.28 - 1.28	0.1980
Friend	40/762	5.2	54/995	5.4	1.14	0.56 - 2.32	0.7236
Boyfriend	128/762	16.8	124/995	12.5	0.58	0.33 - 1.04	0.0826
Another place	14/762	1.8	17/995	1.7	0.98	0.47 - 2.05	0.9642
15-19							
Clinic or hospital	140/280	50.0	197/412	47.8	0.92	0.62 - 1.37	0.6824
Mobile clinic	45/280	16.1	65/412	15.8	0.95#	0.58 - 1.58	0.8582
School	23/280	8.2	37/412	9.0	0.93#	0.48 - 1.83	0.8399
Workplace	2/280	0.7	2/412	0.5	0.54+	0.05 - 5.74	0.6141
Safe space in community	12/280	4.3	18/412	4.4	0.81	0.40 - 1.67	0.5805
Pharmacy	16/280	5.7	24/412	5.8	0.88	0.48 - 1.60	0.6816
NGO in community	3/280	1.1	11/412	2.7	0.78	0.42 - 1.45	0.4376
Friend	15/280	5.4	23/412	5.6	1.18	0.78 - 1.78	0.4359
Boyfriend	55/280	19.6	54/412	13.1	0.49	0.22 - 1.11	0.1021
Another place	4/280	1.4	5/412	1.2	0.94+	0.21 - 4.19	0.9313
20-24							
Clinic or hospital	277/482	57.5	349/583	59.9	1.17	0.86 - 1.58	0.3227
Mobile clinic	71/482	14.7	100/583	17.2	1.67	0.86 - 3.23	0.1431
School	42/482	8.7	47/583	8.1	0.95#	0.58 - 1.53	0.8223
Workplace	15/482	3.1	14/583	2.4	0.72	0.34 - 1.52	0.3976
Safe space in community	20/482	4.1	37/583	6.3	1.03	0.87 - 1.22	0.7439
Pharmacy	39/482	8.1	48/583	8.2	1.07#	0.63 - 1.81	0.8075

	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
NGO in community	10/482	2.1	12/583	2.1	0.97	0.56 - 1.67	0.8997
Friend	25/482	5.2	31/583	5.3	0.98	0.59 - 1.64	0.9537
Boyfriend	73/482	15.1	70/583	12.0	0.63	0.29 - 1.39	0.2683
Another place	10/482	2.1	12/583	2.1	1.05	0.44 - 2.51	0.9126

\# results based on model with site nested within subdistrict random effect (excluding household effect)

\+ results based on model with subdistrict random effect only (excluding household and site effect)

Table 26: Effective use of male condoms and potential barriers to and facilitators of effective use among HERStory 3 study participants who had sex in the past six months, did not report living with HIV and did not have plans to become pregnant at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Indicators of effective use:							
Participant used male or female condoms 100% of the time when having sex with a boy or man in the past six months							
Total	112/762	14.7	135/995	13.6	0.79	0.43 - 1.43	0.4396
15-19	52/280	18.6	52/412	12.6	0.39	0.17 - 0.87	0.0311
20-24	60/482	12.4	83/583	14.2	1.30	0.54 - 3.10	0.5648
Participant always used male or female condoms when having sex with a boy or man in the past six months							
Total	181/762	23.8	236/995	23.7	0.88	0.47 - 1.67	0.7034
15-19	74/280	26.4	88/412	21.4	0.73#	0.45 - 1.20	0.2272
20-24	107/482	22.2	148/583	25.4	1.27	0.59 - 2.75	0.5533
Potential effective use barriers and facilitators:							
Skills							
Participant had instructions or counselling on how to use male condoms							
Total	376/762	49.3	501/995	50.4	1.07	0.85 - 1.34	0.5929
15-19	130/280	46.4	162/412	39.3	0.77	0.50 - 1.18	0.2458
20-24	246/482	51.0	339/583	58.1	1.31	1.02 - 1.68	0.0431
Participant forgot to use condoms when having sex							
Total	109/762	14.3	162/995	16.3	1.24	0.71 - 2.15	0.4574
15-19	45/280	16.1	79/412	19.2	1.21#	0.78 - 1.88	0.4061
20-24	64/482	13.3	83/583	14.2	1.37	0.65 - 2.87	0.4182
Self-efficacy							
Participant was not confident she could get her sexual partner to use condoms with her							
Total	37/762	4.9	48/995	4.8	0.94	0.60 - 1.47	0.8011
15-19	11/280	3.9	20/412	4.9	1.18	0.54 - 2.58	0.6825
20-24	26/482	5.4	28/583	4.8	0.85	0.48 - 1.48	0.5672
Participant was not confident she knew how to use condoms							
Total	28/762	3.7	25/995	2.5	0.66#	0.37 - 1.19	0.1787
15-19	14/280	5.0	14/412	3.4	0.68	0.38 - 1.23	0.2145
20-24	14/482	2.9	11/583	1.9	0.69#	0.31 - 1.53	0.3692
Partner influence/refusals							
Participant agreed or strongly agreed that if she asked her current or most recent main partner or boyfriend to use a condom, he would get angry							
Total	253/762	33.2	301/995	30.3	0.81	0.55 - 1.19	0.2960
15-19	110/280	39.3	133/412	32.3	0.63	0.37 - 1.05	0.0916
20-24	143/482	29.7	168/583	28.8	0.90	0.52 - 1.54	0.6948
Participant worries about what her partner would think if she asked to use condoms							
Total	45/762	5.9	48/995	4.8	0.75	0.36 - 1.54	0.4363
15-19	16/280	5.7	28/412	6.8	1.09#	0.52 - 2.28	0.8243

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
20-24	29/482	6.0	20/583	3.4	0.66#	0.35 - 1.26	0.2234
Participant's sexual partner did not want to use condoms with her when they had sex							
Total	36/762	4.7	44/995	4.4	0.96	0.49 - 1.86	0.8973
15-19	11/280	3.9	21/412	5.1	1.32#	0.62 - 2.80	0.4823
20-24	25/482	5.2	23/583	3.9	0.81#	0.43 - 1.53	0.5204

results based on model with site nested within subdistrict random effect (excluding household effect)

HIV prevention cascade for male condoms

We created HIV prevention cascades for male condoms to describe participant's motivation to use, access to, use and effective use of male condoms among participants who self-reported that they were not living with HIV, had sex in the past six months and did not have plans to become pregnant at the time of the survey. We created separate cascades for the 15-19 (Figure 5a) and 20-24 (Figure 5b) age group, stratified by intervention/comparison sites.

Motivation to use male condoms was defined as definitely wanting to use condoms if they were freely available. Access to male condoms was defined as finding it easy or very easy to access male condoms. Use of male condoms was defined as using condoms throughout sex the last time you had sex. Effective use of condoms was defined as using male or female condoms 100% of the time when having sex in the past six months.

Among participants who were 15-19 years old, there were no statistically significant differences in motivation to use (56.6% in the intervention versus 62.9% in the comparison arm); access to (67.2% in the intervention versus 67.1% in the comparison arm), use (40.8% in the intervention versus 40.0% in the comparison arm), or effective use (12.6% in the intervention versus 18.6% in the comparison arm) of male condoms by study arm (Figure 5a).

Among the 20-24 year olds, there were statistically significantly more participants in the comparison (69.7%) arm with motivation to use male condoms compared to the intervention arm (60.8%). There were no statistically significant differences by study arm for access to male condoms (77.8% in the intervention versus 74.7% in the comparison arm), use of male condoms (42.1% in the intervention and 42.9% in the comparison arm) and effective use of condoms (14.3% in the intervention versus 12.4% in the comparison arm) (Figure 5b).
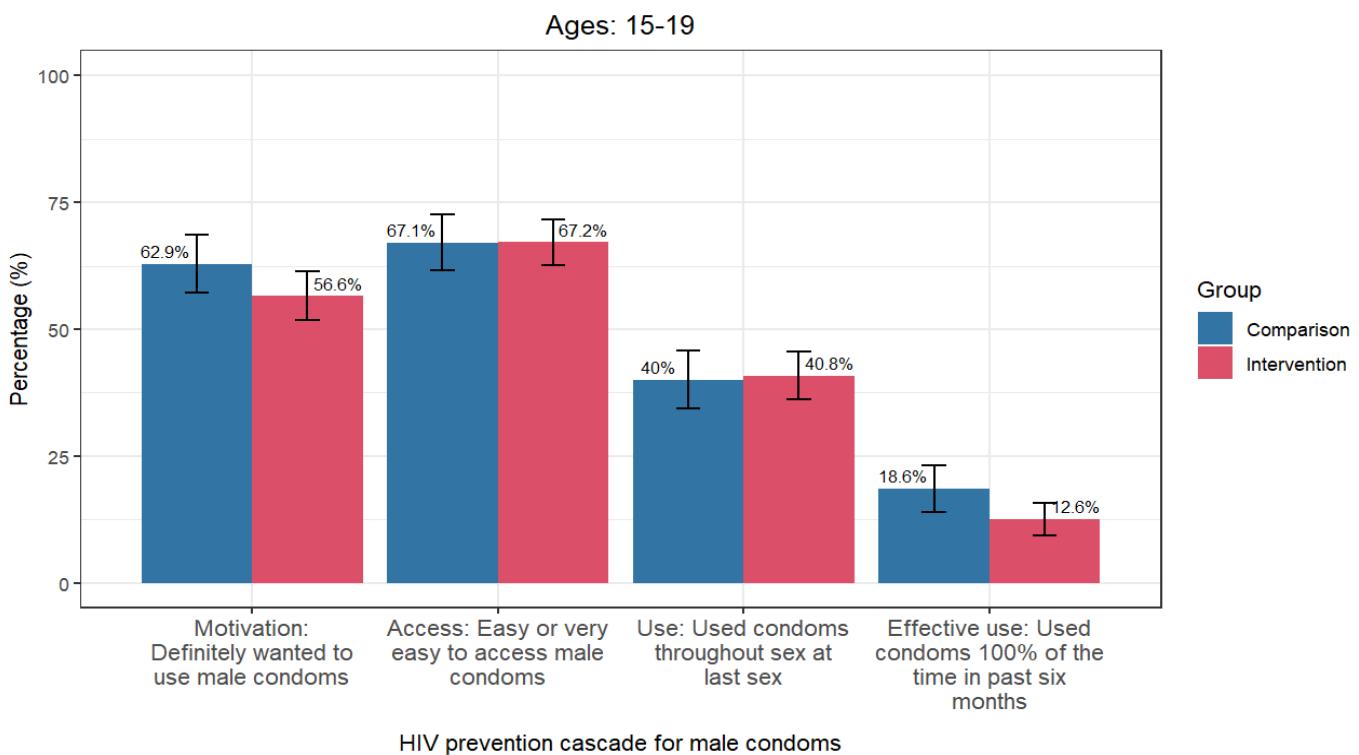
Figure 5a: HIV prevention cascade for male condoms among participants aged 15-19 years who self-reported that they were not living with HIV, had sex in the past six months and did not have plans to become pregnant at the time of the survey, stratified by intervention/comparison sites. The denominator is the same for all bars in the cascade.
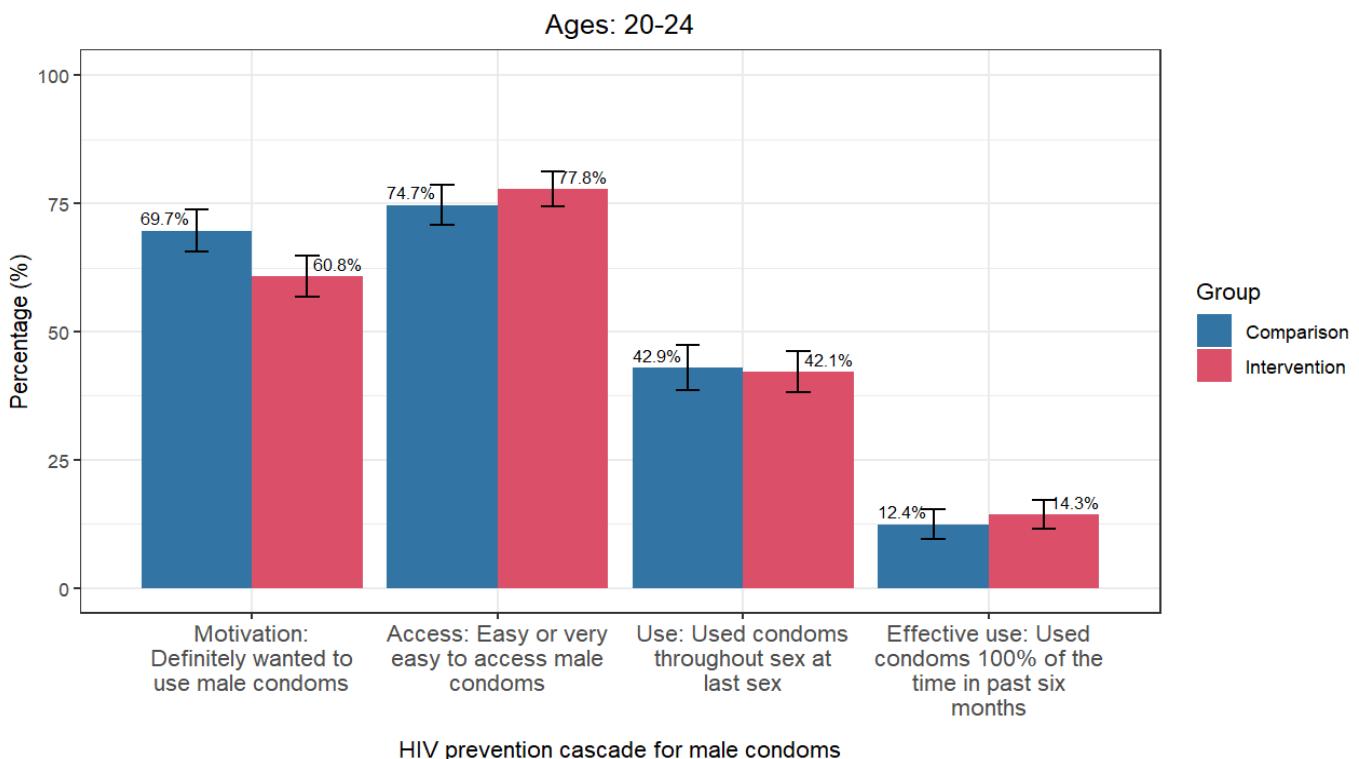
Figure 5b: HIV prevention cascade for male condoms among participants aged 20-24 years who self-reported that they were not living with HIV, had sex in the past six months and did not have plans to become pregnant at the time of the survey, stratified by intervention/comparison sites. The denominator is the same for all bars in the cascade.

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Coverage of FEMALE condoms among participants at risk of HIV infection

Table 27 describes coverage of FEMALE condoms among participants who reported that they had sex in the past six months, did not report living with HIV and did not have plans to become pregnant at the time of the survey. Of these participants, 41.9% in the intervention arm and 35.7% in the comparison arm knew what a female condom was; 67.5% in the intervention arm and 66.9% in the comparison arm had ever seen a female condom; and 38.7% in the intervention arm and 38.1% in the comparison arm had ever received instructions or counselling on how to use female condoms. These differences were very small and not statistically significant (Table 27).

In terms of access to female condoms, 55.6% of participants in the intervention arm knew a place where they could easily get female condoms compared to 52.1% in the comparison arm, with no statistically significant difference by study arm overall. While there was no statistically significant difference by study arm in the younger age group, there were statistically significant more participants in the intervention arm (64.3%) who knew a place where they could easily get female condoms compared to the comparison arm (54.1%) in the older age group (Table 27).

Similarly, 54.6% of participants in the intervention arm and 54.1% in the comparison arm reported that it would be easy or very easy to get female condoms if they wanted to get them, with no statistically significant differences by study arm overall or within each age group (Table 27).

Regarding use of female condoms, 10.1% of participants in the intervention arm and 13.1% in the comparison arm reported that they had ever used a female condom, with no statistically significant differences by study arm overall. In the younger age group, there were statistically significantly more participants in the comparison arm (15.0%) who had ever used a female condom compared to the intervention arm (7.5%). There were no statistically significant differences by study arm in the older age group (Table 27).

Overall, 10.3% of participants in the intervention arm and 13.9% in the comparison arm reported that they had used a female condom once or more in the past six months, with no statistically significant differences by study arm. There were statistically significantly more participants in the comparison arm (15.7%) who used a female condom once or more in the past six months compared to the intervention arm (8.0%) in the younger age group. There were no statistically significant differences by study arm in the older age group (Table 27).

Table 28 describes the locations or people from which participants got female condoms in the past six months among participants who reported that they had sex in the past six months, did not report living with HIV and did not have plans to become pregnant at the time of the survey. Overall, most

participants in both arms got female condoms from a clinic or hospital followed by a mobile clinic, or school (Table 28).

Table 27: Coverage of FEMALE condoms among HERStory 3 study participants who had sex in the past six months, did not report living with HIV and did not have plans to become pregnant at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant knew what a female condom was							
Total	272/762	35.7	417/995	41.9	1.35	1.00 - 1.83	0.0644
15-19	89/280	31.8	147/412	35.7	1.48	0.81 - 2.69	0.2126
20-24	183/482	38.0	270/583	46.3	1.42	0.98 - 2.04	0.0757
Participant had seen a female condom							
Total	510/762	66.9	672/995	67.5	1.10	0.69 - 1.76	0.6859
15-19	186/280	66.4	240/412	58.3	0.66	0.32 - 1.35	0.2656
20-24	324/482	67.2	432/583	74.1	1.82	0.95 - 3.49	0.0840
Participant had received instructions or counselling on how to use female condoms							
Total	290/762	38.1	385/995	38.7	1.02	0.75 - 1.40	0.8821
15-19	99/280	35.4	122/412	29.6	0.75	0.37 - 1.51	0.4251
20-24	191/482	39.6	263/583	45.1	1.25	0.94 - 1.67	0.1417
Participant knew a place she could get female condoms if she wanted to use them							
Total	397/762	52.1	553/995	55.6	1.20	0.92 - 1.58	0.1966
15-19	136/280	48.6	178/412	43.2	0.83	0.58 - 1.19	0.3215
20-24	261/482	54.1	375/583	64.3	1.72	1.24 - 2.38	0.0036
Participant believed it would be easy or very easy to get female condoms if she wanted to use them							
Total	412/762	54.1	543/995	54.6	1.07	0.85 - 1.33	0.5733
15-19	144/280	51.4	185/412	44.9	0.77	0.55 - 1.09	0.1553
20-24	268/482	55.6	358/583	61.4	1.31	0.99 - 1.74	0.0736
Participant has ever used a female condom							
Total	100/762	13.1	100/995	10.1	0.54	0.25 - 1.19	0.1406
15-19	42/280	15.0	31/412	7.5	0.48[#]	0.28 - 0.81	0.0125
20-24	58/482	12.0	69/583	11.8	0.91[#]	0.54 - 1.52	0.7123
Participant used a female condom once or more in the past six months							
Total	106/762	13.9	102/995	10.3	0.47	0.21 - 1.06	0.0825
15-19	44/280	15.7	33/412	8.0	0.47	0.29 - 0.77	0.0060
20-24	62/482	12.9	69/583	11.8	0.83[#]	0.48 - 1.45	0.5259

results based on model with site nested within subdistrict random effect (excluding household effect)

Table 28: Participant got FEMALE condoms from these locations or people in the past six months among HERStory 3 study participants who had sex in the past six months, did not report living with HIV and did not have plans to become pregnant at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total							
Clinic or hospital	304/762	39.9	370/995	37.2	0.87	0.63 - 1.20	0.4008
Mobile clinic	96/762	12.6	111/995	11.2	0.83	0.48 - 1.42	0.5069
School	34/762	4.5	49/995	4.9	1.09	0.78 - 1.51	0.6224
Workplace	10/762	1.3	6/995	0.6	0.49+	0.16 - 1.48	0.2191
Safe space in community	19/762	2.5	24/995	2.4	1.03#	0.56 - 1.90	0.9269
Pharmacy	36/762	4.7	42/995	4.2	0.90#	0.51 - 1.62	0.7379
NGO in community	8/762	1.0	15/995	1.5	1.52+	0.62 - 3.69	0.3694
Friend	20/762	2.6	18/995	1.8	0.66	0.35 - 1.27	0.2275
Boyfriend	13/762	1.7	13/995	1.3	0.78#	0.35 - 1.73	0.5461
Another place	9/762	1.2	12/995	1.2	1.08#	0.46 - 2.55	0.8663
15-19							
Clinic or hospital	105/280	37.5	124/412	30.1	0.61	0.33 - 1.13	0.1284
Mobile clinic	35/280	12.5	34/412	8.3	0.65#	0.33 - 1.29	0.2292
School	16/280	5.7	24/412	5.8	1.04#	0.53 - 2.06	0.9092
Workplace	0/280	0.0	2/412	0.5			
Safe space in community	9/280	3.2	6/412	1.5	0.47+	0.15 - 1.46	0.204
Pharmacy	9/280	3.2	13/412	3.2	1.09+	0.39 - 3.06	0.8647
NGO in community	3/280	1.1	3/412	0.7	0.49+	0.07 - 3.46	0.482
Friend	11/280	3.9	4/412	1.0	0.23+	0.07 - 0.71	0.0185
Boyfriend	5/280	1.8	4/412	1.0	0.58+	0.11 - 2.98	0.5208
Another place	0/280	0.0	3/412	0.7	-	-	-
20-24							
Clinic or hospital	199/482	41.3	246/583	42.2	1.05	0.78 - 1.41	0.7446
Mobile clinic	61/482	12.7	77/583	13.2	1.07#	0.71 - 1.61	0.767
School	18/482	3.7	25/583	4.3	1.42	0.82 - 2.47	0.2235
Workplace	10/482	2.1	4/583	0.7	0.36+	0.11 - 1.19	0.1089
Safe space in community	10/482	2.1	18/583	3.1	1.44	0.83 - 2.50	0.2089
Pharmacy	27/482	5.6	29/583	5.0	0.92	0.49 - 1.75	0.8054
NGO in community	5/482	1.0	12/583	2.1	2.05+	0.74 - 5.66	0.1796

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Friend	9/482	1.9	14/583	2.4	1.25	0.53 - 2.97	0.6183
Boyfriend	8/482	1.7	9/583	1.5	0.87+	0.32 - 2.34	0.7853
Another place	9/482	1.9	9/583	1.5	0.85+	0.33 - 2.19	0.7378

\# results based on model with site nested within subdistrict random effect (excluding household effect)
+ results based on model with subdistrict random effect only (excluding household and site effect)
α/- frequency or sample size too low to obtain a reliable estimate

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

Motivation to use PrEP

Indicators of motivation to use PrEP:

Table 29 describes motivation to use PrEP and potential barriers to and facilitators of motivation among participants who had sex in the past six months and did not report living with HIV. Of these participants, 47.7% in the intervention arm and 50.2% in the comparison arm wanted to use PrEP; 42.0% in the intervention arm and 46.6% in the comparison arm definitely wanted to use PrEP; and 33.0% in the intervention arm and 33.1% in the comparison arm planned to start using PrEP. There were small non statistically significant differences by study arm overall and within age groups for these variables (Table 29).

Barriers and facilitators of motivation to use PrEP:

Knowledge of PrEP:

Regarding knowledge, there were statistically significantly fewer participants in the intervention arm (28.2%) who did not know what PrEP was or were not sure about what it was, compared to the comparison arm (35.0%). In the older age group, there were also fewer participants in the intervention arm who did not know what PrEP was compared to the comparison arm (but the difference was not statistically significant). In the younger age group, there were also fewer participants in the intervention arm (29.2%) who did not know about PrEP compared to the comparison arm (37.2%), and the difference was statistically significant (Table 29).

Overall and in the older age group, there were substantially and statistically significantly fewer participants in the intervention arm (43.2% and 38.9% respectively) who did not believe that PrEP could reduce a person's risk of acquiring HIV by 70% or more, compared to the comparison arm (53.7% and 52.2% respectively). In the younger age group, this difference in favour of the intervention arm was also observed, but it was not statistically significant (Table 29).

In the intervention arm, there were substantially and statistically significantly more participants who had taken PrEP before and then discontinued it (20.1%) compared to the comparison arm (9.1%). There were also substantial differences by study arm in the younger and older age groups in favour of the intervention arm (Table 29).

HIV risk perception:

There were very small differences by arm in HIV risk perception: in the intervention arm, 7.1% of participants did not think they needed PrEP compared to 8.6% in the comparison arm (Table 29).

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Consequences of use and attitudes:

The differences by study arm in beliefs and attitudes about the consequences of PrEP use were very small. Overall, 26.0% of participants in the intervention arm and 28.2% in the comparison arm agreed or strongly agreed that if they used PrEP, they would worry that people will think they were living with HIV; 23.4% in the intervention arm and 26.2% in the comparison arm agreed or strongly agreed that if they used PrEP, they would worry that people will judge them for having sex; 61.1% in the intervention arm and 60.5% in the comparison arm agreed or strongly agreed that they would be happy if they used PrEP because it is an HIV prevention method that they can control; 35.4% in the intervention arm and 37.5% in the comparison arm agreed or strongly agreed that they would be happy because they would be able to fall pregnant while using PrEP; 44.1% in the intervention arm and 46.9% in the comparison arm agreed or strongly agreed that it would be convenient to take the PrEP medication; and 43.7% in the intervention arm and 44.3% in the comparison arm agreed or strongly agreed that if they used PrEP, they would worry about the side effects (Table 29).

Social norms:

The differences by study arm in social norms were very small. Overall, 53.9% of participants in the intervention arm and 51.3% in the comparison arm agreed or strongly agreed that if they used PrEP, their friends would approve of them taking it; and 55.6% in the intervention arm and 54.6% in the comparison arm agreed or strongly agreed that if they used PrEP, their family would approve of them taking it (Table 29).

In the intervention arm, there were substantially more participants who did not think that their friends use PrEP (30.0%) compared to the comparison arm (39.4%), and within age groups there were also substantial differences by study arm in favour of the intervention arm (Table 29).

Access to PrEP

Indicators of access:

Table 30 describes access to PrEP and potential barriers to and facilitators of access among participants who had sex in the past six months and did not report living with HIV. Of these participants, there were substantially and statistically significantly more participants in intervention arm (71.3%) who knew a place where they could easily get PrEP compared to the comparison arm (60.1%) and within age groups there were also substantial differences by study arm in favour of the intervention arm (Table 30).

A very similar proportion of participants in both arms (66.1% in the intervention arm and 58.7% in the comparison arm) reported that it would be easy or very easy to access PrEP if they wanted to get it,

but with no statistically significant differences by study arm overall or within each age group (Table 30).

Barriers and facilitators of access:

Availability:

There were slightly more participants in the intervention arm (3.1%) who reported that the place where they get PrEP sometimes does not have any PrEP (stock-outs) compared to the comparison arm (1.9%), although reporting of this barrier was very low in both arms (Table 30).

Accessibility:

Overall and within the younger and older age groups, there were substantially and statistically significantly fewer participants in the intervention arm (51.9%, 54.0%, and 50.5% respectively) who had never been offered PrEP compared to the comparison arm (69.4%, 69.8% and 69.2% respectively) (Table 30).

Very few participants reported that PrEP is not offered at school in the intervention (6.0%) and comparison (5.3%) arm; the opening hours of the clinic or service where they can get PrEP does not suit them in the intervention (5.1%) and comparison (6.3%) arm; and that it is far to go to a clinic to get PrEP in the intervention (7.8%) and comparison (9.6%) arm. The differences between arms were small (and not statistically significant) for any of these variables (Table 30).

Almost no participants reported that COVID-19 and lockdowns made it difficult to get PrEP in the intervention (0.8%) and comparison (1.0%) arms, with no statistically significant differences overall. However, there was a statistically significant difference between the intervention (0.7%) and comparison (1.1%) arm in the younger age group, but none in the older age group (Table 30).

Acceptability:

In terms of acceptability, there were very small differences between study arms: 3.4% of participants in the intervention arm and 3.5% in the comparison arm reported that PrEP is not offered in youth-friendly places; 15.4% in the intervention arm and 16.6% in the comparison arm worry about a lack of privacy and confidentiality when getting PrEP; and 5.1% in the intervention arm and 7.3% in the comparison arm reported that the negative attitudes of health worders make it difficult to get PrEP (Table 30).

Affordability:

A similar proportion of participants in each arm reported that it would cost too much to get to the clinic or service to get PrEP (16.2% in the intervention arm compared to 17.8% in the comparison arm) (Table 30).

Use of PrEP:

Indicators of use:

Table 31 describes use of PrEP and potential barriers to and facilitators of use among participants who had sex in the past six months and did not report living with HIV. Of these participants, substantially and statistically significantly more participants (26.4%) in the intervention arm had ever used PrEP compared with 13.0% in the comparison arm. There were also substantially and statistically significantly more participants in the intervention arm (24.6% and 27.6%) who had ever used PrEP compared to the comparison arm (11.6% and 13.8%) in the younger and older age group, respectively (Table 31).

Barriers and facilitators of PrEP use:

Skills:

Overall, there were substantially and statistically significantly more participants in the intervention arm (51.0%) who reported that they had ever had instructions or counselling on how to use PrEP compared to the comparison arm (33.8%) and within age groups there were also substantial differences in favour of the intervention arm (Table 31).

Self-efficacy:

In terms of self-efficacy, there were very small (non-statistically significant) differences between study arms: 56.0% of participants in the intervention arm and 53.5% in the comparison arm agreed or strongly agreed that they are confident they could use PrEP if they wanted to; and 57.6% in the intervention arm and 53.4% in the comparison arm agreed or strongly agreed that they could use PrEP in spite of what others may think (Table 31).

Slightly more (58.3%) participants in the intervention arm agreed or strongly agreed that they were confident that they could use PrEP in the way they were supposed to compared with 54.9% in the comparison arm, with no statistically significant differences overall. There was almost no difference by study arm in the older age group, but in the younger age group, substantially and statistically significantly more participants agreed or strongly disagreed with this in the intervention arm (56.6%) compared to the comparison arm (47.4%) (Table 31).

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Partner influence:

In terms of partner influence, there was very little difference between study arms: 53.7% of participants in the intervention arm and 50.6% in the comparison arm agreed or strongly agreed that their partner would approve of them using PrEP (Table 31).

Effective use of PrEP

Indicators of effective use:

Table 49 describes effective use of PrEP among participants who had ever used PrEP. Among participants who had ever used PrEP, a similar proportion of participants in each study arm were on PrEP at the time of the survey (38.1% in the intervention arm and 40.0% in the comparison arm) (Table 31).

Among participants who had ever used PrEP, 62.6% of participants in the intervention arm and 72.7% in the comparison arm reported taking their PrEP medication 100% of the time in the past six months (Table 32).

Barriers and facilitators of effective use:

In terms of barriers to PrEP use, 46.0% of participants in the intervention and 37.6% in the comparison arm reported that they forget to take PrEP; and 13.2% of participants in the intervention arm and 9.1% in the comparison arm reported that they ran out of PrEP (Table 32).

A small proportion of participants reported that their sexual partner did not want them to use PrEP in the intervention (2.3%) and comparison arm (3.0%), while 2.3% of participants in the intervention arm and 1.8% in the comparison arm had parents who did not want them to use PrEP (Table 32).

Similarly, a small proportion of participants reported that they have one faithful partner who they trust in the intervention arm (3.2%) and in the comparison arm (3.0%) (Table 32).

In terms of physically taking PrEP pills as a potential barrier, 1.4% of participants in the intervention arm and 1.2% in the comparison arm reported that they already take other pills; while 6.7% in the intervention arm and 3.6% in the comparison arm reported that they dislike the taste, smell or size of the PrEP pills (Table 32).

Other potential barriers included that participants were not sexually active (6.2% in the intervention arm and 5.5% in the comparison arm); had side effects when taking PrEP (7.4% in the intervention arm and 10.3% in the comparison arm); and participant did not tell anyone that she was taking PrEP (10.4% in the intervention arm and 10.9% in the comparison arm) (Table 32).

After starting PrEP, 19.6% of participants in the intervention arm and 13.9% in the comparison arm reported using condoms less than before, while 11.3% of participants in the intervention arm and 18.8% in the comparison arm reported having more sexual partners than before (Table 32).

Table 33 describes the length of time that participants have been taking PrEP among participants who were on PrEP at the time of the survey. Most participants in the intervention arm had been taking PrEP for six months or more (35.8%) or for one month only (26.7%) (Table 33).

Table 34 describes the quality of PrEP services received by participants the last time they went to get PrEP from the My Journey Programme. Overall, 69.5% of participants reported that they had a reasonably short waiting time and 83.9% reported that the waiting time was one hour or less (Table 34).

Most participants reported that the health worker asked them about their main concerns about PrEP (76.3%); 77.5% reported that the health worker spoke to them about side effects; 68.7% reported that the health worker asked them about missing or skipping PrEP; and 84.7% reported that the health worker asked them about their sexual behaviour and sexual relationships (Table 34).

Approximately 90% of participants reported that the health worker who gave them PrEP treated them in a friendly manner (89.6%) and was respectful of their needs (90.8%). Similarly, 84.7% of participants reported that all other clinic staff including the receptionist, cleaners and security guards treated them in a friendly and respectful way. Nevertheless, 16.5% of participants felt judged by the health worker who gave them PrEP (Table 34).

Around two thirds of participants reported that the health worker checked whether the participant might have symptoms of an STI (65.9%) and 76.7% checked whether the participant was using family planning (Table 34).

Table 29: Motivation to use PrEP and potential barriers to and facilitators of motivation among HERStory 3 study participants who had sex in the past six months and did not report living with HIV from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Indicators of motivation:							
Participant wants to use PrEP if it was available to her							
Total	391/779	50.2	481/1009	47.7	0.87	0.57 - 1.32	0.5192
15-19	126/285	44.2	178/415	42.9	0.96	0.64 - 1.46	0.8645
20-24	265/494	53.6	303/594	51.0	0.87	0.55 - 1.38	0.5595
If PrEP was freely available to her, participant would definitely want to use it							
Total	363/779	46.6	424/1009	42.0	0.79	0.53 - 1.17	0.2580
15-19	117/285	41.1	168/415	40.5	0.97	0.63 - 1.48	0.8781
20-24	246/494	49.8	256/594	43.1	0.73	0.47 - 1.12	0.1591
Participant plans to start using PrEP							
Total	258/779	33.1	333/1009	33.0	0.94	0.59 - 1.50	0.7867
15-19	83/285	29.1	128/415	30.8	1.13	0.63 - 2.01	0.6913
20-24	175/494	35.4	205/594	34.5	0.97	0.56 - 1.68	0.9095
Potential motivation barriers and facilitators:							
<u>*Knowledge*</u>							
Participant did not know about PrEP or was not sure about what it was							
Total	273/779	35.0	285/1009	28.2	0.71	0.52 - 0.96	0.0346
15-19	106/285	37.2	121/415	29.2	0.68	0.49 - 0.93	0.0270
20-24	167/494	33.8	164/594	27.6	0.72	0.47 - 1.10	0.1473
Participant did not believe that PrEP could reduce a person's risk of getting HIV by more than 70%							
Total	418/779	53.7	436/1009	43.2	0.64	0.51 - 0.81	0.0011
15-19	160/285	56.1	205/415	49.4	0.75	0.54 - 1.03	0.0855
20-24	258/494	52.2	231/594	38.9	0.57	0.40 - 0.80	0.0035
Participant has taken PrEP before and then discontinued it							
Total	71/779	9.1	203/1009	20.1	2.38[#]	1.17 - 4.86	0.0256
15-19	21/285	7.4	80/415	19.3	3.17[#]	1.65 - 6.11	0.0023
20-24	50/494	10.1	123/594	20.7	2.13[#]	1.02 - 4.47	0.0573
<u>*HIV risk perception*</u>							
Participant doesn't think she needs PrEP							
Total	67/779	8.6	72/1009	7.1	0.79	0.56 - 1.12	0.2046
15-19	30/285	10.5	28/415	6.7	0.57	0.33 - 1.00	0.0609
20-24	37/494	7.5	44/594	7.4	1.02	0.64 - 1.62	0.9280
<u>*Consequence of use/attitudes*</u>							
Agreed or strongly agreed that if she used PrEP, she would worry that people will think she is HIV positive							
Total	220/779	28.2	262/1009	26.0	0.89	0.68 - 1.16	0.3833
15-19	75/285	26.3	102/415	24.6	0.91	0.63 - 1.31	0.6041
20-24	145/494	29.4	160/594	26.9	0.88	0.64 - 1.23	0.4724
Agreed or strongly agreed that if she used PrEP, she would worry that people will judge her for having sex							

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	204/779	26.2	236/1009	23.4	0.84	0.63 - 1.12	0.2470
15-19	80/285	28.1	109/415	26.3	0.91	0.64 - 1.27	0.5739
20-24	124/494	25.1	127/594	21.4	0.77	0.52 - 1.14	0.2091

Agreed or strongly agreed that if she used PrEP, she would be happy because it is an HIV prevention method she can control

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	471/779	60.5	617/1009	61.1	1.05	0.71 - 1.56	0.7955
15-19	156/285	54.7	235/415	56.6	1.13	0.75 - 1.71	0.5759
20-24	315/494	63.8	382/594	64.3	1.00	0.59 - 1.70	0.9981

Agreed or strongly agreed that if she used PrEP, she would be happy because she would be able to get pregnant while using PrEP

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	292/779	37.5	357/1009	35.4	0.89	0.65 - 1.21	0.4495
15-19	81/285	28.4	115/415	27.7	0.96	0.53 - 1.76	0.9020
20-24	211/494	42.7	242/594	40.7	0.86	0.57 - 1.28	0.4560

Agreed or strongly agreed that if she used PrEP, it would be convenient to take the PrEP medication

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	365/779	46.9	445/1009	44.1	0.91	0.68 - 1.22	0.5276
15-19	110/285	38.6	157/415	37.8	0.99	0.62 - 1.60	0.9712
20-24	255/494	51.6	288/594	48.5	0.87	0.61 - 1.24	0.4535

Agreed or strongly agreed that if she used PrEP, she would worry about the side effects

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	345/779	44.3	441/1009	43.7	0.99	0.75 - 1.30	0.9368
15-19	112/285	39.3	178/415	42.9	1.22	0.77 - 1.92	0.4083
20-24	233/494	47.2	263/594	44.3	0.88	0.68 - 1.12	0.3097

Social norm

Agreed or strongly agreed that if she used PrEP, her friends would approve of her taking it

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	400/779	51.3	544/1009	53.9	1.12	0.84 - 1.51	0.4460
15-19	129/285	45.3	208/415	50.1	1.20	0.86 - 1.69	0.3004
20-24	271/494	54.9	336/594	56.6	1.08	0.75 - 1.54	0.6829

Agreed or strongly agreed that if she used PrEP, her family would approve of her taking it

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	425/779	54.6	561/1009	55.6	1.07	0.83 - 1.38	0.6044
15-19	133/285	46.7	210/415	50.6	1.18	0.87 - 1.61	0.2906
20-24	292/494	59.1	351/594	59.1	1.01	0.75 - 1.37	0.9388

Participant's friends don't use PrEP

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	307/779	39.4	303/1009	30.0	0.60	0.42 - 0.87	0.0132
15-19	125/285	43.9	136/415	32.8	0.61	0.42 - 0.89	0.0190
20-24	182/494	36.8	167/594	28.1	0.59	0.34 - 1.02	0.0700

results based on model with site nested within subdistrict random effect (excluding household effect)

Table 30: Access to PrEP and potential barriers to and facilitators of access among HERStory 3 study participants who had sex in the past six months and did not report living with HIV from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Indicators of access:							
If/when participant wanted to use PrEP, she knows a place where someone like her could easily get it							
Total	468/779	60.1	719/1009	71.3	1.95	1.10 - 3.48	0.0327
15-19	153/285	53.7	268/415	64.6	1.82	0.98 - 3.38	0.0718
20-24	315/494	63.8	451/594	75.9	2.38	1.17 - 4.82	0.0255
If participant wanted to take PrEP, it would be easy or very easy for her to get to a place where PrEP is provided							
Total	457/779	58.7	667/1009	66.1	1.42	0.96 - 2.10	0.0962
15-19	148/285	51.9	248/415	59.8	1.39	0.92 - 2.10	0.1322
20-24	309/494	62.6	419/594	70.5	1.47	0.95 - 2.27	0.0971
Potential access barriers and facilitators:							
Availability							
The place where participant gets PrEP sometimes does not have any PrEP (stock-outs)							
Total	15/779	1.9	31/1009	3.1	1.62	1.11 - 2.38	0.0212
15-19	6/285	2.1	13/415	3.1	1.56[+]	0.56 - 4.38	0.4058
20-24	9/494	1.8	18/594	3.0	1.61[#]	0.67 - 3.86	0.2952
Accessibility							
Participant has never been offered PrEP							
Total	541/779	69.4	524/1009	51.9	0.43	0.28 - 0.66	0.0008
15-19	199/285	69.8	224/415	54.0	0.47	0.30 - 0.74	0.0035
20-24	342/494	69.2	300/594	50.5	0.29	0.15 - 0.55	0.0010
PrEP is not offered at school							
Total	41/779	5.3	61/1009	6.0	1.16	0.76 - 1.77	0.4883
15-19	19/285	6.7	40/415	9.6	1.49	0.84 - 2.64	0.1860
20-24	22/494	4.5	21/594	3.5	0.77	0.42 - 1.41	0.4026
The opening hours of the clinic or service do not suit the participant							
Total	49/779	6.3	51/1009	5.1	1.46	0.74 - 2.89	0.2880
15-19	23/285	8.1	27/415	6.5	0.83[#]	0.44 - 1.55	0.5627
20-24	26/494	5.3	24/594	4.0	0.73[#]	0.37 - 1.46	0.3875
Participant finds it far to go to the clinic or service to get PrEP							
Total	75/779	9.6	79/1009	7.8	0.74	0.37 - 1.50	0.4129
15-19	28/285	9.8	37/415	8.9	0.90[#]	0.42 - 1.90	0.7826
20-24	47/494	9.5	42/594	7.1	0.84	0.57 - 1.24	0.3984
COVID-19 and lockdowns made it difficult to get PrEP							
Total	8/779	1.0	8/1009	0.8	1.01	0.70 - 1.46	0.9518
15-19	3/285	1.1	3/415	0.7	0.72	0.69 - 0.76	<.0001

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
20-24	5/494	1.0	5/594	0.8	0.94[+]	0.27 - 3.33	0.9283

Acceptability

PrEP is not offered in youth-friendly spaces

Total	27/779	3.5	34/1009	3.4	0.96[#]	0.54 - 1.69	0.8793
15-19	10/285	3.5	15/415	3.6	1.02	0.44 - 2.35	0.9685
20-24	17/494	3.4	19/594	3.2	0.91[#]	0.41 - 2.00	0.8187

Participant worries about lack of privacy or confidentiality

Total	129/779	16.6	155/1009	15.4	0.89	0.57 - 1.39	0.6225
15-19	40/285	14.0	70/415	16.9	1.23	0.78 - 1.92	0.3841
20-24	89/494	18.0	85/594	14.3	0.58	0.31 - 1.07	0.0967

The negative attitudes of health workers make it difficult to get PrEP

Total	57/779	7.3	51/1009	5.1	0.65	0.28 - 1.52	0.3308
15-19	18/285	6.3	24/415	5.8	0.87[#]	0.43 - 1.76	0.6942
20-24	39/494	7.9	27/594	4.5	0.61[#]	0.33 - 1.14	0.1363

Affordability

It would cost too much to get to the clinic or service to get PrEP

Total	139/779	17.8	163/1009	16.2	0.67	0.34 - 1.32	0.2617
15-19	59/285	20.7	75/415	18.1	0.84[#]	0.53 - 1.33	0.4680
20-24	80/494	16.2	88/594	14.8	0.88[#]	0.62 - 1.26	0.5011

results based on model with site nested within subdistrict random effect (excluding household effect)

+ results based on model with subdistrict random effect only (excluding household and site effect)

Table 31: Use of PrEP and potential barriers to and facilitators of use among HERStory 3 study participants who had sex in the past six months and did not report living with HIV from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Indicators of use:							
Participant had ever taken PrEP							
Total	101/779	13.0	266/1009	26.4	2.19#	1.11 - 4.30	0.0331
15-19	33/285	11.6	102/415	24.6	2.53#	1.35 - 4.75	0.0084
20-24	68/494	13.8	164/594	27.6	2.15#	1.07 - 4.33	0.0427
Potential barriers to use:							
Skills							
Participant had instructions or counselling on how to use PrEP							
Total	263/779	33.8	515/1009	51.0	2.30	1.22 - 4.32	0.0172
15-19	87/285	30.5	209/415	50.4	3.46	1.62 - 7.37	0.0040
20-24	176/494	35.6	306/594	51.5	2.27	1.04 - 4.93	0.0508
Self-efficacy							
Agreed or strongly agreed that she is confident she can use PrEP if she wanted to							
Total	417/779	53.5	565/1009	56.0	1.14	0.83 - 1.58	0.4329
15-19	130/285	45.6	218/415	52.5	1.42	0.95 - 2.14	0.1054
20-24	287/494	58.1	347/594	58.4	1.02	0.71 - 1.48	0.8980
Agreed or strongly agreed that she is confident she can use PrEP in the way she is supposed to							
Total	428/779	54.9	588/1009	58.3	1.17	0.86 - 1.58	0.3231
15-19	135/285	47.4	235/415	56.6	1.51	1.10 - 2.09	0.0197
20-24	293/494	59.3	353/594	59.4	0.99	0.69 - 1.42	0.9553
Agreed or strongly agreed that she is confident she can use PrEP in spite of what others may think							
Total	416/779	53.4	581/1009	57.6	1.20	0.91 - 1.59	0.2128
15-19	131/285	46.0	221/415	53.3	1.38	1.00 - 1.92	0.0659
20-24	285/494	57.7	360/594	60.6	1.11	0.77 - 1.62	0.5813
Partner influence							
Agreed or strongly agreed that if she used PrEP, her boyfriend or partner would approve of her taking it							
Total	394/779	50.6	542/1009	53.7	1.14	0.86 - 1.52	0.3763
15-19	135/285	47.4	207/415	49.9	1.11	0.82 - 1.51	0.5051
20-24	259/494	52.4	335/594	56.4	1.16	0.79 - 1.71	0.4611

results based on model with site nested within subdistrict random effect (excluding household effect)

Table 32: Effective use of PrEP among HERStory 3 study participants who had ever taken PrEP, from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean			
	Comparison		Intervention	
Variable	Freq/N	%	Freq/N	%
Indicators of effective use:				
Participant was on PrEP at the time of the survey				
Total	66/165	40.0	165/433	38.1
15-19	31/61	50.8	65/182	35.7
20-24	35/104	33.7	100/251	39.8
In the past six months, participant took her PrEP medication in the way she was supposed to 100% of the time				
Total	120/165	72.7	271/433	62.6
15-19	39/61	63.9	96/182	52.7
20-24	81/104	77.9	175/251	69.7
Potential barriers to effective use:				
Participant forgets to take PrEP				
Total	62/165	37.6	199/433	46.0
15-19	23/61	37.7	85/182	46.7
20-24	39/104	37.5	114/251	45.4
Participant runs out of pills				
Total	15/165	9.1	57/433	13.2
15-19	8/61	13.1	20/182	11.0
20-24	7/104	6.7	37/251	14.7
Participants sexual partner does not want her to take PrEP				
Total	5/165	3.0	10/433	2.3
15-19	2/61	3.3	2/182	1.1
20-24	3/104	2.9	8/251	3.2
Participant's parents do not want her to take PrEP				
Total	3/165	1.8	10/433	2.3
15-19	2/61	3.3	5/182	2.7
20-24	1/104	1.0	5/251	2.0
Participant is sometimes not sexually active				
Total	9/165	5.5	27/433	6.2
15-19	4/61	6.6	8/182	4.4
20-24	5/104	4.8	19/251	7.6
Participant has one faithful partner who she trusts				
Total	5/165	3.0	14/433	3.2
15-19	2/61	3.3	3/182	1.6
20-24	3/104	2.9	11/251	4.4
Participant has side effects when she takes PrEP				
Total	17/165	10.3	32/433	7.4

	Prevalence/Mean			
	Comparison		Intervention	
Variable	Freq/N	%	Freq/N	%
15-19	4/61	6.6	8/182	4.4
20-24	13/104	12.5	24/251	9.6
Participant already takes other pills				
Total	2/165	1.2	6/433	1.4
15-19	1/61	1.6	2/182	1.1
20-24	1/104	1.0	4/251	1.6
Participant does not like the taste, smell or size of the pill				
Total	6/165	3.6	29/433	6.7
15-19	4/61	6.6	14/182	7.7
20-24	2/104	1.9	15/251	6.0
Participant did not tell anyone that she was taking PrEP				
Total	18/165	10.9	45/433	10.4
15-19	8/61	13.1	25/182	13.7
20-24	10/104	9.6	20/251	8.0
After starting PrEP, participant used condoms less than before				
Total	23/165	13.9	85/433	19.6
15-19	7/61	11.5	30/182	16.5
20-24	16/104	15.4	55/251	21.9
After stating PrEP participant had more sexual partners than before				
Total	31/165	18.8	49/433	11.3
15-19	8/61	13.1	15/182	8.2
20-24	23/104	22.1	34/251	13.5

Table 33: Effective use of PrEP among HERStory 3 study participants who were on PrEP at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | |
| | Comparison | | Intervention | |
Variable	Freq/N	%	Freq/N	%
Participant has been taking PrEP for the past:				
Total				
Month	24/66	36.4	44/165	26.7
Two months	6/66	9.1	25/165	15.2
Three months	5/66	7.6	17/165	10.3
Four months	5/66	7.6	7/165	4.2
Five months	6/66	9.1	7/165	4.2
Six months or more	19/66	28.8	59/165	35.8
15-19				
Month	10/31	32.3	21/65	32.3
Two months	2/31	6.5	13/65	20.0
Three months	2/31	6.5	4/65	6.2
Four months	4/31	12.9	3/65	4.6
Five months	4/31	12.9	4/65	6.2
Six months or more	8/31	25.8	17/65	26.2
20-24				
Month	14/35	40.0	23/100	23.0
Two months	4/35	11.4	12/100	12.0
Three months	3/35	8.6	13/100	13.0
Four months	1/35	2.9	4/100	4.0
Five months	2/35	5.7	3/100	3.0
Six months or more	11/35	31.4	42/100	42.0
In the past month, participant missed or skipped a dose of PrEP four times or less				
Total	33/66	50.0	75/165	45.5
15-19	15/31	48.4	30/65	46.2
20-24	18/35	51.4	45/100	45.0
In the past month, participant always took her PrEP medication in the way she was supposed to				
Total	15/66	22.7	34/165	20.6
15-19	4/31	12.9	10/65	15.4
20-24	11/35	31.4	24/100	24.0

Table 34: Quality of PrEP services at last visit among HERStory 3 study participants who had ever received PrEP from the My Journey Programme from 24 intervention sites across 8 provinces in South Africa, 2024

Variable	Freq/N	%	95% CI
Waiting time was reasonably short			
Total	173/249	69.5	63.8 - 75.2
15-19	61/95	64.2	54.6 - 73.8
20-24	112/154	72.7	65.7 - 79.7
Waiting time was one hour or less			
Total	209/249	83.9	79.3 - 88.5
15-19	79/95	83.2	75.7 - 90.7
20-24	130/154	84.4	78.7 - 90.1
The health worker asked the participant about her main concerns about PrEP			
Total	190/249	76.3	71.0 - 81.6
15-19	66/95	69.5	60.2 - 78.8
20-24	124/154	80.5	74.2 - 86.8
The health worker spoke with the participant about side effects			
Total	193/249	77.5	72.3 - 82.7
15-19	68/95	71.6	62.5 - 80.7
20-24	125/154	81.2	75.0 - 87.4
The health worker asked the participant about missing or skipping taking the PrEP pills			
Total	171/249	68.7	62.9 - 74.5
15-19	56/95	58.9	49.0 - 68.8
20-24	115/154	74.7	67.8 - 81.6
The health worker asked the participant about her sexual relationships and sexual behaviour			
Total	211/249	84.7	80.2 - 89.2
15-19	74/95	77.9	69.6 - 86.2
20-24	137/154	89.0	84.1 - 93.9
Participant felt judged by the health worker			
Total	41/249	16.5	11.9 - 21.1
15-19	13/95	13.7	6.8 - 20.6
20-24	28/154	18.2	12.1 - 24.3
The health worker who gave participant PrEP treated her in a friendly manner			
Total	223/249	89.6	85.8 - 93.4
15-19	82/95	86.3	79.4 - 93.2
20-24	141/154	91.6	87.2 - 96.0
The health worker who gave participant PrEP was respectful of her needs			
Total	226/249	90.8	87.2 - 94.4
15-19	82/95	86.3	79.4 - 93.2
20-24	144/154	93.5	89.6 - 97.4
All other clinic staff including the receptionist, cleaners and security guards treated the participant in a friendly and respectful way			
Total	211/249	84.7	80.2 - 89.2
15-19	76/95	80.0	72.0 - 88.0
20-24	135/154	87.7	82.5 - 92.9
The health worker checked whether the participant might have symptoms of an STI			

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Variable	Freq/N	%	95% CI
Total	164/249	65.9	60.0 - 71.8
15-19	58/95	61.1	51.3 - 70.9
20-24	106/154	68.8	61.5 - 76.1
The health worker checked whether the participant was using family planning			
Total	191/249	76.7	71.4 - 82.0
15-19	63/95	66.3	56.8 - 75.8
20-24	128/154	83.1	77.2 - 89.0

Biological PrEP results

Self-reported being on PrEP

Of the 209 participants who self-reported being on PrEP at the time of the survey (152 in the intervention arm and 57 in the comparison arm), 23% (95% CI: 18% to 30%) had detectable levels of Tenofovir-Diphosphate (TFV-DP) in their DBS sample (24% in the intervention arm and 23% in the comparison arm). The concentration of TFV-DP in participants who self-reported being on PrEP and had positive drug concentrations of TFV-DP ranged from 21 to 1345 fmol/3mm punch (Figure 6).
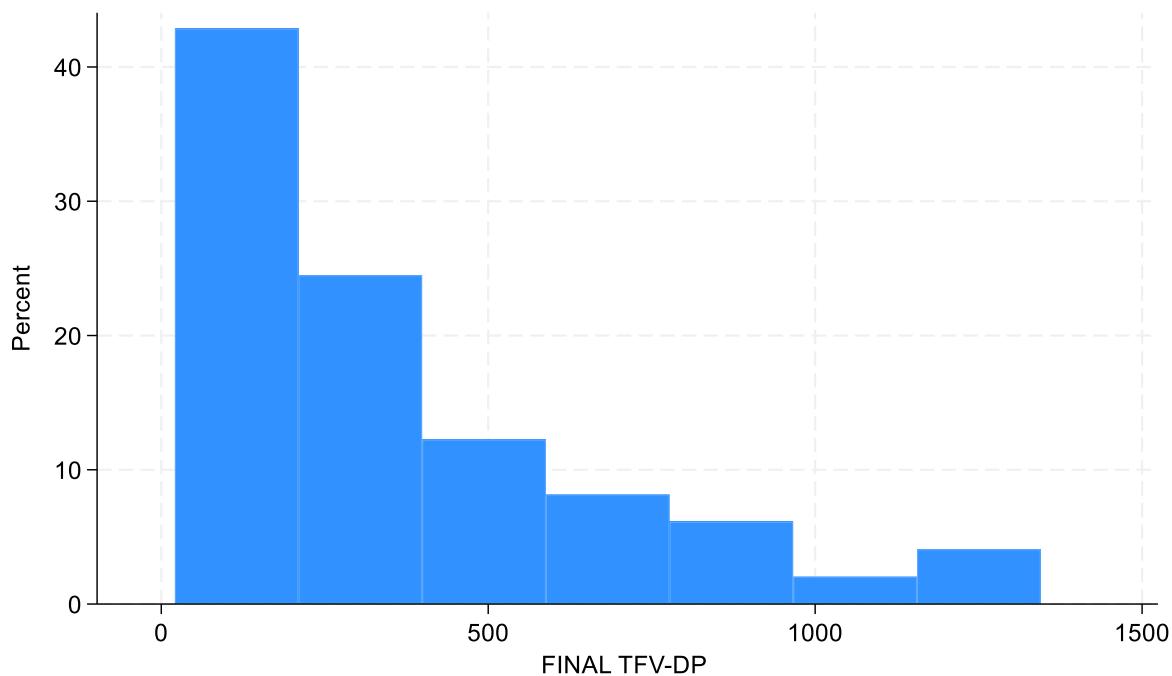
Figure 6. Concentration of TFV-DP (fmol/3mm punch) in participants who self-reported being on PrEP at the time of the survey and had detectable levels of TFV-DP

In the 15-19 age group, 21% in the intervention and 11% in the comparison arm had positive concentrations of TFV-DP. In the 20-24 age group, 26% in the intervention and 33% in the comparison arm had positive concentrations of TFV-DP.

When the intervention and comparison arms were combined, 18% of participants in the 15-19 age group (n=89) had positive concentrations of PrEP compared to 28% in the 20-24 age group (n=120).

Self-reported not being on PrEP

Among the randomly sampled participants who were DBS-confirmed HIV-negative and did not report using PrEP at the time of the survey with (n=148: 73 intervention, 75 comparison), only 1 participant in the intervention arm had a detectable level of TFV-DP, 0.7% (95% CI: 0.1% to 3.7%).

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Seven DBS samples from this random sample were excluded from analyses because they had insufficient/small spots on the DBS card.

HIV prevention cascade for PrEP

We created HIV prevention cascades for PrEP to describe participant's knowledge of PrEP, whether they had ever been offered PrEP, whether they had ever used PrEP, and whether they were currently using PrEP (self-reported and DBS-confirmed) among participants who had a negative HIV status confirmed by DBS and self-reported having sex in the past six months. We created separate cascades for the 15-19 (Figure 7a) and 20-24 (Figure 7b) age group, stratified by intervention/comparison sites.

Knowledge of PrEP was defined as participants who reported that they already knew the following facts about PrEP after reading the below statement:

> *Pre-exposure prophylaxis (PrEP) is when someone who does not have HIV takes a pill on an ongoing basis to prevent them getting HIV. Most people who take PrEP take a pill every day. PrEP needs to be taken for seven days before sex to be effective.*

Ever being offered PrEP was defined as participants who reported ever being offered PrEP. Ever used PrEP was defined as participant who reported ever taking PrEP. Currently on PrEP was defined as self-reporting that you were on PrEP at the time of the survey. Only participants who self-reported that they were currently on PrEP were tested for TFV-DP to determine whether the PrEP drug was present in their DBS sample.

Among participants who were 15-19 years old, 48.2% in the intervention arm and 32.8% in the comparison arm knew what PrEP was; 36.2% in the intervention arm and 16.0% in the comparison arm had ever been offered PrEP; and 22.2% of participants in the intervention arm and 9.6% in the comparison arm had ever used PrEP. There were substantial and statistically significant differences between the intervention and comparison arm for all three of these variables, in favour of the intervention. Finally, 7.1% of participants in the intervention arm and 6.1% in the comparison arm reported currently using PrEP, but there was no statistically significant difference between the intervention and comparison arm for this variable. Only 1.2% of participants had detectable levels of TFV-DP in the intervention arms compared to 0.6% in the comparison arm (Figure 7a). However, the study was not powered to show statistically significant differences for these biological outcomes.

Among participants aged 20-24 years old, 57.6% of participants in the intervention arm and 45.8% of participants in the comparison arm knew what PrEP was; 42.7% in the intervention arm and 23.9% in the comparison arm had ever been offered PrEP; 26.2% in the intervention arm and 13.5% in the comparison arm had ever used PrEP; and 10.5% in the intervention arm and 4.4% in the comparison arm reported that they were currently on PrEP. There were substantial and statistically significant

differences between the intervention and comparison arm for all four of these variables, in favour of the intervention. Only 2.5% of participants had detectable levels of TFV-DP in the intervention arms compared to 1.4% in the comparison arm (Figure 7b).
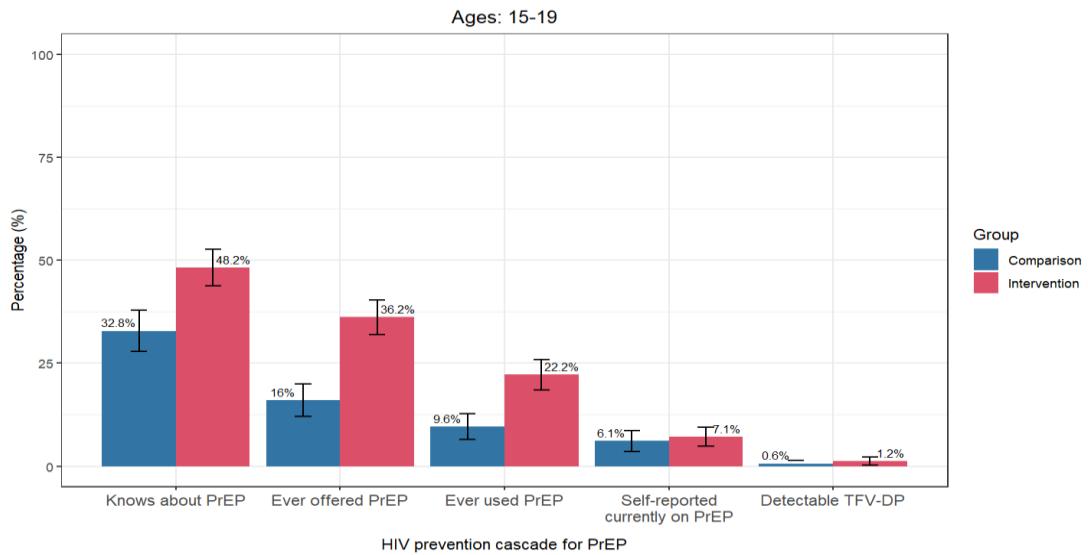
Figure 7a: HIV prevention cascade for PrEP among participants aged 15-19 years old who had a negative HIV status confirmed by DBS and reported having sex in the past six months, stratified by intervention/comparison sites. The denominator is the same for all bars in the cascade. However, only the DBS samples of participants who self-reported currently being on PrEP were tested for TFV-DP (the PrEP drug).
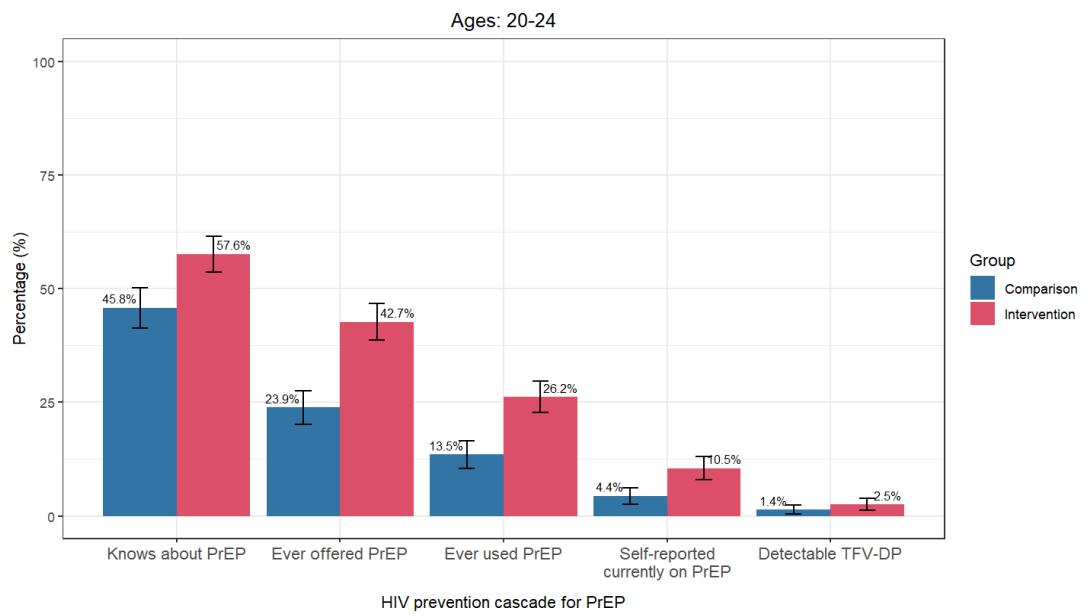
Figure 7b: HIV prevention cascade for PrEP among participants aged 20-24 years old who had a negative HIV status confirmed by DBS and reported having sex in the past six months, stratified by intervention/comparison sites. The denominator is the same for all bars in the cascade. However, only the DBS samples of participants who self-reported currently being on PrEP were tested for TFV-DP (the PrEP drug).

We also created HIV prevention cascades for PrEP among all participants who were eligible for PrEP, that is, all participants who were DBS-confirmed HIV negative. We created separate cascades for the 15-19 (Figure 8a) and 20-24 (Figure 8b) age groups, stratified by intervention/comparison sites.

Among participants who were 15-19 years old, 34.5% in the intervention arm and 20.6% in the comparison arm knew what PrEP was; 21.7% in the intervention arm and 7.8% in the comparison arm had ever been offered PrEP; and 12.2% of participants in the intervention arm and 4.1% in the comparison arm had ever used PrEP. There were substantial and statistically significant differences as shown in the graph between the intervention and comparison arm for all three of these variables, in favour of the intervention. Finally, 4.4% of participants in the intervention arm and 2.0% in the comparison arm reported currently using PrEP, with a small statistically significant difference between the intervention and comparison arms for this variable. Only 0.9% of participants had detectable levels of TFV-DP in the intervention arm compared to 0.2% in the comparison arm (Figure 8a).

Among participants aged 20-24 years old, 53.1% of participants in the intervention arm and 40.7% of participants in the comparison arm knew what PrEP was; 40.5% in the intervention arm and 21.3% in the comparison arm had ever been offered PrEP; 25.0% in the intervention arm and 12.1% in the comparison arm had ever used PrEP; and 9.7% in the intervention arm and 3.9% in the comparison arm reported that they were currently on PrEP. There were substantial and statistically significant differences as shown in the graph between the intervention and comparison arm for all four of these variables, in favour of the intervention. Only 2.5% of participants had detectable levels of TFV-DP in the intervention arm compared to 1.3% in the comparison arm (Figure 8b).
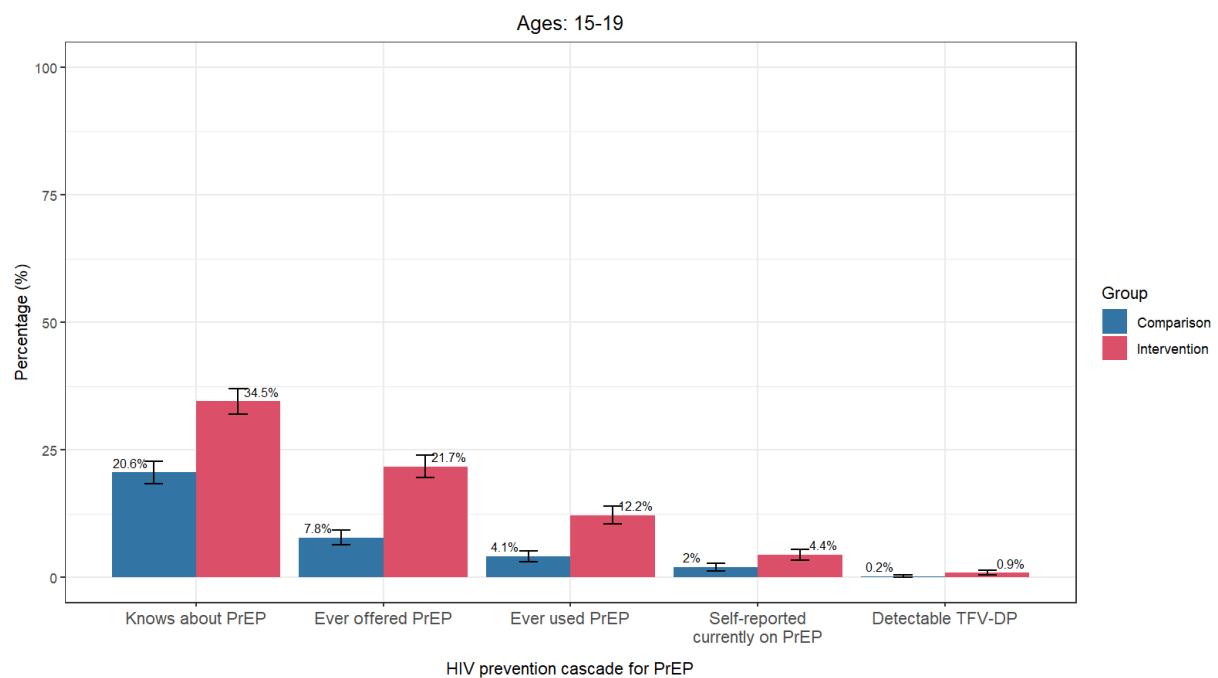
Figure 8a: HIV prevention cascade for PrEP among participants aged 15-19 years old who had a negative HIV status confirmed by DBS, stratified by intervention/comparison sites. The denominator is the same for all bars in the cascade. However, only the DBS samples of participants who self-reported currently being on PrEP were tested for TFV-DP (the PrEP drug).


Ages: 20-24
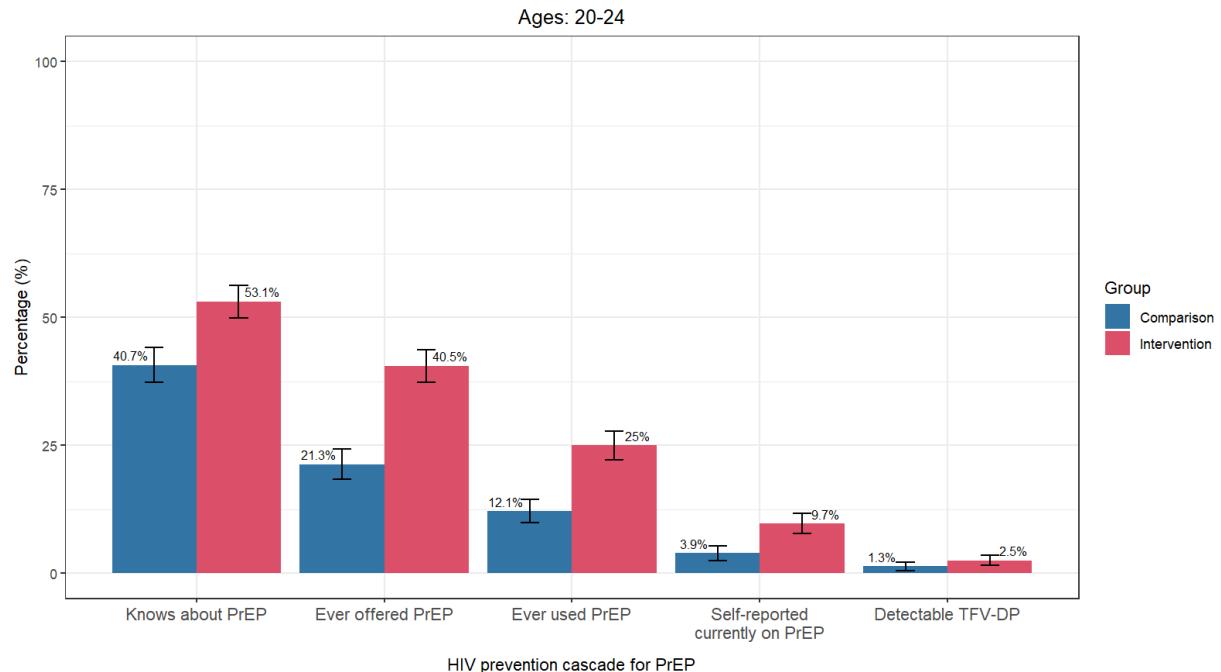
Figure 8b: HIV prevention cascade for PrEP among participants aged 20-24 years old who had a negative HIV status confirmed by DBS, stratified by intervention/comparison sites. The denominator is the same for all bars in the cascade. However, only the DBS samples of participants who self-reported currently being on PrEP were tested for TFV-DP (the PrEP drug).

School dropout

The study was powered to detect a decrease in school dropout among AGYW aged 15-19 years from 8% in the comparison arm down to 3% in the intervention arm, but it was not powered to detect smaller intervention effects. The observed prevalence of school dropout was 10.9% in the intervention arm and 12.4% in the comparison arm. Adjusting for imbalances in age, socio-economic status, maternal orphanhood and sexual behaviour, the prevalence of school dropout was 10.7% in the intervention arm and 12.7% in the comparison arm. This represents a difference of 2.0% (OR=0.80; p=0.226), indicating no statistically significant intervention effect on school dropout (Table 35). All covariates were important predictors of school dropout. It is interesting to note that the school dropout is nearly 50% higher than we had assumed at the planning stage of the study.

Table 35. Observed frequencies, denominators and prevalence of other outcomes: school dropout in both arms overall and by age group.

Population	Comparison		Intervention		Odds ratio	95% CI	p-value
	Freq/N	% (marginal predicted)@	Freq/N	% (marginal predicted)			
School dropout among participants aged 15-19 years							
Total	179/1447	12.4 (12.7)	165/1514	10.9 (10.7)	0.80	0.56-1.15	0.226
Age					**Risk Difference (%)**		
15	27/372	7.3 (8.2)	22/301	7.3 (8.3)	0.2	-4.6-5.0	0.944
16	25/275	9.1 (9.8)	22/283	7.8 (8.0)	-1.8	-7.1 - 3.5	0.510
17	36/271	13.3 (13.0)	26/252	10.3 (10.0)	-3.0	-9.0-3.0	0.325
18	40/285	14.0 (12.4)	44/381	11.6 (10.5)	-1.9	-7.3 -3.4	0.477
19	51/244	20.9 (17.8)	51/297	17.2 (14.3)	-3.5	-10.2-3.1	0.299

* Effect estimates adjusted for age in years, whether the participant had ever had sex, was in school, had piped water in their house, household had a car and were maternal orphans. Being in school was not included in the model for school dropout as this was the outcome variable.

Figure 9 describes the predictive margins of school dropout for ages 15-19 years by study arm. There is a consistent positive effect of the intervention on school dropout among participants aged 16-19 years, although the effect is not statistically significant.

Further details of the analysis of other outcomes can be found in **Appendix J**.
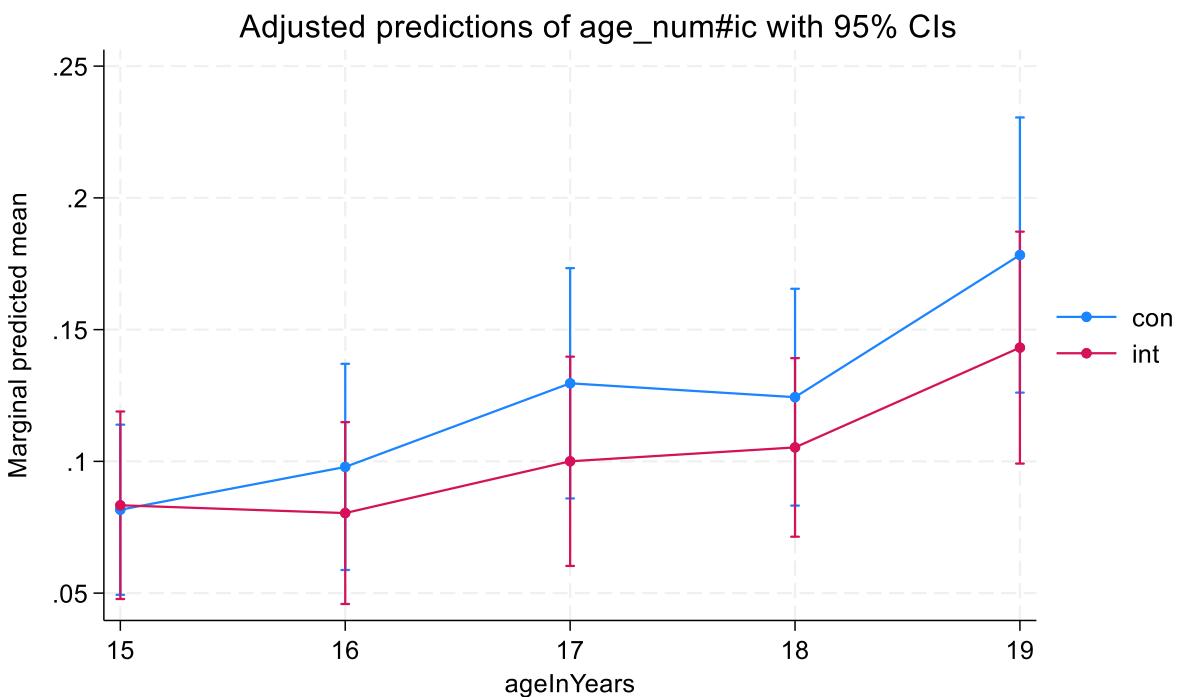
Figure 9. Predictive margins of school dropout for ages 15-19 years by study arm.

NRCCT Impact of My Journey on HIV Treatment and Care

HIV treatment

Participants who reported in the survey that they were living with HIV were asked questions about HIV treatment and care. Table 36 shows that in both the intervention and comparison arms, most participants had ever received education or counselling about taking ART (73.2% in the intervention arm and 67.4% in the comparison arm), and most, but not all had ever taken ART (67.0% in the intervention arm and 68.5% in the comparison arm). After receiving their HIV diagnosis, participants were most likely to report that they started taking ARVs on the same day of their diagnosis (39.7% in the intervention arm and 37.5% in the comparison arm. In both arms, most but not all participants reported that they were taking ARVs at the time of the survey (64.8% in the intervention arm and 64.7% in the comparison arm). Fewer than 40% of participants in both arms had had a viral load test in the year before the survey (39.1% in the intervention arm and 35.3% in the comparison arm). Very few participants reported that they had taken ARVs the way they were supposed to 100% of the time in the past six months (21.2% in the intervention arm and 20.1% in the comparison arm). There were only very small differences between arms in these variables (Table 36).

Participants who had ever taken ARVs were asked about the places from which they had collected their ARVs and most (70.0% in the intervention arm and 70.6% in the comparison arm) reported that

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they had collected them from a mobile clinic or van (Table 53). Other commonly reported collection places were school or college (4.2% in the intervention arm and 7.9% in the comparison arm), "a distribution point in my community" (6.7% in the intervention arm and 0.8% in the comparison arm) and "delivered to participant's home" (2.5% in the intervention arm and 4.8% in the comparison arm) (Table 37).

The small group of participants who self-reported living with HIV and reported that they had never taken ART were asked about their reasons for not taking ART (Table 38). The most common reasons reported by participants in both arms was that they felt healthy (53.2% in the intervention arm and 52.9% in the comparison arm), or they did not think they needed them (31.9% in the intervention arm and 25.5% in the comparison arm) (Table 38).

Participants who self-reported living with HIV and who reported that they had missed appointments to get ARVs in the six months before the survey were asked about the barriers to accessing ARVs (Table 55). The most common barriers reported by participants in both arms were that they had wanted to stop taking ARVs (33.3% in the intervention arm and 44.2% in the comparison arm), that they did not want anyone to see them going to obtain ARVs (17.8% in the intervention arm and 14.0% in the comparison arm), and that the place from which they got ARVs was far away (8.9% in the intervention arm and 18.6% in the comparison arm) (Table 39).

Participants who self-reported living with HIV and who were taking ARVs at the time of the survey were asked questions to assess whether they were using ARVs effectively in the months before the survey (Table 40). Over 50% of participants in both arms reported that they had missed or skipped a dose of ARVs twice or less (61.2% in the intervention arm and 57.1% in the comparison arm) (Table 40). Only 46.6% of participants in the intervention arm and 39.5% of participants in the comparison arm reported that they always took their ARV medication in the way they were supposed to (Table 40).

Participants who self-reported living with HIV and who had ever taken ARVs were asked questions about their reasons for missing or skipping taking their ARVs in the six months before the survey (Table 61). The most common reasons given in both study arms were that they had forgotten to take them (26.7% in the intervention arm and 39.7% in the comparison arm), and that the participant was worried someone would find out she was HIV positive (10.8% in the intervention arm and 10.3% in the comparison arm) (Table 41).

Participants who self-reported living with HIV and who had ever had a viral load or CD4 test were asked questions about viral load testing and there were only very small differences between the study arms (Table 42). Having had one viral load test in the past year was reported by 43.0% in the

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intervention arm and 33.0% in the comparison arm; having two viral load tests in the past year was reported by 28.0% in the intervention arm and 22.0% in the comparison arm; and having three or more viral load tests in the past year was reported by 21.5% in the intervention arm and 36.3% in the comparison arm (Table 42). Participants reported that their last viral load test was less than 100 copies/ml (16.1% in the intervention arm and 11.0% in the comparison arm); that their last viral load test was undetectable (18.3% in the intervention arm and 16.5% in the comparison arm); and that their last viral load test was suppressed (40.9% in the intervention arm and 40.7% in the comparison arm) (Table 42).

Participants who had ever received ART from the My Journey Programme were asked about the quality of the HIV treatment services they had received at their last visit for ART (Table 43). Most participants (71.9%) waited an hour or less for their appointment, most reported that the health worker had asked about her main concerns about ART and health (82.5), that the health worker had talked about side effects (77.2%), that the health worker had asked about adherence (77.2%), that the health worker explained and discussed how viral load affects HIV transmission risk to a partner (71.9%), that the health worker asked the participant about pregnancy intentions (59.6%), and that the health worker asked the participant if she was using family planning (66.7%) (Table 43). Most participants reported that the health worker treated them in a friendly (86.0%) and respectful (82.5%) manner and that all other clinic staff also treated them in a friendly, respectful manner (78.9%). However, only 54.4% of participants reported that the health worker spoke about ARVs in a non-judgmental way (Table 43).

Table 36: Uptake of and adherence to antiretroviral therapy (ART) among HERStory 3 study participants who self-reported living with HIV from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | |
| | Comparison | | Intervention | |
Variable	Freq/N	%	Freq/N	%
Participant has ever received education or counselling about taking antiretroviral therapy (ART)				
Total	124/184	67.4	131/179	73.2
15-19	48/84	57.1	49/77	63.6
20-24	76/100	76.0	82/102	80.4
Participant had a viral load test within the past year				
Total	65/184	35.3	70/179	39.1
15-19	22/84	26.2	20/77	26.0
20-24	43/100	43.0	50/102	49.0
Participant has ever taken antiretrovirals (ARVs)				
Total	126/184	68.5	120/179	67.0
15-19	44/84	52.4	38/77	49.4

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Variable	Prevalence/Mean			
	Comparison		Intervention	
	Freq/N	%	Freq/N	%
20-24	82/100	82.0	82/102	80.4

After receiving a positive HIV diagnosis, participant started ARVs:

Total

On the same day	69/184	37.5	71/179	39.7
One week later	15/184	8.2	19/179	10.6
One month later	1/184	0.5	6/179	3.4
Two months later	2/184	1.1	5/179	2.8
Three months later	3/184	1.6	1/179	0.6
Four months later	1/184	0.5	0/179	0.0
Five months later	2/184	1.1	1/179	0.6
Six months later	3/184	1.6	0/179	0.0
More than six months later	11/184	6.0	7/179	3.9

15-19

On the same day	21/84	25.0	19/77	24.7
One week later	5/84	6.0	7/77	9.1
One month later	0/84	0.0	2/77	2.6
Two months later	1/84	1.2	1/77	1.3
Three months later	1/84	1.2	0/77	0.0
Four months later	1/84	1.2	0/77	0.0
Five months later	1/84	1.2	0/77	0.0
Six months later	1/84	1.2	0/77	0.0
More than six months later	4/84	4.8	3/77	3.9

20-24

On the same day	48/100	48.0	52/102	51.0
One week later	10/100	10.0	12/102	11.8
One month later	1/100	1.0	4/102	3.9
Two months later	1/100	1.0	4/102	3.9
Three months later	2/100	2.0	1/102	1.0
Four months later	0/100	0.0	0/102	0.0
Five months later	1/100	1.0	1/102	1.0
Six months later	2/100	2.0	0/102	0.0
More than six months later	7/100	7.0	4/102	3.9

Participant was taking ARVs at the time of the survey

Total	119/184	64.7	116/179	64.8
15-19	46/84	54.8	40/77	51.9
20-24	73/100	73.0	76/102	74.5

Participant took ARVs the way she was supposed to 100% of the time in the past six months

| Variable | Prevalence/Mean | | | |
| | Comparison | | Intervention | |
	Freq/N	%	Freq/N	%
Total	37/184	20.1	38/179	21.2
15-19	14/84	16.7	12/77	15.6
20-24	23/100	23.0	26/102	25.5

Table 37: Places where participant has collected antiretrovirals (ARVs) among HERStory 3 study participants who self-reported living with HIV and have ever taken ARVs from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean			
	Comparison		Intervention	
Variable	Freq/N	%	Freq/N	%
Mobile clinic or van				
Total	89/126	70.6	84/120	70.0
15-19	35/44	79.5	26/38	68.4
20-24	54/82	65.9	58/82	70.7
School or college				
Total	10/126	7.9	5/120	4.2
15-19	5/44	11.4	3/38	7.9
20-24	5/82	6.1	2/82	2.4
From a distribution point in my community				
Total	1/126	0.8	8/120	6.7
15-19	1/44	2.3	1/38	2.6
20-24	0/82	0.0	7/82	8.5
From an organisation or NGO in my community				
Total	2/126	1.6	2/120	1.7
15-19	2/44	4.5	1/38	2.6
20-24	0/82	0.0	1/82	1.2
They are delivered to participant's home				
Total	6/126	4.8	3/120	2.5
15-19	1/44	2.3	1/38	2.6
20-24	5/82	6.1	2/82	2.4
Other				
Total	15/126	11.9	13/120	10.8
15-19	3/44	6.8	6/38	15.8
20-24	12/82	14.6	7/82	8.5

Table 38: Reasons for not taking antiretroviral therapy (ART) among HERStory 3 study participants who self-reported living with HIV but have never taken ART from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean			
	Comparison		Intervention	
Variable	Freq/N	%	Freq/N	%
Participant feels healthy				
Total	27/51	52.9	25/47	53.2
15-19	20/37	54.1	13/31	41.9
20-24	7/14	50.0	12/16	75.0
Participant doesn't think she needs them				
Total	13/51	25.5	15/47	31.9
15-19	10/37	27.0	14/31	45.2
20-24	3/14	21.4	1/16	6.2
Participant's CD4 count is high				
Total	2/51	3.9	0/47	0.0
15-19	1/37	2.7	0/31	0.0
20-24	1/14	7.1	0/16	0.0
Participant doesn't want to accept her diagnosis				
Total	0/51	0.0	3/47	6.4
15-19	0/37	0.0	3/31	9.7
20-24	0/14	0.0	0/16	0.0
Participant is scared the people close to her will find out that she is HIV positive				
Total	1/51	2.0	1/47	2.1
15-19	0/37	0.0	1/31	3.2
20-24	1/14	7.1	0/16	0.0
The health workers have negative attitudes towards people like her				
Total	3/51	5.9	1/47	2.1
15-19	2/37	5.4	1/31	3.2
20-24	1/14	7.1	0/16	0.0
Someone told her not to take them				
Total	0/51	0.0	2/47	4.3
15-19	0/37	0.0	0/31	0.0
20-24	0/14	0.0	2/16	12.5
Participant is using traditional medicine				
Total	0/51	0.0	0/47	0.0
15-19	0/37	0.0	0/31	0.0
20-24	0/14	0.0	0/16	0.0
Participants reported that the clinic is far away				
Total	1/51	2.0	2/47	4.3
15-19	1/37	2.7	1/31	3.2
20-24	0/14	0.0	1/16	6.2
Participant reported that it is too expensive to go to the clinic to get them				

| Variable | Prevalence/Mean | | | |
| | Comparison | | Intervention | |
	Freq/N	%	Freq/N	%
Total	1/51	2.0	1/47	2.1
15-19	1/37	2.7	0/31	0.0
20-24	0/14	0.0	1/16	6.2
Participant doesn't know where to get ARVs				
Total	2/51	3.9	2/47	4.3
15-19	2/37	5.4	2/31	6.5
20-24	0/14	0.0	0/16	0.0
Other reason				
Total	2/51	3.9	4/47	8.5
15-19	1/37	2.7	3/31	9.7
20-24	1/14	7.1	1/16	6.2
Prefer not to answer				
Total	8/51	15.7	2/47	4.3
15-19	6/37	16.2	1/31	3.2
20-24	2/14	14.3	1/16	6.2

Table 39: Potential barriers to accessing antiretrovirals (ARVs) among HERStory 3 study participants who self-reported living with HIV and had ever missed appointments to get ARVs in the past six months from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean			
	Comparison		Intervention	
	Freq/N	%	Freq/N	%
Participant wanted to stop taking her ARVs				
Total	19/43	44.2	15/45	33.3
15-19	8/15	53.3	4/14	28.6
20-24	11/28	39.3	11/31	35.5
Participant doesn't want anyone seeing her go for her ARVs				
Total	6/43	14.0	8/45	17.8
15-19	2/15	13.3	4/14	28.6
20-24	4/28	14.3	4/31	12.9
The place participant gets her ARVs from is far away				
Total	8/43	18.6	4/45	8.9
15-19	1/15	6.7	2/14	14.3
20-24	7/28	25.0	2/31	6.5
The place participant gets her ARVs from is not open when she has free time				
Total	1/43	2.3	0/45	0.0
15-19	0/15	0.0	0/14	0.0
20-24	1/28	3.6	0/31	0.0
Because of the negative attitudes of health workers who give her ARVs				
Total	0/43	0.0	5/45	11.1
15-19	0/15	0.0	2/14	14.3
20-24	0/28	0.0	3/31	9.7
There was a stock-out and they did not have ARVs for her				
Total	0/43	0.0	0/45	0.0
15-19	0/15	0.0	0/14	0.0
20-24	0/28	0.0	0/31	0.0
COVID-19 and lockdowns made it difficult to get ARVs				
Total	0/43	0.0	0/45	0.0
15-19	0/15	0.0	0/14	0.0
20-24	0/28	0.0	0/31	0.0
Other reason				
Total	7/43	16.3	10/45	22.2
15-19	4/15	26.7	3/14	21.4
20-24	3/28	10.7	7/31	22.6
Prefer not to answer				
Total	4/43	9.3	7/45	15.6
15-19	2/15	13.3	1/14	7.1
20-24	2/28	7.1	6/31	19.4

Table 40: Effective use of antiretrovirals (ARVs) in the months before the survey among HERStory 3 study participants who self-reported living with HIV and were on ARVs at the time of the survey from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean			
	Comparison		Intervention	
Variable	Freq/N	%	Freq/N	%
In the past month, participant missed or skipped a dose of ARVs twice or less				
Total	68/119	57.1	71/116	61.2
15-19	26/46	56.5	26/40	65.0
20-24	42/73	57.5	45/76	59.2
In the past month, participant always took her ARV medication in the way she was supposed to				
Total	47/119	39.5	54/116	46.6
15-19	17/46	37.0	21/40	52.5
20-24	30/73	41.1	33/76	43.4

Table 41: Reasons for missing or skipping antiretroviral therapy (ART) in the past six months among HERStory 3 study participants who self-reported living with HIV and have ever taken ARVs from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | |
| | Comparison | | Intervention | |
Variable	Freq/N	%	Freq/N	%
Participant forgot to take them				
Total	50/126	39.7	32/120	26.7
15-19	22/44	50.0	9/38	23.7
20-24	28/82	34.1	23/82	28.0
Participant was worried someone would find out that she was HIV positive				
Total	13/126	10.3	13/120	10.8
15-19	4/44	9.1	5/38	13.2
20-24	9/82	11.0	8/82	9.8
The ARVs make her sick				
Total	3/126	2.4	6/120	5.0
15-19	3/44	6.8	1/38	2.6
20-24	0/82	0.0	5/82	6.1
The ARVs taste bad				
Total	7/126	5.6	10/120	8.3
15-19	5/44	11.4	2/38	5.3
20-24	2/82	2.4	8/82	9.8
The ARVs get in the way of her daily schedule; she is too busy				
Total	2/126	1.6	2/120	1.7
15-19	0/44	0.0	0/38	0.0
20-24	2/82	2.4	2/82	2.4
Friends and/or family don't remind her to take her ARVs				
Total	1/126	0.8	1/120	0.8
15-19	1/44	2.3	0/38	0.0
20-24	0/82	0.0	1/82	1.2
Friends and/or family told her that she should not take ARVs				
Total	2/126	1.6	0/120	0.0
15-19	1/44	2.3	0/38	0.0
20-24	1/82	1.2	0/82	0.0
She doesn't understand why she has to take her ARVs, she can be healthy without them				
Total	2/126	1.6	4/120	3.3
15-19	1/44	2.3	1/38	2.6
20-24	1/82	1.2	3/82	3.7
She couldn't deal with it: she wanted to forget her HIV diagnosis				
Total	4/126	3.2	1/120	0.8
15-19	1/44	2.3	0/38	0.0
20-24	3/82	3.7	1/82	1.2
She became sick with another illness				
Total	5/126	4.0	1/120	0.8
15-19	0/44	0.0	1/38	2.6
20-24	5/82	6.1	0/82	0.0

Variable	Prevalence/Mean			
	Comparison		Intervention	
	Freq/N	%	Freq/N	%
She had a change in her living situation or she had to move				
Total	1/126	0.8	2/120	1.7
15-19	0/44	0.0	0/38	0.0
20-24	1/82	1.2	2/82	2.4
She keeps getting sick even when she remembers to take her ARVs				
Total	1/126	0.8	1/120	0.8
15-19	1/44	2.3	0/38	0.0
20-24	0/82	0.0	1/82	1.2
She has nowhere to keep her ARVs at home				
Total	1/126	0.8	1/120	0.8
15-19	1/44	2.3	0/38	0.0
20-24	0/82	0.0	1/82	1.2
Other reason				
Total	9/126	7.1	9/120	7.5
15-19	0/44	0.0	2/38	5.3
20-24	9/82	11.0	7/82	8.5
Prefer not to answer				
Total	19/126	15.1	7/120	5.8
15-19	5/44	11.4	1/38	2.6
20-24	14/82	17.1	6/82	7.3

Table 42: Viral load testing among HERStory 3 study participants who self-reported living and had ever had a viral load or CD4 count test from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean			
	Comparison		Intervention	
	Freq/N	%	Freq/N	%
Participant had:				
Total				
One viral load or CD4 count test in the past year	30/91	33.0	40/93	43.0
Two viral load or CD4 count tests in the past year	20/91	22.0	26/93	28.0
Three or more viral load or CD4 count tests in the past year	33/91	36.3	20/93	21.5
15-19				
One viral load or CD4 count test in the past year	9/31	29.0	15/32	46.9
Two viral load or CD4 count tests in the past year	10/31	32.3	8/32	25.0
Three or more viral load or CD4 count tests in the past year	10/31	32.3	6/32	18.8
20-24				
One viral load or CD4 count test in the past year	21/60	35.0	25/61	41.0
Two viral load or CD4 count tests in the past year	10/60	16.7	18/61	29.5
Three or more viral load or CD4 count tests in the past year	23/60	38.3	14/61	23.0
Participant's viral load at her last viral load test was less than 1000 copies/ml				
Total	10/91	11.0	15/93	16.1
15-19	5/31	16.1	8/32	25.0
20-24	5/60	8.3	7/61	11.5
Participant's viral load at her last viral load test was undetectable				
Total	15/91	16.5	17/93	18.3
15-19	4/31	12.9	9/32	28.1
20-24	11/60	18.3	8/61	13.1
Participant's viral load at her last viral load test was suppressed				
Total	37/91	40.7	38/93	40.9
15-19	14/31	45.2	10/32	31.2
20-24	23/60	38.3	28/61	45.9

Variable	Prevalence/Mean			
	Comparison		Intervention	
	Freq/N	%	Freq/N	%

Table 43: Quality of HIV treatment services at last visit for antiretroviral therapy (ART) among HERStory 3 study participants who had ever received ART from the My Journey Programme, from 24 intervention sites across 8 provinces in South Africa, 2024

Variable	Freq/N	%	95% CI
Waiting time was reasonably short			
Total	35/57	61.4	48.8 - 74.0
15-19	11/22	50.0	29.1 - 70.9
20-24	24/35	68.6	53.2 - 84.0
Waiting time was one hour or less			
Total	41/57	71.9	60.3 - 83.6
15-19	13/22	59.1	38.5 - 79.6
20-24	28/35	80.0	66.7 - 93.3
Health worker asked participant about her main concerns about ART and health			
Total	47/57	82.5	72.6 - 92.4
15-19	17/22	77.3	59.8 - 94.8
20-24	30/35	85.7	74.1 - 97.3
Health worker talked with participant about side effects			
Total	44/57	77.2	66.3 - 88.1
15-19	15/22	68.2	48.7 - 87.7
20-24	29/35	82.9	70.4 - 95.4
Health worker asked participant about missing or skipping taking ARV pills			
Total	44/57	77.2	66.3 - 88.1
15-19	13/22	59.1	38.6 - 79.6
20-24	31/35	88.6	78.1 - 99.1
Health worker talked about ARVs in a non-judgmental way			
Total	31/57	54.4	41.5 - 67.3
15-19	10/22	45.5	24.7 - 66.3
20-24	21/35	60.0	43.8 - 76.2
Health worker treated participant in a friendly way			
Total	49/57	86.0	77.0 - 95.0
15-19	17/22	77.3	59.8 - 94.8
20-24	32/35	91.4	82.1 - 100.7
Health worker was respectful of participant's needs			
Total	47/57	82.5	72.6 - 92.4
15-19	15/22	68.2	48.7 - 87.7
20-24	32/35	91.4	82.1 - 100.7
All other clinic staff (receptionist, cleaners, security guards, etc) treated participant in a friendly and respectful way			
Total	45/57	78.9	68.3 - 89.5
15-19	13/22	59.1	38.6 - 79.6
20-24	32/35	91.4	82.1 - 100.7
Health worker explained and discussed how viral load affects HIV transmission risk to a partner during sex			
Total	41/57	71.9	60.2 - 83.6
15-19	10/22	45.5	24.7 - 66.3
20-24	31/35	88.6	78.1 - 99.1
Health worker asked participant if she wished to become pregnant			

| Variable	Freq/N	%	95% CI
Total	34/57	59.6	46.9 - 72.3
15-19	10/22	45.5	24.7 - 66.3
20-24	24/35	68.6	53.2 - 84.0
Health worker asked participant if she was using family planning			
Total	38/57	66.7	54.5 - 78.9
15-19	13/22	59.1	38.6 - 79.6
20-24	25/35	71.4	56.4 - 86.4

HIV care cascades

We created HIV care cascades to describe the 95-95-95 UNAIDS targets for HIV care: 95% of individuals living with HIV know their HIV status; 95% of individuals diagnosed with HIV on treatment; and 95% of individuals on treatment virally supressed. Thus, the first bar of our cascade is participants who self-reported having a positive HIV test result at their last test or who knew they were living with HIV among participants who had ever had an HIV test. The second bar of the cascade shows participants who were DBS-confirmed on ART at the time of the survey. This means that we found the presence of one or more of six antiretroviral drugs (Atazanavir, Darunavir, Dolutegravir, Efavirenz, Lopinavir or Tenofovir) in the participant's DBS sample. The final bar of the cascade is participants who were DBS-confirmed virally suppressed, meaning that they had less than 1000 viral copies per mL of blood. The denominator for each bar of the cascade is participants who were DBS-confirmed living with HIV. We created separate cascades for the 15-19 (Figure 10a) and 20-24 (Figure 10b) age group, stratified by the study arm.

Among participants who were 15-19 years old and who self-reported living with HIV, 34.8% in the intervention arm and 38.6% in the comparison arm knew they were living with HIV; 48.9% in the intervention arm and 55.7% in the comparison arm were DBS-confirmed on ART at the time of the survey; and 59.8% in the intervention arm and 73.9% in the comparison arm were virally suppressed. The differences between study arms were small and there were no statistically significant differences in terms of knowledge, on treatment, and viral suppression by study arm (Figure 10a).

Among participants who were 20-24 years old and who self-reported living with HIV, 39.4% in the intervention arm and 48.9% in the comparison arm knew they were living with HIV; 52.8% in the intervention arm and 57.8% in the comparison arm were DBS-confirmed on ART at the time of the survey; and 63.9% in the intervention arm and 73.3% in the comparison arm were virally suppressed. The differences between study arms were small and there were no statistically significant differences in terms of knowledge, on treatment, and viral suppression by study arm (Figure 10b).
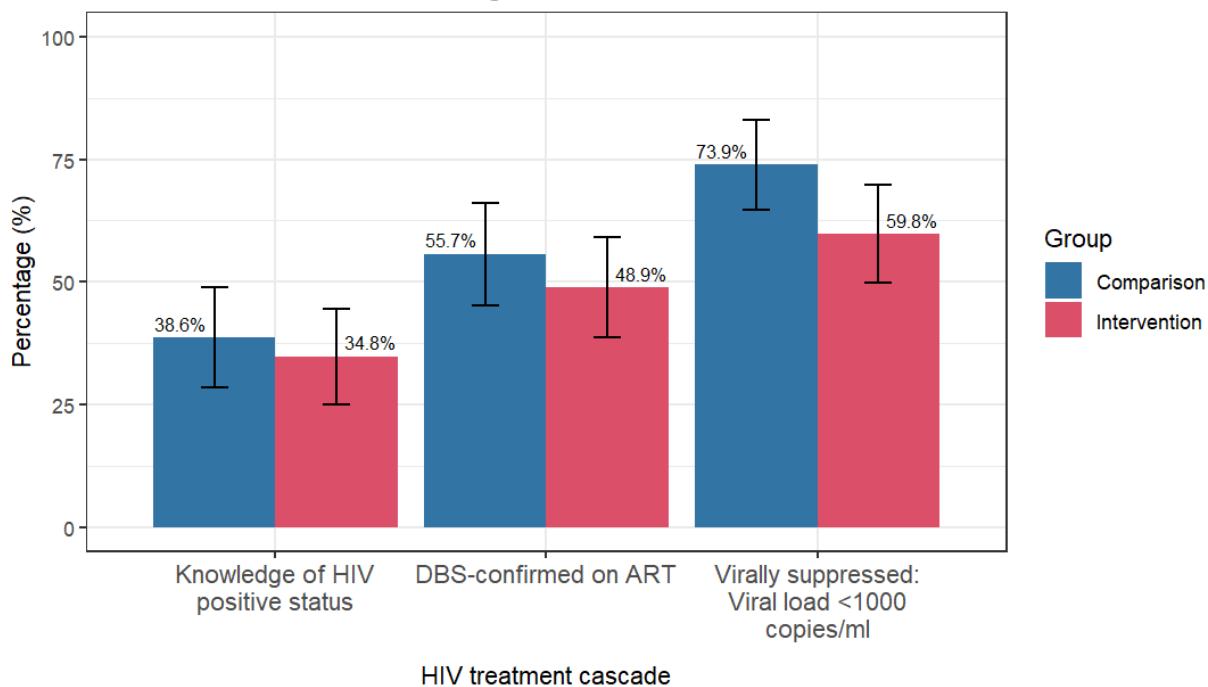
Figure 10a: HIV care cascade for HIV treatment among participants aged 15-19 years who were DBS-confirmed living with HIV, stratified by intervention/comparison arm. The denominator is the same for all bars in the cascade.
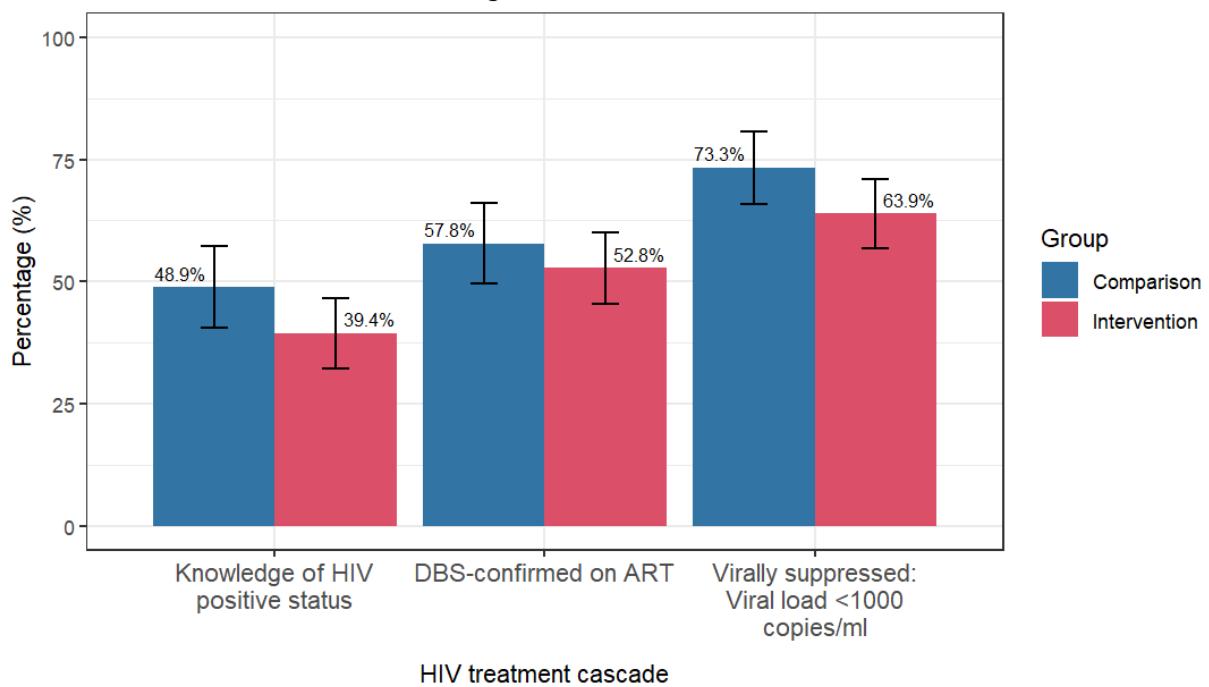
Figure 10b: HIV care cascade for HIV treatment among participants aged 20-24 years who were DBS-confirmed living with HIV, stratified by intervention/comparison arm. The denominator is the same for all bars in the cascade.

NRCCT Impact of My Journey Programme on Gender-Based Violence (GBV)

Intimate partner violence (IPV) and non-partner sexual violence (NPSV)

We asked participants about lifetime experience of IPV perpetrated by a boyfriend or male partner, including different types of emotional, physical, and sexual IPV (Table 44), and there were small differences between the intervention and comparison arms showing that for all variables except NPSV, the intervention arm reported lower prevalences of lifetime IPV. Reports of ever having experienced emotional IPV were 13.8% in the intervention arm and 17.1% in the comparison arm. Reports of ever having experienced physical IPV were 14.4% in the intervention arm and 16.0% in the comparison arm. Reports of ever having experienced sexual IPV were 6.8% in the intervention arm and 8.2% in the comparison arm (Table 44).

Reports of ever having experienced non-partner sexual violence were very similar between arms overall: 9.2% in the intervention arm and 9.7% in the comparison. In the younger age group, they were also very similar, but in the older age group, participants in the intervention arm were somewhat less likely to have ever experienced NPSV compared with the comparison arm (7.7% versus 10.9%) (Table 44).

Table 44: Lifetime experience of intimate partner violence (IPV) by boyfriend or male partner and non-partner sexual violence (NPSV) among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Indicator of emotional IPV:							
Participant's boyfriend or male partner has insulted her, made her feel bad about herself, made fun of her in front of other people, or done things to scare or intimidate her on purpose once or more than once							
Total	407/2387	17.1	365/2638	13.8	0.73	0.54 - 1.00	0.0600
15-19	209/1447	14.4	195/1514	12.9	0.79	0.58 - 1.08	0.1559
20-24	198/940	21.1	170/1124	15.1	0.61	0.35 - 1.06	0.0915
Indicators of physical IPV:							
Participant's boyfriend or male partner has slapped her; thrown something at her that could hurt her; pushed or shoved he; hit, kicked, beat, dragged or burned her; or threatened to use or actually used a weapon against her once or more than once							
Total	382/2387	16.0	381/2638	14.4	0.83	0.58 - 1.19	0.3295
15-19	162/1447	11.2	188/1514	12.4	1.12	0.78 - 1.62	0.5434
20-24	220/940	23.4	193/1124	17.2	0.60	0.36 - 0.98	0.0547
Indicators of sexual IPV:							
Participant's boyfriend or male partner has forced her to do something sexual that she found degrading or humiliating, or forced her to have sex with him when she didn't want to because he physically forced, threatened or pressured her once or more than once							
Total	195/2387	8.2	180/2638	6.8	0.77	0.53 - 1.12	0.1855
15-19	96/1447	6.6	107/1514	7.1	0.93	0.60 - 1.44	0.7511

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
20-24	99/940	10.5	73/1124	6.5	0.50	0.27 - 0.95	0.0444

Indicators of non-partner sexual violence:

Participant has been forced by someone who was not her boyfriend or male partner to have oral, vaginal or anal sex once or more than once

Total	232/2387	9.7	242/2638	9.2	0.93	0.68 - 1.27	0.6404
15-19	130/1447	9.0	156/1514	10.3	1.15	0.77 - 1.72	0.4938
20-24	102/940	10.9	86/1124	7.7	0.57	0.36 - 0.90	0.0258

NRCCT Impact of My Journey Programme on Pregnancy Prevention

Pregnancy and family planning

Table 45 describes characteristics of first pregnancy among participants who have ever had sex, and there were only very small differences between study arms. Among all participants, 22.9% and 11.7% in the intervention arm had their first pregnancy before the age of 17 years and wanted to become pregnant then, compared with 21.2% and 10.0% in the comparison arm, respectively (Table 45).

Table 46 describes the use of family planning methods such as the injection, pill, implant, or IUD among all participants, and there were only very small differences between study arms, none of which were statistically significant. Overall, in the intervention arm, 50.2% of participants have ever been offered a family planning method and 41.7% have been offered a family planning method in the past six months, compared to 47.3% and 38.8% in the comparison arm, respectively.

Among all participants, 37.1% in the intervention arm and 34.6% in the comparison arm had accessed a family planning method from a clinic, hospital, or health worker in the past six months (Table 46).

Overall, 46.2% of participants in the intervention arm and 43.6% in the comparison arm had ever used a family planning method, while 37.6% in the intervention arm and 33.9% in the comparison arm were currently using a family planning method at the time of the survey (Table 46).

In the past month, 13.8% of participants in the intervention arm had used a family planning method 100% of the time, compared to 11.4% in the comparison arm. In the past six months, 10.5% in the intervention arm had used a family planning method 100% of the time, compared with 9.1% in the comparison arm (Table 46).

Table 47 describes the use of family planning methods among participants who have ever had sex, showing that there were only very small differences between study arms, none of which were statistically significant. Overall, 43.3% of participants in the intervention arm and 43.7% in the

comparison arm reported to use condoms at last sex as a family planning method. In the intervention arm, 40.5% of participants reported having used a contraceptive method other than condoms at last sex, compared to 37.9% in the comparison arm. Use of both condoms and another method of contraception at last sex (dual contraception) was reported by 23.1% in the intervention arm, compared to 22.0% in the comparison arm (Table 47).

Table 48 describes the type of family planning method used by participants at last sex and shows that there were only very small differences between study arms, none of which were statistically significant. Overall, injection, male condoms, implant, and the pill were the commonly used types of contraception at 36.6%, 21.1%, 11.9% and 7.6% respectively among participants in the intervention arm, compared with 38.3%, 18.6%, 12.7% and 7.1%, respectively, in the comparison arm. Female condoms, IUD, diaphragm, and sterilization were the least reported types of family planning methods used by participants in both intervention and comparison arms (3.2%, 0.3%, 0.2%, and 0.1% in the intervention arm, vs 3.4%, 0.3%, 0%, and 0.3% in the comparison arm, respectively). Among all participants, 20.3% in the intervention arm and 20.9% in the comparison arm did not use anything to prevent pregnancy (Table 48).

Table 49 describes the quality of services received by participants at their last visit among the My Journey participants. Overall, most participants reported that their waiting time was short (63.2%) and that they waited one hour or less (75.2%) (Table 49).

More than half of participants reported that the health worker checked if she was happy with the family planning methods she had been offered (68.7%) and that the health worker asked her which family planning method she would like the most (78.7%) (Table 49). Most participants reported that they were told about the injection (66.3%) followed by the implant (37.6%), the pill (36.2%), condoms (21.1%), emergency contraception (6.5%) and the IUD (4.9%).

Over a third of participants (42.7) reported that they were steered towards a specific family planning method by the health worker. Most participants reported being steered towards the injection (57.6%) followed by the implant (20.5%), pill (16.2%), condoms (16.2%), the IUD (0.5%) and emergency contraception (0.5%). More than 80% said they received the family planning method of their choice (82.7%).

The majority of participants felt that they had been involved in the decisions regarding their family planning method (72.6%) and that the health worker treated them in a friendly manner (83.3%); 75.4% of participants reported that the other people at the service (receptionist, cleaners, security guards etc.) treated them in a friendly and respectful way. More than 80% of participants believed that the information they shared would be kept confidential (84.1%) (Table 49).

At risk of unintended pregnancy

Participants were considered at risk of unintended pregnancy if they had sex in the past six months, and did not report being pregnant now or have plans to become pregnant at the time of the survey.

Motivation to use family planning

Indicators of motivation:

Table 50 describes motivation to use family planning and potential barriers to and facilitators of motivation among participants at risk of unintended pregnancy. Of these participants, 54.3% in the intervention arm and 56.3% in the comparison arm wanted to use family planning now. These differences were very small and there were no statistically significant differences overall or within each age group for this variable.

Overall, 68.1% of participants in the intervention arm and 70.3% in the comparison arm wanted to use family planning when they next have sex, while 69.2% and 69.0% planned to use family planning the next time they had sex in the intervention and comparison arms, respectively. These differences were very small and there were no statistically significant differences by study arm overall or within each age group (Table 50).

Potential barriers and facilitators for motivation to use family planning:

Knowledge of family planning

In terms of family planning knowledge, there were small differences (which were not statistically significant) between study arms in the prevalence of participants who had ever spoken with their parent or caregiver about using a family planning method (55.9% in the intervention arm and 60.3% in the comparison arm (Table 50).

Pregnancy risk perception:

Regarding pregnancy risk perception, it was very similar between study arms, 9.8% in the intervention arm and 9.9% in the comparison arm did not think that they will get pregnant. A small proportion of participants in the intervention (2.1%) and also in the comparison (2.0%) arms wanted to get pregnant (Table 50).

Consequences of use and attitudes:

There were slightly more participants who did not want their family to know that they were going to get family planning in the intervention arm (4.4%) compared to the comparison arm (2.7%). Similarly, when disaggregated by age group, there were slightly more participants in the 15-19 year age group

in the intervention arm (6.6.%) who do not want their family to know that they are going to get family planning compared to the comparison arm (3.8%) (Table 50).

Overall, 3.9% in the intervention arm and 5.5% in the comparison arm were worried that someone will find out that they are using family planning, and there were no statistically significant differences between study arms overall or within age groups (Table 50).

Positive attitudes towards family were relatively high with majority of participants agreeing that: it is safe for a young woman like them to use the injection, implant and the pill (65.5, 43.5%, and 42.3%, respectively) in the intervention, compared to the comparison arm (63.2%, 44.2%, and 42.1%, respectively). Similarly, most participants agreed that: the injection, implant, and the pill are each a good method to prevent pregnancy for women like them (72.5, 48.8%, and 40.9%, respectively) in the intervention arm, compared to (68.4%, 50.0%, and 42.0%, respectively). The differences between study arms in these variables were small or very small (Table 50).

With regards to negative attitudes towards family planning, participants in the intervention arm agreed that: the injection and the pill make the body change in unpleasant ways (53.0% for the injection and 28.2% for the pill), compared to participants in the comparison arm (56.7% and 31.6%, respectively). Participants in the intervention arm agreed that: the implant causes irregular bleeding, the implant makes it difficult to fall pregnant when it is removed, and they do not like the side-effects of being on family planning (35.4%, 26.8%, and 6.3%, respectively) compared to the comparison arm (40.5%, 30.6%, 42.0%, and 7.9%, respectively) The differences between study arms were very small (Table 50).

Social norms:

Overall, 1.1% of participants in both intervention and comparison arms reported that their friends did not approve of family planning use (Table 50).

Access to family planning

Indicators of access:

Table 51 describes access to family planning and potential barriers to and facilitators of access among participants at risk of unintended pregnancy. Among these participants, 79.3% in the intervention arm reported that they knew a place where they could easily get family planning when they want to use it, compared to 78.9% in the comparison arm; 78.7% in the intervention arm reported that it was easy or very easy for them to get family planning when they wanted to get it, compared to 80.0% in the comparison arms. The differences between study arms were very small for these variables (Table 51).

<u>Potential barriers and facilitators of access to family planning:</u>

Availability:

Overall, 11.3% in the intervention arm and 11.9% in the comparison arm reported that they ran out of supplies of family planning, while 1.6% in the intervention arm and 1.4% in the comparison arm reported that there were stock-outs and they did not always have family planning available at the service for them. The differences between study arms were very small for these variables (Table 51).

Accessibility:

Regarding accessibility, 19.0% in the intervention arm and 22.0% in the comparison arm reported to have been refused or denied family planning when they wanted to get it, while 3.8% in the intervention arm and 4.9% in the comparison arm said family planning services were not open when they have time to go get them. The differences between study arms were very small for these variables (Table 51).

Among all participants, 7.2% in the intervention arm and slightly more (10.7%) in the comparison arm found it far for them to travel to get family planning; and 1.2% in the intervention arm and 0.9% in the comparison arm said COVID 19 and lockdowns made it difficult for them to get family planning. In the older age group, fewer participants in the intervention arm found it far to travel for family planning (6.7%) compared to 11.8% in the comparison arm, but in the younger age group the difference was very small (Table 51).

Acceptability:

Overall, in the intervention arm, 27.7% of participants felt that lack of privacy and confidentiality made it difficult to get family planning, compared to 24.1% in the comparison arm. In the intervention arm, 6.1% of participants worried that someone would see her getting family planning, compared to 6.6% in the comparison arm. The differences between study arms were very small for these variables (Table 51).

Among the participants, 7.4% in the intervention arm and 10.2% in the comparison arm reported that negative attitude of health workers made it difficult for them to get family planning. In the older age group, fewer participants in the intervention arm reported this (5.8%) compared to 10.3% in the comparison arm, but in the younger age group the difference was very small (Table 51).

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Affordability:

Overall, 4.5% of participants in the intervention arm and 5.7% in the comparison arm found it expensive for them to get family planning, and the difference between study arms was very small (Table 51).

Effective use of family planning

Indicators of effective use:

Table 52 describes effective use of family planning among participants at risk of pregnancy. Overall, 15.3% of participants in the intervention arm and 13.4% in the comparison arm reported to use a contraceptive method other than condoms 100% of the time in the past six months, while use of a contraceptive method 100% of the time in the past month was reported by 22.3% in the intervention arm and 19.8% in the comparison arm. These were small differences between study arms which were not statistically significant (Table 52).

Overall, there were more participants in the intervention arm who reported to always use a family planning method when they have sex (17.4%), compared to 11.9% in the comparison arm (which was also a statistically significant difference). When disaggregated by age group, there were also more participants in the intervention arm who reported this, compared with the comparison arm. In the older age group 19.6% of participants always used family planning during sex in the intervention arm, compared to 12.8% in the comparison arm for this variable (and this difference was statistically significant). In the younger group the estimates were 14.4% in the intervention arm and 10.5% in the comparison arm (but this difference was not statistically significant) (Table 52).

Potential barriers and facilitators of effective use of contraceptives:

Skills:

Overall, 16.7% of participants in the intervention arm and 18.7% in the comparison arm reported that they forgot to take their contraceptives (Table 52).

Self-efficacy:

Similarly, 2.0% in the intervention arm and 2.4% in the comparison arm felt unconfident about how to use family planning (Table 52).

Partner influence and refusals:

Regarding partner influence on contraceptive use, slightly more (2.5%) participants in the intervention arm and 1.8% in the comparison arm reported that their partners did not want them to go to get family planning (Table 52).

Overall, fewer participants in the intervention arm who reported that their partners did not want them to use family planning (2.8%), compared to 4.7% in the comparison arm (Table 52).

Among participants, 2.0% in the intervention arm and 2.2% in the comparison arm reported that their parents did not want them to use family planning, while 6.0% in the intervention arm and 6.1% in the comparison arm reported that they and their partner always used condoms when they have sex (Table 52).

Table 45: Characteristics of first pregnancy among HERStory 3 study participants who have ever been pregnant from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Age at first pregnancy was under 17 years of age							
Total	168/793	21.2	208/907	22.9	1.15	0.83 - 1.59	0.4127
15-19	96/214	44.9	115/256	44.9	1.21#	0.79 - 1.86	0.3908
20-24	72/579	12.4	93/651	14.3	1.56	0.71 - 3.46	0.2823
Participant wanted to become pregnant then							
Total	79/793	10.0	106/907	11.7	1.15	0.67 - 1.98	0.6077
15-19	19/214	8.9	25/256	9.8	1.06	0.56 - 2.04	0.8531
20-24	60/579	10.4	81/651	12.4	1.27	0.57 - 2.81	0.5673

results based on model with site nested within subdistrict random effect (excluding household effect)

Table 46: Use of family planning methods such as the injection, pill, implant or IUD among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant has ever been offered a family planning method							
Total	1128/2387	47.3	1324/2638	50.2	1.05	0.74 - 1.49	0.7907
15-19	466/1447	32.2	541/1514	35.7	1.11	0.68 - 1.81	0.6802
20-24	662/940	70.4	783/1124	69.7	0.96	0.67 - 1.37	0.8147
In past six months, participant has been offered a family planning method							
Total	926/2387	38.8	1100/2638	41.7	1.07	0.78 - 1.46	0.6698
15-19	371/1447	25.6	441/1514	29.1	1.18	0.71 - 1.94	0.5267
20-24	555/940	59.0	659/1124	58.6	0.98	0.77 - 1.24	0.8727
In the past six months, participant accessed a family planning method from a clinic, hospital or health worker							
Total	827/2387	34.6	980/2638	37.1	1.04	0.80 - 1.37	0.7606
15-19	365/1447	25.2	410/1514	27.1	1.02	0.71 - 1.48	0.9069
20-24	462/940	49.1	570/1124	50.7	1.07	0.80 - 1.43	0.6423
Participant had ever used a family planning method							
Total	1041/2387	43.6	1219/2638	46.2	1.03	0.74 - 1.44	0.8558
15-19	410/1447	28.3	470/1514	31.0	1.07	0.65 - 1.79	0.7843
20-24	631/940	67.1	749/1124	66.6	0.97	0.70 - 1.34	0.8524
Participant was using a family planning method at the time of the survey							
Total	809/2387	33.9	991/2638	37.6	1.11	0.87 - 1.43	0.4064
15-19	312/1447	21.6	381/1514	25.2	1.24	0.82 - 1.89	0.3228
20-24	497/940	52.9	610/1124	54.3	1.05	0.84 - 1.30	0.6763
In the past month, participant used a family planning method 100% of the time							
Total	272/2387	11.4	364/2638	13.8	1.27	0.81 - 1.98	0.3031
15-19	92/1447	6.4	116/1514	7.7	1.15	0.63 - 2.10	0.6488
20-24	180/940	19.1	248/1124	22.1	1.17	0.85 - 1.60	0.3473
In the past six months, participant used a family planning method 100% of the time							
Total	217/2387	9.1	278/2638	10.5	1.13	0.76 - 1.68	0.5602
15-19	85/1447	5.9	97/1514	6.4	1.07	0.64 - 1.79	0.7938
20-24	132/940	14.0	181/1124	16.1	1.29	0.78 - 2.12	0.3301

Table 47: Use of family planning methods among HERStory 3 study participants who have ever had sex from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Used condoms at last sex							
Total	615/1406	43.7	753/1740	43.3	0.96	0.78 - 1.18	0.7013
15-19	233/576	40.5	327/745	43.9	1.13	0.85 - 1.50	0.4150
20-24	382/830	46.0	426/995	42.8	0.87	0.67 - 1.11	0.2741
Used contraceptive method other than condoms at last sex							
Total	533/1406	37.9	704/1740	40.5	1.11	0.94 - 1.31	0.2114
15-19	193/576	33.5	269/745	36.1	1.17	0.87 - 1.57	0.3106
20-24	340/830	41.0	435/995	43.7	1.12	0.91 - 1.38	0.3056
Reported using both condoms and another contraceptive method at last sex							
Total	309/1406	22.0	402/1740	23.1	1.03	0.75 - 1.40	0.8775
15-19	107/576	18.6	150/745	20.1	1.10[#]	0.79 - 1.53	0.5678
20-24	202/830	24.3	252/995	25.3	1.01	0.68 - 1.49	0.9746
In the past six months, participant used a family planning method 100% of the time							
Total	189/1406	13.4	245/1740	14.1	1.11	0.70 - 1.77	0.6624
15-19	64/576	11.1	73/745	9.8	0.83	0.41 - 1.67	0.6005
20-24	125/830	15.1	172/995	17.3	1.33	0.78 - 2.26	0.3018

results based on model with site nested within subdistrict random effect (excluding household effect)

Table 48: Type of family planning method used at last sex among HERStory 3 study participants who had ever had sex from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant was on the injection							
Total	539/1406	38.3	637/1740	36.6	0.95	0.71 - 1.29	0.7642
15-19	192/576	33.3	241/745	32.3	0.98	0.63 - 1.53	0.9376
20-24	347/830	41.8	396/995	39.8	0.95	0.69 - 1.31	0.7619
Participant was taking the pill							
Total	100/1406	7.1	133/1740	7.6	1.12	0.75 - 1.67	0.5987
15-19	26/576	4.5	51/745	6.8	1.63	0.83 - 3.19	0.1669
20-24	74/830	8.9	82/995	8.2	0.93	0.66 - 1.30	0.6706
Participant was using the implant							
Total	179/1406	12.7	207/1740	11.9	0.85	0.37 - 1.96	0.7118
15-19	67/576	11.6	79/745	10.6	0.94	0.46 - 1.93	0.8639
20-24	112/830	13.5	128/995	12.9	0.85#	0.43 - 1.68	0.6381
Male condom							
Total	261/1406	18.6	367/1740	21.1	1.25	0.79 - 1.99	0.3512
15-19	114/576	19.8	164/745	22.0	1.20	0.73 - 1.97	0.4812
20-24	147/830	17.7	203/995	20.4	1.39	0.77 - 2.53	0.2904
Female condom							
Total	48/1406	3.4	55/1740	3.2	0.92	0.75 - 1.13	0.4238
15-19	25/576	4.3	23/745	3.1	0.62	0.46 - 0.83	0.0042
20-24	23/830	2.8	32/995	3.2	1.69	0.73 - 3.87	0.2318
Participant had an intra-uterine device (IUD)							
Total	4/1406	0.3	6/1740	0.3	1.24α	-	-
15-19	1/576	0.2	1/745	0.1	-	-	-
20-24	3/830	0.4	5/995	0.5	1.45α	-	-
Participant used a diaphragm							
Total	0/1406	0.0	4/1740	0.2	-	-	-
15-19	0/576	0.0	2/745	0.3	-	-	-
20-24	0/830	0.0	2/995	0.2	-	-	-
Participant had had an operation to make her sterile							
Total	4/1406	0.3	2/1740	0.1	0.22α	-	-
15-19	2/576	0.3	1/745	0.1	0.41α	-	-
20-24	2/830	0.2	1/995	0.1	0.39α	-	-
The person the participant had sex with had an operation to make him sterile							
Total	4/1406	0.3	3/1740	0.2	0.59+	0.13 - 2.70	0.5043
15-19	3/576	0.5	0/745	0.0	-	-	-
20-24	1/830	0.1	3/995	0.3	2.59α	-	-
Other							

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	19/1406	1.4	16/1740	0.9	0.67	0.34 - 1.31	0.2537
15-19	9/576	1.6	8/745	1.1	0.64[+]	0.23 - 1.75	0.3936
20-24	10/830	1.2	8/995	0.8	0.66[+]	0.26 - 1.70	0.3997
Participant did not use anything to prevent pregnancy							
Total	294/1406	20.9	353/1740	20.3	0.93	0.72 - 1.21	0.6120
15-19	134/576	23.3	163/745	21.9	0.86	0.57 - 1.32	0.5040
20-24	160/830	19.3	190/995	19.1	0.99	0.69 - 1.41	0.9489
Prefer not to answer							
Total	111/1406	7.9	131/1740	7.5	0.89	0.53 - 1.49	0.6663
15-19	59/576	10.2	69/745	9.3	0.91[#]	0.61 - 1.36	0.6644
20-24	52/830	6.3	62/995	6.2	0.98[#]	0.62 - 1.53	0.9244

results based on model with site nested within subdistrict random effect (excluding household effect)

+ results based on model with subdistrict random effect only (excluding household and site effect)

α/- frequency or sample size too low to obtain a reliable estimate

Table 49: Quality of family planning services at last visit among HERStory 3 study participants who have ever received family planning from the My Journey Programme from 24 intervention sites across 8 provinces in South Africa, 2024

Variable	Freq/N	%	95% CI
Waiting time was reasonably short			
Total	311/492	63.2	59.0 - 67.5
15-19	121/182	66.5	59.6 - 73.3
20-24	190/310	61.3	55.9 - 66.7
Waiting time was one hour or less			
Total	370/492	75.2	71.4 - 79.0
15-19	138/182	75.8	69.6 - 82.0
20-24	232/310	74.8	70.0 - 79.7
Health worker checked she was happy with the family planning method she had been on before			
Total	338/492	68.7	64.6 - 72.8
15-19	112/182	61.5	54.5 - 68.6
20-24	226/310	72.9	68.0 - 77.9
Health worker asked participant which family planning method she would like most			
Total	387/492	78.7	75.0 - 82.3
15-19	143/182	78.6	72.6 - 84.5
20-24	244/310	78.7	74.2 - 83.3
Participant was steered towards a specific method by the health worker			
Total	210/492	42.7	38.3 - 47.1
15-19	78/182	42.9	35.7 - 50.0
20-24	132/310	42.6	37.1 - 48.1
Participant received the family planning method of her choice			
Total	407/492	82.7	79.4 - 86.1
15-19	146/182	80.2	74.4 - 86.0
20-24	261/310	84.2	80.1 - 88.3
Participant felt that she had been involved in the decisions regarding family planning (she could express her opinion or preference and was listened to and heard)			
Total	357/492	72.6	68.6 - 76.5
15-19	121/182	66.5	59.6 - 73.3
20-24	236/310	76.1	71.4 - 80.9
Health worker treated her in a friendly manner			
Total	410/492	83.3	80.0 - 86.6
15-19	148/182	81.3	75.7 - 87.0
20-24	262/310	84.5	80.5 - 88.5
All the other people at the service (receptionist, cleaners, security guards etc.) treated participant in a friendly and respectful way			
Total	371/492	75.4	71.6 - 79.2
15-19	132/182	72.5	66.0 - 79.0
20-24	239/310	77.1	72.4 - 81.8
Participant believed the information she shared would be kept confidential			
Total	414/492	84.1	80.9 - 87.4
15-19	148/182	81.3	75.7 - 87.0
20-24	266/310	85.8	81.9 - 89.7

Table 50: Motivation to use family planning and potential barriers to and facilitators of motivation among HERStory 3 study participants who had sex in the past six months from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Motivation to use contraception:							
Participant definitely wants to use family planning now							
Total	564/1002	56.3	690/1271	54.3	0.93	0.78 - 1.12	0.4629
15-19	192/392	49.0	273/542	50.4	1.04	0.76 - 1.42	0.8131
20-24	372/610	61.0	417/729	57.2	0.86	0.68 - 1.08	0.1965
Participant wants to be using family planning when she next has sex							
Total	704/1002	70.3	866/1271	68.1	0.92	0.70 - 1.20	0.5355
15-19	257/392	65.6	341/542	62.9	0.91	0.60 - 1.37	0.6517
20-24	447/610	73.3	525/729	72.0	0.92	0.58 - 1.46	0.7310
Participant plans to be using family planning the next time she has sex							
Total	691/1002	69.0	880/1271	69.2	1.01	0.82 - 1.26	0.8984
15-19	246/392	62.8	350/542	64.6	1.12	0.78 - 1.60	0.5559
20-24	445/610	73.0	530/729	72.7	1.00	0.69 - 1.44	0.9897
Potential motivation barriers and facilitators:							
<u>*Knowledge*</u>							
Participant has ever spoken with her parent or caregiver about using a family planning method							
Total	604/1002	60.3	711/1271	55.9	0.85	0.68 - 1.06	0.1552
15-19	224/392	57.1	276/542	50.9	0.78	0.57 - 1.05	0.1179
20-24	380/610	62.3	435/729	59.7	0.90	0.69 - 1.17	0.4312
<u>*Pregnancy risk perception*</u>							
Participant does not think she will get pregnant							
Total	99/1002	9.9	125/1271	9.8	1.00	0.75 - 1.33	0.9980
15-19	41/392	10.5	60/542	11.1	1.05	0.69 - 1.60	0.8356
20-24	58/610	9.5	65/729	8.9	0.97	0.67 - 1.41	0.8801
Participant wants to get pregnant							
Total	20/1002	2.0	27/1271	2.1	1.06	0.59 - 1.90	0.8438
15-19	4/392	1.0	8/542	1.5	2.25^{α}	-	-
20-24	16/610	2.6	19/729	2.6	0.93	0.47 - 1.85	0.8450
<u>*Consequences of use/attitudes*</u>							
Participant doesn't want her family to know that she is going to get family planning							
Total	27/1002	2.7	56/1271	4.4	1.63	1.01 - 2.62	0.0580
15-19	15/392	3.8	36/542	6.6	1.87	1.41 - 2.48	0.0002
20-24	12/610	2.0	20/729	2.7	1.42$^{#}$	0.68 - 3.01	0.3631
Participant is worried that someone will find out she is on family planning							
Total	55/1002	5.5	50/1271	3.9	0.55	0.30 - 1.02	0.0711
15-19	28/392	7.1	30/542	5.5	0.76	0.44 - 1.29	0.3165
20-24	27/610	4.4	20/729	2.7	0.62	0.34 - 1.13	0.1363
Agreed or strongly agreed that it is safe for a young woman like her to use the injection							
Total	633/1002	63.2	832/1271	65.5	1.14	0.89 - 1.46	0.3169

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
15-19	237/392	60.5	338/542	62.4	1.09	0.79 - 1.51	0.5912
20-24	396/610	64.9	494/729	67.8	1.26	0.87 - 1.83	0.2261
Agreed or strongly agreed that the injection is a good method to prevent pregnancy for young women like her							
Total	685/1002	68.4	921/1271	72.5	1.28	0.95 - 1.71	0.1136
15-19	253/392	64.5	385/542	71.0	1.61	0.95 - 2.71	0.0879
20-24	432/610	70.8	536/729	73.5	1.18	0.90 - 1.53	0.2415
Agreed or strongly agreed that the injection makes your body change in unpleasant ways							
Total	568/1002	56.7	673/1271	53.0	0.89	0.68 - 1.17	0.4290
15-19	210/392	53.6	292/542	53.9	1.06	0.76 - 1.49	0.7319
20-24	358/610	58.7	381/729	52.3	0.79	0.58 - 1.06	0.1350
Agreed or strongly agreed that it is safe for a young person like her to use the implant							
Total	443/1002	44.2	553/1271	43.5	0.96	0.71 - 1.31	0.8077
15-19	159/392	40.6	215/542	39.7	0.95	0.68 - 1.34	0.7757
20-24	284/610	46.6	338/729	46.4	1.00	0.69 - 1.44	0.9939
Agreed or strongly agreed that the implant is a good method to prevent pregnancy for young women like her							
Total	501/1002	50.0	620/1271	48.8	0.94	0.69 - 1.27	0.6761
15-19	179/392	45.7	254/542	46.9	1.04	0.72 - 1.48	0.8506
20-24	322/610	52.8	366/729	50.2	0.89	0.62 - 1.28	0.5310
Agreed or strongly agreed that the implant causes irregular bleeding							
Total	406/1002	40.5	450/1271	35.4	0.81	0.64 - 1.03	0.1054
15-19	150/392	38.3	189/542	34.9	0.90	0.65 - 1.25	0.5314
20-24	256/610	42.0	261/729	35.8	0.79	0.61 - 1.02	0.0814
Agreed or strongly agreed that the implant makes it difficult to fall pregnant when it is removed							
Total	307/1002	30.6	340/1271	26.8	0.81	0.64 - 1.03	0.0943
15-19	113/392	28.8	131/542	24.2	0.68	0.41 - 1.11	0.1382
20-24	194/610	31.8	209/729	28.7	0.86	0.60 - 1.23	0.4215
Agreed or strongly agreed that the pill is a good method to prevent pregnancy for young women like her							
Total	421/1002	42.0	520/1271	40.9	0.97	0.78 - 1.20	0.7531
15-19	158/392	40.3	197/542	36.3	0.85	0.63 - 1.14	0.2886
20-24	263/610	43.1	323/729	44.3	1.06	0.85 - 1.32	0.6016
Agreed or strongly agreed that the pill is safe for a young woman like her							
Total	422/1002	42.1	537/1271	42.3	1.02	0.86 - 1.20	0.8621
15-19	158/392	40.3	203/542	37.5	0.89	0.67 - 1.19	0.4503
20-24	264/610	43.3	334/729	45.8	1.12	0.90 - 1.40	0.3339
Agreed or strongly agreed that the pill makes your body change in unpleasant ways							
Total	317/1002	31.6	359/1271	28.2	0.86	0.69 - 1.06	0.1730
15-19	114/392	29.1	152/542	28.0	0.98	0.60 - 1.60	0.9361
20-24	203/610	33.3	207/729	28.4	0.78	0.61 - 1.01	0.0690
Participant does not like side-effects of being on family planning							
Total	79/1002	7.9	80/1271	6.3	0.66	0.36 - 1.21	0.1899
15-19	20/392	5.1	32/542	5.9	1.08	0.49 - 2.36	0.8538

	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
20-24	59/610	9.7	48/729	6.6	0.67#	0.42 - 1.05	0.0922
**Social norms**							
Friends did not approve of using family planning							
Total	11/1002	1.1	14/1271	1.1	0.65	0.33 - 1.28	0.2248
15-19	6/392	1.5	8/542	1.5	-	-	-
20-24	5/610	0.8	6/729	0.8	1.06α	-	-

\# results based on model with site nested within subdistrict random effect (excluding household effect)
α/- frequency or sample size too low to obtain a reliable estimate

Table 51: Access to family planning and potential barriers to and facilitators of access among HERStory 3 study participants who had sex in the past six months from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Access to contraception:							
If participant wants to use family planning (like the injection, pill, implant or IUD), she knows a place where she can easily get it							
Total	791/1002	78.9	1008/1271	79.3	1.10	0.74 - 1.64	0.6471
15-19	285/392	72.7	389/542	71.8	1.01	0.53 - 1.93	0.9699
20-24	506/610	83.0	619/729	84.9	1.35	0.82 - 2.20	0.2505
If participant wants to get family planning, it is easy or very easy for her to get it							
Total	802/1002	80.0	1000/1271	78.7	0.98	0.64 - 1.50	0.9115
15-19	291/392	74.2	386/542	71.2	0.87	0.46 - 1.64	0.6707
20-24	511/610	83.8	614/729	84.2	1.09	0.78 - 1.53	0.6022
Potential access barriers and facilitators:							
<u>*Availability*</u>							
Participant ran out of supply of family planning							
Total	119/1002	11.9	144/1271	11.3	0.94	0.62 - 1.43	0.7781
15-19	42/392	10.7	49/542	9.0	0.74	0.32 - 1.72	0.4887
20-24	77/610	12.6	95/729	13.0	1.23	0.65 - 2.33	0.5334
There are stock-outs and they do not always have family planning for her							
Total	14/1002	1.4	20/1271	1.6	1.11[#]	0.55 - 2.21	0.7790
15-19	8/392	2.0	6/542	1.1	0.54[+]	0.19 - 1.58	0.2752
20-24	6/610	1.0	14/729	1.9	1.86[+]	0.66 - 5.19	0.2499
<u>*Accessibility*</u>							
Participant has ever been refused or denied family planning when she wanted to get it							
Total	220/1002	22.0	241/1271	19.0	0.72	0.49 - 1.04	0.0940
15-19	89/392	22.7	99/542	18.3	0.62	0.35 - 1.10	0.1168
20-24	131/610	21.5	142/729	19.5	0.75	0.43 - 1.30	0.3223
The family planning service is not open when the participant has time to go							
Total	49/1002	4.9	48/1271	3.8	0.77	0.51 - 1.16	0.2326
15-19	20/392	5.1	23/542	4.2	0.81	0.44 - 1.50	0.5118
20-24	29/610	4.8	25/729	3.4	0.74	0.43 - 1.29	0.3063
It is far for the participant to travel to get family planning							
Total	107/1002	10.7	92/1271	7.2	0.54	0.28 - 1.02	0.0695
15-19	35/392	8.9	43/542	7.9	0.77[#]	0.38 - 1.56	0.4774
20-24	72/610	11.8	49/729	6.7	0.42	0.20 - 0.87	0.0301
COVID-19 and lockdowns made it difficult to get family planning							
Total	9/1002	0.9	15/1271	1.2	1.35[#]	0.59 - 3.07	0.4879
15-19	6/392	1.5	9/542	1.7	1.08[α]	-	-
20-24	3/610	0.5	6/729	0.8	2.49[α]	-	-

	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Acceptability							
Lack of privacy and confidentiality makes it difficult to get family planning							
Total	241/1002	24.1	352/1271	27.7	1.22	1.01 - 1.47	0.0564
15-19	99/392	25.3	166/542	30.6	1.32	0.98 - 1.77	0.0780
20-24	142/610	23.3	186/729	25.5	1.15	0.89 - 1.48	0.2960
Participant worries someone will see her getting family planning							
Total	66/1002	6.6	78/1271	6.1	0.90	0.47 - 1.73	0.7598
15-19	38/392	9.7	47/542	8.7	0.88#	0.48 - 1.64	0.7016
20-24	28/610	4.6	31/729	4.3	0.99	0.46 - 2.16	0.9879
The negative attitude of health workers makes it difficult for participant to get family planning							
Total	102/1002	10.2	94/1271	7.4	0.58	0.27 - 1.26	0.1852
15-19	39/392	9.9	52/542	9.6	0.93#	0.53 - 1.65	0.8179
20-24	63/610	10.3	42/729	5.8	0.59	0.38 - 0.90	0.0247
Affordability							
It is expensive for participant to get family planning							
Total	57/1002	5.7	57/1271	4.5	0.59	0.28 - 1.25	0.1838
15-19	33/392	8.4	27/542	5.0	0.58	0.34 - 0.98	0.0550
20-24	24/610	3.9	30/729	4.1	1.10	0.66 - 1.84	0.7218

\# results based on model with site nested within subdistrict random effect (excluding household effect)

\+ results based on model with subdistrict random effect only (excluding household and site effect)

α/- frequency or sample size too low to obtain a reliable estimate

Table 52: Effective use of contraception and potential barriers to and facilitators of effective use among HERStory 3 study participants who had sex in the past six months from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Effective use of contraception:							
Used a contraceptive method other than condoms 100% of the time in the past six months							
Total	134/1002	13.4	194/1271	15.3	1.26	0.76 - 2.11	0.3781
15-19	45/392	11.5	61/542	11.3	0.97	0.47 - 2.02	0.9424
20-24	89/610	14.6	133/729	18.2	1.53	0.87 - 2.67	0.1503
Used a contraceptive method 100% of the time in the past month							
Total	198/1002	19.8	284/1271	22.3	1.30	0.82 - 2.05	0.2824
15-19	62/392	15.8	85/542	15.7	0.98#	0.60 - 1.62	0.9457
20-24	136/610	22.3	199/729	27.3	1.28	0.95 - 1.73	0.1142
Participant always used family planning when she had sex							
Total	119/1002	11.9	221/1271	17.4	1.94	1.23 - 3.05	0.0093
15-19	41/392	10.5	78/542	14.4	1.44#	0.96 - 2.17	0.0905
20-24	78/610	12.8	143/729	19.6	2.24	1.25 - 4.01	0.0128
Potential barriers to and facilitators of effective use							
<u>*Skills*</u>							
Forgot to take contraception							
Total	187/1002	18.7	212/1271	16.7	0.81	0.59 - 1.12	0.2100
15-19	75/392	19.1	90/542	16.6	0.86	0.61 - 1.20	0.3782
20-24	112/610	18.4	122/729	16.7	0.79	0.50 - 1.27	0.3460
<u>*Self-efficacy*</u>							
I am not confident I know how to use family planning							
Total	24/1002	2.4	25/1271	2.0	0.81	0.46 - 1.44	0.4819
15-19	10/392	2.6	11/542	2.0	0.78#	0.33 - 1.86	0.5825
20-24	14/610	2.3	14/729	1.9	0.88	0.41 - 1.88	0.7478
<u>*Parent or partner influence/refusals*</u>							
Participant's partner does not want her to go to get family planning							
Total	18/1002	1.8	32/1271	2.5	1.46	0.81 - 2.64	0.2240
15-19	10/392	2.6	9/542	1.7	0.63+	0.26 - 1.53	0.3165
20-24	8/610	1.3	23/729	3.2	1.96	1.43 - 2.69	0.0004
Sexual partner did not want her to use family planning							
Total	47/1002	4.7	35/1271	2.8	0.54	0.45 - 0.65	<.0001
15-19	13/392	3.3	10/542	1.8	0.54	0.23 - 1.28	0.1773
20-24	34/610	5.6	25/729	3.4	0.62	0.37 - 1.06	0.0971
Parents did not want her to use family planning							
Total	22/1002	2.2	26/1271	2.0	0.98	0.59 - 1.61	0.9254
15-19	9/392	2.3	15/542	2.8	1.25#	0.53 - 2.96	0.6200
20-24	13/610	2.1	11/729	1.5	0.71+	0.29 - 1.73	0.4596

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant and partner use condoms when they have sex							
Total	61/1002	6.1	76/1271	6.0	0.81	0.39 - 1.70	0.5856
15-19	23/392	5.9	29/542	5.4	0.90	0.51 - 1.58	0.7162
20-24	38/610	6.2	47/729	6.4	1.04#	0.57 - 1.91	0.9017

results based on model with site nested within subdistrict random effect (excluding household effect)
+ results based on model with subdistrict random effect only (excluding household and site effect)

Pregnancy prevention cascades for family planning services

We created pregnancy prevention cascades for family planning methods like the injection, pill, implant, or IUD to describe participant's motivation to use, access to, use and effective use of family planning among participants who reported having sex in the past six months. We created separate cascades for the 15-19 (Figure 11a) and 20-24 (Figure 11b) age group, stratified by intervention/comparison sites.

Motivation to use family planning was defined as definitely wanting to use family planning. Access to family planning was defined as finding it easy or very easy to access family planning. Use of family planning was defined as being on family planning at the time of the survey. Effective use of family planning was defined as using family planning 100% of the time in the six months before the survey.

Among participants who were 15-19 years old, 50.5% in the intervention arm and 49.1% in the comparison arm were motivated to use family planning; 71.2% in the intervention arm and 74.3% in the comparison arm had access to family planning; 46.0% in the intervention arm and 44.0% in the comparison arm used family planning; and 11.3% in the intervention arm and 11.6% in the comparison arm effectively used family planning. These differences between study arms were very small and there were no statistically significant differences in motivation to use, access to, use and effective use of family planning (Figure 11a).

Among participants aged 20-24 years old, 57.4% in the intervention arm and 61.0% in the comparison arm were motivated to use family planning; 84.2% in the intervention arm and 83.8% in the comparison arm had access to family planning; 60.9% in the intervention arm and 60.0% in the comparison arm used family planning; and 18.3% in the intervention arm and 14.6% in the comparison arm effectively used family planning. These differences between study arms were very small and there were no statistically significant differences in motivation to use, access to, use and effective use of family planning (Figure 11b).
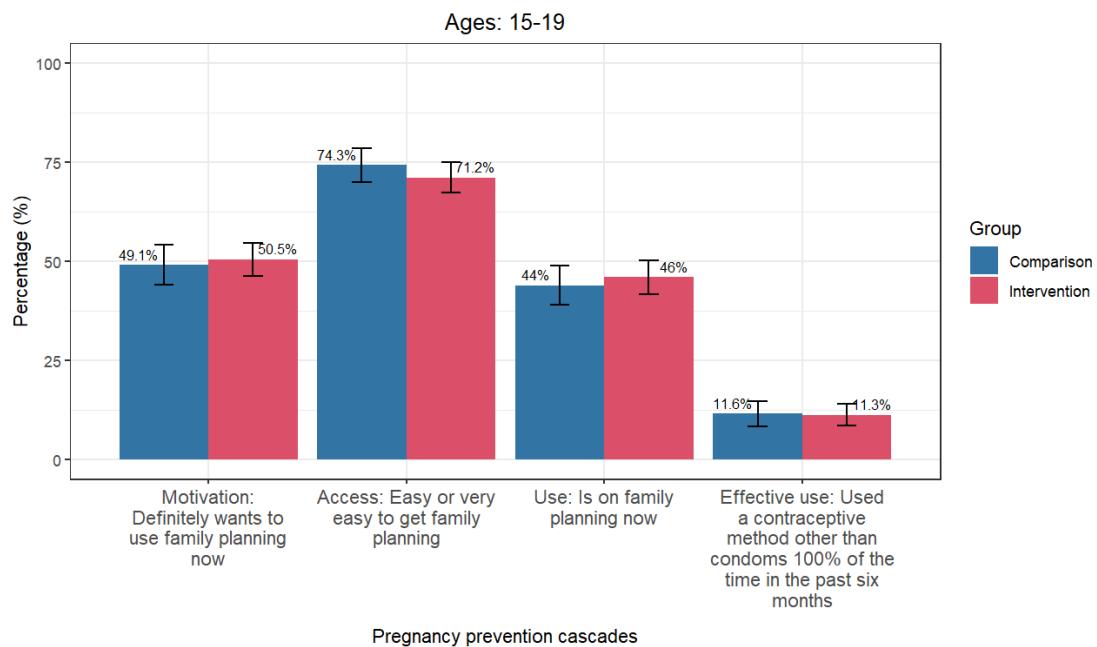
Figure 11a: Pregnancy prevention cascade for family planning methods like the injection, pill, implant or IUD among participants aged 15-19 years who reported having sex in the past six months, stratified by intervention/comparison arm. The denominator is the same for all bars in the cascade.
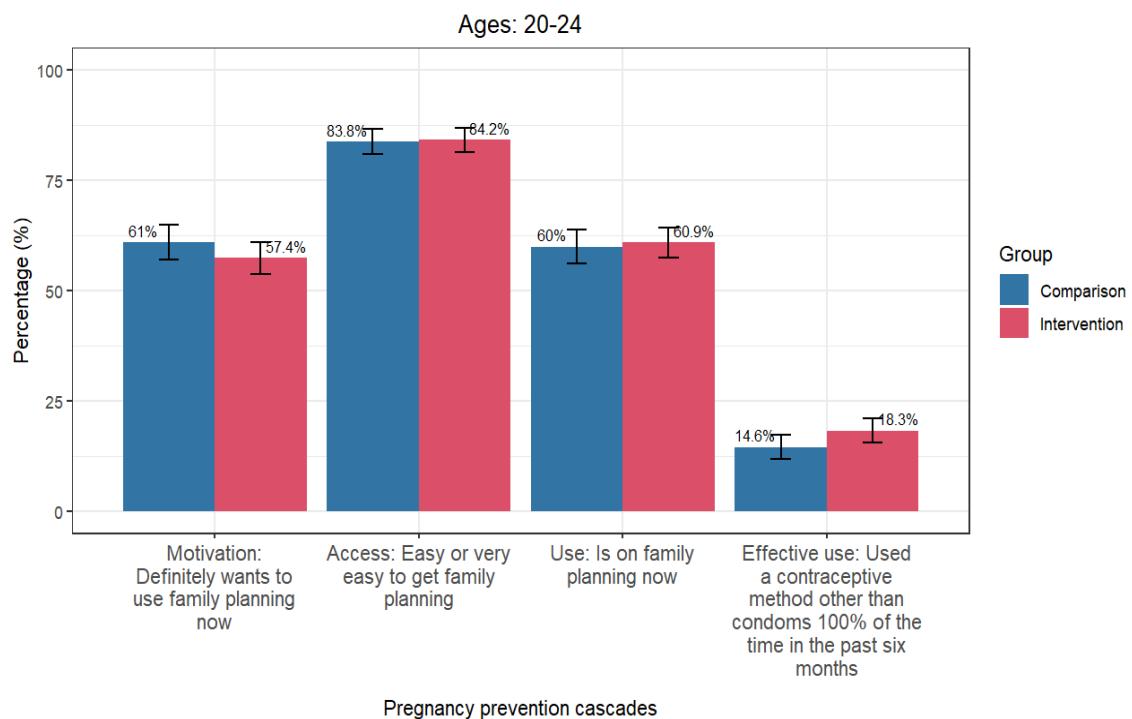
Figure 11b: Pregnancy prevention cascade for family planning methods like the injection, pill, implant or IUD among participants aged 20-24 years who reported having sex in the past six months, stratified by intervention/comparison arm. The denominator is the same for all bars in the cascade.

My Journey Programme Reach and Acceptability

My Journey Programme involvement

This section describes the involvement of participants from targeted intervention sites in the My Journey Programme as well as products and services they received through the Programme, stratified by subdistrict.

Table 53 describes participants' exposure to the My Journey Programme in the intervention arm, stratified by subdistrict and age group. In the intervention arm, the percentage of participants who reported being approached by one of the subrecipients of the My Journey Programme and invited to participate in the Programme ranged from 20.5% in Nelson Mandela C to 72.5% in Dihlabeng. The percentage of participants who reported being enrolled into the My Journey Programme ranged from 27.9% in Klipfontein to 59.7% in Dihlabeng. The age disaggregated results are also reported in this table (Table 53).

The location in which the participant was first approached by someone from the My Journey Programme is described in Table 54, stratified by subdistrict and age group, and including all participants in the intervention arm. The most common places participants reported being approached were at home and at school. Between 13.7% (Nelson Mandela C) and 37.4% (Rustenburg) reported being approached at home. Between 13.2% (Nelson Mandela C) and 38.9% (Nyandeni) reported being approached at school. Between 5.2% of participants (Dihlabeng) and 58.5% (Nelson Mandela C) of participants reported that they had not been approached by anyone from the My Journey Programme (Table 54).

Study participants who had ever been enrolled in the My Journey Programme were asked when the first time was that they had been enrolled, and they could select any year from 2016 to 2024 to align to the years in which the Global Fund had funded combination HIV prevention programmes for AGYW in South Africa. In every subdistrict, the largest proportion of enrolled participants had been enrolled in the most recent year (2024), except among the older age group in Dihlabeng where the largest proportion had been enrolled in 2023 (Table 55).

My Journey Programme-enrolled participants were asked to report on the acceptability of their experiences with the My Journey Programme (Table 55). In every subdistrict, the most common response was "good" or "wonderful", ranging from 78.5% (Abaqulusi) to 92.7% (Nelson Mandela C) (Table 55).

My Journey Programme-enrolled participants were asked whether they had done a risk assessment as part of the My Journey Programme. In all subdistricts, most participants reported that they had done the risk assessment, ranging from 53.7% (Nelson Mandela C) to 79.4% (Dihlabeng).

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Table 56 shows all services that enrolled participants who had done the risk assessment had received from the My Journey Programme, stratified by subdistrict and age group. Participants could select as many services as relevant. Most participants had only done one risk assessment, but a relatively large proportion in each subdistrict had done as many as three or more risk assessments ranging from 8.2% in Rustenburg to 34.0% in Dihlabeng. The service reported by the largest proportion of participants was HIV testing, ranging from 61.2% in Mbombela to 88.0% in Dihlabeng (Table 56). Other services participants reported, as described in Table 56, were:

- Receipt of male or female condoms (ranging from 9.8% in Nyandeni to 28.6% in Mbombela);

- Receipt of lubricants (ranging from 1.6% in Nyandeni to 10.2% in Mbombela);

- Receipt of information on how to use male or female condoms (ranging from 5.3% in Fetakgomo Tubatse to 23.9% in Govan Mbeki);

- Receipt of information about HIV (ranging from 25.0% in City of UMhlathuze to 48.0% in Dihlabeng);

- Receipt of information about STIs (ranging from 12.3% in Fetakgomo Tubatse to 37.0% in Dihlabeng and Goven Mbeki);

- Receipt of information about TB (ranging from 7.0% in Fetakgomo Tubatse to 24.0% in Dihlabeng);

- Receipt of information about abuse perpetrated by boys or men (ranging from 3.5% in Fetakgomo Tubatse to 24.0% in Dihlabeng);

- Having been asked if they were coughing a lot or had night sweats (ranging from 1.8% in Fetakgomo Tubatse to 21.7% in Govan Mbeki);

- Having been asked if they had STI symptoms (ranging from 3.5% in FetakgomoTubatse to 21.0% in Dihlabeng);

- Receipt of a service plan (ranging from 1.8% in Fetakgomo Tubatse to 13.6% in Nelson Mandela C);

- Receipt of a journal (ranging from 0.0% in Fetakgomo Tubatse to 22.7% in Nelson Mandela C);

- Receipt of other services (ranging from 1.8% in Fetakgomo Tubatse to 13.6% in Nelson Mandela C);

- Receipt of a referral to other services (ranging from 0.0% in several sites to 4.5% in Nelson Mandela C).

Table 53: Participant exposure to the My Journey Programme among HERStory 3 study participants from 12 intervention subdistricts across 8 provinces in South Africa, 2024, stratified by subdistrict

Variable	Abaqulusi Freq/N (%)	Dihlabeng Freq/N (%)	Fetakgomo Tubatse Freq/N (%)	Govan Mbeki Freq/N (%)	Klipfontein Freq/N (%)	Mbombela Freq/N (%)	Nelson Mandela C Freq/N (%)	Nyandeni Freq/N (%)	Rustenburg Freq/N (%)	Setsoto Freq/N (%)	Tshwane 1 Freq/N (%)	City of UMhlathuze Freq/N (%)
Participant was approached by one of the sub-recipients of the My Journey Programme and invited to participate in the Programme												
Total	72/216 (33.3)	153/211 (72.5)	113/213 (53.1)	83/213 (39.0)	72/226 (31.9)	95/227 (41.9)	42/205 (20.5)	98/216 (45.4)	94/206 (45.6)	131/218 (60.1)	100/267 (37.5)	69/220 (31.4)
15-19	38/121 (31.4)	90/117 (76.9)	65/125 (52.0)	46/125 (36.8)	44/127 (34.6)	39/84 (46.4)	23/108 (21.3)	71/154 (46.1)	55/128 (43.0)	75/129 (58.1)	64/166 (38.6)	43/130 (33.1)
20-24	34/95 (35.8)	63/94 (67.0)	48/88 (54.5)	37/88 (42.0)	28/99 (28.3)	56/143 (39.2)	19/97 (19.6)	27/62 (43.5)	39/78 (50.0)	56/89 (62.9)	36/101 (35.6)	26/90 (28.9)
Participant was enrolled into the My Journey Programme												
Total	65/216 (30.1)	126/211 (59.7)	78/213 (36.6)	71/213 (33.3)	63/226 (27.9)	71/227 (31.3)	41/205 (20.0)	93/216 (43.1)	81/206 (39.3)	107/218 (49.1)	97/267 (36.3)	62/220 (28.2)
15-19	34/121 (28.1)	74/117 (63.2)	49/125 (39.2)	49/125 (39.2)	41/127 (32.3)	27/84 (32.1)	18/108 (16.7)	69/154 (44.8)	47/128 (36.7)	59/129 (45.7)	61/166 (36.7)	42/130 (32.3)
20-24	31/95 (32.6)	52/94 (55.3)	29/88 (33.0)	22/88 (25.0)	22/99 (22.2)	44/143 (30.8)	23/97 (23.7)	24/62 (38.7)	34/78 (43.6)	48/89 (53.9)	36/101 (35.6)	20/90 (22.2)

Table 54: Location that the participant was first approached by someone from the My Journey Programme among HERStory 3 study participants from 12 intervention subdistricts across 8 provinces in South Africa, 2024, stratified by subdistrict

Variable	Abaqulusi Freq/N (%)	Dihlabeng Freq/N (%)	Fetakgomo Tubatse Freq/N (%)	Govan Mbeki Freq/N (%)	Klipfontein Freq/N (%)	Mbombela Freq/N (%)	Nelson Mandela C Freq/N (%)	Nyandeni Freq/N (%)	Rustenburg Freq/N (%)	Setsoto Freq/N (%)	Tshwane 1 Freq/N (%)	City of UMhlathuze Freq/N (%)
At home												
Total	75/216 (34.7)	70/211 (33.2)	53/213 (24.9)	70/213 (32.9)	46/226 (20.4)	49/227 (21.6)	28/205 (13.7)	67/216 (31.0)	77/206 (37.4)	74/218 (33.9)	88/267 (33.0)	56/220 (25.5)
15-19	42/121 (34.7)	29/117 (24.8)	37/125 (29.6)	40/125 (32.0)	33/127 (26.0)	18/84 (21.4)	11/108 (10.2)	47/154 (30.5)	54/128 (42.2)	33/129 (25.6)	51/166 (30.7)	33/130 (25.4)
20-24	33/95 (34.7)	41/94 (43.6)	16/88 (18.2)	30/88 (34.1)	13/99 (13.1)	31/143 (21.7)	17/97 (17.5)	20/62 (32.3)	23/78 (29.5)	41/89 (46.1)	37/101 (36.6)	23/90 (25.6)
At school												
Total	46/216 (21.3)	79/211 (37.4)	71/213 (33.3)	43/213 (20.2)	46/226 (20.4)	42/227 (18.5)	27/205 (13.2)	84/216 (38.9)	49/206 (23.8)	69/218 (31.7)	73/267 (27.3)	44/220 (20.0)
15-19	34/121 (28.1)	55/117 (47.0)	46/125 (36.8)	35/125 (28.0)	34/127 (26.8)	26/84 (31.0)	21/108 (19.4)	69/154 (44.8)	38/128 (29.7)	51/129 (39.5)	59/166 (35.5)	34/130 (26.2)
20-24	12/95 (12.6)	24/94 (25.5)	25/88 (28.4)	8/88 (9.1)	12/99 (12.1)	16/143 (11.2)	6/97 (6.2)	15/62 (24.2)	11/78 (14.1)	18/89 (20.2)	14/101 (13.9)	10/90 (11.1)
At a TVET college												
Total	4/216 (1.9)	2/211 (0.9)	8/213 (3.8)	6/213 (2.8)	4/226 (1.8)	6/227 (2.6)	0/205 (0.0)	2/216 (0.9)	4/206 (1.9)	8/218 (3.7)	9/267 (3.4)	3/220 (1.4)
15-19	0/121 (0.0)	0/117 (0.0)	0/125 (0.0)	1/125 (0.8)	2/127 (1.6)	2/84 (2.4)	0/108 (0.0)	0/154 (0.0)	0/128 (0.0)	2/129 (1.6)	1/166 (0.6)	0/130 (0.0)
20-24	4/95 (4.2)	2/94 (2.1)	8/88 (9.1)	5/88 (5.7)	2/99 (2.0)	4/143 (2.8)	0/97 (0.0)	2/62 (3.2)	4/78 (5.1)	6/89 (6.7)	8/101 (7.9)	3/90 (3.3)
At a university												
Total	2/216 (0.9)	1/211 (0.5)	1/213 (0.5)	0/213 (0.0)	1/226 (0.4)	1/227 (0.4)	1/205 (0.5)	0/216 (0.0)	0/206 (0.0)	0/218 (0.0)	2/267 (0.7)	3/220 (1.4)
15-19	0/121 (0.0)	1/117 (0.9)	0/125 (0.0)	0/125 (0.0)	0/127 (0.0)	0/84 (0.0)	0/108 (0.0)	0/154 (0.0)	0/128 (0.0)	0/129 (0.0)	1/166 (0.6)	2/130 (1.5)
20-24	2/95 (2.1)	0/94 (0.0)	1/88 (1.1)	0/88 (0.0)	1/99 (1.0)	1/143 (0.7)	1/97 (1.0)	0/62 (0.0)	0/78 (0.0)	0/89 (0.0)	1/101 (1.0)	1/90 (1.1)
At a safe space in the community												
Total	1/216 (0.5)	12/211 (5.7)	5/213 (2.3)	4/213 (1.9)	1/226 (0.4)	13/227 (5.7)	3/205 (1.5)	1/216 (0.5)	2/206 (1.0)	11/218 (5.0)	2/267 (0.7)	1/220 (0.5)
15-19	1/121 (0.8)	6/117 (5.1)	2/125 (1.6)	2/125 (1.6)	1/127 (0.8)	5/84 (6.0)	1/108 (0.9)	1/154 (0.6)	0/128 (0.0)	7/129 (5.4)	1/166 (0.6)	0/130 (0.0)
20-24	0/95 (0.0)	6/94 (6.4)	3/88 (3.4)	2/88 (2.3)	0/99 (0.0)	8/143 (5.6)	2/97 (2.1)	0/62 (0.0)	2/78 (2.6)	4/89 (4.5)	1/101 (1.0)	1/90 (1.1)
At a post office												
Total	0/216 (0.0)	0/211 (0.0)	0/213 (0.0)	0/213 (0.0)	0/226 (0.0)	0/227 (0.0)	0/205 (0.0)	0/216 (0.0)	0/206 (0.0)	0/218 (0.0)	0/267 (0.0)	0/220 (0.0)
15-19	0/121 (0.0)	0/117 (0.0)	0/125 (0.0)	0/125 (0.0)	0/127 (0.0)	0/84 (0.0)	0/108 (0.0)	0/154 (0.0)	0/128 (0.0)	0/129 (0.0)	0/166 (0.0)	0/130 (0.0)
20-24	0/95 (0.0)	0/94 (0.0)	0/88 (0.0)	0/88 (0.0)	0/99 (0.0)	0/143 (0.0)	0/97 (0.0)	0/62 (0.0)	0/78 (0.0)	0/89 (0.0)	0/101 (0.0)	0/90 (0.0)
At a SASSA paypoint												
Total	0/216 (0.0)	0/211 (0.0)	0/213 (0.0)	1/213 (0.5)	0/226 (0.0)	0/227 (0.0)	3/205 (1.5)	0/216 (0.0)	0/206 (0.0)	0/218 (0.0)	0/267 (0.0)	0/220 (0.0)
15-19	0/121 (0.0)	0/117 (0.0)	0/125 (0.0)	0/125 (0.0)	0/127 (0.0)	0/84 (0.0)	1/108 (0.9)	0/154 (0.0)	0/128 (0.0)	0/129 (0.0)	0/166 (0.0)	0/130 (0.0)
20-24	0/95 (0.0)	0/94 (0.0)	0/88 (0.0)	1/88 (1.1)	0/99 (0.0)	0/143 (0.0)	2/97 (2.1)	0/62 (0.0)	0/78 (0.0)	0/89 (0.0)	0/101 (0.0)	0/90 (0.0)
At a shopping centre												
Total	2/216 (0.9)	2/211 (0.9)	0/213 (0.0)	1/213 (0.5)	2/226 (0.9)	16/227 (7.0)	2/205 (1.0)	1/216 (0.5)	1/206 (0.5)	1/218 (0.5)	3/267 (1.1)	2/220 (0.9)
15-19	1/121 (0.8)	1/117 (0.9)	0/125 (0.0)	1/125 (0.8)	0/127 (0.0)	3/84 (3.6)	1/108 (0.9)	0/154 (0.0)	1/128 (0.8)	1/129 (0.8)	2/166 (1.2)	2/130 (1.5)
20-24	1/95 (1.1)	1/94 (1.1)	0/88 (0.0)	0/88 (0.0)	2/99 (2.0)	13/143 (9.1)	1/97 (1.0)	1/62 (1.6)	0/78 (0.0)	0/89 (0.0)	1/101 (1.0)	0/90 (0.0)
At an event in the community												
Total	0/216 (0.0)	0/211 (0.0)	1/213 (0.5)	0/213 (0.0)	5/226 (2.2)	2/227 (0.9)	0/205 (0.0)	2/216 (0.9)	0/206 (0.0)	1/218 (0.5)	0/267 (0.0)	0/220 (0.0)
15-19	0/121 (0.0)	0/117 (0.0)	0/125 (0.0)	0/125 (0.0)	1/127 (0.8)	0/84 (0.0)	0/108 (0.0)	1/154 (0.6)	0/128 (0.0)	1/129 (0.8)	0/166 (0.0)	0/130 (0.0)
20-24	0/95 (0.0)	0/94 (0.0)	1/88 (1.1)	0/88 (0.0)	4/99 (4.0)	2/143 (1.4)	0/97 (0.0)	1/62 (1.6)	0/78 (0.0)	0/89 (0.0)	0/101 (0.0)	0/90 (0.0)
At the clinic												
Total	9/216 (4.2)	6/211 (2.8)	10/213 (4.7)	21/213 (9.9)	5/226 (2.2)	13/227 (5.7)	5/205 (2.4)	6/216 (2.8)	6/206 (2.9)	5/218 (2.3)	12/267 (4.5)	14/220 (6.4)
15-19	4/121 (3.3)	4/117 (3.4)	2/125 (1.6)	6/125 (4.8)	1/127 (0.8)	4/84 (4.8)	0/108 (0.0)	5/154 (3.2)	2/128 (1.6)	3/129 (2.3)	6/166 (3.6)	6/130 (4.6)
20-24	5/95 (5.3)	2/94 (2.1)	8/88 (9.1)	15/88 (17.0)	4/99 (4.0)	9/143 (6.3)	5/97 (5.2)	1/62 (1.6)	4/78 (5.1)	2/89 (2.2)	6/101 (5.9)	8/90 (8.9)

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Table 54: Location that the participant was first approached by someone from the My Journey Programme among HERStory 3 study participants from 12 intervention subdistricts across 8 provinces in South Africa, 2024, stratified by subdistrict

Variable	Abaqulusi Freq/N (%)	Dihlabeng Freq/N (%)	Fetakgomo Tubatse Freq/N (%)	Govan Mbeki Freq/N (%)	Klipfontein Freq/N (%)	Mbombela Freq/N (%)	Nelson Mandela C Freq/N (%)	Nyandeni Freq/N (%)	Rustenburg Freq/N (%)	Setsoto Freq/N (%)	Tshwane 1 Freq/N (%)	City of UMhlathuze Freq/N (%)
At a mobile clinic												
Total	0/216 (0.0)	4/211 (1.9)	1/213 (0.5)	1/213 (0.5)	3/226 (1.3)	3/227 (1.3)	1/205 (0.5)	3/216 (1.4)	3/206 (1.5)	7/218 (3.2)	1/267 (0.4)	2/220 (0.9)
15-19	0/121 (0.0)	3/117 (2.6)	0/125 (0.0)	1/125 (0.8)	1/127 (0.8)	2/84 (2.4)	0/108 (0.0)	1/154 (0.6)	1/128 (0.8)	2/129 (1.6)	1/166 (0.6)	0/130 (0.0)
20-24	0/95 (0.0)	1/94 (1.1)	1/88 (1.1)	0/88 (0.0)	2/99 (2.0)	1/143 (0.7)	1/97 (1.0)	2/62 (3.2)	2/78 (2.6)	5/89 (5.6)	0/101 (0.0)	2/90 (2.2)
At another place in the community												
Total	1/216 (0.5)	11/211 (5.2)	2/213 (0.9)	9/213 (4.2)	9/226 (4.0)	4/227 (1.8)	1/205 (0.5)	1/216 (0.5)	13/206 (6.3)	9/218 (4.1)	4/267 (1.5)	4/220 (1.8)
15-19	0/121 (0.0)	6/117 (5.1)	2/125 (1.6)	6/125 (4.8)	3/127 (2.4)	2/84 (2.4)	0/108 (0.0)	0/154 (0.0)	4/128 (3.1)	8/129 (6.2)	3/166 (1.8)	3/130 (2.3)
20-24	1/95 (1.1)	5/94 (5.3)	0/88 (0.0)	3/88 (3.4)	6/99 (6.1)	2/143 (1.4)	1/97 (1.0)	1/62 (1.6)	9/78 (11.5)	1/89 (1.1)	1/101 (1.0)	1/90 (1.1)
Participant has not been approached by anyone from the My Journey Programme												
Total	43/216 (19.9)	11/211 (5.2)	35/213 (16.4)	41/213 (19.2)	78/226 (34.5)	57/227 (25.1)	120/205 (58.5)	37/216 (17.1)	31/206 (15.0)	13/218 (6.0)	40/267 (15.0)	72/220 (32.7)
15-19	22/121 (18.2)	4/117 (3.4)	23/125 (18.4)	24/125 (19.2)	39/127 (30.7)	11/84 (13.1)	67/108 (62.0)	22/154 (14.3)	17/128 (13.3)	6/129 (4.7)	21/166 (12.7)	37/130 (28.5)
20-24	21/95 (22.1)	7/94 (7.4)	12/88 (13.6)	17/88 (19.3)	39/99 (39.4)	46/143 (32.2)	53/97 (54.6)	15/62 (24.2)	14/78 (17.9)	7/89 (7.9)	19/101 (18.8)	35/90 (38.9)
Prefer not to answer												
Total	33/216 (15.3)	13/211 (6.2)	26/213 (12.2)	16/213 (7.5)	26/226 (11.5)	21/227 (9.3)	14/205 (6.8)	12/216 (5.6)	20/206 (9.7)	20/218 (9.2)	33/267 (12.4)	19/220 (8.6)
15-19	17/121 (14.0)	8/117 (6.8)	13/125 (10.4)	9/125 (7.2)	12/127 (9.4)	11/84 (13.1)	6/108 (5.6)	8/154 (5.2)	11/128 (8.6)	15/129 (11.6)	20/166 (12.0)	13/130 (10.0)
20-24	16/95 (16.8)	5/94 (5.3)	13/88 (14.8)	7/88 (8.0)	14/99 (14.1)	10/143 (7.0)	8/97 (8.2)	4/62 (6.5)	9/78 (11.5)	5/89 (5.6)	13/101 (12.9)	6/90 (6.7)

Table 55: Participant involvement with the My Journey Programme among HERStory 3 study participants who were enrolled into the My Journey Programme from 12 intervention subdistricts across 8 provinces in South Africa, 2024, stratified by subdistrict

Variable	Abaqulusi	Dihlabeng	Fetakgomo Tubatse	Govan Mbeki	Klipfontein	Mbombela	Nelson Mandela C	Nyandeni	Rustenburg	Setsoto	Tshwane 1	City of UMhlathuze
	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)
The first time the participant was enrolled into the Programme was in:												
Total												
2016	0/65 (0.0)	1/126 (0.8)	1/78 (1.3)	0/71 (0.0)	5/63 (7.9)	3/71 (4.2)	1/41 (2.4)	3/93 (3.2)	1/81 (1.2)	5/107 (4.7)	1/97 (1.0)	0/62 (0.0)
2017	1/65 (1.5)	2/126 (1.6)	0/78 (0.0)	4/71 (5.6)	1/63 (1.6)	1/71 (1.4)	1/41 (2.4)	0/93 (0.0)	2/81 (2.5)	2/107 (1.9)	1/97 (1.0)	2/62 (3.2)
2018	0/65 (0.0)	1/126 (0.8)	3/78 (3.8)	1/71 (1.4)	4/63 (6.3)	3/71 (4.2)	2/41 (4.9)	2/93 (2.2)	1/81 (1.2)	3/107 (2.8)	3/97 (3.1)	0/62 (0.0)
2019	0/65 (0.0)	7/126 (5.6)	10/78 (12.8)	1/71 (1.4)	5/63 (7.9)	3/71 (4.2)	1/41 (2.4)	3/93 (3.2)	2/81 (2.5)	1/107 (0.9)	3/97 (3.1)	7/62 (11.3)
2020	6/65 (9.2)	11/126 (8.7)	5/78 (6.4)	7/71 (9.9)	3/63 (4.8)	10/71 (14.1)	8/41 (19.5)	8/93 (8.6)	3/81 (3.7)	5/107 (4.7)	2/97 (2.1)	0/62 (0.0)
2021	1/65 (1.5)	11/126 (8.7)	6/78 (7.7)	4/71 (5.6)	2/63 (3.2)	9/71 (12.7)	2/41 (4.9)	5/93 (5.4)	6/81 (7.4)	12/107 (11.2)	13/97 (13.4)	5/62 (8.1)
2022	5/65 (7.7)	15/126 (11.9)	5/78 (6.4)	10/71 (14.1)	6/63 (9.5)	6/71 (8.5)	5/41 (12.2)	11/93 (11.8)	13/81 (16.0)	10/107 (9.3)	11/97 (11.3)	8/62 (12.9)
2023	6/65 (9.2)	32/126 (25.4)	12/78 (15.4)	9/71 (12.7)	8/63 (12.7)	11/71 (15.5)	4/41 (9.8)	19/93 (20.4)	15/81 (18.5)	24/107 (22.4)	20/97 (20.6)	10/62 (16.1)
2024	38/65 (58.5)	36/126 (28.6)	29/78 (37.2)	31/71 (43.7)	24/63 (38.1)	21/71 (29.6)	14/41 (34.1)	38/93 (40.9)	33/81 (40.7)	38/107 (35.5)	39/97 (40.2)	28/62 (45.2)
15-19												
2016	0/34 (0.0)	0/74 (0.0)	1/49 (2.0)	0/49 (0.0)	1/41 (2.4)	0/27 (0.0)	1/18 (5.6)	1/69 (1.4)	0/47 (0.0)	2/59 (3.4)	0/61 (0.0)	0/42 (0.0)
2017	1/34 (2.9)	1/74 (1.4)	0/49 (0.0)	2/49 (4.1)	0/41 (0.0)	1/27 (3.7)	1/18 (5.6)	0/69 (0.0)	0/47 (0.0)	1/59 (1.7)	1/61 (1.6)	2/42 (4.8)
2018	0/34 (0.0)	0/74 (0.0)	1/49 (2.0)	0/49 (0.0)	3/41 (7.3)	1/27 (3.7)	0/18 (0.0)	2/69 (2.9)	1/47 (2.1)	1/59 (1.7)	1/61 (1.6)	0/42 (0.0)
2019	0/34 (0.0)	2/74 (2.7)	5/49 (10.2)	1/49 (2.0)	1/41 (2.4)	1/27 (3.7)	0/18 (0.0)	1/69 (1.4)	0/47 (0.0)	0/59 (0.0)	2/61 (3.3)	3/42 (7.1)
2020	3/34 (8.8)	6/74 (8.1)	3/49 (6.1)	3/49 (6.1)	2/41 (4.9)	2/27 (7.4)	1/18 (5.6)	7/69 (10.1)	3/47 (6.4)	2/59 (3.4)	1/61 (1.6)	0/42 (0.0)
2021	1/34 (2.9)	4/74 (5.4)	4/49 (8.2)	2/49 (4.1)	2/41 (4.9)	2/27 (7.4)	0/18 (0.0)	3/69 (4.3)	2/47 (4.3)	4/59 (6.8)	8/61 (13.1)	3/42 (7.1)
2022	3/34 (8.8)	6/74 (8.1)	3/49 (6.1)	8/49 (16.3)	4/41 (9.8)	3/27 (11.1)	4/18 (22.2)	8/69 (11.6)	7/47 (14.9)	6/59 (10.2)	5/61 (8.2)	7/42 (16.7)
2023	5/34 (14.7)	22/74 (29.7)	8/49 (16.3)	8/49 (16.3)	7/41 (17.1)	5/27 (18.5)	3/18 (16.7)	14/69 (20.3)	9/47 (19.1)	17/59 (28.8)	14/61 (23.0)	5/42 (11.9)
2024	19/34 (55.9)	27/74 (36.5)	19/49 (38.8)	24/49 (49.0)	16/41 (39.0)	10/27 (37.0)	7/18 (38.9)	30/69 (43.5)	23/47 (48.9)	22/59 (37.3)	26/61 (42.6)	21/42 (50.0)
20-24												
2016	0/31 (0.0)	1/52 (1.9)	0/29 (0.0)	0/22 (0.0)	4/22 (18.2)	3/44 (6.8)	0/23 (0.0)	2/24 (8.3)	1/34 (2.9)	3/48 (6.2)	1/36 (2.8)	0/20 (0.0)
2017	0/31 (0.0)	1/52 (1.9)	0/29 (0.0)	2/22 (9.1)	1/22 (4.5)	0/44 (0.0)	0/23 (0.0)	0/24 (0.0)	2/34 (5.9)	1/48 (2.1)	0/36 (0.0)	0/20 (0.0)
2018	0/31 (0.0)	1/52 (1.9)	2/29 (6.9)	1/22 (4.5)	1/22 (4.5)	2/44 (4.5)	2/23 (8.7)	0/24 (0.0)	0/34 (0.0)	2/48 (4.2)	2/36 (5.6)	0/20 (0.0)
2019	0/31 (0.0)	5/52 (9.6)	5/29 (17.2)	0/22 (0.0)	4/22 (18.2)	2/44 (4.5)	1/23 (4.3)	2/24 (8.3)	2/34 (5.9)	1/48 (2.1)	1/36 (2.8)	4/20 (20.0)
2020	3/31 (9.7)	5/52 (9.6)	2/29 (6.9)	4/22 (18.2)	1/22 (4.5)	8/44 (18.2)	7/23 (30.4)	1/24 (4.2)	0/34 (0.0)	3/48 (6.2)	1/36 (2.8)	0/20 (0.0)
2021	0/31 (0.0)	7/52 (13.5)	2/29 (6.9)	2/22 (9.1)	0/22 (0.0)	7/44 (15.9)	2/23 (8.7)	2/24 (8.3)	4/34 (11.8)	8/48 (16.7)	5/36 (13.9)	2/20 (10.0)
2022	2/31 (6.5)	9/52 (17.3)	2/29 (6.9)	2/22 (9.1)	2/22 (9.1)	3/44 (6.8)	1/23 (4.3)	3/24 (12.5)	6/34 (17.6)	4/48 (8.3)	6/36 (16.7)	1/20 (5.0)
2023	1/31 (3.2)	10/52 (19.2)	4/29 (13.8)	1/22 (4.5)	1/22 (4.5)	6/44 (13.6)	1/23 (4.3)	5/24 (20.8)	6/34 (17.6)	7/48 (14.6)	6/36 (16.7)	5/20 (25.0)
2024	19/31 (61.3)	9/52 (17.3)	10/29 (34.5)	7/22 (31.8)	8/22 (36.4)	11/44 (25.0)	7/23 (30.4)	8/24 (33.3)	10/34 (29.4)	16/48 (33.3)	13/36 (36.1)	7/20 (35.0)
Participant reported that her experiences with the Programme were:												
Total												
Good or wonderful	51/65 (78.5)	113/126 (89.7)	72/78 (92.3)	60/71 (84.5)	58/63 (92.1)	58/71 (81.7)	38/41 (92.7)	83/93 (89.2)	69/81 (85.2)	97/107 (90.7)	89/97 (91.8)	53/62 (85.5)
Neither good nor bad	7/65 (10.8)	9/126 (7.1)	4/78 (5.1)	5/71 (7.0)	2/63 (3.2)	7/71 (9.9)	3/41 (7.3)	8/93 (8.6)	8/81 (9.9)	4/107 (3.7)	4/97 (4.1)	4/62 (6.5)
Bad or very bad	3/65 (4.6)	0/126 (0.0)	1/78 (1.3)	1/71 (1.4)	2/63 (3.2)	1/71 (1.4)	0/41 (0.0)	1/93 (1.1)	1/81 (1.2)	1/107 (0.9)	0/97 (0.0)	2/62 (3.2)
15-19												

Table 55: Participant involvement with the My Journey Programme among HERStory 3 study participants who were enrolled into the My Journey Programme from 12 intervention subdistricts across 8 provinces in South Africa, 2024, stratified by subdistrict

Variable	Abaqulusi	Dihlabeng	Fetakgomo Tubatse	Govan Mbeki	Klipfontein	Mbombela	Nelson Mandela C	Nyandeni	Rustenburg	Setsoto	Tshwane 1	City of UMhlathuze
	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)
Good or wonderful	26/34 (76.5)	67/74 (90.5)	45/49 (91.8)	41/49 (83.7)	39/41 (95.1)	22/27 (81.5)	17/18 (94.4)	61/69 (88.4)	39/47 (83.0)	54/59 (91.5)	56/61 (91.8)	36/42 (85.7)
Neither good nor bad	5/34 (14.7)	6/74 (8.1)	3/49 (6.1)	4/49 (8.2)	1/41 (2.4)	3/27 (11.1)	1/18 (5.6)	6/69 (8.7)	6/47 (12.8)	2/59 (3.4)	2/61 (3.3)	4/42 (9.5)
Bad or very bad	1/34 (2.9)	0/74 (0.0)	1/49 (2.0)	1/49 (2.0)	1/41 (2.4)	0/27 (0.0)	0/18 (0.0)	1/69 (1.4)	1/47 (2.1)	1/59 (1.7)	0/61 (0.0)	0/42 (0.0)
20-24												
Good or wonderful	25/31 (80.6)	46/52 (88.5)	27/29 (93.1)	19/22 (86.4)	19/22 (86.4)	36/44 (81.8)	21/23 (91.3)	22/24 (91.7)	30/34 (88.2)	43/48 (89.6)	33/36 (91.7)	17/20 (85.0)
Neither good nor bad	2/31 (6.5)	3/52 (5.8)	1/29 (3.4)	1/22 (4.5)	1/22 (4.5)	4/44 (9.1)	2/23 (8.7)	2/24 (8.3)	2/34 (5.9)	2/48 (4.2)	2/36 (5.6)	0/20 (0.0)
Bad or very bad	2/31 (6.5)	0/52 (0.0)	0/29 (0.0)	0/22 (0.0)	1/22 (4.5)	1/44 (2.3)	0/23 (0.0)	0/24 (0.0)	0/34 (0.0)	0/48 (0.0)	0/36 (0.0)	2/20 (10.0)
Participant reported doing a risk assessment as part of the My Journey Programme												
Total	47/65 (72.3)	100/126 (79.4)	57/78 (73.1)	46/71 (64.8)	43/63 (68.3)	49/71 (69.0)	22/41 (53.7)	61/93 (65.6)	49/81 (60.5)	69/107 (64.5)	67/97 (69.1)	36/62 (58.1)
15-19	22/34 (64.7)	56/74 (75.7)	33/49 (67.3)	29/49 (59.2)	29/41 (70.7)	15/27 (55.6)	10/18 (55.6)	42/69 (60.9)	27/47 (57.4)	38/59 (64.4)	37/61 (60.7)	24/42 (57.1)
20-24	25/31 (80.6)	44/52 (84.6)	24/29 (82.8)	17/22 (77.3)	14/22 (63.6)	34/44 (77.3)	12/23 (52.2)	19/24 (79.2)	22/34 (64.7)	31/48 (64.6)	30/36 (83.3)	12/20 (60.0)

Table 56: Services received through the My Journey risk assessment among HERStory 3 study participants who were enrolled into the My Journey Programme and participated in a risk assessment from 12 intervention subdistricts across 8 provinces in South Africa, 2024, stratified by subdistrict

Variable	Abaqulusi	Dihlabeng	Fetakgomo-Tubatse	Govan Mbeki	Klipfontein	Mbombela	Nelson Mandela C	Nyandeni	Rustenburg	Setsoto	Tshwane 1	City of UMhlathuze
	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)
Participant has done:												
Total												
1 risk assessment	28/47 (59.6)	36/100 (36.0)	28/57 (49.1)	26/46 (56.5)	29/43 (67.4)	12/49 (24.5)	18/22 (81.8)	28/61 (45.9)	20/49 (40.8)	28/69 (40.6)	33/67 (49.3)	19/36 (52.8)
2 risk assessments	7/47 (14.9)	27/100 (27.0)	13/57 (22.8)	10/46 (21.7)	8/43 (18.6)	20/49 (40.8)	1/22 (4.5)	12/61 (19.7)	21/49 (42.9)	16/69 (23.2)	14/67 (20.9)	7/36 (19.4)
≥3 risk assessments	9/47 (19.1)	34/100 (34.0)	14/57 (24.6)	8/46 (17.4)	5/43 (11.6)	14/49 (28.6)	2/22 (9.1)	15/61 (24.6)	4/49 (8.2)	22/69 (31.9)	13/67 (19.4)	4/36 (11.1)
15-19												
1 risk assessment	14/22 (63.6)	22/56 (39.3)	19/33 (57.6)	17/29 (58.6)	22/29 (75.9)	1/15 (6.7)	8/10 (80.0)	17/42 (40.5)	12/27 (44.4)	15/38 (39.5)	19/37 (51.4)	11/24 (45.8)
2 risk assessments	4/22 (18.2)	14/56 (25.0)	7/33 (21.2)	6/29 (20.7)	4/29 (13.8)	9/15 (60.0)	1/10 (10.0)	12/42 (28.6)	9/27 (33.3)	9/38 (23.7)	6/37 (16.2)	5/24 (20.8)
≥3 risk assessments	3/22 (13.6)	18/56 (32.1)	5/33 (15.2)	4/29 (13.8)	2/29 (6.9)	4/15 (26.7)	0/10 (0.0)	10/42 (23.8)	3/27 (11.1)	13/38 (34.2)	9/37 (24.3)	4/24 (16.7)
20-24												
1 risk assessment	14/25 (56.0)	14/44 (31.8)	9/24 (37.5)	9/17 (52.9)	7/14 (50.0)	11/34 (32.4)	10/12 (83.3)	11/19 (57.9)	8/22 (36.4)	13/31 (41.9)	14/30 (46.7)	8/12 (66.7)
2 risk assessments	3/25 (12.0)	13/44 (29.5)	6/24 (25.0)	4/17 (23.5)	4/14 (28.6)	11/34 (32.4)	0/12 (0.0)	0/19 (0.0)	12/22 (54.5)	7/31 (22.6)	8/30 (26.7)	2/12 (16.7)
≥3 risk assessments	6/25 (24.0)	16/44 (36.4)	9/24 (37.5)	4/17 (23.5)	3/14 (21.4)	10/34 (29.4)	2/12 (16.7)	5/19 (26.3)	1/22 (4.5)	9/31 (29.0)	4/30 (13.3)	0/12 (0.0)
Received an HIV test												
Total	34/47 (72.3)	88/100 (88.0)	47/57 (82.5)	39/46 (84.8)	30/43 (69.8)	30/49 (61.2)	15/22 (68.2)	46/61 (75.4)	33/49 (67.3)	57/69 (82.6)	54/67 (80.6)	31/36 (86.1)
15-19	15/22 (68.2)	50/56 (89.3)	27/33 (81.8)	24/29 (82.8)	20/29 (69.0)	9/15 (60.0)	4/10 (40.0)	31/42 (73.8)	16/27 (59.3)	31/38 (81.6)	29/37 (78.4)	23/24 (95.8)
20-24	19/25 (76.0)	38/44 (86.4)	20/24 (83.3)	15/17 (88.2)	10/14 (71.4)	21/34 (61.8)	11/12 (91.7)	15/19 (78.9)	17/22 (77.3)	26/31 (83.9)	25/30 (83.3)	8/12 (66.7)
Received male or female condoms												
Total	8/47 (17.0)	24/100 (24.0)	6/57 (10.5)	12/46 (26.1)	7/43 (16.3)	14/49 (28.6)	4/22 (18.2)	6/61 (9.8)	9/49 (18.4)	11/69 (15.9)	16/67 (23.9)	7/36 (19.4)
15-19	3/22 (13.6)	10/56 (17.9)	5/33 (15.2)	6/29 (20.7)	6/29 (20.7)	3/15 (20.0)	1/10 (10.0)	5/42 (11.9)	3/27 (11.1)	5/38 (13.2)	8/37 (21.6)	4/24 (16.7)
20-24	5/25 (20.0)	14/44 (31.8)	1/24 (4.2)	6/17 (35.3)	1/14 (7.1)	11/34 (32.4)	3/12 (25.0)	1/19 (5.3)	6/22 (27.3)	6/31 (19.4)	8/30 (26.7)	3/12 (25.0)
Received lubricants												
Total	3/47 (6.4)	6/100 (6.0)	3/57 (5.3)	2/46 (4.3)	1/43 (2.3)	5/49 (10.2)	1/22 (4.5)	1/61 (1.6)	3/49 (6.1)	3/69 (4.3)	4/67 (6.0)	2/36 (5.6)
15-19	0/22 (0.0)	1/56 (1.8)	3/33 (9.1)	0/29 (0.0)	0/29 (0.0)	3/15 (20.0)	0/10 (0.0)	1/42 (2.4)	0/27 (0.0)	2/38 (5.3)	1/37 (2.7)	1/24 (4.2)
20-24	3/25 (12.0)	5/44 (11.4)	0/24 (0.0)	2/17 (11.8)	1/14 (7.1)	2/34 (5.9)	1/12 (8.3)	0/19 (0.0)	3/22 (13.6)	1/31 (3.2)	3/30 (10.0)	1/12 (8.3)
Received information on how to use male or female condoms												
Total	5/47 (10.6)	22/100 (22.0)	3/57 (5.3)	11/46 (23.9)	3/43 (7.0)	6/49 (12.2)	3/22 (13.6)	9/61 (14.8)	4/49 (8.2)	11/69 (15.9)	12/67 (17.9)	3/36 (8.3)
15-19	2/22 (9.1)	6/56 (10.7)	3/33 (9.1)	6/29 (20.7)	2/29 (6.9)	1/15 (6.7)	0/10 (0.0)	6/42 (14.3)	0/27 (0.0)	5/38 (13.2)	5/37 (13.5)	2/24 (8.3)
20-24	3/25 (12.0)	16/44 (36.4)	0/24 (0.0)	5/17 (29.4)	1/14 (7.1)	5/34 (14.7)	3/12 (25.0)	3/19 (15.8)	4/22 (18.2)	6/31 (19.4)	7/30 (23.3)	1/12 (8.3)
Received information about HIV												
Total	19/47 (40.4)	48/100 (48.0)	15/57 (26.3)	19/46 (41.3)	11/43 (25.6)	17/49 (34.7)	8/22 (36.4)	25/61 (41.0)	19/49 (38.8)	29/69 (2.0)	27/67 (40.3)	9/36 (25.0)

Table 56: Services received through the My Journey risk assessment among HERStory 3 study participants who were enrolled into the My Journey Programme and participated in a risk assessment from 12 intervention subdistricts across 8 provinces in South Africa, 2024, stratified by subdistrict

Variable	Abaqulusi Freq/N (%)	Dihlabeng Freq/N (%)	Fetakgomo-Tubatse Freq/N (%)	Govan Mbeki Freq/N (%)	Klipfontein Freq/N (%)	Mbombela Freq/N (%)	Nelson Mandela C Freq/N (%)	Nyandeni Freq/N (%)	Rustenburg Freq/N (%)	Setsoto Freq/N (%)	Tshwane 1 Freq/N (%)	City of UMhlathuze Freq/N (%)
15-19	11/22 (50.0)	22/56 (39.3)	9/33 (27.3)	10/29 (34.5)	7/29 (24.1)	6/15 (40.0)	3/10 (30.0)	18/42 (42.9)	9/27 (33.3)	15/38 (39.5)	16/37 (43.2)	6/24 (25.0)
20-24	8/25 (32.0)	26/44 (59.1)	6/24 (25.0)	9/17 (52.9)	4/14 (28.6)	11/34 (32.4)	5/12 (41.7)	7/19 (36.8)	10/22 (45.5)	14/31 (45.2)	11/30 (36.7)	3/12 (25.0)
Received information about sexually transmitted infections												
Total	13/47 (27.7)	37/100 (37.0)	7/57 (12.3)	17/46 (37.0)	9/43 (20.9)	16/49 (32.7)	5/22 (22.7)	13/61 (21.3)	14/49 (28.6)	22/69 (31.9)	23/67 (34.3)	6/36 (16.7)
15-19	6/22 (27.3)	17/56 (30.4)	7/33 (21.2)	10/29 (34.5)	6/29 (20.7)	5/15 (33.3)	1/10 (10.0)	10/42 (23.8)	4/27 (14.8)	11/38 (28.9)	14/37 (37.8)	5/24 (20.8)
20-24	7/25 (28.0)	20/44 (45.5)	0/24 (0.0)	7/17 (41.2)	3/14 (21.4)	11/34 (32.4)	4/12 (33.3)	3/19 (15.8)	10/22 (45.5)	11/31 (35.5)	9/30 (30.0)	1/12 (8.3)
Received information about tuberculosis												
Total	9/47 (19.1)	24/100 (24.0)	4/57 (7.0)	9/46 (19.6)	8/43 (18.6)	4/49 (8.2)	3/22 (13.6)	13/61 (21.3)	7/49 (14.3)	14/69 (20.3)	9/67 (13.4)	6/36 (16.7)
15-19	6/22 (27.3)	12/56 (21.4)	3/33 (9.1)	6/29 (20.7)	6/29 (20.7)	1/15 (6.7)	1/10 (10.0)	11/42 (26.2)	3/27 (11.1)	7/38 (18.4)	4/37 (10.8)	4/24 (16.7)
20-24	3/25 (12.0)	12/44 (27.3)	1/24 (4.2)	3/17 (17.6)	2/14 (14.3)	3/34 (8.8)	2/12 (16.7)	2/19 (10.5)	4/22 (18.2)	7/31 (22.6)	5/30 (16.7)	2/12 (16.7)
Received information about abuse from boys/men												
Total	6/47 (12.8)	24/100 (24.0)	2/57 (3.5)	11/46 (23.9)	6/43 (14.0)	3/49 (6.1)	2/22 (9.1)	13/61 (21.3)	5/49 (10.2)	8/69 (11.6)	11/67 (16.4)	4/36 (11.1)
15-19	4/22 (18.2)	12/56 (21.4)	2/33 (6.1)	9/29 (31.0)	5/29 (17.2)	1/15 (6.7)	1/10 (10.0)	10/42 (23.8)	1/27 (3.7)	3/38 (7.9)	7/37 (18.9)	3/24 (12.5)
20-24	2/25 (8.0)	12/44 (27.3)	0/24 (0.0)	2/17 (11.8)	1/14 (7.1)	2/34 (5.9)	1/12 (8.3)	3/19 (15.8)	4/22 (18.2)	5/31 (16.1)	4/30 (13.3)	1/12 (8.3)
Asked if you had been coughing a lot or had night sweats												
Total	4/47 (8.5)	19/100 (19.0)	1/57 (1.8)	10/46 (21.7)	3/43 (7.0)	4/49 (8.2)	3/22 (13.6)	7/61 (11.5)	3/49 (6.1)	6/69 (8.7)	7/67 (10.4)	2/36 (5.6)
15-19	1/22 (4.5)	9/56 (16.1)	1/33 (3.0)	5/29 (17.2)	3/29 (10.3)	1/15 (6.7)	1/10 (10.0)	6/42 (14.3)	1/27 (3.7)	2/38 (5.3)	3/37 (8.1)	1/24 (4.2)
20-24	3/25 (12.0)	10/44 (22.7)	0/24 (0.0)	5/17 (29.4)	0/14 (0.0)	3/34 (8.8)	2/12 (16.7)	1/19 (5.3)	2/22 (9.1)	4/31 (12.9)	4/30 (13.3)	1/12 (8.3)
Asked if you had itching, lumps, warts/rash, unusual discharge or pain on your vagina or anus/bum												
Total	3/47 (6.4)	21/100 (21.0)	2/57 (3.5)	8/46 (17.4)	4/43 (9.3)	6/49 (12.2)	1/22 (4.5)	7/61 (11.5)	5/49 (10.2)	8/69 (11.6)	9/67 (13.4)	2/36 (5.6)
15-19	1/22 (4.5)	8/56 (14.3)	1/33 (3.0)	4/29 (13.8)	3/29 (10.3)	1/15 (6.7)	0/10 (0.0)	5/42 (11.9)	2/27 (7.4)	3/38 (7.9)	4/37 (10.8)	1/24 (4.2)
20-24	2/25 (8.0)	13/44 (29.5)	1/24 (4.2)	4/17 (23.5)	1/14 (7.1)	5/34 (14.7)	1/12 (8.3)	2/19 (10.5)	3/22 (13.6)	5/31 (16.1)	5/30 (16.7)	1/12 (8.3)
Received a service plan												
Total	3/47 (6.4)	7/100 (7.0)	1/57 (1.8)	4/46 (8.7)	2/43 (4.7)	2/49 (4.1)	3/22 (13.6)	3/61 (4.9)	2/49 (4.1)	3/69 (4.3)	2/67 (3.0)	4/36 (11.1)
15-19	0/22 (0.0)	4/56 (7.1)	0/33 (0.0)	2/29 (6.9)	1/29 (3.4)	0/15 (0.0)	1/10 (10.0)	1/42 (2.4)	1/27 (3.7)	1/38 (2.6)	0/37 (0.0)	1/24 (4.2)
20-24	3/25 (12.0)	3/44 (6.8)	1/24 (4.2)	2/17 (11.8)	1/14 (7.1)	2/34 (5.9)	2/12 (16.7)	2/19 (10.5)	1/22 (4.5)	2/31 (6.5)	2/30 (6.7)	3/12 (25.0)
Received a journal												
Total	6/47 (12.8)	10/100 (10.0)	0/57 (0.0)	3/46 (6.5)	2/43 (4.7)	2/49 (4.1)	5/22 (22.7)	3/61 (4.9)	2/49 (4.1)	5/69 (7.2)	3/67 (4.5)	4/36 (11.1)
15-19	3/22 (13.6)	4/56 (7.1)	0/33 (0.0)	2/29 (6.9)	2/29 (6.9)	1/15 (6.7)	2/10 (20.0)	2/42 (4.8)	0/27 (0.0)	3/38 (7.9)	1/37 (2.7)	3/24 (12.5)
20-24	3/25 (12.0)	6/44 (13.6)	0/24 (0.0)	1/17 (5.9)	0/14 (0.0)	1/34 (2.9)	3/12 (25.0)	1/19 (5.3)	2/22 (9.1)	2/31 (6.5)	2/30 (6.7)	1/12 (8.3)
Received other services												
Total	3/47 (6.4)	7/100 (7.0)	1/57 (1.8)	1/46 (2.2)	1/43 (2.3)	1/49 (2.0)	3/22 (13.6)	2/61 (3.3)	2/49 (4.1)	5/69 (7.2)	8/67 (11.9)	3/36 (8.3)
15-19	0/22 (0.0)	4/56 (7.1)	0/33 (0.0)	0/29 (0.0)	1/29 (3.4)	0/15 (0.0)	0/10 (0.0)	2/42 (4.8)	1/27 (3.7)	5/38 (13.2)	5/37 (13.5)	3/24 (12.5)
20-24	3/25 (12.0)	3/44 (6.8)	1/24 (4.2)	1/17 (5.9)	0/14 (0.0)	1/34 (2.9)	3/12 (25.0)	0/19 (0.0)	1/22 (4.5)	0/31 (0.0)	3/30 (10.0)	0/12 (0.0)
Received a referral to other services												
Total	2/47 (4.3)	2/100 (2.0)	0/57 (0.0)	0/46 (0.0)	0/43 (0.0)	1/49 (2.0)	1/22 (4.5)	0/61 (0.0)	0/49 (0.0)	0/69 (0.0)	0/67 (0.0)	0/36 (0.0)
15-19	0/22 (0.0)	0/56 (0.0)	0/33 (0.0)	0/29 (0.0)	0/29 (0.0)	1/15 (6.7)	0/10 (0.0)	0/42 (0.0)	0/27 (0.0)	0/38 (0.0)	0/37 (0.0)	0/24 (0.0)
20-24	2/25 (8.0)	2/44 (4.5)	0/24 (0.0)	0/17 (0.0)	0/14 (0.0)	0/34 (0.0)	1/12 (8.3)	0/19 (0.0)	0/22 (0.0)	0/31 (0.0)	0/30 (0.0)	0/12 (0.0)
Participant did not receive any of these services												
Total	1/47 (2.1)	1/100 (1.0)	1/57 (1.8)	1/46 (2.2)	4/43 (9.3)	1/49 (2.0)	2/22 (9.1)	1/61 (1.6)	1/49 (2.0)	1/69 (1.4)	2/67 (3.0)	0/36 (0.0)

Table 56: Services received through the My Journey risk assessment among HERStory 3 study participants who were enrolled into the My Journey Programme and participated in a risk assessment from 12 intervention subdistricts across 8 provinces in South Africa, 2024, stratified by subdistrict

Variable	Abaqulusi	Dihlabeng	Fetakgomo-Tubatse	Govan Mbeki	Klipfontein	Mbombela	Nelson Mandela C	Nyandeni	Rustenburg	Setsoto	Tshwane 1	City of UMhlathuze
	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)	Freq/N (%)
15-19	0/22 (0.0)	0/56 (0.0)	0/33 (0.0)	1/29 (3.4)	1/29 (3.4)	0/15 (0.0)	2/10 (20.0)	1/42 (2.4)	1/27 (3.7)	1/38 (2.6)	1/37 (2.7)	0/24 (0.0)
20-24	1/25 (4.0)	1/44 (2.3)	1/24 (4.2)	0/17 (0.0)	3/14 (21.4)	1/34 (2.9)	0/12 (0.0)	0/19 (0.0)	0/22 (0.0)	0/31 (0.0)	1/30 (3.3)	0/12 (0.0)
Prefer not to answer												
Total	1/47 (2.1)	3/100 (3.0)	0/57 (0.0)	0/46 (0.0)	4/43 (9.3)	4/49 (8.2)	2/22 (9.1)	4/61 (6.6)	4/49 (8.2)	1/69 (1.4)	4/67 (6.0)	1/36 (2.8)
15-19	1/22 (4.5)	2/56 (3.6)	0/33 (0.0)	0/29 (0.0)	3/29 (10.3)	1/15 (6.7)	2/10 (20.0)	2/42 (4.8)	3/27 (11.1)	1/38 (2.6)	2/37 (5.4)	0/24 (0.0)
20-24	0/25 (0.0)	1/44 (2.3)	0/24 (0.0)	0/17 (0.0)	1/14 (7.1)	3/34 (8.8)	0/12 (0.0)	2/19 (10.5)	1/22 (4.5)	0/31 (0.0)	2/30 (6.7)	1/12 (8.3)

Receipt of biomedical, behavioural and structural services

All participants, whether in the intervention arm or the comparison arm, were asked about receipt of biomedical, behavioural, and structural services ever and in the past year, and Tables 57 to 62 describe their responses. It should be noted that these questions were asked in a "multi-select" format, and participants were asked to select all the services that applied. To do this, they had to scroll down on the tablet to see all the many response options. We believe that participants might not have selected all the services they had received and that they had possibly only selected one or a few options that appeared closer to the beginning of the list. Therefore, when reading Tables 57 to 62, it needs to be noted that the way participants answered this question might have compromised the validity of the responses, especially for the services that were lower in the list of response options, which are also presented lower in the list of responses in the Tables.

Table 57 compares the prevalence of reports of receipt of biomedical services ever, from any service provider, among participants in the intervention and comparison arms. Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report having ever received HIV testing (66.5% versus 56.3%), and this was also true in the younger age group (60.1% versus 47.1%) but there were smaller differences in the older age group, but still in favour of the intervention arm (Table 57).

Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report having ever received PrEP (5.7% versus 1.9%), and this was also true in the younger age group (3.1% versus 0.9%) and in the older age group (9.2% versus 3.4%) (Table 57).

Participants in the intervention arm were less likely or slightly less likely than those in the comparison arm to (Table 57):

- report having ever received pregnancy testing;
- report having ever been asked about whether they have STI symptoms;
- report having ever received HIV viral load monitoring and/or CD4 testing services;
- report having ever received abortion and post-abortion care;
- report having ever been asked if they cough a lot and have night sweats;
- report having ever been asked to cough into a cup;
- report having ever received TB treatment.

Table 58 compares the prevalence of receipt of biomedical services in the past year, from any service provider among all participants in the intervention and comparison arms. Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report past year HIV testing (58.8% versus 47.0%), and this was also true in the younger age group (52.6% versus 37.9%) and in the older age group (67.2% versus 61.0%) (Table 58).

Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report past year HIV self-testing (13.7% versus 7.2%), and this was also true in the younger age group (11.0% versus 5.8%) and in the older age group (17.3% versus 9.3%) (Table 58).

Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report having received PrEP in the past year (4.0% versus 1.0%), and this was also true in the older age group (6.4% versus 1.9%). In the younger age group, there was a smaller difference between arms, in favour of the intervention arm (Table 58).

Participants in the intervention arm were less likely or slightly less likely than those in the comparison arm to (Table 58):

- report having received pregnancy testing in the past year;
- report having received contraception in the past year
- report having received abortion and post-abortion care in the past year;
- report having been asked if they cough a lot and have night sweats in the past year;
- report having been asked to cough into a cup in the past year;
- report having received TB treatment in the past year.

Table 59 compares the prevalence of receipt of behavioural services ever, from any service provider among the participants in the intervention and comparison arms. Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report having ever participated in PrEP awareness raising and to have received PrEP information (18.7% versus 7.9%), and this was also true in the younger age group (14.5% versus 6.4%) and in the older age group (24.4% versus 10.2%) (Table 59).

Participants in the intervention arm were less likely or slightly less likely than those in the comparison arm to (Table 59):

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- report having ever participated in sport and aerobics;

- report having ever participated in teen parenting or parenting sessions;

- report having ever participated in teen and caregiver communication sessions;

- report having ever participated in adherence clubs;

- report having ever received support for gender-based violence and or 16 days of GBV activism.

Table 60 compares the prevalence of receipt of behavioural services in the past year, from any service provider among all participants in the intervention and comparison arms. Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report having participated in PrEP awareness raising and to have received PrEP information in the past year (16.9% versus 7.0%) and this was true in the younger age group (13.2% versus 5.3%) and in the older age group (21.9% versus 9.8%) (Table 60).

Participants in the intervention arm were less likely or slightly less likely than those in the comparison arm to (Table 60):

- report having participated in teen parenting or parenting sessions in the past;

- report having participated in teen and caregiver communication sessions in the past year;

- report having participated in adherence clubs in the past year;

- report having received support for gender-based violence and or 16 days of GBV activism in the past year.

Table 61 compares the prevalence of receipt of structural services ever from any service provider among participants in the intervention and comparison arms. Participants in the intervention arm were less likely or slightly less likely or slightly less likely than those in the comparison arm to (Table 61):

- report having ever had help accessing social grants;

- report having ever participated in career jamborees and/or received homework support;

- report having ever received support to return to school;

- report having ever participated in learner's or driver's lessons;

- report having ever received help with CV writing;

- report having ever received support to start a business.

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Table 62 compares the prevalence of receipt of structural services in the past year from any service provider among all participants in the intervention and comparison arms. Participants in the intervention arm were less likely or slightly less likely than those in the comparison arm to (Table 62):

- report having had help accessing social grants in the past year;
- report having received support to return to school in the past year;
- report having received help with CV writing in the past year;
- report having received support to start a business in the past year;
- report having participated in an internship or learnership in the past year;
- report having participated in a community dialogue.

Table 57: Biomedical services ever received among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Received HIV testing							
Total	1344/2387	56.3	1753/2638	66.5	1.50	1.19 - 1.89	0.0024
15-19	681/1447	47.1	910/1514	60.1	1.65	1.19 - 2.29	0.0062
20-24	663/940	70.5	843/1124	75.0	1.34	0.97 - 1.86	0.0923
Received HIV self-testing							
Total	189/2387	7.9	360/2638	13.6	1.92	0.95 - 3.87	0.0817
15-19	91/1447	6.3	178/1514	11.8	1.80#	0.98 - 3.29	0.0695
20-24	98/940	10.4	182/1124	16.2	1.50#	0.86 - 2.60	0.1667
Received pregnancy testing							
Total	909/2387	38.1	794/2638	30.1	0.58	0.48 - 0.71	<.0001
15-19	390/1447	27.0	318/1514	21.0	0.53	0.39 - 0.71	0.0003
20-24	519/940	55.2	476/1124	42.3	0.60	0.46 - 0.79	0.0016
Received emergency contraception (morning after pill)							
Total	93/2387	3.9	90/2638	3.4	0.88	0.54 - 1.43	0.6078
15-19	27/1447	1.9	28/1514	1.8	0.92#	0.54 - 1.58	0.7671
20-24	66/940	7.0	62/1124	5.5	0.75	0.41 - 1.37	0.3572
Received contraception/family planning							
Total	432/2387	18.1	398/2638	15.1	0.65	0.38 - 1.13	0.1432
15-19	150/1447	10.4	124/1514	8.2	0.53	0.28 - 1.02	0.0695
20-24	282/940	30.0	274/1124	24.4	0.74	0.52 - 1.05	0.1095
Received health products from a vending machine							
Total	26/2387	1.1	24/2638	0.9	0.85	0.48 - 1.51	0.5860
15-19	12/1447	0.8	13/1514	0.9	1.06	0.48 - 2.34	0.8902
20-24	14/940	1.5	11/1124	1.0	0.67#	0.30 - 1.50	0.3381
Asked if you had itching, lumps, warts or rash, unusual discharge or pain on your vagina or anus/bum							
Total	165/2387	6.9	116/2638	4.4	0.61#	0.44 - 0.83	0.0050
15-19	82/1447	5.7	48/1514	3.2	0.59	0.48 - 0.74	0.0001
20-24	83/940	8.8	68/1124	6.0	0.68	0.49 - 0.95	0.0343
Received STI treatment							
Total	105/2387	4.4	127/2638	4.8	0.96	0.61 - 1.53	0.8784
15-19	44/1447	3.0	51/1514	3.4	0.92	0.41 - 2.04	0.8357
20-24	61/940	6.5	76/1124	6.8	1.33	0.56 - 3.15	0.5239
Received pre-exposure prophylaxis (PrEP)							
Total	45/2387	1.9	150/2638	5.7	3.72	1.89 - 7.33	0.0010
15-19	13/1447	0.9	47/1514	3.1	2.16	1.08 - 4.32	0.0393
20-24	32/940	3.4	103/1124	9.2	2.89#	1.55 - 5.41	0.0030

Table 57: Biomedical services ever received among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Received post-exposure prophylaxis (PEP)							
Total	14/2387	0.6	26/2638	1.0	1.87#	0.82 - 4.24	0.1489
15-19	4/1447	0.3	11/1514	0.7	2.78α	-	-
20-24	10/940	1.1	15/1124	1.3	1.47+	0.55 - 3.94	0.4466
Received post-violence care							
Total	22/2387	0.9	13/2638	0.5	0.53#	0.25 - 1.11	0.1048
15-19	13/1447	0.9	7/1514	0.5	0.44+	0.13 - 1.54	0.2136
20-24	9/940	1.0	6/1124	0.5	0.58+	0.21 - 1.66	0.3252
Received ARVs for HIV							
Total	69/2387	2.9	60/2638	2.3	0.76	0.44 - 1.30	0.3258
15-19	24/1447	1.7	26/1514	1.7	0.87	0.59 - 1.28	0.4800
20-24	45/940	4.8	34/1124	3.0	0.73	0.53 - 1.01	0.0732
Received HIV viral load monitoring and/or CD4 testing							
Total	47/2387	2.0	24/2638	0.9	0.47	0.28 - 0.77	0.0071
15-19	26/1447	1.8	11/1514	0.7	0.42	0.20 - 0.87	0.0293
20-24	21/940	2.2	13/1124	1.2	0.54#	0.27 - 1.09	0.1001
Received prevention of mother to child transmission (PMTCT)							
Total	27/2387	1.1	24/2638	0.9	0.80#	0.45 - 1.41	0.4520
15-19	13/1447	0.9	12/1514	0.8	0.74#	0.32 - 1.72	0.4918
20-24	14/940	1.5	12/1124	1.1	0.76#	0.35 - 1.66	0.5029
Received abortion and post-abortion care							
Total	30/2387	1.3	17/2638	0.6	0.50#	0.27 - 0.93	0.0385
15-19	12/1447	0.8	10/1514	0.7	0.79#	0.34 - 1.85	0.5978
20-24	18/940	1.9	7/1124	0.6	0.34+	0.14 - 0.82	0.0249
Asked if you had been coughing a lot or had night sweats							
Total	138/2387	5.8	84/2638	3.2	0.84	0.55 - 1.30	0.4485
15-19	79/1447	5.5	45/1514	3.0	0.50	0.31 - 0.79	0.0071
20-24	59/940	6.3	39/1124	3.5	0.58#	0.34 - 0.99	0.0575
Asked to cough into a cup							
Total	81/2387	3.4	46/2638	1.7	0.50#	0.32 - 0.77	0.0045
15-19	41/1447	2.8	28/1514	1.8	0.62	0.48 - 0.79	0.0009
20-24	40/940	4.3	18/1124	1.6	0.35	0.18 - 0.69	0.0062
Received TB treatment							
Total	84/2387	3.5	48/2638	1.8	0.62	0.27 - 1.44	0.2787
15-19	46/1447	3.2	27/1514	1.8	0.61	0.48 - 0.79	0.0008
20-24	38/940	4.0	21/1124	1.9	0.42#	0.23 - 0.77	0.0096

Table 57: Biomedical services ever received among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant reported that she has never received any of these services							
Total	401/2387	16.8	377/2638	14.3	0.85	0.49 - 1.46	0.5622
15-19	340/1447	23.5	287/1514	19.0	0.76	0.41 - 1.40	0.3845
20-24	61/940	6.5	90/1124	8.0	1.15	0.72 - 1.83	0.5676
Prefer not to answer							
Total	234/2387	9.8	208/2638	7.9	0.82	0.60 - 1.12	0.2274
15-19	169/1447	11.7	143/1514	9.4	0.83	0.57 - 1.22	0.3571
20-24	65/940	6.9	65/1124	5.8	0.90	0.47 - 1.75	0.7687

\# results based on model with site nested within subdistrict random effect (excluding household effect)

\+ results based on model with subdistrict random effect only (excluding household and site effect)

α/- frequency or sample size too low to obtain a reliable estimate

Table 58: Biomedical services received in the past year among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Received HIV testing							
Total	1122/2387	47.0	1552/2638	58.8	1.57	1.31 - 1.89	0.0001
15-19	549/1447	37.9	797/1514	52.6	1.81	1.39 - 2.34	0.0002
20-24	573/940	61.0	755/1124	67.2	1.31	1.02 - 1.67	0.0422
Received HIV self-testing							
Total	171/2387	7.2	361/2638	13.7	2.55	1.34 - 4.87	0.0093
15-19	84/1447	5.8	167/1514	11.0	2.72	1.27 - 5.79	0.0168
20-24	87/940	9.3	194/1124	17.3	2.87	1.27 - 6.52	0.0193
Received pregnancy testing							
Total	784/2387	32.8	730/2638	27.7	0.69	0.54 - 0.88	0.0073
15-19	342/1447	23.6	311/1514	20.5	0.65	0.47 - 0.90	0.0162
20-24	442/940	47.0	419/1124	37.3	0.68	0.51 - 0.91	0.0160
Received emergency contraception (morning after pill)							
Total	73/2387	3.1	68/2638	2.6	0.82	0.46 - 1.48	0.5250
15-19	23/1447	1.6	23/1514	1.5	0.89#	0.50 - 1.60	0.7007
20-24	50/940	5.3	45/1124	4.0	0.60	0.27 - 1.34	0.2219
Received contraception/family planning							
Total	351/2387	14.7	332/2638	12.6	0.65	0.44 - 0.95	0.0374
15-19	134/1447	9.3	103/1514	6.8	0.47	0.29 - 0.76	0.0056
20-24	217/940	23.1	229/1124	20.4	0.82	0.61 - 1.11	0.2073
Received health products from a vending machine							
Total	34/2387	1.4	21/2638	0.8	0.57+	0.33 - 0.99	0.0572
15-19	22/1447	1.5	15/1514	1.0	0.64#	0.33 - 1.24	0.1962
20-24	12/940	1.3	6/1124	0.5	0.44+	0.16 - 1.21	0.1238
Asked if you had itching, lumps, warts or rash, unusual discharge or pain on your vagina or anus/bum							
Total	93/2387	3.9	84/2638	3.2	0.88	0.78 - 1.01	0.0746
15-19	48/1447	3.3	46/1514	3.0	0.91#	0.56 - 1.46	0.6893
20-24	45/940	4.8	38/1124	3.4	0.70#	0.44 - 1.11	0.1416
Received STI treatment							
Total	86/2387	3.6	109/2638	4.1	1.16	0.75 - 1.78	0.5069
15-19	35/1447	2.4	42/1514	2.8	1.10	0.75 - 1.60	0.6434
20-24	51/940	5.4	67/1124	6.0	1.68	0.70 - 4.02	0.2540
Received pre-exposure prophylaxis (PrEP)							
Total	25/2387	1.0	105/2638	4.0	3.73	1.90 - 7.32	0.0009
15-19	7/1447	0.5	33/1514	2.2	4.11α		
20-24	18/940	1.9	72/1124	6.4	3.58#	1.57 - 8.18	0.0062
Received post-exposure prophylaxis (PEP)							

Table 58: Biomedical services received in the past year among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	10/2387	0.4	16/2638	0.6	1.37[α]	-	-
15-19	6/1447	0.4	5/1514	0.3	0.83[α]	-	-
20-24	4/940	0.4	11/1124	1.0	2.55[α]	-	-
Received post-violence care							
Total	18/2387	0.8	16/2638	0.6	0.75[α]	-	-
15-19	14/1447	1.0	12/1514	0.8	0.84[α]	-	-
20-24	4/940	0.4	4/1124	0.4	0.89[α]	-	-
Received ARVs for HIV							
Total	63/2387	2.6	58/2638	2.2	0.93	0.45 - 1.91	0.8392
15-19	23/1447	1.6	25/1514	1.7	0.92[#]	0.47 - 1.79	0.7976
20-24	40/940	4.3	33/1124	2.9	0.74	0.53 - 1.04	0.1008
Received HIV viral load monitoring and/or CD4 testing							
Total	28/2387	1.2	26/2638	1.0	0.83	0.36 - 1.88	0.6517
15-19	12/1447	0.8	12/1514	0.8	1.01[+]	0.45 - 2.27	0.9812
20-24	16/940	1.7	14/1124	1.2	0.77[#]	0.36 - 1.63	0.5008
Received prevention of mother to child transmission (PMTCT)							
Total	16/2387	0.7	21/2638	0.8	1.20[#]	0.62 - 2.29	0.5934
15-19	5/1447	0.3	12/1514	0.8	2.32[α]	-	-
20-24	11/940	1.2	9/1124	0.8	0.71[#]	0.29 - 1.70	0.4473
Received abortion and post-abortion care							
Total	21/2387	0.9	15/2638	0.6	0.49	0.38 - 0.64	<.0001
15-19	8/1447	0.6	6/1514	0.4	0.64[+]	0.21 - 1.94	0.4426
20-24	13/940	1.4	9/1124	0.8	0.57	0.24 - 1.36	0.2193
Asked if you had been coughing a lot or had night sweats							
Total	94/2387	3.9	58/2638	2.2	0.48	0.27 - 0.87	0.0233
15-19	48/1447	3.3	30/1514	2.0	0.58	0.36 - 0.92	0.0309
20-24	46/940	4.9	28/1124	2.5	0.52[#]	0.30 - 0.91	0.0318
Asked to cough into a cup							
Total	65/2387	2.7	47/2638	1.8	0.65	0.44 - 0.95	0.0355
15-19	34/1447	2.3	26/1514	1.7	0.72	0.43 - 1.21	0.2294
20-24	31/940	3.3	21/1124	1.9	0.55[#]	0.28 - 1.09	0.1018
Received TB treatment							
Total	68/2387	2.8	44/2638	1.7	0.57	0.38 - 0.87	0.0170
15-19	33/1447	2.3	22/1514	1.5	0.40	0.17 - 0.94	0.0468
20-24	35/940	3.7	22/1124	2.0	0.52[#]	0.30 - 0.93	0.0374
Participant reported that she has not received any of these services in the past year							
Total	163/2387	6.8	132/2638	5.0	0.70	0.41 - 1.18	0.1935

Table 58: Biomedical services received in the past year among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
15-19	121/1447	8.4	98/1514	6.5	0.74	0.42 - 1.29	0.2993
20-24	42/940	4.5	34/1124	3.0	0.66	0.42 - 1.06	0.1034
Prefer not to answer							
Total	291/2387	12.2	243/2638	9.2	0.72	0.55 - 0.96	0.0340
15-19	201/1447	13.9	167/1514	11.0	0.76	0.52 - 1.10	0.1598
20-24	90/940	9.6	76/1124	6.8	0.65	0.38 - 1.12	0.1336

\# results based on model with site nested within subdistrict random effect (excluding household effect)

+ results based on model with subdistrict random effect only (excluding household and site effect)

α/- frequency or sample size too low to obtain a reliable estimate

Table 59: Behavioural services ever received among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participated in peer education (MTV Shuga, Keeping Girls in School, Sole Buddies, The Rise Clubs)							
Total	369/2387	15.5	366/2638	13.9	0.85	0.57 - 1.28	0.4530
15-19	229/1447	15.8	223/1514	14.7	0.89	0.53 - 1.48	0.6535
20-24	140/940	14.9	143/1124	12.7	0.79	0.51 - 1.23	0.3083
Participated in one-on-one or group counselling							
Total	226/2387	9.5	215/2638	8.2	0.89	0.55 - 1.42	0.6157
15-19	147/1447	10.2	117/1514	7.7	0.70	0.38 - 1.29	0.2632
20-24	79/940	8.4	98/1124	8.7	1.20	0.68 - 2.13	0.5325
Participated in PrEP awareness raising and received information							
Total	188/2387	7.9	493/2638	18.7	3.39	1.71 - 6.73	0.0021
15-19	92/1447	6.4	219/1514	14.5	3.01	1.27 - 7.15	0.0205
20-24	96/940	10.2	274/1124	24.4	4.70	2.06 - 10.70	0.0013
Received contraception/family planning information							
Total	271/2387	11.4	305/2638	11.6	0.92	0.60 - 1.41	0.7215
15-19	111/1447	7.7	113/1514	7.5	0.87	0.66 - 1.15	0.3496
20-24	160/940	17.0	192/1124	17.1	0.98	0.57 - 1.69	0.9430
Participated in sport and aerobics							
Total	339/2387	14.2	240/2638	9.1	0.50	0.32 - 0.77	0.0049
15-19	195/1447	13.5	146/1514	9.6	0.58	0.36 - 0.96	0.0453
20-24	144/940	15.3	94/1124	8.4	0.35	0.17 - 0.68	0.0059
Participated in awareness raising about drugs and alcohol							
Total	365/2387	15.3	343/2638	13.0	0.76	0.44 - 1.31	0.3357
15-19	200/1447	13.8	189/1514	12.5	0.78	0.44 - 1.38	0.3949
20-24	165/940	17.6	154/1124	13.7	0.71	0.34 - 1.51	0.3849
Participated in teen parenting or parenting (mom and daughter sessions)							
Total	197/2387	8.3	155/2638	5.9	0.59	0.39 - 0.90	0.0213
15-19	114/1447	7.9	71/1514	4.7	0.66	0.56 - 0.79	0.0001
20-24	83/940	8.8	84/1124	7.5	0.77	0.39 - 1.52	0.4605
Participated in teen and caregiver communication (Hands on Parenting)							
Total	87/2387	3.6	47/2638	1.8	0.54	0.42 - 0.69	0.0001
15-19	57/1447	3.9	32/1514	2.1	0.49	0.26 - 0.91	0.0355
20-24	30/940	3.2	15/1124	1.3	0.38	0.19 - 0.77	0.0129
Participated in Adherence Clubs							
Total	73/2387	3.1	24/2638	0.9	0.19	0.14 - 0.27	<.0001
15-19	39/1447	2.7	10/1514	0.7	0.37+	0.13 - 1.03	0.0713
20-24	34/940	3.6	14/1124	1.2	0.26	0.11 - 0.59	0.0041
Received support for gender-based violence (GBV) and/or 16 days of GBV activism							

Table 59: Behavioural services ever received among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	161/2387	6.7	130/2638	4.9	0.63	0.42 - 0.94	0.0355
15-19	94/1447	6.5	66/1514	4.4	0.55	0.33 - 0.90	0.0269
20-24	67/940	7.1	64/1124	5.7	0.75	0.39 - 1.42	0.3813
Participant has never received any of these services							
Total	756/2387	31.7	863/2638	32.7	1.06	0.76 - 1.47	0.7299
15-19	491/1447	33.9	521/1514	34.4	1.05	0.75 - 1.48	0.7657
20-24	265/940	28.2	342/1124	30.4	1.09	0.70 - 1.70	0.7084
Prefer not to answer							
Total	364/2387	15.2	440/2638	16.7	1.16	0.87 - 1.53	0.3230
15-19	206/1447	14.2	279/1514	18.4	1.52	1.03 - 2.24	0.0469
20-24	158/940	16.8	161/1124	14.3	0.77	0.50 - 1.17	0.2260

+ results based on model with subdistrict random effect only (excluding household and site effect)

Table 60: Behavioural services received in the past year among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participated in peer education (MTV Shuga, Keeping Girls in School, Sole Buddies, The Rise Clubs)							
Total	306/2387	12.8	314/2638	11.9	0.91	0.58 - 1.42	0.6762
15-19	186/1447	12.9	199/1514	13.1	1.07	0.61 - 1.87	0.8122
20-24	120/940	12.8	115/1124	10.2	0.70	0.43 - 1.12	0.1534
Participated in one-on-one or group counselling							
Total	222/2387	9.3	206/2638	7.8	0.78	0.48 - 1.24	0.2997
15-19	143/1447	9.9	111/1514	7.3	0.58	0.31 - 1.09	0.1032
20-24	79/940	8.4	95/1124	8.5	1.01	0.57 - 1.81	0.9646
Participated in PrEP awareness raising and received information							
Total	168/2387	7.0	446/2638	16.9	3.63	1.85 - 7.14	0.0011
15-19	76/1447	5.3	200/1514	13.2	3.91	1.90 - 8.05	0.0013
20-24	92/940	9.8	246/1124	21.9	4.26	1.88 - 9.67	0.0022
Received contraception/family planning information							
Total	246/2387	10.3	272/2638	10.3	0.89	0.61 - 1.31	0.5729
15-19	106/1447	7.3	102/1514	6.7	0.82	0.58 - 1.15	0.2584
20-24	140/940	14.9	170/1124	15.1	1.02	0.61 - 1.71	0.9400
Participated in sport and aerobics							
Total	320/2387	13.4	242/2638	9.2	0.52	0.33 - 0.84	0.0138
15-19	185/1447	12.8	141/1514	9.3	0.59	0.38 - 0.90	0.0223
20-24	135/940	14.4	101/1124	9.0	0.45	0.20 - 1.04	0.0742
Participated in awareness raising about drugs and alcohol							
Total	301/2387	12.6	282/2638	10.7	0.81	0.50 - 1.30	0.3905
15-19	169/1447	11.7	159/1514	10.5	0.83	0.51 - 1.33	0.4417
20-24	132/940	14.0	123/1124	10.9	0.72	0.34 - 1.53	0.3992
Participated in teen parenting or parenting (mom and daughter sessions)							
Total	169/2387	7.1	136/2638	5.2	0.57	0.38 - 0.86	0.0141
15-19	92/1447	6.4	65/1514	4.3	0.64	0.46 - 0.89	0.0139
20-24	77/940	8.2	71/1124	6.3	0.74	0.37 - 1.45	0.3839
Participated in teen and caregiver communication (Hands on Parenting)							
Total	82/2387	3.4	49/2638	1.9	0.55[#]	0.37 - 0.82	0.0080
15-19	52/1447	3.6	25/1514	1.7	0.42	0.19 - 0.91	0.0383
20-24	30/940	3.2	24/1124	2.1	0.68	0.39 - 1.18	0.1795
Participated in Adherence Clubs							
Total	69/2387	2.9	21/2638	0.8	0.36	0.17 - 0.73	0.0101
15-19	37/1447	2.6	10/1514	0.7	0.37	0.17 - 0.79	0.0180

Table 60: Behavioural services received in the past year among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
20-24	32/940	3.4	11/1124	1.0	0.29#	0.13 - 0.63	0.0050
Received support for gender-based violence (GBV) and/or 16 days GBV activism							
Total	137/2387	5.7	116/2638	4.4	0.67	0.46 - 0.97	0.0450
15-19	78/1447	5.4	66/1514	4.4	0.65	0.34 - 1.24	0.2050
20-24	59/940	6.3	50/1124	4.4	0.77	0.62 - 0.96	0.0297
Participant has not received any of these services in the past year							
Total	164/2387	6.9	179/2638	6.8	0.95	0.65 - 1.40	0.8093
15-19	96/1447	6.6	107/1514	7.1	1.04	0.77 - 1.40	0.7975
20-24	68/940	7.2	72/1124	6.4	0.89	0.41 - 1.92	0.7681
Prefer not to answer							
Total	343/2387	14.4	401/2638	15.2	1.10	0.84 - 1.46	0.4863
15-19	199/1447	13.8	243/1514	16.1	1.28	0.90 - 1.83	0.1773
20-24	144/940	15.3	158/1124	14.1	0.87	0.57 - 1.31	0.5098

results based on model with site nested within subdistrict random effect (excluding household effect)

Table 61: Structural services ever received among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

Variable	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Help accessing social grants/SASSA/Home Affairs							
Total	523/2387	21.9	527/2638	20.0	0.83	0.66 - 1.05	0.1357
15-19	274/1447	18.9	289/1514	19.1	0.97	0.72 - 1.31	0.8594
20-24	249/940	26.5	238/1124	21.2	0.75	0.59 - 0.96	0.0313
Received dignity packs, sanitary towels and/or pads							
Total	303/2387	12.7	284/2638	10.8	0.77	0.53 - 1.11	0.1773
15-19	199/1447	13.8	170/1514	11.2	0.69	0.40 - 1.17	0.1795
20-24	104/940	11.1	114/1124	10.1	0.76	0.43 - 1.35	0.3635
Participated in career jamborees and/or received homework support							
Total	214/2387	9.0	176/2638	6.7	0.66	0.43 - 1.02	0.0750
15-19	153/1447	10.6	117/1514	7.7	0.67	0.46 - 0.96	0.0408
20-24	61/940	6.5	59/1124	5.2	0.67	0.32 - 1.38	0.2883
Received support to return to school including home visits							
Total	147/2387	6.2	86/2638	3.3	0.54	0.44 - 0.66	<.0001
15-19	88/1447	6.1	52/1514	3.4	0.56#	0.39 - 0.80	0.0046
20-24	59/940	6.3	34/1124	3.0	0.38	0.22 - 0.64	0.0014
Received vouchers after your baby was born							
Total	27/2387	1.1	29/2638	1.1	0.93#	0.55 - 1.57	0.7810
15-19	12/1447	0.8	13/1514	0.9	1.05#	0.48 - 2.32	0.9037
20-24	15/940	1.6	16/1124	1.4	0.87#	0.41 - 1.83	0.7146
Participated in skills training for jobs							
Total	134/2387	5.6	138/2638	5.2	0.86#	0.65 - 1.13	0.2909
15-19	56/1447	3.9	44/1514	2.9	0.58	0.30 - 1.11	0.1152
20-24	78/940	8.3	94/1124	8.4	1.14	0.54 - 2.42	0.7398
Participated in Learner's or Driver's lessons							
Total	90/2387	3.8	101/2638	3.8	1.07	0.72 - 1.59	0.7450
15-19	45/1447	3.1	35/1514	2.3	0.50	0.39 - 0.63	<.0001
20-24	45/940	4.8	66/1124	5.9	1.04	0.70 - 1.55	0.8387
Received help with CV writing							
Total	405/2387	17.0	304/2638	11.5	0.41	0.28 - 0.60	0.0001
15-19	144/1447	10.0	99/1514	6.5	0.51	0.37 - 0.70	0.0005
20-24	261/940	27.8	205/1124	18.2	0.41	0.23 - 0.71	0.0048
Received support to start a business							
Total	80/2387	3.4	60/2638	2.3	0.64#	0.45 - 0.92	0.0254
15-19	46/1447	3.2	27/1514	1.8	0.54	0.32 - 0.92	0.0341
20-24	34/940	3.6	33/1124	2.9	0.77#	0.47 - 1.26	0.3124
Participated in an internship or learnership							
Total	88/2387	3.7	81/2638	3.1	0.74	0.53 - 1.04	0.0926
15-19	33/1447	2.3	25/1514	1.7	0.66#	0.37 - 1.16	0.1635
20-24	55/940	5.9	56/1124	5.0	0.81#	0.55 - 1.19	0.2928
Received financial support for study or work opportunities							

Table 61: Structural services ever received among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	51/2387	2.1	48/2638	1.8	0.88	0.67 - 1.17	0.3992
15-19	22/1447	1.5	25/1514	1.7	1.03+	0.42 - 2.49	0.9561
20-24	29/940	3.1	23/1124	2.0	0.64	0.36 - 1.12	0.1306
Participated in community dialogue							
Total	45/2387	1.9	30/2638	1.1	0.53	0.28 - 1.03	0.0746
15-19	26/1447	1.8	17/1514	1.1	0.66#	0.33 - 1.31	0.2505
20-24	19/940	2.0	13/1124	1.2	0.60	0.29 - 1.24	0.1815
Participated in youth leadership (camps and influencers)							
Total	79/2387	3.3	73/2638	2.8	0.75	0.48 - 1.16	0.2051
15-19	48/1447	3.3	40/1514	2.6	0.74	0.48 - 1.14	0.1858
20-24	31/940	3.3	33/1124	2.9	0.95#	0.50 - 1.80	0.8675
Participated in gender-based violence (GBV) awareness							
Total	190/2387	8.0	173/2638	6.6	0.68	0.44 - 1.05	0.0945
15-19	104/1447	7.2	105/1514	6.9	0.79	0.44 - 1.39	0.4218
20-24	86/940	9.1	68/1124	6.0	0.71	0.51 - 0.99	0.0536
Participated in self-defence training for GBV, for example, No Means No or other self-defence programmes							
Total	54/2387	2.3	48/2638	1.8	0.79	0.54 - 1.15	0.2237
15-19	38/1447	2.6	31/1514	2.0	0.74#	0.41 - 1.31	0.3105
20-24	16/940	1.7	17/1124	1.5	0.98+	0.44 - 2.19	0.9677
Received incentives (T-shirts, journals, backpacks, hats, water bottles)							
Total	26/2387	1.1	42/2638	1.6	1.31#	0.75 - 2.28	0.3510
15-19	15/1447	1.0	20/1514	1.3	1.04#	0.47 - 2.30	0.9267
20-24	11/940	1.2	22/1124	2.0	1.29	0.58 - 2.88	0.5357
Participant has never received any of these services							
Total	740/2387	31.0	911/2638	34.5	1.21	0.88 - 1.66	0.2515
15-19	497/1447	34.3	558/1514	36.9	1.18	0.83 - 1.68	0.3784
20-24	243/940	25.9	353/1124	31.4	1.48	0.90 - 2.45	0.1397
Prefer not to answer							
Total	335/2387	14.0	424/2638	16.1	1.30	0.95 - 1.77	0.1183
15-19	208/1447	14.4	250/1514	16.5	1.36	0.99 - 1.87	0.0718
20-24	127/940	13.5	174/1124	15.5	1.35	0.86 - 2.09	0.2019

\# results based on model with site nested within subdistrict random effect (excluding household effect)
+ results based on model with subdistrict random effect only (excluding household and site effect)

Table 61: Structural services ever received among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Help accessing social grants/SASSA/Home Affairs							
Total	462/2387	19.4	459/2638	17.4	0.81	0.61 - 1.07	0.1590
15-19	235/1447	16.2	263/1514	17.4	1.07	0.72 - 1.59	0.7514
20-24	227/940	24.1	196/1124	17.4	0.66	0.51 - 0.85	0.0047
Received dignity packs, sanitary towels and/or pads							
Total	266/2387	11.1	263/2638	10.0	0.89	0.63 - 1.24	0.4930
15-19	174/1447	12.0	162/1514	10.7	0.85	0.55 - 1.30	0.4507
20-24	92/940	9.8	101/1124	9.0	0.78	0.42 - 1.45	0.4450
Participated in career jamborees and/or received homework support							
Total	176/2387	7.4	153/2638	5.8	0.72	0.46 - 1.13	0.1641
15-19	125/1447	8.6	105/1514	6.9	0.77	0.50 - 1.21	0.2743
20-24	51/940	5.4	48/1124	4.3	0.56	0.24 - 1.30	0.1910
Received support to return to school including home visits							
Total	119/2387	5.0	83/2638	3.1	0.56	0.48 - 0.66	<.0001
15-19	76/1447	5.3	36/1514	2.4	0.44	0.29 - 0.66	0.0007
20-24	43/940	4.6	47/1124	4.2	0.95#	0.61 - 1.48	0.8109
Received vouchers after your baby was born							
Total	22/2387	0.9	25/2638	0.9	1.01#	0.55 - 1.85	0.9766
15-19	8/1447	0.6	14/1514	0.9	1.47+	0.61 - 3.58	0.4023
20-24	14/940	1.5	11/1124	1.0	0.74#	0.31 - 1.75	0.5017
Participated in skills training for jobs							
Total	113/2387	4.7	125/2638	4.7	0.86	0.60 - 1.23	0.4114
15-19	43/1447	3.0	41/1514	2.7	0.84	0.54 - 1.31	0.4463
20-24	70/940	7.4	84/1124	7.5	1.05	0.59 - 1.85	0.8725
Participated in Learner's or Driver's lessons							
Total	80/2387	3.4	86/2638	3.3	0.96	0.59 - 1.58	0.8877
15-19	35/1447	2.4	34/1514	2.2	1.29	0.60 - 2.77	0.5169
20-24	45/940	4.8	52/1124	4.6	0.94	0.68 - 1.30	0.7191
Received help with CV writing							
Total	344/2387	14.4	290/2638	11.0	0.51	0.32 - 0.81	0.0088
15-19	119/1447	8.2	90/1514	5.9	0.48	0.27 - 0.88	0.0264
20-24	225/940	23.9	200/1124	17.8	0.52	0.26 - 1.03	0.0722
Received support to start a business							
Total	62/2387	2.6	42/2638	1.6	0.56#	0.36 - 0.89	0.0214
15-19	25/1447	1.7	19/1514	1.3	0.91	0.61 - 1.37	0.6677
20-24	37/940	3.9	23/1124	2.0	0.48#	0.28 - 0.85	0.0185
Participated in an internship or learnership							
Total	79/2387	3.3	66/2638	2.5	0.75	0.64 - 0.88	0.0018

Table 61: Structural services ever received among all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
15-19	34/1447	2.3	20/1514	1.3	0.54+	0.31 - 0.94	0.0417
20-24	45/940	4.8	46/1124	4.1	0.78#	0.50 - 1.24	0.3047
Received financial support for study or work opportunities							
Total	41/2387	1.7	31/2638	1.2	0.67	0.41 - 1.08	0.1157
15-19	20/1447	1.4	15/1514	1.0	0.70#	0.35 - 1.43	0.3397
20-24	21/940	2.2	16/1124	1.4	0.68#	0.33 - 1.38	0.2967
Participated in community dialogue							
Total	44/2387	1.8	29/2638	1.1	0.60	0.37 - 0.97	0.0477
15-19	26/1447	1.8	17/1514	1.1	0.41	0.17 - 1.00	0.0615
20-24	18/940	1.9	12/1124	1.1	0.55	0.26 - 1.17	0.1365
Participated in youth leadership (camps and influencers)							
Total	65/2387	2.7	69/2638	2.6	0.91	0.59 - 1.39	0.6609
15-19	38/1447	2.6	41/1514	2.7	1.37	0.72 - 2.60	0.3422
20-24	27/940	2.9	28/1124	2.5	0.91#	0.48 - 1.73	0.7820
Participated in gender-based violence (GBV) awareness							
Total	157/2387	6.6	146/2638	5.5	0.69	0.46 - 1.05	0.0964
15-19	91/1447	6.3	89/1514	5.9	0.71	0.40 - 1.25	0.2487
20-24	66/940	7.0	57/1124	5.1	0.51	0.27 - 0.98	0.0538
Participated in self-defence training for GBV, for example, No Means No or other self-defence programmes							
Total	45/2387	1.9	46/2638	1.7	0.96	0.76 - 1.22	0.7523
15-19	31/1447	2.1	30/1514	2.0	0.88#	0.49 - 1.58	0.6692
20-24	14/940	1.5	16/1124	1.4	1.07#	0.46 - 2.48	0.8716
Received incentives (T-shirts, journals, backpacks, hats, water bottles)							
Total	29/2387	1.2	30/2638	1.1	0.76	0.36 - 1.62	0.4840
15-19	17/1447	1.2	15/1514	1.0	0.69+	0.17 - 2.80	0.6117
20-24	12/940	1.3	15/1124	1.3	1.16+	0.47 - 2.87	0.7530
Participant has not received any of these services in the past year							
Total	165/2387	6.9	177/2638	6.7	0.94	0.67 - 1.32	0.7294
15-19	103/1447	7.1	96/1514	6.3	0.78	0.51 - 1.18	0.2471
20-24	62/940	6.6	81/1124	7.2	1.34	0.65 - 2.76	0.4331
Prefer not to answer							
Total	333/2387	14.0	384/2638	14.6	1.13	0.80 - 1.60	0.4844
15-19	209/1447	14.4	228/1514	15.1	1.21	0.83 - 1.77	0.3289
20-24	124/940	13.2	156/1124	13.9	1.15	0.73 - 1.82	0.5471

\# results based on model with site nested within subdistrict random effect (excluding household effect)
\+ results based on model with subdistrict random effect only (excluding household and site effect)

NRCCT Impact of My Journey on Wellbeing

Table 62 describes wellbeing among all participants and shows there were no or very small differences between flourishing or languishing between arms. Among participants, 65.1% in the intervention arm and 65.1% in the comparison arm were flourishing. Conversely, 12.8% in the intervention arm and 12.4% in the comparison arm were languishing. There were only very small differences by arm in any of the items in the wellbeing scale (Table 62).

Table 62: Wellbeing of all HERStory 3 study participants from 24 intervention and 24 comparison sites across 8 provinces, 2024

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
In the past month, participant felt happy almost every day or every day							
Total	1541/2387	64.6	1720/2638	65.2	1.03	0.86 - 1.23	0.7291
15-19	961/1447	66.4	1016/1514	67.1	1.06	0.85 - 1.31	0.6104
20-24	580/940	61.7	704/1124	62.6	1.03	0.84 - 1.26	0.7765
In the past month, participant felt interested in life almost every day or every day							
Total	1648/2387	69.0	1887/2638	71.5	1.12	0.94 - 1.34	0.2090
15-19	981/1447	67.8	1100/1514	72.7	1.27	1.00 - 1.62	0.0588
20-24	667/940	71.0	787/1124	70.0	0.96	0.75 - 1.24	0.7654
In the past month, participant felt satisfied with life almost every day or every day							
Total	1370/2387	57.4	1452/2638	55.0	0.91	0.76 - 1.10	0.3427
15-19	858/1447	59.3	840/1514	55.5	0.88	0.72 - 1.08	0.2479
20-24	512/940	54.5	612/1124	54.4	0.97	0.77 - 1.22	0.7722
In the past month, participant felt that she had something important to contribute to society almost every day or every day							
Total	516/2387	21.6	515/2638	19.5	0.88	0.70 - 1.12	0.3146
15-19	324/1447	22.4	294/1514	19.4	0.82	0.63 - 1.06	0.1476
20-24	192/940	20.4	221/1124	19.7	0.93	0.59 - 1.46	0.7452
In the past month, participant felt that she belonged to a community almost every day or every day							
Total	856/2387	35.9	910/2638	34.5	0.98	0.83 - 1.16	0.8074
15-19	561/1447	38.8	577/1514	38.1	1.03	0.83 - 1.28	0.8071
20-24	295/940	31.4	333/1124	29.6	0.90	0.69 - 1.18	0.4506
In the past month, participant felt that our society is becoming a better place for people like her almost every day or every day							
Total	1108/2387	46.4	1195/2638	45.3	0.96	0.76 - 1.22	0.7596
15-19	688/1447	47.5	706/1514	46.6	0.99	0.78 - 1.26	0.9190
20-24	420/940	44.7	489/1124	43.5	0.94	0.71 - 1.25	0.6844
In the past month, participant felt that people are basically good almost every day or every day							
Total	1160/2387	48.6	1309/2638	49.6	1.04	0.86 - 1.25	0.6905
15-19	712/1447	49.2	745/1514	49.2	1.01	0.82 - 1.23	0.9358
20-24	448/940	47.7	564/1124	50.2	1.12	0.91 - 1.38	0.2899
In the past month, participant felt that the way our society works makes sense to her almost every day or every day							
Total	955/2387	40.0	1062/2638	40.3	1.04	0.84 - 1.27	0.7411

| Variable | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
15-19	609/1447	42.1	647/1514	42.7	1.06	0.87 - 1.29	0.5702
20-24	346/940	36.8	415/1124	36.9	1.01	0.78 - 1.31	0.9152

In the past month, participant felt that she liked most parts of her personality almost every day or every day

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	1730/2387	72.5	1985/2638	75.2	1.16	0.92 - 1.47	0.2279
15-19	1049/1447	72.5	1140/1514	75.3	1.15	0.86 - 1.53	0.3606
20-24	681/940	72.4	845/1124	75.2	1.21	0.87 - 1.67	0.2654

In the past month, participant felt good at managing the responsibilities of her daily life almost every day or every day

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	1759/2387	73.7	2018/2638	76.5	1.20	0.92 - 1.58	0.1974
15-19	1064/1447	73.5	1161/1514	76.7	1.20	0.88 - 1.64	0.2652
20-24	695/940	73.9	857/1124	76.2	1.26	0.80 - 2.00	0.3269

In the past month, participant felt that she has warm and trusting relationships with others almost every day or every day

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	1580/2387	66.2	1729/2638	65.5	0.97	0.76 - 1.25	0.8440
15-19	940/1447	65.0	981/1514	64.8	1.00	0.78 - 1.28	0.9964
20-24	640/940	68.1	748/1124	66.5	0.98	0.64 - 1.50	0.9122

In the past month, participant felt that she had experiences that challenged her to grow and become a better person almost every day or every day

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	1745/2387	73.1	1851/2638	70.2	0.88	0.69 - 1.12	0.2948
15-19	1039/1447	71.8	1064/1514	70.3	0.92	0.71 - 1.19	0.5129
20-24	706/940	75.1	787/1124	70.0	0.75	0.53 - 1.07	0.1242

In the past month, participant felt confident to think and express her own ideas and opinions almost every day or every day

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	1632/2387	68.4	1809/2638	68.6	1.00	0.85 - 1.17	0.9684
15-19	969/1447	67.0	1029/1514	68.0	1.04	0.85 - 1.28	0.6896
20-24	663/940	70.5	780/1124	69.4	0.94	0.78 - 1.14	0.5514

In the past month, participant felt that her life had a sense of direction or meaning to it almost every day or every day

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	1525/2387	63.9	1695/2638	64.3	1.01	0.86 - 1.19	0.8752
15-19	931/1447	64.3	988/1514	65.3	1.05	0.88 - 1.24	0.6190
20-24	594/940	63.2	707/1124	62.9	0.98	0.78 - 1.22	0.8308

Participants were flourishing

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	1554/2387	65.1	1718/2638	65.1	1.00	0.82 - 1.23	0.9811
15-19	948/1447	65.5	1005/1514	66.4	1.05	0.84 - 1.31	0.6800
20-24	606/940	64.5	713/1124	63.4	0.96	0.73 - 1.25	0.7398

Participants were languishing

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	296/2387	12.4	337/2638	12.8	0.98	0.67 - 1.44	0.9257
15-19	189/1447	13.1	189/1514	12.5	0.83	0.51 - 1.33	0.4420
20-24	107/940	11.4	148/1124	13.2	1.31	0.78 - 2.19	0.3225

Participants were neither flourishing nor languishing

Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Total	548/2387	23.0	593/2638	22.5	0.96	0.80 - 1.17	0.7152
15-19	318/1447	22.0	326/1514	21.5	0.99	0.77 - 1.27	0.9484
20-24	230/940	24.5	267/1124	23.8	0.91	0.66 - 1.25	0.5630

Safe Spaces

All participants, whether in the intervention arm or the comparison arm, were asked about their knowledge about, and utilisation of Safe Spaces, and Tables 63 to 65 describe their responses.

Table 63 compares the prevalence of reports of knowing an organisation in the participant's community that provides a Safe Space for young women like her to hang out and receive support. Participants in the intervention arm were more likely than those in the comparison arm to report knowledge of a Safe Space in their community (44.2% versus 37.0%), and this was also true in the younger and older age groups (Table 63). When asked if they had ever spent time at a Safe Space in their community, similar proportions of participants in each arm reported that they had done so (46.1% in the intervention arm and 48.7% in the comparison arm) and this was also true in the younger and older age groups (Table 63).

Participants who had reported spending time at a Safe Space in their community were asked about the activities that they had participated in at the Safe Space (Table 64). Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report having had an HIV test at the Safe Space (51.2% versus 38.0%), and this was also true in the younger age group (45.1% versus 31.3%) and in the older age group (60.0% versus 48.8%) (Table 64). Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report having received PrEP at the Safe Space (7.2% versus 1.9%), and this was also true in the younger age group (4.6% versus 1.4%) and in the older age group (10.8% versus 2.8%) (Table 64). Participants in the intervention arm were statistically significantly more likely than those in the comparison arm to report having received condoms at the Safe Space (17.0% versus 12.8%), but there were non-statistically significant differences in favour of the intervention in each of the age groups (Table 64).

Participants in the intervention arm were statistically significantly less likely than those in the comparison arm to report having support to get a job (in the younger age group only), participating in a self-defence class (overall and in the younger group only), and participating in a sports activity (overall and the younger group only) at the Safe Space (Table 64). There were only small differences between arms in reports of other activities, and none of them were statistically significant (Table 64).

Participants who reported spending time at a Safe Space in the year before the survey were asked about Safe Space acceptability and their satisfaction with the services they received there (Table 65). Participants in the intervention arm were substantially and statistically significantly more likely than those in the comparison arm to report that it was comfortable for women like her to be at the Safe Space (70.7% versus 60.1%), and this was also true in the younger age group (69.9% versus 59.0%)

and in the older age group (71.8% versus 61.9%) (Table 65). When asked about their overall satisfaction with the services they had received at the Safe Spaces, more participants in the intervention arm reported they were very satisfied (51.8% versus 48.2%) or satisfied (29.5% versus 26.5%) compared with the comparison arm, and these differences were statistically significant in the overall sample, and in the younger age group (for "satisfied" only) (Table 65).

Table 63: Participant's knowledge and utilisation of Safe Spaces from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant knows of an organisation in her community that provides a safe space for young women like her to hang out and receive support							
Total	862/2328	37.0	1150/2604	44.2	1.32	0.90 - 1.95	0.1692
15-19	543/1410	38.5	676/1491	45.3	1.31	0.91 - 1.89	0.1671
20-24	319/918	34.7	474/1113	42.6	1.39	0.86 - 2.26	0.1956
In the past year, participant has spent time at a safe space in her community							
Total	1133/2328	48.7	1201/2604	46.1	0.89	0.63 - 1.24	0.4926
15-19	703/1410	49.9	711/1491	47.7	0.92	0.68 - 1.24	0.5750
20-24	430/918	46.8	490/1113	44.0	0.86	0.57 - 1.31	0.4999

Table 64: Activities in which AGYW have participated in at the Safe Space among AGYW who reported spending time at the Safe Space in the past year from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

	Prevalence/Mean				Effect estimates*		
	Comparison		Intervention				
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Had an HIV test							
Total	430/1133	38.0	615/1201	51.2	1.73	1.24 - 2.40	0.0035
15-19	220/703	31.3	321/711	45.1	1.87	1.18 - 2.95	0.0137
20-24	210/430	48.8	294/490	60.0	2.00	1.16 - 3.45	0.0212
Got contraception/family planning							
Total	136/1133	12.0	157/1201	13.1	0.97	0.63 - 1.50	0.8889
15-19	64/703	9.1	62/711	8.7	0.94	0.51 - 1.73	0.8512
20-24	72/430	16.7	95/490	19.4	1.28	0.65 - 2.52	0.4798
Got pre-exposure prophylaxis (PrEP)							
Total	22/1133	1.9	86/1201	7.2	4.57	2.82 - 7.41	<.0001
15-19	10/703	1.4	33/711	4.6	0.86	0.77 - 0.96	0.0123
20-24	12/430	2.8	53/490	10.8	4.27	2.45 - 7.44	<.0001
Got ART							
Total	43/1133	3.8	40/1201	3.3	0.86	0.47 - 1.58	0.6356
15-19	27/703	3.8	29/711	4.1	1.13#	0.60 - 2.14	0.7059
20-24	16/430	3.7	11/490	2.2	0.61	0.28 - 1.33	0.2274
Got condoms							
Total	145/1133	12.8	204/1201	17.0	1.55	1.01 - 2.37	0.0583
15-19	60/703	8.5	81/711	11.4	1.25	0.56 - 2.83	0.5905
20-24	85/430	19.8	123/490	25.1	1.72	0.95 - 3.12	0.0872
Homework support							
Total	314/1133	27.7	293/1201	24.4	0.81	0.53 - 1.24	0.3420
15-19	242/703	34.4	209/711	29.4	0.74	0.44 - 1.23	0.2538

Table 64: Activities in which AGYW have participated in at the Safe Space among AGYW who reported spending time at the Safe Space in the past year from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
20-24	72/430	16.7	84/490	17.1	0.97#	0.61 - 1.53	0.8885
Support to get a job							
Total	110/1133	9.7	89/1201	7.4	0.54	0.24 - 1.22	0.1519
15-19	42/703	6.0	21/711	3.0	0.41#	0.23 - 0.72	0.0053
20-24	68/430	15.8	68/490	13.9	0.89#	0.52 - 1.52	0.6670
Adherence support/clubs							
Total	7/1133	0.6	9/1201	0.7	1.10+	0.38 - 3.14	0.8670
15-19	4/703	0.6	2/711	0.3	0.44+	0.08 - 2.46	0.3566
20-24	3/430	0.7	7/490	1.4	1.74+	0.47 - 6.51	0.4185
Received help from a social worker							
Total	52/1133	4.6	61/1201	5.1	1.29	0.67 - 2.48	0.4473
15-19	27/703	3.8	37/711	5.2	1.40#	0.80 - 2.47	0.2513
20-24	25/430	5.8	24/490	4.9	0.74	0.42 - 1.28	0.2870
Received counselling to help with distress or grief							
Total	31/1133	2.7	39/1201	3.2	1.16#	0.63 - 2.14	0.6326
15-19	17/703	2.4	19/711	2.7	1.15	0.56 - 2.37	0.7082
20-24	14/430	3.3	20/490	4.1	1.28	0.63 - 2.62	0.5014
Participated in a self-defense class							
Total	46/1133	4.1	27/1201	2.2	0.59	0.47 - 0.75	0.0002
15-19	35/703	5.0	18/711	2.5	0.49	0.30 - 0.82	0.0131
20-24	11/430	2.6	9/490	1.8	0.72+	0.30 - 1.76	0.4826
Participated in a parenting class							
Total	19/1133	1.7	16/1201	1.3	0.81#	0.37 - 1.81	0.6191
15-19	11/703	1.6	6/711	0.8	0.58+	0.23 - 1.49	0.2726
20-24	8/430	1.9	10/490	2.0	1.74	0.77 - 3.91	0.1975
Connected to the Wi-Fi/internet							
Total	102/1133	9.0	118/1201	9.8	1.04	0.45 - 2.45	0.9208
15-19	67/703	9.5	73/711	10.3	0.98#	0.49 - 1.97	0.9557
20-24	35/430	8.1	45/490	9.2	1.10#	0.60 - 2.02	0.7567
Joined a music, game or fun activity							
Total	178/1133	15.7	146/1201	12.2	0.70	0.46 - 1.06	0.1045
15-19	128/703	18.2	105/711	14.8	0.79	0.49 - 1.29	0.3628
20-24	50/430	11.6	41/490	8.4	0.69#	0.43 - 1.12	0.1463
Received services from a mobile clinic at the Safe Space							
Total	45/1133	4.0	59/1201	4.9	0.56	0.25 - 1.26	0.1739
15-19	28/703	4.0	30/711	4.2	1.03#	0.59 - 1.78	0.9173
20-24	17/430	4.0	29/490	5.9	1.53	0.83 - 2.84	0.1900
Sports activity							
Total	270/1133	23.8	207/1201	17.2	0.67	0.52 - 0.85	0.0036
15-19	198/703	28.2	141/711	19.8	0.48	0.32 - 0.70	0.0012

Table 64: Activities in which AGYW have participated in at the Safe Space among AGYW who reported spending time at the Safe Space in the past year from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
20-24	72/430	16.7	66/490	13.5	0.58	0.27 - 1.25	0.1769
Other							
Total	72/1133	6.4	47/1201	3.9	0.59#	0.37 - 0.94	0.0382
15-19	43/703	6.1	30/711	4.2	0.57	0.25 - 1.27	0.1794
20-24	29/430	6.7	17/490	3.5	0.51#	0.24 - 1.10	0.1000
Prefer not to answer							
Total	141/1133	12.4	116/1201	9.7	0.69	0.44 - 1.08	0.1196
15-19	94/703	13.4	76/711	10.7	0.77	0.43 - 1.38	0.3941
20-24	47/430	10.9	40/490	8.2	0.53	0.22 - 1.27	0.1674

\# results based on model with site nested within subdistrict random effect (excluding household effect)

\+ results based on model with subdistrict random effect only (excluding household and site effect)

Table 65: Safe Space acceptability and participant satisfaction with services received at the Safe Space among participants who reported spending time at the Safe Space in the past year from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Participant reported that it is comfortable for young women like her to be at the Safe Space							
Total	681/1133	60.1	849/1201	70.7	1.55	1.17 - 2.05	0.0053
15-19	415/703	59.0	497/711	69.9	1.55	1.15 - 2.11	0.0095
20-24	266/430	61.9	352/490	71.8	1.86	1.14 - 3.02	0.0208
Overall satisfaction with the services received at the Safe Space:							
Total							
Very Satisfied	546/1133	48.2	622/1201	51.8	1.88+	1.01 - 3.49	0.0468
Satisfied	300/1133	26.5	354/1201	29.5	2.01+	1.07 - 3.79	0.0306
Neither satisfied nor dissatisfied	62/1133	5.5	45/1201	3.7	1.24+	0.60 - 2.56	0.5690
Dissatisfied	18/1133	1.6	13/1201	1.1	1.30+	0.51 - 3.33	0.5830
Very dissatisfied	31/1133	2.7	18/1201	1.5	1		
15-19							
Very Satisfied	337/703	47.9	344/711	48.4	1.81$	0.82 - 3.98	0.1402
Satisfied	176/703	25.0	216/711	30.4	2.13$	0.95 - 4.73	0.0648
Neither satisfied nor dissatisfied	40/703	5.7	30/711	4.2	1.30$	0.52 - 3.23	0.5687
Dissatisfied	12/703	1.7	9/711	1.3	1.55$	0.48 - 4.96	0.4622
Very dissatisfied	19/703	2.7	10/711	1.4	1		
20-24							
Very Satisfied	209/430	48.6	278/490	56.7	1.98+	0.79 - 4.96	0.1433
Satisfied	124/430	28.8	138/490	28.2	1.62+	0.64 - 4.10	0.3115

Table 65: Safe Space acceptability and participant satisfaction with services received at the Safe Space among participants who reported spending time at the Safe Space in the past year from 24 intervention and 24 comparison sites across 8 provinces in South Africa, 2024

| | Prevalence/Mean | | | | Effect estimates* | | |
| | Comparison | | Intervention | | | | |
Variable	Freq/N	%	Freq/N	%	β/OR	95% CI	p-value
Neither satisfied nor dissatisfied	22/430	5.1	15/490	3.1	0.97[+]	0.32 - 2.95	0.9546
Dissatisfied	6/430	1.4	4/490	0.8	0.95[+]	0.20 - 4.51	0.9468
Very dissatisfied	12/430	2.8	8/490	1.6	1		

+ results based on model with subdistrict random effect only (excluding household and site effect)

$ results based on model with no random effects

Results of the per protocol analysis of the My Journey Programme

We conducted a per protocol analysis to compare key outcomes between AGYW in the intervention arm who were exposed to the My Journey Programme (reported being enrolled into the My Journey Programme or spending time at a Safe Space in the year before the survey) to an equivalent subgroup in the comparison arm. There were 1,605 participants exposed to the My Journey Programme in the intervention arm based on these two indicators. The size of the subgroup selected in the comparison arm was proportionally similar to the subgroup distribution in the intervention arm.

HIV prevalence

Table 66 describes the results of the per protocol analysis for primary and other outcomes of the study. In the intervention arm among exposed participants, HIV prevalence was 8.8% (95% CI: 5.6%–11.9%) compared to the 9.8% (95% CI: 7.6%–11.9%) among similar participants in the comparison arm.

In the 15-19 year age group, HIV prevalence was 5.2% (95% CI: 3.1%–7.3%) among exposed participants in the intervention arm compared to 6.3% (95% CI: 4.5%–8.1%) among similar participants in the comparison arm. Among the 20-24 year age group, the estimated HIV prevalence was 14.1% (95%CI: 9.3%–18.9%) among exposed participants in the intervention arm compared to 15.4% (95% CI: 10.8%–20.0%) in the comparison arm (Table 66).

There were no statistically significant differences in HIV prevalence between exposed participants in the intervention arm and similar participants in the comparison arm overall, or within each age group.

Knowledge of HIV status

With regards to knowledge of HIV status, exposed participants in the intervention arm were more

likely to report knowledge of their HIV status at 85.9% (95%CI: 83.4%–88.4%) compared to 79.6% (95% CI: 76.5%–82.8%) in the comparison arm (Table 66).

Among the 15-19 year age group, exposed participants in the intervention arm were more likely to report knowledge of their HIV status at 80.8% (95% CI: 77.7%–84.0%) compared to 71.9% (95% CI: 67.3%–76.5%) in the comparison arm. We found a 9.0% (95% CI: 3.6%–14.4%) statistically significant difference in knowledge of HIV status in favour of the intervention arm. In the 20-24 year age group, slightly more exposed participants in the intervention arm reported knowledge of their HIV status at 93.3% (95% CI: 91.5%–95.2%) compared to 92.2% (95% CI: 89.6%–94.8%) in comparison arm, although there was no statistically significant difference (Table 66).

Use of modern contraceptives among participants who had ever had sex

Overall, use of modern contraceptives was reported by 52.0% (95% CI: 48.3%–55.7%) of exposed participants in the intervention arm compared to 51.5% (95% CI: 46.9%–56.0%) in the comparison arm. In the 15-19 year age group, 43.2% (95% CI: 38.7%–47.7%) of exposed participants in the intervention arm reported use of modern contraceptives compared with 43.9% (95% CI: 37.0%–50.7%) in the comparison arm. In the 20-24 year age group, 59.4% (95% CI: 55.4%–63.4%) of exposed participants in the intervention arm reported use of modern contraceptives compared to 57.7% (95% CI: 52.3%–63.0%) in the comparison arm. There were no statistically significant differences in HIV prevalence between exposed participants in the intervention arm and similar participants in the comparison arm overall or within each age group (Table 66).

School dropout

Among participants aged 15-19 years, 10.1% (95% CI: 7.3%–12.9%) of exposed participants in the intervention arm reported school dropout compared to 12.7% (95% CI: 9.6%–15.8%) in the comparison arm with no statistically significant difference (Table 66).

Condom use at last sex

Overall, condom use at last sex was reported by 49.9% (95% CI: 46.3%–53.4%) of exposed participants in the intervention arm compared to 46.9% (95% CI: 42.9%–51.0%) in the comparison arm with no statistically significant difference. In the 15-19 year age group, condom use at last sex was reported by 49.4% (95% CI: 44.8%–54.0%) of exposed participants in the intervention arm compared to 43.3% (95% CI: 37.5%–49.1%) in the comparison arm. Among participants aged 20-24 years, condom use at last sex was reported by 50.3% (95% CI: 46.2%–54.4%) of exposed participants in the intervention arm compared to 49.9% (95% CI: 44.4%–55.5%) in the comparison arm. There were no statistically significant differences by exposure status within either age group (Table 66).

Wellbeing

Overall, 68.5% (95% CI: 64.8%–72.2%) of exposed participants in the intervention arm were flourishing compared to 63.9% (95% CI: 60.2%–67.6%) in the comparison arm. In the 15-19 year age group, 68.5% (95% CI: 64.0%–73.0%) of exposed participants in the intervention arm were flourishing compared to 64.2% (95% CI: 60.0%–68.6%) in the comparison arm. Among the 20-24 year age group, 68.5% (95% CI: 64.3%–72.7%) of exposed participants in the intervention arm were flourishing compared to 63.3% (95% CI: 58.0%–68.6%) in the comparison arm

Overall, 13.3% (95% CI: 10.5%–16.0%) of exposed participants in the intervention arm were languishing compared to 13.1 (95% CI: 11.0%–15.4%) in the comparison arm. In the 15-19 year age group, 12.6% (95% CI: 9.4%–15.8%) of exposed participants in the intervention arm were languishing compared to 14.0% (95% CI: 11.0%–16.8%) in the comparison arm. In the 20-24 year age group, 14.3% (95% CI: 10.8%–17.7%) of exposed participants in the intervention arm were languishing compared to 12.0% (95% CI: 8.8%–15.1%) in the comparison arm.

There were no statistically significant differences in flourishing or languishing by exposure status overall or within age groups.

Table 66: Per protocol^ comparison of primary and secondary outcomes of the My Journey Programme intervention in South Africa

Variable	Comparison arm n=1484 [#]		Intervention arm n=1605	
	%	95% CI	%	95% CI
HIV prevalence				
Total	9.8	7.6 - 11.9	8.8	5.6 - 11.9
15-19	6.3	4.5 - 8.1	5.2	3.1 - 7.3
20-24	15.4	10.8 - 20.0	14.1	9.3 - 18.9
Knowledge of HIV status				
Total	79.6	76.5 – 82.8	85.9	83.4 – 88.4
15-19	71.9	67.3 – 76.5	80.8	77.7 – 84.0
20-24	92.2	89.6 – 94.8	93.3	91.5 – 95.2
Use of modern contraceptives among participants who had ever had sex				
Total	51.5	46.9 – 56.0	52.0	48.3 – 55.7
15-19	43.9	37.0 – 50.7	43.0	38.7 – 48.7
20-24	57.7	52.3 – 63.0	59.4	55.4 – 63.4
Condom use at last sex				
Total	46.9	42.9 – 51.0	49.9	46.3 – 53.4

15-19	43.3	37.5 – 49.1	49.4	44.8 – 54.0
20-24	49.9	44.4 – 55.5	50.3	46.2 – 54.4
School dropout among participants aged 15-19				
Total	12.7	9.6 - 15.8	10.1	7.4 – 12.9
Flourishing (high levels of wellbeing)				
Total	63.9	60.2 - 67.6	68.5	64.8 – 72.2
15-19	64.2	60.0 – 68.6	68.5	64.0 – 73.0
20-24	63.3	58.0 – 68.6	68.5	64.3 – 72.7
Languishing (low levels of wellbeing)				
Total	13.2	10.9 – 15.4	13.3	10.5 – 16.0
15-19	13.9	11.0 – 16.8	12.6	9.4 – 15.8
20-24	12.0	8.8 – 15.2	14.3	10.9 – 17.7

^ Per-protocol exposure defined as either by being enrolled in the Programme or visiting a Safe Space in the past year in the intervention arm

Mean sample size in the comparison arm over the 60 multiple imputations (SD=28)

Results of the pre-post analysis of the My Journey Programme

We conducted a pre-post analysis of the My Journey Programme, comparing pre-intervention survey data from the HERStory 1 baseline evaluation (2018/2019) to post-intervention survey data from the HERStory 3 impact evaluation (2024). HERStory 1 was a general household survey conducted in six intervention districts with a response rate of 60%. HERStory 3 was a household survey conducted in programme targeted areas in 12 intervention subdistricts and 12 comparison subdistricts with no intervention (response rate=97%). Data from the six districts included in the HERStory 1 study were compared to six intervention subdistricts within these districts from the HERStory 3 study using a district level paired analysis (Table 67).

HIV prevalence

Among AGYW aged 15-24 years, the difference in HIV prevalence over time in the six subdistricts was not statistically significant. HIV prevalence was 12.4% in 2018/19 and 12.8% in 2024, risk ratio 0.95 (95% CI: 0.22-1.69; p=0.825). However, it should be noted that in five of the six subdistricts, there was a decline in HIV prevalence over time of between 1.0% and 5.2% (absolute change). In the Mbombela subdistrict, there was an increase in HIV prevalence from 16.6% to 34.8%, and this is an outlier which has a substantial effect on the intervention effect (Table 67).

Among AGYW aged 15-19 years, the difference in HIV prevalence over time in the six subdistricts was not statistically significant. It was 6.8% in 2018/19 and 7.1% in 2024, risk ratio 1.03 (95% CI: -0.16–2.22; p=0.666). Again, it is noteworthy that in four of the six subdistricts there was a decline in HIV

prevalence over time of between 0.9% and 5.2% (absolute change), in one of the six subdistricts (Nyandeni) there was an increase in prevalence of 1.0% (absolute change), and in Mbombela, there was an increase of 20.1% (absolute change). The Mbombela estimate is an outlier which has influenced the total estimate (Table 67).

Among AGYW aged 20-24 years, the difference in HIV prevalence over time in the six subdistricts was not statistically significant. It was 19.7% in 2018/19 and 20.2% in 2024, risk ratio 0.94 (95% CI: 0.46–1.43; p=0.998). In four subdistricts there was a decline over time of between 0.7% and 8.9% (absolute change), in one of the six subdistricts (Tshwane 1) there was an increase in prevalence of 2.9% (absolute change), and in Mbombela, there was an increase of 12.4% (absolute change). The Mbombela estimate is an outlier which has influenced the total estimate (Table 67).

HIV test uptake, past year

Among AGYW aged 15-24 years, the difference in reporting past year HIV testing over time in the six subdistricts was statistically significant. In 2018/19, 62.7% reported that they had had an HIV test in the past year, and this increased to 67.5% in 2024, risk ratio 1.09 (95% CI: 0.98–1.19; p=0.037). The uptake of past year HIV testing increased over time by between 2.3% and 12.0% in five of the six subdistricts (absolute change). Only in one subdistrict, Klipfontein, was there a small decline (3.6%, absolute change) in the prevalence of past year HIV testing (Table 67).

Among AGYW aged 15-19 years, the difference in reporting past year HIV testing over time in the six subdistricts was not statistically significant. In 2018/19, 52.1% reported that they had had an HIV test in the past year, and this increased to 58.1% in 2024, risk ratio 1.14 (95% CI: 0.90–1.37; p=0.116). The uptake of HIV testing over time increased by between 1.7% and 17.4% in four of the six subdistricts and it decreased by 1.0% (Nyandeni) and 9.0% (Klipfontein) in two subdistricts (absolute changes) (Table 67).

Among AGYW aged 20-24 years, the difference in reporting past year HIV testing over time in the six subdistricts was statistically significant. In 2018/19, 76.6% reported that they had had an HIV test in the past year, and this increased to 80.0% in 2024, risk ratio 1.07 (95% CI: 0.98–1.15; p=0.045). The uptake of HIV testing over time increased by between 2.7% and 15.6% in five of the six subdistricts, and it decreased by 4.3% in one subdistrict, Mbombela (absolute changes) (Table 67).

PrEP uptake, ever

Among AGYW aged 15-24 years, the difference in reporting ever having taken PrEP over time in the six subdistricts was statistically significant. In 2018/19, 1.9% reported that they had ever taken PrEP, and this increased to 17.3% in 2024, risk difference 15.8% (95%CI: 7.3%–24.4%; p=0.003). The uptake of

PrEP increased substantially over time in all subdistricts except one (Klipfontein) where it only increased by 1.9% (absolute change) (Table 67).

Among AGYW aged 15-19 years, the difference in reporting ever having taken PrEP over time in the six subdistricts was statistically significant. In 2018/19, 1.6% reported that they had ever taken PrEP, and this increased to 13.1% in 2024, risk difference 11.8% (95% CI: 4.8%–18.1%; p=0.004). The uptake of PrEP increased substantially over time in all subdistricts except one (Klipfontein) where it only increased by 1.6% (absolute change) (Table 67).

Among AGYW aged 20-24 years, the difference in reporting ever having taken PrEP over time in the six subdistricts was statistically significant. In 2018/19, 2.2% reported that they had ever taken PrEP, and this increased to 23.4% in 2024, risk difference 21.5% (95% CI: 10.4%–32.5%; p=0.002). The uptake of PrEP increased substantially over time in all subdistricts except one (Klipfontein) where it only increased by 2.5% (absolute change) (Table 67).

Viral suppression among participants living with HIV

Among AGYW aged 15-24 years, the difference in viral suppression over time in the six subdistricts was not statistically significant. In 2018/19, 62.1% were virally suppressed, and in 2024, 58.9% were virally suppressed, risk ratio 1.21 (95% CI: 0.69–1.74; p=0.179). Viral suppression increased over time in three subdistricts and decreased over time in three subdistricts (Table 67).

Completion of Grade 12 among participants aged 20-24 years

Among AGYW aged 20-24 years, there was no significant difference in having completed Grade 12 over time in the six subdistricts. In 2018/19, 62.7% reported that they had completed Grade 12, and in 2024, 61.6% reported this, risk ratio 0.96 (95% CI: 0.86–1.06; p=0.824). Completion of Grade 12 increased over time in two subdistricts and decreased over time in four subdistricts (Table 67).

Contraception use (other than condoms) at last sex

Among AGYW aged 15-24 years, the difference in last sex contraceptive use over time in the six subdistricts was not statistically significant. In 2018/19, 35.9% used contraceptives at last sex, and in 2024, 41.3% used them, risk ratio 1.19 (95% CI: 0.69–1.68; p=0.192). The use of contraceptives at last sex increased over time in three subdistricts and decreased over time in three subdistricts (Table 67).

Among AGYW aged 15-19 years, the difference in last sex contraceptive use over time in the six subdistricts was not statistically significant. In 2018/19, 31.2% used contraceptives at last sex, and in 2024, 27.6% used them, risk ratio 0.94 (95% CI: 0.45–1.44; p=0.649). The use of contraceptives at last sex increased over time in one subdistrict and decreased over time in five subdistricts (Table 67).

Among AGYW aged 20-24 years, the difference in last sex contraceptive use over time in the six subdistricts was statistically significant. In 2018/19, 39.5% used contraceptives at last sex, and in 2024, 60.2% used them, risk ratio 1.54 (95% CI: 1.14–1.95; p=0.003). The use of contraceptives at last sex increased over time in all six subdistricts (Table 67).

Table 67: Comparison of the My Journey Programme pre-intervention survey (HERStory 1) conducted in 2018/19 to the post-intervention survey (HERStory 3) conducted in 2024, in six subdistricts, South Africa

Variable	Pre-intervention survey (HERStory 1)		Post-intervention survey (HERStory 3)		Risk ratios (95% CI)	p-value
	Freq/N	%	Freq/N	%		
HIV prevalence total						
Klipfontein, City of Cape Town	13/377	3.4	2/224	0.9	0.26	
Mbombela, Ehlanzeni	121/802	16.6	79/227	34.8	2.31	
Nyandeni, O.R. Tambo	99/690	14.4	27/211	12.8	0.89	
Tshwane 1, Tshwane	67/767	8.6	20/264	7.6	0.87	
Mhlathuze, King Cetshwayo	111/747	14.8	21/219	9.6	0.65	
Abaqulusi, Zululand	157/1014	15.6	25/215	11.6	0.75	
Total	*568/4397*	*12.4*	*174/1360*	*12.8*	*0.95 (0.22-1.69)*	*0.825*
HIV prevalence in 15-19 age group						
Klipfontein, City of Cape Town	3/217	1.4	0/125	0.0	.	
Mbombela, Ehlanzeni	41/459	8.5	24/84	28.6	3.20	
Nyandeni, O.R. Tambo	29/417	6.9	12/151	7.9	1.14	
Tshwane 1, Tshwane	27/408	6.5	6/163	3.7	0.56	
Mhlathuze, King Cetshwayo	35/421	8.3	4/129	3.1	0.37	
Abaqulusi, Zululand	50/592	8.4	9/120	7.5	0.89	
Total	*185/2514*	*6.8*	*55/772*	*7.1*	*1.03 (-0.16-2.22)*	*0.666*
HIV prevalence in 20-24 age group						
Klipfontein, City of Cape Town	10/160	6.2	2/99	2.0	0.32	
Mbombela, Ehlanzeni	80/343	26.1	55/143	38.5	1.65	
Nyandeni, O.R. Tambo	70/273	25.7	15/60	25.0	0.98	
Tshwane 1, Tshwane	40/359	11.0	14/101	13.9	1.24	
Mhlathuze, King Cetshwayo	76/326	23.2	17/90	18.9	0.81	
Abaqulusi, Zululand	107/422	25.7	16/95	16.8	0.66	
Total	*383/1883*	*19.7*	*119/588*	*20.2*	*0.94 (0.46-1.43)*	*0.998*
Had an HIV test in the past year total						
Klipfontein, City of Cape Town	229/377	60.7	129/226	57.1	0.94	
Mbombela, Ehlanzeni	474/803	61.8	155/227	68.3	1.16	
Nyandeni, O.R. Tambo	498/690	72.2	163/216	75.5	1.05	
Tshwane 1, Tshwane	466/767	60.6	186/267	69.7	1.15	
Mhlathuze, King Cetshwayo	463/748	61.8	141/220	64.1	1.04	
Abaqulusi, Zululand	591/1014	58.4	152/216	70.4	1.21	
Total	*2721/4399*	*62.7*	*926/1372*	*67.5*	*1.09 (0.98-1.19)*	*0.037*
Had an HIV test in the past year in 15-19 age group						

Klipfontein, City of Cape Town	117/217	53.9	57/127	44.9	0.83	
Mbombela, Ehlanzeni	203/459	45.4	45/84	53.6	1.21	
Nyandeni, O.R. Tambo	294/417	70.5	107/154	69.5	0.99	
Tshwane 1, Tshwane	183/408	44.8	101/166	60.8	1.36	
Mhlathuze, King Cetshwayo	217/422	51.4	69/130	53.1	1.03	
Abaqulusi, Zululand	263/592	44.6	75/121	62.0	1.40	
Total	*1277/2515*	*52.1*	*454/782*	*58.1*	*1.14 (0.90-1.37)*	*0.116*

Had an HIV test in the past year in 20-24 age group

Klipfontein, City of Cape Town	112/160	70.0	72/99	72.7	1.04	
Mbombela, Ehlanzeni	271/344	81.2	110/143	76.9	0.98	
Nyandeni, O.R. Tambo	204/273	74.7	56/62	90.3	1.21	
Tshwane 1, Tshwane	283/359	78.4	85/101	84.2	1.07	
Mhlathuze, King Cetshwayo	246/326	75.4	72/90	80.0	1.06	
Abaqulusi, Zululand	328/422	77.7	77/95	81.1	1.04	
Total	*1444/1884*	*76.6*	*472/590*	*80.0*	*1.07 (0.98-1.15)*	*0.045*

Ever taken PrEP* total

Klipfontein, City of Cape Town	7/377	1.9	8/209	3.8		
Mbombela, Ehlanzeni	30/803	3.4	46/176	26.1		
Nyandeni, O.R. Tambo	10/690	1.4	39/178	21.9		
Tshwane 1, Tshwane	21/767	2.7	47/230	20.4		
Mhlathuze, King Cetshwayo	2/748	0.3	21/201	10.5		
Abaqulusi, Zululand	12/1014	1.2	43/183	23.5	Risk difference	
Total	*82/4399*	*1.9*	*204/1177*	*17.3*	*15.8% (7.3%-24.4%)*	*0.003*

Ever taken PrEP in 15-19 age group

Klipfontein, City of Cape Town	4/217	1.8	4/119	3.4		
Mbombela, Ehlanzeni	16/459	3.3	13/66	19.7		
Nyandeni, O.R. Tambo	4/417	1.0	26/131	19.9		
Tshwane 1, Tshwane	10/408	2.5	23/144	16.0		
Mhlathuze, King Cetshwayo	0/422	0.0	7/122	5.7		
Abaqulusi, Zululand	6/592	1.0	17/107	15.9	Risk difference	
Total	*40/2515*	*1.6*	*90/689*	*13.1*	*11.8% (4.8%-18.1%)*	*0.004*

Ever taken PrEP in 20-24 age group

Klipfontein, City of Cape Town	3/160	1.9	4/90	4.4		
Mbombela, Ehlanzeni	14/344	3.6	33/110	30.0		
Nyandeni, O.R. Tambo	6/273	2.2	13/47	27.7		
Tshwane 1, Tshwane	11/359	3.0	24/86	27.9		
Mhlathuze, King Cetshwayo	2/326	0.6	14/79	17.7		
Abaqulusi, Zululand	6/422	1.4	26/76	34.2	Risk difference	
Total	*42/1884*	*2.2*	*114/488*	*23.4*	*21.5% (10.4%-32.5%)*	*0.002*

Viral suppression among participants living with HIV total

Klipfontein, City of Cape Town	6/13	46.2	2/2	100.0	2.16	
Mbombela, Ehlanzeni	62/121	48.5	36/80	45.0	0.88	
Nyandeni, O.R. Tambo	64/99	64.7	16/27	59.3	0.92	

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Tshwane 1, Tshwane	41/67	61.3	16/20	80.0	1.10	
Mhlathuze, King Cetshwayo	86/111	77.3	14/21	66.7	0.86	
Abaqulusi, Zululand	104/157	66.7	19/25	76.0	1.15	
Total	*363/568*	*62.1*	*103/175*	*58.9*	*1.21 (0.69-1.74)*	*0.179*

Completed grade 12 in 20-24 age group

Klipfontein, City of Cape Town	80/142	56.3	49/98	50.0	0.89	
Mbombela, Ehlanzeni	172/250	65.0	87/143	60.8	0.88	
Nyandeni, O.R. Tambo	89/200	44.5	27/62	43.5	0.98	
Tshwane 1, Tshwane	193/288	67.0	73/99	73.7	1.10	
Mhlathuze, King Cetshwayo	188/247	76.1	59/89	66.3	0.87	
Abaqulusi, Zululand	211/313	67.6	64/92	69.6	1.03	
Total	*933/1440*	*62.7*	*359/583*	*61.6*	*0.96 (0.86-1.06)*	*0.824*

Used contraceptives at last sex among participants who had ever had sex total

Klipfontein, City of Cape Town	96/233	41.2	78/203	38.4	0.93	
Mbombela, Ehlanzeni	163/593	24.8	114/197	57.9	2.10	
Nyandeni, O.R. Tambo	263/546	48.2	98/197	49.7	1.03	
Tshwane 1, Tshwane	193/573	33.5	98/234	41.9	1.24	
Mhlathuze, King Cetshwayo	135/440	30.7	56/196	28.6	0.93	
Abaqulusi, Zululand	222/624	35.8	60/193	31.1	0.87	
Total	*1072/3009*	*35.9*	*504/1220*	*41.3*	*1.19 (0.69-1.68)*	*0.192*

Used contraceptives at last sex among participants who had ever had sex in 15-19 group

Klipfontein, City of Cape Town	33/102	32.4	31/110	28.2	0.87	
Mbombela, Ehlanzeni	70/278	23.6	30/68	44.1	1.75	
Nyandeni, O.R. Tambo	123/282	43.6	52/130	40.0	0.92	
Tshwane 1, Tshwane	67/244	27.3	42/135	31.1	1.13	
Mhlathuze, King Cetshwayo	33/152	21.7	15/114	13.2	0.61	
Abaqulusi, Zululand	74/242	30.6	12/102	11.8	0.38	
Total	*400/1300*	*31.2*	*182/659*	*27.6*	*0.94 (0.45-1.44)*	*0.649*

Used contraceptives at last sex among participants who had ever had sex in 20-24 age group

Klipfontein, City of Cape Town	63/131	48.1	45/83	54.2	1.13	
Mbombela, Ehlanzeni	93/315	25.8	78/116	67.2	2.28	
Nyandeni, O.R. Tambo	140/264	53.1	40/52	76.9	1.45	
Tshwane 1, Tshwane	126/329	38.0	50/84	59.5	1.55	
Mhlathuze, King Cetshwayo	102/288	35.4	38/76	50.0	1.41	
Abaqulusi, Zululand	148/382	39.0	45/81	55.6	1.43	
Total	*672/1709*	*39.5*	*296/492*	*60.2*	*1.54 (1.14-1.95)*	*0.003*

*Ever taken PrEP was defined as ever taking PrEP in the past 12 months in the pre-intervention survey, but as PrEP was a very new intervention at the time this is comparable to ever taking PrEP as defined in the post-intervention survey.

Discussion

Demographic, socioeconomic, and educational characteristics of participants

When considering the demographic characteristics of participants, the intervention and comparison arms were very similar with only two statistically significant differences between arms: slightly fewer intervention participants were born in South Africa, and fewer intervention participants planned to become pregnant in the year following the survey, compared with the comparison participants. The rates of maternal orphanhood were high in both arms (over 15%) and the rates of paternal orphanhood were even higher (over 24%). Approximately one third of all participants reported that they had ever been pregnant. Among adolescent participants (under the age of 20 years) 16.9% in the intervention arm and 14.8% in the comparison arm had ever been pregnant. The levels of orphanhood and teenage pregnancy among the adolescent age group are signs of vulnerability in this population.

When considering socio-economic characteristics, the intervention and comparison arms were very similar on most variables, except that participants in the intervention arm were more likely to live in households with a car and internet, compared with the comparison arm, possibly suggesting lower levels of poverty in the intervention arm. However, it is notable that reports of hunger were extremely high in both arms: over 40% reported that they or someone else in their household had not eaten for a whole day and night because of lack of food. These findings again highlight the vulnerability of the study population in both intervention and comparison sites.

Most participants in both study arms (over 60%) were enrolled full-time in an educational institution at the time of the research. The study arms did not differ in the proportion of AGYW who had completed Grade 12 of high school. Among adolescent participants, those in the intervention arm were less likely to report that they had completed further studies (university, college, or other training institution) compared with the comparison arm. However, in the older age group (20-24 years), participants in the intervention arm were more likely to report that they had completed such further studies. It is possible that these differences were a result of the My Journey Programme structural interventions to promote schooling. Adolescents might be more likely to still be in school and therefore to report they had not completed further studies, while young women aged 20-24 might have been linked to opportunities for further studies through the My Journey Programme. The Programme offered peer education programmes, career jamborees, homework support and home visits. Further, My Journey Programme offered peer mentoring and support, links for job seeking, work readiness programmes and opportunities for young women through Rise Clubs in- and out-of-school. School attendance and increased educational attainment have been associated with lower HIV incidence in South Africa (George

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et al., 2022; Stoner et al., 2017). The importance of schooling is further demonstrated in a modelling study to identify which specific interventions and combinations of interventions would be most effective to prevent HIV among AGYW. In this study, it found that increasing schooling was one of the interventions that showed the largest reduction in incident HIV infection (Stoner et al., 2021).

Intimate partner violence and non-partner sexual violence

AGYW reported alarmingly high prevalences of lifetime experience of IPV and NPSV in both the intervention and comparison arms. For example, over 14% of all participants reported lifetime experiences of physical IPV and over 9% of all participants reported lifetime experiences of NPSV (rape). This highlights the importance of interventions for AGYW to promote gender power equity and reduce gender-based violence. It also highlights the vulnerability of AGYW to HIV, STIs and pregnancy. It is appropriate that the My Journey Programme included structural interventions to promote gender power equity and to reduce GBV. It should be noted that among the older age group (20-24 years), participants in the intervention arm were less likely to report lifetime sexual IPV or lifetime NPSV. It is possible that these differences were a result of the My Journey Programme interventions, such as gender-based violence awareness, prevention and response peer-led interventions in high schools, training institutions and safe spaces.

Alcohol Use

There were no differences between arms in alcohol use. Binge drinking was relatively common (over 15% among participants in both arms). Over a third of participants in both the intervention and comparison arms were at risk of hazardous drinking. Because unhealthy alcohol use can enhance the risk of HIV acquisition and can accelerate the progression of HIV/AIDS, it is appropriate to specifically target HIV prevention and care interventions at the population of AGYW with unhealthy alcohol use (Oldfield & Edelman, 2021; Probst et al., 2018; Rehm et al., 2017; Rehm et al., 2012). The My Journey Programme included a focus on changing behaviour and attitudes related to alcohol and drugs through the MTV Shuga television programme aimed at youth. The Programme also incorporated referrals to substance abuse programmes and individual counselling and behaviour change support when the risk assessment performed with beneficiaries indicated that they had unhealthy alcohol or drug use.

Sexuality and sexual relationships

There were no differences between arms in participants' reports of ever having had sex, of having had sex before the age of 15 years, recency of last sex, and in the number of male and female sexual partners. There was no difference between arms in the prevalence of reports of transactional relationships with boys or men in the six months before the survey. There was a

difference between arms in reporting being in a relationship with a "blesser" in the past six months with adolescent participants in the intervention arm more likely to report this compared with the comparison arm. There was no difference between arms in reporting first pregnancy below the age of 17 years, and there was no difference in the proportion of participants who had wanted to become pregnant at the time of their first pregnancy. These findings suggest that the My Journey Programme did not impact the sexual behaviour of AGYW. An evaluation of the DREAMS combination HIV prevention programme in South Africa also found that after three years of implementation, there was no evidence that the Programme impacted the sexual behaviour of AGYW including condomless sex and transactional sex and the authors postulated that the contextual drivers of sexual relationships including poverty, social norms, and gender inequalities limit women's prevention choices (Floyd et al., 2022).

It is noteworthy that over 20% of participants in both arms reported a first pregnancy below the age of 17 years, and that under 12% of participants in both arms reported that they had wanted to become pregnant at their first pregnancy. This highlights the importance of ensuring coverage of pregnancy prevention interventions among adolescents.

The responses of participants in both the intervention and comparison arms to the items in the sexual relationship power scale indicate that a minority but substantial proportion of AGYW experience inequitable gender power regarding their male partners. For example, over 20% of participants in both arms endorsed the statement "if I asked him to use a condom, he would get angry" and almost a third of participants in both arms endorsed the statement "he wants to know where I am all of the time". There were no differences between the intervention and comparison arms on most of the items in the sexual relationship power scale except that the 20-24 year old group participants in the intervention arm were less likely to endorse the statements "he has more to say than I do about important decisions that affect us" and "he tells me who I can spend my time with" compared with participants in the comparison arm. These findings suggest that the My Journey Programme may have been successful at promoting more gender equitable relationships among young women. The evaluation of the DREAMS combination HIV prevention intervention in Kenya found no impact of the intervention on gender equitable norms around sexual and reproductive health decision-making, violence-related norms, or individual attitudes to gender norms, and they postulated that it might take more time for programmes to lead to measurable change in norms (Nelson et al., 2024).

Intervention effect on primary outcome: DBS confirmed HIV status

This study found a 9.5% HIV prevalence among participants in the intervention arm and 10.4% in the comparison arm. Although not statistically significant, this suggests that the My Journey Programme had a small NRCCT impact on HIV prevalence in the intervention communities. The

HIV prevalence in the HERStory 3 study is higher than the national prevalence (6.9%) among AGYW in 2022, in both intervention and comparison arms (https://hsrc.ac.za/special-projects/sabssm-survey-series/sabssmvi-media-pack-november-2023/). This is to be expected because the My Journey Programme expressly selected subdistricts at highest risk of HIV, and in the study, we broadly matched intervention subdistricts to comparison subdistricts with a similar high risk of HIV. This could also be attributed to one of the HERStory 3 subdistricts (Mbombela) which had an exceedingly high HIV prevalence (35%). This was an outlier as the HIV prevalence in other study subdistricts ranged between 4% to 20%. In an attempt to account for this outlying HIV prevalence estimate, a sensitivity analysis was conducted excluding the Mbombela subdistrict (Appendix J) and we found an HIV prevalence of 7.9% in the intervention arm and 9.9% in the comparison arm (OR: 0.74; 95% CI: 0.44–1.25) which reflects a marginal estimated difference of 2% (95% CI: 1.5%–5.6%) favouring the intervention arm, but not statistically significant (p=0.263). The results of the pre-post-evaluation substudy are aligned with those of the NRCCT, showing small decreases over time in HIV prevalence (absolute declines from between 1.0% to 5.2%) in five of the six intervention subdistricts. The sixth subdistrict, Mbombela, was an outlier, with a large increase in HIV prevalence from 16.6% in 2017/8 to 34.8% in 2024. It is not yet clear why the subdistrict had such a high HIV prevalence, and we hope that further investigations will provide an explanation for this. It is noteworthy that the HIV prevalence among AGYW in several of the 12 intervention subdistricts included in this evaluation was lower than the expected target of 6% (Klipfontein: 0.89; Dihlabeng: 5.74; Fetakgomo Tubatse: 4.72; Rustenberg: 3.47). It is possible that the overall declines in national prevalence contributed to this, as the 2022 National HIV Survey showed a 4% decline in HIV prevalence over the 5-year period among AGYW from 10.9% in 2017 to 6.9% in 2022 (https://hsrc.ac.za/special-projects/sabssm-survey-series/sabssmvi-media-pack-november-2023/).

In the 15-19 year age group, HIV prevalence was 6.0% in the intervention arm and 7.1% in the comparison arm, demonstrating a 1.1% difference in favour of the intervention arm but this difference was not statistically significant. In the 20 – 24 year age group, there was 15.2% prevalence of HIV in the intervention and 15.0% in the comparison, and this difference was also not statistically significant. This age difference in HIV prevalence is consistent with similar studies in the region which also found high HIV prevalence among the older young women compared to the younger ones (Mthiyane et al., 2023).

Evidence shows that reducing HIV prevalence is difficult to achieve, even with combination of multicomponent approaches similar to the My Journey Programme. An evaluation of the impact on HIV of DREAMS, another large-scale combination HIV prevention intervention in South Africa, found no evidence of intervention effect on HIV prevalence (Mthiyane et al., 2022). It was

suspected that the lack of evidence of even small reductions in HIV incidence from DREAMS was due to the overall background declines in HIV incidence and untreated HIV infection among male sexual partners of AGYW (Mthiyane et al., 2022; Shahmanesh et al., 2020; Vandormael et al., 2019).

A systematic review of studies evaluating combination HIV prevention interventions implemented in Southern Africa found of the seven studies evaluating impact on HIV prevalence and incidence, only two had a positive impact (Rogers et al., 2024). Various factors were attributed to this, including poverty and economic vulnerabilities, gender norms, older age, and intervention implementation location (delivery site). First, poverty and economic vulnerabilities among AGYW continue to place them at high risk of HIV infection and other adverse SRH outcomes. Interventions that included a focus on poverty reduction and economic empowerment showed positive results in improving overall health, HIV prevention knowledge and testing, and HIV prevalence (Floyd et al., 2022; Rogers et al., 2024; Stoner et al., 2021). Second, gender norms and inequities are another persistent risk factor driving the HIV prevalence among AGYW. Current interventions do not directly target male perpetrators but rather target AGYW as the population at risk. It will be important for future HIV prevention programming to focus on strengthening interventions among men, promoting HIV testing and treatment but also behavioural change, condom use, social and gender norms, and including escalated efforts to address GBV. Though critical, targeting AGYW directly to impact HIV risks and prevalence may not be enough to bring positive impact on HIV prevalence, as social and gender norms continue to limit AGYW's ability to make life choices that will protect them from HIV and other adverse SRH outcomes. Multi-level HIV prevention interventions were associated with an increase in protective HIV-related behaviours emphasizing the importance of accessible programs within both school and community settings for young people (Mthiyane et al., 2024).

The findings of the systematic review highlight the need to strengthen the structural and socio-economic components of combination HIV prevention programmes, such as poverty alleviation and economic opportunities for AGYW, as well as target social norms and gender inequities. For example, cash transfers, in larger and longer duration were found to have an impact in reducing risk of early sexual debut which is a known contributor to HIV prevalence among AGYW (Chzhen et al., 2021; Rogers et al., 2024). The My Journey Programme included a focus on these structural and socio-economic factors, however, the HERStory 3 findings suggest that this focus might need to be intensified and sustained over a longer period to have a bigger impact on HIV prevalence. Strengthening interventions focusing on structural factors is important to consider but these are difficult and most expensive to implement.

Recent HIV infection

It was not feasible to compare HIV incidence between the intervention and comparison arms due to the large sample size requirement. We have however tested the DBS positive participants for the recency of their HIV infection. The incidence rate was 1.71 cases per 1000 person years in the intervention arm and 2.85 in the comparison arm. The incidence rate ratio is 0.60, indicating a 40% reduction in HIV incidence in the intervention arm compared to the comparison arm. A cohort study looking at the impact of DREAMS on HIV incidence in SA found a decrease in HIV incidence but the decline in HIV incidence is believed to have already started before DREAMS was implemented and thus, the authors could not credit the decrease to the intervention effect (Birdthistle et al., 2021). Further, DREAMS had no impact on sexual risk or prevalence of transmissible HIV, the two pathways through which the intervention was hypothesised would reduce HIV incidence (Mthiyane et al., 2022).

A longitudinal cohort data from the HIV Prevention Trails Network (HPTN 068) also found small reduction in HIV incidence among AGYW in South Africa when comparing all individual exposures among exposed versus none exposed (Stoner et al., 2021). The largest reductions were found in the low school attendance and age-disparate relationship exposures (Stoner et al., 2021). However, another combination prevention intervention for pregnant and breastfeeding women found low HIV incidence among pregnant and postpartum women, indicating that combination HIV prevention intervention may have contributed to reducing HIV incidence (Fatti et al., 2017). The HERStory 3 study found low incidence of HIV overall and in each study arm.

Intervention effect on secondary outcomes:

Knowledge of HIV status

Knowledge of one's HIV status is a prerequisite to accessing HIV treatment or prevention interventions and services and is thus a critical goal for combination HIV prevention programmes. Given the definition of HIV status used in this study (had an HIV test in the past year and knew whether or not you were living with HIV), HIV testing is a key component of this variable. In this study, the secondary outcome "knowledge of HIV status" was statistically significantly higher in the intervention arm, compared with the comparison arm, especially in the younger age group. Overall, 85% of participants in the intervention arm knew their HIV status compared with 81% in the comparison arm. Among the younger, adolescent age group, the positive intervention effect was more pronounced: 83% versus 77%. These positive findings are aligned with the per protocol analysis, the pre- post substudy and other consistent findings on the uptake of HIV testing which confirm that the My Journey Programme increased knowledge of HIV status. We found that HIV testing ever, in the past year, in the past six months and HIV self-testing ever were higher in the

intervention arm compared with the comparison arm. When disaggregated by age group, these measures of HIV testing uptake were substantially higher in the intervention arm compared with the comparison arm among adolescents, but this was not the case in the older age group. In the older age group, the differences between arms were in favour of the intervention arm but small, except for HIV self-testing where the prevalence in the intervention arm was substantially higher than the comparison arm. Further evidence of the reliability of the intervention effect on knowledge of HIV status was observed when we asked participants about their receipt of biomedical services from any service provider: bearing in mind the concerns about the validity of this question, participants in the intervention arm were more likely to report that they had ever received HIV testing (67% versus 56%) and to have received HIV testing in the past year (59% versus 47%), compared with the comparison arm. The results of the pre- post-intervention substudy also showed a statistically significant difference in reporting past year HIV testing over time in the six subdistricts. These findings provide strong evidence that the combination HIV prevention intervention was successful at reaching AGYW, especially adolescents, and increasing the coverage of HIV testing and knowledge of HIV status. This provided the conditions for AGYW to be referred for HIV prevention or HIV treatment interventions as appropriate.

The prevalence of knowledge of HIV status we observed in the intervention arm was very similar to the prevalence of knowledge of HIV status among women 15-24 years after participation in the PopART intervention in South Africa, which ranged between approximately 83% to 90% by age (Floyd et al., 2020). The PopART intervention comprised community HIV care providers who delivered a combination HIV prevention package which included home-based HIV testing, referral of HIV positive individuals for treatment and revisits to support their linkage to HIV care and retention on ART (Floyd et al., 2020). The prevalence of knowledge of HIV status we observed in the intervention arm was not as high as was observed among women aged 16 to 24 years after the five-year Ya Tsie combination UTT intervention in Botswana, which involved home-based and mobile HIV testing, and linkage to HIV treatment and care, where knowledge of HIV status was 100% (Lockman et al., 2020).

Prior to the implementation of the My Journey Programme, the national South Africa Demographic and Health Survey of 2016 identified an unmet need for HIV testing among adolescents 15-19 years of age (Manamela et al., 2024). In sub-Saharan Africa, adolescents and young people living with HIV were least likely to know their status, compared with people in other age groups, according to a study published in 2021 (Giguère et al., 2021). The unmet need for HIV testing not only prevents young people living with HIV from accessing life-saving ART medications and putting them at risk of transmitting HIV to others, but it also limits linkage to effective HIV prevention services for those who test HIV negative (Giguère et al., 2021). The findings of the

HERStory 3 study show that the My Journey combination HIV prevention programme is meeting this need to increase HIV testing and knowledge of HIV status among adolescent girls.

The My Journey Programme's strategies to create demand for HIV testing included door to door mobilisation, and events at schools or colleges and in community settings like Safe Spaces. Every AGYW who was enrolled in the My Journey Programme was offered HIV testing as part of the "core" service. HIV testing services took place in homes, schools, Safe Spaces, mobile clinics, and other community settings. The My Journey Programme used some of the strategies recommended in the WHO guidelines to increase demand and uptake, including peer-led demand creation and mobilisation as well as community-based HIV testing services with linkage to prevention, care, and treatment (WHO, 2019).

Another way that the My Journey Programme increased knowledge of HIV status was through offering HIV self-testing as an additional approach to diagnosis and linkage to prevention and treatment. HIV self-testing has been shown to be safe, acceptable and an effective way to increase HIV testing coverage (Ingold et al., 2019). It can also reach those who do not access health services (Ingold et al., 2019; Lippman et al., 2018; Ortblad et al., 2018; WHO, 2016).

Evaluations of two other large-scale, South African combination prevention programmes also found intervention effects on knowledge of HIV status. An evaluation of the DREAMS combination HIV prevention intervention for young people in South Africa and Kenya, found that the intervention substantially increased knowledge of HIV status among AGYW and postulated that this was because HIV testing was made more accessible and acceptable by offering it in Safe Spaces (Floyd *et al.*, 2022). An evaluation of the PopART combination HIV prevention programme found that the intervention, which included home and community-based HIV testing, increased knowledge of HIV status among adolescents (Shanaube et al., 2021). Together, the three evaluations of the My Journey, DREAMS and PopART programmes show that combination HIV prevention can effectively increase knowledge of HIV status among adolescents aged 15-19 years, and it is likely that this is achieved by offering HIV testing in youth-friendly spaces and other places outside of health facilities, in addition to facility-based services. Home-based HIV testing, mobile clinic HIV testing and community-based HIV testing have been shown to reach a greater proportion of people and more first-time testers, compared with facility-based HIV testing (Lugada et al., 2010; Mannoh et al., 2022). Also, these interventions can reach adolescents and young adults better than facility-based testing (Daniels et al., 2017; Mabuto et al., 2014).

School dropout among AGYW aged 15-19 years

School dropout among adolescents aged 15-19 years was one of the secondary outcomes of the HERStory 3 impact evaluation because improving retention in school was a key objective of the

My Journey Programme. This study detected a small difference in school dropout between study arms of 2% among adolescents, and the direction of the difference was in favour of the intervention arm and consistent across ages 15-19 years. We found that 10.7% of participants in the intervention arm and 12.7% in the comparison arm had dropped out of school before they completed Grade 12 (OR: 0.80; 95% CI: 0.56–1.15), but the difference was not statistically significant because the study was only powered to detect a much larger absolute difference of 5%. At the time of planning the study, a difference of this magnitude was determined to likely be unrealistic, however, to power the study to detect a smaller difference would have been exceedingly expensive because the sample size would have needed to be so much larger. The pre- post-intervention substudy found that among the older subgroup of AGYW aged 20-24 years, there was no significant difference in having completed Grade 12 over time in the six subdistricts. This could suggest that the My Journey Programme has only begun to reduce school dropout in the more recent years, only affecting the younger AGYW participants.

An evaluation of the impact of the DREAMS combination HIV prevention programme on educational attainment among AGYW in informal settlements in Kenya also found that the impact was modest and not statistically significant but in a positive direction (Mulwa et al., 2021). DREAMS was associated with an increase in completing at least two years of secondary education or currently being in high school (Mulwa et al., 2021).

There is evidence that young women who attend school more often and/or have higher grade attainment are at a lower risk of incident HIV and HSV-2 infection (Psaki, Chuang, et al., 2019; Stoner et al., 2017), higher age of first sex (Psaki, Soler-Hampejsek, et al., 2019), lower risk of pregnancies and births and a higher age of first pregnancy (Psaki, Soler-Hampejsek, et al., 2019), and have a lower risk of sexual behaviours linked to HIV transmission (Rudgard et al., 2023).

The pathways from school attendance to HIV prevention and better SRH outcomes have been hypothesised to be numerous and may include greater agency leading to more equitable intimate relationships and less IPV, stronger negotiating and decision-making power, a lack of time and sexual network constraints imposed by school attendance, and safer sexual networks associated with schools (Rudgard et al., 2023; Stoner et al., 2018; Stoner et al., 2017; Zahra et al., 2022). Studies are now seeking to confirm these pathways with empirical evidence (Zahra et al., 2022).

A systematic review of policies and interventions to remove gender-related barriers to girl's participation in school in low- and middle-income countries found evidence that interventions addressing insufficient academic support and financial barriers to schooling (inability to afford tuition and fees and a lack of adequate food) were effective at improving girls' educational outcomes (Psaki et al., 2022). Interventions to provide academic support were part of the My Journey Programme. The My Journey Programme implemented several interventions to promote

retention in school and grade attainment including employing In- school Coordinators, In-school Supervisors, Learner Support Agents, and In-school Champions to implement a range of interventions in the enrolled high schools. The purpose was to ensure referrals of young people for clinical and psychosocial problems, to support the implementation of comprehensive sexuality education and the Integrated School Health Programme, to train Learner Peer Educators, to ensure social workers visited homes to encourage young people to return to school, to promote return to school after childbirth, to assist learners with academic support and to report human rights violations, such as barriers to HIV services and GBV.

The authors of a systematic review of studies conducted in low- and middle-income countries found that the effects of grade attainment on sexual and reproductive health outcomes were smaller than expected (Psaki 2019) and they postulated that reasons for this included poverty and economic factors and gender equality that are barriers to improved sexual and reproductive health, and that in settings in which access to school had been expanded to more young people, there might have been a deterioration of school quality (Psaki, Chuang, et al., 2019). These reasons are particularly relevant in South Africa, where structural barriers such as poverty, gender inequality, and poor-quality schooling might mitigate against interventions to keep young people in school and the consequent SRH benefits. In 2021, the Progress in International Reading Literacy Study found that 81% of South African Grade 4 learners could not read for meaning in any language (Mullis, 2023) and there is evidence mathematical literacy is highly inadequate (Spaull et al., 2022). Thus, in South Africa deficiencies at primary education level and structural barriers to promoting schooling and education for AGYW comprise a complex problem which requires a combined approach focusing on economic and gender inequalities affecting school dropout and sexual behaviour.

Intervention effect on coverage of other sexual and reproductive health services

Intervention effect on PrEP coverage

Acknowledging that we were not able to conduct a randomised controlled trial, this study provides strong evidence that the My Journey Programme had a positive NRCCT impact on PrEP coverage. The evidence of a substantial impact on PrEP coverage emanates from both the NRCCT, the biological PrEP results and the pre- post-intervention substudy. As far as we are aware the My Journey Programme is the first combination HIV prevention programme to demonstrate an intervention effect on PrEP uptake at a community level in sub-Saharan Africa. Other studies have only showed improvements among study participants.

The My Journey Programme provided information about PrEP and conducted risk assessments as part of the Programme's "core" services. PrEP was offered to participants based on their HIV

risk as part of the Programme's "layered" services. PrEP was also promoted through posters, flyers and social media as part of the Programme's demand creation activities.

Indicators of PrEP use

Since PrEP is a relatively new intervention and easy access to PrEP may have been challenging in non-intervention sites, we followed a slightly different conceptualisation of the HIV prevention cascade for PrEP which included knowledge as an indicator of motivation and ever offered PrEP as an indicator of access to PrEP, followed by use and effective use of PrEP (Hensen et al., 2021). We created these cascades for both age groups among participants who were DBS-confirmed HIV negative and self-reported having sex in the past six months.

In the younger age group, knowledge of PrEP (48% vs. 33%), ever being offered PrEP (36% vs. 16%), and ever taking PrEP (22% vs. 10%) were substantially and statistically significantly higher in the intervention compared to the comparison arm, with the latter two indicators being more than double in the intervention arm compared to the comparison arm. This shows that the My Journey Programme was successful at reaching adolescent girls who were at risk of HIV acquisition and increasing their uptake of PrEP. In the last cascade bar, "currently using PrEP", we did not detect a difference between study arms. In the older age group, knowledge of PrEP (58% vs. 46%), ever being offered PrEP (43% vs. 24%), ever taking PrEP (26% vs. 14%), and current use of PrEP (11% vs. 4%) were statistically significantly higher in the intervention arm compared to the comparison arm. These findings indicate that while PrEP uptake was high in the intervention arm, continuation on PrEP was low, especially among adolescents. In addition, when participants were asked if they had ever taken PrEP and then discontinued it, there were statistically significantly more participants who reported that they had done this in the intervention arm (20%) compared to the comparison arm (9%), but this is likely because there were more participants currently on PrEP in the intervention arm and thus more chance for discontinuation. A scoping review of PrEP delivery models among AGYW and men in sub-Saharan Africa reported PrEP initiation at 16%-90% in their studies, but it is difficult to compare results as the studies reviewed did not measure PrEP uptake among a random sample of AGYW in the intervention area, but rather among individuals who were offered PrEP through these studies (Ramraj et al., 2023). Nevertheless, all studies reported discontinuation of PrEP as a challenge, except in the case of serodiscordant couples.

This finding highlights the importance of sustaining high levels of uptake through interventions to promote continuation of PrEP where appropriate. A South African modelling economic evaluation has estimated that the availability of long-acting injectable formulations of PrEP such as cabotegravir (two-monthly) and lenacapavir (twice-yearly), at affordable prices, will result in longer duration on PrEP and will have the potential to avert a greater number of new HIV

infections than oral PrEP (Jamieson et al., 2022; Meyer-Rath et al., 2023). However, these PrEP formulations are not yet available.

Potential barriers to and facilitators of PrEP use

Although we have not yet determined the factors which were associated with each step of the cascade in this report, we did compare the potential barriers to and facilitators of motivation to use, access to and effective use of PrEP across study arms among participants who self-reported having sex in the past six months and did not self-report living with HIV. In addition, we report on factors associated with PrEP use described in the HERStory 2 study and other literature.

The main barriers to motivation to use an HIV prevention method described by the HIV prevention cascade are knowledge of the intervention, HIV risk perception, attitudes or consequences of use and social norms (Schaefer et al., 2019). Although already described in the HIV prevention cascade by age group, we found that overall participants in the intervention arm were less likely to not know what PrEP was (28% vs. 35%) and not believe that it was efficacious (43% vs. 54%) compared to the comparison arm. In addition, participants in the intervention arm were more likely to have friends that use PrEP (39% vs. 30%) compared to the comparison arm, increasing social acceptability of PrEP. In the HERStory 2 study, we found that a lack of knowledge about the efficacy of PrEP was a barrier to motivation, while not being in education or employment, and being confident that you could use PrEP in the correct way and despite what others may think were facilitators of motivation to use PrEP (Bergh et al., 2024). In addition, the qualitative component of the HERStory 2 evaluation highlighted PrEP stigma related to associations with antiretrovirals and being HIV positive as well as associations with promiscuity as major barriers to PrEP acceptability (Jonas, 2021). Studies among AGYW, pregnant and post-partum women in sub-Saharan Africa reported similar barriers to PrEP use as well as the burden of taking so many pills when you are not sick, take other medications or have been taking PrEP for some time (pill fatigue); disliking the taste, smell or size of the pill and fear of side effects; having no sexual partner or having one faithful partner; and a preference for injections, implants or syrups over daily tablets (Beesham et al., 2022; Muhumuza et al., 2021; Ramraj et al., 2023). Facilitators included high HIV risk perception, a preference for PrEP over other HIV prevention methods, the prospect of protection during unwanted sexual encounters, care and financial support from family, partner or friends; and community awareness and sensitisation to PrEP. Taken together these findings indicate that the barriers to PrEP use are complex, but that improving knowledge about PrEP and sensitising communities to PrEP are important first steps in addressing PrEP stigma. Similarly to condoms, addressing unequal social attitudes towards young women's sexuality is another important component of PrEP stigma that needs intervention. In addition, PrEP counselling during PrEP initiation needs to address the challenges

that AGYW experience in taking PrEP daily, beliefs around taking too many pills and for prolonged periods, and side effects experienced by participants.

In terms of the barriers to PrEP use (availability, accessibility, acceptability and affordability), participants in the intervention arm were more likely to report stock-outs when trying to access PrEP (3%) compared to the comparison arm (2%), but the proportion reporting this was very low in both arms (Schaefer et al., 2019). While there were no other potential barriers to PrEP with a statistically significant difference between study arms aside from never being offered PrEP which we have already addressed, the most prevalent potential barriers to PrEP access in the intervention arm were a lack of privacy and confidentiality when accessing PrEP (15%) and thinking that it will cost too much to get to a place where PrEP is provided (16%). In the HERStory 2 study, ever being offered PrEP was the only facilitator of access with a statistically significant association. However, other studies among AGYW in sub-Saharan Africa reported several barriers to accessing PrEP including stock-outs as well as long waiting times at clinics, negative health worker attitudes, the cost of PrEP, and distance to facilities (Beesham et al., 2022; Muhumuza et al., 2021; Ramraj et al., 2023). Convenient, client-friendly and non-judgemental access to PrEP were outlined as the main facilitator of PrEP access. As PrEP is an HIV prevention intervention usually offered to people who are not unwell, accessibility is an important factor in continuation on PrEP.

The broad barriers to effective use of PrEP include skills, self-efficacy and partner influence (Schaefer et al., 2019). Regarding skills, participants in the intervention arm were more likely to have ever received instructions or counselling on how to use PrEP overall (51% vs. 34%) and in both age groups. In terms of self-efficacy, participants in the older age group were more likely to agree or strongly agree that they could use PrEP in the way they are supposed to in the intervention versus the comparison arm (57% vs. 47%). There were no statistically significant differences by study arm in terms of partner approval of PrEP. The factors associated with effective use of PrEP could not be explored in the HERStory 1 and 2 studies as PrEP use was too low. However, other studies described above provide additional evidence that skills and self-efficacy related to taking PrEP at the same time every day is a barrier to PrEP adherence, although PrEP disclosure to partners appeared to be more of a barrier among AGYW than older pregnant and post-partum women (Beesham et al., 2022; Muhumuza et al., 2021; Ramraj et al., 2023). These finding further emphasise the importance of providing instructions and counselling for PrEP which may need to be provided on an ongoing basis to improve continuation on and adherence to PrEP. Additionally, a study among young South African men discussed hypothetical PrEP use among AGYW and men reported that they would be more likely to approve of PrEP if they were involved in their partner's decision to take PrEP, which would also alleviate suspicions

of infidelity (Jani, 2018). The same study suggested couples counselling, PrEP for men and community sensitisation as approaches to improve PrEP uptake and continuation.

Significance of biological PrEP results

This investigation into the presence and levels of Tenofovir-Diphosphate (TFV-DP) had two objectives:

- To quantify the presence and levels of TFV-DP in participants not living with HIV who self-reported taking PrEP at the time of the household interview
- To validate the self-reporting of taking PrEP in the participants not living with HIV for the HIV prevention cascade

Both objectives of conducting the biological PrEP testing for participants not living with HIV were achieved. Firstly, the overall 23% detection of TFV-DP in the self-reported PrEP users is lower than the 31% achieved at the 12-month follow-up time point of the HIV Prevention Trials Network (HPTN) 082 study — also conducted among AGYW but aged 16 to 25 years (Celum et al., 2021). The 28% detection found among 20-24 year olds is close to this external marker. Given the cross-sectional study design, 23% detection is an average detection across different individual adherence profiles, thus one would expect a lower detection proportion (Sidebottom et al., 2018). Secondly, the 0.7% (1/150) TFV-DP detection found in the random sample of non-PrEP users shows minimal misreporting in this stratum. The observed differences in detection proportions observed in the two self-reporting PrEP strata can be seen as a validation for using the self-reported PrEP data as an indicator for the HIV prevention cascade for PrEP.

In the self-reported PrEP stratum, all the self-reported cases were included for detection of TFV-DP. The difference in numbers of these cases between the intervention and comparison arm (152 vs 57) has been shown to have a significant intervention effect. The similarity of the detected proportions for these cases in the two arms (24% vs 23%) reflects equivalent levels of adherence after engaging the healthcare system. When looking at this difference within age groups, a 10% difference is observed in the 15-19 age group (21% vs 11%) in favour of the intervention arm but the number of cases in the finer subgroups in the comparison arm becomes very small and therefore no formal inference was determined.

Among participants who were not living with HIV and did not self-report being on PrEP, biological PrEP testing was originally planned to be done using a pooled testing algorithm in all participants in this category, based on other studies using DBS spot samples. However, the contracted laboratory could not perform this pooled testing, and we reverted to the random sampling, and we acknowledge this as one of the limitations of these analyses. Further, another limitation was the budget which was costed based on the expected number of tests required for the pooled

testing and the random sample had to be restricted to this number. Nevertheless, given the expected low detection of TFV-DP based on previous studies that used this pooled approach, we believed this random sample approach provided adequate precision (Sidebottom et al., 2018; Singh et al., 2023).

Interventions to improve PrEP use

Given that PrEP is still a relatively new intervention, there are not many studies from sub-Saharan Africa which have implemented and scaled up PrEP to have time to show any intervention effect at a community level. In addition, the DREAMS programme, which is the other main combination HIV prevention programme for AGYW in South Africa, has not published any findings to suggest an intervention effect on PrEP in South Africa or sub-Saharan Africa. However, we can learn from studies which showed an intervention effect among their study participants.

A scoping review of PrEP service delivery models for AGYW and men in sub-Saharan African found that PrEP services need to be located in convenient locations near public transport and limit the time clients spend in queues (Ramraj et al., 2023). In addition, services should be client-friendly and delivered by non-judgemental health workers. The review suggests task-shifting among health workers along the PrEP cascade, and provides some evidence for PrEP-dedicated nurses, although the feasibility of this intervention needs to be tested. Innovative and differentiated service delivery models (home deliveries, pharmacies, drop-in centres, salons, mobile clinics near schools, and telemedicine-assisted models) centred around AGYW's needs, that address behavioural and structural barriers, and that minimise the burden on the health system are needed. Furthermore, considering that eligibility for PrEP requires regular HIV testing, there is a need for interventions such as HIV self-testing to address this challenge when PrEP is not delivered in health facilities. Opportunities also exist for the integration of PrEP services into HIV testing, SRH and antenatal care services, but there is mixed evidence for which work best. Same day initiation and multi-months dispensing is recommended.

Other studies such as the POWER study among AGYW in Kenya and South Africa (n=2,550) which offered PrEP to AGYW seeking SRH or primary care services from health facilities and mobile vans endorsed proactive call-back mechanisms and express visits to aid in continuation of PrEP (Celum et al., 2022). The DREAMS programme in Botswana has recently tested the feasibility and acceptability of peer-led mHealth interventions which they will soon be rolling out (Lavoie et al., 2023). The smaller MTN 034/REACH cross-over study of oral PrEP and the dapirivine ring among 247 AGYW from South Africa, Uganda and Zimbabwe demonstrated that in the context of being provided with a choice of HIV prevention method, tailored adherence support and counselling and monthly visits, almost all participants had moderate to high adherence over 18 months (97%) (Ngure et al., 2022). Product switching and choice have shown to increase coverage of family

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planning methods and this could be an important component of PrEP coverage going forward as vaginal rings and long-acting injectable PrEP become available (McGuire et al., 2024).

While programmes are still figuring out the best approaches to improve initiation and continuation on PrEP, it is clear from these findings that while improving knowledge to PrEP and offering participants PrEP may improve PrEP initiation, providing convenient and youth-friendly access to PrEP, reducing PrEP stigma, sensitising communities to PrEP and ongoing counselling and support from partners, family, friends and/or health workers are important interventions to improve continuation on PrEP.

Intervention effect on coverage of male condoms

Coverage of both male and female condoms was assessed in this study as condoms are one of the main biomedical HIV prevention methods available to AGYW through the My Journey Programme and in South Africa in general. All participants who were enrolled into the My Journey Programme were offered male and/or female condoms as part of the Programme's "core" services. In the most recent grant cycle (2022-2025), lubricants were also offered to participants. According to the national Demographic and Health Survey in South Africa in 2016, uptake of female condoms is much lower compared to male condoms with only 0.2% of sexually active women aged 15-24 years using female condoms with their most recent sexual partner compared to 20% for male condoms (National Department of Health, 2019). Although we have reported on both the use of male and female condoms in this report, it should be noted that our indicator for effective use of condoms combines male and female condoms to give a holistic estimate of effective condom use, but is likely more specific to male condom usage given the low uptake of female condoms.

Focusing first on male condoms, we examined motivation to use, access to, use and effective use of male condoms among participants who were at risk of transmitting HIV (self-reported living with HIV, had sex in the past six month and no plans to become pregnant) and among participants at risk of HIV infection (self-reported not living with HIV, had sex in the past six months and no plans to become pregnant).

At risk of HIV transmission

Among participants at risk of transmitting HIV, access to (78% vs. 72%) and effective use (15% vs. 12%) of male condoms were higher in the intervention arm compared to the comparison arm, although there weren't enough participants living with HIV to show any statistically significant differences. The HERStory 3 measure of effective use is particularly rigorous as it only includes participants who reported using condoms 100% of the time while having sex in the past six months. This makes it difficult to compare against other studies in which condom use at last sex,

for example, were used. A review of studies in sub-Saharan Africa reported that condom use ranged from 18%-71%, but none of the studies used a measure as rigorous as the HERStory 3 measure (Toska et al., 2017). Motivation to use male condoms in the HERStory 3 study was slightly lower in the intervention arm (65%) compared to the comparison arm (68%).

In the HERStory 3 study, we have not yet investigated the factors associated with condom use among people living with HIV, but this could be done in future analyses. According to a systematic review of condom use among people of similar ages living with HIV in sub-Saharan Africa, factors associated with inconsistent condom use were alcohol use and depression, while knowing one's HIV positive status and access to HIV support groups were associated with increased condom use (Toska et al., 2017). Although this systematic review did not conclude any statistically significant relationship between condom use and timing of HIV diagnosis, adherence to ART and disclosure to a sexual partner, this was shown to be associated with higher condom use in a recent study of 294 sexually active AGYW aged 14-24 years living with HIV in South Africa (Thurman et al., 2024). These findings emphasise the importance of early diagnosis and knowledge of HIV status in improving condom use, but also highlight that there is limited evidence on the types of interventions that support condom use among AYP living with HIV. The limited evidence indicates that HIV-specific support groups are the best intervention approach, and their impact may be stronger when combined with livelihood support including small grants and vocational training.

At risk of HIV infection

Indicators of coverage

Among participants who were at risk of acquiring HIV, we created HIV prevention cascades to describe motivation to use, access to, use and effective use of male condoms within the 15-19 and 20-24 year age groups. The overall estimates, additional indicators of condom coverage and potential barriers to or facilitators of condom use are described in the tables.

We found that participants in the intervention arm were less likely to report that they definitely wanted to use male condoms (motivation) when having sex (59%) compared to those in the comparison arm (67%), and this was also the case in the older 20-24 year age group but not among the adolescent group. There were no differences by study arm in finding it easy or very easy to access condoms (access) or using condoms at last sex (use) overall or within either age groups. However, among participants in the younger age group, there were statistically significantly fewer in the intervention arm who reported effective use of condoms (13%) compared with the comparison arm (19%), but there were no differences in the overall estimates or in the older age group.

Potential barriers to and facilitators of condom use

Although we have not yet determined the factors associated with motivation to use, access to and effective use of male condoms, we did find some statistically significant differences between the study arms and also draw on findings from additional analyses conducted as part of the HERStory 1 and 2 study as well as other literature.

According to the theory of the HIV prevention cascade, the main barriers to motivation to use HIV prevention methods include knowledge of the intervention, HIV risk perception, consequences or use or attitudes towards the method, and social norms (Schaefer et al., 2019). In the HERStory 3 study, we showed that knowledge about condoms was statistically significantly higher in the intervention arm as fewer participants in the intervention arm (46%) reported that they did not know that condoms can reduce the risk of HIV transmission from an HIV positive to an HIV negative person by more than 70% compared to the comparison arm (54%). While knowledge is an important factor in improving uptake and adherence to condoms, it may not be enough to cause meaningful changes in condom use. Additional analyses conducted on the HERStory 1 and 2 evaluation data found that disliking condoms, having a faithful partner who you trust and unequal social norms favouring male sexual decision making were the main barriers to motivation to use male condoms (Bergh et al., 2024; Duby et al., 2023). Negative attitudes towards condoms among males and females as well as a lack of agency to negotiate condom use in committed, age-disparate and transactional sexual relationship are known barriers to condom use (Aventin et al., 2021). Additionally, we speculate whether the decreased motivation for male condoms in the intervention arm of this study is linked to an increased uptake of PrEP in the intervention arm; 27% of participants in the intervention arm had ever taken PrEP compared to 14% in the comparison arm. Among participants who reported that they had ever taken PrEP, 20% of participants in the intervention arm and 14% in the comparison arm reported that they used condoms less than before after starting PrEP, but this could simply be a chance difference. There is no evidence to support this association from any other study among young women in sub-Saharan Africa.

In terms of access, those in the intervention arm were more likely to know a place where they could easily get condoms (77%) compared with the comparison arm (70%) in the older age group, but there were no differences in the younger age group or in the overall estimates between arms. Nevertheless, it is well-documented that younger women are less likely to access HIV prevention methods compared to older women due to the inequitable social attitudes towards young women's sexuality. Thus, improving youth-friendly access to condoms among adolescent girls may help to improve knowledge of and access to places where condoms are easily provided.

According to the HIV prevention cascade, availability, accessibility, acceptability and affordability

are the main barriers to accessing condoms (Schaefer et al., 2019). This study found that there were statistically significantly fewer participants in the intervention arm who reported that the places where they could get condoms was not open when they had time to go overall and in the older age group (4% vs. 7%) and that it was far to get to a place where condoms are provided in the younger age group (9% vs. 14%) compared to the comparison arm. Findings from HERStory 2 also indicated that finding it far to travel to access condoms was a barrier to accessing condoms (Bergh et al., 2024). Most participants in both the intervention and comparison arm reported accessing condoms from a clinic or hospital (55%), followed by a mobile clinic or van (<17%), boyfriend (<17%), school (<9%) or pharmacy (<8%). Taken together these findings suggest that services at hospitals, clinics, mobile clinics and pharmacies need to be more youth-friendly and should ensure that they are open at hours that are convenient to AGYW who are in school, studying, working or may have other care-giving responsibilities at home. At the same time, condom availability at schools needs to be improved.

The main barriers to effective use of HIV prevention methods according to the theory of the HIV prevention cascade are skills, self-efficacy and partner influence (Schaefer et al., 2019). Among older participants in this study, there were statistically significantly more participants who had received instructions or counselling on how to use male condoms in the intervention arm (58%) compared to the comparison arm (51%), but this was not observed in the younger age group and does not appear to have improved effective use of male condoms in the intervention overall or within either age group. Findings from the HERStory 1 and 2 study also found that receiving counselling and instructions on how to use condoms can facilitate effective use of condoms, but that partner influence plays an important role in condom use as men often have more control over the timing of sex and condom use (Bergh et al., 2024; Duby et al., 2023). The impact of partner influence on effective use of condoms is a consistent barrier to effective condom use in sub-Saharan Africa, thus including adolescent boys and men in the My Journey Programme's interventions is critical to improving effective use of condoms (Aventin et al., 2021).

Female condoms

Regarding female condoms, knowing a place where you could get female condoms was statistically significantly higher in the intervention arm (64%) compared to the comparison arm (54%) among older participants. However, having ever used a female condom was statistically significantly lower in the intervention arm (8%) compared to the comparison arm (15%) among younger participants. Nevertheless, overall use of female condoms was very low with only 10% of participants in the intervention arm and 13% in the comparison arm using a female condom once or more in the past six months. In addition, female condoms still require male partner approval and thus do not solve many of the barriers to effective use of male condoms.

Interventions to improve condom use

These findings, although somewhat contradictory, (some favouring the comparison arm and some favouring the intervention arm), show that the My Journey Programme did not have a reliable impact on the coverage of condoms. An evaluation of the DREAMS combination HIV prevention programme in Kenya and South Africa found a positive impact of the intervention in a rural Kenyan setting, but no evidence of an impact on condom use in an urban Kenya setting or in the South Africa setting (Floyd et al., 2022). The Programme attributed the lack of impact in urban Kenya to poverty in the informal settlements of Kenya and increased socialising which makes it difficult to avoid risky sexual behaviour. In South Africa, the Programme attributed the lack of impact to a discontinuation of the Programme in the South African study site before the Programme had time to embed due to a decision by PEPFAR that this was not a high-priority site. The evaluation team urged the integration of condom promotion activities with SRH services going forward.

The HIV investment case for South Africa in 2021 modelled the impact of various interventions to avert HIV infections and found that improving condom distribution among young people by providing condoms specifically branded for youth and reducing condom wastage to 1 or 2 condoms distributed per 1 condom used, was the most cost-effective intervention, and more cost effective than oral PrEP and similarly cost effective as injectable PrEP (Desmond Tutu Health Foundation, 2023). This highlights the importance of continuing to find ways to increase condom coverage and acceptability among young people.

Additionally, the emerging issue of reduced motivation to use condoms with increased uptake of PrEP is a growing concern in HIV prevention programme which requires careful monitoring. Reduced condom use could increase the prevalence of STIs among AYP in South Africa in turn increasing AGYW's risk of HIV infection despite the protective effect of PrEP for those taking PrEP. Thus, programmes need to encourage condom use among all PrEP users whilst also increasing STI testing and treatment. Future studies should explore the relationship between condoms and PrEP use.

Interventions which have shown to improve motivation and effective use of male condoms include those that teach communication and negotiation skills and economic strengthening interventions to improve women's agency and reduce financial dependence in sexual relationships (Aventin et al., 2021; Krishnaratne et al., 2016). Gender-transformation interventions should also be considered to combat unequal power dynamics in sexual relationships. The inclusion of adolescent boys and young men in these educational and social norms interventions is essential. Interventions to improve access to condoms should focus on reducing the impact of social barriers to access.

Intervention effect on HIV care coverage

While increasing access to HIV treatment for adolescents and young people living with HIV was one of the goals of the My Journey Programme, it was not the main focus of the Programme during the most recent grant cycle. The HIV care coverage cascades produced from the HERStory 3 study show that the My Journey Programme did not increase the proportion of AGYW living with HIV who were diagnosed (i.e., self-reported that they had knowledge of their HIV positive status), DBS-confirmed on ART, and were virally suppressed, when compared with AGYW in the comparison areas. Among participants in both age groups who had a DBS-confirmed HIV positive status, there were no statistically significant differences between arms in self-reporting knowledge of HIV status, being currently on ART or viral suppression (<1000 copies /ml). It is interesting that the prevalence of self-reported knowledge of an HIV positive status was relatively low in both arms compared to the proportion of participants who were DBS-confirmed on ART, and very much lower than the estimates this study produced among all participants on knowledge of HIV status. This might reflect a reluctance among AGYW living with HIV to disclose their status, even in a confidential survey. For example, when we asked all participants whether they were living with HIV, among participants who had DBS-confirmed HIV positive status, 52 reported that they did not know their HIV status and 72 reported that they preferred not to answer. When we asked all participants what their last HIV test results were, 8 reported they were not sure, 8 reported they did not get their test results, and 41 said they preferred not to answer.

Some HERStory 3 participants self-reported living with HIV, but their DBS-confirmed HIV status was negative. Of the 4431 participants who were DBS-confirmed HIV negative, 106 reported in the survey that they were living with HIV. These AGYW might have assumed they were living with HIV because they had a current or past sexual partner who was living with HIV, or because their mother was living with HIV or had died of HIV. Furthermore, some of the 106 participants might have been mistakenly given an HIV positive diagnosis by a health worker (although this is likely to be a very rare occurrence), or they might have mistakenly answered that they were living with HIV. Of the 106 participants who falsely believed they were living with HIV, 20 reported that they had a current partner who was HIV positive. We have no further information from the survey to assist us in understanding why these participants might have believed they were living with HIV.

In both age groups and study arms, the proportion of participants who were DBS-confirmed on ART was lower than the proportion of participants who were virally suppressed. There are several potential reasons for this result. Firstly, this could be because some of the participants who reported that they knew they were living with HIV, were actually DBS-confirmed HIV-negative as mentioned above. These participants are unlikely to have been taking ART if they did not have a

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confirmed HIV positive status, only suspected that they were living with HIV or mistakenly answered that they were living with HIV. Secondly, this could be because some participants were virally suppressed without HIV treatment, although this is very rare. Lastly, participants would only be DBS-confirmed on ART if they had taken their HIV treatment approximately two to three days before the survey, although the half-life of the specific drug differs. For example, Efavirenz has a longer half-life compared to some other antiretrovirals, which might allow it to be detected for a slightly longer period (also dependent on genetics), while Tenofovir has a shorter half-life than some other antiretrovirals, which means it might be detected for a shorter duration. Thus, depending on the drug combination that the participant was on and their adherence to the drug, they might be more or less likely to be DBS-confirmed on ART. Nevertheless, as HIV treatment is meant to be taken on a daily basis, participants should have been DBS-confirmed on ART if they were taking their medication as they are supposed to.

The lack of an intervention effect on HIV treatment cascades is confirmed by other findings of the HERStory 3 Study. Among participants who self-reported in the survey that they were living with HIV, there were no significant differences between study arms in self-reports of the receipt of HIV treatment and care interventions except that participants in the intervention arm were significantly less likely to report having had three or more viral load tests in the past year, compared with the comparison arm. The results of the pre- post-intervention substudy showed no statistically significant difference in viral suppression over time, although it showed that viral suppression decreased over time in three of the six intervention subdistricts.

The HIV care cascades, and other HERStory 3 measures related to ART treatment provide reliable estimates showing that the My Journey Programme did not impact HIV care coverage among participants who had a DBS-confirmed HIV positive status. This is despite the fact that this study shows that the Programme increased knowledge of HIV status to a high level in the intervention areas. HIV testing, diagnosis and knowledge of HIV status are critical prerequisites to ensuring people living with HIV can access treatment and care. It is possible that the intervention effect on knowledge of HIV status was not large enough to have an impact on HIV care coverage for those living with HIV, and/or the Programme did not sufficiently decrease barriers to HIV care other than diagnosis.

It is of concern that under 75% of participants in both arms were virally suppressed, demonstrating the need to reach AGYW living with HIV and offer HIV testing and referral to treatment services, including services to promote adherence to ART. The 2022 SABSSM national survey found that among females aged 15-24 years, viral suppression was 68.2% (95% CI: 59.9%–75.5%) (https://hsrc.ac.za/special-projects/sabssm-survey-series/sabssmvi-media-pack-november-2023/). The HERStory 3 study 2024 estimate of viral suppression among AGYW does

not differ much from the 2022 national estimate. However, it should be noted that unlike the SABSSM national survey, the HERStory study only recruited participants from communities where AGYW were most vulnerable to HIV and poverty, and thus they were possibly less likely to be covered by HIV treatment and care in 2022 compared with AGYW from nationally sampled communities. Therefore, it is difficult to make conclusions about the relative effectiveness of HIV care coverage across surveys from the SABSSM and HERStory estimates.

An evaluation of the PopART combination HIV intervention which aimed to reach all people living with HIV and link them to treatment, found that after four years of intervention, the biggest gap in coverage of ART was among women aged 15-24 years compared with women who were older (Floyd et al., 2020). There were also gaps among young men compared with older men. The difficulty of reaching the most vulnerable people such as AGYW with undiagnosed HIV infection, linking them to care and enabling them to become virally suppressed has been widely acknowledged, leading to calls to engage experts from a wide range of relevant disciplines to understand the gaps and tailor interventions to reach these people (Brault et al., 2020; Brault et al., 2019).

Three large-scale evaluations of community-based HIV testing and linkage to care interventions implemented in southern Africa have now shown that even in the context of community-based HIV testing and linkage to care, repeat referrals through phone calls and home visits were important strategies to increase linkage to HIV care after a first home-based referral (Barnabas et al., 2016; Plazy et al., 2023; Ruzagira et al., 2017). Furthermore, interventions might need to address barriers to linkage to care, such as disbelief of test results, stigma and unwillingness to disclose, family responsibilities, logistic and financial constraints to accessing care, lack of social support, and negative experiences with health workers (Naik et al., 2018). The participants in the HERStory 3 study who self-reported living with HIV gave various reasons for not taking ART (such as feeling healthy), for missing ARV appointments (such as not wanting to be seen at an ART service or ART services being far away), for missing doses (such as forgetting or worrying that someone would find out about their status). Other research among adolescents and young people in South Africa identified these and other barriers to HIV treatment: stigmatizing social norms lead to concerns about being identified as living with HIV, challenges coping with an HIV diagnosis, anticipated stigma in the health facility, concerns about confidentiality in the health facility, school absences and inflexible clinic scheduling, and fears that health workers will lack sensitivity and compassion (Nardell et al., 2021; Ritchwood et al., 2020). Furthermore, IPV has been associated with a higher risk of unsuppressed viral load among AGYW (Gibbs et al., 2022).

A review of interventions to improve the adolescent HIV care continuum in South Africa found that promising interventions are in-home HIV testing and self-testing to increase diagnosis, and

economic support and food support to increase ART adherence (Zanoni et al., 2022).

A review of implementation science strategies to improve the HIV care cascade for adolescents and young people in sub-Saharan Africa recommended greater youth engagement in the development of strategies (Vorkoper et al., 2023). It has been recommended that people living with HIV should not only be treated as the end users of HIV interventions, but rather they should be positioned as main actors, experts and decision-makers in implementation strategies to improve HIV care cascade outcomes (HIV/AIDS., 2004; Lujintanon et al., 2024). Insights from the implementation of DREAMS, another large combination HIV prevention programme, included that the absence of DREAMS programmes to build capacity for local youth leadership was a lost opportunity (Chimbindi et al., 2020). In most published implementation strategies of known-effective interventions to improve the HIV care cascade among people of all ages in low- and middle-income countries, health service providers and other health work force were the strategy implementers, leading to a recommendation that it is also important to change the governance, financial arrangements and implementation processes (Lujintanon et al., 2024).

Using modern contraceptives other than condoms among participants who had ever had sex

The HERStory 3 evaluation produced evidence to suggest that the My Journey Programme probably only had a small impact on the coverage of contraception. This NRCCT found no intervention effect on use of modern contraception other than condoms among participants who had ever had sex in the total sample or within the different age groups. This is despite that the My Journey Programme included pregnancy testing and provision of contraception, including within Safe Spaces, integrating pregnancy testing into community-based HIV testing initiatives and offering contraception to those who tested negative. The finding of an absence of an intervention effect is reinforced by the pregnancy prevention cascades, which show that there were no significant differences in motivation to use, access to, use, and effective use of pregnancy prevention interventions by study arm. Of all the variables assessing use of modern contraceptives, we only found one in which there was a favourable intervention effect: among participants in all age groups who had sex in the past six months, those in the intervention arm were more likely to report having effectively used modern contraceptives compared with the comparison arm.

This study shows that the intervention only increased some (but not all) of the potential facilitators and reduced some (but not all) the potential barriers to motivation, access, and effective use of contraception. Participants in the intervention arm were significantly less likely to report that it was far to travel to get contraception, were significantly less likely to report that the negative attitude of health workers made it difficult for them to get contraception and were

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significantly less likely to report that their sexual partners did not want them to use family planning, suggesting a positive intervention effect on potential barriers. However, participants in the intervention arm were also significantly more likely to report that they did not want their family to know they were accessing contraception (overall and in the younger group) and were significantly more likely to report that their partners did not want them to go to get contraceptives (older age group). These findings are somewhat contradictory, with three significant NRCCT impacts on potential facilitators or barriers favouring the intervention arm and two favouring the comparison arm, suggesting that the My Journey Programme did not have a reliable impact on making it easier for AGYW to access and use contraception effectively.

In the pre-post substudy, there was slight increase in contraceptive use at last sex overall (35.9% in 2018/19 vs 41.3% in 2024) but this increase was not statistically significant. Three of the six subdistricts had positive improvements in contraceptive use at last sex, with Mbombela having the highest increase of more than double from the baseline of 24.8% in 2018/19 to 57.9% in 2024, while three subdistricts had a decrease in contraceptive use at last sex. The pre- post-intervention substudy suggests a substantial and statistically significant intervention impact over time on contraception use among AGYW aged 20-24 years, from 39.5% in 2018/19 to 60.2% in 2024, but no difference between arms among adolescent AGYW. This suggests that programmes for adolescents continue to need strengthening to improve their accessibility and uptake.

An evaluation of the DREAMS programme also found low uptake of contraception among AGYW and that strengthening adolescent and youth-friendly SRH services provision did not translate to uptake of SRH services (Chimbindi et al., 2020; Gourlay et al., 2019).

The systematic review of combination interventions like the My Journey Programme reported low or no intervention impact on contraceptive uptake (Rogers et al., 2024). Of the 13 studies evaluating the intervention impact on SRH outcomes, eight found an increase in contraceptive knowledge, and only one reported an increase on contraceptive use (Rogers et al., 2024). The factors attributed to this are well-documented yet continue to persist suggesting that a different strategy to improve uptake of contraceptives is needed. AGYW fear being seen at health facility for contraceptives, are overwhelmed with myths and misconception about contraceptives, lack parental and partner support for the use of contraceptives, and fear the negative attitudes of health providers (Chimbindi et al., 2020; Jonas et al., 2020; Rogers et al., 2024).

There is a need to increase demand creation for contraceptive use among AGYW to improve the uptake and prevent unintended pregnancies among them. In the DREAMS evaluation, it was suggested that peer outreach programme may have contributed to the increase demand for services and promoted innovations to overcome barriers to uptake of contraceptives (Chimbindi et al., 2020). A recent systematic review of evidence on what works in counselling strategies for

modern contraceptive methods found mixed outcomes of contraceptive uptake among women of all ages (Cavallaro et al., 2020). Of the nine studies that evaluated counselling strategies to improve contraceptive continuation among women of all ages, four studies had a positive impact on contraceptive uptake - two studies positively influenced continuation following detailed counselling on side effects, one halved discontinuation after addressing IUD-related beliefs, and one had higher continuation rates after counselling women with husbands (Cavallaro et al., 2020). The review findings on the pre-post studies focusing on contraceptive counselling for all women attending health facilities for other services found evidence of increased contraceptive use post intervention (Cavallaro et al., 2020).

The HERStory 3 evaluation found that among participants who had ever had sex, under a quarter of participants in both arms reported that at last sex they used both condoms and another contraceptive method, and under 15% of participants in both arms reported that they had used a contraceptive method 100% of the time. These findings show the importance of continuing to promote access to and effective use of contraceptives including dual protection among AGYW. The systematic review of evidence on what works in counselling strategies for modern contraceptive methods found that detailed counselling on side effects for people initiating new methods may improve continuation, and that additional counselling sessions in pregnancy or postpartum may increase postpartum contraceptive uptake (Cavallaro et al., 2020). However, the systematic review identified that there is a need to develop and evaluate novel interventions to promote contraceptive use (Cavallaro et al., 2020). Donor-funded programmes such as the My Journey Programme are ideally placed to take up this challenge.

My Journey Programme reach

One of the factors that determines the effectiveness of programmes such as My Journey Programme is the extent to which they are accessed by the target population (Gourlay et al., 2019). AGYW in intervention communities need to be aware of, able and willing to access the Programme, and the HERStory 3 study provides evidence that this was true, despite a range of levels of uptake across districts, and considering how difficult it was for the interventions to be identified in the questionnaire. The My Journey Programme as a brand is not well known by AGYW in the intervention subdistricts, based on the findings of the qualitative interviews which showed for example that participants more often knew the name of the service provider or SR instead. In the quantitative evaluation in the sections assessing reach and acceptability of the My Journey Programme, we attempted to overcome any potential lack of awareness of the My Journey brand by including questions that were specific, for example which mentioned the names of SRs who worked in each community or described different components of the Programme. Assuming the validity of the survey questions, the survey results show that the My Journey

Programme reached a large proportion of participants in the targeted sites in the intervention subdistricts. For example, between 20.5% and 72.5% of participants across subdistricts reported that they had been invited to participate in the Programme, and between 20.0% and 59.7% across subdistricts reported that they had been enrolled in the Programme. The most common places in which participants reported being enrolled were schools and homes, which aligns with the modus operandi of the My Journey Programme implementation, lending further credibility to the results related to the Programme exposure. Most participants reported that they had been enrolled in the Programme during 2024, however a substantial minority of participants had been enrolled in the preceding eight years. Among participants who had been enrolled in the My Journey Programme, between 53.7% and 79.4% of participants reported that they had done a risk assessment as part of the My Journey Programme. These findings show that the reach of the Programme in intervention communities was substantial, especially considering these are likely to be underestimates of the reach of the Programme, given that the branding of the Programme is not well-known. Programmes such as My Journey aim to reach the most vulnerable AGYW, and future analyses could assess the extent to which those who participated represented AGYW at greater risk of HIV, or at greater risk of non-viral suppression among those living with HIV.

Safe Spaces

We asked participants in both arms about their knowledge about and utilisation of Safe Spaces in their community. Almost half of the participants in the intervention arm reported having spent time at a Safe Space in her community in the past year, which demonstrates a substantial My Journey Programme reach. Participants in the intervention arm were more likely than those in the comparison arm to report knowledge of a Safe Space in their community but when asked if they had ever spent time at a Safe Space in their community, similar proportions of participants in each arm reported that they had done so. That so many participants in the comparison arm (between 40% and 50%) reported knowing of a safe space in their community for young women like her to hang out and receive support and having spent time at the safe space suggests that they were probably not referring to a place that was like the My Journey concept of Safe Spaces. This is also reinforced by the finding that compared with the intervention arm fewer participants in the comparison arm had received HIV testing, PrEP, and condoms from the Safe Space. In the intervention arm, the most common service or activity participants reported was HIV testing, with just over half of those who had spent time at a Safe Space in the past year reporting they had received an HIV test. Among participants who had spent time at a Safe Space in the year before the survey, most participants felt that the space was comfortable to be at, and the majority reported they were satisfied or very satisfied with the services they had received there (81.3% in the intervention arm and 74.7% in the comparison arm).

We asked participants in both arms about their receipt of a variety of biomedical, behavioural, and structural services from any service provider, to assess whether coverage of these was higher among AGYW in intervention communities, and to assess the multiple categories of interventions accessed by individual AGYW. We used a question that was formatted in a way that might have undermined the validity of the response to these questions, using a long list of multi-select response options, and this undermined our ability to describe uptake of multiple categories of interventions. It also undermined our ability to compare the reach of individual interventions, such as those related to TB detection and treatment, or interventions to promote schooling. This question generated results the validity of which need to be questioned. For example, while those in the comparison arm reported higher receipt of past year contraception in the multi-select formatted questions, there was no difference between arms in the pregnancy prevention cascades which were generated from several other questions in the survey, and there was no indication in any of the responses to several other questions about contraception that the comparison arm had better coverage than the intervention arm. While participants in the comparison arm reported higher receipt (ever) of HIV viral load or CD4 testing and a greater level of participation in adherence clubs in the multi-select formatted questions, there was no significant difference between arms in the HIV care cascade which was generated from other questions in the survey. Similarly, while participants in the intervention arm reported higher receipt of interventions to encourage them to stay in school in the multi-select formatted questions, there was no statistically significant difference between arms in the proportion of adolescent participants who had dropped out of school before completing Grade 12, and dropout was higher in the comparison arm. Unfortunately, we did not include multiple different questions about interventions to detect and treat TB, or parenting interventions and therefore we were not able to assess the validity of participants' responses about these interventions in the multi-select formatted questions.

Evaluations of another large South African combination HIV prevention programme found similar levels of participation to those reported in the HERStory 3 study. During 2017 and 2018, it was estimated that from 15.6% to 40.7% (varying across age group) of a representative population-based cohort of AGYW in rural KwaZulu-Natal had been invited to and/or received the DREAMS combination HIV prevention programme, after it had been implemented (Mthiyane et al., 2022). In uMkhanyakude, KwaZulu-Natal, uptake of interventions offered as part of the DREAMS showed that beneficiaries accessed multiple categories of the package of interventions, with HIV testing and school-based HIV prevention most taken up by 13–17-year-old AGYW, and HIV testing, expanded contraception mix, and school-based HIV prevention most taken up by 18–22-year-old AGYW (Gourlay et al., 2019).

Acceptability of the My Journey Programme to AGYW

The acceptability of a health service such as the My Journey Programme is one of the factors that will influence AGYW's motivation to participate and adhere to the interventions, and therefore is one of the underlying concepts influencing the steps of health service coverage cascades. The findings of both the quantitative and qualitative HERStory 3 studies show that the My Journey Programme was highly acceptable to AGYW. In the survey, AGYW reported very high acceptability related to their My Journey Programme participation, with a very large majority (over 78%) reporting "good" or "wonderful" experiences with the Programme and with between 0% and 4.6% across districts reporting bad or very bad experiences. Reports of Programme acceptability and quality from the qualitative interviews were equally high as demonstrated in the complementary process evaluation report, demonstrating that participants highly valued the services they had received from the My Journey Programme including the safe spaces, the HIV testing services, the mobile clinics, the GBV support and self-defence programmes, the teen parenting programme, the homework support programmes, and the psychosocial support services. Participants spoke of the health and psychosocial benefits of participating in the Programme, and that the attitudes of the staff made them feel welcomed and made it easy for them to use the services. However, some participants in the qualitative study expressed disappointment that their initial contact with the My Journey Programme was not followed up by the Programme service providers with the offer of other services, and this might explain why some survey participants rated the acceptability of the Programme as poor.

Quality of care of contraception, HIV testing, PrEP, and HIV treatment services among My Journey Programme beneficiaries

Participants who had ever received contraceptives from the My Journey Programme were asked about their reports of the quality of care at their last visit for contraception. Their reports indicated that most participants had received good quality service, with three quarters waiting no longer than one hour, and most reporting that the health worker had checked whether they were happy with the method they had been using and had asked them what method they would like most. It is of some concern that over 40% of reported that they had been steered towards a specific method by the health worker, however, this concern is allayed somewhat when noting that over 80% reported that they had received the method of their own choice and over 70% reported that they had felt involved in the decisions regarding method choice (they had expressed their opinion and preference and had been listened to and heard). Most importantly 84% of participants believed the information they had shared would be kept confidential. Ensuring a confidential service is an especially important standard to uphold for adolescents who might fear that their family or others in the community will find out that they are seeking the

service. An expert think tank has defined the key principles in contraceptive counselling as being based on "coercion-free and informed choice; neutral, understandable and evidence-based information; collaborative and confidential decision-making process; ensuring respectful care, dignity, and choice" (Ali & Tran, 2022). The findings of this study suggest that most My Journey beneficiaries received contraceptives services that met this definition.

The large majority of participants who had received HIV testing services from the My Journey Programme rated the quality of care at their last HIV test as of high quality, with around 90% reporting waiting no longer than an hour, being treated in a friendly and respectful manner by the person who tested her and receiving clear health information. Over 80% believed that their test and other information that she shared would be kept confidential and reported that everyone else at the testing service treated her in a friendly way.

Participants who reported receiving PrEP services from the My Journey Programme rated the quality of care at their last PrEP service visit as high. Over 80% of participants waited no longer than one hour, approximately 90% reported that the health worker who dispensed PrEP was friendly and respectful, and over 80% reported that the other clinic staff were friendly and respectful. Most (but not all) participants reported that the health worker discussed with them sexual relationships and sexual behaviour, the AGYW's concerns, side effects, adherence, STI symptoms and contraception. According to the South African guidelines for the provision of PrEP, these aspects are important components of a high-quality PrEP consultation (South African National Department of Health, 2020). Assuming AGYW's had a perfect memory of their last PrEP consultation, their responses indicate that there is room to ensure that a greater proportion of consultations take a comprehensive focus, covering all these topics. The finding that 16.5% of participants felt judged by the health worker who gave them PrEP indicates that the Programme implementers could consider ways to actively and explicitly counter this feeling during consultations with young people.

Participants who reported receiving HIV treatment from the My Journey Programme rated the quality of care at their last visit as high. Over 80% or more reported that the health worker treated them in a friendly, respectful way and that the health worker asked the participants about her main concerns. Nearly 80% reported that other clinic staff also treated them respectfully and in a friendly way. Assuming AGYW's had a perfect memory of their last HIV treatment consultation, their responses indicate that there is room to ensure that a greater proportion of consultations take a more comprehensive focus, covering all the topics recommended by the World Health Organization including adherence, side effects, how viral load affects HIV transmission to partners, pregnancy intentions and contraception (WHO, 2004). Only 54% of participants reported that the health worker talked about ARVs in a non-judgmental way, again indicating

that implementers could consider ways to actively and explicitly counter this feeling during consultations with young people.

Intervention impact on wellbeing

Wellbeing refers to a sense of thriving in multiple domains of life (Adler & Seligman, 2016; Govindasamy et al., 2020). Over 65% of participants in both the intervention and comparison arms were flourishing, as determined by the wellbeing scale we used in this study. However, just over 12% of participants in both the intervention and comparison arms were languishing. In the HIV policy evaluation field, there is now increased recognition of the importance of going beyond narrow disease measures in the HIV care and prevention cascades and examining the impact of multi-sectoral programmes on people's quality of life using measures such as wellbeing (Greeff et al., 2010; Lazarus et al., 2016; Reis et al., 2013). Given that the My Journey Programme focuses on multiple key dimensions of young people's wellbeing (for example, improving access to support and social protection services, promoting positive coping and self-worth), it is important to evaluate the Programme's impact on AGYW's wellbeing, and to assess whether coverage of health interventions is associated with improved wellbeing. Although we did not detect a difference in wellbeing across the study arms, it is possible that participants who reported being enrolled in and receiving services from the My Journey Programme might report higher levels of wellbeing than those who did not enrol and receive these services, and this question could be investigated in further analyses.

Strengths and limitations

We believe this study provides a reliable picture of HIV prevalence among AGYW in the subdistricts of the My Journey Programme where the intervention was implemented as well as a reliable picture of the coverage of HIV prevention and treatment interventions. We specifically targeted the sub-areas within each intervention area indicated to us by the Programme implementers to optimise coverage to ensure we were able to capture a sufficient proportion of AGYW who had been adequately exposed to the intervention. For each intervention subdistrict, we identified similar comparison subdistrict in the same district without a large donor-funded intervention, or if this was not possible, we selected comparison subdistricts outside of these metros in subdistricts that were similar, especially in terms of HIV prevalence using the 2017 antenatal surveys. The comparison subdistricts are therefore more generalised which adds validity to the comparisons we performed.

Features of the NRCCT study design follows the recommendations of the NICE real-world evidence framework (Health & Excellence, 2022), such as: a) The NRCCT design prevented exposure misclassification because we knew which sites were intervention and comparison sites. b) The objective and quality controlled biological measure used for HIV status as well as extensive

fieldworker training prevented outcome misclassification. c) We explored results within different age subgroups and exposure groups. d) We controlled for confounding by adjusting for known risk factors for HIV, identified during the HERStory 1 baseline survey. e) There was limited missing data due to the high inclusion rate of AGYW within households and proportion of survey participants with good quality biological samples. Thus, the missing component was very small and similar between study arms. f) Finally, models were prespecified in the statistical analysis plan based on the NRCCT design. Clusters were weighted equally and the intention-to treat principle was applied.

We had assumed that in the comparison arm, 12% of participants would test HIV positive, based on the HERStory baseline survey (https://www.samrc.ac.za/intramural-research-units/HealthSystems-HERStory). The study was powered to show a 6% difference in HIV prevalence overall: 12% in the comparison arm and 6% in the intervention arm. Because we observed a much smaller difference between arms and the study was not powered to detect such small effects.

A substantial strength of this study is that the realised sample represents the actual population of AGYW living in the selected study sites and is not biased by non-participation: our response rate among AGYW was extremely high. We believe that this was a result of the data collection service provider's extensive experience in surveys of this kind and their highly experienced fieldwork teams.

Conclusions

To alleviate the HIV burden among AGYW, since 2016 the Global Fund to Fight AIDS, TB and Malaria has been investing in a South African combination HIV prevention intervention, the My Journey Programme. The HERStory 3 study was a non-randomised controlled trial (NRCCT) evaluating the impact of this combination HIV prevention intervention. The primary evaluation objective was to determine the impact of the My Journey Programme on HIV prevention among AGYW aged 15-24 years living in the implementation subdistricts of the Programme compared to subdistricts where the Programme, or other similar programmes, have not been implemented with HIV prevalence the primary indicator.

 The HERStory 3 evaluation produced evidence that the My Journey Programme made a small NRCCT impact on reducing HIV prevalence. HIV prevalence was 9.5% in the intervention arm and 10.4% in the comparison arm with a risk difference of 0.9%, after adjusting for imbalances across study arms in age, socio-economic status, education enrolment, sexual debut, and maternal orphanhood. This intervention effect was not statistically significant because the evaluation did not have the statistical power to detect an impact of this magnitude. The results of the pre- post-

intervention substudy are aligned with those of the NRCCT, showing small decreases over time in HIV prevalence (absolute declines from between 1.0% to 5.2%) in five of the six intervention subdistricts. The sixth subdistrict was an outlier, showing a large increase in HIV prevalence from 16.6% in 2017/8 to 34.8% in 2024, which had a substantial effect on the overall measure of intervention impact.

 The results of the evaluation provide evidence to suggest that the My Journey Programme had a statistically significant impact on increasing knowledge of HIV status, with 84.7% of AGYW in the intervention arm and 80.5% in the comparison arm knowing their HIV status. Aligned with this, AGYW's reports of HIV testing ever, in the past year, in the past six months and HIV self-testing ever were higher in the intervention arm compared with the comparison arm. Furthermore, the results of the nested pre- post-intervention study also show that there was a statistically significant increase in HIV testing over time in six of the intervention subdistricts. Together, these findings provide reliable evidence of an intervention effect on the uptake of HIV testing and knowledge of HIV status. Thus, the My Journey Programme created the conditions for a greater number of AGYW with knowledge of their HIV status to be referred for HIV prevention or HIV treatment interventions as appropriate.

The HERStory 3 study produced strong evidence that the My Journey Programme substantially increased the coverage of PrEP among AGYW who were not living with HIV, doubling the uptake of PrEP compared with the comparison arm. The HIV prevention cascades for PrEP show substantial and statistically significant differences in favour of the intervention arm in knowing what PrEP is, ever having been offered PrEP, and ever having used PrEP. Furthermore, social norms supporting PrEP, receiving instruction or counselling about PrEP and confidence about using PrEP were significantly more prevalent in the intervention arm compared with the comparison arm. The results of the nested pre- post-intervention study also show that there was a statistically significant and substantial increase in reports of ever having used PrEP over time in six of the intervention subdistricts.

To our knowledge, this is the first demonstration of the effect of a combination HIV prevention programme on PrEP coverage at a community level. Furthermore, the observed and expected difference in prevalence of positive TFV-DP levels in the participants' DBS samples from the two self-reported PrEP usage strata validates the reliability of the self-reported PrEP data by AGYW in the HIV prevention cascade. Until long-acting injectable formulations of PrEP are available at affordable prices, these findings suggest that the My Journey Programme needs to explore more effective strategies to promote continuation on PrEP.

The literature shows that AGYW who attend school more often and/or have higher grade attainment are at a lower risk of incident HIV and have a lower risk of sexual behaviours linked

to HIV transmission. This study produced evidence to suggest that the My Journey Programme had a small NRCCT impact on preventing school dropout among adolescents. In the intervention arm 10.7% of adolescent participants dropped out of school before they completed Grade 12 compared with 12.7% in the comparison arm. This difference was not statistically significant because the study was only powered to detect a much larger absolute difference of 5%. The pre-post-intervention substudy compared completion of Grade 12 among participants aged 20-24 years and found no significant difference over time from 2017/8 to 2024. This could suggest that the My Journey Programme has only begun to reduce school dropout in the more recent years, only affecting the younger AGYW participants.

The HERStory 3 evaluation produced no evidence to suggest that the My Journey Programme impacted HIV care coverage. There are substantial gaps in the HIV care cascades in the first bar, knowledge of HIV status, and second bar, DBS-confirmed on ART. This possibly suggests that the My Journey Programme's HIV testing initiatives, despite reaching a large proportion of AGYW in the intervention communities, are not adequately reaching AGYW living with HIV. However, it is also possible that AGYW were reluctant to disclose in the survey that they were living with HIV, reflected in the finding that more participants were DBS-confirmed on ART than self-reported knowing their HIV status. It is of concern that under 75% of AGYW in both arms were virally suppressed. The results of the pre- post-intervention substudy showed that viral suppression decreased over time in three of the six intervention subdistricts. Maintaining an undetectable viral load is of great health benefit to AGYW living with HIV and is one of the most effective options for preventing onward HIV transmission and thus has potential to contribute to the My Journey Programme HIV treatment and prevention goals. These findings can inform My Journey Programme strategies to ensure better HIV care coverage among AGYW living with HIV.

The evaluation produced no evidence to show that the My Journey Programme impacted the coverage of condoms. The HIV prevention cascades for male condoms for AGYW who self-reported living with HIV and who self-reported not living with HIV show no intervention impact on motivation to use, access to, and effective use of male condoms. To the contrary, among participants aged 20-24 years, motivation to use condoms was lower among AGYW in the intervention arm compared with the comparison arm. However, the My Journey Programme had a positive intervention impact on some of the perceived access barriers to condoms and AGYW in the intervention arm were more likely to have accessed information and counselling about condoms. Promoting condom use in the context of increasing uptake of PrEP is important because PrEP does not prevent against the acquisition of STIs. Therefore, the My Journey Programme needs to strengthen strategies to increase condom coverage.

The HERStory 3 evaluation produced evidence to suggest that the My Journey Programme

probably only had a small impact on the coverage of contraception. The pregnancy prevention cascades showed that there were no significant differences in motivation to use, access to, use, and effective use of pregnancy prevention interventions by study arm. Of all the variables in the NRCCT assessing use of modern contraceptives, there was only a favourable intervention effect on one: among participants in all age groups who had sex in the past six months, those in the intervention arm were more likely to report having effectively used modern contraceptives compared with the comparison arm. There was evidence to suggest that the My Journey Programme had a positive impact by reducing some (but not all) of the perceived access barriers to contraception. The pre- post-intervention substudy suggested a substantial and statistically significant intervention impact over time on contraception use among AGYW aged 20-24 years, from 39.5% in 2017/8 to 60.2% in 2024, but no difference between arms among adolescent AGYW. The NRCCT fundings show that under a quarter of participants in both arms reported that at last sex they used both condoms and another contraceptive method, and under 15% of participants in both arms reported that they had used a contraceptive method 100% of the time. These findings show the importance of continuing to promote access to and effective use of contraceptives including dual protection among AGYW.

The HERStory 3 NRCCT evaluation findings on HIV prevalence, knowledge of HIV status, coverage of PrEP interventions, and school dropout demonstrate that the My Journey Programme is partially successfully meeting key HIV prevention goals and making progress towards preventing HIV among AGYW in South Africa. This study provides valuable evidence which can inform the My Journey Programme implementers' strategy to tailor their interventions to accomplish all their HIV prevention and care and pregnancy prevention goals and to ensure higher levels of coverage among AGYW in South Africa.

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