EVALUATION OF A SOUTH AFRICAN COMBINATION HIV PREVENTION INTERVENTION FOR ADOLESCENT GIRLS AND YOUNG WOMEN

QUALITATIVE STUDY COMPONENT
FINAL REPORT
AUGUST 2020
An evaluation of a South African combination HIV prevention intervention for adolescent girls and young women (AGYW)

Qualitative Study Component

Final Report
August 2020

Health Systems Research Unit
South African Medical Research Council (SAMRC)

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Conflict of Interest

The authors of this study have no potential conflicts of interest in the subject matter discussed in this report.

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Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
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# Acronyms / Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AGYW</td>
<td>Adolescent Girls and Young Women</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<tr>
<td>DBE</td>
<td>Department of Basic Education</td>
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<tr>
<td>DoH</td>
<td>Department of Health</td>
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<tr>
<td>EC</td>
<td>Eastern Cape</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>GBV</td>
<td>Gender-based Violence</td>
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<tr>
<td>GF</td>
<td>Global Fund</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IDI</td>
<td>In-depth Interview</td>
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<tr>
<td>KGIS</td>
<td>Keeping Girls in School</td>
</tr>
<tr>
<td>KI</td>
<td>Kheth’Impilo</td>
</tr>
<tr>
<td>KZN</td>
<td>KwaZulu Natal</td>
</tr>
<tr>
<td>MPU</td>
<td>Mpumalanga</td>
</tr>
<tr>
<td>NACOSA</td>
<td>Networking HIV/AIDS Community of South Africa</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
</tr>
<tr>
<td>OPEC</td>
<td>Operational Performance Excellence and Co-ordination</td>
</tr>
<tr>
<td>PLWH</td>
<td>People Living With HIV</td>
</tr>
<tr>
<td>PR</td>
<td>Principal Recipient</td>
</tr>
<tr>
<td>RYWC</td>
<td>Rise Young Women’s Clubs</td>
</tr>
<tr>
<td>SAMRC</td>
<td>South African Medical Research Council</td>
</tr>
<tr>
<td>SBC</td>
<td>Soul Buddyz Clubs</td>
</tr>
<tr>
<td>SCI</td>
<td>Soul City Institute</td>
</tr>
<tr>
<td>SIDI</td>
<td>Serial In-depth Interview</td>
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<tr>
<td>SR</td>
<td>Sub-Recipient</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>WC</td>
<td>Western Cape</td>
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<tr>
<td>WCDoH</td>
<td>Western Cape Department of Health</td>
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Executive Summary

The Global Fund invested in a South African combination HIV prevention intervention for AGYW aged 10 to 24 years in ten priority districts in South Africa. The intervention was an intensive, comprehensive HIV prevention intervention that aims to use a combination prevention approach to reduce new HIV infections amongst AGYW. The HERStory Study, is an evaluation of the South African combination HIV-prevention intervention for Adolescent girls and young women (AGYW) conducted by the South African Medical Research Council (SAMRC) and partners. The primary objective of the HERStory Study was to determine the intervention impact on HIV incidence over a two-year period. Secondary objectives include assessing the intervention impact on the prevention of HIV risk behaviour and other sexually transmitted infections (STIs) and on the cognitions, behaviour, and social environments of AGYW.

The qualitative component of the HERStory study explored the lives, experiences and social contexts of adolescent girls and young women (AGYW) between the ages of 15 and 24 years, in relation to their sexual and reproductive health (SRH) and education. In addition, the qualitative component examined the impact of a South African combination HIV intervention on the cognitions, behaviour, and social environments of AGYW, perceived enablers and constraints of the intervention, as well as the perceptions of its impact. Qualitative methods complemented a larger quantitative evaluation by providing in-depth insight into perceived successes and failures of the intervention package components on target outcomes, the facilitators and barriers to uptake of the different intervention components, and perceptions of the way in which the intervention affected the lives of AGYW, and the communities in which they live. The narratives of AGYW described in the HERStory qualitative evaluation provide insight into aspects of the social environment that influence decision-making around sexuality, condom and contraceptive use, and other sexual and reproductive health issues, as well as school attendance and completion, amongst AGYW in South Africa, and can help to inform the design of future interventions.

The qualitative study sample included AGYW recipients of the intervention, as well as AGYW in the intervention communities who were not engaged in intervention activities. In addition, the sample included other key informants such as parents/caregivers, male peers, teachers, club facilitators, and community leaders in the intervention communities. A sample of programme implementers were also interviewed about implementation challenges and successes.

Key findings presented in this report have been arranged into two main thematic areas: 1) Understanding the context of AGYW SRH and lives; 2) Impact of the Intervention.

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1 For more information on the HERStory quantitative study, survey findings are available in a separate report, visit: [https://www.samrc.ac.za/intramural-research-units/HealthSystems-HERStory](https://www.samrc.ac.za/intramural-research-units/HealthSystems-HERStory)
Findings theme 1)  
The context of AGYW sexual and reproductive health, and lives

Emerging in our analysis was the intersection between mental health and sexual and reproductive health. In the narratives of study respondents, experiences of stress, anxiety, and feelings of not being able to cope, were associated with HIV status, unintended pregnancy and early child-bearing, parenting responsibilities, compounded by a lack of emotional support. Suicidal ideation amongst AGYW was linked to feelings of not being able to cope with circumstances such as unintended pregnancy, HIV diagnosis, or a lack of social support.

Examining AGYW sexual risk behaviours, this study found that motivations for engaging in transactional sex and transactional relationships could be categorised as 1) “needs”, poverty related factors including food insecurity and education costs, and 2) “wants”, related to desire for glamour/luxury, social prestige and peer approval. Narratives from male peer respondents confirmed the perceived normalcy of transactional sex and relationships among AGYW in these communities. Respondents associated alcohol use with transactional sex, depicting the accepted norm that a man who buys drinks for AGYW can expect to receive sex in exchange. Respondents suggested that AGYW often engage in multiple concurrent relationships comprising of transactional relationships with older men at the same time as romantic relationships with male peers. Although AGYW narratives included assertions of agency and power in choosing to engage in transactional relationships, they also described power inequities which result in increased likelihood of condomless sex.

This study found substantial barriers to consistent condom use and various motivations for condomless sex, amongst AGYW and their male peers. Motivations for condomless sex described by AGYW included relationship factors such as intimacy, trust, and relationship security. Motivations for condomless sex described by young men related to sexual pleasure, masculinity, power, and prestige. The timing and relationship context of sex determined condom use, with condoms less likely to be used in long-term, committed relationships, for the ‘second round’ of sexual intercourse, or when the female partner is using hormonal contraceptives. These findings describe the current condom use landscape amongst AGYW in South Africa and shed light on the lived experiences of gendered power, relationship dynamics, and notions of masculinity which play a part in condom negotiation and use in young heterosexual South Africans’ sexual encounters today.

This study found that barriers towards HIV testing amongst AGYW and their male peers were complex and multi-level, including intrapersonal/individual, interpersonal, and health service level factors. Fear emerged as a major barrier towards HIV testing in the narratives of young men and AGYW. Interpersonal barriers included fear of reprimand by parents/grandparents for being tested, due to its implications of sexual activity. Concern around HIV-related stigma in the family and community setting, including fear of rejection by family and friends was also cited. Lack of knowledge about where to get tested, alongside fear of health care provider judgemental attitudes were also barriers. Findings show that complex, dualistic, and often contradictory views
towards HIV testing exist in this population, with fear of HIV and the consequences of testing positive existing alongside a lack of concern towards HIV infection based on the availability and accessibility of antiretrovirals (ARVs). These findings can help to address issues relating to barriers towards HIV testing amongst this population and ensure that future interventions and HIV messaging are appropriate.

The findings reveal that many AGYW, especially the younger age group 15-19 years, experienced difficulties in accessing contraception services, mainly at the interpersonal and health service levels. Lack of support for the use of contraceptives from parents/caregivers as well as from sexual partners were key barriers at the interpersonal level; while provider’s negative attitude was the main barrier at the health service level. The majority of school-going AGYW felt that bringing contraception services and other sexual and reproductive health (SRH) services on to the school premises would legitimize their use in the eyes of parents and help to overcome barriers related to parental support and acceptance, as well as overcome some of the health services and structural level barriers. However, views among school-going AGYW about school-based provision of contraception services were mixed, clouded with concerns relating to confidentiality.

In terms of interpersonal relationships, this study found that substantial barriers to sexuality communication existed between South African AGYW and their parents. AGYW felt unable or unwilling to discuss SRH or disclose any of their own SRH concerns or challenges to their mothers/female caregivers.

This report uncovered narratives of mistrust and disconnect between female learners and their teachers. Poor student-teacher relationships and connectedness negatively impacted AGYW educational attainment, mental health and wellbeing, as well as sexual and reproductive health. AGYW desire and need better support from teachers, both academic and psycho-social.

This study found that factors contributing to absenteeism of female high school learners included pregnancy, childcare responsibilities, low socio-economic status, interpersonal barriers, the school climate and education delivery overlapped between affecting school attendance and resulting in school dropout.

**Findings theme 2) Impact of the Intervention**

AGYW perspectives on the impact of the intervention included improvements in SRH knowledge and decision making, positive behaviour change, improved communication skills, increased access to psycho-social support, and improved mental health and well-being. AGYW stated that through participating in intervention components such as Keeping Girls in School, Rise clubs and Teen Parenting components, they learned self-respect, improving self-esteem and self-worth. They expressed enhanced emotional coping strategies and improved communication with parents/caregivers, improvements in sexual and reproductive health knowledge, and increased prioritisation of education over romantic relationships. Young women who had participated in
the intervention also described ways in which their participation had improved their self-esteem and self-worth. There was a sense of young women feeling stronger and more empowered not to give into peer pressure. Additionally, young women described improved mental health and wellness, through learning how to communicate feelings and emotions. According to AGYW, being part of the intervention helped improve their knowledge about contraceptives, which combined with improved self-esteem, enabled them to access contraception services. The combination HIV prevention intervention appeared to have helped AGYW as they reported to have gained knowledge about contraceptives, ability to communicate with parents/caregivers about SRH related topics and increased confidence in accessing contraception services.

Our findings show that community members’ perceptions of the impact of the intervention were generally positive.

Summary of Recommendations

From our findings and analysis came the following recommendations for future interventions for AGYW in South Africa:

<table>
<thead>
<tr>
<th>The issue</th>
<th>Future intervention needs</th>
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<tr>
<td><strong>Sexuality communication gaps</strong></td>
<td>- incorporate meaningful engagement of parents in adolescent SRH</td>
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<td></td>
<td>- create opportunities for communication and collaboration among parents/caregivers</td>
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<td></td>
<td>- increase efficacy of parents/caregivers by providing them with accurate and up to date information</td>
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<tr>
<td>- barriers to open sexual and reproductive health communication</td>
<td></td>
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<tr>
<td>- AGYW lack accurate sources of SRH information</td>
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</tr>
<tr>
<td>- AGYW lack social support network required to make safe and healthy SRH decisions</td>
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</tr>
<tr>
<td><strong>AGYW Mental health and SRH syndemic</strong></td>
<td>- comprehensive HIV prevention programming inclusive of mental health support</td>
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<td></td>
<td>- strengthen integration of routine mental health screening in SRH and HIV programming</td>
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<tr>
<td></td>
<td>- mental health screening and services targeted at AGYW, especially those that are HIV positive and/or pregnant, need to be integrated into SRH services</td>
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<td></td>
<td>- social support provided in small facilitated peer groups may help to protect AGYW from the negative effects of stressors and promote more positive mental health outcomes, and in turn lead to a reduction in sexual risk taking and unintended pregnancies</td>
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<td>- interconnectedness and clustering of psychosocial conditions such as:</td>
<td></td>
</tr>
<tr>
<td>- unintended pregnancies</td>
<td></td>
</tr>
<tr>
<td>- psychosocial distress</td>
<td></td>
</tr>
<tr>
<td>- HIV infection dual burden of psychological distress and sexual risk behaviours</td>
<td></td>
</tr>
<tr>
<td>- mental health screening not standard in HIV prevention and care settings and has not</td>
<td></td>
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</table>
been added to the HIV care cascade

- increase social support for AGYW from family and community members, especially female adult caregivers, may prove effective in improving the mental health of AGYW
- mental health interventions delivered at community and school level to overcome barriers related to accessibility, affordability, stigma and discrimination

**HIV testing barriers**

- suboptimal rates of HIV testing due to barriers at individual, interpersonal and health system levels
  - strategies to increase knowledge that promote and increase demand for HIV testing, including provision of more granular, age, gender and sexual-behaviour specific information on HIV risk, and information on where and how to access testing services and post-test support are care
  - address low risk perception, through provision of thorough counselling around negative HIV tests and sources of potential ongoing HIV-infection risk
  - address various forms of stigma that operate across individual, interpersonal, community and structural levels
  - closer attention to the disaggregation of data by age and gender, efforts to facilitate access to antenatal care and postpartum care services
  - creation of youth-friendly services, home-based, community-based and school-based testing services
  - better integration of HIV testing with reproductive health services including the provision of contraceptives

**Condom use barriers**

- suboptimal condom use amongst AGYW due to individual, interpersonal and socio-cultural level factors
  - engage young men and women in dialogues about gender to critique and deconstruct existing notions of manhood and womanhood, and reinforce positive forms of masculinity that enable more equal power in negotiations over condom use
  - shift focus of improved condom negotiation skills from AGYW to young men, engaging men and boys in programmes which work to foster gender-equitable beliefs, behaviours, and actions, through gender-targeted initiatives that address gender norms and attitudes
  - ‘gender-transformative interventions’ to shift harmful gender norms and roles through integrated community-based programming
  - include communication and negotiation skills training components, in order to empower AGYW to translate their safer-sex intentions into actual behaviour

**Lack of school connectedness**

- AGYW desire and need better academic and psycho-social support from teachers to promote healthy SRH decision making and mental health
  - tailored combination social protection for AGYW, inclusive of teacher support
  - provision of staff training and enhanced staff education and mental health literacy
- school based mental health interventions to include a broad spectrum of prevention, referral, assessment, intervention, and counselling.
- teacher training to foster an understanding of how levels of school connectedness and the school climate can influence learners’ academic achievement, positive peer interactions, social acceptance, and overall emotional well-being

### Transactional sex

- widespread practice and normalisation of AGYW engaging in transactional sex and relationships
- association between engaging in transactional sex and relationships with HIV risk
- encourage AGYW to critically reflect on their own agency and choices in transactional sex and relationships, aspirations for consumer items that symbolise a better life, as motivation for sexual exchange, and norms and beliefs that sustain gender inequality in transactional sex relationships
- young men need to be encouraged to reflect on gendered expectations of male provision for sexual exchange
- ‘Gender transformative interventions’ to critically address shared societal expectations of sex in exchange for material/financial support
- combined with economic empowerment interventions for AGYW to reduce extent to reliance on male providers
- address associated HIV risks of transactional sex, and integrate measures into broader empowerment and health interventions, rather than attempt to intervene on transactional sex alone

### School absenteeism and drop-out

- barriers to school attendance and completion include pregnancy and socio-economic factors
- stricter regulations to allow pregnant AGYW to continue going to school
- programmes to focus on offering support to AGYW who want to return to school after giving birth
- improved monitoring and tracing of pregnant AGYW
- provision of food and sanitary pads

### Barriers to contraceptive access

- barriers to accessing contraception services
- lack of support for use of contraceptives from parents/caregivers as well as from sexual partners, and negative attitudes from health care providers
- AGYW limited knowledge of contraceptives
- improve knowledge among AGYW pertaining to contraception services
- dismantle myths and misconceptions around contraceptives
- comprehensive sexuality education inside and outside classroom
- improve parental/caregiver and sexual partner support for AGYW use of contraception services
- expand provision of contraception services in school
- engage male partners in SRH services
- address community norms and myths around contraceptive use
- highlight impact of pregnancy during adolescence with parents
- address providers’ attitudes, ensuring youth-friendly, responsive and time sensitive services
- prioritization and effective implementation of SRH policies for youth
**Other intervention design and planning recommendations**

- consider socio-ecological system of AGYW and involve different stakeholders including parents and caregivers - who need to be provided with similar SRH learning materials that intervention recipients receive in order to improve the sustainability of the interventions
- include key role players in design and implementation of HIV prevention interventions
- work with parents and communities to inform and prepare for intervention, and to ensure participants are fully informed
- select appropriate incentives
- make childcare options available for intervention participants
- ensure safe transport for after-school activities

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**Introduction**

**The South African context**

Adolescent girls and young women (AGYW) aged 15-24 years comprise 10% of the population in sub-Saharan Africa; however, they accounted for 20% of new HIV infections in 2017 (UNAIDS, 2019). As of 2017, the HIV prevalence rate amongst young people aged 15-24 years in South Africa was 8%, with 11% prevalence amongst females aged 15-24 years, compared to 5% amongst males aged 15-24 years (Simbayi et al., 2019). The disproportionate burden of HIV amongst adolescent girls and young women (AGYW) in South Africa is evident, both in the 15-19 year age group (4.7% amongst males, versus 5.8% amongst females), and even more pronounced in the 20-24 age group (4.8% amongst males versus 15.6% amongst females) (George et al., 2020). Rates of HIV-incidence in South Africa are highest amongst AGYW aged 15-24 years (1.5% compared to 0.5% amongst young males of the same age (George et al., 2020). The disproportionate HIV risk faced by AGYW can be attributed to a number of structural and environmental factors including gender inequality, gender-based violence, and gender norms, which combine to negatively impact the ability of AGYW to protect themselves from HIV and other STIs, prevent unintended pregnancy, seek health services, and make informed decisions about their sexual and reproductive health and lives (UNAIDS, 2019). South Africa has the largest HIV epidemic in the world and a quarter of all new infections occur amongst AGYW aged 15-24 years (UNAIDS, 2019). As with rates of HIV, South Africa also has high rates of teenage pregnancy. In 2016, 9% of women aged 15-17 years and 16% of women aged 15-19 years had begun childbearing (Simbayi et al., 2019). Additionally, many AGYW lack knowledge of and access to SRH services and commodities, which combined with social and economic factors, also contribute to high rates of early and unintended pregnancies (Jonas et al., 2016; STATS SA, 2018).
The Global Fund Programme for Adolescent Girls and Young Women (AGYW)

The Global Fund invested in a South African combination HIV prevention intervention for AGYW aged 10 to 24 years in ten priority districts in South Africa. The intervention was an intensive, comprehensive HIV prevention intervention that aims to use a combination prevention approach to reduce new HIV infections amongst AGYW. The objective of the Global Fund intervention for AGYW was to be one of the programmes that will hopefully contribute to the South African government’s target of reducing HIV incidence among AGYW aged 10 to 24 years by 50 percent over a two-year period.

Figure 1: Specific objectives of the Global Fund supported combination HIV prevention intervention for AGYW implemented 2016-2019

The intervention addressed factors that increase the risk for HIV acquisition among AGYW, and promotes factors that increase their resilience, and was comprised of: (1) access to comprehensive HIV, TB and SRH services and commodities, (2) rights-based SRH education², (3) rights-based sexuality education refers to the inclusion of topics pertaining to young people’s sexual rights, which are rooted in their human rights. The rights-based approach is guided by a recognition of adolescents’ fundamental rights to sexual health information and services, self-determination, and non-discrimination, which also are core to frameworks of reproductive rights and reproductive justice. It expands the goals of sexuality education beyond disease and pregnancy prevention to include positive sexuality and empowerment, and
support to keep girls in school including homework assistance, (4) therapeutic services for abused children, (5) financial literacy and career development, (6) vocational programmes to promote economic empowerment, and (7) interventions to maximise social support and social capital. In addition, there was a (8) conditional cash incentive programme in two districts.

The intervention was implemented in ten South African districts purposively selected to include some of the most vulnerable AGYW in the country, with the highest HIV incidence. The intervention for AGYW was planned in close collaboration with the team leading the USAID-funded DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) intervention, to avoid duplication (more information on the DREAMS intervention can be found at https://www.usaid.gov/global-health/health-areas/hiv-and-aids/technical-areas/dreams). The intervention was comprised of a comprehensive package of health, education and support services for boys (10-14 years) and young women and adolescent girls (aged 10-24 years), in and out of school, within the ten districts. The intervention package included several behavioural, biomedical and structural HIV prevention programmes, the main components are described below.

Keeping Girls in School (KGIS)

Keeping Girls in School (KGIS) was a school-based intervention implemented in collaboration with the Department of Basic Education (DBE) that aimed to identify and support female learners who are at risk of dropping out of school prematurely. Through the KGIS initiative, combination packages of age appropriate services were provided to under-resourced public schools. The intervention identified and supported female learners through peer education, homework support, sexual reproductive health and rights (SRHR) education, career guidance and tracking of absence from school. The primary beneficiaries are high school girls aged 14-18 years. Adolescent girls received peer education, health education, and homework support to improve their academic results, career guidance, and when absent from school received a home visit to ensure that they return to school. The KGIS programme included an SRH component for AGYW, including the delivery of SRH counselling and education as well as HIV testing, TB screening, and other SRH services.

The five main sub-components to the KGIS programme were:

1. Health education
2. Peer education
3. Homework support
4. Career jamborees  
5. HIV testing and other mobile clinical services.

**Teen Parenting Programme**

Linked to the KGIS programme, a Teen Parenting Programme was also offered for beneficiaries who are parents or who have significant caregiving responsibilities. This programme was being offered to self-selected adolescent girls and boys in and out of school.

**Rise Young Women’s Clubs (RYWC)**

Rise Young Women’s Clubs (RYWC) were offered to adolescent girls aged 15-19 years in secondary school (typically those who have graduated from Soul Buddyz Clubs) or those aged 19-24 years who are out of school or in post-secondary education. Club members were exposed to a comprehensive package of behaviour change counselling, life skills, and empowerment activities. The RYWC members were also offered financial literacy interventions and linkages with career development, support and vocational acceleration programmes to promote economic empowerment. The clubs offered a comprehensive package of life skills and empowerment activities as its focus, responding to the feminization of the HIV epidemic and the local level gender-specific risk factors and empowerment needs of young women. The clubs met regularly (usually once per month, although this depended on the implementing organisation) to discuss issues that affect AGYW and share experiences and learnings. The clubs aimed to build the resilience of young women and link them to biomedical services such as HTS, prevention of mother-to-child transmission, antiretroviral therapy, modern contraception and other SRH services. In the second year of grant implementation, economic empowerment sub-components were added to the Rise clubs. Members follow a curriculum that promotes sexual and reproductive health knowledge as well as positive social behavioural change within their local contexts. Magazines form part of the curriculum which includes content that encourages members to empower themselves with knowledge, and motivates them to take action to protect themselves. Clubs are incentivised in different ways to carry out activities linked to content in the magazines. In addition, clubs are also positioned to link AGYW to biomedical services such as ART, HIV testing services, contraception and other SRH services.

**Other components**

In addition to the KGIS and Rise Clubs. Additional intervention components included:
- Soul Buddyz Clubs (SBC), an in-school peer-education youth club model for young girls and boys age 10-14 years, originally developed by Soul City Institute, a non-profit, non-governmental organisation and the largest social change communication project in Africa (for more information visit [https://www.soulcity.org.za](https://www.soulcity.org.za)). Soul Buddyz Clubs were offered to young people aged 10-14 years in primary schools. Club members were
exposed to age-appropriate, rights-based comprehensive sexuality education, life skills, empowerment activities and sexual and reproductive health services. Since this component only targeted adolescents under the age of 15 years, it was not included in the qualitative evaluation, as the study population range was 15-24 years old.

- Linked to the Soul Buddyz Clubs, the Hands on Parenting Programme focused on the provision of parenting skills to parents of members enrolled in Soul Buddyz and Rise Clubs.
- Other components comprised of the Child Protection Program, Health and Welfare Jamborees, and Community Dialogues on Gender Norms.
- Comprehensive HIV, TB and SRH services, services for boys at risk of abuse, perpetration, and services for victims of abuse were made available in the districts.
- Several interventions focused on providing a supportive environment for AGYW including mass media interventions, and interventions with school governing bodies, men, and parents. HIV testing services (HTS) were offered to AGYW and the broader community members.

Figure 3: Overview of the Global Fund supported AGYW combination intervention components

Implementing partners

Five Principal Recipients (PRs), comprising of NGOs and government institutions, were responsible for implementing the AGYW intervention components. These included Soul City
Institute (SCI); Networking HIV/AIDS Community of South Africa (NACOSA); Kheth’Impilo (KI); Western Cape Department of Health (WCD) and KwaZulu-Natal Treasury (KZN). Each PR was responsible for appointing and contracting Sub-Recipients (SR) in their respective districts to implement the full package.

The HERStory Study

The HERStory Study, is an evaluation of the South African combination HIV-prevention intervention for Adolescent girls and young women (AGYW) conducted by the South African Medical Research Council (SAMRC) and partners. The primary objective of the HERStory Study was to determine the intervention impact on HIV incidence over a two-year period. Secondary objectives include assessing the intervention impact on the prevention of HIV risk behaviour and other sexually transmitted infections (STIs) and on the cognitions, behaviour, and social environments of AGYW.

When implemented appropriately, combination HIV and SRH prevention efforts which include behavioural and structural interventions can help to overcome many of the barriers that limit preventative, health seeking or treatment behaviours (UNAIDS, 2013). The likelihood of an intervention being successful in achieving its objectives is enhanced if the social and contextual factors are taken into account in the design and implementation (Visser, 2007).

The HERStory study design included a qualitative component to complement the quantitative evaluation by providing in depth insight into perceived successes and failures of the intervention package components on target outcomes, the facilitators and barriers to uptake of the different Global Fund intervention components, and the perceived impact of the intervention on the lives of adolescent girls and young women, both attending and not attending school, aged 15-24 years. This report comprises findings from the HERStory qualitative study component. Further details on the HERStory survey can be accessed at the following: https://www.samrc.ac.za/intramural-research-units/HealthSystems-HERStory.

Dissemination Plan

This report will be uploaded onto the SAMRC website, which is publicly available: https://www.samrc.ac.za/intramural-research-units/HealthSystems-HERStory. The final version of the report will also be shared with Principal Recipients of the intervention, with SANAC and with the Global Fund.
HERStory Qualitative Study Component

Aims

The qualitative component of the HERStory study aimed to explore the impact of the intervention over time on the cognitions, behaviour, and social environments of AGYW in the intervention districts. The purpose of the qualitative component of the investigation was to explore perceived enablers and constraints of the intervention impacting primary outcomes of interest, and the perceived impact of the intervention. In addition to identifying the perceived impact of the intervention on AGYW, the qualitative component also sought to identify gaps and challenges in the intervention components and their implementation, as well as ways to revise and improve the intervention and its implementation.
HERStory Qualitative Study Component Research questions

Figure 4: Key questions of HERStory Qualitative study component

**Perceptions of the Intervention**
- How was the intervention perceived and experienced by AGYW and their communities?
- How did intervention recipients experience particular interventions/components?
  - What aspects were perceived to be most/least useful?
  - What factors impacted perceptions of the impact of the intervention?
- What aspects of the intervention components impacted on the daily lives, cognitions, behaviour and social environments of AGYW?

**Intervention Uptake**
- What were the successes & failures, to uptake and completion of intervention components?
- What factors inhibited or enabled uptake?
- What aspects/components were most/least helpful in achieving uptake?
- What were the barriers/facilitators to uptake of the intervention components and services?

**Social context and lived reality of AGYW lives**
- What are AGYW experiences in: their communities, families, relationships, school & health facilities?
- What factors impact AGYW decision-making around: Sexual and reproductive health Relationships Education
- To what extent did the intervention impact on these?
Methods

The HERStory study was conducted after the adolescent girls and young women (AGYW) intervention had been implemented over a period of two years. Data collection took place between August 2018 and March 2019.

The HERStory study employed a mixed-methods design. Alongside a quantitative survey (reported separately), the HERStory qualitative study component employed various methods including single one-time in-depth interviews (IDIs), longitudinal serial individual interviews – multiple interviews with the same respondent over time (SIDIs), and focus-group discussions (FGDs). Participant demographic data were also collected in using questionnaires.

Population and sampling

Study sites

The qualitative study activities were conducted in five purposively selected districts, to ensure that there was a district from each of the Principal Recipients of the Global Fund grant.

Table 1: Purposively selected districts in the HERStory qualitative study component 2018-2019

<table>
<thead>
<tr>
<th>Province</th>
<th>District</th>
<th>Sub-district</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>City of Cape Town</td>
<td>Klipfontein, Mitchells Plain</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>Gert Sibande</td>
<td>Albert Luthuli</td>
</tr>
<tr>
<td>North West</td>
<td>Bojanala</td>
<td>Moretele, Moses Kotane, Madibeng, Rustenburg</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>Nelson Mandela Bay</td>
<td>Sub-districts A, B &amp; C</td>
</tr>
<tr>
<td>KwaZulu-Natal</td>
<td>Uthungulu</td>
<td>King Cetshwayo, Umfolozi</td>
</tr>
</tbody>
</table>

Sampling

The study population for the HERStory qualitative component included direct recipients of the intervention, as well as a group of AGYW in the intervention communities who were not engaged in intervention activities. In addition, the study population included other key informants such as parents/caregivers of AGYW, male peers and partners, schoolteachers, club facilitators, and
community leaders in the intervention communities. Interviews were also conducted with intervention implementers, or Principal Recipients (PRs), and discussions were held with programme designers.

Within each district, this study purposively selected two schools from a list of schools with Clubs and the Keeping Girls in School programme. Within each district, one out-of-school Rise Club was selected from a list of Clubs provided to this study by the PRs. Within each district, one out-of-school Rise Club was selected from a list of Clubs provided by the PRs. Participants of the sampled Clubs and KGIS programme were invited to participate in FGDs and in-depth interviews.

**Participant Recruitment**

Participants who met the eligibility criteria described below, were recruited and invited to participate in the study by a team of researchers with the assistance of the intervention implementers and school liaison teachers.

A trained research assistant (RA), based at the respective district/s assisted with recruitment in the schools and in the community. For the schools, a formal letter was sent to the school principal requesting permission to conduct the study in his/her school. Upon receiving permission from the school principal, with the relevant school personnel/ teacher to liaise regarding arrangements for participants interviews/FGD. Thereafter, the research assistant liaised with the schoolteacher/ personnel in identifying the AGYW who participated in the intervention and arranged for time and space to conduct the research within the school.

In the community, intervention implementers assisted with providing the contact details and linking us to the eligible/ potential participants to interview for the study. Again, the research assistant went before hand to make contact and arrange for interviews with the participants outside of school. In instances where the RA had difficulties in securing an appointment with the potential participant/s, the experience researcher or co-investigator took the responsibility and often had to visit the participant/s or school in person.

**Participant eligibility**

**Inclusion criteria**

- Female aged 15-24 years who have been direct recipients of the AGYW intervention activities
- Females <18 years of age who have consented and whose parent, guardian, caregiver or household representative has consented
- Parents, guardians or caregivers of females aged 15-24 years who have been direct recipients of the AGYW intervention activities
- Teachers in schools with Soul Buddyz and Rise clubs
- Soul Buddyz and Rise Club facilitators
- Male peer / partner
- Community leader
- Willing to provide written informed consent
- Willing to participate in this study

**Exclusion criteria**
- Cognitive or mental challenged (based on the assessment of the participant's ability to comprehend the study information provided)
- Unable to speak or hear
- Unable to speak English, IsiZulu, isiXhosa, Northern Sotho, Sotho, Tswana, Tsonga, Swazi, Swati, Sepedi, Afrikaans
- Not available for participation between 8 a.m. and 9 p.m.
- Participants who have been living in the district for less than two years

FGDs were conducted with the sample groups described above, stratified as follows: members of the Rise Clubs, members of the KGIS programme, members of the Teen Parenting programme, AGYW who were not involved in any of these intervention components, and male peers. In addition to being separated as per sample group FGD groups were also stratified by age (15-19 years and 20-24 years). Each FGD was conducted with between 6 to 10 participants per group, by an experienced FGD moderator, with assistance from a note-taker.

In-depth interviews were undertaken with intervention participants, AGYW who did not participate in any intervention components, teachers in the schools in which the Clubs and KGIS programmes were based, and facilitators of the Clubs and KGIS, and other Global Fund programmes in the communities in which the Clubs are based, as well as community leaders. IDIs were also conducted with intervention participants where/when an FGD was not possible, e.g. with 1 or 2 participants (those were interviewed individually).

**Ethical considerations**

**Informed Consent**

All participants 18 years and older were informed of the purpose and process of research before being asked to provide their informed, written consent. Those younger than 18 years were given a parental/caregiver consent form for their parents/caregivers to sign or give permission for them to participate. Thereafter, following an informed consent process, they signed a written assent form if their parents had signed the consent form. Intervention implementers were all adults and provided telephonic consent.
Participant Reimbursement

Reimbursement and refreshments were provided to all participants at interviews and FGDs. At the end of an interview or FGD, participants were given a supermarket voucher worth R 50.00 (approximately USD$ 3.50) and light refreshments were served. For those participants who needed transport, an amount of R 30.00 one way (approximately USD$ 2.00) was provided in situations where school transport had already departed, or R 60.00 return (approximately USD$ 4.00) for those participants who had travelled specifically for the interview.

Referrals

SAMRC procured the services of a private-sector social worker for each district to assist with ensuring participants who expressed the wish to link to health care or social support, or who needed to be linked to such services, were able to access the care they need. These services were available for participants who need to access other health care services, or social support services for psychosocial problems.

Data collection procedures

Qualitative IDIs (20-40 minutes) and FGDs (40-90 minutes) were conducted in either English, isiZulu, isiXhosa, seTswana, or siSwati, or a combination of these, depending on the preference of the participant/s. Data collection was conducted by a team of experienced female researchers, accompanied by female research assistants, all of whom had received training on the study protocol, design and research tools. Interviews and FGDs were semi-structured, following topic guides with open-ended questions and probes for potential additional issues, allowing for iteration, probing and digression on relevant themes.

Interviews

HERStory staff (Interviewer/RA) confirmed eligibility and conducted the written informed consent procedures with each participant. Following the informed consent process and prior to the interview, a staff member assigned a unique participant ID number to each enrolled participant. Demographic forms were administered either before or after the IDI.

Focus Group Discussion Procedures

FGDs took approximately 2-3 hours, including provision of informed consent, and administration of demographic forms. FGDs were scheduled to ensure a common language was spoken by all participants and conducted in an appropriate meeting room that is conducive to the number of participants, privacy, and the need to audio-record the session.
All participants chose a pseudonym to use during the discussion. Ground rules for conduct were discussed and described together with participants. These included a review of confidentiality requirements, etiquette, and operational issues. FGD discussions were started by the facilitator using an ice breaker. After the ice breaker, group discussions followed the topic guide. FGD guides were semi-structured, allowing opportunities for probing and exploration of spontaneously generated themes.

Research tools

Research instruments included a brief demographic questionnaire, administered before or after each interview or FGD. All interviews and FGDs were semi-structured and followed topic / question guides with open-ended questions and probes for potential additional issues, allowing for iteration, probing and digression on relevant themes (see Appendices for interview topic guides). In addition, a brief demographic questionnaire captured participant characteristics (see appendices for questionnaire).

Research staff

The two lead interviewers were females and were experienced and qualified social science researchers. At each site they were accompanied by a qualified female research assistant. All researchers had been trained in qualitative research methods, on the study protocol, and were fluent in the predominant languages spoken in the study site communities.

Participant accrual

Table 2: Type of data collected per site and sample group for the HERStory qualitative study component 2018-2019

<table>
<thead>
<tr>
<th>Sample Group</th>
<th>Total</th>
<th>Western Cape (WC)</th>
<th>KwaZulu-Natal (KZN)</th>
<th>Mpumalanga (MPU)</th>
<th>North West (NW)</th>
<th>Eastern Cape (EC)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>IDIs</td>
<td>FGDs</td>
<td>IDIs</td>
<td>FGDs</td>
<td>IDIs</td>
<td>FGDs</td>
</tr>
<tr>
<td>AGYW 15-24 years - Intervention recipients</td>
<td>57</td>
<td>19</td>
<td>5</td>
<td>5</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>AGYW 15-24 years - Non-intervention</td>
<td>6</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Parents of AGYW</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Teachers of AGYW</td>
<td>10</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Intervention club Facilitators</td>
<td>11</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Community Leaders</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Male Peers</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
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HERStory Qualitative Study Component Final Report
<table>
<thead>
<tr>
<th>Intervention Implementers</th>
<th>13</th>
<th>0</th>
<th>2</th>
<th>0</th>
<th>2</th>
<th>4</th>
<th>0</th>
<th>3</th>
<th>0</th>
<th>2</th>
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<tr>
<td>Total</td>
<td>110</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AGYW = Adolescent Girls and Young Women
IDI = In-depth interview
FGD = Focus group discussion

Table 3: Qualitative sample per site for the HERStory qualitative study component

<table>
<thead>
<tr>
<th>Province</th>
<th>Western Cape (WC)</th>
<th>KwaZulu-Natal (KZN)</th>
<th>Mpumalanga (MPU)</th>
<th>North West (NW)</th>
<th>Eastern Cape (EC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>District</td>
<td>City of Cape Town</td>
<td>King Cetshwayo</td>
<td>Gert Sibande</td>
<td>Bojanala</td>
<td>Nelson Mandela Bay</td>
</tr>
<tr>
<td>Sub-district/s</td>
<td>Klipfontein, Mitchells Plain</td>
<td>Umhlatuzhe, Umfolozi</td>
<td>Albert Luthuli</td>
<td>Moretele, Moses Kotane, Madibeng, Rustenburg</td>
<td>Sub-districts A, B &amp; C</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Urban</td>
<td>Rural</td>
<td>Semi-urban</td>
<td>Semi-urban</td>
<td>Urban</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sample Group</th>
<th>N</th>
<th>N</th>
<th>N</th>
<th>N</th>
<th>N</th>
<th>Total N</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGYW* Intervention participants 15-19 years</td>
<td>47</td>
<td>13</td>
<td>33</td>
<td>16</td>
<td>38</td>
<td>147</td>
</tr>
<tr>
<td>AGYW Intervention participants 20-24 years</td>
<td>11</td>
<td>20</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>38</td>
</tr>
<tr>
<td>AGYW Non-intervention participants 15-19 years</td>
<td>5</td>
<td>15</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>AGYW Non-intervention participants 20-24 years</td>
<td>0</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total AGYW 15-24 years</strong></td>
<td><strong>63</strong></td>
<td><strong>50</strong></td>
<td><strong>41</strong></td>
<td><strong>35</strong></td>
<td><strong>48</strong></td>
<td><strong>237</strong></td>
</tr>
<tr>
<td>Parents</td>
<td>1</td>
<td>2</td>
<td>?</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Teachers</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Facilitators</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Community Leaders</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Male peers 18-24 years</td>
<td>7</td>
<td>8</td>
<td>7</td>
<td>2</td>
<td>14</td>
<td>38</td>
</tr>
<tr>
<td>Implementers</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total Respondents</strong></td>
<td><strong>37</strong></td>
<td><strong>73</strong></td>
<td><strong>67</strong></td>
<td><strong>51</strong></td>
<td><strong>75</strong></td>
<td><strong>303</strong></td>
</tr>
</tbody>
</table>

*AGYW = Adolescent Girls and Young Women
Data analysis

Transcription, Translation and Data processing

Audio recordings of IDIs and FGDs were transcribed verbatim into their original language, reviewed by the interviewer/s for accuracy, translated into English and re-reviewed. The rationale for transcribing audio files into their original language, and then having a separate process of translating the original language transcripts into English, is that the way in which participants describe their thoughts, feelings and perceptions in their own language is rich data.

We used a three-step process to the translation of audio files. This three-step process is generally favoured in social and behavioural research and is preferable to direct translation (Guest et al., 2013). Using this process, the original language transcript becomes an important source document, and is a primary data source. This process enables the research team to refer to a source document should questions about translation or meaning arise in the analysis process. Another benefit is that the research team can see the original terms and words that the participants themselves used.

The process is as follows: a transcriber fluent in the language in which the interview was conducted transcribed the audio files verbatim into a text version in the local language. After verbatim transcription of the audio file, the original language transcript was then reviewed by the original interviewer for accuracy. Having the person who conducted the interview perform a review of the transcription enhances the validity of the process, since the interviewer was present for the asking and answering of the questions. Once the original language transcript had been reviewed by the interviewer, it then proceeds to translation. After the document had been translated into an English transcript, this again was reviewed by the interviewer to ensure correct interpretation and accuracy.

Analysis

Qualitative data were coded using thematic analysis. Transcripts were uploaded into NVivo 12 software package (QSR International). Thematic analysis followed an integrated and cyclical approach using a set of pre-determined deductive code types based on the topics included in the interview guides, which were built upon through the inductive development and refinement of codes (Bradley, Curry, & Devers, 2007; Nowell, Norris, White, & Moules, 2017; Vaismoradi, Jones, Turunen, & Snelgrove, 2016). Transcripts were coded first through descriptive coding for key themes and topics, using the preliminary codebook. The codebook and coding process evolved iteratively through a deductive and inductive process reflecting the study’s key objectives and topics that emerged through reading the data. During the early stages of data collection, a set of preliminary codes had been developed based on the research questions (see Figure 4). The analysis coding structure reflected the topics/themes covered in the interview guides. After the initial interviews were completed, and the codebook had been tested by applying this initial set of thematic codes, the codebook, code names and definitions were expanded, modified and
refined as necessary. Additional codes were identified through an iterative process of reading the
textual data and identifying emergent themes, and the codebook was modified accordingly. In
addition to descriptive codes, pattern codes, which achieve a greater level of abstraction, were
used to start linking themes and topics together in order to explore relationships in the data.
Once finalised, this codebook was used for a final coding of transcripts.

Collaborative interpretation by the research team, comprising the two interviewers who were
also co-investigators, along with four other co-investigators, involved research team members
engaging in data immersion and familiarisation, and repeated readings of the data in an active
way searching for meanings and patterns. Team members documented theoretical and reflective
thoughts that developed through immersion in the data, sharing growing insights about the
research topic during regular team discussions. The analysis process included the identification
of themes, coding with NVivo 12 software, and the labelling of relevant text from the raw data,
according to how/where they related to themes. As concepts and themes emerged, the team
collaboratively reviewed them, returning to the raw data, and refining themes through team
consensus. Weekly research meetings were held throughout the data collection and analysis
phases allowing for team debriefing and examination of how thoughts and ideas were evolving
as they engaged with the data.

Feedback workshops

As part of the analysis process, a series of feedback workshops and meetings were held between
stakeholders/participants and the evaluation research team with the objective of reviewing and
discussing the preliminary analysis and interpretations, ensure accurate and appropriate
interpretation of the data, clarify misunderstandings, and/or confirm findings and interpretations.
During the workshops, the research team summarized and presented key
themes and findings to the participants, who were then invited to give feedback, discuss their
interpretation of the findings, and expand or elaborate on themes. The research team facilitated
discussions on each theme, which were captured through notes and audio recordings,
transcribed and reviewed. PR presentations were revised based on feedback from PRs after each
meeting. The transcripts from these feedback sessions were included in the overall analysis.

Findings

Demographic information of the AGYW sample

Amongst the AGYW aged between 15 and 24 years in the qualitative study sample, the mean age
was 17.4 years. Reporting in the demographic questionnaire, 18% (N=41/232) said that they had
ever been pregnant, 82% (N=190/232) reported that they had never been pregnant. Of those
who had been pregnant, the median number of pregnancies was 1. Of the those AGYW who chose to answer, 23% (N=52/229) said that they “are currently taking care of children”, while 77% (176/229) said that they were not currently taking care of any children. Of the 52 AGYW currently taking care of children, the mean number of children being cared for was 1.85, ranging from 1 to 8. Amongst the AGYW sample, 6% (N=13/237) reported that they were “currently earning an income”, while 94% (N=223/237) reported that they were not currently earning an income.

Table 4 below presents the self-reported data from the brief demographic questionnaires that IDI and FGD participants completed.

Table 4: Demographic characteristics of the AGYW sample in the HERStory qualitative study component

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Freq</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex assigned at birth (N=237)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>235</td>
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<tr>
<td>Female</td>
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<td>97</td>
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<tr>
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<tr>
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<tr>
<td>Bisexual</td>
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<td>7.2</td>
</tr>
<tr>
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<td>1.7</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>3</td>
<td>1.3</td>
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</tr>
<tr>
<td>Language/s most spoken at home * (N=237)</td>
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<td></td>
</tr>
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</tr>
<tr>
<td>Sesotho</td>
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<tr>
<td>Afrikaans</td>
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<td>Currently live with * (N=222)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
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<td>%</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>Parent/s / mother / father</td>
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<td>Grandparent/s</td>
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<tr>
<td>Main/steady spouse or partner</td>
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</tr>
<tr>
<td>Casual partner</td>
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<td>0</td>
</tr>
<tr>
<td>Other family member/s</td>
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</tr>
<tr>
<td>Non-family / friend/s</td>
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<td>0</td>
</tr>
<tr>
<td>Alone</td>
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<td>0.9</td>
</tr>
<tr>
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</tr>
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**Highest level of education (N=237)**

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<th>Education Level</th>
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</tr>
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<td>0.4</td>
</tr>
<tr>
<td>Primary school, complete</td>
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<td>1.7</td>
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<tr>
<td>Secondary school, not complete</td>
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<tr>
<td>Attended college or university</td>
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<td>3</td>
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<td>0.4</td>
</tr>
<tr>
<td>Other</td>
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<td>0.8</td>
</tr>
</tbody>
</table>

**Income / financial support sources in last 12 months * **

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<thead>
<tr>
<th>Source of Income</th>
<th>N</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>Formal Employment (working for a company, working in a shop, etc.)</td>
<td>11</td>
<td>4.7</td>
</tr>
<tr>
<td>Informal Employment (recycling, piece work, selling goods/clothes, gardening, etc)</td>
<td>2</td>
<td>0.8</td>
</tr>
<tr>
<td>Self-Employment</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>Social grants (child support, disability, etc.)</td>
<td>94</td>
<td>39.8</td>
</tr>
<tr>
<td>Main/steady spouse or partner</td>
<td>8</td>
<td>3.4</td>
</tr>
<tr>
<td>Casual partner</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Child Maintenance</td>
<td>11</td>
<td>4.7</td>
</tr>
<tr>
<td>Family (other than spouse)</td>
<td>135</td>
<td>57.2</td>
</tr>
<tr>
<td>Friends</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>Selling sex for money</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Exchanging sex for goods (not money)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>1</td>
<td>0.4</td>
</tr>
<tr>
<td>None of the above</td>
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<td>9.3</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>2.5</td>
</tr>
</tbody>
</table>

*Multiple responses were permitted for this variable

**Findings by theme**

**Findings Part I: Understanding the context of AGYW SRH and lives**
Theme 1: Sexuality communication

Lead theme analyst: Zoe Duby

Rationale

Open communication with parents, particularly mothers, plays a role in enabling informed SRH decision-making amongst adolescent girls and young women (AGYW). However, socio-culturally informed norms around sexuality communication between adolescents and parents can impede open communication. Protecting AGYW from the risks of early pregnancy, STIs, and HIV requires a holistic approach, which addresses the social, economic, and structural factors preventing them from practicing safe and consensual sex. South Africa's National Strategic Plan (NSP) for HIV, TB, and STIs seeks to address a number of these issues by prioritizing the provision of comprehensive targeted combination prevention interventions. In addition to access to HIV treatment and services, the NSP specifies that targeted interventions should include the provision of appropriate social support which specifically includes information and emotional support from people including parents, teachers and service providers. With such support, AGYW have a greater likelihood of receiving the information and assistance they need for safe SRH choices.

Summary of key findings

Despite the recognised need for communication about sexuality, substantial barriers to communication exist between South African AGYW and their parents. The majority of AGYW in our study felt unable or unwilling to discuss SRH or disclose any of their own SRH concerns or challenges to their mothers/female caregivers, explaining that attempts to do so, specifically raising the topic of contraception, often garnered angry reactions.

I have never spoken to my mother about these issues... if I talk about going to prevent (use contraceptives), she would think that I’m planning to have sex... if I want to check for HIV, she’d think that I’ve had sex... she ends up hitting me and yelling at me. (KZN, AGYW Intervention Recipient, 15-19 years)

I cannot speak to my mother... I just get scared of her... I prefer not to speak to her and just make my own decisions. (KZN, AGYW Intervention Recipient, 15-19 years)

Respondents described a generation gap; AGYW felt that their parents are old fashioned, and mothers voiced concern that they did not understand their daughters’ SRH needs.

Most parents are old... they are afraid to talk to their children... and tell them (about sex). (KZN, AGYW Intervention Recipient, 20-24 years)

Mothers’ perceptions that their teenage daughters were too young to be engaging in sex were linked to concern that discussing SRH would encourage AGYW to engage in early and unsafe sexual practices.

I don’t want to get started with that (talking about condoms) because that will encourage her to do things (have sex)... like prevention (contraceptives) and so on. She will hear where she hears it (SRH information) but I don’t want it to come out of my mouth... you don’t have to give the child a key to
Parental resistance to communicating about sexual issues also stemmed from their own inadequate knowledge and discomfort. Overall, AGYW want more open communication and better support from their parents relating to SRH decision-making. AGYW who had participated in the intervention components described the impacts that the programmes had in relation to their relationships and communication around SRH with their parents.

_Since I joined (intervention) I was able to talk... because I wasn’t able to talk... about condoms and stuff, I did not know how to share that with anyone.... but (being part of intervention) has made us to be free (to discuss these things) (WC, AGYW Intervention Recipient, 15-19 years)_

Our findings indicate that interventions can be successful in addressing communication barriers between AGYW and their parents, and that by reducing sexuality communication barriers, AGYW access to contraceptives may be improved.

**Recommendations for sexuality communication**

By addressing the barriers to open communication, future interventions can incorporate more meaningful engagement of parents in adolescent SRH. In order to reinforce positive behaviours amongst AGYW, there is a need for empathetic support networks that provide holistic advice and support for managing relationships and SRH overall, rather than focusing only on HIV prevention (AVAC, 2018). For this to be successful, there is a need to ‘bridge the empathy gap’ by helping parents/maternal figures to understand the AGYW context and the implications of their attitudes and communication style on AGYW decision making (AVAC, 2018). Maternal figures are more likely to be able to effectively communicate with AGYW if they have more realistic expectations regarding AGYW relationships and sexual behaviours, framing their role as supporting AGYW to navigate relationships, in order to overcome their own concerns about promoting sex (AVAC, 2018). In addition, it would be beneficial to create opportunities for communication and collaboration among parents/caregivers and increase their efficacy by providing them with accurate and up to date information (AVAC, 2018). It is important that interventions be culturally and linguistically appropriate and address socio-cultural norms and religious beliefs that may create resistance to open, inter-generational communication around sex. There is a need for more in-depth research to further understand how sexuality communication should best be included in SRH interventions in the South African context.

Based on these findings, future interventions need to incorporate more meaningful engagement of parents, helping to address sexuality communication barriers between AGYW and their parents, and facilitating more effective support from AGYW in their SRH decision-making. Open channels of communication, accurate sources of SRH information, and social support network required to enable AGYW to make safe and healthy SRH decisions and adopt prevention practices are critical but missing.
Theme 2: The intersection between mental health and sexual & reproductive health

Lead theme analyst: Zoe Duby

Rationale

In South Africa, adolescent girls and young women are at risk of poor mental health and HIV infection. Poor mental health in AGYW is associated with increased sexual risk behaviours, and impeded HIV testing and care. Considering the overlaps and interactions between mental health and SRH amongst AGYW is critical. We examined AGYW’s qualitative narratives and conceptualisations of their own mental health, that of peers, and of the surrounding emotional and psycho-social support context in order to explore the ways in which these factors might interact with sexual health outcomes.

Summary of key findings

Emergent themes in the qualitative data included AGYW narratives of depression, stress, and suicide. In the accounts of AGYW, stress, anxiety and feelings of not being able to cope, were often associated with HIV status, unintended pregnancy and early child-bearing, parenting responsibilities, compounded by a lack of emotional support. Suicide emerged as a salient theme in discussions with AGYW, who described suicidal ideation linked to feelings of not being able to cope with circumstances such as unintended pregnancy, HIV diagnosis, or a lack of social support.

This thing of suicide is becoming popular now because even here at school now, it’s here, especially when they are pregnant or HIV positive because they can’t share it with anyone, they don’t trust anyone. (WC, AGYW Intervention Recipient, 15-19 years)

When I found out I was pregnant... that was very difficult, I even thought about suicide... it was tough. (KZN, AGYW Intervention Recipient, 20-24 years).

According to AGYW intervention recipients, participation in the intervention had a positive impact on their mental health. Although the intervention was not explicitly designed to address mental health, there were unexpected benefits. Specifically, intervention clubs provided AGYW with a ‘sisterhood’ of peers with which they could share their worries and receive emotional support, resulting in overall improvements in their ability and willingness to access emotional support. In general, AGYW voiced a need for more emotional support, additional information on mental health, and increased access to quality care and support.

I have changed a lot because I am able to talk to people now, I am no longer scared because there are people who have shown me that I can share my problems with them. (WC, AGYW Intervention Recipient, 15-19 years).

I was unable to express my emotions... I was unable to cry or I would keep that pain to myself and it will hurt me for a long time. So, I was taught that, the right approach is to get someone who you can trust and talk with, or cry if needed, so that you can be have peace. (MPU, AGYW Intervention Recipient, 15-19 years)
It is evident that AGYW in South Africa face substantial social adversities and related mental health challenges due to a range of SRH, social, economic, environmental, physiological and interpersonal factors. Building on recent research that found associations between depressive symptoms and psychological distress related to pregnancy, combined with a lack of social support amongst South African women (Choi et al., 2019), our findings provide rich descriptive data on the reality of the interconnected psychosocial risks including stress, emotional isolation, feelings of depression and suicidal ideation, with unintended pregnancy and HIV that AGYW in South Africa face, from their own perspectives. Framing these interconnections within the syndemic framework can help to inform interventions that seek to address AGYW risk. As psychological distress is associated with increased risk behaviours, it is critical that efforts to address unintended pregnancy and HIV infection amongst AGYW incorporate mental health components. Interventions to improve emotional wellbeing and coping mechanisms for AGYW are needed in order to improve sexual and reproductive health outcomes; indeed, in a context where HIV, STIs and unintended pregnancy are common, it is all the more important to have such interventions integrated into SRH services and part of large-scale programmes for AGYW. Understanding the context of mental health is crucial in order to design and implement effective mental health programming, and to provide appropriate psycho-social support to young women, and in turn, address sexual and reproductive health challenges.

**Recommendations for the integration of mental health into SRH services**

In line with the syndemic theory suggesting synergistic interactions between epidemics, and the interconnectedness and clustering of psychosocial conditions such as unintended pregnancies, psychosocial distress, and HIV infection in AGYW, there is a need for comprehensive HIV prevention programming inclusive of mental health support (Sileo et al., 2019). It is clear that interventions aiming to reduce rates of teenage pregnancy and reduce HIV acquisition amongst AGYW in South Africa, need to incorporate mental health components (Docrat et al., 2019). Recommendations have been made for integrating mental health care into care for patients with chronic non-communicable diseases, as well as communicable diseases such as HIV (Docrat et al., 2019b), however, few recommendations for integrating mental health into SRH delivery exist (Schneider et al., 2016). The links between mental health, HIV status, and unintended pregnancy, exacerbate the need to strengthen the integration of routine mental health screening in SRH and HIV programming in order to enhance the health outcomes amongst AGYW (Kuringe et al., 2019). Evidence suggests that addressing underlying mental health risks may be an important additional strategy to promote sexual risk reduction, and that behavioural interventions which are able to improve mental health are also more effective in preventing negative sexual health outcomes such as HIV infection (Hill et al., 2017).

Combination interventions inclusive of psychological and behavioural components may be able to achieve greater reductions in sexual risk behaviour among adolescents, as incorporating psychological health interventions appears to be a critical part of any comprehensive strategy for mitigating HIV risk (Thurman et al 2016). Mental health services targeted at AGYW, especially those that are HIV positive and/or pregnant, need to be integrated into SRH services, especially those that aim to be “youth-friendly”; prevention, diagnosis and management of depressive
symptoms should also be included in the package of comprehensive services (Osok et al., 2018; Nduna et al., 2010). Mental health and SRH interventions and services need to be contextually appropriate and reflective of the reality of people’s lives. Screening tools need to consider the diversity of understandings of emotional suffering and distress, using appropriate terms, language and concepts.

**Recommendations for mental health screening included in SRH services**

The indication of a dual burden of psychological distress and sexual risk behaviours suggest that screening for mental health disorders should be integrated into SRH services (Hill et al., 2017). Despite the evidence of intersecting epidemics, mental health screening is not standard in HIV prevention and care settings and has not been added to the HIV care cascade. Early mental health screening could help catch AGYW who might not yet be diagnostically clinically depressed. Given the evidence, it is likely that AGYW have overlapping epidemics that are clinically significant. Practical recommendations for improving mental health care delivery to AGYW include improving mental health, advocacy, decentralization of services, task-shifting and on-the-job training (Kuringe et al., 2019; Reddy et al., 2013).

**Recommendations for creation of social support networks /peer groups/safe spaces**

Small group interventions can help to promote self-esteem and social support, which are necessary precursors to behaviour change (Thurman et al., 2016). In addition, AGYW may benefit from facilitated social support networks and safe spaces in which they can share their feelings, discuss with peers, and seek advice from trained facilitators. The kind of social support provided in small facilitated peer groups may help to protect AGYW from the negative effects of stressors and promote more positive mental health outcomes, and in turn lead to a reduction in sexual risk taking and unintended pregnancies (Cheng et al., 2014). Efforts to increase social support for AGYW from family and community members, especially female adult caregivers, may prove effective in improving the mental health of AGYW (Cheng et al., 2014). Evidence demonstrates the benefits of life skills programs targeting one or more mental health outcomes and co-occurring risk factors in school and community settings (Singla et al., 2019). Comprehensive programs focusing on multiple life skills related to the individual, his or her social environment as well as interventions focused on parent-child interactions may hold particular promise for addressing the burden of poor mental health and other related health areas (Singla et al., 2019). Importantly, any psycho-social interventions would need to be socio-culturally appropriate, taking into account the specific needs of the communities in which they are provided (Osok et al., 2018). In addition, strategies for ensuring that confidentiality is maintained in the support group/safe space context needs to be given careful consideration.
Recommendations for community-based and school-based mental health interventions

School-based mental health interventions, delivered by teachers, school nurses, social workers and counsellors, have been shown to be effective in improving mental health outcomes amongst adolescents (Davaasambuu et al., 2020). Community-based mental health interventions, particularly complex multi-component interventions, self-confidence and knowledge focused interventions, have also shown success in reducing depression among adolescents and young people (Davaasambuu et al., 2020). Mental health interventions delivered at the community and school level can also help to overcome barriers related to accessibility, affordability, stigma and discrimination (Davaasambuu et al., 2020).

Theme 3: Barriers towards HIV testing

Lead theme analyst: Zoe Duby

Rationale

Low levels of HIV testing, access, and uptake by adolescents and young people in South Africa leads to late diagnosis, late entry into HIV care and treatment, and poor uptake of prevention services. Willingness of young people to be tested does not match uptake, due to various barriers that inhibit testing behaviour. This report explores the perceptions of adolescent girls and young women and male peers relating to the barriers they face in deciding to be tested for HIV and accessing HIV testing services.

Summary of key findings

Barriers towards HIV testing described qualitatively by AGYW and young men were complex and multi-level, including intrapersonal/individual, interpersonal, and health service level factors. Analysis revealed complex, dualistic and often contradictory views towards HIV testing exist in this population, with fear of HIV and the consequences of testing positive existing alongside a lack of concern towards HIV infection based on the availability and accessibility of antiretrovirals (ARVs).

Individual level barriers

With regards to intrapersonal level barriers to being tested for HIV, young men and women in the qualitative component of our study cited fear as a major barrier. Young men described feeling too young to be at risk, too young to be HIV positive, and therefore too young to test. In addition, narratives relating to trust in romantic and sexual relationships was another factor contributing to low risk perception described in the qualitative data by both young men and women. Young men and AGYW voiced the opinion that they would rather remain ignorant of their status than be tested for HIV. Fear of the consequences of testing positive for HIV included narratives of negative mental health outcomes. Feelings of depression and suicidal ideation were linked to the
prospect of testing positive in the perspectives of young men and women we interviewed. Young people interviewed in our study described their views that an HIV diagnosis would lead to depression, and would be reason to commit suicide.

I am afraid because if I discover that I have HIV... I can end up taking a decision of killing myself... I won’t test for HIV because I am afraid and if they can say I have it I can simply kill myself. (KZN, 15-19 years)

I prefer to test when am about to die. (EC, 20-24 years)

Interpersonal level barriers
In our qualitative study component, AGYW expressed fear that they would be reprimanded by parents/grandparents if they went for an HIV test, as it would provide proof, or lead parents to assume, that they were sexually active.

I would like to go just to know about my status because maybe something happened I don’t know... but I know that my mother and grandmother would never agree to that. They will ask what I did... why am I testing?... (so) I have never tested)... (they’ll say) I’ve broken their rules... so if I did that I must deal with the consequences. (EC, 15-19 years)

Young men and AGYW also expressed concern around the potential to experience HIV-related stigma in the family and community setting, including fear of rejection by family and friends

If you have it (HIV) people see that... they see that you coming from testing and then they judge you... you think about if at night and think that it’s true... so you will have depression. (EC, 20-24 years)

Health service level barriers
The lack of knowledge about where to get tested was cited as a key barrier by AGYW in our study. Fear of scolding or judgemental attitudes from health service providers was cited as a barrier by young people in the qualitative study. AGYW voiced the concern that if they requested an HIV test, they would be interrogated and told that they were too young to be sexually active. In addition, clinic level barriers including queues and long waiting times were also described by young people in our study.

The questions (asked by health providers when you go to test)... “Why are you here for testing, are you dating someone?”... “Why are you scared?”...they will ask do you have a boyfriend, and you will say yes, then they will be like “Why are you having a boyfriend while you still young?”, such questions are annoying... what is annoying is their attitude. (WC, 15-19 years)

In order to achieve a reduction in new HIV infections, HIV transmission, and increase access to treatment for HIV positive young people in South Africa, timeous HIV testing is crucial. However, as demonstrated by our findings, significant multi-level barriers to testing remain a reality. It is therefore crucial that future interventions have a thorough understanding of the complexity and underpinnings of adolescents’ and young people’s perceptions of the accessibility of HIV testing, its social context, and the nuanced barriers towards testing, in order to improve testing uptake in this population.
Dualistic and contradictory narratives

Emerging from the data were dualistic notions and contradictory attitudes towards HIV testing, with fear of positive diagnosis on the one hand, and low levels of concern towards HIV infection on the other. Perceptions of ARVs as efficacious and readily accessible were linked views expressing lower levels of concern around getting infected with HIV.

Recommendations for addressing barriers towards HIV testing

Given the multi-level barriers to HIV testing, interventions to increase testing uptake need to be responsive to factors at individual, interpersonal and health system levels (Treves-Kagan et al., 2017; 2016).

At the individual level, recommendations include the utilisation of strategies that increase knowledge in AGYW that promote and increase demand for HIV testing, including the provision of more granular, age, gender and sexual-behaviour specific information on HIV risk, and information on where and how to access testing services and post-test support are care (Maughan-Brown et al., 2018; Mavedzenge et al., 2016) In order to address low risk perception, recommendations include the provision of explicit counselling around the meaning of a negative HIV test and the sources of potential on-going HIV-infection risk (Mavedzenge et al., 2016) Specifically, a component of counselling should be aimed at improving the ability of adolescents to accurately assess their risk level based on prior behaviour, and avoid the tendency to downplay their perceived risk after a negative result (Maughan-Brown et al., 2018) Evidence shows that despite the efforts made with educational campaigns aimed at improving adolescents’ understanding that having unprotected sex with a partner of unknown HIV status places them at high risk of HIV infection, there has been a failure to internalise this message by many young people (Mavedzenge et al., 2016)

At the interpersonal level, it has been shown that parents/caregivers and other influential adults can play a positive influencing role in encouraging testing amongst adolescents (Mavedzenge et al., 2016) There is also need to address the various forms of stigma that operate across individual, interpersonal, community and structural levels in complex ways (Chan & Tsai, 2016; Treves-Kagan et al., 2017) It has been suggested that programmes aiming to increase HIV testing uptake amongst AGYW need to include more community, social or family based interventions for stigma reduction (Treves-Kagan et al., 2017).

At the health system level, recommendations to improve HIV testing rates amongst AGYW include closer attention to the disaggregation of data by age and gender, efforts to facilitate access to antenatal care and postpartum care services (Mavedzenge et al., 2016) Efforts need to be made by service providers to reframe HIV testing services in ways that relieve fear and anxiety (Bell et al., 2019). Recommendations for increasing accessibility of HIV testing for AGYW include the creation of youth-friendly services, home-based, community-based and school-based testing services (Mavedzenge et al., 2016) In addition, better integration of HIV testing with reproductive
health services including the provision of contraceptives would be of benefit (Mavedzenge et al., 2016) Evidence also suggests that HIV self-testing is highly acceptable among adolescents and young people, and should be researched further (Mavedzenge et al., 2016).

**Theme 4: Barriers to condom use and motivations for condomless sex**

Lead theme analyst: Zoe Duby

**Rationale**

Consistent condom use remains one of the most effective methods for preventing the transmission of HIV (Manyaapelo et al., 2017; Ntshiqa et al., 2018). In the 2017 South African National HIV Survey, less than half (49.8%) of females aged 15-24 years reported using a condom at last sex. The proportion of females in this age group reporting condom use at last sex decreased dramatically from previous years, from a high of 66.5% in 2008 (Simbayi et al., 2019). Whilst the development of new HIV prevention products means that condoms are not the only option, new products such PrEP are yet to be widely available, and thus these figures indicating low condom use are worrying.

**Summary of key findings**

Amongst the barriers to condom use described qualitatively by participants, the desire to demonstrate love and trust for a sexual partner, and thus avoid the chance of being ‘dumped’, was the most commonly cited by AGYW. According to the narratives of participants in our study, the type, duration of, and relationship context of sex determine whether a condom is likely to be used or not. Condoms are less likely to be used in long-term, committed relationships, less likely to be used for the ‘second round’ of sexual intercourse than the first, and less likely to be used when the female partner is using hormonal contraceptives.

*From 2-3 months, dating, you can use a condom, but when its 4-5 months... it is unlikely that you can use it... forget it.* (MPU, AGYW 20-24 years)

*When you are preventing (using contraceptives) it’s an excuse for them not to use condom.* (EC, AGYW 20-24 years)

Some AGYW in our study described being too scared to raise the topic of condoms with boyfriends, due to a fear of violent reactions.

*Girls are afraid to tell their boyfriend (to use a condom) because he will say “it means you don’t trust me, and if you don’t trust me it means you don’t love me”.* (MPU, AGYW, 15-19 years)

*(I can’t talk to my boyfriend about condoms because I’m) scared of him.* (WC, AGYW, 15-19 years)
Both male and female participants in our study described beliefs and misconceptions related to condoms that serve as a barrier to their use.

*He is the one who has the authority to take the condom off in the middle of sex, he can remove it if he likes, or decide to continue with it, if he likes. (KZN, Male Peer)*

Respondents listed various perceived negative side effects from condom use. Participants in our study expressed the belief that condoms should not be used at ‘first sex’ (sexual debut). Respondents in our study listed numerous motivations for having condomless sex. For AGYW, motivations included relationship maintenance, proving their love and trust of a partner, showing the extent of their commitment and attaining intimacy. For young men the motivations for condomless sex included increased sexual pleasure, proof of their masculinity and power, and prestige amongst peers. Young men’s desire to attain sexual prowess, respect, and a masculine sexual maturity, links to their ability to engage in condomless sex, demonstrating the ways in which gendered sexual norms and prevalent masculinities can act as a barrier to condom use.

Male condoms remain an important HIV prevention method, and tool for preventing unintentional pregnancies. However, the use of male condoms in South Africa is sub-optimal, with barriers to condom use operating on individual, interpersonal, and sociocultural levels. Many of the motivations for condomless sex that AGYW described were different to those of young men, focused mostly around relationship factors such as intimacy, trust and relationship security. Motivations for condomless sex described by young men were more related to sexual pleasure, masculinity, power and prestige. In light of the themes that emerged in our data pertaining to the way in which AGYW agree to have condomless sex for the purposes of relationship maintenance, or to avoid negative reactions from the boyfriends, it would appear that young men hold the power and agency in condom use decision-making in heterosexual relationships amongst young South Africans. Male condoms remain an important HIV prevention method, in addition to an important tool for preventing the spread of STIs and unintentional pregnancies. In order to improve condom use amongst adolescents and young people in South Africa, the numerous barriers to their use need to be addressed, while close attention needs to be paid to the factors that motivate condomless sex in this population.

**Recommendations to reduce barriers towards condom use**

In light of the centrality of gendered power in determining condom use, interventions aiming to increase condom use need to engage young men and women in dialogues about gender, in order to critique and deconstruct existing notions of manhood and womanhood, and reinforce positive forms of masculinity that enable more equal power in negotiations over condom use (Mantell et al., 2011). Interventions should shift the focus of improved condom negotiation skills from AGYW to young men, engaging men and boys in programmes which work to foster gender-equitable beliefs, behaviours, and actions, through gender-targeted initiatives that address gender norms and attitudes (Closson et al., 2018). There has been some success with ‘gender-transformative interventions’ in shifting harmful gender norms and roles through integrated community-based programming, and in doing so, achieving an improvement in structural and individual-level risk behaviours and sexual outcomes (Closson et al., 2018). Additionally, since condom use is
influenced by both individual and interpersonal level factors, there may be some value in targeting partner-level influences on condom use through interventions which include communication and negotiation skills training components, in order to empower AGYW to translate their safer-sex intentions into actual behaviour (Gause, Brown, Welge, & Northern, 2018).

Theme 5: Mistrust and disconnect between female learners and their teachers

Lead theme analyst: Zoe Duby

Rationale

Effective communication between adolescent girls and young women and teachers is important for positive behavioural outcomes, especially to sexual and reproductive health. There is a dearth of literature pertaining to student-teacher relationships and connectedness in the South African context, and in particular how this impacts on mental health and wellbeing, and SRH amongst AGYW. This paper explored the narratives of AGYW and teachers around support and trust in teacher-student relationships.

Summary of key findings

Emerging clearly in our analysis of the data from IDIs and FGDs with AGYW was the sentiment of the lack of trust that AGYW have in their teachers. Breaches in confidentiality were cited as a major issue.

They (teachers) have that weakness (gossiping)... that’s why we are now afraid to tell them our problem (MPU, IR, 20-24 years).

In situations where AGYW do confide in teachers, they feel that their trust is betrayed, and teachers gossip about them and judge them. Although teachers are in a position to provide accurate and impartial SRH information, and emotional support to AGYW to enable them to make safer and better-informed decisions, AGYW feel unable and unwilling to confide in, and seek support from teachers. The lack of effective communication and emotional support from teachers fosters a sense of isolation amongst AGYW, and negatively impacts their mental health, and school performance.

We can’t share things with our teachers. They are supposed to be our parents at school, but we can’t share things with them, because they can’t keep it with them... they will share it with other people, then you will see people giving you funny looks, so we don’t share our sexual and personal life things with them, because of how they are. (Instead) we keep it to ourselves, then some of us commit suicide (WC, IR, 15-19 years).
AGYW respondents voiced a desire for improved communication with, and increased emotional support from teachers, suggesting that AGYW feel that teachers would be appropriate adult support mechanisms.

Our parents are staying very far, we take them (teachers) as our parents. (MPU, IR, 20-24 years).

It is evident that some teachers themselves recognise that AGYW need psychosocial support, particularly those learners who are socio-economically disadvantaged. However, teachers often feel overwhelmed and lack the capacity to provide learners with the support they need.

I end up being a mother to a lot of children...it becomes a challenge because I reach home exhausted... I also realised that it was too much for me. ..they come if it is a major problem, a major problem, not one they can deal with, so I’ve seen that that challenges me a lot but I was helping no matter how tired I was... it was becoming too much (KZN, teacher).

Support from teachers can be an effective form of social support which helps to reduce HIV risk amongst adolescents; however, tailored combination social protection, inclusive of teacher support, is likely to be the most effective approach to reducing HIV risk amongst this age group. It has been suggested that the ability of South African teachers to engage and connect with their students may be improved by addressing poor working conditions (Fourie & Deacon, 2015). Teachers need to be supported in order to experience more meaning in their work, which would then enable them to make a positive difference in learners’ lives through building positive, trusting relationships.

Our findings provide valuable new insight into student-teacher relationships and connectedness in the South African context, how this impacts on educational attainment, and in particular how this impacts on the mental health and wellbeing, as well as sexual and reproductive health amongst AGYW. As is evident from our findings, AGYW desire and need better support from teachers, both academic and psycho-social. Such support would benefit the academic performance of AGYW, as well as have positive impacts on their mental health, general well-being, and potentially their sexual and reproductive health. It is likely that more trusting and supportive relationships between AGYW and teachers would improve the potential of AGYW for educational attainment and help to decrease rates of teenage pregnancy. For teachers to better provide the psychosocial and academic support that AGYW need, there is a need to leverage AGYW ecosystems to support prevention and risk reduction by addressing the disconnect between AGYW and their teachers. Efforts should be made to facilitate more effective support from AGYW in their SRH decision-making, including transformation of various levels of support, including teachers, ensuring avenues of key support such as integrated health delivery in schools.

**Recommendations for improving school connectedness**

**Support for and from teachers**
Support from teachers can be an effective form of social support which helps to reduce HIV risk amongst adolescents; however, tailored combination social protection, inclusive of teacher support, is likely to be the most effective approach to reducing HIV risk amongst this age group (Cluver et al., 2016). The ability of South African teachers to engage and connect with their
students may be improved by addressing poor working conditions (Fourie & Deacon, 2015). Teachers need to be supported in order to experience more meaning in their work, which would then enable them to make a positive difference in learners’ lives through building positive, trusting relationships (Fourie & Deacon, 2015).

**Staff training and education**
Evidence based interventions to address school connectedness and promote mental health amongst students include the provision of staff training and enhanced staff education and mental health literacy (Kern et al., 2017; Kutcher et al., 2016). School based mental health interventions should include a broad spectrum of prevention, referral, assessment, intervention, and counselling. The mental health literacy of teachers needs to be improved, with the provision of specific training in identifying common presentations of mental health issues, and picking up on early warning signs indicative of stress, anxiety, trauma, abuse, depression (Kern et al., 2017; Kutcher et al., 2016). Standard teacher training programmes need to incorporate curricula targeted at common mental health issues such as depression and suicidality, likely to be present in schools, and those which may affect school attendance and performance. The capacity of teachers to connect their learners to appropriate mental health support should also be enhanced, alongside instruction on how best to approach learners in a way that encourages them to discuss their concerns and feelings (Kern et al., 2017). Providing teachers with skills to assist in the identification and referral of mental health issues amongst learners may also help to address their own sense of feeling overwhelmed by the emotional and behavioural challenges in their classrooms (Fazel, Hoagwood, Stephan, & Ford, 2014).

**Increase awareness about school connectedness**
Teachers can play a critical role in promoting school connectedness through positive relationships with learners, building a positive school climate conducive to learning, and a culture of well-being (Kern et al., 2017). Teacher training should help foster an understanding of how levels of school connectedness and the school climate can influence learners’ academic achievement, positive peer interactions, social acceptance, and overall emotional well-being (Kern et al., 2017). Training teachers on how to identify a learner who is showing signs of disengagement and disconnectedness, and how and when to refer them for psychosocial support would also help to increase school connectedness (Kern et al., 2017).

Our findings provide valuable new insight into student-teacher relationships and connectedness in the South African context, how this impacts on educational attainment, and in particular how this impacts on the mental health and wellbeing, as well as sexual and reproductive health amongst AGYW. As is evident from our findings, AGYW desire and need better support from teachers, both academic and psycho-social. Such support would benefit the academic performance of AGYW, as well as have positive impacts on their mental health, general well-being, and potentially their sexual and reproductive health. It is likely that more trusting and supportive relationships between AGYW and teachers would improve the potential of AGYW for educational attainment and help to decrease rates of teenage pregnancy. Addressing the disconnect between AGYW and their teachers may go some way to improving AGYW psychosocial support, and in turn, lead to mitigating their HIV risk. Efforts to facilitate more
effective support from AGYW in their SRH decision-making and behaviour, need to include the provision of integrated health delivery in schools, of which mental health promotion is a key component.

**Theme 6: Transactional sex and transactional relationships**

**Lead theme analyst: Zoe Duby**

**Rationale**

The association of transactional sex and HIV in adolescent girls and young women (AGYW) in sub-Saharan Africa has been clearly demonstrated, with evidence showing increased susceptibility to HIV infection amongst AGYW who engage in transactional sex (Kilburn et al., 2018; Leclerc-Madlala, 2013; Ranganathan et al., 2018). AGYW who engage in transactional sex are more likely to experience poor sexual and reproductive health outcomes, including unintended pregnancies, unsafe abortions, sexually transmitted infections (including HIV), and sexual coercion (Choudhry, Ambresin, Nyakato, & Agardh, 2015). Amongst the reasons why transactional sex is associated with greater risk of contracting HIV are compromised gendered power relations and the likelihood of having multiple partners (SADHS 2016). Combining quantitative data on AGYW reporting of having engaged in transactional sex and relationships, alongside qualitative narratives and perspectives on transactional sex and relationships from AGYW and their male peers, this report is able to deepen understanding of these complex risk behaviours, and the factors that influence AGYW decision making around transactional sex, and help to inform interventions that seek to address sexual and reproductive health challenges amongst AGYW in South Africa.

**Summary of key findings**

The motivations for engaging in transactional sex and transactional relationships described in the qualitative data were complex, ranging from economic deprivation and contexts of poverty, to the desire for social approval, prestige, glamour and luxury.

> What often lead us to boys and end up sleeping with them is because you are unemployed and you need money... your family home needs money. You end up going out there... your parents are not working and they have nothing. You end up throwing yourself at a boy, not because you love them... because you want money, because that boy supports you. We also end up throwing ourselves at sugar daddies because of such things. (WC, AGYW, 20-24 years)

> I would like someone with money [laughter]. When he gives me money and maintains me, I will be satisfied, I don’t care if he has other girlfriends, I just don’t care [laughter] as long as he gives me money he’s done. (KZN, AGYW, 15-19 years)
Male perceptions of transactional sex amongst AGYW included views around alcohol being used as a currency for sexual exchange, the materialistic demands of AGYW, and concerns about AGYW’s multiple concurrent partnerships and resulting increased HIV risk for young men.

I prefer a girl who asks for money… because the girl who is self-sustained (doesn’t need your money), might leave you, she doesn’t feel like she needs you, she’ll leave. Whereas the one who asks for money, she might love you, even though it’s for the money, she loves you for the money, she still needs you. (NW, Male Peer)

Considering the apparent normalisation of AGYW engaging in transactional sex and relationships in these communities in South Africa, and the association between engaging in transactional sex and relationships with HIV risk, addressing these behaviours is critical as part of South Africa’s HIV response. Our findings help build the evidence base with which to inform the design of contextually appropriate interventions to address sexual risk amongst AGYW in South Africa.

**Recommendations to address issues related to transactional sex**

Interventions need to encourage AGYW to critically reflect on their own agency and choices in transactional sex and relationships, their aspirations for consumer items that symbolise a better life, as motivation for sexual exchange, and the norms and beliefs that sustain gender inequality in transactional sex relationships (Wamoyi, Stoebenau, Kyegombe, Heise, & Ranganathan, 2018). Young men also need to be encouraged to reflect on the gendered expectations of male provision and what it “buys” men in return (Stoebenau et al., 2016). ‘Gender transformative interventions’ that critically address shared societal expectations that women should have sex with men in return for their material/financial support should also be combined with economic empowerment interventions for AGYW that may help to reduce the extent to which AGYW need to rely on male providers (Stoebenau et al., 2019). Importantly, Wamoyi and Stoebenau (2018) make the recommendation that instead of interventions trying to address the practice of transactional sex itself, they should rather try to address the associated HIV risks, and integrate measures into broader empowerment and health interventions, rather than attempt to intervene on transactional sex alone (Wamoyi et al., 2018).

**Theme 7: Factors contributing to absenteeism of female high school learners**

**Lead theme analyst: Kealeboga Maruping**

**Rationale**

Education is a strong predictor of health and higher socio-economic status. A lack of school attendance increases the risk of adolescent girls and young women experiencing unintended pregnancy or contracting sexually transmitted infections, including HIV. In South Africa, school
attending and completing remain a problem, especially for AGYW who have a child before they reach the age of 18 years. This analysis aimed to explore and describe perceived barriers and enablers for AGYW successfully attending school.

**Summary of key findings**

Several factors described by participants overlapped between causing poor school attendance and school dropout. Factors including pregnancy, childcare responsibilities, low socio-economic status, interpersonal barriers, the school climate and education delivery overlapped between affecting school attendance and resulting in school dropout.

- *I dropped out of school and the time went on, I stayed home taking care of the baby... then I called myself to order and went back to school* (KZN, Intervention Recipient, 20-24 years)

- *The main reason for my absenteeism is that I don’t have soap to wash my uniform.* (KZN, Intervention Recipient, 15-19 years)

- *I won’t be able to raise my child, even though the father is maintaining the child, but I also have to play a role in the child’s life... If I decide to sit and do nothing... What if the father decides to leave us... And not maintain the child... I also have to study so that I can be able to work for my child... I am no longer studying for myself.* (IMP, Intervention Recipient, 15-19 years)

Participants further described what they believed enabled and promoted efficient school attendance. Provision of sanitary pads and food at school were described to enable school attendance for some study participants. AGYW who took part in intervention components also narrated how participating in the intervention positively influenced their school attendance, as they were able to see the value of school for their future.

In this study various perceived barriers were identified by study participants that they described as disruptive to school attendance and completion. Pregnancy and socio-economic barriers emerged as the foremost factors reported to result in high school absenteeism amongst our study population. In order to ensure pregnant AGYW remain in school better monitoring and tracing from the education department is needed. Furthermore, continued provision of supplies that decrease the burden of socio-economic barriers to school attendance is required to decrease school absenteeism.

**Recommendations for creating an enabling environment for high school attendance**

Based on the Constitution of South Africa, education is a fundamental human right, to support this, there needs to be stricter regulations to allow for pregnant AGYW to continue going to school, and programmes need to have a focus on offering support to AGYW who would like to return to school after giving birth. Furthermore, there needs to be improved monitoring and tracing of pregnant AGYW by the Department of Basic Education.

Greater efforts need to be made to support AGYW who find themselves in unfavourable circumstances that affect school attendance such as food insecurity and lack of sanitary pads. Our analysis found the provision of food and sanitary pads to have a positive impact on school attendance, thus it is important for policy makers to ensure these provisions continue to be made
and are monitored. Further research needs to be conducted in different quintile areas and report on the outcomes of provision food and sanitary pads which act as socio-economic barriers to school attendance.

**Theme 8: Perceptions of contraception services**

Lead theme analyst: Kim Jonas

**Rationale**

It is critical to ensure that access and use of contraception services for AGYW is aligned with their SRH behaviours, preferences, as well as their reproductive intentions (UNFPA, 2015; WHO, 2014)

Evidence on what works in reducing teenage pregnancy shows that SRH education, counselling and provision of contraceptives are effective in increasing adolescent’s knowledge of sexuality and health, contraceptive use and subsequently decreasing teenage pregnancy (Smith et al, 2018; Pillay et al, 2017; Jonas et al, 2016; Macloed et al, 2010; Wood et al, 2006; Geary et al, 2014). Thus, the health system needs to know to the needs of the AGYW in their specific context in order to be responsive and should have the capacity to deliver the services that meet the SRH needs of AGYW. This analysis sought to explore perceptions of contraception services among AGYW who were exposed to the combination HIV prevention intervention in order to identify barriers and enablers for contraceptive access and use as the intervention aimed to encourage access and linkage to these services.

**Summary of key findings**

At the intrapersonal or individual level, lack of knowledge about the different types of contraceptives and how they work was one of the main barriers to access and use of contraceptives according to the AGYW in this study. Limited knowledge of SRH, including contraception services among AGYW is not uncommon, and contributes to poor access and use of the services.

*To be honest, we are not sure but we know that the injection can prevent you from being pregnant, we don’t have much knowledge about the other issues like the fact that it makes your body to hang, the gaining of weight, and the issue of being wet. (AGYW 15-19 years, FGD, WC)*

With regards to the interpersonal level barriers, lack of support from parents and partners was a common theme in addition to the myths and misconceptions. It is unclear if parents do not support the use of contraceptives among AGYW in this study because of the myths and misconception and community norms around contraceptive use, or because of the thought that if their children are using contraceptives it will mean that they are sexually active, which parents do not approve of.

*I don’t think my mother would understand if I talk about going to prevent (family planning). She would think that I’m planning to have sex or that I have slept with a boy that’s why I want to go*
prevent or if I want to check for HIV she’d think that I’ve had sex with a boy... (AGYW 15-19 years, FGD, EC)

My boyfriend doesn’t know that I am on contraceptives I hide it from him, because if he found out, I don’t know what would happen because he doesn’t approve of me taking the injection... (AGYW 15-19 years, FGD, MP)

It’s not easy for some children to leave their home and go to the clinic because they can’t ask their parents to go to the clinic but here at school it would be easier for them to get help. (AGYW 15-19 years, FGD, KZN)

AGYW in South Africa experience difficulties in accessing contraception services mainly at the interpersonal and health service levels. Lack of support for the use of contraceptives from parents/caregivers as well as from sexual partners were key barriers at the interpersonal level; while provider negative attitude was the main barrier at the health service level. Views among school-going AGYW regarding the provision of contraception services on the school premises were positive but concerns around privacy and trust issues AGYW have about teachers and other learners weakened the feelings.

A substantial proportion of AGYW in this study viewed the use of contraceptives positively and important; however, limited knowledge hindered their potential to fully access and use the services. According to the AGYW, being part of the intervention helped improve their knowledge about contraceptives and improved their self-esteem, which enabled them to access contraception services. The combination HIV prevention intervention appeared to have helped AGYW as they reported to have gained knowledge about contraceptives, ability to communicate with parents/caregivers about SRH related topics and confidence in accessing contraception services.

Recommendations to address barriers to contraceptive access

Efforts to improve knowledge among AGYW pertaining to contraception services requires urgent attention to improve access and use of the services, and ultimately alleviate unintended and unwanted pregnancies among this subpopulation. It is crucial to escalate measures to increase SRH knowledge and information services for AGYW and promote the use of contraceptives. Additionally, this will help dismantle the myths and misconceptions around contraceptives which also came up as a serious barrier, and thereby improve the access and use of the services.

At the individual level, efforts to improve AGYW knowledge and information about contraception services should be strengthened. This can be done through comprehensive sexuality education inside and outside the classroom. Resources containing SRH information, such as myth busters and contraceptive method-specific information pamphlets and posters should be freely available and displayed in major youth-friendly zones, this way AGYW have the information at their disposal and can access it when necessary.

More research is needed to uncover the issues around the lack of parental and sexual partner support for the use of contraceptives for the interpersonal level barriers. Interventions to
improve parental/caregiver and sexual partner support for the use of contraception services by AGYW, as well as efforts to expand the provision of contraception services in the school premises are urgently needed. Partner support for the use of modern contraceptives has been a long-standing challenge in improving contraceptive uptake among women of reproductive age, particularly in the developing countries and is a cause for concern (Pillay et al, 2017; Chersich et al, 2017; Jonas et al., 2019; Mesfin et al., 2002; Ezeanolue et al., 2015; Mishra et al., 2014; Le Guen et al, 2015; Nguyen et al., 2014; Ijadunola et al, 2010; Vouking et al., 2014). Engaging partners, particularly male partners in SRH services has been shown to improve men’s knowledge and attitudes towards the use of contraceptives by their female partners (Ezeanolue et al., 2015; Mishra et al., 2014; Shattuck et al., 2011); Therefore, efforts to involve male partners, particularly young men in SRH interventions need to be accelerated to improve access and use of contraceptives by AGYW.

Community gatherings, church or other religious activities, and sports and recreational facilities and activities should be used to offer educational interventions and promote the use of contraceptives by AGYW as all stakeholders will be found in these settings. Interventions should address community norms and the myths around contraceptive use and the perceived future fertility decrease, as well as highlight the impact of unintended and unwanted pregnancy during adolescence with parents. Addressing the health services level barriers will require an entire health systems transformation where providers’ attitudes are improved, only competent youth-friendly providers are serving AGYW, responsive and time sensitive services are provided to AGYW, and prioritization and effective implementation of SRH policies for the youth are ensured. This requires a strong political will to advocate for and ensure availability of resources, including human resources for health for AGYW to fully access and use contraception services.

Improved access to and use of contraception services will enable AGYW to control their fertility, maximize educational and economic opportunities and enhance their SRH and wellbeing. This in turn, will reduce the unmet need for contraception and decrease the unintended and unwanted pregnancies among AGYW. Future interventions should incorporate multi-level approaches in addressing structural and contextual barriers to access and use of contraception services to gain maximum effect.

**Findings Part 2: Impact of the Intervention**

**Perceived impact of the combination prevention intervention on AGYW beneficiaries**

**Rationale**

Understanding the way in which intervention components are perceived and interpreted, and the ways in which meanings are ascribed to intervention activities is likely to affect not only an intervention’s acceptability, but also the behaviours of intervention recipients (Chandler et al,
Importantly, from the perspective of actors conceived as intervention ‘recipients’, the intervention activities may not be conceptualised in the same way as implementers or researchers conceive them (Chandler et al, 2013). Therefore, qualitative explorations of the experiences of those involved in the intervention can bring to light some of the complex individual, interpersonal, and contextual dynamics that affect behaviour, and ultimately, intervention outcomes (Chandler et al, 2013). It is crucial that intervention designers, implementers, and evaluators consider intervention recipients or beneficiaries’ experienced cognitive and emotional responses to the intervention (Sekhon et al., 2017).

Understanding the way in which AGYW themselves experienced and viewed the intervention and its impacts on their lives and behaviours, was one of the key objectives of the HERStory qualitative study. It is critical that AGYW intervention recipients perceive intervention components to be acceptable, appropriate and valuable, to increase their willingness to engage with intervention components and benefit from them.

**Summary of key findings**

Intervention recipient AGYW reported positive impacts on their lives as a result of participating in the intervention. One predominant theme to emerge in the qualitative evaluation related to AGYW views on how and why the intervention was impactful for preventive behaviour changes. AGYW stated that through participating in intervention components such as Keeping Girls in School, Rise clubs and Teen Parenting components, they learned self-respect, improving self-esteem and self-worth. They expressed enhanced emotional coping strategies and improved communication with parents/caregivers, improvements in sexual and reproductive health knowledge, and increased prioritisation of education over romantic relationships. Young women who had participated in the intervention also described ways in which their participation had improved their self-esteem and self-worth. There was a sense of young women feeling stronger and more empowered not to give into peer pressure, especially in relation to partying and substance use. Additionally, young women described improved mental health and wellness, through learning how to communicate feelings and emotions.

**Improved SRH knowledge and decision making**

Those AGYW who had participated in the intervention felt that improved knowledge pertaining to puberty, physical development, and sexual and reproductive health was one of the benefits of their participation. AGYW reported that they are not taught about puberty and sex at home, by parents and elders, so the information gained through the programme was invaluable. Better information about their bodies and about SRH was seen to contribute to safer sexual decision-making, and greater consideration and awareness of the consequences of having unprotected sex.

*This programme did change our lives because... now I know not to have unprotected sex. I know if I have unprotected sex there is HIV, but I had thought that HIV was something that you can’t get that easily. (KZN, 15-19 years, IR)*
I have learned that we must not engage in risky behaviours such as substance abuse, and people hear about sex but they don’t acknowledge the risks associated with it like teenage pregnancies and diseases. (EC, 15-19 years, IR)

It helped me... I always thought by seeing people having sex with no repercussions that it ends there, I also wanted to have sex because I am now older. With this programme I was able to see that I must not have sex because there are diseases and chances of falling pregnant (KZN, 15-19 years, IR)

There are things they tell us (in programme), that they don’t tell us at home, and you eventually find out that what they tell us can change my life. (KZN, 20-24 years, IR)

Being more informed helps AGYW make safer decisions, feel more empowered, and less vulnerable to influence from peers and boyfriends. In addition, an increase in SRH knowledge helped intervention recipients to negotiate contraceptive use with partners and increase their ability to discuss contraception with parents and caregivers.

One of the key impacts of the intervention as mentioned by participants was the belief in the importance of knowing their HIV status and getting tested regularly for HIV. The decision to get tested induced mixed emotions for AGYW, varying from being afraid and reluctant to being motivated and glad to get tested. AGYW highlighted that through their involvement in the intervention, they learned about the importance of getting tested and the implications it can have on their own personal health and others around them.

**Positive behaviour change**

Young women shared their perceptions of the positive behaviour changes that they have experienced as a result of participating in various intervention components. Through their participation in the intervention, AGYW described how they had a sense of improved self-esteem and self-worth. They felt that they had encouraged and motivated to persevere through the challenging circumstances they experienced in life and felt that they had acquired the skills to overcome limiting self-beliefs and perceptions. One aspect of the intervention that was reported as being impactful was that AGYW learned to consider the potential consequences of their decisions and how this could affect their future. Young women felt that participating in the intervention had helped to improve their motivation to study and do well at school. Several of the AGYW noted how they were encouraged to prioritise their studies and future aspirations rather than socialising, “going out” / partying, and giving into pressure from friends or male partners.

I see myself as someone who is different now because previously, I used to hang out with people who aren’t good, like people who are older than me, they used to pressure me to do things that are wrong.... But since I joined the group, I’m not with them anymore, I hang out with people who are better... (NW, 15-19 years, IR)

Being part of the (KGIS) group... has helped me with a lot of things... it helped me out of things like peer pressure. A lot of the time I was being pushed by peer pressure and they made me do things that I didn’t want to do... My marks started to drop and now I see that they’re increasing. (NW, 15-19 years, IR)
The main cause of this thing of dodging school and stuff is because of alcohol and drug use and peer pressure. So the awareness we got from Keeping Girls in School about these things kind helps us to check what is right and what is wrong. (EC, 15-19 years, IR)

Through their participation in intervention components, AGYW perceived themselves to be more capable of making decisions that promoted their personal well-being. AGYW described improvements in their self-assertiveness and self-efficacy, in making healthy choices about their lives.

I had many friends and they were involved in drugs, and I learned from Rise about how to deal with substances and pressure and I decided to stop going with these friends and associated myself with those who were not on drugs. (EC, 15-19 years, IR)

It (KGIS) has taught me to be more assertive, it was difficult for me to say no to a person so at least now if I am not comfortable to do something for that person I am able to say no. (EC, 15-19 years, IR)

For those AGYW who participated in the intervention, encouragement they received to attend school and motivation for future aspirations played a role in improving school attendance. Credit was given by teachers to the intervention components which helped encourage learners to remain in school even when they have had a child.

Improved communication skills

Participating in the intervention components positively impacted AGYW in addressing communication barriers. Several of the young women reported how participating in the clubs helped them to develop communication techniques which made it easier to connect and build relationships with their parents, and close family members. AGYW who had participated in the intervention described its impacts on their relationships and communication around SRH with their parents. The discussions related to intervention components which included the provision of SRH and rights education to AGYW in and out of school. AGYW felt that the interventions had given them the courage to speak openly with their parents about SRH issues. Specifically, the AGYW explained that by having more accurate SRH information, they felt better prepared and more empowered to talk to their mothers. Intervention participants also noted that their participation had helped them to deal with parents’ adverse reactions to questions/discussions around sexuality, enabling them to negotiate initial communication barriers and have open, informative discussions. A new-found ability to discuss SRH matters more openly also led to some AGYW having greater access to and support for using contraceptives from their mothers. Participating in the intervention clubs also connected AGYW to alternative channels of information, support and advice. Notably, parents of AGYW who had participated in the intervention also felt that there had been positive impacts. The knowledge that their daughters were receiving SRH information facilitated more open and honest conversations, and thus enabling parents to better support their daughters.

Sexual communication skill development was central to AGYW perspectives on the intervention’s impact. For many of the participants, being encouraged to be assertive and say “no” was
perceived to positively impact their behavioural choices. Participants reported that it helped them to withstand peer pressure, negotiate the delay in the onset of sexual intercourse, feeling increased confidence to discuss sex with a partner as well as instilling an awareness to take an active role in protecting their own well-being. Through the encouragement of intervention facilitators and their peers, AWYG learned about the importance of being empowered in the context of sexual relationships and taught them how to communicate their needs and demands to their partners. Learning about what constitutes a healthy relationship and understanding their value and worth as women helped AGYW develop the confidence and skills to deal with difficult encounters.

**Improved access to psycho-social support**

AGYW spoke about the psycho-social support they had gained as a result of being involved in the interventions. One aspect of the intervention that was particularly impactful related to the relationships that AGYW built with the club facilitators. These relationships were characterised by trust and support, boosting AGYW confidence, and fostering an ability to interact and speak openly about their problems. The development of improved behavioural and communication skills, and the creation of spaces for young women to talk and express their feelings, in turn helped AGYW to navigate difficult social settings. Club facilitators were seen as figures of support for AGYW, often extending their role beyond the intervention. AGYW felt that by having someone they could trust, who cared about their well-being was a transformative experience in their lives. In the context of many of the AGYW reporting their challenging relationships with adults in their lives, and their inability to trust and open up to adults, the positive relationships they formed with facilitators was in contrast to this.

**Improved mental health and well-being**

AGYW who had participated in intervention components described positive impacts on their mental health as a result. In terms of AGYW narratives around how participating in intervention components impacted on mental health, most described a positive impact. One way in which participation in the intervention had a positive impact on AGYW well-being is through building self-esteem. Those AGYW who had participated in the intervention clubs also described how their participation had resulted in improved mental health and wellness, through learning how to communicate feelings and emotions. Several intervention recipients reported that through the sessions, they learnt strategies for coping with emotional challenges. Peer-to-peer support was a central aspect of the intervention clubs; as well as receiving support from others, AGYW commented on how they had learned sharing and listening skills. The intervention included specific components designed to build self-esteem and self-confidence amongst AGYW, as well as provide supportive peer networks.

Participating in intervention components, especially the peer clubs, gave AGYW a sense of having a safe space in which to gather and talk about their feelings, problems, and access support from their peers and the club facilitators. AGYW who had participated in the intervention reported
improved ability to communicate their feelings, part of broader improvements in being able to cope with problems.

(In Rise) I have learned that you have to be assertive... and I learned to communicate and I learned that it is not healthy to keep things in you that might damage you, they might have an impact on you. (EC, 15-19 years, IR)

I was unable to express my emotions... I was unable to cry or I would keep that pain to myself and it will hurt me for a long time. So, I was taught that, the right approach is to get someone who you can trust and talk with, or cry if needed, so that you can be have peace. (MPU, 15-19 years, IR)

According to the young women who attended the intervention club meetings, the aspect of “sisterhood” created amongst group members was central. Not only did AGYW feel that they gained support from the clubs, but they also felt that their ability to support others was enhanced. AGYW voiced how during their participation in the intervention that they learned to listen to others and how this could be used as a tool to help other young women needing advice or someone to talk to. Levels of self-awareness increased, with some of the participants recognizing that they themselves had perpetuated cycles of judgement and stigmatization of other young girls and that being part of the intervention has helped them to change by listening, respecting and helping others.

When I got to Rise, I had felt that I had no one but I find that they where my sister, what I learned from them is that I must respect their views and opinions so that they can respect mine as well. So at Rise I learned that each one must teach one, thank you. (Eastern Cape, AGYW 15-19 years, IR)

The majority of empirical evidence on the protective effects of social support for mental health have been based on ‘naturally occurring social relationships’, such as family and friends; there have been many attempts to replicate these positive effects through interventions, with varying success (Casale et al., 2019). Small group interventions can have a positive impact on promoting self-esteem and social support, both of which are necessary precursors to positive behaviour change (Thurman, Kidman, Carton, & Chiroro, 2016). Close peer friendships have been shown to enable adolescents, particularly females, to disclose, and thus seek support (Camara et al., 2015). Emotional support, including offering empathy and simply ‘being present’, is the most appreciated kind of support for adolescents, the feeling of being listened to is valued more than receiving actual advice (Camara et al., 2015). Interestingly, supportive relationships are more effective when they are reciprocal, with the giving of support being inseparable to the process of receiving support (Camara et al., 2015). Interventions for AGYW that comprise of group-based interventions for improving AGYW SRH and reducing HIV risk by providing access to safe social spaces where participants are able to develop and strengthen their peer networks, receive curriculum-based education on SRH and gender have been found to be associated with improved self-esteem and social networks, as well as improvements in SRH knowledge and behaviour (Plourde, Ippoliti, Nanda, & McCarraher, 2017).
Skills development

AGYW reported favourably on the practical support and skill development they received in the intervention, particularly in relation to career advice, learning to write a CV, perform in a job interview, register at university or navigate subject choices at school. For some, the practical support and encouragement helped instil the confidence they needed to pursue further education.

Theme 9: AGYW perspectives on how their lives were impacted by participating in Rise clubs

Lead theme analyst: Wilme Verwoerd

Rationale

HIV incidence among adolescent girls and young women (AGYW) aged 15-24 years in sub-Saharan Africa remains exceptionally high. Evidence shows that no single HIV prevention strategy will be effective in controlling the HIV pandemic. Research in recent years demonstrates the need for combination HIV prevention efforts, including biomedical, behavioural, and structural interventions. Designing combination packages that are population specific, acceptable and effective remains a challenge for researchers. This paper explores the perceived impacts of a combination HIV-prevention intervention on the lives of AGYW in South Africa. This qualitative study explored adolescent girls and young women’s’ perspectives of how their lives were impacted by participating in a combination HIV-prevention intervention in South Africa. The findings add to the growing body of research on combination HIV prevention interventions and enables an in-depth understanding of the barriers that AGYW face in navigating their sexual and reproductive health.

Summary of key findings

Findings suggest that AGYW mostly perceived positive impacts and experiences by participating in the Rise Clubs intervention. Findings show that the intervention was perceived to improve AGYW lives and personal development, specifically sexual self efficacy, self confidence and self esteem. It was perceived to positively impact their ability to communicate and develop and maintain healthy relationships with family, peers and partners. From the perspectives of AGYW, the intervention helped increase their sexual and reproductive health knowledge which improved their ability to better navigate safer sexual relationships while also encouraging positive behavioural choices such as prioritising education and avoiding high risk activities including alcohol and substance abuse.

I love Rise... since this Rise club came yes... Rise woman’s club... if you have problems, you can talk in a group then we are able to help in some other ways (Northern Cape, 20-24 years)
For me Rise has done only good. Only good, because Rise has taught me a lot, and that if you have a problem you must be able to talk and be able to receive help... Our Rise group... has shown us that when a person has a problem, you must talk, maybe there is something we could help with. (KZN, 20-24 years)

I have learned from Rise how to abstain from sexual activities and when you are sexually active that you must use protection, because nowadays, boys can also go for prevention, and also with peer pressure, you must be able to say no if you don’t want to, you must be able to stand your own ground and think things through before you do. (Eastern Cape, 15-19 years)

Overall, the findings demonstrate that intervention recipients perceived positive impacts on their lives as a result of participating in the intervention. Understanding the perspectives of AGYW, a specific population group, who participated in the intervention, is helpful in order to assess the benefits and perceived impacts of such an intervention on the lived realities of intended beneficiaries. The findings also demonstrate the possible benefits of including gender specific components which incorporates peer support as part of combination HIV prevention interventions.

Recommendations for future interventions for AGYW

Given the urgent need to identify strategies that effectively reduce HIV risk among adolescent girls and young women, it is crucial to understand how best to maximize the positive impacts of combination HIV prevention interventions. By exploring the perspectives of intervention recipients, it enabled an in-depth understanding of the challenges AGYW face in their social environments, how this impacts their behaviour and their health outcomes and gave insight into how the intervention was perceived to change this. While the narratives of AGYW described in this study reflects mostly positive impacts of the Rise intervention such as promoting behaviour change and improved SRH knowledge, it also highlights the complex web of factors that need to be considered and addressed when implementing interventions among most-at-risk populations such as AGYW. In the context of this study, the impact of structural and social factors such as poverty, unemployment, unequal and patriarchal gender norms and relations, as well as hindered access to education and health care facilities all played a considerable role in shaping decision making around contraceptive use and access to SRH services and information for AGYW. Ultimately, this research underscores the need for combination HIV prevention strategies, because no matter how empowered or knowledgeable AGYW perceived themselves to be after participating in the intervention, unless other structural, social and personal barriers are addressed, HIV prevention efforts to reduce HIV risk will not be as effective.

Interventions focused on HIV risk reduction among high risk populations such as AGYW, should consider incorporating self-esteem-building components with a “gender transformative” approach which actively seeks to transform harmful gender norms (Dworkin, Treves-Kagan and Lippman, 2013). These findings suggest that combination interventions aimed at preventing HIV incidence in specific populations such as AGYW could benefit from incorporating young men too. While gender inequality disproportionately affects women and HIV incidence continues to disproportionately affect women compared to men, addressing it requires working with both men and women (UNAIDS, 2016; Dunkle and Jewkes, 2007). To protect women from HIV infection we must find ways to empower them through programmes and policies which increase
access to education, SRH information, economic and political resources as well as social support which allows women to meet in groups and gain practical solutions from each other (Gupta, 2002; Dworkin, Treves-Kagan and Lippman, 2013). At the same time, intervention efforts promoting sexual and family responsibility should also be aimed at young boys and men (Gupta, 2002). Dunkle and Jewkes (2007) argue that effective HIV prevention requires work with boys and men which should challenge and actively transform harmful gender norms that legitimize male power, control and risk taking.

**Theme 10: AGYW perspectives on aspects of the intervention that did not work well**

The accessibility and timing of intervention activities was something that AGYW respondents noted as problematic. Specifically, activities that were held after school were viewed as inaccessible to the majority of learners.

*If it is an afternoon programme most kids do not attend, they just rush back home... most kids shy away from these kinds of afternoon programmes and decide to go home... We need to do away with programmes offered only in the afternoon. These programmes should be offered during normal school teaching time... when most learners are at school. (Western Cape, AGYW Intervention Recipient, 15-19 years)*

Additionally, activities that took place during school lunch hours were also regarded as inaccessible and inappropriate.

*(We don’t participate because) most of the time we’re busy during lunch... they come during lunch and we are busy. (KZN, AGYW non-intervention Recipients 15-19 years)*

In situations where logistical or transport plans fell through, and AGYW intervention recipients were not properly or timeously informed of the changes, they became frustrated.

*I did not like the issue of time... When they promise to fetch you at 08:00 they will come at 09:00. We become angry because when we leave our homes, we don’t eat breakfast because we think that they will give us breakfast, but when we arrive there’s no breakfast. The issue of time is a thorny issue... And sometimes, they will call us to meet somewhere, and only to find that, the arranged transport will not come, and if that is the case, they cancel, after waiting for a long time at the station, that too is a thorny issue.... That is what we don’t like because they promise to come and we had to wait for hours at the station and they end up not coming.... They don’t explain, they just say, it has been cancelled.... They don’t tell us... We don’t feel good... (MPU, AGYW Intervention Recipient, 15-19 years)*

Some AGYW felt that the intervention components were not useful or beneficial and were of limited scope.
I think I benefited more on academic programmes currently offered at school. When it comes to girl empowerment programmes, I do not see much change... (Western Cape, AGYW Intervention Recipients 15-19 years)

Theme 11: Community members’ perceptions of the impact of the intervention on the lives of adolescent girls and young women

Lead theme analyst: Kealeboga Maruping

Rationale

Individuals who form part of young people’s interpersonal socio-ecological system play an important role as gatekeepers. Existing research has highlighted the importance of taking into consideration the context of the communities in which health interventions are implemented, as acceptability and understanding of such interventions within the community play an important role to the success of such programmes. Therefore, although it is important to focus on intervention recipients, it is also worth investing time and energy in ensuring that there is buy-in from members of their interpersonal spheres. Within the community context, the success of certain programmes is reliant on the community’s perceived benefit of the programme, not only for intervention recipients, but for the community in general. In this paper we aimed to evaluate the outcome of a combination HIV prevention intervention; with a particular focus on perceptions of individuals in the interpersonal spaces of AGYW.

Summary of key findings

Framing our findings within the interpersonal sphere of the socio-ecological framework, community member respondents narrated various changes they observed in those AGYW who had participated in intervention components. Some positive changes that were noticed by community member respondents included outcomes related to behaviour, health, education/school and AGYWs self-concept. Furthermore, participants relayed some issues that were perceived to have a negative impact on the lives of AGYW, that took place during the implementation of the intervention. Some of the negative occurrences included AGYW being absent from school and missing academic assessments in order to attend intervention activities and learning sessions taking place during class time, as reported in some schools. In our study we found more beneficial aspects in addition to AGYW learning about the topic of sexuality.

A person will say Yes, I know my status, some they never thought about testing you see. We promote that they must go to the clinic (WC, Programme Facilitator)
There’s even a big difference in the rate of pregnancy... there is a big difference... Whereas the statistics were once very high in the previous years. (KZN, Teacher)

It (participating in the intervention) gave them (AGYW) self-confidence. It developed them, their self-image, as a whole, it really was very very positive (EC, Teacher)

In general, it was noticed that community members’ perceptions of the impact of interventions was positive. It was further acknowledged that community member buy-in, played an important role in intervention implementation, especially given the age range of intervention recipients. It is important to take into consideration that the reach of HIV prevention interventions does not only involve intervention recipients, but also key players in their interpersonal lives. Furthermore, as evaluators, it is also important to take into consideration how community-based interventions are perceived by the key role-players in AGYW’s lives. Therefore, for the success of these community- and school-based interventions, it is important that key role players in the interpersonal lives of intervention recipients find the intervention acceptable and have a positive perception of its impact.

**Recommendations to increase community acceptance of interventions**

Future interventions need to consider the socio-ecological system of AGYW and involve different stakeholders. It is important to take into consideration that the reach of HIV prevention interventions does not only involve intervention recipients, but also key players in their interpersonal lives; thus, parents and caregivers, who are the gatekeepers to AGYW need to be provided with similar SRH learning materials that intervention recipients receive in order to improve the sustainability of the interventions. For the success of these community- and school-based interventions, it is important that key role players in the interpersonal lives of intervention recipients are included in the design and implementation of HIV prevention interventions so that they can perceive interventions as acceptable.

**Findings Part 3: Lessons on Implementation**

**Theme 12: Recruitment and Retention of AGYW - Challenges, Successes and Lessons learned**

Lead theme analyst: Tracy McClinton Appollis

**Rationale**

Sufficiently high levels of recruitment and retention of participants is critical for the implementation and evaluation of sexual and reproductive health interventions. In this study, experiences were explored and perceptions of participants, implementers and facilitators of the recruitment and retention strategy for the combination HIV prevention intervention targeting
adolescent girls and young women aged 15-24 years. Our findings highlight the facilitators and barriers to recruitment and retention.

**Summary of key findings**

Both recruitment and retention were a challenge across the three intervention components reviewed. The quantitative analysis shows recruitment to have been low in all three intervention components. Qualitative analysis revealed that retaining AGYW was a key challenge faced by most of the intervention implementers and facilitators, especially for those components engaging out-of-school youth.

Respondents reported facilitators and barriers/challenges to recruitment and retention of the intervention components on the four socio-ecological levels (individual, interpersonal, organizational and community). On the individual level, a key facilitator to successful recruitment and retention found was motivation. Motivation was reported in all forms, AGYW expressing self-motivation where they volunteered to join the activities either due to being driven by curiosity and an interest in extra-curricular activities at school; their desire to want to help other communities, also known as altruism; through seeking help with peer pressure most researchers include incentives, or wanting to be part of the fun activities planned by the components. Another key facilitator was incentives for participants in the study or intervention protocol to aid or motivate participants during recruitment and retention. Incentives such as money, refreshments, and gift vouchers have been shown to play an important role in improving recruitment and retention of participants. Participants report more willingness to participate in future studies if incentives are provided including payment for the cost of transport to the study venue, a small financial incentive (ideally in the form of cash), and the provision of food during the study visit. Facilitators and implementers felt that contextually relevant incentives were needed such as toiletries or vouchers. Among individual level barriers, there appeared to be a false expectation among AGYW that they would receive money or jobs for attending the intervention components, only to later discover that they were not, which led to dropout.

*The hype is always high, everyone wants to be part of the club right... sometimes most of them they get disappointed that they are not giving them a daily job so they start falling off and going because the dynamic and the challenges they are faced with...Some they stay here because they can see the bigger picture, there’s just going to be a struggle it going to take long but at the end of the day there’s light at the end of the tunnel. These are the girls that are having children, they need to feed them these are the girls that are child headed families, they need to put bread on the table. So they want something that is quick quick that can give them money.* (Programme Implementer, North West)

Interpersonal level barriers experienced were due to competing interests in other activities or family responsibilities and a lack of childcare in the older groups.

*You see that a person looks interested in the programme but there is something that poses as a barrier, and when you try to dig deep and hearing others saying this and that, and you feel that no, her boyfriend does not want her to continue says that he does not like this and that, and you can see she is aware that attending this programme could help her so that he gets away from out of the situation she is in.* (Programme Facilitator, KwaZulu-Natal)
These barriers have been reported by previous studies as well, with time spent away from family and other commitments as well as issues relating to transport as barriers or challenges related to all study types. In order to reduce this barrier, other studies provided informal childcare for participants which included toys and snacks for children. On the organizational level, structural barriers such as the inability to disrupt the school curriculum and to conduct intervention components after school hours due to safety concerns. Facilitators’ only option therefore, was to make use of interval sessions which limit the time able to run sessions.

We must not disturb the teachers’ working schedule. So, if I meet them after school, others when they go far, they have to go because they can’t walk alone, (or) go in isolation if she travels a long distance, if those she travels with have left, she also must leave...So, at the end, the attendance drops. (Programme Facilitator, North West)

Another organisational level challenge expressed by intervention implementers that AGYW spoke about was the need to improve communications when it comes to dates and times for meetings as school announcements in the morning can be missed by those who come late to school. Community level challenges centre around the struggle to reach participants who are out of school and in the community. Furthermore, participants trust the school administration and participants are therefore likely to want to participate if the study is done through the school.

Recommendations to improve recruitment and retention in interventions

An intervention is more likely to be successful if enough time is taken to carefully plan the recruitment and retention strategy. This report identified facilitators and barriers reported by AGYW, intervention implementers and facilitators to recruitment and retention of three components of a combination HIV prevention intervention. Recruitment and retention in AGYW SRH interventions is challenging and presents with many barriers as demonstrated by the findings of this study. Addressing some of the findings mentioned in this study can lead to improvements. These include ensuring participants are fully aware of what is expected from them and the benefits of the intervention. This could be achieved by working with parents and communities and preparing short descriptions of the study in easy-to-read flyers highlighting the benefits of the intervention components; choosing appropriate incentives according to your target population’s needs; making childcare options available for intervention participants; safe means of transport for after-school programmes and sending reminders about meeting dates to participants. To the best of our knowledge, there has not previously been any study of this kind in South Africa. These findings can help implementers to plan future interventions or improve and adjust current programmes.

Limitations of the HERStory Qualitative Study Component

There are some important limitations in interpreting the findings of this study. One such limitation is the qualitative nature of the study and thus, the findings cannot be generalized. The purposive sampling approach, both for the districts and AGYW included in this study is another important limitation which may potentially bring bias to our findings. The respondent sample of the qualitative study component was limited in some respects. Other than the AGYW sample
groups, there was a limited number of parents, male peers, teachers, programme facilitators,
and community leaders interviewed. Amongst the parents interviewed, there was a lack of
representation of fathers/paternal figures. Additionally, there was a selection bias in the small
sample of teachers and parents interviewed. Sampled teachers included those who were already
engaged in extracurricular activities at the schools, and/or teaching Life Orientation classes.
There is a likelihood that our sample included only those teachers who were more committed
and engaged.

Limitations regarding the scope of this study relate to it being conducted in specific communities
(5 sites in the qualitative component) in selected districts of South Africa, and therefore these
findings are not generalisable to a national level. However qualitative research rarely aims to be
generalisable, offering rich descriptive data from small samples, rather than representative
samples.

It is possible that positive reports on the impacts of the intervention may have in part be due to
social desirability bias. Although the research team was independent from the intervention,
participants may still have viewed the interviewers as connected to the implementers, and
therefore shared positive opinions. Given that this project was evaluating the combination
intervention within the school and community setting, respondents were often under the
impression that the research team were connected to the intervention, even after going through
the informed consent, and explaining our positionality to the intervention. During analysis, it was
noted and acknowledged that there may be some social desirability bias, particularly amongst
community leaders and teachers who may have wanted the programme to either continue or
return to their communities and schools.

Way Forward

What AGYW want / need

The qualitative evaluation findings showed that among adolescent participants, the lack of
availability of SRH services in the school environment, peers’ negative experiences of
contraceptive services as well as limited parental/caregiver support of the use of such services,
contributed to poor access and use of contraceptives, exacerbating the risk of unintended
pregnancies. AGYW believed that knowledge gaps and misinformation about contraceptives
were further barriers to their use, and they expressed a need for more information on
contraceptives.

AGYW voiced need for provision of contraceptives. Currently family planning and sexual health
services are not available at schools. This means that AGYW have to go to the clinic/hospital for
family planning, where they feel that their needs are not prioritised. AGYW suggested that SRH
services at schools could be framed within broader “student wellness”, which might help to improve AGYW access to contraception, confidential HIV testing & STI screening and treatment services. AGYW shared their views that having contraceptives provided at school would reduce barriers to parental acceptability of young women using contraceptives. The majority of school-age AGYW felt that it would be beneficial to bring contraceptive services and other SRH services such as HIV testing and treatment into the school environment. However, they believed that the branding of such services as “HIV” or “SRH” may limit their acceptability, due to the stigma associated with the use of such services. School endorsement of SRH services in the school environment was perceived as a way of legitimating such services in the eyes of parents, potentially overcoming barriers related to parental support and acceptance. Parents may be more likely to accept their daughters’ use of contraceptives if provided by the school than if acquired at a public clinic.

AGYW also voiced a need for the provision of menstrual management and hygiene products. AGYW described factors such as provision of sanitary pads and the implementation of school food programmes to encourage them to attend school, despite socio-economic difficulties. This supports existing research which has evidenced the provision of food in school to improve learner attendance.

There was a demand from AGYW and other community members for similar programmes and interventions that could reach young men and boys, to reduce rates of teen pregnancy, and other positive SRH outcomes, as well as to reduce gender-based violence, and intimate partner violence. One need identified by AGYW was comprehensive sex education for boys and girls. Respondents suggested that SRH education should be provided at school, preferably by an external educator, not by teachers, whom AGYW mistrust. Based on their own experiences, AGYW who had participated in intervention components, also suggested that parents would also benefit from being engaged in SRH education interventions, to improve parents’ understanding of AGYW SRH issues, update their knowledge with regards to contraception and health services, and in turn help to close the generation/knowledge gap, making it easier for AGYW to seek their support.

There is a need for a standardised approach to supporting for pregnant learners, and teen parents that includes continued schooling during and postpartum. Respondents voiced a need for peer counselling, education and support from AGYW who are already parents. AGYW want school-based support groups where young mothers come to speak about own experiences with pregnancy and having children, to share with other young women how difficult it is in reality, and to dispel misconceptions about the glamour and romance of having a child.

There was a strongly voiced need for better psycho-social support mechanisms for AGYW. AGYW suggested that they would benefit from access to social workers and counselling, specifically mental health support and counselling during school hours. They expressed the desire for access to external counsellors and/or social workers (not affiliated to the school). Another overarching theme that AGYW expressed was the need for better and more meaningful parental support and engagement. AGYW expressed a desire for parents to be engaged in interventions. Other psycho-
social needs that AGYW listed included weekend activities for young people, and better platforms for peer support.

Educational needs that AGYW described included educational support, bursaries for tertiary education, career guidance, financial literacy and business skills. AGYW also shared their wish for improved support from teachers and educators at school.

Conclusions

Through employing qualitative methods as part of the intervention evaluation study, we were able to shed light on the ways in which the intervention was perceived by AGYW who participated in the intervention, as well as a range of other community stakeholders. Importantly, our research also made it possible to contextualise the intervention, providing in-depth data on the lived experiences of AGYW in the study communities, and describing the socio-cultural factors and contexts that influence AGYW risk and vulnerability. Our qualitative analysis was able to complement the quantitative evaluation by providing in-depth insight into perceived successes and failures of the intervention package components on target outcomes, the facilitators and barriers to uptake of the different intervention components, and the perceived impact of the intervention on the lives of AGYW. The narratives of AGYW described in the HERStory qualitative evaluation provide rich insight into aspects of the social environment that influence decision-making around sexuality, condom and contraceptive use and other sexual and reproductive health issues, as well as school attendance and completion, amongst AGYW in South Africa, and can help to inform the design of future interventions.

Our findings show that AGYW in South Africa face substantial social adversities and related mental health challenges due to a range of SRH, social, economic, environmental, physiological, and interpersonal factors. Risk behaviours such as engaging in transactional sex and transactional relationships, and engaging in condomless sex, or having multiple sex partner were described by AGYW respondents, and were informed by a complex range of social and sexual norms including dynamics of gendered power. Low levels of HIV testing, access, and uptake and difficulties in accessing contraception services, are impacted by barriers existing at the individual level, as well as interpersonal, health service and structural levels. A lack of psycho-social support negatively impacts on various domains in AGYW lives, including mental health, SRH, and educational attainment.

AGYW perspectives on the impact of the intervention included improvements in SRH knowledge and decision making, positive behaviour change, improved communication skills, increased access to psycho-social support, and improved mental health and well-being. According to AGYW, being part of the intervention helped improve their knowledge about contraceptives, which combined with improved self-esteem, enabled them to access contraception services. The combination HIV prevention intervention appeared to have helped AGYW as they reported to
have gained knowledge about contraceptives, ability to communicate with parents/caregivers about SRH related topics and increased confidence in accessing contraception services.

To address problems related to the dual burden of psychological distress and sexual risk behaviours and clustering of psychosocial conditions experienced by AGYW, comprehensive HIV prevention programming and SRH services should include mental health support and screening. Efforts need to be made to increase social support for AGYW from family and community members, as well as from teachers. In the educational sphere, where early pregnancy and socio-economic deprivation create barriers to AGYW school attendance and completion, there needs to be better support for pregnant learners, and for those AGYW who want to return to school after giving birth.

In terms of AGYW risk behaviours, our findings show that condom use amongst AGYW was influenced by a range of individual, interpersonal, and socio-cultural level factors. Adding to HIV risk, is the widespread practice and normalisation of AGYW engaging in transactional sex and relationships. To address barriers towards consistent condom use, and address some of the motivations to engage in transactional sex and relationships, there need to be more efforts to engage young men and women in dialogues about gender to critique and deconstruct existing notions of manhood and womanhood, and reinforce positive forms of masculinity that enable more equal power in negotiations over condom use, and gendered expectations of sexual exchange. The focus on improving condom negotiation skills should be shifted from AGYW to young men, engaging men and boys in programmes which work to foster gender-equitable beliefs, behaviours, and actions, through gender-targeted initiatives that address gender norms and attitudes. integrated community-based programming to shift harmful gender norms and roles through ‘gender-transformative interventions’ would also be of benefit. AGYW need to be encouraged to critically reflect on their own agency and choices in transactional sex and relationships, aspirations for consumer items that symbolise a better life, as motivation for sexual exchange, and norms and beliefs that sustain gender inequality in transactional sex relationships. HIV risks associated with transactional sex and relationships, and condomless sex, should integrated into broader empowerment and health interventions, rather than attempt to intervene on these risk behaviours alone.

In order to address barriers to open sexual and reproductive health communication and accurate information, there needs to be meaningful engagement of parents/caregivers in adolescent SRH, with more opportunities for communication and collaboration among parents/caregivers, and the provision of accurate and up to date information to parents/caregivers. In order to overcome barriers to AGYW accessing contraception services, efforts need to be made to dismantle myths and misconceptions around contraceptives, through providing comprehensive sexuality education inside and outside classrooms. Efforts to enhance parental/caregiver and sexual partner support for AGYW use of contraception services and expand provision of contraception services in school would also be of benefit. At the health facility level, efforts need to be made to address providers’ attitudes, ensuring youth-friendly, responsive and time sensitive services.
In order to address the suboptimal rates of HIV testing amongst AGYW in South Africa, strategies to promote and increase demand for HIV testing, including provision of more granular, age, gender and sexual-behaviour specific information on HIV risk, and information on where and how to access testing services and post-test support are care need to be implemented. Efforts need to be made to address low risk perception, through provision of thorough counselling around negative HIV tests and sources of potential on-going HIV-infection risk. Stigma that operates across individual, interpersonal, community, and structural levels needs to be addressed. There should be additional efforts to create youth-friendly services, home-based, community-based and school-based testing services, and improving the integration of HIV testing with reproductive health services.

Recommendations for consideration by future interventions include more involvement of stakeholders including parents and caregivers in SRH intervention for AGYW. Influential community stakeholders could be more involved in the design and implementation of HIV prevention interventions, specifically through working with parents and communities to inform and prepare for interventions and ensure effective and appropriate implementation.
References

AVAC. (2018). Breaking the cycle of transmission: Increasing adoption of and adherence to effective HIV prevention among high-risk adolescent girls and young women (pp. 1-44).


Lewin Simon, Glenton Claire, Oxman Andrew D. Use of qualitative methods alongside randomised controlled trials of complex healthcare interventions: methodological study BMJ 2009; 339 :b3496


Mantell, J. E., Smit, J. A., Beksinska, M., Scorgie, F., Milford, C., Balch, E., et al. (2011). Everywhere you go, everyone is saying condom, condom. But are they being used consistently? Reflections of


Thurman TR, Kidman R, Carton TW, Chiroro P. Psychological and behavioral interventions to reduce HIV risk: evidence from a randomized control trial among orphaned and vulnerable adolescents in South Africa. *AIDS Care*. Taylor & Francis; 2016 Mar 17;0(0):8-15.


Appendices

Appendix 1: HERStory Qualitative manuscripts

Published manuscripts


Manuscripts under journal review

Duby, Z., Isaksen, K., Jonas, K., Maruping, K., Dietrich, J., Lovette, A., Kuo, C. & Mathews, C. (Under review). "I can’t go to her when I have a problem": sexuality communication between South African adolescent girls and young women and their mothers: Implications and recommendations for sexual and reproductive health.


Duby, Z., Jonas, K., Maruping, K., McClinton Appollis, T. & , Dietrich, J., Vanleeuw, L., Mathews, C. (Under review). “There is no fear in me... well, that little fear is there”: dualistic views towards HIV testing among South African Adolescent Girls and Young Women.


Duby, Z., McClinton Appollis, T., Jonas, K., Maruping, K., Dietrich, J., Lovette, A., Kuo, C., Vanleeuw, L. & Mathews, C.. (Under review). “In this place we have found sisterhood”: perceptions of how participation in a peer group club intervention for adolescent girls and young women in South Africa impacted on wellbeing, self-esteem, and peer support.


Manuscripts in development


Chigwanda, R., Duby, Z., Jonas, K., Maruping, K., McClinton Appollis, T., Colvin, C., Mathews, C. (Under review). Understanding the decision-making processes of South African Adolescent girls and young women around accessing Sexual and Reproductive health services


Verwoerd, W., Duby, Z., Jonas, K., Maruping, K., McClinton Appollis, T., Swartz, A. & Mathews, C. (Under review). Perspectives of adolescent girls and young women on how their lives were impacted by participating in a combination HIV-prevention intervention in South Africa: a qualitative study.
Appendix 2: Interview Topic Guides

Appendix 2a
QUALITATIVE GUIDE #1: INTERVIEWS AND FOCUS GROUP DISCUSSIONS WITH AGYW 15-24 YEARS – INTERVENTION RECIPIENTS

Introductory Script for Interviewer:
Thank you for agreeing to be part of this study and to take part in an interview or group discussion. Our goal is to hear the stories and experiences of young women and girls. There are programmes that have been running in your school that provide support to female learners by providing peer education, health education, homework support, career guidance, as well as counselling, education and health services. Some schools also have clubs that offer life skills and empowerment activities, and link young women to educational and economic opportunities and health services. Some of these programmes are run in the community around the school.

Effects / Impact of Intervention
1. What do you know about programmes like these offered
   • in your school
   • in your community

2. Tell me about your experiences with these programmes?
   • what you enjoyed the most
   • what you enjoyed the least

3. We are interested in hearing your stories and thoughts about how the programmes have affected your life.
   • How much and in what ways has the programme, or things you learned in the programme changed: (examples & personal stories)
     o your daily life
     o how you feel about yourself
     o how you act in your romantic relationships
     o how you plan for the future

4. Do you feel that these programmes have changed your situation:
   • At school
   • At home
   • In the community
   • In your relationships

5. If you think about everything you learned in the programme, what was:
   • Most useful for you
   • Least useful for you
• What would you still like more information on?

Health System Experiences
We are interested in hearing from you about the health education and health services you and your friends receive at school and in the community. We are especially interested in health education and health services that focus on HIV, TB, and other STIs, teen pregnancy, and stress and depression, and your experiences with these.

6. What health education have you and your friends received at school?

7. What health services have you and your friends received at school?
   • How much do these services meet you and your friends’ needs?
   • What do you like about these services?
   • What don’t you like about these services?
   • What could be improved about these services?
     Probe on: HIV testing/ HIV treatment / TB / Sexual and reproductive health (STIs, Pregnancy, Contraceptives) / Mental health

Individual and Family Experiences
8. We are interested in hearing about how young women and girls like you have happy and safe sexual relationships.
   • Can you describe:
     o your ideal ‘dream’ romantic partner?
     o the way your partner/s treat you in your romantic and sexual relationships?

9. We would like to hear about how young women and girls like you look after their health in relationships and about what you need to support you to protect yourself and your health in relationships.
   a) How much do you think about health and well-being your daily life?
   b) How much do you worry about your health?
   c) How easy or difficult is to talk about sex and sexual health, to:
      o Your boyfriend/s
      o Your friends
      o Your parents
   d) What makes it easy or difficult for young women and girls like you to use condoms?
   e) What makes it easy or difficult to ask a partner about their HIV status?
   f) To what extent do you worry about violence in your relationships?

10. Which people in your life are most helpful in helping you deal with your problems and concerns?
    • Who do you talk to about relationship problems?
    • Who do you talk to about problems at school?
    • Who do you talk to about health concerns?
      o Probe for parents, siblings, family, teachers, health workers, peers, heath educators / peer educators
• How have they helped/supported you?
• Did you receive any support from the programme?
• What support do you wish you had received? And from whom?

School Experiences and Future Planning
We would like to hear about your school life and education.

11. Could you tell us about any things that make it easy or difficult to:
   • attend school
   • achieve good grades
   • stay in school
   • plan for your future

12. What kind of support do you get at school to help you:
   • attend school
   • get good grades
   • make plans for your future
   • Did the intervention change the way you feel about school?
     ○ Your motivation to stay in school
     ○ Belief in yourself that you can do well and succeed in your education

13. Tell us about your plans and thoughts about your future
   • How do you feel about your future?
   • How do you imagine your ideal future?
   • What are your goals and dreams?
   • How easy or difficult do you think it will be to reach these goals?
     ○ What would make it easier for you to reach your goals?
   • To what extent has being part of the programme helped you plan and prepare for your future - e.g. after you finish school?
   • What did you receive from the programme to help you plan for your future?
     ○ Information received?
     ○ Services received?

Closing
We want to make sure that we have gathered all the advice that we can from young women and girls like you.

14. In this community, what things do you think would help improve the lives of young women and girls like you?
Appendix 2b
QUALITATIVE GUIDE #2: INTERVIEWS AND FOCUS GROUP DISCUSSIONS WITH AGYW 15-24 YEARS – NON-INTERVENTION RECIPIENTS

Introductory Script for Interviewer:
Thank you for agreeing to be part of this study and to take part in an interview or group discussion. Our goal is to hear the stories and experiences of young women and girls.

Programme Participation
We know that there may be different programs for young women and girls like you in your community apart from school, for example programmes offered by NGOs or churches.

1. We would like to hear anything you know or have heard about any programmes for young women and girls in your community?
   - Describe
   - Examples

2. We would like to hear if you’ve had any experiences participating in any kind of programme?
   - (If yes): Can you tell me a bit about any programme that you have participated in?
     - Probe: programme name, activities?
     - To what extent would you say that participating in the programme has affected your life?
     - Probe: education? Health? Livelihood/economic status?

3. We would like you to share with us anything that you might have heard about any of other programmes for young women and girls your community?
   - (If yes) What have you heard about other programmes?
     - Programme activities
     - Community perceptions of programmes
     - Positive things heard
     - Negative things heard
   - How would you describe your feelings about not being involved in these programmes?
     - To what extent would you like to be involved in this kind of programme in the future?
   - Did you know any girls involved in these programmes?
     - (If yes) how would you describe the effects that being in these programmes had on them?

Health System Experiences
We are interested in hearing from you about the health education and health services you and your friends receive at school and in the community. We are especially interested in health education and health services that focus on HIV, TB, and other STIs, teen pregnancy, and stress and depression.
4. What health education have/do you and your friends receive/d at school?

5. What health services have/do you and your friends receive/d at school?

6. What health education have you and your friends received in the community?

7. What health services have you and your friends received in the community?

8. To what extent do these services meet you and your friends’ needs?
   a. What could be improved about these services?
   b. What are the best parts of getting services for:
      - HIV testing?
      - HIV treatment?
      - TB?
      - Sexual and reproductive health (STIs, Pregnancy, Contraceptives)?
      - Mental health?
   c. What is the most challenging part?

Individual and Family Experiences

9. We are interested in hearing about how young women and girls like you have happy and safe sexual relationships.
   • Can you describe your ideal romantic partner?
   • Can you describe the way your partner/s treat you in your romantic and sexual relationships?

10. How much do you think about health and well-being your daily life?
    • How much do you worry about your health?
    • What kinds of things do you do to look after your health and well-being?

11. We would like to hear about how young women and girls like you look after their health in relationships.
    g) What makes it easy or difficult for young women and girls like you to use condoms?
    h) What makes it easy or difficult for young women and girls to get their partner/s to use condoms?
    i) What makes it easy or difficult to go and get tested for HIV?
    j) What makes it easy to ask a partner about their HIV status?
    k) To what extent do you worry about violence in your relationships?
    l) To what extent do you worry about pregnancy in your relationships?
    m) To what extent do you worry about sexually transmitted infections in your relationships?
    n) What kinds of help have you received from people, services or organisations to help you feel safe, protected and happy in your relationships?
12. What adults in your life are most helpful in helping you meet the challenges of being a young women or girl in South Africa? (Probe for parents, family, teachers, health workers)
   - What kinds of support have they given you?
   - If you have not received all the support you need from adults in your life, what kind of support do you wish you had received? And from whom?

13. If you needed help with family planning, condoms, STI treatment, unhappiness, abuse or other health needs, which adult would you trust with these issues?

14. What makes it easy/difficult to approach (name adults below) to get help with these things?
   - Parents? easy / difficult
   - Family? easy / difficult
   - Teachers? easy / difficult
   - Health workers? easy / difficult

School Experiences and Future Planning
We would like to hear about your school life.

15. Could you tell us about any things that make it easy for you to attend school and get good grades?

16. Could you tell us about any things that make it difficult to attend school and achieve good grades?

17. What kind of support do you get at school to help you:
   - Attend school
   - Cope with homework and tests
   - Do well at school?

18. To what extent have you received any help to make plans for your future?
   - Help finding out about careers
   - Training on how to apply for a job
   - Help with planning further studies after you leave school

19. What has helped you most to prepare for your future?
   - Could you describe any things that have made it easy or difficult for you to plan your future when you leave school?

Closing
We want to make sure that we have gathered all the advice that we can from young women and girls like you.

20. In this community, what things do you think would help improve the lives of young women and girls like you?
   - What could help young people to:
• stay healthy and happy?
• feel loved and accepted?

We really value your opinions and we would like to thank you for your time. To end our discussion, is there any other advice you would like to give us or any other information you want to share with us?
Appendix 2c
QUALITATIVE GUIDE #3: INTERVIEWS WITH PARENTS OF INTERVENTION RECIPIENT YOUNG WOMEN AND GIRLS 15-24 YEARS

Introductory Script for Interviewer:
Thank you for agreeing to be part of this study and to take part in an interview or group discussion. Our goal is to hear the views and opinions of parents whose children have been involved in some of the programmes that have been running in schools in your community.

The programmes have been providing support to female learners by providing peer education, health education, homework support, career guidance, as well as counseling, education and health services. Some schools have also been offering clubs that offer life skills and empowerment activities, and link young women to educational and economic opportunities and health services.

Experience and Perceptions of Global Fund Programme
1. Please tell us about what you know about any programmes like this:
   - Programmes at your child’s school
   - Programmes in the community
   - In your understanding, what happens in these programmes?

2. We would like to hear about your daughter’s involvement in any of these programmes
   - How much has your daughter been involved in a club or a programme?
   - In your opinion, to what extent has club membership affected your daughter’s life? Explain.
   - To what extent have there been changes in how your daughter interacts with people in her life after joining the club? (Probe: you, family, other significant people)
   - In your view, to what extent do clubs make a difference to the lives of young women and girls like your daughter?
   - What sort of impact, if any, do you think these clubs have had on your community?
   - Have these clubs made any other differences in your life, your daughter’s life, or the lives of girls in your community that you want to share with us?
     - Positive differences
     - Negative differences

Family Experiences
We would like to hear about how parents interact with young women and girls, especially around topics including relationships, health and well-being.

3. We would like to hear about the ways in which parents like you prepare your daughters for happy, healthy, and safe sexual relationships?
   - How similar is this preparation for sons?
   - How different is it for sons?

4. To what extent do you discuss health and well-being with your daughter?
   a) What kinds of things do you discuss with your daughter about relating to health and well-being?
b) To what extent do you discuss HIV with your daughter?
   o What kinds of things do you discuss?
     ▪ Probe: what it is, how you get it, how to get tested, how to protect yourself
   o How easy or difficult is it to discuss HIV with your daughter?
     ▪ What kinds of things make it easy / difficult?

c) To what extent do you discuss pregnancy with your daughter?
   o What kinds of things do you say to your daughter about pregnancy?
     ▪ Probe: how pregnancy occurs, contraception, ideal timing for pregnancy
   o How easy or difficult is to discuss pregnancy & contraception with your daughter?
     ▪ What kinds of things make it easy / difficult?

d) To what extent do you discuss condoms with your daughter?
   o What kinds of things do you say to your daughter about condoms?
   o How easy or difficult is to discuss condoms with your daughter?
     ▪ What kinds of things make it easy / difficult?

5. What is the most important thing that you can do, as a parent, to help your daughter meet the challenges of being a young woman in South Africa?
   • What kinds of support you have given?
     o Which of these has been the most important?
     o Which of these has been the most helpful?

Health System Experiences
We are interested in hearing about all about the health education and health services your daughter receives. We are especially interested in health education and health services that focus on HIV, TB, and other STIs, teen pregnancy, and stress and depression.

6. What kinds of health education and health services does your daughter receive?
   • Do you think these meet her needs?
   • What can be improved about these services?

School Experiences and Future Planning
We are interested in hearing about your daughters’ school life.

7. Are there things that make it easy for her to:
   • attend school
   • get good grades

8. Are there things that make it difficult for her to:
   • attend school
   • achieve good grades

9. What kind of support does she get at school to help her:
   • Attend school
   • cope with homework and tests
   • succeed
10. Has she had help to:
   • find out about careers
   • apply for a job
   • planning further studies after she leaves school
   • Who has provided this help?
   • What things have helped her?

11. What kinds of things have made it difficult for her to plan her future when she leaves school?

   We’d like to hear anything you know about any programmes running in your daughter’s school that provide homework help and home visits to girls who are absent from school.

12. Please tell us what you know about any programmes like this
   • To what extent has your daughter been involved in programmes like this?
     o To what extent has this her involvement in these programmes changed your daughter’s educational experience?
     • Probe: opinions about attendance, school performance, motivation to engage in homework and other educational activities

13. What sort of impact, if any, do you think programmes like these have had on your community?
   • To what extent have these programmes made any other differences to:
     o your life
     o your daughter’s life
     o the lives of girls in school
   • Positive differences
   • Negative differences

   We want to make sure that we have gathered all the advice that you may have for us.

14. In this community, what things do you think would help improve the lives of young women and girls?
   • What could help young people to:
     • stay healthy and happy?
     • feel loved and accepted?

   We really value your opinions and we would like to thank you for your time. To end our discussion, is there any other advice you would like to give us or any other information you want to share with us?
Appendix 2d
QUALITATIVE GUIDE #4: INTERVIEWS WITH TEACHERS OF YOUNG WOMEN AND GIRLS

Introductory Script for Interviewer:
Thank you for agreeing to be part of this study and to take part in an interview or group discussion. Our goal is to hear the views and opinions teachers in schools in which the Global Fund Programmes have been implemented. We specifically want to explore teachers’ opinions of Soul Buddyz Clubs, Rise Clubs, Keeping Girls in School Programme for girls in secondary schools, and Career Jamborees for Grade 9 learners which all take place at lunch, after school, or on weekends.

Experience and Perceptions of Global Fund Programme
We are interested in hearing what you know of the Soul Buddyz or Rise Clubs / Women of Worth at your school or in the community.

1. Could you tell us what you know about these programmes and clubs?
   • how would you describe these programmes and clubs?
   • Can you describe what happens in the programmes and clubs?

2. How would you describe your experience of participating as a facilitator in these clubs?
   • What was easy?
   • What was difficult?

3. Could you tell us your views and opinions on different aspects of these clubs.
   • What worked well in the clubs?
   • What things would you want to improve about the clubs?

4. To what extent has club membership affected the girls in this school?
   • In what ways has it affected them?
   • examples

5. To what extent do the clubs make a difference to the lives of young women and girls in this school and community?
   • In what ways has it made a difference?
   • In what ways has it made no difference?
   • examples

6. Have these clubs made any other differences in the school environment, the lives of girls, or in your community that you want to share with us?
   • Positive differences
   • Negative differences
We are interested in hearing what you know of the Homework Support Programmes and Career Jamborees at your school or in the community.

7. In your own words, how would you describe:
   • Homework Support Programmes
   • Career Jamborees

8. What kind of support do the girls in this school receive to:
   • help them attend school regularly
   • cope with homework and tests
   • get good grades
   • How well does the support work?
   • How do the girls in this school respond to this support?

9. Please tell us about what is offered to the girls in this school to:
   • help them make plans for their future when they leave school
     o career development
     o help with applying for jobs
     o future studies
   • How well does the support work?
   • How do the girls in this school respond to this support?

10. What else is needed to help girls prepare for their future as successful young adults in South Africa?

**Schools as “One stop shops”**

We would like to hear teachers’ opinions on how well their school functions as a **School Nodes of Care**, or the ability of schools to serve as one-stop shops for service delivery including access to social grants, and to identify and support vulnerable children through mobilising resources in the school and the community.

We are interested in hearing about the health education and health services that the girls in this school are offered. We are especially interested in health education and health services that focus on HIV, TB, and other STIs, teen pregnancy, gender-based violence, and stress and depression.

11. What health education and health services are girls in this school are offered?
   • To what extent do you think schools should serve as a place where children can get access to health services? Why?
   • To what extent has the health education and health services affected the girls in this school? In what ways?
   • What is your own view of the education and services?
   • How well do you think they work?
   • What could be improved?

12. To your knowledge, what kind of help do the girls in this school receive from people, services or organisations to help them:
   • feel safe from violence
   • protect themselves from STIs and teen pregnancy
• be healthy and happy

13. To what extent would you say that the interventions strengthened the school system?
   o How and in what way?

14. To what extent was the intervention integrated into the education system?
   • To what extent would you say that the implementation activities generated ownership of
     the intervention by schools?
     o How and in what way?
     o What could have been done differently?
   • To what extent did the integration result in the intervention being seen to be “co-owned
     by schools?”
     o What could have been done differently?

Closing
We want to make sure that we have gathered all the advice that you may have for us.
15. In this community, what things do you think would help improve the lives of young women and
    girls?
    • What could help young people to:
      • stay healthy and happy?
      • feel loved and accepted?

We really value your opinions and we would like to thank you for your time. To end our discussion, is
there any other advice you would like to give us or any other information you want to share with us?
Appendix 2e
QUALITATIVE GUIDE #5: INTERVIEWS WITH SOUL BUDDYZ AND Rise CLUB FACILITATORS

Introductory Script for Interviewer:
Thank you for agreeing to be part of this study and to take part in an interview or group discussion. Our goal is to hear the views and opinions teachers in schools in which the Global Fund Programmes have been implemented. We specifically want to explore teachers’ opinions of Soul Buddyz Clubs, Rise Clubs, Keeping Girls in School Programme for girls in secondary schools, and Career Jamborees for Grade 9 learners which all take place at lunch, after school, or on weekends.

Experience and Perceptions of Global Fund Programme
We are interested in hearing the experiences of facilitators with Soul Buddy or Rise Clubs / Women of Worth programmes.

1. Please tell us about how you became a facilitator of Soul Buddy/Rise clubs.
2. In your words, what is the main purpose of the clubs?

We are interested in hearing about the Soul Buddy that you facilitate.

3. What happens in the Soul Buddy Clubs?
4. In your view, how well do the Soul Buddy Clubs work?
   a. Which things work?
   b. What doesn’t work?

5. In your own words, describe the last club meeting that you facilitated.
   a. How many young women or girls were present?
   b. Please describe in detail what happened during the meeting
   c. What do you think you achieved from the meeting?
   d. Was anything difficult about the meeting?
      o if yes, please describe.
   e. How typical was this meeting of usual club meetings?
   f. What are the main:
      o barriers for success of these Soul Buddy Clubs?
      o facilitators for success for these Soul Buddy Clubs?

6. How would you describe the experience of facilitating the Soul Buddy Clubs?
   a. What makes facilitation hard?
   b. What strategies make facilitation effective?

7. In your view, to what extent do young women and girls participate in the Soul Buddy Clubs and appreciate them?
8. To what extent has membership of **Soul Buddyz Clubs** affected the young women and girls in this community?

9. What did young women and girls respond most positively to in the **Soul Buddyz Clubs** experience?

10. Do you think **Soul Buddyz Clubs** make a difference in the lives of young women and girls like you?

11. What parts of **Soul Buddyz Clubs**:
   a. work well for young women and girls?
   b. What parts of **Soul Buddyz Clubs** are most useful for giving young women and girls the best skills for protecting themselves from HIV?
   c. What parts of the club do NOT work well for young women and girls (Probe for facilitators, content, place/time/location of delivery, format)
   d. What changes should we make to these clubs so that they prepare young women and girls to be strong, healthy, and successful?

   *We are interested in hearing about the **Rise Clubs / Women of Worth** that you facilitate.*

12. What happens in the **Rise Clubs / Women of Worth**?

13. In your view, how well do the clubs work?
   a. Which things work?
   b. What doesn’t work?

14. In your own words, describe the last club meeting that you facilitated.
   a. How many young women or girls were present?
   b. Please describe in detail what happened during the meeting
   c. What do you think you achieved from the meeting?
   d. Was anything difficult about the meeting?
      o if yes, please describe.
   e. How typical was this meeting of usual club meetings?
   f. What are the main:
      o barriers for success of these **Rise Clubs / Women of Worth**?
      o facilitators for success for these **Rise Clubs / Women of Worth**?

15. How would you describe the experience of facilitating the **Rise Clubs / Women of Worth**?
   a. What makes facilitation hard?
   b. What strategies make facilitation effective?

16. In your view, to what extent do young women and girls participate in the **Rise Clubs / Women of Worth** and appreciate them?

17. To what extent has membership to **Rise Clubs / Women of Worth** affected the young women and girls in this community?
18. What did young women and girls respond most positively to in the Rise Clubs / Women of Worth experience?

19. Do you think Rise Clubs / Women of Worth make a difference in the lives of young women and girls like you?

20. What parts of Rise Clubs / Women of Worth:
   a. work well for young women and girls?
      o facilitators, content, place/time/location of delivery, format
   b. What parts of Rise Clubs / Women of Worth are most useful for giving young women and girls the best skills for protecting themselves from HIV?
   c. What parts of the club do NOT work well for young women and girls (Probe for facilitators, content, place/time/location of delivery, format)
   d. What changes should we make to these clubs so that they prepare young women and girls to be strong, healthy, and successful?

Closing
We want to make sure that we have gathered all the advice that you may have for us.

21. In this community, what things do you think would help improve the lives of young women and girls?
   • What could help young people to:
     • stay healthy and happy?
     • feel loved and accepted?

We really value your opinions and we would like to thank you for your time. To end our discussion, is there any other advice you would like to give us or any other information you want to share with us?
Appendix 2f
QUALITATIVE GUIDE #6: INTERVIEWS WITH COMMUNITY LEADERS

Introductory Script for Interviewer:
Thank you for agreeing to be part of this study and to take part in an interview or group discussion. Our goal is to hear the views and opinions of community leaders from communities in which programmes for young women and girls have been implemented.

The programmes have been providing support to female learners by providing peer education, health education, homework support, career guidance, as well as counseling, education and health services. Some schools have also been offering clubs that offer life skills and empowerment activities, and link young women to educational and economic opportunities and health services.

We would like to hear your thoughts and views on the programmes that have been implemented recently in your community.

2. To what extent has this programme had an effect on your community? – describe effects
   • Short term effects?
   • Long term effects?
   • Beneficial effects?
   • Harmful effects?
   • Expected effects?
   • Unexpected effects?

3. In your opinion, which part of this programme that had the biggest impact on your community?
   • On the girls in the programme
   • On the community in general
   • What would you change about the programme to make it better?

4. To what extent were you, as community leadership, involved in the programme? – explain
   • Describe what role you played
   • Extent to which you were involved in and consulted on programme design?
   • Extent to which you were involved in implementing programme activities?

5. What were your initial thoughts when you first heard about the programme?
   a. What were your expectations for the programme?
   b. Were those expectations met? (probe: how, explain)

6. To what extent would you say that the programme was considered credible and acceptable in your community?
   • To what extent was there any opposition to the programme in the community? – describe what, why, from whom?
   • To what extent did the community support these programmes? – describe what and why

7. To what extent would you say that the programme activities were aligned with established local structures and processes such as:
• Annual district work plans
• Community health committee structures/meetings
• National roadmaps
  o Ways they were aligned
  o Ways they were not aligned

8. We would like to hear your opinions on whether or not the interventions strengthened existing systems:
   • To what extent did the intervention strengthen the school system?
     o How and in what way?
   • To what extent did the intervention strengthen the health system?
     o How and in what way?

9. To what extent was the intervention integrated into:
   • health system
   • education system
   • What features influenced the extent to which it was integrated?
   • To what extent would you say that the implementation activities generated ownership of the intervention by:
     o schools
     o communities
   • How and in what way?
     o What could have been done differently?
   • To what extent did the integration result in the intervention being seen to be “co-owned”?
     o What could have been done differently?

We want to make sure that we have gathered all the advice that you may have for us.

10. In this community, what things do you think would help improve the lives of young women and girls?
   • What could help young people to:
     • stay healthy and happy?
     • feel loved and accepted?

We really value your opinions and we would like to thank you for your time. To end our discussion, is there any other advice you would like to give us or any other information you want to share with us?
Appendix 2g
QUALITATIVE GUIDE #7: IN-DEPTH INTERVIEW / FOCUS GROUP DISCUSSIONS WITH MALE PEERS AND PARTNERS

Introductory Script for Interviewer:
Thank you for agreeing to be part of this study and to take part in an interview or group discussion. Our goal is to hear the views and opinions of people in your community. We’re interested in hearing about relationships between men and women in your community.

1. How should men / boys behave in their relationships?
   - Why?

2. How should women / girls behave in a relationship?
   - Why?

3. Can you describe your ideal partner?
   - Why is this ideal?
   - What would an undesirable partner be like?
     - Why?

We’re interested in hearing about how decisions are made in relationships between men and women in your community.

4. In relationships between men and women, who usually makes decisions?
   - decisions about sex
     - when to have sex
     - if condoms should be used
   - To what extent are these decisions discussed between the partners?
   - Who usually suggests / initiates sex in relationships?
     - Why / how?
   - Other decisions in the relationship
     - Decisions around contraceptives
       - Are these discussed?
     - Decisions about HIV testing

   - Where do young people get their information about sex?
     - About safe sex
     - About HIV?
     - Where do boys get info?
     - Where do girls get info?

   - How easy or difficult is it to get tested for HIV in your community?
     - For boys
     - For girls
   - How easy or difficult is it to discuss HIV with your partner?

Closing
We want to make sure that we have gathered all the advice that we can from people in the community.

5. In this community, what things do you think would help improve the lives of young people?
   
   - What kinds of programmes and services do young people in your community need?
     - Girls needs
     - Boys needs
   - What could help young people to stay healthy and happy?

We really value your opinions and we would like to thank you for your time. To end our discussion, is there any other advice you would like to give us or any other information you want to share with us?
Appendix 2f
QUALITATIVE GUIDE #8: INTERVIEWS WITH PROGRAMME IMPLEMENTERS
Global Fund Principal Recipients and Sub Recipients

Introductory Script for Interviewer:
Thank you for agreeing to be part of this study and to take part in an interview or group discussion. Our goal is to hear the views and opinions of Programme Implementers for the Global Fund Programmes.

We would like to hear about your experiences implementing the Global Fund projects.

1. As an introduction, could you tell us:
   • Which programme you have been involved with?
   • Which community it has been implemented in?
   • What is your role in the implementation?
   • How long have you been involved in this project?

2. How would you describe your experiences implementing the following:
   • *Soul Buddyz Clubs*
   • *Rise Clubs*
   • *Keeping Girls in School Programme*
   • *Other components of the intervention*

3. We would specifically like to hear about the process of setting up the projects
   • What worked well
   • What challenges did you face
   • What would you do differently?
   • Were you supported in this process?
   • What would have improved this?

4. We would like to hear about your relationships with existing structures in the communities
   • To what extent did you link up to existing structures?
     o Describe and give details
   • What worked well?
   • What was challenging?
   • What would you differently?
   • Were you supported in this process?
   • What would have improved this?

   • To what extent did the intervention strengthen the *school system*?
     o How and in what way?
     o Probe on:
       ▪ Care provided
       ▪ Data systems
       ▪ Capacity building

   • To what extent did the intervention strengthen the *health system*?
     o How and in what way?
o Probe on:
  ▪ Care provided
  ▪ Data systems
  ▪ Capacity building

• To what extent did implementation activities aim to generate ownership of the intervention by:
  o schools
  o communities
  o How and in what way?

• To what extent was the intervention integrated into:
  o the health system
  o education system
  o What features influenced the extent to which it was integrated?
  o Probe on:
    ▪ Intervention alignment with priorities of health and education systems
    ▪ Intervention physically integrated into health system, financially and operationally integrated.
  o To what extent did the integration result in the intervention being seen to be “co-owned”?

• To what extent would you say that there were power issues between implementers and key role players?
  o In schools
  o In the health system?
  o To what extent were the relationships between implementers and schools/communities based on trust?

• To what extent did the organisational culture of existing structures affect implementation?
  o Schools
  o Health services

5. We would like to hear about your relationships with other implementing partners
• To what extent did you collaborate with other implementing partners?
  o Describe and give details
• What worked well?
• What was challenging?
• What would you differently?
• Were you supported in this process?
• What would have improved this?

• In what ways could you have established the relational aspects of the partnerships differently?

• To what extent did you have, or not have enough time for establishing the relational aspects of the partnerships?
6. We would like to hear about your relationships and linkages with other services
   • To what extent did you have relationships and linkages with other services?
     o Describe and give details
   • What worked well?
   • What was challenging?
   • What would you differently?
   • Were you supported in this process?
   • What would have improved this?

7. How would you describe the impact that these programmes have had on the communities they have
   been implemented in?
   • Describe & explain
   • Positive impact
   • Negative impact

8. What advice would you give to someone / organisations setting up similar projects in the future?
   • How should one manage the implementation of external interventions in ways to maximise
     implementation?
   • How should one manage the implementation of external interventions in ways to maximise
     sustainability?

9. To what extent were there mid-stream adaptations to the intervention activities in response to:
   • Contextual constraints
   • Iterative learning
     o What were these adaptations?
   • To what extent did shocks and stressors in the wider context affect implementation?
     o Probe on violence

Closing
We want to make sure that we have gathered all the advice that you may have for us.

10. In this community, what things do you think would help improve the lives of young women and
    girls?
    • What could help young people to:
      • stay healthy and happy?
      • feel loved and accepted?

We really value your opinions and we would like to thank you for your time. To end our discussion, is
there any other advice you would like to give us or any other information you want to share with us?
Appendix 3: Demographic Information Forms (DEM)

Appendix 3a: Demographic Information Form for AGYW (English)

INTERVIEWER READS:
Thank you for being a part of our research. As you know, HIV affects many people. People live in different places, with different customs, cultures, sexual practices, and beliefs. We hope to include people from different communities in our research. We respect all people. Not all questions we ask in our research will apply to you. Because we do not want to make assumptions, we ask the same questions to everyone. We want you to be comfortable in speaking with us. You do not have to answer any question that makes you uncomfortable.

The following are some basic questions regarding your background to help us know what type of people participated in the discussion for this study. All the information you provide will be kept confidential and will not be shared with anyone else besides the research study staff.

Now I am going to ask you some questions about yourself. The answer to these questions will tell us more about who you are, such as your age and ethnicity. I will also ask you about your sex and gender. Please feel free to ask any questions about things that you don't understand.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is your date of birth?</td>
<td>dd MMM yy</td>
</tr>
<tr>
<td>2. What is your age?</td>
<td></td>
</tr>
<tr>
<td>3. What sex were you assigned at birth?</td>
<td>1 Male 2 Female 3 Intersex 4 Prefer not to answer</td>
</tr>
</tbody>
</table>
| The next question asks about gender. Gender is the social part of being male or female, and relates to your self-identity. I am asking whether you consider yourself to be male, female, transgender male, transgender female, gender variant, or if you identify yourself in an additional category.
4. **How do you identify your gender?**

   *This item must be self-reported by the participant. Site staff are encouraged to document in chart notes if the participant, during study participation, prefers to be referred to by a specific pronoun or gender*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td>Male</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
</tr>
<tr>
<td>3</td>
<td>Transgender</td>
</tr>
<tr>
<td>4</td>
<td>Gender variant</td>
</tr>
<tr>
<td>5</td>
<td>Prefer not to answer</td>
</tr>
<tr>
<td>6</td>
<td>Other self-identity, specify: __________________</td>
</tr>
</tbody>
</table>

5. **How do you identify your sexual identity?**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>Straight / Heterosexual</td>
</tr>
<tr>
<td>2</td>
<td>Gay / Homosexual</td>
</tr>
<tr>
<td>3</td>
<td>Lesbian</td>
</tr>
<tr>
<td>4</td>
<td>Bisexual</td>
</tr>
<tr>
<td>5</td>
<td>Not sure / Undecided</td>
</tr>
<tr>
<td>6</td>
<td>Prefer not to answer</td>
</tr>
<tr>
<td>7</td>
<td>Other, specify: __________________</td>
</tr>
</tbody>
</table>

6. **What is the language most spoken at home?**

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>IsiZulu</td>
</tr>
<tr>
<td>2</td>
<td>Sesotho</td>
</tr>
<tr>
<td>3</td>
<td>IsiXhosa</td>
</tr>
<tr>
<td>4</td>
<td>Setswana</td>
</tr>
<tr>
<td>5</td>
<td>Siswati</td>
</tr>
<tr>
<td>6</td>
<td>English</td>
</tr>
<tr>
<td>7</td>
<td>Afrikaans</td>
</tr>
<tr>
<td>8</td>
<td>English</td>
</tr>
<tr>
<td>9</td>
<td>Other, specify: __________________</td>
</tr>
</tbody>
</table>

7. **Who do you currently live with?**

   *(Mark all that apply)*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Parent/s / mother / father</td>
</tr>
<tr>
<td>2</td>
<td>Grandparent/s</td>
</tr>
<tr>
<td>3</td>
<td>Main/steady spouse or partner</td>
</tr>
<tr>
<td>4</td>
<td>Casual partner</td>
</tr>
<tr>
<td>5</td>
<td>Other family member/s</td>
</tr>
<tr>
<td>6</td>
<td>Non-family / friend/s</td>
</tr>
<tr>
<td>7</td>
<td>Alone</td>
</tr>
<tr>
<td>8</td>
<td>Prefer not to answer</td>
</tr>
</tbody>
</table>

8. **Name of area / location where you currently live:**

   ____________________________
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. How many pregnancies have you had?</td>
<td>[ ] 1 Prefer not to answer</td>
</tr>
<tr>
<td>10. How many children have you given birth to?</td>
<td>[ ] 2 Prefer not to answer</td>
</tr>
<tr>
<td>11. How many total children are you currently taking care of?</td>
<td>[ ] 3 Prefer not to answer</td>
</tr>
<tr>
<td>12. What is your highest level of education? <em>(mark one)</em></td>
<td>[ ] 1 No schooling</td>
</tr>
<tr>
<td></td>
<td>[ ] 2 Primary school, not complete</td>
</tr>
<tr>
<td></td>
<td>[ ] 3 Primary school, complete</td>
</tr>
<tr>
<td></td>
<td>[ ] 4 Secondary school, not complete</td>
</tr>
<tr>
<td></td>
<td>[ ] 5 Secondary school, complete</td>
</tr>
<tr>
<td></td>
<td>[ ] 6 Attended college or university</td>
</tr>
<tr>
<td></td>
<td>[ ] 7 Prefer not to answer</td>
</tr>
<tr>
<td></td>
<td>[ ] 8 Other, specify: _</td>
</tr>
<tr>
<td>13. Do you currently earn an income of your own?</td>
<td>[ ] 1 Yes</td>
</tr>
<tr>
<td></td>
<td>[ ] 2 No</td>
</tr>
<tr>
<td></td>
<td>[ ] 3 Prefer not to answer</td>
</tr>
<tr>
<td>14. During the last 12 months, where did you get your income or financial support? <em>(mark all that apply)</em></td>
<td>[ ] 1 Formal Employment (working for a company, working in a shop, etc.)</td>
</tr>
<tr>
<td></td>
<td>[ ] 2 Informal Employment (recycling, piece work, selling goods/clothes, gardening, etc.)</td>
</tr>
<tr>
<td></td>
<td>[ ] 3 Self-Employment</td>
</tr>
<tr>
<td></td>
<td>[ ] 4 Social grants (child support, disability, etc.)</td>
</tr>
<tr>
<td></td>
<td>[ ] 5 Main/steady spouse or partner</td>
</tr>
<tr>
<td></td>
<td>[ ] 6 Casual partner</td>
</tr>
<tr>
<td></td>
<td>[ ] 7 Child Maintenance</td>
</tr>
<tr>
<td></td>
<td>[ ] 8 Family (other than spouse)</td>
</tr>
<tr>
<td></td>
<td>[ ] 9 Friends</td>
</tr>
<tr>
<td></td>
<td>[ ] 10 Selling sex for money</td>
</tr>
<tr>
<td></td>
<td>[ ] 11 Exchanging sex for goods (not money)</td>
</tr>
<tr>
<td></td>
<td>[ ] 12 Prefer not to answer</td>
</tr>
<tr>
<td></td>
<td>[ ] 13 None of the above</td>
</tr>
<tr>
<td></td>
<td>[ ] 14 Other specify: _</td>
</tr>
</tbody>
</table>
INTERVIEWER READS:

Thank you for being a part of our research. As you know, HIV affects many people. People live in different places, with different customs, cultures, sexual practices, and beliefs. We hope to include people from different communities in our research. We respect all people. Not all questions we ask in our research will apply to you. Because we do not want to make assumptions, we ask the same questions to everyone. We want you to be comfortable in speaking with us. You do not have to answer any question that makes you uncomfortable.

The following are some basic questions regarding your background to help us know what type of people participated in the discussion for this study. All the information you provide will be kept confidential and will not be shared with anyone else besides the research study staff.

Now I am going to ask you some questions about yourself. The answer to these questions will tell us more about who you are, such as your age and ethnicity. I will also ask you about your sex and gender. Please feel free to ask any questions about things that you don’t understand.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. What is your date of birth?</td>
<td>dd               MMM            yy</td>
</tr>
<tr>
<td>16. What is your age?</td>
<td></td>
</tr>
<tr>
<td>17. What sex were you assigned at birth?</td>
<td>1 Male 2 Female 3 Intersex 4 Prefer not to answer</td>
</tr>
<tr>
<td>18. How do you identify your gender?</td>
<td>1 Male 2 Female 3 Transgender 4 Gender variant 5 Prefer not to answer 6 Other self-identity, specify:</td>
</tr>
</tbody>
</table>
2. Gay / Homosexual  
3. Lesbian  
4. Bisexual  
5. Not sure / Undecided  
6. Prefer not to answer  
7. Other, specify:__________________ |
| 20. | What is the language most spoken at home? | 1. IsiZulu  
2. Sesotho  
3. IsiXhosa  
4. Setswana  
5. Siswati  
6. English  
7. Afrikaans  
8. English  
9. Other, specify:__________________ |
| 21. | Name of area / location where you currently live: | ________________________________ |
| 22. | What is your highest level of education? (mark one) | 1. No schooling  
2. Primary school, not complete  
3. Primary school, complete  
4. Secondary school, not complete  
5. Secondary school, complete  
6. Attended college or university  
7. Prefer not to answer  
8. Other, specify:__________________ |
| 23. | Do you currently earn an income of your own? | 1. Yes  
2. No  
3. Prefer not to answer |
24. During the last 12 months, where did you get your income or financial support? *(mark all that apply)*

- [ ] 1. Formal Employment (working for a company, working in a shop, etc.)
- [ ] 2. Informal Employment (recycling, piece work, selling goods/clothes, gardening, etc.)
- [ ] 3. Self-Employment
- [ ] 4. Social grants (child support, disability, etc.)
- [ ] 5. Main/steady spouse or partner
- [ ] 6. Casual partner
- [ ] 7. Child Maintenance
- [ ] 8. Family (other than spouse)
- [ ] 9. Friends
- [ ] 10. Selling sex for money
- [ ] 11. Exchanging sex for goods (not money)
- [ ] 12. Prefer not to answer
- [ ] 13. None of the above
- [ ] 14. Other specify: ___________________
Appendix 4: Consent Forms

Appendix 4a: Consent form for AGYW 15-17 years (English)

INFORMATION SHEET: YOUNG WOMEN & GIRLS: QUALITATIVE INTERVIEWS AND FOCUS GROUP DISCUSSIONS: 15-17 YEARS

Title of Research Project: Evaluation of the Global Fund Young Women and Girls Intervention

1. Introduction
   Good day. My name is ________________. I work for SAMRC. We are an organization that conducts research to improve the health of South Africans. We invite you today to take part in a study on young women and girls’ health in South Africa. The study is being led by scientists at the South African Medical Research Council together with other scientists in South Africa. This study is sponsored by the Centers for Disease Control and Prevention (CDC).

2. Why are we doing this study?
   We know young women and girls are vulnerable to sexual and reproductive health problems. They face challenges in deciding when and with who they want to have sex, avoiding pregnancy until they are ready, and avoiding sexually transmitted infections including HIV. More needs to be done to support young women and girls. We are doing this study to find out whether or not programmes on HIV and other related sexual reproductive health issues are helping young women and girls in our communities. This information will help government and its partners understand whether these current programmes are working and what needs to be changed to further help other young women and girls in South Africa.

3. Why have I been chosen to take part in this study?
   You have been invited to participate in this study because you: (read appropriate part)
   - Have been part of the Rise Clubs
   - Have been part of the Keeping Girls at School programme
   - Are from a community in which some of these programmes have been taking place.

   The facilitators of one of those programmes referred us to you, because you indicated you might like to be part of the study. We are inviting you to be interviewed, or take part in a focus group discussion.

4. What will happen if I decide to take part in this study?
   - All parts of this study will take place at a convenient location (e.g., a nearby community hall).
   - If you agree to take part in this study, you will be asked to be involved in either a (choose appropriate):
Once off individual interview
Multiple individual interviews over time
Focus group discussion

- An individual interview is when someone asks you questions and you give answers about your views, experiences and opinions. Interviews usually take no more than 1 hour (60 minutes). I and/or my other colleagues will ask questions about HIV, pregnancy, general health and school.
- Multiple individual interviews would mean that the same interviewer comes back three times to interview you over a period of time.
- A focus group discussion would mean that you are in a group of other 8 to 10 people like you, and you sit together with an interviewer and discuss topics and answer questions as a group.
- You will be able to speak to a fieldworker who will be available for you as soon as you have completed the interview or focus group discussion.
- Your name will not be put on the documents or next to any of the responses you give. Instead, you will be given a unique study number that will identify your responses. We will not link your name to the information we collect.
- If you agree to take part, the interview or focus group discussion will be voice-recorded on an electronic device. The voice-recorded file will be copied onto a secure harddrive and then deleted from the device. The voice-recording file from the interview will be labelled with your unique study number. We will not label it with your name.

Researchers working on the project will listen to the recording and write down all the information.

5. What are your rights?
You can decide if you want to take part in the study or not. You can choose NOT to take part in this study, and this will not affect the treatment and care you receive from your school, community, clinic or hospital. If you agree to take part now, you can stop taking part at any time later and this will not affect the treatment and care you receive from your school, community, clinic or hospital. You can ask questions about this study.

6. What could happen to me if I take part in this study?
Some questions we ask you might be hard to answer. We may ask you some questions that cause you to feel embarrassed or uncomfortable. You can choose not to answer questions or take part in the discussion at any time. We will not force you to answer anything you cannot or do not want to answer. Having to attend the interview or focus group discussion can be difficult and might mean that you need to arrange for someone to cover your household chores, or you might have to arrange and pay for transportation to the venue. If you are involved in a focus group discussion, it is important to remember that there will be other people present. All participants will be requested to keep all discussions confidential. There is a possibility that other participants in the group discussion might repeat things outside the group, even though they will be requested to keep everything that is discussed confidential. If any of the discussions that we have upset you or bring up any traumatizing issues for you and you feel you need to speak to someone, we will arrange for you to be referred to a relevant community-based organization that provides counseling and support services.
7. If I take part in the study how will it help me?
There are no immediate benefits to you if you take part. However, the information that we get from you in this study will be used to tell us more about how to support the health of young women and girls in South Africa. You will be able to speak to a trained fieldworker about what it was like to take part in the research study or anything that is troubling you.

8. Will I get anything for taking part in this study?
You will be reimbursed for the time you spend participating in this study with a gift to the value of approximately R50.

9. Will the information I give be kept private?
- Information that we collect will be kept on computer file that will be protected by a password that only researchers working on the project will know. Information that you give us will NOT be seen by other participants, your friends, teachers, parent/guardian/foster parent/caregiver, or school health and clinic staff.
- Any information that you give us will have a study number on it instead of your name.
- Information we get from this study that can be identified with you will be kept safely and in a private place.
- Information from this study will be presented at meetings and published so that the information can be useful to others. This information will not contain your name.
- If you tell us that you plan to hurt a person, I will need to take steps to protect that person. Also, if you tell us that you believe a person is going to harm you, steps will be taken to protect you. If you tell us about feelings related to wanting to take your life, or that a child or elderly person is in danger, actions may be taken to protect others and you. If we suspect, or if you tell us that you or someone else has been neglected, or physically or sexually abused, we will have to report it to the authorities such as child welfare or the police. If you inform us that you are involved in, or have been involved in, sexual activities with someone under the age of 16 (even with their consent), South African law requires that we report it to the police for investigation. However, if you and your sex partner(s) are 12 years of age and above, and no more than two years apart in age, and you indicate that your sexual activities with your partner(s) was or is consensual, we do not need to report it.

10. Who do I contact if I have any questions about this study?
- If you have any questions about the interview you may contact one of the researchers:
  - Senior researcher (TBC): Tel: _______________, E-mail: ___________________

- If you have any questions about the study you may contact the principal investigator:
If you have any problems with the way the study was done/concerns about your rights in the study you may contact the research ethics committee which have approved this study:

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Catherine Mathews</td>
<td>South African Medical Research Council, PO Box 19070, Tygerberg, 7505. Tel. 021-938 0454, E-mail: <a href="mailto:cathy.mathews@mrc.ac.za">cathy.mathews@mrc.ac.za</a></td>
</tr>
<tr>
<td>Adri Labuschagne</td>
<td>South African Medical Research Council, PO Box 19070, Tygerberg 7505, Western Cape South Africa, Tel: 021 938 0687, E-mail: <a href="mailto:adri.labuschagne@mrc.ac.za">adri.labuschagne@mrc.ac.za</a></td>
</tr>
</tbody>
</table>

**INFORMED VOLUNTARY CONSENT FORM**

For 15-17 year old to complete

I, ______________________________________________ (name and surname of 15-17 year old) have had all of the above Information explained and I understand the explanation. I have been given answers to my questions about the procedures involved in the study.

☐ My parent/caregiver has given me permission to decide to participate in this study and I have been shown the consent where they signed

☐ I AGREE to participate in this study and I have received a copy of the information sheet *(Please mark with an X and then complete, sign and date below)*

I agree to be involved in the following interview *(please mark with an X)*:

☐ One-on-one interview

☐ I understand why the interview will be voice-recorded and how my confidentiality will be protected *(please mark with an X).*

☐ I DO NOT AGREE to the interview being voice-recorded.

☐ I AGREE to the interview being voice-recorded.

Signature of 15-17 year old: ___________________________

Today’s date: _______ (day)/ ______ (month) / _____ (year)

If participant is unable to sign:

Name and surname of witness: _________________________

Signature of witness: ________________________________

Today’s date: _____ (day)/ ____ (month) / _____ (year)
Appendix 4b: Consent form for AGYW 18-24 years (English)

INFORMATION SHEET: QUALITATIVE INTERVIEWS AND FOCUS GROUP DISCUSSIONS: 18 - 24 YEARS

Title of Research Project: Evaluation of the Global Fund Young Women and Girls Intervention

11. Introduction
   Good day. My name is ________________. I work for SAMRC. We are an organization that conducts research to improve the health of South Africans. We invite you today to take part in a study on young women and girls’ health in South Africa. The study is being led by scientists at the South African Medical Research Council together with other scientists in South Africa. This study is sponsored by the Centers for Disease Control and Prevention (CDC).

12. Why are we doing this study?
   We know young women and girls are vulnerable to sexual and reproductive health problems. They face challenges in deciding when and with who they want to have sex, avoiding pregnancy until they are ready, and avoiding sexually transmitted infections including HIV. More needs to be done to support young women and girls. We are doing this study to find out whether or not programmes on HIV and other related sexual reproductive health issues are helping young women and girls in our
communities. This information will help government and its partners understand whether these current programmes are working and what needs to be changed to further help other young women and girls in South Africa.

13. Why have I been chosen to take part in this study?
You have been invited to participate in this study because you: (read appropriate part)
- Have been part of the Rise Clubs
- Have been part of the Keeping Girls at School programme
- Are from a community in which some of these programmes have been taking place.
The facilitators of one of those programmes referred us to you, because you indicated you might like to be part of the study. We are inviting you to be interviewed, or take part in a focus group discussion.

14. What will happen if I decide to take part in this study?
• All parts of this study will take place at a convenient location (e.g., a nearby community hall).
• If you agree to take part in this study, you will be asked to be involved in either a (choose appropriate):
  o Once off individual interview
  o Multiple individual interviews over time
  o Focus group discussion
• An individual interview is when someone asks you questions and you give answers about your views, experiences and opinions. Interviews usually take no more than 1 hour (60 minutes). I and/or my other colleagues will ask questions about HIV, pregnancy, general health and school.
• Multiple individual interviews would mean that the same interviewer comes back three times to interview you over a period of time.
• A focus group discussion would mean that you are in a group of other 8 to 10 people like you, and you sit together with an interviewer and discuss topics and answer questions as a group.
• You will be able to speak to a fieldworker who will be available for you as soon as you have completed the interview or focus group discussion.
• Your name will not be put on the documents or next to any of the responses you give. Instead, you will be given a unique study number that will identify your responses. We will not link your name to the information we collect.
• If you agree to take part, the interview or focus group discussion will be voice-recorded on an electronic device. The voice-recorded file will be copied onto a secure harddrive and then deleted from the device. The voice-recording file from the interview will be labelled with your unique study number. We will not label it with your name. Researchers working on the project will listen to the recording and write down all the information.

15. What are your rights?
You can decide if you want to take part in the study or not. You can choose NOT to take part in this study, and this will not affect the treatment and care you receive from your school, community, clinic or hospital. If you agree to take part now, you can stop taking part at any time later and this will not affect the treatment and care you receive from your school, community, clinic or hospital. You can ask questions about this study.

16. **What could happen to me if I take part in this study?**

Some questions we ask you might be hard to answer. We may ask you some questions that cause you to feel embarrassed or uncomfortable. You can choose not to answer questions or take part in the discussion at any time. We will not force you to answer anything you cannot or do not want to answer. Having to attend the interview or focus group discussion can be difficult and might mean that you need to arrange for someone to cover your household chores, or you might have to arrange and pay for transportation to the venue. If you are involved in a focus group discussion, it is important to remember that there will be other people present. All participants will be requested to keep all discussions confidential. There is a possibility that other participants in the group discussion might repeat things outside the group, even though they will be requested to keep everything that is discussed confidential. If any of the discussions that we have upset you or bring up any traumatizing issues for you and you feel you need to speak to someone, we will arrange for you to be referred to a relevant community-based organization that provides counseling and support services.

17. **If I take part in the study how will it help me?**

There are no immediate benefits to you if you take part. However, the information that we get from you in this study will be used to tell us more about how to support the health of young women and girls in South Africa. You will be able to speak to a trained fieldworker about what it was like to take part in the research study or anything that is troubling you.

18. **Will I get anything for taking part in this study?**

You will be reimbursed for the time you spend participating in this study with a gift to the value of approximately R50.

19. **Will the information I give be kept private?**

- Information that we collect will be kept on computer file that will be protected by a password that only researchers working on the project will know. Information that you give us will NOT be seen by other participants, your friends, teachers, parent/guardian/foster parent/caregiver, or school health and clinic staff.
- Any information that you give us will have a study number on it instead of your name.
- Information we get from this study that can be identified with you will be kept safely and in a private place.
- Information from this study will be presented at meetings and published so that the information can be useful to others. This information will not contain your name.
- If you tell us that you plan to hurt a person, I will need to take steps to protect that person. Also, if you tell us that you believe a person is going to harm you, steps will be taken to protect you. If you tell us about feelings related to wanting to take your life, or that a child or elderly person is in danger, actions may be taken to protect others and you. If we suspect, or if you tell us that you or someone else has been neglected, or physically or sexually abused, we will have to report it to the authorities such as child welfare or the
If you inform us that you are involved in, or have been involved in, sexual activities with someone under the age of 16 (even with their consent), South African law requires that we report it to the police for investigation. However, if you and your sex partner(s) are 12 years of age and above, and no more than two years apart in age, and you indicate that your sexual activities with your partner(s) was or is consensual, we do not need to report it.

20. Who do I contact if I have any questions about this study?
   • If you have any questions about the interview you may contact one of the researchers:
     - Senior researcher (TBC): Tel: _______________, E-mail: ______________________
   • If you have any questions about the study you may contact the principal investigator:
     - Dr. Catherine Mathews- South African Medical Research Council, PO Box 19070, Tygerberg, 7505. Tel. 021-938 0454, E-mail: cathy.mathews@mrc.ac.za
   • If you have any problems with the way the study was done/concerns about your rights in the study you may contact the research ethics committee which have approved this study:
     - Adri Labuschagne- South African Medical Research Council, PO Box 19070, Tygerberg 7505, Western Cape South Africa, Tel: 021 938 0687, E-mail: adri.labuschagne@mrc.ac.za

**INFORMED VOLUNTARY CONSENT FORM**

For 18-24 year old to complete

I, ________________________________________________ (name and surname of 18 – 24 year old) have had all of the above Information explained and I understand the explanation. I have been given answers to my questions about the procedures involved in the study.

☐ I AGREE to participate in this study and I have received a copy of the information sheet (Please mark with an X and then complete, sign and date below)
   I agree to be involved in the following interviews (please mark with an X):
   - Once off individual interview
   - Multiple individual interviews over time
   - Focus group discussion

☐ I understand why the interviews and focus group discussions will be voice-recorded and how my confidentiality will be protected (please mark with an X).
  - I DO NOT AGREE to the interview being voice-recorded.
  - I AGREE to the interview being voice-recorded.
Signature of 18-24 year old: _______________________________

Today’s date: _______ (day)/ _____ (month) / _____ (year)

If participant is unable to sign:
Name and surname of witness: _______________________________

Signature of witness: _______________________________

Today’s date: _____ (day)/ ____ (month) / _____ (year)
STATEMENT BY OR ON BEHALF OF THE INVESTIGATORS

I __________________________ (researcher’s name and surname) declare that I have explained the information given in this document to the participant.

She was encouraged and given ample time to ask me questions. Our conversation was conducted in English/Afrikaans/Xhosa/Sesotho/Zulu/Swati (please encircle) and no translator was used.

Was a copy of the signed copy given to the participant?

☐ Yes
☐ No: If no, why not: _____________________________________________

Signature of researcher: ____________________________

Today's date: _____ (day)/ _____ (month) / ______ (year)

Appendix 4c: Consent form for parent/caregiver of AGYW 15-17 years (English)

INFORMATION SHEET: QUALITATIVE INTERVIEW: PARENT/GUARDIAN/FOSTER
PARENT/CAREGIVER OF CHILD (15 - 17 YEARS)

Title of Research Project: Evaluation of the Global Fund Young Women and Girls Intervention

21. Introduction
   Good day. My name is ________________. I work for SAMRC. We are an organization that conducts research to improve the health of South Africans. We invite you today to take part in a study on young women and girls’ health in South Africa. The study is being led by scientists at the South African Medical Research Council together with other scientists in South Africa. This study is sponsored by the Centers for Disease Control and Prevention (CDC).

22. Why are we doing this study?
We know young women and girls are vulnerable to sexual and reproductive health problems. They face challenges in deciding when and with who they want to have sex, avoiding pregnancy until they are ready, and avoiding sexually transmitted infections including HIV. More needs to be done to support young women and girls. We are doing this study to find out whether or not programmes on HIV and other related sexual reproductive health issues are helping young women and girls in our communities. This information will help government and its partners understand whether these current programmes are working and what needs to be changed to further help other young women and girls in South Africa.

23. Why have I been invited to take part in this study?
You have been invited because your daughter is part of the Rise Clubs or the Keeping Girls in School Programme. We are inviting parents of girls between the ages of 15 and 17 years to participate. The facilitators of these programmes indicated to us that you might want to take part in an interview. We are inviting you to take part in an interview about the programmes for your daughter and other young women and girls.

24. What will happen if I decide to take part in this study?
- All parts of this study will take place at a convenient location (e.g., a nearby community hall).
- An interview is when someone asks questions and you give answers.
- The interview with you will take about 1 hour (60 minutes) to do. I and/or my other research colleagues will ask questions about HIV, pregnancy, sexually transmitted infections, violence and general health.
- Your name will not be put on the interview documents or next to any of the responses you give. Instead, you will be given a unique study number that will identify your responses. We will not link your name to the information we collect.
- If you agree to take part, the interview or focus group discussion will be voice-recorded on an electronic device. The voice-recorded file will be copied onto a secure harddrive and then deleted from the device. The voice-recording file from the interview will be labelled with your unique study number. We will not label it with your name. Researchers working on the project will listen to the recording and write down all the information.

25. What are my rights?
You can decide if you want to take part in the study or not. Your participation is completely voluntary. You can choose NOT to participate in the study. Your decision will not affect the treatment and care you receive from your child’s school, your community, clinic or hospital. If you agree to participate now, you can stop taking part at any time later and this will not
affect the treatment and care you receive from your child’s school, your community, clinic or hospital. You can ask questions about this study.

26. What are the risks/inconveniences I may experience?
Some questions we ask you might be hard to answer. We will not force you to answer anything you cannot or do not want to answer. Having to attend the interview in the study can be difficult and might mean that you will need to arrange for someone to cover your household chores, or arrange and pay for transportation to the interview venue.

27. What are the possible benefits of taking part in this study for me?
There will be no immediate individual benefits if you take part. However, the information that we get from you in this study will be used to tell us more about how to support the health of young women and girls in South Africa. You will be able to speak to a trained fieldworker about what it was like to take part in the research study or anything that is troubling you.

28. Will I get anything for taking part in this study?
You will be reimbursed for the time you spend participating in this study with a gift to the value of approximately R50.

29. Will the information I give be kept private?
• Information that we collect will be kept on computer file that will be protected by a password that only researchers working on the project will know. Information that you give us will NOT be seen by other participants, teachers or school health and clinic staff.

• Any information that you give us will have a unique study number on it instead of names.

• Information we get from this study that can be identified with you will be confidential – it will be kept safely and in a private place.

• Information from this study will be presented at meetings and published so that the information can be useful to others. This information will not contain your name.

• If you tell us that you plan to physically or sexually harm an identifiable person including a spouse, I will need to take steps to protect that person. Also, if you tell us that you believe an identifiable person is going to physically or sexually harm you, steps will be taken to protect you. If you tell us about thoughts or feelings to harm yourself or others, or that a child or elderly person is the victim of abuse, actions may be taken to protect others and you. If we suspect, or if you tell us that you, your child or someone else has been neglected, or physically or sexually abused, we will have to report it to the authorities such as child welfare or the police. If you inform us that you are involved in, or have been involved in, sexual activities with someone under the age of 16 (even with their consent), South African law requires that we report it to the police for
investigation. However, if you and your sex partner(s) are 12 years of age and above, and no more than two years apart in age, and you indicate that your sexual activities with your partner(s) was or is consensual, we do not need to report it.

30. Who do I contact if I have any questions about this study?

- **If you have any questions about the interview you may contact one of the researchers:**
  - Senior researcher (TBC): Tel: _______________, E-mail: _______________________

- **If you have any questions about the study you may contact the principal investigator:**
  - Dr. Catherine Mathews- South African Medical Research Council, PO Box 19070, Tygerberg, 7505. Tel. 021-938 0454, E-mail: cathy.mathews@mrc.ac.za

- **If you have any problems with the way the study was done/concerns about your rights in the study you may contact the research ethics committee which have approved this study:**
  - Adri Labuschagne- South African Medical Research Council, PO Box 19070, Tygerberg 7505, Western Cape South Africa, Tel: 021 938 0687, E-mail: adri.labuschagne@mrc.ac.za

**INFORMED VOLUNTARY CONSENT FORM**

*For parent/guardian/foster parent/caregiver to complete*

I, ___________________________ (name and surname of parent/guardian/foster parent/caregiver) have had all of the above Information explained and I understand the explanation. I have been given answers to my questions about the procedures involved in the study.

☐ I AGREE to participate in this study and I have received a copy of the information sheet *(Please mark with an X and then complete, sign and date below)*

I agree to be involved in the following interview *(please mark with an X)*:

☐ One-on-one interview

☐ I understand why the interview will be voice-recorded and how my confidentiality will be protected *(please mark with an X).*

☐ I DO NOT AGREE to the interview being voice-recorded.

☐ I AGREE to the interview being voice-recorded.

Signature of participant: ___________________________
Today’s date: _______ (day)/ ______ (month) / _____ (year)

If parent/guardian/foster parent/caregiver participant is unable to sign:
Name and surname of witness: __________________________
Signature of witness: __________________________
Today’s date: _______ (day)/ ______ (month) / _____ (year)
I ________________________________ (researcher’s name and surname) declare that I have explained the information given in this document to the parent/guardian/foster parent/caregiver.

He/She was encouraged and given ample time to ask me questions. Our conversation was conducted in English/Afrikaans/Xhosa/Sesotho/Zulu/Swati (please encircle) and no translator was used.

Was a copy of the signed copy given to the participant?

☐ Yes
☐ No: If no, why not: ________________________________

Signature of researcher: ________________________________

Today’s date: _____ (day)/ _____ (month) / _____ (year)

Appendix 4d: Consent form for Stakeholders, Programme Implementers and Community leaders (English)

INFORMATION SHEET: QUALITATIVE INTERVIEW: STAKEHOLDERS, PROGRAMME IMPLEMENTERS AND COMMUNITY LEADERS

Title of Research Project: Evaluation of the Global Fund Young Women and Girls Intervention

31. Introduction
Good day. My name is _______________. I work for the South African Medical Research Council (SAMRC). We are an organization that conducts research to improve the health of South Africans. We invite you today to take part in a study on young women and girls’ health in South Africa. The study is being led by scientists at the SAMRC together with other scientists in South Africa. This study is sponsored by the Centers for Disease Control and Prevention (CDC).

32. Why are we doing this study?
We know young women and girls are vulnerable to sexual reproductive health problems. They face challenges in deciding when and with who they want to have sex, avoiding pregnancy until they are ready, and avoiding sexually transmitted infections including HIV. More needs to be done to support young women and girls. We are doing this study to find out whether or not programmes on HIV and other related sexual reproductive health issues are helping young women and girls in our communities. This information will help government and its partners understand whether these current programmes are working and what needs to be changed to further help other young women and girls in South Africa.

33. Why have I been invited to take part in this study?
   You have been invited to participate in this study because (read appropriate part):
   - You have been involved in the organization/implementation of the Rise Clubs
   - You have been involved in the organization/implementation of the Keeping Girls at School programme
   - You have been identified as a community leader in a community where these programmes have been implemented.

34. What will happen if I decide to take part in this study?
   - An interview is when someone asks questions and you give answers.
   - The interview with you will take about 1 hour (60 minutes) to do. I and/or my other research colleagues will ask questions about HIV, pregnancy, sexually transmitted infections, violence and general health.
   - Your name will not be put on the interview documents or next to any of the responses you give. Instead, you will be given a unique study number that will identify your responses. We will not link your name to the information we collect.
   - If you agree to take part, the interview or focus group discussion will be voice-recorded on an electronic device. The voice-recorded file will be copied onto a secure harddrive and then deleted from the device. The voice-recording file from the interview will be labelled with your unique study number. We will not label it with your name. Researchers working on the project will listen to the recording and write down all the information.

35. What are my rights?
   You can decide if you want to take part in the study or not. Your participation is completely voluntary. You can choose NOT to participate in the study. Your decision will not affect the treatment and care you receive from your community, clinic or hospital. If you agree to participate now, you can stop taking part at any time later and this will not affect the treatment and care you receive from your community, clinic or hospital. You can ask questions about this study.

36. What are the risks/inconveniences I may experience?
Some questions we ask you might be hard to answer. We will not force you to answer anything you cannot or do not want to answer. Having to attend the interview in the study can be inconvenient and might mean that you will need to arrange for someone to cover your household chores, or arrange and pay for transportation to the interview venue.

37. What are the possible benefits of taking part in this study for me?
There will be no immediate individual benefits if you take part. However, the information that we get from you in this study will be used to tell us more about how to support the health of young women and girls in South Africa. You will be able to speak to a trained fieldworker about what it was like to take part in the research study or anything that is troubling you.

38. Will the information I give be kept private?
- Information that we collect will be kept on computer file that will be protected by a password that only researchers working on the project will know. Information that you give us will NOT be seen by other participants, health and clinic staff.
- Any information that you give us will have a unique study number on it instead of names.
- Information we get from this study that can be identified with you will be confidential – it will be kept safely and in a private place.
- Information from this study will be presented at meetings and published so that the information can be useful to others. This information will not contain your name.
- If you tell us that you plan to physically or sexually harm an identifiable person including a spouse, I will need to take steps to protect that person. Also, if you tell us that you believe an identifiable person is going to physically or sexually harm you, steps will be taken to protect you. If you tell us about thoughts or feelings to harm yourself or others, or that a child or elderly person is the victim of abuse, actions may be taken to protect others and you. If we suspect, or if you tell us that you or someone else has been neglected, or physically or sexually abused, we will have to report it to the authorities such as child welfare or the police. If you inform us that you are involved in, or have been involved in, sexual activities with someone under the age of 16 (even with their consent), South African law requires that we report it to the police for investigation. However, if you and your sex partner(s) are 12 years of age and above, and no more than two years apart in age, and you indicate that your sexual activities with your partner(s) was or is consensual, we do not need to report it.

39. Who do I contact if I have any questions about this study?
- If you have any questions about the interview you may contact one of the researchers:
Senior researcher (TBC): Tel: _______________, E-mail: ___________________

- **If you have any questions about the study you may contact the principal investigator:**
  - Dr. Catherine Mathews - South African Medical Research Council, PO Box 19070, Tygerberg, 7505. Tel. 021-938 0454, E-mail: cathy.mathews@mrc.ac.za

- **If you have any problems with the way the study was done/concerns about your rights in the study you may contact the research ethics committee which have approved this study:**
  - Adri Labuschagne - South African Medical Research Council, PO Box 19070, Tygerberg 7505, Western Cape South Africa, Tel: 021 938 0687, E-mail: adri.labuschagne@mrc.ac.za

### INFORMED VOLUNTARY CONSENT FORM

*For stakeholders, programme implementers and community leaders to complete*

I, __________________________________________________________ (name and surname of participant) have had all of the above Information explained and I understand the explanation. I have been given answers to my questions about the procedures involved in the study.

- [ ] I AGREE to participate in this study and I have received a copy of the information sheet (*Please mark with an X and then complete, sign and date below*)
  - I agree to be involved in the following interview (please mark with an X):
    - [ ] One-on-one interview

- [ ] I understand why the interview will be voice-recorded and how my confidentiality will be protected (*please mark with an X*).
  - [ ] I DO NOT AGREE to the interview being voice-recorded.
  - [ ] I AGREE to the interview being voice-recorded.

Signature of participant: ______________________________

Today’s date: _______ (day)/ _____ (month) / _____ (year)

If participant is unable to sign:
Name and surname of witness: ______________________________

Signature of witness: ______________________________

Today’s date: _____ (day)/ ___ (month) / ____ (year)
Appendix 4e: Consent form for Male Peers (English)

INFORMATION SHEET: QUALITATIVE INTERVIEW: MALE PEERS AND PARTNERS

Title of Research Project: Evaluation of the Global Fund Young Women and Girls Intervention

40. Introduction
   Good day. My name is ________________. I work for SAMRC. We are an organization that conducts research to improve the health of South Africans. We invite you today to take part in a study on young women and girls’ health in South Africa. The study is being led by scientists at the South African Medical Research Council together with other scientists in South Africa. This study is sponsored by the Centers for Disease Control and Prevention (CDC).

41. Why are we doing this study?
   We know young women and girls are especially vulnerable to sexual and reproductive health problems. We are doing this study to find out whether or not programmes on HIV and other related sexual reproductive health issues are helping young women and girls in our communities. This information will help government and its partners understand whether these current programmes are working and what needs to be changed to further help young people South Africa.

42. Why have I been chosen to take part in this study?
   You have been invited to participate in this study because in order for us to understand the experiences and challenges faced by young women and girls, it is also important for us to hear the views and opinions of young men and boys in their communities.
43. What will happen if I decide to take part in this study?
- All parts of this study will take place at a convenient location (e.g., a nearby community hall).
- If you agree to take part in this study, you will be asked to be involved in a focus group discussion.
- A focus group discussion would mean that you are in a group of other 8 to 10 people like you, and you sit together with an interviewer and discuss topics and answer questions as a group.
- You will be able to speak to a fieldworker who will be available for you as soon as you have completed the focus group discussion.
- Your name will not be put on the documents or next to any of the responses you give. Instead, you will be given a unique study number that will identify your responses. We will not link your name to the information we collect.
- If you agree to take part, the interview or focus group discussion will be voice-recorded on an electronic device. The voice-recorded file will be copied onto a secure harddrive and then deleted from the device. The voice-recording file from the interview will be labelled with your unique study number. We will not label it with your name. Researchers working on the project will listen to the recording and write down all the information.

44. What are your rights?
You can decide if you want to take part in the study or not. You can choose NOT to take part in this study, and this will not affect the treatment and care you receive from your school, community, clinic or hospital. If you agree to take part now, you can stop taking part at any time later and this will not affect the treatment and care you receive from your school, community, clinic or hospital. You can ask questions about this study.

45. What could happen to me if I take part in this study?
Some questions we ask you might be hard to answer. We may ask you some questions that cause you to feel embarrassed or uncomfortable. You can choose not to answer questions or take part in the discussion at any time. We will not force you to answer anything you cannot or do not want to answer. Having to attend the interview or focus group discussion can be difficult and might mean that you need to arrange for someone to cover your household chores, or you might have to arrange and pay for transportation to the venue. If you are involved in a focus group discussion, it is important to remember that there will be other people present. All participants will be requested to keep all discussions confidential. There is a possibility that other participants in the group discussion might repeat things outside the group, even though they will be requested to keep everything that is discussed confidential. If any of the discussions that we have upset you or bring up any traumatizing issues for you and you feel you need to speak to someone, we will arrange for you to be referred to a relevant community-based organization that provides counseling and support services.

46. If I take part in the study how will it help me?
There are no immediate benefits to you if you take part. However, the information that we get from you in this study will be used to tell us more about how to support the health of young women and
girls in South Africa. You will be able to speak to a trained fieldworker about what it was like to take part in the research study or anything that is troubling you.

47. Will I get anything for taking part in this study?
You will be reimbursed for the time you spend participating in this study with a gift to the value of approximately R50.

48. Will the information I give be kept private?
- Information that we collect will be kept on computer file that will be protected by a password that only researchers working on the project will know. Information that you give us will NOT be seen by other participants, your friends, teachers, parent/guardian/foster parent/caregiver, or school health and clinic staff.
- Any information that you give us will have a study number on it instead of your name.
- Information we get from this study that can be identified with you will be kept safely and in a private place.
- Information from this study will be presented at meetings and published so that the information can be useful to others. This information will not contain your name.
- If you tell us that you plan to hurt a person, I will need to take steps to protect that person. Also, if you tell us that you believe a person is going to harm you, steps will be taken to protect you. If you tell us about feelings related to wanting to take your life, or that a child or elderly person is in danger, actions may be taken to protect others and you. If we suspect, or if you tell us that you or someone else has been neglected, or physically or sexually abused, we will have to report it to the authorities such as child welfare or the police. If you inform us that you are involved in, or have been involved in, sexual activities with someone under the age of 16 (even with their consent), South African law requires that we report it to the police for investigation. However, if you and your sex partner(s) are 12 years of age and above, and no more than two years apart in age, and you indicate that your sexual activities with your partner(s) was or is consensual, we do not need to report it.

49. Who do I contact if I have any questions about this study?
- If you have any questions about the interview you may contact one of the researchers:
  - Senior researcher (TBC): Tel: _______________, E-mail: ___________________
- If you have any questions about the study you may contact the principal investigator:
  - Dr. Catherine Mathews- South African Medical Research Council, PO Box 19070, Tygerberg, 7505. Tel. 021-938 0454, E-mail: cathy.mathews@mrc.ac.za
- If you have any problems with the way the study was done/concerns about your rights in the study you may contact the research ethics committee which have approved this study:
INFORMED VOLUNTARY CONSENT FORM

For male peers and partners to complete
I, __________________________________________ (name and surname) have had all of the above Information explained and I understand the explanation. I have been given answers to my questions about the procedures involved in the study.

☐ I AGREE to participate in this study and I have received a copy of the information sheet (please mark with an X and then complete, sign and date below)
   I agree to be involved in the following interview (please mark with an X):
      ☐ Focus group discussion

☐ I understand why the discussion will be voice-recorded and how my confidentiality will be protected (please mark with an X).

☐ I DO NOT AGREE to the focus group discussion being voice-recorded.
☐ I AGREE to the focus group discussion being voice-recorded.

Signature of participant: __________________________
Today’s date: _______ (day)/ ______ (month) / _____ (year)

If participant is unable to sign:
Name and surname of witness: __________________________
Signature of witness: __________________________
Today’s date: _____ (day)/ ____ (month) / _____ (year)
I ____________________________ (researcher’s name and surname) declare that I have explained the information given in this document to the participant.

He/She was encouraged and given ample time to ask me questions. Our conversation was conducted in English/Afrikaans/Xhosa/Sesotho/Zulu/Swati (please encircle) and no translator was used.

Was a copy of the signed copy given to the participant?

☐ Yes
☐ No: If no, why not: ____________________________

Signature of researcher: ____________________________

Today’s date: ____ (day)/ ____ (month) / ____ (year)