Keeping Girls in Schools (KGS): PROCESS EVALUATION

Prepared by

Strategic Analytics & Management and Clacherty & Associates with Stellenbosch University

For

NACOSA and The Global Fund

The Global Fund

NACOSA
COLLECTIVELY TURNING THE TIDE ON HIV, AIDS AND TB

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UNIVERSITEIT STELLENBOSCH UNIVERSITY

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EXECUTIVE SUMMARY

Background

The Keeping Girls in Schools (KGS) programme is a component of the Global Fund Adolescent Girls and Young Women (AGYW) initiative designed to reach 14-18 year old girls in South Africa. It has delivered a package of age-appropriate services to girls in a selection of Quintile 1-3 schools in each of ten districts across South Africa over the three years from April 2016 to March 2019. The aim of the programme is to decrease new HIV infections in girls and young women, decrease learner pregnancies and keep girls in school until they complete high school.

The programme requires local NGO partners to implement sexual and reproductive health and rights (SRHR) education as a core component, a peer education programme that provides life skills and peer support to girls who volunteer to take part, homework support for those girls who ask for it, tracking of and support for girls who are absent from school to ensure they return to school and career guidance for (female and male) learners in Grade 9.

Evaluation Method

This process evaluation was designed to describe how the programme is being implemented across different implementation districts, to gather evidence of fidelity to the designed programme and to reflect on areas for improvement.

The evaluation used a mixed-methods design where we incorporated methods of collecting and analysing data using both quantitative and qualitative approaches that included a survey of a sample of girls who had been enrolled in the programme and school-based implementing staff. Qualitative tools included focus group discussions with girls and implementers and interviews conducted with a range of key informants ranging from education officials to caregivers. Performance data collected over the three years of the project by implementing organisations was also analysed. The evaluation protocol was approved by the Stellenbosch University Human Research Ethics Committee (HREC) certificate number N18/07/075.

Findings

Implementation of Different Components of KGS

This evaluation includes a detailed documentation of the different ways in which the KGS programme has been implemented in different districts. As such it is a valuable record for the development of future work in similar programmes.

Health education was planned as the core component of the programme. Performance data shows that implementing NGOs largely met their targets over the three years of the project. The data from surveys with girls and implementers shows that health education has been experienced by most girls and delivered by most implementers. It is also the component that has the least variation across districts. It is usually delivered to large groups in a classroom setting by a health educator with the help of a manual and flip charts. The main challenge in delivering health education has been accessing girls during school hours. Qualitative data suggests that the most successful implementation of health education takes place in schools where the principal and educator see the value of the programme and make specific formal space for it in the school timetable.

An adapted form of peer education where an adult delivers a life skills curriculum in large groups was provided in five of the districts. A manual was used to direct the content and activities. Findings also show that the content of the Peer Education Manual was seen as relevant and useful as many implementers used it, often in conjunction with health education.

In the remaining five districts a group peer education approach was used where twenty girls formed a Rise Club that met once a week. Members, who run the meetings themselves, focus on the Rise Magazine, which is designed to encourage discussion and local action projects. Responses of girls and implementers to the Rise Clubs and the magazines was generally positive.

Girls who were identified as at risk of dropping out of school by their absences were to be followed up by means of home visits by the school-based implementers and then referred to a local social worker if necessary. The quantitative data showed that not as many home visits were made by implementers as was expected. Implementers talked about several challenges that limit the delivery of this intervention – implementer safety and long distance are the main constraints. Implementers have adapted this component and often see girls at school or invite parents to the school. Referral was difficult in many areas because social workers had high case loads. It was most successful where the NGO partners employed social workers as part of the KGS team in the district.

Homework support was designed as a voluntary and non-core activity of the programme. Even though it was voluntary the data suggests that school-based staff did not implement it as widely as was expected. This was because in some districts the Provincial Department of Education had existing academic support programmes and asked KGS not to intervene in the academic support. Two other barriers were implementer lack of confidence in academic subjects and the fact that girls could not stay behind after school because they had to catch transport home. Career jamborees were implemented, usually with organisational help from the provincial and district DOE in a variety of forms, and were (as planned) accessed by Grade 9 learners only.

Effectiveness of Implementation

Implementation was assessed through the use of a set of indicators of effectiveness based on a thorough review of research on what is needed to create impact in a programme such as KGS. The quantitative and qualitative data showed that the programme was not as multi-layered as planned, mostly because of the constraints related to homework support and home visits. The multi-layered programming seemed to need school-based implementers to be responsible for fewer schools and for dedicated social workers to be available to the programme staff. The quantitative data suggests that the longer a girl receives health education and the more levels of the programme she receives the better her protective knowledge. There is some evidence in the qualitative data of the integrating of knowledge so that girls are empowered and the possibility of behaviour change exists.

Though the quantitative data shows girls and implementers feel the programme is relevant, the qualitative data shows how difficult the family and community context is in which many girls live. In the face of these significant challenges, girls and implementers express significant powerlessness particularly in the areas of community and relationship violence.

There is strong evidence from all PRs, SRs, principals, educators, girls and caregivers in all districts that the KGS implementers play a significant support role for girls. It seems that the more contact the implementers have with girls the stronger the support role they play in their lives. Some implementers lack confidence in dealing with girls' individual problems and need further training in counselling and in providing psychosocial support. They also need emotional support to help them deal with the impact of the work on their own emotional wellbeing.

Quality

The data shows that the more time an implementer can spend in a school the better the quality of the programme. The ratio of schools to adult implementer also influenced quality and supervisors who worked between SR management and the implementers were an important source of quality monitoring and support for the implementers. Implementers and managers thought that involving the broader community would improve the quality of the programme.

Sustainability

The relationship between DBE and the KGS programme appears to be key to the issue of sustainability. While this relationship has been very successful in some districts and many schools, it has not worked everywhere.

Some provincial, district and school level officials perceive the KGS programme as a separate NGO programme and not as it was originally conceived as a national DBE or provincial DOE programme. Some school principals also saw it as an 'outside' programme and this resulted in the difficulty of implementers having to find time during the formal school day to deliver KGS sessions. There was advocacy by the SRs at the district level with principals and officials before the programme was started but this seems to have been insufficient and unsupported by work at national and provincial level by KGS.

Recommendations

Health Education

i) Rework the content of the health education component over the time in which it is delivered so that it is age-appropriate and developmental

ii) Help girls to think critically about the difficult context in which they live by retaining the knowledge component but put more focus on the application of the knowledge so that they are empowered to use the resources they do have to make choices

iii) Place the content into the context of the socio-economic drivers behind HIV and AIDS, teenage pregnancy and dropping out of school.

iv) Explore issues such as poverty, gender norms, violence in relationships and substance abuse explicitly and how they influence choices.

Peer Education and Rise Clubs

i) Retain the Rise Club model with its emphasis on peer-to-peer support and the use of engaging context-related printed resources.

ii) Apply peer education in its true sense where girls themselves educate their peers rather than an adult who delivers life skills content as is presently being done.

Homework Support

i) Explore models that could be applied within the mandate of KGS for assisting girls with content knowledge that could enable them to catch up academically.

ii) KGS staff need to work with school management to make sure homework support is incorporated into the School Implementation Plan (SIP). In particular, educators with subject knowledge should be encouraged to give learner support.

iii) Give implementers training and materials on how to support girls with basic learning skills.

iv) Implement the existing informal strategies presently used in some districts such as small neighbourhood study groups and the use of past learners from the local area as volunteers.

Home Visits

i) Funds should be made available for transport for home visits.

ii) Acknowledge the security concerns of implementers in relation to home visits and find practical ways to overcome these within the local context. In particular, school management should take responsibility for follow up of girls who are at risk as part of the SIP.

iii) Implementers need further training in communication and family counselling skills in relation to families and caregivers.

Career Jamborees

i) KGS should extend the career component to include livelihood education such as entrepreneurial skills. It would be valuable to look at how the aspects of Economic Strengthening for Young Women and Girls programme (part of AGYW) could be integrated into KGS.

Personnel

i) Future iterations of the programme should consider applying the one implementer per school model as this has the most potential for effectiveness.

ii) Consider the employment of social workers within all areas of the KGS programme. This may mean working with fewer districts and schools and providing more in-depth quality care for girls.

Education Departments

i) It is important to do advocacy work with DBE officials at all levels early on in the implementation process and to continue to interact with all levels of DBE on an ongoing basis. The focus on making time in the school day for the programme should be resolved.

ii) Future programming should include education sessions for educators and principals on adolescent sexuality and why KGS uses the particular approach it does.

Community Links

i) Include boys at certain times, particularly in health education topics such as contraception.

ii) The programme needs to strengthen the involvement of parents and community members if the girls are to be supported with positive choices outside the school.

iii) Community dialogues between programme staff, caregivers and girls have been successful in other similar projects and should be explored.

CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGEMENTS

NACOSA, SAM and Clacherty and Associates would like to thank PRs, SRs and KGS implementers in various districts who helped to arrange with the schools and facilitate access to the girls and also provided insight and expertise that greatly assisted the evaluation. We thank the girls who participated in the study for allowing us into their programmes and opening up to give us an understanding of the programme.

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Department of Basic Education (National) and Provincial and District Departments of Education were instrumental in the evaluation by allowing access to the schools and guiding the process to ensure we stayed within the boundaries allowed by the Department. We also acknowledge the school principals and teachers for setting time aside for the evaluation and assisting with the girls, as well as the parents for allowing their children to participate in the evaluation.

ACRONYMS

AGYW	Adolescent Girls and Young Women
ART	Antiretroviral Therapy
CAPS	Curriculum Assessment Policy Statements
DBE	Department of Basic Education (National)
DOE	Department of Education (Provincial)
DOH	Department of Health
FGD	Focus Group Discussion
GDE	Gauteng Department of Education
GF	Global Fund
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
KGS	Keeping Girls in Schools
KII	Key Informant Interview
LFA	Local Funding Agent
LO	Life Orientation
LSA	Learner Support Agent
MIET Africa	Media In Education Trust Africa
M&E	Monitoring and Evaluation
NACOSA	Networking HIV & AIDS Community of Southern Africa
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
PGT	Peer Group Trainer
PR	Principal Recipient
SANAC	South African National AIDS Council
SAW	Social Auxiliary Worker
SW	Social Worker
SIP	School Implementation Plan
SOP	Standard Operating Procedure
SR	Sub Recipient
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TAC	Technical Advisory Committee
TB	Tuberculosis
TOR	Terms of Reference
UNESCO	United Nations Educational, Scientific and Cultural Organization

1 BACKGROUND

The evaluation reported on here is a process evaluation of the Keeping Girls in Schools (KGS) programme, which is a component of the Global Fund Adolescent Girls and Young Women (AGYW) initiative. The purpose of the evaluation is to describe how the programme is being implemented across different geographical areas, to gather evidence of fidelity to the designed programme and to reflect on areas for improvement. The recommendations from the evaluation will be used to inform programme implementation of future school-based AGYW grants in South Africa.

1.1 Programme Description

1.1.1 Global Fund Adolescent Girls and Young Women (AGYW) Initiative

The Global Fund ZAF-C Grant entitled "Investing for Impact against Tuberculosis and HIV" has been operating in South Africa since 1 April 2016 and will continue until 31 March 2019. The grant aims to bolster the country's national response to HIV, TB and STIs by adding value to the substantial commitments from the South African government and other funding partners. The grant is aligned with the South African National Strategic Plan (NSP) on HIV, TB and STIs (2017-22).

The overall goals of the grant are to:

a) Reduce new HIV infections by at least 50% using combination prevention approaches;

b) Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation;

c) Reduce the number of new TB infections as well as deaths from TB by 50%;

d) Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP; and

e) Reduce self-reported stigma related to HIV and TB by at least 50%.

The South African National Strategic Plan for HIV, Tuberculosis (TB) and Sexually Transmitted Infections (STIs) 2017-2022 (SANAC, 2017) comments as follows:

> **Young women in their early 20s have a four-fold burden compared to their male peers, with approximately 2 000 new HIV infections occurring every week, or 100 000 of the 270 000 new infections a year, and one third of teenage girls become pregnant before the age of 20. Responding to the social and structural drivers of this vulnerability (which leads young women towards having sexual relationships – many of which are transactional in nature – with men who are five to 10 years older than they are) is key to controlling the epidemic. (p. 7)**

In response to this situation, part of the ZAF-C Grant was given over to the Adolescent Girls and Young Women (AGYW) programme. The overall aim of the AGYW programme is to provide a comprehensive package of health, education and support services for adolescent girls and young women aged 10-24 years, both in and out of school. The AGYW programme combines different models of life skills-based HIV education, targeting the different age groups, with the aim of effecting behaviour change and empowerment for this key population, as well as offering HIV testing services (HTS) and sexual and reproductive health services (SRH).

The objectives of the AGYW programme are aligned to "She Conquers"[1] and aim to:

a) Reduce new HIV infections among adolescent girls and young women aged 15-24

b) Reduce the incidence of teenage pregnancy

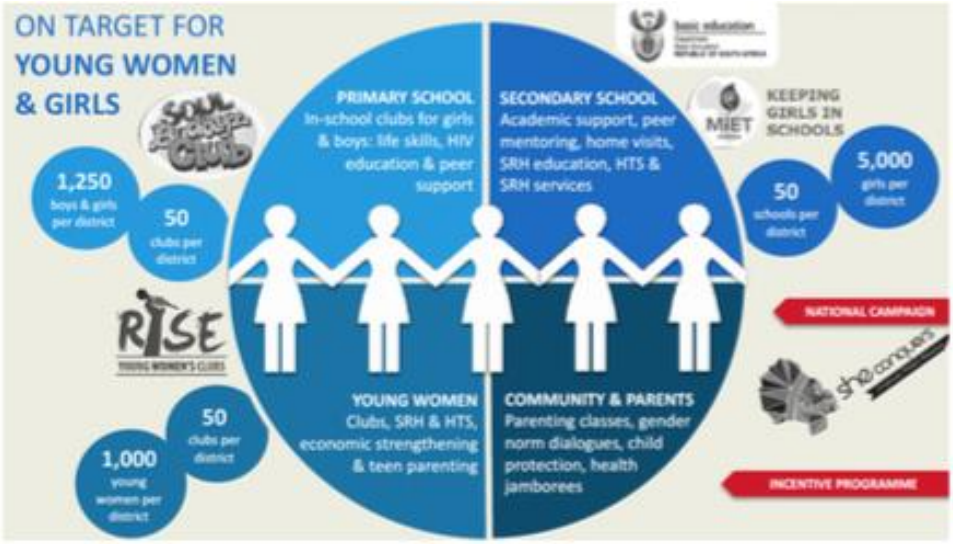
c) Increase retention of girl learners in school until completion of grade 12

d) Reduce sexual and gender-based violence experienced by adolescent girls and young women

e) Increase economic empowerment of adolescent girls and young women

AGYW interventions are "structured, age-appropriate and offer a comprehensive package of prevention, care and support services" (NACOSA, 2018). The figure below gives an overview of the AGYW programme.

Figure 1: AGYW Programme Components



The above figure shows that the interventions are divided into distinct intervention packages that cater for girls and young women at different stages of development:

a) Young girls 10-14 years: This intervention takes the form of Soul Buddyz Clubs run in selected primary schools

b) Adolescent girls 14-18 years: This is the Keeping Girls in Schools programme (KGS)

c) Young women 19-24 years: This intervention takes the form of Rise Clubs, which are community-based clubs for young women out of school

d) Community programme catering for caregivers and other adults, which includes a teen parenting programme for 14-21 year old teen mothers and fathers who are in or out of school and Hands on Parenting for caregivers of Soul Buddyz.

Other interventions include child protection, health and welfare jamborees, community dialogues and economic strengthening.

Component (b), the Keeping Girls in Schools programme, is the subject of this evaluation.

[1] http://sheconquerssa.co.za

1.1.2 The Keeping Girls in School (KGS) Programme Overview

The Keeping Girls in Schools programme (KGS) was designed by the National Department of Basic Education (DBE) in 2014 with the purpose of expanding the Life Orientation (LO) subject offered at high schools in ten districts. The KGS programme aimed to identify and support female learners in Grades 8 to 11 who are at risk of dropping out of school. The young women and girls targeted for the initiative attend no-fee or low-fee schools (mostly Quintiles 1-3)[2] as these girls are seen as the most vulnerable. At these schools selected young women and girls are provided with sexual and reproductive health and rights (SRHR) education, a peer education programme that provides life skills and peer support, homework support, tracking of and support for girls and young women who are absent from school to ensure they return to school and career guidance for learners in Grade 9.

Programme Outcomes

The Standard Operating Procedures (SOP) for KGS list the programme outcomes as follows:

a) Decrease new HIV infections in girls and young women
b) Decrease learner pregnancies
c) Keep girls in school until they complete high school.

Programme Partners

The KGS programme is delivered through five NGOs and government institutions who are known as Principal Recipients (PRs). These PRs then contract Sub Recipients (SRs) to deliver the programme in the schools. The table below outlines the PRs, SRs, provinces, districts and number of schools per district in which the programme is implemented.

2 The criteria (South African Schools Act, 84 of 1996) used for classifying schools are based on levels of poverty in surrounding areas, for example surrounding infrastructure, how many homes are made from brick, wood or iron sheeting, income levels of the community around each school. Schools classified in quintiles 1-3 are generally found in the poorest communities although anomalies do exist. Learners in these schools do not pay fees. It is also important to note that because learners (mostly from township areas) often 'bus in' to schools in other areas, schools in quintiles 4 and 5 often have large numbers of learners from poorer areas – some of these schools are also classified as no-fee or low-fee schools . Some of the schools offering KGS were Quintile 4 no- or low-fee schools.

Table 1: KGS Delivery Agents and School Numbers per Province and District

Principal Recipient	Sub Recipient	Province	District/ Metro	Total No of Schools per District/Metro
NACOSA	MIET Africa	Limpopo	Greater Sekhukhune	48
		Mpumalanga	Ehlanzeni	49
			Gert Sibande	51
		KwaZulu-Natal	Zululand	50
Soul City Institute	Childline Gauteng	Gauteng	City of Tshwane	28
	Show Me Your Number	North-West	Bojanala	47
Western Cape Department of Health	Desmond Tutu HIV Foundation	Western Cape	City of Cape Town	44
Kheth'Impilo	Kheth'Impilo	Eastern Cape	Nelson Mandela Bay	38
	Small Projects Foundation	Eastern Cape	OR Tambo	34
KZN Provincial Treasury	Mpilonhle	KwaZulu-Natal	King Cetshwayo District	50

Description of Programme Components

The components of the KGS programme are:

a) Health education – this is a core component

b) Peer education

c) Homework support

d) Home visits

e) Career jamborees.

Each of these is described in the summary table below. The summary is taken from the standard operating procedures of KGS for each component which is reproduced in Appendix A.

Table 2: KGS Summary of Standard Operating Procedures for each Component

Component	Description	Personnel Responsible	Standard Intervention Requirement
Health Education Core	Classroom-based delivery of five Sexual and Reproductive Health (SRH) topics. Health education facilitation pack provided.	Health educator employed by SR.	All female learners in Grade 8-11. 5x60 minute sessions weekly. All girls cover 5 topics.
Peer Education Model 1 Voluntary	12 one-hour, after-school peer education sessions where they explore attitudes and behaviour relating to self and SRH through discussions and group work, to promote positive behaviour change. Peer education manual, learner handouts and mentor/trainer manual provided.	Peer Group Trainer (PGT) employed by SR to train learner peer educators.	Volunteers from female learners Grade 8-11. 12 sessions of 60 minutes each.
Peer Education Model 2 **In-school Rise Clubs** Voluntary	Clubs meet to discuss topics in the RISE Magazine, which deals with broad life skills issues and to plan local action projects or personal projects.	The SR meets with educators to explain clubs. They ask for a volunteer educator who becomes a club co-ordinator/facilitator, trained by Soul City to mentor the club – club run by girls themselves.	20 volunteer female learners who form a club that meets regularly. Usually once a week for at least a year.
Homework Support 1.1.3 Voluntary	Weekly after-school help to do homework.	PGT	Voluntary attendance by girls who need help. 15-20 in a group.
Home visits Identified girls	Home visit to track why learner is absent. May also refer to an available social worker.	PGT	Girls who are absent for more than a week or for five or more days over a month.
Career Jamborees Grade 9	Career jamborees are organised by Provincial Department of Education in each district. They take different forms in different areas but can include visits to a career exhibition or visits from organisations to the schools.	KGS supervisor at district level and/or DBE District manager	One per year for all Grade 9 learners
School-based implementers PRs who deliver the KGS programme have different naming conventions for school-based staff. These are described below. Kheth'Impilo uses the term Learner Support Agent (LSA) to describe the implementer in each school. This is a formal DBE title used by schools throughout South Africa. The LSA delivers Health Education and supports the Rise Clubs. NACOSA and Western Cape DoH use the terms Health Educator and Peer Group Trainer (PGT). Some districts refer to the PGT as a Peer Educator. Soul City uses the terms Health Educator and Club Co-ordinator (an educator who is trained by Soul City to support the Rise Club) In Bojanala and Tshwane. In some districts the Health Educator supports the Rise Club. In Tshwane the programme is implemented by Childline who call the school-based staff Social Auxiliary Workers (SAWs). KZN Treasury uses the term Lifeskills Coach to refer to the person who delivers Health Education and Peer Education.			

Because of these different naming conventions, we have used the term 'implementer' in this report to refer to all school-based staff of KGS.

1.2 Process Evaluation of KGS

Objectives of the Evaluation

The evaluation focused on the implementation period from July 2016 to October 2018.

There were four evaluation objectives, namely:

a) To document different ways in which the KGS programme is being implemented across the 10 districts;

b) To assess if the programme has the elements for effective implementation;

c) To assess the quality of the KGS programme; and

d) To understand the sustainability of the KGS in high schools

1.3 Methodology

1.3.1 Evaluation Design

The evaluation used a mixed-methods design which incorporated methods of collecting and analysing data using both quantitative and qualitative approaches (Creswell, 2003). This approach allowed answers to questions about both "the complex nature of phenomena from the participants' point of view and the relationship between measurable variables" (op. cit. p. 70). (The evaluation framework is in Appendix G).

We developed a table of indicators (Table 3) for evaluating effectiveness of the KGS intervention after a thorough literature review (Appendix B).

Table 3: Indicators and Key Research Questions Related to Effectiveness and Quality

Indicator of Effectiveness	Key Research Questions[3]
Intervention operates at all systems of development – it is holistic and multi-layered	How much does the programme relate to the multi-systems of development i.e. does it intervene at the level of the: i) individual girl ii) family iii) peers iv) school - especially academic competence v) community vi) macro level i.e. in the area of ○ norms and values ○ structural issues such as ▪ poverty ▪ safety ▪ health services

[3] Terms used here are explained in the literature review.

Indicator of Effectiveness	Key Research Questions[3]
Imparting of protective knowledge.	Is there evidence of education about sexual and reproductive health and rights?
Contextualisation of protective knowledge in the reality of adolescent development i.e. it acknowledges sexuality of adolescents and the fact that adolescents are in relationships.	Is there evidence that SRH content is taught in the context of sexuality and relationships?
Relevance to broad community context.	Is there evidence of application of knowledge to community context and lived experience of the girls i.e. does the curriculum acknowledge the community context of poverty and violence and in particular the gender norms that promote violence?
Empowers girls through critical and communicative competence to look critically at their context and in spite of it have the power and confidence to make healthy decisions.	Does the programme deal with social drivers of HIV and AIDS and pregnancy? Does it promote critical competence or the ability to 'read' context? Does the curriculum include exploration of: - How gender and other norms affect behaviour? - Love and sex and relationships in broader social context of poverty i.e. that decisions are often motivated by poverty - Understanding relationships within context of violence e.g. coercive sex - How poverty affects behaviour? e.g. intergenerational relationships Does it promote participatory competence through encouraging taking part in activities in school and community? Does the programme use dialogue and discussion as a form of engagement with girls and in this way encourage empowerment? Does it encourage communicative competence i.e. assist girls to express themselves assertively?
Builds networks of support	Does the intervention encourage positive peer relationships? Does it create opportunities for girls to engage with supportive adults? Does it create systems to identify girls in particular need? Does it provide access to general psychosocial support and referral to professional support for particularly vulnerable girls?

The choice of research informants and the research tools was informed by a socio-ecological approach (Bray & Dawes, 2016; Bronfenbrenner, 1994) which places the girls and the KGS programme within a set of interacting socio-ecological frameworks.

1.3.2 Evaluation Methods

Research Staff

Researchers were all graduates with research experience in both quantitative and qualitative work. They were assigned to districts according to their language so that research could be conducted in local languages. Training covered the data collection tools, process for conducting field work in schools and briefing in ethical procedures.

Quantitative Method

We used both primary (from surveys) and secondary data sources (delivery data collected by PRs). Primary data was collected using a cross-sectional survey which had two aspects:

a) **School survey.** This survey (Appendix C) was completed for each sampled school by the school-level implementers such as Health Educators and Peer Group Trainers. The School Survey covered:

   i) Programme models of implementation as they are applied in different schools
   ii) Context of implementation in the school environments and the support received
   iii) Implementation experience
   iv) What the school level implementers would like to see improved / changed.

b) **Learner survey.** This survey (Appendix D) was completed by a sample of girls. The survey assessed the extent to which girls had participated in different aspects of the KGS programme looking at the following aspects:

   i) Actual experiences of girls on the programme
   ii) How relevant the programme content has been to the girls
   iii) What gaps they feel exist in the programme
   iv) Perceptions of the girls on the content of programme implementation
   v) The changes that the girls would like to see in the programme in order to align it to their needs
   vi) Levels of knowledge of key messages within the SRH component of the programme.

The survey instruments took the form of structured questionnaires with selectable options inclusive of standard Likert scales. This enabled the participants to rate different aspects of the programme and indicate their level of satisfaction or impression about how the different programme components were implemented.

Qualitative Methods

The qualitative work used three different approaches:

a) Focus group discussions

   Focus group discussions (see Appendix E) were all held in the girls' home languages, recorded and transcribed. They were held with the following project participants:

   i) Learners who had participated in the programme
   ii) Peer Group Trainers or equivalent school-level implementers
   iii) Health Educators or equivalent school-level implementers
   iv) Caregivers.

b) Key informant interviews

   Key informant interviews (Appendix F) were conducted with school staff, PR, SR and M&E managers, supervisors, DBE National, Provincial and District officials, SANAC and Global Fund Representatives.

c) Case Studies

Three case studies were developed from focus group discussions held in the schools and interviews with girls, educators, principals and parents. These case studies provide a more detailed understanding of programme implementation within the context of the young women's lives. They are contained in Appendix L.

1.3.3 Sampling

Quantitative Methods

Sampling and Sample Size: The study population was the 526 schools targeted by the programme in the 10 districts, from which 10% were sampled (52). For the learner sample, all girls (Grade 8-12[4] and confirmed to be participants of the programme) available on the day of data collection who had returned the signed consent forms were included in the study. In total 2686 learners participated in the survey. Additionally, a School Survey was conducted in each of the 52 schools included in the sample. The survey was designed to gather data from the team that implements the programme in the school. In nearly all districts, the School Survey was completed by the implementing team sitting together. However, in Ehlanzeni and Gert Sibande, implementers undertook the School Survey individually bringing the total number of School Surveys completed to 69.

Sampling Procedure: A stratified probability proportional to size sampling approach was employed to reflect the different contexts in which the KGS programme was implemented taking into consideration differential school child population density between the different schools. This was done to attain representativeness of the sampled school child population. For each of the districts included in the survey, a sampling frame was drawn that included the 526 schools that were part the KGS programme. The sampling frame provided by the PRs included the name of the school, whether it was a girls-only high school or co-educational and the school quintile as defined by the Department of Basic Education (DBE). Based on the principle of proportionate representation of schools per KGS district, the schools were selected and within those the samples of girls who were to participate in the survey were drawn. A simple random selection was employed taking into account the location of the school (i.e. urban, peri-urban or rural); and KGS programme performance (i.e. high, medium and low).

Qualitative

Girls were selected randomly for the focus groups from the sample of girls who had completed the Learner Survey. Implementers were purposively sampled. Focus groups with caregivers (parents or guardians whose girls had participated in KGS) were planned in five districts, only four were conducted. Case studies were selected according to context i.e. one from an urban area, (Cape Town) a peri-urban area (Greater Sekhukune) and a rural area (OR Tambo). All the case study schools were identified as high performing by the PR as the aim was to understand how girls experienced KGS at its best. Key Informant Interviews were conducted with school staff, managers of the programme at PR and SR level, the KGS M&E coordinator and the district supervisor. We also interviewed stakeholders from national, provincial and district DBE, SANAC and the Global Fund. A list of key informants is given in Appendix H.

- Focus groups and interviews with the girls and caregivers were conducted in their home languages, although in some cases interpreters were used. Implementer focus groups were also held in the local language, again some with an interpreter. Key informant interviews were all held in English.

The table below outlines sample numbers and individuals in more detail.

[4] Some grade 12 girls who had participated in KGS while in grade 8-11 were included.

Table 4: Summary of Sample Sizes in the Schools across the 10 Districts

District	Number of Schools in study	Total Learner Surveys Completed	Total School Surveys Completed	Number of FGD with SR Implementers	Number of FGD Parents/ Guardians	Number of FGDs with Girls	Number of FGD (Girls) participants	Number of Principal/ teacher interviews
City of Tshwane	8	283	9	1	0	1	8	0
Bojanala	7	340	9	1	1	0	0	0
OR Tambo	3	291	3	1	1	1	12	1
Nelson Mandela Bay	4	94	4	1	0	2	29	1
King Cetshwayo	5	204	5	1	0	3	50	1
Zululand	5	198	6	1	0	4	20	1
City of Cape Town	5	276	6	1	1	2	25	2
Ehlanzeni	5	435	13	1	0	5	41	4
Gert Sibande	5	347	8	1	0	3	21	3
Greater Sekhukhune	5	218	6	1	1	5	50	1
Total	**52**	**2686**	**69**	**10**	**4**	**26**	**256**	**14**

1.3.4 Data Collection Process

Data collection was undertaken by trained field assistants, using an electronic questionnaire completed on pre-programmed tablets. The research team in each district comprised of one researcher and 4 field assistants who together visited one school at a time to undertake the surveys. Senior researcher led the qualitative research work in each district. The research teams were supported by research experts who provided technical oversight and ensured that data collection in each district was completed effectively and that it proceeded as planned with regards to timeliness and quality.

The researchers made prior arrangements with each school, including confirming the number of girls that were reached by the programme, agreeing on a date for the survey with the school management and coordinating with the schools to obtain parental/guardian consent for learners under 18 years. The survey for learners was conducted during schools break as well as immediately after school hours. Focus groups and case studies were also completed at the time that was convenient for the school's stakeholders.

1.3.5 Data Analysis

Quantitative Analysis

Frequency distributions were run to show responses to items by district for both the learner and school survey. The distribution of variables for demographic measures and the KGS implementation and support programmes are presented graphically using bar graphs that are stratified by district.

In the knowledge support domains (See questions 22 to 29 in Learner Survey) of puberty, teen pregnancy, contraceptives, sexually transmitted infections including HIV, unhealthy relationships, sexual coercion and rape, alcohol and drug abuse, self-esteem and career jamborees, values were allocated to each response and scored. The values allocated on a scale of 5 to 1 (5 being strongly agreed and 1 being strongly disagreed). Higher scores suggested better knowledge of the domains as attained through participating in the KGS programmes. Univariate and multivariate regression models were applied to determine factors associated with knowledge support domains. The dependent variable was the domain score and covariates were grade in school[5], whether the mother was alive and the KGS activities perceived to be the most helpful. Statistical analysis was conducted in SAS Enterprise Guide 7.15 (SAS Institute Inc., Cary, NC, USA).

Qualitative Analysis

A contextualized content analysis approach was used to analyse the data (Terreblanche, Kelly, & Durrheim, 2010). All the transcribed focus group discussions and interviews were read several times by the researchers so that a familiarity with the material could be established. On the basis of this familiarity, themes were drawn out revolving around the KGS programme in the schools. Themes were based on emergent dominant patterns in the data as described by Patton (1990). These themes were used to code the focus group discussions and interviews using the **ATLAS.ti** software package. Once the provisional analysis had been done all the interviews were reread as a validity measure to check for contradictory findings, and if any information had been inadvertently excluded. Data from the different research activities and from the different contexts allowed for triangulation of the findings.

[5] Because this would tell us length of exposure to KGS programme

1.3.6 Triangulation of Data

Triangulation (Heale and Forbes, 2013) was used at a number of different levels. We have triangulated qualitative and quantitative data from beneficiaries, schools, district, implementers, PRs and SRs. Scrutinising themes arising from these different levels allowed us to validate the data collected and divergent views helped us to interrogate particular issues of implementation to make relevant recommendations.

1.3.7 Research Ethics

The study protocol complied with the Declaration of Helsinki and the SA Medical Research Council's guideline for research on human beings, which emphasises prior informed consent before the interview and confidentiality of data obtained. Data collection did not use any individual identification and was analysed anonymously. A consent process suited to research with minors was applied. Caregivers of all minors were asked to give consent for their child to participate. All girls under 18 were also asked to give assent. Researchers did not ask questions or probe about topics that might have caused emotional harm. Any girls who researchers identified as needing immediate help were referred to a local social worker who had agreed to assist researchers beforehand. The evaluation protocol was approved by the Stellenbosch University Human Research Ethics Committee (HREC) certificate number N18/07/075.

1.3.8 Limitations of the Research

The main limitation was the reduction of the range of views from key stakeholders in the KGS programme. Educators were often busy and unwilling to meet with researchers. Many caregivers did not attend focus group discussions to which they were invited, so even though we held four focus groups with parents there were often only 2 or 3 parents in the focus group instead of the expected 10 that were planned for. Only three provincial DOE officials were interviewed.. These challenges have reduced the expected number of participants and therefore the robustness of the data gathered.

2 FINDINGS, DISCUSSION AND INTERPRETATION

2.1 Demographics of Research Participants

The majority of the participants were enrolled from the Ehlanzeni (16%), Gert Sibande (13%), Bojanala (13%) and OR Tambo (11%) districts. A distribution of the schools by province, district and municipality is presented in Appendix I.

Survey respondents included learners in Grade 8 (28.6%), Grade 9 (34.4%), Grade 10 (23.3%), Grade 11 (12.5%) and Grade 12 (1.2%) . Forty-five percent were 13-15 years old and 40% 16-18 years old.

Appendix I presents further demographic measures by district; there were more mothers (84%) reported alive than there were fathers (71%) and mothers were often reported as heads of households (36%).

A total of 69 implementers participated in the School Survey. Ehlanzeni district had the most implementers (19%) that completed a School Survey.

2.2 Objective 1: To Document Different Ways in which the KGS Programme is being Implemented Across the 10 Districts

2.2.1 Overview of Implementation

Objective 1 requires documentation of the different ways in which KGS is being implemented in the ten districts. This section is a simple description of implementation. The analysis of the implementation is given in Section 2.2.2 below. Each SR has adapted the standard KGS model as presented in the SOP (Table 2) according to their context and to their organisational strengths. Appendix J gives a detailed overview of implementation and Table 5 below a summary.

Table 5: Summary of KGS Implementation

District PR & SR	Description of implementation	Personnel employed by KGS
Tshwane **Soul City** **Childline Gauteng**	**Health Education** Every quarter with 40 girls a time over a period of 2 hours and 30 minutes. Take place on days that are free such as sport days and they have run some on Saturdays. **Peer Education – Rise Clubs** At school after school hours and on weekends. **Resources** Since July 2018 the sessions have been run with the new DBE health education materials. Rise magazines from Soul City. **Homework Support** Secondary School Improvement programme (SSIP) run by Gauteng Education Department (GDE). Rise Club members form study groups. **Career Jamborees** Organised by GDE **Home visits** Done by social worker when girls are referred by SAW.	10 Social Auxiliary Workers (SAWs) responsible for about 2 schools each. 2 Social Workers (SW) do home visits and deal with referrals. KGS supervisor in district.
Bojanala **Soul City** **Show Me Your Number** **From end of 1st quarter 2018**	**Health Education** Use the LO lessons. **Peer Education – Rise Clubs** At school after school hours and on weekends. **Resources** DBE health education materials Rise magazines from Soul City **Homework Support** Distance between schools and transport and Health Educators lack of training in Homework Support make it difficult to implement. **Career Jamboree** Show Me Your Number developed a Career Guideline used during health education sessions as an add-on for all grades **Home visits** The social worker and SAW do these when girls are referred by the Health Educators. Lack of transport a challenge. .	8 Health Educators responsible for about 5 schools each. 1 SW and 1 SAW do home visits and deal with referrals. KGS supervisor in district.

District PR & SR	Description of implementation	Personnel employed by KGS
Zululand **NACOSA** **MIET Africa**	**Health Education** LO lessons or free periods once a month. One grade at a time. **Peer Education – PGT runs sessions** There are no learner peer educators. PGT uses DBE/MIET Africa Peer Education Manual in a classroom. Once a month with 20 learners from one grade until they have covered all sessions. Then they move on to another grade. **Resources** MIET Africa/DBE Health Education Manual and Peer Education Manual **Homework Support** PGT does Homework Support in their once monthly visit to the school. **Career Jamborees** Provincial Department of Education uses KZN Science Centre to implement jamborees. **Home visits** PGT does these. Refer to state social worker.	10 Health Educators 10 Peer Group Trainers 1 Health Educator and 1 Peer Group Trainer to 5 schools. KGS supervisor in district.
Greater Sekhukhune **NACOSA** **Managed by Lifleline Limpopo for MIET Africa**	**Health Education** As above **Peer Education – PGT runs sessions** As above **Resources** As above **Homework Support** As above **Career Jamborees** Organised by District Education Department officials. **Home visits** PGT does these. Refers to Lifeline social worker.	1 Health Educator and 1 Peer Group Trainer to 5 schools. Lifeline has a few social workers who work in the entire province. KGS supervisor in district.
Gert Sibande **NACOSA** **MIET Africa**	**Health Education** As above **Peer Education – PGT runs sessions** As above **Resources** As above **Homework Support** As above **Career Jamborees** As above **Home visits** PGT does these. Refers to state social worker.	1 Health Educator and 1 Peer Group Trainer to 5 schools

District PR & SR	Description of implementation	Personnel employed by KGS
Ehlanzeni **NACOSA** **MIET Africa**	**Health Education** As above **Peer Education – PGT runs sessions** As above **Resources** As above **Homework Support** As above **Career Jamborees** As above **Home visits** PGT does these. Refers to state social worker.	1 Health Educator and 1 Peer Group Trainer to 5 schools
Nelson Mandela Bay **Kheth'Impilo** **Kheth'Impilo**	**Health Education** During LO lessons, free periods or during break time. LSAs on standby to grab a free spot and conduct a session. An average of 4 sessions are delivered in a week by working grade by grade through a school until all 5 health education topics are done. **Rise Clubs** 1 club per school – 20 girls in a club. Mostly meet at break time. LSA supports but girls run clubs. **Resources** MIET AFRICA/DBE Health Education Manual. Rise magazine. **Homework Support** After school or in free periods. Run by LSA who is always available to help. **Career Jamborees** District Education Department organises. **Home visits** Done by LSAs. Refer to Kheth'Impilo social worker.	Kheth'Impilo are working with Learner Support Agents (LSAs) chosen by DBE and trained by MIET but managed and paid by Kheth'Impilo. There are 38 LSAs and each has responsibility for 1 school and is in the school full time. One social worker in this district employed by Kheth'Impilo. KGS supervisor in district.
OR Tambo District **Kheth'Impilo** **Small Projects Foundation**	**Health Education** As above **Rise Clubs** As above. **Resources** As above **Homework Support** As above. **Career Jamborees** As above. **Home visits** Social worker does these.	34 LSAs one per school. One social worker for the district. KGS supervisor in district.

District PR & SR	Description of implementation	Personnel employed by KGS
City of Cape Town **Western Cape Department of Health** **Desmond Tutu HIV Foundation**	**Health Education** During LO lessons. **Rise Clubs** 20 girls per school in a club, meet during break and after school. Regular Rise district meetings that 2 different girls attend. **Resources** MIET Africa/DBE Health Education Manual Rise magazine. **Homework Support** Done in a free period – learners cannot stay after school because of transport. **Career Jamborees** District Education Department organises for Grade 9s. **Home visits** Not always safe to do these. Refer to school social workers, employed by Western Cape Education Department.	Implementers (called Health Educators) are responsible for 2 schools each. There are 20 implementers.
King Cetshwayo **KZN Treasury** **Mpilonhle** **Started in April 2017**	**Health Education** Once a week usually in LO lessons. One session lasts 90 minutes so the 5 topics are divided into two sessions. **Peer Education – PGT runs sessions** There are no learner peer educators. PGT uses DBE/MIET Africa Peer Education Manual in a classroom. Once a month with 20 learners from one grade until they have covered all sessions. Then they move on to another grade. **Resources** MIET Africa/DBE Health Education Manual and Peer Education Manual **Homework Support** Llife Skills coaches try but KZN Education department has requirements for homework supporters and coaches cannot always meet these. **Career Jamborees** District Department of Education with Mpilonhle **Home visits** Usually done with a social worker – use state social workers.	Health Educators are known as Life Skill Coaches. 44 Life Skill Coaches – one per school. They are also responsible for a Soul Buddyz club in a local primary School.

A review of the implementation period indicated that while programme implementation started in Quarter 1 of 2016, full-scale rollout commenced in the second quarter. In total the programme implementation period that formed the subject of this evaluation between Quarter 2 2016 and Quarter 2 2018 was 9 quarters. The implementation period varied across districts, with 5 districts namely; City of Tshwane, Zululand, Ehlanzeni, Gert Sibande and Greater Sekhukhune implementing throughout the 9 quarters. Bojanala, King Cetshwayo and City of Cape Town implemented the programme fully for 6 of the 9 quarters.

2.2.2 How each Component of the KGS Programme is Implemented

Before looking at how each component was implemented, challenges and adaptations, there is some useful data on how girls found out about the KGS programme and how they were selected.

2.2.2.1 Who participated and how girls joined in KGS

Key informant interviews (KIIs) with SR and PR managers described how girls were selected to be part of KGS. In all the districts SRs aimed to implement health education with all Grade 8 to 11 girls. Peer education was voluntary in all areas and Rise Clubs were voluntary but limited to 20 girls per club, one club per school. Homework Support was voluntary and home visits were offered to vulnerable girls. Career Jamborees were offered to all Grade 9 girls in all of the districts of implementation. The data from the Learner Survey showed that 45% of the girls who participated in KGS heard about the programme when the programme Implementers came to their schools and 35% through their teachers (Appendix I).

2.2.2.2 How KGS is implemented in different areas

This section of the findings outlines data collected from a range of different sources about how each component of KGS is implemented. In particular it looks at what the quantitative and qualitative data says about:

- **when and how** each component is delivered
- the **resources** used (if any)
- the **challenges** faced
- the **adaptations** made.

Each of these is discussed in turn under each programme component below.

2.2.2.2.1 Health Education

When and How

An analysis of annual [6]programme data (see Figure 2 below) for health education shows that in 2016, a total of 31,079 learners were reached with health education, representing 75% of the aggregated annual target. None of the districts were able to achieve the target in 2016, possibly due to delays in start-up activities. Two out of the ten districts namely, Bojanala and Cape Town did not implement health education at all in 2016 because the project had not started up in those districts yet. In 2017, the total reach across districts was 55,157, representing 97% of the aggregated target. As reflected in Figure 2 most districts achieved or exceeded their Year 2 targets, the exceptions being Bojanala with 42%, OR Tambo with 68%, Tshwane with 79% and Greater Sekhukhune with 82%. In 2018, a

[6] The Global Fund grant year commences in April and ends in March of the following year. It should be noted therefore that annual data presented in the report is based on implementation from April to March of the following year.

total reach of 44,758 was achieved for health education, exceeding the overall target by 49%. The only district that fell below target in 2018 was OR Tambo.

Figure 2: Percentage of Annual Targets Achieved for Health Education by District for the three Years 2016 to 2018[7]

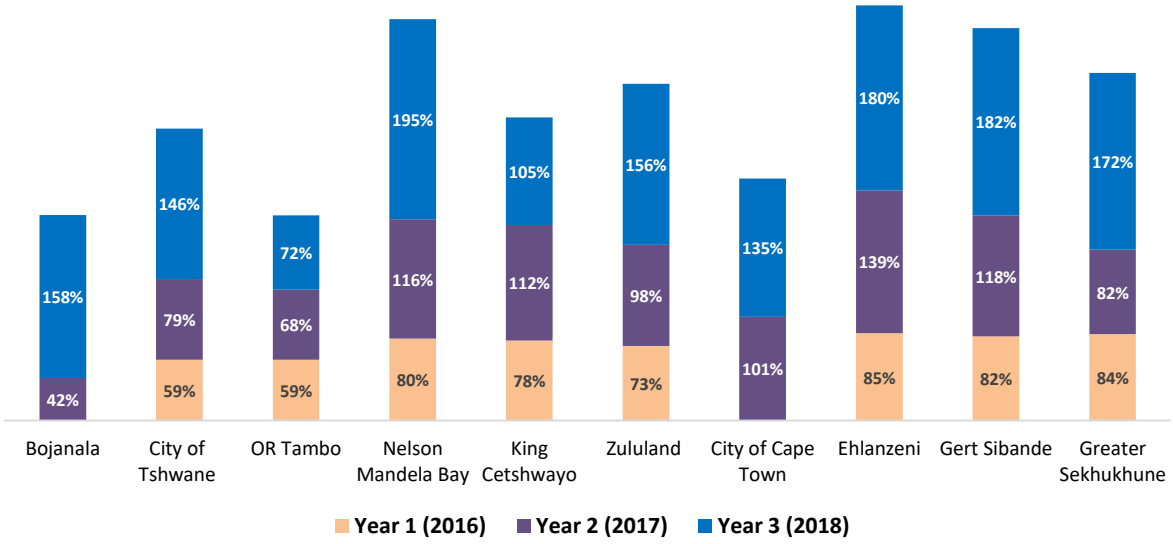
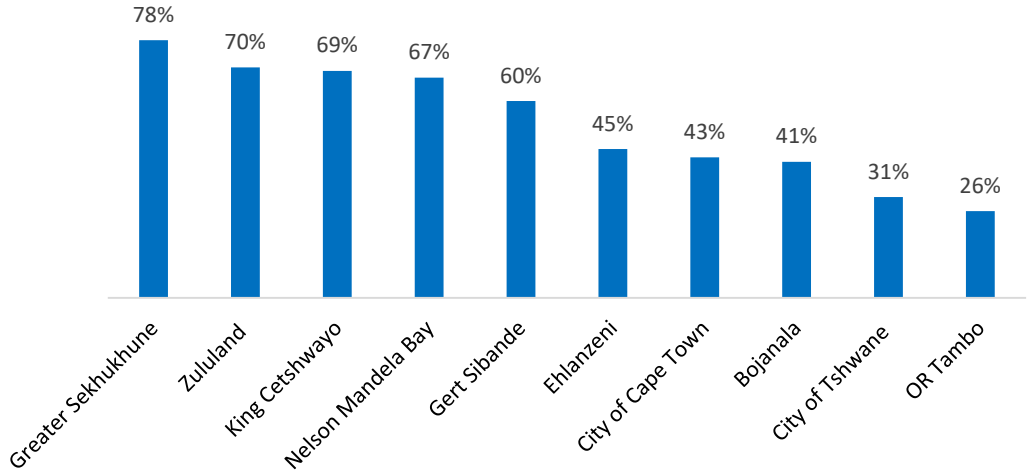


Figure 3 below shows the proportion of Learner Survey respondents who reported having received health education at the time of the survey.

Figure 3: Proportion of Learner Survey Respondents that Reported having Received Health Education



The Learner Survey showed that 51%[8] of the girls reported that they had participated in health education (Appendix I). According to the Learner Survey, more girls indicated that they attended

[7] The Global Fund grant year commences in April and ends in March of the following year. It should be noted therefore that data presented in the report for 2016 is based on implementation from April 2016 to March 2017.

health education sessions than any other activity. Figure 3 shows the proportion of Learner Survey participants that reported receiving health education by district. The data further shows that there was a large variation in the delivery of the implementation across districts, ranging from 27% in OR Tambo district to 80% in Greater Sekhukhune district.

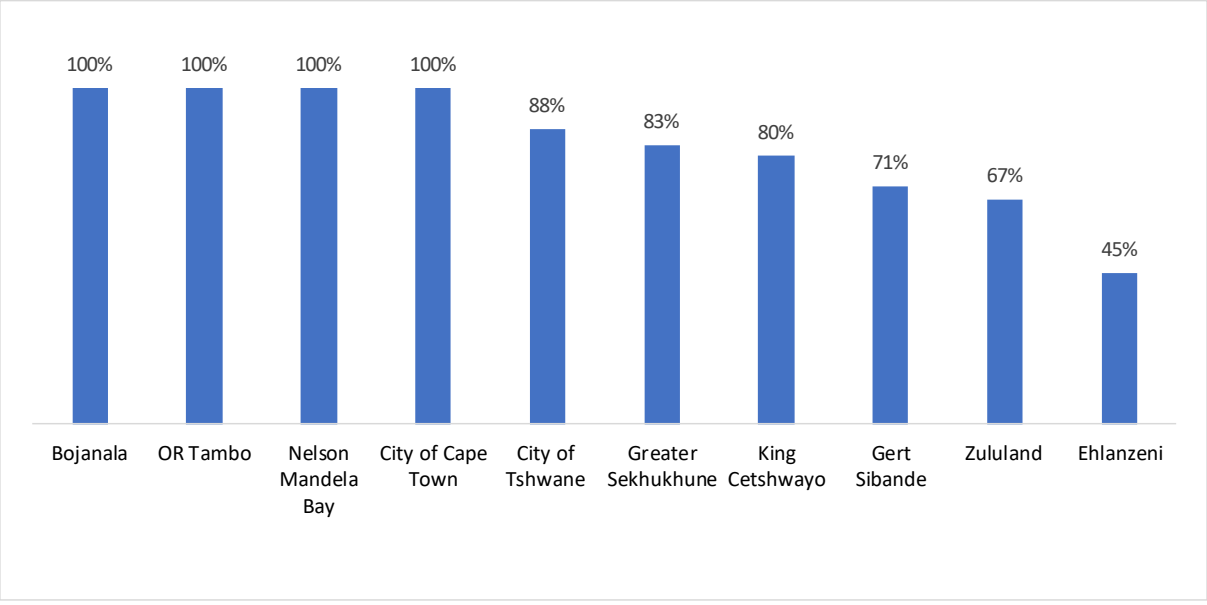
All the girls who participated in the focus groups said they had attended health education sessions. Some listed topics covered in these sessions, but many girls also described what they had learned from the sessions.

> **I drew a picture of health education. This is a condom, this is a pill, this is a girl and she's excited and this one she has a confidence, after we've done the session now they know how to use a condom and the pills. (FGD Girl, OR Tambo)**

- **We learned about contraceptives.**
- **And that at our age – 14 – you mustn't do sex because it's not for you.**
- **You can't be sure you won't get pregnant.**
- **They show us in the book and we can ask questions. (FGD Girls, Cape Town)**

The School Survey findings indicate varying proportions of implementers reporting delivery of health education in the different districts. In some districts, all implementers reported that they were involved in providing health education while in others only a proportion did. This is likely to be the case in districts where some individuals were designated for delivery of health education while others focused on peer education. Figure 4 below shows the variation across districts

Figure 4: Proportion of School Survey Respondents that Reported being Involved in Delivery of Health Education



In the KIIs SRs and PRs described how health education was implemented at different times and in different ways. Most participants commented that the place and time for delivery of health education depended very much on the school principal.

[8] The girls were allowed to select multiple responses depending on the activities they have ever participated in. We created a new column for each activity that was selected by the girls in order to uniquely identify and count the number participating in each. For each column (activity), frequency runs were conducted to determine the number of girls that reported as having participated. Of the 2686 girls interviewed, 2653 (99%) responded to this item with 33 girls having no responses.

> **The school principal decides if you can come in during school time. They decide usually. We have so many different times and places where health education is done. It all depends on what the school allows. (KII Principal Recipient, OR Tambo)**

KIIs with educators and principals showed that they saw the role of health education as complementary to the Life Orientation syllabus offered by the school.

> **I think it is in sync with the curriculum, it's just enhancing, and it also brings that kind of interaction which we might not be able to give our learners. (KII LO Teacher, Cape Town)**

Caregivers expressed their appreciation for the health education sessions because they reinforced their own messages to their daughters about avoiding pregnancy.

- **My child told me they were busy learning about how to protect themselves if they found themselves being engaged in sex. Yes. And how to prevent herself so she can't get pregnant at a young age.**
- **I also guide her that doing such a thing, there is a consequences and you will regret at the end of the day. I said she must keep on participating in that programme so that she can know about boys because she will end up getting pregnant at an early age. (FGD Caregivers, Greater Sekhukhune)**

Resources for Health Education

Most implementers (74%) rated the availability of resources to support health education sufficient or more than sufficient. These resources include; information pamphlets, training materials, and training resources (manuals, flip charts, markers, highlighters, and learning aids). The table below provides a summary of findings across districts, which show that in 7 of the 10 districts, implementers felt that resources were sufficient or more than sufficient. Worth noting is that 11% of implementers from Bojanala indicated that they had not been provided with resources for health education.

Table 6: Availability of Resources for Implementation of Health Education Based on Respondents' Feedback in the School Survey

District	No resources	A few resources	Sufficient / more than Sufficient
Bojanala	11%	22%	67%
Cape Town	0%	50%	50%
Ehlanzeni	0%	20%	80%
Gert Sibande	0%	20%	80%
Sekhukhune	0%	0%	100%
King Cetshwayo	0%	0%	100%
Nelson Mandela Bay	0%	0%	100%
OR Tambo	0%	67%	33%
Tshwane	0%	43%	57%
Zululand	0%	25%	75%
Total	2%	25%	73%

In the focus groups girls mentioned the health education flip charts as good learning resources.

I learnt about STIs and contraceptives. Everything was learned through the book – like a flip chart. (FGD Girls, Cape Town)

In all implementer focus groups they talked about how resources such as posters and pamphlets were useful. It seems that they had access to more printed resources for health education in 2016 and 2017 but in 2018 some districts had no printed resources for health education.

They love the posters, I think visual aids are very good in explaining things especially for STI's. (FGD Implementer, Ehlanzeni)

We used to have big flip charts that had all the info that we needed but now they say they are out of stock. We've actually gone through this whole year with no aids. (FGD Implementer, Cape Town)

Challenges with Health Education

The quote below from an implementer sums up the biggest challenge faced in implementing health education.

It is getting the girls to come for the sessions as other teachers will tell you that you spoke to them last week and I am busy with them, which means that they will not attend a session that has already been scheduled. (FGD Implementer, Cape Town)

Every stakeholder from implementers to principals to national level officials mentioned time not being made available during the school day to deliver health education as a challenge. Even the girls mentioned this.

We don't get enough time for the KGS (health education) programme, so we wish there would be more time for the KGS programme. (FGD Girl, King Cetshwayo)

The focus in the schools (understandably) was on the formal curriculum. In some schools the principals allowed implementers to use Life Orientation (LO) lessons. However, this was not always possible as LO educators also had a curriculum to finish and educators worried about what to do with the boys while the girls attended KGS sessions. In some cases, where KGS implementers did use LO lesson time they allowed the boys to join in KGS health education sessions – this was common in Nelson Mandela Bay. In fact, in some schools boys also joined Rise Clubs, also in Nelson Mandela Bay.

Another challenge mentioned by implementers was the fact that they delivered the same topics each year as the girls moved up a grade. Implementers mentioned that girls became tired of hearing about the same topics over and over. They also suggested that there was a need to differentiate the content by age. For example, the sessions on puberty would be given to girls in Grade 8, sessions on contraception in Grade 9 and 10 and issues of future planning in Grade 11.

To have different topics for different ages e.g. talking about puberty to an 18 year old they have already passed the stage. If you think of a 14 and an 18 year old they are completely different. If you can visit one class of younger girls and start talking about actual sex they will be very shy and no one responds or answers questions. When you speak to the 18 year olds about sex they are very interactive and enjoy the topic. (KII SR Supervisor, Cape Town)

A further challenge was that in the more rural districts where schools were dispersed over a large distance (e.g. Bojanala, Zululand, Greater Sekhukhune) implementers struggled with transport to get to the school regularly and on time.

The main challenge here for us has been transport. We tried to appoint Health Educators who lived close to the schools but the schools are so spread out that they

cannot all be close. Two Health Educators must take a taxi to town and then out to the school and the money they allocate for transport for them is too little. When we first started the programme we requested for a vehicle but we did not get it. I end up using money from my pocket for transport. I think that there should be money allocated in the budget for transport for Health Educators to schools in rural districts. (KII SR manager)

Adaptations

The most common response to the lack of time during the school day was to hold KGS health education sessions after school. In two of the schools who participated in the research the principals had made a regular Wednesday afternoon session available to KGS while other learners did sports and cultural activities. This worked well as all learners were required to stay at school during this time. Other implementers had to make do with a limited time after school. This was not suitable as many girls had to leave to catch their transport after half an hour or to walk the long distance home.

The only challenge now is that we have to interact with the time table and make time for them (KGS), we usually make break time for them, and then if we could also make a permanent slot for them it would be more effective. It becomes very difficult for us to squeeze time for them because all the time is based on the curriculum, so that is the only challenge we are facing. (KII School Principal, OR Tambo)

Finding a teaching spot became especially difficult around the end of term and end-of-year examinations.

I think they (the teachers) are (happy with the programme). They think that it is very helpful except when it comes to exams because they are under pressure to complete the work. I don't blame (the health Educator) because sometimes she comes and there aren't many students so she is also under pressure to meet up with them; as well as the teachers we have a fight plan and need to complete the work. (KII LO Educator, Cape Town)

One way to get around this challenge was to use days when learners were free from lessons such as sports days or cleaning days at the end of term – they then ran the KGS session with large groups of girls. In some districts SRs had tried Saturday sessions with large groups. These had worked to some extent but often girls could not attend as they did not have the extra transport money.

In the two districts managed by Kheth'Impilo one implementer (called a Learner Support Agent[9] in this case) was placed permanently in each school in which the KGS programme was delivered. They were in the school full time and took responsibility for running health education sessions and Rise Clubs and doing Homework Support and home visits. The LSAs used lessons when educators were absent and any time made available for sports or other activities to run the KGS sessions. They worked in small class-size groups for this. This proved particularly effective as it helped create a relationship between the girls and the LSA. This is discussed in more depth under Objective 2. Another adaptation made in Nelson Mandela was the inclusion of boys in health education sessions. This was initially in response to educators complaints about what to do with boys when the LSA was working with the girls in LO lessons but implementers realised that boys were interested in the topics and that there were benefits to having the girls and boys engage together in discussions.

[9] The Department of Education does appoint LSAs in some districts. In this case the model was adopted by Kheth'Impilo – the LSAs were employed by them though.

2.2.2.2.2 Peer Education

When and How

Peer education is one of the KGS components. There were two ways in which this was implemented. One was the Rise Club model that involved creating a club of 20 girls in a school who ran the club themselves, doing activities directed by a Soul City magazine delivered every quarter to the school. Soul City, Kheth'Impilo and Western Cape DOH chose to implement this model.

The second model was designed to be a peer-to-peer life skills activity based on a manual. A Peer Group Trainer (PGT) was to train learners to run these sessions. However, in practice, the PGTs delivered the life skills sessions, not a learner peer educator, which made it an adult-delivered component. NACOSA and KZN Treasury implemented this model. One of the SR managers describes the reason for this adaptation below.

> **Initially, the brief was to train up peer educators from among the learners of the participating schools and work through the existing structures of the school such as the LO programme and the school-community linkages. These peer educators were to be trained and skilled up to tackle mainly HIV prevention and sex awareness programmes. The reality in the field dawned very quickly that the peer educator model was not effective because of the structural challenges that faced the programme to properly skill-up learners to the work. Issues of competency, attrition and putting a structured programme with learners in the school threatened to derail the programme. (KII SR Manager)**

Table 7 below shows that programme data reflecting total numbers of learners reached by these adult-delivered life skills sessions in the five districts. As no formal targets were set for the PRs[10], we have only presented absolute numbers reached.

Table 7: Peer Education Annual Reach Attained by District Over the Three Years 2016 to 2018[11]

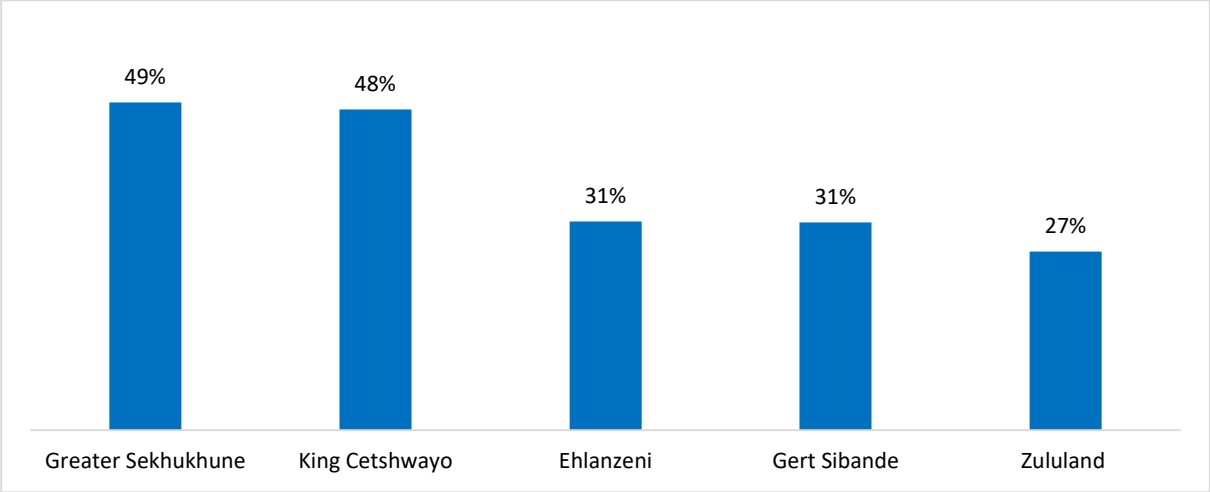
District	Year 1 (2016)	Year 2 (2017)	Year 3 (2018)
Ehlanzeni	5214	6747	3990
Gert Sibande	7077	6422	4938
Zululand	6374	5192	3870
King Cetshwayo	-	1911	811
Greater Sekhukhune	7568	5041	5250
Total	26 233	25 313	18 859

Based on the Learner Survey of the 1380 girls in the districts that primarily implemented the peer education model, 502 (36%) reported participating (Appendix I). In Figure 5 below, it's evident that there was a substantial variation in the feedback from the learners, ranging from 49% in Greater Sekhukhune reporting that they had received peer education to only 27% in Zululand indicating the same.

[10] In some cases, individual PRs did set internal targets, however, because they were not uniformly determined, we decided not to use them to compare across districts.

[11] The Global Fund grant year commences in April and ends in March of the following year. It should be noted therefore that annual data presented in the report is based on implementation from April to March of the following year.

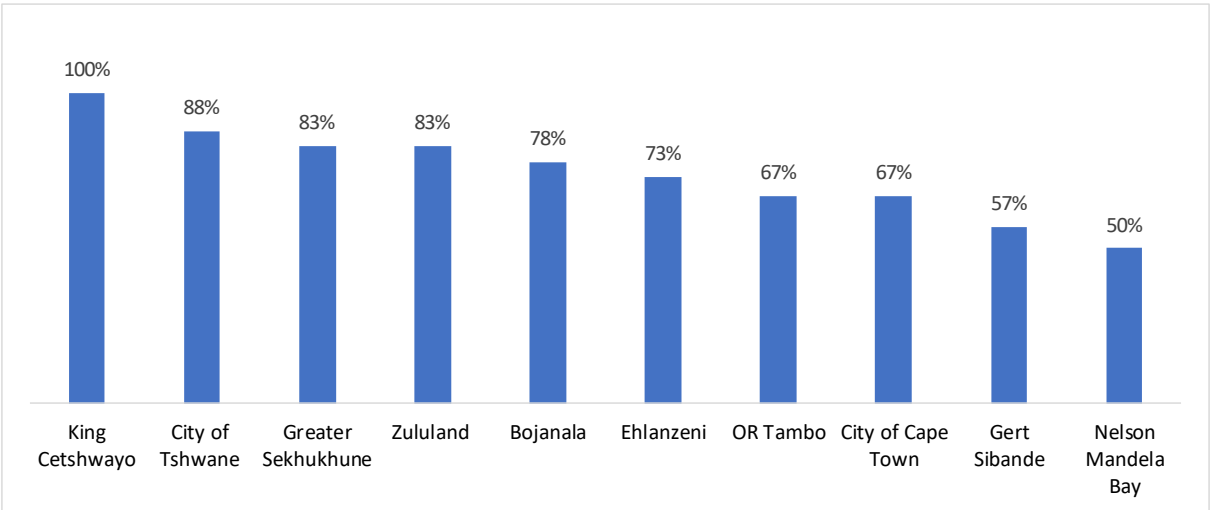
Figure 5: Proportion of Learner Survey Respondents that Reported Receiving Peer Education in the Five Districts that Primarily Implemented the Peer Education Model



It should be noted that Learner Survey respondents from the other districts also reported receiving peer education including 40% in Tshwane, 35% in Bojanala, 22% in both Cape Town and Nelson Mandela Bay and 10% in OR Tambo (Details included in Appendix I).

The implementers reported on the activities they implemented as part of the programme, and across the 5 peer education model districts. 77% reported that they were involved in delivery of peer education activities. As reflected in Figure 6 below, implementers from all ten districts reported being involved in implementing peer education. Similar to the learners, implementers in the Rise Model districts also reported that they were involved in peer education.

Figure 6: Proportion of School Survey respondents that reported being involved in delivery of Peer Education



Implementers in all districts (even those who had chosen to deliver Rise Clubs) appear to have used the peer education content taken from the Manual in their health education sessions. This shows a laudable level of initiative by implementers.

> **I thought that the girls needed to understand contraception but also how to be assertive to ask boys to use it. So I do some of the peer education topics when I do health education. (FGD, Implementer, Cape Town)**

In the focus groups girls did not often mention peer education by name when we asked what they did as part of KGS. This is because it is often not called this in the school and it is frequently delivered in conjunction with the health education sessions (see quote from implementer below) which would make sense, as the topics were designed to complement each other. But they did mention topics that are covered in the Peer/Life Skills Education component of the programme, for example, "We learn to make decisions, about how to cope with bullying." They also tended to talk about peer education and health education topics interchangeably for example, "We learn about puberty and self esteem and confidence." When they did describe a Peer/Life Skills Education session it seemed to be delivered in much the same way as a health education session.

Sis, P she comes and tells us about self esteem and being confident. We talk together and ask her questions. (FGD Girl, Gert Sibande)

The above quote shows that the peer education sessions are very similar to the health education sessions in form – an implementer delivers a particular body of content to a large group of learners in a classroom setting. In some cases, the same implementer delivers these sessions, in others the Peer Group Trainer and Health Educators share sessions.

- **Researcher: What is the difference between what a PGT does and what a Health Educator does?**
- **There is not much difference. They are interlinked. So we work together. When she is teaching about some of the STI's and I have to do the topic 'Health Challenges' which includes Testing for STIs. Also I do teenage pregnancies but she does contraception. So we each have an hour and sometimes we combine the topic. (FGD Implementer, Sekhukhune)**

Resources for Peer Education

These resources included training manuals and training materials (flip charts, markers, highlighters and learning aids). As would be expected, implementers from the 5 districts reported having access to sufficient or more than sufficient resources. This ranged from 60% of implementers in Zululand to 100% in King Cetshwayo. However, in Zululand, 40% reported having few resources while in Ehlanzeni, 25% reported having no access to resources at all.

Table 8[12]: Availability of Resources for Implementation of Peer Education Based on Respondents' Feedback in the School Survey

District	No resources	A few resources	Sufficient / More than Sufficient
Zululand	0%	40%	60%
Ehlanzeni	25%	13%	63%
Gert Sibande	0%	25%	75%
Sekhukhune	0%	20%	80%
King Cetshwayo	0%	0%	100%

In the focus groups the only resource mentioned by implementers from the 5 districts that implement peer education exclusively was the DBE Peer Education Manual that they used to guide content and delivery of this component.

[12] Colours used on tables are for ease of interpretation. Red is 'neagtive', yellow is 'moderate' and green is 'good'.

I am a PGT. I run peer education sessions. I have one hour every Wednesday afternoon. I use the Peer Education Manual. I take one grade at a time – 45 girls or more. I am teaching 'standing up to abuse' and 'building self confidence'. We usually use the Manual and teach and then they ask questions. I also ask them to discuss in small groups. (FGD Implementer, Zululand)

2.2.2.2.3 Rise Clubs

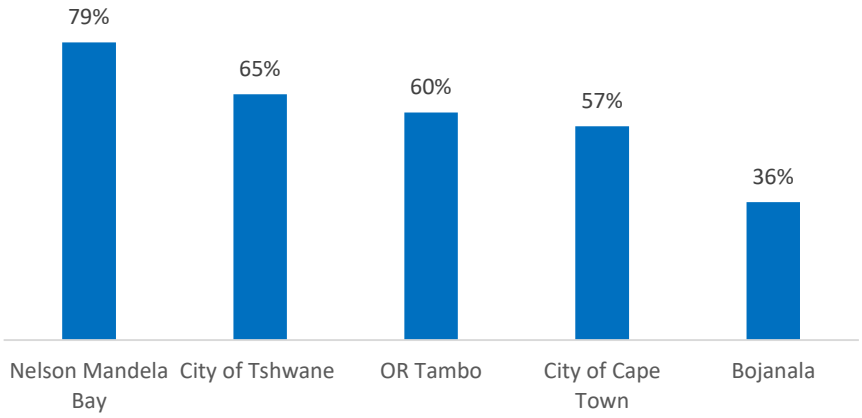
When and How

Rise Clubs are implemented primarily in five districts, including Cape Town, Tshwane, Bojanala, Nelson Mandela and OR Tambo. The data presented in Table 9 below provides insights into the extent to which learners participated in Rise Clubs over the three years of the programme. Rise activities had commenced in 4 of the 5 districts by Quarter 4 of 2016, the exception being Cape Town, where implementation commenced in Quarter 2 of 2017. In all five districts, the total numbers reached grew steadily, resulting in a total reach of 4287 across all districts by the end of Quarter 2 in 2018.

Table 9: Rise Clubs Quarterly Results by District over the Three Years 2016 to 2018

Year	Quarters	City of Tshwane	Bojanala	OR Tambo	Nelson Mandela Bay	City of Cape Town
2016	**Q1**					
	Q2	6				
	Q3	52				
	Q4	42	69	147	247	
2017	**Q1**	356	66	985	60	0
	Q2	906	0	985	1197	95
	Q3	636	27	1456	895	91
	Q4	1200	0	879	865	262
2018	**Q1**	1098	42	1559	818	404
	Q2	1278	122	1393	841	653

Figure 7: Proportion of Learner Survey Respondents that Reported having Participated in Rise Clubs in the 5 Rise Club Districts



In the five districts implementing Rise Clubs, an average of 56% of Learner Survey respondents reported that they had been involved in Rise Club activities (Appendix I). The responses varied widely across districts.

Rise Clubs were usually held after school or at break time. They were facilitated by the girls themselves though this was challenging at first (see below). Most often the implementer in the school supported the girls. This quote from an implementer shows how they worked to support the Rise Club meetings.

> **The Rise Clubs is not a problem (to find a time to meet) because they only meet when there is a break and do not disturb lessons. I have created a whats app group and I do tell them that tomorrow I will be at the school and when I get there I will also post that I have just arrived. I also confirm with them the time when we will meet for example we will meet at the second interval in the class. (FGD Implementer, Cape Town)**

In some schools the implementers said that after the initial support the girls now ran the meetings themselves, even meeting without the implementer. Implementers suggest that the magazines have made this possible as the girls had them to lead and focus the discussion. They also mention that magazines also provided a 'correct message' on the topic even if the adult implementer is not there.

> **I am very grateful for the Rise Club programme because it has brought a lot of change to many young girls, I can give an example of the girls from P Secondary, they are very interested in the programme and you don't even have to be there for them to hold a meeting. They can plan and hold a meeting on their own. They talk about the magazine together. (FGD Implementer, Cape Town)**

In the focus groups girls listed the activities they did in the clubs. This quote from a group discussion shows the range of activities the girls do in a functioning club. Note how the girls describe the factual content as embedded in the other activities such as gardening. They also talk about life skills and education about health together. This suggests a measure of integration of knowledge and also illustrates how the clubs combine education with other competencies such as civic involvement.

- **Researcher: What do you do in your Rise Club?**
- **We talk and discuss things. We do dancing to exercise, We do flash bomb, teenage pregnancy, women taking power back, HIV and AIDS, low self-esteem, gardening, donating food and clothes.**

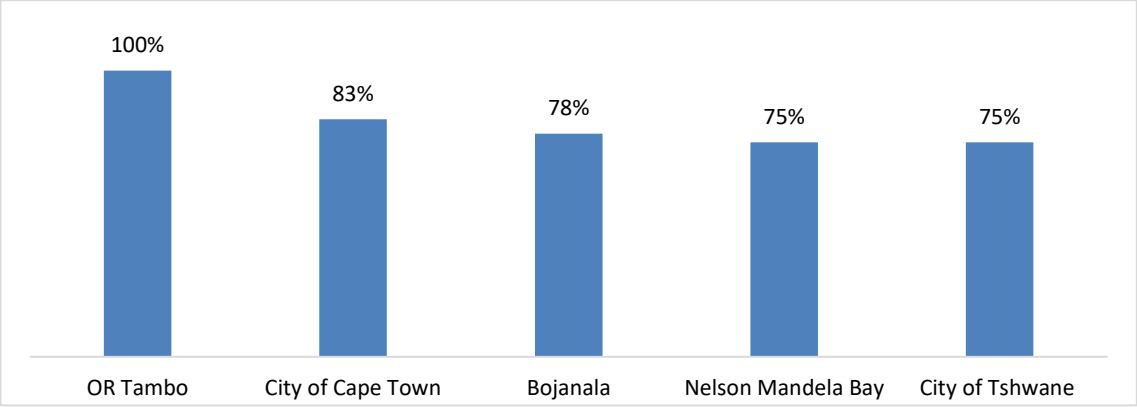
- They give us books to read.
- Dancing because some of us need exercise. donating foods and clothes.
- We do gardening. We are going to give the vegetables to those who do not have enough. We are collecting clothes as well.
- We do drama and poems about challenges we face as young girls. (FGD Girls, Tshwane)

Some principals and educators mentioned the value of the Rise Clubs.

> Great, there are activities that are happening in school, they divide themselves into small groups and these activities are very vital for their minds and physical side. (KII Principal, OR Tambo)

Based on the implementers' feedback in the School Survey, 81% of respondents from the five Rise Districts reported that they were involved in delivery of Rise activities. As reflected in Figure 8 below, there is a variation across districts from 100% in OR Tambo to 75% in Tshwane and Nelson Mandela Bay

Figure 8: Proportion of School Survey Respondents that Reported being Involved in Delivery of Rise Clubs



Resources for Rise Clubs

Based on responses from the School Survey, implementers generally indicated that resources to support delivery of Rise Club activities are available. These resources include magazines, reference materials, guest speakers, and mentors.

Table 10: Availability of Resources for Implementation of Rise Clubs Based on Respondents' Feedback in the School Survey

District	No resources	A few resources	Sufficient / More than Sufficient
Bojanala	0%	43%	57%
Cape Town	0%	33%	67%
Nelson Mandela Bay	0%	0%	100%
OR Tambo	0%	67%	33%
Tshwane	0%	50%	50%

In the focus groups implementers who worked with the Rise Clubs talked about how the girls enjoyed the magazines because they found they related to their context and they had interesting photographs and stories.

They have stories of girls like them. They talk about the topics. It is easy to get them discussing as they experience those things themselves. (FGD Implementer, Cape Town)

They love the magazine style, the photographs and the stories. They get so excited to read them and they talk about them together. You do not have to even introduce a topic. They just talk. (FGD Implementer, Nelson Mandela Bay)

Challenges and adaptations

There were some challenges with the Rise Clubs though. It seemed from discussions with implementers that it took time to help the girls to have the confidence and commitment to run the clubs themselves, particularly when there was little time set aside during the school day to do this and when implementers were not in the school every week.

It does take time for the girls to organise alone. If I am not able to get to the school because I am in another school they do not meet. I have tried to motivate them … They really enjoy it when I am there. I think that if we can run for some time they will get to be running themselves. (FGD Implementer, Tshwane)

The PR had experimented with training educators in the school to support the clubs as they do with the Soul Buddyz model. In schools where educators were recognised for this extra work and motivated by the principal this had worked well.

2.2.2.2.4 Homework Support

When and How

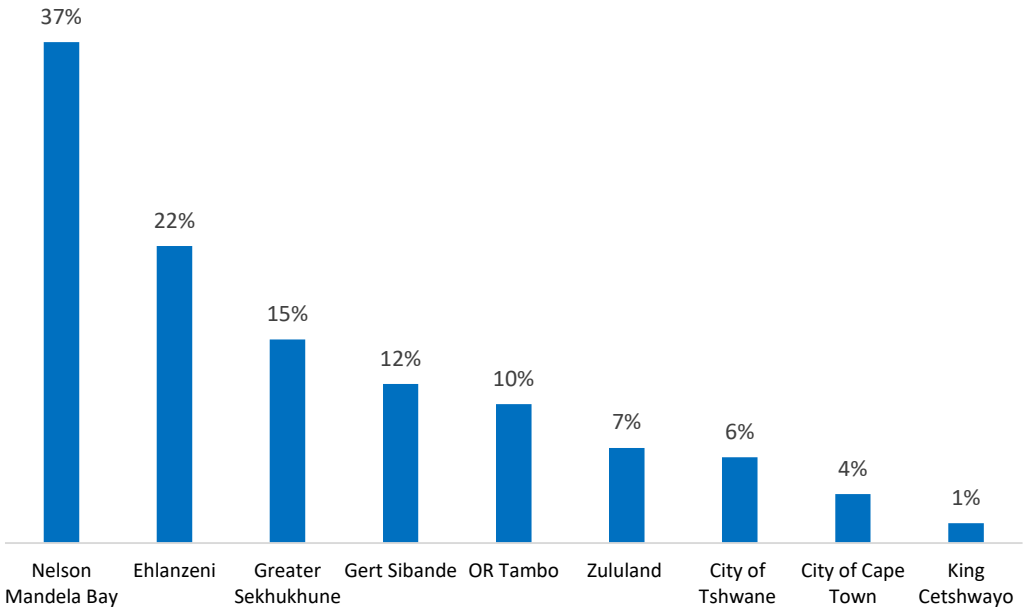
Programme performance data received from PRs for the period April 2016 to Sept 2018 is presented below in Table 11. From the data presented here, it is evident that OR Tambo delivered the highest numbers reached overall, with 7246 learners supported in Year 3, nearly seven times the number supported in Year 2. Three of the districts did not produce any results for Homework Support, namely Bojanala, Tshwane and King Cetshwayo.

Table 11: Homework Support Annual Reach by District over the Three Years 2016 to 2018

District	Year 1 (2016)	Year 2 (2017)	Year 3 (2018)
OR Tambo	415	1067	7246
City of Cape Town	-	2722	4719
Gert Sibande	727	1913	2139
Ehlanzeni	387	2596	1645
Greater Sekhukhune	1073	1688	1202
Zululand	332	1547	1179
Nelson Mandela Bay	494	526	850
Bojanala	-	-	-
City of Tshwane	-	-	-
King Cetshwayo	-	-	-

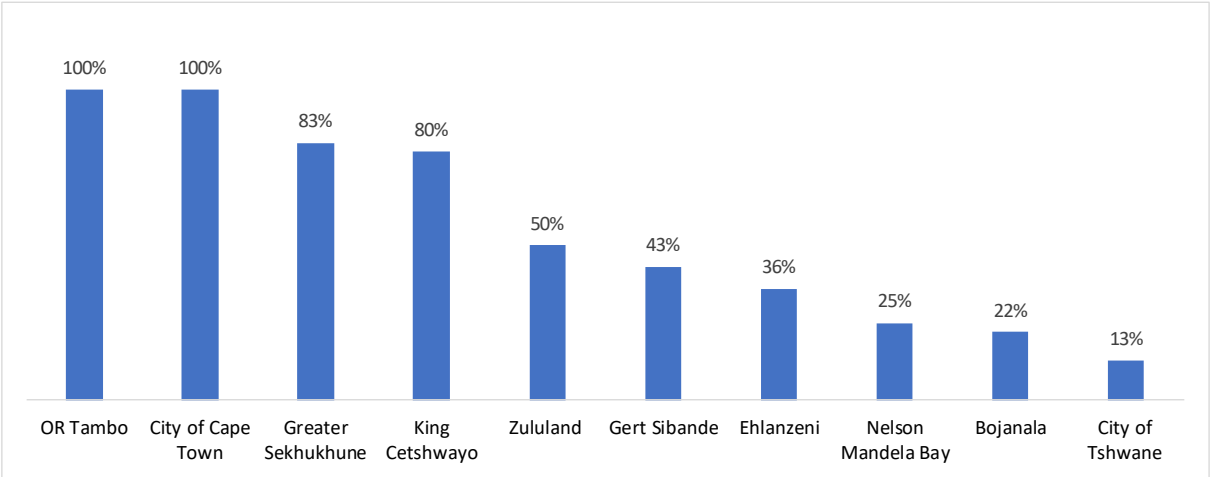
Data from the Learner Survey shows that overall, only 12% of respondents indicated that they had received Homework Support (Appendix I). The proportion of girls reached with this intervention varied greatly across districts as reflected Figure 9 below. None of the respondents from Bojanala districts reported receiving Homework Support.

Figure 9: Proportion of Learner Survey Respondents that Reported having Received Homework Support by District



The difference between what the girls report (which is low) and what PRs report in the performance data could be explained by the fact that Homework Support is a voluntary activity for girls and the girls who participated in the Learner Survey were amongst those who had chosen not to take part. However, the School Survey, which was completed by implementers, also shows low levels of delivery of Homework Support in some districts. This is consistent with what the girls reported.

Figure 10: Proportion of School Survey Respondents that Reported being Involved in Delivery of Homework Support



In focus group discussions implementers described what they did as part of Homework Support.

> **We assist with homework. If there is something they don't understand just explain to them and tell them what to do.**
>
> **Or sometimes organise previous question papers or if they ask questions we don't understand we refer them to their teachers to assist them. (FGD Implementers, OR Tambo)**

The literature review suggests that falling behind with academics is a significant reason for young people dropping out of school. Data from the focus groups with implementers suggests that they come across this, hence their concern with their inability to support girls with academic work.

Resources for Homework Support

Overall, 58% of implementers rated the availability of resources to provide Homework Support as either few or not available at all. The resources for Homework Support include: access to spaces where the girls can do their homework, access to teachers who can support the girls, and access to study materials. It's evident from the data in Table 12 below that implementers in most districts struggled to access resources needed to provide Homework Support. The exceptions to this are implementers from Gert Sibande who all reported having access to sufficient or more than sufficient resources. Respondents from both Ehlanzeni and King Cetshwayo also mostly (75%) reported having sufficient or more than sufficient resources.

Table 12: Availability of Resources for Implementation of Homework Support Based on Respondents' Feedback in the School Survey

District	No resources	A few resources	Sufficient / More than Sufficient
Bojanala	50%	50%	0%
Cape Town	0%	67%	33%
Ehlanzeni	0%	25%	75%
Gert Sibande	0%	0%	100%
Sekhukhune	60%	20%	20%
King Cetshwayo	0%	25%	75%
Nelson Mandela Bay	0%	0%	0%
OR Tambo	100%	0%	0%
Tshwane	0%	100%	0%
Zululand	67%	0%	33%
Total	**29%**	**29%**	**42%**

The section below on challenges gives some explanation about why some implementers did not run Homework Support sessions.

Challenges and Adaptations

In Tshwane and King Cetshwayo districts the Education Department had asked KGS *not* to implement Homework Support as they had an existing academic support programme.

Another reason given for the low implementation of Homework Support sessions was the lack of resources made available. In the School Survey implementers in Bojanala, City of Cape Town, Greater Sekhukhune, OR Tambo and Zululand reported 'no resources' or 'few resources' for

Homework Support. Implementers were particularly interested in receiving resources on study skills and exam technique. Another challenge was that there was not time after school to run the sessions – girls did not attend as they had to catch transport home or if they lived nearby the school was locked soon after lessons ended. Lastly, in some districts SRs did not offer Homework Support because they felt their implementers were not trained for it. Implementers expressed this too.

> **I feel that we need training on our Homework Support. I feel that we need training on how to assist the learners more in the subjects that they have. Take myself for example, I did maths and physical science at school and the learners will come to me with a geography problem and I can't help. (FGD Implementer, Zululand)**

What the qualitative data also showed, though, was that some implementers tried innovative ways of dealing with their lack of subject knowledge and the lack of time to implement actual sessions. They encouraged learners to do homework together and they asked educators for help. They helped girls work out individual homework plans that included family members or a friend that could help them and quiet places near their homes where they could do homework. Often implementers just made sure there was a safe space to do homework.

> **Some homes, it will be a two-roomed house that 14 people stay in. The learner will not have space at home to do homework. So most of the time the LSA is just there to create a safe space for them to write. They have offices and it's a comfortable place for them to work in before they go home. (KII Supervisor, Nelson Mandela Bay)**

Girls from some Rise Clubs talked about helping each other with homework and setting up study groups during exam time.

- **When we have assignments, we help each other.**
- **In exams we have our own study groups.**
- **Some [Rise Club) members study on their own, but sometimes when we do have time on a weekend, we open here at school and study by ourselves. (FGD Girls, Nelson Mandela Bay)**

Linked to the issue of academic subject content support is the fact that the review of research on what keeps girls in school (See Appendix B) suggests that falling behind in subject content is one of the main reasons why young people drop out of school. This suggests that the KGS project should find ways, within its mandate to support girls academically beyond homework support.

2.2.2.2.5 Home Visits

When and How

Home visits to vulnerable girls, especially to those who have missed school are part of the KGS implementation strategy.

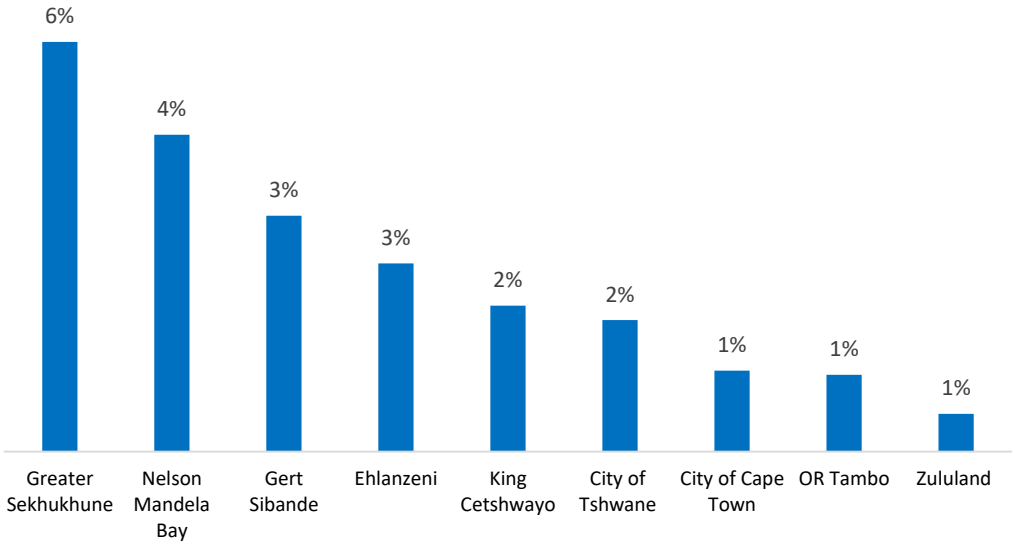
Programme data on home visits was analysed between 2016 and 2018. The data in Table 13 below shows that there were significant variations across districts in the implementation of home visits, and that these activities commenced only in Year 2 in most districts. There were no home visits implemented at all in Tshwane throughout the 3 years.

Almost half (47%) of the total number of home visits in Year 3 were undertaken in two districts namely OR Tambo and Bojanala. In Year 2, the top contributors to the total home visits undertaken were Greater Sekhukhune and Bojanala, which together delivered over 50% of the annual results.

Table 13: Home Visits Undertaken by District over the Three Years 2016 to 2018

District	Year 1 (2016)	Year 2 (2017)	Year 3 (2018)
OR Tambo	0	29	124
Bojanala	0	95	73
Gert Sibande	19	45	49
king Cetshwayo	0	0	39
Greater Sekhukhune	2	107	27
Cape Town	0	4	24
Ehlanzeni	9	16	14
Zululand	10	20	12
Nelson Mandela Bay	0	40	50
Tshwane	0	0	0

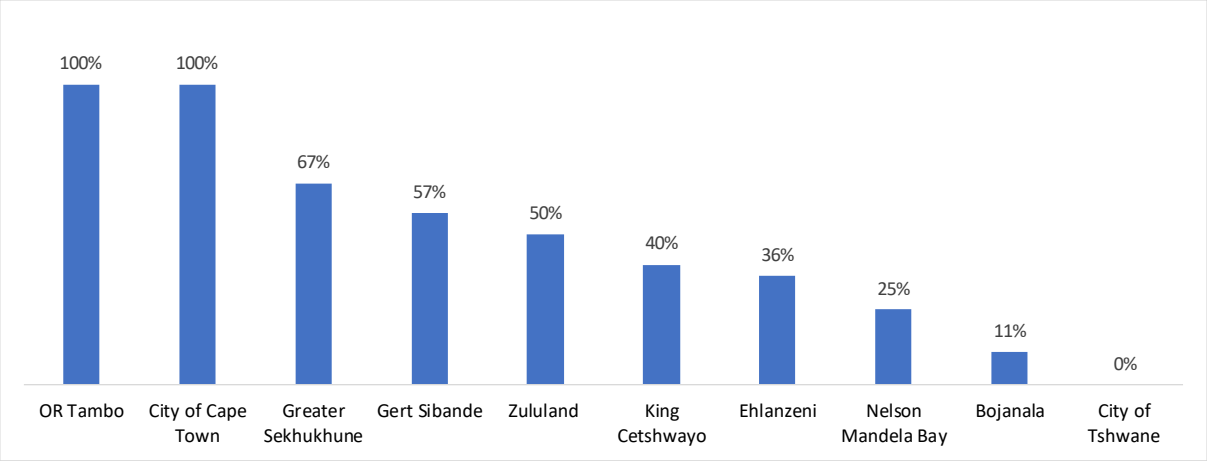
Figure 11: Proportion of Learner Survey Respondents that Reported having Received a Home Visit by District



The Learner Survey data is closely aligned to the programme performance data in reflecting the fact that home visits were not widely implemented. According to the Learner Survey, only 2% of the girls indicated that they had experienced a home visit (Appendix I). The KGS SOP indicates that home visits are done on a case-by-case basis according to need. It is, therefore, not surprising that this was the intervention with the lowest number of girls reached across districts as it did not target all girls.

Data from the School Survey indicates that the average proportion of respondents that had been involved in undertaking home visits across districts was 49%. It is evident from Figure 12 below that this varied greatly across districts from as high as 100% in OR Tambo and Cape Town to 0% in Tshwane. Though home visits were targeted only to vulnerable girls it could be assumed that all districts had some vulnerable girls, this means that all implementers who participated in the School Survey should have indicated delivering some home visits.

Figure 12: Proportion of School Survey Respondents that Reported being Involved in Delivery of Home Visits



In the girls' focus groups no one drew pictures of home visits when they made the drawing of KGS activities in their schools. Most implementers did describe doing home visits though.

> **I do home visits because sometimes the teachers identify that there might be an issue with a certain learner and we get to their home so as to find out what exactly is the problem. (FGD Implementer, Cape Town)**

Resources for Home Visits

It is evident from Table 14 below that resources such as money for transport, transport itself and record forms for home visits were a challenge for most implementers. While implementers in King Cetshwayo and Bojanala reported having sufficient or more than sufficient resources, the numbers of home visits undertaken were still quite few. This indicates that other challenges over and above resources may have impeded implementation of these activities. Some insights can be drawn from the section below on challenges and adaptations.

Table 14: Availability of Resources for Implementation of Home Visits Based on Respondents' Feedback in the School Survey

District	No resources	A few resources	Sufficient / More than Sufficient
Bojanala	0%	0%	100%
Cape Town	0%	50%	50%
Ehlanzeni	25%	50%	25%
Gert Sibande	0%	50%	50%
Sekhukhune	50%	25%	25%
King Cetshwayo	0%	0%	100%
Nelson Mandela Bay	0%	0%	0%
OR Tambo	67%	33%	0%
Tshwane	0%	0%	0%
Zululand	33%	33%	33%
Total	**21%**	**39%**	**39%**

Challenges and Adaptations

The most common reasons for not doing home visits given by implementers in the focus group discussions were fears for their safety, lack of transport to get to homes and the complexity of the family-based problems girls faced.

> **We look at the address and see the reputation of the area. If the area is not safe we don't go. (FGD Implementer, Cape Town)**

> **Home visits are hard, the children have so much baggage and the family situations are so difficult. Sometimes the family members are not even there for you to talk to. They say you are interfering in family business. It is very hard. (FGD Implementer, King Cetshwayo)**

Most implementers and SRs have found ways around these challenges. They describe how they see girls individually at school or they ask parents to come to the school.

> **Home visits are a challenge because of time constraints and safety of areas where the girls stay. We try to see them alone at school. Most important thing is to spend time with them. (FGD Implementer, Bojanala)**

> **Sometimes we call the parents and then arrange to meet with the learner at school because their areas of abode are not safe. (FGD Implementer, OR Tambo)**

A few of the implementers described using WhatsApp to stay in touch with girls.

> **Since we are working in 5 schools it is not on a daily basis that we go to schools. Some will even follow you on social media and post questions and their homework as well, since they cannot get in touch with you every day. (FGD Implementer, Gert Sibande)**

The section on the relationship between girls and implementers under Objective 2 gives additional information on how implementers interact with individual girls.

2.2.2.2.6 Career Jamborees

Programme Data on Career Jamborees

Career jamborees targeted learners in Grade 9, and different models were implemented under each PR. In some areas the district education office organised a career expo and learners were transported to a central venue, while in others, stakeholders in the district including universities and companies were invited to the schools where information sessions were held.

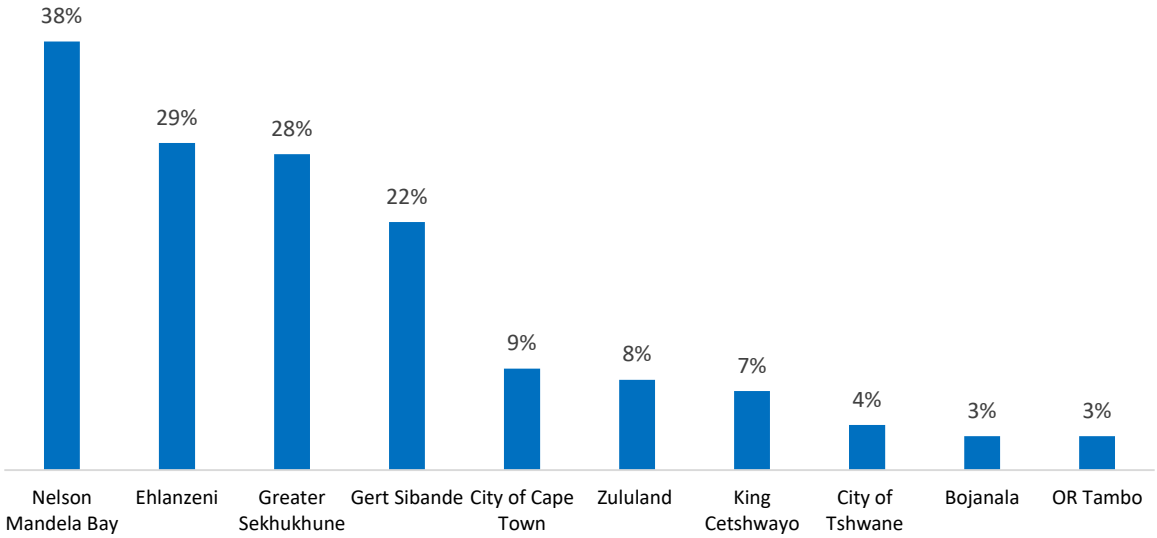
Table 15: Number of Learners that Participated in Career Jamborees by District, over the Three Years 2016 to 2018

District	Year 1 (2016)	Year 2 (2017)	Year 3 (2018)
Bojanala	-	-	1106
City of Tshwane	-	288	-
Zululand	2421	2332	2331
Gert Sibande	734	1762	1857
Ehlanzeni	867	2619	2460
Greater Sekhukhune	1429	1041	949
King Cetshwayo	-	-	373
City of Cape Town	-	2334	-
OR Tambo	-	804	502
Nelson Mandela Bay	-	258	522

During the first year of the programme (2016), career jamborees were held in only four districts as reflected in Table 15 above. This grew to 8 districts in both 2017 and 2018, resulting in doubling of the 2016 total reach of 5451. The total number of learners that attended these events was 11,438 in 2017 and 10,100 in 2018. The districts where the largest number of learners attended career jamborees were Zululand in 2016 and Ehlanzeni in both 2017 and 2018.

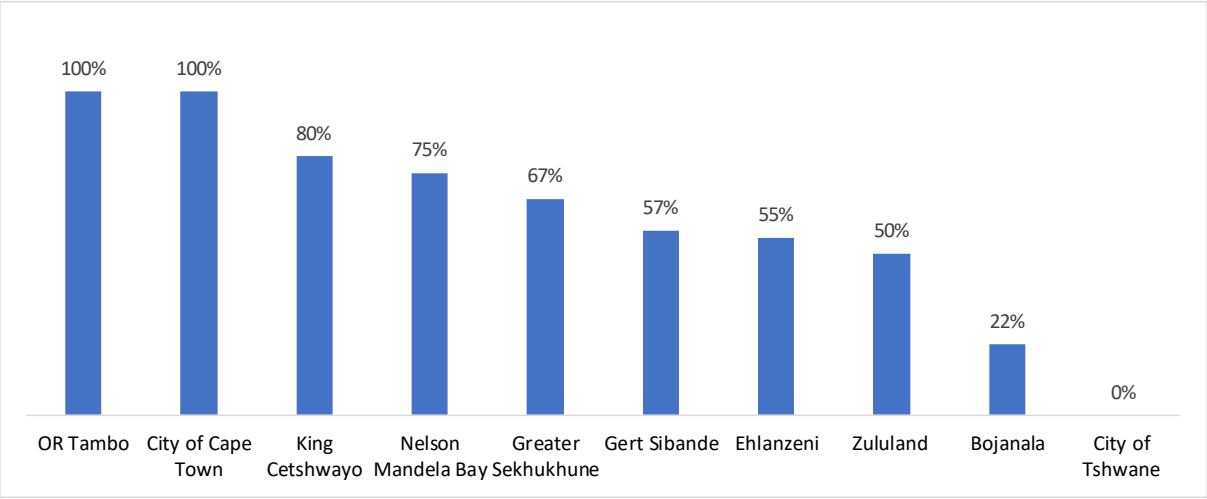
In the Learner Survey, an average of 15% of the girls in Grade 9 or above who were eligible for the career jamborees indicated that they had participated in at least one event. Nelson Mandela district had the highest proportion of girls (in Grade 9 and above) that participated in career jamborees (38%) while Tshwane, OR Tambo and Bojanala all had less than 5% reach for this intervention as shown in Figure 13 below.

Figure 13: Proportion of Learner Survey Respondents (Excluding Grade 8 Learners) that Participated in at Least one Career Jamboree



Based on the School Survey, 43 of the 69 respondents said they had been involved in a career jamboree. Figure 14 below shows that variation in the proportions of implementers that reported being involved in those activities.

Figure 14: Proportion of School Survey Respondents that Reported being Involved in Delivery of Career Jamborees



It is not clear from the qualitative data why more girls did not indicate receiving this component of KGS When asked by researchers directly, girls in some groups said they had been to an "expo" about careers. It could be that the girls did not recognise the name "Career Jamboree" or see the career activity they had done as part of KGS. It could also be that the career activity they did was not an exhibition or large group activity, for example, in Bojanala we know that the SR uses a small group career education activity. The girls who did mention the career activity in the focus group, valued it.

> **We go for a career expo, it's only for Grade 9 girls so I think that everyone need it, all the classes so I think if they could change the Grade 9 only girls and take all of us, I think that could give us more knowledge about the careers that we want to pursue. (FGD Girl, Greater Sekhukhune)**

Resources for Career Jamborees

The majority (over 70%) of implementers that responded to the School Survey indicated that there were enough resources to implement career jamborees. Resources for career jamborees include access to career brochures, access to venues, and access to external stakeholders / career experts. However, 67% of implementers from OR Tambo and Zululand noted that the resources for the implementation of career jamborees were not sufficient.

Table 16: Availability of Resources for Implementation of Career Jamborees Based on Respondents' Feedback in the School Survey

District	No resources	A few resources	Sufficient / More than Sufficient
Bojanala	0%	0%	100%
Cape Town	0%	17%	83%
Ehlanzeni	0%	33%	67%
Gert Sibande	0%	0%	100%
Sekhukhune	0%	25%	75%
King Cetshwayo	0%	0%	100%
Nelson Mandela Bay	0%	33%	67%
OR Tambo	33%	67%	0%
Tshwane	0%	0%	0%
Zululand	0%	67%	33%

Challenges and Adaptations

The costs related to getting learners to events arranged outside schools especially in rural areas, were highlighted as one of the main challenges. Having district level support from DBE in coordinating such events was cited by several respondents as useful. Bringing Expos into schools was one of the ways implementers adapted the programme in order to minimise the negative effect of the high cost of transport.

2.2.2.2.7 Referrals

When and How

One of the key components of the KGS implementation was referring girls needing help to social workers. In the School Survey data 72% of implementers indicated that referral or "linking the girls to receive additional care/support" had worked well or very well (Appendix K).

However, the qualitative data suggests a much more complex picture. No girls mentioned referral to a social worker though this is possibly because they were shy to talk about this in a group. In some of the focus groups implementers talked about referring girls to a social worker. It seemed that those programmes that had a social worker as part of KGS or in the school (e.g. areas managed by Kheth'Impilo who had appointed KGS social workers or social auxiliary workers) found it easier to find a social worker to refer to.

There were no programme data available on referrals.

Challenges with Referrals

In the districts where there were no social workers linked to the programme, referral was very difficult.

> **We tried to speak to the social workers. The problem that we have as a Lifeline team is that we do not have our own social worker. We rely on the one from Department of Education. When we take up problems to that social worker, she**

> **doesn't go to the school and assist those learners. That is the biggest challenge that we have. There are many cases that need a social worker and they don't come and assist. (FGD Implementer, Limpopo)**
>
> **Sometimes when we refer them to the social workers, the social worker department will be complaining about their work load or sometimes about transport to go to the schools. (FGD Implementer, Ehlanzeni)**

2.3 Objective 2: To Assess if the Programme has the Elements for Effective Implementation

This section looks at data that helps us assess if KGS has the ***potential for effectiveness.*** The data in this section is presented under headings taken from the indicators of effectiveness presented in Table 3.

- Multi-layered intervention
- Protective knowledge
- Relevance to context
- Empowerment
- Networks of support

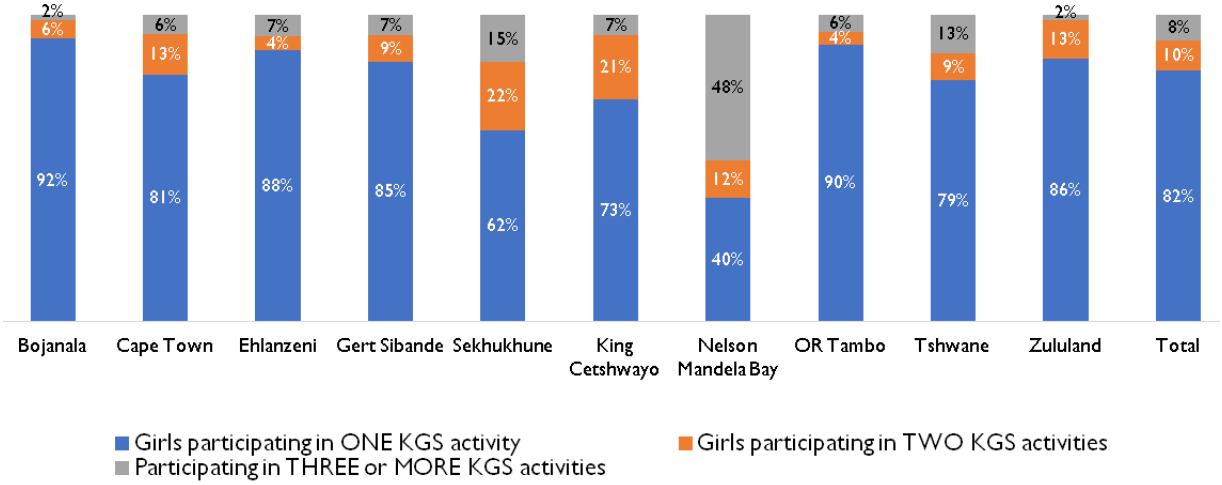
2.3.1 Multi-Layered Intervention

KGS was intended to be a multi-layered programme that enables learners to receive a package of interventions based on their individual needs.

> **Providing multiple services is important to make sure the messages are reinforced and that all the needs of the girls are covered. These needs may change over time. *At the very least* every girl should attend peer education and health education sessions as well as a career jamboree in Grade 9. Some girls might also need the additional services of homework support or home visits. (p. 11 KGS SOP emphasis added)**

However, the findings, as represented in Figure 15 below show that many girls did not receive the minimum of three services.

Figure 15: Proportion of Participants that Received at Least One, Two or Three Interventions



A large majority of learners reported receiving only one intervention. This ranged from 40% in Nelson Mandela to 92% in Bojanala. The proportion of learners that received two interventions ranged from 4% in Ehlanzeni to 22% in Sekhukhune. Nelson Mandela Bay had the highest proportion of learners that received three or more interventions while Bojanala and Zululand had the least at 2% each. This suggests that the intention to provide a multi-layered programme was not met. Future iterations of the KGS programme need to address this issue. This is discussed in more detail in the recommendations. For more information on what the learners said they received, please look at figures 3, 5, 7, 9, 11 and 13.

2.3.2 Protective Knowledge

Factors influencing knowledge gained from participating in the KGS programme were determined for the nine domains that were assessed and are presented in Appendix I. We report here on five areas of protective knowledge in the tables below. Each table contains three categories that were analysed independently. In each category there is one item compared with another. The second of those two items is, by convention, always the largest of the groups in that category (i.e. in the first category, Grade in School, there were more Grade 9s than in any other grade) we call this the reference group. This is done to maximise the reliability of the analysis. The second column of numbers in each table (p-value) shows a measure of significance. The cut-off value for identifying significance is a value of less than 0.05. In the comparison of any two items a p-value of 0.05 or less is considered to show that there is a significant difference between those two items. These items have been presented in bold and they are commented on in the text below. The values under Est give a sense of magnitude of difference. Any Est value that has a positive number suggests the girls in the first of the two groups being compared has more knowledge of the topic.

Table 17: Factors Associated with Higher Knowledge on Teen Pregnancy

Variable	Multivariate	
	Est (Std Error)	p-value
Grade in school		
Grade 8 vs. Grade 9	**-0.55 (0.19)**	**0.0049**
Grade 10 vs. Grade 9	0.34 (0.20)	0.0960
Grade 11 vs. Grade 9	**0.59 (0.25)**	**0.0207**
Grade 12 vs. Grade 9	**2.15 (0.63)**	**0.0009**
Mother alive		
Don't know vs. Alive	**-1.96 (0.62)**	**0.0023**
Passed on vs. Alive	-0.08 (0.18)	0.6616
Activities that helped most		
Career jamborees vs. Health education	0.46 (0.29)	0.1187
Home visits vs. Health education	**-1.56 (0.71)**	**0.0283**
Homework support vs. Health education	**-0.63 (0.27)**	**0.0227**
Peer education vs. Health education	0.15 (0.18)	0.4114
Rise Club vs. Health education	-0.02 (0.19)	0.9196
Rise Congress vs. Health education	-0.37 (0.48)	0.4498

With regard to knowledge on teenage pregnancy girls in Grade 11 and 12 were found to have higher knowledge than those in Grade 9 (the reference group) whereas girls in Grade 8 had poorer knowledge than those in the reference group. At face value it is logical that older girls should know more however this finding should be interpreted within the context of the programme where girls receive health education over the years of the programme and this effect is likely, therefore, to be much greater than other external factors. We can conclude from this that repeated exposure over a period of years is beneficial.

In the second category the question asked was Mother: Alive/Passed on/Don't know. This was used as a measure of vulnerability with those who don't know whether their mother is alive being the most vulnerable. Those in the 'don't know if mother is alive' group showed significantly lower levels of knowledge about prevention of teen pregnancy. This shows a clear link between psychosocial vulnerability and protective knowledge and suggests that psychosocial support to the most vulnerable girls should form an important part of the KGS programme.

While those who reported that home visits and homework support were significantly less helpful than health education it should be noted that very few girls experienced home visits and homework support (Figure 9 and 11) and it is not certain that any firm conclusions can be drawn from this given the small sample size.

Table 18: Factors Associated with Higher Knowledge on Contraceptives

Variable	Multivariate	
	Est (Std Error)	p-value
Grade in school		
Grade 8 vs. Grade 9	**-0.83 (0.18)**	**<.0001**
Grade 10 vs. Grade 9	0.36 (0.19)	0.0659
Grade 11 vs. Grade 9	**0.57 (0.24)**	**0.0190**
Grade 12 vs. Grade 9	**2.49 (0.60)**	**<.0001**
Mother alive		
Don't know vs. Alive	**-1.26 (0.59)**	**0.0379**
Passed on vs. Alive	-0.26 (0.17)	0.1420
Activities that helped most		
Career jamborees vs. Health education	0.40 (0.28)	0.1548
Home visits vs. Health education	**-1.88 (0.68)**	**0.0061**
Homework support vs. Health education	-0.34 (0.26)	0.1923
Peer education vs. Health education	**0.40 (0.18)**	**0.0245**
Rise Club vs. Health education	0.24 (0.18)	0.1914
Rise Congress vs. Health education	-0.22 (0.46)	0.6374

In looking at the data on knowledge of contraceptives, as before being in a higher grade can be associated with greater knowledge of contraceptives. The same pattern applies for girls who don't if their mother is alive, they have significant less knowledge. Home visits were rated significantly less helpful than health education. However those who rated peer education as more helpful than health education had higher knowledge of contraceptives. This suggests that the strong emphasis on contraceptives in the peer education curriculum was successful.

Table 19: Factors Associated with Higher Knowledge on Unhealthy Relationships

Variable	Multivariate	
	Est (Std Error)	p-value
Grade in school		
Grade 8 vs. Grade 9	**-0.39 (0.18)**	**0.0344**
Grade 10 vs. Grade 9	0.01 (0.20)	0.9667
Grade 11 vs. Grade 9	0.30 (0.24)	0.2224
Grade 12 vs. Grade 9	**1.51 (0.61)**	**0.0149**
Mother alive		
Don't know vs. Alive	**-1.87 (0.60)**	**0.0029**
Passed on vs. Alive	-0.08 (0.18)	0.6682
Activities that helped most		
Career jamborees vs. Health education	0.18 (0.28)	0.5244
Home visits vs. Health education	**-1.58 (0.69)**	**0.0227**
Homework support vs. Health education	**-0.54 (0.26)**	**0.0437**
Peer education vs. Health education	**0.44 (0.18)**	**0.0138**
Rise Club vs. Health education	**0.48 (0.18)**	**0.0094**
Rise Congress vs. Health education	-0.47 (0.47)	0.3233

In the data on unhealthy relationships grade in school and 'not knowing if mother is alive' follow the same pattern and home visits and homework support as being less helpful than health education is also the same. However, those who rated peer education and in particular the Rise Club as significantly more helpful than health education had better knowledge about unhealthy relationships. One reason for this could be because the Rise magazines dealt comprehensively and contextually with this issue.

Table 20: Factors Associated with Higher Knowledge on Sexual Coercion and Rape

Variable	Multivariate	
	Est (Std Error)	p-value
Grade in school		
Grade 8 vs. Grade 9	**-0.47 (0.17)**	**0.0085**
Grade 10 vs. Grade 9	0.36 (0.19)	0.0554
Grade 11 vs. Grade 9	**0.49 (0.23)**	**0.0342**
Grade 12 vs. Grade 9	**1.93 (0.59)**	**0.0014**
Mother alive		
Don't know vs. Alive	**-2.09 (0.59)**	**0.0007**
Passed on vs. Alive	-0.20 (0.17)	0.2611
Activities that helped most		
Career jamborees vs. Health education	-0.07 (0.27)	0.7876
Home visits vs. Health education	**-2.82 (0.67)**	**<.0001**
Homework support vs. Health education	**-0.67 (0.26)**	**0.0102**
Peer education vs. Health education	0.33 (0.17)	0.0565
Rise Club vs. Health education	0.22 (0.17)	0.2193
Rise Congress vs. Health education	-0.03 (0.46)	0.9451

In the table above grade in school and 'not knowing if mother is alive' follow the same pattern as previously and home visits and homework support as being less helpful than health education is also the same.

Table 21: Factors Associated with Higher Knowledge on Sexually Transmitted Infections Including HIV

Variable	Multivariate	
	Est (Std Error)	p-value
Grade in school		
Grade 8 vs. Grade 9	**-0.43 (0.17)**	**0.0148**
Grade 10 vs. Grade 9	0.20 (0.18)	0.2886
Grade 11 vs. Grade 9	0.35 (0.23)	0.1269
Grade 12 vs. Grade 9	**1.93 (0.58)**	**0.0011**
Mother alive		
Don't know vs. Alive	**-1.31 (0.57)**	**0.0238**
Passed on vs. Alive	-0.27 (0.17)	0.1143
Activities that helped most		
Career jamborees vs. Health education	-0.08 (0.27)	0.7587
Home visits vs. Health education	-1.12 (0.65)	0.0853
Homework support vs. Health education	-0.43 (0.25)	0.0877
Peer education vs. Health education	0.23 (0.17)	0.1693
Rise Club vs. Health education	0.05 (0.17)	0.7682
Rise Congress vs. Health education	-0.28 (0.44)	0.5218

When looking at knowledge of STIs and HIV grade and school and 'not knowing if mother is alive' follow the same pattern as previously. In this table no activities were rated as significantly more helpful than health education.

The focus group discussions with the girls give us additional information on protective knowledge. The girls often talked about what they had learned from KGS. In many of the groups this was described as a topic from the sessions e.g. 'teenage pregnancy', 'condoms', 'self esteem', 'contraceptives'. But in a number of groups they described learning *beyond* knowledge as evidenced by this quote which illustrates empowerment.

> **It has had a BIG help, because after the sessions we become more aware of things that happen around us, we have solutions, we are more equipped, we have more information, we find creative ways to say no to peer pressure. We find ways to voice our dissatisfaction. (FGD Girls, Greater Sekhukhune)**

The quote below shows knowledge linked to interpreting the context and also to creating a positive identity – again, all issues the literature suggests are important for changed behaviour.

> **I grew up in the Eastern Cape. There I was exposed to an environment where women are treated weak and exposed to abuse sometimes. Women treated as material for men to use. But the Rise Club has helped me to *know* I am important and I can do whatever I want – whatever I can put my mind to. (Girl, Cape Town)**

The case studies (Appendix L) have particularly strong evidence on how girls have gained protective knowledge from the KGS programme. The girls describe how they have learned the importance of being tested for HIV, strategies for saying no to peer pressure and getting their questions answered. One of the case study girls describes here how knowledge empowered her.

It has empowered me when it comes to decision making because I was afraid of making decisions on my own because I have a lack of knowledge but now since I've known more about things I have more power to make decisions on my own. It has taught me to not rush into sex; not having sex until I'm ready. (Koketso[13], Limpopo case study)

2.3.3 Relevance

In the Learner Survey 85% of the girls agreed that they had learned something they could apply in their own life. 41% felt that they had learned the most from health education, 18% from peer education and 24% from Rise Clubs. Table 22 below, shows Learner Survey respondents choices (percentage that selected the option) of the most beneficial KGS program interventions. The choices shaded in green highlight the most popular intervention selected in each district while yellow is the second most popular.

Findings indicate that learners from peer education model districts all generally selected health education as the most beneficial, while interestingly, those from the Rise model districts all selected Rise Clubs as the most beneficial with exception of Bojanala district. For learners from the peer education districts, peer education was consistently selected as the second most beneficial intervention, while for the Rise districts, in 3 districts namely OR Tambo, Nelson Mandela Bay and Cape Town, the second choice was health education while in Bojanala, it was peer education. In Tshwane, equal proportions of respondents selected peer education and Rise Clubs as the most beneficial interventions relevant to the needs of the girls they work with.

Table 22: Learner Survey Respondents' Selection of Interventions that they Considered Most Beneficial

District	Health Education	Rise Club	Peer Education	Homework Support	Career Jamborees	Rise Congress
Bojanala	37%	16%	26%	16%	3%	3%
Cape Town	28%	42%	22%	3%	3%	2%
Ehlanzeni	41%	2%	23%	20%	14%	0%
Gert Sibande	48%	2%	22%	10%	17%	0%
Sekhukhune	60%	0%	31%	5%	5%	0%
King Cetshwayo	60%	2%	36%	0%	2%	0%
Nelson Mandela Bay	33%	38%	17%	2%	8%	2%
OR Tambo	32%	43%	7%	11%	4%	4%
Tshwane	23%	34%	34%	3%	1%	4%
Zululand	69%	0%	24%	3%	3%	0%

[13] Name changed

What emerged from the focus groups though was that the KGS programme seemed to have limited relevance to some areas of their lives. This was particularly true in the girls' ability to deal with violence, especially sexual violence, as the quotes below illustrate.

- **We have problems in the household, for example, violence (abuse) and inequality. This could lead to some girls deciding to run away from home, and with that, they could be involved in substance abuse.**
- **Researcher: How has Keeping Girls in School helped you in facing these issues?**
- **The programme has not helped, it hasn't made change that we needed. (FGD Girls, Zululand)**
- **Researcher: Do you think there are ways we can prevent rape – maybe before it happens?**
- **Stop it miss?**
- **No miss … They will take you for who you are and some only take you for rape and sex and that. (FGD Girls, Cape Town)**

The girls showed particular powerlessness in the context of relationships with boys.

- **That's the problem we as girls – we do not have the power to say no to our boyfriends. Because we have that thing that if we say no then he will find another girl. Which is wrong.**
- **Our boyfriends – they are like If we say no– they are like charmers and charmers. The moment you start smiling that is like a yes to them.**
- **Yoh – to have a boyfriend it just happens automatically. When a boy says I love you and then you start to develop some feelings and you start to love him too.**
- **Then sex just happens. It just happens.**
- **It's just how it is. (FGD Girls, Cape Town)**

It seems that the Rise Clubs magazines did help girls to deal with this issue.

> **I like the stories about real girls like me, who have problems with boyfriends – the pushing and fighting. (FGD Girl, Nelson Mandela Bay)**

This is corroborated by the quantitative data described under protective knowledge where there was a positive correlation between being part of a Rise Club and having knowledge about what an unhealthy relationship was. However, an examination of the KGS curriculum suggests that contextual issues of community and interpersonal violence and in particular how gender norms shape relationships could be dealt with more extensively both in the health education and peer education sessions.

The girls also made the point that it is not enough to have knowledge and skills they also need help with the larger macro-structural issues related to poverty - they need outside support with food at home and friendly clinics and fenced schools to stop men coming into their schools – these are what Fergus and Zimmerman (2005) would call "resources for resilience'' (see Literature Review in Appendix B).

- **We want KGS to bring contraceptives to school.**
- **And testing.**

(FGD, Girls, Ehlanzeni)

> **It is the need for food. Many girls go to bed hungry. There is no money for school things. There is poverty. KGS can help with advice but we need food. (FGD, Girl, Ehlanzeni)**

Though the KGS programme could not deal directly with structural issues such as poverty or safety and security in living spaces it should be able to help girls cope with these issues better through the use of empowerment approaches. Research suggests (see Literature Review in Appendix B) that even if an

intervention is not able to intervene in macro-structural issues such as poverty, if young people can view these with a critical consciousness it can help them to cope with a sense of agency. This applies too to the issue of understanding gender norms and how they impact on girls' and women's lives.

The focus groups with the girls explored their sense of critical consciousness and whether they understood how gender norms impacted on their lives at home, with peers, at school and in the broader community. What emerges is that the girls' critical consciousness of how their context impacts on them is restricted to questioning gender norms related to household work. There is little evidence that the KGS programme encourages them to develop a critical consciousness which could help them to see their own agency and reduce their sense of powerlessness.

A review of the KGS curriculum shows that looking critically at context, especially at gender norms and their impact on girls' lives, is not dealt with in the peer education and health education content. There is material on values in the peer education curriculum but it does not problematize norms or explore why men/women and boys/girls behave the way they do as emphasised below.

> **We tell about condoms but the girls say, my boyfriend won't use one – how do I talk to get him to use? We talk about not having sex till you are older but the girls say boys force them. I wish for scenarios and stories to help. I do role plays in the sessions to help the girls to think of applying the knowledge but… (FGD Implementer, Ehlanzeni)**

Linked to the issue of creating consciousness of context is the fact that the *form and style* in which a curriculum is delivered can encourage empowerment (Literature Review, Appendix B). Given the importance the literature places on this we asked a set of questions in the School and Learner Surveys on the form of programme delivery. We looked at levels of discussion in the KGS sessions, how much the girls taught each other and participation of the girls in sessions, all things that the theory says help build consciousness and a sense of power.

The data shows evidence of effectiveness of delivery of the programme by the implementers. Eighty three percent of implementers indicated that discussion took place in sessions 'a lot or all the time', 77% indicated that the girls taught each other (Appendix K).). The table below also shows that girls often taught each other, an indicator of participation.

Table 23: How Often the Girls Teach Each Other

District	Happening a lot / all the time	Happening some of the time	Seldom happening	Not happening
Bojanala	78%	22%	0%	0%
Cape Town	83%	17%	0%	0%
Ehlanzeni	54%	31%	8%	8%
GertSibande	63%	38%	0%	0%
Sekhukhune	33%	33%	33%	0%
King Cetshwayo	100%	0%	0%	0%
Nelson Mandela Bay	75%	25%	0%	0%
OR Tambo	33%	67%	0%	0%
Tshwane	67%	33%	0%	0%
Zululand	50%	17%	0%	33%
Overall	64%	28%	4%	4%

In the focus groups with implementers we explored *how* implementers worked with the girls. Many of them talked about rooting the sessions in the girls' reality, which is an important starting point for making knowledge empowering.

> **We tell them as it is and give real life scenarios. (FGD Implementer, Ehlanzeni)**

- **We once had a discussion on alcohol and drugs and found out that most of the girls were drinking alcohol. They argued that alcohol was not a drug as it had different side effects compared to drugs.**
- **They said alcohol made them hyper active and gave them a confidence to do things they wouldn't usually do when sober, but it was not a drug.**
- **I later had to explain the similarities of drugs and alcohol and the effects and that's when they now realised that it was indeed a drug. (FGD Implementer, Greater Sekhukhune)**

Implementers are also aware of the need to build a safe environment where girls will ask about difficult issues through activity. Here a group of implementers describe how they try to make the sessions fun and engaging so that the girls learn to trust them.

- **We like dancing in our sessions; we usually sit in a circle then discuss the topic we have for the day. We share our ideas then after that we dance.**
- **The girls love to dance and sing so it's easy for them to relate and connect when we do those activities. It's like a release and a bond at the same time, to break the shell around them. It's also a comfort zone as its something different to being in a class setting all the time.**
- **They trust us now but it wasn't always like that, it was a work in progress, we had to motivate a lot and be very open and friendly to them so we could gain their trust.**
- **The time you're at their level they open up better and easier to you, they feel closer to you. (FGD Implementer, Cape Town)**

The pattern of evidence in the focus groups suggests that this use of empowering approaches is not common across all districts. It seems to have been something adopted by the more confident and creative implementers rather than a chosen strategy for implementation. The published materials on health and peer education for use by the implementers encourage group work and discussion but do not explicitly encourage an empowering approach – in fact the adoption of a didactic adult-driven approach over the peer-to-peer model at the start of the project suggests a lack of understanding of the importance of empowerment methodologies. The Soul City Rise Clubs model is rooted in a methodology that encourages individual and group empowerment and it seemed that this had worked well.

2.3.4 Networks of Support

The literature suggests that supportive peer networks and also access to supportive adults are protective factors for vulnerable girls. The Learner Survey, focus group discussions and case studies showed evidence of peer-to-peer support amongst Rise Club members.

There is stronger evidence that implementers had become the supportive adults that can be important in girls' lives. This was strongest in districts where the implementers were in contact with the girls regularly and frequently. The more frequent the contact, the stronger the supportive role the implementer played. Ninety percent of the girls agreed that the KGS implementer was 'kind and friendly' (Appendix I) and in most of the focus groups girls talked enthusiastically about the role implementers played in their lives.

- **You see with me, it's more like, she is more like my counsellor. She is the person that I talk to … I go to her and speak and she would advise me.**
- **Well with me, sis'K … yhooo … I do not want to say friend, but our relationship is open. I say anything to her. The thing is sis'K is more that understanding, I talk to her about my relationships, even when I have fights. Yes, she is old, but jaaa…**
- **Jaa…as M said she is of great help, she does not judge jaaa. (FGD Girls, Nelson Mandela Bay)**

One of the characteristics mentioned most often by girls was that implementers could be trusted with confidential information.

- **She is different to a teacher because if we talk to N she will understand us and talk to us. But if we go tell our teacher then she will go tell everyone.**
- **We don't trust the teachers. (FGD Girl, Cape Town.)**

The girls talked about how the implementers were important to them because they could not talk about sex and relationships with anyone else.

> **If we speak about those things at home our parents say we know too much. I am not shy here at Rise but I will never speak about these things out there. (FGD Girls, Nelson Mandela Bay)**

The quote below from an implementer describes how much they have become a role model for girls.

> **No the relationship is more like that of a role model. It is kind of a friendly, role modellish way but they know they can. In a way there is some kind of respect and they sometimes say that when I grow up Sister Lebo I want to work at lifeline so how do I get there? On another level they are casual with us and say hi. (FGD Implementer, Gert Sibande)**

Caregivers also talked about the relationships the girls had with the implementers, they acknowledged that they could not always be open with their children but that the KGS implementers could. Educators and principals also highlighted how they valued the role the implementers played in being able to create relationships to support the girls, something they could not do easily.

> **They can talk to her. She must carry on to be smiling and friendly to them because then they can talk to her. (FGD Caregiver, Zululand)**

2.4 Objective 3: To Assess the Quality of the KGS Programme

This section focuses on how PRs and SRs have sought to maintain the quality of the programme and its fidelity to the aims of AGYW and the KGS programme. The data is presented under themes that emerged from the KIIs with SRs and PRs, some data from implementers is also included:

- Resources and time for programme delivery
- Meeting targets: Quantity or quality?
- The importance of monitoring for quality
- Implementer quality
- Supervisors
- Relationship with the school and community

2.4.1 Resources and Time for Programme Delivery

A review of data provided by the different PRs and SRs revealed variations in human resources available for programme delivery in the different districts. Findings from the evaluation also indicate variations in time available during the school day for implementation as well as materials handed out to learners during programme activities.

Human Resources

Based on programme data provided by PRs and SRs, it is evident that the human resources available to support implementation of programme activities in schools varied greatly across districts, both in terms of numbers (ratio of schools allocated per implementer) and skills levels. Table 24 below indicates that King Cetshwayo, Nelson Mandela Bay and OR Tambo were the most well-resourced districts, with each having one implementer allocated to each school. Bojanala district had the largest ratio of schools per implementer, with eight Health Educators supporting over five schools each[14]. Some of the districts also had social auxiliary workers and social workers available to support the programme. These include Tshwane, Nelson Mandela Bay and OR Tambo.

[14] Other districts had 5 schools but there were two implementers per school.

Table 24: Human Resources Supporting Programme Delivery per District

	Bojanala	Cape Town	Ehlanzeni	Gert Sibande	Greater Sekhukhune	King Cetshwayo	Nelson Mandela Bay	OR Tambo	Tshwane	Zululand
Ratio of Health Educator to supported Schools	1:6	1:2	1: 5	1: 5	1: 5	1 :1	1 :1	1:1	1:3	1:5
Ratio of Peer Group Trainer to Supported Schools	N/A	N/A	1: 5	1: 5	1: 5	1:1	N/A	N/A	N/A	1:5
Ratio of schools per Supervisor	1:24	1:22	1:50	1: 50	1:50	1:17	1:19	1:17	1:14	1:50

Did the better human resourcing ratios translate into better service provision? One clear point made by the KIIs was that SRs linked quality to the number of school-based implementers. In districts where the implementers served high numbers of girls the PRs expressed concern about giving girls the in-depth education and experience they felt was needed.

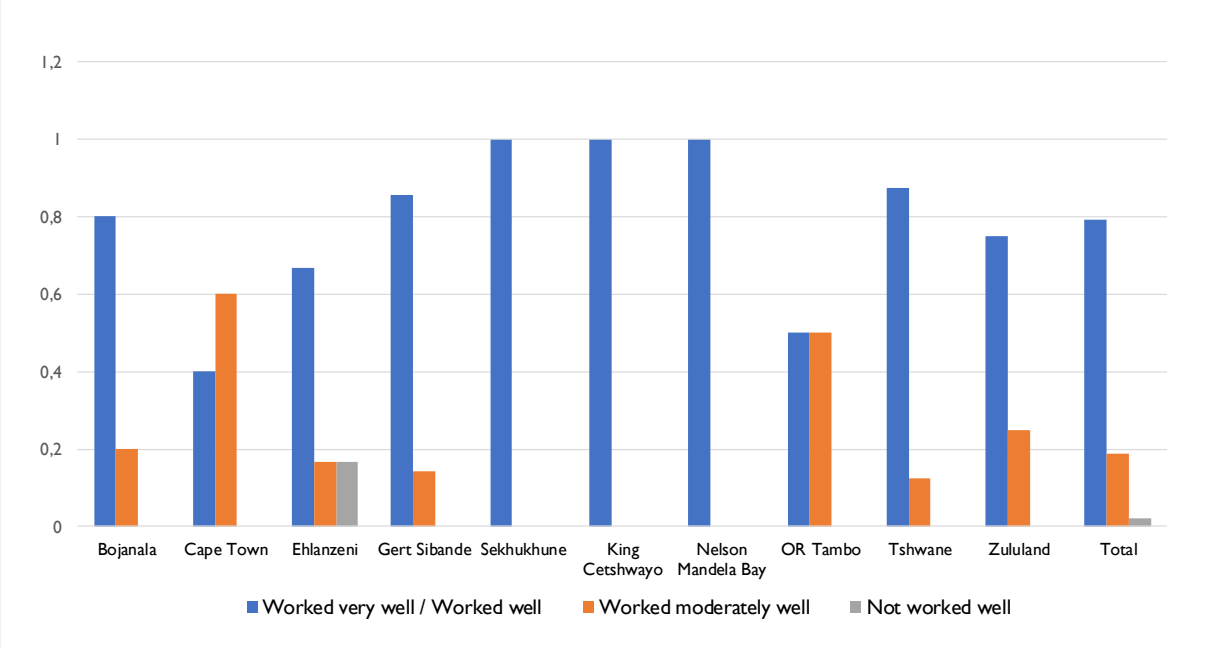
> **Sometimes it's more than just numbers. We need to build relationships with the girls and if it's one health worker for 10 Schools then that's more than 200 girls and so no bond can really be formed with ratios like this. (PR)**

However, it is difficult to be definitive about this as so many factors affect delivery, for example skills levels and confidence of implementers, time available during school hours, relationships between implementers and schools and so on. The number of interventions girls received (Figure 15) could be related to number of implementers per school, which could be the case for Nelson Mandela Bay and to some extent King Cetshwayo, both of which have high implementer ratios and high levels of participation in KGS activities, but this does not hold true in OR Tambo. Greater Sekhukhune has quite good results for multi-interventions, yet a low implementer ratio of 1:5. The qualitative data seems to suggest that the support of provincial and district education officials, principals and educators could have made the difference in terms of delivery in Greater Sekhukhune. Another example is home visits which one would assume were more likely to take place where the ratio of implementer to schools was higher. But again, the pattern is not consistent. Figure 12 (number of home visits) shows that ORT Tambo district, with an implementer ratio of 1:1, and Cape Town, with a ratio of 1:2, reported high delivery of home visits yet Greater Sekhukhune, with a ratio of 1:5, also reports a high delivery of home visits.

Time to implement activities in schools

Feedback from the implementers in the School Survey indicates variations in the extent to which they were allowed access to learners for the different activities.

Figure 16: Implementers' Ratings of the Time to Implement Activities in Schools



The issue of time within the school day came up often in interviews with managers and implementers.

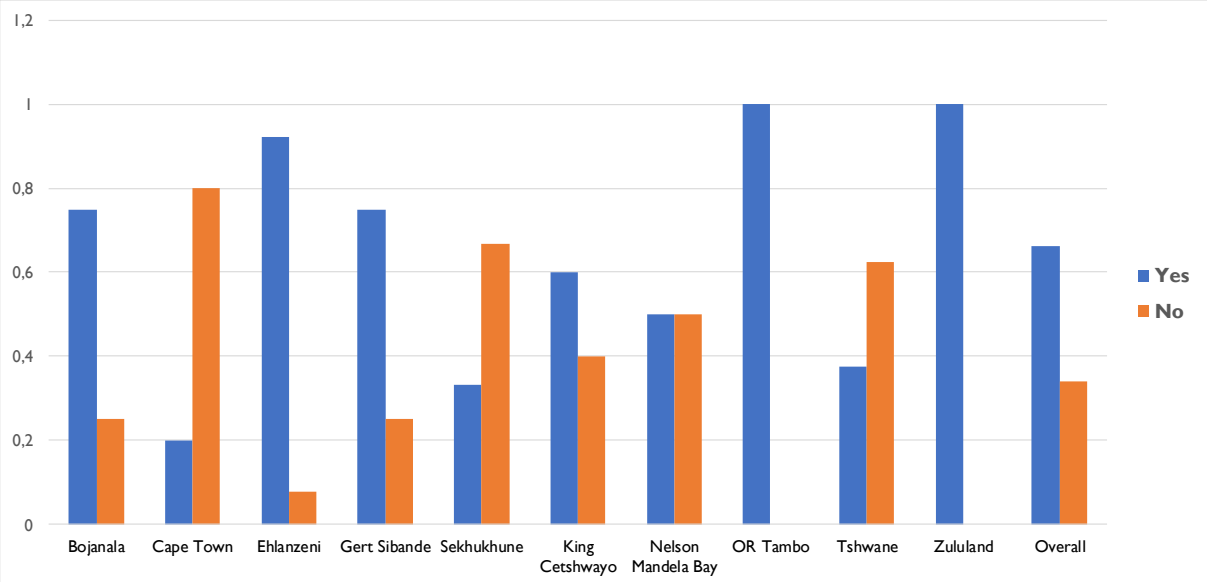
> **The challenges of the programme lie in the way it is rolled out in the school itself. Although there are clear agreements with the school administration with regards to**

access to the learners; in reality, this does not happen on a regular basis. The haphazard manner in which learners are accessed is problematic in the face of fixed milestones and quotas. Despite agreements and promises to allow our staff access to the learners, our LSAs find it very difficult to meet their operational targets in the schools. Not because they are not present at school, but because there are no free periods to teach it in. This is especially true towards the end of each term. (SR Manager)

Written Materials for Learners

Implementers also provided information on whether they handed out written materials e.g. handouts, magazines, photocopies, to the girls. Findings again indicate variations across districts on availability of such resources.

Figure 17: Implementers' Feedback on whether they Handed out Written Materials to the Girls



In analysing this data, it is useful to look at how access to written materials affected delivery. Again, it seems that multiple factors were at play. For example, Figure 4 shows that not every district that reported having written materials produced high delivery of health education. Ehlanzeni and Zululand data from the School Survey showed low delivery of health education but Figure 17 above suggests they had materials. In Figure 4 Tshwane had high delivery of health education but in Figure 17 above the same implementers say they did not often hand out written material. What emerges again is the multiple factors that influence delivery of the different components of the programme. Further in-depth research would be needed to analyse which factors dominate.

2.4.2 Meeting Targets: Quantity or Quality?

Discussions in interviews with SR and PR managers and M&E staff all included mention of the need to meet targets i.e. numbers of girls attending different components of the KGS programme. The challenges discussed under Objective 1 are relevant here.

There is huge pressure. The whole process is that you must reach a certain target so if you don't reach a target you are telling us all these wonderful stories about Cape Town but what about the target. It doesn't go down well with the top people. (SR supervisor)

> **We are also chasing a target; if I come to my manager and say I didn't reach my target for this month because the school didn't want to open the gate he will simply say 'Go speak to DBE'. (SR Manager)**

Almost all of the SR and PR managers described how they tried to meet targets and to deliver a quality programme, but this was a challenge.

> **In as much as numbers are important the in-depth is also important because remember preaching about something is different from when it happens. To make it happen needs depth. (SR supervisor)**

> **When the programme started the focus had been so much on the targets. Of course the money and the disbursements and the performance of the programme are dependent on numbers. So we all know that in order for us to keep going we need to meet the numbers and people then are so sensitised on numbers when we also need to focus on the quality of the work i.e. what are the girls doing? We as a PR needed to have balanced it better. I mean at every monthly meeting when your officers visit the SR we are constantly informing them the focus is on both the numbers and the quality. But somehow we couldn't get it right no matter how many times we said it – there was a focus on numbers. (PR)**

As discussed in the data under Objective 1, SRs and PRS had found innovative ways of dealing with meeting targets, such as Saturday sessions and using break times.

The Importance of Monitoring for Quality

The School Survey provided data on monitoring of implementers. Eighty one percent of implementers indicated that programme management checked 'often or very often' to discuss the progress of implementation and monitored and supported them in their work. Seventy eight percent of implementers said that programme managers advised them on changes to make the programme better 'a lot or most of the time'.

Qualitative data corroborates this as almost all implementers we spoke to in the focus groups indicated that they received support from SR KGS management.

- **Yes, a lot. We have monitoring tools and apps. Our supervisors or the teachers can just pop in out of the blue and see what is happening in the classrooms**
- **Researcher: When do the supervisors come to see you?**
- **Because we are many we can't say how often, she has to circulate amongst the four of us and then the office as well, so as often as she can. (FGD Implementer, Ehlanzeni)**

This suggests that SR and PR managers did their best to ensure quality delivery of the programme. PR managers and SR M&E officers talked about how the monitoring systems were important not only for making sure targets were met but for monitoring quality too. A biometric system used for recording attendance by girls is being introduced in all areas of KGS, although not all areas have used it fully. Where it has been implemented it was seen as an important way to monitor quality, particularly in relation to the layering of the different components of the programme.

> **I need to monitor delivery on targets and the layering of the different parts of the programme. The biometric system is where I can check on a regular basis about targets. They can correct things if I get regular feedback. It allows them on a daily basis to check up on how the staff are doing. So they can say educator 1 has done 15 sessions in this month and educator 2 has only done 2 sessions and then they can do an intervention as to find out what is going on. (PR)**

Some evidence on challenges with the biometric system came up in the different discussions with implementers. These are:

- Implementers, particularly those in rural areas, lacked technical literacy and in spite of training they struggled with the everyday technical expertise needed to manage the system.
- There were connectivity challenges in rural areas.
- Security related to the tablets – schools had refused to let implementers store the tablets at the school so they had to carry them from school to school which placed them at risk in some areas.

It should also be noted that we picked up a perception in the girls' focus groups that the devices used for recording attendance were 'testing' the girls ("that thing that tests you"). They were unsure what the device was for.

PRs also made suggestions about the need to monitor more than just attendance. Two PRs asked for a system that could also monitor implementer knowledge over time.

> **What worries me is no one has bothered to assess whether the kids actually know what they have been taught or if they are applying it in their lives. We are not getting feedback that shows if the sessions have translated into new knowledge for the learner and whether the learner can integrate that knowledge. This feedback needs to go to the SR so they can rectify things. I also think there is a need to check on the staff levels of understanding on an ongoing basis. (PR)**

2.4.3 Implementer Quality

The School Survey and focus groups with implementers gathered data on implementer confidence in delivering the KGS programme. Across the ten districts, 46% of implementer participants reported that implementing health education was 'not challenging'. However, all respondents from Zululand and Gert Sibande indicated that they found health education very challenging. The majority of respondents from Bojanala (83%) also reported that they found health education challenging. Home visit support was reported to be challenging or very challenging by the majority of respondent, including 100% of survey respondents from 6 of the 10 districts. However, in the focus group discussions the implementers talked about being confident to deliver the health education and peer education sessions.

- **For me personally I don't mind doing these lessons as I did a course on HIV and sexuality so it's right up my alley.**
- **For me it's easy to teach on this topic as well as I was almost raped and then I decided to do research on why guys end up doing things like this. The young girls didn't know that if they didn't want to have sex they could say no, I explained to them that this was rape. Had I not researched I'd not have been able to explain to them**
- **We also teach them on how to use condoms and different contraceptives. Luckily I had been trained for this as well, (FGD Implementer, Cape Town)**

They talked about how they took the initiative to find answers when they did not know the information.

> **We write down the questions we can't answer and go to the clinics and ask them for assistance then we come back fully informed. (FGD Implementer, OR Tambo)**

> **I have the Peer Education Manual that is provided and I have my own text book that I prepare from before I come to school. Some of the pamphlets that I get at the clinic I do refer to and some of the questions that I come across that are not in the Manual. I then go out and find the answers and come back to the learners and give them that**

information. Sometimes I go to the clinic at D which is quite far because I live in P. (Interview for Case Study Implementer, Greater Sekhukhune)

- **They'll ask if gays can have children, what exactly happens and how do you establish you're gay.**
- **How do lesbians have sex. Sometimes we won't even have the answers.**
- **Researcher: How do you get out of sticky situations like these?**
- **We usually ask them to write down their questions and we'll take them to the nurses and Health Educators and ask them to give us appropriate responses (FGD Implementer, Ehlanzeni)**

The level of initiative and sense of empowerment of implementers is obvious from the above quotes. However, while this and data presented in the discussion of effectiveness under Objective 2 show generally high levels of skills among implementers, 46% believed the work they do needs someone with more formal training in youth work than they have. Most implementers felt that they lack skill in individual counselling, especially in helping girls solve difficult issues caused by their 'toxic' context. The area they seemed to lack confidence in was, helping girls with individual problems and general counselling. They also wanted training on how to give effective Homework Support.

We did training for Keeping Girls in School. I can say it's not enough because some of the learner's problems need us to refer them to the social workers and we can't get them so we must do the counselling and we don't know how. (FGD Implementer, King Cetshwayo)

Implementers also show a sense of powerlessness, similar to the girls, in the face of sexual and gender-based violence.

- **Researcher: What do you do to help the girls with the violence around?**
- **How can you protect yourself from rape?**
- **Researcher: What do you think is the answer to that question?**
- **I don't know, I don't have an answer because it's unplanned.**
- **Tell them not to walk alone, they don't have to talk to strangers and they don't have to accept things like money from strangers and they don't have to keep quiet if there is someone who is sexually harassing them because it starts there, these social issues are tough. (FGD Implementer, OR Tambo)**

They expressed a need for their training to include a process of conscientisation around the underlying drivers of violence and the consequences of pregnancy and HIV. The discussion under Objective 2 about the difficult contextual challenges they face is also important here. The implementers face significant emotional challenges in the work they do with the girls. The evidence suggests that they are not given enough support in this regard. This must affect the quality of their work. All implementers and SR managers talked about the emotional stress experienced by the implementers as they tried to help individual girls. The quotes below illustrate this and they also show the level of commitment and care that implementers have for the girls. Note that the kind of interaction described here took place most often at school.

It is more because sometimes it's you who ends up counselling the child because they don't want to talk to anyone else but you. You have to comfort them when they cry and at times you don't know what to say to them but you just reassure them, sometimes you even go and check on them after a couple of lessons if you're still at the school just to make sure they are still ok and to show you care for them. (FGD Implementer, Greater Sekhukhune)

The work is overwhelming at times because we have to take into consideration the girls emotions and vulnerability. At times we also end up needing counselling when you hear

some of the traumatic cases the girls go through especially with suicidal referrals. (FGD Implementer, Cape Town)

2.4.4 Supervisors

One of the innovations to ensure quality that many SRs had made was to introduce a supervisor level (sometimes called programme co-ordinators) between the school-based implementers and the manager of the programme. These supervisors were responsible for a number of implementers and made regular school visits. They also ran regular trainings. The implementers often called on them when they needed help with referral to a social worker.

We had administrative challenges to keep track of the LSAs' progress in the schools, especially the far-flung ones, so we created another administration level of programme co-ordinators [supervisors]. These coordinators went to the schools and acted as liaisons between the KGS programme and the school implementer. They made sure that the LSAs were supported and managed and that the participating schools were cooperating with the programme's requirements. They also made sure that effective M&E programmes were in place in the schools. There was a high attrition rate among the LSAs as they were overworked because (they had to do a lot) of administration and tracking tasks (and their work with the girls). Co-ordinators took over these tasks (so the implementers had time to focus on the girls only). (KII, SR Manager)

2.4.5 Relationship with the School and Community

The School Survey carried out with programme implementers looked at the relationship with DBE. 90% of implementers indicated that they had a good relationship with educators and principals. In this survey 61% said that school management discussed how the programme was progressing 'half of the time' or 'often'. This suggests a good working relationship in individual schools. The School Survey also looked at the relationship between the implementers and the District DOE. Table 25 below presents these results.

Table 25: Rate how Good your Relationship is with the Department of Education in your District

District	Excellent / Good	Neither good nor bad	Poor
Bojanala	100%	0%	0%
Cape Town	83%	17%	0%
Ehlanzeni	91%	9%	0%
Gert Sibande	100%	0%	0%
Sekhukhune	100%	0%	0%
King Cetshwayo	100%	0%	0%
Nelson Mandela Bay	75%	25%	0%
OR Tambo	67%	0%	33%
Tshwane	89%	11%	0%
Zululand	100%	0%	0%

Looking at this data in relation to the layering of the programme (Figure 15) it is difficult to discern any definitive pattern but the fact that OR Tambo scored low in terms of layering of the programme could be explained by the fact that they indicate here that their relationship with DOE in their district is poor but

Bojanala scores badly on layering and indicates here that their relationship with DOE in their district is good. Again it is difficult to discern a single pattern suggesting that multiple factors affect delivery.

In the focus group discussion implementers talked about how they worked hard to maintain their relationship with educators and school management.

> **Working in a school is quite difficult because you do not want to step on the teacher's foot. You have to make sure that you have friendly relations with the teachers if you want their help when girls have problems (with a particular subject). And you watch what you say because you are also looking after your girls to make sure that they pass and get to matric. So it's been difficult and especially when they complain about a teacher not helping them enough on a subject. (FGD Implementer, Bojanala)**

The above quote hints at the often difficult position the implementers find themselves in. They are a bridge between the girls and the educators in the school but not formally part of it. The nature of this complex relationship was handled better by some implementers than others. It seemed to us from the focus group discussions that the more confident implementers where able to form relationships with the educators and principals and therefore, negotiate for time in the school day more easily than the less confident ones. Another pattern that emerged in our discussions with implementers was that those who worked in rural areas, where the staff and institutional culture was more conservative and hierarchical, struggled to find a space and voice for the project because it was hard to build a relationship with staff.

> **They thought we were taking their jobs and they were suspicious. They also thought we were encouraging the girls to talk about things that should not be spoken about. (FGD Implementer, OR Tambo)**

> **They look down on us and don't see us as teachers. They think we are too young. They tell us our lessons are more important than your work. (FGD Implementer, Ehlanzeni)**

One of the issues raised by a number of stakeholders which relates to the quality of the programme was the need to make sure that the KGS messages were reinforced and not undermined by educators and school communities.

> **You know we are living in a very difficult area, a rural area and some of the schools where we are working, other principals are seeing what we teach as taboo. I got a letter of complaint last week from a school saying we are there to promote sex and encouraging children to be pregnant. (SR manager)**

> **Here is an LO teacher that might come and tell the girls that there is no sex before marriage that might challenge the KGS messages about safe sex. So there has to be some kind of capacity building with the educators too. In another programme where the teenagers who have fallen pregnant will come back to school and complain of being severely stigmatized by the educators and when they often feel like not participating in a teen parenting program and the educators feel that such a programme will only encourage them to have sex. What educators do not accept is that kids are having sex and no matter what message you tell them they are biological beings and will have sex. So you might as well give them the appropriate messages. The educators need some kind of training as they have the potential of undoing our work. (PR)**

Some educators and principals asked for training so they could support the KGS programme.

> **It's just that when where are such programmes, would it be possible for us as an institution to have two or more meetings per year, so that we could better understand the programme? (Principal, OR Tambo)**

There was also a suggestion from PR staff and some principals that another way of ensuring quality was to involve the broader community in the process.

> **To be successful here, the programme needs to mobilise the community, not necessarily the whole community, but to interact with the headmen, chief and the police can also be so helpful in trying to minimize this matter. (Principal, OR Tambo)**

> **For me personally I thought that it could have worked if we had some sort of capacity building with the schools, where you train the principal, management, some teachers and some SGB members and get them to understand how to deal with vulnerable children and come up with their own referral resources. (PR)**

Another theme that emerged from focus groups with implementers and caregivers and KIIs with SRs was the need to involve boys in some way, especially in health education and peer education.

2.5 Objective 4: To Understand the Sustainability of KGS in High Schools

The data we gathered on sustainability related mostly to the involvement of DBE in the KGS programme because if the project is to be sustained beyond a Global Fund grant, DBE is the most suitable partner to take over the programme. National level stakeholders talked about KGS as "owned by the Department" and about the fact that "DBE is expected to step in and take over implementation".

> **The education department had put forward the KGS programme because it is actually their product. They develop the content, the focus groups and all went through the education department. (PR)**

What emerged from our interviews though is that some District and even Provincial level officials see the KGS programme as separate from DBE, as an NGO programme.

> **When we made agreements with KGS the first thing was that they will not replace the educators; that was our agreement number one. Agreement number two, their activities will still be done in school but outside the teaching and learning periods, it can be during break time, it can be after school, it can be before the school starts, it can be on weekends, it can be whatever time that they shall have agreed with the school and another thing is that they have their model of implementation but then their model must fit into our model. We can't have parallel models running you know? And then now in most cases, the NGOs you know like you go into a setup and then you find them teaching inappropriate things. So when any NGO comes, we sit together and discuss these issues and then we also give them the model of the template of reporting because at the end of the month, they must give us a report. It is only our work with master trainers that is sustainable because as long as the Department of Education exists, we will have master trainers, yeah. And this other model (KGS), it is not sustainable because when funding stops it has stopped. Nothing happens. (DBE Provincial Official)**

- **Researcher: So, how are we going to make KGS sustainable so that whatever the programme has been doing, the department can continue?**

- **The department? It won't be possible for the department to continue because we have another programme called life skills/ HIV AIDS from the Department of Education. They're also teaching learners on peer education. So they will say they won't have a duplication of programmes. (DBE district official)**

Some of the findings from KIIs with SRs echo similar sentiments at school level too.

- **There are some principals that are not receptive to the programme. When you go to their schools and introduce yourself the principal will just say who are you and what are you talking about? Some of the principals do not seem interested and because it is not a DBE program they think we are pushing our own agenda. We have reported them to DBE and have sent people from the provincial offices to speak to the principals.**
- **Researcher: Was there any improvement after you reported them?**
- **Yes.**
- **Researcher: Let's talk about sustainability of the programme. If tomorrow they close the programme for Global Fund, do you think that all the things that you have been doing will continue?**
- **No they will fall flat to the ground. This is because the teaching component does not want anything with what we are doing. (SR manager)**

It was clear that the SRs had spent time doing advocacy at local level with the principals and district officials but as one SR manager explained principals did not always attend the meetings they called.

> **We had to do advocacy - we had to go to the principals for them to allow us in their schools and also agree on the time. Some of them are difficult. Not all of them came to advocacy so now they don't know the Programme and don't understand what it is they need to support us with. (SR manager)**

PR and SR managers mentioned that 'buy in' takes time. Note that the SR manager speaking above had been implementing the KGS Programme for less than a year.

> **For me, I don't think we have spent enough time to say the Programme is sustainable. We have 50 or 60 schools and with us, we spent almost the first part of the Programme concentrating on building relationships. It just takes time. (SR manager)**

3 CONCLUSIONS & RECOMMENDATIONS

3.1 KGS Components

Conclusion

Most girls who participated in the KGS programme received one level of service rather than the multi-layers planned for the intervention.

Recommendations

i) Future programme implementation designed to keep girls in schools needs to apply the programming, funds and ongoing monitoring and support to implementers to make sure more girls access multiple services.

3.1.1 Health Education

Conclusion

This component of the KGS programme was widely delivered and girls clearly appreciated what they had learned. The findings suggest that some adaptation of content is needed so that it is developmental across ages and is more responsive to context.

Recommendations

i) Rework the content of the health education component over the four years in which it is delivered so that it is age-appropriate and developmental

ii) Changing the socio-economic context through a programme like KGS is not achievable. Many factors operate at a macro-level that a programme such as KGS cannot address. Nevertheless, KGS can help girls to think critically about the context so that they are empowered to use the resources they do have to make choices. Some of the recommendations listed here could address this issue:

   a) Retain the knowledge component but put more focus on the application of the knowledge in the context in which the girls live. Look at introducing activities that allow girls to internalise the knowledge and then apply it to their own lives. These activities should involve discussion, debate, and communicative skills. It would be important to find ways of using a discursive and problem-solving approach in larger group settings. (Examples of such programmes: Cooper, 2016; Matthews, 2014)

   b) Place the content into the context of the socio-economic drivers behind HIV and AIDS, teenage pregnancy and dropping out of school. For example, when exploring contraception look at it in the context of use by young women who have their power constrained by norms related to gender power and violence.

   c) Explore issues such as poverty, gender norms, violence in relationships and substance abuse explicitly and how they influence choices. Look at health in the context of relationships, for example, not just condom use but how one might negotiate condom use in a relationship.

3.1.2 Peer Education and Rise Clubs

Conclusions

Given the importance placed by the research literature on positive peer networks as a protective factor it is a pity that programme implementers did not persevere with the peer-to-peer model as originally proposed. The positive response to Rise Clubs that emerged from the evaluation suggests that peer-based activities are effective. The findings also show that the content of the Peer Education Manual was seen as relevant and useful as many implementers used it, but that it needs to be related more closely to contextual realities.

There is substantial evidence throughout the findings that points to the value of Rise Clubs. Quantitative findings suggest links between magazine content and internalised knowledge and also relevance. Feedback was positive from all stakeholders and also supported by evidence from the research around elements of effectiveness and programme quality. This was particularly true with regards to the benefits of the peer-driven interactions within Rise Clubs and the materials available to the learners, which had content that addressed key life issues and went beyond factual information.

There are many examples of programme adaptations and innovation by implementers that enriched the programme and increased elements of effectiveness and quality. The fact that programme teams in several sites introduced new aspects to the initial models in order to augment the standard package shows that implementers thought deeply about what learners needed and what would keep them interested and engaged. For example, programme managers in Nelson Mandela Bay and Cape Town used DBE and DOH resources alongside KGS resources to make the health education curriculum more relevant. This brought about a blend of the models in these two districts and contributed to the increased opportunities for learners to access more interventions through KGS. Implementers also innovated around home visits and homework support in many districts.

Recommendations

i) Retain the Rise Club model with its emphasis on peer-to-peer support and the use of engaging, context-related printed resources.

ii) Apply peer education in its true sense where girls themselves educate their peers. Not falling back on a didactic approach would create greater depth and quality in the programme and give girls supportive peer networks to help them negotiate their complex context. The approach has worked successfully in many contexts so it must be possible to find ways of applying it in KGS.

3.1.3 Homework Support

Conclusions

Challenges related to the availability of time during the school day for homework support affected delivery as well as implementer confidence. A lack of implementer capacity and materials to boost implementer confidence in this area also hampered the implementers. Research (see literature review, Appendix B) suggests that 'falling behind' in academics is one of the reasons girls drop out of school. It would be important, therefore, for future programmes designed to keep girls in school consider ways to address this issue.

Recommendations

i) Explore models that could be applied within the mandate of KGS for assisting girls with content knowledge that could enable them to catch up academically.

ii) KGS staff need to work with school management to make sure homework support is incorporated into the School Implementation Plan (SIP). In particular, educators with subject knowledge should be encouraged to give learner support.

iii) Extend the innovations already taking place that help young people cope with school work in a difficult context such as small neighbourhood study groups and the use of past learners from the local area as volunteer tutors. Training for SRs and implementers should include exposure to such strategies. Implementer training should include information on how to support girls with basic learning skills.

iv) Materials on basic learning skills, study skills and exam skills should be made available for use by implementers.

3.1.4 Home Visits

Conclusions

Findings suggest that implementers have not conducted home visits as often as proposed by the SOP. Significant challenges such as security concerns, transport and the complexity of family-related issues have had an impact on the delivery of this component.

Recommendations

i) Funding should be made available for transport for home visits.

ii) Acknowledging the security concerns of implementers in relation to home visits and finding practical ways to overcome these within the local context. In particular, school management should take responsibility for follow up of girls who are at risk as part of the SIP.

iii) Implementers need further training in communication and family counselling skills in relation to families and caregivers.

3.1.5 Career Jamborees

Conclusions

Careers guidance is valued by the girls and many girls have received this through the KGS programme. There is some confusion about who offers this service. Girls ask for interventions into their context of poverty, this is one area where KGS could intervene in the macro context.

Recommendations

i) KGS should promote and market the education department's career jamborees but focus on broader career and livelihood programmes beyond jamborees.

ii) KGS should introduce a component that includes livelihood education such as entrepreneurial skills. It would be important to look at how the aspects of Economic Strengthening for Young Women and Girls programme (part of AGYW) could be integrated into KGS.

3.2 Monitoring

Conclusion

Monitoring of attendance has been successfully carried out. This is useful for accountability but this evaluation shows that ongoing collection of other data would allow for understanding and enhancing programme effectiveness.

Recommendations

i) Collection of data beyond attendance of core components, including completed referrals to other service providers, would allow the programme teams to ensure that learners receive a comprehensive package of services aligned to their needs.

ii) A careful and regular review of data from the different sites including information related to operational issues is needed in order for PRs to remain in touch with implementation realities and to provide the necessary guidance and support for programme quality improvement.

iii) Technical and capacity challenges related to the use of the biometric system should be addressed through close work with SRs and implementers.

iv) It is important to make sure the girls understand very clearly that the biometric devices are not testing but merely recording their attendance.

3.3 Personnel

Conclusions

Findings show that the ratio of implementers to girls affects quality of the programme. Those implementers who could spend time with the girls could develop supportive relationships with them, for example. It also affected delivery as those implementers who had more schools and girls to reach often had to spend time travelling from school to school leaving less time for the delivery of health education or peer education sessions, for example. Implementer confidence and creativity also seemed to affect delivery in that those implementers who felt confident to negotiate time for the programme were often able to use school time and some of them developed creative ways of dealing with challenges such as inviting parents to meetings at the school. Implementers largely felt supported by training and mentoring by managers and supervisors but they have expressed a need for more training in individual counselling. Access to social workers has affected referral and the quality of response provided to vulnerable learners. Where social workers were employed by the KGS programme referral has been effective.

The findings suggest that the quality of relationships between girls and implementers was one of the most effective aspects of the programme. In almost all districts implementers are appreciated by girls, caregivers and educators as important positive adults and they use significant personal resources in building and maintaining relationships with the girls.

Recommendations

i) Future iterations of the programme should consider applying the one implementer per school model as this has the most potential for effectiveness.

ii) Consider the employment of social workers within all areas of the KGS programme. This may mean working with fewer districts and schools and providing more in-depth quality care for girls.

3.4 Relationship with Education Departments

Conclusion

This has been a key factor in delivery of the programme – the biggest challenge to delivery has been accessing time in the school day through negotiation with principals and educators. In areas where District and Provincial Education officials supported the KGS programme this does not seem to have been a problem. An example of this is Greater Sekhukhune where support from the provincial and district education staff has resulted in better delivery results in all components of the programme.

Recommendations

i) It is important to do advocacy work with DBE officials at all levels early on in the implementation process and to continue to interact with all levels of DBE on an ongoing basis. This interaction should come from National level if possible and also from PR level and should not be left to smaller NGOs that are implementing the programme, as they do not have the power to influence provincial education officials, for example. The focus on making time in the school day for the programme should be resolved.

ii) Implementers and managers emphasise how important it is for educators to create a supportive environment for the key KGS messages. This is why future programming should include education sessions for educators and principals on adolescent sexuality and why KGS uses the particular approach it does.

3.5 Community Links

Conclusions

There is little evidence of interaction between the programme and caregivers yet caregivers express appreciation for the work done by KGS and for the specific skills the implementers have. The potential exists for enhancing the relationship between the programme and families of girls. There is also evidence from this evaluation that girls, caregivers and implementers would like to see boys involved at certain times in the programme to enhance communication and also begin to build a supportive environment for girls to make decisions.

Recommendations

i) Include boys at certain times during the programme, particularly for health education topics such as contraception, where dialogue between boys and girls would enhance learning and communication skills.

ii) The programme needs to strengthen the involvement of parents and community members if the girls are to be supported with positive choices outside the school.

iii) Community dialogues between programme staff, caregivers and girls have been successful in other similar projects and should be explored.

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APPENDICES

NOTE: Appendices are provided as a separate document.

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