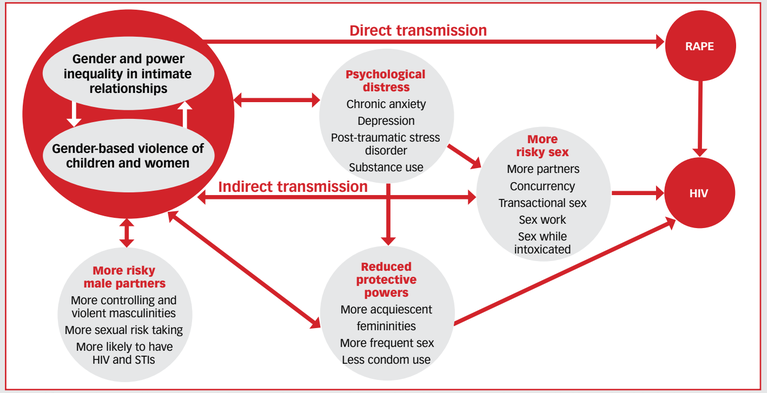
Figure 1: Pathways through which gender-based violence and gender inequality increase women's risk of HIV infection



Adapted from: Jewkes R, Dunkle K, Nduna M, Shai N (2010) Intimate partner violence, relationship gender power inequity and incidence of HIV infection in young women in South Africa: A cohort study. *The Lancet*, 367: 41-48.

Key components of the Young Women and Girls Programme

Within this context, the Global Fund funded the South African government to deliver a comprehensive package of health, education and support services for young women and girls in order to reduce new HIV infections.

The YWG's programme was implemented in districts with a high HIV burden and included the following package of services:

- **Soul Buddyz clubs** offering peer education for primary school girls and boys aged 10 – 14 years;
- A **Keeping Girls in Schools** intervention for high school girls at risk of dropping out of school;
- **Rise Young Women's Clubs** offering life skills and empowerment activities for young women aged 15 – 24 years who are out of school;
- **Parenting programmes** for parents of young people attending the Soul Buddyz and Rise clubs and teen parents; and
- A **child protection** component which consists of a residential therapeutic programme for girls (aged 10 – 17 years) who have been victims of sexual violence, and for boys (aged 10 – 14 years) who display inappropriate sexual behaviour.

Five organisations known as Principal Recipients (PRs) were funded to oversee the implementation of the YWG programme and they, in turn, contracted implementing organisations known as Sub-Recipients (SRs).

The child protection component

The child protection component is the focus of this learning brief. This component was based on a residential therapeutic programme developed by Childline South Africa and the National Association of Child and Youth Care Workers (NACCW) in collaboration with the Department of Social Development (DSD).

The therapeutic residential programme took place over the course of a week and consisted of individual and group therapeutic sessions for children and their primary caregivers. Therapy at the camps was provided by social workers, commonly referred to as therapists.

Recommendations

We make the following recommendations to strengthen alignment between the child protection intervention and broader HIV prevention programmes:

Conceptualise the child protection component as part of the broader HIV prevention programme

- Develop an evidence-based theory of change which explains the pathways between violence against women and children and HIV and how the child protection component supports HIV prevention goals.

Strengthen programme fidelity by identifying and communicating the core elements of the child protection programme

- While some adaptation may be necessary to ensure that the programme responds to local contexts and is scaleable, core elements that are instrumental for its success should not be adjusted or omitted. In addition, standardised procedures need to be developed and shared with all relevant stakeholders at the outset of programme implementation to ensure programme fidelity.

Consider continuity of services in the design of child protection interventions

- To promote sustained impact, the child protection component needs to build in different levels of support (e.g. caregivers; CYCWs; case conferencing for referrals and after-care services) and should be delivered in collaboration with key government stakeholders (e.g. the Departments of Social Development, Health and Basic Education).

Explore alternative, community-based models of therapy

- Consider alternate evidence-based treatment approaches at the community level which can provide therapy and support over a longer period of time, and which lend themselves to scale-up. Evidence from other low-resource settings suggests that therapeutic models using using lay-counsellors hold potential, but will require further investigation in the South African context.

Suggested citation:

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Endnotes

1 A more detailed description of the evaluation findings is available in the full evaluation report: Röhrs S, Delany A, Mathews S & Berry L (2019) *Programme Evaluation of the Child Protection Component of the Global Fund's Young Women and Girls Programme in ten districts in South Africa – Final Report*. Cape Town: Children's Institute, University of Cape Town.
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Lessons learnt from the child protection component of the Global Fund's Young Women and Girls Programme in ten districts in South Africa

Background

In South Africa, young women and girls are exposed to extremely high levels of gender-based violence (GBV) and HIV infection. Given the links between the two epidemics, it is important that HIV prevention programmes also address violence against women and children.

The Global Fund's Young Women and Girls (YWG) programme is a multi-pronged HIV prevention programme targeting young women and girls and was implemented in 10 districts in South Africa from April 2016 to March 2019. This briefing paper reports on the lessons learnt from a process evaluation of the child protection component of the programme.[1]

Understanding the links between violence and HIV infection

The National Strategic Plan for HIV, TB and STIs (2017 – 2022) emphasises HIV prevention among adolescent girls and young women because of this groups' disproportionate and extremely high rate of infection. The HIV incidence rate among young women aged 15 – 24 years is over four times that of men of the same age.[2]

At the same time, young women and girls experience high levels of violence. More than a third of children in South Africa have experienced some form of sexual abuse.[3] This may result in physical injury, mental health problems, self-harm and risk-taking behaviour, and increases the risk of intimate partner violence in adulthood.[4]

The consequences of sexual abuse can differ between boys and girls. While the psychological consequences for girls include depression, anxiety disorders, suicidality, substance abuse and unwanted pregnancy (as well as stigma associated with these), consequences for boys include externalising behaviour such as aggression, truanting, gang violence and crime.[5] Young women who have been sexually abused as children also have a considerably higher risk of acquiring HIV.[6]

Research has identified various pathways through which sexual violence and gender inequality can increase women's risk of HIV infection.[7] Figure 1 shows the direct pathways between rape and HIV, as well as the indirect pathways through which GBV and gender inequality can increase women's risk of HIV infection. For instance, child sexual abuse may cause psychological distress which may in turn increase risky sexual behaviour (e.g. more partners) and reduced protective powers (e.g. decreased condom use), both of which are risk factors for HIV infection.

HIV prevention should therefore address structural drivers of the disease such as GBV and gender inequalities. In addition, it is important to provide mental health services to reduce psychological distress which could help reduce risky sexual behaviour and promote healthier intimate relationships.

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An overview of the process evaluation

The Children's Institute (University of Cape Town) conducted a process evaluation to assess the implementation of the child protection component of the programme and the extent to which it was implemented with fidelity across the 10 districts. The impact of the intervention was not evaluated.

The process evaluation used qualitative methods and included a desktop review; interviews with key informants at national and local level; and, at site level: (1) interviews with PRs, SRs and caregivers of children who participated in the camps; and (2) focus group discussions with selected social workers implementing the camps. The study also included a short online survey for a larger group of social workers. Ethics approval was received from the Research Ethics Committee of the Faculty of Health Sciences (University of Cape Town).

Lessons learnt

In the following section, we summarise 'what works' and 'lessons learnt' in relation to the implementation, relevance, effectiveness, efficiency and sustainability of the child protection component of the YWG programme.

Implementation

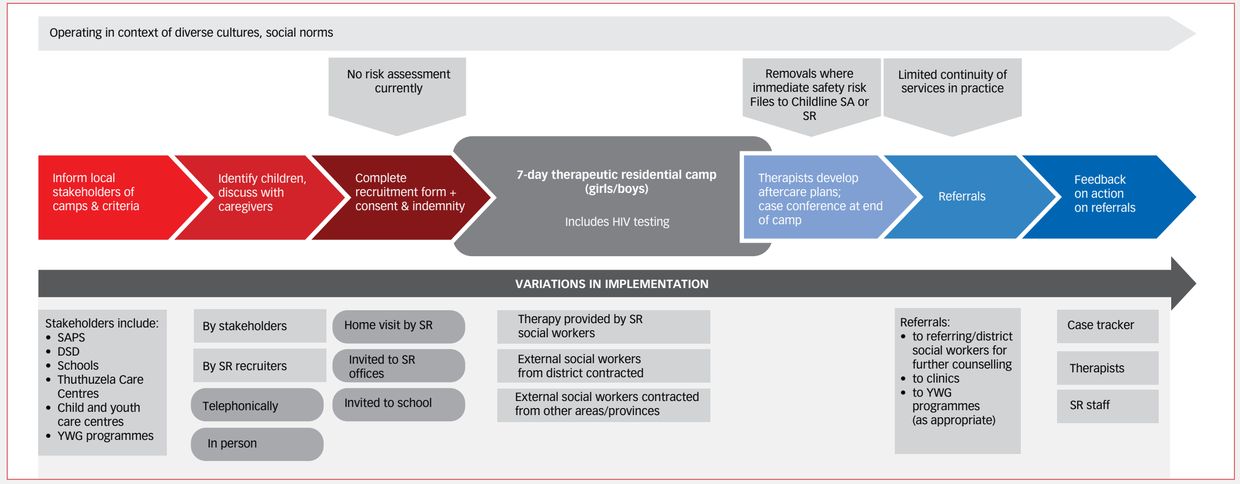
'Fidelity' or the ability to remain true to the core principles and functions of a particular programme is essential when 'scaling up' or expanding a programme beyond its original setting. It is therefore important to pay careful attention to a range of context-specific factors that may impact on implementation. It is also essential to identify core elements of the programme that are likely to lead to programme success and ensure that these are implemented consistently when the programme is implemented in new environments.

A set of core elements are necessary to support effective programme implementation (see Box 1), and these are noted where relevant below.

Standardised implementation

A key question was whether the child protection component was implemented consistently across the 10 districts. In the YWG programme, a large number of role players were involved in oversight and implementation which led to variations in how the intervention was delivered across the districts and how its objectives were understood. Figure 2 outlines the way in which the child protection component was implemented and shows how the PRs and SRs used different modalities (strategies and methods) to meet the programme goals, particularly with regards to the recruitment of therapists and the recruitment and referrals of children.

Figure 2: Variations in the implementation of the child protection component of the YWG programme



Box 1: Core elements necessary to support effective implementation of programmes include:

- a defined target population;
- a programme design adapted to the needs and cultures of service beneficiaries;
- a programme theory or conceptual framework based on evidence;
- realistic goals;
- an adequate and appropriate amount of intervention and specific intervention components to promote consistency;
- structured service delivery components including well-trained and well-supervised staff; and
- continuous improvement components including rigorous monitoring and evaluation processes to ensure that the programme is implemented with fidelity.[8]

Research on successful implementation and scaling up of programmes indicates that the core elements of the intervention need to be identified and shared with all role players from the outset to promote programme fidelity. In addition, Standard Operating Procedures (SOPs) or other guidelines which clearly outline all necessary processes should be made available to all role players to promote consistency. This is particularly important where some role players have not had prior experience in child protection work generally or in implementing this particular intervention.

Availability of skilled therapists

Successful programme implementation requires well-trained and well-supervised staff. For the child protection component, all therapists needed to receive standardised training to ensure that they are equipped to provide both individual and group therapy. Given the emotional intensity of the camps, access to formal, one-on-one supervision and debriefing after the camps would be a good practice to prevent burn-out of therapists. Interventions should also be adapted to the needs and culture of beneficiaries, which suggests that the therapists should understand the local context and culture.

Not all SRs were able to draw on their own pool of therapists for the camps. Where therapists needed to be contracted for the camps, it was good practice to recruit therapists from local DSD, child welfare organisations and child and youth care centres, as these therapists are likely to be familiar with the local language and culture and to have experience working with children in difficult circumstances. Drawing on local social workers also allows for skills transfer and leaves the community with increased capacity to deal with child sexual abuse and inappropriate sexual behaviour once the programme ends.

Recruitment of beneficiaries

When a therapeutic intervention is designed for a specific target group, it is important that the inclusion criteria are clearly defined and recruiters are trained to ensure that prospective participants meet these criteria. It is also important for children and caregivers to understand the purpose of the camp.

Having recruiters with experience in child protection and an understanding of the objectives of the camp, and conducting home visits prior to the camp helped ensure appropriate recruitment. Given the focus on child abuse, the recruitment process should also have included a risk assessment to ensure the safety of children and consistency with legal requirements under the Children's Act.

Continuity of care

Those involved in the implementation of the residential programme identified several factors that contributed to the successful delivery of the camps. These included proper planning and preparation, having a cohesive team with clearly defined responsibilities, creating a conducive environment, and having a structured programme of recreational activities to complement the therapy.

In its original design, the intervention incorporated various levels of support for children to sustain the positive outcomes of the camps, such as the inclusion of primary caregivers and community-based child and youth care workers (CYCWs) to provide support for children and families before, during and after the camps. As the first line of support for children, the participation of primary caregivers is key to assisting children's recovery in the longer term. However, their involvement in the camps (as well as that of CYCWs) was limited. The absence of these forms of support is likely to undermine the outcomes of the child protection component.

Successful programme implementation requires the delivery of a structured package of services. This includes components such as case conferencing at the close of the camp, referrals and after-care services which were elements of the original programme design. Efforts should be made to implement these elements in order to ensure continuity of support and services. Clear processes for referrals and after-care services need to be established so that all role players understand their roles in follow-up services. Continuity of services was achieved where the intervention was delivered by a child protection organisation that had the additional capacity (i.e. beyond this grant) to provide further therapeutic services and monitor the provision of other follow-up services. A common concern among role players was a general lack of services that children could be referred to, as well as the lack of responsive child protection services.

Relevance

The child protection component responds to an urgent need given the scarcity of publicly available therapeutic services for girls who have been sexually abused and boys who display inappropriate sexual behaviour. Furthermore, due to the links between sexual violence and HIV, the child protection component is highly relevant for HIV prevention.

As noted earlier, the inclusion criteria for beneficiaries need to be clearly defined to ensure that the child protection component reaches the defined target population. In addition, successful programme implementation requires the programme design to meet the needs of its beneficiaries. This was a challenge given that the target group of the YWG programme - in terms of age, sex and location - is narrower than the group of children who are in need of child protection services.

Successful programme implementation also requires an evidence-based theory of change. This should clearly outline how the child protection component helps to reduce HIV infection. All stakeholders need to understand the theory of change and how the various programme components are linked together to support the overall goal.

Effectiveness

Monitoring and evaluation is another core element to ensure continuous improvement of programmes. The main indicator for monitoring the success of the programme was measuring the number of participants in the camps. Targets were achieved (and sometimes surpassed) in most districts, although implementers did not always understand the rationale for setting these targets or why they differed for girls and boys.

Monitoring should ideally also include indicators to improve programme delivery and monitor ongoing effectiveness. For example, monitoring referrals and follow-up by district social workers and child protection organisations would provide insight into the sustainability of the intervention's effects and the services children and caregivers require to improve and sustain the outcomes of the camps. Participants viewed the child protection component as beneficial for children and caregivers. Caregivers reported how their children's and/or their own participation in the camps improved children's and caregivers' emotional wellbeing as well as caregivers' communication and parenting skills.

Efficiency

Some participants considered the child protection component to be costly, and time- and resource-intensive for the relatively small number of children reached. In addition, the implementation of this component requires highly specialised staff. These factors limit the potential for scaling up the child protection component of the programme.

Given the scale of child sexual abuse and the demand for therapeutic services, there is a need for interventions that are more cost-effective and easy to scale up. It would therefore be useful to identify other kinds of therapeutic programmes that work for children who have been sexually abused or are displaying inappropriate sexual behaviour in other low-resource settings. For example, there is a growing evidence-base of effective therapeutic responses in Sub-Saharan Africa (see Box 2).

Box 2: A task-shifting approach to therapy

A Zambian study tested the use of trauma-focused cognitive behaviour therapy (TF-CBT) to address trauma symptoms in HIV-affected children and their families in a low-resourced setting.[9] A trained lay-counsellor conducted sessions with the child, caregiver, and family over an 11-week period. The treatment model showed a reduction in trauma and stress-related symptoms over a six-month follow-up period.

The use of TF-CBT is an evidence-based practice worth considering for the treatment of traumatised children in South Africa. A task-shifting approach using paraprofessionals with limited formal mental health training is also proving to be effective in evidence-based interventions implemented in other settings in low- and middle-income countries.[10]

Sustainability

Child protection interventions depend on support from donors and the state, as well as the state's willingness to integrate them into routine services. Buy-in from key government departments, such as the Department of Social Development, needs to be negotiated at the outset of the programme to establish how sustainability of the intervention can be achieved.

Given the cost and specialised skills required to deliver the child protection component, it cannot easily be integrated into routine social services. In low-resource contexts such as South Africa, a community-based therapeutic programme and the use of lay counsellors may prove more sustainable