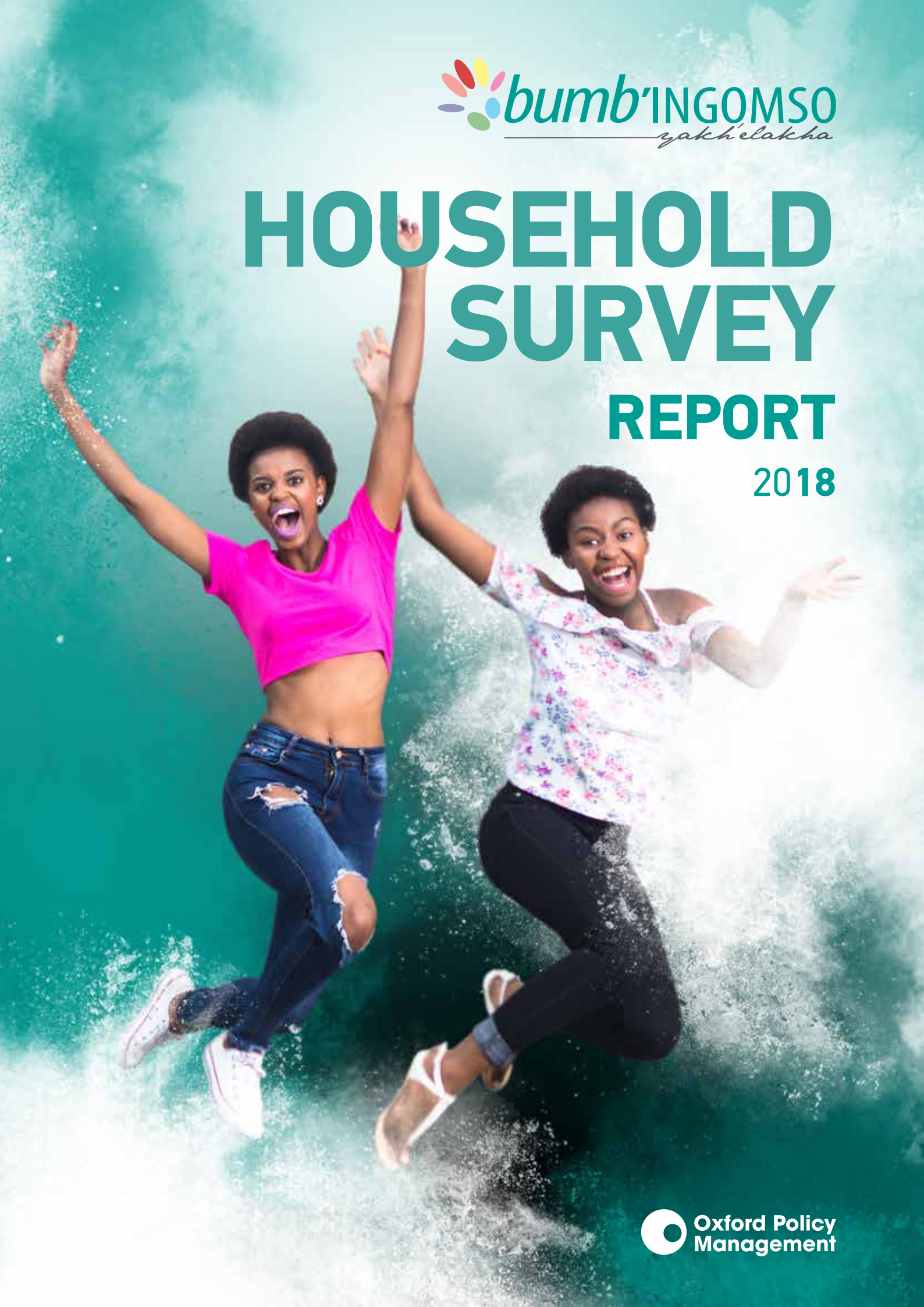
bumb'INGOMSO
yakh'elakha

HOUSEHOLD SURVEY REPORT 2018



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ACKNOWLEDGEMENTS

This report is the result of a collaborative effort and OPM is grateful to our DG Murray Trust colleagues, including David Harrison, Zukisani Samsam, Athenkosi Sopitshi, Babalwa Dunga, and Thabisa Nqwaba, who have participated in the process through reviewing earlier documents, providing support in relation to communication to communities and stakeholders, and suggesting approaches to the analyses that have shaped the report.

We would also like to acknowledge the funders of the project, KfW for this development project of the National Department of Health co-financed by the Federal Republic of Germany through KfW and the DG Murray Trust.

OPM would also like to acknowledge the support received from Buffalo City Municipality's Special Projects Office, who were of help during the community sensitisation phase of the project.

The project would not have been successful without the participation of all the fieldwork teams, who, for more than eight weeks, spent considerable time in the field gathering information.

This assessment is being carried out by OPM. The project manager is Tafara Ngwaru. The remaining team members are Alex Doyle, Daniella Davila Aquije, Gabi Elte, Johanna Wallin, Joy Banda, Katharina Keck, Robert Greener, Sean O'Leary, and Stephanie Brockerhoff. For further information contact Tafara Ngwaru (Tafara.ngwaru@opml.co.uk).

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This project has been made possible by the generous contribution of the Federal Republic of Germany through KfW and the support of the DG Murray Trust.

EXECUTIVE SUMMARY

THE PROJECT

The Bumb'INGOMSO programme is a cross-sectoral intervention directed by the DG Murray Trust and implemented by its operational partners in 18 wards across Buffalo City Metropolitan Municipality (BCMM). The overall aim of the programme is to reduce the incidence[1] of HIV among vulnerable groups in the municipality, particularly young women aged 15 - 29 years, through a set of community-based interventions that influence the choices available to young people.

THE PROGRAMME AIMS TO DECREASE THE NUMBER OF NEW INFECTIONS IN BUFFALO CITY BY CREATING AN ECOSYSTEM THAT SUPPORTS YOUNG WOMEN AND ENABLES THEM TO THRIVE. BUMB'INGOMSO ALSO MAKES AVAILABLE KEY SERVICES TO YOUNG WOMEN IN THEIR SCHOOLS AND COMMUNITIES:

Empowering young women is at the heart of Bumb'INGOMSO's work. The programme encourages young women to use their agency to make choices that contribute to their development and well being; Directly addressing gender -based violence as a key factor that exacerbates young women's vulnerable to infections . By reducing the incidence of violence in communities, young women are free to decide on their partners, sexuality and health seeking behaviour; and Reducing the rate at which HIV is transmitted among high-risk groups such as women in sex work (WSW) and men with genital ulcers.

[1] The number of new HIV infections in a population over a period of time

THE PROGRAMME IS FUNDED BY THE GERMAN GOVERNMENT THROUGH ITS DEVELOPMENT BANK, KFW AND THE DG MURRAY TRUST. IMPLEMENTATION STARTED IN 2016 AND IS EXPECTED TO RUN FOR AT LEAST THREE YEARS. THE BASELINE EVALUATION FOCUSES ON FOUR INTEGRATED INTERVENTIONS, WHICH ARE IMPLEMENTED BY DIFFERENT PARTNERS, EACH WITH A DEDICATED AREA OF FOCUS, SUMMARISED BELOW.

1. A behaviour change component to disseminate behaviour change messages to in and out of school young women, and recruit some of them into a leadership network, implemented by The Small Projects Foundation (SPF);

2. A health services intervention to strengthen the quality and youth-friendliness of health services in BCMM implemented by Beyond Zero;

3. An intervention to reduce the incidence of gender-based violence (GBV) and empower young women and girls, implemented by Masimanyane; and,

4. An intervention to expand access to economic opportunities for young women implemented by Harambee

THE OVERALL OBJECTIVE OF THESE PROGRAMMES IS TO ACHIEVE LARGE ENOUGH CHANGE IN THE RESPONSE AND SUPPORT ENVIRONMENT TO INFLUENCE A CHANGE IN:

a) Agency, as young women and girls feel they are able to access the services required to maintain good health and have economic independence;

b) Vitality, as young women and girls adopt health-seeking behaviours, including accessing health services when needed; and

c) Belonging, as women feel that they are able to achieve their objectives through access to services in their own communities.

THE EVALUATION

IN THIS REPORT, WE PRESENT A BASELINE ASSESSMENT OF THE INDICATORS THAT ARE EXPECTED TO CHANGE AS A RESULT OF THE PROGRAMME (IMPACT), AND ASSESS THE STRENGTHS AND WEAKNESSES OF THE PROGRAMME DESIGN (RELEVANCE). THE EVALUATION TAKES A THEORY-BASED APPROACH AND USES MIXED METHODS. A THEORY-BASED APPROACH MAKES EXPLICIT USE OF THE THEORY OF CHANGE (TOC) TO DRAW CONCLUSIONS ABOUT WHETHER AND HOW AN INTERVENTION CONTRIBUTED TO THE OBSERVED RESULTS. THE EVALUATION USES MIXED METHODS IN THAT IT EMPLOYS BOTH QUANTITATIVE RESEARCH AND QUALITATIVE RESEARCH.

At endline, it is expected that a further household survey will be implemented that targets the same respondents who were interviewed during the baseline round of research. Statistical analysis will be used to determine whether there has been a change in the main outcome indicators targeted by the programme, and whether this change is likely to have been caused by the programme.

The quantitative component of the evaluation consists of a survey with 1,002 women aged 15-29. The sample for the survey was drawn in such a way that it is representative of Bumb'INGOMSO's key target population, that is young women aged 15 – 29 living in the 18 wards targeted by the programme. The qualitative component of the evaluation comprises a combination of focus group discussions (FGDs) with young women and men, in-depth interviews (IDIs) with young women and key informant interviews (KIIs) with key individuals in the communities, who are likely to have in-depth information about the lives of young people in the communities (e.g. youth leaders). A total of 52 FGDs, eight IDIs and eight KIIs were conducted.

BASELINE EVALUATION FINDINGS

CREATING REAL OPPORTUNITIES FOR YOUNG WOMEN

BUMB'INGOMSO AIMS TO IMPROVE ACCESS TO OPPORTUNITIES FOR YOUNG WOMEN IN THE 18 WARDS TARGETED BY THE PROGRAMME. THE PROGRAMME ASSUMES THAT THIS WILL RESULT IN A FEELING THAT THESE OPPORTUNITIES ARE REAL, BECAUSE THEY ARE NOW AVAILABLE, ACCESSIBLE AND ULTIMATELY ACHIEVABLE.

Physical access to schools or other educational institutions appears high, with 86% of 15-19 year olds and 49% of 20-24 year olds enrolled in school or other educational institutions. Low matriculation rates and poor grades, however, pose barriers to young women being able to pursue further education and training, or employment opportunities. Less than half of respondents aged 20 – 29 have successfully completed matric. The reasons for the low marks are likely varied, but include 'supply side' issues, where, for example, teachers do not care enough, are absent from class often, and in some cases make young women uncomfortable by harassing them. Young women also cite a lack of study materials at schools (textbooks) and limited support at home with homework.

There are also 'demand side' barriers to passing and completing matric linked to the social, cultural and economic factors. There is a lack of social and peer support for those who fall pregnant while still in school, and they are often are stigmatised and do not complete school post pregnancy. Harmful substances are easily available, and young women (and men) sometimes miss school or do not perform well in school due to substance abuse. There are financial constraints too, where the costs of fees, uniform and meals prohibit respondents from attending and completing school. Lastly, one of the commonly cited reasons for not completing school was the disillusionment about completing school, because employment opportunities are scarce even for those who have completed matric and gone on to secure higher level of qualifications such as the National Senior Certificate.

Employment levels are very low in the wards visited and many young women find it very difficult to transition to employment with only 32% of 25-29 year olds employed. Part of this is explained by the low education levels as described above. The rest is explained by various socio economic factors, the main ones of which are the following. First, employment opportunities are generally limited in BCMM and the metro has higher unemployment than all the other metros in South Africa. Second, information on the employment opportunities is scarce – 46% do not know where to access information on opportunities. Third, personal and social networks strongly predict to employment – 43% of all women in employment identify friends/relatives as the source of information on where to find jobs.

Physical access to health services appears good and most young women (99%) visit a formal health facility as the point of first call. The quantitative survey reported high levels of user satisfaction among those who went to a facility, although respondents in the focus group discussions (FGDs) often described the service they received as poor, citing long waiting times and unavailability of medication. For those that were dissatisfied with their last visit to a public health facility (14% of the sample, or 140 women), long waiting times (58%), uncaring or rude staff (43%) and unavailability of medication (29%) were reported to be the reason. When asked about sexual and reproductive health services in particular, respondents in the FGDs expressed that there is stigma attached to seeking contraceptives and testing for HIV.

Findings from the quantitative survey suggest that there is a moderate level of trust in the police. On a five-point scale, the average level of trust in the police is 3.25. In other words, about half of the respondents agreed or strongly agreed that they trust the police, that the police provide a service when the community needs it, and that the police treat people with respect. The other half of respondents either disagreed, strongly disagreed, or felt neutral about these statements. However, when asked more specifically about how the police responds to incidents, respondents in the qualitative interviews and FGDs expressed concerns about the fairness and efficacy of the police's response, particularly with regards to incidents of intimate partner violence (IPV). Respondents reported they felt that the police were slow and selective in their response, often arriving at the scene hours later or even only the following day. With regards to IPV, both young men and young women felt that the South African Police Service (SAPS) did not take such reports seriously, and they did not trust the police to keep their reports confidential.

Rates of reporting experiences of IPV to the police were low. Twenty percent (20%) of women who had experienced violence in the last 12 months reported the incident to the police, while the vast majority (73%) did not seek help from any official institution. Reasons for not reporting included the normalisation of violence, where acts of violence towards young women, especially in relationships were considered normal or 'not serious' (41%). In other cases, violence was also considered a sign of love, likely as a coping mechanism. Respondents also talked of a sense of shame associated with abuse, therefore only sharing experiences of abuse with a smaller group of friends, and indeed about 60% of those that experienced violence did speak about experiences with friends or family.

CREATING IMMINENT OPPORTUNITIES FOR YOUNG WOMEN

The concept of 'real opportunities' refers to the programme's assumption that young women have a sense that opportunities are available to them, accessible by them, and, in the case of education and employment opportunities, achievable even if young women have not yet accessed them. The evaluation conducted in-depth interviews (IDIs) to understand the motivators for young women. Through IDIs, we establish that identity is vulnerable to shocks; shocks defined as the factors that may drastically change the circumstances under which young women live, the opportunities they have access to, and the risks they are exposed to. Three of the women in the IDIs had all experienced shocks in life – drastic reduction in family income due to the breadwinner in the family losing a job, going to prison, losing a job, losing a parent, among others. These women identify themselves differently before the shock and after the shock. Their identity is also affected by what they thought they could achieve in life going forward, and their ability to set boundaries on what they think could be damaging and negative consequences.

Our conclusion is that young women's sense of identity is important, as it affects their agency. In this programme setting, identity appears vulnerable to shocks that appear to occur every so often. These all affect how young women see themselves.

ONLY **44%**
OF YOUNG WOMEN BELIEVE IN COMMUNITY SUPPORT TO REACH A COMMON GOAL

THE SOCIAL FABRIC IN THE PROGRAMME'S TARGET COMMUNITIES CAN BE DESCRIBED AS WEAK AND GETTING WORSE – ONLY 44% BELIEVE IN COMMUNITY SUPPORT TO REACH A COMMON GOAL. WHEN WE EXPLORED WHY, SOME OF THE FINDINGS WERE THE FOLLOWING:

- Some young women feel that not only is the community not supportive, in cases it actually actively sabotages those attempting to improve their lives by spreading (bad) rumours about them, stopping to talk to them, avoiding their businesses, reducing/eliminating financial support;
- Friendships appear to be characterised by peer pressure rather than trust or support, and a perception that there were hardly any 'genuine' friendships in many of these communities is rife; and
- Dating is associated with women's sense of worth and belonging, rather than companionship, affection and support.

However, many appear to have at least one confidante to whom they can talk about sensitive topics such as pressure to have sex, relationships, HIV and violence in relationships. Further, although many stressed the importance of belonging to satisfy expectations of friends, they also were able to isolate themselves from networks or friendships they thought were harmful. Our conclusion is that a leadership network can fulfil a needed role in providing young women with a positive sense of belonging, where like-minded young women can support each other.

Among young women, the sense of 'purpose' was largely influenced by sex and age. When asked what they could do if they were president for a day and could change things, young women tended to be focused on jobs or activities that would improve their communities such as, to become a psychologist, a social worker, lawyer, a tv presenter to focus on programmes with subjects that affect children. We interpret this to be as a clear an indication by young women of some of the issues that affect them the most – social services and support for them and their children.

Young men on the other hand were focused on more personal objectives and careers, e.g. becoming a lawyer, a pilot, policeman. While these professions are not necessarily different in all respects to those identified by young women, on the balance it is clear that young women prioritise improving their communities over themselves.

Across the age groups, sense of purpose was higher among the younger, than the older women. Older (23-29) women in the sample appeared to have given up on their dreams, most often speaking of them in past tense "I wanted to be a lawyer", "I wanted to be a police officer"; compared to younger women (15 - 18, for example who speak of their ambitions and purpose more in the presence "I want to be a tour guide"; "I want to be a chartered accountant". Some of this can be understood in the context of the extent of difficulty young women have in transitioning from school to employment. Further, this difficulty in meeting their goals increases their vulnerability, An opportunity to get a tertiary education, for example (normally a good thing) is associated with the likelihood of exploitation if the young woman does not have enough money to fend for herself adequately at school.

Qualitative findings point to the fact that, although there is an intention to engage in positive activities, young women perceive these opportunities as inaccessible or non-existent. Recreational opportunities are not easily accessible and the lack of appealing activities strongly influences young women to develop a sense of hopelessness. Many report being bored most of the time. This lack of recreational activities and general sense of boredom leads some women to engage in negative behaviours, such as alcohol and drug use. Boredom seems to have created a vicious cycle where boredom and idleness lead to a sense of frustration because there is nothing (or very little) for young women to do in their communities.

ONLY **29%**
OF FEMALE RESPONDENTS HAVE COMPREHENSIVE KNOWLEDGE OF **HIV**

GENDER RELATIONS, SEXUAL BEHAVIOUR AND VIOLENCE IN BCMM

Only 29% of female respondents have comprehensive knowledge of HIV, defined as knowing the major ways of preventing HIV and rejecting common misconceptions about HIV transmission. This is even lower among those who did not complete high school and those who are poorer. This finding is partly explained by the proportion of those with misconceptions about HIV where for example, 42% of young women, believe HIV can be spread by mosquito bites and about 30% believe it can be spread by witchcraft. This is an important finding. If young believe that HIV infection can be as a result of factors outside their control, people may be less likely to engage in safe sex practices to prevent HIV.

Seventy one percent (71%) of all respondents report having tested for HIV in the past 12 months and receiving the results for the test. 15-19 year olds, the poorer among those that that never have sex were less likely to have tested for HIV. Among those who never tested, 31% did not test because 'they did not believe they have HIV'.

Only 5% of respondents reported having sex before the age of 15. Debate in FGDs suggests that some of these are having sex with men much older than themselves. A third of respondents have partners more than 5 years older while more than half the sexually active respondents did not use condoms consistently in the past year. It appears low condom use is not due to access to condoms, but rather, inconsistent use. Condoms are not used consistently because of a number of reasons, including a perception that sex is more enjoyable without condoms, because young women and men are under the influence of drugs and alcohol when they have sex and sometimes because of abuse, where young women have sex when they are not fully in control of the situation.

About 14% of the sample reports having multiple partners, with women 20-24 years more likely to report multiple sexual partners in the past year. Those reporting multiple partners are also more likely to report inconsistent condom use. Reasons for multiple partners often included a transactional element – receiving money for gifts and for drinks. Only 2% reported that they were engaged in transactional sex, although this appears to specifically refer to incidences where money was directly exchanged for sex. There are blurry lines around what is and what is not transactional sex, but women describe a range of exchanges after which sex is 'expected to happen' including being bought drinks at the tavern during the night.

In multivariate analysis, age, employment status and drug abuse influences sexual behaviour, defined by as having multiple partners in the past year. 15-19 year olds have the lowest reports of multiple partners, while 20-24 year olds have the highest. Those employed are less likely to report having multiple partners while those who drink more than 3 units of alcohol a week or take drugs are more likely to have many partners. There was no effect of school enrolment on multiple partners.

There are gendered views on practising safe sex. Male partners may not want to use condoms and young women are not always able to insist on condoms. Sometimes this is explained by power relations and belonging – not doing what the partner wants may lead to them leaving the young woman, which is not preferable for the young woman. Other times by situational risk – a male partner may chase you out of his home if you insist on condoms and if this happens at night, you may run the risk of violent crime. Some women also exercise agency, making sure their partners get tested or insisting on condom use.

Young women describe their communities as unsafe and the risk of experiencing crime is very high. Approximately 23% of young women have experienced physical IPV and among these, younger women 15-19 years and the less poor are less likely to have experienced violence. Violence from partners is normalised, often misconstrued for love or affection, or as deserved. Further, 19% have experienced emotional violence while 7% have experienced sexual violence.

RELATIVE RISK PERCEPTION AND BEHAVIOURAL TRADE-OFFS WITH REGARD TO RISKS

When asked to rank in order of severity, the risks young women face in their community, violence, is the most significant risk they face. Within this risk domain, rape is cited as the most severe, followed by violent crime, physical abuse, verbal abuse and abuse by blessers, in that order. Financial risks are the next most severe risk domain reported by young women, and within this broad category, financial risk due to unemployment ranked the highest, followed by not having an education, poverty and corruption. Health risks ranked third, with pregnancy being the highest, followed by HIV. It is intriguing to note that, on the balance, young women considered the health risks from falling pregnant more severe than contracting HIV. Social risks ranked fourth, and within these, not fitting in, peer pressure and boredom were the specific risks they identified.

Young women in the programme communities do make various trade-offs that place them at risk, particularly when it comes to social risks. For example, to increase their sense of belonging, they strengthen ties with peers through engaging in similar activities with those peers (peer pressure) which may include binge drinking or taking drugs. Young women intimated that, again as an example, when faced with a risk of not fitting in or pregnancy, they weigh the risk of not fitting in more heavily. Young women also make trade-offs to avoid financial risks. In relationships they consider the 'provider' dimension of relationships over the health (non-violent) relationships, some of which leads to relationships with blessers, etc. Linked to these 'provider' relationships, or being with an intimate partner comes a risk of violence for young women and they also make trade-offs to avoid violence. In FGDs, not using condoms, for example, is one way to avoid violence in relationships, in the case where the partner insists on not using condoms.

KEY CONCLUSIONS

EMPLOYMENT AND EDUCATION OPPORTUNITIES POST SCHOOL ARE SCARCE, AND NOT BEING EMPLOYED OR IN EDUCATION ARE KEY FACTORS ASSOCIATED WITH NEGATIVE BEHAVIOURS SUCH AS TAKING DRUGS OR ABUSING ALCOHOL. Young women who are unemployed and not in school are bored and often lack a sense of purpose. Idleness increases the likelihood of engaging in coping mechanisms such as taking drugs and alcohol abuse, and women who engage in these are more likely to engage in sexually risky behaviour.

BEING ACCEPTED IN ONE'S COMMUNITY (BELONGING) IS INCREDIBLY IMPORTANT - for young women to the extent that they will often engage in negative or risky behaviours to achieve this sense of belonging. First, young women do not make use of certain services (e.g. SRH services) because of stigma and fear of judgement (related to support mechanisms). Second, young women are afraid to stand out or 'be better' because they think that this will not be supported or will in fact be actively sabotaged (related to imminent opportunities). Third, young women will choose risky alternatives (unsafe sex, staying in a violent relationships) if that means being accepted by their community (related to relative risk trade-offs).

YOUNG WOMEN HAVE GOOD KNOWLEDGE OF SAFE SEX, BUT LACK FULLY COMPREHENSIVE KNOWLEDGE OF HIV. While most young women are aware of how to practise safe sex, few young women have comprehensive knowledge about HIV. In particular, young women believe some of the common myths around the spread of HIV, e.g. that it can be spread through witchcraft or through getting bitten by a mosquito. If young women continue to have misconceptions that there are other external factors that may lead to them acquiring HIV, i.e. that avoiding HIV infection is out of their control, they may not prioritise sexual behaviour practices that prevent HIV, as they feel they may become infected anyway.

INTIMATE PARTNER VIOLENCE (IPV) AS WELL AS CONTROLLING BEHAVIOUR IN RELATIONSHIPS IS PREVALENT AND YOUNG WOMEN DO NOT HAVE ENOUGH SUPPORT FROM THEIR COMMUNITIES AND FROM ESTABLISHED SUPPORT STRUCTURES TO REPORT THESE INCIDENTS AND SEEK HELP. Young women experience high rates of violence within relationships and it is often their partners that determine whether sex is safe. There are also many situations where sex is expected of young women. In many of these cases where young women would want to have safe sex or no sex, they face the risk of violence or of the relationship ending. Further, reporting IPV to the police is not always an options young women feel they have, due to limitations in the support offered by the police including, for example, being encouraged by the police to talk things through with their partners.

YOUNG WOMEN HAVE AGENCY IN MANY WAYS, BUT THEIR AGENCY IS CONSTRAINED BY MANY STRUCTURAL FACTORS. First, most attend school and want to engage in activities that will improve their lives, but in the case of education and employment opportunities, many fail to find opportunities that are relevant for them. In their communities, young women are also aware of the services they need, e.g. sexual and reproductive health (SRH) services and policing services but they face stigma and sometimes poor quality services when they access these services. They also make risky choices when it comes to sex and partners because they know that the alternative choices are even riskier for them.

STRENGTHS OF THE PROGRAMME

THE PROGRAMME HAS IDENTIFIED SOME OF THE KEY CONSTRAINTS THAT PREVENT YOUNG WOMEN FROM MAKING RISKY CHOICES, IN PARTICULAR, LACK OF EDUCATION (NO MATRIC OR POOR MARKS) AND EMPLOYMENT OPPORTUNITIES, AMONGST OTHERS. YOUNG WOMEN FACE BARRIERS IN ACCESSING SERVICES AND OFTEN, WHEN THEY DO HAVE ACCESS TO SOME OF THESE SERVICES, THE QUALITY OR NATURE OF THE SUPPORT THEY RECEIVE IS NOT ADEQUATE AND DOES NOT MAINTAIN THEIR CONFIDENCE THAT THEY MAY BE ABLE TO RELY ON THE SUPPORT MECHANISMS. THE PROGRAMME'S APPROACH TO IMPROVE THE QUALITY OF AND ACCESS TO THESE SERVICES THEREFORE ADDRESSES A KEY CONSTRAINT FOR MANY YOUNG WOMEN.

Young women's sense of motivators are low, as anticipated by the programme. While there are some differences by age (with younger women likely to have a greater sense of purpose than older women, for example) on the balance, young women have a low or negative sense of the motivators, e.g. a sense of belonging closely associated with having a boyfriend, or that life and opportunities outside BCMM was better or low vitality due to lack of education, employment and recreational activities.

Gender Based Violence (GBV) and IPV are key contextual factors that influence young women's actions, especially in relation to accessing services and the agency young women have in relationships. Community support for young women to avoid GBV and IPV in relationships is very limited and yet these have a direct bearing on young women's sexual behaviour. The programme's thrust to improve community perceptions around these, and the quality of support young women who experience GBV and IPV should have, is therefore aligned with the objective to increase agency among young women in order to make them less likely to make trade-offs that place them at risk.

The findings also support the TOC, in that where young women perceive a risk to be more severe, they are less likely to engage in the activity that exposes them to the risk. The programme rightly realises that considering risks that young women face in isolation therefore does not help better understand how young women make decisions.

The programme also realises that community perceptions are a key element in assisting young women make choices that do not place them at elevated HIV risk. Community perceptions affect the expectations of men in relationships, those of young women and the also the support young women have in the community. They thus shape the environment in which young women make choices around safer sex, but also more generally around the actions they take (or do not take) to belong.

There are therefore multiple strong points for the programme. Bumb'INGOMSO is a holistic programme that targets various facets that influence young women's lives in BCMM and ultimately HIV risk. Overall, this baseline evaluation finds the theory of change (TOC) for the programme to be plausible and the programme relevant.

POTENTIAL WEAKNESSES OF THE PROGRAMME

WITH THE FOCUS BEING ON YOUNG WOMEN, IT IS UNCLEAR HOW THE BUMB'INGOMSO PROGRAMME WILL BE ABLE TO ADDRESS COMMUNITY PERCEPTIONS MORE BROADLY. FOR EXAMPLE, THE LEADERSHIP NETWORK IS LIKELY TO BUILD SELF-CONFIDENCE AND LEADERSHIP SKILLS, BRING YOUNG WOMEN TOGETHER WITH PEERS WHO CAN ACT AS A POSITIVE INFLUENCE AND SUPPORT NETWORK, PROVIDE ACCESS TO OPPORTUNITIES – BUT TO WHAT EXTENT WILL YOUNG WOMEN BE ABLE TO USE THESE SKILLS, OR TO WHAT EXTENT WILL YOUNG WOMEN REALLY BE ABLE TO CHANGE THEIR PERCEPTIONS OF THEMSELVES AND OF AVAILABLE OPPORTUNITIES IF THE COMMUNITIES THAT THEY RETURN TO ARE NOT SUPPORTIVE OF THIS.

The general point here is that, what constitutes community perceptions is very broad, and there appears to be a wide range of community perceptions that affect how young women perceive opportunities to be imminent that the programme is not explicitly targeting. This will have the effect of potentially reducing the magnitude of change that may be achieved by the programme.

Lack of education and employment opportunities are a key constraint for young women. While the work-link and psychosocial support elements at the technical and vocational education and training (TVET) colleges will go some way to addressing this, they make not be able to fully alleviate the constraint and an intervention such as Harambee will not be able to tackle this issue comprehensively either. Harambee's intervention is levelled at women that have passed matric, and only less than half of the women in the target communities are likely to meet this requirement. It is then likely that there will be a sizeable number of women that this specific intervention is not able to reach.

The extent to which the programme may be able to influence the sense of motivators for many of the women in the 25-29 age group that are unemployed and not enrolled in education activities may be limited. The unemployment is largely due to the lack of job opportunities in BCMM, and the limited enrolment post school due to these women either having failed or attained low marks in school. The degree to which the programme is able to help these women perceive opportunities as real and imminent, without addressing unemployment in general, might be constrained due to the limited options available to these women. The programme will need to consider how to tackle boredom and lack of purpose amongst a large group of women who have not completed matric or achieved very poor academic results and may therefore turn to negative behaviours including drug and alcohol use.

Findings also show that young women perceive most of the risks they face to be high and to have severe consequences. It appears unlikely then, that the programme will be able to increase the severity young women ascribe to violence or sexual risks, as these are already very high. A change in relative risk seems only feasible in as much as the programme will be able to lower the non-sexual risks, such as violence. Now, given the structural nature of violence as a social problem in BCMM (and elsewhere in South Africa), the extent to which the programme is able to make these communities less violent may be limited.

If young women become more active, come up with ideas of what they want to do (e.g. sports) or other initiatives, there may be a the risk that the programme will not be able to support some of these activities that young women would want to engage in. In a setting where motivators are generally low, inability to maintain the enthusiasm young women may have as a result of the programme may result in a waning of the enthusiasm that would have been generated among young women. Lastly, increased agency and a leadership network may result in young women standing out or being perceived to be better or different in their communities. This evaluation shows that belonging is closely associated with not appearing to be different, therefore, through standing out in their communities by making more positive choices, young women may be exposed to social risks that come with not belonging. It is likely that young women's motivators will change faster than community perceptions in support of these will change, possibly placing these young women at the risk of being excluded or sabotaged by community members.

RECOMMENDATIONS

THE BASELINE EVALUATION RECOMMENDS THE FOLLOWING:

1. THE PROGRAMME SHOULD CONSIDER MORE OPTIONS FOR ENGAGING COMMUNITIES MORE BROADLY TO CHANGE COMMUNITY PERCEPTIONS. This includes working more closely with men, and in this regard, the following options can be pursued:

a) The programme could expand work with key male influencers in the communities. There should be broader membership to the programme's activities in communities that can include community leaders, tavern owners, church leaders and ward committee members;
b) Bumb'INGOMSO may identify positive male role models in these communities and actively invite them to the community mobilisation activities. These men can be part of the support mechanisms for young women, including, for example, through ensuring that they understand the referral protocols when dealing with GBV or IPV victims;
c) The programme should continue support groups of men who struggle with particular social issues that make them a higher risk for women that may live with them or associate with them, such as violence and substance and alcohol abuse. The findings thus support the already launched higher risk group support for men; and
d) The programme can include young men in the communication and materials that the programme disseminates.

2. BUMB'INGOMSO SHOULD INTEGRATE THE LEADERSHIP NETWORK INTO COMMUNITIES AS MUCH AS POSSIBLE.

3. TO INCLUDE:

a) providing comprehensive information about HIV prevention, including dispelling common myths; and
b) working to reduce the stigma associated with SRH services in particular, and making sure these are private, confidential and of high quality.

4. STRENGTHENING THE SYNERGIES ACROSS THE DIFFERENT PROGRAMME INTERVENTIONS WILL BE KEY TO ACHIEVE THE OVERALL PROGRAMME GOALS. Some ways to enable the programme components work together better may include the following:

a) Harambee can work with other employment programmes e.g. YES and EPWP more directly;
b) The leadership network can work with Masimanyane to enhance communication on BCC, such as referral protocols and messaging;
c) SPF can also work with Beyond Zero to communicate effectively to young women the changes at health facilities as a result of the health services intervention; and
d) Other synergies will include ensuring that all the interventions convey common messages, have some common materials easily identifiable across the implementing partners (such as GBV referral protocols).

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LIST OF ABBREVIATIONS

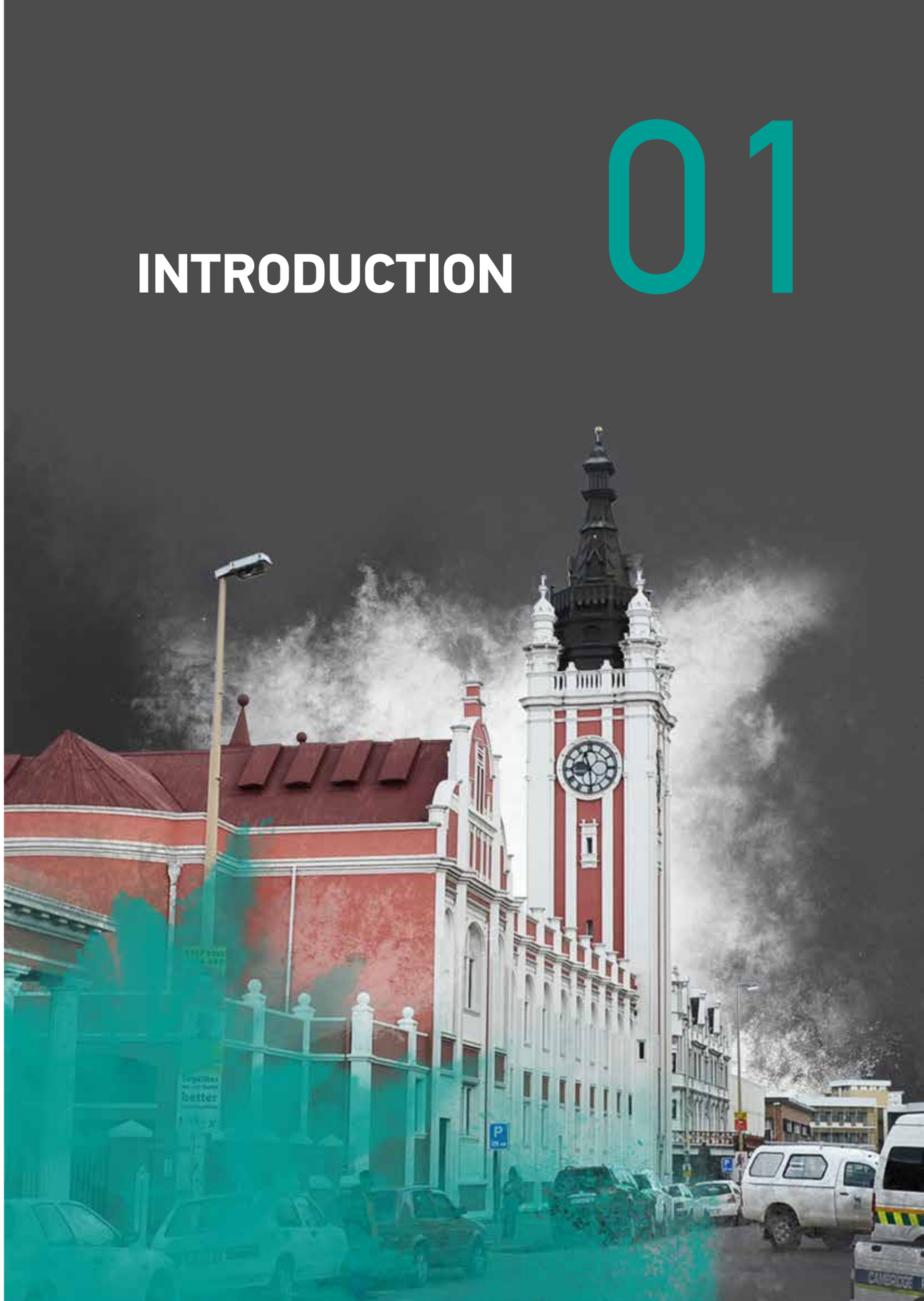
BCMM	Buffalo City Metropolitan Municipality
CAPI	Computer-assisted personal interviewing
DOSPERT	Domain-specific risk-taking
EAs	Enumeration areas
ERC	Ethical Review Committee
EPWP	Expanded Public Works Programme
FGDs	Focus group discussions
GBV	Gender-based violence
GPs	General practitioners
IDIs	In-depth interviews
IPV	Intimate partner violence
KIIs	Key informant interviews
NDOH	National Department of Health
NEET	Not in employment, education, or training
NSFAS	National Student Financial Aid Scheme
OPM	Oxford Policy Management
PLA	Participatory learning and action
PMT	Proxy means test
PPS	Probability proportional to size
PSU	Primary sampling unit
QLFS	Quarterly Labour Force Survey
SABSSM	South African National HIV Prevalence Behaviour and Communications Survey
SAPS	South African Police Service
SPF	Small Projects Foundation
SRH	Sexual and reproductive health
SRS	Simple random sampling
STI	Sexually transmitted infection
TBE	Theory-based evaluation
TOC	Theory of change
TVET	Technical and Vocational Education and Training
WSW	Women in Sex Work
YES	Youth Employment Service
ZAR	South African Rand

GLOSSARY OF TERMS

Physical violence	Refers to the intentional use of physical force that has the potential to cause death, disability, or any type of harm. Types of physical violence include scratching, pushing, throwing, choking, burning, the use of restraints against a person, and the use of a weapon.[2]
Emotional/psychological violence	Involves threats of violence or harm; stalking; emotional abuse, such as verbal attacks and humiliations; and attacks against a person's self-worth or role as a partner, parent, friend, or community member.[3]
Sexual violence	Encompasses any sexual act or attempt to obtain a sexual act, unwanted sexual comments or advances, or acts directed against a person's sexuality using coercion. As stated by the World Health Organization, coercion can cover a spectrum of degrees of force, from physical to psychological intimidation and threats. Sexual violence can be exerted by any person, regardless of their relationship to the victim.[4]
Gender-based violence (GBV)	This is used to refer to any act of violence that occurs 'as a result of the normative role expectations associated with each gender, along with the unequal power relations between the two genders, within the context of a specific society.'[5] Thus, GBV includes physical, emotional/psychological and sexual violence, and it is an umbrella term also encompassing intimate partner violence.
Intimate partner violence (IPV)	Refers to the physical, sexual, and emotional aggression by a current or former intimate partner. As defined by the Centers for Disease Control and Prevention, intimate partners are individuals with whom one has a close personal relationship.[6] The term 'domestic violence' has traditionally been used to describe partner violence. However, that term more largely encompasses violence perpetrated by any member towards any other member of a household. Thus, we have chosen the term IPV to indicate violence suffered by a partner, in both public and private spaces. It is important to note that although IPV is most commonly experienced by women at the hands of male perpetrators, it can also be experienced in same-sex relationships and by men in heterosexual relationships.
HIV incidence	This is the number of new infections over a specified time period, usually a year.
'Blesser'	A blesser is a man with disposable income that he uses in exchange for companionship, friendship, or sex, typically with women younger than he is. To our knowledge there is no official definition of what a blesser is (or is not) and the term is used more in popular culture and the media, than in peer reviewed research, but the phenomenon is very similar to the 'sugar daddy' phenomenon.

[2] CDC (2017) available at http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html
[3] UNAIDS (2005) available at http://www.un.org/womenwatch/daw/egm/vaw-stat-2005/docs/expert-papers/Kishor.pdf
[4] WHO (2014) available at http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf
[5] Bloom, Shelah (2008) "Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators" available at https://www.measureevaluation.org/resources/publications/ms-08-30
[6] CDC (2017) available at https://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html

01 INTRODUCTION



THE BUMB'INGOMSO PROGRAMME IS A CROSS-SECTORAL INTERVENTION DIRECTED BY THE DG MURRAY TRUST AND IMPLEMENTED BY ITS OPERATIONAL PARTNERS IN 18 WARDS ACROSS BUFFALO CITY METROPOLITAN MUNICIPALITY (BCMM). THE OVERALL AIM OF THE PROGRAMME IS TO REDUCE THE INCIDENCE OF HIV [7] AMONG VULNERABLE GROUPS IN THE MUNICIPALITY, PARTICULARLY YOUNG WOMEN AGED 15–29, THROUGH A SET OF COMMUNITY-BASED INTERVENTIONS THAT INFLUENCE THE CHOICES AVAILABLE TO YOUNG PEOPLE.

THE PROGRAMME AIMS TO DECREASE THE NUMBER OF NEW HIV INFECTIONS IN BCMM BY:

- Changing the way young women perceive themselves and the options available to them, as well as how communities perceive young women;
- Empowering young women and girls in BCMM so that they are less likely to make trade-offs that place them at risk;
- Reducing the occurrence of GBV and ensuring that women are free to make personal decisions that affect their well-being, such as the partners they decide to be with and health-seeking behaviour; and
- Reducing the rate at which HIV is transmitted among high-risk groups, such as women in sex work (WSW) and men with genital ulcers.

THE BUMB'INGOMSO PROGRAMME CONSISTS OF FIVE INTEGRATED INTERVENTIONS, EACH WITH A DEDICATED AREA OF FOCUS, WHICH ARE IMPLEMENTED BY DIFFERENT PARTNERS:

1. A behaviour change component to disseminate behaviour change messages to in-school and out-of-school young women, and to recruit some of them into a Leadership Network, implemented by the Small Projects Foundation (SPF);

2. A health services intervention to strengthen the quality and youth-friendliness of health services in BCMM, implemented by Beyond Zero;

3. An intervention to reduce the incidence of GBV and empower young women and girls, implemented by Masimanyane;

4. An intervention to expand access to economic opportunities for young women, implemented by Harambee;

The programme also includes other education-support and worklink programmes, namely: psychosocial support at universities (implemented by Rural Education Access Programme (REAP)); psychosocial support at TVET colleges (implemented by Masibumbane) and worklink programmes at TVET colleges (implemented by Dreamworker); and

5. A focus on high risk groups, including men. This focus area includes programmes aimed at sex workers, men recently released from correctional services, and men who have sex with men.

THE OVERALL OBJECTIVE OF THESE PROGRAMMES IS TO ACHIEVE LARGE ENOUGH CHANGE IN THE RESPONSE AND SUPPORT ENVIRONMENT TO INFLUENCE A CHANGE IN:

- Agency, as young women and girls feel they are able to access the services required to maintain good health and have economic independence;
- Vitality, as young women and girls adopt health-seeking behaviours, including accessing health services when needed; and
- Belonging, as women feel that they are able to achieve their objectives through access to services in their own communities.

The main activities of each implementing partner and how these activities are linked to the overall programme objective are outlined briefly in the section below, and described in more detail in Annex A.

The programme is funded by the German Government through its development bank, KfW and the DG Murray Trust. Implementation started in 2016 and is expected to run for at least three years. OPM was contracted to conduct a baseline evaluation for the programme. This report presents the findings from the evaluation study, which was conducted between March 2017 and November 2017.

[7] The number of new HIV infections in a population over a period of time

1.1 PROGRAMME THEORY OF CHANGE

The theory of change (TOC), summarised in Figure 1, was developed through an iterative and participatory process that ensured careful reflection and validation by the implementing stakeholders, including the Bumb'INGOMSO programme, DG Murray Trust, and the initial four implementing partners. In addition, qualitative research was conducted in selected communities to further explore whether initial assumptions made by the programme reflected challenges on the ground. The OPM team shared these findings with the stakeholders developing the TOC and facilitated discussions around how these findings could be used to further strengthen or challenge the assumptions made in the TOC.

THE CORE PART OF THE BUMB'INGOMSO PROGRAMME (REPRESENTED BY THE YELLOW, GREEN, AND PURPLE BOXES IN THE FIGURE) IS FOUNDED ON THE PREMISE THAT THE HIGH RATE OF NEW HIV INFECTIONS AMONG YOUNG WOMEN IN BCMM IS DRIVEN, TO A SIGNIFICANT EXTENT, BY BEHAVIOURS THAT ARE MOTIVATED BY THE LIMITED PERSONAL AND SOCIAL CHOICES AVAILABLE TO YOUNG WOMEN AROUND KEY ASPECTS OF THEIR LIVES, SUCH AS EDUCATION, EMPLOYMENT, PARTNERSHIPS AND SEX, ETC.

In this context of limited choice, many of the decisions young women have to make to improve their wellness [8] involve trade-offs between risky alternatives.

The limited environment is further exacerbated by elevated levels of social disadvantage, with high levels of crime, poverty, HIV, GBV, etc. as is the case with the programme's target communities.

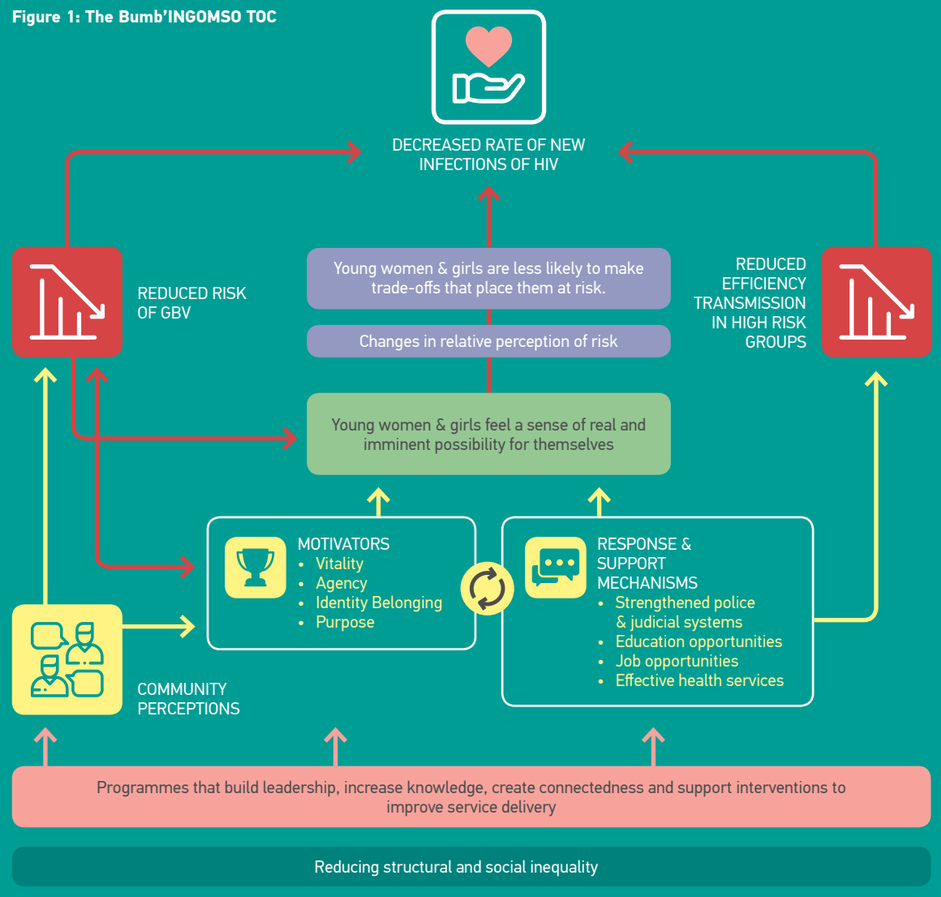
To illustrate this with an example, young women in BCMM could take different actions in order to increase community acceptance of them, and in doing so improve their wellbeing. One such action could be to get an education. Another could be to date or be with a specific partner, perhaps someone who is in a more desirable financial position.

These choices are limited, however, given the perceived and real scarcity of educational opportunities, as well as the perceived low social acceptance of getting an education in BCMM communities. Thus, the reward resulting from this choice is low. Further, although the possibility of having a partner is real - i.e. dating is accessible to young women - this choice may have to be evaluated against the risk that the partner is abusive, which may be to the physical [9] and emotional detriment of the young woman. Therefore, if the set of options available to young women remains limited, choices that place them at higher odds of being HIV positive - such as being in an abusive relationship, having unprotected sex, and receiving gifts, money or food in exchange for sex - remain prevalent when young women consider their risk–reward trade-offs in regard to personal choices.

[8] Wellness in this sense is used as a catchall term describing the overall state of 'being well', which consists of various dimensions, including social, emotional, physical, environmental, occupational, intellectual, and spiritual dimensions.

[9] Indeed, young women's health is likely to be compromised as abuse in relationships is related to higher HIV risk in South Africa.

Figure 1: The Bumb'INGOMSO TOC



By increasing the options that young women have with regard to their physical, social, and economic choices, and increasing the perceived reward from behaviour that is also associated with lower HIV odds - such as staying in school, seeking employment, and using protection during sex, young women may re-evaluate the risk-reward trade-offs and become less prone to making decisions that negatively affect their well-being. Specifically, the programme makes the assumption that if a young woman feels that opportunities exist out there and that she has a good or fair chance of realising them, then she is likely to change the choices she makes so as to not jeopardise the likelihood of improving her life.

FOR YOUNG WOMEN TO EVALUATE RISK DIFFERENTLY - I.E. CHANGE THEIR RELATIVE PERCEPTION OF RISK - THE PROGRAMME INTENDS TO TARGET THREE BROAD FACTORS THAT INFLUENCE INDIVIDUAL ASSESSMENT OF RISK:

- The first factor is community perceptions. The assumption here is that communities in BCMM perpetuate perceptions and expectations that are negative or not supportive of young women who want to make positive choices regarding their well-being. Therefore, for young women to make choices that are more positive in their lives, their own communities should be more supportive.
- The second factor relates to how young women see themselves. This perception of self is reflected through five psychosocial motivators (see Box 1 for definitions). These psychosocial motivators govern young women's choices and behaviours and, ultimately, their willingness to adopt risky HIV-related behaviours in the context of other personal hazards. The main assumption the programme makes is that young women's levels of these motivators are currently either low or negative. The programme therefore attempts to improve this set of motivators.
- The third factor relates to the support young women have available in the form of services (such as health, policing, judicial) and their access to opportunities (e.g. economic and education) – collectively termed "response and support mechanisms." The assumption here is that for young women to make choices that place them at less risk of contracting HIV, response and support mechanisms need to provide better support to young women.

MORE SPECIFICALLY, THESE FACTORS AIM TO HAVE THE FOLLOWING INTENDED OUTCOMES:

INTERMEDIARY OUTCOMES:
1. Changes in relative perception of risk;
2. Young women and girls feel a sense of imminent possibility for themselves; and
3. Young women and girls feel there are real possibilities (options available).

FINAL OUTCOMES:
1. Young women and girls are less likely to make trade-offs that place them at risk (behavioural change);
2. Reduced incidence of GBV; and
3. Reduced efficiency transmission in high-risk groups (including WSW and men with genital ulcers).

In short, the programme assumes that by changing community perceptions so that they become more supportive of young women, and improving their personal motivation and how they see themselves, young women will have a stronger sense of imminent possibility – in other words, their perceptions of the opportunities available to them now or in the immediate future will improve. The programme further assumes that by improving the response and support mechanisms available to young women, they will have an increased understanding of real possibilities – the assumption here is that even if a young woman does not herself find a job, or access health services, she has a sense and certainty that the option is there. The programme ultimately believes that, together, a stronger sense of imminent possibility and an increased understanding of real possibilities will lead young women to be less willing to adopt risky HIV-related behaviour. This implicitly assumes that there are strong links between the observed changes in intermediary outcomes (changes in relative perception of risks resulting in young women being less likely to make decisions that place them at risk) and reduced HIV incidence. The assumption here is that, as young women's perceptions of HIV risk change, they will be less likely to make decisions that place them at higher HIV risk (e.g. have unprotected sex, or stay in abusive relationships), and this will result in lower HIV incidence.

BOX 1: DEFINITIONS OF PSYCHOSOCIAL MOTIVATORS

VITALITY is defined as the sense of well-being experienced by an individual. The programme assumes that a young woman in BCMM often does not have a high level of well-being in her life and at times engages in substance abuse, experiences high degrees of boredom, and lacks recreational activities, etc. The programme assumes that a low, or negative, sense of vitality is expressed through low levels of health-seeking behaviour.

AGENCY is defined as a young woman's capacity to make her own choices, which is limited by the environment or her ability to take up the choices.

IDENTITY is defined as a young woman's sense of who she is and how she relates to others, such as partners, peers, parents, and institutions (formal and informal), etc. This includes a young woman's sense of self-worth and sense of potential.

BELONGING 'Positive belonging' is defined both as being part of positive peer and social networks and as having a sense that one belongs in facilities that provide basic services, i.e. a young woman feeling that she has the right to be in a clinic, a school, or a police station, etc.

PURPOSE is loosely defined as goals and aspirations. The programme assumes that a young woman in BCMM often does not feel a strong degree of hope for her future and/or that her goals and aspirations are limited by the environment/social reality in which she lives.

To support its main causal chain, the programme also aims to reduce the incidence of GBV (red box, top), which is a determinant of HIV among women in South Africa.[10] The programme aims to achieve a reduction in GBV incidence by working with the police and judicial systems to improve the support that is offered to young women who experience GBV, and by working with communities and young women to strengthen the image of young women and young women's ability to assert themselves. In addition, the programme also intends to reduce HIV transmission among high-risk groups, namely men with genital ulcers and WSW (red box, bottom). The programme aims to affect these groups through stronger and more effective health services by: 1) making health services more sex worker-friendly; and 2) introducing and training general practitioners (GPs) on syndromic management in order to improve the way in which genital ulcers are cured and not simply 'treated'. A more detailed description of the programme TOC and outline of specific change pathways is presented in Annex C. [11]

1.2 THE LINK BETWEEN RISK TRADE-OFFS AND HIV INCIDENCE

As discussed, the TOC and the programme make an explicit assumption that achievement of intermediary outcomes - changes in risk-reward trade-offs, young women's sense of imminent and real possibility – and final outcomes – behavioural change, reductions in GBV and reductions in transmission amongst high risk groups – translates directly into a reduction in HIV incidence.

While the evaluation seeks to understand the impact the programme has had on these outcomes, it will not measure impact on the final outcome related to a reduction in HIV incidence. While measuring HIV incidence is important, it remains a challenge, both from a technical perspective and from a cost perspective. Traditional surveillance methods (e.g. tracking the number of HIV positive pregnant women at antenatal care sites), require multiple rounds of surveillance over many years in the same population groups, but this is not feasible given the programme's duration. Prospective follow-ups of cohorts of HIV-negative people are able to give direct and more accurate measurements of incidence, but they are expensive and technically challenging to conduct well, and raise ethical issues.

Individual HIV infection can be seen as the result of a complex interplay between a number of factors, some that are in the control of young women (e.g. having multiple partners or not) and others that are not (e.g. a large underlying HIV prevalence rate in the population). These broad groups of factors affect the chances that young women will be exposed to HIV, while their health status will influence whether HIV transmission occurs or not. This distinction between factors that are under an individual's control and those that are not provides the basis for a classification of drivers of the HIV epidemic as structural, behavioural, or biomedical.

Structural drivers are environmental conditions and life circumstances that predispose individuals to behaviour that directly increases the risk of HIV infection. For example, conditions which can negatively influence individuals' behaviour include the cultural context, the home and neighbourhood environments, violence (e.g. racial, physical, sexual, or emotional (e.g. stigma and discrimination), government policies (e.g. economic policies that influence work availability or health policies which influence access to healthcare and public health conditions), and demographic factors (e.g. population migration and mobility or urbanisation). Poverty is also sometimes identified as a structural driver in the sense that it is a proxy for individuals' circumstances, such as unemployment, low socioeconomic status, and low or inadequate education. The programme identifies community perceptions, GBV, and 'response and support mechanisms' as structural factors, and assumes that by improving these, or 'the environment' within which young women live and make choices, the negative influence on their behaviour will be reduced.

Behavioural drivers refer to sexual practices (e.g. using protection or not, sex with many partners or one, age of sexual debut, etc.) that, in principle, are under an individual's control and which, in the context of an HIV epidemic and the circumstances of sexual behaviour, indicate an individual's susceptibility to HIV infection. The programme assumes that individual behaviour is partly or largely influenced by marginal risk–reward trade-offs, and therefore if these risk–reward trade-offs change, young women will be less likely to engage in riskier activities.

Biomedical factors relate to the health status of individuals or populations that influence the probability of infection (e.g. whether a man is circumcised, whether an individual's internal health is compromised by another illness, such as a sexually transmitted infection (STI), or by his/her diet, etc.). Here, the programme assumes that some health services (especially for high-risk populations), particularly syndromic management of STIs, are poor, and that by treating STIs better, HIV transmission involving high-risk groups will be lower.

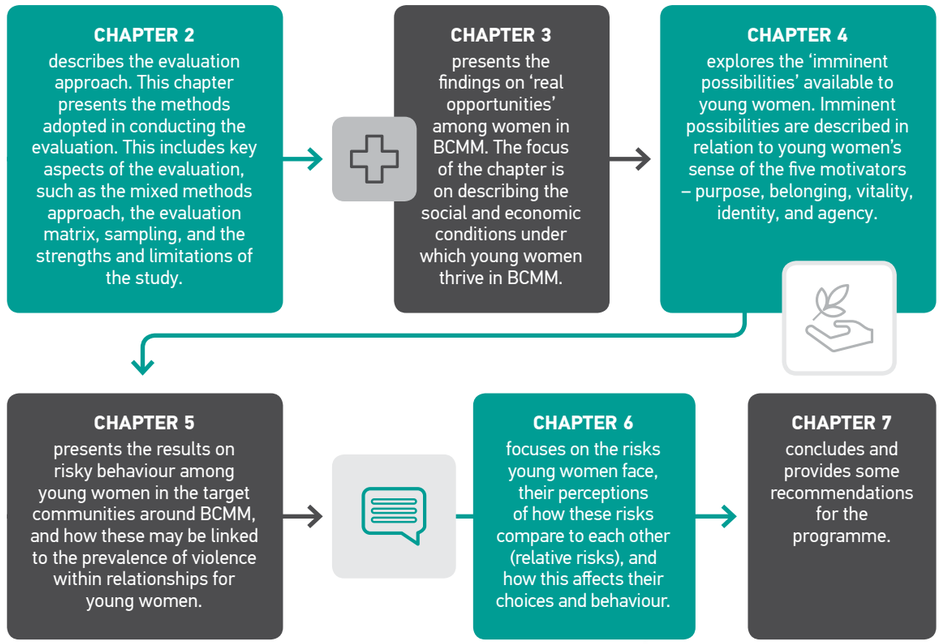
Therefore, while it is not possible for the evaluation to measure impact on HIV incidence, understanding HIV infection as an interplay of factors will allow the evaluation to make a judgment on how likely it is that changes in measurable outcomes (namely risk perception, sexual behaviour, and GBV incidence) will lead to a reduction in HIV incidence. This is further discussed in Chapter 2.

[10] *See for example Dunkle et al. (2014).*

[11] *There is an additional implementation area, (Focus Group 5) which was always part of the design and which is being implemented), namely High Risk Groups, in recognition of the fact that there are population hot spots in HIV transmission. These include programmes aimed at sex workers, men recently released from correctional services, and men who have sex with men*

1.3 STRUCTURE OF THE REPORT

THE REST OF THE REPORT IS STRUCTURED AS FOLLOWS:



02

EVALUATION APPROACH

THIS SECTION OUTLINES THE EVALUATION APPROACH OF THE BUMB'INGOMSO PROGRAMME. IT PROVIDES A ROADMAP FOR THE EVALUATION OF BUMB'INGOMSO IN TERMS OF APPROACH, SCOPE, AND EVALUATION QUESTIONS. THE SECTION IS ORGANISED AS FOLLOWS. SECTION 2.1 PROVIDES OUR OVERALL APPROACH TO THE EVALUATION, DRAWING PARTICULAR ATTENTION TO HOW WE HAVE DEALT WITH THE ABSENCE OF A CLEARLY DEFINED CONTROL GROUP. SECTION 2.2 PRESENTS OUR APPROACH TO MIXING QUANTITATIVE AND QUALITATIVE METHODS. SECTION 2.3 PRESENTS THE EVALUATION MATRIX, WHICH IS OUR TRANSLATION OF THE PROGRAMME TOC INTO A SET OF MEASURABLE THEMES AND INDICATORS THAT WILL ALLOW US TO TRACK THE PROGRESS OF THE BUMB'INGOMSO PROGRAMME IN MEETING ITS OBJECTIVES. SECTIONS 2.4 AND 2.5 DETAIL THE QUANTITATIVE AND QUALITATIVE APPROACHES THAT WILL BE USED FOR THE EVALUATION. SECTION 2.6 DISCUSSES THE RESEARCH ETHICS THAT ARE OBSERVED IN THIS EVALUATION. FINALLY, SECTION 2.7 SETS OUT THE LIMITATIONS OF THE EVALUATION.

2.1 THEORY-BASED EVALUATION

The main challenge in any evaluation is essentially a problem of missing information. In the case of the Bumb'INGOMSO programme we would ideally like to compare the same individuals in two states across time: that is, to compare an individual in a state where she has been exposed to the programme with that same individual in a state where she has not been exposed to the programme. Whilst this is not possible, many evaluations solve this problem by comparing those treated by the programme with those who have not been treated by the programme and using statistical methods to ensure that these groups are comparable.

However, in the context of the Bumb'INGOMSO programme an evaluation including treatment and control groups is not possible. In particular, the programme is being implemented across 18 wards in BCMM, reaching all women in this target population. Therefore, a suitable control group of women could not be identified ex-ante i.e. prior to the rollout of the programme.

In response to this problem the evaluation is a mixed methods theory-based evaluation (TBE). TBE approaches use an explicit TOC to draw conclusions about whether and how an intervention contributed to observed results. Such approaches provide a 'logic of enquiry', which can complement and be used in combination with a range of other evaluation approaches and data collection techniques.

Two key ideas distinguish a TBE from traditional approaches: (1) the influence of context on programme results, and (2) a mechanistic rather than counterfactual approach to determining causality.

First, TBE approaches are characterised by the explicit attention they pay to the context of the intervention. They acknowledge that contextual factors can help an intervention achieve its objectives, or act against it. For example, in an intervention aimed at promoting HIV testing in the population, contextual factors might include the social makeup of the targeted population and the effectiveness of available health services, which can influence how trusting individuals are of the health system and how likely they are of accessing it. These factors are often essential in making causal inferences and need to be part of the evaluation design.

Second, TBE approaches attempt to understand an intervention's contribution to observed results through a mechanistic or process interpretation of causation, rather than determining causation through comparison to a counterfactual. In theory-based approaches, the specific steps in a causal chain – the specific causal mechanisms – are tested. If these can be validated by empirical evidence (whether primary quantitative or qualitative data, or data from secondary sources) then there is a basis for making a causal inference. At the same time, TBE approaches seek to identify and assess any significant contextual factors that may also play a role in the causal chain and thus affect the contribution claim.

2.1.1 MECHANISTIC CAUSATION

It is important to be explicit about what can and cannot be inferred from a TBE. Some impact evaluations enable the evaluator to precisely attribute changes in key indicators to programme activities – in other words, to identify the cause of an effect and estimate quantitatively how much of the effect is due to the programme, i.e. estimate the impact of the programme. Impact in such a case is defined as the difference in the indicator of interest (Y) between those who are exposed to the intervention (Y1) and those who are not exposed to the intervention (Y0). Thus, impact would be defined as Y1 – Y0, with such an impact evaluation tackling the issue of attribution by identifying the counterfactual value of Y (Y0) in a rigorous manner. A TBE will not deliver a definitive attribution of changes in outcomes to the Bumb'INGOMSO programme.

INSTEAD, THEN, THE RELEVANT QUESTION IN THIS TBE BECOMES: *IN LIGHT OF THE MULTIPLE FACTORS INFLUENCING A RESULT, HAS THE BUMB'INGOMSO PROGRAMME MADE A NOTICEABLE CONTRIBUTION TO AN OBSERVED OUTCOME, AND, IF SO, IN WHAT WAY?*

The mechanistic process that will be followed as part of this evaluation is outlined below:

STEP 1
SETTING OUT THE ATTRIBUTION PROBLEM TO BE ADDRESSED

At the outset of the evaluation it was important to: (1) determine what outcomes could reasonably be expected to be influenced by the Bumb'INGOMSO programme, and (2) define other key influencing factors and their significance in relation to the expected outcomes. Throughout the design and formative research phases of the evaluation, we refined the particular attribution problems the evaluation would tackle. The evaluation measures intermediate outcomes, i.e. improvements in options and choices for young women and girls [12] (green boxes in the TOC in Figure 1), and the changes in how women perceive sexual risk and the resulting reduction in their engagement in risky behaviours (purple boxes). The evaluation does not measure the change in HIV incidence, the highest-level intended outcome of the programme, but will assess the evidence to infer whether there could have been a change at this level.

STEP 2
DEVELOP A TOC

The TOC is the key tool of a TBE, as it allows evaluators to explore what the likely contribution of the Bumb'INGOMSO programme is. A TOC explains how the programme is expected to bring about the desired results – the intermediary and final outcomes of the programme.

The TOC for the programme was developed in collaboration with DG Murray Trust and the Bumb'INGOMSO implementers through a series of workshops. This work was further supported by a small piece of qualitative research, which sought to test the TOC developed during the initial workshops – in particular, to challenge some of the assumptions that underpin links in causal chains.

This TOC was then used to develop the evaluation matrix presented in Section 2.3, which provides the full details for: (1) the four hypotheses that this evaluation will assess the Bumb'INGOMSO programme's performance against, (2) the particular assumptions that underpin these hypotheses, and (3) how these will be tracked by the evaluation, as well as the particular indicators that will be used to track progress against programme objectives.

STEP 3
DETERMINING THE EVIDENCE FOR THE PROGRAMME TOC

After developing the TOC, the evaluation sought to test whether the assumptions in it held true. Thus, the focus of the baseline evaluation has been to explore potential results chains, through which we expect the Bumb'INGOMSO programme to lead to expected results. For example, the Harambee programme is expected to provide women with greater access to economic opportunities. This, in turn, is expected to have the following results: (1) lead women to develop a greater sense of real possibility, (2) alter women's perceptions of risks, and (3) encourage them to adopt less risky behaviour. The main focus of the baseline evaluation as it relates to this example is determining whether or not access to economic opportunities is indeed linked to less risky behaviour, proving or disproving the results chain that suggests this in the TOC.

It is important to highlight that one portion of the TOC is intrinsically more difficult to unpack. This relates to the results channel through which motivators affect young women feeling an imminent sense of possibility in their lives. In this case, the evaluation seeks to understand the contribution of the group of motivators to the achievement of increased sense of possibility, given that differentiating between the contributions of each motivator is an unlikely task.

The baseline evaluation also involves conducting an exploration of external factors to understand whether there are other significant factors that may influence women's choices and behaviour, but which are not captured by the TOC. It is expected that the endline evaluation will also explore both the results chains and external factors, additionally making a judgement on whether the programme was implemented as expected.

This will explore implementation of the programme from two perspectives:

1. Fidelity to the original design (i.e. whether there were variations between implementation design and implementation on the ground); and
2. Variations across BCMM. Doing this will help us understand whether the quality of implementation plays a determining role in the achievement (or not) of programme objectives.

[12] *Described as 'real and imminent possibilities' in the TOC.*

2.2 MIXED METHODS APPROACH

The evaluation implements a mixed methods approach combining both primary quantitative and qualitative data collection. The basic rationale behind mixing quantitative and qualitative methods is to optimise on the strengths of each and minimise their weaknesses.[13] Mixing ultimately provides the 'best of both worlds' as combines a depth of understanding with results that are statistically representative of the population of interest.

WE HAVE USED A COMBINATION OF VARIOUS TECHNIQUES TO MIX METHODS THROUGHOUT THE EVALUATION. THESE INCLUDE THE FOLLOWING:

1. **Integrating methodologies for better measurement:** The evaluation matrix presented in Table 1 illustrates how various evaluation questions will be answered using a variety of quantitative and qualitative methods. During data collection, the evaluation team ensured that the best combination of tools was used, recognising that some elements of the evaluation questions would be best answered through qualitative tools, while others would rely solely on quantitative data.
2. **Sequencing information for better analysis:** Careful sequencing of quantitative and qualitative methods allows for each method to build upon the other. In Figure 2, below, we outline the sequencing of the qualitative and quantitative research methods adopted during baseline.

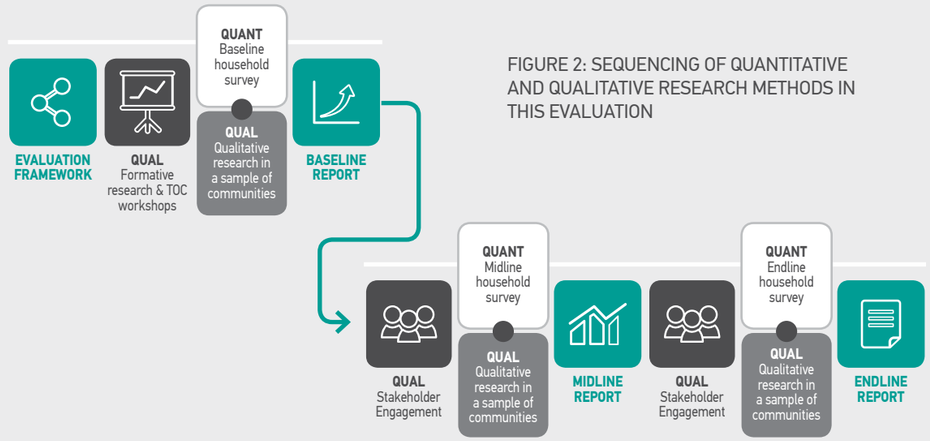


FIGURE 2: SEQUENCING OF QUANTITATIVE AND QUALITATIVE RESEARCH METHODS IN THIS EVALUATION

This demonstrates how a set of formative qualitative research was conducted prior to the roll-out of the main quantitative and qualitative fieldwork at baseline. This 'formative' research was used to support the development of the programme TOC and the assumptions that underpin this TOC, as well as to inform the design of the instruments to be used in the main quantitative and qualitative fieldwork. For future evaluation rounds, we suggest including a small qualitative study at the start of data collection in order to inform the design of qualitative and quantitative tools at that stage.

3. **Triangulation of findings for better action:** Triangulation of findings across multiple sources of information increases the confidence in the robustness of evaluation results. Additionally, it increases the understanding of particular contexts and factors that lead to these results. The evaluation team has thus relied on both quantitative and qualitative data in answering evaluation questions, presenting both where applicable.

[13] *Qualitative research makes it possible to explore in-depth phenomena from the point of view of the subject of study in its natural context. However, findings tend not to be generalisable given the small sample sizes involved. In contrast, quantitative research, through its use of randomised sampling and larger sample sizes, allows for generalisation, though it cannot provide the same depth of study.*

2.3 EVALUATION MATRIX

The focus of the evaluation is on how Bumb'INGOMSO is contributing to changes in young women's choice trade-offs with regard to risky behaviour, rather than the extent to which HIV incidence or GBV are reduced. There are two main reasons for this: (1) measurability and (2) the magnitude of the likely impact.

First, the evaluation does not intend to measure HIV incidence directly (largely due to the costs involved), which means direct changes in incidence cannot be observed. Therefore, to assess impact, the evaluation focuses on those aspects that can be observed – in this case, the change in young women's choice trade-offs with regard to risky behaviour.

Second, we anticipate some of the links between the programme activities and higher-level outcomes, such as reduced incidence of GBV, to be very small – especially over the lifespan of the project. This is because some of these outcomes are driven by stronger social and cultural factors that are more difficult to change, and that can be expected to change slowly, over a longer time period than the project implementation period. The evaluation does not attempt to measure HIV incidence directly, and thus cannot observe the direct changes in HIV incidence.

Considering that the evaluation is currently at the baseline stage, and that key programme features (such as the length of the programme and the scope for midline and endline) are yet to be determined, the set of cause–effect assumptions is likely to be refined following baseline. In addition to setting a baseline for the project, this report also provides a situational analysis for the programme; therefore, in the follow-up midline and endline evaluations, the evaluation matrix and pursuant analysis may be tailored to reflect the programme activities at that stage more accurately. The baseline evaluation is set up to work as a stand-alone situational analysis.

Table 1 presents an overview of the evaluation questions, together with a summary of the sources of evidence for answering the questions. The matrix also lists the hypotheses drawn from each causal chain in the TOC, as well as the key assumptions made by the programme. Questions are presented under each of the following four thematic areas: motivators, response and support mechanisms, relative perception of risk, and behavioural change.

Each hypothesis, TOC pathway, and set of assumptions is explored via a series of research questions, sub-questions, and specific indicators. The evaluation matrix also presents which assumptions are being tested by which specific indicators, and how the data for these indicators are collected, i.e. through the quantitative household survey or the qualitative research.

TABLE 01: EVALUATION MATRIX

HYPOTHESIS 1:

CHANGES TO PSYCHOSOCIAL MOTIVATORS LEAD TO CHANGES IN YOUNG WOMEN'S AND GIRLS' SENSE OF IMMINENT POSSIBILITY FOR THEMSELVES

ASSUMPTIONS:

1. Current levels of motivators are either negative or low
2. Young women's and girls' motivators are influenced by how others perceive and relate to them, and the programme is able to shift community perceptions of young women
3. The way young women and girls perceive and experience violence influences motivators, and the programme is able to reduce incidence of GBV and increase understanding of GBV (including young women's rights and response and support mechanisms)
4. Infrastructure/social/environmental realities influence motivators, and the programme is able to achieve a large enough change to support a change in motivators

SUB-QUESTIONS	INDICATORS	ASSUMPTIONS TESTED	QUALITATIVE/ QUANTITATIVE	INSTRUMENTS
RESEARCH QUESTION: To what extent do psychosocial mediators influence young women's sense of imminent possibility in BCMM?				
[Agency/Belonging] How do women perceive their sense of agency and ability to assert themselves?	Young women's self-reported perceptions of motivators	1, 3, and 4	Qualitative	Focus group discussions (FGDs) on motivators/ opportunities
	Perceived explanations of change in young women's sense of imminent and real opportunities			In-depth interviews (IDIs)
	Perceptions of gender roles (including perceived rights)	1, 2, and 3	Qualitative	FGDs on motivators/ opportunities FGDs on community perceptions Key informant interviews (KIIs)
	Self-efficacy scale (Agency)	1	Quantitative	Household survey
	Use of leisure time (measurement of boredom) (Vitality)	1 and 4	Quantitative	Household survey
[Vitality] How and to what extent do young women engage in health-seeking behaviour?	Do young women feel that they are able to achieve things in life? (Purpose/Agency)	1	Qualitative	FGDs on motivators
[Purpose/agency] What is young women's sense of who they want to be, and how do they view their own role in achieving these goals?	Do women feel that they can overcome barriers to employment/education/services? (Agency/Sense of possibility)	1 and 4	Qualitative	FGDs on motivators
RESEARCH QUESTION: To what extent do community dynamics influence the lives of young women??				
[Identity/belonging] How does the community perceive women, and to what extent does this affect the way women perceive themselves?	Perceptions of gender roles	2	Qualitative	FGDs on motivators/ FGDs on community perceptions
	Perceptions of expectations Community attitudes toward young women Young women's perceptions of community attitudes	2	Qualitative	FGDs on motivators/ opportunities FGDs on community perceptions
	Exploration of vitality (Well-being)	1 and 2	Quantitative/ qualitative	FGDs on motivators/ opportunities FGDs on community perceptions KIIs IDIs Household survey
	Perceived community norms/ social risk	2	Qualitative	FGDs on motivators/ opportunities FGDs on community perceptions
	Perceptions of community support	2	Qualitative	FGDs on motivators/ opportunities KIIs FGDs on community perceptions
	Gender perceptions scale (questions asked of both men and women) (Identity/Belonging)	1 and 2	Quantitative	Household survey

HYPOTHESIS 2:

IMPROVEMENTS IN ACCESS TO ECONOMIC OPPORTUNITIES AND QUALITY AND ACCESS TO RESPONSE AND SUPPORT MECHANISMS LEAD TO CHANGES IN YOUNG WOMEN'S AND GIRLS' SENSE OF REAL POSSIBILITY

ASSUMPTIONS:

TOC pathway: Yellow box on response and support mechanisms --> green box on real possibilities

1. Young women do not see health services as viable services and options when facing health issues or wanting to seek health related advice. The programme will enhance the efficiency of health services (including making them more youth-friendly) so that young women increasingly see health services as viable services and options when facing health issues or wanting to seek health-related advice

2. Young women do not see police and judicial services as viable options when experiencing violence. The programme will strengthen the police and judicial services (in particular, with regard to GBV) so that young women increasingly see police and judicial services as viable options when experiencing violence

SUB-QUESTIONS	INDICATORS	ASSUMPTIONS TESTED	QUALITATIVE/ QUANTITATIVE	INSTRUMENTS
What are the barriers faced by young women in accessing health services?				
Has access to healthcare services improved for youth?	Distance to nearest health centre	1	Quantitative	Household survey
	Means of transport to health facility	1	Quantitative	Household survey
	Satisfaction with health service provision	1	Quantitative	Household survey
	Proportion of target group accessing formal healthcare services as a first point of call	1	Quantitative	Household survey
	Perceptions of health services (including barriers to accessing sexual and reproductive health (SRH), particularly for high-risk populations)	1	Qualitative	FGD guide on motivators/ opportunities FGD guide for WSW
	Access to information about sexual health, usefulness of information	1	Quantitative/ qualitative	FGD guide on motivators/opportunities FGD guide for WSW Household survey
How do young women in BCMM identify and respond to violence?				
What support structures are in place for women to respond to GBV?	Perceptions of coping structures, including both formal and informal structures (in particular, with regard to GBV)	2	Qualitative	FGD guide on motivators/opportunities FGD guide on community perceptions KIIs
	To whom do women turn for help following incidents of GBV?	2	Quantitative	Household survey
	Perceptions of police and judicial systems (in particular, with reference to GBV)	2	Qualitative	FGD guide on motivators/opportunities FGD guide on community perceptions KIIs
What are the barriers faced by young women in accessing economic and education opportunities?				
What challenges do women face when transitioning into the world of work? (work readiness, motivations, factors for success in the workplace)	To what extent are women able to access information about economic opportunities? How? What kind of information is most useful?	3	Quantitative	Household survey
	Perceptions of barriers to employment in BCMM Perceptions of opportunities available to young women	3	Qualitative	FGD guide on motivators/opportunities FGD guide on community perceptions KIIs
Has the economic well-being of young women in BCMM improved?	Proportion of target group (15–29 years old) who are economically active	3	Quantitative	Household survey
	Household poverty score	3	Quantitative	Household survey
What challenges do women face when accessing education?	Proportion of target group who are in school/ completed matric	3	Quantitative	Household survey
	Proportion of target group who are in/have completed tertiary education	3	Quantitative	Household survey
	Reasons for not attending school/tertiary education	3	Quantitative	Household survey
	Perceptions of barriers to attending school/tertiary education	3	Qualitative	FGD guide on motivators/opportunities FGD guide on community perceptions KIIs

HYPOTHESIS 3:

ENHANCEMENT OF YOUNG WOMEN'S AND GIRLS' SENSE OF IMMINENT AND REAL POSSIBILITY LEADS TO CHANGES IN THEIR RELATIVE PERCEPTION OF RISK

ASSUMPTIONS:

1. Changes in personal and collective identities (through motivators) lead to a changed/expanded social reference group, i.e. what it means to be a young woman in BCMM changes due to programme activities

2. A change in, and expansion of, young women's social reference group leads to changes in relative perceptions of risk

SUB-QUESTIONS	INDICATORS	ASSUMPTIONS TESTED	QUALITATIVE/ QUANTITATIVE	INSTRUMENTS
RESEARCH QUESTION What are the risks young women are facing?				
Sexual behaviour	Perceptions of HIV and other STIs (prevalence and risk)	1 and 2	Qualitative	FGDs on motivators/ opportunities FGDs on community perceptions FGDs on WSW KIIs
	Perceptions of sexual behaviour and risk (including perceptions of how it is influenced by, for example, deprivation, poverty, religion, traditional values)	1	Qualitative	FGDs on risk KIIs
	Has knowledge of HIV and AIDS improved among the target group?	1 and 2	Quantitative	Household survey
	Has the target group decreased the extent to which their sexual behaviour would be considered risky?	2	Quantitative	Household survey
	Domain-Specific Risk-Taking (DOSPERT) scale – measures level of risk adverseness/loving in several domains: social, safety, sexual behaviour	2	Quantitative	Household survey
Are young women exposed to GBV?	Exposure to physical violence	2	Quantitative	Household survey
	Exposure to emotional violence	2	Quantitative	Household survey
	Exposure to sexual violence	2	Quantitative	Household survey
	Perpetration of physical violence (question asked of men)	2	Quantitative	Household survey
	Perpetration of emotional violence (question asked of men)	2	Quantitative	Household survey
	Perpetration of sexual violence (question asked of men)	2	Quantitative	Household survey
What are the perceptions around various forms of violence?	Perceptions of violence and expectations	2 (and H1, A3)	Qualitative	FGDs on risk FGDs on motivators/ opportunities FGDs on community perceptions KIIs
What other risks do young women perceive as being the most prevalent in their lives?	Perceptions of other risks faced by young women, e.g. financial or social	2	Qualitative	FGDs on risk
RESEARCH QUESTION How are these risks weighed against each other?				
What risks have the most impact on young women's lives?	Perceptions of risk which have the greatest impact on the lives of young women	2	Quantitative/ qualitative	FGDs on risk Household survey

HYPOTHESIS 4:

CHANGES IN YOUNG WOMEN'S RELATIVE RISK PERCEPTIONS LEADS TO YOUNG WOMEN BEING LESS LIKELY TO MAKE TRADE-OFFS THAT PLACE THEM AT RISK

ASSUMPTIONS:

1. Less risky or non-risky trade-offs exist, allowing women to have a choice between high-risk and low-/no-risk alternatives (more choices lead to behaviour change)
2. The enabling environment is supportive of women asserting themselves in making decisions that are positive for their lives (supportive enabling environment leads to less risky behaviour)
3. Young women are able to exercise their agency, despite infrastructural challenges or absence of community and/or structural support (increased assertiveness exercised leads to less risky behaviour)

SUB-QUESTIONS	INDICATORS	ASSUMPTIONS TESTED	QUALITATIVE/ QUANTITATIVE	INSTRUMENTS
RESEARCH QUESTION To what extent are young women making different trade-offs with regard to risk?				
Sexual behaviour	To what extent are young women engaging in safe sex?	1 and 3	Quantitative/ Qualitative	Household survey/FGD guide on risk
	Has the use of prevention methods improved among the target group?	2	Quantitative	Household survey
	Perceptions of risk trade-offs	2	Qualitative	FGD guide on risk
RESEARCH QUESTION What challenges do young women face in making trade-offs with regard to risk?				
Do young women feel able to assert themselves and make decisions regarding their sex life, regardless of partners' expectations?	Women's perceived ability to assert their sexual choices	2 and 3	Qualitative	FGD guide on risk FGD guide on motivators/opportunities
RESEARCH QUESTION To what extent do community dynamics influence the lives of young women?				
What are the support structures available to young women?	Group membership and benefits of group membership	2 and 3	Quantitative	Household survey
	Perceptions of support structures available to women	2 and 3	Qualitative	FGD guide on risk FGD guide on community perceptions
	Perceptions of how community actors can support young women in BCMM	2 and 3	Qualitative	FGD guide on risk FGD guide on motivators/opportunities FGD guide on community perceptions KIIs
What makes women/youth feel safe/ unsafe within a community?	Level of trust in community	2 and 3	Quantitative	Household survey
	Level of solidarity in community	2 and 3	Quantitative	Household survey
	Trust in police	2 and 3	Quantitative	Household survey
	Perceived changes in the enabling environment	2 and 3	Qualitative	FGD guide on risk FGD guide on motivators/opportunities FGD guide on community perceptions KIIs
	Perpetration of sexual violence (question asked of men)	2	Quantitative	Household survey

2.4 QUANTITATIVE METHODS

The evaluation includes a clustered random sample of 1,000 households in 100 enumeration areas (EAs) within BCMM that are targeted by the Bumb'INGOMSO programme. To be eligible for the survey a household must have contained at least one young woman aged 15–29 years old (the programme's target population group). If more than one young woman was in the household, then one was randomly selected for the interview. Additionally, if a man aged 15–45 years old lived in the randomly selected household, that man was also interviewed. However, during the analysis stage all analyses based on interviews with the men were dropped due to a lack of statistical representativeness. Additional details on this are provided in Annex E.

It is expected that the survey will be a panel survey, i.e. that the same households and the same respondents will be tracked and re-interviewed at the time of the follow-up survey. The focus of the household survey in terms of research questions, sub-questions, and specific indicators is presented in the evaluation matrix presented in Table 1.

2.4.1 HOW THE QUANTITATIVE METHODS CONTRIBUTE TO THE TBE

IT IS NOT POSSIBLE TO IDENTIFY A CREDIBLE CONTROL GROUP FOR THIS EVALUATION (SECTION 2.1 DETAILS WHY THIS IS THE CASE). AS A RESULT, THIS EVALUATION ADOPTED A TBE, WHICH SEEKS TO IDENTIFY CAUSAL LINKS TO PROGRAMME ACTIVITIES THROUGH A MECHANISTIC PROCESS, RATHER THAN *ATTRIBUTING IMPACT* TO THE PROGRAMME BY A COMPARISON OF TREATMENT AND CONTROL GROUPS.

AS SUCH, VARIOUS QUANTITATIVE METHODS ARE ADOPTED TO PROVIDE EVIDENCE THAT SUPPORTS THE TBE, WHICH IS TRIANGULATED BY OTHER SOURCES OF EVIDENCE USED IN THE EVALUATION, PARTICULARLY THE QUALITATIVE RESEARCH. THE QUANTITATIVE METHODS THAT WERE USED AT BASELINE ARE THE FOLLOWING:

- *Descriptive statistics:* A range of descriptive statistics are provided in the baseline research report to help the Bumb'INGOMSO programme better understand its target population within BCMM. These statistics include: (1) background statistics on individuals in the target population and their households (e.g. education level, age, race, household wealth); and (2) baseline levels of the expected outcomes of the Bumb'INGOMSO programme detailed in the evaluation matrix (e.g. self-efficacy, relative risk perception, risky sexual behaviours, economic opportunities).
- *Multivariate analysis:* Multivariate regression analysis is used to understand the key drivers of risky sexual behaviour. A range of potential drivers are assessed, including factors that are in the direct sphere of influence of the Bumb'INGOMSO programme, as well as those that are not. This regression analysis supports the assessment of the most significant drivers of risky sexual behaviour for the target population in BCMM and supports an understanding of whether or not it is likely that the Bumb'INGOMSO programme interventions are appropriately designed and targeted.

The evaluation includes a clustered random sample of 1,000 households in 100 enumeration areas (EAs) within BCMM

IN LATER ROUNDS OF EVALUATION RESEARCH IT WILL BE POSSIBLE TO IMPLEMENT FURTHER QUANTITATIVE APPROACHES, SUCH AS:

- *Exploring change over time:* During follow-up rounds of research it is expected that a further household survey will be implemented targeting the same respondents who were interviewed during the baseline round of research. Statistical analysis will be used to determine whether there has been a change in both the situation of individuals as well as their behaviours, focusing on those that the Bumb'INGOMSO programme is expecting to influence (e.g. a change in the individual motivators presented in the TOC that is expected to lead to a change in the sense of imminent possibility for young women and girls).
- *Exposure analysis:* During follow-up rounds of research, the evaluation team will explore the possibility of conducting an exposure analysis. This method may allow for an assessment of the attribution of impact directly to the Bumb'INGOMSO programme. This type of analysis will seek to exploit heterogeneity during programme implementation to assess the impact of the programme on key outcomes. For example, a suitable control group on which to assess attribution of impact may be constructed if it turns out that the programme is not implemented at all, or at least as a full holistic package, in all targeted areas within the evaluation sample in BCMM. To enable this type of analysis a process evaluation will have to be conducted at the follow-up research stage in order to allow the evaluation to fully understand variations in programme implementation (see below).
- *Assessing programme implementation through process evaluation:* During follow-up rounds of research it is expected that the household survey instrument will also include an exploration of programme implementation. This analysis will seek to explore a number of issues, including: (1) exposure of sampled respondents to the Bumb'INGOMSO programme and its various components; and (2) perceptions of the quality of services provided by the Bumb'INGOMSO programme and its various components on the part of those respondents who have been exposed to the programme. This analysis will help to explore whether the Bumb'INGOMSO programme has had the expected coverage among its target population, as well as whether there are any programme implementation issues that might dilute its potential impact.

2.4.2 OVERVIEW OF THE QUANTITATIVE INSTRUMENT

Table 2 provides an overview of the different sections of the quantitative questionnaire that was administered, and the primary respondents.

TABLE 2: OVERVIEW OF THE HOUSEHOLD QUESTIONNAIRE

SECTION	SECTION DESCRIPTION	TO BE ANSWERED BY
Roster	This section collects names and general background information on all household members. This information includes gender, year of birth, age, relation to the household head, and race.	Any household member
Respondent selection	This section is used to randomly select the female and male respondents for each household. The computer-assisted personal interviewing (CAPI) program randomly selects the respondents, after which the enumerator is required to confirm this selection.	Enumerator
Consent	Read to the selected respondent to obtain informed consent for the interview.	Main respondent (female)
Household	Questions about the type of dwelling, as well as household assets.	Main respondent (female only)
Education opportunities	Respondent-level questions on education completed, educational aspirations, and access to information about education opportunities.	Main respondent (female and male)
Economic opportunities	Respondent-level questions on economic activities and reasons for not working.	Main respondent (female and male)
Social capital	This section contains three sub-sections: group membership, trust and cooperation, and solidarity. It gathers information about formal and informal networks within the community and the extent to which the community supports and trusts each other.	Main respondent (female only)
Health services	This section gathers data on access to health services and the barriers faced by youth in accessing health services.	Main respondent (female and male)
Sexual and risk behaviour	The first part of this section focuses on alcohol and drug use and then focuses on sexual behaviour, including condom use, multiple sexual partners, age-disparate relationships, and transactional sex.	Main respondent (female and male)
HIV/AIDS knowledge and testing	This section includes questions on respondents' knowledge about the transmission of HIV and the respondents' HIV testing behaviour.	Main respondent (female and male)
Self-efficacy	A series of statements to which respondents can agree/disagree regarding the respondents' feeling of being able to do things for themselves.	Main respondent (female and male)
Risk preferences	A series of statements relating to scenarios in which respondents could choose to take a risk, assessing the benefits, likelihood and riskiness of each choice.	Main respondent (female and male)
GBV perceptions	This section starts with a series of statements with which respondents can agree/disagree regarding gender norms and roles. The section moves on to experiences of GBV and reporting.	Main respondent (female and male)

2.4.3 SAMPLING STRATEGY

A MULTI-STAGE RANDOM SAMPLING STRATEGY WAS DESIGNED TO RANDOMLY SELECT HOUSEHOLDS TO PARTICIPATE IN THE HOUSEHOLD SURVEY. THE SAMPLE WAS DESIGNED TO BE REPRESENTATIVE OF YOUNG WOMEN AGED 15–29 ACROSS THE 18 WARDS TARGETED BY BUMB'INGOMSO, THAT IS, THE SAMPLE IS REPRESENTATIVE OF BUMB'INGOMSO'S PRIMARY TARGET POPULATION. THE VARIOUS STAGES INCLUDE THE FOLLOWING:

1. *Selection of EAs:* A master sampling frame of EAs was constructed by mapping Bumb'INGOMSO programme target areas onto the map of all EAs in BCMM, provided by Statistics South Africa. One hundred EAs were then randomly selected from the full list of all EAs in BCMM targeted by the programme using the probability proportional to size (PPS) sampling approach, a technique that provides an efficient method of sampling when population figures for each EA are known. With PPS sampling, EAs with larger populations have a higher probability of being selected, to offset the fact that each individual household within larger EAs has a lower probability of being selected in the subsequent stages compared to households in smaller EAs.
2. *Listing exercise:* Within each of the 100 randomly selected EAs a full dwelling listing was conducted. The listing exercise delivered the master sample frame of all dwellings from which the sample of households for the household survey was drawn.
3. *Selection of households:* From the master sample of frame of dwellings, 10 dwellings per EA were randomly selected for enumeration using a simple random sampling approach. In cases where more than one household lived within a dwelling, one household was randomly selected. A team of fieldworkers then visited every sampled household to confirm that the household contained a young woman aged 15–29 years. In cases where a household did not contain a young woman in that age group, a replacement household was drawn randomly[14] from the same EA.
4. *Selection of the survey respondent:* In cases where there was more than one person in the household who fit either of the two respondent groups (women aged 15–29 or men aged 15–45), one person from each group was randomly selected.

Table 3 summarises the interview outcomes for the female respondents. In total, 4,985 households were visited, out of which 1,002 interviews with female respondents were conducted.

The refusal rate for female respondents was 16.5%. Refusals were concentrated in higher income, urban areas. 10 households in the PSU had already been met.

TABLE 3: INTERVIEW OUTCOMES FOR FEMALE RESPONDENTS

OUTCOME	NUMBER
Completed	1,002
Partially complete (refused after start)	3
Permission refused	166
Long-term unavailable	95
Unavailable after three visits	109
No eligible female respondent	3,316
Dwelling not inhabited	142
Dwelling not found	105
Appointment made, but not interviewed	47
TOTAL HOUSEHOLDS VISITED	4,985

Notes:
Long-term unavailable: eligible female respondent in the household not available for an interview, e.g. because of extended vacation, hospitalisation, etc.

Unavailable after three visits: dwelling looked inhabited but no household member could be found on any of three different visits made to the dwelling.

Appointment made, but not interviewed: households identified as eligible but not interviewed because the quota of 10 households in the PSU had already been met.

[14] *This was done automatically through CAPI, to avoid any bias created by enumerators replacing households that did not need to be replaced.*

2.4.4 HOW TO READ THE TABLES IN THIS REPORT

The quantitative tables included in the report show descriptive statistics that represent the background characteristics of the target population and establish a baseline.

THE TABLES PRESENTED IN THIS REPORT TYPICALLY HAVE THE FOLLOWING HEADINGS:

VARIABLE	TOTAL	AGE OF FEMALE RESPONDENT			PROXY MEANS TEST (PMT) SCORE	
		15–19	20–24	25–29	ABOVE MEDIAN	BELOW MEDIAN
NAME OF INDICATOR						

The *Total* column presents the baseline proportion of female survey respondents who meet the indicator. Unless specified in the table, the sample size in the table or graph is 1,002 female respondents. Some indicators are limited to particular groups of respondents and this is indicated in a note underneath the table.

The columns under *Age of female respondent* show the proportion of respondents who meet the indicator, split across three different age groups.

In the columns under *PMT* score, the indicator is presented for the less poor half of respondents (those who fall above the median score on the PMT) and for the poorer half of respondents (those who fall below the median score on the PMT). A proxy means test (PMT) allowed us to estimate income by using observable characteristics of a household and its members, such as household size, the type of toilet household members have access to and ownership of household assets such as fridge, car, washing machine or computer. As the name suggests, these indicators are used as proxies to evaluate household members' means. The full list of indicators used estimating the poverty score are listed in *Annex H.*

T-tests were conducted to test whether the proportion of respondents in one group differs significantly from the proportion of respondents in the other group. For the age groups, two t-tests were run: one that tests whether the proportion of younger women (15–19-year-olds) meeting an indicator is significantly different from the proportion of 20–24-year-olds meeting the indicator; and one that tests whether the proportion of older women (25–29-year-olds) meeting an indicator is significantly different from the proportion of 20–24-year-olds meeting the indicator. For the PMT, one t-test was run to test whether the proportion of women in the poorer half of the sample (below the median) meeting an indicator is significantly different from the proportion of women in the less poor half of the sample (above the median) meeting the same indicator. If the difference between two groups is statistically significant, this is marked with asterisks (* significant at the 10% level, ** significant at the 5% level, *** significant at the 1% level). The more asterisks that are shown, the more likely it is that the difference in proportion is real across the target group, rather than due to chance as regards who was interviewed. Where results are not given an asterisk this does not mean that there is no difference between the proportions, but rather that the difference cannot be asserted with such a high degree of confidence (90% certainty or more).

2.5 QUALITATIVE METHODS

THREE MAIN TOOLS WERE USED TO STRUCTURE THE QUALITATIVE METHODS (COLLECT DATA, STRUCTURE FINDINGS, AND DRAW CONCLUSIONS) AGAINST THE OVERALL OBJECTIVES OF THIS EVALUATION. THESE ARE THE TOC, THE EVALUATION MATRIX, AND DATA FROM A SMALL NUMBER OF CASE COMMUNITIES, WHICH WERE COLLECTED DURING THE FORMATIVE RESEARCH STAGE.

2.5.1 RIGOUR

A challenge in qualitative research is the definition and achievement of 'rigour' – particularly when the research methodology should be open to the identification of new hypotheses, causes, and unexpected impacts, as is the case here. Qualitative research is often accused of being (1) open to research bias or anecdotal impressions, (2) impossible to reproduce, and (3) difficult to generalise (Mays and Pope 1995). OPM followed a protocol to ensure rigour throughout the research by implementing specific strategies at each stage of the evaluation process – design, sampling, fieldwork, analysis, and write-up. The main aim of these strategies is to minimise single-researcher bias and to be transparent in demonstrating the research process, as well as data analysis. How the qualitative design addresses issues of rigour, in terms of sampling, fieldwork, and analysis, is discussed in the sections below.

2.5.2 SAMPLING STRATEGY

The qualitative sampling strategy was informed by the formative research carried out in January/February 2017 and discussions with implementers and DG Murray Trust. It was agreed that the sampling strategy would need to ensure the team's ability to gain an in-depth understanding of the context in order to evaluate the concepts in the TOC. Further, the strategy was designed so as to maintain a level of flexibility, to allow new hypotheses to be tested if new implementing partners were added to the programme.

SITE SELECTION

The qualitative research explores four case communities in-depth, using an approach informed by ethnographic research where within-case sampling, whilst guided by a prior structure, remains open to on-the-spot decisions about sampling in order to take advantage of new opportunities during data collection.

The sample was chosen based on high or low proximity to basic services, and to represent a variety of contexts. However, given the need to spend considerable time within communities, security played a limiting factor in some instances. We are confident that this did not skew our sample, as the visited communities differed significantly in terms of security level and presence of basic services – including active police stations etc. First, wards were randomly sampled within the quantitative sample and then, within these wards, communities were purposefully selected along the criteria above (in cases where more than one community within a ward fell within the criteria and met the security requirement a case was randomly selected from within these).

The qualitative research further included two extreme case communities. Extreme cases were cases deemed too risky for teams to spend a longer time researching in, selected from within the random sample. As such, a sub-set of the team (including two researchers and the team lead) spent 0.5–1 day in the community conducting the FGD on risk. The objective of this was to help situate the findings from the in-depth case communities in relation to relative risk rankings from communities deemed to have a higher rate of violence/crime, in order to explore the influence of absolute risk on relative perception of risk.

SELECTION OF RESPONDENTS

At the community level, a mixture of purposeful sampling, snowball sampling and opportunistic sampling was used. Purposeful sampling ensured that we had similar numbers of respondents by age, and so respondents fitting the required age representation were selected intentionally. To this effect, three sub-age groups were determined:15–18, 19–22, and 23-29. Opportunistic sampling allowed for on-the-spot decisions about who to conduct interviews with in order to follow new leads during fieldwork and utilise events as they unfolded. This is particularly important in exploratory and ethnographic research, as it ensures an iterative approach to data collection whilst accounting for the complex setting in which fieldwork may be taking place. In order to ensure rigour, opportunistic sampling was overseen by team leads, and any decisions were discussed during the daily debriefing sessions. In some communities, respondents were also able to inform their peers within the target age range about the case studies and they too were eligible to attend the case study interviews.

THE FOLLOWING RESPONDENT GROUPS AND INSTRUMENTS WERE INCLUDED IN THE QUALITATIVE SAMPLE:

- **FGDs with young women and girls:** young women and girls were sampled in three age groups (15–18, 19–22, 23–29) to take part in two FGDs (one around motivators, and one around risk, as detailed below).
- **FGDs with young men and boys:** young men and boys were sampled in three age groups (15–18, 19–22, 23–29) to take part in two FGDs (one around motivators, and one around risk, as detailed below).
- **FGDs with women and men outside the target age group:** Separate FGDs were held with women and men outside the target age group to explore the baseline situation in terms of community perceptions regarding young women in BCMM, and to help triangulate findings from FGDs and interviews with youth.
- **IDIs:** purposeful and/or snowball sampling was used to identify information-rich key cases, either within FGDs with young women and girls or through snowball sampling. The purpose was to allow an element of longitudinal ethnographies, where the same individuals are interviewed again at midline and end line to allow for an in-depth analysis of individual change (detailed below).
- **KIIs:** purposeful and snowball sampling was used to identify key informants who are likely to have in-depth information about the lives of young women and girls in the communities. Sampling of key informants depended on access and availability of these informants during the time spent in a case community. Respondents included youth ward committee members, (informal) youth leaders/volunteers, and tavern owners/workers.

2.5.3 OVERVIEW OF QUALITATIVE INSTRUMENTS

The baseline data collection utilised three main instruments during fieldwork: KIIs, FGDs, and IDIs. A total of 52 FGDs, eight KIIs, and eight IDIs were conducted, as summarised in Table 4. Each interview/FGD had a lead facilitator and a note-taker. KIIs and IDIs were conducted by the team leads, either in English or with a translator. This was due to the highly unstructured nature of these interviews, and thus the need for highly experienced interviewers.

TABLE 4: SUMMARY OF QUALITATIVE RESEARCH CONDUCTED

INSTRUMENT	YOUNG WOMEN AND GIRLS (15–29)	YOUNG MEN AND BOYS (15–29)	WOMEN AND MEN OUTSIDE THE TARGET AGE GROUP	KEY INFORMANTS
KIIs				8
FGD (motivators)	11	11		
FGD (risk)	11	11		
FGD (community)			8	
IDIs	8			

The tools for the KIIs and FGDs were developed in order to capture information on the core areas to probe (as outlined in the evaluation matrix), which were derived from the underlying assumptions in the TOC. Discussion guides were used for the FGDs, tailored toward the areas that were to be probed and making use of age-appropriate language. Semi-structured interview guides were used that were organised around the core areas to probe, thus ensuring a degree of standardisation while at the same time allowing the national and OPM qualitative researchers enough flexibility to pick up on interesting themes and emerging topics and concerns. The interview guides for IDIs were largely unstructured, outlining a few of the core themes to explore as part of probing a respondent's life-history. The various tools are outlined below:

FGDS WERE CONDUCTED WITH YOUNG WOMEN AND GIRLS, YOUNG MEN AND BOYS, AND WOMEN AND MEN NOT IN THE TARGET AGE GROUP (+35). FGDS WERE FOCUSED ON THEMES, AND THE OBJECTIVE WAS TO GATHER THE PERSPECTIVES OF A GROUP ON SPECIFIC ISSUES, RATHER THAN *INFORMATION* ON SPECIFIC ISSUES. THREE TYPES OF FGDS WERE CONDUCTED:

- **FGDs (motivators/opportunities):** The objective of the FGDs on motivators/opportunities was to explore the baseline situation of young women's and girls' *sense of real and imminent possibility*. The discussion centred on the motivators and how these are influenced by contextual realities (such as perceptions and experiences of GBV, infrastructural challenges, and barriers to accessing services and jobs) and community perceptions. Considering the subjective nature of the questions (i.e. *sense* of agency), the aim was to focus on the discussion of perceptions of young women's situation and how this relates to agency, their self-view, and view of others (identity) etc., but also to discuss how young women and girls themselves view their lives, and how they see their futures (including potential barriers). FGDs on motivators took place with youth (both young women and young men) in three age groups, 15–18, 19–22, and 23-29. Groups were divided by age and gender in order to begin to mitigate power dynamics, and to provide a forum where youth could feel comfortable discussing potentially sensitive topics (such as violence). Training included researchers learning about how to adapt the instruments slightly depending on the age group – in particular, with regard to the depth of probing.
- **FGDs (community perceptions):** The main objective of the FGDs on community perceptions was to triangulate the findings from FGDs with young women and girls. The FGDs focused on the role of young women and girls, including expectations, and if/how this changes over time. The FGDs were separated by gender in order to allow for discussion of potentially sensitive topics (such as violence), but also to probe into, and triangulate, community perceptions of young women and girls, which may be gender-specific.
- **FGDs (risk):** The FGDs explored young people's perceptions of their vulnerabilities, and their *relative* perception of risk. The discussion also focused on how young people perceive their agency with regard to risk, and how they consider risk in making choices. In order to explore this fully, the FGDs also included a participatory tool called pairwise ranking.
  - Pairwise ranking: Through discussions, respondents (together with the facilitator) draw tables deciding on certain key risks faced by young women and girls, such as poverty, IPV, HIV, or social stigma. Each item is then paired against each other asking participants 'which one for young women and girls is more of a risk/worse to experience'. Thus, each item receives a score – which adds up to an overall ranking. This ranking is discussed with respondents, and provides a space for contest and deeper insight into experiences and perceptions of the various risks and vulnerabilities faced by youth. The key data are thus obtained through the discussion, rather than the ranking itself.

The evaluation matrix indicates that FGDs with Women in Sex Work (WSW) would be employed as a tool to answer some of the evaluation questions. However, Beyond Zero informed the evaluation team they would be conducting two full-day group discussions with WSW, and the team decided not to conduct any further interviews to avoid respondent fatigue. Although we attended the discussions organised by Beyond Zero, we did not collect data that helped to answer our evaluation questions. Thus, little to no reference to WSW is made in this report.

IDIs: IDIs were conducted with a small sample of young women and girls. Taking on the approach of narrative enquiry, these interviews capture personal dimensions of experience over time, taking into account the relationship between individual experience and cultural context (Clandinin and Connelly, 2000). By gathering and analysing stories as told by young women and girls we can begin to analyse more subjective meanings and sense of self and identity, and how these are negotiated as stories unfold. The focus is thus on *how* stories are told, *which* stories are told, and how they are presented and interpreted. By speaking to the same young women at baseline, midline, and endline, adopting an unstructured narrative inquiry (focusing on what women themselves choose to share), the qualitative research will be able to explore more in-depth changes over time in regard to the *sense* of possibility and an exploration of potential narrative stories of change.

KIIs: KIIs were conducted with respondents identified to be particularly knowledgeable around the situation of young women in the case communities. The key informant sampling was largely opportunistic, and participants included ward committee members, tavern owner/representatives and youth leaders. For the purpose of this evaluation, KIIs had three objectives: 1) to gather data around the context for the intervention; 2) to gather data around the overall themes of the evaluation on an overarching rather than individual experience; and 3) to triangulate data from FGDs.

QUALITY ASSURANCE
In order to ensure the rigour of the qualitative research, the team leads provided quality assurance at each stage of the research.

Firstly, rigorous training of field researchers took place prior to fieldwork.

Secondly, quality assurance procedures were implemented during data collection. Each team had a team lead present at each stage of the research, to address technical queries in the field. Debriefs were led by the OPM qualitative team leads and provided an initial synthesis of the findings. The sessions involved a guided discussion around themes, linking data to evaluation questions and objectives. Notes collated during the interviews and FGDs were used to facilitate team debriefs, as well as to provide a backup source of information should the audio recordings be unclear or if we were unable to record an interview (e.g. due to respondents' preferences or if the recording device failed). Debriefs served as a quality assurance mechanism, through which technical queries that arose during the day were addressed. The debrief sessions marked the start of the process of building a narrative around the findings, discussing emerging themes, and identifying additional areas to explore throughout the fieldwork. The OPM core team had a further debrief each night to discuss differences between the case communities visited that day and consult on any challenges. Briefings were held each morning before the team set out, to feed back to the rest of the team what had emerged from the second debrief.

Thirdly, quality assurance of the transcription was aided by separate training after the first week of fieldwork, which focused on translation and transcription. Researchers were also provided with transcription templates, and guidance notes that they could refer to throughout this process. In the end, due to some logistical challenges, a team of four researchers and one of the OPM researchers completed the transcription process. These researchers were given individual training sessions with the qualitative lead, and the transcripts were quality assured by the OPM qualitative research team. Transcripts were done *verbatim* to help mitigate bias at the stage of data capturing.

Fourthly, different members of the team were included in the analysis (at debriefs as well as during analysis and write-up), which heightened reliability and consistency in analysis, and mitigated single-researcher bias. The OPM core team also held a separate analysis workshop to discuss emerging findings, as well as several discussions with the quantitative team in order to strengthen the interpretation of the findings.

2.5.4 ANALYTICAL APPROACH

The first stage of analysis took place during debriefs in the field. Afterwards, the transcribed scripts were analysed using qualitative analysis software (NVivo 11). Although the interpretation of the raw data is influenced by the evaluation questions and objectives, the findings arose directly from the raw data rather than a *prior* expectations. The evaluation questions formed the domain in which the data were analysed and focused the researchers' attention, but in a less rigid way than deductive analysis, which seeks to test specific hypotheses or models. This allowed for exploratory analysis to take place, after which confirmatory analysis was applied to align the findings with, and situate them within, the programme TOC and evaluation matrix.

The team therefore used an inductive, iterative process of reading and re-reading transcripts in order to analyse the data. An inductive approach to qualitative analysis requires detailed readings of the raw data or transcripts to derive concepts, themes, or a model, through which interpretations are made. Hence, inductive analysis allows the themes to emerge from the data without the restraint of imposing pre-conceived concepts on the data in order to test hypotheses or assumptions (deductive analysis).

First, a close reading of the transcriptions was made to ensure that the researchers were familiar with the content of the transcripts and to develop an initial understanding of the themes. Initial brush coding took place at this stage, in which categories ('nodes'), were developed inductively from the findings based on sample of case communities. The rest of the cases were then coded to these 'nodes', with new 'nodes' developing throughout the coding process. Second, the qualitative team lead synthesised these initial nodes into thematic areas. Thematic nodes were drawn both from the evaluation questions but also, more importantly, from multiple readings of the raw data to determine recurring ideas and concepts. The IDIs were not coded, but the team used narrative analysis to analyse each transcript as a 'story'.

Considering the subjective nature of the Bumb'INGOMSO TOC around concepts such as 'identity' and 'sense of possibility', analysis took a social anthropological perspective where the *way in which someone describes their sense of self* is what is analysed. The cognitive nature of self cannot be explored under this design, and, as such, analysis did not be focus on measuring the change in agency, for example, but rather the change in *sense*, and *self-described agency*. The findings thus arise from public portrayals of self. These findings are situated within the findings from other respondents, and their view on young women's agency, in order to provide depth of analysis from a thematic perspective.

The findings were considered both within a case community as well as through common themes across the six communities visited. The analysis was undertaken by the same researchers who conducted the fieldwork, to ensure that errors of interpretation were minimised, and the findings were discussed amongst the team during team debriefs each evening of fieldwork, and during an analysis workshop in Oxford after data processing had been completed.

Considering the subjective nature of the Bumb'INGOMSO TOC around concepts such as 'identity' and 'sense of possibility', analysis took a social anthropological perspective where the way in which someone describes their sense of self is what is analysed

2.6 ETHICS AND INCLUSION

Ethical approval for the study was provided by the independent Ethical Review Committee (ERC) within OPM. The committee was established in 2013 to ensure that all OPM research activities are carried out to the highest ethical standard.

The ERC has a Chair, Co-Chair, Coordinator, an External Member from the Ethox Centre of the University of Oxford, [15] three Members and a Secretary. The committee is currently chaired by Professor Hugh Annett, who is a public health specialist and was a member of the Appeal Committee of the National Institute for Health and Clinical Excellence (NICE). A multidisciplinary team, including medical demographer, clinician, public health specialist, sociologist, economists, and a communication expert are also included in the committee.

THIS BASELINE EVALUATION IDENTIFIED THE FOLLOWING MAIN ETHICAL RISKS:

1. working with children under 18 (but older than 15);
2. working with vulnerable groups (young women who may have experienced abuse);
3. psychological risks, such as re-traumatisation of victims of abuse if they are asked to talk about it; and
4. social risks, where women may be targeted in their communities for taking part in the research.

[15] *www.ethox.ox.ac.uk/*

Given that the quantitative instrument focused heavily on perceptions around, ability to cope, and direct experience with violence, we recognised that the risk of re-traumatisation was high. In order to mitigate psychological risks and properly respond to instances of re-traumatisation, we worked with Masimanyane to create a referral protocol for any cases where the researcher felt that re-traumatisation may have occurred. The instruments were also informed by the formative research on these sensitive issues.

In order to mitigate social risks, OPM conducted extensive community sensitisation in the target areas, informing the communities through their councillors and council ward committees about the study in detail. The study made it clear that the information shared was confidential, that respondents were randomly selected across all the implementation wards, and, importantly, that any respondents could opt not to be a part of the survey – either at all or at any point during the survey.

On collecting sensitive data, the baseline evaluation did not ask questions around whether or not a respondent is HIV positive, but discussed issues relating to HIV (for example, stigma in accessing health clinics). No respondent was required or asked to disclose personal health information. Respondents were not required to disclose any detailed experience of violence and, if the interviewer sensed, or the respondent indicated, that due to privacy concerns or other reasons the respondent was not able to answer all the questions freely, the interviewers were trained to immediately switch the conversation and to end the interview, for follow-up at a different time.

2.7 RISKS TO AND LIMITATIONS OF THE EVALUATION

Building on OPM's extensive evaluation experience and a review of project documents, we have, in Table 5, outlined the anticipated risks to the evaluation, and the potential risk mitigation strategies that were employed during the evaluation.

TABLE 5: RISKS TO THE EVALUATION

DESCRIPTION	RISK/IMPACT	MITIGATION
		Risks to participants
Young women are harmed, traumatised or threatened by the research in any way	Low/high	OPM has a safeguarding policy and has developed a detailed research ethics and protection plan that was updated throughout the evaluation. These documents outline procedures and considerations that protect the physical and emotional well-being of child participants (as well as all other participants) at all points.
		Risks to data quality/evaluation design
Sample attrition	Medium/high	It is expected that the survey will be a panel survey, i.e. it is expected that the same households and the same respondents will be tracked and re-interviewed at the time of the follow-up survey. Households may not respond to the survey in future rounds for a variety of reasons, including refusal and relocation/migration. To minimise the possibility of sample attrition at the cohort and household level it was important to collect as much information as possible about the young women and households when they were visited for the baseline survey, including contact phone numbers and GPS coordinates of the household. OPM developed appropriate protocols for tracking cohorts and households that have relocated, which seek to balance the need to reduce sample attrition with the cost of locating households.
Logistical challenges (e.g. inaccessible areas, limited ability to communicate with survey team, limited internet connectivity for timely transmission of data)	Low/medium	Logistical arrangements were conducted in close partnership with local community members and guides, and security oversight in this respect was provided by the OPM service provider, Spearfish. With regard to working in areas with limited connectivity, teams were provided with backup power banks to charge tablets and all completed surveys were saved on the tablets until they reached areas with better connectivity. All tablets also had dual SIM cards, that could be used interchangeably if either had a stronger network reception.

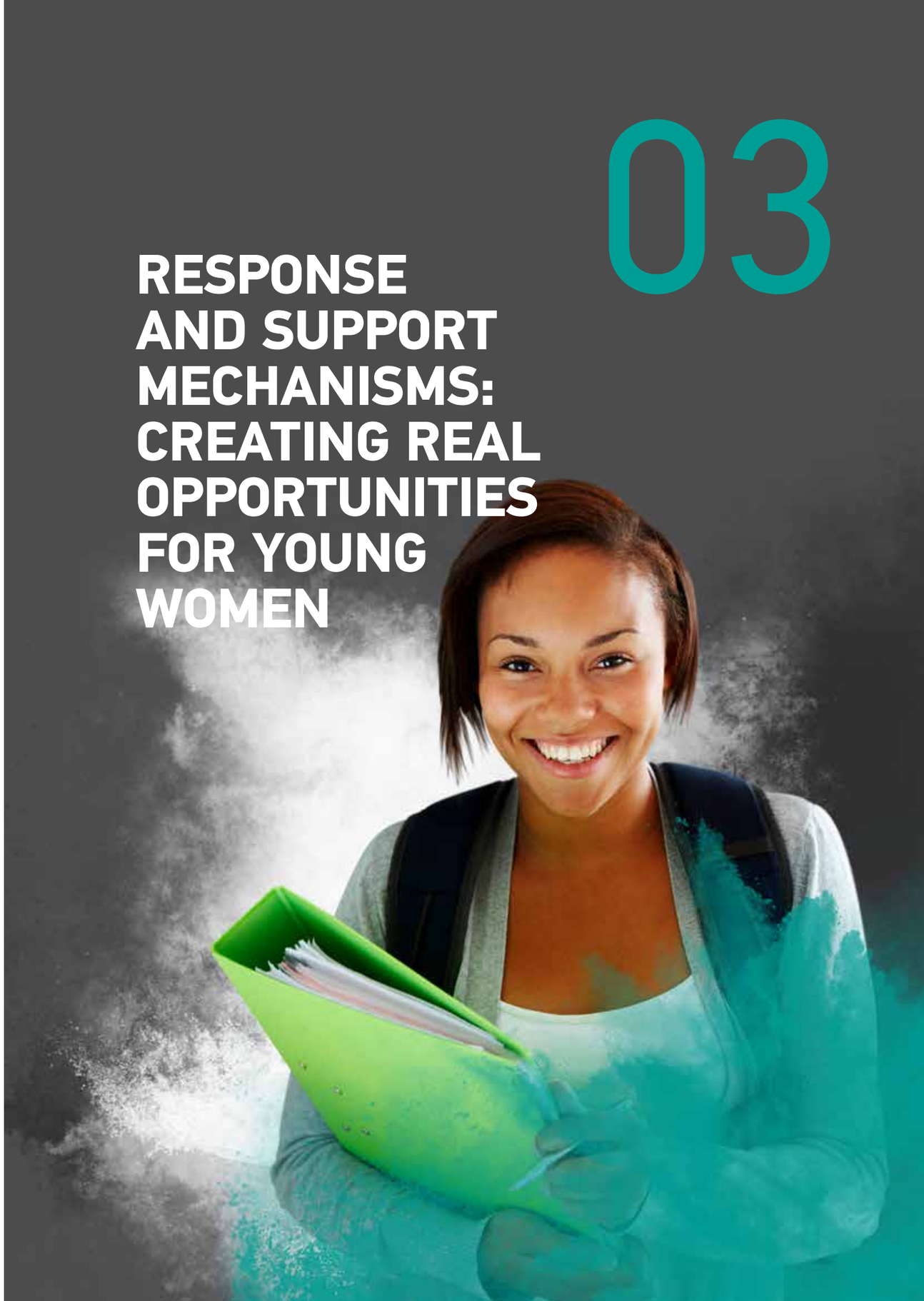
The limitations of the evaluation are outlined in Table 6.

TABLE 6: LIMITATIONS OF THE EVALUATION

LIMITATION	MITIGATION
The impact evaluation is not able to *attribute* the impact of the Bumb'INGOMSO programme as a whole on the outcomes of interest, assuming there is no variation in the implementation of the programme. The interventions will be implemented in all areas that the Bumb'INGOMSO programme is operating in. Given that all areas are intended to be exposed to all interventions, we cannot identify a credible counterfactual for *specific interventions* that form part of the Bumb'INGOMSO programme.	We have employed a TBE approach to unpack the linkages between project activities, outputs, intermediate outcomes, and final outcomes, and to the degree possible, to understand the contribution that the various programme interventions have made towards achieving progress against headline outcomes. For example, we will not be able to say what the percentage change in employability is as a result of a specific intervention, such as Harambee, but rather we will be able to tell a credible contribution story as to whether, given the available evidence, it is credible to say that job matching has or has not made a significant contribution to observed changes in behaviour.
Due to the nature of some of the evaluation questions it is not possible to assess all research questions using quantitative data. This means that it will not be possible to fully assess some of the pathways in the TOC using quantitative data.	This evaluation uses a mixed methods approach to assess the impact of the Bumb'INGOMSO programme. Where possible, we will triangulate information about the efficacy of the programme in achieving desired outcomes across quantitative and qualitative sources. However, where quantitative data are not available we will weigh the strength of the qualitative evidence before making statements about the contribution of the programme to expected outcomes.
Time to impact of the Bumb'INGOMSO programme: given that the length of the programme is yet to be determined.	It is our understanding that the timeline for the programme is yet to be determined. The subjective nature, and expected subtle changes, of the TOC changes are unlikely to be observed within too short a timeframe, in which case the scope of what the evaluation is able to assess will be limited.
The Bumb'INGOMSO programme takes a holistic approach to achieving its expected outcomes and is working across multiple dimensions. It is expected that it is the combination of these efforts that will lead to real impact on the lives of young women in BCMM. However, given that the programme is implemented as a package, and that young women will be exposed to multiple interventions simultaneously, it may not be possible to quantitatively assess which intervention had the most impact.	We suggest a number of mitigating approaches: We recommend at the next round of research that a process evaluation is also conducted to understand the efficacy of implementation. If an intervention is poorly implemented it limits the expectations one can have that the intervention will have had a meaningful impact on the lives of young women. We recommend that the qualitative research in future research rounds is used to qualitatively assess the relative importance of each intervention in achieving the desired outcomes, including how interventions build on and support each other. Both would complement the TBE approach to the evaluation, which seeks to understand the linkages between programme activities, outputs, outcomes, and impacts.
Inference beyond the selected qualitative case study sites is limited.	While the evaluation has been designed holistically – approaching the evaluation questions from a variety of angles and through the perspectives of various respondents – the findings of the qualitative research will reflect the particular communities selected. In contrast to a quantitative design, qualitative research does not aim to facilitate sample-to-population inference but rather to gather an in-depth understanding of how the Bumb'INGOMSO TOC unfolds within a specific context. Purposeful sampling will be carefully considered to ensure in-depth learning about the focus areas of the TOC, and analysis will be 'thick' and iterative through the choice of a data collection procedure that is informed by ethnographic approaches. Nevertheless, it remains a limitation that the learning will be affected by the choice of communities.
Given the non-representative nature of the qualitative selection of communities, the information provided will be indicative.	The qualitative component of the evaluation will offer nuanced first-person accounts of people's perspectives and experiences of the activities, without claiming that these accounts are representative of other similar communities' experiences. However, when considered together with the quantitative findings, the qualitative findings will allow us to explore further the underlying issues and factors that situate the programme implementation.
The impact evaluation does not include quantitative results on men, and yet they are a key group that also shapes and influences the risks that young women in the affected communities face.	The impact of this limitation on the evaluation of the programme will be limited, as the programme does not target men specifically. Further, young men were part of the qualitative research and will be expected to be included in the follow-up rounds of the programme evaluation.
There are multiple drivers of HIV risk and often many manifest themselves through complex pathways that cannot be easily traced and measured. While all effort was made to ensure the survey was holistic and covered as many aspects of HIV risk as possible, it is likely that some pathways remain unexplored, or cannot be explored adequately. It is also likely that some findings cannot be triangulated across the quantitative and qualitative methods.	The mixed methods approach adopted attempts to mitigate some of this limitation by providing more in-depth qualitative insights where quantitative methods cannot provide such. In cases where the findings appear contradictory, the evaluation will suggest likely reasons why this could have been the case.

03

RESPONSE AND SUPPORT MECHANISMS: CREATING REAL OPPORTUNITIES FOR YOUNG WOMEN



A LACK OF AVAILABLE AND ACCESSIBLE OPPORTUNITIES FOR YOUNG WOMEN WAS IDENTIFIED AS A KEY CHALLENGE BY THE PROGRAMME. AS A RESULT, ONE OBJECTIVE OF THE PROGRAMME IS TO IMPROVE ACCESS TO OPPORTUNITIES FOR YOUNG WOMEN AND GIRLS IN THE 18 WARDS TARGETED BY THE PROGRAMME IN BCMM. THE PROGRAMME ASSUMES THAT THIS WILL RESULT IN A FEELING THAT THESE OPPORTUNITIES ARE REAL, BECAUSE THEY ARE NOW AVAILABLE, ACCESSIBLE, AND, ULTIMATELY, ACHIEVABLE. IN PARTICULAR, THE CONCEPT OF 'REAL OPPORTUNITIES' REFERS TO THE PROGRAMME'S ASSUMPTION THAT EVEN IF A YOUNG WOMAN DOES NOT HERSELF FIND A JOB, OR ACCESS HEALTH SERVICES, SHE HAS A SENSE THAT THE *OPTION* IS THERE, WHICH CHANGES HER PERCEPTION OF THE POTENTIAL SHE CAN ACHIEVE.

Three of the programme's four interventions speak to this objective specifically by working to enable access to education and employment opportunities, healthcare services, policing, and judicial services. Harambee focuses on working with young women to improve their access to job opportunities by providing training and support to young job-seekers. At the same time, it works with employers to open up opportunities for young women to gain employment by advocating for inclusive hiring practices. Beyond Zero promotes the establishment of adolescent- and youth-friendly health services, with the aim of increasing the extent to which young women and men feel comfortable using health services, particularly for SRH. While Masimanyane predominantly focuses on behaviour change to reduce the incidence of GBV, it is also committed to strengthening referral and response mechanisms by providing training on GBV to the South African Police Service (SAPS) and police community forums, as well as interventions for legal professionals. Finally, Masimanyane will establish a hotline and virtual support services (such as a virtual shelter) to increase the accessibility of support mechanisms for young women and girls.

This section discusses the baseline findings relating to real opportunities, including access to education and employment opportunities, access to health services, and strengthened policing and judicial services. The chapter concludes with implications for the TOC and the Bumb'INGOMSO programme as a whole.

3.1 ACCESS TO EDUCATION OPPORTUNITIES

In general, it appears that physical access to schools and other education institutions is not a problem. Table 7 indicates that, amongst respondents of the household survey, 48% were currently enrolled in secondary education or tertiary education, or in other courses or classes. As expected, women aged 15–19 were significantly more likely to be enrolled than women aged 20–24, and especially women aged 25–29. Equally, women in the less poor half of the sample were also more likely to be enrolled in school or classes.

TABLE 7: EDUCATION INDICATORS

VARIABLE (INDICATORS REFER TO THE PROPORTION OF WOMEN (%))	TOTAL	AGE OF FEMALE RESPONDENT			PROXY MEANS TEST SCORE	
		15–19	20–24	25–29	ABOVE MEDIAN	BELOW MEDIAN
Currently enrolled in school/class	47.71	86.23***	49.44	12.95***	55.96***	41.38
Has successfully completed high school	38.4	15.34***	53.2	43.39*	54.67***	25.91

*Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20–24), and between the top age group (25–29) and the middle age group (20–24).*

3.1.1 SCHOOL ATTENDANCE, POOR GRADES, AND LOW MATRICULATION RATES

Despite high enrolment rates amongst 15–19-year-olds, less than half of 20–29-year-old respondents have successfully completed high school. High school completion rates are significantly lower in the poorer half of the sample, with 26% of respondents having completed high school in this group, compared to 55% of respondents in the less poor half of the sample. While a few respondents, in the qualitative research, spoke about people in their communities who were not interested in attending school, most respondents expressed their desire to complete matric and/or further their education, with the ambition of working in various professions, such as nursing, engineering, and catering, among others. Despite these aspirations, respondents face a number of obstacles in achieving good marks, resulting in low rates of completion of matric, and low rates of enrolment in tertiary institutions.

Teenage pregnancy was identified by respondents as one of the factors leading to dropout and poor attendance amongst young women in the communities visited. While young women would be unable to attend school in the final stages of their pregnancy and just after the birth of their child, some young women reported that they were still not able to return to school once the baby was born as there was no one else who would be able to care for their child. In addition, young women also reported that there is a stigma attached to teenage pregnancy and that they felt ashamed and embarrassed returning to school. For some, this stigma meant that young women did not return to school for fear that '[…] *other children at school are going to laugh at her or they will judge her'* (FGD young women 15–18, C4).

Substance abuse was also widely discussed as a factor causing absenteeism and dropout. Community members reported that, because youth do not have access to leisure activities, such as sport, they often feel bored and commonly turn to drugs and alcohol as a source of recreation. Additionally, drugs and alcohol were described as a means to escape the pressures they face in their communities. Many young people begin drinking or taking drugs after school or on the weekend. This makes it difficult to focus on completing homework and affects learners' behaviour and attitudes towards school. However, in more extreme cases, adolescents were reported to *'smoke drugs'* at school, skip school, or drop out altogether as they are no longer able to cope with the demands of school. As one respondent noted: '[…] *education is being overpowered by drugs. When given money for lunch, he will use it to buy [drugs] and then, the following day, he will not be feeling well enough to go to school.'* (FGD young women 23–29, C3).

In addition, respondents spoke about the stigma attached to alcohol and drug abuse. Young men and women perceive drugs and alcohol to be associated with school dropout and committing crime (such as mugging others). The shame of this association prevents adolescents from returning to school as *'people start to gossip about your condition (of abusing alcohol or drugs) so you just become demotivated and you end dropping out of school' (FGD young women 23-29, C3).*

Financial constraints were also cited as a barrier to completing high school. Some respondents noted that the cost of school fees, school uniform, and school meals precluded adolescents in their communities from attending and completing high school. Discussions during the qualitative research, however, suggest that the issue of funding appears to be more acute in the context of tertiary education (see Section 3.1.2).

FINALLY, RESPONDENTS SUGGESTED THAT PEOPLE FELT THERE WAS LIMITED VALUE IN COMPLETING MATRIC BECAUSE EMPLOYMENT OPPORTUNITIES ARE SCARCE EVEN FOR THOSE WITH THE NATIONAL SENIOR CERTIFICATE (SEE SECTION 3.2.1). AS ONE YOUNG WOMAN EXPLAINED:
'People leave school because there are many people who have matriculated and are sitting at home and they cannot further their studies, and they cannot find employment. So that is why people leave school.' (FGD young women 23–29, C2)

While teenage pregnancy, substance abuse, and financial constraints appear to result in learners dropping out of school, respondents also noted that they faced challenges in excelling at school and achieving the marks they required to continue their education. Some respondents noted that they lacked learning materials in their schools due to a lack of supplies – such as textbooks – and, in one case, due to theft. Across the communities, respondents felt that their teachers' attitudes towards education were discouraging, which affected learner attendance and the marks learners were able to achieve at the end of matric. In particular, respondents perceived high rates of teacher classroom absenteeism, ill-qualified teachers, and a lack of teachers as hindrances to learning and achieving good marks at school. Young women face additional pressure from male teachers, some of whom make sexual advances; one respondent recounted how she had left school as she felt *'very uncomfortable'* after being sexually harassed by her teacher (FGD young women 23-29, C1).

Outside of school, respondents suggested that their home environment made successfully completing matric more challenging. Parents often do not have the level of formal education that would enable them to provide adequate support to learners with their homework, which can result in poor academic performance.

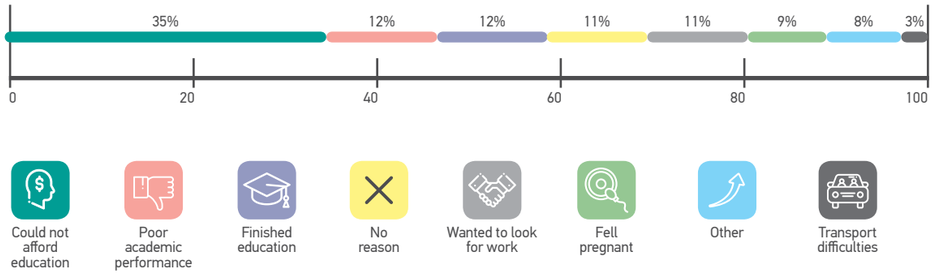
FURTHER, THERE ARE LIMITED OPPORTUNITIES FOR LEARNERS TO GET ADDITIONAL SUPPORT WITH THEIR WORK OR EXTRA CLASSES, ESPECIALLY WHEN LEARNING AT A SLOWER PACE, RESULTING IN UNDER-ACHIEVEMENT. A YOUTH REPRESENTATIVE DESCRIBED THE CHALLENGES YOUTH FACE IN ACHIEVING ACADEMICALLY:

'[…] another problem that made people not to go to school is the lower pass rate we have in our schools. That is a challenge we are facing. So even when I was applying, you will find out that I failed English. Therefore I don't meet the requirements to be admitted into tertiary. So because of the very low pass rate people end up sitting here in the location. I don't want to put blame on teachers but most parents are not educated and teachers are given a [high workload] by the government whereas classrooms are few. For example, there is a school called [name anonymised] here which has about 900 students but there are three classes without desks so about 70 learners are being taught in one class. So that low pass rate becomes a challenge for us to apply to universities and other tertiary institutions.' (KII youth representative, C6)

3.1.2 BARRIERS TO ACCESSING FURTHER EDUCATION AND TRAINING

As described above, even those who are able to successfully complete Grade 9 or matric still face challenges in gaining acceptance to tertiary institutions or securing bursaries as their marks often do not meet the minimum requirements. *Figure 3* shows the reasons given by unenrolled 20–24-year-olds [16] for why they are not currently enrolled in any form of education or training. Only 12% of these respondents stated that they had finished their education, while the vast majority of respondents listed other obstacles as the reason that they are not currently enrolled.

FIGURE 3: REASONS FOR NOT BEING ENROLLED GIVEN BY UNENROLLED 20 - 24 YEAR OLD WOMEN



Source: bumb'INGOMSO baseline survey (2017). Limited to 182 women aged 20 - 24 who are not currently enrolled. This age group (20 - 24 year olds) are expected to be the most likely candidates for further education and training.

FIGURE 3 INDICATES THAT 12% OF RESPONDENTS AGED 20–24 WHO ARE NOT ENROLLED IN EDUCATION OR TRAINING REPORTED THAT THEIR ACADEMIC PERFORMANCE WAS TOO POOR TO ENROL – A FINDING ECHOED IN THE QUALITATIVE RESEARCH:

'I passed my matric with a diploma but that D is not working for me because in order to get a bursary, I need to have at least two distinctions. My points are not enough.' (FGD young women 23–29, C1)

[16] *This age group (20–24-year-olds) are expected to be the most likely candidates for further education and training.*

The same figure shows that unenrolled young women (aged 20–24) listed financial constraints as the most common barrier to accessing further education. Similarly, for those who are accepted into tertiary education, funding was commonly cited by respondents in the qualitative research as a barrier to pursuing further education. Across the communities, respondents noted that they relied on money from the government to fund tertiary education as, in many cases, their parents were unemployed. While their households were no longer eligible to receive child support grants [17], respondents relied on funding from the National Student Financial Aid Scheme (NSFAS) but this was perceived to be awarded in an ad hoc manner or based on luck.

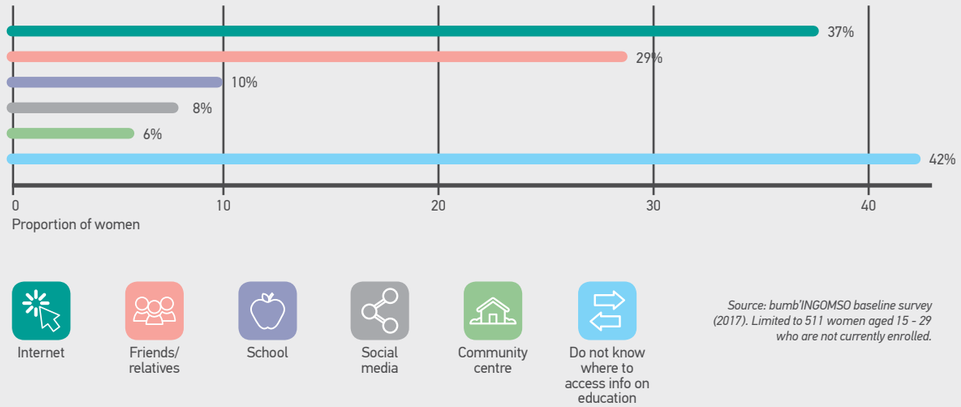
ONE RESPONDENT DESCRIBED WHAT THEY REGARDED TO BE CORRUPTION WITHIN THE NSFAS:

'[…] there is the NSFAS, but you will find out that there is nepotism from the employees and then you will be rejected. For example, at the beginning of the year, when you go and apply for school there will be many students and it will be full already because most of them are coming from as far as [location anonymised] then you will be rejected although you were told to come at a certain time and date. What hurts most is the fact that our parents are not employed – they are pensioners and they have borrowed the money to travel so it will not be easy for you to travel now and again so you end up losing the opportunity.' (FGD young women 23–29, C3)

While the government's policy of fee-free higher education [18] implemented from January 2018 may ease this constraint, learners also face additional costs, such as accommodation, transport and food, which often precludes them from enrolling in tertiary education.

For learners who are not accepted into tertiary institutions, it is important to ensure that information about opportunities available to them is accessible. Amongst respondents who are currently not enrolled in any education or training, 42% were not aware of a single source of information about education opportunities (see *Figure 4*), indicating that a lack of information about education opportunities may be a hindrance to enrolling in further education. The findings show that respondents are not well-informed with regard to the process for repeating matric – if they failed or if they want to improve their marks – or the education opportunities available to those with a Grade 9 certificate. [19]

FIGURE 4: SOURCES OF INFORMATION ON EDUCATION OPPORTUNITIES AMONGST 15 - 29 YEAR OLD WOMEN



Source: bumb'INGOMSO baseline survey (2017). Limited to 511 women aged 15 - 29 who are not currently enrolled.

[17] *A household that meets the eligibility criteria for a child support grant will only receive the money while the child is under 18 years of age.*
[18] *At the end of 2017, former president Jacob Zuma announced that in 2018 free higher education would be provided to all new first year students from households that earn less than South African Rand (ZAR) 350 000 per year.*
[19] *Since 2017, technical and vocational education and training colleges have offered training programmes for Grade 9 certificate holders. For more, see www.ecdoe.co.za/htmls/fet-scholar-information.html*

3.2 ACCESS TO EMPLOYMENT OPPORTUNITIES

Table 8 shows the proportion of women in the population targeted by Bumb'INGOMSO who are employed, unemployed, or discouraged work-seekers [20]. The employment rate for the population of women targeted by Bumb'INGOMSO is 19%. As expected, the employment rate is significantly higher for older women (25–29-year-olds) in the sample, compared to the younger age groups. When comparing these figures to statistics from the national QLFS, the employment rate of women in areas targeted by Bumb'INGOMSO is 4 percentage points lower than the national average for women aged 15–29 years in other urban areas (23%), and 15 percentage points lower than the average for women aged 15–29 in BCMM (34%). This is largely driven by lower employment rates amongst the older women in the sample: only 33% of 25–29-year-olds in the Bumb'INGOMSO target population are employed, compared to 42% of 25–29-year-olds nationally in urban areas and 55% of 25–29-year-olds across BCMM. [21]

TABLE 8: EMPLOYMENT INDICATORS

VARIABLE (INDICATORS REFER TO THE PROPORTION OF WOMEN (%))	TOTAL	AGE OF FEMALE RESPONDENT			PROXY MEANS TEST SCORE	
		15–19	20–24	25–29	ABOVE MEDIAN	BELOW MEDIAN
Employed	18.65	3.66***	17.63	32.52***	20.71	17.07
Unemployed	24.47	10.29***	26.03	35.83***	24.37	25.01
Discouraged work-seeker	6.61	2.89**	7.97	8.44	2.88***	9.47
Not in employment, education or training (NEET)	37.49	12.46***	38.9	57.56***	28.96***	44.04

DEFINITIONS:
Employed – a respondent who:
in the week preceding the interview, did any work for at least one hour or had a job or business but was not at work (e.g. temporarily absent)

Unemployed (narrow definition) – a respondent who:
a) was not employed in the week preceding the interview;
b) actively looked for work or tried to start a business in the four weeks preceding the interview; or
c) was available for work, i.e. would have been able to start work or a business in the week preceding the interview.

Discouraged work-seeker – a respondent who:
was not employed, wanted to work but had not looked for work in the four weeks preceding the interview provided that the main reason given for not seeking work was any of the following: no jobs available in the area; unable to find work requiring her skills; lost hope of finding any kind of work.

NEET – a respondent who:
is no longer in the education system and who is not working or being trained for work.

*Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20–24), and between the top age group (25–29) and the middle age group (20–24).*

[20] *We use the definitions used in the Quarterly Labour Force Survey (QLFS) and these definitions are included in the table.*
[21] *Quarterly Labour Force Survey 2017, Quarter 3 (www.statssa.gov.za/).*

24%
OF WOMEN TARGETED BY BUMB'INGOMSO ARE NOT EMPLOYED

Twenty-four percent (24%) of the population of women targeted by Bumb'INGOMSO are not employed. This proportion is lower than the national average unemployment rate and the main reason for the difference is due to the much smaller proportion of discouraged workers in this sample, as many of the 15-19 year olds are still in school and not looking for employment.

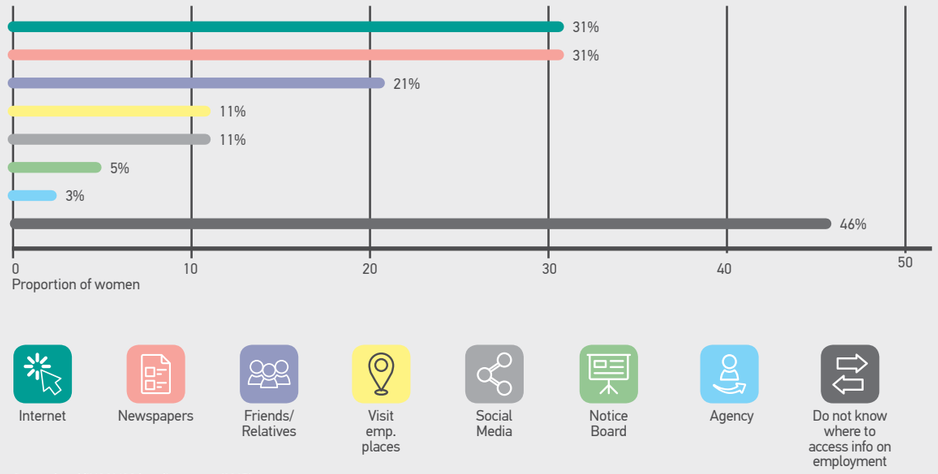
The unemployment rate is also significantly higher for older women in the sample, as older women finish education and enter the labour force but are unable to find employment. Unemployment rates in the areas targeted by Bumb'INGOMSO are higher than the average unemployment rate for BCMM, and higher than the average unemployment rate in urban areas, particularly amongst the older group of women. Amongst 25–29-year-olds, 36% of women in the Bumb'INGOMSO target population are unemployed compared to 31% of women aged 25–29 years in urban areas, and 26% of women aged 25–29 years in BCMM.

Overall, 38% of women in the Bumb'INGOMSO's target population are not currently engaged in any form of employment, education or training (NEET), meaning they are disengaged from both work and education. This includes women who are unemployed, those who are discouraged from finding work, and those who are not working or studying for other reasons – including due to lack of money for transport, health reasons, or being a home-maker. These rates are relatively low for the youngest women in the sample (15–19-year-olds), because these youngest women have the highest school enrolment rates. However, the rates increase drastically amongst the older women in the sample, which demonstrates that many young women experience difficulties transitioning from school/ education into employment.

3.2.1 BARRIERS TO ACCESSING EMPLOYMENT

Across all communities included in the qualitative research, respondents reported that job opportunities, especially in their communities, are scarce. Figure 5 shows that 46% of respondents in the household survey reported that they were not aware of any source of information on employment opportunities. This suggests that young women may perceive employment opportunities to be even scarcer than they are, and may not know where and how to access information on opportunities that are relevant for them.

FIGURE 5: HOW WOMEN RECEIVE INFORMATION ABOUT EMPLOYMENT OPPORTUNITIES (18 - 29 YEARS)

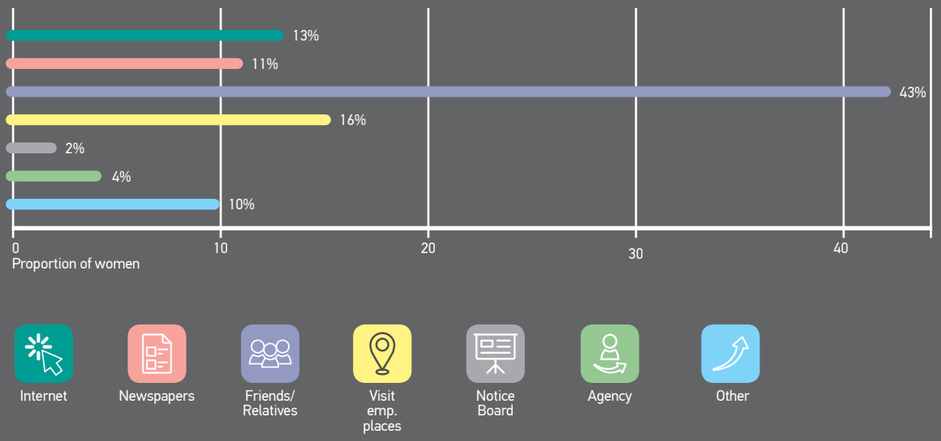


Source: bumb'INGOMSO baseline survey (2017)

[22] *Quarterly Labour Force Survey 2017, Quarter 3 (www.statssa.gov.za/).*

Interestingly, there is a large discrepancy between where women know they can find information about work, and where those women who are employed heard about their current job. For those respondents that did know where to receive information about work, the most commonly reported sources of information were the internet and newspapers, with 31% of women reporting these. However, when you consider where women who are currently employed actually received information about their current job, the overwhelming majority reported that they heard about their current job through friends or family, with 43% of women reporting this as the source of information. This suggests that personal networks are important in helping to connect young women to employment opportunities. 16% of employed women reported that they proactively visited a place of employment to search for a job.

FIGURE 6: HOW WOMEN RECEIVED INFORMATION ABOUT THEIR CURRENT JOB (18 - 29 YEARS)



Source: bumb'INGOMSO baseline survey (2017)

While respondents noted that there were more job opportunities in East London, they still reported that these were scarce in comparison to opportunities available in other South African cities. In addition, respondents face financial constraints in trying to access jobs in East London and other urban areas, as transport to these areas is expensive. Amongst respondents in the quantitative survey, 13% of unemployed women wanting to work had stopped looking for work because they did not have money to pay for transport. Respondents also reported facing other costs in applying for jobs. Particularly, the cost of printing CVs and other documents as part of the application was mentioned, as preparing these documents usually involves paying for transport.

THESE COSTS WERE CONSIDERED ESPECIALLY HIGH BY RESPONDENTS WHO FELT THEIR CHANCES OF GETTING THE JOB WERE SLIM:
'But you sacrifice and take the last money that you have and go make a CV to help the family buy food. Making a CV is very expensive. You make your CV and hand it only for it to be thrown in the bin.' (FGD young women 23–29, C2)

When job opportunities were available, respondents felt that they were given to relatives and friends of the employers and ward councillors, and that these jobs were therefore inaccessible if one was not 'well connected'. Respondents also claimed that the same people were repeatedly hired for the Expanded Public Works Programme, and that these jobs were given to the 'councillor's favourite' (FGD young women 15–18, C1).

ACROSS THE COMMUNITIES, RESPONDENTS REPORTED FEELING DISCOURAGED BY WIDESPREAD NEPOTISM AND THE PERCEIVED UNFAIRNESS OF THE WAY IN WHICH PEOPLE GET JOBS:
'We speak to the ward committee about the matters happening in our area. Even a street sweeping job is scarce. When tenders come, our people employ their families. People call their sisters and cousins for the posts we have applied for. They don't employ fair and square.' (FGD young women 23–29, C2)

Further, respondents felt that they lacked work experience or the necessary qualifications to be considered for a job. A number of respondents noted that employers asked for references along with their applications but, without previous work experience, respondents were unable to provide these. In addition, they felt that their applications were not considered as employers want 'qualifications together with experience' (FGD young women 23–29, C2). While those with only a matric certificate felt that there were limited opportunities available to them, those without matric felt that there were even fewer opportunities for them due to their lack of formal qualification or skills.

FINALLY, SOME RESPONDENTS REPORTED THAT THEY DID NOT KNOW HOW TO WRITE A CV IN ORDER TO APPLY FOR A JOB, OR HOW TO APPROACH AND PREPARE FOR A JOB INTERVIEW. THE PARENTS OF MANY OF THE RESPONDENTS ARE NOT EMPLOYED AND THEREFORE DO NOT HAVE ACCESS TO SUPPORT STRUCTURES THAT COULD SUPPORT THE YOUTH WITH THE APPLICATION OR INTERVIEW PROCESS. IN ONE OF THE COMMUNITIES, A YOUTH VOLUNTEER DESCRIBED A TRAINING PROGRAMME, SIYA SEBENZA [23], WHICH HAD HELPED YOUTHS IN THE COMMUNITY TO GAIN EXPERIENCE IN THE PROCESS OF APPLYING FOR JOBS:
'So it's a training basically designed to help the youth to actually achieve the jobs that they are looking for. Because most do have the qualifications (Grade 12), but the problem now is that if I come with my CV, I don't know what to expect in an interview, I don't know what to expect when I want to speak to the manager about my application. So that actually brings you to the light knowing that, okay, this is what happens at work.' (KII youth volunteer, C5)

IN TWO COMMUNITIES, THERE WAS A FEELING, PARTICULARLY AMONGST MALE RESPONDENTS, THAT THE STIGMA OF BEING FROM A CERTAIN COMMUNITY OR FAMILY PRECLUDED THEM FROM GETTING JOBS:
'If there are jobs in this area, some of us are not called because of the way we dress. They think that maybe because I dress a certain way, I will not be able to do the job. Sometimes they look at the family you come from and your history.' (FGD young men 23–29, C1)

Without employment, respondents noted that they had nothing else to do and many spoke about feeling bored: 'What I do today, I will also be doing it tomorrow. Nothing new happens, it is just boring here.' (FGD young women 23–29, C2). Consequently, respondents noted that people turned to alcohol and drugs for recreation. They also felt that people turned to crime because of this. In addition, in order to get money for food, alcohol or amenities, women reporting having 'blessers'. Relationships (including with blessers) as a risk factor for HIV among young women is discussed in more detail in Section 5.3.

[23] *For more information, see http://siya-sebenza.co.za/*

3.3 UTILISATION AND PERCEPTION OF HEALTH SERVICES

This section discusses respondents' utilisation and perception of health services. The first part of this section focuses on health services in general as the quantitative survey did not ask respondents specifically about the reason for their visit to a health facility. *Section 3.3.1*, however, focuses specifically on SRH services, which was discussed specifically as part of the qualitative research. It is interesting to note, as illustrated throughout the section, that respondents are more satisfied with their experience of using health services in general, in comparison to their experience of using SRH services more specifically.

Table 9 shows that when ill or requiring medical advice, almost all respondents choose to visit a formal health facility first, as opposed to an informal health service provider, such as a traditional healer. Furthermore, most respondents choose to visit public rather than private health facilities. However, younger women and women in households that are less poor are significantly more likely to visit a private health facility. Almost all respondents (90%) visited a health facility during the last year, although older women were significantly more likely to have visited a health facility.

TABLE 9: USE OF FORMAL, PUBLIC, AND PRIVATE HEALTH SERVICES

VARIABLE (INDICATORS REFER TO THE PROPORTION OF WOMEN (%))	TOTAL	AGE OF FEMALE RESPONDENT			PROXY MEANS TEST SCORE	
		15 – 19	20 – 24	25 – 29	Above median	Below median
Accesses formal health facility as first point of call	99.47	98.48	100	99.78	100	99.06
Accesses private health facility as first point of call	10.65	15.36**	8.85	8.4	22.38***	1.75
Visited a health facility in the last year	89.64	83.60**	89.81	94.66**	85.7***	92.65

*Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20–24), and between the top age group (25–29) and the middle age group (20–24).*

24%
OF RESPONDENTS REPORTED THAT IT TAKES 30 MINUTES OR LONGER TO TRAVEL TO THEIR CHOSEN HEALTH FACILITY

For those respondents who visited a public health facility during the last year, *Table 10* shows their experience in their most recent visit. Most respondents are able to reach their health facility of choice in 30 minutes or less, with just under a quarter of respondents (24%) reporting that it takes 30 minutes or longer to travel to their chosen health facility. However, the poorer half or respondents travel significantly longer to reach the health facility. In light of these findings regarding ease of access to health facilities, the qualitative research confirms that, in general, young men and women do not face significant physical barriers, such as distance and transport issues, to accessing health services.

Three-quarters of respondents reported being satisfied or very satisfied with the service they received during their most recent visit to a health facility [24], and the vast majority of respondents reported that facilities were clean, that they were listened to, and that their privacy was respected. However, respondents also reported often facing long waiting times, particularly amongst the poorer half of the sample, where 69% waited more than 90 minutes before being seen.

[24] *Respondents were asked to rate their satisfaction on a seven-point scale, with scores of 6 and 7 corresponding to satisfied and very satisfied, respectively.*

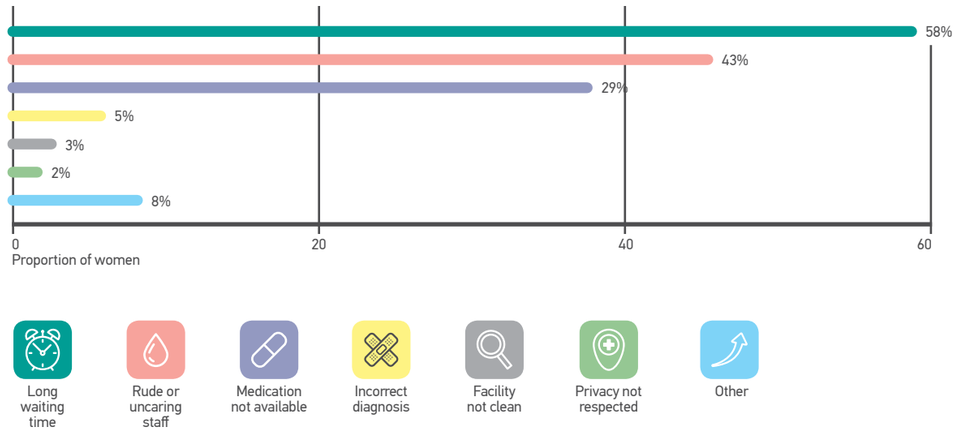
TABLE 10: EXPERIENCE DURING RESPONDENTS' MOST RECENT VISIT TO A PUBLIC HEALTH FACILITY

VARIABLE (INDICATOR REFERS TO THE PROPORTION OF WOMEN (%))	TOTAL	AGE OF FEMALE RESPONDENT			PROXY MEANS TEST SCORE	
		15 – 19	20 – 24	25 – 29	ABOVE MEDIAN	BELOW MEDIAN
Walks to health facility	71.42	80.52	73.06	63.58*	65.5*	74.72
Travel time >= 30 min	24.25	25.95	24.18	23.14	15.15***	29.34
Waiting time > 90 min	61.25	59.02	61.52	62.55	47.33***	68.99
Satisfied or very satisfied	75.92	83**	69.68	76.71	78.15	74.67
Facility was either 'clean' or 'very clean'	96.32	98.07	95.72	95.65	97.93*	95.43
Respondent was listened to well or very well	95.46	94.14	94.92	96.86	96.94	94.63
Privacy was respected	92.29	95.60	90.99	91.17	91.13	92.95

*Limited to respondents who visited a public health facility in the last year. Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20–24), and between the top age group (25–29) and the middle age group (20– 24).*

Amongst those respondents who were not satisfied with their most recent visit to a health facility (14%) [25], long waiting times was the most common reason given for their dissatisfaction *(see Figure 7)*. According to the Department of Health's national policy, patients should not have to wait more than two hours for services. [26] However, over half of respondents interviewed waited longer than 90 minutes to be seen, with over a quarter of respondents waiting longer than three hours. In the qualitative research, respondents reported waiting the whole day at the clinic without being seen and that, oftentimes, they would be told to return the following day. They felt that this was because many of the nurses did not work and took prolonged lunch breaks. Respondents also mentioned cases where only those who knew the staff or paid a small bribe were seen by the nurses.

FIGURE 7: REASONS FOR DISSATISFACTION WITH PUBLIC HEALTH FACILITY AT MOST RECENT VISIT



Source: bumb'INGOMSO baseline survey (2017). Limited to 108 respondents who visited a public health facility in the last year and were not satisfied with their most recent visit.

[25] *Satisfaction with the most recent visit at a public health facility was measured on a seven-point scale (very dissatisfied, dissatisfied, somewhat dissatisfied, neither dissatisfied nor satisfied, somewhat satisfied, satisfied, very satisfied). As quoted in the table, about 76% of respondents were very satisfied or satisfied, while 14% of respondents were very dissatisfied, dissatisfied, or somewhat dissatisfied. The remaining 10% of respondents were neither dissatisfied nor satisfied, or somewhat satisfied.*
[26] *National Department of Health (2015) National Policy on management of patient waiting time in out-patient departments. Pretoria.*

Other reasons for this dissatisfaction given in the quantitative survey, by those who were not satisfied with their most recent visit to a health facility, include staff being rude or uncaring (43%) and medication not being available (29%). When asked about the quality of health care services, respondents in the qualitative sample described the service as poor, citing long waiting times linked to shortages of staff, rude and lazy staff, and lack of medication as reasons for this judgement.

YOUNGER RESPONDENTS (AGED 19–22) ALSO REPORTED THAT THE CLINIC HOURS WERE INCONVENIENT AS THE CLINICS CLOSED EARLY AND THEY WERE UNABLE TO GET THERE UNLESS THEY SKIPPED SCHOOL. ONE YOUNG WOMAN DESCRIBED HER EXPERIENCE OF HER LOCAL CLINIC:
'The nurses just sit there. People arrive there in the morning. The nurses just take the files and sit down without calling anyone's name until lunchtime. When it's approaching knock-off time, that's when they start to work accordingly. Most who woke up and arrived early in the morning are told to come back tomorrow because they won't be able to get help today or that they don't have certain medication. At times, there are break-ins and some medication is stolen. They are unable to help the people.' (FGD young women 15–18, C2)

However, some respondents supplied a caveat to these observations by noting that nurses were very busy and under a lot of pressure, given staff shortages, and that many nurses showed care and tried to help patients.

In terms of missing services, despite the high prevalence of alcohol and drug abuse (see Section 4.1.4 in Chapter 4 on alcohol abuse), community members noted that there were no community support structures that the youth could turn to for specific help regarding substance abuse.

3.3.1 PERCEPTIONS OF SRH SERVICES

Throughout the qualitative interviews and FGDs, it became clear that there is a stigma attached to SRH issues in the communities visited. In particular, respondents reported that those in the community who were known to be HIV positive were judged and, in some instances, discriminated against. Respondents noted that those people who were HIV positive in the community came to feel a sense of shame fostered by this negative community reaction. Men were perceived to feel particularly uncomfortable with the stigma associated with HIV testing and HIV status, and expressed that they did not like to visit the clinic. One male respondent explained that 'it's a place for women' and that he preferred to visit the chemist, where they do not ask questions which he perceived as creating a sense of being judged (KII male youth volunteer, C5).

However, in some communities, and especially amongst older respondents (aged 23–29), this perception of stigma was challenged: 'Honestly it's all about taking good care of yourself. People are no longer scared to go to the clinic. Times have changed.' Another respondent added that 'People are no longer keeping it a secret. They are able to speak openly about it.' (FGD young women 23–29, C2).

ON BALANCE, THE DEGREE TO WHICH HIV REMAINS STIGMATISED WITHIN COMMUNITIES APPEARS STRONGER THAN THE EXTENT TO WHICH THERE IS ACCEPTANCE OF PEOPLE'S STATUS, AND THIS STIGMA IS ENOUGH TO DETER SOME PEOPLE GETTING TESTING:
'[…] people don't go to check [their status] because some people make jokes of other people when they see them in the room where pills are taken. So a person would rather give up and get sick because we as people judge each other.' (Female community member, C1)

The quantitative findings suggest that 92% of respondents who visited a health facility in the last year felt that their privacy was respected (see Table 10), with only 2% of women stating that lack of privacy was the reason for their dissatisfaction (see Figure 7). However, the qualitative research found that, across communities, there was a feeling that the privacy of those at the health facility was not respected, particularly with regard to SRH services and, in particular, HIV testing. This discrepancy between the quantitative and qualitative findings is likely to be because stigma and issues of privacy were largely spoken about with regard to SRH services, but respondents in the quantitative sample may have visited a health facility for any number of services, and therefore privacy may not have been as pertinent an issue.

Respondents listed a variety of factors that contributed to the lack of privacy they, and other community members, experienced when visiting health facilities [27] for SRH services. Practices within the clinics signal who is there for HIV treatment. Respondents complained that those seeking HIV treatment have to queue separately, the files used for these patients look noticeably different and pills handed to these patients reveal the type of treatment they are receiving to anyone present at the time. However, in some communities, steps have been taken to ensure the privacy of patients. In C2, young women spoke about a mobile testing facility that operated in the ward. Respondents felt that it was now much easier to be tested as nurses, from outside the community, came to people's homes, providing privacy and anonymity to those being tested (FGD young women 23–29, C2). In another clinic, pills were no longer distributed from a public window but rather from inside a room. Finally, in hospitals such as Frere, respondents noted that patients were not put into separate queues to seek HIV treatment. One suggestion for creating an environment in which young women and men feel comfortable to share their problems was to incorporate loveLife [28] into the clinics.

[27] *Respondents most commonly spoke about their experiences at the clinic*
[28] *Package of services including sexuality awareness among teenagers in South Africa*

Those who work at the clinic also live in the community and respondents feared that nurses and other people working at the clinic would reveal their status to others without respect for patient confidentiality. Respondents reported that gossip was rife within communities, which leads to fears about being judged for getting an HIV test or gossip about one's status. In some communities, nurses were said to make patients feel embarrassed and ashamed when they came in for treatment related to HIV.

YOUNG WOMEN IN C4 HAD TAKEN TO VISITING CLINICS IN OTHER COMMUNITIES WHERE NURSES WERE NOT KNOWN TO THEM, TO AVOID GOSSIP. A FEMALE RESPONDENT RECOUNTED HER EXPERIENCE AFTER VISITING A HEALTH FACILITY FOR AN HIV TEST:
'When you go to the section that caters for people that are HIV positive, the security also knows that you were there. For instance, I was married. I went to the clinic with my ex-husband at 2 pm because at that time the majority of people have knocked off. We went to test. We got tested. It was only a nurse and a security officer from my village. You know what, I was called by someone who was at [location anonymised] and said you went for an [HIV] test. You see what is happening in that clinic of ours?' (FGD young women 19–22, C4)

The issue of stigma, coupled with a lack of privacy at clinics, was also mentioned in relation to accessing family planning services by women aged 15 to 18. Young women reported feeling stigmatised for accessing contraceptives at local clinics. They reported feeling judged by the nurses as well as the community.

SOME RESPONDENTS REPORTED THAT THIS FEAR OF JUDGEMENT PREVENTED THEM ACCESSING CONTRACEPTION, WITH THE RESULT THAT THEY HAD TO 'LATER LIVE WITH THE CONSEQUENCE' (FGD YOUNG WOMEN 15–18, C2)
'When you go to the clinic, the first thing they ask me when I go for family planning is […] why are you coming for family planning? Are you sleeping with men? They make you feel uncomfortable because they ask you many questions instead of helping me or advising me. They judge me that I am still young and doing certain things. They do not even know why I am there, they just conclude.' (FGD young women 15–18, C3)

3.4 POLICE SERVICES AND SUPPORT SERVICES FOR GBV AND IPV

3.4.1 POLICE SERVICES

Table 11 shows the level of trust that respondents to the household survey have in the police. On a five-point scale, the average level of trust in the police is 3.25. In other words, about half of the respondents agreed or strongly agreed that they trust the police, that the police provide a service when the community needs it, and that the police treat people with respect. The other half of respondents either disagreed, strongly disagreed, or felt neutral about these statements.

TABLE 11: LEVEL OF TRUST IN THE POLICE AMONG WOMEN AGED 15–29

VARIABLE	TOTAL	AGE OF FEMALE RESPONDENT			PROXY MEANS TEST SCORE	
		15 – 19	20 – 24	25 – 29	ABOVE MEDIAN	BELOW MEDIAN
Police are trusted, respected, and provide a good service (out of 5)	3.25	3.23	3.26	3.25	3.27	3.23

*Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20–24), and between the top age group (25–29) and the middle age group (20–24). These scores are out of 5.*

The findings from the quantitative survey therefore suggest that there is a moderate level of generalised trust in the police. However, when asked more specifically about how the police respond to incidents, respondents in the qualitative interviews and FGDs expressed concerns about the fairness and efficacy of the police's response, particularly with regard to incidents of IPV.

Throughout the qualitative interviews and FGDs, it was clear that violent crime, including rape, murder, muggings, and robbery, is pervasive in the communities visited, and this is often fuelled by drug use. Respondents articulated that they did not feel safe in their communities and young women, in particular, felt targeted and threatened, especially at night and when alone. Negative perceptions of the efficacy of SAPS across the communities contributed to this feeling of insecurity.

IN DESCRIBING POLICE RESPONSES IN THE COMMUNITY, RESPONDENTS FELT THAT THE POLICE WERE SLOW AND SELECTIVE IN THEIR RESPONSE, OFTEN ARRIVING AT THE SCENE HOURS LATER OR EVEN ONLY THE FOLLOWING DAY. THEIR NARROW FOCUS MEANT THAT RESPONDENTS FELT THERE WERE CERTAIN CRIMES THAT THE POLICE TOOK MORE SERIOUSLY THAN OTHERS – WITH THIS DIFFERING FROM ONE COMMUNITY TO ANOTHER. A TAVERN OWNER DESCRIBED WHICH CRIMES ARE TAKEN SERIOUSLY IN C2:
'When people are killed. Sometimes they take rape seriously. What else? Fraud. If however the thieves broke into your house. You call them at 16h00, they will only arrive at 07h00. […] They weigh the cases and decide which ones to pay attention to.' (KII tavern owner, C2)

With regard to IPV, both young men and young women felt that SAPS do not take such reports seriously, encouraging women to 'talk it out' with their partners (FGD young women 23–29, C1), while men are laughed at. In addition, respondents reported that the police are afraid of thugs and therefore intervene only at times. This was considered, by some, as the police siding with criminals and failing to protect the community. This perceived neglect of duty put some community members off reporting crimes such as domestic violence or IPV, as they felt nothing would come of it. In cases where IPV is reported and protection orders issued, respondents reported that these were constantly violated and one respondent speculated that, because the victim and perpetrator allegedly often disregard the protection orders, the police might take reports of domestic abuse less seriously.

However, some respondents reported that the SAPS were understaffed and under-resourced in the communities, contributing to reduced efficacy. In particular, there were reports of not having enough vans to respond to calls. A tavern owner (C2) also perceived the police to be 'overpowered by crime', suggesting that they do not have the resources to respond to everything that happens within the community.

Respondents did not appear to have much faith in the justice system, recounting instances where dockets were lost, and cases where culprits were arrested and released the following day. Respondents reported that the police accepted bribes and, in exchange, dropped charges and released perpetrators.

OVERALL, RESPONDENTS FELT THAT THE COMMUNITIES IN WHICH THEY LIVE ARE UNSAFE AS THEY CONTINUE TO LIVE AMONGST CRIMINALS, BUT EQUALLY THEY FELT THAT THEY COULD NOT TRUST OR TURN TO THE POLICE FOR PROTECTION:
'We live with these people and we know that they are [criminals] but they have never been arrested for even a single crime they committed, but the police chose to side with them and arrest the members of the community. They have killed, they've murder[ed] and they have raped people but never have they been arrested. The police do nothing to protect the community of C2.' (FGD young women 23–29, C2).

Respondents also noted that they did not trust the police to keep their reports confidential. Firstly, respondents described that people in the community gossiped and, for cases of rape and IPV, they feared that the community would come to know of their situation, which would bring shame to them due to the stigma attached to experiencing sexual abuse or being raped. Furthermore, young women reported that they knew of cases where women did not report IPV because they wanted to protect their reputation and that of their partner: 'Violence happens in relationships [and] we cover up for [our partners] because we love them.' (FGD young women 19–22, C1).

SECONDLY, THROUGHOUT THE FGDS, IT WAS EVIDENT THAT RESPONDENTS HAD A REAL SENSE OF FEAR REGARDING REPORTING CRIME. THIS WAS PARTICULARLY RELATED TO FEAR OF RETALIATION OR REVENGE FROM EITHER THE COMMUNITY OR THE PERPETRATOR WHEN NAMING THE PERPETRATOR OF A CRIME:
'Still people are afraid of pinpointing the dealers because they will become victims and there is no confidentiality from the police station because you may report someone and then when the police go and search, they will mention your name. So I can say people are being selfish. They only think for themselves in this community.' (FGD young women 23–29, C4)

Other, more physical barriers to reporting crime or criminals include distance to the police station and a lack of airtime to be able to call 10111 [29], the emergency number. Finally, younger female respondents (aged 15–18) felt that they could not report instances of violence or other crimes to the police because they would not be believed due to their age.

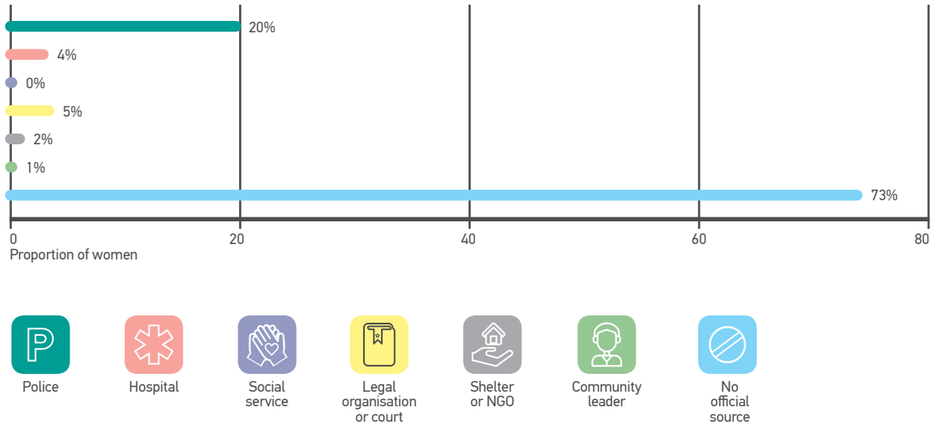
Across the communities (except C4) [30] there were many accounts of the community taking matters of justice into their own hands due to the widespread loss of trust in SAPS and the judicial system amongst community members.

RESPONDENTS REPORTED THAT, WHEN THE COMMUNITIES FELT THE POLICE WERE NOT TAKING MATTERS SERIOUSLY, THEY WOULD ADDRESS THE INCIDENTS THEMSELVES, USUALLY VIOLENTLY:
'It is painful for the community when they see people getting away with a crime. I do not understand how the court of law would give a murderer bail. I honestly don't understand. I think that the community doesn't understand either, because they end up coming with the solution to either kill or beat the culprit.' (FGD young women 23–29, C2)

This extra-judicial violence can result in members of the community being arrested for taking matters into their own hands, while the perpetrator of the original crime remains free. These situations further undermine people's perceptions of fairness, as they do not accept that the behaviour of the police services and the justice system meets their needs while upholding the rule of law.

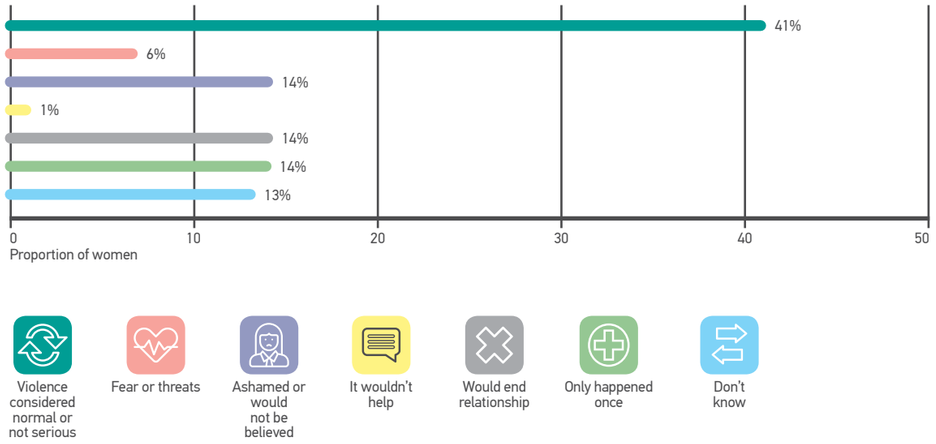
[29] *Normal cell phone call rates apply when calling 10111 from a cell phone but it is free to call from a landline. Calling the alternative emergency number, 112, is free from a cell phone and is possible on a cell phone without airtime.*
[30] *C4 is a unique community in terms of reporting to the police as all reports have to go through the headman or local council, who then choose what to report to the police and take charge of the incident.*

FIGURE 8: OFFICIAL SOURCES WHERE RESPONDENTS WHO HAD EXPERIENCED IPV SOUGHT HELP



Source: bumb'INGOMSO baseline survey (2017). Limited to 169 respondents who were in a relationship in the last 12 months and experienced sexual or physical IPV in the last 12 months.

FIGURE 9: REASONS WHY WOMEN DID NOT SEEK HELP AFTER EXPERIENCING IPV



Source: bumb'INGOMSO baseline survey (2017). Limited to 126 respondents who were in a relationship in the last 12 months and experienced sexual or physical IPV in the last 12 months and did not seek help from an official source.

3.4.2 HELP-SEEKING BEHAVIOUR FOR GBV AND IPV

Experiences of GBV and IPV are common for young women. The quantitative survey found that 26% of young women who had been in a relationship in the past 12 months had experienced sexual or physical violence perpetrated by their partner in the past 12 months. However, given the stigma and unwillingness to report *(see Section 3.4.2)*, this is likely a lower bound estimate. Experiences of GBV and IPV are discussed further in Chapter 5, while the remainder of this section focuses on respondents' help-seeking behaviour amongst those respondents who had experienced GBV or IPV.

Of the women in the household survey who reported having experienced physical or sexual violence in the last 12 months, the vast majority (73%) did not seek help from any official institution (see Figure 8). Amongst the respondents who did seek help, 20% went to the police, 5% went to a legal organisation, and 4% went to a hospital or health service. Almost no one sought help from social services, shelters, or NGOs. While we did not ask any follow-up questions to confirm this, it is possible that respondents lack awareness of these services or how to access them. Respondents in the qualitative research also felt that ward committees, in particular, and other support structures did not have the requisite skills to deal with these incidents. While few respondents who had experienced IPV went to an official source for help, the majority of respondents (60%) did speak about their experiences to their friends or family.

Figure 9 shows the reasons provided by women for not seeking help from an official source after experiencing IPV. The most frequently reported reason was that they considered violence to be normal or not serious (41%). However, young women in the qualitative research were able to clearly identify acts of emotional, physical and sexual violence and talked about them in a serious manner during the FGDs, particularly when violence happened to someone they knew rather than to themselves.

Respondents justified violence and coped with physical violence by associating it with love, stating that 'we often say that when your man hits you, he is strengthening the love or the relationship, he shows his love by beating you up' (FGD young women 19–22, C1). For some, a relationship without violence was considered to be a relationship without love. However, young women recognised the flaw in this logic and acknowledged that, while they wanted to break out of this cycle, it was difficult to change. Additionally, young women stated that they covered up for their partners, often lying about the source of their injuries, and did not report because 'we want our relationships to survive' (FGD young women 19–22, C1), a finding supported by the quantitative survey, in which 14% of women said they did not report for fear it would end the relationship.

Some respondents admitted that there was also a feeling of shame associated with experiencing physical or sexual abuse, and therefore they did not want others to know about these experiences. Others stated that 'few people report [sexual abuse] because they are scared of seeing that person again and what that person will do' (FGD young men 23–29, C2). Finally, younger women (aged 15–18) and women who have experienced abuse from an older man, especially a provider in the household, felt that reporting was futile as no one would believe them.

3.5 MAIN CONCLUSIONS AND IMPLICATIONS FOR TOC

3.5.1 WHAT FACTORS INFLUENCE YOUNG WOMEN'S PERCEPTIONS OF OPPORTUNITIES AS 'REAL'?

The concept of 'real opportunities' refers to the programme's assumption that young women have a sense that opportunities are available to them, accessible by them, and, in the case of education and employment opportunities, achievable even if young women have not yet accessed them. While there are individual factors that influence the 'realness, or reality' of each type of opportunity or service targeted by the programme, stigma and the fear of being judged by the community is an overarching theme that holds young women back from making the most of opportunities and utilising services, and, hence, renders them 'unreal'. While drug abuse and teenage pregnancy do not, in and of themselves, force learners to drop out of high school, the stigma associated with both of these is considered powerful enough to deter young women from returning to school. Similarly, the stigma associated with HIV testing, coupled with a lack of privacy at health facilities, or the stigma associated with reporting sexual violence to the police, as well as the police's perceived disregard of confidentiality, deters young women from utilising these support services within the community.

Aside from stigma, each opportunity or support structure faces unique challenges in being perceived as 'real' for young women in BCMM. In terms of education opportunities, financial constraints are considered a large barrier to completing high school and enrolling in tertiary education, and lack of funding makes tertiary education opportunities, in particular, feel 'unreal' or unattainable. Similarly, poor academic performance, coupled with a lack of information about education opportunities, contributes to the feeling that further education opportunities are out of reach and therefore, not an option (or unreal), for some young women.

Employment opportunities are considered particularly 'unreal' amongst young women in BCMM. Given the extent of unemployment of young women aged 15–29, women perceive job opportunities to be scarce, making jobs feel 'unreal' because they are perceived to be unavailable. This sense is particularly acute for those residing outside of East London and facing high transport costs to get to the city in order to apply for and interview for jobs. In addition, respondents believed that jobs were only available for those who were 'well connected', and that issues of nepotism dictated who was given a job. In terms of accessibility, young women feel underqualified and inexperienced for jobs they might like to apply for, and do not feel well-equipped to prepare their CV or prepare for a job interview, further contributing to a sense that employment opportunities are not real for them.

Physical access to health services does not appear to be an issue. While waiting times are reported to be long, and some patients are not seen on the first visit, this does not seem to result in respondents viewing health services as inaccessible or unavailable, and hence 'unreal', but rather it results in them considering service delivery to be poor. As mentioned above, the stigma of accessing SRH services is the main deterrent for young people who would like to access health services. However, respondents noted that there were no health facilities that provided support for young people abusing drugs and alcohol, and that this was an area in which they felt additional support was needed.

Finally, in terms of police and judicial support structures, the selective response of the police to crime in the communities makes police services feel ineffective. This lack of or limited response deters some community members from reporting crime, and particularly IPV, as they consider police services to be lacking and hence unavailable or 'unreal' for young women. This is exacerbated for the youngest women, aged 15–18, who reported refraining from reporting incidents of IPV because they felt they would not be believed. At the community level, this sense of 'unrealness' with respect to police and judicial structures results in community justice, where community members take matters into their own hands as they feel that there is nowhere else to turn.

3.5.2 HOW DOES THIS RELATE TO THE PROGRAMME'S DESIGN?

IN TRYING TO CREATE REAL POSSIBILITIES, BUMB'INGOMSO ASSUMES THAT ADDRESSING RESPONSE AND SUPPORT MECHANISMS WILL LEAD TO YOUNG WOMEN IN BCMM FEELING THAT THERE ARE REAL POSSIBILITIES AVAILABLE TO THEM. THESE POSSIBILITIES AFFECT THE CONTEXT IN WHICH YOUNG WOMEN PERCEIVE RISK, WHICH THE PROGRAMME ASSUMES GOVERNS INDIVIDUALS' CHOICES AND THE BEHAVIOUR OF YOUNG WOMEN AND GIRLS.

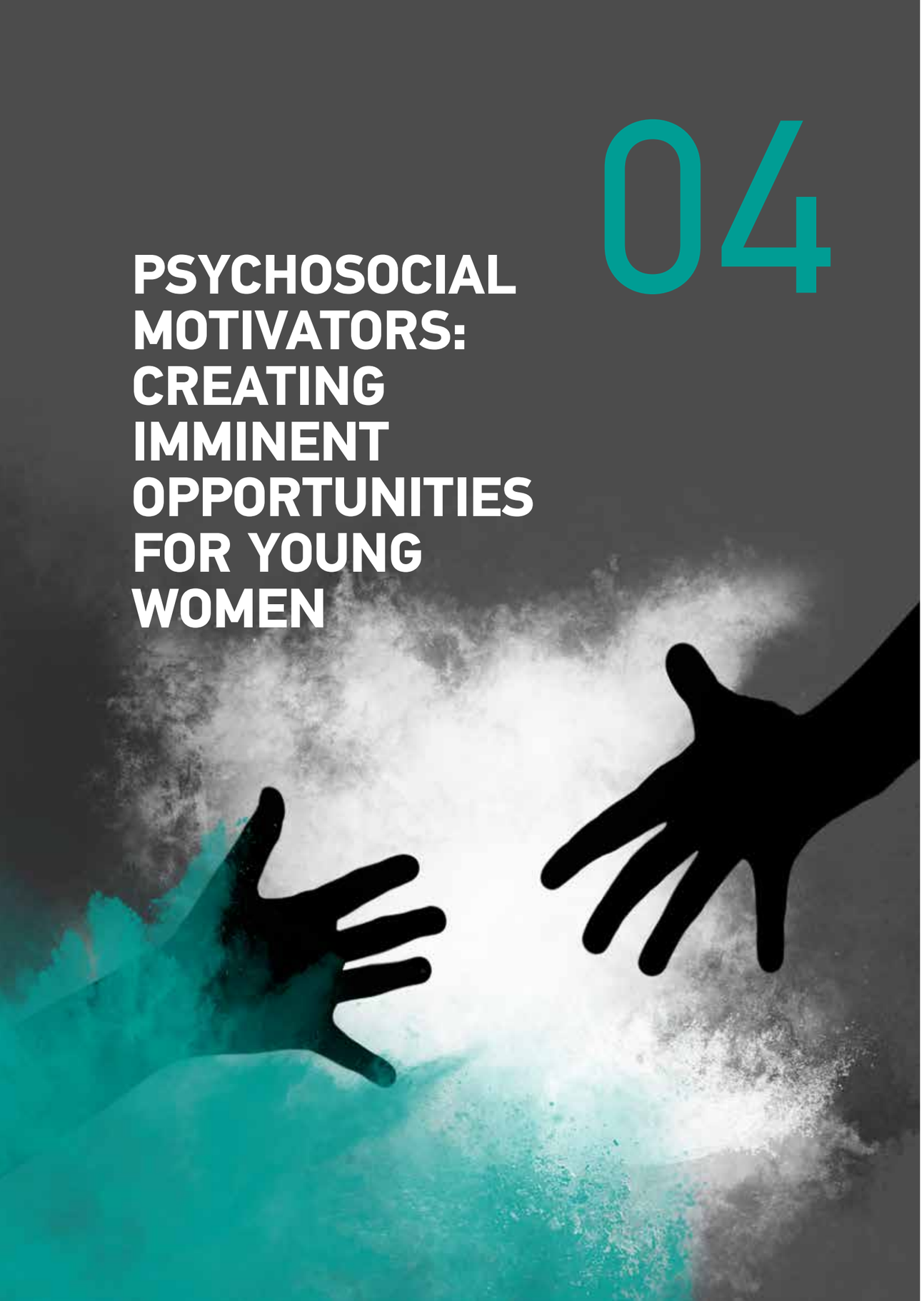
As the findings indicate, young women have interacted with each of the 'response and support mechanisms' highlighted in the TOC and have had varied experiences with each. In terms of education, young women generally tend to value education but, due to poor academic performance and financial constraints, are not able to pursue further education opportunities. Young women tend to have quite a pessimistic outlook in terms of the possibility of finding a job and the findings indicate that many young women have become discouraged and have stopped looking for work. Young women's experiences with health services are varied. It appears that, despite poor service delivery and long waiting times, young women are generally satisfied with general health services but face stigma and a lack of privacy when it comes to accessing SRH, which deters some young women from accessing SRH services. Finally, young women have a negative perception of police and judicial services and many young women have been deterred from reporting crimes, and particularly incidents of GBV or IPV.

While a key assumption behind the Bumb'INGOMSO programme is that youth will use services if service delivery is improved through established response and support mechanisms, our findings caution that respondents' past experiences may to some extent influence whether or not they choose to embrace these opportunities and services once they are improved. In this respect, it will be important to ensure good communication and sensitisation as part of the programme, to change young women's perceptions of these opportunities and services.

While the design of the programme as a whole speaks to the needs of young people in terms of improving access to education and employment opportunities, and improving service delivery in terms of health services and police and judicial services, each intervention will need to be tailored to the factors outlined in Section 4.2.1 that contribute to each of these possibilities currently being perceived as 'unreal'. In particular, each of the interventions, and the programme as a whole, will need to tackle stigma in the communities in order to ensure uptake of the opportunities and use of the services. Of particular relevance for the programme in pursuing its ultimate intended impact of reducing the rate of new infections of HIV will be tackling the stigma around HIV, which creates a barrier to testing and treatment and adds to the risk of potential transmission of HIV, which has implications for how Bumb'INGOMSO will achieve this goal.

04

PSYCHOSOCIAL MOTIVATORS: CREATING IMMINENT OPPORTUNITIES FOR YOUNG WOMEN



THE BUMB'INGOMSO HIV PREVENTION PROGRAMME INTENDS TO DECREASE THE RATE OF NEW INFECTIONS OF HIV IN BCMM, ESPECIALLY FOR YOUNG WOMEN AND GIRLS. THE PROGRAMME INVOLVES FOUR INTEGRATED INTERVENTIONS, WHICH, THROUGH DIFFERENT CHANNELS, ARE EXPECTED TO POSITIVELY INFLUENCE FIVE PSYCHOSOCIAL MOTIVATORS: 1) IDENTITY; 2) AGENCY; 3) BELONGING; 4) VITALITY; AND 5) PURPOSE. OUR ANALYSIS OF THESE MOTIVATORS FOCUSES ON 'PUBLIC PORTRAYALS', WHICH REFER TO HOW YOUNG WOMEN AND GIRLS DESCRIBE, EXPLAIN, AND SPEAK OF THEMSELVES. [31]

The chapter is structured around the motivators. The first section presents findings on identity by looking at how women view themselves in relation to others in their community, who they were in the past, and how others see them. This section relies mainly on life histories to illustrate the fluidity of identity across time, circumstances, and experiences. The second section discusses purpose, women's ambitions, their perceived ability to attain their dreams, and how they respond to the perceived and real opportunities in their environment. Next, the discussion focuses on community and interpersonal dynamics, and how these affect young women's sense of belonging in BCMM. The last part of the chapter presents findings on vitality, analysing feelings of boredom, coping mechanisms, and young women's sexual health attitudes. Agency is a motivator that cuts across and accompanies decision making related to the other four motivators. It is thus discussed in the context of the data presented in the other sections of the chapter.

A brief description of the interventions in light of their linkages to the motivators is presented below.

The SPF focuses on influencing behavioural change, ultimately creating a collective sense of identity, belonging, and purpose. SPF aims to inspire and enable young women and girls to access information, develop skills, take charge of their own lives (agency), and take action (at individual and collective levels). It aims to do so through, for instance, the creation of a Leadership Network, which will offer a platform for young women and girls to develop leadership skills, build a sense of community, and encourage action.

Masimanyane aims to reduce the incidence of GBV through mechanisms that affect women at individual, community, and structural levels. Like SPF, Masimanyane's objective is to influence behaviour change by increasing young women's sense of agency and by challenging traditional gender roles that may place men in positions of power over women. To achieve this, some of the activities focus on individual counselling and support groups, as well as training women on GBV and rights. Additionally, Masimanyane aims to change community perceptions and attitudes toward young women and violence, through community forums, training, and mobilisation. Ultimately, these activities aim to increase young women's and girls' sense of belonging in their community. Masimanyane's programming is intended to influence young women's sense of agency, by ensuring they are able and have the support to make decisions concerning their safety and well-being.

AS NOTED IN THE INTRODUCTION AND ELABORATED IN *ANNEX A*, BEYOND ZERO AND HARAMBEE FOCUS ON IMPROVING THE INFRASTRUCTURE OF RESPONSE MECHANISMS AVAILABLE FOR YOUNG WOMEN AND GIRLS. THE OBJECTIVE OF THESE PROGRAMMES IS TO ACHIEVE LARGE ENOUGH CHANGE IN THE RESPONSE AND SUPPORT ENVIRONMENT TO INFLUENCE A CHANGE IN:

a) agency, as young women and girls feel they are able to access the services required to maintain good health and have economic independence;

b) vitality, as young women and girls adopt health-seeking behaviours, including accessing health services when needed; and

c) belonging, as women feel that they are able to achieve their objectives through access to services in their own communities.

[31] *There is a limitation of social desirability bias when relying on public portrayals of self, i.e. respondents aim to portray the image of themselves that they believe to be 'right' or that the interviewer 'wants to hear'.*

4.1 WHO IS A YOUNG WOMAN IN BCMM?

This section describes and analyses the experiences of young women in BCMM with respect to the five motivators presented above: identity, belonging, purpose, vitality, and agency. [32]

4.1.1 IDENTITY

In this evaluation, identity refers to young women's sense of self. To grasp identity across time, circumstance, and experience, we collected women's life histories, analysing how respondents described and viewed themselves in relation to those histories. These life histories are illustrative – they do not represent the experience of all young women in BCMM, but serve to show how context and experience influence how women think of themselves and the opportunities they have (perceived or real). This section thus relies primarily on IDIs, which helped us better understand how young women's sense of identity in BCMM was formed, how it has changed over time, and how it is very vulnerable to change due to changed circumstances. These themes are then triangulated with discussions from FGDs.

Our findings highlight the vulnerability of identity to shocks. By shocks we refer to factors that may drastically change the circumstances under which young women live, the opportunities they have access to, and the risks they are exposed to. The way women's sense of self changes in response to these shocks stresses the fluidity of identity. Several respondents alluded to the impact of these shocks on their identity, marking a stark difference between how they described themselves before and after the shock. In some cases, these shocks are associated with a place, and therefore their identity is also tied to their relationship to place. The case of Nande, a respondent from Community 1, clearly illustrates these complexities of identity.

Nande was born in East London but grew up in Port Elizabeth. She described her life in Port Elizabeth as good: her family had a house; she was able to attend a school with adequate resources and provisions, where teachers supported her; and she had a good social network, where her family friends and her own friends treated her well. However, her family had to return to East London when her father lost his job and was unable to make a living in Port Elizabeth. In East London, her father 'ate the money', and started drinking, unable to support his family financially. She was unable to continue studying in East London, as she could not pay her registration fees.

HER LIFE IN EAST LONDON WAS ALSO MARKED BY TWO SIGNIFICANT EVENTS: SHE CONTRACTED HIV, AND SHE SERVED TIME IN JAIL FOR STABBING A WOMAN HER THEN-BOYFRIEND WAS ALSO DATING WITHOUT HER KNOWLEDGE:
'When I was in Port Elizabeth I was a good girl. I was a listener. I was always humble. I didn't have any anger. I was, it seems like I was a blessing to others because I could share…When I came here I became a rascal. A thug. So many things that I became here in East London. And I've been known to be a stabber. A jailbird. So things change.'

Nande described her life in East London with anger and embarrassment, given the difficulties she faced, the lack of opportunities she had, and the ways in which these factors pushed her to lead a different life than the one she had in Port Elizabeth. While Port Elizabeth was associated with a positive sense of identity, the move to East London was presented as the backdrop to negative experiences, namely the fall in socioeconomic status that followed her father's loss of employment, and the situation of vulnerability she and her family were in. Although her sense of self changed as a response to shocks, she attached her identity mainly to place, even though she could have faced the same circumstances in Port Elizabeth.

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[32] *All names and direct personal identifiers have been changed throughout the report to protect the respondents' anonymity.*

In another example, a respondent from Community 2, whom we will name Sisanda, highlighted how her identity has changed in response to shocks. Sisanda was born in East London but moved to Cape Town and Pretoria after finishing school. She decided to return to East London after the passing of her mother and to claim RDP housing. [33] She describes her life in Pretoria as 'great' because she was working and earning an income. When she moved to East London she faced unemployment and was unable to start a catering business, which was her dream.

THIS IDLENESS AND HER INABILITY TO SUCCESSFULLY CLAIM RDP HOUSING SEEMED TO HAVE IMPACTED HER SELF-CONFIDENCE. WHEN SHE SPOKE OF HERSELF IN THE PAST, SHE PROUDLY PROVIDED EXAMPLES OF PERSEVERANCE AND MOTIVATION:
'Even by the time my sister was graduating. I was the one who was doing the speech. And they told me "you know what? On your sister's graduation, you were the one who was doing the speech". I said, "Serious? I can't remember that." But they told me that the words [I] said [were] so big, they were bombastic words. I said, "hmm…me saying those things! How old was I?" They said, "I think you were 10–13."'

Sisanda relied on stories from others to give the interviewer an idea of who she had been. All the stories she shared pointed to her personal qualities, but she spoke of this from the perspective of the past, rather than the present. It seemed like these stories were used as an external validation to herself and to others that who she was now was not definitive or static, and was not who she had always been.

FOR EXAMPLE, SHE SPOKE OF A COUSIN WHO HAD ONCE TOLD HER THAT SHE WAS BRILLIANT BUT HAD NOW CHANGED:
'My cousin…once told me "you know, Sisanda, by the time you were growing up, you were very very brilliant…" And then she asked me, " what happened to you because now you are not the same as you used to be?"…Maybe something disturbed me…I don't want to lie, I don't know what changed…maybe [at some point] I will find out what went wrong, but they are saying that I was brilliant.'

The shock of losing her mother and having to return to East London had a negative impact on Sisanda's sense of self. While in Pretoria she had opportunities, in East London she felt she was faced with an absence of employment. Additionally, her inability to obtain RDP housing proved to be a significant source of frustration, impacting her confidence and perseverance. As in Nande's case, Sisanda reflected on a distant past where she was considered 'brilliant', and perceived herself as a better person, while now the difficulties of her life in East London have led to lower confidence and self-esteem.

Identity is also shaped in response to how young women set boundaries for themselves. These boundaries are set around attitudes and behaviours, such as not being willing to consume drugs or engage in transactional sex. Boundaries are motivated both by women's own experiences and the impact of past behaviour on their lives, and by what they perceive to be 'wrong'.

For example, a respondent from Community 2, whom we will call Zethu, grew up in a household that was not supportive, with parents she later found out were not her biological parents. She grew up witnessing her grandfather abusing her grandmother, and her family struggling with poverty. She also described herself as the victim of abuse from her father and her brother, both of whom mistreated her emotionally and physically. She survived these circumstances without the support of her mother, who ignored the abuse. Zethu defined herself primarily in relation to her role as a mother. She commented that she wanted to be strong for her children, and did not 'want to be a loser mom…who cannot be protective [of] her children'. She continued: 'I don't want my past to control my future…I do need help but my past is not written in my face and [I] will not go prostituting because I want to make ends meet for my children, I am not that kind of person…'. Zethu established boundaries to what she was willing to do to improve her life and that of her children. How she defined herself and whom she wanted to be (i.e. 'a good mother') were influenced by her past experiences – her identity was built to support a future for herself and her children that ensured her children did not grow up under the same negative circumstances she did.

IN NANDE'S CASE, SHE WANTED TO ATTEND HIGHER EDUCATION DESPITE HER INABILITY TO PAY FOR REGISTRATION FEES. SHE MENTIONED THAT A BUSINESS COLLEGE HAD ESTABLISHED A CAMPUS SHE COULD ATTEND OR GET A JOB AT. HOWEVER, TO GET IN 'YOU HAVE TO BRIBE SOMEONE'. SHE EXPLAINED:
'I'm afraid because most of the things that other children have experienced are that when they are looking for work, their bosses want to sleep with them. So, since I've heard some other stories from other children, I couldn't go and look for work because I don't want someone to take advantage of me just because I'm poor or because I'm hungry. Because I know I'm hungry in my stomach but I'm not hungry in my mind.'

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[33] *In fact, this seemed to be the focus of her life. This respondent was not only part of an IDI but also participated in an FGD. In both, she spoke about herself in relation to her struggle with getting the property that should have been rightfully awarded to her mother.*

As illustrated earlier, Nande expressed a sense of embarrassment when she spoke about how others perceive her: 'a jailbird', 'a rascal'. Part of the way she fought this negative identity attributed to her by others was by pursuing her objectives in ways that would not confirm what others were saying about her. In this case, that vulnerability would come from engaging in a form of transactional sex that would guarantee her employment. As she stated: 'I can't let anyone force me to do something anymore because I've seen the consequences.' Her boundaries were therefore informed by the impact her past actions had had on her life and her sense of self.

Although in these examples, poverty and the negative circumstances surrounding the lives of Nande and Sisanda had influenced their perception of who they were (in relation to who they had been, in a different place and time that were both 'better'), they still held a sense of control over who they could become. In both cases, the person they wanted to become was not someone who achieved 'success' or progressed in life on the back of transactional sex.

This boundary-setting was also apparent in conversations with women in FGDs. One participant commented: 'As a woman you must love and respect yourself. Men love women who respect themselves. As a woman in a relation[ship] you have dignity and pride. If you respect yourself, then people will respect you. Men will respect you for loving yourself.' (FGD young women 23–29, C2). Another respondent commented: 'I am not like many in my area because I love telling the truth. I stand for the truth, therefore I stand for what I believe. I don't have friends, nor do I have a boyfriend.' (FGD young women 19–22, C1).

These examples illustrate that young women's sense of self influences their sense of agency and their ability to set boundaries in relation to what they think could be damaging or negative responses. Respondents had a strong idea of what they were and were not willing to do to have friends, be in a relationship, get a job, or study. Indeed, young women had a strong sense of self-awareness of who they were and wanted to be – i.e. a protective mother, a woman who loves herself, a woman who tells the truth, a woman who has to respect her partner – and this sense of self had the potential to shape the boundaries they set around their attitudes and behaviours. As discussed in the following section, young women's sense of self in BCMM influences how they describe their futures and their sense of purpose and ability to achieve what they want for themselves.

4.1.2 BELONGING

In this evaluation, belonging refers to an affinity with a place and the people who live in it. It is characterised by feelings of 'Ubuntu' [34] or unity, and marked by a sense of active membership to a community where individuals trust and support each other. Belonging as a thematic area was consistently raised by respondents in BCMM. Belonging was typically presented by young women as a feeling they desired to have but currently did not experience. In this way, young women spoke of belonging in negative terms, describing the absence of belonging rather than a sense of current belonging.

There appears to be a generally weak social fabric in Bumb'INGOMSO's target communities that manifests itself in a general absence of support and trust. Amongst respondents aged 15–29 in the quantitative research, over half of the respondents perceived trust in their community to have gotten worse over the past two years, as presented in *Table 12* below.

TABLE 12: PERCEPTIONS OF TRUST AND SOLIDARITY

VARIABLE (INDICATORS REFER TO THE PROPORTION OF WOMEN (%))	TOTAL	AGE OF RESPONDENT			PROXY MEANS TEST SCORE	
		15 – 19	20 – 24	25 – 29	ABOVE MEDIAN	BELOW MEDIAN
Believes trust in community has gotten worse	56.45	52.64	58.27	57.86	54.49	57.93
Believes in community support towards common goal	44.25	43.64	42.99	46.04	49.02**	40.59

*Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20–24), and between the top age group (25–29) and the middle age group (20–24).*

[34] *A common description of unity or working together in the South African context, derived from the Zulu statement 'Umuntu ngumuntu ngabantu', which, literally translated, means 'a person is a person through other people'.*

The absence of trust and support was particularly evident in cases where young women wanted to improve their lives and took steps to self-actualise. Respondents offered examples of cases where they not only lacked support from their peers or their community, but where they were actively sabotaged. For example, when Nande decided to stop giving into peer pressure, and stopped drinking and doing drugs, her friends responded negatively: 'Nobody wanted me, even in my area. Those I used to smoke with, they said you are making yourself better now, you think you are better now. Look, you are ugly.' Another respondent from Community 2, whom we will call Singa, explained how she wanted to 'build a future for [her] kids' and had started a business as the organiser of events and parties in her community. However, she found the process of making her business grow difficult. She explained: 'In my business, there are people that are saying that I have bad service and if someone comes to me for help, they would say that I [did not] help them.' Other respondents raised similar issues. When asked how the community would react to youth graduating from high school, finding a job and fulfilling their dreams, a respondent commented: 'People react differently…There are those who say that you think you are better than them. [These people] will isolate themselves from you because [of who] you are…They will not want to be close to you.' (FGD young women, 15–18, C3).

REMINISCING OF HER CHILDHOOD, A RESPONDENT PRESENTED A STORY THAT ENCAPSULATES THE WAYS IN WHICH PEOPLE TEND TO REACT TO PERCEIVED SUCCESS:
'You see, the experience I had was very tough…My mother left me [to live] at a friend's house…At first, I was treated well where she left me. I attended school and did well in class, but [then] the family started to think I was trying to be better than their children. So I was pulled out of school to herd animals and when the teachers asked them about me, they would say I am preoccupied with boys. So the very people who were supposed to be my parents had turned on me because how could I be better than their children.' (FGD women 30+, C1)

The expressed absence of support and trust is arguably symptomatic of the weak social fabric underlying these communities. Given that the context in which people live is marked by a lack of opportunity, violence, substance abuse, unemployment, and poverty, a sense of belonging often comes from the fact that community members feel they are in a poor situation together. When individuals try to improve their lives, they act as reminders to the rest of the community of what they are not or do not have. These instances appear to encourage feelings of jealousy and rejection towards those who succeed or are trying to achieve improvements, with respondents indicating that communities are not founded on a strong sense of unity or Ubuntu, but on an affinity that is weak and limited to negative experiences that are common to most. In fact, less than half of the respondents aged 15–29 in the quantitative research believed that community members would be willing to contribute time or money towards a community project that serves a common goal. While this could be a positive common ground on which to encourage unity, the current sense of 'belonging' seems to be born out of the common negative circumstances the community lives in.

This weak social fabric guides how young women define and describe friendship. Indeed, friendships seem to be largely characterised by peer pressure rather than trust or support. The desire to fit in leads to friend dynamics that are largely guided by the wish to meet group expectations, rather than expectations that may be informed by individual interests and objectives. Speaking of why young women drop out of school or get pregnant, a respondent asserted: 'If your friends are doing something and you do not want to, they will not want to go with you [so] you are forced to join as you do not want to lose [their] friendship'. (FGD young women, 15–18, C3).

Similarly, dating and belonging appear to be closely intertwined, with much of women's worth and sense of belonging dependent on having a boyfriend. When asked why young women date, a respondent explained: '[They date because of] peer pressure from home and friends. People laugh at you as if there is something wrong [if you are not dating].' (FGD young women, 23–29, C3). There is thus a sense of 'value' attached to having a boyfriend, and respondents described how in order to 'fit in' with your friend group, you need to have a boyfriend as 'all your friends have one' (FGD young women, 19-22, C2). To this extent, 'belonging' or 'fitting in' does not only define your direct actions and behaviours within the friendship, but also your broader life choices, such as staying with a boyfriend.

Moreover, in the case communities friends are mostly described as people you spend time with, with a perception that there is a lack of 'genuine' friendships. For example, with regard to friendship and trust, a young woman said: 'A friend is the one who will backstab you at the end' (FGD young women, 23–29, C1).

EVEN WHEN A FRIEND IS DEFINED POSITIVELY, THERE IS STILL A HIGH LEVEL OF MISTRUST AND SCEPTICISM IN THE VIEWS ON FRIENDSHIP:
'A friend is someone who will go through your ups and downs with you. Someone who will never make your life something for others to joke about, even if you fight, no matter what happens, even if a third party enters the equation. [But] you can't have three people being friends. That's not a friendship. What happens when one person isn't there? With the two that are left, one will ask something about the other one that isn't there and that can lead to lies. Maybe you like both your friends but then one will tell you that the other said something bad about you but if there were two of us, there would be no talking behind each other's backs…The good thing about being two people in a friendship is that you always know who is spreading your secrets.' (FGD young women, 19–22, C1)

In this case, although the respondent started by defining friendship positively she put boundaries on that friendship, motivated by the fear that, otherwise, the friendship could lead to lies, gossiping, and the spreading of secrets. In other words, friendship can only be good and trusted when the opportunities for betrayal are minimised.

The quantitative study found that the majority of respondents reported having at least one confidante with whom they could talk about sensitive topics, such as relationships, pressure to have sex, HIV, and violence in relationships. Having a confidante implies placing a high level of trust in someone, particularly when the issues discussed can be difficult and triggering. Thus, although it may seem that the quantitative findings contradict the qualitative study's finding that friendships are not characterised by trust, it is important to highlight that a confidante may not necessarily be a friend – it could be a teacher, a relative, or someone outside the peer group. Further, younger respondents, who were likely to be at a time in their lives when they were having their first intimate or sexual relationships, were significantly less likely to have such a confidante compared to older women. Similarly, poorer women were less likely to have confidantes, which may speak to the fact that access to non-peer confidantes (such as teachers) was lower. Therefore, these findings suggest that young women in Bumb'INGOMSO's target population currently have few sources of support and guidance, particularly amongst their peers.

Although respondents stressed that they desire to belong and satisfy the expectations of friendships, many exercised their agency by choosing to 'not belong' and to isolate themselves from the circles of peers they considered negative. From the perspective of peer pressure, respondents described the ultimate sense of agency as rejecting friends and, in some way, isolating themselves from those deemed to be a bad influence, despite the rejection and potential sabotaging that followed. This was well illustrated in exchanges between participants during FGDs. In one FGD, a participant said that bad friends are those who 'tell me that we must go out every weekend', to which another respondent replied: 'Look, you are able to say no if you do not want to go to [the tavern]. You are not forced to go there, you go because you want. [Friends] don't force you to drink, you drink because you want to.' (FGD young women, 15–18, C1). In the case of Nande, she decided to leave friends behind and attend church in order to improve her life.

A YOUTH VOLUNTEER (C5) WE SPOKE TO ALSO GAVE INSIGHT INTO HOW THE DECISION TO LEAVE FRIENDS BEHIND, ALTHOUGH DIFFICULT, IS A CLEAR WAY TO ASSERT ONESELF IN COMMUNITIES WHERE PEER PRESSURE CLOSELY GUIDES BEHAVIOUR:
'For me, fitting in is not an option. I don't even prioritise that…I'll fit in with myself…for me I came here on my own for starters. To make friends here and then decide to be like them is actually not an option for me. If my friends tell me [that] tonight it's Friday and [we should] go to [the tavern], I simply tell them [that] that place is not for me. And for that I [would] rather lose the friend.'

Despite the pressures to 'fit in' being motivated by a desire to satisfy peer and community expectations, respondents acknowledged that behaviour is ultimately an individual decision. In other words, even if it seems that peer pressure forces youth into acting in certain ways, those actions are, in the end, the result of individual decision making of people who have the agency to say no. However, the alternative to 'belonging' is not easy, as it involves not having friends and isolating yourself in communities where the opportunities to build a sense of belonging are so scarce.

Thus, with regard to belonging, youth identified agency in the context of choosing friends and determining how to respond to the negative attitudes of the community towards them should they choose to 'be better'. This is tied to purpose and identity, as young women suggested that being better may sometimes require losing friends, isolating yourself from the community. However, this is by no means an easy decision, as the choices are limited and often negative. Thus, while a level of agency is present and young women seem to have a desire to be fully in control of themselves, their lives, and their futures, a context that is restrictive does not allow for agency to play a strong role in decision making.

4.1.3 PURPOSE

PURPOSE REFERS TO THE ABILITY OF INDIVIDUALS TO HAVE DIRECTION IN LIFE AND TO BELIEVE THAT THEY CAN ACHIEVE ONE OR MULTIPLE ULTIMATE GOALS. IN OTHER WORDS, PURPOSE REQUIRES BOTH HAVING AN OBJECTIVE AND BELIEVING THAT YOU CAN ACHIEVE THAT OBJECTIVE. THIS SECTION THEREFORE STUDIES THE SENSE OF PURPOSE IN YOUNG WOMEN IN BCMM BY LOOKING AT THEIR DREAMS AND MOTIVATIONS.

In BCMM, young women's sense of purpose is influenced by their gender and age. While young women focus more on professions that allow them to help others, men are more detached from a desire to improve life in their communities. For instance, when young women were asked what they would do if they were president for a day, their responses focused on improving their communities. In FGDs, the following jobs were identified: psychologist, social worker, lawyer, and even TV presenter, to focus on programmes with subjects that affect children. Responses from men, on the other hand, generally included being a pilot, a police officer, and a soldier, and they did not suggest that these professions were motivated by desires to help the vulnerable or contribute to their communities. This is likely to be largely influenced by often strong normative stereotypes and ideas of 'masculinity' and 'femininity', where a stronger care responsibility is typically placed on women from an early age, and then continues as a gendered expectation. Men are more often encouraged to consider individual drive, as expectations are typically more related to a responsibility to provide, than to care.

Common to both men and women was the fact that dreams changed with age, and moved from 'dreams' to, what was perceived as, more realistic expectations, largely motivated by poverty and basic needs. Respondents in older age groups primarily showed an ambition to work, no matter the profession or job: 'I would like to get employment so that I am able to put food on the table. [Before] I would have pursued my dream of becoming a social worker. Now I'm looking for anything that would help me put food on the table.' (FGD young women, 23–29, C2). 'My dream is to work' (FGD young men, 23–29, C2). The findings show that older women and men too often have given up on their dreams, and instead focus on making ends meet or having something to do. In this manner, respondents spoke of their dreams in the past tense (i.e. what they would have wanted to be), while school-aged children spoke of their dreams in the future tense (i.e. what they would like to be). An example of this is the responses during an FGD with young women, aged 15–18: 'I want to be a lawyer', 'I want to be a tour guide', 'I want to be a chartered accountant' (FGD young women 15–18, C3). In comparison, responses from the two older age groups in the same community exemplifies this shift in tense: 'I wanted to further my studies…I wanted to be a civil engineer', 'I wanted to be a lawyer', 'I wanted to be a police officer' (FGD young women 19–22, C1), or 'I wanted to be a chef', 'I would have pursued my dream of becoming a social worker' (FGD young women 23-29, C2). By speaking of their dreams in the past tense, older respondents portrayed their great sense of hopelessness, as their dreams existed only in memory and achieving them did not seem within the realm of possibility.

THIS SENSE OF HOPELESSNESS APPEARS TO AFFECT YOUNG WOMEN'S MOTIVATION TO IMPROVE THEIR LIVES IN TRADITIONAL WAYS (I.E. GETTING TRAINED AND FINDING A JOB). A RESPONDENT EXPLAINED:
'Many people are unemployed. And the youth didn't get far with their education. Many of them got to Grade 12 but didn't pass it. Those who have passed can't further their studies because of not having money. We can't seek employment because they want qualifications together with experience. We can't find employment because we don't have Grade 12 and we don't have the skills they need. I think that is why a lot of people are on drugs.' (FGD young women 23–29, C2)

Another respondent noted: 'But you also get those people who failed Grade 12 and then have no interest in going back to school. And there are schools where you don't have to pay anything but they don't want to go back because even after they have finished school, they will not get a job so why should they try?' (FGD young women 19–22, C1). On the difficulties of moving forward, even after finishing high school, one respondent highlighted: 'You must first have Grade 12. And then pursue your dreams afterwards. But, if you did not pass Grade 12 it is difficult to move forward because of money. Even if you have passed, it is difficult to move forward. So, I do not know.' (FGD young Women 23-29, C4). Thus, even if young women 'do well' and are able to achieve matric, there are many hurdles that would prevent them from getting further.

The perception of a lack of viable options influences young women's sense of purpose. As discussed in Chapter 3, purpose is largely driven by a perception that opportunities are 'real'. In a situation where youth perceive hurdles to be extensive even if they pass matric, the question for youth really becomes: 'If I know I will not get far with an education, why study anyway?'. The opportunity cost of getting an education is the time that cannot be spent on recreational activities, be it hanging out with friends, or going to the tavern. The absence of long-term opportunities influences how young women perceive their circumstances in the present, and the decisions they make with respect to how they spend their time and energy. A youth volunteer in one of the communities visited (C5) raised this as an issue: 'There was this one time when we had a training here…The first day, everybody attended. It was a full hall…Come the following day, there were only 22 people…On the third day, only 15. So it kept decreasing until only three stayed.' This key informant explained that youth do not want 'anything which enforces books', be it programmes or trainings, because they do not want to do anything from which they cannot earn money. Again, the question becomes: 'Why bother studying if I will not be able to do anything with that training?'.

The inability to fulfil dreams or find employment puts young women in a vulnerable position. In one FGD, an exchange between four participants raised this vulnerability. After one respondent commented that she had passed matric but was unable to get a bursary to study due to her marks, another explained 'Everything in [this area] works with connections', to which another young woman said: 'Yes, but if they accept you, how will you pay? What will you eat at school?' (FGD young women 23–29, C1). The response to this question was: 'That is how these men take advantage of us. I don't want to have sex. I no longer want to have sex. I am so tired. I don't want it anymore.' (FGD young women 23–29, C1). In this quote, this respondent was referring to what are called 'blessers'. Even if a young woman was accepted into a school and was to get funding, there are basic needs she would still need to meet, which could put her in a vulnerable position. Thus, like the respondent, they may rely on blessers to get an education. Although this can indicate a strong sense of purpose because they know what they want and how to get it, as the quote shows, women are in a vulnerable position in relation to their blesser, who can exert power over them by virtue of being able to provide them with money. The opportunities available to 'get what they want' are indeed too scarce to truly afford women power to make the decisions they want to make, rather than those they need to make. In short, women in BCMM tend to know what they want and to make decisions on what actions they will take based on the opportunities available. To this extent, in an environment where they perceive many constraints with regard to going to school or finding a job, there may be a sense of hopelessness, but not inaction.

4.1.4 VITALITY

Vitality is defined as the extent to which young women in BCMM enjoy life. Vitality is closely linked to mental health, as well as the sense of hopefulness, strength and liveliness young women show. The analysis below therefore looks at how women feel about themselves and their lives, and the behaviours these feelings trigger. The research thus relies entirely on young women's assessments and descriptions of themselves and their lives, rather than on observations or assessments by the research team.

The qualitative findings point to the fact that although there is an intention to engage in positive activities, young women perceive these opportunities as inaccessible or non-existent. Young women consistently raised that they would like to have more activities available to them. They characterised themselves as 'bored', mainly because there was little that attracted them in their communities: 'There is nothing to do here, we sleep the whole day…We have people playing sports but it is just a few of them. We only have netball and soccer, but then I do not like sports, so people end up taking drugs.' (FGD young women 19–22, C2). Older adults (aged 30 and over) involved in the community, such as a sports coach and a youth ward committee member, also pointed to the absence of recreational facilities and activities, stressing that this was one of the main reasons youth were bored.

Young people perceive positive recreational opportunities as inaccessible, which influences their agency in engaging in a 'healthy' lifestyle. This element of seeing opportunities as 'unreal' or not as viable options, unpacked in Chapter 3, is perceived by young people as directly linked to negative behaviours and a sense of dissatisfaction. Young people continuously mention how 'life is better' in other communities, with socioeconomic constraints in their environment seen as restricting their abilities to engage in a 'healthy' lifestyle.

A RESPONDENT STATED:
'How I spend my weekend and my lifestyle will not be the same as with her [who lives in a different community]. She can walk to the mall and go watch movies, whereas I have to spend ZAR 26 just to get to her community. So how we spend our Saturdays [is] totally different…the chances are I am going to engage with alcohol and be exposed to what is affordable.' (FGD young women 19–22, C3)

The cost of transportation can thus limit access to positive recreational opportunities. Even when available, cost is a significant impediment for accessing these opportunities, whereas drugs

and alcohol are much more affordable and easier to access, by comparison. Young people thus continuously perceive opportunities as being inaccessible to them, and that this affects their sense of vitality.

This lack of appealing activities seems to strongly influence young women developing a sense of hopelessness. This was particularly apparent in women outside of the school system. As noted under Section 4.1.3, younger women had a sense of hopefulness when they spoke about their future, which is likely to be because all younger women interviewed were in school and, though also limited, had resources available to them and a stronger structure to their days. In other words, the fact that they had class, even if many missed class, meant that they had the opportunity to do something.

NEVERTHELESS, OLDER WOMEN EXPRESSED HOPELESSNESS WHEN DISCUSSING THEIR FUTURE, AS THEY WERE UNCERTAIN AS TO WHAT WOULD COME NEXT (I.E. FURTHER EDUCATION AND EMPLOYMENT), AND THE OPPORTUNITIES TO AVOID BOREDOM, SUCH AS CLASS, WERE NOW MORE SCARCE. AS ONE YOUNG WOMAN NOTED:

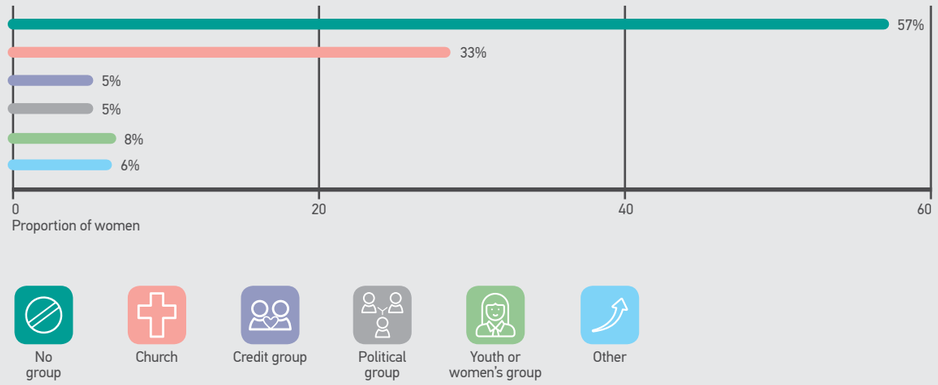
'Yes [life here] is boring. I just finished school and I did not think that sitting at home would be so boring…The bad things that are happening in our community put a lot of strain on us. It makes us lose hope for a better tomorrow. But we would have hope if we knew that with each waking moment, we [had] stuff to do. I mean positive things to do for our families and for the community.' (FGD young women 23–29, C2)

For some young people, church was considered as a coping mechanism against boredom, and as an alternative to drug and alcohol use. Nande's story highlights the importance church has had in her life. Before, she used to do drugs and drink with friends. However, now, she says: *'I feel like I have to go [to church] so that I can fix my life there…On Sundays I go because [I] feel better and I have time to express my feelings to the Lord…And I've seen [that] my life now [is] changing. So I'm saying no to [my friends], no to drugs.'* Nande's story demonstrates the agency that young people still hold when responding to boredom, hopelessness and frustration due to the absence of employment and opportunities. The taverns are an important source of entertainment, but there is an element of choice in the decision to go to taverns, do drugs and drink alcohol, even if the alternatives are indeed limited.

In fact, the quantitative study found church to be an important space for youth. When respondents were asked whether they belonged to any group, organisation or club [35] in their community, the most common answer amongst respondents who are members of a group was church, with one-third of respondents reporting that they were active members. However, it is important to note that over half of women aged 15–29 in Bumb'INGOMSO's target population are not currently part of any group. Membership of any other groups is very low: for example, only 8% of respondents are part of a youth or women's group. As shown in *Table 13*, younger women (15–19 years) are significantly more likely to belong to at least one group, and to at least one group other than church, than 20–24-year-old women. Again, these findings seem to be consistent with the qualitative study. First, group membership could be understood as a proxy for the general level of activity. Given that most respondents do not belong to any groups, this is consistent with the fact that idleness is pervasive. Second, younger, typically school-age, women are more likely than older women to be active in their community through group membership. This thus stresses the higher level of engagement and vitality amongst younger respondents.

[35] *These could be formal organisations, or informal groups of people who get together regularly, including sports groups, social groups, political groups, credit groups / saving clubs, or volunteering.*

FIGURE 10: PROPORTION OF WOMEN AGED 15 - 29 BELONGING TO DIFFERENT GROUPS



Source: bumb'INGOMSO baseline survey (2017).Respondents were asked to select all groups that they belong to.

TABLE 13: GROUP MEMBERSHIP AND LEVEL OF ENGAGEMENT WITH GROUPS AND PEERS

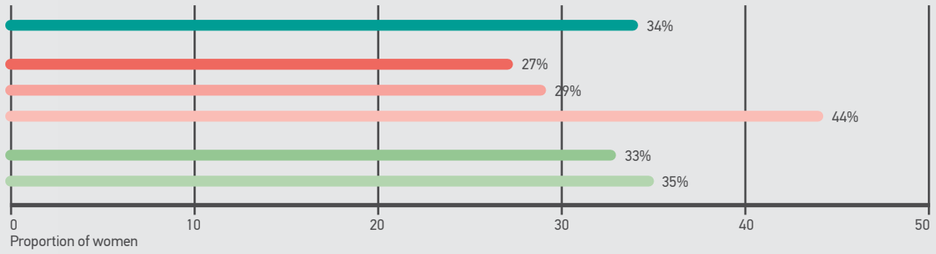
VARIABLE (INDICATORS REFER TO THE PROPORTION OF WOMEN (%))	TOTAL	AGE OF RESPONDENT			PROXY MEANS TEST SCORE	
		15 – 19	20 – 24	25 – 29	ABOVE MEDIAN	BELOW MEDIAN
Belongs to 1+ group	42.77	47.5*	37.78	43.7	36.71**	47.42
Belongs to 1+ group excl. church	19.51	24.32**	13.7	21.18**	18.46	20.31
Very active in 1+ group[a]	59.39	59.79	55.86	62.06	56.95	60.83
Very active in 1+ group excl. church[b]	59.22	63.35	51.62	60.06	71.98***	50.31
Leader in 1+ group[a]	24.52	30.9	19.13	23.24	30.7	20.85
Speaks to 1+ person about relationships	83.98	80.42*	87.33	83.69	88.59**	80.44
Speaks to 1+ person about pressure to have sex	71.81	71.04	76.02	68.27	78.49***	66.69
Speaks to 1+ person about HIV	79.16	72.76*	80.81	82.98	79.74	78.71
Speaks to 1+ person about violence in relationships	60.03	52.93**	64.77	61.37	64.87*	56.31

a) *As a proportion of the 432 respondents who belong to at least one group.*
b) *As a proportion of the 196 respondents who belong to at least one group excluding church.*
*Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20–24), and between the top age group (25–29) and the middle age group (20–24).*

[36] *One measure is approximately 250 ml of standard beer with 4% alcohol, or a 76 ml glass of wine. In the survey respondents were asked what they typically consumed on a night out (ciders, spirits, beer, whisky etc.), and they were asked the amount of their drink of choice they had and how often.*
[37] *See South Africa Demographic and Health Survey of 2016: www.statssa.gov.za/publications/Report%2003-00-09/Report%2003-00-092016.pdf*

The lack of availability of positive recreational opportunities, and the general sense of boredom and hopelessness, have led young women to engage in negative behaviours, such as alcohol and drug use. Negative behaviours, such as alcohol and drug use, were often considered as cheaper or more accessible outlets for boredom, when positive recreational opportunities were not available or not appealing. Amongst respondents aged 15–29 from the quantitative survey, 52% reported ever having had a drink of alcohol, while 18% reported having engaged in binge drinking in the last 30 days, defined as having five or more measures of alcohol in one sitting.[36] While alcohol use and risky drinking does not affect everyone in Bumb'INGOMSO's target population, the rates of drinking and binge drinking are substantially higher than the national averages for women in similar age groups reported in the South African Demographic and Health Survey (2016). For example, nationally, 5.1% of 15–24-year-olds report binge drinking in the last 30 days, compared to 14% of respondents from Bumb'INGOMSO's target population.[37] In addition, amongst respondents who do consume alcohol (52% of the sample), rates of risky drinking are high, particularly among the oldest age group of 25–29-year-olds, who are significantly more likely to have engaged in binge drinking in the last 30 days compared to younger women ($p < .05$, see *Figure 11*). Choosing to engage in risky drinking may be linked to the sense of hopelessness and lack of purpose that many older women expressed when speaking of themselves and their futures.

FIGURE 11: PERCENTAGE OF WOMEN AGED 15 - 29 WHO ENGAGE IN BINGE DRINKING IN THE LAST 30 DAYS



Source: bumb'INGOMSO baseline survey (2017). Limited to 494 women aged 15 - 29 who drink alcohol.

5% OF WOMEN 15 - 29 YEARS HAVE USED RECREATIONAL DRUGS

Overall, 5% of women aged 15–29 reported ever having used recreational drugs. Since these questions are asking about illegal behaviour, it is likely that rates of drug use were under-reported. In the qualitative research, respondents spoke about drugs being easily available and frequently used. Drugs are described as being available in all forms: mandrax, tsuff, tik, dagga, 'the pill', and whoonga/nyaope. As one respondent commented, every year there was a new drug 'in fashion' (FGD young women 23–29, C1). Young people take different drugs, each of which has different effects, from not being able to sleep for three days, to only being asleep, or from being able to go without eating for several days, to feeling powerful, as if you could 'lift a bus' on your own (FGD young women 19–22, C4). What all drugs have in common, however, is giving youth the sense that they are losing control. For this reason, young women identified boredom as a significant challenge, often categorising it as more harmful to their lives than other challenges, such as poverty or teenage pregnancy. The reason for this seems to be the impact that boredom has on behaviour. As one young woman described: 'There is nothing to do so we spend our time drinking alcohol and taking drugs.' (FGD young women 19–22, C1)

Boredom seems to have created a vicious cycle where boredom and idleness lead to a sense of frustration because there is nothing (or very little) for young women to do in their communities. Lack of employment has contributed to a sense of hopelessness, which, coupled with idleness and frustration, motivates young people in general, and women in particular, to engage in negative activities, such as drinking and doing drugs. These activities are a primary coping mechanism for the stress young people feel from living in what they perceive to be such a limiting environment for their growth and potential. Indeed, boredom does not lead to the consumption of drugs or alcohol, or to negative behaviour per se – it is not a causal relationship. However, boredom seems to be the main and strongest factor creating the space for negative behaviours and coping mechanisms to arise.

However, although boredom leads to a high sense of hopelessness, young people expressed a sense of agency in determining how to respond to it. It remains true that there are very few recreational opportunities, but young people exercise agency in what they choose to do. For instance, unlike in many other places where individuals have to carve time out of their schedules to participate in an interview, respondents in BCMM had so much time available that they were happy to be distracted from their boredom by anything – including our research, as it turned out. Indeed, with respect to vitality and boredom, agency was brought up when young people identified that they were ultimately responsible for deciding whether to drink, do drugs, go to church, or stay at home. Young people recognised the limited amount of choices they had, but still highlighted their responsibility in making a positive choice.

4.2 MAIN CONCLUSIONS AND IMPLICATIONS FOR TOC

4.2.1 WHAT FACTORS INFLUENCE YOUNG WOMEN'S PERCEPTIONS OF OPPORTUNITIES AS 'IMMINENT'?

At the baseline stage, the two motivators that seem to play the strongest role in are vitality and belonging. With vitality, high levels of boredom seem to set a context that reinforces: 1) a sense of hopelessness; and 2) the use of negative coping mechanisms, such as drinking and doing drugs. Boredom in itself does not cause a reliance on drinking or doing drugs, but in a context which lacks employment and recreational opportunities it sets the stage for these negative coping mechanisms to become an easy way to deal with hopelessness.

Boredom is also related to belonging, through the absence of Ubuntu and community trust: when young women want to grow and lead better lives that do not involve perceived negative behaviour, parts of the community deny them support, and often actively sabotage them. This may occur in situations where women are building businesses, decide to study, or even if they decide to remove themselves from groups of peers they feel do not have a good influence on them.

Belonging plays an important role in women's definition of self, as their self is tightly influenced by community and place, and is therefore relational. With regards to identity, women tend to define themselves in opposition to what they are not, which generally refers to perceived negative traits in the community, such as engaging in sex work to achieve goals. In relation to purpose, vitality and belonging influence how young women decide to pursue their dreams, and whether they have any dreams at all. For instance, hopelessness in a context of few to no opportunities leads youth in BCMM to 'not try', as based on experience they know that trying does not lead to anything fruitful. Therefore, they are not attracted to educational or training opportunities. This will be of particular importance for the component of the Bumb'INGOMSO programme to be delivered by Harambee, as the marketing of educational and training opportunities will need to consider how to best cater to youth who do not believe these opportunities will bring them positive change.

4.2.2 HOW DOES THIS RELATE TO/AFFECT THE PROGRAMME'S DESIGN?

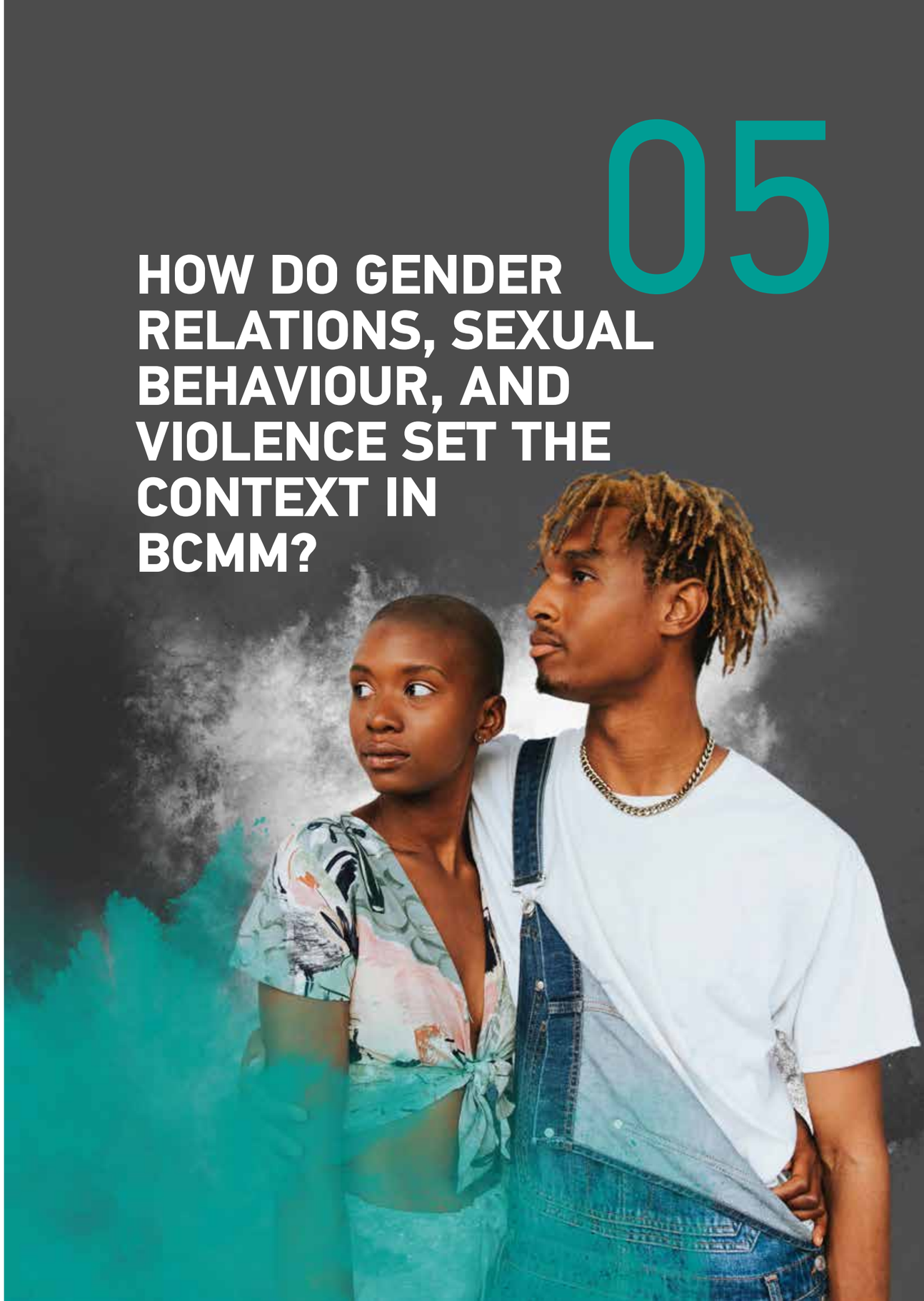
The different ways in which motivators influence young women's imminent sense of possibility have several implications for the programme. First, given the influence that boredom has on youth in BCMM, the Bumb'INGOMSO programme will have to address boredom in order to increase the likelihood of impact. The main partner offering opportunities to counter boredom is Masimanyane, particularly through the Leadership Network. It will be imperative that the Leadership Network is accessible, however. As noted, access in terms of availability, cost and distance, seems to be a main impediment for young people engaging in positive recreational opportunities. For the Leadership Network to reach its potential through a physical hub, the programme will need to account for costs incurred by participants to reach the hub.

Second, the absence of Ubuntu and community support is of special interest to SPF and Masimanyane, which look to influence community perceptions and dynamics with respect to young women. It will therefore be necessary to consider how the programme will anticipate, respond to, and ultimately change a weak social fabric. Additionally, the absence of Ubuntu may impact the ability of all partners to attract participants to their programme. For instance, although Harambee offers training and workshops to make young women better prepared for the labour market, community perceptions on young women improving themselves, finding a job and succeeding may impact uptake of programme activities. Thus, in general, partners will need to ensure that programme activities are not marketed in a way that could alienate participants from their communities, but rather, that creates an image of unity instead of one where participants are perceived to be better than non-participants.

Finally, it is important to acknowledge that although a sense of purpose exists for young women in BCMM, the older that women get, the less hopeful that women become with regards to achieving their dreams. The programme will therefore need to account for this when recruiting participants, making sure that the opportunities for growth in the programme feel tangible for older women. In this way, the programme can minimise the risk of attrition, and ensure the programme caters to the needs of all its participants.

05

HOW DO GENDER RELATIONS, SEXUAL BEHAVIOUR, AND VIOLENCE SET THE CONTEXT IN BCMM?



SEXUAL BEHAVIOUR, GENDER RELATIONS, AND VIOLENCE INFLUENCE YOUNG WOMEN'S VULNERABILITY TO HIV IN SOUTH AFRICA. RISKY SEXUAL BEHAVIOUR, INCLUDING HAVING MULTIPLE PARTNERS AND UNPROTECTED SEX, IS OFTEN ASSOCIATED WITH INCREASED CHANCES OF HIV INFECTION AMONG BOTH MEN AND WOMEN, TYPICALLY THOUGH INCREASING EITHER THE LIKELIHOOD OF EXPOSURE TO INFECTION (E.G. WITH MULTIPLE PARTNERS) OR INCREASING THE LIKELIHOOD OF HIV TRANSMISSION DURING SEX (E.G. WHEN CONDOMS ARE NOT USED DURING SEX). RISKY SEX IN ITSELF MAY BE INFLUENCED BY KNOWLEDGE AND ATTITUDES, PARTICULARLY KNOWLEDGE ON HOW HIV IS TRANSMITTED AND, MORE IMPORTANTLY, PREVENTED.

However, the causal pathways between gender relations and HIV, and those between violence and HIV, are less clear, and are often complex, confounded by various other factors, including background characteristics, such as socioeconomic status, sexual behaviour, and biomedical factors. Despite the complex nature of these pathways, it is widely accepted that HIV vulnerability in South Africa, especially amongst young women, needs to be understood within the context of gender relations and violence in South Africa.

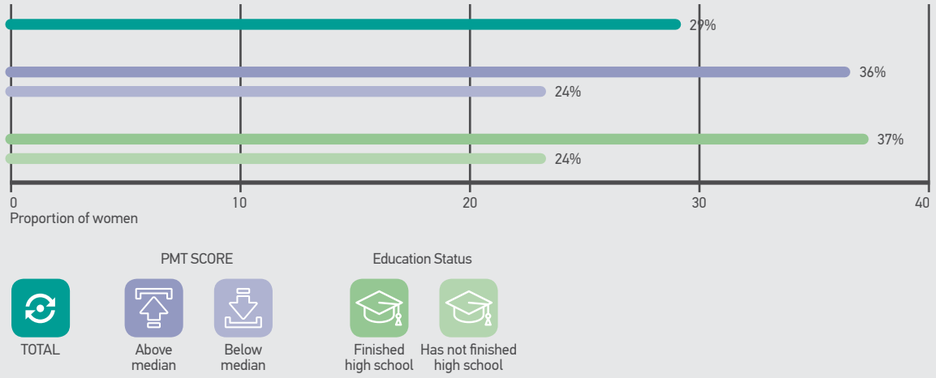
This chapter begins by presenting the baseline findings regarding young women's knowledge of HIV and safe sex. This sets the scene for a discussion of the key determinants of HIV risk among young women in BCMM in the 18 programme wards, namely sexual behaviours, gender relations, and violence. Specifically, Section 5.2 looks at risky sexual behaviour, showing the extent to which young women engage in activities that may directly lead them to contracting HIV. The chapter then discusses gender relations and the main gendered expectations that influence women's perceptions of self and dynamics with each other and with men. The final part of this chapter provides an overview of the main types of violence experienced by young women. This context will be important to understand the deeper and more nuanced analysis of how young women behave and the decisions they make, which is explored in the final chapter on risk and relative risk perceptions.

5.1 KNOWLEDGE OF HIV AND SAFE SEX

HIV knowledge is generally considered a prerequisite for the adoption of safe sexual behaviour and can be used as a measure of HIV prevention, although it is insufficient in itself (Shisana et al., 2014). Knowledge of HIV and its transmission pathways is also likely to be a precondition for wanting to get tested. The household survey asked respondents a series of questions to determine their level of knowledge regarding HIV, defining comprehensive knowledge of HIV [38] as knowing the major ways of preventing the transmission of HIV [39] and rejecting common misconceptions about HIV and its transmission[40].

As *Figure 12* illustrates, only 29% of female respondents have comprehensive knowledge of HIV, as defined above. The proportion of respondents that have comprehensive knowledge of HIV is even lower amongst the poorer half of respondents, and amongst those who have not finished high school. While rates of HIV knowledge in this sample are low, they are similar to those reported in the 2012 SABSSM (Shisana et al., 2014). Low rates of comprehensive knowledge about HIV are explained in part by a relatively large proportion of respondents believing common myths about transmission of HIV. Approximately 42% of respondents believe that HIV can be transmitted by mosquito bites, while a third of respondents believe that HIV can be transmitted by witchcraft. Believing that HIV can be transmitted by an uncontrollable event (such as a mosquito bite or witchcraft) may reduce young people's likelihood of engaging in safe sexual practices, because even if they make the effort to engage in safe sexual practices, they believe that they may contract HIV through an event that is outside of their control. It is therefore important to develop comprehensive knowledge of HIV, including dispelling common myths.

FIGURE 12: COMPREHENSIVE KNOWLEDGE OF HIV AMONG YOUNG WOMEN



Source: bumb'INGOMSO baseline survey (2017). Comprehensive knowledge means knowing that: condoms reduce HIV risk, having one partner reduces HIV risk , a healthy looking person can have HIV. HIV is not transmitted by witchcraft, and HIV is not transmitted by mosquitos.

Knowledge of safe sexual practices to reduce one's chances of contracting HIV was found to be relatively high, with 90% of respondents knowing that using a condom reduces one's chances of contracting HIV and 78% of respondents knowing that having only one partner reduces one's chances of contracting HIV. Similarly, during the qualitative study, respondents explained that safe sex involves 'using condoms', 'having one partner', and 'know(ing) your own and your partner's status'. Respondents also mentioned safe sexual practices not related to HIV, such as 'girls to use contraceptives'. Young women perceive themselves to be well-informed about sex through various sources, such as life orientation, but explained that 'because it (sex) is something engaging, you [end up] putting your life at risk because there are so many things that are involved in sex' (FGD young women, 23–29, C3). Engagement in risky sexual behaviours is discussed in further detail in *Section 5.2*.

5.1.1 HIV TESTING AND AWARENESS OF STATUS

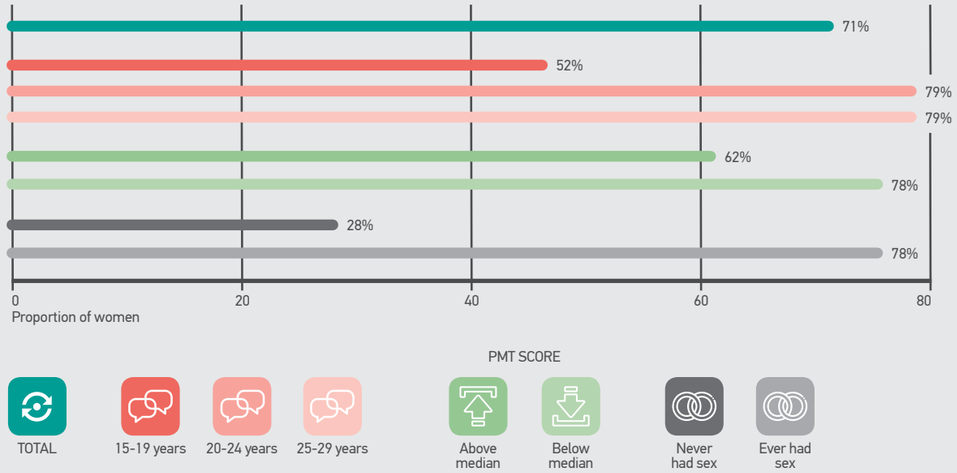
As outlined in the National Strategic Plan for HIV, TB and STIs 2017–2022, South Africa has set a national target for 90% of people living with HIV to be aware of their HIV status by 2022. [41] Among respondents to the household survey, 83% reported that they had had an HIV test and received the results at some point in their lives. As shown in *Figure 13*, 71% of all respondents reported that they had been tested for HIV in the past 12 months and had received the results of the test. Younger women (15–19-year-olds), respondents in the less poor half of the sample, and those who had never had sex were significantly less likely to have had an HIV test in the last 12 months ($p < .01$). Amongst those respondents (17%) who had never been tested for HIV, the most common reason for not getting tested was that the respondent did not believe that they had HIV (31%), followed by the respondent never having had sex (26%).

HIV testing rates in the last 12 months are higher in our sample than those reported amongst female respondents in the 2016 SADHS for similar age groups (38% amongst 15–19-year-olds, 67% amongst 20–24-year-olds, 68% amongst 25–29-year-olds) [42], although the pattern of results in the Bumb'INGOMSO sample is similar, with younger and wealthier respondents and those who had never had sex reporting lower testing rates (NDOH, 2017). Respondents who know that condom use prevents HIV transmission are significantly more likely to have been tested for HIV. However, having comprehensive knowledge of HIV is not correlated with HIV testing. This is intriguing. It partially implies that prevention-specific knowledge (in this case the knowledge that using condoms prevents HIV) may be more effective in changing risky behaviour than more general awareness of HIV (e.g. correctly identifying a number of risk factors for HIV).

[38] *This is in line with the indicator proposed in the DHS database and a respondent is considered as having comprehensive knowledge if they answer all five questions correctly. For details, see https://hivdata.dhsprogram.com/ind_tbl.cfm*
[39] *Respondents were asked whether using condoms and whether having only one sexual partner reduces one's chances of contracting HIV; that is, these questions assess knowledge of safe sexual practices specifically in relation to HIV transmission.*
[40] *Respondents were asked whether HIV can be transmitted through mosquito bites, whether HIV can be transmitted through witchcraft, and whether a healthy-looking person can have HIV.*

[41] *In line with this, Beyond Zero's target for the end of Year 3 of Bumb'INGOMSO is that 90% of young people know their HIV status.*
[42] *This difference may be explained by the fact that our sample only targets areas considered at high risk of HIV/AIDS, while the SADHS presents statistics for a nationally representative sample. Testing rates in high-risk areas may be higher due to increased sensitisation and service delivery (e.g. community health workers or NGOs that offer community-based testing sites in higher risk areas).*

FIGURE 13: HIV TESTING AMONG YOUNG WOMEN IN BCMM



Source: bumb'INGOMSO baseline survey (2017).

5.2 WHAT KIND OF BEHAVIOURS DO YOUNG WOMEN ENGAGE IN THAT PLACE THEM AT RISK OF CONTRACTING HIV?

EVIDENCE FROM BOTH THE HOUSEHOLD SURVEY AND QUALITATIVE RESEARCH INDICATES THAT YOUNG WOMEN ENGAGE IN A RANGE OF RISKY BEHAVIOURS, DESPITE ACKNOWLEDGING THAT THERE ARE NEGATIVE CONSEQUENCES ASSOCIATED WITH THESE BEHAVIOURS AND THAT THESE BEHAVIOURS ARE RISKY. THIS SECTION OUTLINES THE TYPES OF RISKY SEXUAL BEHAVIOURS IN WHICH YOUNG WOMEN ENGAGE.

5.2.1 RISKY SEXUAL BEHAVIOUR

Table 14 presents the proportion of respondents who report engaging in different types of risky sexual behaviour[43]. Almost 5% of the household survey respondents reported having had sex before the age of 15, and respondents in the case study communities reported sexual debut as happening even before the age of 15, with young women stating that girls as young as 12 or 13 were having sex, when 'the teenage years' start. Young women explained that early sexual debut for girls allows them to be with older men, but perceived this behaviour as risky: 'from our age group and at the age of 12 children start having sex [debate] and they are not dating guys of their age, that's how they become infected.' (FGD young women 23–29, C3).

Findings from the household survey show that a third of young women have partners more than five years older than themselves [44], especially amongst 20–24- and 25–29-year-olds. Young women explain that older men prefer not to use condoms, and are less likely to accept a woman's insistence on using condoms due to the power imbalance between an older man and a younger woman. However, young women engage in these risky behaviours as older men are seen to be able to provide for younger women (e.g. through transactional exchanges such as sex in exchange for drinks, clothes, or airtime vouchers).

[43] *Rates of early sexual debut and inconsistent condom use are comparable to the national averages amongst women aged 15–49 reported in the 2012 SABSSM (Shisana et al., 2014).*
[44] *An age gap of more than five years is considered to be an age-disparate relationship.*

Across all age groups, more than half of sexually active respondents reported not using a condom consistently in the last year *(Table 14)*. The findings indicate that this is not an issue of accessing condoms, but rather of consistent use. Whereas young men state that it is the responsibility of both men and women to bring condoms, most young women feel that, in the end, they are the ones that need to make sure that they have condoms. [45]

INDEED, YOUNG MEN EXPRESSED A PREFERENCE NOT TO USE CONDOMS, AND, DESPITE THEIR OWN PREFERENCES TO USE A CONDOM, YOUNG WOMEN AGREED THAT THEY WOULD STILL HAVE SEX EVEN IF THAT MEANS THEY DO NOT USE A CONDOM. AS A YOUNG MAN EXPLAINED:
'We have sex without condoms because we see it as a jackpot, but that is when we get these infections. To tell you the truth my sister, when a girl is on contraceptives we don't see the need to use a condom because it is nice without.' (FGD young men 19–22, C2).

Finally, substance abuse, and particularly binge drinking, was mentioned in relation to sexual decision making: 'he makes sure you drink to the point where you are almost blacked out' (FGD young women 23–29, C1). Young women acknowledged that drinking heavily or taking drugs can lead them to lose control or make bad decisions, and at times they linked this to risky sexual behaviour such as 'forgetting' to use condoms. Similarly, young men stated: 'because you have smoked tic you will sleep with a girl even though she has HIV…and the same for alcohol. Tic, alcohol and HIV.' (FGD young men 23–29, C2).

TABLE 14: PREVALENCE OF RISKY SEXUAL BEHAVIOUR

VARIABLE (INDICATORS REFER TO THE PROPORTION OF WOMEN (%))	TOTAL	AGE OF RESPONDENT			PROXY MEANS TEST SCORE	
		15 – 19	20 – 24	25 – 29	ABOVE MEDIAN	BELOW MEDIAN
Sexual debut before age 15	4.84	4.91	6.76	2.91*	4.7	4.95
Has a partner 5+ years older*	32.94	19.67**	32.93	40.03	29.67	35.12
Did not use condom consistently in the last year**	59.18	50.11	58.19	64.99	55.51	61.5
Had multiple sexual partners in the last year**	13.77	8.42***	20.48	10.17***	13.77	13.77
Did not use condom consistently in the last year (amongst respondents who had multiple sexual partners)**	62.62	60.22	63.2	62.58	70.68	57.44
Had transactional sex in the last year**	1.96	2.63	2.45	1.12	2.79	1.42

Limited to respondents who have ever had sexual intercourse (n = 811)
*** Limited to respondents who had sexual intercourse in the last year (n=774)*
*Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20 – 24), and between the top age group (25–29) and the middle age group (20–24).*

5.2.2 MULTIPLE SEXUAL PARTNERS AND TRANSACTIONAL SEX

As discussed in Section 5.1, despite young women displaying knowledge of how to practise safe sex, a high proportion of women reported engaging in risky sexual behaviours. Specifically, women aged 20 to 24 were most likely to report having had multiple sexual partners during the last 12 months and women who reported having had multiple partners were slightly more likely to report that they did not use a condom consistently during the last 12 months. The proportion of women who reported having had multiple sexual partners in the last year is higher than national averages for female respondents in similar age groups reported in the 2016 SADHS survey (NDOH et al., 2017) and in the 2012 SABSSM survey (Shisana et al., 2014). Amongst female respondents, the 2016 SADHS reports that, nationally, only 2.7% of 15–19-year-olds, 6.6% of 20–24-year-olds and 6.9% of 25–29-year-olds had multiple sexual partners in the last 12 months. [46]

[45] *'Condoms' appeared to universally refer to male condoms. None of the respondents in the case communities considered female condoms a viable option. Although all respondents in the case study communities were aware of these when probed, young women explained that they are uncomfortable and unpractical, partly due to the eight-hour insertion window prior to having sex.*
[46] *This difference may be explained by the fact that our sample only targets areas considered at high risk for HIV, where engaging in risky sexual behaviours is likely to be more common while the SADHS presents statistics for a nationally representative sample.*
[47] *While the household survey asks about how many sexual partners the respondent has had in the last 12 months (which are not necessarily concurrent), the qualitative research discussed multiple concurrent sexual partners with respondents.*

In the case study communities, several respondents indicated that they did not remain faithful to their partners. [47] The motivations for multiple concurrent sexual partners appeared to be varied, but one of these motivations had a transactional element – justified by reference to the fact that young women may 'need money' or 'need guys to buy you drinks'. Young women do not perceive this as 'cheating' but as a means to an end: 'on Monday you wake up with a hangover and then you find another guy to buy you two drinks for the hangover' (FGD young women 23–29, C2). In addition, some young women noted one-night stands taking place if the main partner was not around: 'if you go to a tavern and your partner is not there, then you can have another partner just for that night' (FGD young women 23–29, C1).

Respondents stated that they know that having multiple partners increases their risk of contracting HIV, with some young women even citing relationships as an additional risk factor for contracting HIV due to the low levels of condom use in relationships. On the one hand, there is an expectation that primary partners (should) trust each other and therefore can have unprotected sex, but, on the other, respondents also agreed that it is common for young men and young women to have partners outside of their primary relationship, therefore increasing the risk of contracting HIV within a relationship.

'It becomes worse when you say the person is your one and only. It means you have sex skin on skin. I must be honest with you, condoms are not used at all.' (FGD young women 23–29, C1).

The household survey data show that only around 2% of respondents answered 'yes' to having had sex for gifts or money in the past 12 months. However, it is important to note that young women have a very narrow definition of what constitutes transactional sex. There are a number of situations described by respondents where sex is 'expected' as a form of reward (e.g. sex for drinks) but which are not considered by respondents as transactional. Rather, transactional sex is seen narrowly as a situation in which 'sex for money' occurs, often with a price or other arrangement agreed in advance. Some respondents agreed that this included arrangements with blessers. Yet it would be conceivable that if most women considered relationships with blessers to be transactional sex, and if blessers are as common as suggested by the qualitative research, then the proportion of respondents reporting transactional sex would be much higher.

Despite the blurry lines around what young women perceive to be transactional sex, such engagements appear to be frequent around taverns. There is a mutual awareness of the fact that if a man buys you drinks, you are expected to go home with him, but this is seen rather as a norm and as acceptable than as a 'transactional' or 'business' arrangement. Some respondents debated this, and agreed that there are instances where the 'transactional' aspect feels clearer: *'let's say I have to go out with my friend and I don't have an outfit, I'll meet with another guy, do the deed and get what I want from him. I think that is also a form of prostitution. It's not that you have to go to [another area] to do it, it also happens here in our community.'* (FGD young women 19–22, C1). However, respondents stressed that these 'agreed transactions' are done more secretively, which may explain the low reporting in the household survey, as there is a higher element of social desirability bias.

Most women in the FGDs mentioned having or having had a blesser. In all case study communities apart from C1, having a blesser was described as taboo, though everyone agreed that it was common practice in the area. In C1, however, having a blesser appeared to be normalised. There, young women described having multiple blessers, for example stating that 'there is the one for hugs, one you enjoy the nights with you, one that makes you feel special…there's Mr Monday to Sunday… there's Mr Transport…Mr Airtime' (FGD young women 19-22, C1).

5.2.3 DETERMINANTS OF RISKY SEXUAL BEHAVIOURS

As indicated, engaging in risky sexual behaviours is common practice in the Bumb'INGOMSO target communities. In this section, we aim to investigate the association of risky sexual behaviour, as measured by the likelihood of having multiple sexual partners in the last one year, with different types of risk perceptions, as well as with a range of demographic characteristics and experiences that have been discussed in preceding sections.

Figure 14 presents the results of a probit model [49] on a range of background characteristics, positive behaviours (including being in school or currently employed), negative behaviours (including binge drinking and taking drugs), risk perceptions (based on the DOSPERT scale (see Chapter 6)), and indicators related to HIV knowledge and sexual behaviour.

We find that women aged 20–24 and aged 25–29 are 11% and 7%, respectively, more likely to have had multiple sexual partners compared to 15–19-year-olds, a finding related to the lower probability of 15-19-year-olds ever having had sex. Furthermore, individuals who had a sexual debut before the age of 15 are 20% more likely to engage in this behaviour, compared to those who had a later sexual debut.

In terms of engaging in positive behaviours, we find that respondents who are employed, and who by implication have more opportunities available to them, are 7% less likely to have multiple sexual partners. This echoes the discussion in Section 4.1.3 suggesting that those that fail to find employment give up on their dreams, which can lead to negative behaviour, such as alcoholism and drug abuse, due to a lack of a sense of purpose.

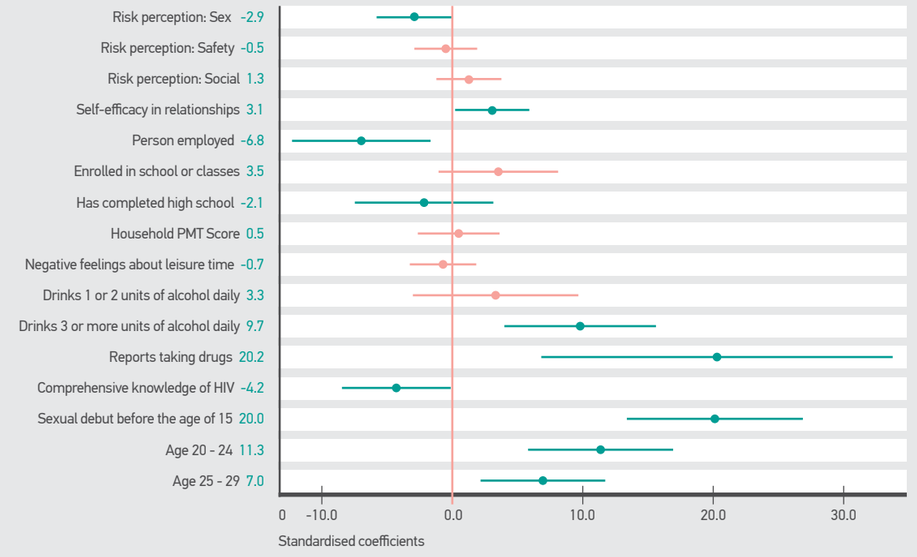
However, we do not find that *being enrolled in school or completing high school* have a statistically significant impact on the likelihood of having had multiple sexual partners. In the first case, those still enrolled in school are generally younger and therefore less likely to have ever had sex. The second finding, however, is unusual given that the literature often links improved academic performance with reduced engagement in risky sexual behaviour [50]. Section 3.2 reports that only 18% of 20–24-year-olds and 33% of 25–29-year-olds are currently employed, suggesting that having completed matric does not necessarily translate to improved opportunities for women in the sample. This is echoed in the findings presented in Section 3.1.2, which suggest that even if young women do well and achieve matric there are *other barriers that prevent them succeeding further.*

The results indicate that substance abuse is strongly related to an increased likelihood of having multiple sexual partners, with the analysis reporting that, for the average respondent, taking drugs would increase the likelihood by 20%, *whilst drinking three or more units of alcohol daily* would increase the likelihood by 10%, compared to individuals who do not take drugs or drink, respectively.

The qualitative research findings indicate that boredom is a 'soft risk' that can lead to other behaviours, including drinking and doing drugs, which in turn lead to engaging in risky sexual behaviour. The findings from the probit model confirm this hypothesis as, after controlling for drinking and drug use, the analysis presented in Figure 14 suggests that boredom[51] itself does not drive risky sexual behaviour, but rather it creates an enabling environment for engaging in negative behaviours, which can then lead to engaging in risky sexual behaviour.

In terms of an individual's perception of risk, we investigate the link between the probability of having multiple sexual partners and the three domains of risk, as measured by our DOSPERT scale. We find that only perceptions of risk around *sexual behaviour* have a significant role in explaining having had multiple sexual partners, with a 1% increase in the perceived riskiness of engaging in sexual behaviours leading to a 3% reduction in the likelihood of engaging in this behaviour. Similarly, having *comprehensive knowledge* of HIV reduces the likelihood of having had multiple sexual partners by 4%.

FIGURE 14: PROBIT REGRESSION: DETERMINANTS OF PARTICIPANTS HAVING MULTIPLE SEXUAL PARTNERS IN THE LAST YEAR. [52]



Source: bumb'INGOMSO baseline survey (2017).

[47] *See Annex D for details of the probit model.*
[50] *For example Marteleto et al. (2008) show high-schoolers who perform better on numeracy and literacy exams are less likely to become sexually active in Cape Town.*

[51] *Our indicator negative feelings about leisure time is based on five items: (1) in my leisure time, I want to do something, but I don't know what to do; (2) I waste too much of my leisure time sleeping; (3) I am not physically or mentally active during my leisure time; (4) leisure time activities do not excite me; (5) my leisure time is boring. Each is measured on a five-point Likert scale.*
[52] *The blue bars represent the 95% confidence interval. Point estimates (blue dots) for which the 95% confidence interval does not cross the 0 line (in red) can be considered to be statistically significant. Point estimates to the right of the 0 line indicate a positive relationship between the dependent variable and multiple sex during the past year.*

5.3 HOW RELATIONSHIPS INTERSECT WITH GENDER NORMS AND INCREASE THE RISK OF HIV INFECTION AMONG YOUNG WOMEN IN BCMM

Gender norms, which in turn shape gender roles, are an important factor in how young women make decisions about themselves, their behaviour and their relationships. It is therefore necessary to explore gender norms to understand how and why young women make decisions that place them at risk of infection.

As discussed in Section 4.1.2, young women base much of their self-worth and sense of belonging on 'having a boyfriend'. This is further evident in the discussions around violence, in which several respondents stated that they would rather stay with a partner who treated them violently than risk being alone. This notion of wanting to belong, of having a boyfriend to fulfil certain expectations of what it means to be a young woman, is evident throughout the analysis of risk and behaviour, as will be further unpacked in Chapter 6. Whilst young women may acknowledge that men do not treat them well, this urge to remain in a relationship creates a context where men can be highly controlling without women leaving. Respondents explained this as a need for intimacy, based on having a lack of intimacy in their home: *'When people bring you down when doing positive things that's emotional abuse and when you don't experience love from home in just small things like hugs and kisses then we end up getting excited when we get them from outside.'* (FGD, young women 23–29, C3).

Further, discussions from the qualitative research indicate that young women struggle to exercise agency within their relationships with boyfriends or blessers. Both men and women generally knew how to have safe sex and recognised that it is the responsibility of both partners to practise safe sex.

HOWEVER, WOMEN FELT THAT THE ONUS GENERALLY FELL ON THEM BECAUSE MEN WANTED TO HAVE SEX WITHOUT A CONDOM, (SAYING IT *'FELT NICER'* TO HAVE UNPROTECTED SEX) AND FELT LESS INCLINED TO GET TESTED IN CLINICS FOR HIV/AIDS. A YOUNG WOMAN EXPLAINED:
'I remember when my boyfriend didn't want to go to work because they were going to get tested. He strongly refused to go. He had sores like shingles and I lied to him and told him that only people with AIDS get those shingles. The next morning he went to work and asked to be tested.' (Young women 23–29, C1)

Another noted: *'I remember telling my boyfriend that if he goes to the clinic I will buy him drugs, he agreed because he likes his drugs.' (Young women 23–29, C1).*

These examples show that women recognise that they have some agency to negotiate safe sexual behaviour. However, this agency is not immediately obvious. Respondents in the qualitative research felt that they were able to take deliberate actions with respect to their sexual health; however, this was only possible to a certain extent. For example, young women expressed that, for them, safe sex often implied avoiding sex or avoiding a risky situation in the first place. In other words, there is an element of choice in terms of exposing yourself to a situation where you might engage in risky sexual behaviours.

Young women, however, felt that their agency to insist on condom use was limited when having sex. In the quantitative sample, 52% of 15–29-year-old women 'agreed' and 42% of respondents 'strongly agreed' with the statement 'I am able to insist on condom use when I want to'. Young women in the case communities indicated that this agency to insist on condom use is often undermined by men: *'[The man] makes sure you drink to the point where you are almost blacked out…if [he] wants to use it, he does.'* (FGD young women 23–29, C1).

ANOTHER RESPONDENT EXPLAINED THAT POWER RELATIONS BETWEEN MEN AND WOMEN AND THE DESIRE TO FIT IN MEANT THAT ONE *'NEVER'* TELLS THE MAN WHETHER THAT YOU WANT TO USE A CONDOM OR NOT:

Moderator:	*So, you don't tell him whether you want to use a condom or not?*
Participant 4:	*No, you will never say that. What if he chases you out of his house?*
Moderator:	*So, what happens then?*
Participant 3:	*If the guy wants to use it, he does.*
Moderator:	*So, you don't have a say on the matter?*
Participant 2:	*It depends on the person, some like to use a condom.*
Participant 3:	*If he really wants to be your boyfriend, then he will respect what you are saying, but if it's only for that night he doesn't care. If he doesn't want a condom then he we won't use it. (FGD young women, 23–29, C1)*

Therefore, while young women seem to have a sense of agency in some situations with respect to their sexual health, the choice of wearing a condom is often made for them. Unequal power relations undermine the opportunity of women to truly exert deliberate decision making, even if they have consented and chosen to have sex with a man.

Finally, while young women acknowledge that one does not have to have sex with someone just because they are a boyfriend, there is a clear emphasis on sex as being 'expected' in a relationship, despite the risks that may be associated with having sex. Young women state how their boyfriends will threaten to leave, or get angry if they do not give in to agreeing to have sex, and as discussed under Section 4.1.2 on belonging, young women do not want to risk losing their boyfriends. Hence, though young women know they have the *right* to refuse sex, they describe that it is difficult to do so based on their boyfriends' reactions and expectations. The concept of 'pay-back' or an obligation to sleep with a partner is evidenced throughout the discussion with young people as something that highly influences sexual behaviour and young women's perceptions of their own agency. This element of young women questioning if it is their own choice is not to be underestimated, as it blurs the line between what is perceived as violent behaviour and what is perceived as 'not ideal' but happening. Consequently, whilst young women may report having been forced to have sex in some cases, the understanding of 'force' and 'expectations' blurs the perceptions of what 'sexual violence' comes to mean (discussed in further detail in Section 5.4).

[53] In the quantitative survey, a respondent was defined as having experienced physical IPV in the last 12 months if their current or most recent partner had 1) slapped you or thrown something at you that could hurt you, 2) pushed or shoved you, 3) hit you with his fist or with something else that could hurt you, 4) kicked you, dragged you or beaten you up, 5) choked or burnt you on purpose, or 6) threatened to use or actually used a gun, knife, or other weapon against you.

5.4 EXPERIENCE OF VIOLENCE IN BCMM

THIS SECTION OUTLINES YOUNG WOMEN'S (AND MEN'S) EXPOSURE TO AND EXPERIENCE OF VIOLENCE, PROVIDING A CONTEXTUAL UNDERSTANDING OF VIOLENCE FOR THE NEXT CHAPTER ON RISK AND RELATIVE RISKS.

Young women in BCMM are exposed to many types of violence in their communities and their homes, including violence related to gender, intimate partners, and society at large (family, criminal, etc.). Gender norms, unequal power relations between men and women, and norms on the acceptability of violence against women (discussed in Section 5.3) are a root cause of violence against women. This section focuses on the main types of violence described by young women, which include violent crime, physical violence, emotional and psychological violence, and sexual violence.

5.4.1 CRIME AND SAFETY

BCMM communities were described as unsafe and the risk of experiencing crime as high. Respondents defined crime as either robbery, murder, house break-ins, or mob justice, and expressed that they tried to avoid spaces where crime may occur. However, they also noted that avoiding crime is extremely difficult, as crime occurs at all times of day and in all public spaces, including shops, taverns, and open areas where others are present. Additionally, respondents stated not feeling safe in private spaces either, as house break-ins are common.

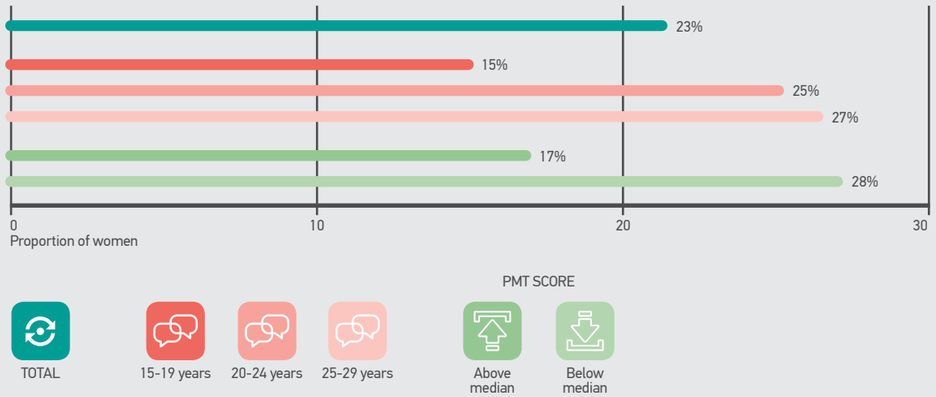
Further, it was clear that while young people see crime as a risk, respondents perceived many young people in their communities to be involved in criminal activities. Young people thus view the risks associated with crime as two-fold, one is that of 'experiencing crime,' most commonly expressed by young women but considered severe by young men, whilst young men additionally also pointed to doing crime as a risk they face. This is an important distinction in how perceptions of crime as risk differ between women and men. Whilst women fear becoming victims of crime, young men express the fear of 1) experiencing violence because of crime (i.e. through mob justice, or through fights with others who are doing crime); and 2) 'getting caught' and getting a criminal record, affecting their chances of employability.

5.4.2 PHYSICAL VIOLENCE

Recent results from the 2016 SADHS show that the Eastern Cape is the province with the highest proportion of women aged 18 and older (12.6%) who report having experienced physical violence perpetrated by a partner in the last 12 months (NDOH, 2017). Respondents in the Bumb'INGOMSO study reported rates of physical violence [53] from a partner that are substantially higher than those reported in the SADHS: on average, 23% of young women who had been in a relationship with a man in the last 12 months reported having experienced physical IPV from their current or most recent partner. Younger women (15–19-year-olds) and women who live in the less poor half of households were significantly less likely to report having experienced physical violence perpetrated by a partner in the last 12 months ($p < .05$ for both).

Discussions with young people revealed that physical violence perpetrated by partners is normalised in the lives of young women. Young women emphasised that it is difficult for them to recognise IPV, highlighting that though one may experience it, one may not necessarily 'see that it is wrong' (FGD young women 19–22, C1). As stated by one respondent: 'you are so used to getting hit that if he doesn't hit you, you feel like he doesn't love you' (FGD young women 19–22, C1). The quantitative results show that 36% of women who had reported experiencing physical or sexual violence stated their partner being jealous as a situation that tended to lead to violence. Jealousy was the most frequent reason given, followed by 32% stating that there was no particular situation that led to violence, which further testifies to the normalisation of violence.

FIGURE 15: PROPORTION OF WOMEN WHO HAVE EXPERIENCED IPV IN THE LAST 12 MONTHS



Source: bumb'INGOMSO baseline survey (2017). Limited to 718 respondents who were in a relationship with a male partner in the last 12 months.

That young women may interpret violence within a relationship differently to violence perpetrated by other perpetrators is not unusual but is important. Although young women may report having 'been slapped' or 'been beaten', this does not necessarily mean that they always perceive this as 'experiencing violence'. Women may be also less likely to be open about violence from a current partner than from a previous partner, and less likely to acknowledge current experiences as 'violent'. This is supported through findings in the discussions with young people, where young women talked about prior partners, or partners of others but less often brought up examples of current experiences [54]. While a substantial proportion, of respondents in the quantitative survey (23%) reported having experienced behaviours such as 'slapping' or 'beating' perpetrated by a current or previous partner, the sensitive nature of these questions may mean that some women did not disclose their experiences, and the actual proportion may be higher.

5.4.3 EMOTIONAL AND PSYCHOLOGICAL VIOLENCE

The quantitative study suggests that 19% of young women who have been in a relationship with a man in the last 12 months answered yes to having experienced any type of emotional violence [55], although, similarly to the findings around physical IPV, they may not recognise this as emotional violence. Women in the older age group (25–29-year-olds) were more likely to report having experienced emotional violence (24%) compared to women in the younger age groups, a difference that was weakly statistically significant ($p < .01$). In addition, half of the respondents reported that they had experienced a form of controlling behaviour from their current or most recent partner in the last 12 months.

[54] *The discussions did not ask directly about individual experiences with a partner (either current or prior), but discussed violence on a 'thematic' and/or 'community' level. However, young women still referenced their own experiences.*

[55] *In the quantitative survey, a respondent was defined as having experienced emotional IPV in the last 12 months if their current or most recent partner had 1) insulted you or made you feel bad about yourself, 2) belittled or humiliated you in front of other people, 3) done things to scare or intimidate you on purpose, or 4) threatened to hurt you or someone you care about. The quantitative survey also included questions on controlling behaviour in relationships. Respondents were defined as having experienced controlling behaviour from a partner in the last 12 months if their current or most recent partner, 1) tried to keep you from seeing your friends, 2) tried to restrict contact with your family, 3) insisted on knowing where you are at all times, 4) ignored you and treated you indifferently, 5) got angry if you spoke to another man, 6) was often suspicious that you were unfaithful, or 7) expected you to ask his permission before seeking healthcare for yourself.*

TABLE 15: EMOTIONAL IPV

Variable	Total	Age of female respondent			Proxy Means Test score	
		15–19	20–24	25–29	Above median	Below median
Has experienced emotional violence in the past 12 months	18.76	15.7	15.45	23.89*	15.93	20.64
Has experienced controlling behaviour from partner in the past 12 months	49.51	43.93	49.85	52.56	46.77	51.32

Note: Limited to 718 respondents who have been in a relationship with a male partner in the past 12 months

*Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20–24), and between the top age group (25–29) and the middle age group (20–24).*

Emotional and psychological violence tends to be under-reported in comparison to physical and sexual violence, due to its more subjective nature. The qualitative data indicate that emotional violence is widespread, with women across age groups expressing high vulnerability to this form of abuse. In particular, emotional violence is evident through the fear or threat of experiencing other types of violence. Some young women reported feeling anxious about experiencing emotional violence in a relationship, in the home, and on the streets – again, making no space truly safe.

An example of emotional abuse within a relationship is men using the threat of leaving their partners as a form of control. Respondents stated that some men threaten to leave if women do not agree to sex without a condom, or if they ask them to stop doing certain things. Furthermore, young women explained that men are aware of this fear of being left, and that one of the worst types of emotional abuse is for men to play on this insecurity. Young women stressed that the emotional abuse is not the cheating itself, but when a man actively shows his partner or tells them that he is cheating, in order to hurt the partner. This idea of being treated as disposable, or not valued, is one of the main aspects of emotional abuse brought up by young women, in all age groups.

Apart from IPV, respondents highlighted emotional abuse outside of intimate relationships: *'there are many forms of bullying. You can be bullied at home, in the street or anywhere'* (FGD young women 19–22, C1). With regard to bullying, or emotional abuse, respondents referred to this violence as largely verbal and based on insults, which in turn are often gendered. Respondents stated how parents, friends, and people on the street use *'vulgar'* words such as *'bitch'* and *'whore'*. Respondents stated how experiencing abuse can affect one's confidence.

[56] *In the quantitative survey, a respondent was defined as having experienced sexual IPV in the last 12 months if their current or most recent partner had 1) physically forced you to have sexual intercourse when you did not want to, or 2) forced you to do something sexual that you found degrading or humiliating, or 3) if the respondent had sexual intercourse they did not want because they were afraid of what their partner might do.*

7% OF SAMPLED WOMEN WHO HAVE BEEN IN A RELATIONSHIP WITH A MALE PARTNER IN THE LAST 12 MONTHS HAVE EXPERIENCED **SEXUAL VIOLENCE**

5.4.4 SEXUAL VIOLENCE

The quantitative study found that 7% of sampled women who have been in a relationship with a male partner in the last 12 months have experienced sexual violence from a partner [56], as compared to 23% having experienced some form of physical violence. However, what young women consider to be 'force' influences whether they perceive a sexual interaction to be violent or not. Findings from discussions with youth indicate that the concept of 'coercion', or being talked into having sex, is not always perceived as violence. A reason for this is that sex is often seen as something that is 'expected' in a relationship, as discussed in Section 5.3.

Additionally, young women stated that 'perpetrators' of sexual violence are mostly someone close to them. Young women described how they may have a 'main partner' but this does not mean that they do not have other sexual partners or experience sexual violence from others. Rather than these 'others' being strangers, young women explained that they are exposed to sexual violence from people they know: *'No, the people in the area. And people we meet at night. Even an uncle. The one you stay with at home.'* (FGD young women 23–29, C1). This 'IPV beyond a direct relationship' is highlighted by young women through their references to *'multiple boyfriends'* and *'one-night stands'*. Considering the close nature of the communities visited, most people appear to know each other, so sexual violence appears to be perpetrated by members of the community that are known to young women.

5.5 MAIN CONCLUSIONS AND IMPLICATIONS FOR THE TOC

5.5.1 WHAT FACTORS INFLUENCE HIV AMONG YOUNG WOMEN IN BCMM AND HOW DOES THIS RELATE TO THE PROGRAMME DESIGN?

There is an assumption in the TOC that young women, and young men, in BCMM are well-informed about the transmission of HIV and how to practice safe sex. Subsequently, the TOC assumes that rather than there being an issue of knowledge, there is an issue of relative risk, which results in young women making decisions that place them at risk. However, the baseline findings indicate that, while most young women are aware of how to practice safe sex, few young women have comprehensive knowledge of HIV. In particular, young women believe some of the common myths around the spread of HIV, which may result in a feeling that avoiding HIV infection is out of their control. While knowledge should not be the primary focus of Bumb'INGOMSO, ensuring that young women have comprehensive knowledge of the transmission of HIV should be incorporated as part of the programme.

The baseline findings indicate that few young women hav comprehensive knowledge of HIV

06

RELATIVE RISK PERCEPTION AND BEHAVIOURAL TRADE-OFFS WITH REGARD TO RISKS

THIS DISCUSSION BUILDS ON THE ANALYSIS IN CHAPTERS 3 AND 4 THAT UNPACKS THE SOCIAL REFERENCE GROUP (I.E. WHAT IT CURRENTLY MEANS TO BE A YOUNG WOMAN IN BCMM) TO PROVIDE A BASELINE SITUATIONAL ANALYSIS OF HOW YOUNG WOMEN CURRENTLY PERCEIVE RISKS, HOW THEY PERCEIVE THESE RISKS AS RELATIVE TO EACH OTHER, AND HOW THIS RELATES TO SEXUAL BEHAVIOUR. IN THE ANALYSIS BELOW, WE FIRST SEEK TO UNDERSTAND THE DIFFERENT RISKS THAT YOUNG WOMEN PERCEIVE THEY FACE, AND THEN UNPACK SEVERAL STAGES OF UNDERSTANDING RELATIVE RISK AND HOW YOUNG WOMEN MAKE TRADE-OFFS THAT OFTEN RESULT IN ENGAGING IN RISKY BEHAVIOUR.

Young women and young men living in the Bumb'ING0MSO target communities in BCMM face a large number of risks on a daily basis, including violent crime, GBV, rape, unemployment, poverty, HIV/AIDS, and teenage pregnancy, among others. The environment in which young people live has already been discussed in detail in Chapter 3 and Chapter 5. In this chapter, we build on that discussion by outlining the main risks that respondents described as facing frequently, and the main risks that they consider and weigh up when making decisions, to come to an understanding of young women's relative perception of risks and how they make trade-offs when considering these risks. Section 6.1 describes the risks that young men and women perceive they face, Section 6.1 discusses the types of risky behaviours that young women engage in, and, finally, Section 6.2 describes how young women make trade-offs when making decisions that result in them engaging in risky behaviours.

6.1 HOW DO YOUNG WOMEN PERCEIVE RISKS IN BCMM?

This evaluation seeks to understand the risks faced by young people in BCMM, both quantitatively, through the household survey, and qualitatively, through FGDs and the use of a participatory pairwise ranking tool. The household survey uses a DOSPERT scale [57] to measure respondents' attitudes towards risk, the results of which are presented in Table 16. The DOSPERT scale measures both conventional risk attitudes (defined as the reported likelihood of taking a risk), as well as perceived risk attitudes (defined as the magnitude of the perceived risk associated with a particular activity). These are investigated across three domains of risk: sexual behaviour risks [58]; safety risks [59]; and social risks [60]. Both the conventional risk attitudes and the perceived risk attitudes are measured on a scale of 1 to 5, with a score of 5 indicating the highest possible likelihood of engaging in an activity or the highest possible perception of the risk associated with that activity.

Table 16 shows that, as might be expected, young women report being more likely to engage in behaviours that they perceive to have a lower level of risk. This suggests that there is a link between risk perception and behaviour. However, as the rest of this chapter illustrates, the relationship between risk perception and behaviour is not always straightforward, and young women may choose to engage in behaviours that they consider risky when the alternative choices are considered equally risky or riskier.

In terms of the respondents' characteristics, respondents of different age groups perceive risk relatively similarly. Respondents in the less poor half of the sample associate a higher level of risk with sexual and safety risks, and report being less likely to engage in these activities, compared to respondents in the poorer half of the sample. Finally, respondents who have experienced violence perceive sexual, safety and social risks as less risky and report a greater likelihood of engaging in these behaviours. These findings suggest that experiencing poverty or violence may be associated with how one perceives other risks, although these relationships are likely to be complicated and not necessarily causal. The remainder of this chapter discusses in more detail findings from the qualitative research that show how young people perceive different types of risks as interacting with one another.

57 The DOSPERT scale is a psychometric scale that assesses risk-taking in five content domains: financial decisions (separately for investing versus gambling), health/safety, recreational, ethical, and social decisions. Respondents rate the likelihood that they would engage in domain-specific risky activities (Part I). An optional Part II assesses respondents' perceptions of the magnitude of the risks and expected benefits of the activities judged in Part I. For further details, see Blais, A. and Weber, E (2006) 'A Domain-Specific Risk-Taking (DOSPERT) scale for adult populations'. Judgement and Decision Making, Vol. 1, No. 1, July 2006, pp. 33–47.

58 Measured by the following items: (1) having unprotected sex with someone you just met or did not know well; (2) having sex for gifts or money; (3) having sex under the influence of alcohol; (4) being in two or more sexual relationships at the same time

59 Measured by the following items: (1) drinking heavily at a social function; (2) walking home at night in an unsafe area of town; (3) staying in a taxi even if the driver drives recklessly; (4) riding a motorcycle without a helmet.

60 Measured by the following items: (1) wearing provocative or unconventional clothes; (2) disagreeing with an authority figure on a major issue; (3) moving to a city far away from your extended family; (4) leaving an unhappy relationship although you have children together; (5) admitting your tastes are different from those of a friend; (6) arguing with a friend who has a different opinion on a social issue

In terms of the three types of risks presented, sexual risks are considered to be slightly riskier than safety risks, and riskier than social risks. A limitation of the application of the DOSPERT scale is that the behaviours that are asked about are predetermined ahead of the survey, and respondents may find it difficult to think about hypothetical behaviours that may not be immediately relevant to their lives. As is discussed in the remainder of this chapter, when respondents are probed in more depth about how they weigh risks against each other, respondents consider certain social risks, such as the fear of not fitting in, as extremely risky.

TABLE 16: RISK PERCEPTION MEASURED BY THE DOSPERT SCALE (WOMEN AGED 15–29)

VARIABLE (INDICATORS REFER TO THE PROPORTION OF WOMEN (%))	TOTAL	AGE OF FEMALE RESPONDENT			PROXY MEANS TEST SCORE		EXPERIENCED VIOLENCE IN THE LAST YEAR1 [61]	
		15 – 19	20 – 24	25 – 29	ABOVE MEDIAN	BELOW MEDIAN	HAS NOT	HAS
Sexual risks								
Perception of risk	4.42	4.47	4.39	4.42	4.5***	4.36	4.45**	4.32
Likelihood of taking risk	1.66	1.54*	1.66	1.75	1.59**	1.71	1.6***	1.86
Safety risks								
Perception of risk	4.31	4.33	4.32	4.3	4.36**	4.28	4.35**	4.21
Likelihood of taking risk	1.97	1.88	1.92	2.08***	1.9**	2.02	1.9***	2.19
Social risks								
Perception of risk	2.85	2.96	2.82	2.77	2.81	2.87	2.9**	2.66
Likelihood of taking risk	2.83	2.76	2.8	2.91	2.83	2.82	2.79**	2.96
Full DOSPERT scale								
Perception of risk	3.75	3.82	3.74	3.72	3.79	3.73	3.8***	3.61
Likelihood of taking risk	2.2	2.11	2.17	2.3**	2.16*	2.24	2.15***	2.39

*Asterisks indicate significant differences between the groups: * p < .01, ** p < .05, *** p < .001. For the age groups, tests for differences in means were conducted between the bottom age group (15–19) and the middle age group (20–24), and between the top age group (25–29) and the middle age group (20–24).*

Respondents in the qualitative research were asked in an open-ended manner about the risks that they face in their communities. For the purposes of the analysis, we group these risks into four broad risk categories: the risk of violence, financial risks, health risks, and social risks. In this section, we provide a description of each of these broad risk categories, as well as why respondents consider these to be risks. In addition to describing risks, respondents were asked to rank the risks they face using a pairwise ranking tool, described in Box 2, from which risks were ranked as more or less severe in respondents' opinions. In terms of language, we use the term 'severe' to indicate the degree to which risks [62] are considered relatively worse than the other risks that young women and young men face. In the context of this chapter, we consider a risk to be 'severe' when, across all of the pairwise ranking exercises [63], a risk was frequently selected into the top six risks and ranked highly amongst the risks respondents face. The most 'severe' risk is that risk that was chosen the most times across all of the pairwise ranking exercises (i.e. that risk which scored the most points collectively as part of the exercises).

[61] *Defined as having experience sexual, physical, or emotional IPV.*
[62] *For the purposes of the analysis, we categorise specific risks chosen during the pairwise ranking exercise into broad categories of risks (e.g. financial risks, risks of violence).*
[63] *As part of the qualitative research, 13 pairwise ranking exercises with women and 12 exercises with men were conducted.*

BOX 2: USING THE PAIRWISE RANKING TOOL TO ASSESS RISK PERCEPTIONS

The pairwise ranking tool was used to facilitate a discussion about the risks that young women and young men face in BCMM. In the first part of the discussion, respondents were asked to brainstorm different risks that they experience, and to construct a list of risks as a group. From this list, six key risks that are considered the 'worst to experience' were chosen (such as poverty, IPV, HIV, social stigma etc.) and these were included in a table for pairwise ranking. Each item was then paired against each other, asking participants 'which one is more of a risk/worse to experience for you'. In each pairwise ranking, the 'worse' risk was given one point. Thus, each item received a score which was used to rank the risks. This ranking was discussed with respondents, which provided a space for contest and deeper insight into experiences and perceptions of the various risks and vulnerabilities faced by young people. The key data were thus obtained through the discussion, rather than the ranking itself, though the overall ranking gives an understanding of perceived severity. For a more detailed explanation of the pairwise ranking tool, see Annex E.

Both young men and young women described **violence** as the most severe risk they face in their communities. Discussions during the FGDs highlighted some gendered differences in young women's versus young men's primary experiences of violence. Whilst men experience violence mainly from (or through) crime, young women spoke most often of violence in the context of experiencing GBV. In particular, young women consider rape to the most severe form of violence, followed by crime, physical abuse, verbal abuse, and abuse by blessers. Of the risks of violence brought up by young women, apart from crime, the other four forms of violence that women discussed can all be classified as forms of GBV. Results from the household survey show that a large proportion of respondents have themselves experienced GBV in the form of IPV [64] : 31% of female respondents [65] had experienced some form of IPV in the last 12 months. Of these respondents, 16% had experienced multiple forms of IPV. In addition to the violence associated with rape, young women explained that they also fear the stigma that is attached to being a victim of rape, and to the possible consequences of rape: falling pregnant at a young age and/or contracting HIV.

Respondents also identified several **financial risks**, including, in order of severity, the risk of unemployment, not having an education (including dropping out of school), poverty, and corruption as risks they have experienced. During discussions with respondents, it became clear that these financial risks are interlinked and young people are likely to experience multiple types of financial risks. For example, poverty was discussed as a barrier to education [66] and was said to result in dropout or not being able to complete or pursue education. Lack of education is perceived in turn to impact one's employability and reduce one's chances of finding employment. Respondents also explained that experiencing financial hardship means that one is more likely to engage in risky behaviours. For example, unemployment was seen to push young people towards crime, engaging in transactional sex, and substance abuse, and putting young women at risk of teenage pregnancy, and, as such, young women and young men perceive financial risks as leading to other negative behaviours.

In terms of **health risks**, young women in the sample spoke about the risk of pregnancy, followed by the risk of contracting and living with HIV/AIDS. They considered pregnancy to negatively impact their lives, referring to dropping out of education both due to needing to physically (and financially) look after the baby, and due to the stigma of returning to school, as discussed in Chapter 3.

INTERESTINGLY, YOUNG WOMEN COMPARED THE RISK ASSOCIATED WITH TEENAGE PREGNANCY TO THE RISK OF CONTRACTING HIV, STATING THAT IT IS 'NOT AS BAD' TO CONTRACT HIV AS IT IS TO FALL PREGNANT. AS EXPLAINED BY ONE RESPONDENT:
'With HIV, no one knows that you have it. It's not an illness that is written on a person's body. You can live with other people without them knowing as long as you take your medication and look after yourself.' (FGD young men 23–29, C3)

[64] *The household survey asked about experiences of IPV in particular and did not capture other forms of GBV that women may have experienced. During the qualitative research, GBV was discussed more broadly.*
[65] *This question was only asked of female respondents who had been in a relationship in the last 12 months.*
[66] *Discussed in detail in Chapter 3.*

To this extent, respondents felt that pregnancy was worse as it could not be hidden, whereas HIV could be kept a secret. In the context of communities in which gossip is rife and there is a stigma attached to both teenage pregnancy and HIV (see Chapter 3), being able to hide one's status results in HIV being considered less severe. In addition, young women do not seem to associate HIV with dropping out of school, reiterating that, as long as you take your medication, you can continue to study.

Finally, in terms of **social risks**, the risk of not fitting in, stemming from peer pressure, was perceived as the most severe, followed by boredom/lack of activities. As with other risks discussed above, young women perceived both boredom and peer pressure to lead to other risks. Young women explained how boredom means they end up taking drugs or binge drinking, having sex with multiple partners, or becoming involved in crime, simply because they have nothing to do (see Chapter 4 for a full discussion of boredom).

However, whilst boredom is perceived to create an enabling environment for negative or risky behaviours, and, if reduced, would decrease the risk of young people engaging in drug use or crime, respondents stressed peer pressure (i.e. the pressure to fit in to avoid the risk of not fitting in) as a root cause for everything else. Respondents highlighted that peer pressure is such a 'severe' risk because it leads young people to engage in negative behaviours, and they linked this strong pressure and desire to fit in in a perceived causal manner to teenage pregnancy, HIV/AIDS, experiencing violence, blessers, crime, drugs and alcohol, as well as dropouts and unemployment.

AS DISCUSSED IN FURTHER DETAIL IN SECTION 6.2, THROUGHOUT THE FGDS, IT BECAME CLEAR THAT PEER PRESSURE, AND PARTICULARLY THE STRONG DESIRE TO FIT IN, IS ONE DRIVING FORCE BEHIND ENGAGEMENT IN RISKY BEHAVIOURS:

Moderator: *When does this peer pressure happen most of the time?*

Participant 3: *From friends, like seeing your friend having a big fancy phone that was bought by the sugar daddy and you also feel the pressure of having that same phone.*

Participant 2: *Even at work. You meet people there and feel pressured to do what they are doing. Then you end up losing your job.*

Participant 4: *And they are used to doing it.*

Participant 2: *They are used to doing it, you do it only once and end up losing your job.*

(FGD young women 19–22, C2)

As a consequence of peer pressure, young people spoke about the pressure to binge drink and take drugs in order to fit in. Findings from discussions with young men and young women indicate that risks are often considered in a causal manner. Respondents explained that they considered the consequences of the risk when choosing which risks they consider most severe in the pairwise ranking. In this way, substance abuse, and particularly drug abuse, was considered a severe risk in that young women are often exposed to violence as a consequence of drug use. Specifically, young women stated how drugs and alcohol can make people (in particular, partners) violent, a finding echoed in the household survey, where 28% of women who reported having experienced physical or sexual IPV selected 'he was drunk' as a situation that tends to lead to their partner becoming violent.

In addition, drugs and alcohol were brought up as a risk in terms of abuse in the home, linked to physical, verbal, and sexual abuse. There is a strong causal perception of drugs and alcohol leading to abuse in the home, but likewise that the situation at home – and the associated stress – is what leads to young people drinking and taking drugs. Consequently, substance abuse – in terms of both alcohol and drugs – is perceived as a risk not in terms of negatively affecting one's health, but based on the negative behaviours it leads to.

6.2 HOW DO YOUNG WOMEN MAKE TRADE-OFFS THAT PLACE THEM AT RISK?

So far, this chapter has outlined the risks that young women perceive they face in BCMM, as well as the types of risky behaviours they engage in. Specifically, the preceding section discussed some of the determinants of engaging in risky sexual behaviours – in particular, having multiple sexual partners. Building on this discussion, this final section seeks to understand how young women's assessment of relative risks results in young women engaging in behaviours that place them at risk, and it describes the types of trade-offs that young women make in order to reduce their perceived overall risk in an inherently risky environment.

From our discussions, it became clear that young women make many different trade-offs on a daily basis, depending on the risks with which they are confronted in a given situation. However, for the purposes of this evaluation, we present the findings most relevant to Bumb'INGOMSO's ultimate impact, which is to decrease the rate of new infections of HIV. The discussion that follows focuses on the trade-offs that young women make that result in them engaging in risky sexual behaviours. In such situations, young women make a trade-off that, on the one hand, allows them to avoid certain risks, such as violence, but that, on the other hand, places them at risk of contracting HIV. This discussion focuses on three main trade-offs that young women discussed with respect to engaging in risky sexual behaviours: namely, making trade-offs to fit in, making trade-offs to avoid violence, and making trade-offs to avoid financial risks.

6.2.1 MAKING TRADE-OFFS TO FIT IN

Whilst young women did not necessarily describe the fear of not fitting in as the most severe risk faced in itself, the way in which young women described other risks they face and the way in which they rationalised their rankings of risks was situated within a lived reality of immense peer pressure to fit in. To this end, when asked why they are afraid of peer pressure, respondents described that they are afraid because the desire to fit in pushes them to engage in what they perceive to be negative behaviours. Respondents explained that they are afraid of not having friends, of being left out, or of being isolated [67]. Respondents expressed that, for example, they did not want to 'appear better' than their peers: 'firstly with your friends. If you want to belong to the group of friends you have, your friends do something and you don't do it, they will think that you think you are better than them or that you do not belong with them.' (FGD young men 23–29, C3). This fear behind the expression 'peer pressure' comes out strongly from all six case communities, in all age groups.

Ultimately, the fear young peopled expressed relates to 'not fitting in'. Discussions with respondents highlighted that what it means to 'fit in' is guided by a set of social norms which appear to be well known in the case communities and young people – and young women in particular – feel a strong pressure to comply with these social norms: 'if you drink Hunter's Dry [a type of cider], we don't include you. Because you drink the expensive stuff.' (FGD young women 23–29, C1). As discussed in depth in Chapter 4, structures of friendship appear to be highly complex for young women, and friendships appear to be deeply connected to the need to 'fit in' or 'belong' somewhere.

Findings from the FGDs indicate that, in their desire to fit in and belong, young women engage in what they know to be risky sexual behaviours, risking pregnancy and/or HIV infection. In other words, when faced with the risk of not fitting in versus pregnancy and/or HIV, young women weigh the risk of not fitting in more heavily. For example, young women were clear that they need money to be able to fit in, and stated that they get this money from boyfriends or by having blessers. However, young women indicated that they feel pressure to keep a man [68] which influences their agency within these relationships (be that blessers or boyfriends) and hence their ability to insist on condom use.

Beyond this fear of losing a partner, young women appear to be highly influenced by the sexual behaviour of their friends. In an environment where other young women are engaging in risky sexual behaviours, young women choose to do the same in order to belong.

Similarly, many young women spoke about binge drinking and taking drugs in the context of fitting in with their peers, despite the knowledge that substance abuse leads them to engage in risky behaviours. Young women highlighted the causal risk of doing drugs leading to negative behaviours, such as having unsafe sex: 'most of the youth here do drugs and drink alcohol. With that, I say peer pressure is very common. You do this because you want to fit into that group. You do what they do because of wanting to fit in.' (FGD young women 19–22, C1).

YOUNG WOMEN ALSO MAKE OTHER TRADE-OFFS IN ORDER TO FIT IN. FOR EXAMPLE, FITTING IN ALSO MEANS NOT APPEARING BETTER THAN OTHERS:

'Let us say Sisanda [69] was full time employed, then we will become jealous and we will just monitor her and we see many mistakes she is doing, we even look at when is she doing another hairstyle, what is she doing about the money those pity things or we will say she is full of herself what not and what not and we pass bad remarks when we see an achiever just to make her feel bad.' (FGD young women 20–27, C5).

As the quote above exemplifies, there is a strong feeling of pressure to comply with the norms of fitting in, such that young women take on additional risks in order not to risk social exclusion. To this extent, young women explained how they may be prepared to lose job opportunities to keep their friends (i.e. take on the risk of facing unemployment), or that they will go along with other elements of fitting in that come with other negative consequences.

[67] *Analysed in depth in Chapter 4.* [68] *Discussed further in Chapter 4.* [69] *Name changed for anonymity.*

6.2.2 MAKING TRADE-OFFS TO AVOID FINANCIAL RISKS

Linked to fitting in, young women expressed that not having money is one of the main risks that they seek to avoid. Not having money is different to being unemployed in that it relates to the need to have money to spend, i.e. to be able to buy things you perceive you to need to fit in. As stated by a respondent: *'we compete about clothes most of the time so we always think about making money and buy clothes so if you don't have these you cannot be able to fit in'* (FGD young men 19–22, C1).

The findings indicate that young women thus consider the 'provider' dimension of relationships over a healthy (non-violent) relationship [70], with the idea that *'love is money'* frequently referenced by respondents. Due to this, young women frequently engage in behaviours and spaces that they associate with experiencing violence, such as having blessers or going to taverns.

'I have a friend who has a blesser and she dresses so nicely. She is no longer my friend because she has all these fancy things. She is dating five other men, one of them is white. When you see here you'd think that she is working but she doesn't even have Grade 12. She even has his own bed at home. I used to be her friend, then I thought that my standard doesn't match hers.' (FGD young women 23–29, C1).

In the context of high youth unemployment in BCMM, the risk of not having money is high and many young women are not able to provide for themselves. As such, young women reiterated their need to have access to 'fast cash' in order to buy things such as clothes, alcohol etc., and, to this end, would sleep with blessers who are able to provide these things for them.

HOWEVER, THEY ARE CONSCIOUS THAT THEY PUT THEMSELVES AT RISK BY SLEEPING WITH BLESSERS, STATING THAT HAVING A BLESSER CAN BRING OTHER RISKS SUCH AS DISEASES:

Moderator: *Why do you think that they date these sugar daddies?*
Participants: *They want money.*
Moderator: *What else do they get from in that relationship?*
Participant 2: *Illnesses.*
Moderator: *So why do we date these older men?*
Participants: *For money…I know of a girl that used to date sugar daddies but now she is too ill to get out of bed. (FGD young women 19–22, C2)*

[70] *See Chapter 4 for a detailed discussion of how this links to young women's self worth.*

6.2.3 MAKING TRADE-OFFS TO AVOID VIOLENCE

Young women in the case communities considered violence as the most severe risk (i.e. the worst to experience) that they face. Whilst there were widespread reports of IPV, across all communities it was acknowledged that blessers tend to be especially violent. Young women reported that blessers may become aggressive if they insist on using condoms and so condoms are rarely used in those interactions. Young women admitted, in the FGDs, that they agree to not using condoms in order to avoid experiencing violence [71]. This appears to emanate from two things. First, the transactional nature of the blesser-blessee relation is clearer *'we all know that you must give him sex in return'* (FGD young women 19–22, C1). Second, since it is a pre-arranged agreement, respondents explained that sex would then most likely occur on the blesser's terms, and should these terms not be met, it was common for blessers to find someone else: *'old men like dating young girls because girls of your age [referring to moderator, age 30] are too demanding. We don't ask a lot of questions. If he gives me money and buys me all the things I want, I'm happy.'* (FGD young women 19–22, C2).

Findings from the household survey also point to this trade-off. The results indicate that individuals who have experienced violence perceive a lower level of risk attached to engaging in risky sexual activities, and would consider themselves more likely to engage in these activities than respondents who have not experienced violence (see Table 16). This may suggest that young women who have experienced violence perceive risks differently to women who have not experienced violence. This link, however, is not causal and is likely to be related to other factors that make a woman more vulnerable to being exposed to violence.

In particular, we report in Section 5.4.1 that individuals in the poorest half of the sample are significantly more likely to have experienced IPV in the last year, compared to those in the less poor half of the sample, as measured by the PMT.

By contrast, young women also explained that there are situations in which they may accept the risk of violence (often in the context of relationships). For example, young women spoke about enduring violence as they did not want to lose their boyfriend and, by extension, wanted to fit in. Two aspects of this are explained in the quote below: 1) the role of boyfriends as providers (having money), where *'love is money'*, and 2) you do not want to be the only one without a boyfriend.

'We have this thing that if you are not dating at this age, you must at least have a casual partner or throw yourself at anyone. Or if I have a boyfriend that has money, you don't know what I have to do to get that boyfriend with money, now you have to do what I do to get that boyfriend just because you are tired of sitting at home. You'll look at me and say, she is never here, she has clothes but you don't now, you are going to force yourself to date older men so you can live the life I'm living. You don't know if that person is sick or not because you are chasing to live the life I am living.' (FGD young women 19–22, C1).

As such, women make a trade-off in which they accept violence in exchange for fitting in. The violence that they accept is most commonly GBV, which includes sexual violence. This trade-off, however, also puts young women at an increased risk of contracting HIV. Therefore, in situations in which women make a trade-off that exposes them to violence, they may also be putting themselves at risk of contracting HIV, depending on the type of violence they encounter.

Young women in the case communities considered violence as the most severe risk, it was acknowledged that blessers tend to be especially violent.

[71] *This is not to say that respondents do not try to avoid some of the risks associated with sex without a condom by, for example, going to get contraceptive pills to mitigate the risk of pregnancy in situations in which they have less agency to insist on the use of a condom,*

6.3 MAIN CONCLUSIONS AND TOC LINKAGE ASSESSMENT

THE DISCUSSION IN THIS CHAPTER HIGHLIGHTS THAT YOUNG WOMEN AND YOUNG MEN LIVING IN BCMM LIVE IN AN ENVIRONMENT IN WHICH THEY ARE CONFRONTED BY MANY RISKS.

Furthermore, it is clear that young people consider these risks, and the consequences of these risks, to be severe. However, a fundamental contradiction is apparent as young people make choices that they know will place them at risk of violence, unemployment, pregnancy etc. Of particular relevance to Bumb'INGOMSO is that young people engage in what they know to be risky sexual behaviours, and which they know to have negative consequences, such as the risk of contracting HIV. The question that is relevant for the programme is: why do young women engage in risky sexual behaviours when they know that this places them at risk of contracting HIV?

The discussions with young men and women made clear that considering risks in isolation of the other risks that young people face does not help us to understand how young people make decisions. For example, given that young women consider violence to be a severe risk, considering violence in isolation would lead one to assume that young women always make choices that avoid violence, but this is not necessarily correct. This is because young people are often faced with choices in which they are forced to decide between options, each with its own risk. Hence, an important aspect of understanding how young women, in particular, make decisions is to understand how young women understand relative risk, as shown in the purple box in the TOC, and how they make trade-offs to minimise the risks that they face as a result of the choices they make.

The discussion on relative risk suggests that young women engage in risky sexual behaviour, which puts them at risk of contracting HIV, because they weigh this risk less heavily than the other risks that they face in that situation. It seems that there are two primary reasons that women fear contracting HIV (i.e. why they consider it to be a risk), which are 1) the health impacts of HIV, and 2) the stigma associated with HIV. In the first instance, there is a general perception that if one takes medication for HIV, one can live a normal life and hence the negative health impacts of HIV do not appear to weigh heavily in the minds of young women. In many of the discussions, young women did not appear to associate having HIV with being sick. More often than the health impacts of HIV, young women emphasised that the stigma attached to contracting HIV is what they fear most. However, young women also explained that, in comparison to pregnancy, one's HIV status can be kept a secret. In fact, it seems that young women perceive the risk associated with contracting HIV to be less severe the more easily one's status can be kept to oneself.

In addition to the consequences of HIV being considered as less severe, there are other risks that young women face that they consider to be more severe than HIV. The desire to fit in or to belong comes out most strongly as a factor that influences young women's decisions. Particularly when faced with a decision in which a young woman might feel she needs to engage in risky sexual behaviour or risk not fitting in, it seems that most young women would consider it worse not to fit in. This finding indicates that, for Bumb'INGOMSO to alter the way in which young women perceive relative risk, the programme will need to focus on the way in which young women understand and perceive belonging. Crucially, shifting from a sense of 'negative belonging' (i.e. belonging because you are not considered to be better than anyone else) to a positive sense of belonging, in which communities work to build each other up, will change the way in which young women perceive fitting in. If fitting in is perceived to include striving to complete one's education, to find employment, to have a single sexual partner, and to practise safe sex, perhaps the way in which young women consider decisions and make choices will change.

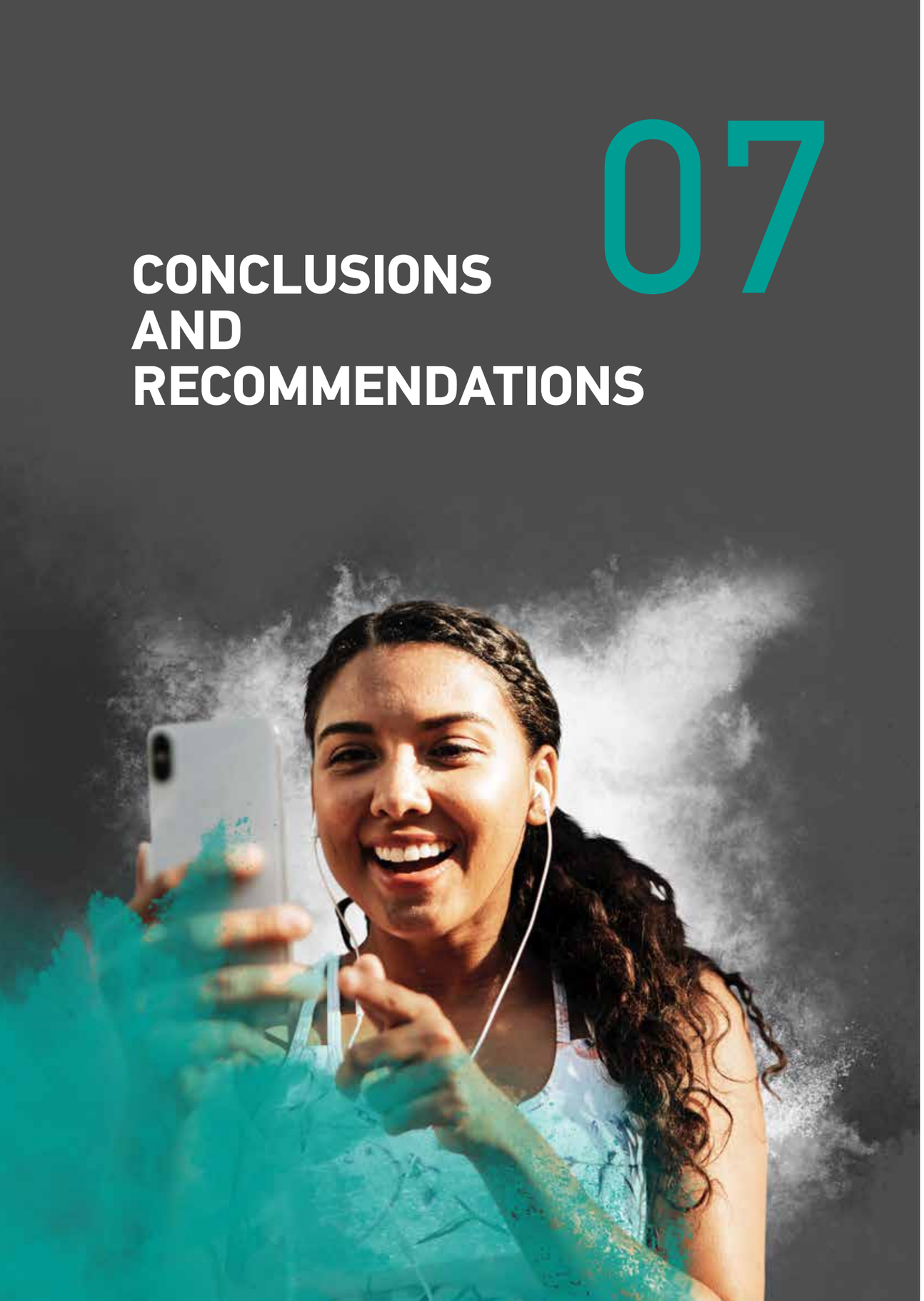
From the discussions with young women, it became apparent that GBV is another risk commonly faced by young women in Bumb'INGOMSO's target communities. The household survey findings show that a large proportion of women reported having experienced IPV. The household survey also found that IPV is rarely reported by young women through any official channel and, furthermore, young women rarely seek support after having experienced IPV. Given the prevalence of GBV, in relationships or with other sexual partners, it appears that young women are commonly faced with a situation in which they might either experience violence or, by engaging in risky sex (particularly sex without a condom), avoid violence. Therefore, Bumb'INGOMSO's focus on tackling GBV, through the intervention implemented by Masimanyane, is a crucial pillar in altering the type of risks, and hence trade-offs, young women face, by reducing the incidence of GBV, such that young women are not faced with a situation in which they may experience violence as a result of insisting on practising safe sex.

Of course, young women also face other trade-offs that do not necessarily place them at risk of contracting HIV, but that may place them at risk of experiencing other negative consequences. For example, young women stated that, whilst at school, they may binge drink (in order to fit in with their peers) and end up missing school and ultimately dropping out of school. Following the logic of relative risk, young people are willing to risk dropping out of school to avoid the risk of not fitting in with their peers. If young women perceive the risks of dropping out to be more severe than the risks of not fitting in, because they believe that job opportunities are real, they may weigh the risk of binge drinking and missing school more heavily. Alternatively, if young women perceived 'fitting in' differently, and completing education was considered as part of fitting in, dropping out of school would threaten their sense of belonging and would be considered a risk they would wish to avoid.

From this analysis, it seems that the TOC adequately captures the way in which young women consider relative risk in order to make decisions. However, altering the severity young women ascribe to different risks, and hence changing the way in which risks are considered relative to each other, will be a challenging task for Bumb'INGOMSO in an inherently risky environment.

07

CONCLUSIONS AND RECOMMENDATIONS



THROUGH EACH OF CHAPTERS 3 TO 6 WE PRESENTED THE BASELINE FINDINGS AND THEIR IMPLICATIONS FOR THE PROGRAMME. IN THIS CONCLUDING CHAPTER, WE HIGHLIGHT THE FINDINGS THAT STAND OUT, DISCUSS THE RELEVANCE OF THE PROGRAMME (PLAUSIBILITY OF THE TOC) AND PROVIDE SOME RECOMMENDATIONS.

7.1 KEY CONCLUSIONS

Employment and education opportunities post school are scarce, and not being employed or in education are key factors associated with negative behaviours such as taking drugs or abusing alcohol. Young women who are unemployed and not in school are bored and often lack a sense of purpose. This boredom due to idleness increases the likelihood for engaging in coping mechanisms such as taking drugs and alcohol abuse, and women who engage in these are more likely to engage in sexually risky behaviour.

Being accepted in one's community (belonging) is incredibly important for young women to the extent that they will often engage in negative or risky behaviours to achieve this sense of belonging. First, young women do not make use of certain services (e.g. SRH services) because of stigma and fear of judgement (related to support mechanisms). Young women in BCMM endure stigma across many aspects of their lives, including when they are associated with drug abuse, fall pregnant while in school, go to a health facility to receive contraception or other reproductive health services, test for HIV, report sexual violence to the police etc. Stigma and the fear of being judged by the community is an overarching theme that holds young women back from making the most of opportunities and utilising services. Stigma thus renders a number of opportunities or services targeted at young women 'unreal', despite some of these opportunities or services being available.

Second, young women are afraid to stand out or 'be better' because they think that this will not be supported or will in fact be actively sabotaged (related to imminent opportunities). Many young women are therefore likely to maintain friendships and relationships that may influence them to abuse alcohol, do drugs, engage with blessers etc. Sabotage by the community sometimes also means their initiatives to better themselves, such as starting a business, quitting drugs or trying to find a job often fail.

Third, young women will choose risky alternatives (unsafe sex, staying in a violent relationships) if that means being accepted by their community (related to relative risk trade-offs). Young women engage in a range of risky behaviours, despite acknowledging that there are negative consequences associated with these behaviours and that these behaviours are risky, in order for them to belong. Being in a relationship, particularly having a boyfriend, is one of the likely influences of risky sexual behaviour among young women and it is such a strong motivator for young women, young women sometimes tolerate not being treated well by their partners and they may engage in risky sexual behaviour for them to keep a man [72].

Young women have good knowledge of safe sex, but lack fully comprehensive knowledge of HIV. While most young women are aware of how to practice safe sex, few young women have comprehensive knowledge of HIV. In particular, young women believe some of the common myths around the spread of HIV, e.g. that it can be spread through witchcraft or through getting bitten by a mosquito. If young women continue to have misconceptions that there are other external factors that may lead to them acquiring HIV, i.e. that avoiding HIV infection is out of their control, they may not prioritise sexual behaviour practices that prevent HIV, as they feel they may become infected anyway.

IPV as well as controlling behaviour in relationships is prevalent and young women do not have enough support from their communities and from established support structures to report these incidents and seek help. Young women experience high rates of violence within relationships and it is often their partners that determine whether safe is sex. There are also many situations where sex is expected of young women. In many of these cases where young women would want to have safe sex or no sex, they face the risk of violence or of the relationship ending. Further, reporting IPV to the police is not always an options young women feel they have, due to limitations in the support offered by the police, including for example, being encouraged by the police to talk things through with their partners.

Young women have agency in many ways, but their agency is constrained by many structural factors. First, most attend school and want to engage in activities that will improve their lives, but in the case of education and employment opportunities, many fail to find opportunities that are relevant for them. In their communities, young women are also aware of the services they need, e.g. SRH services and policing services but they face stigma and sometimes poor quality services when the access these services. They also make risky choices when it comes to sex and partners because they know that the alternative choices are even riskier for them.

[72] Part of this highlights how important men's perceptions and community perceptions in general are in shaping HIV risk for young women. While young women consent to being in relationships, it is clear that this is partly in response to a need to belong, which is driven by community perceptions.

7.2 RELEVANCE OF THE PROGRAMME (PLAUSIBILITY OF THE TOC)

7.2.1 STRENGTHS OF THE PROGRAMME

The programme has identified some of the key constraints that prevent young women from making risky choices, in particular, lack of education (no matric or poor marks) and employment opportunities, but also others. Young women face barriers in accessing services and often when they do have access to some of these services, the quality or nature of the support they receive is not adequate and does not maintain their confidence that they may be able to rely on the support mechanisms. The programme's approach to improve the quality and access for these services therefore addresses a key constraint for many young women.

Young women's sense of motivators are low, as anticipated by the programme. While there are some differences by age (with younger women likely to have a greater sense of purpose than older women, for example) on the balance, young women have a low or negative sense of the motivators, e.g. a sense of belonging closely associated with having a boyfriend, or that life and opportunities outside BCMM was better or low vitality due to lack of education, employment and recreational activities. To this effect, the programme has identified important motivators and in particular when it comes to identity and belonging. These motivators appear to be guiding young women's behaviour and play a key role in shaping young women's sexual behaviour.

GBV and IPV are key contextual factors that influence young women's actions, especially in relation to accessing services and the agency young women have in relationships. Community support for young women to avoid GBV and IPV in relationships is very limited and yet these have a direct bearing on young women's sexual behaviour, therefore the programme's thrust to improve community perceptions around these, and the quality of support young women that experience GBV and IPV should have, is aligned with the objective to increase agency among young women to make them less likely to make trade-offs that place them at risk.

The findings also support the TOC in that where young women perceive a risk to be more severe, they are less likely to engage in the activity that exposes them to the risk. The programme rightly realises that considering risks that young women face in isolation therefore does not help understand better how young women make decisions. This is because young people are often faced with choices in which they are forced to decide between options, each with its own risk. In this regard, the programme TOC adequately captures the way in which young women consider relative risk in order to make decisions.

The programme also realises that community perceptions are a key element in assisting young women to make choices that do not place them at elevated HIV risk. Community perceptions affect the expectations of men in relationships, those of young women and the also the support young women have in the community. They thus shape the environment in which young women make choices around safer sex, but also more generally around the actions they take (or do not take) to belong.

THERE ARE THEREFORE MULTIPLE STRONG POINTS FOR THE PROGRAMME. BUMB'INGOMSO IS A HOLISTIC PROGRAMME THAT TARGETS VARIOUS FACETS THAT INFLUENCE YOUNG WOMEN'S LIVES IN BCMM AND ULTIMATELY HIV RISK. OVERALL, THIS BASELINE EVALUATION FINDS THE TOC FOR THE PROGRAMME TO BE PLAUSIBLE AND THE PROGRAMME RELEVANT.

The programme realises that community perceptions are a key element in assisting young women to make choices that do not place them at elevated HIV risk

7.2.2 POTENTIAL WEAKNESSES OF THE PROGRAMME

With the focus being on young women, it is unclear how the Bumb'INGOMSO will be able to address community perceptions more broadly. For example, the Leadership Network is likely to build self-confidence and leadership skills, bring young women together with peers who can act as a positive influence and support network, provide access to opportunities – but to what extent will young women be able to use these skills, or to what extent will young women really be able to change their perceptions of themselves and of available opportunities if the communities that they return to are not supportive of this. The general point here is that, what constitutes community perceptions is very broad, and there appears to be a wide range of community perceptions that affect how young women perceive opportunities to be imminent that the programme is not explicitly targeting. This will have the effect of potentially reducing the magnitude of change that may be achieved by the programme.

LACK OF EDUCATION AND EMPLOYMENT OPPORTUNITIES ARE A KEY CONSTRAINT FOR YOUNG WOMEN, BUT AN INTERVENTION SUCH AS HARAMBEE WILL NOT BE ABLE TO TACKLE THIS ISSUE COMPREHENSIVELY. HARAMBEE'S INTERVENTION IS LEVELLED AT WOMEN THAT HAVE PASSED MATRIC, AND ONLY LESS THAN HALF OF THE WOMEN IN THE TARGET COMMUNITIES ARE LIKELY TO MEET THIS REQUIREMENT. IT IS THEN LIKELY THAT THERE WILL BE A SIZEABLE NUMBER OF WOMEN THAT THIS SPECIFIC INTERVENTION IS NOT ABLE TO REACH.

The extent to which the programme may be able to influence the sense of motivators for many of the women in the 25-29 age group that are unemployed and not enrolled in education activities may be limited. The unemployment is largely due to the lack of job opportunities in BCMM, and the limited enrolment post school due to these women either having failed or attained low marks in school. The degree to which the programme is able to help these women perceive opportunities as real and imminent, without addressing unemployment in general, might be constrained due to the limited options available to these women. The programme will need to consider how to tackle boredom and lack of purpose amongst a large group of women who have not completed matric or achieved very poor academic results and may therefore turn to negative behaviours including drug and alcohol use.

Findings also show that young women perceive most of the risks they face to be high and to have severe consequences. It appears unlikely then, that the programme will be able to increase the severity young women ascribe to violence or sexual risks, as these are already very high. A change in relative risks seems only feasible in as much as the programme will be able to lower the non-sexual risks, such as violence. Now, given the structural nature of violence as a social problem in BCMM (and elsewhere in South Africa) the extent to which the programme is able to make these communities less violent may be limited.

If young women become more active, come up with ideas of what they want to do (e.g. sports) or other initiatives, there may be a the risk that the programme will not be able setting where motivators are generally low, inability to maintain the enthusiasm young women may have as a result of the programme may result in a waning of the enthusiasm that would have been generated among young women.

Lastly, increased agency and a leadership network may result in young women standing out or being perceived to be better or different in their communities. This evaluation shows that belonging is closely associated with not appearing to be different, therefore, through standing out in their communities by making more positive choices, young women may be exposed to social risks that come with not belonging. It is likely that young women's motivators will change faster than community perceptions in support of these will change, possibly placing these young women at the risk of being excluded or sabotaged by community members.

7.3 RECOMMENDATIONS

THE BASELINE EVALUATION RECOMMENDS THE FOLLOWING:

1. **The programme should consider more options for engaging communities more broadly to change community perceptions.** The current strategy involves working with communities, and this report reinforces the need to strengthen this aspect of the programme. Working with communities more broadly will be necessary to change community perceptions and improve the safety of young women in communities. This includes working more closely with men, and this regard, the following options can be pursued:

    a) The programme could work with key male influencers in the communities. These can be men that will participate and help shape the programme activities so that the activities are delivered as community interventions accessible to both men and women. Which men to include will have to vary by community, depending on those identified as key influencers in the specific communities by young women. There should be broad membership to the programme's activities in communities that can include community leaders, tavern owners, church leaders and ward committee members.
    b) The programme may also support groups of men that struggle with particular social issues that make them a higher risk for women that may live with them or associate with them, such as violence and substance and alcohol abuse.
    c) The programme can include young men in the communication and materials that the programme disseminates. Communication should remain targeted at young women but should be accessible young men as well, ensuring that they are not portrayed in a negative image, and more generally that young men do not feel excluded from the solution process.
    d) Linked to this, the programme can then also do more work to increase level of social, or leisure time activities in these communities as a way of reducing inactivity and boredom among young women. Relevant existing structures could be used, including community groups, church groups and other social groups that may be available in these communities.

2. **Bumb'INGOMSO should integrate the Leadership Network into communities as much as possible.** If the Leadership Network operates only outside of young women's communities (e.g. through leadership camps), there is a real risk that a) the most vulnerable women will not be reached, and b) young women may not be able to apply their skills in their communities, because communities may not be supportive (e.g. the Leadership Network may be seen as exclusive).

3. Beyond Zero's work should consider to include
    a) **Providing comprehensive information about HIV prevention, including dispelling common myths;** and
    b) **Working to reduce the stigma associated with SRH services in particular, and making sure these are private, confidential and of high quality.** Health services already seem to be accessible for young women and general perceptions of quality are moderate to good. The main issues, therefore, probably relate to more correct information on HIV risk factors and the stigma associated with seeking SRH services. Addressing stigma would include communication and sensitisation outside of the clinic, because women who think that they will not be treated well at a clinic may not go there in the first place.

4. **Strengthening the synergies across the different programme interventions will be key to achieve the overall programme goals.** The programme TOC rightly identifies that the various constraints and issues young women face in making choices that place them at HIV risk are multifaceted. The programme has to ensure that the activities are not delivered independent of each other, but instead as one well-coordinated complementary suite of interventions. The programme therefore needs to keep thinking about how the different components work together and interact with each other. Some ways to enable the programme components work together better may include the following.
    a) Harambee can work with other employment programmes e.g. YES and EPWP more directly, where Harambee has contacts from these programmes in their intervention, and those young women that approach Harambee but do not meet the minimum criteria can be directly linked to other programmes into which they may qualify
    b) SPF offers some of the bigger opportunities to synergise programme activities. The leadership network can work with Masimanyane to enhance communication on BCC, such as referral protocols as part BCC messaging and discussions in the network. The community mobilisation work by SPF is also an opportunity to engage the wider community on changing community perceptions.
    c) SPF can also work with Beyond Zero to communicate effectively to young women the changes at health facilities as a result of the intervention and the support young women can expect to receive once they walk into the intervention health facilities.
    d) Other synergies will include ensuring that all the interventions convey common messages, have some common material easily identifiable across the implementing partners (such as GBV referral protocols).

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ANNEX A
SUPPLEMENTARY INFORMATION ON BUMB'INGOMSO

BUMB'INGOMSO IS IMPLEMENTED BY FOUR SERVICE PROVIDERS, WHO EACH TARGET DIFFERENT AREAS OF HIV PREVENTION. THIS SECTION PROVIDES A DETAILED DESCRIPTION OF THE PLANNED ACTIVITIES CARRIED OUT BY EACH SERVICE PROVIDER.

A.1 SPF

SPF focuses on the **behavioural change component** of Bumb'INGOMSO. The component aims to create a collective sense of identity, belonging, purpose, and possibility that inspires and enables young women and girls to access information, develop skills, take charge of their own lives (agency), and take action (at both individual and collective levels). SPF recruits young women and girls into the Bumb'INGOMSO programme through the Leadership Network, which will form a platform for young women and girls to access the rest of the interventions and officially join the Bumb'INGOMSO programme (including gaining the Bumb'INGOMSO card and access to the hub). The behaviour change component of Bumb'INGOMSO has three main activity streams:

1. THE LEADERSHIP NETWORK: IN ADDITION TO BEING AN ENTRY POINT INTO BUMB'INGOMSO, THIS COMPONENT HAS THE FOLLOWING ACTIVITIES:
   - Leadership clubs for youth (in/out of school), which aim to create safe spaces for young women and girls, and to increase young women's and girls' sense of identity, agency, belonging and purpose (and ultimately sense of imminent possibility).
   - Leadership residential workshops, which aim to build the aspirations of young women and girls through residential programmes capacitating the network members (including in terms of self-identity, personal development, sexual health, human rights, leadership skills, problem-solving, and innovation).
   - Mentoring young women and girls to develop interventions and take action, with the network acting as a further platform for young women and girls to create plans for change within their communities (utilising participatory learning and action (PLA)).
   - Behaviour change communication activities (under the leadership clubs/workshop/mentoring).

2. COMMUNITY MOBILISATION:
   - Recognition, acknowledgement, and visibility activities.
   - Annual forum (stakeholders + young women and girls).
   - Parent/youth workshops.
   - PLA workshops in communities and the creation of community scorecards: SPF will conduct community dialogues, discussions and workshops with identified community members to support communities in conducting an assessment of the situational reality for young women and girls in their community. The aim is for the plan to result in community needs being identified, and intervention plans being developed that are aligned with the objectives of the Bumb'INGOMSO programme (utilising PLA).
   - Interface workshops.
   - Community social marketing.

3. RESPONSE MECHANISMS
   - Bumb'INGOMSO jamboree (facilitate and advocate stakeholders).
   - Training and mentoring teachers on comprehensive sexuality education. SPF will work with life orientation teachers in identified schools to improve teaching on SRH.
   - Response mechanisms created to improve referral and access to services: SPF will set up a response mechanism within the Bumb'INGOMSO programme that consists of a call centre for providing information (text-based), emergency, counselling, and referral services (voice-based). This will improve the linkages between the various interventions, and the linkage to opportunities, resources and services available in BCMM more widely.

A.2 BEYOND ZERO

Beyond Zero focuses on **improving the effectiveness and youth-friendliness of health services.** The component aims to provide quality healthcare services that will stimulate demand and increase the response of young people. Beyond Zero speaks both to the pathway for young women and girls making different trade-offs with regard to risky behaviour, and the reduced efficiency transmission rate of high-risk groups. The Beyond Zero component of Bumb'INGOMSO has the following activities, among others:

- training facilities on the Youth-Friendly Services package;
- supporting facilities in being youth-friendly;
- training health workers on SRH, youth issues, and sex worker health services and rights;
- supporting facilities in allocating time and personnel to youth and to sex workers;
- awareness campaigns (including social media);
- distributing customised information education communication materials for youth and sex workers;
- mobilising youth to be part of health facility governance;
- training sex worker support groups;
- training GPs on syndromic management of STIs;
- implementing a primary healthcare patient record system; and
- providing training on the primary healthcare patient record system.

A.3 MASIMANYANE

Masimanyane ultimately focuses on **reducing the incidence of GBV**, with the intermediate aims of increasing young women's and girls' sense of opportunity, changing community perceptions and attitudes toward young women and violence, and making young women and girls feel safer and more supported within their communities. This component of Bumb'INGOMSO has three main activity streams:

1. INDIVIDUAL LEVEL:
   - individual counselling;
   - support groups for young women;
   - training of young women on GBV and rights; and
   - human rights and other in-school clubs (in conjunction with SPF).

2. COMMUNITY ENGAGEMENT:
   - men and parents/caregivers receive training on GBV;
   - intergenerational forums (men and women);
   - community mobilisation (including general meetings and working with 'gatekeepers', i.e. traditional leaders, faith-based organisations, etc.); and
   - primary prevention of GBV through the safer cities model.

3. REFERRAL AND RESPONSE MECHANISMS:
   - SAPS interventions (training on the law, implementation, expectations and requirements, GBV booklets, etc.);
   - police community forums receive training;
   - health professional-focused interventions (training of doctors, allied health professionals. and counsellors);
   - legal professional-focused interventions (training of legal clerks and prosecutors);
   - 8- to 10-hour hotline established;
   - virtual interventions (e.g. virtual shelter); and
   - equipping hospitals, clinics, and police stations with tablets, hardware, software (to monitor and follow cases) --> (yet to be determined).

A.4 HARAMBEE

Harambee focuses on empowering young women in BCMM to **access opportunities that enable economic participation**. The component aims to improve access to information about available opportunities, and to demonstrate how best to navigate those opportunities. In addition, Harambee aims to improve young women's and girls' sense of agency, vocational skills, and work experience, in tandem with the BCMM labour market. The Harambee component of Bumb'INGOMSO has two main activity streams:

1. SUPPLY-SIDE ACTIVITIES, WHICH INVOLVE:
   - providing work-seeker support services (including digital citizenship, job search skills, interview skills, and CV building);
   - work-seeker support (sharing information about existing opportunities);
   - creating a referral network to share other opportunities outside of the Bumb'INGOMSO network;

- building foundational skills development programmes;
- providing an opportunity matching service (including learning potential, technical and psychometric assessments);
- work readiness programmes (bridging);
- facilitating short-term work experience opportunities (including volunteering opportunities);
- developing and implementing demand-led learning programmes for youth to transition into scarce skills job opportunities; and
- establishing an opportunity hub in East London.

2. DEMAND-SIDE ACTIVITIES, WHICH INVOLVE:
   - advocating for the use of alternative signals in determining learning potential, technical capability and behaviour;
   - advocacy to improve inclusive hiring;
   - establishing a consultative forum with critical stakeholders; and
   - demand-catalytic activities for work opportunities.

A.5 REAP

REAP provides **psychosocial support & academic monitoring** through One-on-one conversation with Walter Sisulu University first year students. Also providing developmental workshops in trying to equip students with some skills such as time management and goal setting and through these workshops students get to network with other like- minded peers, build friendship and have fun in the process.

A.6 DREAMWORKER

Dreamworker works as a **complimentary and support partner to the TVET Colleges** within the BCMM to enhance inservice training for Work Intergrated Learning (WIL) and Work Based Exposure (WBE) students. This is done by making sure that:

- available Seta funding in the SETA sector had been applied for.
- Learners are placed on their relevant work place as per their field of study
- Secure host employers
- Monitoring & Evaluation/ site visits must be done when students are place

A.7 MASIBUMBANE DEVELOPMENT ORGANISATION

Masibumbane Development Organisation provides **psychosocial support services to first year level students**. The project aims to curb students dropout rate and contribute towards the retention as well as throughput of students in Buffalo City and Lovedale TVETs. This is done through the following activities:

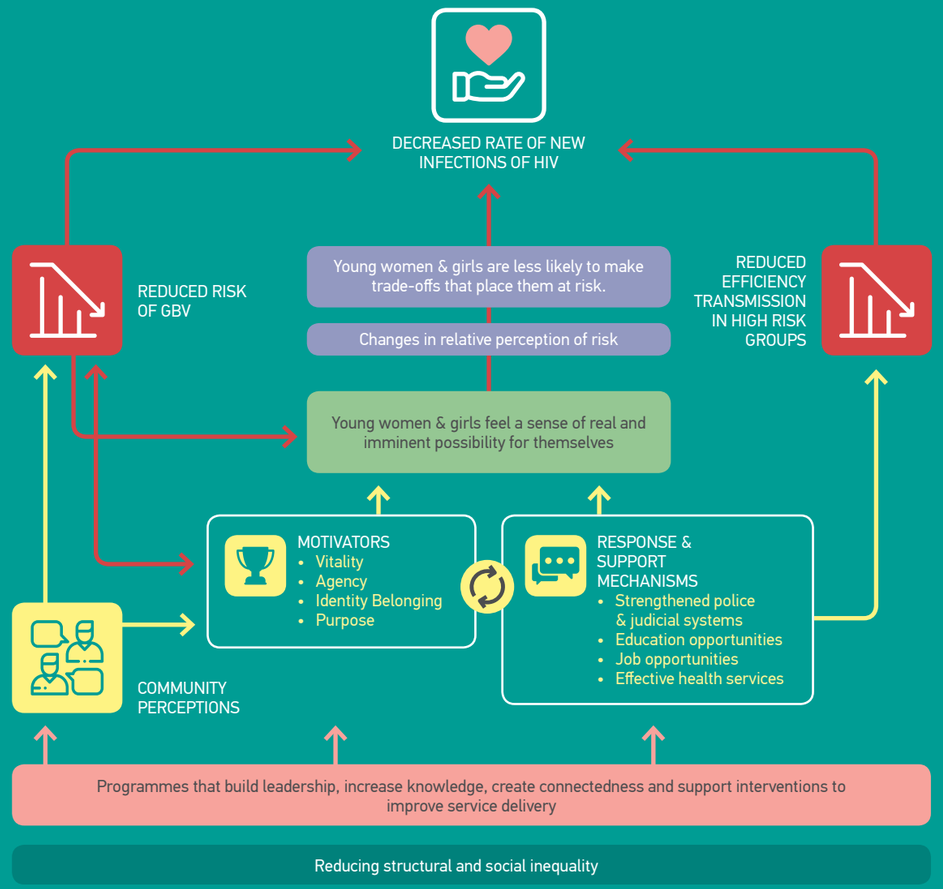
- The establishment of mechanisms that support students coping skills, resilience and ability to navigate effectively through the TVET system.
- Enhancement of academic performance, through creating mechanisms which immediately identify if students are falling behind and coach them on how to address the gaps in their learning.
- Establishment of a peer support programme that creates a sense of community, which will support students and maximise their chance of obtaining their qualifications.

ANNEX B
THEORY OF CHANGE CAUSAL PATHWAYS

The TOC for the Bumb'INGOMSO programme as a whole is detailed in Figure 1. The overall aim of the programme is to achieve a decreased rate of new infections of HIV in BCMM. To achieve this overall aim, the programme focuses on change in three channels: (1) through empowering young women and girls in BCMM so that they are less likely to make trade-offs that place them at risk; (2) through a reduced incidence in GBV; and (3) through reduced efficiency transmission in high-risk groups.

The TOC diagram maps the causal pathways at a high level. The narrative description briefly articulates the main causal assumptions, i.e. the hypotheses of how change is expected to happen.

FIGURE 16: THE BUMB'INGOMSO TOC



1. THE BUMB'INGOMSO TOC HAS THE FOLLOWING INTENDED OUTCOMES:

FINAL OUTCOMES:

4. Young women and girls are less likely to make trade-offs that place them at risk (behavioural change);
5. Reduced incidence of GBV; and
6. Reduced efficiency transmission in high-risk groups (including WSW and men with genital ulcers).

INTERMEDIARY OUTCOMES:

4. Changes in relative perception of risk;
5. Young women and girls feel a sense of imminent possibility for themselves; and
6. Young women and girls feel there are real possibilities (options available).

The central part of the Bumb'INGOMSO programme (1: yellow boxes → green boxes → purple box → purple box) aims to provide young women with a sense of real and imminent possibility in their lives. This is guided by the belief that young women live by the choices that they make in their lives at any one time, which are shaped by the possibilities that they face or perceive in the immediate future. This is under the assumption that knowledge in itself is not sufficient to change the choices made by young women, but that choices are guided by the overall sense of whom one is, and how that relates to one's environment.

In order to achieve this change, the programme seeks to identify strategic levers of change through two channels: (1) the programme seeks to change a set of overall motivators of women aged 15–29 years. These constitute the psychological motivators that govern one's choice and behaviours and, ultimately, one's willingness to adopt risky HIV-related behaviours in the context of other personal hazards; and (2) improve the service delivery of response and support mechanisms in operation in BCMM, in particular those related to economic opportunities, education opportunities, health services and the police and judicial systems, which affect the context in which young women perceive risk (assumed to govern one's choices and behaviour).

THE PROGRAMME THUS ADDRESSES ITS TWO MAIN LEVERS OF CHANGE IN THE FOLLOWING MANNER (displayed in yellow in the TOC, linking with the green boxes):

1. IMPROVING SERVICE DELIVERY OF RESPONSE AND SUPPORT MECHANISMS:
   - **Job opportunities (led by Harambee):** the component aims to improve youth's access to economic opportunities, through information on existing opportunities, career and job-seeker guidance and support (e.g. advice, CV and interview help, etc.) as well as working with employers and the wider labour market to increase the opportunities available for youth in BCMM.
   - **Education opportunities:** the implementer for this part of the intervention is yet to be confirmed and as such, the exact details of this objective are yet to be defined.
   - **Effective health services (led by Beyond Zero):** the component aims to improve youth's access to health services by supporting clinics to become more youth friendly (e.g. via integrated services, staff attitudes, youth-friendly hours and environment, etc.).
   - **Strengthened police and judicial systems (led by Masimanyane):** the component's objective in this area relates to police and judicial responses to GBV. The aim is to work with the police and judiciary to strengthen their commitment and response both when GBV is witnessed and when it is reported.

The programme assumes that improving service delivery will lead to a young woman in BCMM feeling there are *real possibilities available to her*. The assumption is that even if a young woman does not herself find a job, or access health services, she has a sense that the *option* is there. For example, once she finishes school, or if she keeps applying, there are job options available to her. Likewise, if she needs to visit the clinic that is *an option*, and if she experiences GBV reporting this is a *viable option*. The emphasis is thus on how improving these response and support mechanisms will affect young women in terms of BCMM's sense of *real (options) possibilities*.

2. POSITIVELY AFFECTING FIVE IDENTIFIED KEY MOTIVATORS:

   - **Vitality:** identified as a sense of well-being. The programme assumes that a young woman in BCMM often does not have a high level of well-being in her life. Formative findings indicated that young women frequently engage in substance abuse, experience high degrees of boredom and lack recreational activities, etc. The programme assumes that a low, or negative, sense of *vitality is expressed through low levels of health-seeking behaviour.*
   - **Agency:** identified as a young woman in BCMM having a low sense of self-guidance, and a feeling of low ability to assert herself in in her choices. This low sense of agency is assumed both with regards to partners and the immediate community, as well as more broadly referring to institutions. The programme assumes a young woman in BCMM experiences a degree of powerlessness, both with regards to wider society and to her community/peers. Though a young woman may feel she does have a choice, her choice may be limited by the environment/social reality in which she lives.
   - **Identity:** identified as a young woman's sense of *who she is* and *how she relates* to others (partners, peers, parents, institutions (formal and informal), etc.). This includes a young woman's sense of self-worth and sense of potential.
   - **Belonging:** identified in a positive sense, with a young woman in BCMM assumed to either have a low sense of belonging or to belong in a negative manner (peer pressure, for example). 'Positive belonging' is defined as both being part of positive peer and social networks and as having a sense that one belongs in services, i.e. a young woman feeling she has the right to be in a clinic, a school, a police station, etc.
   - **Purpose:** loosely identified as goals and aspirations. The programme assumes that a young woman in BCMM often does not feel a strong degree of hope for her future and/or that her goals and aspirations are limited by the environment/social reality in which she lives.

An underlying assumption that the programme makes is thus that young women in BCMM's current sense of these five motivators are either low or negative (for example, a negative self-image). The motivators are assumed to further be affected by a change in response and support mechanisms (for example, an increased sense of belonging in clinics as they become more youth friendly). Motivators are also assumed to be affected by community perceptions, and as such the programme (mainly through Masimanyane and SPF) has some interventions working with the communities in which young women in BCMM live, in order to impact the way in which communities view young women, and young women's role in the community as well as how communities view young women's potential.

The identified causal chain is that a change in motivators, and a change in response and support mechanisms, will lead to young women now feeling there are real and imminent possibilities for themselves (displayed in green in the TOC, linked from the yellow boxes). A change in motivators and a change in response and support mechanisms lead to an expanded and re-identified social reference group for young women. Here, 'social reference group' means the social group to which young women see themselves as being part of, the meaning of the collective (common) identity of 'young women'. Thus, *what it means to be a young woman in BCMM changes.*

The second causal chain (from the green box in the TOC to the purple) has its basis in cultural theory. In line with cultural theory, a social reference group – i.e. the group young women see themselves as relating to – provides the inter-cultural context in which perceptions and judgements about risk are constructed. An expanded and re-identified social reference group (for example through positive peer networks, or a sense of being part of BCMM's labour market, or having the option to access health services and police services as required) *thus changes the inter-cultural context for young women, which is then assumed to affect how young women view and weigh risk.*
The third causal chain that follows is thus based on the assumption that should young women change their relative perception of risk i.e. the way young women judge and weigh risks against each other, this has an influence for how young women make choices regarding trade-offs that place them at risk (purple to purple box).

Rather than viewing risk within a rational choice approach, where *knowledge* of the risk is a key lever in risk behaviour, the assumption is that it is rather the relational perception of risk (and thus how young women view a risk as compared to other risks) that affects the choices young women make. This is based on the underpinning assumption that, *although absolute risk may not change, young women's judgement of one type of risk as compared to another is what results in a trade-off being made.*

For example, young women may judge the direct social risk of not partaking in drinking activities as higher than not finishing school when perceiving that there are no imminent or real possibilities available to them. However, as young women's sense of the imminent or real possibilities available to them increases, the risk of not finishing school may be seen as a higher risk *relative* to not 'fitting in' by not partaking in drinking activities. This would be since not attending school may remove the option of future employment, and the opportunity to pursue one's purpose.

As such, this change in relative perception of risk leads to a young woman now choosing to stay at home and study in order to keep attending school, rather than going to the tavern. A young woman thus chooses the social risk over the risk of not finishing school, a trade-off choice that is less likely to place a young woman at risk of HIV. I*t is thus not solely the knowledge of risk but the judgement made about these risks as relative to other risks (affected by an expanded and re-identified social reference group) that affects how young women make trade-offs with regards to risk.*

ADDITIONALLY, THE PROGRAMME AIMS TO DECREASE RATES OF NEW INFECTIONS OF HIV THROUGH BIOLOGICAL TRANSMITTERS:

- (2): *(yellow boxes → red box on left hand side → turquoise box)* **a reduced incidence of GBV.** The programme aims to achieve this change in GBV through a focus on a combination of response and support mechanisms change (working with police and judicial systems), and working with communities and young women to strengthen the image of young women, and young women's ability to assert themselves in making choices (led by Masimanyane).

- (3): *(effective health services → red box on right hand side → turquoise box)* **reduced efficiency transmissions in high-risk groups** (defined as older men with genital ulcers and WSW). The programme aims to affect these through strengthening effective health services (led by Beyond Zero) by: 1) making health services more sex worker friendly; and 2) introducing and training GPs on syndromic management in order to improve the way in which genital ulcers are *cured and not simply treated.* The assumption here is that men already seek health services for treatment of ulcers, and thus that demand is already present. If supply is thus more effective in its approach, it is likely to have an effect on the rate of new infections of HIV, as while men may continue to have unprotected sex the treatment of genital ulcers leads to a reduced efficiency transmission.

ANNEX C
SAMPLING

C.1 SAMPLING STRATEGY

A multi-stage random selection process was used to select respondents for the survey. The targeted respondents were young women aged 15–29, which represents the main target group for Bumb'INGOMSO. The adopted sampling strategy ensures that the sample is representative of young women aged 15–29 in the 18 wards that are targeted by Bumb'INGOMSO. The following sampling stages were completed: (1) selection of PSUs; (2) selection of households; and (3) selection of the random respondent, conditional on there being at least one eligible woman (aged 15–29) in the household.

C.1.1 SELECTION OF PSUS

A master sampling frame of PSUs was constructed by mapping the 18 targeted Bumb'INGOMSO programme target wards against a map of Small Area Layers, the smallest publicly available administrative unit provided by StatsSA. 100 PSUs were then randomly selected from the full list of targeted PSUs in BCMM using the **PPS** sampling approach. PSUs were implicitly stratified by ward to ensure that the sample was spread across all wards. PPS provides an efficient method of sampling when population figures for each PSU are known. PSUs with larger populations have a higher probability of being selected, to offset the fact that each individual household within larger PSUs has a lower probability of being selected in the following stages, compared to households in smaller PSUs.

C.1.2 REVIEW OF PSU SAMPLE AND SEGMENTATION OF LARGE PSUS

We reviewed the sample of 100 PSUs to ensure that the sample comprised only inhabited PSUs (i.e. excluding industrial or other commercial activity areas; or specialised habitation areas, such as military barracks) of a meaningful and workable size. An initial desk-based screening of the PSUs revealed that eight PSUs were too large to be listed within the parameters of the survey and needed to be **segmented**. Where only one section of the PSU appeared to be inhabited, only the inhabited section was retained and included in the sample. Where the entire PSU was inhabited, the PSU was split into two parts, with both parts containing an approximately equal number of dwellings, as determined by a count of the rooftops on Google Earth. One part of the PSU was then randomly selected to be part of the sample.

TABLE 17: SEGMENTATION OF PSUS

PSU	APPROACH TO SEGMENTATION
56	Split PSU in half, and randomly choose one segment.
61	Almost all inhabited dwellings are in one part of the PSU. Keep only the inhabited section of the PSU.
72	Almost all inhabited dwellings are in one part of the PSU. Keep only the inhabited section of the PSU.
73	Split PSU in half, and randomly choose one segment.
76	Split PSU in half, and randomly choose one segment.
77	Almost all inhabited dwellings are in one part of the PSU. Keep only the inhabited section of the PSU.
78	Almost all inhabited dwellings are in one part of the PSU. Keep only the inhabited section of the PSU.
92	Almost all inhabited dwellings are in one part of the PSU. Keep only the inhabited section of the PSU.

C.1.3 SELECTION OF HOUSEHOLDS

The listing exercise produced a master sample frame of dwellings. In each PSU, 10 dwellings were selected using a **simple random sampling (SRS)** approach, meaning each dwelling has an equal probability of being selected. The fieldwork team visited each selected dwelling, and determined for each household whether a young woman aged 15–29-years-old was a member of the household.

Given the definition of the household [73] used in the study, it is possible, although unlikely, that there could be more than one household living in the same dwelling, given the condition that household members must share *food from a common source* and *contribute to and/or share in a common resource pool*. In cases where there was more than one household living in a dwelling, one household was randomly selected for the study using the SRS technique. The household selection was programmed into the survey software, so that the selection could be done automatically in the field within the device.

When a household did not contain a woman aged between 15- and 29-years-old, if an eligible woman refused to be interviewed, or if an eligible woman was unavailable for an interview (for example, because she went on an extended holiday or because she was in hospital), the household was replaced by the next household in the replacement list. The replacement list was also generated through SRS.

C.1.4 SELECTION OF THE SURVEY RESPONDENT

In the case where there was more than one woman aged between 15 and 29 years in the household, one woman was randomly selected for the interview using SRS, with each woman having the same probability of selection. The respondent selection was programmed into the survey software, so that the selection could be done automatically in the field within the device.

C.2 SAMPLE WEIGHTS

To obtain results that are representative of the targeted BCMM programme wards, estimates in this report were weighted using survey weights that are the inverse probabilities of selection into the sample for each unit of observation.

Sample weights are given by the inverse of the probability of a particular respondent being selected. The following procedure was used to calculate the weights, with a respondent's probability of selection being broken down into four component parts: (1) probability of selection of the PSU; (2) probability associated with segmentation of a large PSU; (2) probability of a household being selected from amongst the eligible households in the PSU, i.e. households that contain at least one woman aged 15–29; and (4) probability of the respondent being selected from amongst the eligible women in her household.

P1. Probability of the PSU being selected. PSUs were selected using **PPS** sampling. The number of households per PSU from the 2011 census was used to calculate this probability as follows:

$$P_1 = \frac{(\text{number of households in PSU} * 100)}{(\text{number of households in sample frame})}$$

where 100 is the total number of PSUs to be selected.

P2. Probability attached to the segmentation of a PSU at the household listing stage:

$$P_2 = \frac{(\text{number of segments selected in the PSU})}{(\text{total number of segments in the PSU})}$$

P3. Probability of a household being selected from amongst the eligible households in the PSU. There was no prior information on whether a household contained a woman aged 15–29, and it was not feasible to assess the eligibility of each household during the household listing exercise. Interviewers therefore began each visit by determining the household's eligibility and proceeded with the interview only if the household was eligible (contained a woman aged 15–29).

Data from the household visits were used to estimate the number of eligible households in each PSU, i.e. the number of households that contain at least one woman aged 15–29. The proportion of households that contain an eligible woman was estimated from the outcome of the visits conducted by the interviewing team. This was multiplied by the total number of households in the PSU, obtained from the household listing exercise, to arrive at an estimate of the total number of eligible households for each PSU (P3a).

$$P_{3a} = \frac{(\text{number of visited eligible households in PSU})}{(\text{number of visited households in PSU}) * \text{total numer of households in PSU}}$$

The probability of a household being selected from amongst the eligible households was then calculated as follows. The targeted number of interviews completed in the PSU was 10. However, there were a few PSUs that had less than 10 eligible households, while more than 10 interviews were completed in some PSUs.

$$P_3 = \frac{(\text{number of interviews completed in the PSU})}{P_{3a}}$$

P4. Probability of the respondent being selected from amongst the eligible women in her household:

$$P_4 = \frac{1}{(\text{number of eligible respondents in the household})}$$

The final probability of a household being selected for the BCMM survey is calculated by combining the above probabilities as follows:

$$P_{selection} = P1 * P2 * P3 * P4$$

Thus, the final sample weights applied to each household are constructed by taking the inverse probability of selection:

$$Weight = \frac{1}{P_{selection}}$$

[73] *A household consists of one or more people who live under the same roof, share food from a common source, and contribute to and/or share in a common resource pool. 'Live under the same roof' needs to be interpreted as 'live together'. However, this could be in a different building (within a compound, for instance).*

ANNEX D
EDUCATION AND EMPLOYMENT OPPORTUNITIES SUPPLEMENTARY EVIDENCE

D.1 EMPLOYMENT INDICATORS

Table 18 presents the full set of employment indicators for the respondents of the household survey.

TABLE 18: EMPLOYMENT INDICATORS

VARIABLE	TOTAL	AGE OF FEMALE RESPONDENT			PMT SCORE		DISTANCE TO HEALTH FACILITY	
		15 – 19	20 – 24	25 – 29	ABOVE MEDIAN	BELOW MEDIAN	LESS THAN 1.5 KM	MORE THAN 1.5 KM
Person employed	18.65	3.66***	17.63	32.52***	20.71	17.07	18.86	18.08
Discouraged work-seeker	6.61	2.89**	7.97	8.44	2.88***	9.47	4.36***	12.52
Person unemployed	24.47	10.29***	26.03	35.83***	24.37	25.01	25.45	22.86
Person long-term unemployed	4.45	.22***	3.09	9.45***	3.88	4.89	3.8	6.17
Person under-utilised	34.64	15.49***	36.86	48.85***	30.38*	37.91	33.23	38.35
Currently unemployed but wants to work	59.66	25.93***	60.66	87.60***	54.16**	63.88	57.64	64.98
Number of years in job	1.82	1.07	.85	2.42***	1.91	1.74	1.95	1.49
ACTIVE: currently enrolled or employed	62.51	87.54***	61.1	42.44***	71.04***	55.96	65.68**	54.18

EMPLOYMENT INDICATORS WERE DEFINED ACCORDING TO THE DEFINITIONS USED BY THE QLFS:

- **currently employed** – a person who, in the last week between Monday and Sunday, did any work for at least one hour; or a person who had a job or business in the last week but was not at work (e.g. temporarily absent, ill, on leave);
- **discouraged work-seeker** – a person who was not employed, wanted to work but had not looked for work in the last four weeks because: no jobs were available; unable to find work requiring his/her skills; or lost hope of finding any kind of work;
- **long-term unemployed** – a person who has been unemployed for one year or more;
- **under-utilised** – a person who is:
  - **underemployed** – who was willing to work additional hours and was working less than 35 hours a week; or
  - **unemployed** – who was not employed during the reference week but was actively looking for work; or
  - **discouraged** (see above for definition)
- **active** – either employed or in education

ANNEX E
NOTES ON THE PROBIT MODEL

In Chapter 5 we present findings from an investigation of the association between risky sexual behaviour, as measured by the likelihood of having *multiple sexual partners* in the last one year, and different types of risk perceptions, as well as a range of demographic characteristics and experiences. In order to conduct this analysis, we use a probit model. A probit model is a type of regression in which the dependent variable can only take two values, 0 or 1. The model is used to estimate the probability that an observation, with certain background characteristics, will fall into one of the two categories.

THE FOLLOWING PROBIT MODEL WAS USED TO UNDERSTAND THE PROBABILITY OF HAVING MULTIPLE SEXUAL PARTNERS IN THE LAST ONE YEAR:

$$\emptyset^{-1}(Pi) = \sum_{k=0}^{k=n} \beta_k \boldsymbol{x}_{ik}$$

Where Pi indicates whether or not individual i has had multiple sexual partners in the last one year, $\boldsymbol{x}_{ik}$ represents the k covariate characteristics for individual i and β_k represents the $\sum$ score effect of covariate $\boldsymbol{x}_k$ on Pi. For ease of interpretation, we report the marginal effects of $\boldsymbol{x}_k$ on Pi in this section, rather than the $\sum$ scores.

ANNEX F
METHODS OF ASSESSING RELATIVE RISKS

The evaluation team used a variety of methods at baseline to explore perceptions of relative risks in depth, including Likert-scale risk analysis in the household survey, and a mixture of qualitative tools, including the participatory pairwise ranking tool . Central to the relative risk analysis are the data collected in the case study communities, where the team engaged with respondents (groups of young men and women of different ages) using multiple tools to get a deeper understanding of how risks interact with each other and how this relates to behaviour. This annex describes the methodology of the participatory pairwise ranking tool used to assess relative risk.

The tool was used in a group setting and conducted by a moderator.

1. Respondents were asked to brainstorm and construct a list containing all the types of risk that young women/ men in their age group (15–18, 19–22, 23–29) may experience.

2. Respondents were then asked to collectively select the **top six risks** that they felt were the 'worst to experience'. These risks were added into a pairwise ranking table, as below (Table 19).

3. Each risk was then 'paired against each other', with the moderator asking respondents 'out of risk A, and risk B: which one is *worse to experience*', or 'which one would you *rather not experience*'. Respondents would then debate as a group, and decide on which risk was worse for each of the pairings. The 'worse' risk was given a score of 1 for that pairing. If respondents could not agree, they could 'split' a square, so that, for example, Risk A and Risk B received 0.5 each.

TABLE 19: EXAMPLE OF COMPLETED TEMPLATE

	A	B	C	D	E	F	TOTAL	RANKING
A		A	A	A	A	A	5	1
B			C	B	B	B	3	3
C				C	C	C	4	2
D					E	E	0	6
E						F	2	4
F							1	5

4. The scores were then tallied for each risk and this was recorded in the total column. Risks were then ranked based on the score.
5. This ranking was then discussed with the respondents, to see if they agreed or disagreed, and if this was in accordance their experience and perception of each risk. In addition, each of the 'pair comparisons', or the *relative risk perceptions*, were then discussed and related to hypothetical scenarios in which respondents may face a choice of taking on one risk or the other: i.e. if you were in a scenario where you were at risk of A and B (for example, the risk of being beaten by your boyfriend if you insisted on using a condom, but if you did not use a condom you might be risking HIV/AIDs), what would you do?). This helped the team understand how respondents' perceptions of relative risk relate to behaviour.

A total of 13 pairwise ranking exercises were conducted with groups of young women, and 12 with groups of young men. The results of these ranking exercises were collated in order to understand which risks respondents, across the groups, considered to be most severe. In order to do this, risks were categorised (e.g. unemployment and poverty were considered to be financial risks, rape and crime were considered to be risks of violence etc.) and the total score of each risk was tallied across all of their pairwise ranking exercises. It was these relative scores that were used to understand how risks were perceived relative to each other and how severe risks were perceived to be by young men and young women. It is important to note that the sample size for the pairwise rankings cannot be considered representative, nor statistically significant. However, the perceptions, and relative perceptions around severity, provide an interesting insight into how risks are considered amongst young women and men, which is analysed in depth in Chapter 6.

ANNEX G
REPRESENTATIVENESS OF THE QUANTITATIVE DATA FROM MEN

We recognise the importance of the role that the attitudes and behaviour of men play in determining outcomes for young women in BCMM. Whilst a separate quantitative survey that specifically sampled men was outside of the scope and resources available for this baseline evaluation, we attempted to interview men within households that we visited, which were selected because they contained at least one woman aged 15–29 years of age.

In the design of the quantitative component of the evaluation we used the best available information – the 2011 Income and Expenditure Survey – to make predictions about the number of men we might reasonably expect to interview based on this approach. This analysis suggested that we could expect to interview just over one man per every two households, for a predicted sample of 600 men. However, in the end we had a final sample size of just 260 men interviewed as part of the baseline survey. Given the very small sample size, and the fact that this is already not a representative sample of men in BCMM (just those who happen to live in a household containing a woman aged 15–29 years) we felt that reporting on these data would be misleading.

As such, our consideration of the role that the attitudes and behaviours of men play in determining the outcomes for young women in BCMM is restricted to the qualitative analysis.

ANNEX H
PROXY MEANS TEST INDICATORS

Proxy means test (PMT) allows us to estimate the income or consumption when precise measures are unavailable or difficult to obtain. Using observable and verifiable characteristics of households, PMT tests enables us to rank households in order of income. Developing a PMT score entails 5 general steps:

1. Consumption data is analysed to determine total household consumption
2. Household consumption is adjusted for the number of people in the household
3. A regression model of the correlates of poverty is estimated, and a number of indicators that best provide a nuanced understanding of the underlying poverty situation are used
4. A PMT regression then provides a scoring system for any household, based on that household's observable characteristics
5. PMT scores are then calculated for each household in the BCMM sample

We used the South Africa income and expenditure household survey of 2010 to determine the indicators to predict poverty in South Africa, as well as the appropriate scores to assign to each of these indicators. The following indicators were used:

- The type of toilet household members have access to
- Household size
- If at least one member of the household has medical aid
- If the dwelling has DSTV
- If someone in the household has a computer
- The race of the head of the household
- The material the roof of the structure is made of
- If a member of the household owns a car
- The type of income that the head of the household has
- If the household has a fridge

Based on these indicators, a PMT score for each household in the survey was estimated. Those above the median score represent the less poor half of the sample.

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