

UNIVERSITY OF CAPE TOWN: FACULTY OF HEALTH SCIENCES

Negotiating access and buy-in from communities in the context of a South African combination HIV prevention intervention for adolescent girls and young women

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Part A

Glossary of terms

Community is defined as a group of people who live in the same geographical area or who have a non-spatial element of shared social identity (MacQueen et al., 2001)

Community engagement has been defined as “The process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.”(CTSA Consortium, 2011)

A **stakeholder** is defined as a person with an interest or concern in something, especially business. Denoting a type of organisation or system in which all the members or participants are seen as having an interest in its success (“Stakeholder”, 2019).

Acronyms and Abbreviations

AGYW	Adolescent girls and young women
AIDS	Acquired immune deficiency syndrome
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus infection
FGD	Focus group discussion
IDI	In-depth Interview
KGIS	Keeping Girls in School
NGO	Non-governmental organisation
PR	Principal recipient
RWC	Rise women's club
SAMRC	South African Research Medical Council
SBC	Soul Buddyz Club
SR	Sub-recipient
SRHR	Sexual and reproductive health and rights
TB	Tuberculosis
UCT	University of Cape Town
UNAIDS	The Joint United Nations Programme on HIV and AIDS

Abstract

Background: In response to the persistently high incidence of HIV in adolescent girls and young women in South Africa, the Global Fund invested in a combination HIV prevention intervention aimed at adolescent girls and young women in 10 high priority districts. The HERStory study evaluated the combination HIV prevention intervention after two years of implementation. Using the findings of the HERStory evaluation, this study aims to contribute

towards the literature related to understanding factors related to successfully accessing communities and gaining community buy-in or support for community based interventions. The HERStory study explored the identification of the gaps and challenges in the intervention components and the intervention implementation to be able to revise and improve the intervention and its implementation. **Methods:** In-depth interviews and focus group discussions with community leaders, program implementers and intervention facilitators were conducted. The data consisted of 32 transcripts; a subset of the qualitative data collected for the HERStory evaluation. The analysis for this study sought to better understand the barriers and facilitators of community access and the importance of community buy-in using the HERStory evaluation. Thematic analysis of the data was conducted, supported by Nvivo 12 qualitative data analysis software. **Results:** The main themes of this secondary analysis were 1) the complexity of negotiating access to communities through key stakeholders, 2) challenges to gaining buy-in, and 3) facilitators and barriers to community based intervention implementation. There were clear facilitators to community access and intervention buy-in such as creating clear communication lines between stakeholders and scheduling regular meetings. Delayed or rushed community engagement resulted in misunderstandings and was identified as barriers to community access and intervention buy-in. **Conclusion:** Quality community engagement was essential in the facilitation of access and intervention buy-in to promote successful intervention implementation. Recommendations for future interventions include planning enough time for community engagement throughout the intervention including the design phase and establishing clear and effective communication channels between intervention implementers and community stakeholders.

Introduction

The HIV epidemic has affected the lives of millions of people worldwide (Price et al., 2018). According to UNAIDS (2019), the global distribution of HIV from data collected in 2019 shows that an estimated 37.9 million people globally were living with HIV. There were an estimated 1.7 million new infections and 770 000 HIV related deaths in 2018 globally (Global AIDS update, 2019). Eastern and Southern Africa, together, have approximately 20.6 million people living with HIV and a high rate of newly diagnosed individuals of 15 years and older (Global AIDS update, 2019). The estimated amount of people in South Africa living with HIV

in the year 2018 was 7.7 million (UNAIDS, 2019). The consequences of the HIV epidemic in South Africa include high morbidity and mortality rates, broken homes, poor economic growth, high health care demands with poor resources and continued incidence (Price et al., 2018).

Adolescent girls and young women (AGYW) living in South Africa between the ages of 15 and 24 years are twice as likely to be living with HIV than males of the same age (UNAIDS, 2019). The estimated total for women aged 15 years and older living with HIV is 4.7 million (UNAIDS, 2019). There are many possible contributing factors promoting the spread of HIV among males and females including individual sexual behaviour and sexual partnership factors, socio-economic and demographic factors (Price et al., 2018). Potential behavioural drivers include commercial and transactional sex, sex and alcohol consumption, violence in sexual relationships, non-disclosure of HIV status, intergenerational sex, partner concurrency and low levels of condom usage (Price et al., 2018).

Strategies to address the contributing factors to the continued rise in HIV incidence for AGYW include community interventions that have the potential to target a large audience including those most vulnerable to HIV (Shanaube et al., 2017). Many health-related community interventions promote access to health promotion and prevention strategies to the community as it brings interventions to the people and not in far off inaccessible hospitals or clinics (Shanaube et al., 2017). Community interventions are however, not easily implemented if there is a barrier to access (not being able to enter the community or not being able to implement the intervention in certain communities) by community stakeholders or no buy-in or support from the key stakeholders within the community (Campbell, Nair & Maimane, 2007; Musesengwa & Chimbari, 2017; Reynolds & Sariola, 2018). Community engagement has therefore been a strategy used to gain access into communities and to facilitate buy-in from the community leaders and the people living in the community who could benefit from community interventions (Reynolds & Sariola, 2018).

Community engagement is defined as “the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.”(CTSA Consortium,

2011). Over the last 30 years, the term community engagement has gained momentum in the literature surrounding community work and has now become a common component of community research (Reynolds and Sariola, 2018). Community engagement has the potential to improve trust between the relevant stakeholders and allow for marginalised voices to be heard (Reynolds and Sariola, 2018). Planning an intervention around problems identified by the stakeholders themselves is important as Wilcock (1999) has emphasised that communities need to be enabled towards what they want to become to achieve well-being. Without community engagement, communities may not be ready to engage in community interventions like HIV prevention strategies, increasing the risk of the intervention being rejected (Campbell et al., 2007; Musesengwa & Chimbari, 2017). Communities have the power to impede public health interventions such as HIV prevention strategies or, on the contrary, ensure its success (Campbell, Nair & Maimane, 2007). De Weger, Van Vooren, Luijkx, Baan and Drewes (2018) have found that many community engagement articles have spoken to different types of community engagement practices and how it can mobilise the people of the community and improve participation, health outcomes and well-being of the community. Tugendhaft and others (2020) have found there are community engagement methods that have been researched and outlined in the literature although the best way to achieve community engagement is debatable. They have found that there are deliberative community engagement methods that can elicit deeper engagement with groups (Tugendhaft et al., 2020), One example of a deliberative community engagement method is the use of a game-like tool called chat (Choosing All Together) which facilitates an interactive process that encourages group decision-making (Tugendhaft et al., 2020), With the variety of community engagement guidelines and the different social contexts, researchers or implementers have to find the best fit for a successful implementation of an intervention. A community based project, the Sonagachi Project, was initiated in Calcutta, India assessed the context and realised that the social and cultural norms were influencing the behaviours of the sex workers who were the target group (Jana, Basu, Rotheram-Borus, Newman, 2004). The Sonagachi Project implementers then adapted their project strategies to engage with key community stakeholders to make the social context more conducive to participation and thus, promoted positive outcomes (Jana et al., 2004). Understanding how different social contexts can influence community

engagement is important as some community leaders have the power to obstruct or promote community interventions (Campbell et al., 2007).

Rationale

This study aims to add to literature related to access and community buy-in by using the HERStory evaluation of the combination community HIV prevention intervention aimed at AGYW funded by the Global Fund. For this study, we define 'access' as being able to enter a community with permission from community leaders to engage with participants and other relevant community stakeholders to be able to implement an intervention. Community buy-in can be defined in this context as the active support or endorsement received for the intervention by the community leaders and stakeholders of that community. This body of work could contribute towards future HIV prevention community intervention designers and implementers to potentially strengthen their interventions for better health outcomes.

The UNAIDS Start free Stay free AIDS Free report (2019) states that effective HIV interventions need to have a combined delivery of interventions which should include the following:

1. Biomedical Intervention: This strategy includes providing access to sexual reproductive health services, male and female condom distribution and pre-exposure prophylaxis for high risk groups such as sex workers.
2. Socio-behavioural strategies: Community mobilisation that aims to reduce fear and stigma of HIV and to discourage norms and attitudes that feed stigma, comprehensive sexuality education and parenting
3. Structural interventions: Social protection services, girl-responsive education, strategic communication and a supportive legal environment.

These strategies can be used individually or in combination to reach adolescent girls and young women in various contexts via HIV prevention community interventions. Structural interventions could be advocated for by the community intervention implementers to increase the effectiveness of the intervention. Community interventions are useful as a HIV prevention strategy because they have the power to reach large numbers of the population with the aim of knowledge dissemination and skills training to empower communities

towards better health (Shanaube et al., 2017). Without engaging with a community and its key stakeholders, the intervention implementers run the risk of identifying issues that are not important to the community and even plan inappropriate interventions that may not be successful because of minimal community buy-in (Molyneux et al., 2016; Musesengwa & Chimbari, 2017). Key community stakeholders are therefore, important to engage. Stakeholders in this context could include community chiefs, councillors, teachers, school principals, parents, religious leaders and traditional healers.

[Background to the combination community HIV prevention intervention for AGYW](#)

All the information stated below regarding the combination community HIV prevention intervention and AGYW evaluation was sourced from the Global Fund Technical Brief: Adolescent Girls and Young Women in High-HIV Burden Settings (2017) and the HERStory evaluation study materials (2019) made available by the South African Medical Research Council.

The Global Fund is a partnership organisation created in 2002 and designed to accelerate the goal of ending AIDS, tuberculosis (TB) and malaria epidemics. The Global Fund has partnerships with governments, civil society, private sector, technical agencies and people affected by the disease with the aim of pooling resources to strategically invest in programs related to AIDS, TB and malaria epidemics. This organisation came about as a response to the devastating effects of these 3 deadly epidemics. The Fund has managed to save 27 million lives in the communities that it is has funded. The Fund has also promoted social justice for the communities themselves and families within them across the world. The Global Fund is now channelling resources into the area of adolescent girls and young women because of the high incidence of HIV in Southern Africa. The organisation recognises that the leading cause of death among women of reproductive age is HIV. This has led the Global Fund to invest in programs that specifically target the needs of young women and adolescent girls to break down the major drivers of the spread of HIV. The Global Fund has also invested into programs that offer prevention strategies that address gender norms that contribute towards gender based violence, keeping girls out of school and restricted access to health services (The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2018). One of these programs was the combination community HIV prevention intervention aimed at adolescent girls and young women (AGYW) which offered an intensive combination

prevention approach to reduce the number of new infections of HIV among young women and adolescent girls in South Africa. This program was pertinent in the South African context because of the higher risk of HIV in young women and girls as compared to males of the same age.

In response to the ongoing incidence of HIV in young women and children, a combination community HIV prevention intervention funded by the Global Fund was designed and implemented in 10 districts in South Africa. These districts were chosen due to the high incidence of HIV and the vulnerability of young women and girls. The intervention included a comprehensive package of services including health, education and support services to boys between the ages of 10 – 14 years and young women and adolescent girls between the ages of 10 to 24 years old. The intervention includes the following programmes:

Soul Buddyz Clubs (SBC) was offered to young people between 10 – 14 years in Primary School. The clubs were established in all the 10 districts with each club consisting of 25 members. The club programme used age-appropriate sex education, life skills, empowerment activities and sexual and reproductive health services.

The Keeping Girls in School (KGS) identified young female learners between the ages of 14 to 18 years old. These young female learners were provided with peer support, homework support, sexual and reproductive health and rights (SRHR) education, career guidance and absenteeism tracking in school. The KGS programme also offered HIV testing, TB screening and other appropriate sexual and reproductive health services.

Rise Clubs were community and school based clubs that was offered to young women aged 15 to 24 years old. These clubs were established within all the districts with at least 20 members per club. The club programme included behaviour change counselling, life skills and empowerment activities. The Rise Women's Club (RWC) members were offered linkages with career development, financial literacy, support and vocational acceleration programmes to promote economic empowerment.

The intervention provided comprehensive HIV, TB and sexual and reproductive health services, services for young boys at risk of abuse and perpetration and services for victims of abuse across all districts. A few interventions aimed to provide a supportive environment

for AGYW including mass media interventions and interventions with school governing bodies, teachers and parents. These services were provided over and above the programmes mentioned above.

The HERStory evaluation conducted qualitative research to explore if and how the intervention has managed to change the cognitions, behaviours and social environments of the AGYW participants over time. The evaluation included direct engagement with participants, community leaders, club facilitators and caregivers in the intervention communities.; This study was a secondary analysis of a subset of the qualitative data collected for the HERStory evaluation. The combination community HIV prevention intervention for AGYW was implemented across 10 South African districts and aimed to contribute to the national government's goal of reducing the HIV incidence by over 50 % in 2 years. The HERStory evaluation of the Combination community HIV prevention intervention tested the effectiveness of the combination community HIV prevention intervention for AGYW on reducing the HIV incidence among AGYW between the ages of 15 and 24 years old in the 10 districts by 33% over two years. The HERStory evaluation measured the impact the combination community HIV prevention intervention had on the new HIV infections among young women and girls between the age of 15 and 24 years as well as to measure the factors that make these young women and girls more vulnerable and what makes them more resilient with to HIV. The HERStory evaluation was conducted in a household representative sample of AGYW aged 15 to 24 years in 5 of the 10 districts in South Africa. The districts chosen for the combination community HIV prevention intervention for AGYW were Bojanala (North West Province), City of Cape Town (Western Cape), Ehlanzeni (Mpumalanga), Gert Sibande (Mpumalanga), Greater Sekhukhune (Limpopo), OR Tambo (Eastern Cape), Nelson Mandela Bay (Eastern Cape), Tshwane (Gauteng Province), Uthungulu (KwaZulu-Natal), and Zululand (KwaZulu-Natal). The HERStory evaluation also conducted qualitative research to explore the impact of the evaluation over time on the cognitions, social environments and the behaviour of AGYW in 5 of the districts that the intervention took place. The sample included teachers, parents, partners, caregivers, club facilitators and community leaders that were involved in the intervention. The aim of the qualitative component of the HERStory evaluation was to investigate perceived enablers and constraints of the intervention impacting primary

outcomes of interest mentioned above and the perceived impact of the intervention. This study will be using a subset of the qualitative data collected by the HERStory research team that is most relevant to this study as determined by the HERStory evaluation team. The data used in this study is therefore, secondary data that will be thematically analysed and presented in this mini dissertation.

Purpose and Aim

The purpose of this study is to understand the barriers and facilitators of gaining access to communities and gaining buy-in from community stakeholders to promote successful community interventions. This study aims to use the HERStory evaluation study experience to examine some of the potential facilitators to, and barriers for negotiating community stakeholder buy-in and access to communities for HIV prevention interventions and aims to provide practical suggestions to promote access to communities and buy-in for community based interventions. The HERStory qualitative evaluation was conducted in the following 5 communities: City of Cape Town (Western Cape), Uthungulu (KwaZulu-Natal), Gert Sibande (Mpumalanga), Bojanala (North West) and Nelson Mandela Bay (Eastern Cape).

Research Question

What were the barriers to, and facilitators for, gaining access to communities and obtaining community buy-in during the implementation of the combination community HIV prevention intervention for adolescent girls and young women in 5 South African Districts?

Objectives

- Describe the programme implementers' experiences of facilitators and barriers to negotiating access into communities.
- Understand and describe what practical measures were taken to build trust and promote intervention buy-in

Literature Review

A "community" is defined as a group of people who live in the same geographical area or who have a non-spatial element of shared social identity (MacQueen et al., 2001). Interventions taking place at a community level have the potential to reach large numbers

of people and can help to improve access to services and information that a community may not have had before. Glandon and others (2017) have observed that community engagement is a strategy that can be used to facilitate co-operation and action towards shared goals. Peters, Tran and Adam (2013) have similarly observed that at the heart of community interventions are community engagement efforts involving the implementers, community stakeholders and decision makers in the identification and design of community interventions.

Community based HIV prevention interventions have shown some success. One example is the Sonagachi Project in 1992, that sustained itself for 12 years; this project will be elaborated on below (Kirby, Obasi & Laris, 2006; Pascoe et al., 2010). However, not all community interventions designed to reduce HIV incidence have shared the same success. There are differences between programmes that have been successful and those that have not. This literature review aims to present research that will shed light on these differences and what can improve the likelihood of an intervention being successful.

[What works well in community based interventions?](#)

Community based research has shown that successful community interventions have a large degree of community engagement which contributes to their effectiveness (Maticka-Tyndale & Brouillard-Coyle, 2006). Community engagement has been quoted as the key to any community interventions' success (Glandon et al., 2017). Community engagement can be defined as the meaningful, respectful and purposeful engagement with relevant community stakeholders to be involved in the identification of the study, defining its purpose, design and stages of implementation, interpretation and use of results (Glandon et al., 2017). Community engagement has been an important part of research studies as seen in the case of the Frew and others (2014) study where women reported that they preferred face-to-face interactions when taking part in the research. This illustrates the notion that engagement is crucial to encouraging participation in studies and building relationships to foster trust and cooperation between the research team and the community (Frew et al., 2014).

Acceptance into the community took significant time and effort for the study team of the Project Accept initiative that took place across multiple research sites in Africa which looked

at mobilisation strategies (Tedrow et al., 2012). Through continued engagement over time, they found that they had laid a foundation based on trust and relationship building which was crucial to mobilising the community (Tedrow et al., 2012). They identified that by adapting the project to the needs of the people, the community members were more likely to participate in the project (Tedrow et al., 2012). This was also seen in the Sonagachi Project where the project could not have succeeded without proper community engagement and relationship building to enhance the capacity of the project and increase participation (Tedrow et al., 2012). These examples all illustrate the importance of gaining access and community buy-in to improve the chances of a successful intervention.

Two projects will be presented as case studies will be discussed in this literature review namely the Sonagachi Project and Project Accept. The use of these two projects will provide concrete examples of how community engagement can be a facilitator towards the successful implementation of a community based intervention. Challenges and lessons learnt will also be highlighted from the two case studies.

[Case Study: The Sonagachi Project](#)

The Sonagachi Project, a community based intervention for sex workers was initiated and implemented in Calcutta, India (Jana et al., 2004). The project developed and evolved to become a project that was useful to the target population (Jana et al., 2004). The project aimed to redefine sex work to reduce stigma and increase safe sexual practices among sex workers (Jana et al., 2004). The project aimed to shift the view of prostitution to sex work to validate safer sexual practices and rights of the workers which would contribute towards the reduction of HIV incidence. The project personnel engaged an array of stakeholders on the importance of condom use, sexual and reproductive health services and redefining how the stakeholders of the community and broader society viewed sex workers (Jana et al., 2004). They used various strategies to mobilise the community to assume more responsibility, gain more resources and decrease environmental barriers to implementing the intervention (Jana et al., 2004). The project also engaged with local politicians, brothel owners and other key stakeholders to deepen the intervention and sustain the project over the years (Jana et al., 2004). Through the use of community engagement strategies and working towards shared goals, the project was able to sustain itself for more than 12 years with a host of positive results (Jana et al., 2004).

What were the key strategies used in the Sonagachi Project?

Studies have found that engaging community members in dialogue surrounding locally pertinent issues improved the shared understanding of the needs of the community (Tedrow et al., 2012; Adhikari et al., 2019). The Sonagachi Project implementers not only engaged with sex workers themselves but also politicians and community members who made use of sex worker services (Jana et al., 2004). Involving community leaders like the politicians was an important strategy used to promote community buy-in and support in the Sonagachi Project and was also seen as an important strategy in other studies as well (Jana et al., 2004; Tedrow et al., 2012). The project was able to evolve towards the needs of the community because of the continued engagement with key stakeholders. Building partnerships and fostering trust between key stakeholders are important to gaining buy-in and support of the community in community interventions (Tedrow et al., 2012; Adhikari et al., 2019). Gilson (2003) has also noted that without cooperation among health system agents which include intervention implementers, community leaders and community members, health care services and interventions may not be effective. The Sonagachi Project personnel took the time to build relationships and partnerships for ongoing support and successful implementation.

What does not work in community based interventions?

In examining examples of projects that have not been successful, Frew and others (2014) have found in their study that poor dialogue and engagement between the study team and the community members, led to the clinicians' unwillingness to promote their study. Their study looked at research around challenges, facilitators and best practices towards the recruitment of pregnant women in studies (Frew et al., 2014). They identified that pregnant women were underrepresented in studies due to a host of reasons such as potential harm to the foetus or baby and mother's leaving the study (Frew et al., 2014). Many pregnant women who participated in studies reported feelings of uneasiness and distrust when they did not receive information and advice from the respective research team (Frew et al., 2014). Lack of trust could cause barriers to effective communication and lead to possible poor knowledge/information dissemination (Gilson, 2003). Lack of trust between the researchers and the community can be a key reason as to why an intervention is unsuccessful. A HIV prevention project was set up in the same location and around the same time as the Sonagachi Project in India but this project failed when the project organisers

mobilised the police to forcefully bring women to clinics for sexual and reproductive health services (Jana et al., 2004). There was no community engagement to promote the benefits of taking part in the project's services and the women were forced to use services they may not have understood or wanted (Jana et al., 2004). There was no relationship built between the project implementers and the community they were targeting. Thus, no trust and cooperation were fostered between the key stakeholders (Jana et al., 2004).

Case study: Project Accept (Tedrow et al., 2012)

Community Interventions have been unsuccessful partly due to poor community engagement. One such example was Project Accept, a multi-site community randomized controlled trial using community mobilisation as the main intervention for HIV prevention in low to middle income countries. Project Accept was implemented in Thailand, Zimbabwe, South Africa and Tanzania. The implementers observed that poor community engagement led to, amongst other consequences, respective community leaders not accepting the intervention. The community, in turn, stayed away from the intervention activities because they trusted the judgment and followed their leader's example by not supporting the intervention. When project Accept began, the implementers struggled with dispelling rumours, reducing stigma and misconceptions regarding the project. An example of one of the misconceptions was the Zimbabwean name for the project personnel: The Blood People. There was the misconception that the project personnel were only interested in collecting the blood of the community. In the Tanzanian and Sowetan study sites of Project Accept, the VCT (voluntary counselling and testing) uptake was low because due to fear of being stigmatised by other community members. The project personnel attributed these problems to a lack of information.

The community intervention research evidence provides lessons on what we can learn from the challenges and failures of previous community interventions to improve on future community projects (Campbell et al., 2007; Musesengwa & Chimbari, 2017; De Weger et al., 2018). The Project Accept example clearly illustrates a few consequences of poor community engagement including poor participation, misconceptions and rumours regarding the intervention. Trust and acceptance, amongst other factors, were two key components that were missing in this project which potentially contributed towards an unsuccessful community intervention.

The South African context

South African communities can facilitate or become a barrier to community interventions (Campbell et al., 2007). Some communities in South Africa are led by community leaders who have the power to allow or deny access to the communities (Campbell et al., 2007; Musesengwa & Chimbari, 2017). No access to communities means that the intervention cannot reach those who may benefit from it the most. Barriers to accessing vulnerable communities are a major challenge in some communities especially where HIV and AIDS prevention interventions are concerned (Bond et al., 2016). Access and community buy-in are essential to the success of any community intervention (Campbell et al., 2007).

In the South African setting, Galvaan and Peters (2013) have emphasised the need for buy-in and support in community interventions. Galvaan and Peters (2013) have noted that without community support and participation, community interventions are likely to fail. This can be illustrated in the study by Frew and others (2014) where they found that support and approval from friends and family of pregnant women greatly influenced the perceptions and behaviours of the women participating in the study. If the family and friends did not support the women's participation in the study or buy-in to the study, the women were likely to drop out of the study (Frew et al., 2014). In another example, in Soweto, stigma was the driver of community members not participating in Project Accept as well (Tedrow, et al., 2012). Project Accept personnel dispelled these misconceptions by building trust through information sharing and thereafter, started seeing a shift in the behaviours and perceptions of the community (Tedrow et al., 2012). Nhamo, Campbell, Gregson (2010) have found that a programme's success depends on the wider community context which will frame the conditions of the intervention which is well illustrated in the previous example. Community engagement is therefore, of utmost importance to gaining access, buy-in and support of the target community.

What does community intervention literature suggest to promote the chances of success?

Community intervention studies have suggested strategies that can be used to gain community access and buy-in to improve the likelihood of successful intervention implementation (Tugendhaft et al., 2020). Adhikari and others (2019) however, have found that engaging the community with the design of the research is rare. Factors that literature has suggested for access and buy-in include: trust facilitation through respectful interaction,

active listening and expressing recognition and being responsive (Adhikari et al., 2019). Differences in contexts will therefore, require different strategies to suit the community's needs (Adhikari et al., 2019). The research by Adhikari and others (2019), have found that through the last century, community engagement is affected by social cohesion or lack thereof. The social hierarchies, political factions, cultural beliefs and perceptions around the research will all affect community engagement and buy-in (Adhikari et al., 2019). The research does not highlight the experiences or perceptions of community leaders and members of community interventions to be able to learn from them and adapt approaches to promote co-operation towards improved community interventions (Campbell et al., 2007; Musesengwa & Chimbari, 2017). Giving community stakeholders the voice to describe their experiences of community interventions may ensure further collaboration and community members playing a more active role in future interventions to improve the chances of success (Reynolds & Sariola, 2018). There could be other potential key learnings from the community stakeholders themselves on improving future community intervention strategies (Reynolds & Sariola, 2018).

Intervention implementers need to be sensitive to the context in which they plan to conduct activities or provide services. The South African context will have its challenges that the intervention implementers need to be sensitive to and be willing to adapt to navigate through with the relevant stakeholders (Campbell et al., 2007; Adhikari et al., 2019). Although there is conclusive evidence that community engagement is important to the success of community interventions, there is still no clear voice from other stakeholders involved in community interventions in the research other than the intervention implementers and research teams (Campbell et al., 2007; Musesengwa & Chimbari, 2017; Reynolds & Sariola, 2018).

This study aims to build on the recommendations of previous studies for gaining community buy-in and access to communities by using the HERStory evaluation experiences. This study will aim to describe the programme implementers', community leaders and programme facilitators' experiences of gaining access and obtaining buy-in and how this promoted the successful implementation of the programme. This body of work will aim to identify and describe practical measures that were taken to gain buy-in and access into the communities. This study will endeavour to provide recommendations for how best to engage with

communities to encourage access and community buy-in based on the results of the analysis with support from the literature.

Methodology

Type of research approach

Qualitative research methodology has been defined in numerous ways. Creswell (2013) defines qualitative methodology as an inquiry process that explores the meaning individuals or groups attribute to a social or human phenomenon. This research approach is used to study a specific issue in detail to identify and understand the categories of information that become visible from the data collected (Blanche, Durrheim & Painter, 2006). A qualitative research approach has been used for this study as it is most suited to understanding the barriers and facilitators of community access and the importance of community buy-in for the combination HIV prevention intervention for AGYW.

Study population and setting

The study participants and the setting were determined by the broader HERStory research objectives and evaluation protocol. Five Principal Recipients (PRs), comprising NGOs and government institutions, were responsible for implementing the AGYW intervention. Each PR was responsible for appointing and contracting Sub-Recipients (SR) in their respective districts to implement the full package. The qualitative study activities were conducted in five purposively selected districts, to ensure that a district from each of the Principal Recipients of the Global Fund grant was selected. From the larger HERStory study sample, the study participants chosen for this research include the implementers of the programme, the facilitators for the intervention groups as well as the community leaders of the five districts chosen for the HERStory evaluation. The sample groups were chosen because of their experiences surrounding negotiating access and intervention implementation which are valuable for the aims of this study. The study sites are named in table 1.1 below:

1.1 A table showing the 5 study sites and their respective provinces

Provinces	Sites
Western Cape	City of Cape Town
KwaZulu-Natal	Uthungulu
Mpumalanga	Gert Sibande
North West	Bojanala
Eastern Cape	Nelson Mandela Bay

Community Leaders

Community leaders from the respective sites were invited because they had rich information to share regarding the intervention and their experiences around the intervention within their district. The community leaders that were interviewed included ward councillors who are in positions of power and have a duty to implement policies within the community, provide leadership and participate in decision making regarding the community (26). The community leaders were able to share their experiences about how they were approached by the implementers and what factors influenced their decision to commit to an interview and give the implementers access to the community participants.

Implementers

The programme implementers were chosen as a study population to provide information and insights into how they approached community leaders and what strategies they used to build trust between themselves and the community leaders. The implementers were able to provide insights into the challenges of negotiating access to the AGYW study participants. Some of the implementers are members of the chosen communities and were able to provide insights into how they promoted the intervention and gained permission and support for the intervention from the community leaders as community members themselves. The implementers would have experience and knowledge regarding the facilitation between the community, community leaders and facilitators

Facilitators

The programme facilitators were chosen to be part of the sample to provide insight into the facilitators and barriers to negotiating access to communities and implementing the intervention. The programme facilities that were interviewed included facilitators of peer mentor groups including facilitators of the Clubs and Keeping Girls in School programme which are further explained below. The facilitators had rich information regarding barriers and facilitators to access the AGYW participants. They also had information regarding interaction with community leaders and insights into building trust and fostering buy-in. Some of the facilitators are community members from those communities where the intervention was implemented and would have experiences and insights into negotiating access and intervention buy-in as a member of the community.

Sampling and recruitment

Sampling was completed by the HERStory research team. Purposive sampling was used as a strategy to get the participants who had rich information regarding the community intervention to share their experiences. The HERStory research team purposively selected two schools from the list of clubs where the KGIS program was running. A trained research assistant based at the respective district or who assisted with the recruitment was important for participant recruitment. Within the school setting, the principal received a formal letter requesting permission to conduct the research within the school. When permission was received, consultation with the appropriate stakeholders such as the teachers and other school personnel took place to arrange interviews or focus group discussions. The research assistant liaised with the school teacher or other personnel in identifying the AGYW who participated in the intervention and arranged for the time and venue to conduct the research within the school.

In the community setting, the programme implementers were essential to providing the contact details and the linkage to potential participants to interview for the study. The research assistant made contact with the participant and arranged the time and venue to conduct interviews. If the research assistant had difficulty with securing a time and space for the interview, an experienced researcher or co-investigator assisted by contacting the participant or making contact with the participant in person.

Inclusion criteria used by the HERStory research team:

- Soul Buddyz and Rise Club facilitators
- Community leader
- Willing to provide written informed consent
- Willing to participate in this study

Exclusion criteria used by the HERStory research team:

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

This mini dissertation did not include any direct participants. The criteria described above are the population that was engaged by the HERStory research team. Only a subsection of the overall HERStory data was analysed for this mini dissertation. This subsection was made available for this study because it related to community engagement as determined by the HERStory evaluation team.

1.2 A table showing the total number of enrolled participants within each of the 5 provinces that were selected.

Sample Group	WC	KZN	MP	NW	EC	TOTAL
Facilitators	0	5	4	2	3	14
Community Leaders	0	2	1	2	1	6
Implementers	2	2	3	3	2	12
Total	2	9	8	7	6	32

Data collection methods

The data had already been collected in 5 study sites by the HERStory evaluation study team. The researchers or trained interviewers conducted semi-structured in-depth interviews and focus group discussions with participants from the Combination community HIV prevention intervention within 5 of the 10 districts where the Combination community HIV prevention intervention had taken place. All the interviewers had open ended questions as part of their topic guide to guide the discussion. The interviews took place in the language of the participant's choice. With consent from the participant, the interviews were audio recorded. Audio recordings of the IDIs and FGDs were transcribed verbatim into their original language, reviewed by the interviewer/s for accuracy, translated into English and re-reviewed. The audio files were uploaded onto a secured Google Drive by the study coordinator. The English transcripts of the sample group chosen for this mini dissertation were made available after a confidentiality contract was signed to ensure participants' identities were protected, and that the data was not shared, or made available to unauthorised personnel.

1.3 A table showing the number of in-depth interviews (IDIs) and focus group discussions (FGD) conducted within the various sample groups within the 5 selected study sites.

Sample Group	Total	City of Cape Town, Western Cape	Uthungulu, KwaZulu-Natal	Gert Sibande, Mpumalanga	Bojanala, North West	Nelson Mandela Bay, Eastern Cape
Soul Buddyz & Rise Club Facilitators	11 IDIs 2 FGDs	3 IDIs	2 IDIs 1 FGD (3 participants)	1 FGD (3 participants)	2 IDIs	4 IDIs
Community Leaders	6 IDIs	0	2 IDIs	1 IDI	2 IDIs	1 IDI
Programme Implementers	13 IDIs	2 IDIs	2 IDIs	4 IDIs	3 IDIs	2 IDIs

Data Analysis

A thematic analysis will be used for this mini dissertation. A thematic analysis uses coding and sorting to create categories of themes and sub-themes. This type of analysis allows the researcher to recognise patterns within the data which facilitates the process of gaining a deeper understanding of the participant's experience to interpret (Daly, Kellerhear & Gilksman, 1997). Braun and Clarke (2006) suggest 6 steps as a guide towards a thematic analysis which will be used for this study. These steps are as follows:

1. Familiarisation of the data
 - a. Braun and Clarke suggest emerging oneself in the data as a bedrock for the analysis. Notes can be taken during this stage which the researcher can come back to use or discard.
2. Initial Coding

- a. This step involves seeing important points before the process of interpretation. Encoding the information will assist in the organisation of the data and the development of themes.
3. Generating themes
 - a. Using all the codes generated from the data, themes will merge as stories pieced together to form a picture of the experiences of the participants. The codes are, in other words, analysed and combined into overarching themes.
4. Validity and reliability of themes
 - a. This process involves refining themes. Some themes may not be themes due to not enough data supporting them and others may merge as they speak about the same experience. Two themes should not represent the same 'story'.
5. Defining and naming themes
 - a. This step involves defining the theme that will present the analysis. This step will identify the essence of what each theme means and represents.
6. Interpretation and reporting
 - a. The last step is the conclusion of the process whereby all themes are refined and defined and are ready to be presented or disseminated. The literature will be used to substantiate claims made to validate themes and conclusions.

For this mini dissertation's thematic analysis, data will be organised using the qualitative data package Nvivo 12. The Nvivo software will be used to label and code data as part of the analysis. Through the use of the Nvivo software and using the guidelines suggested by Braun and Clarke (2006), the researcher will gain a better understanding of the data to make interpretations and present an in-depth analysis.

Potential limitations

The data used for this research paper was provided by the HERStory evaluation study. The interviews were conducted by the trained HERStory research staff and those interviews that were not conducted in English were translated into English. The information collected from

the interviews included challenges of initiating the intervention within communities, how were systems strengthened such as the health system and so forth. The goal of the interviews was to hear the views, experiences and opinions of the implementers, community leaders and facilitators of the intervention. Using data collected for the HERStory evaluation for the purpose of this mini dissertation is considered secondary data as the data.. The use of secondary data has increased over recent years because of its benefits including the elimination of financial and logistical issues that occur with primary data collection (Trinh, 2018). However, caution needs to be taken when using secondary data to answer a research question (Trinh, 2018). This includes choosing the right data set to answer a question and using appropriate and rigorous approaches to analysing the data according to Trinh (2018). The following methodological considerations will be adhered to by the researcher:

Reflexivity

Being reflexive in a qualitative study involves understanding and acknowledging the primary role of the researcher in the process of constructing new knowledge (Brown et al., 2011). The researcher should be able to recognise that the findings are constructs of both the researcher and the study participants' reality (Brown et al., 2011). This means that the findings are often shaped by the effects of gender, class and age (Brown et al., 2011). The researcher needs to be aware of her position within the study (Brown et al., 2011). In this study, the researcher will engage in discussions with a fellow master student to discuss thoughts, feelings and understandings during the analysis of the data. The researcher will be making use of memos within Nvivo 12 to record what is happening in the research process and how her values or interests may be influencing the process. The researcher will also be checking in with her supervisors to obtain guidance on the analysis and the findings. In this way, the researcher will be able to identify her subjectivity and influence on the analysis of the data.

Rigour

Rigour in qualitative research is an active process of checking and questioning during the analysis of the data (Kallem, Renner, Ghebremichael & Paintsil, 2011). As this is secondary

data, the following steps will be used to ensure validity and reliability throughout the data analysis process:

- Member checking

The researcher will aim to involve data collectors by sharing findings and requesting feedback where possible. This will allow the data collectors to correct the researcher if there are any misunderstandings or misinterpretations of the data by the researcher. The researcher has arranged with a data collector of the study to communicate via email to share findings and request feedback. The data collector has agreed to answer questions and shed light on any misunderstandings. Another data collector will be contacted for member checking as well. The researcher will also consult her supervisor, who was involved in the HERStory evaluation, to clarify any misinterpretations and guidance for further member checking. This process can improve the validity of the findings and assist the researcher with her understanding of the data.

- Confirmability

In light of the data being secondary data, the researcher will recognise her subjectivity and role in defining and interpretation of the data. The researcher aims to make sure that the findings are true to the participants' narratives and not her own potential biases. The researcher will use audit trails to assist with confirmability. The researcher will use audit trails by keeping a record of all data and analyses (through the use of Nvivo memos) throughout the research process to track all processes, thoughts and decisions that led to the interpretations and conclusions of the study.

[Ethical approval](#)

Ethical approval for this study was sought from the University of Cape Town (UCT) Health Sciences Faculty of Human Research and Ethics Committee and the School of Public Health and Family Medicine of UCT. The ethics reference number is: 329/2020. This research is a sub-study of the larger HERStory evaluation study and permission was granted to use a subset of their data by the principal investigator, Catherine Mathews and the study coordinator, Zoe Duby. The HERStory protocol and all the research tools were approved by the South African Medical Research Council Research Ethics Committee – Protocol ID EC036-11/2016 (Please refer to Appendix A for ethics approval letter).

Ethical considerations

The research aims to protect the dignity and well-being of all participants involved in the research (Blanche et al., 2006). The four philosophical principles of research that will be adhered to throughout the process will be named and described below:

1. Non-maleficence refers to no harm being done to or befalling a participant as a direct or indirect consequence of the study and is a commitment to the principle of Beneficence (Creswell, 2013). Beneficence will be ensured by not putting participants at risk in any way (Blanche et al., 2006). All of the participants were 18 years and older and were informed of the purpose and process of the HERStory research before being asked to provide their informed consent. Those younger than 18 years signed written assent with written guardian consent. Programme implementers were all adults and provided telephonic consent. Non-maleficence has been ensured by the HERStory research team by upholding confidentiality as they have not used any names when labelling the interview transcripts. Therefore, the transcripts that have been made available to the researcher of this thesis contained no identifying information that could potentially lead to a participant being harmed in any way. The data sets will not be made available to others outside of the study as the researcher has signed a confidentiality form provided by the MRC.
2. Respect for the dignity and autonomy of the participants were upheld because they were assured of their voluntary participation and were allowed to leave at any point during the interviews or group discussions. They were provided with the information to be able to make their own decision to participate in the study or not. The names of the participants were not used to on the transcripts to respect their privacy and therefore, the names are unknown to the researcher of this study. Thus, their identities are well protected. The researcher will be treating all the data as rich sources of information as the participants shared lived experiences which were sometimes, challenging. The researcher therefore, will avoid being prejudiced or discriminatory towards the transcripts and treat them equally.
3. Justice would be ensured by allowing the participants to receive what is due to them (Blanche et al., 2006). The HERStory research team had selected and recruited

participants in a fair manner whereby community leaders were involved in granting access to communities and the participants themselves provided informed and voluntary consent. The research conducted by the HERStory evaluation team is a form of justice as the population under study is vulnerable and needs to be provided with responsive health and social services. This study aims to contribute towards justice by analysing the data to generate findings and thereafter, make recommendations for future research that may benefit AGYW.

1.4 A table showing the timeline for the proposed study

Activity	Expected timeline
Meetings with co-supervisor every 4 weeks	ongoing
Proposal drafting	By the end of September 2019 (Time to receive feedback and incorporate it)
Ethics approval	HERStory Protocol and research tools were approved by the MRC. Ethical approval still to be obtained by UCT ethics committee in February 2020
Data Collection	N.A
Transcribing	N.A
Coding and Data analysis	To be done by mid-October
Literature Review	To be completed by the end of December
Thesis manuscript write-up and submission	Writing to take place in Jan 2020
Draft Submission	First draft for review by February 2020 Second draft for review by mid-March 2020
Final write-up and submission	To be completed end of May 2020
Journal manuscript draft	To be completed end of June 2020
Journal manuscript submission	July 2020

[Write up and dissemination of findings](#)

The findings of this study will be submitted to fulfil the requirements for the Master of Public Health Degree, Specialisation: Social and Behavioural Sciences at UCT. The findings will be represented in a report and disseminated to any of the stakeholders involved in the HERStory evaluation including the community members who are interested in the information.

[Implications for Policy and Practice](#)

The study aims to provide findings that will provide future researchers with new insights into community engagement especially with regards to building trust with community stakeholders, gaining community access and ultimately, community buy-in. The literature provides evidence that community buy-in is crucial for the success of any community intervention and that community engagement is a crucial strategy to achieve buy-in. The research is intended to be able to provide insights to facilitate community buy-in to be able to provide guidelines for future community research projects and interventions.

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Appendix A



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



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29 June 2020

HREC REF:329/2020

A/ Prof C Cozisa
Division of Social & Behavioural Sciences
Public Health & Family Medicine-FHS
Email: c.cozisa@gmail.com
Student: r.zqa.armien@gmail.com

Dear A/Prof Cozisa

PROJECT TITLE: GAINING ACCESS AND COMMUNITY BUY-IN FOR COMMUNITY BASED INTERVENTIONS –MASTERS CANDIDATE-RIZQA ARMIEEN

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee (HREC) for review.

It is a pleasure to inform you that the HREC has formally approved the above-mentioned study.

This approval is subject to strict adherence to the HREC recommendations regarding research involving human participants during COVID -19, dated 17 March 2020.

Approval is granted for one year until the 30 June 2021.

Please submit a progress form, using the standardized Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/hrs/research/humanethics/forms)

The HREC acknowledges that the student: - Ms Rizqa Armien will also be involved in this study.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator must obtain appropriate institutional approval, where necessary, before the research may occur.

Please quote the HREC reference number in all your correspondence.

Yours sincerely

Signature Removed

PROFESSOR M. BLOKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

HREC 329/2020a

Part B

Negotiating access and buy-in from communities in the context of a South African combination HIV prevention intervention for adolescent girls and young women

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Target journal: BMC Public Health

Abstract

Background: In response to the persistently high incidence of HIV in adolescent girls and young women in South Africa, the Global Fund invested in a combination HIV prevention intervention aimed at adolescent girls and young women in 10 high priority districts. The HERStory study evaluated the combination HIV prevention intervention after two years of implementation. Using the findings of the HERStory evaluation, this study aims to contribute towards the literature related to understanding factors related to successfully accessing communities and gaining community buy-in or support for community based interventions. The HERStory study explored the identification of the gaps and challenges in the intervention components and the intervention implementation to be able to revise and improve the intervention and its implementation. **Methods:** In-depth interviews and focus group discussions with community leaders, program implementers and intervention facilitators were conducted. The data consisted of 32 transcripts; a subset of the qualitative data collected for the HERStory evaluation. The analysis for this study sought to better understand the barriers and facilitators of community access and the importance of community buy-in using the HERStory evaluation. Thematic analysis of the data was

conducted, supported by Nvivo 12 qualitative data analysis software. **Results:** The main themes of this secondary analysis were 1) the complexity of negotiating access to communities through key stakeholders, 2) challenges to gaining buy-in, and 3) facilitators and barriers to community based intervention implementation. There were clear facilitators to community access and intervention buy-in such as creating clear communication lines between stakeholders and scheduling regular meetings. Delayed or rushed community engagement resulted in misunderstandings and was identified as barriers to community access and intervention buy-in. **Conclusion:** Quality community engagement was essential in the facilitation of access and intervention buy-in to promote successful intervention implementation. Recommendations for future interventions include planning enough time for community engagement throughout the intervention including the design phase and establishing clear and effective communication channels between intervention implementers and community stakeholders.

Keywords

Community engagement, access, buy-in, community based intervention, HIV, adolescents, South Africa

Background

The Human Immunodeficiency Virus (HIV) epidemic has affected the lives of millions of people worldwide (1). The estimated amount of people in South Africa living with HIV in the year 2019 was 7.7 million (2). The consequences of the HIV epidemic in South Africa include high morbidity and mortality rates, poor economic growth, high health care demands with poor resources and continued incidence (1, 2).

Adolescent girls and young women (AGYW) living in South Africa between the ages of 15 and 24 years are twice as likely to be living with HIV than males of the same age (2). The estimated total number of women aged 15 years and older living with HIV is 4.7 million (2). There are many possible factors contributing to this gender disparity in incidence including individual sexual behaviour and sexual partnership factors, socio-economic and demographic factors (1). Potential behavioural drivers include commercial and transactional sex, sex and alcohol consumption, violence in sexual relationships, non-disclosure of HIV status, intergenerational sex, partner concurrency and low levels of condom usage (1).

Strategies to address the contributing factors to the continued rise in HIV incidence for AGYW include community interventions that have the potential to target a large audience including those most vulnerable to HIV (3). In response to the ongoing incidence of HIV in AGYW, a combination HIV prevention intervention for AGYW was implemented in 10 districts in South Africa. These districts were chosen due to the high incidence of HIV and the vulnerability of AGYW. The intervention included a comprehensive package of services

including health, education and support services to boys between the ages of 10 to 14 years and AGYW between the ages of 10 to 24 years old (21, 22).

Community interventions run the risk of not achieving their objectives or reaching their targets if there is resistance from stakeholders which creates a barrier to access or no buy-in or support from the gatekeepers within the community (4-6). For this study, we defined 'access' as being able to enter a community with permission from community leaders to engage with participants and other relevant community stakeholders to be able to implement an intervention. Community buy-in was defined in this context as the active support or endorsement received for the intervention by the community leaders and stakeholders of that community. Community leaders like chiefs or traditional leaders are not elected to be in a position of power but rather assume the leadership position by virtue of his ancestry and maintains this position for life (25). The chief or traditional leader is responsible for social leadership like providing safety and security, settling disputes and regulating social behaviour (25). Community engagement has therefore, been a strategy used to gain access into communities and to facilitate buy-in from the community leaders and the people living in the community who could benefit from community interventions (6).

This study aims to add to the literature related to community buy-in and access by using the HERStory evaluation of the combination HIV prevention intervention targeting AGYW funded by the Global Fund. The literature includes the identification of facilitators and barriers to negotiating access into communities who are in need of community interventions (7). For example, previous research has noted the barrier of mistrust that can develop between community members and professionals if there are power imbalances at play or inaccessible organisational power structures or processes (7, 24). There are also limited studies that have provided insights into how different contexts can influence the outcomes of community engagement (7). Another study aiming to promote community participation found that health and social exclusion disparities between communities and external funders or agencies remain deeply ingrained in the society which influenced the outcomes of the study (24). This study could contribute towards future HIV prevention community intervention designers and implementers to potentially strengthen their community engagement practices and promote better community based intervention outcomes.

Background to the combination HIV prevention intervention for AGYW

All the information stated below regarding the combination HIV prevention intervention and AGYW evaluation was sourced from the Global Fund Technical Brief: Adolescent Girls and Young Women in High-HIV Burden Settings (21) and the HERStory evaluation study materials (22) made available by the South African Medical Research Council (SAMRC).

The intervention included a comprehensive package of services including health, education and support services to boys between the ages of 10 – 14 years and young women and adolescent girls between the ages of 10 to 24 years old. The intervention includes the following programmes:

- Soul Buddyz Clubs (SBC) was offered to young people between 10 – 14 years in Primary School.
- The Keeping Girls in School (KGIS) identified young female learners between the ages of 14 to 18 years old. These young female learners were provided with peer support, homework support, sexual and reproductive health and rights (SRHR) education, career guidance and absenteeism tracking in school.
- Rise Clubs were community and school based clubs that were offered to young women aged 15 to 24 years old. These clubs were established within all the districts with at least 20 members per club.
- The intervention provided comprehensive HIV, TB and sexual and reproductive health services, services for young boys at risk of abuse and perpetration and services for victims of abuse across all districts. These services were provided over and above the programmes mentioned above.

Aim of the study

This study aims to use the HERStory evaluation study data to examine some of the potential facilitators to, and barriers for negotiating community stakeholder buy-in and access to communities for HIV prevention interventions. This study aims to provide practical suggestions to promote access to communities and buy-in for community based interventions.

Methods

Research approach

A qualitative research approach has been used for this study as it is most suited to understanding the barriers and facilitators of community access and the importance of community buy-in for the combination HIV prevention intervention for AGYW

Study population and setting

. Five Principal Recipients (PRs), comprising NGOs and government institutions, were responsible for implementing the AGYW intervention. Each PR was responsible for appointing and contracting Sub-Recipients (SR) in their respective districts to implement the full package. The qualitative study activities were conducted in five purposively selected districts, to ensure that a district from each of the Principal Recipients of the Global Fund grant was selected. From the larger HERStory study sample, the study participants chosen

for this study include the implementers of the programme, the facilitators for the intervention groups as well as the community leaders of the five districts chosen for the HERStory evaluation. The sample groups were chosen because of their experiences surrounding negotiating access and intervention implementation which are valuable for the aims of this study. The study sites are named in the table below:

1.1 A table showing the 5 study sites and their respective provinces

Provinces	Sites
Western Cape	City of Cape Town
KwaZulu-Natal	Uthungulu
Mpumalanga	Gert Sibande
North West	Bojanala
Eastern Cape	Nelson Mandela Bay

Community Leaders

Community leaders from the respective sites were invited because they had rich information to share regarding the intervention and their experiences around the intervention within their district. The community leaders that were interviewed included ward councillors who are in positions of power and have a duty to implement policies within the community, provide leadership and participate in decision making regarding the community (26). The community leaders were able to share their experiences about how they were approached by the implementers and what factors influenced their decision to commit to an interview and give the implementers access to the community participants.

Implementers

The programme implementers were chosen as a study population to provide information and insights into how they approached community leaders and what strategies they used to build trust between themselves and the community leaders. The implementers were able to provide insights into the challenges of negotiating access to the AGYW study participants. Some of the implementers were members of the chosen communities and were able to provide insights into how they promoted the intervention and gained permission and support for the intervention from the community leaders as community members themselves. The implementers had experience and knowledge regarding the facilitation between the community, community leaders and facilitators.

Facilitators

The programme facilitators were chosen to be part of the sample to provide insight into the facilitators and barriers to negotiating access to communities and implementing the intervention. The programme facilitators that were interviewed included facilitators of the

peer mentor groups, Clubs and Keeping Girls in School programme which are further explained below. The facilitators had rich information regarding barriers and facilitators to access the AGYW participants. They also had information regarding interaction with community leaders and insights into building trust and fostering buy-in. Some of the facilitators were community members from those communities where the intervention was implemented and would have experiences and insights into negotiating access and intervention buy-in as a member of the community.

Sampling and recruitment

Purposive sampling was used as a strategy to get the participants who had rich information regarding the community intervention to share their experiences. The HERStory research team purposively selected two schools from the list of clubs where the KGIS program was running. A trained research assistant based at the respective district or who assisted with the recruitment was important for participant recruitment. Within the school setting, the principal received a formal letter requesting permission to conduct the research within the school. When permission was received, consultation with the appropriate stakeholders such as the teachers and other school personnel took place to arrange interviews or focus group discussions. The research assistant liaised with the school teacher or other personnel in identifying the AGYW who participated in the intervention and arranged for the time and venue to conduct the research within the school.

In the community setting, the programme implementers were essential to providing the contact details and the linkage to potential participants to interview for the study. The research assistant made contact with the participant and arranged the time and venue to conduct interviews. If the research assistant had difficulty with securing a time and space for the interview, an experienced researcher or co-investigator assisted by contacting the participant or making contact with the participant in person.

Inclusion criteria used by the HERStory research team:

- Community leader
- Programme facilitators and implementers
- Willing to provide written informed consent
- Willing to participate in this study

Exclusion criteria used by the HERStory research team:

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

- Unable to speak English, IsiZulu, isiXhosa, Northern Sotho, Sotho, Tswana, Tsonga, Swazi, Swati, Sepedi, Afrikaans
- Not available for participation between 8 a.m. and 9 p.m.
- Participants who have been living in the district for less than two years

This study did not include any direct participants. The criteria described above are the population that was engaged by the HERStory research team. Only a subsection of the overall HERStory data was analysed for this study. The 32 transcripts were chosen based on the content of the interviews which were all related to community participation and engagement.

1.2 A table showing the total number of enrolled participants within each of the 5 provinces that were selected

Sample Group	WC	KZN	MP	NW	EC	TOTAL
Facilitators	0	5	4	2	3	14
Community Leaders	0	2	1	2	1	6
Implementers	2	2	3	3	2	12
Total	2	9	8	7	6	32

Data collection methods

The data had already been collected in 5 study sites by the HERStory evaluation study team. The researchers or trained interviewers conducted semi-structured in-depth interviews and focus group discussions with participants from the Combination HIV prevention intervention within 5 of the 10 districts where the intervention had taken place. All the interviewers had open ended questions as part of their topic guide to guide the discussion. The interviews took place in the language of the participant's choice. With consent from the participant, the interviews were audio recorded. Audio recordings of the in-depth interviews (IDIs) and focus group discussions (FGDs) were transcribed verbatim into their original language, reviewed by the interviewer/s for accuracy, translated into English and re-reviewed. The audio files were uploaded onto a secured Google Drive by the study coordinator. The 32 English transcripts of the sample group chosen for this study were made available after a confidentiality contract was signed to ensure participants' identities were protected, and that the data was not made available to unauthorised personnel.

1.3 A table showing the number of in-depth interviews (IDIs) and the focus group discussions (FGD) conducted with the various purposively chosen sample groups within the 5 selected study sites.

Sample Group	Total	City of Cape Town, Western Cape	Uthungulu, KwaZulu-Natal	Gert Sibande, Mpumalanga	Bojanala, North West	Nelson Mandela Bay, Eastern Cape
Soul Buddyz & Rise Club Facilitators	11 IDIs 2 FGDs	3 IDIs	2 IDIs 1 FGD (3 participants)	1 FGD (3 participants)	2 IDIs	4 IDIs
Community Leaders	6 IDIs	0	2 IDIs	1 IDI	2 IDIs	1 IDI
Programme Implementers	13 IDIs	2 IDIs	2 IDIs	4 IDIs	3 IDIs	2 IDIs

Data Analysis

A thematic analysis was used for this study. Braun and Clarke (19) suggest 6 steps as a guide towards a thematic analysis which was used to guide the analysis of this study. These steps include familiarisation of the data, initial coding, generating themes, refining themes to ensure validity and reliability of the themes, naming and defining the themes and lastly, interpreting and reporting the themes (19).

The data was organised using the qualitative data package Nvivo 12. The Nvivo software was used to label and code data as part of the process of analysis. Through the use of the Nvivo software and using the guidelines suggested by Braun and Clarke (19), interpretations were made to present and an in-depth analysis of the data.

Throughout the analysis, a member of the HERStory evaluation team was consulted to clarify any misinterpretations and guidance for further member checking. This process has improved the validity of the findings and assisted the researcher with her understanding of the data. To promote confirmability, memos made on Nvivo were consulted to remain true to the participants' narratives. The transcripts that have been made available for this study contained no identifiable information that could potentially lead to a participant being identified in any way. The data sets will not be made available to others outside of the study as a confidentiality form has been signed and submitted it to the SAMRC. Participants were assured of their voluntary participation and were allowed to leave at any point during the interviews or group discussions. The participants all provided written consent. The HERStory protocol and all the research tools were approved by the South African Medical Research Council Research Ethics Committee – Protocol ID EC036-11/2016. The research protocol was reviewed and approved by the Faculty of Health Sciences Human Research Ethics Committee. The ethical approval reference number is 329/2020

This study aims to contribute towards justice by analysing the data to generate findings and thereafter, make recommendations for future research that may benefit AGYW. This study will be published and can be used for the justifications of more interventions to prevent the spread of HIV and policy change.

Results

In analysing the in-depth interviews and the focus group discussions, 3 themes have emerged and will be discussed in this section. These themes are 1) the complexity of negotiating access to communities through key stakeholders, 2) challenges to gaining intervention buy-in, and 3) facilitators and barriers to community based intervention implementation.

The complexity of negotiating access into communities through key stakeholders

Negotiating access into the communities held many unexpected challenges for the combination HIV prevention intervention team. The intervention used different community engagement strategies to build relationships with community stakeholders and ensured all stakeholders understood what the intervention entailed and its potential benefits for the community which assisted negotiating access into the communities.

Identifying the community stakeholders in positions of power

Many of the facilitators and programme implementers reported that negotiating access for the intervention to be implemented in the communities was complex. In the interviews, they expressed having to firstly identify and find the individuals within the community who have the power and authority to give them permission and grant access to the community. After identifying these key stakeholders they would negotiate and arrange a meeting to explain what the intervention aims to do and the potential benefits of the intervention. One implementer said that she initiated the process of negotiating access into the community by finding the head of the community first:

I do the advocacy... I deal with the communities because there is some communities where if you don't speak to uMaDlamini (example name given by implementer, not actual person), it won't happen . . . So I ask them, so, who is the leader? . . . Who is the ma Dlamini in your area, when I go and speak to the, to the counsellor, I start with uMaDlamini. . . . And I bring uMaDlamini with me to speak to the counsellor... Because if you start with the counsellor, then you won't enter that community . . . Ya that's my part, I find out who is the ring leader... I rope them in, I even involve them (Implementer, Nelson Mandela Bay, Eastern Cape)

The data shows how implementers approached the community members to negotiate access by seeking out the community leader first. Community leaders may not be obvious or visible and engaging with community members was one way of locating leaders of the

community. This increased the amount of time taken to find and engage with community leaders.

Negotiating access by meeting and engaging with community stakeholders

Once the community stakeholders were identified, the process of arranging a meeting date that was suitable for all invited community stakeholders was challenging. Some implementers were faced with the difficulty of working with multiple stakeholders where the stakeholders either did not have the time or were not always willing to meet to discuss the intervention.

Some implementers found it easy to approach stakeholders by using existing meeting times like community meetings or strategic planning meetings. This was advantageous as relevant stakeholders were present to be informed about the intervention. These meetings were also useful because they occurred regularly which allowed the implementers to return and provide feedback to the stakeholders confusion regarding the intervention. These meetings provided the space for the implementers and the stakeholders to engage in conversations regarding the intervention such as what is it about, who will benefit from it and what resources are needed to successfully implement the intervention. A community leader reported that feedback is given by intervention representatives at these meetings to inform community leaders and other community representatives:

'and they're not just at the war room to come and observe, they have a report to give... the NGOs give reports of what they have done and it's a way for us to monitor that they are around, and what they are doing. What they do with our kids at school. If they had challenges, the facilitator should indicate what challenges she had and at which school.' (Community Leader, Uthungulu, KwaZulu-Natal)

The data shows that a crucial part of getting access from a stakeholder is making sure the stakeholder understands exactly what the intervention entails. With this understanding, stakeholders granted permission for the intervention to commence. There were however, community members who were not well informed about the intervention and what it entailed, which resulted in some participants being denied access to some of the intervention activities. This shows that key community stakeholders were missed or overlooked that should have been engaged and had negative consequences for the AGYW who may have wanted to participate in the intervention.

Unanticipated family and partner dynamics

There were community members who did not allow their loved ones to attend the events and clubs of the intervention because they did not understand what the intervention entailed. Some of the facilitators reported that they had several dropouts during the intervention. Upon investigation, it was found that some parents and partners of the AGYW did not allow them to participate in the intervention because they were uncomfortable with the topics being discussed such as sex education which could lead to feared negative behaviour change like promiscuity among the AGYW. One of the facilitators stated:

Sometimes let's say I have a boyfriend, so if I have to join, I choose to join Rise, there are situations that we sometimes come across with, where your boyfriend does not allow you to attend. (Facilitator, Uthungulu, KwaZulu-Natal)

This quote illustrates that partners of AGYW could be a barrier towards access and participation in the intervention and it also highlights gendered power dynamics. There may be multiple reasons why intimate partners of the intervention participants may not want their AGYW partners to attend the sessions like fearing the empowerment of AGYW which could lead to the females challenging the power of males. There seemed to be a poor response to mitigate this challenge as some of the AGYW were lost to the intervention. Intimate partners, friends and family were missed during the engagement process which may have increased the likelihood of misinformation being circulated in community households resulting in the loss of AGYW participants.

Poor communication between stakeholders was a challenge

A challenge to negotiating access that surprised the implementers was poor communication channels between the stakeholders themselves. Many of the implementers found that although access was granted by stakeholders at provincial or district level, those stakeholders on the ground like teachers and principals were not informed and therefore, were reluctant to allow the intervention to commence in their schools. The facilitators would then have to take the time to engage with the stakeholders and explain the intervention to them before they were allowed to begin. One of the implementers explained this challenge:

So those were some of the implementation challenges we obviously worked with Department of Education and Department of Health. But I still find that even though the agreement was done at an inter-sectoral level, the actual people on the ground may, or may not approve the programme so that relationship uhmmm took a bit of a while uhmmm that was from the agreement we also had to settle the staff. (Implementer, City of Cape Town, Western Cape)

After engaging and negotiating access with the stakeholders like the school principals, the implementers were able to facilitate buy-in and implement the intervention. Employing community engagement strategies with community stakeholders like the school principals was a well-adapted response to mitigate the poor communication from those at the provincial or district level to those stakeholders working in the community.

Presenting potential benefits facilitated access into the communities

From the interview data, it was clear that stating the potential benefits of the intervention was pertinent to negotiating access to the communities. Many of the community leaders were happy to grant access once they could see the potential benefits for the AGYW. This was clear when one of the Implementers stated:

'...if you first introduce the program to all relevant stakeholders and unpacked the program to them so that they will understand as to what extent the program will help those young girls, because you first need a buy in from relevant stakeholders. (Implementer, Uthungulu, KwaZulu-Natal)

Providing an overview of the program and discussing the program's potential benefits with the relevant stakeholders was a critical step in the process of community engagement to gain access to the community.

Relationships built on trust assisted access in communities

Building relationships through engagement and building trust between the intervention implementers, facilitators and community stakeholders played a role in negotiating access to communities. Although the intervention sounded like it was beneficial, it was the face to face open engagement and discussions that facilitated access. The data shows that building relationships was not easy, but through continuous meetings where feedback is provided and new plans are made, relationships become stronger and a useful resource. One of the Implementers stated that she managed to build relationships and trust by keeping her word. She wanted the participants and the stakeholders to know that she was trustworthy and reliable so she made sure she kept her word:

Say you coming in on a Monday, you actually come on a Monday. You say you will take the kid in the school you do that, once we started building trust with the schools it became much easier so like I'm saying this year for us we can actually say in the project yeah seems to be a much easier year. (Implementers, City of Cape Town, Western Cape)

Access, however, was not the only component noted within the data to ensure a successful intervention. The second theme that emerged from the data was facilitators and challenges experienced by the combination HIV prevention intervention team which influenced intervention buy-in.

Challenges and facilitators to gaining intervention buy-in

The data showed that intervention buy-in was achieved similarly to how access was obtained. The data revealed that community leaders promoting the intervention to other community leaders who had not yet had the intervention implemented in their areas facilitated intervention buy-in from the community leaders. As in the case of negotiating community access, sharing the potential benefits of the intervention to the community stakeholders, building relationships and trust facilitated buy-in from the community stakeholders. Challenges identified for intervention buy-in from community stakeholders include rushed or delayed community engagement and poor communication between the intervention team and key community stakeholders.

Community leaders promoting the intervention to other community leaders

Some of the community leaders stated that they supported the intervention because the intervention was promoted and supported by leaders from other wards where the intervention was up and running. This promotion assisted with community leader buy-in and support and facilitated the successful implementation of the intervention. One of the community leaders stated that she supported the program because she knew the facilitators for a long time before the intervention started and already trusted them when they came to her to request her permission and support to implement the intervention in her ward:

So I just got involved there because I understood how it started . . . She's just a church mother the organisation mother, she belongs to church but I don't know in which organisation even now I even laugh at her saying what is it, so I gave her a backup for that, by saying that this is an NGO . . . They will do this project to help our children, so I have tried to put it into councillors not be discouraged because they were already discouraged and at that time the children were recruited in their wards.(Community Leaders, Uthungulu KwaZulu-Natal)

The relationship between knowing the potential benefits and intervention buy-in

Understanding the benefits of the program not only assisted with access to the community but community leader buy-in as well. The community leaders were happy to support a program that aimed to reduce HIV incidence and promote healthy sexual behaviours amongst the youth. The community leaders were supportive of the intervention because it had the potential to assist the participants with studying further and obtaining work. Other incentives also attracted the support of the participants like going on camps or staying at hotels. Some participants left the program but soon returned when they could see their peers prospering by obtaining work or being accepted into a university as illustrated in the following quote by a facilitator:

Things were done, people started getting jobs, January came people started going back to school now even those who didn't, those who didn't come to the sessions wanted to come back now and we tell them, 'No, it's too late now'. (Facilitator, City of Cape Town, Western Cape)

Building relationships and trust further facilitated buy-in from community stakeholders

The implementers engaged in a variety of activities to facilitate buy-in from community leaders. The data shows that building relationships and trust were as important for access as it was for buy-in from community leaders. The exposure that they received at community meetings was crucial to provide information on the intervention and to further promote any other services that were being offered like HIV counselling and testing. Some of the implementers were invited to other community events or activities which they found were

advantageous to attend to be visible and to network with other stakeholder as illustrated by a comment by an implementer:

So we part of the forums and we get invitations and we attend their meetings and we do report back in terms of the work that we do and I would say in the areas the local AIDS councils are functional they find value in us, you can even see with the way they are communicating with us when things, like when they've got like forum meetings or when they need support because they also initiate their own events. (Implementer, Gert Sibande, Mpumalanga)

Another way the intervention implementers built strong relationships with key community stakeholders was by creating clear and effective lines of communication like creating groups on social media applications like WhatsApp. By creating these lines of effective communication, information can be disseminated faster resulting in quicker action if it is needed.

The barriers and facilitators to negotiating access into the communities and obtaining intervention buy-in from key community stakeholders provided learning opportunities for all stakeholders involved. The new insights obtained from going through the process of implementing the combination HIV prevention intervention are highlighted in the last theme which emerged from the data.

[Facilitators and barriers to community based intervention implementation](#)

Identified Barriers to intervention implementation

The combination HIV prevention intervention implementers found that the Department of Basic Education did not operate as a homogenous department as offices located in different areas, operated very differently. This required the implementers to adapt their approach to suit the context of the different stakeholders in the different offices. One implementer found it difficult to work with and implement the intervention in schools governed by different heads even though they were situated in the same area as illustrated in the quote:

One big challenge we found was metro central, this is now education, the metro central schools verses metro south schools works differently. So depending on the head at a district level that in itself became a challenge. (Implementer, City of Cape Town, Western Cape)

The intervention implementers had to adapt their approach to the various contexts and stakeholders that they were engaging. This illustrates that organisations do not always function as a homogenous group which was experienced as a barrier to the implementation of the intervention..

Introducing a ready-made intervention was a barrier that the intervention implementers and community leaders identified. Both groups of stakeholders felt that the community

needs to be engaged first to assess the community needs to be able to implement appropriate community based interventions. Community involvement from the beginning was an ideal that emerged from the data that was valued by the community and the intervention team. Apart from involving the community in the planning of community interventions, the community stakeholders and the intervention implementers identified the need to set aside enough time for community engagement strategies, relationship and trust building as illustrated in the quote:

We know for a fact that were places where we could not really go deeper into engaging fully and we wanted to because you know we are always rushing against time and targets and the planning is important when you go into any community to do work, engaging the gatekeepers whenever is important, in some communities, we are able to help with your what councillors, when we have time to engage. (Facilitator, City of Cape Town, Western Cape).

Identified Facilitators towards intervention implementation

Using existing programs to build upon was also identified as beneficial by the implementers because they only had to promote the addition of new services and elements to the program instead of promoting a completely new program that needs to be approved by community leaders. Community leaders were aware of the existing program and the personnel in the community which may make the task of negotiating for the addition of components easier.

Face to face discussions provided the ideal space for clear dialogue between community stakeholders and intervention implementers allowing all participants the opportunity to voice concerns and receive feedback especially when misinformation was circulating in the community. The regular meetings taking place in the community were useful platforms for these discussions to take place and facilitated the building of strong relationships between the implementers and the community stakeholders.

Discussion

This study demonstrates how the relationship between different stakeholders, open communication and dialogue can create strong partnerships that facilitate a successful community intervention. This study also provides insights into the learnings of the intervention implementers and the community workers which could inform future community based interventions. One of the key findings of this study is the importance of identifying the leader of the community to engage and gain permission to enter the community. The importance of engaging with community leaders is illustrated in the example of a Zimbabwean study where the community chief who had authority and power did not support the activities such as offering HIV counselling and testing (HCT) services offered by the intervention (12). The community, in turn, did not support the intervention

resulting in low uptake of HCT (12). Community leaders may need to be identified through engaging with the community because those who hold power in the community may not be obvious. Without gaining the leaders' permission and trust, the intervention team was unable to implement the intervention. In some rural communities, the community leaders and elders are the main opinion leaders and decision makers who influence the lives of the community members (9, 10). If the community leaders do not support the health interventions being offered, they have the power to influence the community's perception of the health service and subsequent health-seeking behaviour (11). Community leaders are therefore, an important group of stakeholders to identify and engage to facilitate successful access and community intervention buy-in.

Poor communication and engagement from top-down personnel within the Department of Basic Education contributed towards delayed access and buy-in at some schools within the community. School principals hold positions of authority and are responsible for granting external visitors or groups of people entry to the school and permission to access and engage the learners. Without prior knowledge of the arrival of the intervention team, principals would be less likely to allow them access to the female learners for a range of reasons like safety and the authenticity of the intervention. This phenomenon has been described by Singh and Wassenaar (13) in their research where they found that the formal process of negotiating access through higher levels of an organisation does not guarantee cooperation from those gatekeepers and stakeholders lower down in the organisation hierarchy.

Stating the potential benefits of the combination HIV intervention for AGYW was an important strategy used by the intervention team to gain access to the communities. Tedrow and colleagues (12) also found that they obtained support easily once they discussed the potential benefits of their program to the community leaders and the community. Similarly, Singh and Wassenaar (12) suggest that stating potential risks, benefits and value that an intervention can bring to a community will facilitate access and buy-in for an intervention.

The facilitators of the intervention gained the support and trust of the community members by using community engagement. The community engagement between intervention facilitators and community members fostered trust and working partnerships which assisted the implementation of the intervention. Gilson (14) has explored the notion of trust amongst individuals and has highlighted the importance of trust between intervention teams and community members. Trust can enable beneficial working relationships that could bring about the achievement of improved health which was seen in the combination HIV prevention intervention (14).

Community engagement throughout the processes of intervention design through to monitoring and evaluation are essential for facilitating successful intervention implementation (15). The intervention implementers and community leaders both identified

the need for community engagement throughout the intervention process including the designing phase of the intervention. Galvaan and Peters have found that involving the community in the design phase of an intervention can guide the intervention to be more relevant and appropriate for the community (15). Iterative community engagement can allow for refinement and adjustments to meet the needs of the community instead of a pre-designed intervention which may be irrelevant (15).

The practical strategies that have been identified to facilitate community access and intervention buy-in include involving the community throughout the intervention including the designing of the intervention, identifying all the key stakeholders and planning enough time for regular engagement, promoting relationship building and creating clear communication pathways between stakeholders. These practical strategies could be used to inform future community based interventions which may assist with successful implementation.

Challenges of underlying cultural beliefs and power dynamics

From the findings of the study, the decision to allow the intervention team to enter the community and implement the intervention seemed to be facilitated by quality community engagement. The decision made by community leaders to allow access to AGWY is complex. Without the community leaders' permission and support to implement a community intervention, the chances of a successful intervention are slim because of the influential power they have on community members' everyday lives (9). Denying access to AGYW may be an attempt on the leader's part to exercise power which may be challenged by the potential empowerment of AGYW and disruption to perceived community harmony. Metz (18) has explained that community leaders may be more likely to strive for social harmony by steering away from that which could disrupt perceived harmonious living and social norms.

The empowerment of adolescent girls and young women may be seen as contrary to the norm where male dominance and female subservience is valued. According to the Africa Human Development Report (16), Africa has made remarkable progress with HIV/AIDS prevention interventions but gender dynamics like power imbalances between men and women still place women at risk for HIV/AIDS. In some communities, sexually empowered women may not be welcomed either due to cultural norms around sexuality and navigating sexual practices as a female within a heterosexual relationship (16). The combination HIV prevention intervention promoted the empowerment of AGYW which may not have aligned with the cultural views and norms of the community. Providing sex education to AGYW may be perceived by the community leaders as going against conservative norms and potentially promoting promiscuity. Khau (17) conducted qualitative research in rural Lesotho where it was found that teachers were afraid to be teaching learners about sex and sexual pleasure as they did not want to be negatively labelled as promoting sex to learners who the community regarded as sexually innocent children. In Lesotho, males and females were

taught by their elders on what they regard as normal and culturally valued sexual practices which was in conflict with modern sex education taught in schools (17). These opposing views on sex education create tension between community members, teachers and potential external interventions that may include sex education for school going males and females.

On the other hand, community leaders who allowed the combination HIV intervention to be implemented in the community may have seen the value and potential benefits of the intervention. Many of the community leaders anticipated a positive outcome and decided to endorse to the intervention because of this anticipated positive outcome for the community in general. Metz (18) explains that community leadership is often underpinned by moral philosophical values where promoting the wellbeing and the good for the community is valued and individualistic practices should be avoided. Intervention buy-in from community leaders and their cooperation seemed to be facilitated by strong partnerships and trust between all stakeholders. The quality of the community engagement brought about greater collaboration and cooperation between the community stakeholders and the intervention team. Galvaan and Peters (15) promote the use of participatory approaches and participation to foster community support to facilitate successful intervention implementation. Through their experience of community work in the Western Cape, they have found that without community engagement and participation throughout the design and implementation, community interventions are not sustainable and run the risk of failure (15).

Limitations: The data used for this research paper was provided by the HERStory evaluation study. The interviews were conducted by the trained HERStory research staff and those interviews that were not conducted in English were translated into English. This is considered secondary data as the data was not collected for this study. The use of secondary analysis could be a potential weak point because the right data set needs to be chosen to answer a question and using appropriate and rigorous approaches needs to be ensured to analysing the data (20). The analysis was only done by one of the authors of this study but this limitation was mitigated as the analysis of this study was shared with one of the authors who were part of the HERStory evaluation who then provided pertinent insights into the analysis and interpretation of the data.

Conclusion

This study showed that the most important facilitator for negotiating community access and intervention buy-in is the quality of the relationships between key community stakeholders, such as community leaders, ward councillors and the intervention implementers. Poor community engagement was described as rushed, delayed or a once-off event which resulted in the implementation of the intervention being delayed or halted. Community engagement that involved key stakeholders and provided the opportunity for clear

communication and open-end engagement resulted in the intervention being accepted into and supported by the community. This study showed that negotiating access and intervention buy-in from communities is complex and requires flexibility to adapt to different contexts to increase the chances of successful intervention implementation.

List of Abbreviations

AGYW	Adolescent girls and young women
AIDS	Acquired immune deficiency syndrome
AHRU	Adolescent Health Research Unit
CCM	Country Coordinating Mechanism
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus infection
FGD	Focus group discussion
IDI	In-depth Interview
KGIS	Keeping Girls in School
NACOSA	Networking HIV and AIDS Community of Southern Africa
NGO	Non-governmental organisation
PEPFAR	President's Emergency Plan for AIDS Relief
PR	Principal recipient
SAMRC	South African Research Medical Council
SANAC	South African National AIDS Council
SBC	Soul Buddyz Club
SRHR	Sexual and reproductive health and rights
TB	Tuberculosis
UCT	University of Cape Town

Declarations

- Ethics approval and consent to participate
 - Approval was given by the Faculty of Health Sciences Human Research Ethics Committee. The ethics reference number is: 329/2020
- Consent for publication
 - Not applicable as the data does not contain any identifying information of any individuals.
- Availability of data and materials
 - The datasets used during the current study are available from the corresponding author on a reasonable request.
- Competing interests
 - The authors declare that they have no competing interests.
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Authors' contributions

- Rizqa Armien¹: analysed the qualitative data and wrote up the manuscript. Rizqa liaised with Zoe and Christopher for guidance and assistance
- Zoe DUBY^{1,2}: Designed and conducted the HERStory study, oversaw data collection, provided guidance on writing up manuscript and proof-read this manuscript
- Christopher Colvin¹: Provided guidance on the writing up of the manuscript and proof-read this manuscript.
- Kim Jonas^{2,3} and Kealeboga Maruping²: Conducted interviews with the sample group, performed data processing and translations.

- Catherine Mathews^{1,3}: Principal investigator of overall HERStory evaluation study, from which you are looking at a subset of data, design of study protocol, research tools.
- Tracy McClinton Appollis^{1,2,3}: Assisted with study management, data collection and data processing

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