IIMPLEMENTATION FRAMEWORK TO ADDRESS AND MONITOR SOCIAL AND STRUCTURAL DRIVERS OF HIV/ AIDS, TB, & STIs AMONGST ADOLESCENT GIRLS AND YOUNG WOMEN (AGYW)

Acknowledgements

The South African National AIDS Council (SANAC) wishes to express its appreciation for the support it received in developing the Social and Structural Drivers Implementation Framework. South Africa must address the underlying challenges that fuel the epidemic in order to achieve an AIDS-free generation by 2030. Towards achieving this goal, this work represents a significant step forward. Members of the Steering Committee played a critical role in developing the terms of reference and providing guidance. Strategic Analytics and Management (SAM) took on the challenge by facilitating the development of the Theory of Change (TOC) for the framework as well as rationalizing the integration of interventions that address social determinants into South Africa's HIV, TB and STI response. These factors are fundamental to ensuring that biomedical interventions yield positive health outcomes. A key contribution of SAM was highlighting what South Africa is already doing to address HIV social and structural drivers and identifying how to strengthen monitoring and evaluation. Furthermore, young people from Gauteng and Northern Cape Provinces are acknowledged and appreciated for their contributions to community resource mapping. Based on the experiences of youth from diverse places, these exercises brought to light different realities.

Socioeconomic factors have been identified by the youth sector as critical barriers to HIV prevention among young people as a result of developing the TOC for social and structural determinants. We are grateful for their contributions in defining and crafting a vision for ending HIV, TB, and STI epidemics. In addition, SANAC would like to thank its own Technical Leads for providing technical guidance and input. Furthermore, SANAC acknowledges the insightful ideas and comments of the Prevention Technical Working Group.

It is our hope that this Social and Structural Drivers Implementation Framework will guide the successful implementation of programs, and that it will continue to benefit from the collaboration of stakeholders (government departments, donors, private sector and organisations) that are doing invaluable work to end the HIV, TB and STI epidemics and to improve the lives of young people.

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1 Background Information

Ending AIDS by 2030 remains an ambitious goal of Project 2030 as expressed in the Sustainable Development Goals (SDGs) as it includes prioritising and addressing the intersecting structural and social inequalities and inequities. South Africa is one of the more adversely affected countries of the Sub-Saharan region, with HIV prevalence being roughly 20% nationally, though it can be as high as 40% in some provinces[1]. The top four provinces with high HIV-prevalence are KwaZulu-Natal, Mpumalanga, Free State, and the Northwest, with residents in rural informal areas having a significantly higher HIV prevalence than urban formal area residents. The relative ranking of provinces by HIV prevalence has remained the same since 2005, implying that particular attention needs to be paid to HIV prevention behaviours, treatment, and counselling in these areas[2].

Estimations indicate that over one-fifth of South African women in their reproductive ages (15-49 years) are HIV positive[3]. Adolescent girls and young women (AGYW) are a particularly at-risk age group[4]. New HIV infections among AGYW are substantially higher than among males of the same age because HIV is more commonly acquired from male sexual partners who are a few or several years older. As such, gender inequality disproportionately affects girls and women[5]. Studies show that HIV infection rates among AGYW aged 15-24 years are three times higher than of young men of the same age group. This group accounts for 20 percent of all new HIV infections globally, 25 percent of all new infections in sub-Saharan Africa, and 71 percent of all new infections among adolescents in sub-Saharan Africa.

New infections rates among women aged 15-24 were more than four times greater than of men in the same age range, accounting for 25% of new infections in South Africa[2]. Some of the key social and structural drivers of the HIV epidemic that undermine adolescent girls' and young women's health are high HIV prevalence at the community level, gender inequality and inequity, negative social norms and traditions, limited educational opportunities, pervasive poverty and unemployment, and gender-based violence. Due to these underlying factors, AGYW are less able to negotiate and advocate for themselves, or to use readily available, innovative biomedical prevention technologies, thus undermining their ability to exercise their sexual reproductive health rights.

These social and structural drivers are described as the main factors that shape and influence the HIV, TB and STIs risk behaviours, thus impeding an individual's or group's ability to prevent these infections, access services, and adhere to prevention and treatment interventions. As such, systematically addressing the social and structural drivers is critical to interrupting and eventually breaking the cycle of HIV, TB and STIs among adolescent girls and young women. Goal 4 of the National Strategic Plan centred its HIV prevention approach on decisively dealing with the social and structural drivers of the three epidemics.

The South African National AIDS Council (SANAC) seeks to develop an HIV combination prevention framework for scaling up efforts to address the social and structural drivers of the HIV epidemic in South Africa. Accordingly, a consultant has been appointed to develop an Implementation Framework to address social and structural drivers of HIV, TB and STIs affecting adolescent girls and young women (AGYW), and to integrate these with factors affecting adolescent boys and young men (ABYM). The framework will include targeted social and structural interventions that will address gender inequalities and drive HIV prevention programmes aimed at AGYW in the country. Guided by the existing policies, strategies and evidence-based programmes that are already operational in the country, the framework will propose, categorise, and systematically package practical interventions.

2 Literature Review: Summary of Findings

Introduction

In the context of HIV, TB and STIs, structural drivers refer to a range of factors that shape and influence patterns of risk behaviour and facilitate, or impede, an individual or group's ability to access services and/ or adhere to treatment for these diseases. During the NSP 2012–2016, in response to the HSRC survey[6], South Africa began to place a particularly high priority on addressing the social and structural factors that lay beneath the growth of those diseases. Evidence suggested that adolescent girls' high risk of HIV infection was driven by a combination of factors that included gender inequality, stigma and discrimination, alcohol availability, lack of economic opportunity, lack of secondary school education, and poor healthcare access[7].

Structural interventions aim to alter the social, economic and political contexts that influence the drivers or mediators of HIV/TB and STIs. Unless these social and structural factors or drivers are addressed in the context of disease control, public health goals for HIV, TB and STIs will be undermined, and the gains achieved will not be sustainable. This underscores the assumption that interventions are needed both within and outside the healthcare system to achieve set goals.

The recently ended NSP 2017-22 for South Africa focused on addressing social and structural drivers by emphasizing a multi-sectoral approach. The NSP highlighted the need for government departments to work together to optimise and co-ordinate social-structural responses with emphasis placed on improving co-ordination, joint planning and integrated service delivery in high-burden districts, aided by the rigorous implementation of scientific methodologies to underpin programme execution. The NSP 2017-22 proposed the following key structural strategies.

- Implement social and behaviour change programmes to address key drivers of the epidemic and build social cohesion
- Increase access to, and provision of, services for all survivors of sexual and gender-based violence in the 27 priority districts by 2022
- Scale up access to social protection for people at risk of and those living with HIV and TB in priority districts
- Implement and scale up a package of harm reduction interventions targeting harmful use of alcohol and drugs in all districts
- Implement economic strengthening programmes with a focus on youth in priority focus districts
- Address the physical building structural impediments for optimal prevention and treatment of HIV, TB and STIs
- Reduce stigma and discrimination by half among people living with HIV or TB by 2022
- Facilitate access to justice and redress for people living with, and vulnerable to, HIV and TB
- Promote an environment that enables and protects human and legal rights, and prevents stigma and discrimination

A mid-term evaluation of the NSP 2017-22 showed that achievements were made in implementing some of the targeted interventions. Some of the key achievements included:

- Stakeholder alignment of AGYW interventions under the integrated 'She Conquers' National Campaign.

- Social protection programmes reaching parents/ caregivers through the Families Matter Programme. About 17,666,235 beneficiaries received social grants, and all nine provincial food distribution centres (PFDCs) were operational.
- Development of Scripted Lesson Plans (SLPs) for Intermediate Phase (IP) and Further Education and Training (FET) to strengthen comprehensive sexuality education.
- Scaling up of SBCC interventions under the DSD resulted in people who had high exposure to SBCC (78,7%) reporting that they had taken an HIV test (SABSSM; 2019).
- From a legal perspective, 75 Regional Courts were upgraded to sexual offences courts, and the conviction rate on sexual and GBV offenses reportedly increased to 74% by the end 2017/2018.

However, the MTR highlighted gaps in the implementation that included inadequate funding for the coordination, monitoring and communication for the flagship 'She Conquers' campaign. In addition, there was no clear evaluation framework to monitor the efficacy of social structural interventions at different levels in reducing the risk of HIV, TB and STIs among key populations, including AGYW[8]. Despite having been at the mid-term implementation phase of the NSP, the MTR was not able to show clear intermediate outcomes linked to interventions that target key SSD such as poverty, poor education attainment, and negative gender norms and stigma.

Evidence on Social Structural Interventions

Several reviews have been conducted to show evidence from rigorous evaluations of interventions that seek to negate or mitigate social structural drivers of HIV among AGYW. One of the latest and most significant reviews was conducted by STRIVE. It compiled evidence from 28 evaluations of structural interventions that work for adolescent young people,[9] a tabular summary of which is shown below of the interventions reviewed, targeting specific social structural drivers.

Table 1: Interventions Reviewed Targeting Specific Social Structural Drivers

Education Interventions	Outcomes	Reference
Cash transfer for OVC project provided an unconditional cash transfer to caregivers of OVC.	Significant impact on increasing school enrolment	Handa et al.2014, 2015[10],
School-based intervention that paid tuition and provided uniforms and community outreach workers to monitor and help avoid absenteeism	Initial reduction in school dropout, delayed sexual debut and attitudes supporting delaying sex, prosocial bonding and gender equity attitudes	Cho et al., 2011[11]; Hallfors et al., 2012[12]
School-based intervention that paid tuition and provided uniforms and community outreach workers to monitor and help avoid absenteeism for OVC (Large Scale)	Positive educational outcomes with reduced school dropout, more age-appropriate progression, higher average grade higher matriculation into secondary school and increased expectations of completing college/university; reduced transactional sex among sexually active participants, increased circumcision for male participants and improved quality of life indicators, including fewer reported problems with depression/anxiety and performance of usual activities	Cho et al., 2017[13], Cho et al., 2018[14]
Universal daily feeding program. In addition, intervention participants received fees, uniforms and a school-based helper to monitor attendance and resolve problems	At 3 yrs., beneficiaries were less likely to drop out of school or get married, and they were more likely to endorse gender equity. At the five-year follow-up, the intervention group were more likely to still be in school and had achieved almost one additional year of schooling, and reported reduced sexual debut, marriage and pregnancy	Hallfors et al., 2011[15], 2015[16]; Iritani et al., 2017[17]

Education Interventions	Outcomes	Reference
Community-based intervention that provided payment of school fees; school supplies; food, health and psychological services; and HIV prevention training	The intervention was associated with reduced school dropout for 8–13- year-olds	Chatterji et al., 2010[18]
Suubi-Maka intervention, which included a matched savings account for post primary schooling, 12 one-hour workshops on financial education, asset-building, and future planning, and monthly peer mentorship sessions.	Reduced the likelihood of orphans dropping out of school or repeating a year, and improved their grades, with girls faring better than boys. The intervention also resulted in lower levels of hopelessness, higher levels of self-concept increased cash savings and increases in HIV prevention attitudinal scores.	Ssewamala et al., 2016[19]; Jennings et al., 2016[20]
A community cash-transfer programme that offered unconditional and conditional (school attendance) cash transfers	The programme found that receipt of unconditional and conditional (school attendance) cash transfers increased the likelihood of 6– 12-year-olds and 13–17-year-olds attending school at least 80% of the time. Conditional, but not unconditional, transfers reduced the likelihood of young people repeating a school grade. Both cash transfer options resulted in young people spending less time in paid employment	Robertson et al., 2013[21]; Fenton et al., 2016[22]
The HPTN068 intervention provided a conditional cash transfer of ZAR 100 for girls	Young women who received transfers were less likely to report having a partner in the past 12 months, physical IPV in the past 12 months (relative risk 0.66) or condomless sex in the past three months.	Pettifor et al., 2016[23]
Government grants in Malawi and South Africa on school attendance and performance.	Associated with higher odds of attending school, lower absenteeism and being in the correct grade Grant receipt was associated with a reduced 'educational risk' (based on poor attendance, incorrect grade for age, slow learner, struggling in school, missing more than a week	Sherr et al., 2017[24]

Poverty alleviating interventions	Outcomes	Reference
Combination of life kills and health education, vocational training, micro-grants and social support to life-skills	Reduced food insecurity, increased independent income, lowered the risk of transactional sex and increased the likelihood of using a condom with a current partner	Dunbar et al., 2014[25]
Program provided training and materials to improve agricultural practices and product marketing, home visits for psychosocial support and referral to social services to families affected by HIV	Positive trends over time in economic well-being and psychosocial functioning In comparison to national data, completion of primary school and entry into secondary school was also higher in the intervention group	Zuilkowski and Alon, 2015[26]
Combined cash transfer, income generation and empowerment programme that aimed to reduce poverty among orphans and vulnerable children in OVC headed households.	Exposure to the programme improved financial status, access to essential medical care, food security, safe water access, literacy and completion of eight years in education. I Reduced the number of sexual partners in the last year and increased condom use at last sex for females but not for males.	Goodman et al., 2014[27]
Vocational training programme consisting of apprenticeships with local artisans	The intervention group were more likely to be employed and report better quality of life, greater increases in social support and fewer delinquent act	Rotheram-Borus et al., 2012[28]
Empower adolescent girls through the simultaneous provision of life skills to build knowledge and reduce sexual risk behaviours, and vocational training enabling girls to establish small-scale enterprise	AGYW in the intervention group were more likely to be engaged in income-generating activities, report safer sexual behaviour knowledge and practices, and report higher indices of gender empowerment. There was a near elimination of reports of having sex unwillingly	Bandiera et al., 2012[29]
Child-focused state cash transfer grant.	Grant was associated with a reduction in transactional and age-disparate sexual relationships among girls	Cluver et al., 2013[30]

Poverty alleviating interventions	Outcomes	Reference
14 different social protection grants	Child-focused grants, free schooling, school feeding, teacher support and parental monitoring were independently associated with reduced HIV-risk behaviour. Grant receipt was associated with lower reported economic sex (transactional and age disparate), higher-risk sex and pregnancy among girls	Cluver et al., 2016[31]

Gender transformative and stigma alleviation interventions	Outcomes	Reference
Steppingstones	• Intervention demonstrated a 33% reduction in HSV-2 incidence in women and men • Among men, the intervention reduced reported IPV perpetration, sexual risk behaviours, engagement in transaction sex, problem drinking, drug misuse initiation and depression	Jewkes et al., 2008[32]
Steppingstones was combined with the economic empowerment intervention (Creating Futures)	• The intervention resulted in a 38% reduction in women's experience of physical and sexual IPV • Increased earnings for women and men, improved gender attitudes among women and men, and reduced reported controlling behaviours by men in their relationships. • Increase in HIV testing behaviour • Reduction in reported symptoms of depression and suicidal ideation among men, • Reduction in alcohol and alcohol-related conflict among women	Jewkes et al., 2014[33]
Multi-component, school-based HIV prevention intervention that provided an educational programme, a school health service and a school safety programme that aimed to reduce IPV (PREPARE)	• The intervention reduced IPV victimization by 30% b	Mathews et al., 2016[34]
Life-skills education combined with empowerment, de-escalation and self-defence training	• Incidence of sexual assault reduced by 60% • Disclosure of sexual assault also increased significantly	Sarnquist et al., 2014[35]
Empowerment-based, two-session HIV intervention designed to address alcohol and other drug use risks, IPV, sexual risk behaviours and gender inequality among underserved women using drugs - Women's Health Coops (WHC)	• Intervention in Cape resulted in a 54% reduction in drug use	Wechsberg et al., 2013[36]
Three-components program – a youth programme to improve knowledge and skills for in-school and out-of-school youth; a parents and community stakeholder to improve knowledge and communication skills; and a training programme for nurses and other staff working in rural clinics	• Positively impacted on women's attitudes to relationship control and gender empowerment • Women in the intervention were less likely to report ever being pregnant	Cowan et al., 2010[37]
Sports-based intervention aiming to empower young women by providing opportunities to develop 'important transferable life skills', including psychosocial and interpersonal skills, and psychological constructs such as confidence and self-efficacy.	• The duration in the intervention improved outcomes related to female empowerment perceived life skills, social life, insights about HIV and leadership skills	Woodcock et al., 2012[38]

Gender transformative and stigma alleviation interventions	Outcomes	Reference
National multimedia campaign which aimed to shift social norms about cross-generational sex.	• The campaign increased discussion about cross-generational sex and willingness to intervene to challenge such • Women who had been exposed to the campaign were less likely to be involved in cross-generational relationships with increasing exposure.	Kaufman et al., 2013a[39]

Another comprehensive review of interventions targeting AGYW on the impact of HIV prevention was conducted by the Human Science Research Council[40] and it reached similar conclusions .

For both reviews, it is clear that while there is strong evidence for social structural drivers, the pathways for outcomes are not consistent, and that in most instances the Theory of Change (TOC) is not paramount in the design. For example, biomedical results of structural interventions rely on self-reported behavioural outcomes; gains from conditional incentives are lost when incentives stop. Moreover, several interventions are being implemented in different countries in Eastern and Southern Africa.

Funding Social Structural Interventions

The resource demands of the global HIV response have called for integrating interventions that deal with the broader health system to tackle the structural drivers of HIV. The caveat is that structural interventions have been recognized as benefiting multiple sectors, thus necessitating that the funding burden for such interventions be distributed among beneficiary sectors. Nonetheless, established frameworks for modelling HIV outcomes and cost-effectiveness have not made the required adjustments, given that they continue to apply cost effectiveness criteria related to single outcomes.

In light of this, STRIVE researchers and health economists have proposed a new analytic approach with a mechanism to share financing amongst sectors for interventions that yield multiple benefits[41 42]. The idea is that if an intervention (e.g., cash transfers to keep girls in school) leads to benefits like reductions in school dropout, teen pregnancy, early marriage, and HSV2 risk, such an intervention should be prioritized, and each sector would make commensurate contributions using an agreed allocation formula.

One of the challenges of financing/ co-financing structural drivers for HIV is that there has been a limitation of models that incorporate interventions that have multi-sectoral benefits. The HIV response has greatly benefited from donor and government funding based on resource allocation models that do not value non-HIV transmission interventions. This, however, does not negate the fact that the South African government's funding is committed to structural interventions that eventually impact on young people through multi-sectoral national budgets. For example, the National Youth Development Agency (NYDA) runs a Grant Programme designed to provide young entrepreneurs with an opportunity to access both financial and non-financial business development support in order to enable them to establish or grow their businesses[43]. A co-financing model for HIV that recognizes the outcomes/ benefits of NYDA-like programs will enable the country to benefit from interventions implemented by other sectors.

Implementation Frameworks for Public Health

Most change that is introduced in primary care takes the form of complex interventions. The concept of structural interventions as one of the components to mitigate HIV, TB and HIV is a case in point. The need for context-specific, and lately, patient-centred approaches means that population health managers need to be clear on how to implement evidence-based interventions

in a manner that promotes rather than hinder the implementation processes. This calls for bridging the gap between evidence and the contextual practice, or the deployment of interventions in the real world. Implementation Frameworks (IFs) provide guidance on how evidence-based interventions can be successfully executed. Implementation frameworks also provide guidance to stakeholders with practical approaches for planning, executing, and evaluating real-world implementation efforts.

There are several IFs for which guidance has been written. These include the Exploration, Preparation, Implementation, Sustainment (EPIS) framework[44]; the Consolidated Framework for Implementation Research (CFIR)[45]; Theoretical Domains Framework (TDF)[46], RE-AIM[47] and combined frameworks[48]. Moullin et al 2020 argue that IFs should be used prior to and throughout an implementation effort, including when considering implementation science research. They make ten recommendations for using IFs for practice and research[49]. The key considerations include the following:

- Select a suitable framework
- Establish and maintain community stakeholder engagement and partnerships
- Define issues and develop hypotheses and evaluation questions (learning agenda)
- Develop implementation program theory or logic model
- Determine overall information management methods (overall design, data collection, data analysis)
- Determine both key barriers to, and enablers of, implementation
- Select and tailor develop implementation strategies
- Specify implementation outcomes and evaluate implementation
- Use a framework(s) at micro level to conduct and tailor implementation

In Summary

There is a significant and growing body of literature on social structural interventions to mitigate HIV among adolescents and young people. The SAG addressed this approach in the now-ended NSP 2017-2022. A key aspect of the structural interventions is the need to use a multi-sectoral approach to design, plan, fund, and monitor the implementation. The process should include a clear definition of the underlying TOC for each intervention in order to ensure that the combined package of services is responsive to the individual and communities, and that it can be evaluated. By using objective, yet pragmatic, implementation frameworks for the NSP 2023-2028, the SAG and the districts will be able to generate more evidence on the multiple health and social outcomes that will be unveiled from the multisectoral implementation (and co-financing) of different service packages at individual and population levels.

Social Structural Interventions "Refocusing Upstream"

The impact of social structural interventions has been illustrated by the Parable of Zola to demonstrate the need to refocus highest impact interventions[50]. The parable depicts an emergency rescue at a river attempting to save a drowning man. However, he along with others, keep needing to be rescued again and again. Despite this repeated pattern, the emergency rescue team is too busy doing its job that it fails to investigate the reason people keep getting pushed from the upstream into the river. Focusing on what could stop people from falling into the river upstream would clearly be a more efficient and effective approach than continually rescuing them. The graphic below is an adaptation of one used by public health Districts in the Ontario province to explain Zola's parable using AGYW upstream-downstream issues[51].

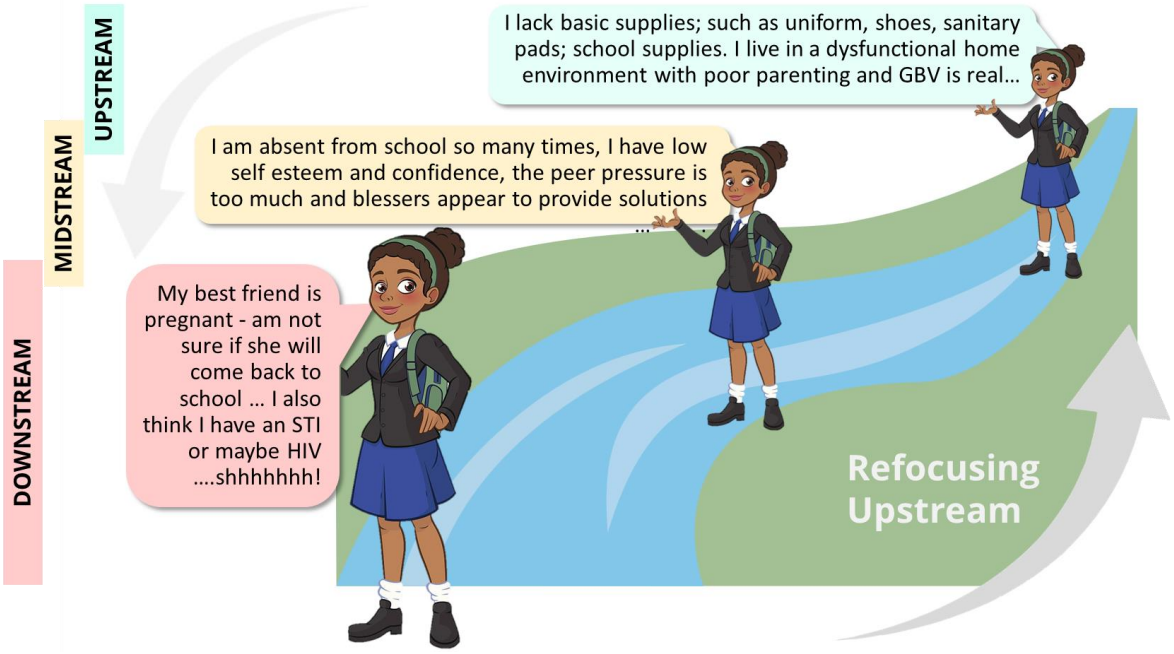

Figure 1 Upstream – Downstream Issues for AGYWs in South Africa

Downstream interventions (that target illness directly) will strive to change the effects of ill health by screening and treating an illness. The bulk of health care expenditure goes towards biomedical activities, including improving access equity and quality of services. This is followed by mid-stream interventions that focus on promoting changing behaviour and these occur at local, community and organizational level with the goal of mitigating the actual cause of the illness. Conversely, upstream interventions create positive environments that impact both midstream and downstream conditions and interventions by focusing on factors that increase the risk of illness.

Upstream interventions can be generated through policies that impact systems through broad-based initiatives with multisectoral benefits. While structural interventions can be challenging to assess, due to the complexity in pathways and links to direct health outcomes, they often have a long-term yield[52]. Consequently, the impact of such interventions is the focus of the SDG strategy and South Africa's National Development Goals 2030[53] [54]. It calls for deliberate improvement in multi-sectoral collaboration, as well as private and community partnerships to use evidence-based implementation and financing frameworks to improve health outcomes.

3 Theory of Change

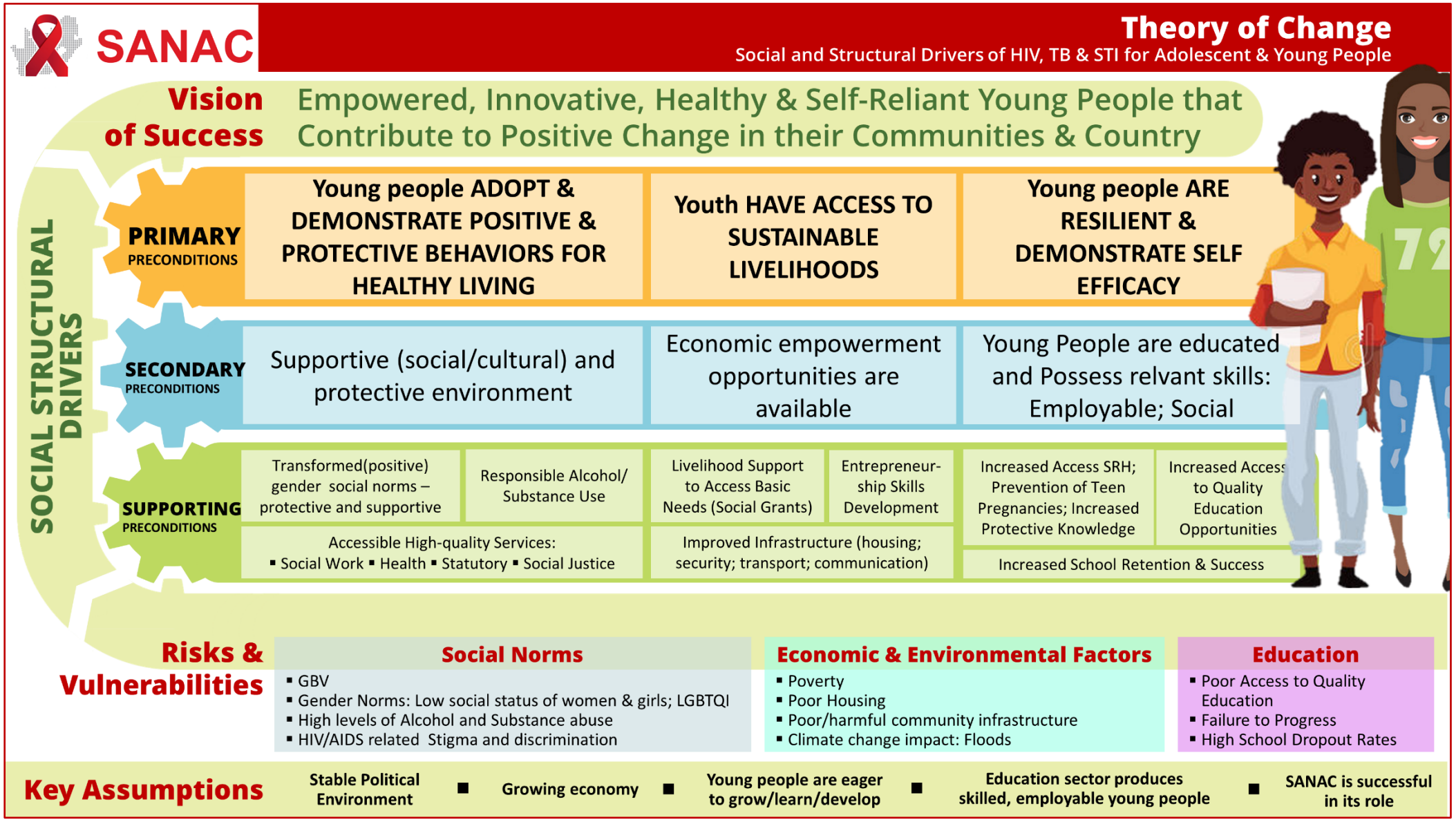

Figure 2 Theory of Change

In addressing social structural drivers, the ultimate vision is that young people in South Africa are **empowered, innovative, healthy, self-reliant, and that they can contribute to positive change in their communities and country.**

To achieve this, there are three fundamental (primary) preconditions that must be met. Firstly, that young people adopt and demonstrate positive, protective behaviours for healthy living; secondly, that youth have access to sustainable livelihoods, and thirdly, that young people are resilient and demonstrate self-efficacy

These pre-conditions are realizable when the following secondary preconditions are achieved; 1. Supportive (social/cultural) and protective environment; 2. Economic empowerment opportunities are available and 3. Young people are educated and possess marketable skills, including being employable and having desirable social skills.

Several supporting preconditions are necessary to bring about these results. These include transformed (positive) gender social norms – protective and supportive; responsible alcohol/ substance use; accessible high-quality services, including social work, health, statutory services, and social justice. Supporting preconditions for addressing the economic strengthening of youth include livelihood support to access basic needs through Social Grants; entrepreneurship skills development and investments in improved infrastructure, including housing; security; transport and communication. To achieve desired educational outcomes, the following supporting preconditions are essential; increased access to quality education opportunities; increased access to sexual and reproductive health services that enable prevention of teen pregnancies and increased protective knowledge among youth, and increased retention and success in school. It should be noted that these preconditions may contribute to multiple secondary preconditions that, together, generate the results sought at higher levels of the TOC.

The TOC consists of context-specific assumptions representing factors that must exist for the supporting, secondary and primary preconditions to occur. Assumptions can be considered as external factors or risks that influence change. Some of the key assumptions underpinning this Theory of Change include the following:

- That the overall political environment in the country will remain stable and conducive for sustainable development.
- That the economy of South Africa continues to grow and makes it possible for national, provincial and local governments to continue investments in youth development as well as in more jobs and viable entrepreneurial opportunities created by government, the private sector, and civil society.
- That young people recruited into programs are keen to develop themselves and take full advantage of opportunities availed to them.
- That the education sector is transformed towards results-orientated systems that produce employable youth with marketable skills based on the current needs in the country.
- That SANAC is successful in its role of effective multi-sectoral engagements and coordination to mobilize support for, and investments in, implementation of interventions towards the preconditions and vision reflected in the TOC.

4 Service Packages of Social Structural (SS) Interventions

Guided by the evidence of successful structural interventions in table 1 and based on the current needs and scope of AGYW in South Africa, the following package of social structural services is proposed. The interventions are organised according to the objectives and sub-objectives related to the TOC for social structural drivers.

Table 2: Goal, Objectives, Key Social Structural Interventions

Goal: To target and address the upstream underlying causes of social structural drivers of HIV, TB and STI epidemics to mitigate risk of acquiring infections among adolescents and young people in South Africa

KEY INTERVENTION AREA: EDUCATION **Objective 1**-Improve school attendance enrolment, completion and education attainment for adolescents and young people	
INTERVENTIONS	**KEY STAKEHOLDERS**
Sub-Objective 1.1 - improve access to essential needs to enable regular attendance of school by learners	
1. Conditional and un-conditional cash transfers (caregivers, beneficiaries;)	SAG - DSD/ SASSA; Funding Agencies
2. Pay for school tuition/ fees for vulnerable learners	SAG – DHE (NFSAS); SETAS; Government department bursaries; Private sector – Learner bursaries
3. Pay for school-related supplies e.g., uniforms, stationery	SAG – DSD/SASSA; Private sector – CSI programs; NGOs; FBOs
4. School transport for learners in remote areas	SAG –DBE/ DT; Private sector
5. Deploy education outreach workers to monitor and resolve school absenteeism and other problems	SAG – DSD/SASSA; DBE; NGOs/FBOs; Funding Agencies
6. Sanitary supplies for AGYW	SAG – DWYD/DSD/DBE; Private sector; Funding Agencies; NGOs/FBOs
Sub-Objective 1.2 - Improve the comprehensiveness and quality of services provided in schools to support learners' educational attainment	
7. School feeding programs	SAG – DBE; Funding Agencies; NGOs – FBOs; Private sector
8. Psychosocial counselling for learners	SAG – ISHP; Funding Agencies; NGOs/FBOs
9. Recreation activities for learners	SAG –DBE/DSR/Sports arts & culture sector (SANAC); NGOs/ FBOs; Private sector
10. HIV prevention and SRH education for AYP (In-school and out of schools)	SAG – DBE; DSD; DHE (Higher Health); Funding Agencies; NGOS/FBOS
11. Education on finance, asset building, and future planning	Private sector; Funding Agencies; NGOs/FBOs
12. Peer mentorship sessions	SAG – DBE; Funding Agencies
13. Renovate or build school infrastructure in underserved populations	SAG – DPWs/ COGTA/ DWS/DBE; Private sector; Funding Agencies; NGOs/FBOs
KEY INTERVENTION AREA: POVERTY **Objective 2:** Mitigate impact of poverty on increasing HIV risk among AYP	
INTERVENTIONS	**KEY STAKEHOLDERS**
Sub Objective 2.1 - Expand access to skills development opportunities by AYP including marketable artisan and entrepreneurship skills	
1. Targeted and relevant vocational training and/ or apprenticeships	SAG – DHET (TVET and training colleges; SETAs); DBE; DSD; Private sector – Training colleges
2. Training on targeted small-scale enterprise management and marketing	SAG - NYDA/DSME/DTI/COGTA/DAFF/NDA DoST/Rural development/DoLE; Funding agencies; NGOs/ FBOs; Private sector

3. Life skills training with an emphasis on career guidance	SAG –DBE/DSD/; Funding agencies and NGOs/FBOs; private sector
Sub-Objective 2.2 - Improved access to funding and support for entrepreneurship development	
4. Procurement of supplies and materials for small-scale enterprises	SAG - NYDA/DSME/DTI/COGTA/DAFF/ DoST/Rural development/DoLE; Funding agencies and NGOs/FBOs; Private sector
5. Direct micro-finance grants	SAG – NYDA/DSME/DTI/COGTA/DAF/ NEF; Private sector (Grants & loans); Funding agencies
Sub Objective 2.3 - Provide linkages and support to access livelihoods through employment opportunities, social assistance, and improved infrastructure	
6. Social protection grants and food	SAG –DSD/SASSA/DAFF; Funding agencies - WFP; NGOs/FBOs; Private sector
7. Youth employment initiative(s)	SAG –NYDA/DIC/ Dept of Science and innovation; Provincial & LG youth economic initiatives; Public Private Partnerships e.g., YES4YOUTH/ Harambee; Private sector; NGOs/FBOs
8. Affordable housing and public transport to access services and work	SAG – DHS/DT/DCDT
KEY INTERVENTION AREA: GENDER NORMS AND STIGMA **Objective 3** -Transform gender norms that encourage gender-based violence and stigmatization of women and non-gender conforming key populations	
INTERVENTIONS	**KEY STAKEHOLDERS**
Sub-objective 3.1 - community engagement towards transformed social norms that are supportive and protective of women and other vulnerable populations	
1. Structured training on gender inequality, relationship skills, communication and HIV prevention for AGYW, educators and/ or community leaders (as change agents)	SAG – DWYD/DSD/COGTA; Funding agencies; AYP change agents; NGOs/FBOs
2. Elicit the voice of AYP on negative gender norms and stigma-increasing risk to HIV/TB including advocacy against negative norms	Parastatal –STATSSA; HSRC; Advocacy groups and campaigns; NGOs/ FBOs; Maiden schools
3. Use workshops, support groups, and SBCC tools to engage community, community leadership, and the private sector on understanding prevailing restrictive gender norms, practices, and mitigating strategies	SAG – COGTA (House of traditional leaders); Parastatal – CDA; Premier's offices (Office on the status of Women); Religious leaders, School governing bodies and PTAs; NGOs/FBOs; Advocacy groups and campaigns
4. School-based training for ABYM on attitudes and behaviour related to IPV and healthy relationships	SAG – ISHIP; Funding agencies; CBOs/NGOs
Sub-objective 3.2 - increase access to safe spaces to mitigate risk of GBV and effectively respond to the needs of survivors	
5. Generate geospatial data on GBV hotspots and responses	SAG – DSD (National GBV command centre)/ DWYD/ Justice cluster; Parastatals - STATSSA; HSRC; MRC; NGOs/ FBOs
6. Effective community policing and security to address risks in vulnerable communities	SAG- SAPs / SANDF; community policing forums
7. Social support for post-violence care and management of child-protection registers	SAG – Justice cluster; Social cluster; NGOs/FBOs
8. Create safe spaces for AYP that are at risk or who have suffered violence	SAG – DSD (BEP)/DOH; Funding agencies; NGOS/FBOs
9. Health worker initiated and self-reported screening & follow-up for intimate partner violence	SAG –DOH; Funding agencies; NGOs/FBOs
Sub-objective 3.3 - mainstream gender-responsive planning and coordination of programs across sectors	
10. Adopt gender-responsive planning tools in key departments/ sectors to identify barriers and develop strategies to address them	SAG – DWYD/DSD/COGTA/ DBE/ DPME; Funding agencies – UN agencies

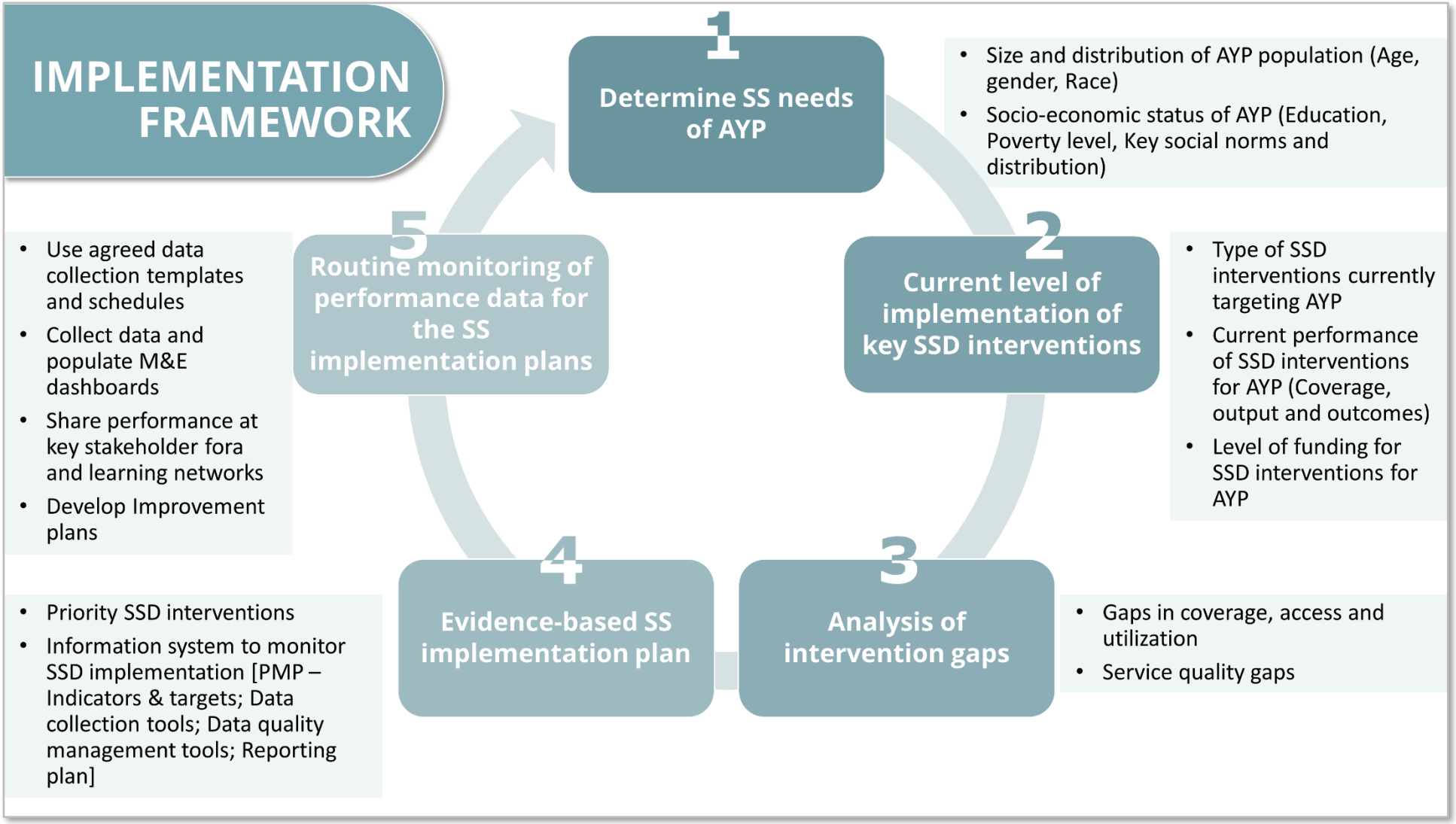

Figure 3 **Implementation Framework**

5 Implementation Framework

We propose the pragmatic use of the RE-AIM implementation framework to guide the planning, execution, and evaluation of social structural interventions/ strategies. The pragmatic approach involves use of a familiar set of "who, what, when, where, how, and why" questions based on the RE-AIM framework. In summary the implementation

framework is illustrated as a cycle in Figure 3. Below are the details of each step, including included the recommended approach.

1 Determining SS Needs of AYP [WHO]:

- Size and distribution of AYP population (Age, gender, Race)
- Socio-economic status of AYP (Education, Poverty level, Key social norms and distribution)
- HIV and TB Prevalence and deaths among AYP

"Status Report on SS Needs of AYP"

The Approach here would include:

- Using secondary data from Statistics SA on AYP population demographics including age, gender, race and social economic status
- WAZI maps (wazimap.co.za) which use Stats SA community survey show data at ward level are extremely useful for information on AYP social economic status. See Figure 4
- This data should be secured across all wards in all districts across the country in order to inform planning
- HIV and TB prevalence and deaths data are available in DHIS and TIER.net

2 Determining Current Level of Implementation of Key SSD Interventions [WHAT, WHERE & WHEN]:

- Type of SSD interventions currently targeting AYP
- Level of funding for SSD interventions for AYP
- Current performance of SSD interventions for AYP (Coverage, output and outcomes)

Recommended Methods Include:

- Using available secondary data from implementing departments/ agencies/institutions to determine current coverage by type of services provided
  - Secondary data gathered from all key stakeholders delivering SSD interventions
  - Key informant interviews may be useful to get more insights on context, issues, and challenges
  - Funding available for those services (cash and in-kind support)
- Community Resource Mapping with AYP
  - This activity enables involvement of AYP in providing feedback on the services – what is available, rating of quality of those services, what is missing.

3. Gap Analysis and Development Evidence-based SS Implementation Plans [HOW AND WHY]:

- Gaps in coverage, access, utilization and Service quality
- Priority SSD interventions needed
- Information system to monitor SSD implementation [PMP – Indicators & targets; Data collection tools; Data quality management tools; Reporting plan]

Approach:

- Workshop with key stakeholders in the district
- Present findings from the needs, current delivery, and gap analysis
- Engagement to identify conduct root cause analysis and agree on priorities (by type of intervention; location; priority/key population)
- Documenting key assumptions and considerations specific to the district
- Engagement and agreement on the performance monitoring framework and input into the districts implementation plan and annual performance plans (APPs)
- This workshop may require three (3) days to cover all the items and to produce required outputs

4 Routine Monitoring of Performance Data for the SS Implementation Plans [WHY]:

- Use agreed data collection templates and schedules
- Collect data and populate M&E dashboards
- Share performance at key stakeholder fora and learning networks
- Develop Improvement plans

Approach:

- DAC/PAC complete NSP dashboards - (Quarterly)
- Districts conduct bi-annual "pause learn" sessions with key stakeholders (1-2 Day session)
- PAC conducts annual NSP learning workshops with district teams (2-Day district workshop at end of year)
- Districts update APPs with improvement plans
- Annual performance monitoring based on APPs by departments

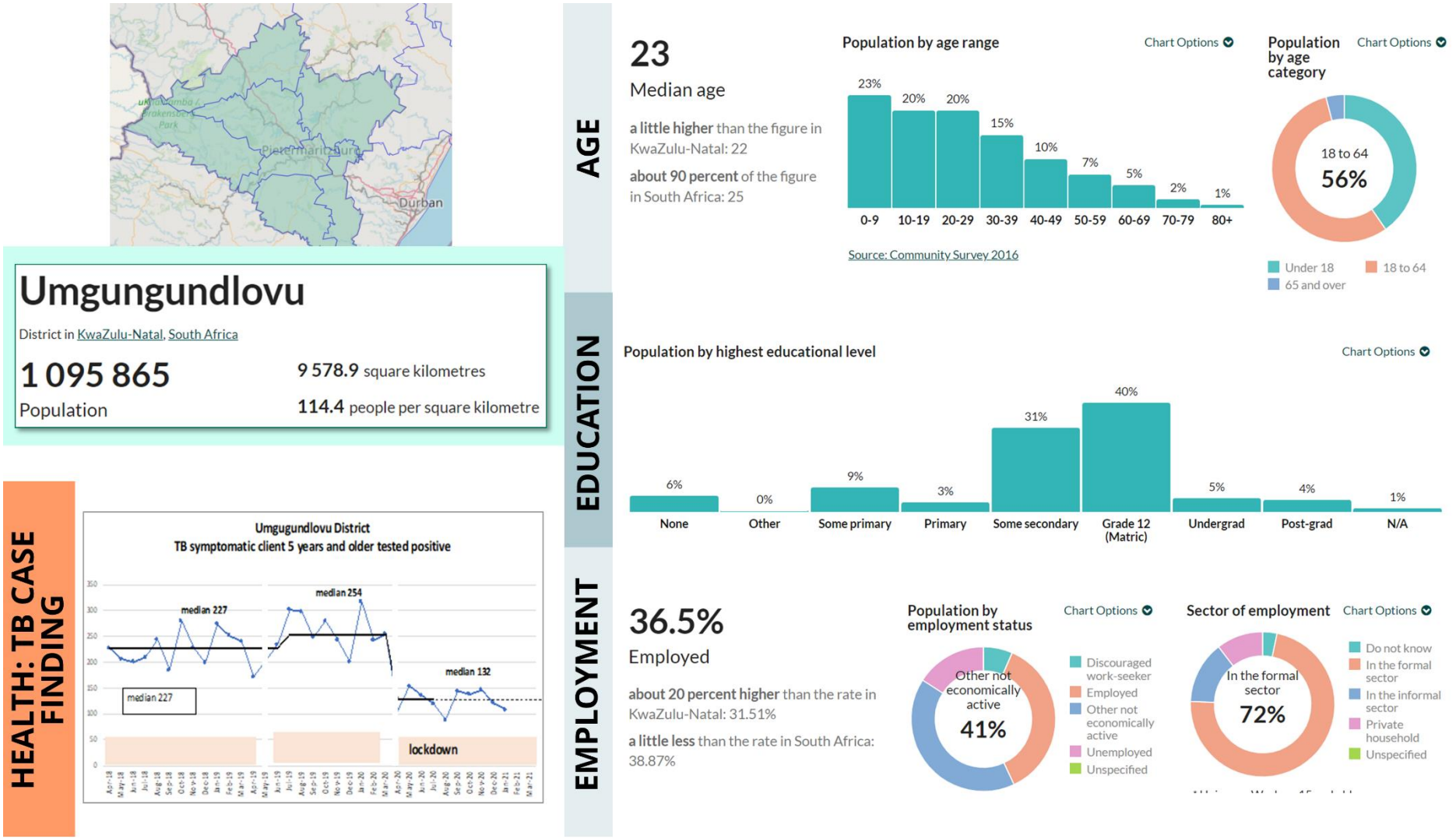

Figure 4 **Example of Use of Secondary Data: uMgungundlovu Statistics on Heath, Poverty and Employment**[1]

[1] Source: https://wazimap.co.za/profiles/district-DC22-umgungundlovu/#education; Accessed 26 Aug 2022

6 Monitoring and Evaluation Framework

The table below includes Key illustrative indicators for measuring progress towards achievement of results reflected in the TOC for social structural drivers. The matrix includes the associated result area, data sources, and suggested lead entity that would be responsible for reporting on the indicator.

Table 3: Monitoring and Evaluation Framework

Result	*Type*	*Indicator*	*Data Disaggregation*	*Data Sources*	*Frequency*	*Lead Entity*
Empowered, Innovative, Healthy & Self-Reliant Young People that Contribute to Positive Change in their Communities & Country	Impact	HIV incidence rates among AYP	gender; age-group, disability status, district, and province	Thembisa Model	Annual	SANAC
		HIV Prevalence rates		Thembisa Model	Annual	SANAC
		HIV related deaths among AYP		TIER.net DHIS	Annual	DOH
		TB related deaths among AYP		TIER.net DHIS	Annual	DOH
Young people adopt and demonstrate positive and protective behaviours for healthy living	Outcome	Proportion of young people demonstrating positive and protective behaviours for healthy living	gender; age-group, disability status, district, and province	HSRC Behavioural sentinel survey	Bi-annual	HSRC
Youth have access to sustainable livelihoods	Outcome	Proportion of young people with sustainable livelihoods	gender; age-group, disability status, district, and province	Stats SA General household Survey	Annual	Stats SA
Young people are resilient and demonstrate self-efficacy	Outcome	Proportion of young people demonstrating resilience and self-efficacy	gender; age-group, disability status, district, and province	HSRC Behavioural sentinel survey	Bi-annual	HSRC
Supportive (social/cultural) and protective environment	Outcome	Number of Communities/ wards where young people report feeling safe and can access required support	gender; age-group, disability status, district, and province	Stats SA General household Survey CRM activities	Annual Annual	Stats SA SANAC
Young people possess marketable skills: employable and social	Outcome	Percentage of young people with marketable/employable skills	gender; age-group, disability status, district, and province	Stats SA General household Survey	Annual	Stats SA
Jobs and viable entrepreneurial opportunities are available to youth in communities across the country;	Outcome	Youth employment rates	gender; age-group, disability status, district, and province	Stats SA General household Survey	Annual	Stats SA

Result	Type	Indicator	Data Disaggregation	Data Sources	Frequency	Lead Entity
Improved Infrastructure (housing; security; transport; communication)	Intermediate outcome	Percentage of youth reporting access to secure housing	gender; age-group, disability status, district, and province	Stats SA General household Survey	Annual	Stats SA
Transformed(positive) gender social norms – protective and supportive	Intermediate outcome	GBV prevalence rates	gender; age-group, disability status, district, and province	GBV command Centre	Annual	DSD
Responsible Alcohol/ Substance Use	Intermediate outcome	Prevalence of substance and alcohol abuse among youth	gender; age-group, disability status, district, and province	MRC data	Annual	CDA
Access to Social Justice	Intermediate outcome	Successful prosecution rates of GBV cases	Victims' Gender, age-group and disability status; district, and province; type of crime	IJS/ NPA-Data	Annual	NPA
Livelihood Support to Access Basic Needs (Social Grants)	Intermediate outcome	Number of vulnerable youth accessing government social grants	gender; age-group, disability status, district, and province	SOCPEN	Annual	DSD-SASSA
Increased Access SRH; Prevention of Teen Pregnancies; Increased Protective Knowledge	Intermediate outcome	Teenage pregnancy rates	disability status, district, and province	DBE-EMIS	Annual	DBE
Increased Access to Quality Education Opportunities	Intermediate outcome	School graduation/ matriculation rates	gender; age-group, disability status, district, and province	DBE-EMIS	Annual	DBE
Increased School Retention & Success	Intermediate outcome	Secondary School retention rates	gender; age-group, disability status, district, and province	DBE-EMIS	Annual	DBE
	Intermediate outcome	School Absenteeism rates		DBE-EMIS	Annual	DBE
Increased support to ensure regular school attendance	Output	Proportion of vulnerable learners accessing scholar transport	gender; age-group, disability status, district, and province	Dept of Transport (DT) Data	Annual	DT
	Output	Proportion of vulnerable learners provided with school supplies (uniforms, books; shoes)		DSD databases DBE databased NPO data	Annual	DBE And DSD
	Output	Proportion of vulnerable AGYW provided with sanitary pads	disability status, district, and province	DWYD data NPO data	Annual	DWYD DSD

Result	Type	Indicator	Data Disaggregation	Data Sources	Frequency	Lead Entity
Referral and linkages of young people to opportunities	Output	Number of young people that are successfully linked to jobs and or supported entrepreneurial activities	gender; age-group, disability status, district, and province)	NYDA database NPO data	Annual	NYDA
	Output	Number of youth benefiting from Youth Employment services initiatives		NYDA database NPO data	Annual	NYDA
Availability and access to various skills development programs by youth across South Africa	Output	Number of young people provided with vocational skills development support (training and or apprenticeships)	gender; age-group, disability status, district, and province)	NYDA data DHET data	Annual	NYDA and DHET
Young people actively participate in information gathering and sharing related to pertinent issues in their communities related to social norms and	Output	Number of wards where young people actively contribute to information gathering and sharing related to social norms	sub-district/ district/ province	DSD Youth Development Database	Annual	DSD
Youth are capacitated in key areas such self-mastery, leadership and Asset Based Community Development	Output	Number of structures where young people are active participants in leadership	Ward/sub-districts/ districts/ Province	DSD Youth Development Database	Annual	DSD
	Output	Number of youth leaders participating youth camps for leadership development	gender; age-group, disability status, district, and province	DSD Youth Development Database	Annual	DSD
School-based training for ABYM on attitudes and behaviour related to IPV and healthy relationships	Output	Number of ABYM reached with school-based training on attitudes and behaviours related to IPV and healthy relationships	age-group, disability status, district, and province	Integrated School Health Program database	Quarterly	DBE
Social support for post-violence care and management of child-protection registers	Output	Number of clients receiving care at Thuthuzela centres	gender; age-group, disability status, district, and province	TTC databases	Quarterly	DSD
Use workshops, support groups, and SBCC tools to engage community, community leadership and the private sector on understanding prevailing restrictive gender norms, practices and mitigating strategies	Output	Number of wards where community engagement on gender norms, practices and mitigation strategies are conducted	sub-district/ district/ province	COGTA databases	Annually	COGTA
Adopt gender-responsive planning tools in key departments/ sectors to identify barriers and develop strategies to address them	Output	Number of government departments and institutions using gender responsive planning tools in program design and improvement	Sector	DPME database	Annually	DPME

7 Costing Framework

To aid the development of a comprehensive costing model, the table below illustrates current approved budget votes for key interventions under different government departments.

Table 4: Approved Budget Votes by the South African Government -2022-2023 for Key Social Structural Interventions

KEY INTERVENTION AREA: EDUCATION. OBJECTIVE 1: Improve school attendance enrolment, completion and education attainment for adolescents and young people		
INTERVENTIONS	**KEY STAKEHOLDERS**	**2022/2023 APPROVED SAG BUDGET VOTES**
Sub-Objective 1.1- improve access to essential needs to enable regular attendance of school by learners		
1. Conditional and un-conditional cash transfers (Caregivers, beneficiaries;)	SAG - DSD/ SASSA; Funding Agencies	DSD/ SASSA
2. Pay for school tuition/ fees for vulnerable learners	SAG – DHE (NFSAS); SETAS; Government department bursaries; Private sector – Learner bursaries	DHE (NFSAS)
3. Pay for school-related supplies e.g., uniforms, stationery	SAG – DSD/SASSA; Private sector – CSI programs; NGOs; FBOs	DBE and DSD
4. School transport for learners in remote areas	SAG –DBE/ DT; Private sector	Dept of Transport
5. Deploy education outreach workers to monitor and resolve school absenteeism and other problems	SAG – DSD/SASSA; DBE; NGOs/FBOs; Funding Agencies	DBE
6. Sanitary supplies for AGYW	SAG – DWYD/DSD/DBE; Private sector; Funding Agencies; NGOs/FBOs	DWYD and DSD
Sub-Objective 1.2 - Improve the comprehensiveness and quality of services provided in schools to support learners' educational attainment		
7. School feeding programs	SAG – DBE; Funding Agencies; NGOs – FBOs; Private sector	DBE
8. Psychosocial counselling for learners	SAG – ISHP; Funding Agencies; NGOs/FBOs	ISHP- DBE/DOH/DSD
9. Recreation activities for learners	SAG –DBE/DSAC/Sports arts & culture sector (SANAC); NGOs/ FBOs; Private sector	Dept of sports, Arts and Culture
10. HIV prevention and SRH education for AYP (In-school and out of schools)	SAG – DBE; DOH; DSD; DHE (Higher Health); Funding Agencies; NGOS/FBOS	ISHP- DBE/DOH/DSD DHE-Higher health
11. Education on finance, asset building, and future planning	Private sector; NYDA; Funding Agencies; NGOs/FBOs	NYDA
12. Peer mentorship sessions	SAG – DBE; Funding Agencies	NYDA
13. Renovate or build school infrastructure in underserved populations	SAG – DPWs/ COGTA/ DWS/DBE; Private sector; Funding Agencies; NGOs/FBOs	DBE and DHET

KEY INTERVENTION AREA: POVERTY. OBJECTIVE 2: Mitigate impact of poverty on increasing HIV risk among AYP		
INTERVENTIONS	**KEY STAKEHOLDERS**	**2022/2023 APPROVED SAG BUDGET VOTES**
Sub Objective 2.1 - Expand access to skills development opportunities by AYP including marketable artisan and entrepreneurship skills		
1. Targeted and relevant vocational training and or apprenticeships	SAG – DHET (TVET and training colleges; SETAs); DBE; DSD; Private sector – Training colleges	DHET
2. Training on targeted small-scale enterprise management and marketing	SAG - NYDA/DSME/DTI/COGTA/DAFF/NDA DoST/Rural development/DoLE; Funding agencies; NGOs/ FBOs; Private sector	DSME, NYDA, DTI
3. Life skills training with an emphasis on career guidance	SAG –DBE/DSD/; Funding agencies and NGOs/FBOs; private sector	DBE and DSD
Sub-Objective 2.2 Improved access to funding and support for entrepreneurship development		
4. Procurement of supplies and materials for small-scale enterprises	SAG - NYDA/DSME/DTI/COGTA/DAFF/ DoST/Rural development/DoLE; Funding agencies and NGOs/FBOs; Private sector	NYDA, DSME, DTI
5. Direct micro-finance grants	SAG – NYDA/DSME/DTI/COGTA/DAF/ NEF; Private sector (Grants & loans); Funding agencies	NYDA, DSME, DTI
Sub Objective 2.3 - Provide linkages and support to access livelihoods through employment opportunities, social assistance, and improved infrastructure		
6. Social protection grants and food	SAG –DSD/SASSA/DAFF; Funding agencies - WFP; NGOs/FBOs; Private sector	DSD/SASSA DAFF
7. Youth employment initiative(s)	SAG –NYDA/DIC/ Provincial & LG youth economic initiatives; Public Private Partnerships e.g., YES4YOUTH/ Harambee; Private sector; NGOs/FBOs	NYDA, DSME, DTI Dept of Science and innovation
8. Affordable housing and public transport to access services and work	SAG – DHS/DT/Dept of Communication and Digital Tech (DCDT)	Dept of Human Settlement Dept of Transport DCDT

KEY INTERVENTION AREA: GENDER NORMS AND STIGMA. OBJECTIVE 3: Transform gender norms that encourage gender-based violence and stigmatization of women and non-gender conforming key populations		
INTERVENTIONS	**KEY STAKEHOLDERS**	**2022/2023 APPROVED SAG BUDGET VOTES**
Sub-objective3.1 community engagement towards transformed social norms that are supportive and protective of women and other vulnerable populations		
1. Structured training on gender inequality, relationship skills, communication and HIV prevention for AGYW, educators and or community leaders (as change agents)	SAG – DWYD/DSD/COGTA; Funding agencies; AYP change agents; NGOs/FBOs	DWYD COGTA
2. Elicit the voice of AYP on negative gender norms and stigma increasing risk to HIV/TB including advocacy against negative norms	Parastatal –DSD; DWYD; STATSSA; HSRC; Advocacy groups and campaigns; NGOs/ FBOs; Maiden schools	DSD DWYD
3. Use workshops, support groups, and SBCC tools to engage community, community leadership and the private sector on understanding prevailing restrictive gender norms, practices, and mitigating strategies	SAG – COGTA (House of traditional leaders); Parastatal – CDA; Premier's offices (Office on the status of Women); Religious leaders, School governing bodies and PTAs; NGOs/FBOs; Advocacy groups and campaigns	COGTA DWYD CDA DSD
4. School-based training for ABYM on attitudes and behaviour related to IPV and healthy relationships	SAG – ISHP; Funding agencies; CBOs/NGOs	ISHP- DBE/DOH/DSD
Sub-objective 3.2 increase access to safe spaces to mitigate risk of GBV and effectively respond to the needs of survivors		
5. Generate geospatial data on GBV hotspots and responses	SAG – DSD (National GBV command centre)/ DWYD/ Justice cluster; Parastatals - STATSSA; HSRC; MRC; NGOs/ FBOs	DSD SAPS
6. Effective community policing and security to address risks in vulnerable communities	SAG- SAPs / SANDF; community policing forums	SAPS SANDF
7. Social support for post-violence care and management of child-protection registers; Social justice for victims	SAG – Justice cluster; Social cluster; NGOs/FBOs	Justice Cluster Depts Social Cluster Depts
8. Create safe spaces for AYP that are at risk or who have suffered violence	SAG – DSD /DOH; Funding agencies; NGOS/FBOs	DSD DOH
9. Health worker initiated and self-reported screening & follow-up for intimate partner violence	SAG –DOH; Funding agencies; NGOs/FBOs	DOH
Sub-objective 3.3 mainstream gender-responsive planning and coordination of programs across sectors		
10. Adopt gender-responsive planning tools in key departments/ sectors to identify barriers and develop strategies to address them	SAG – DWYD/DSD/COGTA/ DBE/ DPME; Funding agencies – UN agencies	Social Cluster Depts Justice Cluster Dept Economic Cluster Dept

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