POWER, PEOPLE AND PROCESSES: A GENDER ANALYSIS OF ADOLESCENT HEALTH POLICY IN SOUTH AFRICA

Tanya Jacobs

A thesis submitted in fulfilment of the requirements
for the degree of Doctor of Philosophy
in the School of Public Health,
Faculty of Community and Health Sciences,
University of the Western Cape

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ABSTRACT

Background: The Sustainable Development Goals (SDGs) and the United Nations Global Strategy (2016-2030) emphasise that all women, children and adolescents 'survive, thrive and transform'. A key element of this global policy framework is that gender equality is both a standalone goal, as well as a cross-cutting priority. Gender power relations are both social and structural determinants of health and shape health policy content, processes and systems. There are critical gaps in knowledge in terms of how gender inequality, and its intersectionality with other axes of power, shape adolescents' health, as well as health policy and systems in South Africa.

Aim: The overall aim of the PhD research was to describe and analyse how gender inequality and its intersectionality with other axes of power, influence the interactions between policy content, actors, context and processes to construct adolescent health policy in South Africa.

Methodology: The research brought together fields of health policy and systems research (HPSR) and social sciences, drawing particularly from gender studies and critical policy studies. A macro-level, qualitative case study of adolescent health policy in South Africa was undertaken. Data included 15 policy documents, as well as in-depth interviews with a purposively selected sample of 30 adolescent and youth health actors from government, civil society and academia, conducted iteratively from 2019-2021. Data analysis was guided by relevant conceptual frameworks, the research question, as well inductive and deductive themes in the data. Qualitative data analysis methods included thematic content analysis and critical discourse analysis.

Findings: The research findings are presented in four chapters, which are also published, under review or submitted as articles in peer-reviewed academic journals. Firstly, this thesis presents a conceptual framework that brings together approaches to understanding context in health policy and systems research (HPSR) and the social determinants of health, to guide the understanding of the key contextual social and structural determinants of adolescent health in South Africa. A key finding is how current experiences and health of adolescents is shaped by past and present intersectional social and structural determinants and power relations, with apartheid inequalities still echoing in the lives of the adolescents, 27 years into democracy. The second 'Findings' chapter notes that only three South African policy documents have defined gender. Where gender is addressed, it was mostly in gender-sensitive and sometimes gender-specific ways, but rarely in gender-transformative ways. The discourse analysis

revealed that dominant and marginalised discourses reflect how gender is conceptualised as fixed, categorical identities, rather than as fluid social processes. This has implications for how rights and risks are understood. The discourses substantiate an overriding focus on adolescent girls, with no reference to the context of power relations in which they live; minimal attention is paid to boys in terms of their own health or through a gender lens, and there is little consideration of LGBTIQA+ adolescents beyond HIV. The third 'Findings' chapter documents how youth participation in the Adolescent and Youth Health Policy (AYHP) was enabled by leadership from certain government actors and the involvement of key academics with a foundation in long-standing youth research participatory programmes. When, how and which youth were involved remained a challenge, however, and youth participation was not consistent throughout the health policy formulation process. This is related to broader contextual challenges, including the lack of a representative and active youth citizenry; siloed health programmes and policy processes; segmented donor priorities; and the lack of institutional capability for multi-sectoral engagement required for youth health. The fourth chapter presents findings that describe an interrelated constellation of diverse and juxtaposed actor gender narratives, ranging from framing gender as equating girls and women; gender as inclusion; gender as instrumental; gender as women's rights and empowerment; and gender as power relations in the AYHP. Despite gender power relations and more gender-transformative approaches being discussed during the policy-making process, these were not reflected in the final policy. The way gender is framed in policy processes is shaped by actor narratives, and these diverse and contested discursive constructions were shaped by the dynamic interactions within the South African context, and processes of the AYHP.

Key threads across these 'Findings' chapters foreground the dynamic interactions between the social and structural determinants of adolescent health, the construction of gender in the content of adolescent policy documents and the significant role of actors, as part of dynamic policy processes shaping gender and intersecting power relations. Key learnings from youth participation in the AYHP demonstrate understandings of how power, people and policy processes interact in health policy development. Contributions of the thesis include building the scholarship on how gender inequality and intersecting axes of inequality shape adolescent health policy processes and systems in South Africa. On a methodological level, the thesis demonstrates and strengthens gender analyses in HPSR. In so doing, it contributes to research and praxis as part of transforming health and social systems in working towards gender-equal and just societies in the SDG era.

Conclusion: The thesis provides insights into the ways in which gender is problematised and framed in policy processes and is shaped by actor narratives, as well as by dynamic and complex relationships between the South African context, content and processes. This has significant implications for policy, programmes and systems. In conclusion, gender analyses are important for both policy analysis and praxis. Leaving no-one behind in the SDG era means addressing and transforming gender and intersecting power relations, identifying and disrupting dominant discourses and narratives that sustain contexts which enable gendered inequality, and implementing gender-transformative adolescent health policy and programming in working towards a gender-equal, inclusive and just world.

DECLARATION

I declare that *Power, people and processes: A gender analysis of adolescent health policy in South Africa* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Tanya Jacobs

Signed:

November 2022

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My PhD journey was made possible through the enabling, facilitating and supportive collective of people who accompanied me and were fellow travellers along the way.

I would like to acknowledge and express my deepest gratitude to Professor Asha George, my supervisor, guide and thinking partner. Thank you for both keeping me focussed, as well as taking me to the edges of my thinking; your insights and generosity of time mean so much. I also greatly appreciate the financial support provided through Professor George's Chair in Health Systems, Complexity and Social Change, funded by the South African Research Chair's Initiative (SARChI) of the Department of Science and Technology and the National Research Foundation (NRF) (Grant No 82769) – as well as the South African Medical Research Council (SAMRC).

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studies and health policy and systems research (HPSR). Thank you too, Penny Morrell, for copy-editing and moral support in working towards the finish line!

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My hugest thanks go to Nik for constant support and encouragement and holding the home space, especially while I was away at PhD retreats, meetings or conferences. To my beloved young ones, Azzara and Khiran – thank you for giving me space to study again, for being quiet when I needed the silence, as well as for your loud enthusiasm at celebrating the milestones along the way. You have been my greatest inspiration and supporters; collectively we celebrate learning as lifelong experience and journey. May this inspire you to follow your dreams with passion and courage and never stop learning and growing.

DEDICATION

To all past, present and future generations of scholars and activists working in solidarity towards a gender equal, inclusive and just world, yet to come.

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PREFACE

The preface speaks to my positionality in relation to the research undertaken, locating my personal and professional relationships to the PhD study. This reflexive stance is critical to being a researcher and is a thread throughout the thesis chapters.

I conceptualised my PhD as a 'journey' of sorts, a gift of travel. This metaphor remained central to the experience and provided an ever-expanding reference point to accommodate experiences, observations and explorations. The 'journey' was something that I had longed for, planned for, and even moved geographies for, in order that it may take form. It has truly been a gift of exploration, of both external and internal landscapes.

Part of my positionality has arisen from coming to the PhD space after more than two decades of work experience in various South African provinces and in the African region, focusing on programmes addressing interrelated dimensions of sexual and reproductive health and rights (SRHR), gender-based violence and HIV – all 'symptoms' of underlying root causes related to systems of gendered power relations. Much of my work was premised on addressing gender and intersecting inequalities – such as racism, poverty, geographical disparities, access to education and services, etc. – through research, implementing programmes and engaging in advocacy. I worked across several sectors such as health, education, social development, water and sanitation and rural development – working with a range of actors including government, civil society actors, and funders. This work grounded me, inspired me, as well as brought me to tears – seeing the personal and collective destruction that gender inequality and compounding inequalities are creating in the lives of women and girls in their diversity, as well as in the South African social fabric as a whole. Given South Africa's legacies of colonialism and apartheid, both systems of violence and exclusion, I am acutely aware how these have compounded the deeply patriarchal contemporary context, shaping gender power relations, gender norms and notions of masculinities and femininities, for example. My work experience in these different contexts has shaped my insights, approaches, values and positionality in relation to the complexity and challenges of working with these multiple intersectional systems of power and inequality.

Despite the initial gains made, and accompanying increased awareness, following the advent of democracy in 1994, gender inequality remains in South Africa – characterised by a deeply patriarchal and misogynist society that does not sufficiently acknowledge and address how gender-based exclusion and inequality harms everyone. The plethora of health and education programmes mostly address the surface level 'symptoms' such as gender-based violence and HIV; and they provide services to individuals i.e. they are gender-responsive rather than gender transformative which would entail addressing the underlying gender inequality and systems of power.

Holding a brief for gender across these programmes was extremely challenging and frustrating at times, as programmes are often pre-conceptualised, with funders shaping the focus and agenda, contributing to siloed programming. Much of the work left me with unanswered questions, as a result of which I started this PhD with much curiosity, wanting to think more deeply about these issues. I wanted to focus on the social and structural systems that create and sustain exclusion, inequality, and disease and move beyond the normalisation of the status quo – and to begin to look at transformation of systems of power.

I intentionally chose to return to the School of Public Health at UWC, an academic department with a history of addressing the social and structural determinants of health and which had significantly shaped my understanding of health as deeply political i.e. being about power. It is also where I met my life partner, Bupendra Makan, a fellow public health researcher, practitioner and activist. I have felt the absence of his collegiality, companionship and critical engagement during this journey, as he passed away in 2006.

While working on this research I found myself reading the poem *Every three hours* by Koleka Putuma (included below) as it addresses the ways in which the lives of women and girls do not matter in a patriarchal society and how gender-based violence, including femicide, has become normalised in South Africa. The poem locates my thesis in a broader scope of research for social change and transformation. It reminds me how my focus on gender inequality in adolescent health policy and systems needs to be located in a wider national and global picture of gender power relations which are maintained by violence at the individual, institutional and societal levels. It propelled me to think deeply about my scholarship, practice and activism, and recharged my courage at times when I needed it.

Along the PhD journey I observed how I incrementally returned to my identity as a scholar, after many years of being immersed in practice. I have been able to connect to, grow into and occupy dormant parts of myself. Being a student has allowed me into spaces with other departments and other universities, a ticket into presentations and conversations to discuss and explore with actors across the sectors and landscapes of ideas, literatures, theories, disciplinary frameworks and methodological approaches. It has been an important process of joining parts of the intellectual and disciplinary puzzle that is central to my PhD. This aspect of my positionality is indeed about privilege – to be in these spaces and to be part of contemporary conversations – and I have been acutely aware of the power that comes with being a researcher and academic.

Through my reflexive practice I have also been aware of my positionality as an older, white, intersectional feminist. I am conscious of the importance of bringing multiple perspectives and voices, especially diverse young actors, into the conversations and to create spaces that are about disrupting power relations and being inclusive.

My PhD journey has not been without challenges, 'unsettlings' and discomforts. It has been very consuming at times, sometimes being the first thing I thought about upon waking, demanding attention and reflection. Part of the discomfort has also included being in the intersections between disciplines, audiences and actors, which has required constant reflexivity as part of intentionally bringing together different perspectives and conversations. My reflective practice has entailed staying with the challenges, trying to find comfort in the discomforts. Being acutely aware of my positionality as a researcher in this context is a thread in this work – and to write and discuss this with others has been central to my learnings and growing along the way.

During the research process, I often took with me on my mountain walks questions or issues with which I was grappling, to enable me to think more deeply about them. Often the big sky above or the wild winds allowed for insights, new ideas and thinking – and Silvermine nature reserve and the dancing fynbos will forever be part of PhD observations, growth and journey.

My PhD experience has generated many insights, provided several answers to my questions and opened up further areas for scholarship, practice and partnerships. It would have been wonderful if it could have been more of an 'interventionist' or basic science type of research, that could provide a 'cure' or panacea to end gender and intersecting inequalities, as well as gender-based violence and HIV. It has, however, been about 'slow' transformation – about making 'visible' some of the systems of power relations that are part of health policy and systems, and exploring the policy processes that produce and reproduce gendered power relations. It has also revealed how patriarchal and other forms of power are inscribed in social political systems and the complexity and collective efforts it will take to transform them.

The PhD journey has helped me sharpen my scholarship, amplify my voice, reinfuse my passion, link me to communities of practice and locate my future work in health systems and policy, as part of working towards a gender equal, inclusive and just world yet to come.

EVERY / THREE HOURS

this country buries us before we are born.
calls us by our obituaries before it calls us by our names.

makes us.
womxn with nervous conditions.
nervous conditions with their guard up.
law enforcement with a broken system.
a broken system with too much power.
power in authority with guns that gun down their spouses.

telephones with missing person details.
missing person details with no follow up.
garages with toddlers who should be in school.
vehicles with evidence.
evidence with no power to prosecute.
post offices with weapons.
shopping malls with kidnappers.
bathrooms with carnage.

a carnage with no expiry date.
clubs with druggers.
alleyways with not enough light.
and. even. with.
all the light. you would still not be safe.
ubers with panic.
taxify with paranoia.

walks with tasers. in groups. in public.
in places you wouldn't think it could happen.

graves with girls.
taken too soon.
too brutal.
too horrifying to name.
to document. to find.
to mark as danger zones.
danger zones disguised as safe spaces.
safe spaces with murderers.
murderers who are husband material.
schools with paedophiles.
paedophiles with degrees in working with children.
lecture halls with molesters.
terminals with predators.
construction sites with men old enough to understand 'NO!'
churches with men who use your prayers for safety to get you on your knees
with your arms raised.

[every 3 hours, one of us does not make it]

this country hangs our dignity at half-mast.
waves our bodies as lessons to be learnt.
as moments that should teach us something.
as modules. tests. experiments.

my existence is not for your teaching
to dislocate my mother's throat six feet under
and compensate her grief with scholarships and amended policies.
policies that have gathered dust before they have even been drafted.

this country buries us before we are born.
calls us by our obituaries before it calls us
by our names.

ABBREVIATIONS

ASRHR	Adolescent sexual and reproductive health and rights
AYHP	Adolescent and Youth Health Policy
CDA	Critical discourse analysis
GPPPH	Global Public Private Partnerships for Health
HIV	Human immunodeficiency virus
HPA	Health policy analysis
HPSR	Health policy and systems research
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer, asexual, plus
LNOB	Leave No One Behind
NAFCI	National Adolescent Friendly Clinic Initiative
NGO	Non-governmental organisation
SDGs	Sustainable Development Goals
SOGIE	Sexual orientation, gender identity and expression
SRHR	Sexual and reproductive health and rights
UWC	University of the Western Cape
WHO	World Health Organization
WPR	'What's the problem represented to be?' approach

CHAPTER 1: INTRODUCTION

1. INTRODUCTION

This chapter introduces and establishes the foundation for subsequent chapters of the thesis. It starts by contextualising the research in terms of gender equality as a global priority as well as in the national policy landscape. It then frames the focus on adolescence and health and provides a brief overview of the demographic and health context of adolescents in South Africa. Further, it maps the research setting, rationale and phenomena of interest and then outlines the aim and specific objectives of the PhD research. Finally, an outline and guide of chapters 2 to 8 is provided.

This study is grounded in the field of health policy and systems research (HPSR) and lies at the nexus of various interlinking interests; it combines scholarship related to health policy analysis, gender, public participation, and adolescent health and wellbeing. It responds to the call for researchers to generate scholarship that addresses gendered power relations to transform inequitable health systems and society at large (Theobald *et al.*, 2017). HPSR as a field is premised on inclusion of different disciplines and multiple perspectives and knowledges. Part of locating the PhD in HPSR is about enhancing both the commitment to interdisciplinary work as well as strengthening the field by integrating gender analysis, both conceptually and methodologically.

The research therefore provides a platform for deepening our understanding of how gender is constructed and framed in adolescent health policy in South Africa as well as identifying the key implications for realising the ambitious SDGs. The context in which the research takes place is South Africa; adolescent health policy is used as a case study, serving as a prism through which to understand gendered and intersectional health policy and systems issues, complexities and power dynamics.

2. GENDER EQUALITY AS A GLOBAL PRIORITY

This thesis is located within the global context of the Sustainable Development Goals (SDGs), the following three being directly relevant to this research:

- Goal 1: No Poverty – End poverty in all its forms everywhere.
- Goal 3: Good Health and Well-being – Ensure healthy lives and promote well-being for all at all ages.
- Goal 5: Gender Equality– Achieve gender equality and empower all women and girls.

In addition to being a standalone goal, gender equality is recognised as a cross-cutting issue following widespread consensus that it needs to be prioritised to achieve the SDGs. While the past decades have seen some gains and improvements towards achieving substantive gender equality, transforming structures and systems that contribute to reproducing gender and intersecting inequalities remain a priority for action, both globally and in South Africa (UN Women, 2018; George, Amin, *et al.*, 2019; Gupta *et al.*, 2019; Hay *et al.*, 2019; Heise *et al.*, 2019). Addressing these inequalities was the impetus and focus of the UN Women's Generation Equality Forum held in 2021. This forum was held in the context of the COVID-19 pandemic which has made more 'visible' the persistent entrenchment of these intersectional gendered inequalities (Lokot and Avakyan, 2020; UN Women, 2020; Kabeer, Razavi and van der Meulen Rodgers, 2021).

Given the ongoing importance of, and challenges to, achieving gender equality, this thesis contributes to these efforts by focusing on how national policies address gender equality for a key population group – namely adolescents.

3. ADOLESCENCE AND HEALTH

Adolescence is one of the most significant periods of human development, with wellbeing at this stage influencing lifelong trajectories of health and wellbeing (World Health Organization (WHO), 2017). Adolescents are not old children or young adults but are in a distinct life stage marked by critical physical, cognitive, emotional and social development (Salam *et al.*, 2016; Blum, Mmari and Moreau, 2017; Sheehan *et al.*, 2017). While recognising this as a development phase that affects how adolescents think about themselves and their world, it is also critical to note that adolescents are not homogenous. Adolescents as a group are also marked by various social characteristics that intersect – e.g. gender, sexual orientation, living in an urban or rural setting, attending school or not, family context etc. – all of which influence their attitudes, behaviours and skills in decision making and risk assessment, as well as access to services and resources (Chandra-Mouli, Lane and Wong, 2015; Singh *et al.*, 2019).

Crucially, it is important to locate adolescents beyond a public health lens to also consider them from a rights approach – as significant societal assets whose contributions and meaningful participation needs to be acknowledged(World Health Organization (WHO), 2017). The comprehensive aims of the SDGs, which are aligned with the Global Strategy (2016-2030) of the United Nations Secretary General, emphasise that all women, children and adolescents not only survive, but thrive and transform. This convergence of global political will, coupled with increased funding for adolescent health, provide a window of opportunity to develop new paradigms for ensuring that initiatives are inclusive of, and responsive to, the rights and needs of adolescents (Patton *et al.*, 2016; World Health Organization (WHO), 2017; Ross *et al.*, 2020). This includes consideration of factors that shape health beyond health care to broader systems and social structures. This research, therefore, is an opportunity to take stock of the social and structural determinants of adolescent health, to assess how they have been able to engage with adolescent and youth policy, and to evaluate how well adolescent health policies respond to their gendered and intersectional needs and rights.

Having located the thesis within the global prioritisation of achieving gender equality and the importance of an expanded view of adolescent health, the sections below provide details of the setting of this research – namely the South African context; demographic and health information about South Africa's adolescents; as well as the national legal and policy framework.

4. SOUTH AFRICAN CONTEXT: THE SETTING FOR THE RESEARCH

South Africa is characterised by a complex and multi-dimensional set of historic and current intersectional inequalities related to 'race', gender, class, geospatial location, (dis)abilities, sexual orientation etc., resulting in unequal access to education, health and other services. According to the Stats SA report on *Inequality Trends in South Africa* (2019), some aspects of inequality have declined, while others have increased in the recent past (StatsSA, 2019). The recently published Oxfam Report on inequality in South Africa describes intersecting and multiple axes of inequality, where labour market inequality is a key driver of stubborn gender, 'race', income and wealth inequality in the country. By any measure, South Africa is one of the most unequal societies in the world, despite notable achievements since democracy (Leibbrandt, Finn and Woolard, 2012; StatsSA, 2019).

Gender inequality is a significant and cross-cutting system of power and inequality. The legacies of colonialism and apartheid, combined with neo-liberal market dynamics and government failures, have created a South African context in which gender inequality intersects with, and compounds, other forms of inequality, especially poverty, socio-economic disadvantage and 'race'. For example, structural gender divisions of labour, both paid and unpaid, are a persistent compounding factor of gender inequality, particularly for women residing in rural areas of South Africa (South African Human Rights Commission (SAHRC), 2017). As a result, an average white male CEO in South Africa earns as much as 149 average black women put together (Oxfam, 2020).

5. ADOLESCENTS IN SOUTH AFRICA: BRIEF DEMOGRAPHIC AND HEALTH OVERVIEW

The social determinants of health invariably impact on various dimensions of health, including health seeking behaviour and health status. These have implications for adolescent health and health systems as a whole.

In 2016 the approximately 10,294,894 adolescents aged 10 to19 years, constituted 18,5% of the South African population (StatsSA, 2018). While national school attendance was reported in 2017 to be 98%, estimates in 2016 were that only 49% completed secondary education (Hall *et al.*, 2018). Of equal concern is the very high unemployment rate for both youth and adults in South Africa. In the first quarter of 2018, 38% of young people aged 15 to 34 were unemployed (StatsSA, 2018) and it is estimated that 36.5% of those not in education, employment or training (NEET) in South Africa are young people between the ages of 15 and 29, exacerbating other forms of inequality in terms of 'race', gender and geographical location (de Lannoy and Mudiriza, 2019).

The levels of violence experienced by adolescents in South Africa are alarming. Recent research notes that approximately one in three adolescents (35%) reported that they had experienced some form of sexual abuse during their lifetime (Mathews *et al.*, 2016; Devries and Meinck, 2018). Gender power relations underline the perpetration and experience of violence – and mark other dimensions of adolescent health. For example, 16% of women aged 15 to19 years have begun childbearing. Of these, only 52% were reported to be attending school, compared to 83% of childless adolescents in 2016 (StatsSA, 2018).

Despite HIV incidence decreasing from 2012, it remains high – particularly among female youth aged 15 to 24 years whose incidence, in 2017, was three times that of their male counterparts (Simbayi *et al.*, 2019). These infection rates are compounded by high levels of teenage pregnancy, school dropout, sexual and gender-based violence, and limited opportunities for economic independence, all of which create, and are reinforced by, gender inequality.

These macro-level structural determinants relating to education, employment, gender inequality and violence have only worsened during the lockdowns associated with the COVID-19 pandemic – and they powerfully shape the experiences of adolescent health.

6. NATIONAL LEGAL AND POLICY FRAMEWORK

The South African Constitution and the national policy context enshrine gender equality. Post-1994 there have been determined efforts to address the injustices of apartheid and to build a society that reflects the vision of equality enshrined in the country's Constitution. The democratic government has been successful in the structural establishment of institutional mechanisms for advancing women's empowerment across all state functions, and in inserting gender equality principles into legislation. While gender equality is at the centre of 'formal' laws and policies, there are still firmly entrenched structural or systemic hierarchies and power relationships within society and the economy, however, that prejudice women and persons based on their sexual orientation and gender identity and expression (SOGIE) (South African Human Rights Commission (SAHRC), 2017). As a result, the policy commitment to gender equality does not always translate into gender-transformative policies and programmes across various sectors and policy spheres.

The adolescent health policy landscape includes several key policies, led by various government departments and multiple actors supporting adolescents and adolescent health. These are the new National Youth Policy (2020) the National Adolescent and Youth Health Policy (2017), and the National Adolescent Sexual and Reproductive Health Rights Framework Strategy (2015) – as well as two policies related to health in schools, namely the Integrated School Health Policy (2012) and the National Policy on HIV, STIs and TB for Learners, Educators, School Support Staff and Officials in Primary and Secondary Schools in South Africa (2017).

7. RATIONALE AND PHENOMENA OF INTEREST

At the policy level, gender and other social determinants are often not considered, despite their significance in determining health outcomes, particularly for adolescents. If included at all, gender is often mentioned in a binary, descriptive, heteronormative form, or as an issue not relevant to health systems. When gender is included in policy documents as part of key contextual factors, considerations of gender often evaporate during policy implementation. Within HPSR therefore, there is a need for gender analysis to make visible how gender and intersectionality as key power relations influence people and policy processes which, in turn, influence the content and outcomes of health policies and programmes.

The key phenomena which are driving this research are premised on wanting to further understand how gender, as a power relation, influences the interactions between policy content, actors, context and processes to construct adolescent health policy in South Africa. A central focus of the research will be how gender is constructed and framed both in the content (i.e. the 'what') as well as the process (i.e., the 'how') of policy formulation, using adolescent health policy in South Africa as a case study.

Both globally and in South Africa there is a paucity of research and analysis that describes and analyses health policy processes through a gender lens, and that engages what this means for conceptualising and addressing gender and intersecting inequalities (Theobald *et al.*, 2017; UN Women, 2018; Ravindran *et al.*, 2021). Consequently, this thesis responds to this knowledge gap and strengthens scholarship in the social and political contexts that impact the construction and framing of gender in adolescent health policy in South Africa. The focus of this PhD is how gender is constructed in health policy by examining the interactions between policy content, context, actors and processes. In addition, the Adolescent and Youth Health Policy (2017) has been used as a tracer of broader health systems issues.

8. AIM AND OBJECTIVES

The overall aim of this research is to describe and analyse how gender and its intersectionality influences the interactions between policy content, actors, context and processes to construct adolescent health policy in South Africa.

The objectives are as follows:

- To describe the social and policy contexts of adolescence in South Africa, taking into consideration gender and intersectionality.
- To analyse from gender and intersectionality perspectives, the content of national adolescent health policy documents.
- To map and describe the actors in terms of their roles and relationships, and the process of developing the Adolescent and Youth Health Policy (AYHP) in South Africa.
- To understand how the context, content, actors and processes in adolescent health policies interact to construct and frame gender and intersectionality, as a feature of power.
- To reflect on the implications for gender transformation of this articulation of power, people and processes in adolescent health policies.

This PhD has been undertaken by publication. The table below outlines the objectives in relation to the thesis chapters as well as the four papers which have been published or are currently under review by journals. In order to provide a complete thesis, these four papers have been included in the main body as full transcripts to facilitate the coherence of the thesis' 'Findings' chapters. They have retained the style and format required by the journals, however, and their references have been listed in each instance and not added to the reference list at the end of the whole thesis.

Copies of the published articles are attached as appendices. As they have been published as open-access, the journals allow or permit unrestricted use, distribution and reproduction in any medium, provided the original work is properly cited.

Table 1: Objectives, Chapter and Publication details

Objective	Chapter and Title of Publication	Publication Details
To describe the social and policy contexts of adolescence in South Africa, taking into consideration gender and intersectionality.	Chapter 4: Democratic South Africa at 25 – a conceptual framework and narrative review of the social and structural determinants of adolescent health	Jacobs, T. and George, A., 2021. Democratic South Africa at 25 – a conceptual framework and narrative review of the social and structural determinants of adolescent health. *Globalization and Health*, *17*(1), pp.1-11.
To analyse from gender and intersectionality perspectives, the content of national adolescent health policy documents	Chapter 5: Policy foundations for transformation: A gender analysis of adolescent`1 health policy documents in South Africa	Jacobs, T., George, A. and De Jong, M., 2021. Policy foundations for transformation: a gender analysis of adolescent health policy documents in South Africa. *Health policy and planning*, *36*(5), pp.684-694.
To map and describe the actors in terms of their roles and relationships, and the process of developing the AYHP in South Africa.	Chapter 6: Between rhetoric and reality: Learnings from youth participation in the adolescent and youth health policy in South Africa	Jacobs, T. & George, A. 2022. Between rhetoric and reality: Learnings from youth participation in the adolescent and youth health policy in South Africa. Published online by *International Journal of Health Policy and Management*, x (x), pp.1-13
To understand how the context, content, actors, and processes in adolescent health policies interact to construct and frame gender and intersectionality, as a feature of power.	Chapter 7: Looking back and moving forward: Actor narratives on gender in adolescent and youth health policy and programmes in South Africa	Jacobs, T. & George, A. Looking back and moving forward: Actor narratives on gender in adolescent and youth health policy and programmes in South Africa. Currently under review at the *International Journal for Equity in Health.*
To reflect on the implications for gender transformation of this articulation of power, people and processes in adolescent health policies.	All chapters and publications	

9. KEY CONCEPTS AND DEFINITIONS

Several key concepts and definitions used throughout this thesis have been included in the introduction to ensure conceptual clarity and are further explored and integrated in respective analyses and findings Chapters. They are as follows.

Table 2: Key concepts and definitions

Adolescents and young people	Adolescents are between 10 and 19 years of age. Most adolescents are therefore included in the age-based definition of 'child' – being under the age of 18 – adopted by the United Nations Convention on the Rights of the Child. This age range falls within WHO's definition of 'young people', being individuals between ages 10 and 24. To address the different phases of development, adolescence is often divided into early (10–14 years old) and late (15–19 years old) stages. Sources: (United Nations (UN), 1990) World Health Organization (WHO) – https://www.who.int/health-topics/adolescent-health#tab=tab_1
Gender	Gender is the socially constructed roles, behaviours, activities, attributes and opportunities that any society considers appropriate for men and women, boys and girls and people with non-binary identities. Gender is often relational, shaping how men/boys, women/girls and people with non-binary identities interact with each other and the world around them. Due to its social construction, gender frequently varies through spaces, contexts and time, as individuals construct differing roles and identities that are shaped by broader political, social and economic circumstances. Gender as a power relation shapes vulnerability to, or risk of, disease, access and utilisation of health services and ultimate disease experience. Gender is just one axis of social advantage/disadvantage and, although it is a key entry point into exploring how marginalisation and disadvantage can impact health, consideration also needs to be given to other individual and power factors that may improve our understanding of health inequalities and why they exist. Sources: World Health Organization – https://www.who.int/health-topics/gender
Gender analysis	Gender analysis is the process of analysing how gender power relations affect the lives of women, men and those with non-binary identities; how gender relations create differences in their needs and experiences, and how policies, services and programmes can help to address these differences. Source: (Morgan *et al.*, 2016)

Gender mainstreaming	Gender mainstreaming is the process of assessing the implications for women, men and those with non-binary identities of any planned action, including legislation, policies or programmes, in all areas and at all levels. It is a strategy for making their concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all political, economic and societal spheres – so that people of all genders benefit equally, and inequality is not perpetuated. The ultimate goal is to achieve gender equality. *Source:* (United Nations (UN), 1997)
Intersectionality	The concept of intersectionality which was first used by Crenshaw in 1989 is now being applied in many disciplines, including in health and in different African contexts. Intersectionality builds analyses of inequality and deeper reflection of complex situations where inequality in terms of axes of 'race', class and gender, for example, are not seen as separate or additive but as dynamic, mutually constitutive and compounding. Intersectionality promotes an understanding of human beings as shaped by the interaction of different social locations (e.g. 'race'/ ethnicity, indigeneity, gender, class, sexuality, geography, age, disability/ability, migration status, religion). These interactions occur within a context of connected systems and structures of power (e.g. laws, policies, state governments and other political and economics unions, religious institutions, media). Through such processes, interdependent forms of privilege and oppression are created, shaped by colonialism, imperialism, racism, homophobia, ableism and patriarchy among others. Intersectional gender analysis is the process of analysing how gender power relations intersect with other social stratifiers to affect people's lives and create differences in needs and experiences. It also analyses how policies, services and programmes can help to address these differences. While intersectionality analysis aims to move away from one dominant social category of analysis, resists essentialising and is non-additive, it can sometimes be necessary to prioritise one social axis as an entry point into more complex analysis. Sources: (Larson *et al.*, 2016; World Health Organization (WHO), 2020)
Sex	Sex is the biological or chromosomal attributes that separate males, females and intersex people. Sex is assigned at birth and may differ from a person's gender identity. Source: UN Women - https://www.unwomen.org/en/digital-library/genderterm

Sexual orientation, gender identity and expression (SOGIE)	Sexual orientation refers to a person's emotional, affectional and/or sexual attraction towards other people of the same gender, a different gender or more than one gender. Sexual orientation is not related to gender identity and sex characteristics. Gender identity reflects a person's deeply felt and experienced sense of their gender, which may or may not align with the sex assigned to them at birth. Gender expression is the way in which we express our gender through actions and appearance and may be a combination of male, female and androgynous. Source: UN Women - https://www.unwomen.org/en/digital-library/genderterm

10. OUTLINE OF THESIS CHAPTERS

This thesis is organised into eight chapters and is structured in the following manner:

Chapter 2: Literature: Describes key threshold concepts and presents a review of relevant and cross-cutting literature presented in the following interrelated sections: The social and structural determinants of adolescent health in South Africa, including gender inequality; gender in health policies and programmes in the South African context; the making of policy from a gender perspective: role of actors and processes and power and intersectionality as a central concepts to gender analyses. These do not duplicate the reviews undertaken for each specific publication (chapters 4 to 7).

Chapter 3: Methodology: Outlines the overall methodology employed in the research. It includes the disciplinary and conceptual grounding, research design, conceptual framework, data collection methods, data analysis, reflections on my positionality and concludes with ethical considerations.

Chapter 4: Democratic South Africa at 25 – a conceptual framework and narrative review of the social and structural determinants of adolescent health: Describes the social and policy context of adolescence in South Africa, taking into consideration gender and intersectionality. It presents the conceptual framework and narrative review that was developed.

Chapter 5: Policy foundations for transformation: A gender analysis of adolescent health policy documents in South Africa. Describes and explores how gender is constructed in 15 policy documents relevant to adolescent health and analyses the implications for health systems and policy research as programmes.

Chapter 6: Between rhetoric and reality: Learnings from youth participation in the adolescent and youth health policy in South Africa: Describes the actors, contexts and processes of developing the AYHP in South Africa. It explores the learnings from youth participation in the development of the AYHP with a view to informing future policy processes.

Chapter 7: Looking back and moving forward: Actor narratives on gender in adolescent and youth health policy and programmes in South Africa. Describes the constellation of actor gender narratives within the context and process of making the AYHP. It contextualises these narratives in terms of the implications for advancing gender equality in current and future adolescent and youth health policy and programmes in South Africa.

Chapter 8: Discussion, conclusion and recommendations: Describes and integrates the key threads and learnings across the thesis and identifies findings that contribute to scholarship in terms of gender and adolescent health policy and systems research. It also outlines the strengths and limitations of the research and makes recommendations for future research in terms of policy analysis and praxis.

CHAPTER 2: LITERATURE REVIEW

1. INTRODUCTION

This chapter presents the literature review for this thesis, outlining threshold concepts and mapping relevant bodies of literature in relation to gender in adolescent health policy in South Africa.

Using the research question as an anchor, the review presents a nexus of literature intentionally drawn from a range of disciplines and brings together scholarship from health policy and systems research (HPSR), social sciences, gender studies and public health. This is part of recognising the richness and strength that comes from synergising multiple perspectives and knowledges and bringing them to bear on complex and 'wicked' problems or phenomena, such as gender considerations in adolescent health policy and systems.

The purpose of reviewing the literatures is to outline and review key conceptual and contextual understandings, as well as to highlight the gaps and questions that the thesis has explored and with which it has critically engaged. In doing so, it provides clarity and explicitly locates the contribution of the thesis in relation to prior scholarship by presenting what is known, as well as where key gaps or 'unknowns' are situated. In this way it intentionally foregrounds the scholarly conversations of which this research is part, within the broader endeavour of growing and expanding knowledges.

In addition, as a focused review of literature was also completed in the process of developing each publication presented in the 'Findings' chapters 4 to 7, the purpose of this chapter is to integrate the literatures that have informed the thesis as a whole, while seeking to avoid repeating the literature in the individual papers (although some overlap is inevitable).

Relevant threshold concepts and literature are presented in the following sections:

- The social and structural determinants of adolescent health in South Africa.
- Gender inequality as a key social and structural determinant shaping health and health systems.

- From margins to the mainstream: Gender in health policies and programmes.
- Integration of gender in South African health policy context.
- The making of policy from a gender perspective: The role of actors and processes.
- Power as a central concept in gender analysis.

2. SOCIAL AND STRUCTURAL DETERMINANTS OF ADOLESCENT HEATH

The health of adolescents is shaped by determinants at individual, interpersonal, community, organisational and structural levels (World Health Organization (WHO), 2017; Jonas *et al.*, 2019). As part of understanding and describing the social and structural determinants of adolescent health from a health systems perspective, it is helpful to describe the literature of interrelated social and structural determinants at micro (interpersonal), meso (organisational), and macro (structural) determinants levels.

At a micro level, individual adolescent sexual and gender identities are expressed through multiple and evolving forms as they experience growing autonomy and agency within a broader context. These are characterised by regressive social norms, gender inequality and other intersecting power relationships. In South Africa, these adolescent femininities and masculinities are constructed simultaneously by historical processes of cultural and religious integration and by contemporary pressures. These gendered and sexual identities are not just passively absorbed, but also actively re-enacted (Bhana, 2017; Sofika and van der Riet, 2017; Bhana *et al.*, 2021).

At the meso level, organisational and sectoral determinants shape adolescent health and rights, both in being supportive, but also in replicating the biases and inequalities that characterise South African society. South Africa has enacted comprehensive and progressive legislation and policy frameworks to enable the provision of, and access to, adolescent and youth-friendly health services through the National Adolescent Friendly Clinic Initiative (NAFCI) investments, however, adolescents report dissatisfaction with the quality of care received, in terms of respect and confidentiality, long waiting times and stockouts of medicines (Lince-Deroche *et al.,* 2016). They also report prejudicial attitudes of health workers (Schriver *et al.*, 2014; Müller *et al.*, 2016; Jonas *et al.*, 2018; Mulaudzi *et al.*, 2018). Importantly, programmes do not specifically consider services for diverse adolescents and young people in their design and delivery (Müller *et al.*, 2018).

At the macro level, adolescent health is shaped by national and global determinants, such as the structural colonial and apartheid legacies, whose inequalities still echo in the lives of the 'Born Frees' (Maseti, 2018). Despite numerous interventions and substantial funding that have largely been directed to preventing HIV incidence among adolescent girls and young women (e.g. DREAMS and the 'She Conquers' Campaign), gender inequality remains firmly entrenched and is reproduced by the dominant social and structural determinants. These include the intersections of patriarchy, the racial and the geo-spatial legacies of apartheid, heteronormativity, poverty and class, among others (Msibi, 2012; Hallman *et al.*, 2015; Toska *et al.*, 2016; Francis, 2018; Graham and Mphaphuli, 2018).

Despite a growing interest in adolescent health across disciplines, there are gaps in the literature that tends to largely understand the health of adolescents at the micro level; this means it focuses on the individual, and on interventions and individual services (Amin *et al.*, 2018; George, LeFevre, *et al.*, 2019; George *et al.*, 2020). Building on this, this thesis explores and raises critical questions about adolescent health at the interrelated and dynamic meso and macro levels – specifically how gender inequality is a cross-cutting determinant across all the levels and what this means for health policy processes and systems as a whole.

3. GENDER INEQUALITY AS A KEY SOCIAL AND STRUCTURAL DETERMINANT SHAPING HEALTH AND HEALTH SYSTEMS

Gender inequality is a key cross-cutting social and structural determinant of health (Sen *et al.*, 2007; Morgan *et al.*, 2016; Gupta *et al.*, 2019). Moreover, as health policy and systems are gendered, health systems are not gender neutral; and gender intersects and compounds other axes of inequality to shape both the experiences of health and health systems (Larson *et al*., 2016; World Health Organization (WHO), 2020).

Gender and gender inequalities are key social stratifiers power relations in understanding how needs, processes and outcomes are determined within health and social systems (Sen *et al.*, 2007; Theobald *et al.*, 2017; Morgan *et al.*, 2018). As noted by George, Amin, *et al*., (2019. p 2369), 'gender inequality remains one of the most pervasive inequalities in health, and one of the most insidious, because it is one where backlash against progress retains legitimacy and actively contests progressive change'.

Importantly, health systems are embedded in broader social and political contexts, both of which reflect and shape the context in which policies and programmes are created and implemented. As the dynamics of power relationships are often not 'visible' in policies and programmes, however, they inadvertently reproduce the status quo (Ravindran and Kelkar-Khambete, 2008; Research in Gender and Ethics: Building Stronger Health Systems (RinGs), 2020; Ravindran *et al.*, 2021). A key message highlighted by Morgan *et al*. (2016) is that gender is part of complex, multi-dimensional and contextual interactions, illuminating a range of values, power and interests which are central to health systems research and the understanding of health in general. Adopting a gender lens in health policy and systems research and implementation, therefore, contributes towards more gender-equitable and transformative health system.

A number of international agencies and researchers have used the concept of a 'gender continuum' to classify policies and programmes (Interagency Gender Working Group, 2013; World Health Organization (WHO), 2016). This has further informed the conceptualisation and analysis of gender in adolescent health policy in South Africa in this research.

Figure 1 presents a visual representation of the gender continuum, ranging from gender-blind to gender-transformative approaches, with features for assessing programmes and policy as and Table 2 provides criteria for criteria for assessing programmes and policies as per the WHO Gender Responsiveness Assessment Scale (World Health Organization (WHO), 2016). While it is a helpful heuristic tool for analysis, challenges have been raised in terms of measuring intentionality versus what is actually achieved, as well as the need for locating these criteria in specific contexts (Malhotra, 2021).

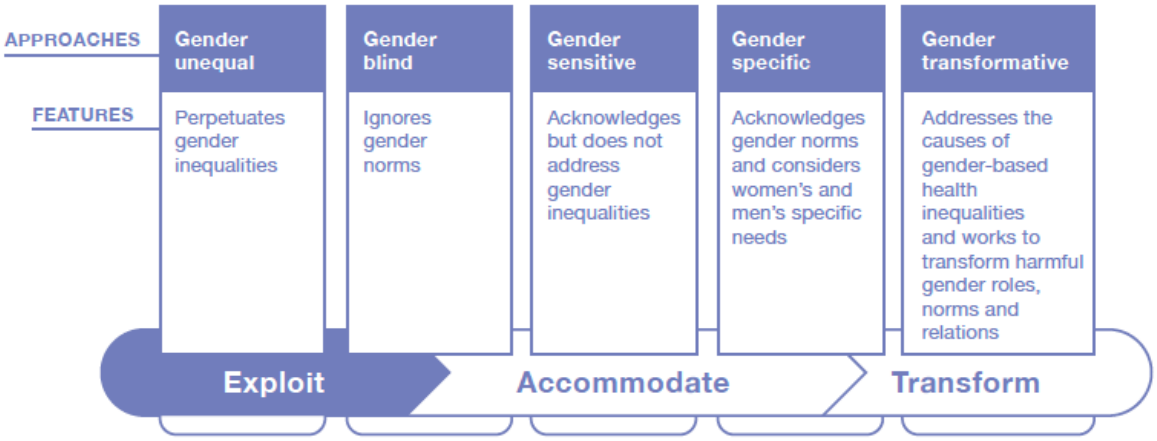


Figure 1: Continuum of gender unequal to gender transformative

Source: World Health Organization (2020)

Table 3: Criteria for assessing programmes and policies

Source: WHO Gender Responsive Assessment Scale (2016)

Gender-unequal	• Perpetuates gender inequality by reinforcing unbalanced norms, roles and relations. • Privileges men over women and those with non-binary identities and (or vice versa). • Often leads to one sex enjoying more rights or opportunities than the other.
Gender-blind	• Ignores gender norms, roles and relations. • Very often reinforces gender-based discrimination. • Ignores differences in opportunities and resource allocation for women and men and those with non-binary identities. • Often constructed based on the principle of being "fair" by treating everyone the same.
Gender-sensitive	• Considers gender norms, roles and relations. • Does not address inequality generated by unequal norms, roles or relations. • Indicates gender awareness, although often no remedial action is developed

Gender-responsive	• Considers gender norms, roles and relations for women and men and those with non-binary identities and how they affect access to and control over resources. Considers women's and men's specific needs. • Intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet certain needs. • Makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles.
Gender-transformative	• Considers gender norms, roles and relations for women, men and those with non-binary identities that these affect access to, and control over, resources. • Considers women's, men's, and those with non-binary identities specific needs. • Addresses the causes of gender-based health inequities. • Includes ways to transform harmful gender norms, roles and relations. • The objective is often to promote gender equality. • Includes strategies to foster progressive changes in power relationships between women, men and those with non-binary identities

While the focus of the thesis is on health policy, it also raises critical questions on how gender, at both conceptual as well as praxis levels, could be appropriately incorporated into all levels of health systems. It seeks to do this in ways that do not reinforce or perpetuate gender inequalities, and which are, ideally, transformative in terms of gender power relations as part of working toward gender equality.

The next section presents key concepts and ideas from the literature which focus on gender in health polices processes, including the debates and challenges related to gender mainstreaming, both globally and in South Africa.

4. FROM MARGINS TO THE MAINSTREAM: GENDER IN HEALTH POLICIES AND PROGRAMMES

The United Nations' adoption of gender mainstreaming as a key strategy was an important outcome of the Fourth UN World Conference on Women held in Beijing in 1995. Since then, gender mainstreaming has been positioned as the main strategy for achieving the ambitious goal of gender equality for most UN agencies, international development organisations as well as those working within countries, for achieving the ambitious goal of gender equality (Moser and Moser, 2005; Magar, 2015; Manandhar *et al.*, 2018; UN Women, 2018). Several critiques of this strategy have emerged, however, both conceptually and in terms of praxis, with several tensions found between policy intention and practice (Ravindran and Kelkar-Khambete, 2008; Kabeer, 2015; Lamprell, Greenfield and Braithwaite, 2015).

For instance recent analysis indicates that gender remains inadequately mainstreamed in the functioning of Global Public Private Partnerships for Health (GPPPH) such as the Global Fund to Fight AIDS, TB and Malaria. As such these partnerships or organisations are often described as 'gender blind' (Hawkes, Buse and Kapilashrami, 2017). Despite mainstreaming being framed and operationalised in guidelines and toolkits, implementation is also still a persistent challenge in many programmes – for example in Prevention of Mother to Child Transmission (PMTCT) and HIV programmes and across UN agencies (Nyamhanga, Frumence and Simba, 2017; Ravindran and Govender, 2020; Ravindran *et al.*, 2021).

Significantly, at a global level there is an increasing call for greater analysis and for attention to be paid to gender in public health policy as well as for a research focus on gender inequality in health (United Nations University International Institute for Global Health (UNU-IIGH), 2019; World Health Organization (WHO), 2019). This thesis is part of those conversations, particularly how to understand the construction and framing of gender in health policy processes, both in terms of gender being integrated into the content as well as within policy-making processes.

The barriers to integrating gender in health policy, and further disconnections between health policy intentions and implementation, is shaped by several factors: conceptual (i.e. lack of agreement of framings of gender terms); pragmatic (i.e. approaches and capacities for implementation), as well as political (i.e. shifting away from a focus on gender relations of power and social justice agendas) (Moser and Moser, 2005; Ravindran and Kelkar-Khambete, 2008; Payne, 2011; Malhotra, 2021).

Feminist academics and activists have long argued against the diversion from a focus on transformation of gender power relations – i.e. the depoliticisation of 'gender' – to technocratic application, i.e. a focus on tools, and checklists. They have also argued against the insufficient inclusion of women's movements in gender policy making (Payne, 2014; Razavi, 2016; Tallis *et al.*, 2018). Narrow framings of gender can make organisations blind to the ways in which they themselves are gendered environments. Only focusing on technocratic gender tools and on measurable gender-disaggregated data reframes the challenge to one of lack of knowledge and deflects from power and systems issues (Mannell, 2014, 2016; Payne, 2014; Lombardo, Meier and Verloo, 2017).

In the health sector, this is exacerbated by traditional bio-medical approaches to women's issues. Gender is most often mentioned in relation to programmes such as maternity and childcare for women, which leads to a separate focus on women's health and reinforces the equation of sex with gender in the health sector(Lamprell and Braithwaite, 2017). Equating women's health with mainstreaming of gender into health policies also creates a discourse or narrative of 'vulnerability' of women and places an emphasis on reproductive health. It leaves out men and /or reinforces essential binary categories of 'women' and 'men', girls and boys (Allotey and Remme, 2020; Katz *et al*., 2020).

While several lessons and insights in relation to gender mainstreaming initiatives at institutional level have been documented, more analysis is needed to make visible and address embedded patriarchal organisational norms and systems (Ravindran *et al.*, 2021). This research has responded to this gap in knowledge and to it being a priority area for ongoing research.

5. INTEGRATION OF GENDER IN THE SOUTH AFRICAN HEALTH POLICY CONTEXT

Following an international perspective, it is important to ground this research in the South African context where, since 1994, the Constitution has outlined gender equality as a national goal and central to democracy. Despite this, a substantial lacuna exists in recent literature on gender in health policy in South Africa, with little having been done since the foundational work undertaken by Klugman in the early years of democracy – and the associated development of new policy frameworks.

Klugman (1999) argues that an understanding of the institutional mechanisms and processes is essential for translating these gender equality goals into health policy. Institutional processes included a range of structural changes in creating gender positions or organisations, (often referred to as 'gender machinery' in South Africa), with mandatory budget allocation for gender/women, as well as stipulated percentages for gender parity in positions in organisational structures. In addition, Klugman, (1999) emphasised that mainstreaming gender equality into health policy is shaped by the process of policy development and implementation, with structural (i.e. social systems) and human resource barriers having a significant impact on the goal of gender equality (Klugman, Stevens and Arends, 1995; Klugman, 2000).

Moreover, in the South Africa context, the absence of a gender champion in the policy process – i.e. influencing whether it reaches the policy agenda and actual policy – is described by Daniels, Clarke and Ringsberg, (2012). Champions need to have the capacity and skills beyond a narrow framing of gender as quantitative and 'tick box' additions; they need to understand the broader social and political contexts, and be able to develop and implement gender-transformative processes and interventions.

In the context of the dearth of recent literature on the topic in South Africa, one of the few highlights has been how the technicalisation of gender makes organisations blind to the ways in which they themselves are gendered environments – and how this can contribute to gender practitioners rejecting core concepts that currently frame gender and development work. In addition, critical reflections on the efforts made to address gender norms and biases since 1994 include how these efforts have functioned to reproduce the very discourses that

underpinned the gender norms and biases they aimed to change (Mannell, 2012; Mannell, 2014). Reproducing binary terms such as 'male-female' and 'victim-agency' within heteronormative research and programmes leaves very few spaces for understanding the complexity and intersectionality of gender and related discourses – and therefore for understanding the myriad pathways and processes for transformation (Shefer, 2016; Ngabaza and Shefer, 2019).

Klugman also describes the influence in policy formulation processes of the South African political and ideological contexts and related policy discourses, as well as the roles of multiple actors such as those in civil society (Klugman, 2000b). These complex contextual factors include the loss of civil society organisations doing policy advocacy, the dominance of HIV/AIDS programmes and funders, and the active role of non-governmental organisations (NGOs) in policy processes in a post-apartheid context.

In the South African context, the mainstreaming of gender equality has been shaped by the processes of policy development; by institutional mechanisms as well as the political and ideological contexts; and by multiple actors such as those in civil society. Mainstreaming of gender equality in the democratic South Africa has also been influenced by the impact on gender transformation policies of activism by women's movements (Klugman, 1999, 2000a). While their activism played a significant role in the advancement of gender transformation policies, there are several barriers which impede more feminist agendas and substantive gender transformation (Gouws and Coetzee, 2019; Mkhize and Mgcotyelwa-Ntoni, 2019). For instance, civil society has included a shift from mass-based women's movements to more localised temporal movements that engage the state to promote gender equality; and the health sector has also been shaped by this national and global political context and agenda (Klugman, Stevens and Arends, 1995; Mbali and Mthembu, 2012; Gouws, 2017; Stevens, 2021).

6. MAKING POLICY FROM A GENDER PERSPECTIVE: THE ROLE OF ACTORS AND PROCESSES

While the above literature on gender mainstreaming is from development and health programme perspectives, there is a separate literature that examines policy analysis from a gender perspective that is located in the interstices of social sciences, health policy analysis and gender studies.

Gender itself is a contested concept in both policy content and processes of integrating and mainstreaming gender in policies and programmes (Eveline and Bacchi, 2005; Connell, 2012; United Nations University International Institute for Global Health (UNU-IIGH), 2019). Therefore, in analysing gender in policy content and processes it is important to foreground politics as central to the meaning of gender analysis (Eveline and Bacchi, 2005; Bacchi and Eveline, 2010). This entails how we might define, construct and frame key concepts and constructs such as 'gender', 'gender equality' etc. – and to what end. Therefore, the productive or constructivist nature of gender in policy explores notions of policy as a gendering process – as producing 'gender' as a relation of inequality, rather than as reacting to gender 'differences' or to 'gender relations' (Bacchi, 2000, 2017).

A review of the literature suggests that some ways in which gender inequalities are generated or contested include how health policy is shaped by gender in both its content and processes (Bacchi, 2005, 2009). Bacchi, (2000) argues that viewing 'policy-as-discourse' frames policy not as a response to existing conditions and problems, but as a discourse in which both 'problems' and 'solutions' are co-created i.e. as a very dynamic process.

Policy discourses can be understood as intersections between language and power, given that they reflect interests and values of individuals, institutions and systems in positions of power (Bacchi, 2016). They can reveal biases in the policy process and in the development of strategies to mainstream gender into policy making (Lombardo, Meier and Verloo, 2017). As argued by Bacchi, (2017), policies are 'gendering' practices and there is a need to reconceptualise categorical distinctions and to direct attention to how inequality is 'done' i.e. how the conceptualisation or problematisation of a phenomena informs how it is addressed in policy.

As the gendered power relationships and assumptions that are often embedded within the content of policy documents are not always immediately obvious or explicit, a central question is, therefore, how these 'invisible' assumptions and ideas function to reproduce the status quo of gendered power relations, and the central role of actors' ideas, ideologies and institutional contexts in this.

How gender and gender inequality is constructed is dependent on how the policy actors understand, interpret and represent the problem or issue (Koduah, van Dijk and Agyepong, 2015; Bacchi, 2016; Jacobs, George and de Jong, 2021). Policy makers may have limited capacity in, or knowledge about, gender, producing a barrier to integration in policy and practice (Olinyk, Gibbs and Campbell, 2014; Morgan *et al.*, 2018). In addition, translating broad gender policy commitments into practice, and goals into action, can be very challenging. This is exacerbated by limited frameworks, implementation and accountability processes as well as by people with resources and political commitment, often resulting in compounding manifestations of inequality (Malhotra, 2021; Ravindran *et al.*, 2021).

Mannell identified three narratives used by development actors to construct the 'problem' of, and 'solutions' to, gender inequality: gender equality as instrumental for development; gender as women's rights and empowerment; and gender as power relations requiring transformation (Mannell, 2014). These diverse understandings of gender and approaches to gender equality led to fractured relationships between policy actors and poor collaboration amongst practitioners. These continue to arise in debates and diverse approaches to gender mainstreaming, including, for example, involving men in gender programmes in South Africa. In the policy processes these tensions and diverse narratives act as inhibitors to building consensus to support implementation of gender policy recommendations and other efforts to address and transform gender power relations (Mannell, 2012; Mannell, 2014a).

In working towards understanding the construction of gender in policy processes and the central role of actors, this research has drawn extensively on the scholarship generated by those working in the fields of HPSR. This is presented in the sections below.

Health Policy and Systems Research: Role of actors

The field of HPSR, particularly health policy analysis (HPA), has generated several theories, frameworks and ideas about policy processes (Reich, 1995; Walt *et al.*, 2008; Sheikh, George and Gilson, 2014; Gilson *et al.*, 2018; Gilson, Shroff and Shung-King, 2021). HPA in particular has theorised the role of actors in policy processes and how their ideas, perceptions and understandings are shaped in different contexts. Furthermore, dynamic relationships which exist between policy contexts, actors, content and processes also shape how gender is problematised and how 'solutions' are represented as part of the social construction of policies (Ingram, Schneider and Deleon, 2007; Shiffman and Smith, 2007; Bacchi, 2016).

Within HPA, there is a growing body of literature which documents how health policy is socially constructed and how actor narratives, decisions and actions are influenced by individual, organisational, national and global factors (Ingram, Schneider and Deleon, 2007; Berlan *et al.*, 2014; Walt and Gilson, 2014; Shearer *et al.*, 2016; Shiffman *et al.*, 2016). Their roles in agenda setting is a complex mix of political, evidence-based, path-dependent, and donor-driven processes (Koduah, van Dijk and Agyepong, 2015; Fischer and Strandberg-Larsen, 2016).

Actor narratives articulate and structure the ideas that are part of the policy context in which a policy issue is understood and enacted; the notion of policy frames/framing is how they make sense of the world as well as of policy processes (Koon, Hawkins and Mayhew, 2016; van Hulst and Yanow, 2016). Framing is therefore a meaning-making process, through language and communication, and involves the social construction of social phenomena. A key conceptual and analytical thread within this research is, therefore, how actors make sense of – or understand, construct or 'frame' – policy issues such as gender; how this happens through discursive process involving social construction.

The notion that policies are socially constructed allows for in-depth examination of how gender issues are narrated and framed in specific policy-making contexts – as explored in this thesis. This talks to the scholars and practitioners who are interested in the interpretive and strategic processes through which issues are understood and addressed. In their unpacking of the narrative framings, they offer insights into the nature of political debate by providing an explanation of both structure and agency in the policy process (Carstensen and Schmidt, 2016; Colombini *et al.*, 2016; Koon, Hawkins and Mayhew, 2016).

There is a paucity of research and analysis, both globally and in South Africa, that describes and analyses actor narratives and engages what this means for conceptualising and addressing gender and intersecting inequalities. This thesis responds to this paucity by analysing the various policy and related discourses relevant to adolescent health – how they are framed by actors and how they interact with, and are nested in, broader discourses and social contexts in South Africa. Exploring actor gender narratives therefore helps to unearth individual and organisational assumptions about, and ideological commitments to, gender equality and transformation of power relations nested in broader social systems (Ingram, Schneider and Deleon, 2007; Shiffman and Smith, 2007). It shines the light on the pervasiveness of patriarchy, ideology and hegemonic ideas related to gender that infuse policy processes and different types and levels of power. These include power through institutional positions and norms; power over ideas in terms of certain ideas being accepted and rejected; and power in ideas in terms of reproduction. These are also documented by Acosta, Carstensen and Friel (Carstensen and Schmidt, 2016; Acosta *et al.*, 2019; Friel *et al.*, 2021) and are further presented below.

7. POWER AND INTERSECTIONALITY AS A CENTRAL CONCEPT IN GENDER ANALYSES

The last section of the literature review presents threshold concepts that are central to the thesis, namely the notions of power and intersectionality. These are thread that runs across the chapters and is central to understanding gender as well as policy processes. As practices of power are at the heart of every policy process, it is a critical concept for understanding how health systems function and how particular actors exercise their different kinds of power in the system (Erasmus and Gilson, 2008; Sen *et al.*, 2020). This is inadequately explored as

part of analysing health policy processes (Erasmus and Gilson, 2008; Lehmann and Gilson, 2013; Topp *et al.*, 2021) .

As noted by Sriram *et al*., (2018) , as power is evident implicitly or explicitly at multiple levels of the system and is present where actors interface, it shapes all actions, processes and outcomes. Centering power in HPSR requires building on theoretical positions and the notion of policy as discourse and 'meaning making' as defined by various scholars (Bacchi, 2000; van Hulst and Yanow, 2016). The notion that ideas and discourse have power, and that this discursive power can determine the very field of action as described by (Fischer, (2003) and Lombardo, Meier and Verloo, (2017) is of great relevance to this research.

Within the field of HPA, Powercube is a consolidated framework and tool that is well documented for understanding power. It does so in terms of dimensions – of levels (i.e. different layers of decision making), spaces (i.e. areas for participation called 'invited', 'created/claimed' and 'closed'), and forms of power (i.e. the ways it manifests including 'visible', 'invisible' and 'hidden'). Initially described by Gaventa, (2006), Powercube is now widely applied by several authors and in different contexts (Pantazidou, 2012).

To understand actor interfaces in this thesis, the interrelationships between Powercube's levels, spaces and forms of power have been used in conjunction with the types of power approaches articulated in the Power Matrix – namely power 'over', 'to', 'with' and, 'within' (Veneklasen *et al.*, 2007). These tools for analysing power are also documented by other authors (Carstensen and Schmidt, 2016; Acosta *et al*., 2019; Friel *et al*., 2021).

Unmasking power, and understanding how it is operationalised during the health policy process – from agenda setting to implementation – is central to deepening the scholarship in how social cultural beliefs and ideas are enacted in institutions (Schaaf *et al.*, 2021). This thesis therefore applies this analysis of levels, spaces and forms of power as seen through a gender lens, to understanding individual actors, organisations, and related processes and discourses in the context of health and other systems.

Central to understanding gender power relations is the concept of intersectionality which was first used by Crenshaw in 1989 and is now being applied in many disciplines, including in health and in different African contexts (Larson, *et al*, 2016; Meer & Müller, 2017). Further, African feminists such as Desiree Lewis and Sylvia Tamale (2020) have also made similar arguments, stating that we cannot look at the relationship between patriarchy and gender from a universalist lens. Intersectionality builds analyses of inequality and deeper reflection of complex situations where inequality in terms of axes or race, class and gender for example, are not seen as separate or additive but as dynamic, mutually constitutive and compounding. As articulated by (Hankivksy, *et al*., 2014), 'intersectionality seeks to demonstrate the convergence of different types of exclusion and marginalization'. The principles of intersectionality include consideration of intersecting categories, multi-level analyses, power, reflexivity, time and space and multiple knowledges and social justice. Importantly, it requires reflection on power in methodologies applied to understand and transform inequalities, not just a research method, but also on the positionality of researchers and other actors engaged with a social problem (Larson *et al*., 2016). Intersectionality is very relevant to HPSR as it helps to illuminate the complexity and dynamic nature of gender inequality and power as they manifest through policies and programmes.

8. SUMMARY COMMENTS

Drawing on a nexus of disciplines and literatures, this chapter has provided an overview of key concepts and literatures in order to locate the contributions this thesis is making to existing scholarship and to identifying the current scholarly conversations in which it is participating.

In addition, this chapter has identified some of the key gaps and questions in the literature in terms of getting, and sustaining, gender on the health policy agenda. These gaps in the literature, particularly in contemporary South Africa, were an essential factor which informed the key questions underpinning this research. The literature review therefore was the foundation from which to build and scaffold the extensive and esteemed work of other scholars in order to continue the ongoing academic discussions and knowledge generation in this critical field. Further, through an in-depth and detailed analysis, it has provided contextual knowledge and insights into adolescent health policy in the South African context.

CHAPTER 3: METHODOLOGY

1. INTRODUCTION

This chapter provides a descriptive overview of the theoretical and conceptual frameworks for the whole thesis; the study design; and the data collection and analysis methods for each objective. Details of data collection and analysis for each publication linked to the objectives are also provided. These are linked to, and underpin, the aims and objectives presented in Chapter 1: Introduction.

This chapter also maps my positionality as a central component of methodology, and addresses rigour and validity. It ends with key ethical considerations for the thesis.

2. DISCIPLINARY LOCATION AND CONCEPTUAL APPROACHES

The well-established and growing field of HPSR facilitates interdisciplinary and engaged research in order to strengthen health systems (Sheikh *et al.*, 2011; Daniels, Hanefeld and Marchal, 2017; Topp *et al.*, 2018; Hanson, Rasanathan and George, 2019). Key features of HPSR include the systems approach, multi-disciplinarity and the emphasis on policy and power – all of which are strongly aligned with the phenomena of interest, centred around gendered power in health policy processes.

Concerned with the deliberate and intentional analysis of health policy, this thesis is guided by a bricolage approach which combines theories and frameworks in order to enrich and expand the conceptual and analytical frameworks (Gilson, 2012; Rogers, 2015; Broom, 2021; Jones, Gautier and Ridde, 2021). Conceptual and theoretical grounding for this research draws on health policy analysis, gender studies and social sciences – particularly critical policy studies and feminist approaches to policy analysis – to illuminate the gender and intersectional power relations and dynamic interactions in adolescent health policy processes. Further details of the key conceptual approaches used are provided in the sections that follow.

3. HEALTH POLICY ANALYSIS

Health policy is defined by the WHO as 'decisions, plans, and actions that are undertaken to achieve specific [health and] health care goals within a society'. At its essence, however, health policy is also about processes and power; who the actors are and how policy making happens (Walt and Gilson, 1994; Erasmus *et al.*, 2014; Gilson *et al.*, 2018).

Health policy analysis (HPA) is a central approach to HPSR. Moreover, HPA has been understood in various ways, including 'a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process' (Walt *et al.*, 2008). The general purpose of HPA is to inform policy actors involved in the future design and implementation of policies (Gilson and Raphaely, 2008).

Within HPSR, a range of theories, conceptual frameworks and models focus on HPA and consider diverse policy elements and configurations of actors, institutions, power, problems and politics (Walt and Gilson, 1994, 2014; Sabatier, 2011; Weible *et al.*, 2012). HPA goes beyond content and specifically considers the behaviours of actors – their processes of decision making and the roles of their actions and unintended actions. It also considers the influence of actors who affect policy change at different levels, and the context that shapes, and is shaped by, individual, organisational, national and global factors (Walt and Gilson, 2014; Shawar and Shiffman, 2017; Shiffman *et al.*, 2018; Chipendo *et al.*, 2021). Importantly, HPA aims to make visible power relations within policy processes and to integrate this into the study of health policies and systems (Gilson and Raphaely, 2008; Gilson, Schneider and Orgill, 2014; Gilson, Orgill and Shroff, 2018). There is a paucity of literature in HPA that foregrounds this in terms of gendered power relations.

Importantly, the thesis draws on the Health Policy Triangle as a key heuristic model. Developed by Walt and Gilson (1994), this framework is grounded in a political economy perspective, and considers how the content of policy, actors, context and processes shape policy making. The authors argue that too much attention has been paid to the content of policies and that more attention needs to be paid to the actors and processes, as well as the context and how these interact in a dynamic manner. This would emphasise the 'how' and 'why' of policy processes and not only the 'what' of the policy – an approach which is central to understanding what and how gender is constructed within adolescent health policy in the South African context.

4. SOCIAL CONSTRUCTIVISM AND THE SOCIAL CONSTRUCTION OF POLICIES

Theoretical and conceptual approaches were also integrated from social sciences, a key concept being 'social constructivism'.

There is a growing body of literature in HPA that is rooted in post-structuralism, which recognises that all social phenomena, including policies, are socially constructed (Shiffman, Stanton and Salazar, 2004; Ingram, Schneider and Deleon, 2007). Drawing on the intellectual tradition of social constructivism from social and political studies, Shiffman argues that priority and agenda-setting is the complex interplay between interests, institutions, and the beliefs, values and norms of actors – and that 'problems' in a policy context are socially constructed (Shiffman, 2009). The values, ideological stances, intentions and meaning-making of/by actors are central to the construction of policy (Gilson, Schneider and Orgill, 2014; McDougall, 2016; Ramani, Sivakami and Gilson, 2019). Importantly, policy processes also involve contestations of power and the interests of the actors involved in the policy formulation process (Marshall, 2000; Shaw, 2010; Ciccia and Lombardo, 2019).

5. CRITICAL AND FEMINIST APPROACHES TO POLICY ANALYSIS

A further theoretical and conceptual contribution to this research from the social sciences has included critical and feminist approaches to policy analysis.

Discourses are the interactive and social processes that conveys substantive ideas and exist in policies, ideologies, programmes and institutions (Schmidt, 2008; Fairclough, 2013). Discourse analysis is linked to constructivism which offers a useful theoretical and conceptual approach to making sense of the roles of language, discursive constructions, rhetoric, narratives and framing (an approach which can improve our understanding of policy processes) (Fischer, 2003).

Critical discourse analysis (CDA) is an emerging theoretical and methodological approach in the analysis of health policy. It probes beneath the surface –i.e., into embedded expressions of policy – providing alternative insights for understanding the beliefs and practices which influence policy (Fairclough, 2013; Wodak and Meyer, 2016). CDA as a particular approach in discourse analysis, is informed by critical social theories and draws its theoretical antecedents from the body of work by Foucault (Cheek, 2008; Bonham and Bacchi, 2017).

The notion of discourse as 'social practice' implies a dialectical relationship – one in which discourse constitutes, and is constituted by, social situations, institutions and structures (Fairclough, 2013; Wodak and Meyer, 2016). It allows us to make interpretative connections between the complex relationships between the content of policies, ideologies, power relations and social contexts.

Gender studies and frameworks and principles of intersectionality

Drawing on the substantial literature from gender studies, the thesis has applied a gender lens to discourses in adolescent health policy, as this adds to the critical analysis of discourses which sustain, contest and perpetuate complex patriarchal power relations, in order to transform these relationships (Lazar, 2007).

Several theories and gender frameworks are documented in the available literature, including those directly relevant to gender and development more broadly. These are the Moser Framework (Moser, 1993), the Harvard Analytical Framework (March, Smyth and Mukhopadhyay, 1999), the Social Relations Framework (Kabeer, 1994), the Gender Integration Framework (FHI 360, 2012). Those more directly applicable to health and health systems are mHealth for MNCH: An analytical Framework (Deshmukh and Mechael, 2013) and those seen in the working in health (Liverpool School of Tropical Medicine (LSTM), 1996; PAHO, 2009; Jhpiego, 2016). The framework developed by Morgan *et al*. (2016) outlines how gender power relations, and drivers of inequality across various domains, constitute gendered power relations. It also shows how power is negotiated and changed at the individual and institutional or systems levels, and this further informed how the constructs related to gender were considered in the methodological approaches. Importantly, the research intentionally applied the principles of intersectionality noted in Chapter 1. An intersectional gender analysis is therefore of relevance to the area of the research as it will augment the analysis of gender in adolescent health policy on how gender and other social stratifiers such as race, class and sexual orientation for example, intersect and compound each other in the South African context.

In addition, from the fields of sociology and gender studies we have drawn on Fraser's theoretical concepts of redistribution, recognition and representation, as starting points for 'sense-making' of different perspectives on gender, gender inequality and gender justice (Fraser, 1995, 2007, 2012, 2018). Fraser links dimensions of recognition of identities and redistribution of resources as gender struggles, that combine the inclusionary and the transformative approaches.

In summary, bringing together disciplines and their related diverse theoretical and conceptual lenses, has facilitated the depth of analysis in this research. In helping to 'stitch' together the descriptions and explorations of the phenomena of interest, it has added important insights to the findings and has enriched the field of HPSR.

6. CONCEPTUAL FRAMEWORK

The conceptual framework used in this research and given in Figure 2 below is a synergy of theories and frameworks from the fields of HPSR and the social sciences, particularly gender studies, as outlined in the section above. With a view to understanding how conceptual and pragmatic elements of gender are constructed in adolescent health policy in South Africa, these different disciplinary perspectives were also brought together to analyse the different layers and complexity of, and interlinkages between, policy content, policy process, context and actors, and the related discourse and power dynamics.

As articulated in the literature review in Chapter 2 – and depicted in the conceptual framework – the policy processes, content and actors are shaped by social and political contexts at both global and national levels. Bringing together these different disciplines provided an opportunity to create a richer description of the situation and new ways of thinking and analysing the phenomena being studied. Having a diverse theoretical and methodological framework and toolkit did not necessarily generate simpler categories, but contributed to critically analysing the complexity; it also generated questions for further research.

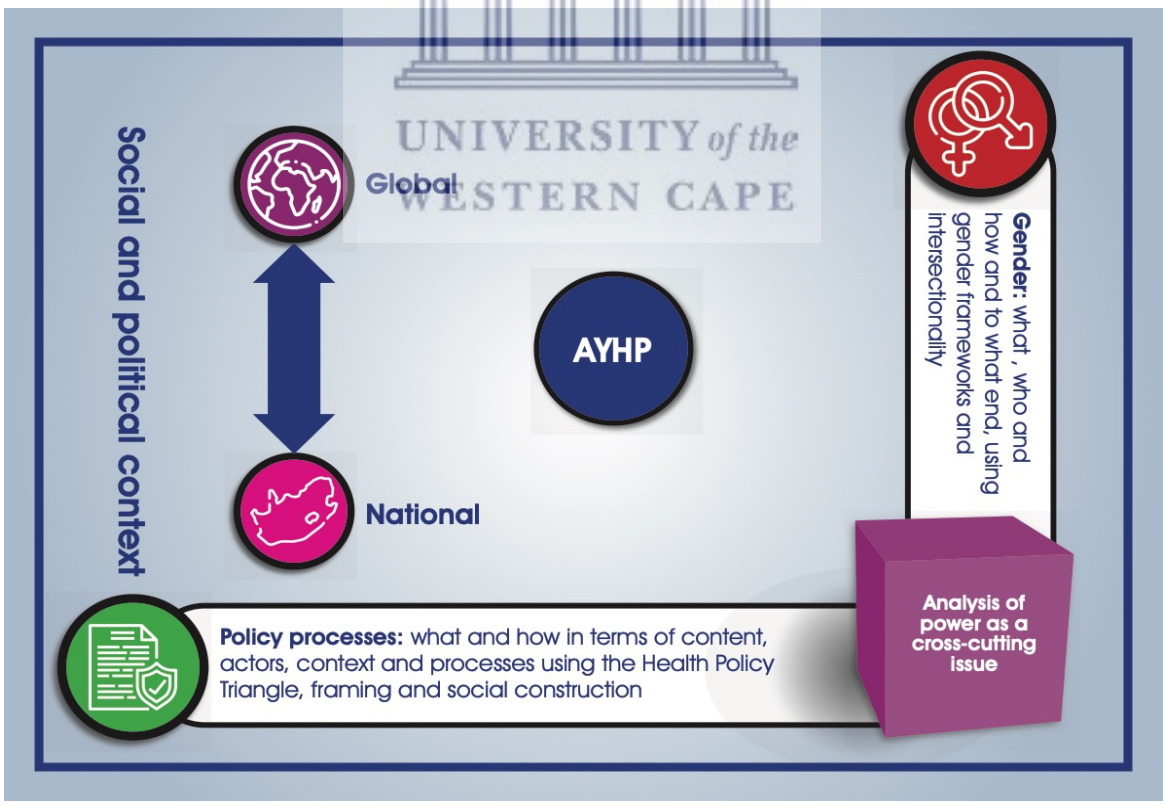


Figure 2: Conceptual Framework

The conceptual framework above is a diagrammatic representation of how theories and frameworks from HPA, policy framing and social construction will be combined with theories and frameworks from gender studies and intersectionality, to analyse adolescent health policy processes – particularly the development of the Adolescent and Youth Health Policy (AYHP 2017) as a tracer for broader health policy and system dynamics. Power, a cross-cutting component of this research, is shown in the conceptual framework as central to understanding gender, and how it is understood and negotiated within adolescent health policy processes. It is a key feature of the social context, what is included in the content, what discourses are dominant and how actors interact in relation to adolescent health policy.

7. STUDY DESIGN

The epistemological position encapsulated in the research is a constructivist one – namely that knowledges and evidence are socially constructed (Green and Thorogood, 2018; Mason, 2018). Following the constructivist acknowledgement that there are different ways of understanding and framing questions, this research explored how participants understood or constructed 'gender' and 'adolescence' for example – as well as how meaning was made by both the participants and the researcher in the research process.

The research comprised a qualitative study, which provided the opportunity to explore the social and political contexts, perspectives and experiences of participants; the institutional and social and political processes, discourses and relationships between various actors were also explored – all with a focus on meaning-making (Mason, 2018). As noted by Green and Thorogood, (2018), a key principle in qualitative research is that it is interested in understanding the complexity of a phenomenon. The choice of a descriptive and exploratory qualitative study was appropriate to exploring and describing the gender considerations of adolescent health policy as it enabled the combination of different sources of data, methods, and approaches to understand both the breadth and depth of issues. It therefore, asked several 'why' and 'how' questions. In so doing, it generated thick descriptions and explanations of the complexities, depth and nuances related to how gender is constructed and framed within adolescent health policy; it also generated important contextual understandings and insights into the perspectives and interpretations of participants.

A case study

A flexible, single, macro-level case study was used as an appropriate design to undertake this in-depth analysis. This provided an opportunity for holistic descriptive and explanatory study to understand the phenomena through the conceptual framework and theoretical underpinnings, and how the phenomena of interest is embedded in the context (Yin, 2018).

Further, in case study research, the contextual features used to help explain findings are not the background to the case, but are a central part of the analysis. In this study, as South Africa is the ' case', the macro-level focus explored how gender is constructed and framed in adolescent health policy contextualised in the broader South African health system and embedded in the social and political fabric and set of actors in that society. Through the use of the case of adolescent health policy, the study has contributed to generating further contextual knowledge, understandings and insights related to the complexities of health policy-making processes.

Within the HPSR systems-level focus, the AYHP was a 'tracer'. This allowed for an in-depth analysis and exploration of both youth participation and actor gender narratives, which have resonance with broader health policy and systems considerations (Gilson, Alliance for Health Policy and Systems and World Health Organization (WHO), 2012). As the AYHP (2017) was relatively new when this study commenced in 2018, the focus was on the early parts of the policy processes – i.e. agenda setting and formulation – and not on implementation per se. There was a consistent focus on how gender was being framed and on the dynamic interaction between content, context, process and actors.

It also needs to be noted that while the main focus of this thesis is on adolescent health policy there are diverse terms and age ranges for what is defined as 'adolescents', 'youth' and 'young people', as noted in Chapter 1. The AYHP uses the ages 10-24 years to refer to range of adolescents and young people and hence these terms and age range was used in the in-depth analysis of this policy.

The research questions and phenomenon to be explored, and the macro-level focus, have helped to define the boundaries and unit of analysis. With South Africa as the national 'case', the parameters of the case study included:

- content of adolescent health policies;
- policy processes related to the AYHP;
- health systems macro-level analysis focusing on national policy actors; and
- key sectors in adolescent health, such as government and civil society actors working in health, education and social development.

As the broad purpose of the research was to inform policy and system actors in order to contribute towards more strategic, effective and equitable health systems, concrete steps were taken to share findings and make recommendations, as well as to engage in discussions. These have been with key policy and systems actors in adolescent health as well as those in gender studies in South Africa, and have taken place through a range of conferences, presentations, webinars and workshops.

8. DATA COLLECTION AND GENERATION METHODS

Case study evidence can come from at least six different sources, with the use of multiple sources contributing to the triangulation of data (Yin, 2018).

In this research, qualitative data were collected through document review (e.g., policies, documents, literature, websites) and interviews with key actors, in order to combine different data sources for triangulation. The table below maps out the relationship between the research objectives and data collection methods.

Table 4:
Mapping relationship between research objective and data collection methods

Objectives	Data collection methods
To describe the social and policy contexts of adolescence in South Africa, taking into consideration gender and intersectionality	Document review
To analyse, from gender and intersectionality perspectives, the content of national adolescent health policy documents	Document review
To map and describe the actors in terms of their roles and relationships, and the process of developing the AYHP in South Africa	Document review Interviews
To understand how the context, content, actors, and processes in adolescent health policies interact to construct and frame gender and intersectionality, as a feature of power	Document review Interviews
To reflect on the implications for gender transformation of this articulation of power, people and processes in adolescent health policies	Document review Interviews

8.1 Document review

The document review comprised largely of two types of documents, being literature and policy documents. As shown in Table 4 above these were the primary sources of data for the first two objectives and which correspond to 'Findings' chapters 4 and 5.

Literature

Documents were sourced from official sites as well as through searches of relevant websites and other media sources identified iteratively during internet searches undertaken from September 2018 to December 2019. The focus of the searches was on the phenomena of interest i.e. social and structural determinants shaping adolescent health in post-apartheid South Africa. Search terms included combinations of 'adolescent', 'social determinants', 'structural determinants', 'inequality', 'gender', 'context', 'health', 'macro', 'meso', 'micro', 'global', 'South Africa' and 'intersectionality'. The 65 sources found included publications

from the fields of public health but also, intentionally, from the social sciences, to integrate disciplinary perspectives. This included fields such as sociology, anthropology, history and cultural studies, gender studies, sexualities studies, education, and criminal justice.

Policy documents

A document review process was undertaken to analyse how gender is framed and to identify the policy discourses and actors involved in both adolescent health policy and programmes. The scope was limited to key and recent policy documents and sectors which have a direct mandate and impact on adolescent health. It did not include all policies that could have an impact on adolescent health like, for example, in sectors such as water and sanitation, agriculture, transport, sports and recreation etc. Additional documents were sourced during the course of the study, through following up references in other documents as well as those suggested by participants. The list and details of 15 policy documents used for analysis are given in Chapter 5. See Appendix 1 for a policy review data extraction tool which outlines the key categories and search terms for all relevant policy texts related to adolescents, gender and health.

8.2 Interviews

In-depth interviews were conducted with a range of actors working in adolescent health in order to understand their perspectives and roles in terms of their interactions between content, context and processes. Criteria for selection included ensuring that there were both proximal and distal actors involved in the AYHP development process, as well as actors working in the field of adolescent health policy and programmes in South Africa.

Through purposive sampling, the interviewees represented a range of experiences and perspectives. They were AYHP policy authors in government, academia and development funders as well as members of the AYHP Advisory Panel and youth representatives from the Adolescent and Youth Advisory Panel; officials of the Commission on Gender Equality and National Youth Development Agency; and adolescent and youth health and gender policy actors in government, academia and civil society .

The table below provides an overview of the social locations or positions of the policy actors interviewed.

Table 5:
Social locations or positions of policy actors interviewed in each category

Category	Number
AYHP authors – government	5
AYHP authors – academia	2
AYHP author – development funder	1
Government actors	6
AYHP Advisory Panel members	5
NDoH Adolescent and Youth Advisory Panel members	3
Civil society actors	6
Members of academia	2

In-depth semi-structured interviews were conducted with these 30 participants between September 2019 and April 2021. This was done in an iterative manner with an initial analysis being conducted after the first round of 15 interviews, which then guided subsequent interviews.

The first round of interviews was conducted face-to-face at a time and place that was convenient to each participant. Within the COVID-19 context, however, the majority of the second round of interviews were conducted virtually via whichever medium each participant preferred (Zoom, Googlemeet, WhatsApp).

The Interview Guide is in Appendix 2. Informed consent was obtained from all participants and they were assured of confidentiality and anonymity throughout the research process. All interviews were audio-recorded with permission and transcribed in full. See attached Appendix 3 for the Participant Information Sheet and Consent Form.

Data saturation was achieved when no new data and or insights were being garnered in additional interviews. Inductive thematic saturation was achieved when no new themes emerged during the analysis of policy documents and interview data (Bowen, 2009; Silverman, 2013; Pope *et al*., 2017).

9. DATA ANALYSIS

This section provides a summary of the aims and detailed data analysis methods used in the published papers that comprise the 'Findings' chapters 4 to7.

9.1 Overview of data analysis methods

The table below provides a summary of the PhD objective, the chapters and publication titles, and data analysis methods, which are then further described in the sections below.

Table 6: Linking the objective with the 'Findings' chapters and the data analysis methods

Objective	Chapter and Title of Publication	Data Analysis Methods
To describe the social and policy contexts of adolescence in South Africa, taking into consideration gender and intersectionality.	Chapter 4: Democratic South Africa at 25 – a conceptual framework and narrative review of the social and structural determinants of adolescent health	Narrative review
To analyse from a gender and intersectionality perspectives, the content of national adolescent health policy documents	Chapter 5: Policy foundations for transformation: A gender analysis of adolescent health policy documents in South Africa	Content and discourse analysis
To map and describe the actors, in terms of their roles and relationships, and the process of developing the AYHP in South Africa.	Chapter 6: Between Rhetoric and Reality: Learnings from Youth Participation in the Adolescent and Youth Health Policy in South Africa	Thematic analysis of interview data Actor mapping
To understand how the context, content, actors, and processes interact to construct and frame gender and intersectionality, as a feature of power, in adolescent health policies	Chapter 7: Looking back and moving forward: Actor narratives on gender in adolescent and youth health policy and programmes in South Africa	Thematic analysis of interview data
To reflect on the implications for gender transformation of this articulation of power, people and processes in adolescent health policies.	All chapters and publications	Triangulation by methods and sources

9.2 Summary of aims, research questions and data analysis methods of 'Findings' chapters

Chapter 4: Publication/Study:
Democratic South Africa at 25 – A conceptual framework and narrative review of the social and structural determinants of adolescent health

Aim and research question

To conceptualise the contextual factors that shape adolescent health, by presenting a conceptual and narrative review of existing multi-disciplinary literature which describes the social and structural determinants of adolescent health at micro, meso and macro levels, as well as how these intersect with and compound with other axes of power and inequality.

Data analysis methods

A conceptual framework (given in Figure 1 in Chapter 4) guided the narrative review examining the key contextual social and structural determinants of adolescent health in South Africa, as well as the search strategy for publications, including grey literature.

The conceptual framework was central to the analysis, and findings from the thematic analysis of the literature were used to further refine the framework in an iterative manner. Importantly, this paper does not aim to provide a definitive analysis of all the social and structural determinants that shape adolescent health in South Africa. Rather, it foregrounds key insights across disciplines with illustrative examples which describe and link the determinants across micro, meso and macro levels of society, their global determinants, and their intersections with compounding axes of power and inequality.

Chapter 5: Publication/Study:
Policy foundations for transformation: A gender analysis of adolescent health policy documents in South Africa

Aim and research question

To better understand the dynamic interaction between the South African context, policy actors and content as part of policy processes, this paper applies a critical gender lens to the content of national government health policy documents relevant to adolescent health in

South Africa. Furthermore, it explores the nexus of the construction of gender and related discourses in adolescent health and raises considerations for what this means for policy analysis and praxis in South Africa.

Data analysis methods

Using a combination of content and critical discourse analysis, this paper applied a gender lens to policy documents produced by national government bodies that have mandates for adolescent health in South Africa. The content analysis was guided by key lines of enquiry and policy documents were classified along the continuum of gender-blind to gender-transformative. Building on this, a critical discourse analysis identified what is problematised, and what is left unproblematised, by actors, identifying the key interrelated dominant and marginalised discourses, as well as the 'silences' embedded in policy documents.

Policy documents were uploaded into ATLAS.ti and a coding framework and code list were developed using an initial broad coding structure derived from propositions in the research. The initial coding framework was applied to four policy documents by the first author and reviewed by the second author before the completion of the coding processes. A deductive analytical approach was initially used, whereby the data were organised using pre-defined codes which included 'gender', 'adolescent', 'youth', 'health', 'inequality', 'rights', 'participation' and so on (Bowen, 2009). These were linked to the key lines of enquiry and an allowance was made for new themes to emerge during the analysis process. These additional codes included, for example, 'sexual orientation', 'gender identity', 'non-binary', 'determinant' and 'responsive'.

For the content analysis (shown in Table 1 in Chapter 5), key lines of enquiry into the content of the adolescent health policies included the following questions , as a basis for understanding policy discourses:

- How is adolescence constructed?
- How is adolescent health constructed?
- How is gender constructed?
- How is gender inequality and its intersectionality with other form of inequality constructed?

- How are adolescent rights and engagement constructed?

The following types of questions were also asked in relation to gender: how gender and key gender terms are defined; the extent and nature of gender analysis undertaken; and whether gender inequality is also recognised as a social and structural determinant of health. In addition, following World Health Organization guidance (World Health Organization (WHO), 2016) and discussions between the first two authors, the nature of the content of the policy documents were classified along the following continuum:

- **Gender-blind**: content that ignores gender norms, roles and relations and differences in opportunities and resource allocation for women and men [and those with non-binary identities].
- **Gender-sensitive:** content which indicates awareness of the impact of gender norms, roles, and relations, but no remedial actions are developed.
- **Gender-specific:** content goes beyond indicating how gender may hinder health of adolescents to highlighting remedial measures, such as programmes for adolescent girls and/or boys [and those with non-binary identities].
- **Gender-transformative:** content which includes ways to transform harmful gender norms, roles and relations.

Building on this, the discourse analysis drew on the work of Bacchi (Bacchi, 2000, 2016, 2017) and the 'What's the problem represented to be?'(WPR) approach. This asks questions related to what is problematised and what is left unproblematised in policies – that is, the 'silences' or what is missing – as well as what assumptions are made and how these have come about. The 'silences' were measured against global and national literature, as well as subject and contextual knowledge. Elucidating what effects are produced by this representation and how it has been (re)produced, identifies opportunities for disruption. As such, this is a useful approach to analysing both the dominant and marginalised discourses, as well as the 'silences', related to gender in South African adolescent health policy documents.

The first author led the analysis of the relationship between the discourses, including those that were dominant and marginalised. The 'silences', that is, what was missing in relation to gender and adolescent health, were measured against global and national literature, as well as subject and contextual knowledge. The initial analyses were reviewed by the second and third

authors and consensus was achieved through discussions and further refinement of the analysis.

Chapter 6: Publication/ Study:
Between rhetoric and reality: Learnings from youth participation in the Adolescent and Youth Health Policy in South Africa

Aim and research question

To describe and analyse youth participation in the AYHP process; also to raise critical questions and lessons in terms of the 'how' of youth participation in health policy making.

Data analysis methods

Acknowledging and building on prior work which conceptualises youth participation, this paper expands and adapts a relatively new conceptual framework synergised from fields of feminist, post-structural and critical theory, as well as youth studies and citizenship research into youth participation in conceptualising and planning programmes (Cahill and Dadvand, 2018) . The model directs attention towards seven inter-connected domains, namely purpose, place, process, positioning, protection, perspective and power relations. To these we added two domains i.e. people (the actors), as well as partnerships, across government departments and with civil society, for example. We focus on process as a dynamic cross-cutting domain, and how it intersects with the domains of positioning, protection, perspective and power relations . The final conceptual framework, (given in Figure 1 in Chapter 6) therefore, has place or context as the broader setting, which encompasses process (positioning, protection, perspective and power relations) and purpose; people and partnerships are embedded throughout.

Given that the phenomenon of interest is youth participation in health policy processes, we also integrate approaches from health policy analysis (HPA). These go beyond content and specifically consider the context that is shaped by individual, organisational, national and global factors, as well as actors in terms of their roles and influence on policy processes, at different levels (Walt and Gilson, 1994, 2014; Walt *et al.*, 2008)

The Health Policy Triangle (Walt and Gilson, 1994) – which explores the dynamic interactions between content, actors, context and processes that shape policy processes – was integrated into the interview guide. It has been used extensively at global and national levels and has been applied largely to public health concerns such as health human resources, services and systems, communicable and non-communicable diseases, physical and mental health. It has not yet been applied to youth participation in policy processes, however (O'Brien *et al.*, 2020). Mapping and understanding the actors, including youth, and how they interface with other actors in health policy making processes is, therefore, an important line of enquiry in order to understand the complexity and dynamics of policy processes and to address the gaps between rhetoric and reality.

Data analysis was guided by the conceptual framework and the interview transcripts were analysed using thematic analysis which included both deductive and inductive coding and categorisation (Braun and Clarke, 2013, 2021; Clarke and Braun, 2014). Initial deductive codes were based on Cahill and Dadvand, (2018) and included purpose, place, process, positioning, protection, perspective and power relations. Through the thematic analysis, the other two codes – people and partnerships – were added inductively, and the conceptual framework was also refined through this iterative process. In addition, interview data were triangulated across respondents, as well as with data from document analysis of the AYHP.

Chapter 7: Publication/Study:
Looking back and moving forward: Actor narratives on gender in adolescent and youth health policy and programmes in South Africa

Aim and research question

To describe the constellation of actor gender narratives within the context and process of developing the Adolescent and Youth Health Policy (2017); and to contextualise these narratives and their implications for advancing gender equality in current and future adolescent and youth health policy and programmes.

Data analysis methods

From sociology and gender studies, we draw on Fraser's theoretical concepts of redistribution, recognition and representation as starting points for 'sense-making' of different perspectives on gender, gender inequality and gender justice (Fraser, 1995, 2007, 2012). Fraser links dimensions of recognition of identities and redistribution of resources as gender struggles that combine the inclusionary and the transformative approaches. These different aspects of gender equality are reflected in the actor narratives identified by Mannell (2014), further elaborated upon in this paper.

The paper also incorporates concepts and approaches from health policy analysis, specifically the Health Policy Triangle, which views policy content in conjunction with the role of actors, and how their ideas, perspectives and actions shape policy processes, as well as policy contexts (Walt and Gilson, 2014; Koduah, van Dijk and Agyepong, 2015). In addition, the analysis also drew on the notion of policy 'frames' and 'framing' by various actors and how they make sense of policy processes (Yanow, 2007; Koon, Hawkins and Mayhew, 2016; van Hulst and Yanow, 2016).

A descriptive and explanatory case study design was chosen which allowed for enquiry into the phenomenon as located in the social and political contexts. It also provided rich and thick descriptions and sense-making of the complexity and nuances that shape actor gender narratives in adolescent health policy (Walt *et al.*, 2008; Gilson, 2012; Yin, 2018)

Thematic data analysis was guided by the literature cited earlier. Interview transcripts were analysed both deductively – i.e. along the lines of enquiry related to gender and actor narratives – and inductively i.e. issues emerging from the data (Braun and Clarke, 2013, 2021; Clarke and Braun, 2014). In addition, interview data were triangulated both across respondents as well as with data from the document analysis of the AYHP.

10. POSITIONALITY AND REFLEXIVITY

A key component of HPSR is the importance of reflexivity in understanding the researcher's positionality in the research process (Sheikh, George and Gilson, 2014; Green and Thorogood, 2018). Being reflexive in research requires that the researcher is conscious of being the instrument in the research as well as part of the context and setting that is being researched (Liamputtong and Ezzy, 2005; Silverman, 2013; Mason, 2018). Reflexive practice was a central thread across all components of the research process. It was introduced in the Preface, is also addressed here in the 'Methodology' chapter, is in each of the 'Findings' chapters and is also reflected on in the 'Discussion' chapter.

As the researcher, I remained mindful in applying the principles of reflexivity in terms of my interests, analytical lenses, power and relationships with the actors and policy process. In order to enhance my self-awareness, I kept a journal to document and reflect on my own views, experiences and position within the research process. As a PhD researcher I had the opportunity to participate in feminist methodologies modules in Women's and Gender Studies at UWC. Exploring and foregrounding positionality and power was central to those discussions and enhanced my knowledge and understandings of this component of the research (Chadwick, 2021).

The researched is centered on interpretation by respondents and as the researcher I was constantly aware of, and reflexive in terms of, my positionality. This included being an intersectional feminist, a white, middle-class woman with many years of work experience in gender-based violence and HIV, largely with civil society and health systems actors. My positionality and privilege as a researcher included having more than 25 years of knowledge and working experience in the South African context, and knowing several policy actors, which gave me easier access to many of them.

Also, as part of my positionality as a researcher I had the opportunity of engaging and speaking with various actors grappling with similar questions, but who were not in conversation with each other and, ideally, should be. In the interest of advancing HPA, I made my research design, power and positionality explicit amongst academics and peers as I was acutely aware of the spaces I occupied across these contexts. Working across academic and practice spaces also allowed me to be mindful of the power that comes with being able to

generate knowledges from both sides, and of the importance of creating and enabling spaces where knowledges and understanding are shared.

Being located in the intersections of fields and belonging to several conversations – and not being 'neatly' located in one field per se – made for 'discomforts' at times, particularly when trying to bring together different ideas, disciplines and communities. As part of grounding my reflexivity as a researcher I found that staying with, and finding comfort within, the 'discomforts' was central to my research praxis; both engaging in individual reflective practice, as well as with peers, enhanced this awareness. Working with my positionality as part of disciplinary discomforts was challenging at times, particularly when writing for certain journal audiences. While these 'discomforts' unsettled and challenged me, they were ultimately generative and allowed me to locate my 'voice' and contributions across disciplines more clearly. Reflexivity as central to the research was also practiced in several ways and reflections on positionality, particularly the power that comes with being a researcher, was a core element of the Feminist Methodologies course I participated in. In addition, I was in constant reflective conversation with my supervisor, CHESAI colleagues and other experts in the field to offer critical perspectives on the researcher's biases and assumptions. Keeping a reflective journal was also part of building mechanisms and support for critical reflexivity throughout the research process.

11. RIGOUR AND VALIDITY

The research rigour and ethics were guided by the processes for ensuring rigour in case studies and qualitative data collection and analysis as outlined by Gilson, Hanson and Sheikh (2011).

The following were applied to demonstrate rigour i.e. being thorough, accurate and exhaustive in all aspects of the research (Braun and Clarke, 2013; Silverman, 2013; Mason, 2018).

Triangulation by methods and sources

Multiple sources of data and evidence, collection methods, disciplines and theories were used to ensure convergence of evidence. In addition, participants comprised a range of social actors from different sectors and from a range of actors which allowed for a variety of perspectives and understandings to be reflected in the data. These brought together various disciplines and lenses to analyse how gender is constructed in adolescent health policy.

Having different sources and methods strengthened the construct validity of the case study and the phenomena of interest. Data were triangulated across different sources. For example, Chapter 5 used policy documents as data and the findings are aligned those in Chapter 7 which comprised an analysis of a range of policy actor gender narratives. These triangulated findings complemented each other and, together with Chapter 4 which describes the context of adolescent health in South Africa, provided an in-depth set of insights into the phenomena of interest.

Prolonged and active process of checking and questioning

The researcher engaged in a prolonged and active process of questioning the findings, asking further questions about the policy documents, policy actors and the South African context in terms of why and how gender was constructed in adolescent health policy processes.

During the process of sense-making, initial interpretations were checked against theory in an iterative process in order to deepen and expand the initial analysis. This informed subsequent data collection and interpretation was also undertaken in an iterative manner.

Peer debriefing and support

The researcher engaged in continuous debriefing discussions with the supervisor and other peers as part of enhancing the transparency of the content and throughout the entire process of the research. She also encouraged critical feedback on interpretations, thus strengthening the reliability of the research. This also enhanced the rigour by ensuring that the researcher's interpretation and analysis of the findings were clear and congruent with the data.

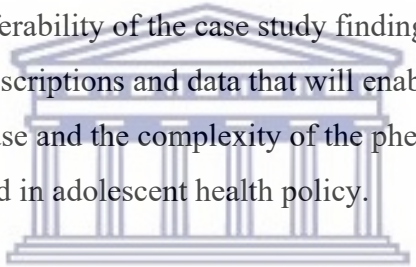
An additional layer of rigour was provided by journal peer-review processes, and the presentation of findings in conferences and meetings which allowed for critical engagement and feedback.

Case study data base and audit trail

The researcher created a database to document and organise the data – which was accessible to the supervisor. In addition, an audit trail was maintained which documented and described decisions made during the research process. These included decisions about methodology, as well as those made during data collection and in the analytical stage of the research. Maintaining a chain of evidence outlined the steps and relationship between the research protocol, the citations of sources used in the document review and data analysis, the case study database – and the findings.

Transferability and generalisability

In order to strengthen the transferability of the case study findings, the research generated thick and detailed contextual descriptions and data that will enable various audiences to understand the context of the case and the complexity of the phenomenon in terms of why and how gender was constructed in adolescent health policy.



As qualitative research, the intention was not to generate findings that are generalisable in other contexts, but rather to enable the construction of validity that can potentially be used by other researchers. As the case study used theory to describe and explore a gender analysis of adolescent health policy as well as the interactions between content, context process and actors, some of the theories, concepts and methodological issues may be relevant to other policy foci or HPSR more generally.

12. ETHICS STATEMENT

This study was approved by the Biomedical Science Research Ethics Committee of the University of the Western Cape (Appendix 4), and was also registered on the National Health Research Database as required by the National Department of Health.

Written informed consent to conduct interviews was obtained from each participant (see Appendix 3 for Participation Information Sheet and Consent Form). The process of informed consent ensured interviewees were given the information about the nature of the research, the usage of the research results and possible implications for them. In addition, interviewees were assured that their participation was voluntary and that they had a right to discontinue during the study or decline to answer any questions without any consequences. The researcher ensured that interviews were conducted at a time and place that was convenient to the participants.

The identity of participants was protected during the entire research process, ensuring that findings were reported anonymously. Only the researcher and supervisor had access to all field notes, interview recordings and transcripts, which will be kept in a locked cabinet and in password protected electronic files for five years, after which they will be destroyed.

The findings of the research were disseminated through various processes: to key stakeholders including colleagues in academia and to relevant civil society organisations and NGOs; through publishing in peer-reviewed journals; and through presentations and feedback to policy makers and health systems actors and those working in gender studies and/or focusing on gender within their programmes.

CHAPTER 4:
DEMOCRATIC SOUTH AFRICA AT 25 – A CONCEPTUAL FRAMEWORK AND NARRATIVE REVIEW OF THE SOCIAL AND STRUCTURAL DETERMINANTS OF ADOLESCENT HEALTH

Chapter 4 was published as a peer-reviewed research article: Jacobs, T., & George, A. (2021). Democratic South Africa at 25 – a conceptual framework and narrative review of the social and structural determinants of adolescent health. *Globalization and Health*, 17(1), 1–11. https://doi.org/10.1186/s12992-021-00679-3.

1. SUMMARY

This paper was developed through a narrative review of literature that described the social and structural determinants of adolescent health in South Africa. It presents the conceptual framework that was developed and illustrative examples of the narrative review to provide a systematic way of analysing the determinants across micro, meso and macro levels of society, their global determinants, and their intersection with compounding axes of power and inequality that shape the health of adolescents in South Africa.

2. CONTRIBUTION TO THE THESIS

This paper contributes to the first objective of the thesis: To describe the social and policy contexts of adolescence in South Africa, taking into consideration gender and intersectionality. This descriptive exercise and the development of a conceptual framework provided an important foundation for subsequent papers. It also contributes to the fifth and cross-cutting objective, which is to reflect on the implications for gender transformation of this articulation of power, people and processes in adolescent health policies.

3. CONTRIBUTION OF THE CANDIDATE

The candidate designed the study, conducted the literature search and developed the conceptual framework, with input from the supervisor. The candidate wrote the first draft, and the supervisor provided critical input on this and subsequent drafts, as well as on the comments from the journal peer-review process. The candidate led the submission process and revisions back on the comments from the journal peer review. The paper was presented by the candidate as a poster at the Public Health Association of South Africa Conference in 2019.

A copy of the published article is available in Appendix 5. It is also reproduced here to facilitate the coherence of the thesis' 'Findings' chapters, retaining the style and format required by the journal. Comments from the peer review process are available in Appendix 6.

4. PUBLICATION/STUDY: DEMOCRATIC SOUTH AFRICA AT 25 – A CONCEPTUAL FRAMEWORK AND NARRATIVE REVIEW OF THE SOCIAL AND STRUCTURAL DETERMINANTS OF ADOLESCENT HEALTH

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Abstract

Twenty-five years into South Africa's constitutional democracy provides an opportunity to take stock of the social and structural determinants of adolescent health. Those born in democratic South Africa, commonly known as the 'Born Frees', are perceived to be able to realise equal rights and opportunities, yet many factors constrain their lives. In bringing together approaches to understanding context in health policy and systems research and the social determinants of health, the paper develops a conceptual framework to guide the narrative review examining the key contextual social and structural determinants of adolescent health in South Africa. Illustrative examples drawing from 65 papers from public health and the social sciences describe and link these determinants across micro, meso and macro levels of society, their global determinants, and their intersection with compounding axes of power and inequality.

At a micro level individual adolescent sexual and gender identities are expressed thorugh multiple and evolving forms, while they experience growing autonomy and agency, they do so within a broader context characterised by regressive social norms, gender inequality and other intersecting power relationships. At the meso level, organisational and sectoral determinants shape adolescents health and rights, both in being supportive, but they also replicate the biases and inequalities that characterise South African society. In addition, the macro level national and global determinants, such as the structural colonial and apartheid legacies shape adolescent health. Despite constitutional and other legislative rights, these

determinants and compound economic, geographic, gender and other intersecting inequalities.

A key finding is that current experiences and health of adolescents is shaped by past social and structural determinants and power relations, with apartheid inequalities still echoing in the lives of the adolescents, twenty five years into democracy. More research and work is needed to provide insights into determinants of adolescent health beyond just the micro level, but also at the interrelated and dynamic meso and macro levels, nested in global determinants. The findings raise critical considerations and implications for understanding the social and structural determinants in the South African context and what this means for adolescent health in the SDG era.

Key words: social and structural determinants, adolescent health, gender, intersectionality, South Africa, micro, meso, macro

Background

Twenty-five years into South Africa's constitutional democracy provides an opportunity to take stock of the social and structural determinants that shape adolescent health. Those born in democratic South Africa, commonly known as the 'Born Frees', are perceived to be able to realise equal rights and opportunities. However, the persistence of past inequalities continues to shape their lives, their health and the systems in which they live.

Adolescents, make up almost a fifth of South Africa's population (1) and while national school attendance stands at 98% (2), estimates for completion of secondary education are at 49% (3). Equally of concern is the very high unemployment rate for both youth and adults in South Africa. In the first quarter of 2018, 38% of young people aged 15–34 were unemployed (4)(Stats SA, 2018). Also alarming is the level of violence experienced by adolescents in South Africa. Approximately one in three adolescents (35%), reported that they experienced some form of sexual abuse during their lifetime (5,6). Gender power relations underline the perpetration and experience of violence. In one study, in Cape Town, 10% of boys reported forcing a partner to have sex, while 39% of girls reported physical victimization (7). These macro level structural determinants related to education, employment, gender inequality and violence have only gotten worse with COVID-19 and they powerfully shape the experience of adolescent health. For example, in terms of adolescent sexual and reproductive health, 16% of women aged 15-19 years have begun childbearing. Of these only 52% were reported to be attending school, compared to 83% of childless adolescents in 2016 (1). Despite HIV incidence decreasing from 2012, it remains high, particularly among female youth aged 15-24 years (8). HIV incidence rates for females aged 15-24 years were three-times that of their male counterparts in 2017.

While these descriptive statistics help illustrate one dimension of adolescent health, it is also important to locate adolescents beyond a public health lens. The comprehensive aims of the Sustainable Development Goals (SDGs), aligned with the United Nations Secretary General's Global Strategy (2016-2030), emphasises that all women, children and adolescents not only survive, but thrive and transform. This provides a window of opportunity to develop new paradigms for ensuring inclusiveness and responsiveness to the rights and needs of adolescents (9,10) as significant societal assets whose contributions and meaningful participation are critical for societal wellbeing (10).

The paucity of conceptual frameworks which take into account the social and structural determinants of adolescent health in South Africa, and their dynamic interaction across the micro, meso and macro levels, nested in global contexts, limits the ability of policy makers and practitioners, as well as researchers, to optimally identify their role and contribution to adolescent health. Seizing this window of opportunity, this paper seeks to conceptualise the contextual factors that shape adolescent health, by presenting a conceptual framework (Figure 1) and narrative review of existing multi-disciplinary literature which describes the social and structural determinants of adolescent health at micro, meso and macro levels, as well as how these intersect with and compound other with axes of power and inequality. In doing so it aims to provide greater understanding of the implications of these contextual determinants shaping adolescent health for South African health systems and policy in the SDG era.

Methods

The review considers approaches to understanding and conceptualising 'context' from Health Systems and Policy Research (HPSR), the Social Sciences, as well as intersectional perspectives to develop a conceptual framework to map the social and structural determinants of adolescent health in South Africa (Figure 1). It builds on the WHO Social Determinants of Health Framework (12) and recent publications on adolescent health (13–16), many of which draw on socio-ecological theory (17). It presents interrelated micro (interpersonal), meso (organisational), and macro (structural) contextual determinants within the lasting legacy of apartheid, 25 years after South Africa's transition to democracy. In addition, it emphasises cross-cutting past and present social and structural determinants, such as racial and gender inequality. These intersect with and compound other cross-cutting social and structural determinants, such as class, (dis)ability, sexual orientation, and other forms of discrimination and marginalisation to construct and determine the health of adolescents (18). Importantly, these national determinants are nested in broader global contextual determinants, such as alcohol and tobacco policies, global trade, global health and development policies and processes, such as the SDGs, religious and neo-liberal ideologies, globalisation, migration, war/conflict and climate change, as well as social media and access to the internet.

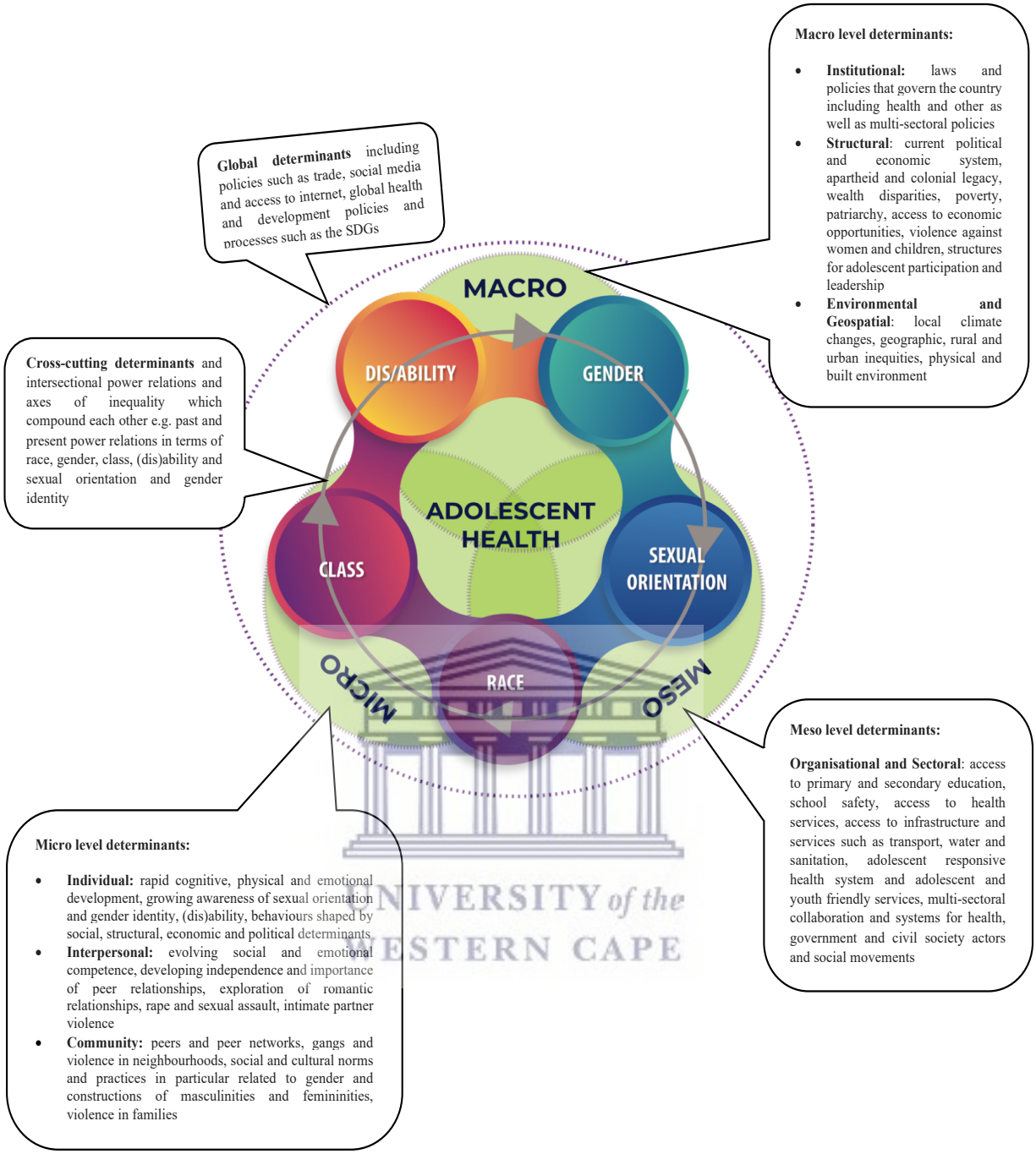

Figure 1: Social and structural determinants of adolescent health in South Africa

The paper's conceptual framework (Figure 1) guided the search strategy for publications, including grey literature, which were sourced in an iterative manner through systematic internet searches from September 2018 to December 2019. The focus of the searches was on the phenomena of interest i.e. social and structural determinants shaping adolescent health in post-apartheid South Africa. Search terms included a combination of 'adolescent', 'social determinants', 'structural determinants', 'inequality', 'gender, 'context', 'health, 'macro', 'meso', 'micro', 'global' 'South Africa', 'intersectionality'. The 65 included publications were sourced from Public Health, but were also intentionally selected from the Social Sciences to integrate disciplinary perspectives. This included fields such as Sociology, Anthropology, History and Cultural studies, Gender studies, Sexualities studies, Education and Criminal Justice. The conceptual framework was central to our analysis and findings from the thematic analysis were used to further refine it in an iterative manner. Importantly, this paper does not aim to provide a definitive analysis of all the social and structural determinants that shape adolescent health in South Africa, however it foregrounds key insights across disciplines with illustrative examples.

Social and structural determinants: intersecting micro, meso and macro levels

We describe key social and structural determinants shaping adolescent health in South Africa, starting from the micro level through to the macro level as well as the global level, noting that there is dynamic interaction between levels, also shaped by intersectional cross-cutting determinants, as illustrated in Figure 1.

Micro level: individual, interpersonal and community

In this section we describe micro level determinants which include the individual, interpersonal and community aspects. As presented in the conceptual framework (Figure 1) and we illustrate how gender identities and sexual orientation are shaped by social and cultural norms and practices influenced by violence in relationships and communities, class inequality, spatial segregation, racism and homophobia.

Adolescence is a time of key developmental transitions towards adulthood with significant cognitive, biological, physical, psychosocial and emotional changes, which can bring both excitement and challenges (10). The reviewed literature details how the individual experiences and behaviour of adolescents in South Africa is shaped by inequalities and violence at the meso and macro level, as mapped out in the sections below.

In South Africa, adolescent femininities and masculinities are constructed simultaneously by historical processes of cultural and religious integration and contemporary pressures, where there is a resurgence of 'traditionalism,' in some parts of the country (19). These gendered and sexual identities are not just passively absorbed, but also actively re-enacted. Young women in the rural Eastern Cape province activate diverse femininities and foreground their agency in pursuit of their own sexual and emotional agendas, while at times accepting violence and patriarchal norms in return for economic and emotional benefits in the face of enduring poverty (20). Furthermore, while young women's agency was most notable at the start or initiation of relationships, this agency was constrained once relationships were more established, and patriarchal roles of male control were entrenched (21). The authors document a diverse and dynamic set of femininities, ranging from a 'modern girl' femininity, a dominant conservative cultural model, as well as a blend of an emerging feminist consciousness, albeit still blended with a more traditional femininity. However, none of these included a significant challenge to the dominant gender arrangements that are patriarchal and heteronormative. Strikingly, femininities constructed by young women, some of which invoked the discourse of 'empowerment', do not fundamentally destabilise men's power, but serve to legitimize and reinforce patriarchal power structures.

Interpersonal relationships are constructed by gendered socio-economic material and physical contexts (e.g. gendered ownership of space by young men) and related cultural practices as they are 'scripted' into the functioning and practices of relationships. These provide barriers for young women to negotiate safer sexual practices (22). Bhana, (2018) similarly shows how adolescent ideas and experiences of love are located within the broader social, economic and gendered context which include, chronic unemployment, poverty and historical legacies

of apartheid. Both these papers illustrate the need for more nuanced approaches when researching and analysing adolescent interpersonal relationships, as they illustrate how the social and structural determinants, such as poverty, intersecting with and compounded by gender inequality, are part of reproducing inequality and vulnerabilities to HIV and gender-based violence.

Further illustrating the cross-cutting determinants of the conceptual framework beyond heteronormative identities, learners in school who identify as LGBTIQA+ are often marginalised or bullied, ranging from derogatory language to violence, perpetrated by both learners and teachers (24). These deeply patriarchal and heteronormative contexts have rendered queer learners 'invisible', compounded by racial and other inequalities in constructing their experiences in the South African education system. Despite this, queer learners also resist dominant narratives, reflecting resistance and agency in trying to resist homophobia by developing counter narratives. Addressing heteronormativity as a social and structural determinant in school contexts will therefore require a more inclusive curriculum, informed by the experiences of queer learners and including counter-normative sexualities in the content and process of teaching sexualities education in South Africa (25).

Despite numerous interventions and substantial funding (e.g. DREAMS and the She Conquers Campaign) that has largely been directed to preventing HIV among adolescent girls and young women, gender relations remain firmly entrenched and reproduced by the dominant social and structural determinants, such as the intersections of patriarchy, racial and the geo-spatial legacy of apartheid, heteronormativity, poverty and class, for example (26,27). Within public health, many HIV and gender-based violence (GBV) interventions in South Africa focus on norms experienced at the micro level and attempt to change individual behaviour related to sexual practices such as condom use, for example (28). Moreover, in terms of retention in care and adherence to HIV treatment, there is need for interventions that go beyond health facilities, to address broader social and structural determinants at the meso and macro levels (33,34.) As illustrated by the conceptual framework and narrative examples summarised above, this alone is not enough. Further, interventions, including those which aim to be gender-transformative are often only partial, in that the individual behaviour they attempt to address, is shaped by and embedded in, the broader dynamic of social, cultural and interpersonal realms within structural contexts, that are left unaddressed (28,31).

There is a need for expanded paradigms beyond just a focus on individual identities and vulnerabilities at the micro level, but to conceptualise how these are created and reproduced by the social and structural determinants at the meso and macro level, as well as the cross-cutting determinants and axes of inequality based on gender, race, class and sexual orientation. This is one of the key threads of our analysis and central to the conceptual framework we present.

Having noted the need for different paradigms and approaches it is important to highlight that globally there has been work done related to gender and economic interventions and addressing poverty as a central approach to preventing GBV and HIV. However, there is a need for more research looking specifically at adolescents, including those living in South Africa (32). There is also a growing body of research on the role of adolescent-sensitive social protection, mostly focussed on HIV positive adolescents, as an approach to address both immediate and distal determinants, beyond just the micro level. (33,34).

Meso level: organisational and sectoral

The meso level determinants described in this section focus on the organisational and sectoral as institutions and sites that determine adolescent health, with a focus on access to health care, education, school safety and sexualities education, as illustrative examples of the conceptual framework (Figure 1). While recognising the importance of access to infrastructure and services such as transport, water and sanitation, there is a paucity of adolescent-specific data and research on these sectors. Therefore, they are not discussed further in this section and should be the focus of further research.

South Africa has enacted comprehensive and progressive legislation and policy frameworks to enable provision of and access to adolescent and youth friendly health services through the National Adolescent Friendly Clinic Initiative (NAFCI) (35). Despite these investments adolescents report dissatisfaction with the quality of care received, in terms of respect and confidentiality, long waiting times and stockouts of medicines, as well as attitudes of health workers (36–38), as organisational determinants that shape their health. The NAFCI was followed by The Ideal Clinic Initiative, a process of standard setting and quality improvement, which includes measures towards adolescent and youth friendly programmes. These include access and availability of adolescent services, relevant information and

communication and a management system to support service delivery (39). As this is a relatively new approach, further research is required to assess its impact on health systems responsiveness to diverse adolescents' needs and experiences.

Within these initiatives to improve access of services to adolescents, interactions between adolescents and health workers are critical. Nurses providing sexual and reproductive health services to adolescents navigate conflicting roles as service providers, educators and law enforcers. In making decisions and ideological judgments about adolescents seeking services, they create barriers and differential access to services (40). Apart from prejudicial attitudes and responses of providers, as well as lack of knowledge on sexual and reproductive health and rights by service providers, adolescents are also constrained by a lack of physical access to health facilities, limited range of contraceptives, as well as programmes that do not include adolescents and young people in their design and delivery (38,41).

In addition, there are several additional barriers to sexual and reproductive health information and services for sexual and gender minority adolescents, which include stigma related to their sexual orientation, further compounded by age-related stigma in terms of being sexually active as adolescents (42). Furthermore, adolescents living with disabilities also experience additional barriers to services and education, thus increasing their vulnerability to issues such as HIV and sexual violence (43).

The meso level also looks at the role of other sectors, and we review research on the education sector, and how it can create systems that promote and sustain the health of adolescents, as illustrated in the conceptual framework. In South Africa, schooling is compulsory to the age of 15 and a no fee schools policy removes financial barriers to access in principle. However, for many children their school experience is marked by irregular attendance, absent teachers, teenage pregnancy and school-related abuse and violence. Despite huge strides being made in terms of access to education, persistent racial, geographic, socio-economic and gender inequalities shape access to and quality of education (44). Around 27% of public schools do not have running water, 78% are without libraries and 78 % do not have computers.

Adolescent girls face multiple additional barriers to education and specific risks to their health once in school. The use of poor quality sanitation in schools or avoidance due to their poor quality results in poor menstrual hygiene for adolescent girls (45). In addition, the experience of sexual violence, from both male teachers and students, prevails as part of a broader school environment that is not safe and healthy for girls. While the national education policy is committed to gender equality and ensuring access to education for all learners, including those who may be pregnant or parents, in practice this is not the case. Macro level determinants such as broader societal narratives and dominant ideas on teenage pregnancy, parenting and also female sexuality, also shaped by the power relations between school management teams, educators and learners, determine how this is addressed at schools (46). These dominant discourses make schools a place of exclusion and unwelcoming of learners who are pregnant, by perpetuating normative gender roles and framing female sexuality and teenage pregnancy as social and moral degeneration.

We further illustrate the conceptual framework to show how the meso level determinants intersect with macro level and cross-cutting determinants, with the example of the provision of sexualities education. Life Orientation sexualities curriculum bombard learners with messages of 'disease, danger and damage' (47), unknowingly promoting rigid versions of gender, some of which underlie sexual violence, as well heteronormativity as macro level determinants of adolescent experience and health. Dominant notions of masculinity and femininity also include holding young women accountable for upholding both their own and societal moral practice, for example by placing the burden of preventing pregnancy, HIV and rape largely on them (48).

While it is important for adolescents to understand the contextual factors and risks related to sexual relationships, the dominant construction of young women as inevitable victims, needing protection and needing to self-control and restrain, is problematic for working towards gender justice. In addition, educators feel under-prepared and under-supported in teaching sexualities education and in providing support to learners who approach them with personal issues. Educators who themselves embody and perpetuate dominant gender norms, are not neutral, and are part of organisational determinants that reinforce gender inequality by what and how they teach i.e. largely didactic methods reinforcing narratives of illness and disease and girls needing to take responsibility (49).

Research comparing Life Orientation manuals with the songs voted most popular by these students highlight the contradictory pressures they face (50). The findings illustrate the gaps between what adolescents are required to learn i.e. being responsible sexual subjects and danger of sexual victimisation, as opposed to what they are engaging with in their free time i.e. songs about sexual pleasure and tensions in relationships. In addition, the subjective experiences and what adolescents are wanting to discuss, is not addressed at school, however this is important for comprehensive sexualities education programmes in and out of school (51) .

Despite global evidence and national support, progress has been slow to develop and implement comprehensive sexualities education that includes a positive understanding of sexualities and gender and which creates a safe and non-judgemental space to meaningfully engage adolescents themselves. The current pedagogy is largely 'expert'-based and didactic missing out on the critical space for to actively engage adolescents in making meaning of gender and sexualities (52). A recent development is that the Department of Basic Education is planning to roll out an updated Comprehensive Sexualities Education programme in 2020, and this is already facing steep resistance from religious and some parent groups (53,54). Despite the furore, the new curriculum provides a significant opportunity to support adolescents to build an accurate understanding of their bodies and develop healthy attitudes and behaviours when it comes to sexualities, identity and relationships and begin to address some of the cross-cutting social and structural determinants, such as gender inequality, gender-based violence and homophobia, for example.

This meso level focus highlights how health services and schools are not neutral spaces, but are shaped by the social and structural determinants and are highly gendered organisations, that both reflect and replicate notions of masculinities and femininities that are present in the broader social and political national and global contexts as cross-cutting determinants. Further, it shows that the rights to health and education and non-discrimination described in policies, evaporate in organisations where adolescents, providers and management hold and reinforce regressive views and assumptions related to gender and related social and structural determinants, such as race, sexual orientation and class, for example.

Macro level: institutional, structural, environmental and geospatial

As foregrounded in the conceptual framework (Figure 1), the macro level determinants illustrated in this section include the institutional i.e. national laws and policies that govern the country and what the implications are for adolescent health. In addition there is a focus on the structural i.e. colonial and apartheid legacies, as well as current political and economic systems as well as environmental and geospatial components. It also includes broad outcomes and consequences of such legacies and systems, such as the nature of poverty and inequality, as well as violence and how these intersect with cross-cutting determinants.

Current inequality in South Africa has its roots in the historical influences of colonialism through the dispossession of land, migrant labour system and extraction of resources (55). In addition, the apartheid system, articulated through legislation and structural racial inequalities, denial of democratic rights and violent state oppression, also deeply marked the nature of inequality. These historical legacies shaped power relations which are persistent post-1994. Key 'fault lines' in health system weaknesses remain including leadership, management and governance (56). There is a disconnect between the progressive Constitution and the limited critical public discourse around the historical intersections of racial and gender inequality for example (57,58). The apartheid era policies created structural constraints, limiting possibility for social and economic opportunities and mobility for the vast majority of South Africans (59). Despite political freedom in 1994, legacies of disadvantage remain and are reproduced across generations, i.e. intergenerational transmissions of economic and social capital or lack thereof. Importantly, South Africa's social and economic context is part of a broader system of global economic trends, which contributes to combined and uneven development, further perpetuating inequalities. This includes the nature of macroeconomic policy, economic regulation and the economy as a whole (60).

The historical context of colonialism, apartheid with its plethora of laws and policies that violated human rights, was interwoven with systems of patriarchy and complex constructions of masculinities through violence and gender hierarchies, all of which impact on the context in which adolescents are socialised and live (57,58,61). Contemporary South Africa has some of the highest prevalence rates of violence against women and children, as well as HIV in the world, which are fuelled by gender and intersecting inequalities. Adolescent girls and young women in South Africa bear the brunt of HIV and GBV and these both and illustrate how past and present macro level determinants dynamically interact, shaping the health of adolescents.

The rape and murder of a nineteen-year-old female student in August 2019 was a catalyst for national outrage and re-emerging protests against the continuing high rates of sexual violence and the persistent failure by government to reduce and stop gender-based violence, including femicide (62,63). These protests focussed the national debates again on the normalisation of gender base violence including femicide and how this is perpetuated by a patriarchal and unequal society. While there is an increased awareness around gender-based violence, there is limited focus on problematising patriarchy as a social and structural determinant and how it constructs masculinities and femininities. With reference to the conceptual framework, it highlights the importance of the macro level determinants of gender based violence when conceptualising and planning interventions and services, addressing underlying causes and prioritising prevention, when allocating specific resources in the South Africa context (64).

A further illustration of the interaction between the social and structural determinants at macro, meso and micro levels are the many gangs, located in urban and peri-urban areas created by apartheid, which often operate as subcultures and an expression of, and resistance to, the dominant political systems. These physical and social spaces are also sites for creation of gendered identities which are layered with racial and economic and patriarchal power relations (65,66). In these spaces there is a complex dynamic between physical space, economics, gender and race as adolescent boys and young men have limited access to the key resources that define a dominant masculine identity and therefore use physical violence, murder and rape as an alternative means to assert their masculinities and personhood in these local contexts. Research conducted with young men in urban informal settlements highlights how diverse masculinities, often with disjuncture of hegemonic masculinities, including hierarchy of masculinities, are expressed (67). This research demonstrates how cross-cutting

and intersectional axes of inequality in terms of gender, race, and class shape masculinities and endorses gender-transformative work, at the micro, meso and macro levels in order to address interrelated national priorties of HIV and gender-based violence prevention, in the context of inclusive violence prevention.

The macro level also includes environmental and geospatial determinants that shape the physical and social spaces that adolescents occupy and are contemporary effects of the past intentional racial segregation, as noted in the conceptual framework. An illustration of this in post–apartheid South Africa is how these social and structural determinants continue to provide significant contextual challenges and barriers for adolescents in terms of access to education, employment and safe spaces to live and learn (68). These findings suggest that spatial geographies of adolescents are significantly shaped by race and also gender, in that that girls have 'shrinking' or curtailed spaces they access and very limited geographical spaces where they feel safe, whereas boys' areas expand and contain a balance between safe and unsafe places. As per the conceptual framework, these findings illustrate that experiences of violence and the fear of violence, curtail the geographic spaces for adolescents and that this is a very gendered issue in that girls and boys manage their social and physical spaces very differently. The implications for adolescent health are important as we consider the relevance of creating safe spaces to access education and engage in productive and leisure activities as part of their growth and development into adulthood.

The interactions between macro, meso and micro levels determinants are also reflected in the narratives of lived experiences of everyday life for adolescents living in 3 proximal neighbourhoods in Cape Town, in terms of their relationships at school and home in a democratic South Africa, where apartheid 'echoes' in the continuing relationship of physical and social spaces being divided and unequal in terms of race and class as cross-cutting determinants (69). The neighbourhoods are largely still organised along race and class and this has implications for how adolescents engage with the physical and social space, each other as well as the exchange of ideas. In addition, the cross-cutting determinants impact on experiences and narratives of adolescents' in terms of relationships, highlighting the very binary stereotypes that dominate in terms of masculinities and femininities and the intersectionality of multiple forms of inequality. As noted by the authors, *"For boys who have few material resources and poor prospects, masculinity can become dependent on heterosexual success with girls, and even on violence and coercion. Girls in poor*

communities whose consumer aspirations do not fit with parental means of provision can become dependent on boyfriends, which can lead to submission in the face of sexual demands and acceptance of sexual coercion and violence (2010:292).”

This builds on earlier work which describes the dynamics of racial and gendered identities in Manenberg in Cape Town, a township created by racial segregation, where adolescents and young people manage and mediate their identities as they interplay with global forces such as soap operas, rap music and international brand name clothes, which they make sense of through their local contextual realities (70,71). This body of work describes how the construction of adolescent sexuality, personhood and identity is shaped both by the apartheid history and articulated through the current social, geospatial and political contexts and speaks to the dynamics between global macro, meso and micro level determinants.

Another macro level determinant noted in the conceptual framework is the institutional i.e. the laws and policies that govern the country. In South Africa, we have a progressive Constitution and Bill of Rights, supported by national legal and policy frameworks, which are aligned to international conventions that seek to protect and promote human rights. Various key policies supporting adolescents and adolescent health include the National Youth Policy (2015), the National Adolescent and Youth Health Policy (2017), National Adolescent Sexual and Reproductive Health Rights (ASRHR) Framework Strategy (2015), as well as two policies related to health in schools, Integrated School Health Policy (2012) and the National Policy on HIV, STIs and TB for learners, educators, school support staff and officials in primary and secondary schools in South Africa (2017).

Despite various policies in place, the institutional and regulatory framework around adolescent health is complex and contradictory at times and illustrates the interactions between macro and meso level determinants. For example, the legal framework on sexual and reproductive health for adolescents aims at providing access to services and promoting and protecting their rights, by providing access to contraception and termination of pregnancy from 12 years, while the Integrated School Health Policy allows children to access health services without consent from parents from 14 years. In addition the Sexual Offence and Amendment Act (2015), which sets the age of consent to sex at 16, also requires reporting by all services. This can create an environment which is infused with contradictions, confusing reporting requirements and differential access to services for adolescents (40) and create

confusion and multiple roles for service providers as described in the meso level section. Of interest is the Standard Operating Procedures for the provision of Sexual and Reproductive Health, Rights and Social Services (2019), issued by the Department of Basic Education, which is a step towards policy alignment and more coordinated provision of sexual and reproductive health services. However, much work remains in implementing and realising the policy visions and scaling up initiatives, particularly those working across multiple sectors (73).

In summary, this section illustrates how the past and present macro level social and structural determinants have a significant impact on the meso and micro level determinants of adolescent health in South Africa, highlighting the critical role of broader contextual factors and systems that need to be considered. It raises critical issues in terms of needing to address and transform the past and present axes of inequality, such as sexism and racism, as central to our efforts to address the health and well-being of adolescents.

As shown in the conceptual framework, the South African context at micro, meso and macro levels is nested within a global context, however there is limited research on impact of these global social and structural determinants with specific focus on health of adolescents. Global level determinants that have an impact at national level include trade policies, social media and access to internet, neo-liberalism, ideologies, globalization, migration, war and conflict, climate change and planetary health, for example. South Africa's social and economic context is part of a broader system of global economic which contributes to combined and uneven development and perpetuating inequalities (60). The Lancet Commission on adolescent health (2016) highlighted the impact of global food, alcohol and tobacco polices as well as the role of social media on adolescent health.

A significant, but under-researched global level determinant is access to the internet and the use and experiences of digital resources targeted at providing adolescents with information about sexual and reproductive health and rights, contraception and education, as well as career guidance, however there is a paucity of empirical research for South African adolescents specifically. A recent study which reported on young people's use of mobile phones for sexual and reproductive health and rights related activities identified nineteen services, none of which have been evaluated (74). Going forward, given the COVID-19

pandemic, this remains an area for further content development based on best-practices and consultation with adolescents themselves as well as rigorous research.

Key messages

- Micro level: adolescent health is shaped by individual, interpersonal and community determinants. Adolescents exercise important autonomy and agency, however they do so within South African society that is still characterised by regressive norms and gender and intersecting power relationships and inequalities
- Meso level: adolescent health is shaped by organisational and sectoral determinants and the health and education sectors provide important entry points for supporting the health and rights of adolescents, but they also can replicate the biases and inequalities that characterise South African society
- Macro level: adolescent health continues to be shaped by the structural colonial and apartheid legacies and despite constitutional and other legislative rights, intersecting and compounding economic, geographic, gender and other inequalities, at national and global levels, shape adolescent health in democratic South Africa
- Micro, meso and macro levels are also shaped by cross-cutting and intersectional social and structural determinants, and other forms of inequality and marginalisation based on gender, race, class, (dis)ability and sexual orientation, for example

Conclusions

Using a conceptual framework (Figure 1) we describe and illustrate key social and structural determinants across interrelated and dynamic macro, meso and micro levels, as well as key cross-cutting and intersecting determinants, all of which dynamically interact with global determinants, to shape adolescent health in South Africa. In foregrounding the South African context, our analysis contributes to the international literature on adolescent health by demonstrating a systematic manner for moving beyond the micro level and also addressing social and structural determinants at the meso, macro and global levels (14,15,75–77). A key message from our review is that current experiences and health of adolescents is shaped by

past social and structural determinants and power relations, with apartheid inequalities still echoing in the lives of the 'Born Frees' (78). Therefore, understanding both the historical context as well as contemporary social and structural determinants and intersecting and compounding power relations, provides significant insights into determinants of adolescent health beyond just the micro level, but also at the interrelated and dynamic meso and macro levels, nested in global determinants, as presented in our conceptual framework.

Our analysis shows the complexity of intersectional inequalities and how those at individual and interpersonal (micro) level are mediated through the institutional structures and organisational factors in health and other sectors (meso) level and how this is underpinned by the structural determinants such as the national and global political economy (macro) level. These are not linear relationships and gender and intersecting power relations are complex to change. They require careful analysis across macro, meso and micro levels, consultation with adolescents themselves and detailed research as part of understanding and transforming past and present social and structural determinants of adolescent health in South Africa. In addition, further work needs to build on insights gained from individual agency of adolescents, gender-transformative programme responses and implementation of progressive policy and legislative measures.

Going forward addressing the meso and macro level social and structural determinants, for example, poverty and youth unemployment, provision of quality education, improved alignment and implementation of laws and policies with and across departments, will contribute to transforming society in being more responsive to the rights and needs of adolescents, and in this way contribute to their health. Importantly, there is a need to strengthen and activate citizenry where adolescents can advocate for themselves and create and mobilise networks and organisations that raise critical issues and hold government and other actors accountable. Twenty-five years into democracy much work still remains to be done towards the health of adolescents centering their collaboration, in realising the rights enshrined in the Constitution and working towards the ambitious SGD goals and ensuring the principle of leaving no one behind.

Declarations

Ethical and consent to participate

This article is part of a larger PhD research case study titled: People, power and processes a gender analysis of adolescent health policy in South Africa which has received ethical approval by the Biomedical Science Research Ethics Committee of the University of the Western Cape. Reference number: BM18/9/9. This paper was based on a review of documents and did not include any human participants. Ethnics approval was not required.

Consent for publication

Not required.

Availability of supporting data

Data for this paper included publicly available articles and documents and no additional data was generated. These articles and documents can be made available should that be required.

Competing interests

The authors have no competing interests to declare.

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Authors' contributions

Both TJ and AG developed the Conceptual Framework and TJ reviewed the literature for the narrative review. Both authors contributed to the analysis and interpretation of the findings and the drafting of the paper. Both authors read and approved the final manuscript.

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CHAPTER 5:
POLICY FOUNDATIONS FOR TRANSFORMATION – A GENDER ANALYSIS OF ADOLESCENT HEALTH POLICY DOCUMENTS IN SOUTH AFRICA

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1. SUMMARY

This paper describes and explores how gender is constructed in 15 policy documents relevant to adolescent health and analyses the implications for health policy and systems research as programmes. It illustrates the dynamic and complex relationships between the South African context, actors, content and processes, in shaping both how gender is problematised and how 'solutions' are represented in these policies. How gender is conceptualised matters, both for policy analysis and praxis, and policy documents can be part of foundations for transforming gender and intersecting power relations.

2. CONTRIBUTION TO THE THESIS

This paper contributes to the second objective of the thesis: To analyse from a gender and intersectionality perspective, the content of national adolescent health policy documents. It also contributes to the fifth and cross-cutting objective, which is to reflect on the implications for gender transformation of this articulation of power, people and processes in adolescent health policies.

3. CONTRIBUTION OF THE CANDIDATE

The candidate designed the study, conducted the search for policy documents and undertook the initial analyses, with input from the supervisor and third author. The candidate wrote the first draft of the paper, and the supervisor and co-author provided critical input on this and

subsequent drafts. The candidate led the submission process and revisions back on the comments from the journal peer review.

The paper was presented by the candidate in a number of forums:

- as part of a panel at the Public Health Association of South Africa Conference in 2019;
- at a Health Systems Global Policy Analysis Seminar in 2020;
- at a session on discourse analysis capacity building at the Health Systems Research Symposium in February 2021;
- as part of a South African panel at the World Association of Sexual Health in September 2021; and
- as part of a panel focusing on adolescent health at the Gender Studies in Africa Conference in February 2022.

A copy of the published article is available in Appendix 7. It is also reproduced here to facilitate the coherence of the thesis' 'Findings' chapters, retaining the style and format required by the journal. Comments from the peer review process are available in Appendix 8.

4. PUBLICATION/STUDY: POLICY FOUNDATIONS FOR TRANSFORMATION – A GENDER ANALYSIS OF ADOLESCENT HEALTH POLICY DOCUMENTS IN SOUTH AFRICA

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Key words: gender analysis, gender, adolescent health, policy analysis, critical discourse analysis, intersectionality

Key messages:

- Integrating gender, both as theoretical and methodological approach, is an important contribution to Health Policy Analysis (HPA), with implications both for analysis of policy and implementation
- Policy documents are socially constructed, and the content represents ideas, understandings and assumptions about gender in the South African context, and by actors, shaping both what is problematized and what is unproblematized i.e., left out

- Our analysis describes a complex landscape consisting of multiple actors and foci that lack coherence and alignment as well lack of detailed gender analyses. In addition, our gender analysis identified key interrelated, often juxtaposed, dominant and marginalized discourses, as well as the 'silences', embedded in the policy documents, with significant implications for policy implementation
- Researchers, policy makers and implementers should integrate gender-transformative approaches as part of addressing gender inequality as a key social and structural determinant of adolescent health and policy documents are foundations to be part of re-imagining policy and health systems

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Ethical approval

This article is part of a larger PhD research case study titled: People, power and processes a gender analysis of adolescent health policy in South Africa which has received ethical approval by the Biomedical Science Research Ethics Committee of the University of the Western Cape. Reference number: BM18/9/9

Data availability

Data for this paper is government policy documents and no additional data was generated. These policy documents can be made available should that be required.

Abstract

The Sustainable Development Goals (SDGs) and the United Nations Global Strategy (2016-2030) emphasize that all women, children and adolescents 'survive, thrive and transform'. A key element of this global policy framework is that gender equality is a standalone goal as well as a cross-cutting priority. Gender inequality and intersecting social and structural determinants shape health systems, including the content of policy documents, with implications for implementation. This article applies a gender lens to policy documents by national government bodies that have mandates on adolescent health in South Africa. Data was fifteen policy documents, authored between 2003-2018, by multiple actors. The content analysis was guided by key lines of enquiry and policy documents were classified along the continuum of gender-blind to gender-transformative. Only three policy documents defined gender, and if gender was addressed, it was mostly in gender-sensitive ways, at times gender-specific, but rarely gender-transformative. Building on this, a critical discourse analysis identified what is problematized and what is left unproblematized by actors, identifying the key interrelated dominant and marginalized discourses, as well as the 'silences' embedded in policy documents.

The discourse analysis revealed that dominant and marginalized discourses reflect how gender is conceptualized as fixed, categorical identities, versus as fluid social processes, with implications for how rights and risks are understood. The discourses substantiate an over-riding focus on adolescent girls, outside of the context of power relations, with minimal attention to boys in terms of their own health or through a gender lens, as well as little consideration of LGBTIQ+ adolescents beyond HIV. Dynamic and complex relationships exist between the South Africa context, actors, content and processes, in shaping both how gender is problematized and how 'solutions' are represented in these policies. How gender is conceptualized matters, both for policy analysis and praxis, and policy documents can be part of foundations for transforming gender and intersecting power relations.

Introduction

The Sustainable Development Goals (SDGs) adopted by the United Nations (United Nations General Assembly, 2015) is aligned with the United Nations Secretary General's Global Strategy (2016−2030). Both call for all women, children and adolescents to 'survive, thrive and transform' as a priority for global health. This goes beyond ensuring that women and children 'survive' against threats to mortality addressed by health care interventions and represents a broader vision of health and well-being, that is 'thrive,' while also addressing development more holistically, that is 'transform'. Within this reconceptualization, gender equality is both a standalone goal and a cross-cutting concern, and adolescents are a key priority.

In South Africa, social transformation inclusive of gender equality and adolescent rights is also a national priority for government and civil society (South African National AIDS Council, 2017; Toska *et al.*, 2019). However, despite the Constitution of the Republic of South Africa of 1996 being grounded in equality, significant challenges and intersecting inequalities remain post-apartheid. For example, gender inequality contributes to the extremely high prevalence of gender-based violence and HIV incidence in adolescent girls and young women in particular (Meyiwa *et al.*, 2017; Nduna, 2020).

Gender as a social construct is fluid and relational and refers to the roles, attributes, norms and behaviours considered to be appropriate for girls/women, boys/men and other genders (World Health Organization, 2020). Gender inequality also intersects with various other axes of inequality in terms of race, class, sexual orientation and (dis)ability, thus compounding power dynamics and stratification (Hankivsky, 2014; Larson *et al.*, 2016; Morgan *et al.*, 2016).

Some ways in which gender inequalities are generated or contested include how health policy is shaped by gender, in both its content and processes (Bacchi and Eveline, 2010; Lombardo, Meier *et al*, 2017). The gendered power relationships and assumptions that are often embedded within the content of policy documents are not always immediately obvious or explicit. This is problematic because, unacknowledged, these kinds of assumptions in policy documents can function to reproduce the status quo and block the transformation of gender inequality.

Health policy analysis aims to make visible power relations within policy processes and to integrate this into the study of health policies and systems (Gilson and Raphaely, 2008; Gilson, Orgill *et a*l., 2018). The intentions, ideological positions, values and meaning making of/by actors are central to the construction of policy (McDougall, 2016; Gilson, Orgill and Shroff, 2018) and there is a paucity of literature in health policy analysis that foregrounds this in terms of gendered power relations.

To better understand the dynamic interaction between the South African context, policy actors and content, as part of policy processes, this paper applies a critical gender lens to the content of national government health policy documents relevant to adolescent health in South Africa. Furthermore, the paper explores the nexus of the construction of gender and related discourses in adolescent health and raises considerations for what this means for policy analysis and praxis in South Africa.

Methodology

Theoretical and methodological approach

The analysis of socially constituted and contested policy processes is the focus of a growing body of literature in health policy analysis that is rooted in post-structuralism that recognizes that all social phenomena, including policies, are socially constructed (Shiffman *et al*., 2004; Ingram *et al*., 2007). An examination of policy documents as 'artefacts' is one way of understanding the underlying meanings and consequences of how policies are socially constructed by policy actors and how these intersect with local social, political, economic, and cultural contexts, (Parkhurst, *et al*., 2015) including the policy discourses involved.

Discourse analysis, an element of health policy analysis, seeks to further understand meanings underlying policies by examining how representations of 'problems' come about, structuring 'solutions' and subjectivities (Bacchi and Eveline, 2010; Bacchi, 2016). While the ways in which 'problems' are commonly conceptualized in public health are not always perceived as socially constructed, the policies and the problems they seek to address are not neutral. Furthermore, the consequences of constructing certain issues as 'problems' are often unacknowledged (Walt *et al.*, 2008; Bacchi, 2016; Gilson *et al*., 2018)

Critical discourse analysis is a growing theoretical and methodological approach in the analysis of health policy. It is informed by critical social theories and draws its theoretical antecedents from the body of work by Foucault (Fairclough, 2013; Wodak and Meyer, 2015). It can be used in combination with any other methodology and is 'critical' in that it aims to illustrate the non-obvious ways in which language or texts are intricately linked to power relations and ideological positions.

Despite the increased interest and utilization of discourse analysis in health policy analysis (Harmer, 2011; Raphael, 2011; Shapiro, 2014; Parkhurst *et al*., 2015; Evans-Agnew *et al.*, 2016), there is a paucity of discourse analysis with a gender lens, let alone any applied to adolescent health policy. While there is an increasing focus on adolescent health in South Africa (Cluver *et al.*, 2019; Toska *et al.*, 2019), to our knowledge our research using a gender analysis of adolescent health policy documents in South Africa is unique, both in terms of focus and methodology.

When working with the notion of discourse as 'social practice' and policies as productive, it is evident that discourses are created in the dialectical and dynamic relationships between content of policy documents and social contexts (Bacchi, 2000; Fairclough, 2013; Wodak and Meyer, 2016). Discourse analysis allows us to make interpretative connections and complex relationships between the content of policies, actors and social contexts. By applying a gender analysis, we are able to focus on gender discourses in national government's adolescent health policy documents, in order to identify discourses which sustain, contest and perpetuate complex patriarchal power relations, in order to transform them (Lazar, 2007).

Data collection

Given our focus on policy documents by national government bodies that have the mandate and are technically responsible for policy development related to adolescent health in South Africa, we iteratively searched for them on national government websites and the internet with a focus on the previous fifteen years, that is from 2003 to 2018. Search terms included a combination of 'youth', 'young', 'adolescent', 'health', 'gender', 'multi-sectoral', 'school health', 'sexual and reproductive health', 'mental health', 'policy' and 'policy development'. Key experts in the field were also consulted to ensure that the search for policy documents

was comprehensive. The scope and relevance of the national policy documents related to their direct contribution to adolescent health were collected and reviewed by the first and second authors.

Data analysis

Policy documents were uploaded into ATLAS.ti and a coding framework and code list were developed using an initial broad coding structure derived from propositions in the research. The initial coding framework was applied to four policy documents by the first author and reviewed by the second author before completion of coding processes. A deductive analytical approach was initially used, whereby the data was organized using the pre-defined codes which included: gender, adolescent, youth, health, inequality, rights, participation and so on (Bowen, 2009). These were linked to the key lines of enquiry and an allowance was made for new themes to emerge in the analysis process. These additional codes included sexual orientation and gender identity, non-binary, determinant and responsive, as examples.

For the content analysis, key lines of enquiry included the following questions in terms of the content of the adolescent health policies, as a basis for understanding policy discourses:

- How is adolescence constructed?
- How is adolescent health constructed?
- How is gender constructed?
- How is gender inequality and its intersectionality with other form of inequality constructed?
- How are adolescent rights and engagement constructed?

Further, for the content analysis shown in Table 1, the following types of questions were asked in relation to gender: how gender and key gender terms are defined, the extent and nature of gender analysis undertaken, and whether gender inequality is also recognised as a social and structural determinant of health. In addition, following World Health Organization guidance (World Health Organization, 2016), and discussions amongst the first two authors, the nature of the content of the policy documents were classified along the continuum of:

- **Gender-blind**: content that ignores gender norms, roles and relations and differences in opportunities and resource allocation for women and men
- **Gender-sensitive:** content which indicates awareness of the impact of gender norms, roles, and relations, but no remedial actions are developed
- **Gender-specific:** content goes beyond indicating how gender may hinder health of adolescents to highlighting remedial measures, such as programmes for adolescent girls and/or boys
- **Gender-transformative:** content which includes ways to transform harmful gender norms, roles and relations

Building on this, the discourse analysis draws on the work of Bacchi (Bacchi and Eveline, 2010; Bacchi, 2016) and the 'What's the Problem Represented to be?'(WPR) approach. This approach asks questions related to what is problematized and what is left unproblematized in policies, that is, what is missing, as well as what assumptions are made and how these have come about. By elucidating what effects are produced by this representation and how it has been (re)produced, it identifies opportunities for disruption. It is, therefore, a useful approach in analysing both the dominant and marginalized discourses as well as the 'silences' related to gender in South African adolescent health policy documents. The first author led the analysis of the relationship between the discourses, including those that were dominant and marginalized. The 'silences', that is, what was missing in relation to gender and adolescent health, were measured against global and national literature, as well as subject and contextual knowledge. The initial analyses were reviewed by the second and third authors and consensus was achieved through discussions and further refinement of the analysis.

Positionality and reflexivity

Doing a critical discourse analysis of adolescent health policy documents is a process of interpretative policy research. It requires us to be aware of our positionality in relation to the research and to our own epistemological views of the world. This positionality includes a situatedness as feminist researchers. In addition, the lead author has more than 20 years' experience of working in gender, HIV and health programmes in South Africa.

Findings

In this section we first present the content analysis of policy documents, followed by our critical discourse analysis.

Description of content of policy documents

Within the specified time range and scope of research, we found fifteen government policy documents that are relevant to adolescent health, with different lead departments, actors and diverse foci, as presented in Table 1.

Among these fifteen policies, six list the National Department of Health (NDoH) as the formal lead actor, one lists both the Department of Basic Education (DBE) and the NDoH as co-leads and two list DBE as the lead actor. The balance lists a range of multiple actors, including the Presidency, the Department of Social Development, the South African National AIDS Council, the Department of Justice and Constitutional Development, as leads.
In terms of focus and specificity, only one policy has a focused mandate on adolescents, namely, the Adolescent Sexual Reproductive Health Rights (ASRHR) Framework Strategy. This is also the only one to follow the WHO in delineating adolescents as 10 to 19 years, distinguishing between early, mid and late adolescence. Two policies focus on adolescents with youth (with inconsistent age ranges), the National Adolescent and Youth Health Policy (AYHP) and National Youth Policy (NYP), while five consider them with children. The remaining seven policy documents cover topics important for adolescents but are directed to the general population.

Many of the policy documents focus largely on key SRHR issues and HIV/AIDS, or on other issues such as mental health and nutrition in separate vertical policies and programmes. Only one policy, the National Adolescent Youth Health Policy, is more comprehensive. Figure 1 illustrates that most policies emerged after 2010 and this mirrors the global and national context at the time, that of the Millennium Development Goals leading into the SDG era, as well as the prioritization of HIV in South Africa.

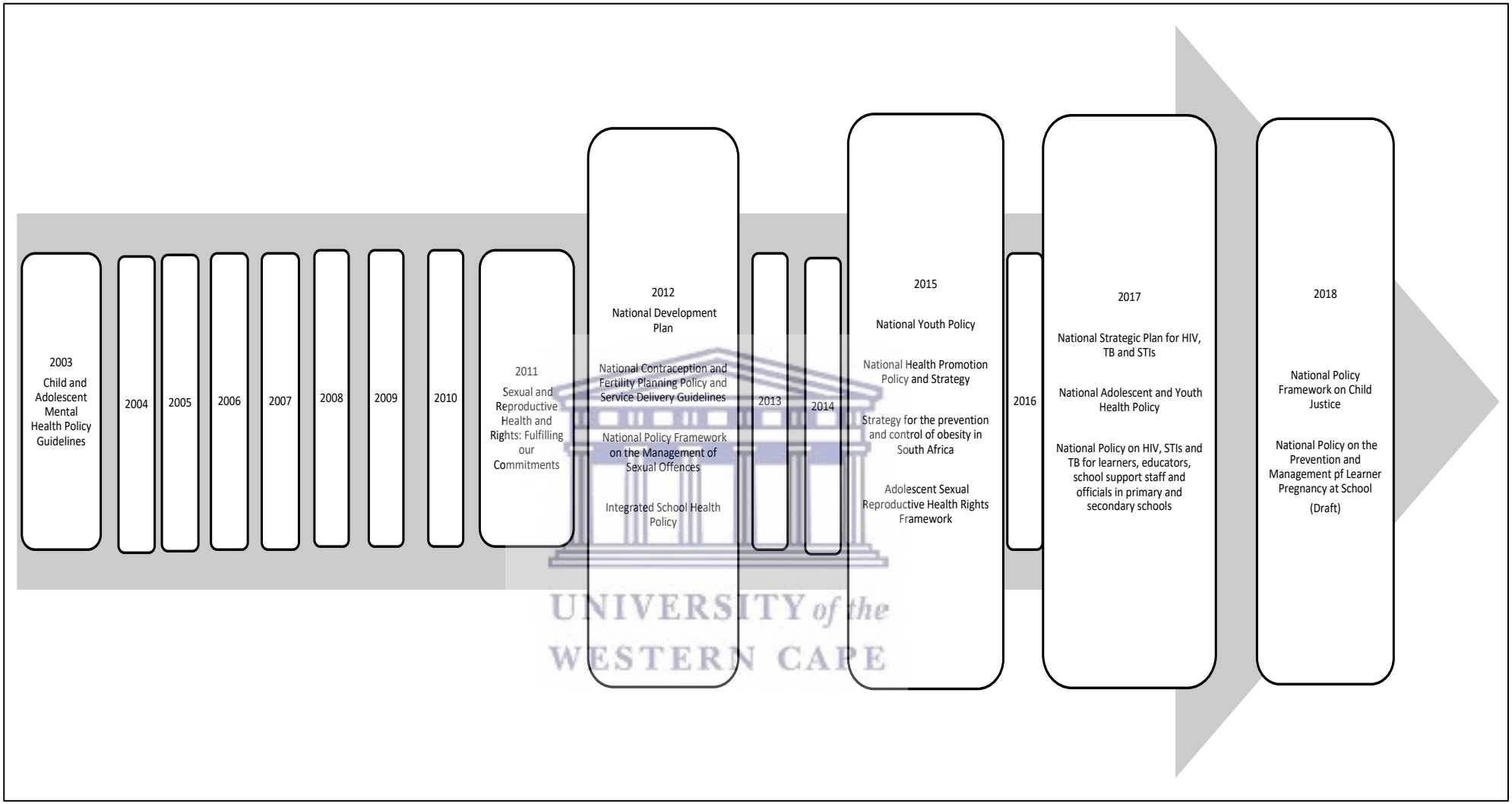

Figure 1. Timeline of policy documents

The analysis of the content of the national government policy documents highlights that key gender concepts such as 'sex', 'gender', 'gender in/equality', 'gender identity', 'sexual orientation', and the like are defined in only three documents (Table 1). Even if gender and/or gender inequality are listed as social and contextual factors that impact on health, and/or are defined in the glossary of terms, there are no detailed gender analyses that are a systematic analysis and response to gender inequality as a social and structural determinant of power relations at individual, institutional and systems levels.

As shown in Table 1, in instances in which gender is addressed in policy documents, most documents are gender-sensitive (that is, they have content that indicates some awareness of the impact of gender norms, roles, and relations but no remedial actions), with some having gender-specific responses overwhelmingly for adolescent girls and young women. Adolescent boys and young men are only briefly mentioned in three policies. Only two of the policies could possibly be classified as gender-transformative, with some mention of intention or suggested interventions that transform harmful gender norms, roles and relations, but with little detail provided.

Despite there being some acknowledgement that adolescents face many contextual challenges and are not homogenous, the vast majority of the policy documents explicitly and implicitly refer to adolescents as largely homogenous and do not reflect their diversity, either in terms of identities or social contexts. Across the policy documents there is a range of descriptions of historical and present social and structural determinants. This often lists, consecutively, poverty, violence and inequalities based on race, class, gender, ability, geographic location and sexual orientation and gender identity, as seemingly separate determinants, without addressing the intersectionality of these.

All the policy documents make reference to the South African Constitution and legal and policy frameworks that centre human rights. However, only three of the policies include make explicit reference to the rights and empowerment of adolescents. Despite there being some consultation with learners during the drafting of the National Policy on the Prevention and Management of Learner Pregnancy at School, only the Adolescent and Youth Health Policy (2017) explicitly describes the engagement of adolescents, as a key actor group, in the policy development process.

Dominant and marginalized interrelated discourses and 'silences'

Building on the content analysis that describes what is included in the policy documents at a literal level, through critical discourse analysis we deepen our understanding of what is being said in more indirect ways. Importantly, the content of policy documents is evidence of the ideas, understandings and assumptions of multiple policy actors in the South African context and as such provides some insights into in how and why gender is understood by policy actors in policies relevant to adolescent health.

This analysis reveals through a gendered lens some of the key interrelated, often juxtaposed, dominant and marginalized discourses, as well as the 'silences', embedded in the policy documents. We explore the discourses that shape how gender is conceptualized and the influences this has on how gender is addressed by these policy documents.

Gender as biological sex and a fixed category versus social processes

Dominant discourses throughout South African adolescent health policy documents construct gender as a fixed category rather than as social processes, and this is expressed in various ways. It is found in the ways in which gender is equated with biological sex, without recognizing the social construction of femininities and masculinities, as well as the relational aspects of gender. As a result, there are conceptual conflations, for example assuming gender to mean a focus on girls, separate from the social contexts, relations, structures and actors that create inequality. Further, as mentioned earlier, the representation of adolescent boys, both in terms of their own health (which is also shaped by gender) but also in terms of their role in pregnancy, for example, and gendered power relations, are conspicuously absent.

A further set of interrelated dominant discourses, explicitly and implicitly, emphasize fixed binaries, such as 'boys/girls', 'masculine/feminine' and 'heterosexual/homosexual'. Discourses representing key gender concepts, including sexual orientation and gender identity, as fluid, diverse and non-binary, are more marginalized and less visible in the policy documents. These binary discourses are related to the understandings and assumptions of gender as a fixed individual characteristic, as discussed above. Together they reproduce dominant ways of conceptualizing gender well as how they construct the subjects of those policy solutions, making invisible non-binary persons but also inhibiting understandings of a continuum of diverse, dynamic and nuanced forms of sexual orientation and gender identity

for adolescents, as well as among the general population. Correspondingly, many of the policy documents tended to catalogue groups as mutually exclusive target populations, including LGBTIQA+ persons, adolescent girls and young women, particularly in relation to HIV infection and sexual and gender-based violence, ignoring cross-cutting determinants and overlapping identities, as illustrated by the example below:

"Goal 3: Reach all key and vulnerable populations with customised and targeted interventions for:

- Vulnerable populations for HIV and STIs
- Adolescent girls and young women
- Children including orphans and vulnerable children
- People living in informal settlements
- Mobile populations,
- Migrants and undocumented foreigners
- People with disabilities
- Other lesbian, gay, bisexual, transgender and intersex (LGBTI) populations"

Source: NSP on HIV and STIs and TB (2016−2020)

Discourses representing how gender inequality intersects and compounds other axes of inequality such as race, class and (dis)ability, for example in the South African context, are 'silent' in the analysed policies. If adolescent health is not located in these intersecting and compounding inequalities and power relations, they will continue to be seen as separate and hence insufficiently addressed or problematized by the policy documents.

Corresponding focuses on vulnerability and risks versus rights

The categorical focus on adolescent girls and young women is problematic in the way it shapes how gender is addressed. It constructs them as inevitably vulnerable, often without an acknowledgement of the multiple power relations that generate intersecting and compounding inequalities, therefore their health is constructed out of context of power relations and as apolitical. By consistently and uncritically representing adolescent girls and young women and other categories as vulnerable, the idea that this vulnerability is expected, unchangeable or even 'normal' is supported.

While co-existing with the categorical focus on 'addressing gender as addressing girls' described above, most of the policy documents construct adolescent health and sexuality negatively and predominantly about risks and problems. This is juxtaposed against more positive understandings of health and well-being and comprehensive constructions of adolescent health in recent national and global policy documents. However, the majority of the policy documents framed adolescent sexual and reproductive health outcomes as a result of engaging in 'risky behaviour', for example having sex too early, having too many sexual partners, not making use of contraception and contracting HIV. Not only are girls and femininities generally constructed as being more 'at risk' or 'vulnerable,' without any critique of why and how this has come about, but they are also constructed as the target groups of policy measures with no attempt made to address the power relations, systems, and actors that construct that vulnerability. Across the policy document, 'silences' also include attention to boys in terms of their own health and through a gendered lens, as well as LGBTIQ+ adolescents beyond issues pertaining to HIV.

Juxtaposed against these dominant discourses of 'risks', described above, we also identified marginalized discourses representing adolescent rights. These representations see adolescents from a broader rights approach as opposed to a more public health approach. It views adolescents as societal assets whose contributions can be nurtured and amplified through meaningful engagement and participation, including outside of the health sector. These kinds of discourses are only represented in recent policies, and mostly in relation to SRHR, as illustrated in the example below.

"Investing in the sexual and reproductive health of adolescents and youth is of a great imperative. Through the advancement of sexual and reproductive health and rights for adolescents acknowledging and including those underserved groups such as lesbians, gay, bisexual, transgender and intersex(LGBTI), sex workers, HIV positive youth and those living with a disability calls for the development of an inclusive agenda that intends to promote the quality of life and the right to choose whether and when to have children; the right to exercise sexuality free of violence and coercion; the right to seek pleasure with respect for other people's rights; the right to protect fertility; and the right to access modern techniques for the prevention, diagnosis and treatment of sexually transmitted infections."

Source: *National Adolescent Sexual and Reproductive Health and Rights (ASRHR) Framework Strategy (2015−2019).*

While there is a recognition of a rights perspective within the focus on sexual and reproductive health, there is relative 'silence' across the policy documents with regards to the inclusion of interventions and programmes that address the full spectrum of rights. This includes sexual rights, particularly in ensuring comprehensive services (one being access to abortion) and how these are related to gender equality, human rights and social and reproductive justice.

More positive constructions of sexuality are emerging, but also contested, in recent policies which include Comprehensive Sexuality Education (CSE). There is much public debate linked to sexuality education and strong resistance from some actors, such as parents and religious groups, to the plans of the Department of Basic Education to implement a new CSE curriculum aligned to global best practices. The multiplicity of discourses, some emphasizing risk and vulnerability, some articulating rights even if challenged, reflects how contested social realities and interests permeate into the content of policy documents. This dynamic between discourses of risks versus rights described above, also highlights the underlying assumptions and beliefs around adolescence, health and adolescent sexuality held by a range of policy actors. Importantly, the actors shaped how the 'problem' and 'solutions' as represented in these policies, which has implications both in terms of what this means conceptually, but also how services are planned and implemented.

Policy implications: addressing 'symptoms' or transforming gender power relations

With the above in mind, we identified a general tendency across the policies where 'symptoms,' of gender power relations (such as gender-based violence) were foregrounded while excluding the underlying causal determinants. As an example of this the extract below directs attention to violence as a concern for adolescent health and identifies post-violence care for meeting the immediate needs of survivors. This is an essential short-term response crucial in a country with extremely high prevalence rates of both HIV and GBV and where gender inequalities fuel and exacerbate the vulnerability of girls and women to both epidemics.

The policy documents do not, however, adequately acknowledge that violence in South Africa is gendered and shaped by intersecting and compounding past and present social and structural determinants, such apartheid and patriarchy, for example.

"Violence and substance abuse have major negative impacts on the health of adolescents and youth in South Africa and increase risks to physical and mental health and wellbeing. The abuse of drugs and alcohol is increasing among adolescents and youth, with alcohol abuse in particular linked to high levels of violence and motor vehicle accidents. Post-violence care is part of the comprehensive package of sexual and reproductive health and emergency services, but the provision of post-exposure prophylaxis for rape survivors remains inadequate."

Source: *National Adolescent Youth Health Policy (2017)*

The underlying understandings across most of the policy documents are that adolescent health can be addressed using targeted, treatment-focused strategies rather than simultaneously including prevention-focused gender-transformative strategies that foreground gender and intersecting power relations. Across the policy documents there was almost never an attempt to dismantle or critique the social and structural determinants which lead to these 'symptoms' and instead the focus was placed on interventions to manage them.

Further, there was much 'silence' on how to transform gender inequality beyond the focus on providing services and biomedical and behavioural interventions for adolescent girls and young women. The effects of this are that these 'symptoms' are then addressed by providing services and interventions targeted largely at the individual level and responding to the immediate consequences. Importantly, while it is essential to address the short-term consequences of gender inequality, that is the 'symptoms', the longer term and cross-cutting determinants also need to be included in policy documents. Given the significant impact of both GBV and HIV, it is crucial to prioritize services. However, without the equal prioritization of underlying common determinants such as gender inequality, our responses will be partial and maintain − not transform − the status quo. While a service delivery focus on adolescent girls is an important practical component, the challenge remains how also to address and transform gender inequality strategically.

This decontextualized focus on ‘symptoms’ further reproduces understandings that adolescent health is largely the domain of the health sector and is mostly about providing services for health problems. This deflects from the understandings that health is political and constructed by the unequal social, political and economic systems that are gendered and also require action by other sectors and actors.

Correspondingly, we found that policy documents predominantly focus on gender as an issue of importance at the micro level (individual or interpersonal) and understandings of the role of gender inequality at the meso (organizational) and macro (structural) levels, are largely absent. Understanding gender as mainly about categorical thinking, counting girls versus boys in terms of sex-disaggregated data or gender parity, discounts the ability to see gendered processes that affect health and society as systems of power, including at the meso and macro levels, that require transformation.

Discussion

The landscape of policy documents relevant to adolescent health in South Africa consists of multiple actors and focuses and lacks coherence and alignment. Furthermore, the policy documents define and consider adolescents and their health with varying specificity. This highlights the tension between having policies that are adolescent-specific or having an Adolescent Health in All Policies (AHiAP) approach (World Health Organization, 2017). While the Departments of Health and Education lead many policies, the plethora of government agencies involved flags the need for further multi-sectoral collaboration and coordination on adolescent health.

Within this fragmented landscape the gender analysis of the content of South African adolescent health policy documents revealed that while gender is sometimes mentioned as a social determinant in some policy documents, little systematic gender analyses and gender integration is undertaken. The policy documents can be categorized as mostly gender sensitive (recognizing gender but not addressing it), at times gender specific (addressing girls

needs pragmatically), but rarely gender transformative, that is in ways that change gender power relations. Intersectional approaches to understanding adolescent health were not present. While rights in the South African Constitution were always referenced, policy documents did not prioritize adolescent empowerment, with only one engaging adolescents in its development.

Our discourse analysis reveals that the superficial and non-transformative ways in which gender is addressed reflects its framing as an individual characteristic lost within the fragmented landscape of adolescent health policies in South Africa. Further, our analysis highlights the influence of multiple actors, as the content of the policies reflect and reproduces the range of understandings and discourses related to adolescence, adolescent health, gender and rights. These multiple discourses in the content of the policy documents, provide insight into the complexity of perspectives of policy authors and actors, in terms of adolescent health and gender.

In contrast, the development of shared understandings of gender as socially constructed and the prioritization of gender inequality as key social and structural determinants of adolescent health, would imply further policy coordination across sectors and corresponding policies. What is needed are broader conceptualizations of gender which open pathways for transformation and a disruption of power relations at the micro, meso and macro levels of the health and broader systems.

Importantly, the content of policy documents is evidence of the understandings and the multiple ways in which gender and gender equality are represented in policy documents. It reflects the ideas, understandings and assumptions held by policy actors in the South African context and as such provides some insights into how and why gender is problematized in policies relevant to adolescent health. The findings contribute to the literature on how policies are socially constructed, influenced by the dynamic interactions between context, actors and processes located in organizational, national and global contexts (Ingram, Schneider and Deleon, 2007; Weible *et al.*, 2012; Walt and Gilson, 2014).

Our analysis recognizes that the discourses described are interwoven with each other and are therefore interdiscursive and intertextual, therefore interrelated to each other within and across the policy documents. Collectively, they produce and reproduce what is problematized and what is left unproblematized in policy documents, both how gender is conceptualized as well as the implications of this conceptualization for how gender is addressed in policies with meaningful consequences for the lives of adolescents.

Across the policy documents dominant discourses construct gender as equating biological sex and gender identity and sexual orientation as binary and heteronormative. A resonating thread of dominant discourses construct gender as equating girls, and a focus on health problems which disproportionately affect women in ways which are decontextualized from power relations and the social and structural determinants that shape them. In addition, our findings illustrate that in most policy documents addressing gender is equated to addressing vulnerability and 'risks' and thus it responds only to immediate 'symptoms' of gender inequality and does not transform the upstream social and structural determinants and root causes such as the underlying patriarchal belief and practices that perpetuate gender power relations.

These dominant gender discourses co-exist and are juxtaposed against marginalized discourses related to adolescent health and gender that focus on rights, social and structural determinants of health, as exemplified through attention to Comprehensive Sexuality Education. We also identified certain 'silences' interwoven with the dominant and marginalized discourses. These 'silences' include gender as socially constructed, gender identities as fluid and non-binary, lack of attention to boys in terms of their own health and also in terms of gender power relations as well as LGBTIQ+ adolescents beyond issues pertaining to HIV.

These 'silences' are interrelated with marginalized discourses and embedded in the broader discourse of adolescent health, gender equality, human rights and social and reproductive justice, all of which is informed by the South African social and political context.

Collectively, these dominant, marginalized discourses and 'silences' produce and reproduce what is problematized and what is left unproblematized in policy documents, for they shape what is in health policy documents and what is excluded, with significant implications for policy subjects and implementation.

The constructions of gender and adolescent health and related discourses identified in our analysis produce and reproduce broader discourses present in South African society. These discourses are located in a history of structural violence under colonialism and apartheid and continuing neo-liberal economic policies which collectively directly influence the health of all South Africans (Chopra and Sanders, 2004). This social and economic context is interwoven with and exacerbated by the legacies of structural inequalities, compounded by patriarchy and related constructions of masculinities and femininities. These have collectively resulted in South Africa's being one of the most unequal societies, where gender inequality intersects and compounds other inequalities such as race, geographical location and class (Coovadia *et al.*, 2009; Hassim, 2014; Gouws, 2017).

Part of this historical and contemporary context has created interrelated dominant discourses related to adolescent health and sexuality which are about social 'ills', disease and dangers of pregnancy, HIV and rape (Bhana, Crewe *et al*, 2019; Ngabaza and Shefer, 2019). Further, the HIV epidemic and dominance of HIV discourses also shape the dominant discourses as well as 'silences' in terms of what and who are focused on in adolescent health policy. Importantly, the discourses identified in our analysis are underpinned by many ideas and actor perspectives, related to gender and gender inequality in the South African context. Consequently, these discourses could also be playing a role in sustaining and reproducing complex patriarchal power relations. They raise the critical point that policy documents not only reflect the status quo but are also productive and, hence, potential foundations for transforming gender power relations. Future policies would benefit from foregrounding gendered power relations and the gendered social and cultural norms which have an impact on adolescent health within the content of policy documents. The addressing and illustrating of these unequal power relations also need to be part of a comprehensive programmatic response to inequalities in adolescent health in South Africa.

Implications for policies, programmes and systems

As shown in the findings, most policy documents outline programmes and interventions focused on adolescent girls and young women who bear the brunt of the dual epidemics of HIV and gender-based violence and are already the focus of many government and civil society services. In the South Africa context at the meso and macro levels there are initiatives led by various actors such government and donors and at times complement and/or contradict the policy documents. These include the She Conquers campaign (Subedar *et al*., 2018), the DREAMS initiative and other Global Fund programmes, which largely focus on HIV and adolescent girls and young women and on providing services.

While this service delivery lens is essential to ensure that their practical needs are met through gender-specific services and interventions to empower them, we would argue, at the same time, for a broader systems lens and the prioritizing of strategic gender-transformative programmes (George *et al*., 2019). This would include building on the growing body of evidence of gender-transformative approaches based on the foregrounding gender power relations, including the re-conceptualization of constructions of masculinities and femininities (Ellsberg *et al*., 2018). We therefore recommend that including gender-transformative responses and addressing gender inequality as a structural determinant should be integrated into both response and prevention to ensure a greater impact. Further, we recommend that these be implemented across sectors in order to disrupt and transform the power relations that create ill-health and, in so doing, re-politicize adolescent health and combine public health and rights-based approaches at micro, meso and macro levels of systems.

As policy makers, implementers and researchers we also need to question how and why adolescent health becomes gendered in ways that largely reduce it to a focus on girls, problems, rather than a comprehensive focus on all adolescents and also on their well-being. We need to critically analyse how the social and political context mediates this and ‘silences out’ more positive discourses on adolescence health, in order to develop more adolescent-

responsive and gender-transformative health policies and systems. While understanding that the main purpose of policies is to respond to problems and to address priorities, we need to consider a more comprehensive and gender-transformative perspective on adolescent health, as encouraged by the WHO (2017). In addition, in terms of the health system, we endorse the need for the development of a shared vision for adolescent health in South Africa, for a greater alignment of policies within and across departments as well as clear guidelines as to how the complementary multi-sectoral programmes should be implemented (World Health Organization, 2017; Cluver *et al*., 2018, 2019; Toska *et al.*, 2019). For example, the COVID-19 pandemic has foregrounded and exacerbated the pre-existing and widespread scourge of GBV in South Africa − also highlighted through civil society activism and high-profile media cases. The newly launched National Strategic Plan on GBV and Femicide (2020–2030) and the attention given to it by President Ramaphosa and other actors is encouraging, although a huge gap still remains between these commitments and the reality on the ground in terms of gender and intersecting inequalities.

In order to realize a more comprehensive and cohesive response, we suggest there should be strong leadership at multiple levels, collaborative governance frameworks and the capacity to develop and implement policy as well as capacity to analyze and integrate gender into programmes beyond tick-box exercises. As illustrated in the findings, the dominant, marginalized and even 'silent' discourses have implications for how adolescent health is addressed at policy and programme level and how adolescents in their diversity experience the health system. It also raises the critical question as to the role actors in constructing the content of policy documents and what this means for reproducing or transforming gender power relations. We need to reconsider how the content of policies shapes and limits the programmes we implement and the pathways and processes for transformation within health and social systems in order to meet the needs of all adolescents and leave no one behind.

Implications for gender integration

Our findings contribute to the literature on minimal gender integration and prioritization in policy documents, similar to the analyses of PMTCT policies (Nyamhanga *et al*., 2017), lay health worker policy (Klugman, 2000; Daniels *et al*., 2012) as well as global health policy (Gibbs *et al*., 2012; Olinyk *et al*., 2014). Further, our analysis of adolescent health policy documents contributes to the body of evidence highlighting the absence of in-depth gender analysis as part of transforming inequitable systems and structures within the health system (Theobald *et al*., 2017; Witter *et al*., 2017; Morgan *et al*., 2018). In terms of policy processes this could be due to the absence of gender expertise and/or a gender champion as well as structural issues that influence whether it reaches the policy agenda and actual policy, as described by Daniels *et al*., (2012) and Klugman (1999). The analysis of the content of policy documents highlights multiple gendered discourses which provide insight into the complexity of perspectives of policy authors, thus adding to the literature on how policies are socially constructed processes (Klugman, 2000; Mannell, 2014; Koduah *et al*., 2015; Lombardo, Meier *et al*., 2017).

We acknowledge that policy documents may have limitations and boundaries in terms of space and scope and that these will shape what is included in the final policy document. While it may not be reasonable to expect in-depth, detailed gendered analyses within the policy documents themselves, an acknowledgement of power, context and the relationships between different issues affecting adolescent health is crucial if these important factors are to be integrated into programming. Further, there should be some caution around the way policy documents simplify certain issues for the sake of brevity, as it is also important to acknowledge some of the complexities if these issues are to be effectively and comprehensively addressed.

Our research also echoes the call by others for greater attention to addressing gender inequality as a social and structural determinant of adolescent health, as key to transforming gender inequalities in health (Sen e*t al*., 2007; George and Amin, 2020). In addition, they also contribute to the debates and productive tensions in the gender mainstreaming literature which calls for a focus on addressing unequal power relations and promoting a bigger contextual picture of how gender intersects with race, class, sexuality and nationality, beyond any quantitative gender parity approaches (Ravindran and Kelkar-Khambete, 2008; Garcia-Moreno and Amin, 2019).

Implications for research

As a theoretical and analytical approach, combining content and critical discourse analyses has offered new lines of enquiry. Applying a critical discourse analysis to the content of policy documents reveals the underlying understandings, values and meaning making of actors, as central to the construction of policy (Parkhurst, Chilongozi and Hutchinson, 2015; McDougall, 2016; Gilson, Orgill and Shroff, 2018). Further, it has enabled critical reflections and deepened the analyses of the relationships between the content of adolescent health policy and social context in South Africa and opens up spaces for engagement with policy actors, building on other authors (Harmer, 2011; Parkhurst, 2012; Payne, 2014; Parkhurst *et al*., 2015; Evans-Agnew *et al.*, 2016). Our application of Bacchi's WPR approach also enabled critical engagement in terms of what is 'problematized' and also what is left out of adolescent health policies, as applied by others (Payne, 2014; Archibald, 2019; Baum *et al.*, 2019; Pringle, 2019). Our analysis also shows that in the policies, power and relational aspects of gender are not adequately analysed and this underscores the importance of paying greater attention to power relations that construct individual health (for example, that of adolescent girls) and asks the questions as to what social and structural systems create, thus reiterating the importance of the interrelationship between the personal and the political.

Further, our analysis also shows that in the policies, power and relational aspects of gender are not adequately analysed. We support the call by Morgan *et al*., (2018) for sex disaggregated data to be a trigger for further research and to deepen our analyses on gender power relations, including constructions of masculinities and femininities and what these mean for health and broader social systems. In addition, we also suggest further intersectional analyses in terms of gender and adolescent health, that is how gender and other axes of power and marginalization intersect and compound each other. Understanding the perspectives, experiences and roles of policy actors, in terms of how gender inequalities are produced and reinforced in health policy processes, is an area for further research in South Africa.

Limitations

The data analysed in this paper are policy documents which both provide an opportunity for in-depth analysis of their content, but also has significant limitations. Viewing policy documents as products or 'artefacts' of the policy making process allows us to explore how these texts represent ideologies and beliefs which are part of the social and political context. However, using policy documents alone has certain limitations in terms of understanding the dynamic interaction of other policy elements such as policy processes and actors, as the voices of the latter are not present in this paper. This will thus be the focus of a forthcoming research paper.

This paper shares insights from an in-depth gender analysis of fifteen policy documents relevant to adolescent health in the South African context. It does not aim to provide empirical generalizations to other sectors or contexts, although the authors acknowledge how gendered policy approaches to education and employment policy, as structural determinants, impact on adolescent health.

Conclusion

This assessment of South African adolescent health policy documents foregrounds how gender is not systematically incorporated across a fragmented policy landscape and that gender inequality and intersecting axes of inequality are not sufficiently analysed as social and structural determinants of adolescent health. Our findings show that how gender is conceptualized in policy documents, for example as equating biological sex and constructing adolescent health to be largely about vulnerable adolescent girls, rather than about social and structural power relations, has implications for gender-transformative multi-sectoral approaches.

Our analysis contributes to the understanding that policies are not just words or decontextualized texts. Their content is socially constructed and reflects and reproduces the conceptual understandings and ideological terrain related to gender, embedded in the policy documents. Our research makes visible the often taken for granted 'problems', ideas and interpretations, with implications for how they are addressed by means of 'solutions'. We conclude that how gender is conceptualized matters, both for policy analysis and praxis, and that policy documents can be foundations for transforming gender and intersecting power relations.

Table 1: Content analysis of adolescent health policy documents

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
1	Adolescent Sexual Reproductive Health Rights (ASRHR) Framework Strategy (2015) Adolescent specific	DSD	Age range: 10-19 years (early adolescence 10-14, late adolescence 15-19) Adolescence is defined in the policy as well as the overlap with youth Adolescents framed as diverse; e.g. groups that do not have access to services include LGBTQI+ or HIV positive adolescents	The Framework has a focus on SRHR for adolescents as a basic human right and outlines various priorities and components related to improving coordination and strengthening service delivery and creating community support networks for adolescents	Gender and key gender concepts are defined, including sexuality and LGBTIQ+ Gender is presented beyond a male/female binary and as fluid, diverse and socially constructed Some analysis of gender and mention and acknowledgement of social determinant of SRHR Gender-transformative interventions mentioned i.e. including ways to transform harmful gender norms, roles and relations noted in content. CSE is seen as an to address gender power relations and promote access to services for all adolescents	Notes diverse and multiple forms of inequality particularly around access to education and services No detailed intersectional analysis	Aligned to Constitution and to global and national rights policies Rights and agency, particularly related to access to SRHR services and non-discrimination, is a strong thread across the policy Adolescents not mentioned as part of the development of the policy
2	National Adolescent and Youth Health Policy (AYHP) (2017) Adolescents combined with youth, both in and out of school	NDoH	Age range: 10-24 years Adolescence is defined as a period of emotional and social development, growing independence and changing relationships within families, friendships and communities Adolescents framed as largely a homogenous group	Policy has broad positive definition of health with objectives related to the use of innovative technology, provision of SRHR services integrated with HIV, prevention of violence and substance abuse, promotion of healthy nutrition and	Gender and key gender concepts are not defined Gender is largely presented as a male/female binary and heteronormative ways. No substantial gender analysis and some acknowledgement of gender as part of the social determinants of health Gender is noted in a basic and implicit way (e.g. mentions that patriarchal gender norms can	Lists that social and structural deprivations such as poverty, income shocks, mental health distress, stigma, as 'intersecting' with gendered norms that disempower girls and women, as key drivers of risky behaviours	Aligned to Constitution and to global and national rights policies Adolescent rights, agency and engagement is a central tenant of the policy Adolescents explicitly mentioned as

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
				empowerment to engage with policy and programming e.g. AYHFS	reduce freedom to seek and secure health services, Gender-specific interventions i.e. highlighting remedial measures with a focus on AGYW as well as note of and MMC for boys. Gender-based transformative programmes in collaboration mentioned once with DSD and CBOs but minimal detailed	and poor health outcomes understood within a social ecological framework that recognises the interconnected influences of family, peers, community and society No detailed intersectional analysis	part of the development of the policy
3	Child and Adolescent Mental Health Policy Guidelines (2003) Adolescents combined with children	NDoH	Age range: prenatal period (conception to birth), childhood (birth to 9 years) and adolescence (12 to 18 years) Adolescence not defined but policy mentions childhood and adolescence as developmental stages but does not give a detailed overview of adolescence Adolescents framed as largely as homogenous, despite noting that different contexts shape mental health	Policy has a broad understanding of child and adolescent mental health, addressing risk and protective factors across various domains such as individual, family school and community	Gender and key gender concepts are not defined Gender is largely presented as a male female binary and heteronormative ways Gender is noted in an basic way (e.g. is noted to influence vulnerability but in a way that doesn't question gender power relations Gender-blind interventions noted in content i.e. ignores gender norms, roles and relations and differences in opportunities and resource allocation	Describes social and contextual factors such a poverty, intellectual disabilities, physical, emotional and/or sexual abuse, experiencing or witnessing violence No detailed intersectional analysis	Aligned to Constitution and to global and national rights policies Rights, agency and engagement of adolescents not mentioned Adolescents not mentioned as part of the development of the policy

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
4	Integrated School Health Policy (2012) Adolescents combined with children Grades: Reception-12 All learners including learners with special needs	ND0H DBE	Age range: None Adolescence is defined as a separate developmental stage Adolescents are framed as largely homogenous	The focus of the policy is on the improvement of the general health of school-going children as well as the environmental conditions in schools Adolescents are mentioned in the sections dealing with ARV adherence, mental health and risky behaviour as well as the importance of providing services in an adolescent friendly manner	Gender and key gender concepts are not defined Gender is largely presented as a male/female binary and in heteronormative ways No substantive gender analysis and not acknowledged as social determinant e.g. no recognition of how issues such as violence are gendered. Gender-specific interventions with a focus on girls, but notes boys to be provided with information on male circumcision	Situational analysis of social inequality and access to basic services and how that impacts on children No detailed intersectional analysis	Aligned to Constitution and national and global policies Rights, agency and engagement of adolescents not mentioned. Adolescents not mentioned as part of the development of the policy, however participation of learners noted as essential to implementation through established leadership structures and clubs
5	National Policy on HIV, STIs and TB for learners, educators, school support staff and officials in primary	DBE	Age range: None Adolescence not defined Adolescents are framed as largely as homogenous but policy notes that they have specific rights in terms of access to contraceptive and HIV	The focus of the policy is to improve coordination of the response to HIV, STIs, TB and unintended pregnancy, to accelerate implementation of a comprehensive	Gender and key gender concepts are defined Gender is presented beyond male/female binary and as a fluid, diverse and socially constructed Includes some gender analysis of vulnerability beyond just mentioning girls and young women, but also affecting boys	Social and structural drivers noted, inlcuding access to information and not be discriminated against, inlcuding in terms of access to CSE	Aligned to Constitution and national and global policies. Rights, agency and engagement of adolescents is mentioned in order to make informed life

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
	and secondary schools in South Africa (2017) Adolescents combined with children Learners from Grade 1-12, educators and support staff		testing and termination of pregnancy	strategy for prevention, treatment, care and support	Gender-transformative interventions noted including ways to transform harmful gender norms, roles and relations e.g. The CSE curricula is seen as one of the main mechanisms to talks about gender sexual orientation and gender identity and power relations	No detailed intersectional analysis	choices to protect themselves from HIV, STIs and TB as well as unintended pregnancy Adolescents not mentioned as part of the development of the policy though some leaners were consulted as part of stakeholder groups
6	National Policy on the Prevention and Management pf Learner Pregnancy at School (Draft 28 June 2018) Adolescents combined with children	DBE	Age range: None Adolescence is not defined as policy only makes reference to learners Adolescents are (implicitly) framed as homogenous	The focus of the policy is the prevention and management of learner pregnancy at school and through providing comprehensive SRH services, inlcuding CSE, HIV/AIDS services and access to termination of pregnancy, access to antenatal care and to ensure schools provide a stigma-free, non-discriminatory	Gender and key gender concepts are not defined Gender is largely presented as a male/ female binary and in heteronormative ways No substantive gender analysis but some recognition as a social determinant in that female learners, are particularly vulnerable and often exposed to sexual and gender-based violence, sometimes leading to coercion and assault, including rape. Gender specific interventions in terms of a focus on girls as part of the pregnancy policy	No detailed intersectional analysis	Aligned to Constitution and national and global policies Rights, particularly the rights of girls to education mentioned Adolescents not mentioned as part of the development of the policy although some learners participated in

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
	Learners from Grade 1-12			and non-judgemental environment for pregnant learners, pre- and post-delivery	mandate, but also gender transformative with a focus on CSE as essential		consultative workshops
7	National Policy Framework on Child Justice (amended in 2018) Adolescents combined with children Any person younger than 18 years in contact with the criminal justice system	DJ&CD	Age range: None Adolescence not defined and they are subsumed in the category with children Adolescents are (implicitly) framed as homogenous	The focus of this policy is on supporting any person younger than 18 years in contact with the criminal justice system There is some recognition of mental health concerns and details of how this needs to be provided by both the Departments of Health and Social Development Adolescent health and wellness is not addressed specifically	Gender and key gender concepts are not defined Gender is largely presented as a male/ female ways and in heteronormative ways No substantive gender analysis and not acknowledged as a social determinant Gender blind i.e. ignores gender norms, roles and relations but notes that girls and boys need to be housed separate	No detailed intersectional analysis	Aligned to the Constitution and global and national policies Rights, agency and engagement of adolescents not mentioned Adolescents not mentioned as part of the development of the policy

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
8	National Youth Policy (2015-2020) Adolescents combined with youth	National Youth Development Agency	Age range 14 to 35 years Adolescence not defined Young people are framed as diverse and non-homogenous and unequal but does not have a specific analysis and focus on adolescents	The focus of the policy is the social and economic development of youth and has a section on health addressing HIV/AIDS prevalence, violence and substance abuse and notes that many of these behaviours start in adolescence Notes that SRHR of youth should be supported by both schools and the family to enable access to necessary information and health care	Gender and key gender concepts are not defined Gender is largely presented as a male/ female ways and in heteronormative ways No substantive gender analysis and minimal focus on gender as a social determinant Gender sensitive with content which indicates awareness of the impact of gender norms, roles, and relations, but no gender specific interventions noted	Mentions high level principles based on non-discrimination on the basis of age, gender, race, sexual orientation, disability or any other form of discrimination No detailed intersectional analysis	Aligned to Constitution and to global and national rights policies Adolescent rights not mentioned specifically but the rights and participation of young people in society is noted as very important Adolescents not mentioned as part of the development of the policy
9	National Development Plan (2012) General population	Planning Commission	Age group: None Adolescence not defined Young people are framed as being unequal and there is a commitment to them as priority for employment and access to education, but does not have a specific analysis and focus on adolescence	The focus of this policy is on several areas of national development such as education, economic development etc. It has a section/chapter on health, but this is largely focussed on financing of health, National Health Insurance, HIV and	Gender and key gender concepts are not defined Gender is largely presented as a male/ female ways and in heteronormative ways No substantive gender analysis and minimal focus on gender as a social determinant Gender sensitive with content which indicates awareness of the impact of gender norms, roles, and relations, but no	Describes high level values related to gender equality and a commitment to addressing inequalities base on race and gender No detailed intersectional analysis	Aligned to Constitution and to global and national rights policies. Adolescent rights not mentioned specifically but equal rights for all is mentioned Adolescents not mentioned as part of the

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
				issues around violence and safety	gender specific interventions noted		development of the policy
10	National Health Promotion Policy and Strategy (2015-2019) General population	NDoH	Age range: None Adolescence not defined but policy recognises youth as a key target audience Youth(Adolescents) are framed as largely a homogenous group	The focus of the policy is on health promotion for the general population with emphasis on the process of enabling people to increase control over their health and its determinants, and thereby improve their health Focus is risky sexual behaviour, of healthy lifestyle practices and healthy nutrition, physical activity to prevent obesity and abstinence from tobacco and alcohol as well as focus of SGVB prevention	Gender and key gender concepts are not defined Gender is largely presented as a male/ female binary and in heteronormative ways No substantive gender analysis and not acknowledged as a social determinant Gender specific interventions noted with a focus females, but also that males should be targeted in campaigns to increase levels of awareness towards of gender norms and broader involvement in health programmes	Lists some key social determinants of health and notes that addressing the key social, behavioural and structural determinants of health and understood within a social ecological framework that recognises the interconnected influences of family, peers, community and society on health seeking behaviours No detailed intersectional analysis	Aligned to Constitution and to global and national rights policies Rights, agency and engagement of adolescents not mentioned Adolescents not mentioned as part of the development of the policy

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
11	National Strategic Plan for HIV, TB and STIs (2017-2022) General population	SANAC	Age range: 10-19 Adolescence not defined Adolescents are largely framed as homogenous but the policy notes that vulnerability varies by age, geography and gender	The overall focus of this policy is on HIV, STI's and TB for the general population. The policy includes prevention, adherence support, reaching all key and vulnerable populations, addressing the social and structural drivers, human rights and promotion of leadership and shared accountability Adolescent girls and young women (AGYW) are in the category of key and most vulnerable populations	Gender and key concepts are defined Gender is largely presented as a male/female binary and in heteronormative ways, but LGBTIQ+ persons in programming No substantive gender analysis and with minimal focus on gender as a social determinant e.g. survivors of GBV but not addressing structural issues such as patriarchy Gender sensitive and gender specific interventions noted with a focus on AGYW and ABYW mentioned in terms of specific interventions e.g. Medical Male Circumcision. One mention of gender-transformative interventions but no detail	Lists social structural factors such as poverty, inequality, inadequate access to quality education, poor nutrition, migration, gender inequality, gender-based violence, and alcohol and drug use as increase vulnerability to HIV, TB and STIs No detailed intersectional analysis	Aligned to Constitution and to global and national rights policies Rights, agency and engagement of adolescents not mentioned but has Chapter focussed on Human Rights Adolescents not mentioned as part of the development of the policy

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
12	Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011-2021 and beyond (2011) General population	NDoH	Age range: None Adolescence not defined but policy recognises that SRHR services have had a focus on women of reproductive age and lists adolescent as part of several groups that have not received adequate attention and whose needs have not been met. Adolescents are framed as largely a homogenous group	The policy has a focus on SRHR for the general population and is grounded in key rights principles and outlines services that will be provided to all based on their diverse needs at the community level as well as the health systems components needed.	Gender and key gender concepts are defined Gender is presented beyond male/female binary and as fluid, diverse and socially constructed Some gender analysis with a focus on SRHR and emphasis on gender equity and the barriers to access services e.g. poverty, gender-based violence etc Gender-sensitive i.e. indicates awareness of the impact of gender norms, roles, and relations on SRHR services and supports CSE	Acknowledges gender and other forms of inequity as key barriers to SRHR. No detailed intersectional analysis	Aligned to Constitution and to global and national rights policies. Rights and adolescent engagement is implied through school and community and health service provision but not explicitly discussed or outlined Adolescents not mentioned as part of the development of the policy
13	National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012)	DOH	Age range 12-19 years Adolescence not defined Adolescents are framed as not being homogenous in terms of contraceptive needs which may vary in terms of age, physical and emotional development, culture	The overall focus of the policy is on contraception for general population but has a dedicated chapter which focusses on the needs of specific and defined groups i.e. adolescents; LGBTI; men; sex workers, migrants and disabled	Gender and some key concepts are defined Gender is largely presented as a male/ female binary and heteronormative ways No substantive gender analysis but acknowledgement that contraception has always been feminized and that men need to be included more as partners and for their own needs	Notes that discrimination in terms of sexual orientation, sexual preferences gender, age and culture and access to education No detailed intersectional analysis	Aligned to Constitution and to global and national rights policies Rights, agency and engagement of adolescents not mentioned specifically but part of general population

	General population		and maturity as well as life circumstances	persons. It outlines the legal context and access to contraception, HCT and termination of pregnancy and access to AYHFS	Gender-sensitive i.e. indicates awareness of the impact of gender norms, roles, and relations and gender-specific interventions noted		Adolescents not mentioned as part of the development of the policy
14	Strategy for the prevention and control of obesity in South Africa (2015-2020) General population	NDOH but signed by Trade and industry, Education, Public Service and Administration	Age range: None Adolescence is not defined and they are grouped with children as policy only makes reference to adults and children Adolescents are (implicitly) framed as homogenous	The focus of the policy is on prevention and control of obesity of the general population and addresses nutrition, physical activity and links to NCDs, with no broader aspects of health e.g. mental health, SRHR etc.	Gender and key gender concepts are not defined Gender is largely presented as a male/ female binary and in heteronormative ways No substantive gender analysis and not acknowledged as a social determinant Gender is described to equate biological sex, despite some mention that gender inequality is interaction of complex social, cultural and bio- logical factors Gender sensitive interventions noted	Acknowledges that gender inequality is a complex interplay of social, cultural and biological factors and influence of age and race are mentioned No detailed intersectional analysis	Aligned to Constitution and to global and national rights policies Rights, agency and engagement of adolescents not mentioned specifically but part of general population Adolescents not mentioned as part of the development of the policy

#	Policy & Mandate	Lead Actors	Definition and framing of Adolescence	Adolescent Health	Definitions and framing of Gender	Intersectionality	Rights and engagement
15	National Policy Framework on the Management of Sexual Offences (2012) General population	DJCS	Age range: None Adolescence not defined and they are subsumed in categories of vulnerable groups i.e.. women and children. Adolescents are (implicitly) framed as homogenous	The focus of this policy is on the prevention of secondary victimisation of victims of sexual offences and outlines key principles and procedures to address these. In the general population, with emphasis on women and children, without specifying adolescents	Gender and key gender concepts are not defined. Gender is largely presented as a male/female and in heteronormative ways No substantive gender analysis and not acknowledged as social determinant but notes that women and children are victims vulnerable and victims Gender inequality is noted in an implicit way e.g. to influence vulnerability does not question gender power relations Gender sensitive with content that indicates awareness of the impact of gender norms and notes gender specific interventions	Mentions equal and equitable access to services and prevention discrimination on access of race, class, a gender, disability and sexual orientation No detailed intersectional analysis	Aligned to the Constitution and global and national policies. Rights, agency and engagement of adolescents not mentioned , but policy adopts a victim centred rights approach Adolescents not mentioned as part of the development of the policy

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CHAPTER 6: BETWEEN RHETORIC AND REALITY: LEARNINGS FROM YOUTH PARTICIPATION IN THE ADOLESCENT AND YOUTH HEALTH POLICY IN SOUTH AFRICA

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1. SUMMARY

Youth participation in the Adolescent and Youth Health Policy (AYHP) was a 'first' and unique component for health policy in South Africa. Youth participation was enabled by leadership from certain government actors and the involvement of key academics with a foundation in longstanding youth research participatory programmes. Challenges nonetheless remained relating to when, how and which youth were involved – and youth participation was not consistent throughout the health policy formulation process. This is related to broader contextual challenges including the lack of a representative and active youth citizenry; siloed health programmes and policy processes; segmented donor priorities; and the lack of institutional capability for multi-sectoral engagement required for youth health.

2. CONTRIBUTION TO THE THESIS

This paper contributes to the third objective, which is to map and describe the actors in terms of their roles and relationships, and the process of developing the AYHP in South Africa. It also contributes to the fifth and cross-cutting objective, which is to reflect on the implications for gender transformation of this articulation of power, people and processes in adolescent health policies.

3. CONTRIBUTION OF THE CANDIDATE

The candidate designed the study, undertook the review of literature, conducted the interviews and undertook the initial analysis, with input from the supervisor. The candidate wrote the first draft of the paper, and the supervisor provided critical input into this and subsequent drafts. The candidate led the submission process and revisions on the comments from the journal peer review.

A copy of the published article is available in Appendix 9, pending publication. It is also reproduced here to facilitate the coherence of the thesis' 'Findings' chapters, retaining the style and format required by the journal. Comments from the peer review process are available in Appendix 10.

This paper was presented as a poster at the Health Systems Global Research Symposium, held in Bogota, Colombia, 30 October to 4 November 2022.

4. PUBLICATION/STUDY: BETWEEN RHETORIC AND REALITY: LEARNINGS FROM YOUTH PARTICIPATION IN THE ADOLESCENT AND YOUTH HEALTH POLICY IN SOUTH AFRICA

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Ethical issues:

This article is part of a larger PhD research case study titled: People, power and processes a gender analysis of adolescent health policy in South Africa which has received ethical approval by the Biomedical Science Research Ethics Committee of the University of the Western Cape. Reference number: BM18/9/9

Authors' contributions:

Both TJ and AG developed the Conceptual Framework and TJ collected the data. Both authors contributed to the analysis and interpretation of the findings and the drafting of the paper. Both authors read and approved the final manuscript.

Abstract

Background: Youth participation makes an essential contribution to the design of policies and with the appropriate structures, and processes, meaningful engagement leads to healthier, more just, and equal societies. There is a substantial gap between rhetoric and reality in terms of youth participation and there is scant research about this gap, both globally and in South Africa. In this paper we examine youth participation in the Adolescent and Youth Health Policy (AYHP) formulation process to further understand how youth can be included in health policy-making.

Methods: A conceptual framework adapted from the literature encompassing Place, Purpose, People, Process and Partnerships guided the case study analysis of the AYHP. Qualitative data was collected via 30 in-depth, semi-structured interviews with policy actors from 2019-2021.

Results: Youth participation in the AYHP was a 'first' and unique component for health policy in South Africa. It took place in a fragmented policy landscape with multiple actors, where past and present social and structural determinants, as well as contemporary bureaucratic and donor politics, still shape both the health and participation of young people. Youth participation was enabled by leadership from certain government actors and involvement of key academics with a foundation in long standing youth research participatory programs. However, challenges related to when, how and which youth were involved remained. Youth participation was not consistent throughout the health policy formulation process. This is related to broader contextual challenges including the lack of a representative and active youth citizenry, siloed health programs and policy processes, segmented donor priorities, and the lack of institutional capability for multi-sectoral engagement required for youth health.

Conclusion: Youth participation in the AYHP was a step toward including youth in the development of health policy but more needs to be done to bridge the gap between rhetoric and reality.

Keywords: Youth Participation, Health Policy, Policy Process, Actors, Youth, South Africa

Key Messages

1. Implications for policy makers

- Youth participation in policy-making is a right and involving young people in all that is relevant to them is part of global legal and policy commitment to end discrimination and exclusion and reduce inequalities.
- Policymakers need to meaningfully engage youth in their diversity and in representative and accountable ways, in all stages and spaces of the policy-making process, as part of building youth citizenship and leadership.
- Understanding the dynamic relationships between context (place), people (actors) and processes, is crucial when analysing, planning and facilitating youth participation in policy processes.
- Multi-sectoral collaboration across government departments, with civil society, with researchers and with representative youth structures, can enhance the meaningful participation of young people in policy processes.
- A key area for action is for policymakers to reimagine principles and ways of working, to ensure the enabling contexts, capabilities, resources, actors and processes are in place, to centre youth participation and bridge the gap between policy commitments on paper and lived realities of young people.

2. Implications for public

Youth participation in policy-making is a right and it is very important to meaningfully involve young people in all policies that affect them, in order to build healthier, more just, and equal societies. It is really important to acknowledge the diverse experiences and voices of young people and include their participation in all stages and spaces of policy-making processes, beyond tokenism. A greater understanding of the benefits, *who* is involved and the *how* of ensuring participation in policy processes, will be good for youth, policy actors and all of society. As such, policy-makers should make sure that they create the enabling contexts, have the required capabilities, resources and partnerships, that put youth at the centre of all policies that affect them. We all need work together to ensure that young people, as current and future leaders, are not left behind in the Sustainable Development Goal (SDG) era.

Background

The principle of 'Leave no one behind' is central to the 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs). Involving young people in all that is relevant to them is part of this global commitment to eradicate poverty in all its forms, end discrimination and exclusion, and reduce inequalities and vulnerabilities. Prior to the SDGs, youth participation was recognised as a right in global legal policy through the United Nations (UN) Convention on the Rights of the Child.[1] This right underscores the importance of the involvement of children (defined as up to 18 years) in decisions, that affect them, including their health. The Convention on the Rights of the Child is often applied as the legal and policy foundation to encourage and legitimise youth participation as a civil, political, economic and cultural right and is complemented by the African Youth Charter as a regional commitment[2] and other global policy frameworks such as, Beijing+25, and statements such as the Global Consensus Statement Meaningful of Adolescent & Youth Engagement.[3,4] In South Africa, the National Development Plan and the new National Youth Policy (2020-2030) are aligned to the Constitution and to global and national rights policies which articulate youth participation as right.

Participation is a right and it should be a priority to involve youth voices and policy beneficiaries as they can they make significant contributions and provide leadership in both programme and policy processes and meaningful engagement leads to healthier, more just, and equal societies.[3,5,6] In addition to rights based legal and policy framework of youth participation as a right, there is increasing acknowledgement of youth participation as important for development of policies and programmes, including health.[5,7] The meaningful engagement of young people in all aspects planning, implementing, monitoring and evaluating programmes and policies has multiple benefits for their own, and their communities' health and development.[8–10] From a health systems perspective, national policy frameworks need to recognize the meaningful engagement, participation and leadership of young people and understand them as active actors, not merely beneficiaries of health programming.[5,11]

Despite the substantive global and national commitments to youth participation in policy processes on paper, several barriers and challenges exist in terms of youth participation in both health policy processes and programmes. Challenges include varied understandings and approaches related to young people, both in terms of diverse definitions and strategies to integrate them in decision-making, reflecting how constituencies and sectors shape adolescent policy priorities and programmes. Further, policy discourses about youth can be somewhat contradictory, constructing young people simultaneously as both 'a risk' to social cohesion and democracy and 'a solution' to 'wicked problems.'[12] Although various approaches have been used to engage and collaborate with youth in the development of health policies and programmes, significant gaps exist between policy-makers' understandings of young people's needs and their lived realities.

In reviewing adolescent health policies in South Africa from 2003 to 2018,[13] the content of the policy documents make reference to the South African Constitution and legal and policy frameworks that centre human rights, including commitments to health as a right, access to services, and addressing historical and current barriers to access for all South Africans. Participatory governance is an important right in the relatively recent democratization in South Africa.[14] However, only three of the polices include explicit reference to the rights and empowerment of youth[15–17] and only one mentions the engagement of youth in the policy development process, the Adolescent and Youth Health Policy (AYHP) (2017). The absence of youth participation in policy development processes across the health policy landscape in South Africa, is the backdrop and our paper provides contextual insights from the AYHP process to address this paucity. While the new National Youth Policy included consultation with youth across the nine provinces, scant details are provided on how this was done. Furthermore, delays in the process due to concerns raised by civil society actors, compounded by the coronavirus disease 2019 (COVID-19) pandemic, meant that the final policy was only released in March 2021.

Definitions of youth participation and how terms such as “adolescents” and “youth” are applied are relevant starting points for understanding youth participation in policy processes. The UN defines youth participation as “the active and meaningful involvement of young people in all aspects of their own, and their communities' development, including their empowerment to contribute to decisions about their personal, family, social, economic, and political development.” The World Health Organization defines “adolescents” as 10-19 years and ‘‘youth’’ as those aged 15–24 years, and ‘‘young people’’ as being 10–24 years old.[18,19] The African Youth Charter defines youth as 15-35 years and the South African National Youth Policy, defines youth as 14-35 years. Given the diverse terms and age ranges, in this this paper we refer to adolescent and youth, being from 10-24 years and use the term ‘youth’ to refer to range of adolescents and young people, as this is consistent with the age range referred to in the AYHP. Due to the inconsistent use of age ranges, proportions differ, but it is estimated that, the youth (15-34 years) constitute more than a third of the population. Adolescents (10-19 years) are estimated to make up 18,5% of the total population of South Africa.[20]

There is a substantial gap between rhetoric and reality in terms of youth participation with scant research on youth participation in health policy-making, both globally and in South Africa. In this paper we describe and analyse youth participation in the AYHP process and also raise critical questions and lessons in terms of the *how* of youth participation in health policy-making. The key research question and lines of enquiry for this paper are: How was youth participation facilitated in the AYHP, which youth were involved and whose voices were heard, how was this facilitated, what was the context, who were the actors? What can be learned about strengthening youth participation in health policy overall? In addition, ‘zooming in’ on the AYHP and South African context is also a foundation to then ‘zoom out’ and engage with more meta questions in terms of youth participation in health policy-making processes more broadly, in order to identify learnings for those working in the fields of adolescent and youth studies, as well as health policy and systems research.

Methods

Several frameworks located in the intersecting fields of adolescent and youth health and critical youth studies explore youth participation in programmes.[5,12] Over time the dominant frameworks on youth participation have included Arnstein's "Ladder of Citizen participation" (1969)[21], Hart's "Ladder of participation" (1992)[22], which has been adapted by several authors, including Treseder (1997) and Shier (2001)[23]. Wong et al developed the typology of youth participation and empowerment pyramid, where the ultimate aim was to achieve a balance between youth and adult control, through the empowerment of both, by establishing shared power relationships. The Lancet Commission framework for youth participation describe training and mentorship, adult partnerships, systems and resources as essential elements of meaningful youth engagement.[24] These current frameworks are designed largely to monitor and evaluate youth participation in programmes, consequently there is an evidence gap in terms of youth participation in health policy processes.

Conceptual Framework

Acknowledging and building on prior work conceptualising youth participation noted above, we expand and adapt a relatively new conceptual framework synergised from fields of feminist, post-structural and critical theory, as well as youth studies, and citizenship research for conceptualising and planning for youth participation in programs.[12] The model directs attention towards seven inter-connected domains of Purpose, Place, Process, Positioning, Protection, Perspective and Power relations. We expanded this model by adding 2 additional domains ie, P for People, the actors, as well as an additional P for Partnerships, across government departments and with civil society, for example. We also focus on Process, as a dynamic cross-cutting domain, and how it intersects with the domains of Positioning, Protection, Perspective, Power relations, Protection. The final conceptual framework (Figure 1) therefore has Place or context as the broader setting, which encompasses Process (Positioning, Perspective, Protection, Power relations) and Purpose, with People and Partnerships embedded throughout.

Given the phenomenon of interest being youth participation in health policy processes, we therefore also integrate approaches from health policy analysis (HPA). Importantly, HPA goes beyond content and specifically considers the context that is shaped by individual, organisational, national and global factors, as well as the actors, in terms of their roles and influence on policy processes, at different levels.[25,26] The Health Policy Triangle[26], which explores the dynamic interactions between content, actors, context and processes, was

integrated into the interview guide. It has been used extensively at global and national levels and applied largely on public health concerns such as health human resources, services and systems, but not youth participation in policy processes.[27] Mapping and understanding the actors, including youth, and how they interface with other actors, in health policy-making processes, is therefore an important line of enquiry, in order understand the complexity and dynamics of policy processes and to address the gap between rhetoric and reality.

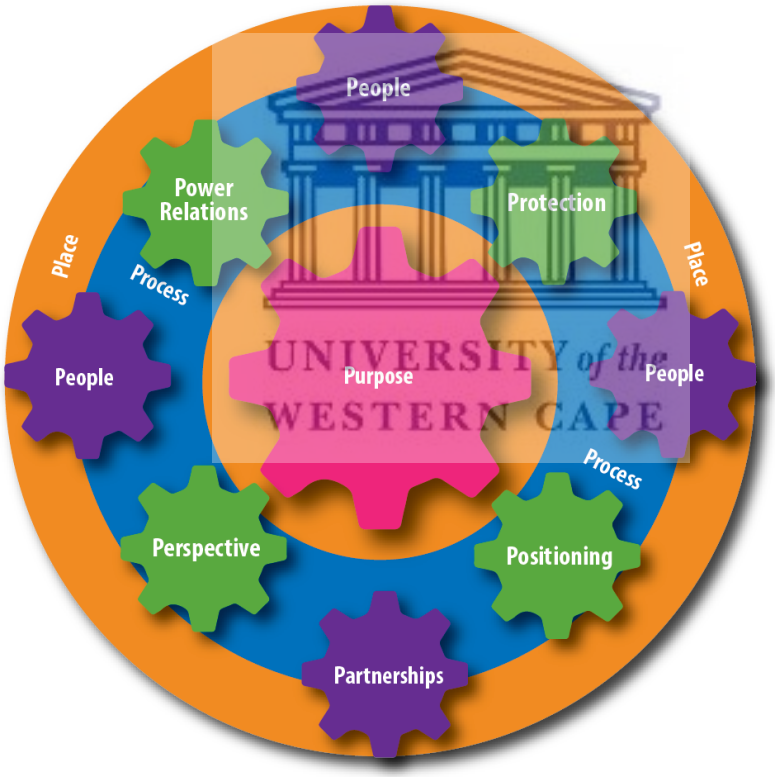

Figure 1. Conceptual Framework: Interactive and dynamic domains of Place, People, Purpose, Process, Positioning, Protection, Perspective, Power relations and Partnerships

Research Design

A case study design based on qualitative interviews was chosen which allowed for an enquiry of the phenomenon located in the social and political context, enabling sense-making of the complexity and nuances of context and processes that gave rise to and shaped youth participation, in the AYHP.[28,29] These methods were used to unpack the research questions which were focused on describing the systems and processes of policy-making and exploring the perspectives of actors. Data was collected via in-depth, semi-structured interviews with a range of policy authors and actors. Through purposive sampling, AYHP policy authors in government, academia and donors, members of the Advisory Panel, youth representatives from the National Department of Health (NDoH) Adolescent and Youth Advisory Panel (AYAP), National Youth Development Agency, as well as youth health policy actors, in government, academia and civil society, representing a range of experiences and perspectives were identified (Table 1).

Data Collection

Thirty respondents were interviewed between September 2019 and April 2021, in an iterative manner i.e., after a first round of 15 interviews, initial analysis was conducted which guided subsequent interviews. The first round of interviews was conducted face-to-face, however in the COVID-19 context, the majority of the second round of interviews were conducted via the medium which participants preferred (Zoom, Google Meet, WhatsApp).
Informed consent to interview and audio record was obtained from each participant and each interview was transcribed in full. Each participant was assured of anonymity and confidentiality.

Reflexivity in understanding the researcher's positionality in the research process is critical to understanding study design and findings.[30–32] As part of our reflexive analysis, we were aware of how our power and positionality as two middle-class, South African academics, shaped the research process, including researcher-participant interactions and the power and privilege that is part of that positionality and is further reflected on in the discussion. For

example, the lead author has twenty years of experience working in the field of adolescent health and therefore brought an understanding of the national context and histories that framed the topic. She also had relationships with many of the respondents that enabled access to key policy-makers and academics. Belonging to a university with a political history of advancing social justice, may have also influenced respondents willingness to participating in the research.

Table 1. Categories of Actors and Number of Participants Interviewed

Category	Number
AYHP author government	5
AYHP author academic	2
AYHP author international NGO funder	1
Government Actor	6
AYHP Advisory panel members	5
Civil Society Actor	6
Academic Actor	2
NDoH Adolescent and Youth Advisory Panel	3

Data Analysis

Data analysis was guided by the conceptual framework and the interview transcripts were analysed using thematic analysis, and included both deductive and inductive coding and categorisation.[33,34] Initial deductive codes were based on Cahill and Dadvand[12] mentioned above and included Purpose, Place, Process, Positioning, Protection, Perspective and Power relations. Through the thematic analysis, People and Partnerships were added as inductive codes, as they emerged from the data and the Conceptual framework was refined through this iterative process. In addition, interview data was triangulated both across respondents, as well as with data from document analysis of the AYHP undertaken for a previous paper.[13]

Results

The findings of youth participation in the AYHP are presented along the domains of Place, Purpose, People, Process, and how this included dynamic interactions between Positioning, Perspective, Protection, Power relations, as well as Partnerships, per the conceptual framework (Figure 1).

Place: i.e. Context

The AYHP was developed in a national context where youth participation in policies relevant to their health had not taken place historically and there was therefore strong support for this as a 'first' and unique component, in the context of existing international and national commitments to the rights of young people, including the right to participate in policies and programmes that affect their lives.

The AYHP timeline is contextualised in a history and current policy context that promotes proactive approaches to youth empowerment and health promotion, and was also intended to link the Integrated School Health Policy (2012) and the National Youth Policy (2015-2020). It is built on the foundations of earlier national health policies that focus on the health and wellbeing of adolescents and youth and this landscape includes the first National Policy Guidelines for Youth and Adolescent Health (2001), which was followed by the draft AYHP (2012). An internal NDoH review in 2014 highlighted critical gaps, such as lack of youth participation and evidence-based interventions. This was the impetus for the NDoH to initiate a new AYHP in 2015, in partnership with an appointed academic team to lead the technical support and with additional technical and financial support by the United Nations Population Fund (UNFPA) and was finalized in 2017.

In addition, the AYHP is located in a policy context that is fragmented and uncoordinated, with several actors and unaligned policies relevant to adolescent and youth health and this was articulated by all types of actors. These co-exist and correspond to many vertical programmes both within the NDoH, within other government departments and with other

national programmes. An example of this is the Adolescent and Youth Health Friendly Services (AYHFS), which was not really integrated into policy and programming: *"A review of AYHFS [*Adolescent and Youth Health Friendly Services *shows that it has not been successful after 20 years and the challenge remains in terms of where and how to create safe zones for adolescents within and beyond the health service and how services are not designed for young people"* (AYHP Author Government 14).

The contextual realities of youth are shaped by key social and structural determinants, such as legacies of colonialism, apartheid, contemporary social and economic inequalities, as well as racial and gender inequality, which all intersect and compound each other. This context includes a historical denialism and neglect of the HIV epidemic, which resulted in delays and failures in the management of integrated HIV prevention, treatment and care, exacerbated by gender inequality, lack of access to education and training and unemployment. All the actors spoke to the history of intersecting social and structural determinants which construct the current realities and priorities of young people and also manifest in key challenges they face, as illustrated in the following quote, *"Young people experience intergenerational poverty and high levels of youth are not in educational employment or training. Gender-based violence and the problem of violence, so those are the big things they face"* (AYHP Advisory Panel Member 11).

With a post-Mbeki shift in political leadership that turned HIV policy around, the AYHP was developed in a context where HIV became a national priority, with a focus on adolescent girls and young women in particular, given the incidence data, with several corresponding government and donor initiatives addressing the interlinked national priorities of HIV and *gender-based violence* (GBV). This is evidenced in the national She Conquers Campaign,[35] the regional DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) Initiatives, UN Agencies initiatives such as the She Decides campaign. All of these programmes and activities include a component of youth participation, often through 'ambassadors' and or 'trail blazers' and programmatic interventions, both with a focus on notions of 'empowerment' and agency, particularly young women, in the context of HIV and GBV epidemics.

A key theme that emerged from many policy actors, is the concern that this type of youth participation has created a pattern and practice in South Africa, largely driven by HIV actors and donors. This includes positioning these individuals as social media influencers and 'celebrities,' that are not necessarily representative of diverse realities and youth civil society movements. Participants mentioned that while individual empowerment is important, it deflects from the substantive transformation of social and structural determinants and systems: "They participate, they sit in forums and stand on platforms, so they make a very valuable contribution, but they are not necessarily connected back to a diverse youth constituency. They are basically eloquent people who happen to be young and there is a space for that, because I think obviously that is where the experts and the subject matter leaders of the future are going to emerged from. But those structures are often not connected downwards, in a way where there is accountability" (AYHP Advisory Panel Member 21) Of further relevance is that, 27 years into South Africa's constitutional democracy, the youth sector is still fragmented, includes some party political structures, but no organised, nationally representative civil youth structures and movements, as voiced by several policy actors from both civil society and government.

Purpose

The purpose of youth participation was to identify and address adolescent and youth needs and priorities and was described in the AYHP document as central to the development. *"Youth participation and engagement have been central to this policy's development"* (2017:2). Further, the purpose of participation, as a process of informing and gaining access to youth perspectives, was articulated by policy authors, "*It was very clear that we weren't getting to what I thought were the key issues. So, we then switched gears and said, well, let's ask young people"* (AYHP Author Government 14). Participation of youth in developing the AYHP was described as a unique, ground-breaking and 'business unusual,' across the spectrum of policy actors interviewed, including youth actors.

Importantly, there are various nuanced actor perspectives in terms of the overall purpose of the policy and the role of youth participation in achieving this, as articulated by the participants. This continuum of perspectives includes the AYHP as a vehicle to operationalise the vision for youth health, meet the particular and changing needs of needs of youth, which had not been met by previous policies and services. In addition, another perspective includes that the overall purpose is to align policies, especially National Youth Policy and Integrated School Health Policy, as well as letting youth have a voice and involvement in the design and review of programmes.

People: i.e. Actors

The actor landscape included the NDoH, as lead government actor and authors, who also triggered and managed the overall policy process. Additional lead authors included the academic team, as well as UNFPA. The academic team were selected based on their extensive experience in developing and facilitating participatory research with youth expert advisors. The authors were supported by an Advisory Panel comprised of key academics, researchers and other civil society actors in youth health, who led and contributed to the evidence reviews, as well as review of the AYHP. The absence of an AYHP policy champion to work across branches within the NDoH, as well as across departments and actors, in a structured mechanism and iterative manner, was highlighted by several policy actors. Youth, as key policy actors, participated in the policy process in particular ways and through existing research collaboration workshops and consultations, facilitated by the academic team. (See Box 1). Youth included the Young Carers research groups, Mzantsi Wakho and the Sinovuyo Teen parenting programme. The NDoH also established an AYAP, consisting of one representative per province, that contributed to the policy development, as well as ongoing implementation advice and monitoring of services. Another layer of more distal actors includes key government departments, ie, Departments of Social Development and Basic Education, who participated in some of the AYHP consultative meetings. These actors also have an adolescent and youth health mandate, as well their own related policies and youth structures, that they consult and collaborate with.

Actors in government that did not participate in the AHYP include Departments of Higher Education and Training, Women, Youth and Persons with Disability, as well as key government led agencies, such as the South African National AIDS Council and the National Youth Development Agency. The South African context has multiple civil society actors of both youth-led and youth-focused groups and organisations, addressing several interrelated priorities such as youth development, HIV, Sexual Reproductive Health and Rights, and GBV, funded largely by donors and only a few were included in the stakeholder consultative processes. Importantly, less 'visible,' but powerful actors, including the funders such as Global Fund, 'President's Emergency Plan for AIDS Relief' and the United States Agency for International Development, shape the programmatic agenda in South Africa, but were not directly included in the development of the AYHP.

Process, Including Positioning, Protection, Perspective and Power Relations

The process of making the policy included dynamic interactions between the domains of process, positioning, protection, perspective and power relations as per the conceptual framework. We describe what worked well, as well as what the challenges were in the sub-sections below.

What Worked Well

This sub-section describes what worked well during the process and in summary these include, there being a policy window, participation through established participatory research programmes, and building of relationships between policy actors. These are expounded upon in further detail below.

A key enabling trigger was the policy window with government explicitly articulating and valuing involvement of youth and alignment with academic actors. Therefore, the positioning of young people was in terms of long standing participatory research programmes, being the Young Carers, Sinovuyo Teen research partnerships and the Mzantsi Wakho research programme, based in the Amathole District in the Eastern Cape.[36–39] This positioning of youth as research participants in established participatory research programmes, had allowed relationships of trust to be built over time and their perspectives were gathered to establish

the core objectives for the policy and the sixth objective makes direct reference to participation of youth to engage with policy and programming. See Figure 2 as an example of a Dream Clinic which included an ambulance, a mobile clinic, a good road, wheelchair room, a water tank and a comfortable waiting room.

Box 1. Process of how of youth were consulted as part of the AYHP development

- •Convening a Youth Health Parliament
- •Visual exercises including 'dream consultations' and 'dream clinics'
- •Participatory research to investigate substance abuse, mental health/illness and adherence to chronic medicines
- •Health clinic report cards in which adolescents and youth evaluated public health services
- •Focus groups on sexual and reproductive health, intimacy, romance, risk and aspiration among youth and adolescents and their caregivers

Source: AYHP (2017)

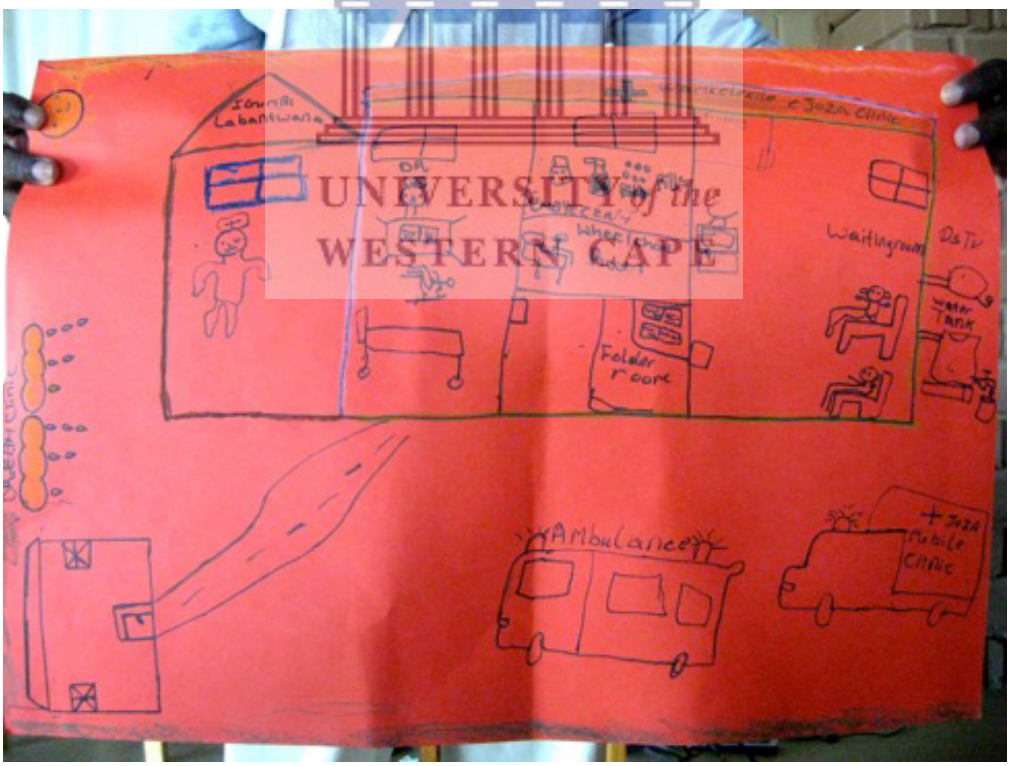

Figure 2. Example of a 'Dream Clinic'

Source: AYHP (2017)

Further, NDoH senior staff also participated in some of these activities and this enabled building of relationships between academics, government and youth participants. This combination of a participatory research process, as well as generating evidence through reviews, was appreciated by the NDoH, and is illustrated by the quote: *"They loved that we had an empirical aspect of Mzanzi Wakho. So, we were going to be able to give them very strongly evidence-based data. But they also wanted something which would clearly have youth input*" (AYHP Author Academic 9).

In terms of power relations, the academic authors described the process of participatory research as being mindful of the voice and agency of young people and this is expressed in the quote, "*It was participatory and democratic and was following a kind of ethos of human rights and of engaging with children as powerful agents, not just subjects*" (AYHP Author Academic 9*).* An example of this was engaging youth in assessing clinics and giving them a report card using an inversion of authority as it is usually leaners who get report cards which were shared with the NDoH (See Figure 3).

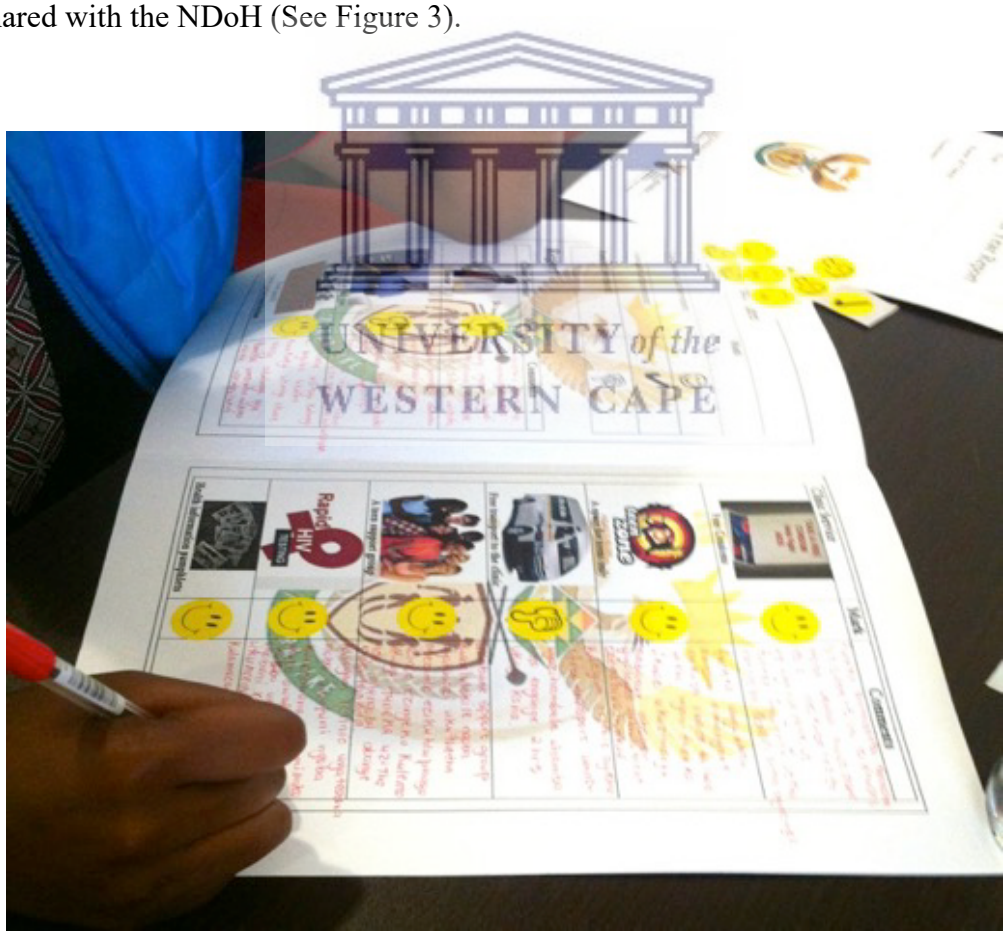

Figure 3. Health Clinic Report Card in Terms of Staff, Services and Availability of Treatment. Source: AYHP (2017)

A further unique feature of the AYHP is that a team of academics were co-authors with the NDoH and there was a lot of leeway to develop the policy in an innovative way. This is expressed in the quote, "*The NDoH said specifically that the previous attempts had been too narrow and they wanted us to think outside the box, but didn't really guide us on what that outside the box would be" (*AYHP Author Academic 10*).*

Diverse perspectives exist in terms of the overall process, as many actors described the process as respectful and without obvious hierarchies and power relations, with well-intentioned lead authors. However, other actors' perspectives included the lack of co-ordination and a national coordinating mechanism, poor stewardship, as well as it being an ad-hoc process, political fighting amongst actors, highlighting the complex and diverse perspectives as well as positionality of different actors.

What Were the Challenges

In addition to what worked well and the significant achievements, the AYHP process also raised certain key challenges in term of positioning and perspectives: how to embrace diversity and differences, how to manage power relations, as well as competencies and contexts for youth engagement. These are described in further detail below.

Many policy actors raised critical questions about youth participation in the AYHP, that are also relevant to other policy processes in terms of the *how* of participation. Key questions highlighting important components of the planning, process and review of policy-making included: Which adolescents and youth were involved? Whose voices were heard? How was this facilitated? As stated, "*When thinking about policy-making processes we need to ask how participation was gained and how different constituencies of adolescents and youth were considered"* (AYHP Advisory Panel Member 11).

In describing some of the challenges, policy actors noted that the youth that participated in the policy development process were not representative of youth diversity with different intersecting identities. For example, the need for inclusion of intersecting perspectives of youth across all geographical settings, LGBTIQA+ (lesbian, gay, bisexual, transgender,

intersex, queer/questioning, asexual) young people, those living with disability, as well as across the age continuum, were voices and perspectives and representative structures, that were inadequately included in the AYHP process. Given the contextual landscape, several policy actors described that these diverse positionings and perspectives were not sufficiently taken into account during the process and that this also possibly constituted tokenism. A quote that captures this concern is *"Young people's agency is now being expanded upon. Girl power, with all the different logos and buzz words. Young people are the future of the world and of our country and we need to provide them with the space and their participation in policy is laudable, but it's also problematic because we have to recognise how age relations, gender, all impacts on who those voices are recognised"* (Academic Actor 27).

In foregrounding power relations, some participants mentioned that in long term participatory research programmes, relationships of trust are built and this is conducive for youth to express themselves in supportive and facilitated spaces, also protected by research ethics. However, several actors noted the importance of always being aware of contextual power relationships between adults and young people, amongst young people, as well as the institutional power relations, when consulting with them in research, policy and programmes, as these are also shaped by the societal power relations.

The need for consistent and sustained engagement of young people throughout the policy process was also highlighted by several actors, particularly in youth having decision making power in finalization of the AYHP. The following quote illustrates this, "So *in the decision-making processes towards, in the finalisation of the documents you found that there were technical experts from different universities and government departments and multilateral organisations, like the UNFPA. So, there were two very different processes. You had the consultations where they focused on getting the expertise of the youth demographic, but then when it comes to the decision-making and high level discussion platforms they were completely excluded, there needs to be consistency" (*NDoH AYAP Member 20).

In addition to participation by youth as part of the process, there were broader process challenges related to who was 'at the policy-making table,' given time and resource limitations. As one of the authors noted, "*Lots of people weren't involved and that was partly because we were just trying to get it done. There was quite a short deadline and we were just trying to get it done" (*Academic Author 10*).* However, other policy actors raised concerns about a lack of clarity and transparency in terms the inclusion of actors and stakeholders who were not consulted in the AYHP process. This was articulated follows, "*What I don't know is how coherently all of that pulls together in terms of people really trying, how much do all the people who care about and would, could be positioned to influence policy or practice, are really sitting around a table?"* (Civil Society Actor 16).

Further, the NDoH organisational context was described by several policy actors as being in 'emergency mode' and responding to health challenges, with little time to think, plan and reflect, including on youth participation in policy processes. Also, the importance of organisational processes, leadership and capacities for youth engagement, as well as collaboration with other sectors as routine, was raised as critical considerations, by several of policy actors. For example, this included the individual and organisational skills and competencies, commitment, alignment and systems to work with youth, within and across departments.

Key reflections by actors during the interviews, on both the AYHP and other health policies, includes the importance of engagement with youth beyond health services and the health sector, meaningfully engaging diverse youth on topics such as changing social and economic and work realities, education systems, mental health, nutrition, climate change and gender equality, for example, to bridge the disconnect the between policy documents and lived realities to addressing some of the challenges in ensuring that there is an enabling environment. This is captured in the quote *"The first thing that we need to do, we need to stop thinking for young people. Through a lot of dialogues we need to find out what is it that young people want, not what we think that young people want"* (Government Actor 25). Digital modes were highlighted as potential ways to further engage youth, but critical concerns were raised of how this also potentially reinforces and exacerbates existing and intersecting inequalities, as highlighted in COVID-19 context.

Several policy actors noted, that despite the commitment to 'nothing about us without us,' there in an evidence gap, as well as capacity deficit, in terms of *how* to engage youth in policy processes. This vexing question was articulated as follows, *"I am saying it is extremely complex and sometimes I think very often we try but I don't think we succeed all the time. In fact, I think most times we don't succeed and it would be really helpful to get some lessons and ideas and guidance of how we can do this better as policy-makers"* (Government Actor 17).

In addition, several actors highlighted the importance of youth participation beyond tick-box exercises and once-off consultations, but that it requires enabling environments, financial and human resources and capacities of older and young people to be able to meaningfully, systematically and continuously, engage with young people from a rights framework. An illustrative quote is, "I think the challenge, is that if you really want proper youth participation you need to have an enabling environment for them to participate and the tools, the support, the capacitation and the resources they need. So we can't just come in and be part and parcel of a meeting or writing a policy document or having a once off consultation, but it needs to be an ongoing inclusion in that process" (Government Actor 28).

Partnerships: Actor Interfaces and Multi-sectoral Collaboration

Youth Participation in the AYHP also foregrounded the sectoral contexts (e.g., Health, Education, Social Development), actor interfaces (e.g., between government departments and between government and civil society), as well as the importance of multi-sectoral partnerships, which are all relevant to how youth are engaged in policy and programmes.

Within the NDoH, the health of youth is the mandate of several departments, including departments of adolescent and youth health and HIV. The HIV youth programme did not participate in the AYHP process and have their own youth consultation processes and structures, linked to Youth Councils at the South African National AIDS Council and through certain civil society actors that they fund.

In addition to the internal consultation processes, the process of consulting with other government departments and actors was described as a challenging journey, as captured in the quote, "*Sometimes it was like climbing Mount Kilimanjaro, sometimes it was really difficult but at the end we managed to work together on the AYHP" (AYHP* Author Government 6*)*. A further key theme that was highlighted by several policy actors, is the history of silo approaches, turf issues and lack of synergy in ways of working between key government departments and across various policy processes, relevant to youth. The following quote illustrates this: "Government departments are weird things; people will not come and publicly announce that, yes thank you very much, if it was not for this group of people we would not have been able to do our job. They present it at the end as if they did it on their own" (Government Actor 22).

All policy actors raised concern about the challenges of collaboration and coordination across departments and the importance of a shared vision and this concern was expressed as follows, "*You can set up the processes but it needs the right leadership, the mindset of people, to be about working together for a common thing. The challenge is how to get people to work in teams"* (Government Actor 19*)*.

Importantly, in addition to the above, in the South African context there is a plethora of youth groups including youth-led and youth-focused), linked to government departments, donors, non-governmental organisations and civil society organisations, (eg, Siyakwazi Youth Network, Mmhoho campaign, Soul Buddyz Clubs, Agape youth movement, Sexual and Reproductive Justice Coalition and several HIV focussed youth structures), which contributes to inadequate coordination of youth-focused stakeholders. Given this range and multiplicity of actors, a key message from all policy actors interviewed, is the need for a dedicated, capacitated, national coordinating mechanism department, ideally led by the Presidency. In addition, several actors highlighted the current debates in terms of the underlying determinants of health and the roles of different sectors and this was captured as follows, "*Does the input need to be health for the output to be health? What we have learnt over the last decade is that often the input is something quite different or a combination of health and something quite different*" (AYHP Author Academic 10). The need for multi-sectoral co-ordination and collaboration was highlighted by all policy actors, particularly in how youth health is complex and by definition, requires the participation of multiple sectors and actors, including centering the meaningful engagement of youth themselves.

Discussion

Summary of Main Findings

This article examines the phenomenon of youth participation and the results draw attention to the complex nature of youth participation in the AYHP, which was a 'first' and unique component in health policy in South Africa.

Despite various positive features, the experience also highlights various enduring challenges when facilitating youth participation in health policy-making. Youth participation was enabled by leadership from certain government actors and involvement of key academics with a foundation in long standing youth research participatory programmes. However, challenges related to when, how and which youth were involved remained. Youth participation was not consistent throughout the health policy formulation process. This is related to broader contextual challenges including the lack of a representative and active youth citizenry, siloed health programmes and policy processes, segmented donor priorities, and the lack of institutional capability for multi-sectoral engagement required for youth health. In addition, a key contextual factor is that some young people as treated as celebrity ambassadors, but without representation or accountability to the broader population of young people.

Focussing on youth participation in the AYHP policy development process has also provided a concrete example for gaining insights into meta questions and lessons and these are further discussed below.

Participation as Right, Beyond Tokenism

The conceptual framework (Figure 1) and the results contribute to the intersections of youth studies and health policy literature, by deepening understanding of youth participation in policy processes and builds on existing scholarship.[5,12,40,41]

A key message from our findings is the importance of moving beyond individual notions of youth participation and 'celebrity' status, to more systematic processes of routinely including the voices and agency of young people, in their full diversity, in all policies and programmes, which remains both an ambitious goal and a vexing challenge to implement in reality. An important theme that emerged from the findings is that of including perspectives of diverse young people, as an essential component of youth participation. This is crucial in a South Africa and global context where past and present social and structural determinants shape the health of young people and foregrounds challenging debates in the context of multiple actors, power relations and inequalities.

Our findings are similar to that of Wigle *et al*,[9] who describe the gaps of involving young people in SRH policy-making in Malawi and the importance of integrating youth in all stages of the policy-making, beyond tokenism, but as equal partners and experts on their health. This 'first' participation of youth in developing health policy in South Africa, highlights critical questions in terms of how to ensure youth participation, beyond being instrumental, but realizing the principles of meaningful engagment.[19,42] The findings share some learnings of what worked well and what the challenges were and contributes to policy debates on understanding rights-based approaches to youth participation in all that affects them. This talks to the theme of youth participation as a right, as part of fostering citizenship and leadership, both in South Africa and globally.[43–48]

Implications for Policies, Programmes and Systems

The innovation of youth participation in health policy in South Africa is a step in the right direction, however our findings raise implications for how to include perspectives of diverse youth, meaningful participation in all stages of the policy-making processes, as well as required contextual and organisational systems, as also highlighted by other authors.[10,49] Linked to the point above of avoiding tokenism when youth participate in policy processes, the AYHP process also generates lessons and insights into participation of policy beneficiaries and how they can make contributions and leadership through their position and in realising the 'Leave no one behind' principle. This point is also made by Campbell *et al*,[10] who discusses the importance of participation of networks of HIV positive youth in HIV programmes, as well as by Peta[50] and Ngunyen *et al*,[51] who describe how girls living with disabilities, can participate in policy processes.

A policy window opened for youth participation through the AYHP, but it took place in a complex and dynamic context of multiple actors, with its own particular momentum, urgency and time pressures. The AYHP process highlights some of the tensions and complexities of managing policy development processes and the interactions between place, people and processes, how this shapes youth participation, in terms of who and what is included in the final policy, without organised youth health actors and youth citizenry.[52,53] Therefore, the AYHP youth participation process also highlights how policies are socially constructed, the importance of good intentions and building of relationships between researchers and policy-makers, as well as the challenges in terms of balancing urgency versus more democratic and deeper processes, as part of the interplay between ideas, interest and institutional processes.[25,54] Further, it raises critical questions in terms of the purpose of youth participation, that should be based on rights principles and can contribute to policy and programmes, but that consultation does not replace investments in enabling deeper engagement and other health systems challenges.

Process: Capacities, Organizational Architecture and Power Relations

The results provide insights into the organisational architecture of youth participation and underscores the necessity to strengthen capacities, necessary platforms and the training, ongoing mentorship needed, as also highlighted by others.[12,55,56] As policy-makers, researchers and young people, we need to prioritise the competency gaps and determinants of youth participation to ensure sustained, deep and meaningful ways, beyond just a few youth ambassadors and 'older' experts in policy processes.

In addition to the enabling contexts and organisational architecture, our findings also reiterate the need for shifts in mindsets, paradigms, developing innovative partnerships and capacity strengthening for government and civil society, as well as resources, for ethical youth engagement in South Africa, as well as at the global level.[57,58]

The results have implications for health systems and provides insights into how actors interface in relation to policy processes, and illustrates that the policy processes are also a function of power and politics at play. This includes , both 'politics' i.e, micro politics in interpersonal relationships, different ideas and power relations between government actors, academic researchers, donors, young people and civil society, as well as between government

departments, and how these interact with 'Politics,' ie, macro politics of the country and layers of social and historical contexts of South Africa.[59,60] In addition, this research has described some of complexities of policy processes that happen and provide insights into the contours and dimension of agenda setting and the processes before implementation, as also analysed by other HPA scholars.[61,62]

Further, our findings talk to themes of power and problematizes concepts such as 'empowerment,' 'youth participation' beyond the buzzwords and mantras, also re-framing young people from "passive" and "recipients" to "capable" and "active," which opens up possibilities to re-imagine policy processes. It is aligned to what Gaventa and Cornwall[63–65] have written in terms power relations and the spaces for participation. We would argue that there is need for further analysis of spaces and relationships for participation at micro, meso and macro levels and how these are embedded in broader unequal social systems. Importantly, the results open up significant debates on multi-sectoral collaboration, which is largely the terrain of governance, and essentially about brokering and sustaining these complex relationships and interactions, as described in the literature.[66–71] Similarly, our results point to the importance of a shared vision, leadership, relevant capabilities and co-ordination across government and civil society actors, in working with youth, to ensure alignment of policies and programmes in the SDG era.

Positioning and Research Processes

To our knowledge, this research is the first to apply and adapt the Cahill and Dadvand[12] framework, which could also be the basis for further empirical studies. By telling the story of youth participation in the AYHP and how this was shaped by domains of Place, People, Partnerships and Processes for example, opens up several research opportunities. A priority is research that is located in the synergies between youth studies and HPA, particularly, focussing on policy processes that facilitate meaningful participation, as well as actor and power analyses.[72–74] There is a significant gap between what policy-makers think and the imaginations, experiences and realities of young people and research can contribute to addressing this.

The AYHP has demonstrated that youth participation is possible through long standing research partnerships and is a foundation on which to build and contextualise youth as expert actors, as a more proactive approach to youth engagement in policy processes and programmes. As documented by Cluver *et al*[75] participatory research approaches, such as youth participatory action research, photo-voice, and digital modes, can acknowledge and attempt to address the power imbalances that privilege researchers and adult perspectives and agendas, as well as challenge top-down policy development.[76–81] However, it is also important to be aware of the relevant methodological, pedagogical approaches as well as tensions, power relations and potential resistance by policy-makers and other actors.[10,82–86] In this way researchers can play a role as mediators, facilitators and partners, to address the research gaps, development of toolkits/resources and contribute evidence.[19,87]

As part of our reflexive analysis throughout the research process, we were aware of how our positionality including having power as researchers and the privilege to undertake the study, provided the opportunity of speaking with a range of diverse youth health policy actors, who should ideally be in conversation with each other. As part applying the principles of reflexivity, we constantly reflected on how our Health Policy and Systems Research (HPSR) analytical lenses, power and privilege as academics shaped our relationship with the actors and the research process and results as a whole. While the extensive practitioner experience of the lead author brought deeper understanding of context to the issue under study, respondents may have also been more open to talking adolescent health issues knowing your background.

Strengths of this paper include that it presents perspectives of a range of AYHP authors, as well as policy actors concerned with youth health, including the AYAP members involved in the policy process. However it also has limitations, in that it does not include perspectives of representative and diverse youth and structures in the general population, and this could be an area for future research. Also, youth from the Mzantsi Wakho and Sinovuyo Teen participatory research programmes were not interviewed, as their confidentiality is protected as part of the research ethics.

Looking ahead, an essential element is a mobilised, capacitated, diverse youth citizenry as important actors to ensure youth participation, and the use of available tools and resources and guidance in a reflexive manner.[88–91] Building on Cahill and Dadvand,[12] we also suggest a list of prospective questions to guide youth participation in policy processes that can be used by a range of actors e.g., policy-makers, youth focused/led organisations and researchers (Box 2):

Box 2. Questions to Guide Youth Participation

- **Place:** how will you consider and respond to the role of context and the social and structural determinants of both youth health and youth participation?
- **Purpose:** What contribution to policy development do you want to achieve through youth participation and how will you ensure that?
- **People:** Who are all the actors and stakeholders involved and how will you map, engage and manage them?
- **Positioning:** How will you get young people to participate? How will you consider their positioning within the wider context and in relation to others, within broader democratic processes?
- **Perspectives:** How will you embrace diversity and difference and how facilitate/ensure that perspective of diverse young people in terms of e.g., age, location gender identity and sexual orientation, dis(ability) etc., are included?
- **Protection:** How will you ensure safety and ensure that their rights are respected, upheld and protected?
- **Power relations:** How will you build inclusion and respect and manage power relationships between actors in terms of interpersonal as well as within the institutional practices and structures?
- **Process:** What approaches, pedagogies and methods will you use and do you have the sufficient competencies and resources to enable a sustained process?
- **Partnerships:** What partnerships and institutional spaces and mechanisms exist and how will you manage these/do you have the competencies to manage these?

Conclusion

This paper sought to describe youth participation in the AYHP and draw out lessons to bridge the gap between rhetoric and reality, so doing responds to the call for support from policy-makers on the *how* of meaningful participation and leadership of young people in policies. Dynamic and complex relationships exist between place, people, partnerships and processes and this shaped how the AYHP was developed in South Africa, which was a novel and unique step toward including youth in development of health policy. Despite these achievements and steps in the right direction, several vexing questions and lessons were identified in terms of how to ensure meaningful participation of diverse young people across all stages of and spaces of policy-making. A key learning from this research is that policy-makers need to meaningfully engage youth in their diversity and in representative and accountable ways, in all stages and spaces of the policy-making process, as part of building youth citizenship and leadership.

We add to the call for the reimagining of new paradigms, policy processes and systems which give more power to young people, as an important and powerful demographic. Leaving no one behind in the SDG era means ensuring the enabling contexts, resourced and sustained processes, appropriate competencies that centre leadership and voices of young people, in all policies and programmes that matter to them.

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CHAPTER 7: LOOKING BACK AND MOVING FORWARD: ACTOR NARRATIVES ON GENDER IN ADOLESCENT AND YOUTH HEALTH POLICY AND PROGRAMMES IN SOUTH AFRICA

Chapter 7 is currently under review as a peer-reviewed article for the *International Journal of Equity in Health (IJEH)*: Looking back and moving forward: Actor narratives on gender in adolescent and youth health policy and programmes in South Africa.

1. SUMMARY

The findings presented in this paper comprise an interrelated constellation of diverse and juxtaposed actor gender narratives. These range from framing gender as equating girls and women; gender as inclusion; gender as instrumental; gender as women's rights and empowerment; and gender as power relations. Some of these narrative framings were dominant in the policy-making processes being examined and were consequently included in the final policy document, unlike other narratives.

The way in which gender is framed in policy processes is shaped by actor narratives. These diverse and contested discursive constructions have, in turn, been shaped by the dynamic interactions with the South Africa context, and with the processes of developing the Adolescent Youth Health Policy. These actor narratives were further contextualised in terms of considerations of what is needed to advance gender equality in adolescent and youth health policy and programming.

Understanding actor narratives in policy processes contributes to bridging the disconnect between policy commitments and reality in advancing the gender equality agenda.

2. CONTRIBUTION TO THE THESIS

This paper contributes to objective four of the thesis, namely to understand how the context, content, actors, and processes interact to construct and frame gender and intersectionality, as a feature of power, in adolescent health policies. It also contributes to the fifth and cross-cutting objective, which is to reflect on the implications for gender transformation of this articulation of power, people and processes in adolescent health policies.

3. CONTRIBUTION OF THE CANDIDATE

The candidate designed the study, reviewed the literature, conducted the interviews and undertook the initial analysis, with input from the supervisor. The candidate wrote the first draft of the paper, and the supervisor provided critical input on this and subsequent drafts. The candidate led the submission process and will lead the revisions on the comments from the journal peer review.

The submitted article is included here to facilitate the coherence of the thesis' 'Findings' chapters, retaining the style and format required by the journal.

4. PUBLICATION/STUDY: LOOKING BACK AND MOVING FORWARD: ACTOR NARRATIVES ON GENDER IN ADOLESCENT AND YOUTH HEALTH POLICY AND PROGRAMMES IN SOUTH AFRICA

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Abstract:

Background:

Gender equality remains an outstanding global priority, more than 25 years after the landmark Beijing Platform for Action. The disconnect between global health policy intentions and implementation is shaped by several conceptual, pragmatic and political factors, both globally and in South Africa. Actor narratives and different framings of gender and gender equality are one part of the contested nature of gender policy processes and their implementation challenges. The main aim of this paper is to foreground the range of policy actors, describe their narratives and different framings of gender, as part exploring the social construction of gender in policy processes, using the Adolescent Youth Health Policy (AYHP) as a case study.

Methods:

A case study design was undertaken, with conceptual underpinnings combined from gender studies, sociology and health policy analysis. Through purposive sampling, a range of actors were selected, including AHYP authors from government and academia, members of the AHYP Advisory Panel, youth representatives from the National Department of Health Adolescent and Youth Advisory Panel, as well as adolescent and youth health and gender policy actors, in government, academia and civil society. Qualitative data was collected via in-depth, semi-structured interviews with 30 policy actors between 2019-2021. Thematic data analysis was used, as well as triangulation across both respondents, and the document analysis of the AYHP and 14 other policies relevant to adolescent health.

Results:

Despite gender power relations and more gender-transformative approaches being discussed during the policy making process, these were not reflected in the final policy. Interviews revealed an interrelated constellation of diverse and juxtaposed actor gender narratives, ranging from framing gender as equating girls and women, gender as inclusion, gender as instrumental, gender as women's rights and empowerment and gender as power relations. Some of these narrative framings were dominant in the policy making process and were consequently included in the final policy document, unlike other narratives. The way gender is framed in policy processes is shaped by actor narratives, and these diverse and contested discursive constructions were shaped by the dynamic interactions with the South Africa

context, and processes of the Adolescent Youth Health Policy. These varied actor narratives were further contextualised in terms of reflections of what is needed going forward to advance gender equality in adolescent and youth health policy and programming. This includes prioritising gender and intersectionality on the national agenda, implementing more gender-transformative programmes, as well as having the commitments and capabilities to take the work forward.

Conclusions:

The constellation of actors' gender narratives reveals overlapping and contested framings of gender and what is required to advance gender equality. Understanding actor narratives in policy processes contributes to bridging the disconnect between policy commitments and reality in advancing the gender equality agenda.

Keywords: actors, narratives, policy process, framing, gender, South Africa, adolescent and youth health policy, intersectionality

Introduction

More than 25 years after the landmark Beijing Platform for Action, advancing gender equality remains an ongoing global priority, as signalled by the impetus and focus of the UN Women Generation Equality Forum [1–4]. Over the past decades there have been some gains and improvements towards achieving substantive gender equality, however transforming policy, structures and systems that contribute to reproducing gender and intersecting inequalities remain a priority for action, both globally and in South Africa [5–10]. Moreover, COVID-19 has made more 'visible', the persistent entrenchment of intersectional gendered inequalities [11–14].

The disconnect between global health policy intentions and implementation is shaped by several factors: conceptual (i.e. lack of agreement of framings of gender terms); pragmatic (i.e. approaches and capacities for implementation), as well as political (i.e. shifting away from focus on gender relations of power and social justice agendas) [15–19]. Furthermore, dynamic relationships between policy contexts, actors, content and processes also shape how gender is problematized and how 'solutions' are represented as part of the social construction of policies [20–23]. Actor narratives and different framings of gender and gender equality are one part of the contested nature of gender policy processes and their implementation challenges [19,24] .

Mannell identified three narratives used by development actors to construct the problem of and solutions to gender inequality: gender equality as instrumental for development; gender as women's rights and empowerment, and gender as power relations requiring transformation [25]. These diverse understandings of gender and approaches to gender equality, led to fractured relationships between policy actors and collaboration amongst practitioners. This continues to arise in terms of debates and diverse approaches to gender mainstreaming, including involving men in gender programmes in South Africa, for example. These tensions and diverse narratives act as inhibitors to building consensus to support implementation of gender policy recommendations and other efforts to address and transform gender power relations [26–28]

A key factor of how gender and gender inequality is constructed in health policy is dependent on how policy actors understand, interpret and represent the problem or issue [19,23,29] , and this is process of framing is also relevant to other issues, such as sexual and reproductive health and rights. Actor narratives articulate and structure the ideas that are part of the policy context and the notion of policy framing is how they make sense of the world, as well as policy processes [30,31]. Policy actors participate in social systems that are gendered and unequal and bring their ideas, perspectives and discursive constructions to policy processes and health systems. Therefore it is important to foreground that how gender and gender equality is framed or problematised, will shape its outcomes [23,24,32]. Understanding actor narratives provides an opportunity for understanding the complex mix of ideational, institutional and systems factors, operating at macro, meso and micro levels, in health policy processes [33–37].

There is a gap in terms of gender analyses of the role of actors in health policy making in the South African health scholarship since the work of Klugman (2000). Scaffolding on this and our earlier research on 15 adolescent health policy documents in South Africa [29]. The overarching aim of this paper is to foreground the policy actors, describe their narratives and different framings of gender as part of developing the Adolescent Youth Health Policy (AYHP) and explore the implications for policy processes. The main findings of our earlier research shows that there was minimal integration of gender in policy documents and if so, it was mostly in gender-sensitive ways, at times gender-specific, but rarely gender-transformative [38]. Further, a critical discourse analysis revealed that dominant and marginalized discourses in these documents reflect how gender is conceptualized as fixed, categorical identities, versus as fluid social processes, with implications for how rights and risks are understood. The discourses substantiate an over-riding focus on adolescent girls, outside of the context of power relations, with minimal attention to boys in terms of their own health or through a gender lens, as well as little consideration of LGBTIQA+ adolescents beyond risks related to HIV [29].

To our knowledge there is a paucity of research, both globally and in South Africa, that describes and analyses actor narratives in adolescent and youth health policy processes, thorugh a gender lens. In response to this gap, the main aim of this paper is to foreground the range of policy actors, describe their narratives and different framings of gender, as part of the social construction of in policy, using the Adolescent Youth Health Policy (AYHP) as a case study.

The results are presented in three interrelated parts. Firstly, a description of the actor landscape and how gender was considered during the processes of making the AHYP. Secondly, a description of the constellation of gender narratives of authors and proximal actors and thirdly, contextualisation of these narratives and further reflections from a range of actors working in adolescent and youth health, for advancing the gender equality in current and future policy and programmes.

Methods

Theoretical and conceptual grounding

Our conceptual grounding is guided by a bricolage approach, which combines theories and frameworks from Social Sciences (Gender Studies and Sociology) and Health Policy Analysis [39–42]. From Sociology and Gender Studies, we draw on Fraser's theoretical concepts of redistribution, recognition and representation, as starting points for 'sense making' of different perspectives on gender, gender inequality and gender justice [43–45]. Fraser links dimensions of recognition of identities and redistribution of resources, as gender struggles that combine the inclusionary approach and the transformative approach (See Figure 1). These different aspects of gender and gender equality are reflected in the actor narratives identified by Mannell (2014a), further elaborated upon in this paper (See Figure 2).

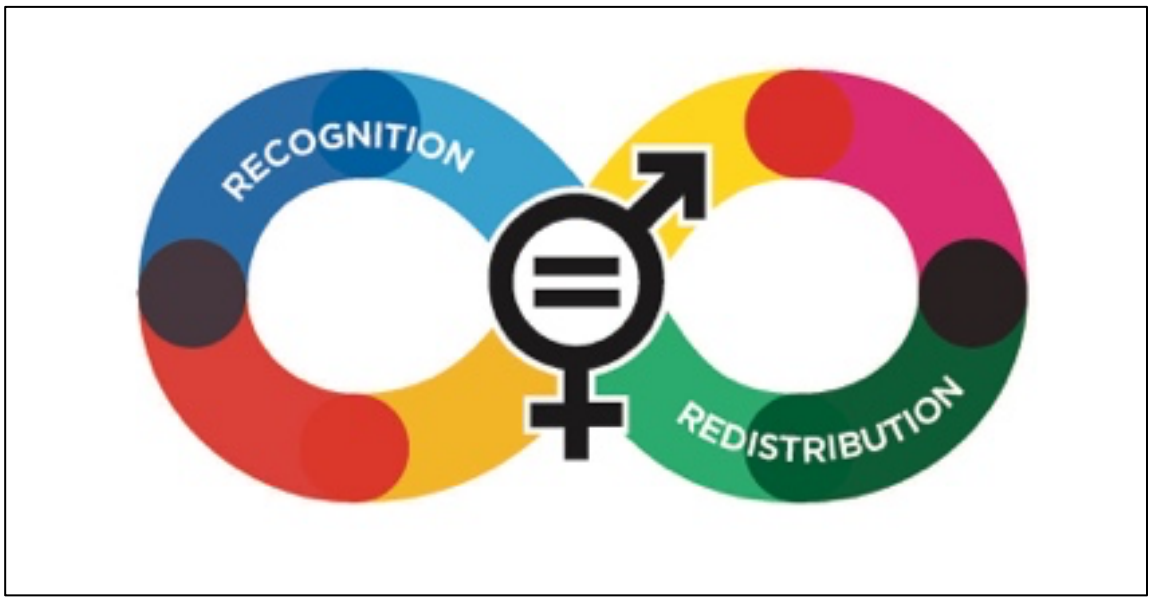

Figure 1: Fraser's dimensions of recognition of identities and redistribution of resources

We also incorporate concepts and approaches from Health Policy Analysis, specifically the Policy Triangle, which views policy content in conjunction with the role of actors, and how their ideas, perspectives and actions shape policy processes, as well as policy contexts [35,37]. In addition, we also draw on the notion of policy 'frames' and 'framing' by various actors and how they make sense of policy processes [30,31,46].

A case study design was chosen which allowed for an enquiry of the phenomenon located in the social and political context and to provide rich and thick descriptions and sense-making of the complexity and nuances that shape actor gender narratives in adolescent health policy [47,48].

Data collection and analysis

Qualitative data was collected via in-depth, semi-structured interviews with a range of AYHP policy authors and actors. Through purposive sampling policy authors in government, academia and donors, members of the Advisory Panel (AP), youth representatives from the Adolescent and Youth Advisory Panel (AYAP), Commission on Gender Equality, as well as adolescent and youth health and gender policy actors, in government, academia and civil society, representing a range of experiences and perspectives were identified (Table 1).

Table 1. Categories of Actors and Number of Participants Interviewed

Category	Number
AYHP author government	5
AYHP author academic	2
AYHP author international NGO funder	1
Government Actor	6
AYHP Advisory panel members	5
Civil Society Actor	6
Academic Actor	2
NDoH Adolescent and Youth Advisory Panel	3

Thirty interviews were conducted between September 2019 and April 2021, in an iterative manner i.e., after a first round of 15 interviews, initial analysis was conducted which guided subsequent interviews. The first round of interviews was conducted face-to-face, however in the COVID-19 context, the majority of the second round of interviews were conducted via the virtual medium which participants preferred (Zoom, Googlemeet, WhatsApp).

Thematic data analysis was guided by the literature cited earlier and interview transcripts were analysed both deductively i.e. along the lines of enquiry related to gender and actor narratives and inductively i.e. emerging issues from the data [49–51]. In addition, interview data was triangulated both across respondents, as well as with data from the document analysis of the AYHP and 14 other policies relevant to adolescent health.

Ethical approval

Informed consent to interview and audio record was obtained from each participant and each interview was transcribed in full. Ethical approval for the study was obtained from the University of the Western Cape (Reference number: BM 18/9/9) and each participant was assured on anonymity and confidentiality.

Results

The results are presented in three sections: firstly, the actor landscape and how gender was considered during the process, secondly the constellation of actor gender narratives and thirdly, these actor narratives were further contextualised in terms of reflections of what is needed going forward.

Actor landscape and how gender was considered in the process of policy making

In developing the AYHP, the actor landscape consisted of proximal actors, being the National Department of Health (NDoH) authors and academic authors and UNFPA. Additional actors include youth that participated through the Mzantzi Whako research project, policy advisory panel members, as well as the youth members of the advisory panel (AYAP), established by the NDoH. In addition, more distal actors include government departments who have policies and mandates for adolescent and youth health, such as the Departments of Social Development, Basic Education, Women, Youth and Persons with Disability, the National Youth Development Agency, as well as civil society organisations and structures working in adolescent health and gender (e.g. Soul City, Lovelife, Ibis, Sexual and Reproductive Justice Coalition, and the Siyakwazi SRHR youth network.)

As part of this actor landscape, the She Conquers campaign was a significant contextual feature, developed and implemented at a similar time to the AYHP and enjoyed high level political support. This campaign was initiated to address the high HIV incidence amongst adolescent girls and young women in South Africa [52]. Some actors mentioned that the AYHP and She Conquers campaign were aligned in terms of their approach to gender due to its focus on girls and young women. However, other actors had divergent and conflicting narratives and described She Conquers as overshadowing the AYHP, creating confusion at implementation level and some also mentioned that they understood it as linked to donor-driven regional initiatives, such as DREAMS [53,54]. These dimensions of the landscape, related to visibility and political priority were part of the broader policy context of the policy processes. In terms of gender narratives, some actors mentioned concerns that the focus was placing the burden on individual girls, to "conquer", instead of transforming broader systems and structures that create gendered inequalities and mitigate against gender equality. Also,

some actors mentioned concerns that the focus was placing the burden on individual girls, to "conquer", instead of transforming broader systems and structures that create gendered inequalities and mitigate against gender equality.

As part of the AYHP policy making process, gender was considered in a gender-sensitive, implicit way and gender power relations were not explicitly addressed. As a participant noted, a focus on direct needs superseded broader transformation goals even though participants were not averse to such broader goals:

> *"I think that there is a focus on sexual and reproductive health, and of rights, I don't think there's a huge gendered content to it.... Where there is a gendered content, it's through the prism of problems that girls or young women might have, and problems that boys or young men might have, rather than a conscious gender and power content to it. I think the people who were working on it, might have been very sympathetic to it, but I think the brief from the Department of Health was very much, we want something that is going to cater for youth". (*AYHP Advisory panel member_1*)*

Several actors mentioned that there were discussions of the impact of gender inequality on health during the policy making process, with some acknowledgement of gender systems of power, but that these were not systematically included or operationalized in the finalisation of the policy.

> *"Gender was discussed, but I don't think that the Policy itself was very detailed on the specific gender issues that exist. But I remember that we wanted to see gender-transformative programmes and initiatives being highlighted in the policy and in practice. So, we did find that there were conversations around gender norms, harmful traditional gender practices in the country, and a whole lot more, and I think that that is reflected in the Adolescent and Youth Policy, but not as boldly as it should be. Gender equality I'm sure it's very much highlighted there as a term, but not necessarily what it looks like for these adolescents and young people."* (Civil society actor_20)

In summary, the actor landscape was quite a complex terrain, including a range of civil society and government actors, powerful actors such as NDoH, as well as significant contextual factors such as the She Conquers campaign. Despite discussions of certain aspects of gender and certain actors wanting more gender-transformative approaches to be included, these more transformative framings were not included in the final versions of the policy document, as acknowledged by many actors. This indicates how the policy making process was shaped by diverse gender narratives and how certain narratives and actors were dominant during the making of the AYHP, as well as the pragmatic decisions of the lead actors and limitations of the policy process.

Description of the constellation of actor gender narratives

AYHP policy actors had diverse and at times conflicting, conceptual framings of gender, as part of a constellation of gender narratives. These included actor framings of gender in a range of interrelated ways: gender as girls and women, gender as inclusion, gender equality as instrumental, gender as women's rights and empowerment and gender as power relations. These are described below and presented in Figure 2.

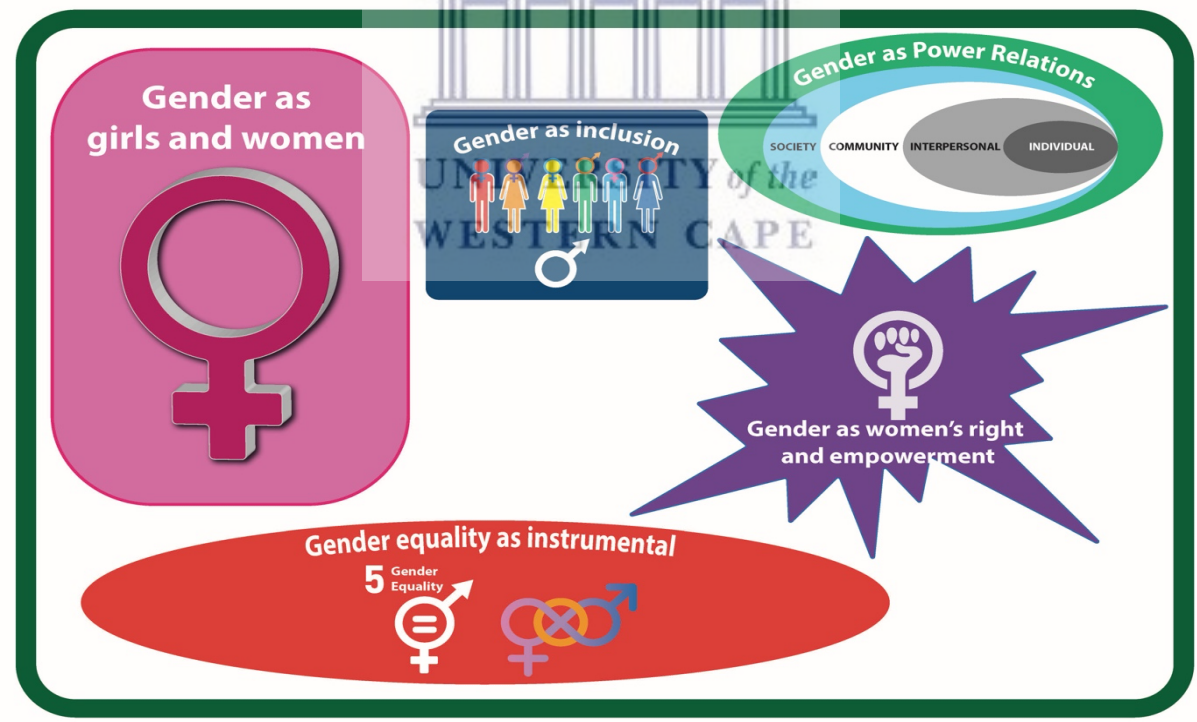

Figure 2: Constellation of actor narratives

Gender as girls and women

A dominant gender narrative expressed both explicitly and implicitly by policy authors, is that gender was framed as a focus on girls and women.

Actor narratives focussed on the key health consequences of gender inequality on girls and women. An illustrative example is, *"I think there was a big focus on the needs of adolescent girls, for the reason that they do bear the brunt of illness, in the fact that they're the ones who get pregnant, they're the ones who get disproportionally infected with HIV."* (Government author_2). This also entailed a focus on the corresponding services needed and this was framed as, "*There is a part where the policy addresses the issue of young girls so the issues of gender, they were represented. It might not have covered all the gender related issues, but it tackled the services, like services for abuse."*(AYHP author government_15*)*

Gender as inclusion

A linked narrative framing was gender as being inclusive of different elements. Firstly, some actors referenced sex-disaggregated data as demonstration that gender considerations were integrated in the AYHP. Woven in to this, was the actor narrative that gender is about inclusion, equal focus and participation of binary categories of boys and girls and numeric parity. This narrative of gender as quantitative parity, somewhat tied to sex-disaggregated data, was reflected by policy actors to include an inadequate consideration of adolescent boys and young men, being 'invisible', beyond Medical Male Circumcision services, as illustrated by the following quote:

> *"I think the way in which this policy is written, including in the section on sexual and reproductive health, is far more on young women than on young men. I think we are now beginning to realize that you need to focus on young men as well. I think we've left young men behind and we only catching up on that in the HIV program. I'm a foregrounding HIV, because I think we've done much more thinking around these issues in HIV than anything else. When we started the She Conquers campaign, we didn't mention young men at all. Even though if you look at the diagram that shows the route of transmission you will see men there."* (AYHP author government_14)

Separately, more distal actors mentioned the complex interplay of diverse youth identities and multiple forms and axes of inequality as part of the notion of inclusivity as follows,

> "*Youth are not just a marginalized group, you need to look at the diversity of youth. There's young boys, there are young girls, there is the different age groups, there are those with different orientations, there are those who come from different parts of the country the rural. Their perspectives are so different."* (Government actor_*28)*

The narrative of gender as inclusion was articulated by policy authors to be interrelated with framings about the inclusion at times of the LGBTIQA+ community:

> *"So during these youth engagements, we were having both representatives, we were having males and females. Some of them were from the LGBTIQA+ community, but both males and females were represented. So it took care of the gender sensitivity."* (AYHP author government_6)

This actor narrative of the inclusion of LGBTIQA+ individuals was still very much described as a group to 'add on/in'. It was linked to the recognition that discrimination of the basis of sexual orientation and gender identity and expression (SOGIE) and homophobia is very present in South Africa and is a significant barrier for gender diverse young people to access services and experience full rights as equal citizens.

The actor narratives of gender as girls and women and gender as inclusion (whether in terms of disaggregating by sex, parity with boys, or inclusive of diverse adolescents including LGBTIQA+) all tended to consider gender as a binary, fixed and essentialised category. They underplayed how fluid and dynamic gender relations and identities are, shaped by the social and structural systems of patriarchy, racism, sexism, social economic and other intersecting inequalities in the South African context.

Gender equality as instrumental

Actor narratives that focus on *gender equality as instrumental* were not explicitly mentioned, but rather inferred and referenced in broader national policies such the National Youth Policy. Despite *the gender equality as instrumental* narrative as more 'silent' in the AYHP,

there were related actor framings of adolescent health as social and economic assets for adolescent and broader national development, as echoed in the National Youth Policy and in the following quote:

> *"I think that if we are going to truly address adolescent and youth health we need increasingly to think about them as the next generation of entrepreneurial fourth industrial revolution workforce. We have the capacity to think of youth health as a springboard for the country's enormous success. So it is not just about the fact that they don't have HIV or they don't have malaria. It is about having a next young generation who have the kind of capacity to fly."* (AYHP author academic_10)

Gender as women's rights and empowerment narrative

As part of the constellation of narratives, the *gender as women's rights and empowerment* actor narrative was relatively absent and mentioned in terms a number of challenging contextual factors. Actors mentioned that the policy context included a number of intersecting factors: lack of prioritisation/operationalisation of gender equality by government bureaucracy, weakened civil society, lack of organised youth activism, dominance of the HIV sector, as well as closing of spaces to focus on gender and intersectional systems of inequality. The following quote gives insight into this context,

> "W*e've got a good Constitution and we've had some progressive people in critical places…[but] there aren't shared values among bureaucrats, and the things that push bureaucrats and the things that determine bureaucrats' interests, aren't necessarily anything to do with gender equality. So, it just seems to me sad that there was this kind of hope and commitment, and I think it's slowly ebbed away, really after the Mandela era. The close relationship between civil society and people in government collapsed, and government became much more of a bureaucracy, not feeling any accountability to civil society groups, and not recognising what level of support they could get. There wasn't a force, neither on gender issues, women's rights generally, nor on sexual reproductive health, if you compare it to the brilliant strategic work that went on in relation to HIV*. (Civil society actor_18)

A narrative of women's rights and empowerment also cannot be asserted in isolation from South Africa's history of institutionalised racism and violence. Nested in this broader context, the epidemic of gender-based violence highlights the need to address constructions of masculinities, and transformative work with men. A quote that underscores this perspective is,

> "*Apartheid and the patriarchal bargain made men feel they have lost power in the democratic South Africa. They use violence to achieve that control. I think that post-apartheid a lot of men feel very betrayed and let down. They have lost a lot of authority; they have lost authority over the women and the youth. And there is a kind of a crisis of patriarchs and men are not going to stop brutalizing each other and women, while they still feel so powerless. How do we uplift people so that violence isn't how you assert your power?"* (AYHP author academic_9)

Gender as power relations

Included in the constellation of actor narratives, was the *gender as power relations* narrative, being about gender as relational, requiring social transformation and disruption of system of power and inequality. This actor narrative, co-existed, but somewhat in juxtaposition and divergence with the *gender as girls* narrative. As mentioned earlier, this narrative was not dominant amongst AYHP authors and proximal actors and did not gain much traction in the AYHP policy making process. In addition, some actors involved in the making of the AYHP, expressed that gender as power relations was not comprehensively understood and conceptualised by NDoH, as lead policy author, and hence this shaped the content and process of the AYHP:

> "*So I don't think gender is even understood or talked about. It is silent in terms of gender in relation to the social constructs of masculinities and femininities, about power relations. I don't think it is on the horizon and understanding of most people in the NDoH.*" (AYHP Advisory panel member_3)

Another policy actor expressed the relative absence of *gender as power relations* narrative in the final policy. In addition, intersectionality, as multiple forms of inequality which compound and exacerbate each other, was only mentioned by a small minority of actors,

> *"I think in a few places gender inequality is explicit, when it comes to HIV and maybe pregnancy. But it's more in the way that these are problems, and some of them are gender driven. I don't think there's consciousness of intersectionality beyond that. I don't think there's much focus on if a person is also disabled or if they are LGBTIQ, anything of that sort. So, I don't think it takes an approach that says, let's look at diversity and intersectionality. I think it recognizes some of the main divisions, like rich-poor, which in South Africa, is very race based."* (AYHP Advisory panel member_1)

Further, reflections from more distal actors included the importance of addressing gender inequality, homophobia and other axes of inequality and power relations, as part of addressing health of young people in South Africa:

> "*One cannot talk about HIV without being aware, particularly if you are looking at the factors that put young people at risk, that gender relations and power plays a very important role. One can also not ignore the fact that the LGBTIQA+ community is also disproportionately affected, as well as learners with disability. In our responses it will become very important for us to really begin to deal with these issues of power relations, having a rights-based approach.*" (Government actor_17)

In summary, the constellation of actor narratives are diverse and contested with a lack of shared understanding of framings of gender amongst actors. The most dominant narrative was of gender as girls and women, with gender as inclusion mentioned thereafter. Narratives of gender equality as instrumental, as women's rights and empowerment, or as gender power relations, while articulated by some policy actors, remained largely absent from the adolescent and youth health policy making process.

Looking back and moving forward: contextualizing the gender narratives

When asked to reflect on the status quo in order to look forward in term of gender and adolescent and youth heath in South Africa, a broad range of actors contextualised some of the narratives described in the previous section. Three key themes emerged and include firstly, the importance of gender-transformative intersectionality approaches, secondly examples of how to implement these more gender transformative approaches and thirdly, the commitments and capabilities needed to take such work forward.

Importance of gender–transformation and intersectionality on the agenda

Partly in recognition of the past challenges of advancing gender in a deeper and transformative manner, looking forward distal policy actors to the AYHP emphasised of the importance of addressing compounding and intersectional inequalities in South Africa. This is captured in the following quote,

> "*So the political commitment and the rhetorical commitment is there, but the commitment of the resources, but the institutional capacity and the knowledge and the other mechanisms tend to be weak. South Africa is a developing country, so it has to juggle all kinds of priorities. There are huge levels of poverty in this country, huge amounts inequality, not just gender inequality, racial inequality, all kinds of inequalities that the country has to grapple with."* (Government actor_30)

Certain tensions and challenges related to siloed ways of working and lack of intersectional approaches, for example:

> "*I think is there is a long standing tension around gender in any kind of development or social program in terms of mainstreaming. So you have the gender sector, the disability sector and …and we are not going to carve out separate spaces, we are going to mainstream gender, mainstream disability, mainstream whatever else. That is not…just conceptually not a feasible plan and politically it is not a plan, if those sectors are competing for resources and attention. So it has to be a different way to*

imagine what the state is, what the community is, what the intervention is, that uses some set of cross cutting principles or some way to imagine the world that then does less injustice to issues of gender or disability or race." (AYHP Advisory panel member_13)

Importantly, actors also advocated for more learning, reflection and detailed intersectional gender analyses, at micro, meso, as well as macro levels. An exemplary quote is,

"I don't think we have ever sat down to look at where we come from and the underlying historical forces that still shape where we are going. I mean this country came from a violent patriarchal background that still holds true. There is a mantra about toxic masculinity, but some of these have become clichés. These have turned into slogans, there is no deep analysis and deep thought behind them. Our debate is shallow and we haven't addressed some of the underlying causes of why South Africa is where it is. We are going to repeat our past because we don't have effective ways of reflecting some of the dynamics that caused us to be where we are today." (Civil society actor_21)

Examples of more gender-transformative programmatic approaches

A second and related theme that emerged in looking forward was the need for more gender-transformative, feminist and multi-component programmatic work to address the inherently patriarchal, homophobic and unequal society. In the South African context, GBV programmes were used as an example of how to include boys in gender-responsive programming, as part of moving towards transformation of gender power relations:

"*So firstly we need to involve the adolescent boys and use different approaches, because they don't want to be approached in the same manner we approach women. So you need to have programs that are relevant to addressing different age groups of males, instead of just targeting young women and girls."* (AYHP author government_15).

Actors also highlighted that gender-transformative feminist work needs to focus on masculinities, starting with young ages and across generations:

"*It is bigger than just speaking to the boys, it is speaking to the fathers, speaking to the religious leaders, speaking to the cultural leaders. All of these are grooming young boys into becoming these dominant men in the society."*(Civil society actor_23)

In addition, many actors mentioned Comprehensive Sexuality Education (CSE) as an important example of a structural and more gender transformative programmatic approach. This was described as follows, *"I mean there is no question that CSE is a necessary and important element of addressing gender matters. South Africa has committed to having compulsory, comprehensive sexuality education in the curriculum and it is something that we must hold our government accountable for. Now, implementation assumes a number of things. It assumes that there is a clear, age appropriate curriculum, that teachers have sufficient skill and content knowledge to be able to deliver this curriculum. It also assumes that there are available learning resources for teachers as well as for the learners, like we have for Mathematics and Geography and sufficient time to cover the necessary building blocks. Each of those things needs commitment and needs delivery to be able to achieve the ultimate goal."* (Government actor_17)

Further, actors emphasised that an essential component of CSE is not reinforcing patriarchal systems, to be grounded in lived realities of young people and to be implemented by capacitated adults. The following quote captures this point,

"So, if I was to be the Minister, I would introduce the syllabus that educates them about sex and also teach our teachers to be comfortable about teaching and speaking about sex in schools, because a lot of teachers are not comfortable. All they teach about is what they read in the book, and when you read it in the book it is, it doesn't come as effective as it should be when you are a student listening to someone who is educating you about it. So I believe that introduction of the new syllabus is what would really bring change to the health of youth." (NDoH AYAP member_29)

Commitments and capabilities to take the work forward

Given the diverse narratives, actors also emphasised the importance of developing a shared vision, political will, high level leadership by government, and institutional capabilities to

lead and co-ordinate, with commitment at all levels to mainstreaming a more feminist gender agenda that advances gender and intersectional transformation. The processes and contexts needed going forward articulated by several actors included having collaboration and alignment within government and with civil society to encourage collective work and accountability for this more political feminist agenda:

> *"We need to build broad alliances around gender, gender-based violence and sexual orientation and gender identity. So for me one has to keep much more feminist and a much more critical agenda alive.*" (Government actor_22)

Moreover, key messages from actors include that 'working with gender' and notions of transformation should include both top-down and bottom-up processes with 'messy middles', which create platforms for working with the nuances. Importantly, actors noted that these spaces need to be well-facilitated and centre representative youth structures and gender movements, which can be quite challenging in a contemporary context dominated by individual social media influencers and lack of representative youth citizenry and organised women's movement. Consequently, actors also called for working with complexities and intersectionality of gender and other axes of power in the South African context, by also bringing together various actors in government, youth representative structures, civil society, working in gender, SOGIE and (re-)creating of spaces for discussion, activism, building alliances and findings way of operationalising gender transformative policy.

Discussion

In summary, this paper describes the actor landscape during the development of the AYHP, examines the constellation of actor gender narratives involved and explores the implications of the actor landscape and narratives for policies and programmes moving forward. The South African adolescent and youth health policy landscape consists of multiple proximal and distal actors in government and civil society. Despite the commitment to gender equality and more gender-transformative approaches being discussed during the policy making process, these framings largely did not materialize in the final policy. Upon further exploration, diverse and juxtaposed actor gender narratives co-existed in an interrelated constellation with

dominant narratives consequently included in the final policy document, which was also shaped by pragmatic elements of the policy process. These narratives were further contextualised by actors as to what is needed going forward to advance gender equality in adolescent and youth health policy and programming. This includes prioritising gender and intersectionality on the national agenda, implementing more gender-transformative programmes, as well as having the commitments and capabilities to take more critical feminist work forward.

Implications for gender in adolescent and youth health policy

The analysis makes visible the constellation of multiple actor narratives and framings of gender in the AYHP, which have implications for how gender is addressed in adolescent and youth health policy and more broadly, for gender equality and social justice in the South Africa context. The analytical insights build on the foundations of Mannell [27], who also highlighted the tensions between narratives and how they impact and inhibit the uptake of gender policy recommendations and collaboration between actors. From the constellation of actor narratives and framings of gender and gender equality, it is evident that actors have different starting points when talking about gender, which informs how they respond to situations. Fraser's concepts of recognition, representation and redistribution help to understand the underlying motivations behind these diverse actor narratives and framings. Some actors understand gender to be about the recognition of identities, some about equal representation, and some about the redistribution of power and resources [43–45]. Given the complexity of transforming gender power relations and sustaining gender equality, re-cognising the co-existence of these narratives as potentially complementary rather than in competition with one another is critical [55]. This is a central to understanding how gender is socially constructed and surfacing the co-existence of diverse narratives is part of creating spaces for dialogue and critical engagement on what this means for health policy and systems.

In deconstructing actor narratives, the dominance of the *gender as girls and women* narrative, both reflects and reproduces dominant societal narratives in South Africa, which are largely that gender is equated to biological sex, binary, further shaped by the social and structural

systems of patriarchy, racism, sexism, social economic and other intersecting inequalities. Importantly, most of the identified actor narratives focusing on girls and young women did so outside of power relations i.e. as decontextualised and depoliticized. These actor narratives mirror the content of the AYHP policy document as well as an analysis of dominant discourses across 15 adolescent health policies in South Africa [29], which are predominantly gender-sensitive and respond to consequences of gendered inequalities, rather than being gender-transformative. While responding to health consequences of gender inequality is an important part of the NDoH mandate, we would argue that in order to move beyond the status quo of adolescent health in South Africa, we need both gender-responsive, as well as gender-transformative policy and programmes, focussing on the broader societal context and disrupting gender power relations, as part of moving towards a gender equal and just society [56–58].

Also, the actor narratives of gender as inclusion through consideration of essentialised identities, highlights that this can lead to a binary and competing agenda on women's/girls' and boys'/men's health, without consideration and analysis of underlying gender inequalities [55,59]. This emphasises that categorical and binary understandings of gender are now inadequate and these can lead to zero-sum arguments for competing agendas and resources, and so diluted efforts to advance gender equality [59]. Moreover, the findings highlights the tensions in addressing gender in policy and programmes and that 'gender work' is both technical, but also about power and hence deeply political work [14,60–63]. This talks to some of the global debates and paradigm shifts that have taken place over time from Women in Development (WID) to Gender and Development approaches [63–65]. The findings also speak to some of the tensions for actors of how to both address the practical gender needs (i.e. be gender-responsive) as well as address the strategic gender needs (i.e. be more gender-transformative) within programmes. Importantly, the findings also foreground critical questions for how we work with gender in adolescent and youth health, beyond binaries, heteronormativity, and notions of 'vulnerability' and which are often not problematised and the importance of engaging with these in policy and programmes.

Actors and the policy making process

Our findings add depth and nuanced understanding of the dynamic and complex relationships between the actors, South African context, policy content and processes, in shaping both how gender is problematized or framed and how this is related to how 'solutions' are represented in policy processes [19,23,66,67].

Firstly, in terms of the dynamic policy making process, our findings foreground the role of actors, providing in-depth insights into the range of actor narratives, how these interacted during the process and which made it the final policy document. These findings, which explore the relationship between the South Africa context, characterised by historical and contemporary racism, sexism, intersecting inequalities and the actor narratives, show how actor narratives are contextualised and constructed by broader societal narratives and in turn shape policy processes in other contexts such as Tanzania, Ghana and Nepal [34,35,68].

Secondly, the findings provide insights into the *how* of policy making, particularly how the *gender as girls and women* narratives was dominant and more gender-transformative narratives 'evaporated' and did not make it to the final agenda and policy document, due to lack of shared conceptual framing, pragmatic institutional processes and divergence from gender as power relations. Making visible the role of ideas and actor narratives contributes to explain some of challenges in addressing gender and gender equality in health policy processes. Possible additional reasons for this could be the absence of a gender transformation champion, as well as policy processes and institutional spaces that did not draw on the gender expertise in civil society and academia, as also noted by Daniels *et al*. [69].

The constellation of actor gender narratives helps to unearth individual and organizational assumptions about, and ideological commitments to, gender equality and transformation of power relations. nested in broader social systems [21,22]. Importantly, it shines the light on the pervasiveness of patriarchy and hegemonic ideas related to gender that infuse policy processes and different types and levels of power i.e. power through institutional positions and norms, power over ideas in terms of certain ideas, being accepted and rejected and power in ideas in terms of reproduction, as also documented by Acosta, Carstensen and Friel [33,70–72].

In focussing on actor policy narratives this paper contributes to the discussions on the ideational power of actors, lack of understanding about gender concepts and language, pragmatic limitations in policy processes and deepens the understandings of policy processes related to gender mainstreaming.

Given the contested nature of gender narratives there is a need for consideration of the tensions and dynamics between dominant ideas, frames, narratives, and values which can shape priorities, competing agendas and power relations amongst actors, i.e. government, civil society, academia and young people, as also described by Gaventa and Harris[73,74]. Further, our findings contribute to the debates on policy processes, policy coherence, as well power relations between actors [75,76], when working towards a gender equal and just society. Reimagining a healthier future for adolescents and youth in South Africa and globally will require including adolescent and young people in their diversity as key actors as well as investing in feminist movements that hold government accountable, building on lessons learned to date.

What does this all mean in practice?

The findings raise significant implications for addressing gender (in)equality, as an important cross-cutting social and structural determinant of health for adolescents and young people and the need to both respond and address the underlying root causes [77,78]. While there is no silver bullet to achieving gender inequality, we however would advocate for enhancing both the technical and political competencies of health and other sectors to be able to address the nuances and complexities of gender and intersecting inequalities.

Further, key message from the findings is that CSE is an important example of a gender-transformative structural and systems level intervention, requiring collaboration between education, health sector in government and civil society, also centering voices and realities of adolescents and young people in their diversity [79–82]. We therefore advocate for the health sector to also focus on programmes and partnerships with other actors that address social and structural systems and work with other sectors. This should include sectors such as Education and civil society, through for example CSE and other gender-transformative collaborations that address gender-inequality as an underlying determinant of health [83–85].

Enhancing capabilities and building policy communities and actor alliances, using governance approaches are critical for brokering multisectoral action for collaboration, including the relationships between government and civil society, also as part of bringing more feminist narratives to policy making processes [75,86–89]. However, certain challenges remain, as civil society and women's movements, as key actors in South Africa, have changed over time, are more fragmented, have different foci [90–92]. This raises the importance of actor management, intergenerational dialogues and talking about points of commonality as well as divergence, which are aligned to current global debates in terms of meaningful participation of diverse youth.

Getting and sustaining gender on the agenda of the NDoH and other national government departments will also require recognizing the diverse actor narratives, development of shared understandings and conceptual framings different aspects and dimensions and creating spaces for building relationships between key actors. This will also entail enhancing the capacity and skills, beyond a narrow framing of gender as binary, heteronormative, quantitative and 'tick box' additions, to understanding the broader social and political context, and being able to develop and implement more gender-transformative processes and interventions, and further critical engagement with power systems [29,93,94]. This builds on the arguments by feminists who call for a focus on transformation of gender power relations, as well including women's movements in policymaking [65,93,95]. Taking this forward is urgent, also terms of developing gender-responsive transformation, particularly in the context of COVID-19 [87,96–98].

Gender and intersectionality on the research agenda

The contestations in the constellation of actor gender narratives is a significant foundational theme and it is crucial to unpack what this means for both policy analysis and praxis, as part of working towards a gender equal and just society. Therefore, there is a need for further gender and intersectional analyses and scholarship on the role of actors in health policy analysis, exploring their narratives, experiences, power relationships and potential resistance to gender equality transformation. More in-depth actor-centric analyses, including exploring

their ideologies and lived gendered experiences will enrich the understanding of the complexities of policy processes and gendered systems of power.

Also, research opportunities could include doing more theoretical and empirical work on gender and power analyses of different actor groups, to learn more about policy processes and how best to make it more visible [99,100]. Importantly, there is a need for more gender and intersectionality research to explore the different dimensions of policy contexts including the role of history, politics, geographical locations and intersecting social identities and locations to generate transformative insights into structural determinants that shaped the health of adolescents [60,101–106]. Our research has provided a case study of poststructuralist policy analysis of gender narratives as complex and contested and shaped by broader contexts and policy processes. This work could be the foundation for expanding the boundaries of HPA and do further research on gender and intersectionality, as features of power [60,101,107].

This paper has both strengths and limitations, with some of the strengths being related to researcher's positionality, which includes more than 20 years of contextual knowledge and programmatic experience and this grounding also enabled access to a range of policy actors. However, limitations include that the analysis was retrospective with actors having to remember back to 2016/2017. The COVID-19 pandemic also created an additional demand for some actors and hence created delays in participating in the research.

Conclusions

We took a magnifying glass to the AYHP as a case study and the research findings provide a foundation for further insights, meta analyses and implications for gender transformation in other health policies and programmes, as well analyses of actors in policy process.

The way gender is framed in policy processes is shaped by actor narratives, and these diverse and contested discursive constructions were shaped by the dynamic interactions with the South Africa context, and processes of the AHYP. This paper contributes to the scholarship on actors' gender narratives, the social construction of policy processes and critically engages

with what the implications are for gender transformation and intersecting power relations in adolescent and youth health policy and programmes. Advancing the gender equality agenda both globally and in South Africa should include analysis and attention to how actors understand and address gender as part of socially constructed policies. The mapping of the constellation of narratives is an important foundation for further analysis and action. Gender equality is an imperative for future health and wellbeing of young people and re-conceptualizing the role actor narratives can contribute to bridging the disconnect between policy commitments and reality in advancing the gender equality agenda.

Declarations

Ethical and Consent to participate

This article is part of a larger PhD research case study titled: People, power and processes a gender analysis of adolescent health policy in South Africa which has received ethical approval by the Biomedical Science Research Ethics Committee of the University of the Western Cape. Reference number: BM18/9/9. This paper was based on interview data and informed written consent was obtained from all participants.

Consent for publication

Not required.

Availability of supporting data

Data for this paper included interview data from participants and these interviews were transcribed in full. These are available from the corresponding author on request.

Competing interests

The authors have no competing interests to declare.

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Authors' contributions

Both TJ and AG conceptualized the paper and TJ collected the data. Both authors contributed to the analysis and interpretation of the findings and the drafting of the paper. Both authors read and approved the final manuscript.

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CHAPTER 8:
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

1. INTRODUCTION

This PhD undertook a gender analysis of adolescent health policy and systems in South Africa, with each 'Findings' chapter analysing a component shaping dynamic health policy making i.e. context, content, process, and actors. At the nexus of theoretical lenses and methodologies from the fields of HPSR and social sciences, this thesis

- describes the social and structural determinants contextualising adolescent health (Chapter 4);
- critically analyses the content of key adolescent health policy documents through a gender lens (Chapter 5);
- explores the learnings about youth participation in the process of making the AYHP (Chapter 6); and
- examines the role of actor gender narratives in shaping adolescent health policy in South Africa (Chapter 7).

Through integrating the 'Findings' chapters as a whole, the story of adolescent health policy in South Africa, through a gender lens, is documented, building on what is known on the topic. As captured in the title of the thesis, 'people, power and processes' were key threads across the study, being aspects of the essence of health policy in shaping both the 'what' and 'how' of policy making (Gilson, Orgill and Shroff, 2018).

This chapter presents the discussion of key findings, bringing together analytical threads and conclusions of this research as a whole, and contextualising these in relation to theories and scholarly conversations in the field. In addition, it maps the contributions of the thesis to knowledge, research and praxis at different levels, as well as disciplinary contributions to the field of HPSR. Based on the overall findings and conclusions, the chapter ends with reflections on the limitations of this research as well as recommendations for future research and praxis.

2. KEY CONTRIBUTIONS OF THE THESIS

The key interrelated contributions of this PhD research are mapped below in the following domains:

- enhancing and building the field of HPSR;
- making constructions of gender 'visible' through gender analysis;
- mapping dynamics between context, content, process and actors in adolescent health policy making;
- presenting problematisation, discourse analysis and framing;
- making contributions to policy analysis; and
- mapping/describing adolescent health policy landscape, actors and systems.

2.1 Enhancing and building the field of HPSR

This PhD enhances and builds both the breadth and depth of HPSR by intentionally drawing on other disciplines, theoretical lenses and methodological approaches from the social sciences (critical policy studies, gender studies and sociology). The receptiveness of HPSR to other fields and disciplines, and the 'fuzziness' of disciplinary boundaries, provided an important opportunity for strengthening and enhancing HPSR, by integrating gender analyses and centering gender and its intersectionality in the research questions and methodologies. This opened up opportunities for productive and critical methodological discussions with other scholars on both the possibilities and also limitations of drawing on different fields and frameworks as part of a more 'bricolage' approach in HPSR.

The contribution of the research to enhancing the field of HPSR and the intentional integration of disciplines i.e., interdisciplinarity, is both at the interrelated conceptual and methodological levels. On a conceptual level, it contributes to enhancing the understanding of applying gender and related concepts – such as 'gender inequality', 'gender-responsive', 'gender-transformative,' 'intersectionality', 'gender mainstreaming' etc. – to the context of adolescent health policy in South Africa. In addition, it has foregrounded how conceptual conflations of 'gender' with girls and women, as binary and heteronormative, is problematic,

with significant implications for HPSR. It contributes to the field by unpacking gender as it is socially constructed – to include its fluidity, with dimensions of sexual orientation, gender identity and expression (SOGIE) as well as to underscore that it is further shaped by intersectional systems of power and inequality.

Given the paucity of conceptual frameworks that bring together gender and adolescent health policy considerations within HPSR, the thesis developed two conceptual frameworks. Firstly, in Chapter 4, a conceptual framework guides the examining of the key contextual social and structural determinants of adolescent health in South Africa – across micro, meso and macro levels of society, their global determinants, and their intersections with compounding axes of power and inequality. Secondly, an existing conceptual framework (Cahill and Dadvand, 2018) – encompassing domains of place, purpose, people, process – was adapted from critical youth studies to guide the analysis of youth participation in the AYHP (Chapter 7) and as a framework for analysing youth participation in other policy processes going forward.

On a methodological level, this thesis contributes to HPSR by advancing and applying gender frameworks which demonstrate how to examine the ways in which gender influences policies and programmes as well as the health system. This research strengthens HPSR by providing a case study of how gender and intersectional analyses of power can be included in research, which has implications for the development of more strategic interventions and effective policies as part of transforming health and social systems (Larson *et al.*, 2016; Morgan *et al.*, 2016; Theobald *et al.*, 2017)

Analysing gendered power relations

In exploring and describing gendered power relations, this thesis also contributes to current debates regarding the growing interest in how to analyse power more generally, as discussed recently by other scholars (Sriram *et al.*, 2018; Ryan and el Ayadi, 2020; Friel *et al.*, 2021; Topp *et al.*, 2021). Gendered power and intersections with other forms of inequality was a central thread across all the 'Findings' chapters, particularly the different spaces and levels in which they operate, including policy processes.

The research findings contribute important contextual and critical knowledge to the field of HPSR, by illustrating how gender power relations are also grounded in the policy processes which are part of the historical, political, and social contexts of South Africa. They shine a light on the pervasiveness of patriarchy and hegemonic ideas and constructs related to gender that infuse policy processes as part of different types and levels of power; these are power through institutional positions and norms; power over ideas in terms of certain ideas being accepted and rejected; and power in ideas in terms of reproduction, as also documented by Acosta, Carstensen and Friel (Carstensen and Schmidt, 2016; Baker *et al.*, 2018; Acosta *et al.*, 2019; Friel *et al.*, 2021). This PhD expands and enriches scholarly HPSR conversations and practices and advances the HPSR agenda as outlined in the Liverpool statement (2018), namely to focus on power, inequality and the social and structural determinants of health and health systems (Hanson, Rasanathan and George, 2019).

The sections below elaborate on making constructions of gender 'visible' in policy processes through gender analyses, as these are often taken-for-granted ideas, beliefs and hegemonic ideologies which are embedded in policy processes.

2.2 Making constructions of gender 'visible' through gender analysis

A key contribution of this thesis is foregrounding the gender inequality and power relations at the heart of adolescent health policy making in South Africa. Across the findings, it is evident that gender power relations are not adequately or appropriately considered in adolescent health policy and programmes. For example, Chapter 4 clearly describes how gender power relations are a cross-cutting social and structural determinant at the macro, meso and micro levels of society in shaping adolescent health. In addition, the thesis as a whole emphasises how gender power relations, which intersect and compound other axes of marginalisation and exclusion, are not considered in adolescent health and related policy making and programmes in South Africa.

The findings in both chapters 5 and 7 clearly demonstrate that adolescent health policy making in South Africa does, at times, consider gender and gender inequality by being gender-sensitive and gender-responsive, but that this is invariably not gender-transformative i.e. it does not address gender power relations and the underlying social and structural determinants in the policy making processes. Making constructions of gender, gender inequality and gender power relations more 'visible' in adolescent health policy has foregrounded the diverse, juxtaposed and often contested understandings of gender discourse in policy documents (Chapter 5) and the constellation of actor gender narratives (Chapter 7). These findings highlight both the complexity of understandings related to gender concepts as well as how this plays out in adolescent health policy making processes as part of broader health systems. These findings highlight both the complexity of understandings related to gender concepts and power relations and how they emerge in the interactions between actors, content and processes in adolescent health policy making processes as part of broader health systems.

A further valuable contribution across both the analysis of policy discourses (Chapter 5) and actor narratives (Chapter 7), is that it makes 'visible' and questions conceptual understandings, and often taken-for-granted ideas, assumptions, and ideologies about gender. In surfacing how constructions of gender are contested and shaped by the broader social, ideological and political environment in South Africa, it exposes how policy processes are embedded in systems of power. A valuable contribution of this thesis is therefore making gender and intersecting power relations 'visible' in adolescent health policy and programmes, in order to transform them.

As a whole, this research responds to the call to produce knowledge to transform gender power relations and inequalities, by illuminating how important it is to deconstruct policy narratives from a gender perspective. Gender inequality and patriarchy as dominant systems of power and inequality were the entry points to understanding the impact on adolescent health, however it is vital that gender power relations are considered alongside other social

stratifiers and axes of inequality particularly race, given South Africa's past and present systemic inequalities. Consequently, the research amplifies the voices of many feminist academics, scholars and activists by advocating for more sex and gender analyses to make visible how gender systems of power and inequality shape health and social systems (Morgan *et al*., 2016; Theobald *et al*., 2017; Hawkes *et al*., 2020; Amin *et al*., 2021).

Being fully cognisant that transforming gender inequality is complex and multi-dimensional, – and that it will also require leadership, governance, and organisational changes, as well as whole-of-society engagement – policy analysis and transformation is part of that broader goal and agenda. Making gender power relations visible in adolescent health policy processes is therefore not a quick fix, nor a panacea for the transformation of systems of gender and intersecting power relations; rather, it contributes to the slow systems transformation of identifying, initiating and sustaining change towards a gender just and equal world yet to come.

2.3 Mapping dynamics between context, content, process, and actors in adolescent health policy making

A unique contribution of this thesis is the demonstration of the dynamic interactions that exist between context, content, process, and actors in the making of policy – and that these are powerfully 'gendered'. Building on the existing scholarship in HPSR, particularly health policy analysis, the thesis presents a picture of the dynamic and complex interactions between these policy elements, with a focus on gender in adolescent health policy in South Africa. As mentioned at the start of this chapter, each of the 'Findings' chapters describe and foreground one of these policy elements: Chapter 4 focusses on context; Chapter 5 focusses on content; Chapter 6 on process; and Chapter 7 on actors. They all simultaneously explore the dynamic interactions between these, as further discussed below.

The findings in Chapter 5 show how the content of policy documents is evidence of the understandings and multiple ways in which gender and gender equality are represented and problematised in policy. The policy documents reflect the ideas, understandings and assumptions held by policy actors in the South African context and, as such, provide some

insights into how and why gender is problematised in policies relevant to adolescent health. The findings contribute to the literature on how policies are socially constructed, highlighting the gendered ideas, discursive constructions and discourses located in organisational, national and global contexts (Ingram, Schneider and Deleon, 2007; Weible *et al.*, 2012; Colombini *et al.*, 2016) .

In foregrounding the South African context (Chapter 4), the analysis contributes to the international literature on adolescent health by demonstrating a systematic manner for moving beyond the micro level and also addressing social and structural determinants at the meso, macro and global levels (Marcus and Harper, 2014; Malhotra, Amin and Nanda, 2019; Pulerwitz *et al.*, 2019; George *et al.*, 2020).

In addition, the learnings about youth participation in the development of the AYHP presented in Chapter 6, tell the story of this 'first' time of youth participation in adolescent and youth health policy making in South Africa. Moreover, it is an example of bringing to light the key storyline that emerged from inductive analysis of interviews with policy actors, which clearly demonstrated the dynamic interaction between the context (i.e. place), actors (i.e. people), process and content of the policy. This is also documented in relation to other policy topics (Walt and Gilson, 1994; Shawar, 2014; Mokitimi, Schneider and de Vries, 2018; Roy *et al*., 2019; O'Brien, 2020; Jones, Gautier and Ridde, 2021).

Chapter 7 focusses on the actor gender narrative and these actor-centric findings and analysis foregrounds this important focal area in HPA, contributing to this area of knowledge, as also described by other scholars (Koduah, van Dijk and Agyepong, 2015; Fischer and Strandberg-Larsen, 2016; Scott *et al.*, 2017; Ramani *et al.*, 2020).

2.4 Presenting problematisation, discourse analysis and framing

An important contribution of this thesis is that it highlights how gender is 'problematised' constructed and framed, as central to understanding adolescent health policy and programmes in South Africa. The empirical findings contribute to advancing the theoretical and conceptual understandings drawn from HPA and critical policy studies, which were the

foundations for the research. In particular, Chapter 5 is an example of the application of Bacchi's WPR Framework – 'What's the problem represented to be?' – which showed how gender was problematised in the policy documents, determined what was focused on as 'solutions' as well as what was left unproblematised or 'silent'. The 'silence' was measured in relation to gender and adolescent health, in terms of global and national literature, as well as subject and contextual knowledge. The PhD was also a learning experience and the type of questions related to power and gender needed to go beyond content analysis and needed to integrate more critical approaches, such as CDA and also Bacchi's WPR approach – this was very fruitful but also raises a lot of questions in relation to the challenge of bringing together different epistemological positions Methodological reflections include the possibility of diluting the complexity that comes with each approach and this is a potential limitations when integrating different frameworks, methods and disciplines.

Further, the content and discourse analysis of policy documents in Chapter 5 made visible how gender is conceptualised as fixed, categorical identities and as heteronormative – as opposed to gender as fluid social processes; these have implications for how rights and 'risks' are understood and addressed. The discourses reveal an overriding focus on adolescent girls, outside of the context of power relations in which they live, with minimal attention to boys in terms of their own health or through a gender lens; it also shows little consideration of LGBTIQA+ adolescents beyond HIV programming.

These findings are complemented by those in Chapter 7 which provides an analysis of actor framings of gender – i.e. gender narratives. It reiterates this finding and adds to the insights of how problematisation of gender shapes programmes in terms of focus and policy subjects. The interrelated constellation of diverse and juxtaposed actor gender narratives – ranging from framing gender as equating girls and women; gender as inclusion; gender as instrumental; gender as women's rights and empowerment; and gender as power relations in the AYHP – shows that while there is diversity of gender narratives, some are dominant (e.g. gender as girls and women) in the policy-making process and in the final policy document.

Moreover, what is illustrated across the findings is that the dominant and marginalised discourses and actor narratives in adolescent health policy processes – as well as the 'silences'– are interrelated, productive and co-construct each other. What is dominant effectively 'silences', or shapes, what is included or what is not, almost as if the discourses and narrative are in 'conversation' with each other. Crucially, these policy discourses are produced by, and are embedded in, the broader discourses and narratives of adolescence, adolescent health, youth, gender equality, human rights and justice – all of which is informed by South African past and present social and political context. A key message from this research is that what is problematised and what is left unproblematised in adolescent health policy documents has significant implications for policy subjects and implementation and health and social systems as a whole, as also highlighted by other scholars (Osborne, Bacchi and Mackenzie, 2010; Bacchi, 2017; Baum *et al*., 2017).

The findings in both chapters 5 and 7 illustrate that the ways in which gender is problematised shapes how gender is addressed; how 'solutions' are represented in these policies and bring together theory and empirical dimensions. A resonating thread across the thesis is that gender is largely constructed as equating with girls and women decontextualised from power relations; there is also an overriding focus on the 'symptoms' i.e., consequence of gender power relations (e.g. HIV and gender-based violence), rather than an equal focus on the underlying social and structural determinants of health, including as the underlying patriarchal beliefs and practices that perpetuate gender power relations. This is seen in a predominance of service delivery through an individual lens, rather than through a systems lens, as also documented by other scholars (George, LeFevre, *et al.*, 2019). Significantly the research has elucidated the diversity of ideas, understandings, discourses and complex discursive actor framings and narratives of gender, gender inequality. Much work is needed in facilitating spaces where these nuances can be discussed amongst government and civil society policy actors.

A meta observation across the respective 'Findings' chapters is how the 'wicked' nature of adolescent health and wellbeing, with its contextual diversity, is reduced to a focus on 'illness' and 'disease' and is feminised to focus on adolescent girls and young women in South Africa. While it may be argued that health policy should address the immediate service

delivery needs of those most affected – i.e. be gender-responsive and deal with 'symptoms' of gender inequality – this research argues for a simultaneous gender-transformative approach, which addresses root causes at a more systemic level.

Consequently, a thread across chapters 4 to7 is the need to expand the analysis to also focus on a systems level to address the social and structural determinants of adolescent health, which should be prioritised in future research and praxis. Further, the findings of the thesis is a call for researchers, policy makers and implementers to engage in on-going critical analysis and debate on how the social and political contexts mediate and 'silences out' more positive discourses and narratives on adolescent health, in order to develop more adolescent-responsive and gender-transformative health policies and systems.

Subsequently, a key question with which this thesis grappled is what and where the opportunities are to transform and disrupt the dominant, limiting discourses and actor narratives related to gender in order to work towards a gender equal, socially just and inclusive society. This is central to achieving the SDGs and realising the Leave No One Behind (LNOB) principles. Scholars, policy makers and activists have to consider and locate gender and intersecting power relations and axes of inequality at the centre of research and praxis. Without this, our analysis and actions will be partial, and will reproduce, or even reinforce, gendered power relations. This intention to undertake and be deliberate in analysis of heath policy is expounded upon below.

2.5 Making contributions to policy analysis

This thesis contributes to the intentional, deliberate, retrospective analysis of policy processes by presenting how gender and adolescent health was problematised in the content of policy documents (Chapter 5), learnings about youth participation in the policy formulation process (Chapter 6), and ideas and narratives of actors (Chapter 7) – all of which are shaped by the social and structural determinants of adolescent health in the South African context (Chapter 4).

As consistently argued in this thesis and supported by the empirical findings, health systems are part of broader societal systems which shape how gender is constructed in both policy content and processes with implications for programmes. This cross-cutting theme talks to similar arguments by other scholars (Eveline and Bacchi, 2005; Bacchi and Eveline, 2010; Lombardo, Meier and Verloo, 2017; Morgan *et al.*, 2018) and highlights the question as to where and at what level (micro, meso and macro) there are opportunities to resist, transform and disrupt the gendered power relations.

A key theoretical and methodological thread of the thesis is that of social constructivism which illustrates how actors understand and frame gender and construct the ways in which gender and adolescence is problematised in policy documents. Its main point is that this is a social process. There is a paucity of literature in HPA that explores the intentions, ideological positions, values and meaning-making of/by actors who are central to the construction of policy (McDougall, 2016; Gilson, Orgill and Shroff, 2018; Parashar, Gawde and Gilson, 2020). This thesis makes this more 'visible' through a gender lens.

As demonstrated by both chapters 5 and 7, the actors' ideas and discursive constructions of gender and adolescent health, shaped both what and who is problematised as the target audiences in adolescent health policy in South Africa. In documenting the ideological terrain, beliefs and understandings of actors in terms of gender and adolescent health, the research findings have contributed to the scholarship on the impact and power of ideas, ideologies and the interpretive nature of policy making, embedded in broader systems and structures. This is also described by others working in HPSR (Shiffman, 2009; Berlan *et al.*, 2014; Shiffman *et al.*, 2018; Chipendo *et al.*, 2021).

Understanding the social construction of gender in policy content and processes is, therefore, critical. This thesis contributes to the literature on ways in which health policy is shaped by gender in both policy content and processes – which, in turn, has implications for programmes (Lombardo, Meier and Verloo, 2017; Ciccia and Lombardo, 2019). The power of policy analysis includes using innovative ideas, concepts and methodologies to generate insights and knowledge and, in so doing, making the people and power more visible in policy

processes as part of working health systems change(Gilson *et al.*, 2021; Gilson, Shroff and Shung-King, 2021).

The intentional and deliberate analysis of health policy matters in this PhD thesis has produced a clear example of the social construction of gender in adolescent health policy in South Africa. It also foregrounded the contested, complex and 'messiness' of the policy-making processes, thereby adding to the research and praxis conversations amongst researcher and practitioners.

2.6 Mapping adolescent health policy landscape, actors and systems

The final part of the contribution of this research is premised on providing a detailed description of the adolescent health policy landscape, multiple actors, and the systems in which they are nested.

As shown across the various chapters, the research has described the fragmented adolescent health policy landscape to be one of multiple actors across government departments, civil society organisations, and government agencies focused on youth. Chapter 4 mapped the adolescent health policy landscape comprising various lead departments, actors, and diverse foci. While the national departments of Health and Education lead many policies, the plethora of government agencies involved highlight the need for further multi-sectoral collaboration and co-ordination on adolescent health. Similarly, Chapter 6, which described youth participation in the AYHP, also foregrounded the sectoral contexts (e.g., health, education, social development), actor interfaces (e.g., between government departments and between government and civil society), as well as the importance of multi-sectoral partnerships – all of which are relevant to how youth are engaged in policy and programmes as active citizens. As consistently argued in this thesis, adolescent health should be the mandate for all government departments and the research underscores the importance of multi-sectoral alignment and action for adolescent health, as also documented by other authors (Cluver *et* al., 2018; Patton *et al*., 2018; Meinck, Orkin and Cluver, 2019; Toska *et al*., 2019; George *et* al., 2020).

Focussing on actors as part of adolescent health policy-making processes has also highlighted several systems and governance elements. Firstly, there is a need for a shared vision for adolescent health in South Africa that is comprehensive, gender-transformative and inclusive of adolescents in their diversity. Secondly, to realise this vision there is a need for political will, high level leadership by government, and institutional contexts, capabilities, and systems to lead and co-ordinate across sectors. Thirdly, the thesis has identified a range of competencies and capacities that need to be enhanced – in particular how to centre adolescent and young people as actors in entire policy processes and ensure their meaningful participation, as described in Chapter 6. Meaningful participation and leadership by diverse adolescents and young people is also called for in current global debates, where it is also asserted as a right (Määttä and Aaltonen, 2016; Patton *et al.*, 2016; Cahill and Dadvand, 2018; Choonara *et al.*, 2018; Botchwey *et al.*, 2019; Kwon, 2019; Bečević and Dahlstedt, 2021).

Furthermore, as articulated in both chapters 5 and 7, there is a need for capacities for, and commitments to, working with gender that go beyond providing gender responsive services at an individual level and focus on the power relations that advance gender and intersectional transformation at a systems level. Consequently, there is also a need to bring together various actors – in government, youth representative structures and civil society who are working in gender, sexual orientation, gender identity and expression (SOGIE) – to (re-)create spaces for discussion, activism, building alliances and for finding ways of operationalising gender transformative policy that centre the voices and experiences of the diversity of adolescents and young people in South Africa.

A key thread across the various 'Findings' chapters is that certain challenges remain. As key actors in South Africa, civil society – especially youth movements and women's movements, – have changed over time. They have become more fragmented and have changed their foci, underscoring the need for building policy communities and actor alliances, as also argued by others (Gouws, 2014; Kapilashrami and Hanefeld, 2014; Klugman and Jassat, 2016; Gouws and Coetzee, 2019). The findings also show a complex, and often contested, terrain of adolescent and youth health actors in South Africa, with persistent challenges of ensuring

collaboration and alignment within government and with civil society, to encourage collective work and accountability for this more political and feminist agenda.

Supported by the findings, this thesis amplifies the arguments by feminist scholars and academics for building the relationships between government and civil society, including women's and gender structures, as part of bringing more feminist narratives to bear in policy-making processes (Klugman, 2000a; Gouws, 2014; Tallis *et al.*, 2018; Mkhize and Mgcotyelwa-Ntoni, 2019; Sen *et al.*, 2020; Townsend *et al.*, 2020). This builds on the arguments by feminists who call for a focus on transformation of gender power relations, which includes ensuring the participation of women's movements in policy making. Taking this forward is urgent given the growing inequality surfaced by, and contributed to by, COVID-19 – as part of developing gender-responsive transformation (Wenham, Smith and Morgan, 2020; Fisseha *et al*., 2021; Smith *et al*., 2021).

In summary, this discussion section has presented the interrelated multi-level contributions of the PhD thesis to knowledge and praxis, which described and explored a gender analysis of adolescent policy processes in South Africa. By bringing together diverse theoretical lenses to complex phenomena such as gender in policy processes, this research makes a novel contribution to the field of HPSR and has generated important implications for policy, programmes and systems as a whole.

3. LIMITATIONS

Alongside the contributions to scholarship, this research also has limitations. These are reflected on below, in addition to those which have been noted in each publication (in chapters 4 to 7).

The research process commenced in 2018, at a time when key policy documents were relatively new. The focus of the thesis, therefore, has been on the early phases of the policy processes i.e. agenda-setting, framing, readiness for, or early, implementation; it has not been on the implementation aspects of policy processes.

Also, as a retrospective policy analysis, there may have been recall bias in terms of the formulation of the AYHP, as the participants had to remember a process in which they had participated during 2016 and 2017.

In addition, despite establishing trust and making the participants feel safe at all times during the interview process, there was some reluctance from a few participants to talk about the complex issue of power which was one of the key phenomena being researched. This may have been exacerbated by the fact that half the interviews were conducted online (during the COVID-19 pandemic), which may have created additional demands for some participants; it this may also have created delays in their participating in the research and, possibly, undermined their comfort during the interview process. Having longstanding and established relationships with many of the actors through many years of practice could have contributed to counter-balancing this potential limitation.

While a range of adolescent and youth policy actors participated in the research, there were limited perspectives by adolescents and young people themselves. Not only did the research not set out to present perspectives of representative and diverse youth and structures in the general population, but youth from the Mzantsi Wakho and Sinovuyo Teen participatory research programmes were not interviewed, as their confidentiality is protected as part of the research ethics. This could be an area for future research.

The research focused on a gender analysis of adolescent health policy in South Africa and used a gender lens as an entry point to begin to unpack gender and intersecting power relations. This focus on gender inequality was a foundation and an acknowledgment across the findings that these are compounded by past and present systems of inequality, however a full a intersectionality analysis was limited, particularly in Chapter 6. Thus ‘silences’ remain in terms of the analysis and how for example gender, race and disability are important areas for future research and which will strengthen debates and discussions both conceptually and empirically.

As a case study located in South Africa and focusing on adolescent health policy, there may be potential limitations related to the transferability of the findings and lessons to other contexts and policy foci. This was counter-balanced by detailed, thick description of the case within its context and the application of key ethical principles and processes to ensure rigour and validity in the entire process. Despite the potential limitations of transferability of findings, a contextualised understanding of how gender is constructed and framed during policy processes could be considered as conceptually and methodologically generalisable.

4. CONCLUSIONS

This thesis set out to describe and analyse gender in health policy processes in adolescent health policy in South Africa. Located in the intersections of HPSR and social sciences, the research has integrated theories and constructs in this case study to explore the phenomena of interest and contribute to knowledge and praxis. Premised on the findings across chapters 4 to 7, a number of conclusions can be drawn.

The research adds further understanding of how current experiences and health of adolescents is shaped by past social and structural determinants and power relations, with apartheid inequalities still echoing in the lives of those born post-1994, in a democratic South Africa. Understanding the historical context and contemporary social and structural determinants, as well as intersecting and compounding power relations, provides significant insights into determinants of adolescent health. It does so beyond just the micro level– also at the interrelated and dynamic meso and macro levels, nested in global determinants.
Gender and intersecting power relations are complex to change. Those at the individual and interpersonal (micro) level are mediated through the institutional structures and organisational factors in health and other sectors (at the meso level) – which, in turn, are underpinned by the structural determinants such as the national and global political economy (macro) level.

Secondly, as shown in the analysis of health policy documents, gender is not systematically incorporated, and gender inequality and intersecting axes of inequality are not sufficiently analysed as social and structural determinants of adolescent health. A key message of this thesis, then, is that the way gender is constructed and framed in policy processes is shaped by actor narratives. These diverse and contested discursive constructions – for example, equating gender with girls; only addressing consequences of gender inequality and not root causes – were shaped by the dynamic interactions within the South Africa context. This has significant implications for programmes and systems.

The PhD contributes to the understanding that policies are not just words or decontextualised texts. Policy documents are socially constructed and the content reflects and reproduces the actors' ideas, conceptual understandings and ideological terrain related to gender, which, in turn, are nested in broader societal ideologies and systems. The research makes visible the often taken-for-granted 'problems', ideas and interpretations, with implications for how they are addressed by means of 'solutions'. How gender is conceptualised matters, both for policy analysis and praxis, and policy documents can be foundations for transforming gender and intersecting power relations.

Thirdly, youth participation in the AYHP drew out lessons to bridge the gap between rhetoric and reality and, in so doing, responded to the call for support from policy makers on the 'how' of meaningful participation and leadership of young people in policy making. The dynamic and complex relationships which exist between context (i.e. place), actors (i.e. people), and processes shaped how the AYHP was developed in South Africa, which was a novel and unique step toward including youth in development of health policy. A key contribution made by this research, then, is the provision of a conceptual framework for how policy makers can meaningfully engage youth – in all their diversity and in representative and accountable ways – in all stages and spaces of the policy-making process, as part of building youth citizenship and leadership.

Fourthly, constellation of actors' gender narratives reveals overlapping and contested framings of gender and what is required to advance gender equality. Understanding actor narratives in policy processes contributes to bridging the disconnect between policy commitments and the realities of implementation in advancing the gender equality agenda.

Finally, doing a gender analysis is important for policy analysis and praxis; and 'leaving no-one behind' – LNOB – in the SDG era means addressing and transforming gender and intersecting power relations. This analysis contributes towards identifying and disrupting dominant discourses, narratives and systems that sustain gender inequality, as part of bigger processes in working towards a gender equal and just world.

5. RECOMMENDATIONS

More than 27 years into South Africa's democracy, much work remains to be done towards achieving the health and wellbeing of adolescents and young people – towards realising their rights enshrined in the Constitution and working towards the ambitious SDG goals. Below are some recommendations for future research and praxis that could make contributions to this.

5.1 Future research and analysis

The PhD research has expanded and enhanced the field of HPSR by undertaking a gender analysis of adolescent health policy in South Africa. The research process has generated recommendations and suggestions for future research and analysis, which are outlined below.

Additional detailed and in-depth gender analyses to generate further evidence for social change

This gender analysis of adolescent health – both in terms of the 'what' and 'how' of policy processes – has contributed to the body of evidence of in-depth gender analysis, as part of transforming inequitable systems and structures within the health system. In doing so, it has surfaced the need for on-going and detailed analyses of what works in gender and health, as this is a priority for both the national and global health agenda (United Nations University

International Institute for Global Health (UNU-IIGH), 2019). COVID-19 has made more visible the systems of power and intersectional inequality, generating in-depth and detailed evidence, policy and programmatic learning which underscore the urgency of addressing these intersecting inequalities.

Intersectional feminist analyses focussing on how gender inequality intersects and compounds other axes of inequality

These research findings also echo the call by others for greater attention to address gender inequality as a social and structural determinant of adolescent health, as key to transforming gender inequalities in health (Sen *et al.*, 2007; George *et al.*, 2020). Future research should include deliberate intersectional analyses of how gender and other axes of power and marginalisation intersect and compound each other in adolescent health policy and programmes as well other policy areas in health and development. In so doing it will continue to advance the debates and productive tensions in the gender mainstreaming and intersectionality literature (Garcia-Moreno and Amin, 2019; George *et al.*, 2020; Ravindran *et al.*, 2021).

Future lines of enquiry should include analysis to understand the health of adolescents and young people in the systems of power and political contexts in which they live. This, in turn, shows how deeply political personal health is, meaning that systems of power and inequality shape personal experiences.

Ongoing interdisciplinary research on gender and policy making in HPSR

The fields of HPSR and HPA provided an important foundation from which to expand both the depth and the breadth of analysis, by deliberately also drawing on the vast scholarship from the social sciences. This provided critical insights into, and understandings of, the phenomena of interest i.e., how gender is framed and constructed in adolescent health policy and systems in South Africa.

Integrating theoretical lenses – using a bricolage of conceptual and methodological approaches drawing on e.g., the Health Policy Triangle, social constructivism, gender analyses, among others – allowed for the illumination of interesting findings in exploring the complex phenomena. This work has just begun, however, and further scholarship and research capacities should be generated in the intersections of gender studies and health, and policy and systems, possibly with a focus on interdisciplinary Fellowships. Next steps should include bringing together researchers, activists and practitioners from difference disciplinary fields – particularly those working in HPSR, critical policy studies and gender studies – to generate new insights as well as develop shared research agendas going forward.

Prospective and deliberate policy analysis

Understanding the perspectives, life experiences and roles of policy actors, in terms of how gender inequalities, gendered power inequalities and systems are produced and reinforced in health policy processes, is an area for further research in South Africa. In addition, deepening the knowledge repository on how gendered power and patriarchy operate in the health system will advance the work on systems of power.

As this PhD focussed on adolescent health policy as a case study in South Africa, there is also a need for further research in other policy environments – to understand the dynamic and complex relationships between the actors, contexts, policy content and processes in shaping both how gender is problematised or framed and how this is related to how 'solutions' are represented in other policy processes. As part of this, prospective and deliberate policy analysis should be undertaken to make more visible the role and power of ideas, and discursive constructions to explain some of the challenges in addressing gender and gender equality in health policy processes.

Policy documents should increasingly be used as 'artefacts' of the socially constructed policy processes as they provide valuable sources of data for in-depth and detailed gender analysis. This can be done using content and/or discourse analysis and, possibly, further applying more critical and feminist analysis of discourses and narratives.

Adolescents and young people as key actors in research

The research underscores that there is a significant gap between what policy makers think and the expectations, experiences and realities of young people. Centering adolescents and young people as key actors in research can contribute to addressing this gap.

Therefore, it is recommended that adolescents and young people need to be meaningfully engaged in research about them – both as a right and to realise the LNOB principle. The AYHP process has demonstrated that youth participation is possible through longstanding research partnerships. This should be a foundation on which to build and contextualise youth as key actors in research processes.

There is a need for more participatory research approaches, such as youth participatory action research, photo-voice, and digital modes, which can acknowledge and attempt to address the power imbalances that privilege researchers and adult perspectives and agendas. Being aware of their own positionality, researchers should play a role as mediators, facilitators, and partners, to address the research gaps and build the evidence base with adolescents and young people at the centre.

5.2 Praxis

In addition to recommendations for future research, this thesis has also generated recommendations for praxis i.e. translating the ideas into practice. There are limited global and national examples in relation to multi-sectoral, multi-level, intersectional and transformative gender equality in praxis and there is a need to build that evidence base andshare learnings.

Getting gender power relations on the agenda of adolescent and youth policy making

Policy makers and actors should prioritise transforming gender and intersectional inequalities on the national agenda; and policy windows should be maximised to frame gender as systems of power as these will inform programme design as well as who is focussed on as policy subjects.

As part of this there is a need to ensure capacitated gender champions and advocates who can work with policy actors in terms of the complexity of transforming gender power relations and sustaining gender equality. In so doing it would be critical to recognise the co-existence of a constellation of narratives as potentially complementary rather than in competition with one another.

It is recommended that various actors in government, youth representative structures and civil society who are working in gender and SOGIE are brought together to (re-)create spaces for discussion, activism, building alliances and findings way of operationalising gender transformative policy. Importantly, this will require partnerships with and amongst feminist actors and the amplification of more feminist approaches and agency of actors working in gender and adolescent health.

Leadership, governance and multi-sectoral alignment of policy and programming for health and wellbeing of adolescents

The health and wellbeing of adolescents and young people in their diversity will require

- strong leadership at multiple levels;
- collaborative governance frameworks to broker the relationships within government and across government and with civil society actors; and
- multi-sectoral alignment of policy and programming with a shared vision.

This requires the institutional contexts, enablers and capabilities to develop and implement policy and programmes in a coordinated way, and to address complex and 'wicked' problems such as gender inequality in order to advance gender and social justice. The time is now, to collectively use our power to spark, implement/amplify and sustain multi-sectoral adolescent-centred policy and programmes.

Working towards gender-transformative approaches and programming

Gender responsive service programming and service delivery is essential to ensure that the practical needs are met through gender-specific services and interventions to empower girls, boys and gender-diverse adolescents and young people.

Importantly, to ensure that strategic gender needs are also addressed, it is recommended that gender-transformative approaches and programming, which address gender inequality as a structural determinant, should be integrated into both responsive and preventative programming, to ensure a greater impact. This would include building on the growing body of evidence of gender-transformative approaches. This would be based on foregrounding gender power relations, including the re-conceptualisation of constructions of masculinities and femininities. Key programmes – such as comprehensive sexualities education and working with gender-based violence programmes that focus on gender power relations – should be taken to scale, with the necessary financial commitments and human capabilities to take the work forward.

Addressing the social and structural determinants of adolescent health

Addressing the meso- and macro-level social and structural determinants will contribute to transforming society to being more responsive to the rights and needs of adolescents and young people and, in so doing, will contribute to their health. This would include, e.g., addressing poverty and youth unemployment, the provision of quality education, improved alignment and implementation of laws and policies with and across departments. In order to disrupt and transform the power relations that create ill-health amongst adolescents and young people, public health and rights-based approaches should be combined at micro, meso

and macro levels of systems to ensure that the root causes are addressed – i.e. the social and structural determinants and not just the 'symptoms'.

Meaningful engagement with adolescents in their diversity and strengthening active youth

As part of building youth citizenship and leadership, health policy makers need to meaningfully engage youth in their diversity and in representative and accountable ways, in all stages and spaces of the policy-making process.

Importantly, there is a need to strengthen and activate citizenry where adolescents can advocate for themselves and create and mobilise networks and organisations that raise critical issues and hold government and other actors to account. While this can be a challenge in contexts like South Africa – where there are multiple and compounding inequalities at play, often with limited time for policy processes – this should be essential within policy processes. To bridge the gap between rhetoric and the lived realities of young people, policy actors need to reimagine principles and ways of working, to ensure that enabling contexts, capabilities, resources, actors, and processes are in place.

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APPENDICES

APPENDIX 1: POLICY REVIEW DATA EXTRACTION TOOL

Name of Document:

Date of Document:

Authors:

Key departments and /or institutions leading development and implementation:

DATA EXTRACTION GUIDELINES

- Each policy document will be first read from start to finish to understand the overall content.
- Pilot the extraction terms to ensure that key dimensions relevant to the PhD are captured.
- Depending on the focus of the policy document, some of the search terms will not be discriminatory enough. For example, it may not be useful to search for adolescents in the Adolescent Youth Health Policy given that the policy focuses on adolescents. A separate set of synthesis questions will be used in such instances to capture, for example, how adolescents as a group are framed in these policy documents.
- Search policy documents using the following finalised key terms and insert as per the tables below.
- Extracted data will be imported into an Excel spreadsheet for further analysis.

POLICY CONTENT

- Target population: Adolescent, teen, youth, young
- Gender as a social identity: Gender, male, female, boy, girl, man, woman, gender non-conforming/binary
- Other forms of social inequality: class, race, disability, rural/urban
- Health and wellbeing status, including mental health, violence, HIV, sexual, reproductive
- Interventions or programmes addressing health and wellbeing of adolescents
- Multi-sectoral/other sectors: education, justice, social development, sports & recreation.
- Other policy content.

POLICY CONTEXT AND PROCESSES

- Theories and concepts on gender as social process, gender mainstreaming, gender equality, gender equity, intersectionality, power, vulnerability, agency, feminism
- Global, national, sub-national contexts
- Historical and political contexts
- Policy processes and mechanisms
- Actors
- Other contexts and processes

1. Extract data as per the tables below, inserting text and noting section in document as well as page number.
2. Based on the data extracted and the reading of the document, develop a summary of the document following a series of synthesis questions responding to the analytical focus of the PhD research.

A: POLICY CONTENT

Adolescents: Keywords: adolescent, teen, young, youth

Adolescent

Data extraction	Page	Notes

Teen

Data extraction	Page	Notes

Young

Data extraction	Page	Notes

Youth

Data extraction	Page	Notes

Gender as a social identity: Keywords: gender, male, female, boy, girl, man, woman, gender non-conforming/binary

Gender

Data extraction	Page	Notes

Male

Data extraction	Page	Notes

Female

Data extraction	Page	Notes

Boy

Data extraction	Page	Notes

Girl

Data extraction	Page	Notes

Man

Data extraction	Page	Notes

Woman

Data extraction	Page	Notes

Gender non-conforming/binary

Data extraction	Page	Notes

Other forms of social inequality: class, race, disability, rural/urban

Race

Data extraction	Page	Notes

Class

Data extraction	Page	Notes

Disability

Data extraction	Page	Notes

Rural/urban

Data extraction	Page	Notes

Health: keywords: health, well-being, mental health, violence, HIV, sexual, reproductive

Health

Data extraction	Page	Notes

Wellbeing

Data extraction	Page	Notes

Mental health

Data extraction	Page	Notes

Violence

Data extraction	Page	Notes

HIV

Data extraction	Page	Notes

Sexual

Data extraction	Page	Notes

Reproductive

Data extraction	Page	Notes

Interventions or programmes addressing health and wellbeing of adolescents

Data extraction	Page	Notes

Multi-sectoral / other sectors: education, justice, social development, sports & recreation

Data extraction	Page	Notes

B: POLICY CONTEXT AND PROCESSES

Theories and concepts on gender as social process, gender mainstreaming, gender equality, gender equity, intersectionality, power, vulnerability, agency, feminism

Data extraction	Page	Notes

Global, national, sub-national contexts

Data extraction	Page	Notes

Historical and political context

Data extraction	Page	Notes

Policy processes and mechanisms

Data extraction	Page	Notes

Actors

Data extraction	Page	Notes

APPENDIX 2: INTERVIEW GUIDE

PhD Interview guide for semi-structured interviews with AYHP actors, adolescent health policy actors and She Conquers Campaign actors

Standard Information

Name	
Position	
Organisation	
Date of interview	
Place	
Mode	Face to face/ Skype/telephonic
Duration and name of file	
Consent form signed	yes/ no
Permission to audio record	yes/no
Notes	

- AYHP actors: Section 1 and 2A & Section 4
- Other adolescent health policy actors: Section 1 and 2B & Section 4
- She Conquers actors: Section 1 and Section 3 & Section 4

*Note that the number of questions will be adjusted according to who will be interviewed i.e. AYHP and/or She Conquers actors.

Section 1: Introduction

1. Profile

- Describe your work in terms of your roles, responsibilities and organisational location.
- Experience of working in adolescent health policy and programmes within government and/or civil society.
- Experience of working in the fields of HIV/AIDS, SRHR and gender, with specific experience of working adolescents.
- Describe policy content area and what parts of the AYHP in terms of phases or stages have you have been involved in. E.g. formulation, implementation, review etc. (if not AYHP go to Section 2B)

Section 2A: AYHP

2. AYHP policy process in South Africa

a) Content

- Describe overall aim and purpose of the AYHP.
- Describe key features/elements of the AYHP in terms of content.
- Evidence: what was considered, include or excluded and why?
- How does gender feature in the policy? Who, what and how?
- Other elements of gender not included? Why?
- How does multi-sectoral action feature in the policy? Who, what and how? / Does current policies focus on adolescents within health as well as outside health sector?
- How is intersectionality addressed?
- How do existing policies address, maintain or create inequities between different groups?
- How does engagement with adolescents' feature?
- Linkages with the She Conquers Campaign
- Linkages with other AH policies
- Linkages with other policies/laws

b) Process

- What started or triggered the process?
- Process of developing AYHP? Can you describe it? Overall process of Adolescent and Youth Health Policy (AYHP)?
- Nature of policy spaces for participation
- Levels of participation
- Management of policy process
- How are/ were different views, debates/discourses and understandings managed ? Who managed the process? / How are different policy debates/discourses in terms of gender and adolescents/adolescent health in South Africa managed?

c) Actors

- Who are/were the actors/stakeholders, voices and champions? Who is/was left out?
- Describe relationship between actors/stakeholders/policy communities.
- What are/were the hierarchies involved? Were there tensions between actors? Differences of opinion? How are/were they resolved?
- Nature of power relations amongst the actors/stakeholders (What kind/s of power)
- Who has responded to the AYHP post the release – how and why?

d) Context

- What are the key contextual factors relevant to the AYHP? Why are they relevant? How were they considered in content and process?
- Describe key contextual elements of the AYHP in terms of:

    - Global policy alignment e.g. SDGs
    - National policy alignment e.g. policy and legal framework

Section 2B: Other adolescent health policy

3. Other adolescent health policy processes in South Africa

- Experience of working in adolescent health policy and programmes within government and/or civil society, other than AYHP. Based on that policy/policies discuss:

a) Content

- Describe overall aim and purpose of the adolescent health policy you were involved in.
- Describe key features/elements of the adolescent health policy in terms of content.
- Evidence: what was considered, include or excluded and why?
- How does gender feature in the policy? Who, what and how?
- Other elements of gender not included? Why?
- How does multi-sectoral action feature in the policy? Who, what and how? / Does current policies focus on adolescents within health as well as outside health sector?
- How is intersectionality addressed?
- How do existing policies address, maintain or create inequities between different groups?
- How does engagement with adolescents' feature?
- Linkages with the She Conquers Campaign.
- Linkages with AYHP and other adolescent policies.
- Linkages with other policies/laws.

b) Process

- What started or triggered the process?
- Process of developing adolescent health policy? Can you describe it? Overall process of developing the adolescent and youth health policy that you were involved in.
- Nature of policy spaces for participation.
- Levels of participation.

- Management of policy process.
- How are/ were different views, debates/discourses and understandings managed? Who managed the process? / How are different policy debates/discourses in terms of gender and adolescents/adolescent health in South Africa managed?

c) Actors

- Who are/were the actors/stakeholders, voices and champions? Who is/was left out?
- Describe relationship between actors/stakeholders/policy communities.
- What are/were the hierarchies involved? Were there tensions between actors? Differences of opinion? How are/were they resolved?
- Nature of power relations amongst the actors/stakeholders. (What kind/s of power?)
- Who has responded to the AYHP post the release – how and why?

d) Context

- What are the key contextual factors relevant to the adolescent and youth health policy? Why are/were they relevant? How were they considered in content and process?
- Describe key contextual elements of the AYHP in terms of:
    - Global policy alignment e.g. SDGs
    - National policy alignment e.g. policy and legal framework

- Do current policies focus on adolescents within health as well as outside health sector
- How do existing policies address, maintain or create inequities between different groups?
- Linkages with other AYHP policies.
- Linkages with other AH policies.
- Linkages with other policies.
- Linkages with the She Conquers Campaign.

Section 3: She Conquers

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4. She Conquers Campaign

- Overall aim and purpose of the She Conquers Campaign.
- How and why the She Conquers Campaign was developed.
- Linkages in the process of adolescent health policy context e.g. AYHP, NSP etc.
- Involvement in the She Conquers campaign in for example:
    - Steering Committee
    - Technical Committee
    - Package of services
    - Other

a) Content

- Describe key features in terms of content of the She Conquers Campaign.
- Package of interventions.
- How does gender feature in the She Conquers Campaign? Who, what and how?
- Other elements of gender not included? Why?
- How does multi-sectoral action feature in the Campaign? Who, what and how?
- How is intersectionality addressed?
- How does engagement with adolescents feature?

b) Process

- What started or triggered the She Conquers Campaign?
- Process of developing the She Conquers Campaign? Can you describe it?
- Nature of spaces for participation.
- Levels of participation.
- Management of policy process.
- How is She Conquers Campaign process managed in terms of different views, debates/discourses and understandings? Who managed the process?

c) Actors

- Who are actors, stakeholders voices and champions? Who is left out?
- Describe relationships between actors and stakeholders.
- What are/were the hierarchies involved? Were there tensions between actors? Differences of opinion? How are/were they resolved?
- Power relations amongst the actors/stakeholders/ Nature of power relations amongst the actors/stakeholders.

d) Context

- What are the key contextual factors relevant to the She Conquers Campaign the? Why are they relevant?
- Describe key contextual elements of the She Conquers Campaign in terms of:
    - Global policy alignment e.g. SDGs
    - National policy alignment e.g. policy and legal framework
- Linkages with the AYHP process.
- Linkages with other AH policies and programmes.

Section 4: Gender integration - Additional questions

- What are the gender policy narratives and how are they shaped by national and global factors?
- In your view, how does gender influence policy processes in terms of how context, content and actors shape the policy process?
- What are the opportunities and challenges related to integrating gender in policy processes?
- How can we strengthen capacity for gender analysis and integration in the health system?
- What have we learned about how gender influences policy processes and programmes?
- What have been the barriers and challenges to gender mainstreaming over the past 25 years in South Africa?

- What do we need to think about and do to ensure that gender is addressed at all levels of the health system?
- What are the implications for health policy and programmes development and implementation in terms of AH?

Section 5: Summary reflections and conclusions

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5. Reflections and suggestions for the future

- Are there any further reflections on what you have shared with me about adolescent health policy and social and political context affecting adolescents?
- Describe any suggestions going forward in terms improving adolescent health in South Africa? What is there left to do?
- How does this include /influence how gender is addressed and why?
- Discuss enablers and blockers for greater consideration of gender
    - What can be done to ensure greater inclusion of gender going forward in terms of content, process and outcomes of the national policy, such as adolescent health policy?

6. Conclusion and recommendations

- In conclusion, do you have any further thoughts or recommendations?
- Do you have any questions?
- Is there anyone else you would you recommend I interview or talk to?

Thank you very much for your time and insights

Notes

APPENDIX 3: PARTICIPANT INFORMATION SHEET AND CONSENT FORM

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

INFORMATION SHEET

Project Title: Power, people and processes: a gender analysis of adolescent health policy in South Africa

What is this study about?

This is a research project being conducted by Tanya Jacobs at the University of the Western Cape. We are inviting you to participate in this research project because you are a key stakeholder working in adolescent health in South Africa. The purpose of this research project is to analyse how gender is framed in adolescent health policy as well as the She Conquers Campaign, in order to inform adolescent health policy and programmes going forward. This information sheet will tell you a few things about the study. If there are any words that you don't understand as you read it, please let me know so that I can explain. You may ask questions at any time. If you wish to take part in the study, you will be asked to sign the consent form.

What will I be asked to do if I agree to participate?

If you agree to participate, you will be approached for an interview where you will be asked questions regarding your understanding of how gender is framed adolescent in health policy and the She Conquers Campaign in South Africa in terms of the content, context and actors and processes shaping its development. A summary of the questions that you will be asked is attached to this form. The interviews will last for about an hour and will be conducted in a location that is convenient for you.

Would my participation in this study be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution at all times. Should you agree, this study will involve the use of audio recordings during the interviews to assist in capturing all the information correctly. To ensure your anonymity, a code will be used instead of your name on interviews and audio files. Only the researchers will have access to the identification key for the codes. All interview transcripts will be kept in a secured storage area and password-protected computer files. Your contributions obtained from the interviews will be kept confidential so no-one will know how you responded to the questions. If we write a report or article about this research project, your identity will be protected.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. You may also choose not to have the interview audio-taped. If you feel uncomfortable discussing topics or answering any questions you do not have to answer them and don't have to explain why. You may stop at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized.

What are the risks of this research?

There may be some risks from participating in this research study as all human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the responses you provide will help inform our understanding of gender in adolescent health policy. This will benefit other policy processes intending to include gender as a means to reduce health inequalities.

What if I have questions?

This research is being conducted by **Tanya Jacobs** from the School of Public Health at the University of the Western Cape. If you have any questions about the research study itself, please contact Tanya Jacobs at: +270828907022 or by email at tanyaj@iafrica.com. Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Prof Uta Lehmann

School of Public Health

Head of Department

University of the Western Cape

Private Bag X17

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Prof Anthea Rhoda

Dean of the Faculty of Community and Health Sciences

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BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office

University of the Western Cape

Private Bag X17

Bellville 7535

research-ethics@uwc.ac.za

Tel: +27 21 959 2988

This research has been approved by the University of the Western Cape's Research Ethics Committee. (REFERENCE NUMBER: *BM 18/9/9*)

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809, Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

CONSENT FORM

Title of Research Project: Power, people and processes: a gender analysis of adolescent health policy in South Africa

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits

□ I agree to be audiotaped during my participation in this study

□ I do not agree to be audiotaped during my participation in this study

PARTICIPANT'S NAME……..

PARTICIPANT'S SIGNATURE…….

DATE……

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office

New Arts Building,

C-Block, Top Floor, Room 28

University of the Western Cape

Private Bag X17

Bellville 7535

APPENDIX 4: ETHICS APPROVAL LETTER

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

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13 March 2020

Ms T Jacobs
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM18/9/9

Project Title: Power, people and processes A gender analysis of adolescents' health policy in South Africa.

Approval Period: 14 February 2020 – 14 February 2023

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The permission letter to conduct the research must be submitted to BMREC for recordkeeping purposes.

Please remember to submit a progress report by 30 November for the duration of the project.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

NHREC REGISTRATION NUMBER -130416-050

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

APPENDIX 5: PUBLISHED ARTICLE: CHAPTER 4

Jacobs and George *Globalization and Health* (2021) 17:35
https://doi.org/10.1186/s12992-021-00679-3

Globalization and Health

REVIEW Open Access

Democratic South Africa at 25 – a conceptual framework and narrative review of the social and structural determinants of adolescent health

Tanya Jacobs* and Asha George

Abstract

Twenty-five years into South Africa's constitutional democracy provides an opportunity to take stock of the social and structural determinants of adolescent health. Those born in democratic South Africa, commonly known as the 'Born Frees', are perceived to be able to realise equal rights and opportunities, yet many factors constrain their lives. In bringing together approaches to understanding context in health policy and systems research and the social determinants of health, the paper develops a conceptual framework to guide the narrative review examining the key contextual social and structural determinants of adolescent health in South Africa. Illustrative examples drawing from 65 papers from public health and the social sciences describe and link these determinants across micro, meso and macro levels of society, their global determinants, and their intersections with compounding axes of power and inequality.

At a micro level individual adolescent sexual and gender identities are expressed through multiple and evolving forms, while they experience growing autonomy and agency, they do so within a broader context characterised by regressive social norms, gender inequality and other intersecting power relationships. At the meso level, organisational and sectoral determinants shape adolescents health and rights, both in being supportive, but they also replicate the biases and inequalities that characterise South African society. In addition, the macro level national and global determinants, such as the structural colonial and apartheid legacies, shape adolescents' health. Despite constitutional and other legislative rights, these determinants and compound economic, geographic, gender and other intersecting inequalities.

A key finding is that current experiences and health of adolescents is shaped by past social and structural determinants and power relations, with apartheid inequalities still echoing in the lives of the adolescents, 25 years into democracy. More research and work is needed to provide insights into determinants of adolescent health beyond just the micro level, but also at the interrelated and dynamic meso and macro levels, nested in global determinants. The findings raise critical considerations and implications for understanding the social and structural determinants in the South African context and what this means for adolescent health in the SDG era.

Keywords: Social and structural determinants, Adolescent health, Gender, Intersectionality, South Africa, Micro, Meso, Macro

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APPENDIX 6: REVIEWERS' COMMENTS AND AUTHORS' RESPONSES: CHAPTER 4

"Democratic South Africa at 25 – a conceptual framework and narrative review of the social and structural determinants of adolescent health"

	Comments to the Author	Response from authors
	REVIEWER #1	
1	This study does not provide effective data to support your point of view, for example, in the macro perspective, during the Cold War, South Africa used to be one of the developed countries. It was the "sixth largest economy in the world" after the five largest countries. In 1994, Nelson Mandela was elected as the first black President of South Africa. He abolished apartheid and expelled whites mainly by "black people". After free trade, South Africa's economy continued to decline and the social macro environment changed greatly, the author can take Mandela as the node to study the impact of social macro changes on adolescent health.	Thank you for your comments. We fully acknowledge the role of apartheid in shaping the South African context and that the historical social and structural determinants still shape the society, including the lives of adolescents. The paper maps out the macro level determinants including structural and institutional factors, colonial and apartheid legacies, and despite the constitutional and other legislation rights, intersecting and compounding economic, geographic and gender inequalities are perpetuated in democratic South Africa. See lines 409-570. As further noted in the manuscript there is a paucity of conceptual frameworks as well as empirical research that locates adolescent health within macro level determinants and therefore we encourage more work in this area, particularly given COVID-19 realities.
2	This study only presents an overview of the factors that influence adolescent health problems, describing how these factors affect health in different studies. The review lacks evaluation of previous studies and offers no new insights.	Thank you for your comments. The purpose of this paper is to present a conceptual framework that includes social and structural determinants of adolescent health. The narrative review uses the framework to present illustrative examples at micro, meso and macro levels, as well as cross -cutting and intersecting determinants. The purpose of the review was therefore not to evaluate previous studies by assessing study design or quality to assess the nature of the evidence base.

	Comments to the Author	Response from authors
	REVIEWER #2	
3	This is a very well-developed paper that represents a contribution to this journal. The review of the literature fits well with the conceptual framework, which is well laid out. Aside for a few grammatical glitches that can be easily identified and remedied, my only recommendation is that the three levels of analysis (micro, meso, and macro), which are highlighted in boldface, should be better constructed since they are key to what follows in each respective section. In particular, the use of "e.g. and "etc." should be eliminated, since this suggest that the reader should figure out what else might be included. This is easy in something like "the cars were red, blue, green, etc." but not in this case. Perhaps bullets would be useful here	Thank you for the feedback and the recommendations have been incorporated into the revised draft of the manuscript. For the revised structure and description of micro, meso and macro levels of analysis see the introduction to each of the following levels of analysis: Micro: lines 177-182 Meso: lines 277-297 Macro: lines 409-416
	REVIEWER #3	
4	This is an interesting paper. I recommend tidying up the writing--there are times where the writing was repetitive and sentences could be better structured. I left comments toward the beginning of the paper.	Thank you for your feedback and the suggested edits and comments submitted have been incorporated in the revised draft of the manuscript. See lines 16-129 based on the comments, as well edits to remainder of the manuscript.

APPENDIX 7: PUBLISHED ARTICLE: CHAPTER 5

Health Policy and Planning, **00**, 2021, 1–11
DOI: 10.1093/heapol/czab041
Original Article

Policy foundations for transformation: a gender analysis of adolescent health policy documents in South Africa

Tanya Jacobs*, Asha George and Michelle De Jong

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Accepted on 23 March 2021

Abstract

The Sustainable Development Goals (SDGs) and the United Nations Global Strategy (2016–30) emphasize that all women, children and adolescents 'survive, thrive and transform'. A key element of this global policy framework is that gender equality is a stand-alone goal as well as a cross-cutting priority. Gender inequality and intersecting social and structural determinants shape health systems, including the content of policy documents, with implications for implementation. This article applies a gender lens to policy documents by national government bodies that have mandates on adolescent health in South Africa. Data were 15 policy documents, authored between 2003 and 2018, by multiple actors. The content analysis was guided by key lines of enquiry, and policy documents were classified along the continuum of gender blind to gender transformative. Only three policy documents defined gender, and if gender was addressed, it was mostly in gender-sensitive ways, at times gender specific, but rarely gender transformative. Building on this, a critical discourse analysis identified what is problematized and what is left unproblematized by actors, identifying the key interrelated dominant and marginalized discourses, as well as the 'silences' embedded in policy documents. The discourse analysis revealed that dominant and marginalized discourses reflect how gender is conceptualized as fixed, categorical identities, vs as fluid social processes, with implications for how rights and risks are understood. The discourses substantiate an over-riding focus on adolescent girls, outside of the context of power relations, with minimal attention to boys in terms of their own health or through a gender lens, as well as little consideration of LGBTIQ+ adolescents beyond HIV. Dynamic and complex relationships exist between the South Africa context, actors, content and processes, in shaping both how gender is problematized and how 'solutions' are represented in these policies. How gender is conceptualized matters, both for policy analysis and for praxis, and policy documents can be part of foundations for transforming gender and intersecting power relations.

Keywords: Gender analysis, gender, adolescent health, policy analysis, critical discourse analysis, intersectionality

Introduction

The Sustainable Development Goals (SDGs) adopted by the United Nations (United Nations General Assembly, 2015) are aligned with the United Nations Secretary General's Global Strategy (2016–30). Both call for all women, children and adolescents to 'survive, thrive and transform' as a priority for global health. This goes beyond ensuring that women and children 'survive' against threats to mortality addressed by healthcare interventions and represents a broader vision of health and well-being, i.e. 'thrive,' while also addressing development more holistically, i.e. 'transform'. Within this reconceptualization, gender equality is both a stand-alone goal and a cross-cutting concern, and adolescents are a key priority.

In South Africa, social transformation inclusive of gender equality and adolescent rights is also a national priority for government and civil society (South African National AIDS Council, 2017; Toska *et al.*, 2019). However, despite the Constitution of the Republic of South Africa of 1996 being grounded in equality, significant challenges and intersecting inequalities remain post-apartheid. For example, gender inequality contributes to the extremely high prevalence of gender-based violence and HIV incidence in adolescent girls and young women in particular (Government of South Africa, 2020; Nduna, 2020).

Gender as a social construct is fluid and relational and refers to the roles, attributes, norms and behaviours considered to be appropriate for girls/women, boys/men and other genders (World Health Organization, 2020; Springer *et al.*, 2012; Connell, 2012). Gender inequality also intersects with various other axes of inequality in terms of race, class, sexual orientation and (dis)ability, thus compounding power dynamics and stratification (Hankivsky, 2014; Larson *et al.*, 2016; Morgan *et al.*, 2016).

Some ways in which gender inequalities are generated or contested include how health policy is shaped by gender, in both its content and its processes (Bacchi and Eveline, 2010; Lombardo *et al.*, 2017). The gendered power relationships and assumptions that are often embedded within the content of policy documents are not always immediately obvious or explicit. This is problematic because, unacknowledged, these kinds of assumptions in policy documents can function to reproduce the status quo and block the transformation of gender inequality.

APPENDIX 8: REVIEWERS' COMMENTS AND AUTHORS' RESPONSES: CHAPTER 5

"Policy foundations for transformation: A gender analysis of adolescent health policy documents in South Africa"

Revision 1

Comments to the Author	Response from authors
REVIEWER #1	
Line 8 – 9 of the introduction and line 11 – 12 of the abstract reads like an incomplete sentence……that women and girls not only survive, but thrive and transform under…….conditions. If SDGs 5 and the Global Strategy 2016 – 2030 are the guiding documents from which the authors are framing the paper, the introduction needs to further and clearly contextualize this, and also provide more background about the South African context on gender inequalities experienced by women and adolescents. Line 6 – 10 of the introduction starts to do this.	Thank you for the feedback and revised as per the comments. A sentence and references have been added to contextualize SDG 5 in South Africa in the Introduction. See lines 70-78.
The two sentences in line 31 – 35 of the introduction "gender dynamics of power relationships……are not clear, please revise. Yes, gender is a social construct, but the argument about social construction of gender in policy content and process needs to be unpacked to help the reader to understand and to set the scene for the paper. • The introductions paper needs some editing …… for example line 6- 7, page 2 of the introduction, the sentence is missing some words!	Thank you for your feedback and the manuscript is revised to make it clearer to the reader in the Introduction see lines 87-91.

Comments to the Author	Response from authors
Methods • Please provide details on who did the analysis of the policy documents, was it conducted by one person, 2 or 3 independent reviewers? and how was agreement reached between the reviewers who conducted the analysis? What happened when the reviewers could not agree, how was consensus reached? • Did you exclude and policy documents, and was the exclusion criteria?	Further details in terms of the analytical process and which authors did the analysis and review was added to the Methodology section see particularly lines 316- 320. As noted in the methodology, the data focused on policy documents by national government departments who have the mandate and technical responsibility for policy development. Criteria for inclusion included policies that are primarily focused on adolescent health, however we acknowledge that other policies could have an impact on adolescent health, but are beyond the scope of this paper. The scope did not include all policies that could have an impact on adolescent health, for example in sectors such as water and sanitation, agriculture, transport, sports and recreation. In addition, we also acknowledge, but place beyond the current scope of the analysis, policy documents by non-governmental stakeholders; legislation developed by parliament and courts; levels of government that are not national, such as provinces and districts, and global health policies related to adolescent health.
Results and Discussion • The results section is well written and comprehensive, it goes in-depth in the analysis of the policy documents under review	Thank you for your feedback, greatly appreciated.
I agree that violence in South Africa is gendered, shaped by intersecting and compounding social and structural determinants, but do not agree that race is an important driver that shapes gender-based violence in South Africa. This needs to be further unpacked and explained	The feedback is appreciated and the manuscript is further revised to provide more detailed explanation, See lines 499-501.

Comments to the Author	Response from authors
Gender-transformative strategies/interventions proposed in this paper also needs to make recommendations to address the underlying social and cultural norms that shapes and fuels unequal power relations as some of the societal level determinants to transform gender inequality	The recommendation is well noted and additional reference to cultural and social norms is included. See lines 630-634.
CSE should be written in full in the discussion	Completed. See lines 593-594.
The discussion section is also well written, comprehensive and engages with existing literature. It clearly highlights the contribution of the paper in the broader literature. The following are some few points the authors need to consider in the review of the manuscript. The analysis of the policy documents mainly focused on the actors and the content of policies, and little engagement of the interwoven contribution on the process and context within which these policies are developed and implemented. In both the results and discussion section, the paper would benefit from an elaborate discussion of process and context which are also critical components of the health policy analysis framework. The paper does engage on the historical and contextual factors in South Africa that shapes gender inequalities in society, including patriarchy and other factors, however not much has been said about the policy context and processes which also shape and contribute to how policies and gender is conceptualized in the policy documents under review.	Thank you for your feedback and suggestion for inclusion in the review of the manuscript. Additional sentences describing the context and link between content and context has been added to both the Findings and Discussion section. See particularly lines 640-645. As noted in the manuscript the data for this paper are policy documents; providing an opportunity to conduct an in-depth critical discourse analysis of the content of these policy documents. A focus on actor perspectives as part policy processes is beyond the scope of this paper but is included in a forthcoming paper focusing on the dynamic interaction between actors, content, context and processes as part of health policy analyses frameworks.

Comments to the Author	Response from authors
REVIEWER #2	
Overall comments Thank you for the opportunity to review this paper. Its an interesting and important topic and glad the researchers sought to address it. However, the small sample of documents, the limited expansion to other sectors and unclear methods make it hard to interpret if the discussion is a true reflection of what is occurring in S. Africa and moreover if these documents are representative of the south African government as a whole. The paper needs strengthening in several areas that I provide detailed comments on later. …. While the discussion is extremely well written with a very different style from the rest of the paper, it is unclear whether the conclusions are fair given information from only 15 policy documents that are embedded in only one sector and only from National level.	Thank you for your comments and feedback and support for the topic. Based on the criteria for inclusion and scope of the paper noted above, we conducted an in-depth analysis of policy document for the previous 15 years i.e. ranging between 2003 and 2018. The analysis revealed significant complexity in terms of actors, foci as well as what is described in the content and discourse analyses. The purpose of the qualitative research was to provide an in-depth gender analysis of policy documents relevant to adolescent health not to provide empirical generalizations to other sectors but contributes on a methodological level and provides lessons relevant to other sectors and contexts by demonstrating and how to examine the ways in which gender influences policies and programmes. A sentence to this effect has been added to the Limitations and please see lines 753-757.
Overall however, the justification for the study is extremely confusing with lots of jargon, interwoven constructs and a loss of meaning. would be good to use the literature to support rather than cloak your argument. It is also unclear really what your guiding questions are for this research. Some of this appears on page 4 in the methods but would perhaps be better as you anchor the paper.	Thank you for the feedback. The justification for the study has been further revised to make it clearer for the reader to understand. In addition the purpose and guiding questions have been linked more directly. In revising the manuscript, we have sought to further unpack the jargon and simplify concepts when applicable.
The methods are rather weak and need a lot more detail for the reader to understand what exactly was done. If one would want to replicate the study the details would be suboptimal.	The methods section has been strengthened to add further detail for the reader to be able to understand what exactly was done and to possibly replicate certain elements of this type of analysis in a different context.

Comments to the Author	Response from authors
Would be helpful perhaps to have a proof reader review this as there are several grammatical errors and at times its hard to ensure that the reader genuinely understands intent.	Thank you, the services of a proofreader have been used in further revision of the entire manuscript as well as the referenced in the manuscript with all changes accepted.
IT would also be helpful to unpack whether you mean gender equality or equity?	The focus is on gender equality and not equity.
Examples of gender transformative policies? The underpinning changes to culture and social structures Policy interventions would need to be coupled with programmatic and socio-cultural interventions in order to be truly transformative. Can this occur on its own?	Thank you for your feedback and the issue has been addressed and the suggestion has been incorporated in the Discussion lines 640-644.
Abstract Line 32-33: This sentence is unclear. "There is a dynamic relationship between the content of policy documents and the South African context" There are too many i.e after this to explain it but unfortunately left me more confused	Thank you for your comments and the abstract has been revised to provide clarity. See the revised Abstract.
Intro It would be helpful to the reader if you split your introduction with subheadings that focus on the different aspects you speak about. Furthermore, more background on the focus on adolescents in South Africa is needed to better anchor the argument for this study. It would also be helpful to understand in the introduction why this study is helpful. The aims are unclear…the intro speaks more to the importance of the methods than the issues that requires this study.	The feedback is appreciated, and additional detail is added to the background to provide further contextual detail in which to anchor the study. The purpose of the paper is made more explicit in the introduction. See lines 155-159.
Page 2: Lne 6-10. This is a very long sentence and the meaning is lost. It appears that a word or to might be missing but its unclear what exactly the author is saying the UN is emphasizing.	Thank you for comments and revisions made accordingly. Please see lines 61-64.

Comments to the Author	Response from authors
Page 2 line 12: For the statement "adolescents are a key priority." it would be good to support this with a policy document or to that state this in the national guidelines or prioritisation process.	Thank you, the manuscript has been revised to include reference to specific policy documents as supporting information. See lines 70-76 for references
Page 2: Line 19: the citation needs to follow convention for referencing websites	Thank you, citation has been revised.
Page 3 line 13: Here the authors say government documents but later say only national health government documents. Would be good to keep consistent and clear.	The feedback is appreciated, and the manuscript has been edited to ensure consistency.
Methods Page 3: Line 21: isn't sexual orientation embedded within gender inequality if you are looking at a wider interpretation of gender?	We followed an inclusive approach to understanding gender, one that acknowledges conceptual understandings of gender, both in terms of gender identity and sexual orientation and expression (SOGIE) as well as gender as related to gender power relations and gender inequality as a social and structural determinant
Line 29-31…there is a lot of jargon in this sentence but the meaning is unclear. What are you hoping to say and impress upon the reader?	Thank you for your feedback and further detail is added to make it clearer to the reader.
Line 31 to 34: same comments as above. There is a mixing of ideas and it leads to confusion. Needs simplification (eg connections between the complex relationships between…)	Thank you for the feedback and the sentence is simplified. .
Line 44-46: were these terms used independently or in combination using Booleans? If in combination, what were these combinations?	The following search terms were used in various combinations and included a youth, young, adolescent, health, gender, multi-sectoral, school health, sexual and reproductive health, mental health, policy, policy development. The Boolean phrases were therefore not applied.

Comments to the Author	Response from authors
Line 48-54: what was the rationale for a) focusing only on national policies b) excluding national policies from other sectors?	Thank you for the feedback and similar feedback is provided in response to reviewer #1. Please see the revised Methodology. The rationale for focusing on policies from national government departments is that these departments have the mandate and technical responsibility to develop policy documents. In addition, discourse analysis is concerned with the construction of ideas and language in texts and the data set of 15 policies provided the necessary data for the kind of analysis we were conducting.
Line 57: what was this coding structure?	Policy documents were uploaded into ATLAS.ti and for the analysis, a coding framework and code list was developed using an initial broad coding structure derived from propositions in the research. The coding structure included for and this information has been is added to the Methodology See lines 248-281.
Line 58: Integrative data analysis (IDA), if I'm not mistaken, is the analysis of multiple data sets that have been pooled into one. This doesn't seem to appear to be how you analysed your data based on your description which appears to have employed deductive and inductive coding to guide your subsequent analysis. Could you provide more information perhaps?	Thank you for your feedback and the manuscript has been revised to more accurately reflect the use of both deductive as well as inductive coding to guide the analysis. See Methodology lines 248-281.
Page 4 line 7: probably better to put your guiding questions in the introduction where you talk about the aim of the research or paper.	The suggestion has been incorporated in the revised manuscript and the purpose and key lines of enquiry are more clearly linked.
Line 38: need a citation for the WPR approach which is new to me as a reader. Would have liked to learn ore through the paper as well as citations of other scholars who have used the approach.	Further citations for the WPR approach have been added in the methodology as well as in the Discussion with reference to other scholars who have used this approach see lines 724-727.

Comments to the Author	Response from authors
Results page 8: While there are valid concerns the authors have about recognition of many angles from which to appreciate the complexities of gender equity, I am confused about what the boundaries around expectations of a policy document are here. There appear to be many criticisms of the policy documents (such as inadequate discussion of the intersect of race and class) that while undoubtedly are important, may be relevant to documents and deliberations that lead up to a final policy document. It may be that the policy documents are influenced by many considerations but the amount that is included in the actual policy document may be limited by space and scope as it often the case. I would be curious to know whether the authors sought to analyse the deliberations of the technical working groups (or equivalent) that led to the final policy documents. And if so, to reflect on these. And if not, how that affects the interpretation of these policy documents.	Thank you for these comments and it is an area that the authors have discussed and considered noting the point you have raised. While it may not be reasonable to expect in depth, detailed gendered analyses within the policy documents themselves, an acknowledgement of power, context and the relationships between different issues affecting adolescent health is crucial if these important factors are to be integrated into programming. Further there should be caution around the way policy documents simplify certain issues for the sake of brevity is also important in order not to erase some of the complexities necessary to acknowledge if these issues are to be effectively and comprehensively addressed. Sentences reflecting these considerations in terms of what the expectations and boundaries or limits of policy documents have been added to the discussion. See lines 702-710. As noted in the limitations section, data for this paper focusses on policy documents and does not include an analysis of actor perspectives and policy processes that were part of the development of the policy. This, however, is the focus of a forthcoming publication with a particular focus on actor narratives and description of policy processes.

Comments to the Author	Response from authors
The recognition of interventions focused on "symptoms" versus a root cause analysis is interesting. I would be curious to hear how S. Africa is addressing the more meso and macro level determinants outside of these policy documents. ie are adolescent South Africans only addressed through these policy documents or are there parallel initiatives in the country that either complement or contradict these policies? Who is filling the meso, macro gap? The recent COVID-19 pandemic has brough GBV to the full attention of the President with many initiatives underway to protect those who are subject to it. Updating this paper in light of the current context would be helpful.	The comments are well received, and further contextual details added in terms of meso and macro level initiatives that address adolescent health. COVID-19 has foregrounded and exacerbated the pre-existing and widespread scourge of problem of GBV in South Africa. Civil society activism and high-profile media cases have encouraged commitment by the President and government and other actors to address GBV. We also have a newly launched National Strategic Plan on GBV and Femicide (2020-2030) however a huge gap still remains between these commitments and the reality on the ground. Please see the paragraph focusing on implications for policy, programmes and systems lines 555-559 of the discussion. The revised manuscript includes updates reference to the current COVID-19 pandemic. See lines 670-676.
Discussion The discussion is very interesting and extremely well written. It repeats a lot of the findings however and would be better if the implications of the findings were discussed further. I did however really enjoy reading the greater context around some of this policies including the socio cultural nuances and histories. It therefore strengthens my request to better explain why this wider context was not a part of the consideration in the methods to look beyond national policies from the health sector only that relate to adolescents.	Thank you for the feedback on the discussion. Paragraphs 1 and 2 are a summary and the subsequent paragraphs highlight the implications for policy, programmes, systems, gender integration and research. The wider context was included in the discussion in terms of how it relates to the findings and because it is part of the discourse analytical approach which analyses the dialectical relationship between content and context. Further, it is important that these policies are analyzed and interrogated to identify inconsistencies and have lack of coherence, as this is vital to developing coordinated and comprehensive programmes across sectors and aligned to contextual realities. As per the request, further relevant details of the context are added to provide more in-depth explanation for the reader as part of the discussion, see lines 640-644.

Revision 2

	Comments to the Author	Response from authors
	REVIEWER #1	
1	Thank you for addressing all the relevant comments and sharing a much stronger paper. The paper needs a thorough review for grammatical and spelling errors that may have been introduced in the revision process. Apart from that, its a very interesting and relevant paper that has implications for how gender considerations could be better integrated into policy and practice. Thank you!	Thank you for your feedback and your contributions in making the paper stronger. The services of a proofreader have been used and the manuscript has been further reviewed for any additional spelling and grammatical errors.
	REVIEWER #2	
2	Thank you for the revised manuscript and the opportunity to review the current draft. The manuscript has greatly improved, however the following few points still need attention: • I understand that the authors said the paper on actors is yet to come, but a summary about actors as it relates to the questions raised by the reviewers still needs to be incorporated in this manuscript. A review of policy documents without a consideration of actor's influence both on the content, development and implementation process is a big gap in the analysis and the manuscript. The question about actors raised by both reviewer 1 and 2 on the manuscript needs to be addressed	Thank you for your comments and contributions towards improving the manuscript. In addition to what was included, our analysis on the role of actors in the policy making process has been strengthened and integrated throughout the manuscript. See lines: • 76-82 • 261-264 • 367-372 • 448-453 • 464-467 • 574-576 • 615-617
3	Line 14 in the introduction says the content analysis was guided by key lines of enquiry, what are these?	Thank you for your comment. The line you refer to is as part of the abstract, which notes that the content was guided by key lines of enquiry and these are described in detail in the methodology. See lines 154-164.

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Original Article

Between Rhetoric and Reality: Learnings From Youth Participation in the Adolescent and Youth Health Policy in South Africa

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Abstract

Background: Youth participation makes an essential contribution to the design of policies and with the appropriate structures, and processes, meaningful engagement leads to healthier, more just, and equal societies. There is a substantial gap between rhetoric and reality in terms of youth participation and there is scant research about this gap, both globally and in South Africa. In this paper we examine youth participation in the Adolescent and Youth Health Policy (AYHP) formulation process to further understand how youth can be included in health policy-making.

Methods: A conceptual framework adapted from the literature encompassing Place, Purpose, People, Process and Partnerships guided the case study analysis of the AYHP. Qualitative data was collected via 30 in-depth, semi-structured interviews with policy actors from 2019-2021.

Results: Youth participation in the AYHP was a 'first' and unique component for health policy in South Africa. It took place in a fragmented policy landscape with multiple actors, where past and present social and structural determinants, as well as contemporary bureaucratic and donor politics, still shape both the health and participation of young people. Youth participation was enabled by leadership from certain government actors and involvement of key academics with a foundation in long standing youth research participatory programmes. However, challenges related to when, how and which youth were involved remained. Youth participation was not consistent throughout the health policy formulation process. This is related to broader contextual challenges including the lack of a representative and active youth citizenry, siloed health programmes and policy processes, segmented donor priorities, and the lack of institutional capability for multi-sectoral engagement required for youth health.

Conclusion: Youth participation in the AYHP was a step toward including youth in the development of health policy but more needs to be done to bridge the gap between rhetoric and reality.

Keywords: Youth Participation, Health Policy, Policy Process, Actors, Youth, South Africa

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Background

The principle of 'Leave no one behind' is central to the 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs). Involving young people in all that is relevant to them is part of this global commitment to eradicate poverty in all its forms, end discrimination and exclusion, and reduce inequalities and vulnerabilities. Prior to the SDGs, youth participation was recognised as a right in global legal policy through the United Nations (UN) Convention on the Rights of the Child.[1] This right underscores the importance of the involvement of children (defined as up to 18 years) in decisions, that affect them, including their health. The Convention on the Rights of the Child is often applied as the legal and policy foundation to encourage and legitimise youth participation as a civil, political, economic and cultural right and is complemented by the African Youth Charter as a regional commitment[2] and other global policy frameworks such as, Beijing +25, and statements such as the Global Consensus Statement on Meaningful Adolescent & Youth Engagement.[3,4] In South Africa, the National Development Plan and the new National Youth Policy (2020-2030) are aligned to the Constitution and to global and national rights policies which articulate youth participation as right.

Participation is a right and it should be a priority to involve youth voices and policy beneficiaries as they can they make significant contributions and provide leadership in both programme and policy processes and meaningful engagement leads to healthier, more just, and equal societies.[3,5,6] In addition to rights based legal and policy framework of youth participation as a right, there is increasing acknowledgement of youth participation as important for development of policies and programmes, including health.[5,7,8] The meaningful engagement of young people in all aspects planning, implementing, monitoring and evaluating programmes and policies has multiple benefits for their own, and their communities' health and development.[9-11] From a health systems perspective, national policy frameworks need

Full list of authors' affiliations is available at the end of the article.

APPENDIX 10: REVIEWERS' COMMENTS AND AUTHORS' RESPONSES: CHAPTER 6

"Between rhetoric and reality: Learnings from youth participation in the adolescent and youth health policy in South Africa"

Revision 1

	Comment	Response
	REVIEWER 1	
	Major revisions	
1	***Background*** P.3. Line 31: "varied understandings and approaches related to young people" – clarify what this means (e.g., diverse definitions of adolescents/youth/young people? Strategies to integrate them in decision-making?)	Thank you for the question and further clarity has been added. See p.3 lines 31-33
2	Providing evidence that briefly describes and acknowledges the (relatively) recent democratization in South Africa would perhaps help to provide background knowledge/context for the reader (particularly as it relates to participatory governance and engaging the public and youth)	Thank you for the observation, further detail and a reference have been added to provide details about participatory governance in the relatively recent democratised South Africa. See p.4 lines 8-10
3	Methodology p.4-5 Lines 32-4 – Definitions/understandings of youth (broadly and within this paper) would be better situated in the background section. It would also be useful to define youth according to the African Youth Charter (e.g., 15-35 years), and to indicate how youth are defined in the South African Youth Policy (and which definition it aligns with)	Your contributions are appreciated, and the definitions have been moved to the background section. Additional definitions for youth have been added as per the suggestion. See p.4 lines 20-33

	Comment	Response
4	p.8 Coding/Theorizing – provide further detail on how the authors conducted thematic analysis. For example, Braun and Clark describe specific stages of thematic analysis. If these were employed, it would be useful to briefly describe the process of coding, generating themes, naming themes, and moving from concepts to "theories" of youth participation	Thank you for asking more about the process of coding as part of the thematic analysis. As mentioned in the methodology, data analysis was guided by the conceptual framework and the interview transcripts were analysed using thematic analysis, and included both deductive and inductive coding and categorisation. An additional sentence was added to explain the iterative process of coding and refining the conceptual framework. See p. 8 lines 21-24. Initial deductive codes were based on Cahil (2018) mentioned above and included Purpose, Place, Process, Positioning, Protection, Perspective and Power relations. Through the thematic analysis 2 codes were added inductively and included People and Partnerships and Conceptual framework was refined through this iterative process
5	p.4 Methodology – reorganizing and using subheadings within the methodology section would more clearly guide the reader on the components/elements of the study: i) methodology (case study design); ii) methods (document analysis and qualitative in-depth interviews); and iii) policy analysis of documents and thematic analysis. Further justification on "why" qualitative methods was a useful approach to address the research questions would also strengthen this section. It is not clearly communicated whether document analysis was employed as a result method (e.g., described in background p.4, line 5 as "reviewing adolescent health policies")	Thank you for you feedback and subheadings have been added to make it clearer for the reader. See the Methodology section. In addition, a sentence has been added to justify the use of qualitative methods to address the research question. See p.7 lines 6-8. Data for this study included qualitative interview data and this was triangulated with the AYHP policy document. See number 9 for details of the referenced publication which formed part of the PhD as a whole.
6	p.6 Policy Triangle Framework – clarify how/where this framework was applied (e.g., used to analyze specific policy documents, inform interview guides, analysis of qualitative data, etc.)?	Thank you, the question has been responded to. See p. 6 line 13.

	Comment	Response
7	p.7 Participants – Please provide a breakdown of the number of each "type" of participant. It would be useful to know how many of each type of stakeholder was consulted for this work. Perhaps this could be placed in a table and some of the description of different youth NGOs/groups engaged integrated in the table (rather than in text).	Your request is noted and a table has been added providing the categories and number of actors/stakeholders that were interviewed. See Table 1 p.8 lines 15. Also please note that the descriptive details of the actors is kept under the People section of the Results.
8	p. 8 Methods – given the nature of qualitative research, integrating positionality and discussing the researchers' position, power and privilege is necessary in the methods (in addition to the discussion). Please provide further detail on the research team/researcher and indicate who conducted various aspects of the study.	Thank you for emphasising this aspect of research and we have integrated some of our reflections on our positionality in both the methods and discussion sections. See p.8 lines 12-14 and p. 22 lines 27-28. In addition, we have also provided further detail on the roles of the authors. See the end of the manuscript.
9	Results Overall, the conceptual framework is very visually appealing and well applied throughout. - It is unclear what data is generated through interviews or based on policy/document analysis (which as outlined previously, needs to be clarified/specified as a method if this is the case). For example, under "place" the information on the policy context is not clearly described as coming from participants or from document analysis.	Thank you for your feedback on the conceptual framework. As specified in the methodology section data for this paper was collected via in depth qualitative interviews and triangulated across respondents as well as the AYHP policy document. We have clarified that while our reading of the AYHP guides our analysis, this is drawn from another paper of ours and is not a primary source of data for this paper. Jacobs, T., George, A. S., & De Jong, M. (2021). Policy foundations for transformation – a gender analysis of adolescent health policy documents in South Africa. *Health Policy and Planning*, 1–11. https://doi.org/10.1093/heapol/czab041

	Comment	Response
10	Connecting findings/results to participants' perspectives is more clearly needed. For example (p.9 line 16-27), the insightful discussion about legacies of colonialism, apartheid and other structural influences is important, yet unclear whether this originated from participants' perspectives (and if so – was this largely from youth? Decision-makers?). Supporting this idea with a quote would also be useful to ground interpretation.	Thank you for this feedback and the results are more clearly linked to participants perspectives across the manuscript. See p.10 lines 8-9 for example.
11	- p.11 lines 3-9 – I am interested to hear what the youth indicated was the overall purpose of the policy and their roles. This section is largely descriptive, and there is a need to move beyond to provide a more analytic interpretation (e.g., did youth feel that their voices and involvement were recognized?)	Thank you, we agree that we present a continuum of perspectives in this section and have added a sentence to clarifying youth perspectives. See p.11 lines 14-15 In the discussion section we further interpret the data and explain how youth participation in the beginning shaped the agenda and objectives but not throughout the policy process. As discussed this was one of the as one of the key challenges and that is one of the key learnings from the AYHP process.
12	p. 11 People i.e. actors – clarify how youth were engaged (e.g., did they attend a workshop and engage in consultation?) and provide further interpretation of young people's experiences/perspectives. Second, is it possible to provide a comment beyond describing the actors – how did these partners work together in practice? Were there obvious unequal power imbalances between different stakeholders (e.g., were youth perspectives given equal weight to donors or the NDoH)? This section also needs a quote or evidence as support.	Thank you, further details were added in terms of how exactly youth participated. See p. 12 lines 2-3 as well as Table 2. The issue of obvious unequal power relations between different stakeholders did not emerge a clear theme from the data. Some participants described it as a relatively democratic process and no obvious power relations, however it was evident that the NDOH had the final decision-making power.

	Comment	Response
13	p.12 Process section – this is a very broad and important section. Instead of organizing data into the "what worked well"/"challenges" sections, this analysis would benefit from integrating subheadings that reflect the themes within the data (e.g., supportive policy environment, structures/mechanisms for youth participation, power dynamics, etc.)	Thank you for the feedback. We initially had subheadings but think the section flows better as an integrated one. The themes a summarised in the first paragraph of both what worked well and what were the challenges. See p.12 lines 24-27 and p.16 lines 11-14
14	p. 16, lines 4-10 – this discussion on power relations would benefit from providing a supporting quote (preferably from a youth to illustrate the potential dynamics/inequities encountered). Describing further how power dynamics shaped youth participation (if relevant) in the policymaking process would significantly strengthen this section. If this was not a significant challenge to engagement, it would be worth noting why this was.	Thank you for focusing on this important topic. The AHYP was novel in terms of including youth voices, but there were limitations of how they were included, this is detailed in the paper. Youth perspectives of how and when they were included is detailed in the section on Process. See p.13-15. In this section we outline the following challenges to engagement, which are shaped by power: how to embrace diversity and differences, how to manage power relations, as well as competencies and contexts for youth engagement. See p.16 -17.
15	p.16 line 19 – does this not highlight issues of tokenistic engagement of youth?	Agree, thank you and that has been added. See p.15 line 28-29
16	p.17-18 lines 29-2 – this quote (while interesting/relevant) appears to contradict the earlier discussion by the authors describing the policy environment as enabling. It would be useful to provide a brief sentence that highlights this disconnect.	Thank you for noticing some of the tensions and disconnects in opinions of policy actors and further text highlighting this point has been added. See p.17. line 5-6
17	p.18, lines 9-13 – It would be useful to move past description here, what does the separate HIV youth structures mean? E.g., duplication of efforts? Inadequate coordination of youth-focused sectors/stakeholders?	Your feedback is appreciated, and further detail is added. See p.18 lines 22

	Comment	Response
18	p.19 lines 16-18 – this quote does not seem to fit here, as it indicates that they were able to work together successfully (but above its indicated that the HIV youth stakeholders still weren't involved and below that vertical programs/challenges remain), perhaps an alternative quote would better suit this concept.	Thank you for reviewing in such detail. The quote speaks to the reality that actors who were involved in the process found ways of developing the policy notwithstanding the process and contextual challenges. It also highlights the pragmatic element of policy making process and the tensions of more systematic and inclusive process, which would be ideal.
19	***Discussion*** p. 22 line 17 – has the adopted conceptual framework been applied by other empirical studies? This would represent both a novel contribution of this work that could be highlighted, but also an area of future inquiry (e.g., further application/testing of this approach in other contexts)	Thank you for making this observation and to our knowledge this is the first empirical study that has applied the Cahil framework and we have noted this. See p. 23 lines 9-10.
20	p. 23, line 32 – discuss further the positionality of researcher(s) (e.g., composition of the research team, responsibilities, and critical reflection of power/privilege) should be integrated here (and possibly methods as outlined above).	Thank you for highlighting the importance positionality researchers of HPSR. We have expanded on our original reflections on the positionality of the researcher. See p. 22 lines 27-28 and in the methodology section as noted above.
21	p.24 – unclear who the "youth from the participatory research programmes" refers to. Participatory research programs were described several times (e.g., methods), but this should be clarified (here and where previously mentioned).	Thank you for requesting specificity and the name of the participatory research programme is added i.e. Mzantsi Wakho. See p.23 line 31
22	p. 24 – guiding questions – it is unclear the audience for these "questions", is it aimed for youth? Policymakers? Please clarify.	Your observation is appreciated and further details as to the intended audience has been added. See p. 25 line 3-4
	Minor revisions	Thank you, all the minor revisions have been, incorporated.
	Abstract	
23	Line 10: "to further understand how youth participation" – perhaps this could be "how youth can be included in…"	

	Comment	Response
	Key messages	
24	Line 9 – remove second i.e.	Completed to make use of terms explicit, for example actors to be the people. See line 9 in Key messages.
25	Line 15 – "Reimagine paradigms" – this is quite broad/vague, please specify.	Replaced it with principles and ways of working. See line 15 in key messages
26	Line 25-26 – grammar/awkward phrasing "how to do youth participation in policy processes", perhaps this could be "how to ensure youth participation in policy processes"	Replaced with the following phrase to make it more explicit: the ***how*** of ensuring participation in policy processes. See lines 25-26
	Background	
27	P.3 Line 2: put "leave no one behind" in quotes (or perhaps italics depending on style)	Completed and replaced with 'Leave no one behind'. See p.3 line 2.
28	P.4 Line 2: spelling – "youth people"	Spelling corrected. See p.4 line 2
	Methodology	
28	p.4, Line 9 – Arnstein's ladder of participation is also an important (and one of the first) participation frameworks.	Thank you for this addition and Arnstein's ladder of participation has been added. See p.5 line 17
30	p.7 line 2 - Case Study Design – case studies often integrate multiple methods of data generation (e.g., document analysis, qualitative interviews, etc.), it would be useful to link your methodology to research methods employed.	Your feedback is appreciated, and the Case study design and research methods are linked. See p.7 line 3
31	p.8 line 27 - spelling mistake/missing word – "The is contextualised"	Thank you for pointing this out, the missing acronym is added: The AYHP is contextualised in a history. See p.9 line 4
32	p.8 line 33 – "critical gaps" – please clarify what the gaps identified were, as this seems important to the readers' understanding of the SA health policy landscape.	Further clarity as to some of the key gaps has been added to the manuscript. See p.9 lines 24-25.
33	p.9 line 27 – clarify/specify the shift in political leadership and when this transition occurred	Additional specificity has been added: "With a post-Mbeki shift in political leadership. See p.10 line 7
34	p.10 lines 6-9 – long, run on and difficult to follow sentence	The sentence has been divided into two sentences. See P.10 lines 13
35	p.11 lines 3-4 – sentence starting "importantly, there are various…" is difficult to follow. Recommend rewording this for clarity.	Thank you for the feedback and the sentence has been reworded for clarity: Importantly, there are various nuanced actor perspectives in terms of the overall purpose. See p.11. lines 16

	Comment	Response
36	Please also provide a description of what proportion of the population in South Africa is adolescent/youth, to help inform the reader and to reiterate the importance of youth participation.	Further details have been added. See p.3 lines 32-34
	Results	
37	p.12, line 25 – this appears like it should be part of the previous paragraph, rather than a new sentence/idea.	The sentence has been joined to the previous paragraph. See p.12 lines 34
38	p.14 lines 14-16 – repetitive, this has been described previously.	Thank you, even though this is relevant to both people and process sections, we have deleted.
39	p.15 lines 17-19 – disjointed sentence, perhaps this should be reworked. E.g., Key questions highlighting importance components of the planning, process and review of policymaking included:….	Thank you, the suggestions have been incorporated. See p.15 lines 16-18
40	p. 16, line 11 – spelling error/missing word: "the need to for consistent…"	Spelling error corrected. See p.16 line 8
41	p.16, line 32-33 – "organisational processes, leadership and capacities for youth engagement…" – can you expand on these ideas? What about them?	Additional details are provided. See p. 16 lines 32-34
42	p.18, line 5 – "sectoral contexts, actor interfaces" – unclear what these refer to (what sectors? what interfaces? Who are the actors?). Please clarify.	The sentence has been edited to provide further clarity. See p.17 lines 31-33
43	p.19, line 6 – "plethora of youth groups" are these autonomously/youth-led or youth-focused, it would be useful to specify here. Secondly, much of this information would be relevant/important to indicate in the "People"/actors section (e.g., the diversity of youth groups/organizations).	Thank you for the comment and edits have been made in on p.18 line 21-26 and in the People section, p.12 lines 23-25
44	p.19 lines 13-16 – this quote suggests a discussion on the underlying determinants of health (rather than the cross-sectoral nature of young people's health), perhaps this claim could also be highlighted here.	This point has been added, thank you. See p.18 lines 29.
45	p.22, lines 20-24 – awkward phrasing – perhaps you could indicate this includes "politics" vs "Politics	The suggested edits have been incorporated. See p.21 lines 20-24
46	p.23, line 10 – missing word "programmes IN the SDG era"	Missing word has been added. See p.22 line 6

	Comment	Response
47	p. 23, line 31 – two commas	Extra comma deleted. Thank you
	Conclusion	
48	p.25, line 6 – repetitive use of referencing youth engagement in AYHP as a "first" throughout the paper. Suggestion perhaps to vary terms, e.g., "novel", "innovative", or "alternative".	Thank you for the suggestion and the term "novel" has been used in the conclusion. See p.24 line 5
49	p. 25, line 9 – missing word: "how TO ensure"	Missing word has been added. See p.24 line 8

Revision 2

	Comment	Response
	REVIEWER 1	
	Major revisions	
1	Table 1 – unclear what "author" in this context means (e.g., government, academic, funder), and how these differ from government actor of academia below. What type of "funder" – multilateral? Bilateral? International/national NGO?	Thank you for your feedback and further details have been added to Table 1 to make the distinction between categories of participants more explicit. The attribution of quotes in the manuscript have also been revised to be consistent with Table 1 Also please see p7 which outlines the categories of participants "Through purposive sampling AYHP policy authors in government, academia and donors, members of the Advisory Panel (AP), youth representatives from the Adolescent and Youth Advisory Panel (AYAP), National Youth Development Agency, as well as youth health policy actors, in government, academia and civil society, representing a range of experiences and perspectives were identified.

	Comment	Response
2	Positionality (p.8) – this response is inadequate in terms of what should be outlined in a researcher's positionality statement. Providing details on the composition of the research team (e.g., who was part of this research), and describing aspects of their social identity (e.g., education, class, geography, etc.) is necessary. Although this is outlined in the contributions section, for a qualitative study this should also be clearly integrated in the methods.	Thank you for further highlighting this important component of research and we have added a sentence as part of positionality statement in the Methodology section. See p8 lines 12-16
3	Data analysis P.8, line 23 – what is an "indicative" code? Should this be inductive? Also please outline how/why was this addition was necessary.	Thank you for picking up this spelling mistake. This has been corrected and the addition of these codes that emerged from the data has been further clarified. See p8 lines 23-24
4	#10 – please provide data/evidence quote to support the claims/information around colonialism, apartheid, and social and economic inequalities as requested in the first review. This comment was not sufficiently addressed.	Thank you for your additional feedback and request to provide a quote to support this summary of perspectives of how the legacy of the past has shaped different forms of discrimination faced by young people. A quote has been added to illustrate the views of all the actors interviewed. See p10, lines 10-13
5	#11 – I was hoping for further efforts to address this comment in the results (not just discussion) as it seems particularly relevant to the "findings" of this work.	Thank you for your further comments on the points related to how youth participated in the beginning, but not throughout the process. As noted we have addressed this this as one of the learnings in the key messages, discussion and conclusions of the manuscript

	Comment	Response
6	P.12, line 4 – the term "gathered" is awkward, this table title should clarify that this was the process for consulting youth for the youth policy.	Thank you for your comment. The title of Table has been changed and the AYHP document has been added as the source.
7	P.13, lines 7-8 – including a quote from an "academic" author (?) does not fit well with the topic and aim of examining young people's perspectives on their engagement.	Thank you for your follow-up question. As mentioned our research set out to include perspectives from a range of actors in order to learn lessons about youth participation in policy process. We acknowledge that including a quote from the AHYP academic author on page 14 lines 13-15 is one perspective on the topic and the manuscript as a whole includes quotes from a range of actors on the topic.
8	#13 – I disagree, I find having the "challenges" as a subheading at the same "level" as the overall themes (derived from the conceptual framework) is confusing for the reader (and does not align with the conceptual diagram created). This needs to be clarified/addressed.	Your further comments and request for clarification is appreciated and the manuscript has been revised to show how the conceptual framework was used and how the dynamic process evolved. The level of the headings have also been changed to make it clearer to the reader. See p12 lines 24-27
9	Discussion P.22 – positionality – again, this is insufficient. The researchers must more critically summarize and discuss possible sources of power and inequity (e.g., education? Language? Race/ethnicity?) which shaped the relationships with participants, data generated and the analysis. I would recommend the authors read further on qualitative inquiry and positionality of researchers to more deeply and clearly address this feedback (For example: Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. Qualitative health research, 12(4), 531-545.)	As mentioned above, thank you for drawing attention to this important component of the research process, which we have further detailed in the paper. Thank you too for the recommended paper on reflexivity which we have read and included in our manuscript. We have revised the discussion section to make our reflexivity analysis more explicit in the manuscript. See p23 lines 21-23

	Comment	Response
	REVIEWER 2	
1	The authors primarily responded to my suggestions with comments that they were not given more space to respond to most of my queries. If they in fact do not have more space then there is not much more they can do. I think that their addition of the "Cahil" method without much explanation is now a bit confusing. I think more space is likely needed to explain their analytic methods.	Your feedback and comments on our revised manuscript is greatly appreciated, thank you. We did revise and edit the text as per your suggestions and also added additional text as per your request without reference to a word limit. We include a copy of the revisions submitted in the table below referencing how your suggestions were previously incorporated. An adapted version of the Cahil framework was the original framework used in this paper and not an additional method added subsequently. Please see p5, lines 28-34.