Conclusion

Kaymarlin Govender and Nana K. Poku

The writers of this book have come together to provide critical insights on HIV interventions in terms of ‘what works’, why they work and the limitations in our knowledge to curb the sexual transmission of HIV among young people across Eastern and Southern Africa (ESA). While the UNAIDS-prescribed prevention targets for 2020 are likely to be missed (UNAIDS, 2020), the writers of the volume are driven by the collective purpose to move swiftly towards ending the HIV pandemic as a public health threat by 2030, if not before.

As we have noted in preceding chapters, across the region, efforts to mitigate the risk for the acquisition of HIV among young people have produced mixed results. This is mostly due to the HIV pandemic being characterised by its heterogeneous and dynamic nature, the slow progress in reducing the number of new HIV infections and the many factors that are linked with the sexual transmission of HIV (see Chapter 1). For several years, adolescent girls and young women (AGYW) have been the ‘face’ of ongoing acquisition of HIV in the region; young men have been reluctant to seek HIV services with AIDS-related deaths increasing; there are also rising rates of new HIV infections among young key populations (YKP) with widespread prejudice, stigma, sexual exploitation and human rights violations limiting their access to HIV and sexual and reproductive health (SRH) services.

While new HIV infections are stabilising in some of the hardest-hit countries, the rate of new infections is still far too high and the future cost of maintaining an ever-expanding pool of people reliant on daily treatment for survival is unsustainable. Financial resources to support the increasing number of people on antiretroviral treatment (ART) have taken away the investments for intensifying prevention efforts in the region’s youthful population. In addition, the span (and costs) of the Sustainable Development Goals (SDGs) have shown that HIV/AIDS is not the only global priority and it now has to share the stage with the growing burden of non-communicable diseases, re-emerging infections and new public health threats such as the coronavirus disease 19 (COVID-19) pandemic.

Speeding up the reduction of new HIV infections and securing and protecting the sexual and reproductive health of young people becomes even more of an imperative to avoid these looming future challenges. In the

sections below, we draw on some key insights on ‘what works’ in preventing the sexual transmission of HIV, discuss gaps in knowledge on the implementation of interventions and present some possibilities for sector wide HIV prevention programming going forward.

What works in addressing psychosocial, behavioural and structural drivers of HIV risk

There is currently a wide range of tools that work for the primary prevention of HIV for different sub-populations, e.g. condoms, voluntary medical male circumcision, oral pre-exposure prophylaxis (PrEP), clean needles as well as risk reduction information and the promotion of specific behaviours, such as regular HIV testing, information sharing between partners about HIV serostatus and the use of HIV viral load monitoring before making decisions about sex and drug-using activities (Hargreaves et al., 2020).

Even so, the effectiveness of these prevention tools among young people in ESA have been limited primarily by the interplay between individual, interpersonal, social and structural factors (Govender et al., 2019a). Interventions to especially address psychosocial, behavioural and structural drivers of HIV risk have not been emphasised in resource allocations and policy dialogues in ESA. Reasons include gaps in knowledge on how to improve women’s use of HIV prevention tools, obstacles to challenging prevailing stigmas (stigmas associated with being HIV positive and or having expressions of different gender or sexual orientation) that are associated with poor uptake of prevention services and the difficulties associated with attempting to change cultural norms of masculinity (e.g. inconsistent condom use, multiple sexual partners, low HIV testing behaviours) that ultimately contribute to the spread of HIV. Furthermore, HIV prevention programming is hampered by complexities involved in combining these different types of interventions in certain contexts to substantively reduce new HIV infections. Programming is also impeded by the failure to address human rights, gender and other equity barriers in accessing services. In this section, we draw on some key points made by writers in this book regarding evidence on what works in primarily reducing the sexual transmission of HIV.

Gafos and colleagues, in their review of a decade of evidence (see Chapter 7), discussed the benefits of social and structural interventions that address education, poverty and gender equality to mitigate HIV vulnerability among young people in ESA. The case for increasing educational enrolment is strong, with evidence suggesting that each additional year of schooling reduces the risk of HIV (Barnighausen et al., 2007), particularly for young women. Similarly, school attendance and educational attainment can impact on future socio-economic status, self-esteem, social networks and exposure to HIV prevention education (Jukes et al., 2008). Youth poverty can also be a motivator for engaging in risky sex, as has been emphasised

in the results of a recent phylogenetic study showing age disparate sexual partnerships between younger women and older men in a HIV hyper-endemic area of South Africa (De Oliveira et al., 2017). Emerging evidence on the benefits of interventions to alleviate youth poverty has increased the urgency of implementing the UNAIDS fast-track target to strengthen national and child social protection policies (UNAIDS, 2018).

As regards gender-based violence (GBV), research shows that intimate partner violence (IPV) – physical, sexual and psychological – increases susceptibility to HIV among young women (Durevall and Lindskog, 2015; Jewkes et al., 2010). Even though violence among AGYW is seen as a problem that will take generations to change, several GBV interventions have shown that it is possible to reduce GBV incidence and improve HIV risk outcomes (refer to Chapter 7).

More generally, while the evidence for psychosocial and structural interventions for affecting HIV risk pathways is encouraging, there are still significant gaps in our knowledge. We are not clear on exactly how to implement structural interventions in an effective manner in specific settings. Further, mechanisms through which structural interventions operate to mitigate HIV risk and acquisition are not necessarily straightforward or have sustained effects. For instance, in the case of cash transfers interventions to improve school attendance, success is dependent on the nature (conditional or unconditional cash transfers), scope (type of youth that are reached or not reached) and duration of the intervention, including specification of HIV and related outcomes. The significance of context is also aptly demonstrated in the HPTN068 study, which showed that providing equivalent cash transfers in settings with prevailing high levels of social protection (e.g. existing child support grant to poor households, free schooling and school feeding programmes) may not be beneficial to HIV outcomes. Such interventions will have better effects where there is low social protection coverage or low school attendance (Pettifor et al., 2016). Further, incentives to keep girls in schools (as measured only through school attendance) excludes girls who have dropped out of school, those who are pregnant from poor homes (noting that there are a few countries in ESA region which have policies that encourage girls to re-enter school after birth of their children, see Chapter 12), leaving them vulnerable to exploitative sexual relationships.

While efforts to shift gender norms and reduce GBV show some promise, outcomes have not been convincing, partly due to the design weaknesses in GBV interventions (lack of standardised measures for gender norms, short-term duration of interventions and failure to directly measure clinical or biological outcomes (pregnancy, HIV incidence). Even so, the entrenched and prevailing gender dynamics that dominate women's lives are a huge challenge for HIV prevention efforts. The recent findings of the ECHO multi-country study in South Africa, Kenya, Eswatini and Zambia is a poignant illustration (Evidence for Contraceptive Options and HIV

Outcomes (ECHO) Trial Consortium, 2019). While the study showed no links between use of birth control methods and HIV infection, it sketches a grim picture of our fight against HIV, where young women continue to bear the brunt of the epidemic. Despite individualised HIV prevention packages provided to all participants during the study, HIV incidence was alarmingly high (infection rate of almost 4%). Even when HIV prevention commodities like condoms were available, condom use was low, reflecting the struggles heterosexual women have to go through in convincing their sexual partners to use condoms.

Female-centred approaches are key to HIV prevention and better sexual health among young people. This can only be realised if their male sexual partners are seen as part of the solution and not just the problem. Mantell and colleagues (see Chapter 9) assert that patriarchal norms (physical strength, sexual domination over women, independence and emotional bluntness) that govern men's behaviours also drive poor health outcomes in men; these norms are developed and institutionalised as boys' transition into adulthood. Men's use of violence within relationships, sexual infidelity and heavy alcohol use have been associated independently with GBV and HIV infection (Jewkes et al., 2014). Shifting hegemonic masculine norms in GBV interventions targeted at young men have produced mixed results (see reviews on interventions targeted at young men in Chapters 7 and 9). For example, young men who completed the GBV Stepping Stones intervention in South Africa (Jewkes et al., 2008) showed lower incidence of herpes infection (HSV-2) and related sexual and alcohol use behaviours, while the Regai Dzive Shiri (Zimbabwe) (Cowan et al., 2010) and the Fataki campaign (Kaufman et al., 2013) showed no effects for shifting gender norms in young men. A more recent full trial of the Stepping Stones and Creating Futures intervention did however show a reduction of men's self-reported perpetration of intimate partner violence, however a similar finding was not present for young women in the study (Gibbs et al., 2020).

Shifting gender/sexual norms for young people is complicated; there is no magic bullet. Gittings and colleagues (see Chapter 10), in their research with young men at risk for HIV, suggest that interventions also should consider the dynamics of engagement (demographic and personal qualities of facilitators, participants, researchers, and programme workers) and contextual mediators (socio-economic, cultural and geographical) that work to influence gender norms. Social change is not linear, rather it is refracted through fluctuating life circumstances of participants, their sexual relationships and the communities in which they live in that ultimately shape HIV risk. Interventions that rely on gender transformative principles through employing critical thinking and learning activities in process-type engagements with participants are more likely to see shifts in social norms. These authors also raise an ethical issue: what does it mean to be working with young men for HIV prevention in settings where women and girls are more

biologically and socially vulnerable to HIV infection, especially if such work is seen to compete for the same resources? Interventions with men therefore also needs to be able to articulate how its methods and objectives are aligned with broader feminist principles of inquiry (see, Govender, 2012).

Freedman and colleagues (see Chapter 8) assert that in certain settings, structural factors are more likely to drive inequities in health outcomes for young people. Members of young key populations face, what they term, 'compounded vulnerabilities' since they share a number of specific barriers and challenges concerning their sexual and reproductive health that is linked to legal, social and political structures, which undermine their ability to access healthcare. Social, health and human rights struggles related to citizenship is thus reflected in HIV and SRH outcomes. The authors go on to argue that the paucity of research with young key populations and the neglect in using a more expansive social determinants of health framework (Solar and Irwin, 2010) makes it difficult to decipher and affect pathways linked to better sexual and reproductive health.

Siloed approaches to HIV programming based on rigid categories of social identity and sexual or drug use practices, without the recognition that such practices are in constant flux among young people, are additional barriers to preventing HIV. It therefore seems that a predominantly HIV-dominated intervention response with little attention paid to young people's holistic reproductive health, (including access to contraception, the problem of unintended pregnancy or unsafe abortion) obscures that systemic links between both. This is because SRH challenges bare inextricably linked with HIV prevention efforts (e.g. elimination of mother-to-child transmission of HIV or safer conception strategies). Moving forward requires, first and foremost, addressing the substantial evidence gap surrounding the diverse nature of young people's lives, as well as addressing head-on the prevailing and seemingly intransigent levels of stigma, discrimination and exclusion that drives HIV risk and access to SRH services for these groups. It also entails moving beyond the locality of specific interventions and working more broadly to strengthen HIV and SRH-related rights of young key populations in law, programming and policy (see Levy et al.,'s 2019 review of successful programmes targeting gender inequality and restrictive gender norms).

While biomedical interventions combined with social protection programmes can reduce new HIV infections among young people, it is also important to support those already living with HIV to lead healthy lives, through viral suppression and engaging in safer sex and planned parenthood. Young people living with HIV (YPLHIV) are not a homogenous group. Social vulnerabilities may stem from geographical location (rural, urban), orphanhood (maternal, paternal, dual), length of illness and mode of HIV acquisition (perinatal infection vs behaviourally infected). We are aware of chronic vulnerabilities suffered by children who were perinatally infected with HIV, however recent research also shows that horizontally HIV-infected

children are also prone to having poor clinic experiences, lack of ART adherence and multiple psychological challenges (Sherr et al., 2018). The recent findings of the HPTN 084 trial on the effectiveness of a long-acting antiretroviral (ARV) injection now significantly increases options for HIV positive women who struggle to take the daily tablet (WHO, 2020). Zungu and colleagues (Chapter 11) further assert that social support grants, travel vouchers to get to facilities and school lunch programmes are essential to improving adherence in low-resource settings. They also point out that the ‘care’ element of these combination interventions needs more emphasis. Psychosocial support and care at home and clinics has been strongly associated with reduced unprotected sex, especially among AGYW living with HIV (Toska et al., 2017). An emergent concern is how to strengthen community systems to support ART adherence, enabling beneficiaries’ access to livelihood opportunities and health services (Busza et al., 2014). Developing capabilities among people living with HIV to realise their aspirations (completing school, finding employment, managing parenthood) needs to be emphasised in future programming.

The evidence, in sum, suggests that interventions, in combination, that tackle upstream drivers of HIV and SRH risk (gender inequalities, poverty, education, repressive social norms and policies, intersectional stigma) have the potential to interrupt multiple pathways of vulnerability, thereby enabling young people to remain HIV negative and also preventing continued transmission of HIV among YPLHIV. As such, no single casual pathway can be drawn from a single social or structural driver to a set of practices or behaviours; rather, a range of potential outcomes may arise. Making inferences about correlations between drivers of HIV risk and HIV burden, therefore, involves identifying ‘sociologically plausible’ pathways drawn from extant social sciences literature and epidemiological data (Auerbach, Parkhurst and Caceres, 2011).

A key resource for developing relevant HIV prevention interventions is knowledge and experiences *in situ*, together with knowledge about how young people navigate and are made vulnerable by structural challenges in specific contexts. This approach will help explain why adolescent girls (15-19 years) acquire HIV much earlier in some countries in the region (e.g. South Africa and Kenya, see chapter 1). Cowden and colleagues (in Chapter 2), in elucidating pathways of HIV risk use a psychosocial and development approach to show that transitions from childhood to young adulthood is associated with potentially disruptive role transitions (especially with the onset of puberty) and social and economic inequalities often amplify risk for HIV. These authors also emphasise how people can develop capabilities (resiliency) through drawing on a range of resources (both individual and social) to buffer these environmental insults (Ungar, 2004). The developmental processes associated with life course transitions are not necessarily linear (Sameroff, 2009) and devoid of context. These ideas resonates with the ‘slow research’ agenda that has been gaining ground recently (Adams et al., 2014), where in-depth understandings of context and locally

constructed experiences of sexual risk and health can also be relevant to HIV prevention (see earlier work on AIDS-competent communities and health enabling environments (Campbell et al., 2009)).

Based on the above, prevention interventions with young people needs to consider not only ‘what prevention interventions work’ but under ‘what circumstances’ and ‘who is the target population’ of interest. The importance of recognising the heterogeneity of a single population and the need for differentiated HIV prevention approaches is evidenced in the HIV prevention cascade perspective. The ‘prevention cascade’ is useful because it provides a guide to the design and monitoring of HIV prevention programmes through a multi-pronged approach that includes demand-side interventions, supply-side interventions and adherence interventions (Hargreaves et al., 2016; 2020). Therefore, interventions that are well conceptualised, with intersectoral partnerships and finely attuned to local realities of young people are more likely to be effective in preventing HIV (see Chapter 13, where DeSoto and colleagues discuss their lessons learnt from a community-based HIV program to reduce school drop-out among adolescent girls).

Conversely, questions also remain about the scalability and relevance of HIV interventions within the rapidly evolving and sector-wide approaches to health programming. The many health and development priorities facing nations in the ESA region, in the light of dwindling resources, mean that opportunities for synergies outside the HIV sector is now urgent and necessary. In the following section, we put forward some considerations for future HIV prevention programming.

Evolving the prevention response: synergies, co-investments and contextual enablers

The Sustainable Development Goal (SDG) 3, healthy lives and well-being and pandemic preparedness, presents some opportunities and challenges for a more inclusive approach to HIV/AIDS programming, given that limited global resources for HIV programming are being spent on HIV prevention (Resch, Ryckman and Hecht, 2015). The value of a synergetic type approach is that when opportunities exist to address one set of issues; this can lead to multiple development outcomes (Isbell et al., 2016).

As indicated previously, there is now overwhelming evidence in ESA for an interlinked set of structural drivers leading jointly to poor HIV and SRH outcomes (e.g. unwanted pregnancies, poor access to contraception among AGYW as a result of gender inequalities and poverty is linked with higher concentrations of HIV infection).

There is also evidence for a range of structural HIV interventions to mitigate poverty, poor education and GBV that can achieve multiple downstream impacts: keeping girls in school, improving future livelihoods and improving HIV and sexual health outcomes.

At national levels, HIV programming in ESA has been historically premised on government and development assistance for health (DAH) funding

being very rigid, vertical and disease-specific (Sundewall and Forsberg, 2020), with non-HIV sectors and funders not willing to consider the spillover effects of their policies and programmes on HIV, or vice versa. Notwithstanding these institutional challenges, the shift towards holistic healthcare under the banner of Universal Health Coverage (UHC) (Political Declaration of the High-level Meeting on Universal Health Coverage, 23 September 2019) has spurned the need for delivering a basic package of health services (across different sectors and different SDG targets) (also refer to: The global financing facility framework for women, children and adolescents: Roadmap for advancing gender equality, 2020). Investing across a broad set of HIV and SRH interventions to address the most common health needs of the population is being typically defined in a country's essential health-care package, with such a package becoming increasingly central to how resources, including DAH should be allocated (Sundewall and Forsberg 2020).

Cost-effectiveness data has also shown that pooling of resources across sectors through a co-financing mechanism can jointly improve HIV and related health outcomes (Remme et al., 2014). Conceptual shifts towards integrated approaches (HIV and SRH) to health delivery have already occurred; for example the Southern Africa Development Community (SADC) implemented the Minimum Standards for the Integration of HIV and Sexual and Reproductive Health (Southern African Development Community, 2015); (also note the Eastern and Southern Africa (EAC) Ministerial Commitment to Comprehensive Sexuality Education, 2013).

Even so, there are many challenges to implementing multi-sectoral health programming in low-resource settings which include: different prioritization processes, predominance of single-modality economic models, poor domestic resource mobilisation and institutional barriers to adopting co-financing models (limited financial autonomy of government and non-government budget holders, potential loss of budget control and threats to current institutional arrangements) (Remme and Mcguire, 2018). In addition, funding for health is scattered across government ministries and external donors, which complicates resource allocation for essential health benefits packages, with lost opportunities for HIV prevention also being incurred. More feasibility work is required to assess the practicalities of operationalizing the co-financing approach in governmental planning and budgeting. In addition, there is a need to support in-country technical capacity to improve local capability and ownership in recording and analyzing data, and to support health planning and budget allocation exercises as well as increasing reliance on domestic funding (Remme et al., 2014).

Apart from operational challenges related to delivery of health packages (which include HIV and SRH services), there are ongoing dialogues with between government and stakeholders on the key elements of these health benefits packages. While HIV basic services are covered, key SRH services are sometimes not included because of political, religious, legal and moral concerns (e.g. safe abortion services, interventions for MSM communities, people who sell sex and people who inject drugs) (refer to Prioritising Essential Packages of Health in Six countries in Sub Saharan Africa report, 2019). The

point is aptly made by Machawira and colleagues (see Chapter 12) that even with EAC Commitments to Comprehensive Sexuality Education, most country policies and sociocultural environments are still not conducive to reaching the goals of empowerment-based sexuality education for young people.

So how should we ensure sector-wide participation in prioritization processes for health service packages? Inclusivity and transparency are indeed challenges, and civil society needs to hold governments and other health providers more accountable. There are examples where advocacy by gender activists for inclusion of specific health services has worked (e.g. inclusion of cervical cancer services as part of an essential health package in Eswatini; National Cancer Prevention and Control Strategy, 2019). Activating multiple constituencies to obtain more accurate and timely in-country data on HIV, SRH and other health indicators to inform decision-making is important. The All In approach for optimizing HIV data on adolescents in ESA countries, through engaging players across the health and development sectors, is a multi-sectoral strategy which has shown some promise (see Armstrong and colleagues, Chapter 4).

At a regional level, African intergovernmental bodies have elaborated a wide array of policy documents that address the health and well-being of young people, many of them connected to HIV and SRH programming. Even so, many of these frameworks are top down, with insufficient emphasis on building national ownership, coupled with faltering political will and lack of consultation and accountability to constituents (Gabelnick and colleagues, see Chapter 3). Advocacy for regional HIV and SRH programming is not new, especially given the links between HIV and migration in a rapidly growing youthful population in sub-Saharan Africa (Ilfie, 2006). There are some good examples of cross-border health initiatives that cater for health needs of mobile and remote populations (e.g. North Star Alliance Roadside Wellness Clinics along trucking routes in ESA; Govender et al., 2019b), but enabling foreign migrants to access HIV and SRH services in ‘receiver’ countries is a growing challenge (Gupta et al., 2012) with some arguing for the establishment of regional health passports as an option for improving regional health and security (Šehović, see Chapter 6).

While country efforts towards UHC are being formalised, we should however not lose important research, policy and programming opportunities to strengthen investments in programming for particularly young and marginalised groups (AGYW, YPWSS, MSM, LGBTI communities). Our experience on investing in reducing new HIV infections among AGYW through evidence based and multi-sectoral programming (e.g. PEPFAR-funded DREAMS HIV prevention programming; Global Fund programming to reduce human rights barriers to accessing HIV and SRH services, see Chapter 3) has provided some key lessons on implementation, it also raises some general issues for future programming. How can we collectively capitalise on these opportunities and use them as avenues to engage with young people themselves on the multiple issues affecting their lives? Why is embracing diversity among young people is key to effective HIV/and SRH

research and programming? How would the prioritisation of young people increase prospects for more inclusive and ethically sound research, policy and programming?

Misalignments with international and regional human rights laws and commitments compromises young people's fundamental health rights because of insufficient guidance on how to navigate the legal-ethical complexities associated with capacity to consent for research on HIV and access to SRH services (UNFPA, 2017). Behaviours deemed illegal (under-age consensual sex, same-sex behaviour, sex work) could mean the systematic exclusion of vulnerable participants who are potential beneficiaries of such research and interventions. Given these imperfect legal frameworks that exist in many countries in ESA, Strode and Slack (see Chapter 5) assert that we should be more transparent on how we make decisions regarding the nature and extent of issues entailed in consenting and participation processes. Adolescents should also understand the personal implications of consent to research, the extent of privacy clauses and requirements of mandatory reporting. Adopting approaches to adolescent participation in HIV and SRH research needs to be thoughtful, well-grounded in relevant ethics principles (The United Nations General Assembly, 1989) and guided by their *primary* role to protect research participants rather than to adopt the role of law enforcement. In-country, research ethics committees (RECs) are key institutions who play a role in determining whether adolescent protocols are 'ethically acceptable' and sometimes will have to make uncomfortable decisions to enable balanced, nuanced, well-justified ethical approaches.

In sum, if we are to capitalise on emerging synergies in policy and programming for HIV and related health outcomes, we then need to address multiple contextual enablers. These include more granular-level data on HIV and SRH drivers to improve programme efficiencies and better decision-making; strong political will with inclusiveness in decision-making; intergovernmental mechanisms to facilitate programming and accountability; strong monitoring and evaluation frameworks; cost effective analysis with local expertise for implementation.

At a wide-ranging level, there is also a need to capacitate civil society to push for investments in social and human rights programming to reduce forms of stigma, shift harmful social norms and promote social inclusion of its sexually and gender diverse minorities. More support is required for public interest litigation, training and advocacy to advance sexual and human rights of young people and instigate reform of national laws that do not comply with international human rights law (Southern African Litigation Centre 2017). It is encouraging to note the current and ongoing advocacy work for law and policy reform (UNFPA, 2017). The recent landmark decision by the high court of Botswana (on June 11, 2019) decriminalizing same-sex sexual contact (Collison, 2019) has been as a result of long-term public activism and support by human rights organizations. There could be many sexual and reproductive health gains for all if more societies on the continent could honor, celebrate and protect the innate diversity of human sexuality. The

immediate likelihood of a broader and similarly inspired wave of change across the region looks uncertain, but Botswana has shown that it is possible.

The evidence for social and structural interventions in reducing new infections among young people has shown that progress is indeed possible (see also reviews by Harrison et al., 2015; Govender et al., 2018), however as we have outlined thus far, there are indeed many challenges in getting the difference sectors to work together, achieve health and development synergies, promote the full inclusion of its diverse citizenry, improve efficiencies in programming and benefit from joint outcomes.

The SDG framework offers new hope to realise our ultimate goal in getting to zero new HIV infections through integrated HIV and SRH programming (under UHC) and opportunities to deliver multiple impacts at scale. While there is a need for integrated services, optimal paths will differ between settings, populations and services. In the strive for UHC, there is a genuine risk of wholesale relinquishment of the exceptionalism approach to HIV (Bekker et al., 2018). AIDS exceptionalism has brought an array of human, financial and technical skills to fighting the HIV epidemic. It has also ensured global commitment to producing systemic, incremental interventions and also to engaging diverse communities in far reaching ways. As global attention shifts towards achieving the SDG 3 goal of universal health coverage, there needs to be a rigorous appraisal of the risks and benefits of mainstreaming the HIV and SRH response into national health systems. Ending the HIV epidemic for young people requires more resources, global commitment to addressing related health issues, and more emphasis on people-centred systems.

References

- Adams, D. A., Jajosky, R. A., Ajani, U., Kriseman, J., Sharp, P., Onweh, D. H., Schley, A. W., Anderson, W. J., Grigoryan, A., Aranas, A. E. and Wodajo, M. S. 2014. *Summary of notifiable diseases – United States, 2012*. <https://europepmc.org/article/med/27736829>.
- Auerbach, J. D., Parkhurst, J. O. and Caceres, C. F. 2011. Addressing social drivers of HIV/AIDS for the long-term response: Conceptual and methodological considerations. *Global Public Health*, 6(Suppl 3), S293–S309.
- Barnighausen, T., Hosegood, V., Timaeus, I. M. and Newell, M. L. 2007. The socioeconomic determinants of HIV incidence: Evidence from a longitudinal, population-based study in rural South Africa. *AIDS*, 21(Suppl 7), S29–S38.
- Bekker, L. G., Alleyne, G., Baral, S., Cepeda, J., Daskalakis, D., Dowdy, D., . . . Beyrer, C. 2018. Advancing global health and strengthening the HIV response in the era of the sustainable development goals: The International AIDS Society-Lancet Commission. *Lancet (London, England)*, 392(10144), 312–358. doi:10.1016/S0140-6736(18)31070-5.
- Busza, J., Besana, G. V., Mapunda, P. and Oliveras, E. 2014. Meeting the needs of adolescents living with HIV through home based care: Lessons learned from Tanzania. *Children and Youth Services Review*, 45, 137–142, February.
- Campbell, C., Nair, Y., Maimane, S. and Gibbs, A. 2009. Strengthening community responses to AIDS: Possibilities and challenges. In P. Rohleder, L. Swartz and S. Kalichman (Eds.), *HIV/AIDS in South Africa 25 years on* (pp. 221–235). London: Springer Verlag.

- Collison, C. 2019. Botswana decriminalises homosexuality in historic judgment. *Mail and Guardian*, 11 June. <https://mg.co.za/article/2019-06-11-botswana-high-court-ruling-a-victory-for-countrys-queer-communities> [Accessed 22 July 2019].
- Cowan, F.M., Pascoe, S.J., Langhaug, L.F., Mavhu, W., Chidiya, S., Jaffar, S., Mbizvo, M.T., Stephenson, J.M., Johnson, A.M., Power, R.M., Woelk, G., Hayes, R.J. and Regai Dzive Shiri Trial, T. 2010. The Regai Dzive Shiri project: Results of a randomized trial of an HIV prevention intervention for youth. *AIDS*, 24, 2541–2552.
- De Oliveira, T., Kharsany, A., Gräf, T., Cawood, C., Khanyile, D., Grobler, A., Puren, A., Madurai, S., Baxter, C., Karim, Q. and Karim, S. 2017. Transmission networks and risk of HIV infection in KwaZulu-Natal, South Africa: A community-wide phylogenetic study. *Lancet HIV*, 4, e41–e50.
- Durevall, D. and Lindskog, A. 2015. Intimate partner violence and HIV in ten sub-Saharan African countries: What do the demographic and health surveys tell us? *Lancet Glob Health*, 3, e34–e43; Cross-sectional study. *PLoS One*, 6, e24256.
- Eastern and Southern Africa (ESA). 2013. *Ministerial Commitment Meeting and Affirmation Ceremony*. Report [pdf]. www.youngpeopletoday.org/wp-content/uploads/2018/06/2013-ESA-Commitment-Report_Feb.pdf.
- Evidence for Contraceptive Options and HIV Outcomes (ECHO) Trial Consortium. 2019. HIV incidence among women using intramuscular depot medroxyprogesterone acetate, a copper intrauterine device, or a levonorgestrel implant for contraception: A randomised, multicentre, open-label trial. *Lancet (London, England)*, 394(10195), 303–313. doi:10.1016/S0140-6736(19)31288-7.
- Gibbs, A., Dunkle, K., Ramsomar, L., Willan, S., Jama Shai, N., Chatterji, S., Naved, R. and Jewkes, R. 2020. New learnings on drivers of men's physical and/or sexual violence against their female partners, and women's experiences of this, and the implications for prevention interventions. *Global health action*, 13(1), 1739845. doi: 10.1080/16549716.2020.1739845.
- Global Financing facility: Roadmap for advancing gender equality. 2020. https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF-Roadmap-for-Advancing-Gender-Equality_EN.pdf
- Govender, K. 2012. Researching young masculinities: Theorizing processes of identification in the research setting. *International Proceedings of Economics Development & Research*, 31, 234–238.
- Govender, K., Masebo, W., Nyamaruze, P., Cowden, R. G., Schunter, B. T. and Bains, A. 2018. HIV prevention in adolescents and young people in the Eastern and Southern African region: A review of key challenges impeding actions for an effective response. *The Open AIDS Journal*, 12, 53–67. doi:10.2174/1874613601812010053.
- Govender, K., Cowden, R. G., Oppong Asante, K., George, G. and Reardon, C. 2019a. Sexual risk behavior: A multi-system model of risk and protective factors in South African adolescents. *Prevention Science*. Advance online publication. doi:10.1007/s11211-019-01015-3.
- Govender, K., Beckett, S., Masebo, W., Braga, C., Zambezi, P., Manhique, M., . . . Durevall, D. 2019b. Effects of a Short Message Service (SMS) Intervention on Reduction of HIV Risk Behaviours and Improving HIV Testing Rates Among Populations located near Roadside Wellness Clinics: A Cluster Randomised Controlled Trial in South Africa, Zimbabwe and Mozambique. *AIDS and Behavior*, 23(11), 3119–3128.
- Gupta, R.K., Jordan, M.R., Sultan, B.J. et al. 2012. Global Trends in antiretroviral resistance in treatment-naïve individuals with HIV after rollout of antiretroviral

- treatment in resource settings: A global collaborative study and meta regression analysis. *Lancet*, 380, 1250–1258.
- Hargreaves, J. R., Delany-Moretlwe, S., Hallett, T. B., Jonson, S., Kapiga, S., Bhat-tacharjee, P., Dollabetta, G. and Garnett, G. P. 2016. The HIV prevention cascade: Integrating theories of epidemiological, behavioural, and social science into programme design and monitoring, London school of hygiene and tropical medicine, London. *Lancet HIV*, 3, e318–e22. doi:10.1016/S2352-3018(16)30063-7.
- Hargreaves, J. R., Davey, C., Auerbach, J., Blanchard, J., Bond, V., Bonell, C., Burgess, R., Busza, J., Colbourn, T., Cowan, F., Doyle, A., Hakim, J., Hensen, B., Hosseinipour, M., Lin, L., Johnson, S., Masuka, N., Mavhu, W., Mugurungi, O., . . . Yekeye, R. 2020. Three lessons for the COVID-19 response from pandemic HIV. *The Lancet HIV*, 7(5). doi:10.1016/S2352-3018(20)30110-7.
- Harrison, A., Colvin, C. J., Kuo, C., Swartz, A. and Lurie, M. 2015. Sustained high HIV incidence in young women in Southern Africa: Social, behavioral, and structural factors and emerging intervention approaches. *Current HIV/AIDS Reports*, 12(2), 207–215. doi:10.1007/s11904-015-0261-0.
- Iliffe, J. 2006. *The African AIDS epidemic: A history*. Oxford: James Currey.
- Isbell, M. T., Kilonzo, N., Mugurungi, O. and Bekker, L.-G. 2016. We neglect primary HIV prevention at our peril. *The Lancet HIV*, 3(7).
- Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A. and Duvvury, N. 2008. Impact of stepping stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: Cluster randomised controlled trial. *British Medical Journal*, 337, a506.
- Jewkes, R. K., Dunkle, K., Nduna, M. and Shai, N. 2010. Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *Lancet*, 376, 41–48.
- Jewkes, R., Gibbs, A., Jama-Shai, N., Willan, S., Misselhorn, A., Mushinga, M., Washington, L., Mbatha, N. and Sikweyiya, Y. 2014. Stepping stones and creating futures intervention: Shortened interrupted time series evaluation of a behavioural and structural health promotion and violence prevention intervention for young people in informal settlements in Durban, South Africa. *BMC Public Health*, 14.
- Jukes, M., Simmons, S. and Bundy, D. 2008. Education and vulnerability: The role of schools in protecting young women and girls from HIV in Southern Africa. *AIDS*, 22(Suppl 4), S41–S56.
- Kaufman, M. R., Mooney, A., Kamala, B., Modarres, N., Karam, R. and Ng'wanansabi, D. 2013. Effects of the Fataki campaign: Addressing cross-generational sex in Tanzania by mobilizing communities to intervene. *AIDS Behaviour*, 17, 2053–2062.
- Levy, J. K., Darmstadt, G. L., Ashby, C., Quandt, M., Halsey, E., Nagar, A., and Greene, M. E. 2019. Characteristics of successful programmes targeting gender inequality and restrictive gender norms for the health and wellbeing of children, adolescents, and young adults: a systematic review *Lancet Glob Health*, 8: e225–36.
- National Cancer Prevention and Control Strategy. 2019. *Report* [pdf]. Ministry of Health Kingdom of Eswatini. www.iccpportal.org/system/files/plans/Eswatini%20NCCP%202019.pdf [Accessed 22 July 2019].
- Pettifor, A., Macphail, C., Hughes, J. P., Selin, A., Wang, J., Gomez-Olive, F. X., Eshleman, S. H., Wagner, R. G., Mabuza, W., Khoza, N., Suchindran, C., Mokoena, I., Twine, R., Andrew, P., Townley, E., Laeyendecker, O., Agyei, Y., Tollman, S. and Kahn, K. 2016. The effect of a conditional cash transfer on HIV incidence in young women in rural South Africa (HPTN 068): A phase 3, randomised controlled trial. *Lancet Global Health*, 4, e978–e988.

- Prioritizing Essential Packages of Health Services in Six countries in Sub-Saharan Africa. 2019. *Partnership for Maternal, Newborn & Child Health*. <https://www.who.int/pmnch/media/news/2019/Full-report.pdf> [Accessed 15 Sep. 2020].
- Political Declaration of the High-level Meeting on Universal Health Coverage “Universal health coverage: moving together to build a healthier world” 23 September 2019. <https://www.who.int/news-room/events/detail/2019/09/23/default-calendar/un-high-level-meeting-on-universal-health-coverage>
- Remme, M. and McGuire, F. 2018. *STRIVE technical brief: Development synergies and co-financing*. London: STRIVE.
- Remme, M., Vassall, A., Lutz, B., Luna, J. and Watts, C. 2014. Financing structural interventions: Going beyond HIV-only value for money assessments. *AIDS*, 28(3), 425–434.
- Resch, S., Ryckman, T. and Hecht, R. 2015. Funding AIDS programmes in the era of shared responsibility: An analysis of domestic spending in 12 low-income and middle-income countries. *Lancet Global Health*, 3(1), e52–61.
- Sameroff, A. 2009. The transactional model. In A. Sameroff (Ed.), *The transactional model of development: How children and contexts shape each other* (pp. 3–21). Washington, DC: American Psychological Association.
- Sherr, L., Cluver, L. D., Toska, E. and He, E. 2018. Differing psychological vulnerabilities among behaviourally and perinatally HIV infected adolescents in South Africa - Implications for targeted health service provision. *AIDS Care*, 30(Suppl 2), 92–101. doi:10.1080/09540121.2018.1476664.
- Solar, O. and Irwin, A. 2010. *A conceptual framework for action on the social determinants of health* (76 p.). Geneva: WHO World Health Organization. http://www.who.int/social_determinants/publications/9789241500852/en/
- Southern Africa Development Community (SADC). 2015. *Minimum standards for the integration of HIV and sexual and reproductive health in the SADC region* [pdf]. <http://menengage.org/wp-content/uploads/2016/09/Minimum-Standards-for-Integration-of-HIV-and-SRH-in-SADC-Region.pdf>.
- Southern Africa Litigation Centre. 2017. *Human rights of key populations in Southern Africa Southern Africa litigation centre*. www.southernafricalitigationcentre.org/annual-reports-and-newsletters/ [Accessed 22 July 2019].
- Sundewall, J. and Forsberg B. C. 2020. Understanding health spending for SDG 3. *The Lancet*, ISSN: 0140-6736.
- The United Nations General Assembly. 1989. *Convention on the rights of the child: Adopted and opened for signature, ratification and accession by general assembly resolution 44/25 of 20 November 1989*. https://ec.europa.eu/anti-trafficking/sites/antitrafficking/files/un_convention_on_the_rights_of_the_child_1.pdf.
- Toska, E., Pantelic, M., Meinck, F., Keck, K., Haghighat, R. and Cluver, L., 2017. Sex in the shadow of HIV: A systematic review of prevalence, risk factors, and interventions to reduce sexual risk-taking among HIV-positive adolescents and youth in sub-Saharan Africa. *PLoS One*, 12(6), p.e0178106. <https://doi.org/10.1371/journal.pone.0178106>
- UNAIDS. 2018. *Social protection: A fast-track commitment to end AIDS. Guidance for policy-makers, and people living with, at risk of or affected by HIV*. Geneva: UNAIDS.
- UNAIDS. 2020. Fast-track: Ending the AIDS epidemic by 2030. <https://reliefweb.int/report/world/fast-track-ending-aids-epidemic-2030-0>
- UNFPA. 2017. *Harmonizing the legal environment for adolescent sexual and reproductive health and rights: A review of 23 countries in East and Southern Africa*. Johannesburg: UNFPA.

- Ungar, M. 2004. A constructionist discourse on resilience: Multiple contexts, multiple realities among at-risk children and youth. *Youth & Society*, 35(3), 341–365. doi:10.1177/0044118X03257030.
- WHO. 2020. Trial results reveal that long-acting injectable cabotegravir as PrEP is highly effective in preventing HIV acquisition in women. <https://www.who.int/news/item/09-11-2020-trial-results-reveal-that-long-acting-injectable-cabotegravir-as-prep-is-highly-effective-in-preventing-hiv-acquisition-in-women>