



MAKING THE MONEY WORK FOR YOUNG PEOPLE

INTERNATIONAL AIDS SOCIETY POLICY BRIEF SERIES: YOUNG LIVES, OLD EXCUSES



AIDS is the leading cause of death among adolescents in sub-Saharan Africa. Compared with other age groups, youth and adolescents have less access to HIV testing, treatment and care, and the number of HIV-related deaths among them is increasing. Young women and girls are especially vulnerable to HIV acquisition; HIV prevalence among them in sub-Saharan Africa is higher than anywhere else in the world. If the UNAIDS 90-90-90 targets are to be reached by 2020, youth and adolescents must be front and centre in the planning, funding and implementation of HIV programming in the region. Focusing on the six sub-Saharan African countries with the highest HIV prevalence rates among adolescent girls – Botswana, Lesotho, Mozambique, South Africa, Swaziland and Zimbabwe – the International AIDS Society conducted an extensive literature review to identify priority areas for investment to accelerate the response for youth in the region.



THE FUTURE BEGINS NOW.
INVESTING IN ME AS A
YOUNG PERSON BEGINS
NOW. INVESTING IN WELL-
BEING AND WELFARE OF
YOUNG PEOPLE LIVING
WITH HIV BEGINS NOW AND
ACTION BEGINS NOW.

YOUNG MAN LIVING WITH HIV, ZAMBIA



OVERVIEW: FUNDING FOR ADOLESCENT HIV PROGRAMMES

EPIDEMIOLOGY: HIGH VULNERABILITY, LOW ACCESS TO HIV SERVICES

AIDS is the leading cause of death among adolescents (aged 10-19 years) in sub-Saharan Africa, and 86% of all AIDS-related deaths among adolescents worldwide occurred in the region¹. Almost half of all new infections among adolescents aged 15-19 occurred in East and southern Africa¹. The epidemic among adolescents has disproportionately affected young women and girls. Seventy-four percent of new infections among adolescents in sub-Saharan Africa were among adolescent girls, and young women in the region are twice as likely as young men to be living with HIV. Exposure to sexual and physical violence increases young women's vulnerability to HIV acquisition. In some settings, women exposed to intimate partner violence are 1.5 times more likely to become infected. Low access to healthcare in general, particularly sexual and reproductive health services, damaging gender norms, and limited access to secondary education all play a role in putting young women in sub-Saharan Africa at an increased risk of infection.

BARRIERS TO ACCESSING SERVICES: DIVERSE YOUTH, DIVERSE NEEDS

Adolescents face a number of unique barriers to accessing health services, contributing to low rates of HIV counselling and testing (HCT); only 10% of young men and 15% of young women living with HIV in sub-Saharan Africa know their HIV status¹. Laws requiring parental consent to access HCT services can dissuade sexually active adolescents from getting tested. In Zimbabwe, for example, the age of consent for HCT is 16, but an estimated 22% of adolescents in the country have had sex before the age of 15. Health services are often not tailored to the specific needs of adolescents, contributing to low retention in care; median antiretroviral (ARV) coverage for adolescents in sub-Saharan Africa is estimated to be 18%¹. Due to the fact that many countries do not collect age- or sex-disaggregated data on service delivery, it is difficult to ascertain exactly how well existing interventions are serving adolescent clients, presenting a serious challenge to the design and implementation of appropriate services for them.

Young key populations face a number of additional barriers to accessing HIV services, including widespread stigma, discrimination and violence. These include young men who have sex with men (MSM), people who inject drugs (PWID), sex workers, and transgender individuals. There is a significant gap in research on young key populations, but research on adults suggests that stigma or perceived stigma can lead members of key populations to self-exclude or be excluded from health services. The criminalization of same-sex relations and drug use make key populations especially vulnerable to human rights violations, violence and harassment. Health services specifically tailored to the needs of key populations – much less young key populations – are often rare or entirely absent in contexts where governments are unwilling to support them.

INVESTMENTS: RENEWED FOCUS, CHALLENGING TO MONITOR

In response to the growing weight of evidence about the scale and urgency of adolescents' needs in sub-Saharan Africa, a number of

important sources of HIV-related funding have been strengthened, prioritized and/or scaled up. With the exception of South Africa and Botswana, where the majority of HIV funding comes from domestic sources, international donors remain the primary source of funding for HIV programmes in the six countries surveyed, particularly PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria, the two largest international funders of the global AIDS response. Both PEPFAR and The Global Fund have highlighted the need to prioritize adolescents, particularly young women and girls, in their most recent strategies, and a number of new initiatives have been introduced to support this renewed focus (see below.)

Despite their commitment to improving the AIDS response for adolescents, tracking PEPFAR and the Global Fund's investments in adolescents and the results of those investments is often difficult. Services reaching adolescents are often provided through non age-specific HIV programmes. Though this approach takes into account diversity of adolescent identities, it does not, respond to heightened HIV vulnerability due to young age (e.g. dependence on caregivers; domestic violence; limited legal rights; lack of HIV prevention knowledge; high-risk sexual behaviours). Furthermore, this approach presents significant challenges to monitoring investments and their ultimate impact on the epidemic among adolescents.

GLOBAL INITIATIVES TARGETING CHILDREN AND ADOLESCENTS

THE DREAMS PARTNERSHIP focuses on the 10 countries that, in 2014, accounted for nearly half of all HIV infections among girls and young women. Through the investment of US\$385 million and collaboration with the Global Fund, partner countries and the private sector, its target is a 25% reduction in HIV incidence among 15- to 24 year-old females by the end of 2016 and 40% by the end of 2017. The Partnership is aimed at helping adolescent girls and young women to lead **D**etermined, **R**esilient, **E**mpowered, **A**IDS-free, **M**entored and **S**afe lives. DREAMS addresses the socio-economic factors, including poverty and gender-based violence (GBV) that increase HIV vulnerability. This includes supporting interventions, such as GBV prevention and educational and economic opportunities. Such interventions involve partnership with further stakeholders, such as the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences and ViiV Healthcare. In March 2016, US\$40 million of the US\$85 million DREAMS Innovation Challenge (that aims to encourage new approaches) was allocated to keeping girls in secondary school.

ACCELERATING CHILDREN'S HIV/AIDS TREATMENT (ACT) INITIATIVE is a two-year, US\$ 200 million partnership with the Children's Investment Fund Foundation. It is aimed at increasing the number of children and adolescents living with HIV who receive antiretroviral therapy (ART) in 10 sub-Saharan African countries. The target is to reach 500,000 children and adolescents in 2016. ACT has seven pillars: policy development for paediatric HIV services; community engagement; case detection; linking HIV care and treatment; treatment initiation, monitoring, adherence and retention; strategic information; and domestic funding. It addresses bottlenecks in the spectrum of care and support, such as retention of adolescents in ART. ACT's guiding principles are that its activities align with national programmes, incorporate sustainability strategies; and work in conjunction with existing ministry of health and PEPFAR structures.

COUNTRY SPOTLIGHTS: IMPROVING ACCESS TO HIV TESTING FOR ADOLESCENTS

Many countries in sub-Saharan Africa do not collect age- or sex-disaggregated data on HTC; nor do they specify the legal age of consent for accessing those services. With an estimated 85-90% of adolescents in sub-Saharan Africa unaware of their HIV status, governments must urgently address social and legal barriers that prevent young people from accessing HTC services. To close the testing gap, governments should establish national legal and policy frameworks that are specific, consistent and take into

account adolescents' realities. This includes acknowledging the fact that many adolescents have sex at an early age and may not feel comfortable asking their caregivers for consent to HIV testing. More governments in the region should follow the examples of South Africa and Lesotho, who specifically state in their laws and policies that HTC services are to be provided to all clients from the age of 12 years onwards, regardless of caregiver consent⁴.

BOTSWANA

HIV prevalence 15-24: Male 3.9; female 9.8

Age of consent to sexual activity: 16⁵

Age of consent to HTC: no minimum age; case by case decision by healthcare provider

Adolescents who had sex before the age of 15: No data

Adolescent programme example: Teen Club Botswana, funded by PEPFAR, UNICEF, the Botswana Ministry of Health, the US CDC, the US NIH and the Baylor International Pediatric AIDS Initiative, provides support to youth living with HIV, and facilitates their transition to adulthood. It offers weekly programmes that include an educational component on HIV disclosure and adherence, personal finances and goal setting.

SWAZILAND

HIV prevalence 15-24: Male 7.3; female 16.7

Age of consent to sexual activity: 16⁶

Age of consent to HTC: 16

Adolescents who had sex before the age of 15: 3.2%

Adolescent programme example: Super Buddies Club, funded by PEPFAR and the Ministry of Education and part of the Adolescent and Youth Peer Education for HIV Prevention Project, targets children and youth aged 5-25. It reaches this population through radio and television programmes, workshops on business skills and peer education training. It also promotes prevention and empowers youth to cope with challenges in their communities.

MOZAMBIQUE

HIV prevalence 15-24: Male 2.3; female 4.0

Age of consent to sexual activity: 18⁷

Age of consent to HTC: 16

Adolescents who had sex before the age of 15: 22.8%

Adolescent programme example: Bantwana Mozambique, funded by the Government of Mozambique, ChildFund International and local partners works in nine districts to provide information and strategies to children and adolescents vulnerable to HIV. It provides the following services: child and parenting education, reproductive health education, psychosocial support for those diagnosed with HIV, and entrepreneurship and life skills building to provide economic stability.

ZIMBABWE

HIV prevalence 15-24: Male 3.8; female 5.9

Age of consent to sexual activity: 16⁸

Age of consent to HTC: 16

Adolescents who had sex before the age of 15: 4%

Adolescent programme example: PSI, funded by the Zimbabwean Government, targets youth, children and young couples. It has implemented several programmes in Zimbabwe in partnership with the Ministry of Health and community-based organizations. Its New Start initiative provides HTC and post-test support services, including psychosocial and ART adherence counseling; it also supports the government's priority of achieving universal access to treatment in Zimbabwe. Other services include condom distribution, voluntary male circumcision (VMMC), tuberculosis (TB) screening, family planning, cancer screening and TB treatment.

SOUTH AFRICA

HIV prevalence 15-24: male 4.0; female 11.6

Age of consent to sexual activity: 16 (with another minor)⁹

Age of consent to HTC: 12

Adolescents who had sex before the age of 15: No data

Adolescent programme example: The South African multimedia "edutainment" programme, *Soul City*, helps change social norms around HIV/AIDS and domestic violence, contributes to increased individual knowledge about condom use and domestic violence, and contributes to the empowerment of local communities¹⁰.

LESOTHO

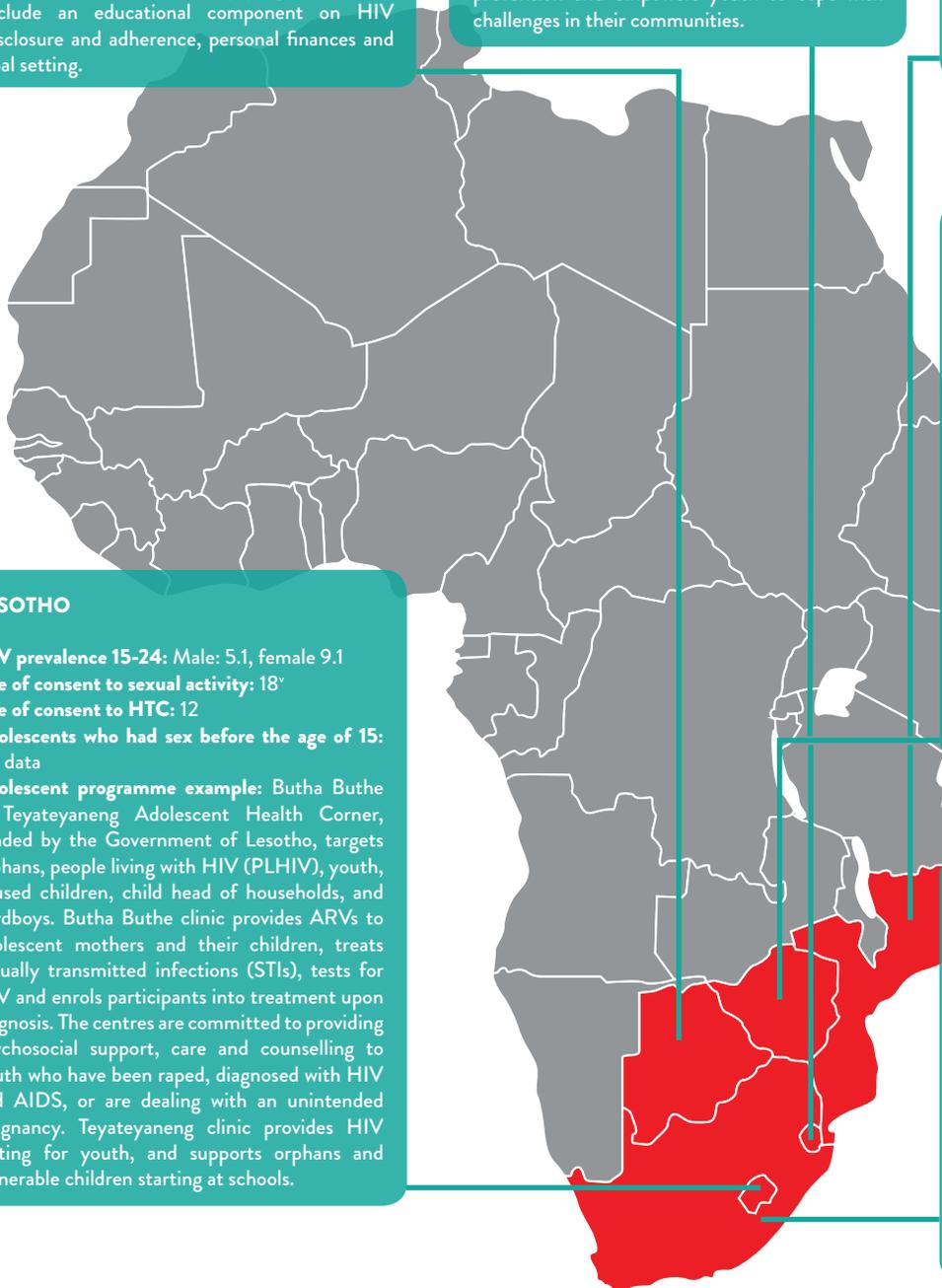
HIV prevalence 15-24: Male: 5.1, female 9.1

Age of consent to sexual activity: 18¹¹

Age of consent to HTC: 12

Adolescents who had sex before the age of 15: No data

Adolescent programme example: Butha Buthe & Teyateyaneng Adolescent Health Corner, funded by the Government of Lesotho, targets orphans, people living with HIV (PLHIV), youth, abused children, child head of households, and herdboys. Butha Buthe clinic provides ARVs to adolescent mothers and their children, treats sexually transmitted infections (STIs), tests for HIV and enrolls participants into treatment upon diagnosis. The centres are committed to providing psychosocial support, care and counselling to youth who have been raped, diagnosed with HIV and AIDS, or are dealing with an unintended pregnancy. Teyateyaneng clinic provides HIV testing for youth, and supports orphans and vulnerable children starting at schools.



SIX WAYS TO MAKE THE MONEY WORK: HIV PROGRAMMING PRIORITIES FOR ADOLESCENTS

Effective action on HIV for this age group is not just about *what* is provided, but *how*. Based on our analysis, the focus areas listed here should be prioritized in future programming for adolescents, in particular within the region's hardest hit countries.

1) SCALE UP OF HIV COMBINATION PREVENTION

Catering for adolescents' specific needs, a range of services that address their health, social and economic vulnerabilities must be provided. Alongside "traditional" HIV information, services and commodities and comprehensive sexuality education^{vii}, proven programmes^{viii} include those that give access to education (in particular "keeping girls in school"), social protection^{iv} and cash transfers^x.

A study in Kenya, Malawi and South Africa found that providing economic support, food, psychosocial care and cash transfers had positive health outcomes for adolescents, in particular girls and young women^{xi}. It helped reduce HIV infection by decreasing risk behaviours, such as by delaying sexual debut^{xii} and reducing intergenerational sex.

2) ACCESSIBLE HIV TESTING, COUNSELLING, TREATMENT AND CARE PROGRAMMES

Adolescents need to have the opportunity to know their HIV status through access to a range of options for user-friendly and confidential HCT services. This includes attention to: where the services are provided (such as through mobile clinics in communities or local venues where adolescents feel safe); how they are delivered (such as by adolescent peers or professionals trained in youth-friendly approaches); and what they cost (such as being free or low cost)^{xiii}.

A cohort study in Zimbabwe^{xiii} showed high retention rates and low mortality rates for adolescents in large-scale ART programmes when combined with adolescent-specific activities, such as peer and non-peer counselling, engagement in service planning decisions and youth clubs. Studies on community-based adherence clubs in South Africa showed that they are associated with reduced risk of loss to follow up compared with facility-based care^{xiv} and are the more cost-effective model of care^{xv}.

3) LINKAGES TO HIV TREATMENT AND CARE

After adolescents get tested for HIV, they need to be quickly linked to a range of appropriate follow-on services. This includes providing, or giving referrals to, HIV care, support and treatment services, such as ART, adherence support and counselling on positive living. It also includes ensuring access to related health and social services, for example, concerning their sexual and reproductive health or economic development.

Findings from a study on linkage to care following a home-based HIV counselling and testing intervention in rural South Africa showed that the younger age (15-24 years) of HIV-positive clients was one of the factors that predicted decreased linkage^{xvi}.

4) STRENGTHENED PSYCHOSOCIAL SUPPORT

Alongside other HIV information, services and commodities, adolescents living with HIV need to have access to psychosocial support. Support should be: age-appropriate; holistic (looking at the "whole adolescent", not just their HIV status); and provided by peers and/or appropriately trained community or health workers.

A study conducted in Uganda^{xvii} highlights the need to develop and evaluate psychosocial interventions for adolescents living with HIV. The identified key psychosocial challenges for study participants were stigma and discrimination, HIV status disclosure to family and sexual partners, and difficulties with treatment adherence.

5) ADDRESS SPECIFIC NEEDS OF YOUNG KEY POPULATIONS

Adolescents who are part of key populations often "fall between the gaps" of youth HIV services (that often don't recognize the specific needs of key populations) and key population HIV services (that often don't recognize the specific needs of adolescents). Therefore, access to HIV prevention, care, support and treatment that understands and addresses the specific needs of young key populations, while not further isolating or stigmatizing them, is needed.

A comprehensive literature review^{xviii} of needs, gaps and barriers for young key populations to access services found that coverage of key population-targeted services is low, largely because of stigma and discrimination experienced at both the health system and policy levels. Human rights-based approaches are necessary to remove legal and structural barriers, and service delivery models should be informed by user preferences.

6) SUPPORT STRUCTURE FOR CAREGIVERS

This involves ensuring that the caregivers of adolescents who are vulnerable to or living with HIV are engaged in, and supported by, interventions to reach young people. Caregivers include parents, other family members, guardians and the staff and volunteers of institutions, such as schools and youth centres. Interventions should be designed to support both: the adolescents (for example, by building the caregivers' understanding about how to support those living with HIV to adhere to their treatment); and the caregivers themselves (for example, by giving them access to HCT or family counselling).

Studies in Tanzania and Zambia highlighted how strategies that include the targeting of adolescents' caregivers and educational institutions are crucial for ensuring a holistic care package that supports adolescents living with HIV in adhering to treatment^{xix,xx}.

AREAS FOR ACTION: SIX KEY RECOMMENDATIONS

The evidence summarized in this policy brief confirms the need for specific budget allocations to high-quality evidence-informed adolescent HIV programmes, improved monitoring and evaluation data of existing programmes, and calls for reinforced political and financial commitment from funders and decision makers to respond to adolescent HIV. In order to protect and engage a generation of young people, policy makers and funders, programme implementers and researchers should take urgent action in six key areas to improve the scale, quality and impact of existing interventions.

POLICY MAKERS AND FUNDERS

1) Allocate specific budget to respond to adolescent hiv

2) Prioritize evidence-informed interventions for adolescents

Programming for adolescents should be identified as a political and financial priority within national responses to HIV and donor investments in sub-Saharan Africa. Funding should be specifically earmarked for interventions – such as combination HIV prevention and accessible HCT – that are known to have particular impact on the age group, yet may have been under-resourced to date.

A recent study showed that PEPFAR resources spent on abstinence and “be faithful” programmes have not been associated with reductions in HIV risk behaviour in sub-Saharan Africa^{xvi}; these should be reduced or eliminated. Instead, high-impact interventions, such as VMMC for 10- to 49-year-old males and programming for orphans and vulnerable children, in particular for girls and young women, should be prioritized. Improved reporting linking investments to implemented programmes for adolescents is needed to better monitor and evaluate whether resources are spent effectively and efficiently.

PROGRAMME IMPLEMENTERS

3) Actively engage adolescents in service delivery and programming

4) Deliver targeted and linked health services

It is critical to improve not only the scale, but also the quality of HIV programming and investment for adolescents in sub-Saharan Africa. Programmes should be strengthened through the active engagement of adolescents – taking them beyond the role of “recipients” to being central decision makers and implementers in the design, management, monitoring and evaluation of programmes. Such engagement not only ensures that current interventions are relevant and appropriate, but also helps identify emerging trends to which programmes have to adapt and respond. This includes ensuring that services are fully accessible to the age group – by making them generally “adolescent friendly” and specifically welcoming and appropriate for specific populations, including young men and young key populations.

To increase the reach of HIV services, other health programmes should include a sexual and reproductive health and rights component, for example, linking men who access VMMC programmes to HCT services to improve testing rates among adolescent boys and men.

RESEARCHERS

5) Collect age- and sex-disaggregated data, including key populations

6) Conduct further research on innovative models of service delivery

To ensure a strong evidence base – and to inform the design of effective HIV interventions – it is critical to have a full and accurate picture of the scale and nature of adolescents’ needs and of the results of interventions to support them. At a minimum, all HIV-related programme data should be disaggregated by sex and age groups. Specific data should also be collected – through sensitive and innovative methods – on the scale and needs of young key populations, such as adolescents who are sex workers, MSM, transgender people or people who inject drugs. Such efforts should be supported through agreement across relevant stakeholders of the definitions of appropriate age categories and of the reporting requirements for programmes.

To ensure a holistic and effective response to HIV among adolescents, it is critical to address the wider social and economic factors that increase adolescents’ vulnerability. Such strategies should be seen as central to effective action on HIV, not “added extras”. More research is needed on the outcomes of existing and innovative approaches in HIV service delivery and programming for adolescents, across the health and development sector.

ACRONYMS AND DEFINITIONS

ART: Antiretroviral therapy

ARVs: Antiretrovirals

GBV: Gender-based violence

HCT: HIV counselling and testing

MSM: Men who have sex with men

SRHR: Sexual and reproductive health and rights

STI: Sexually transmitted infections

TB: Tuberculosis

VMMC: Voluntary male medical circumcision

90-90-90 targets: By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

Key populations: Men who have sex with men, transgender people, sex workers, people who inject drugs

UNAIDS: Joint United Nations Programme on HIV/AIDS

UNICEF: United Nations Children's Fund

US CDC: United States Centers for Disease Control and Prevention

US NIH: United States National Institutes of Health

PEPFAR: President's Emergency Plan For AIDS Relief

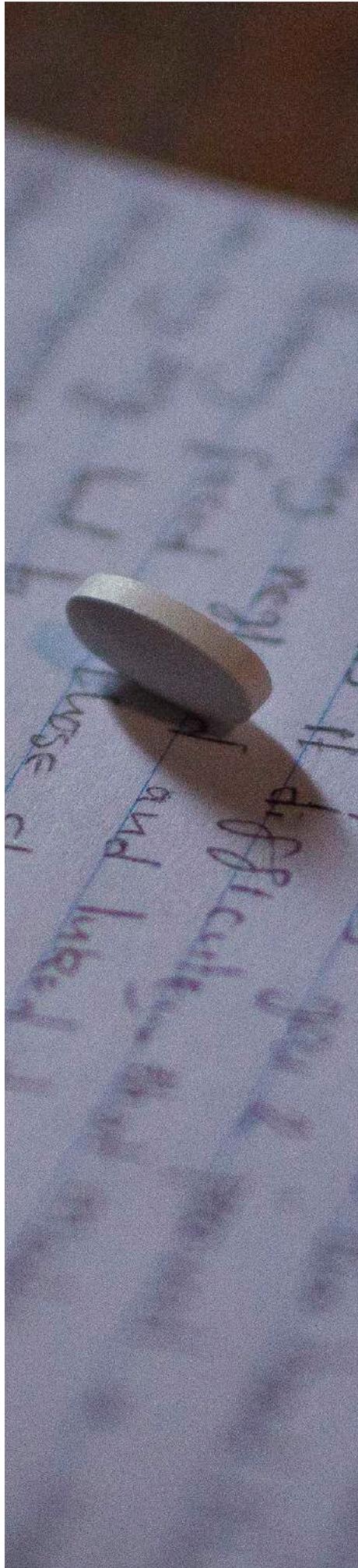
PSI: Population Services International

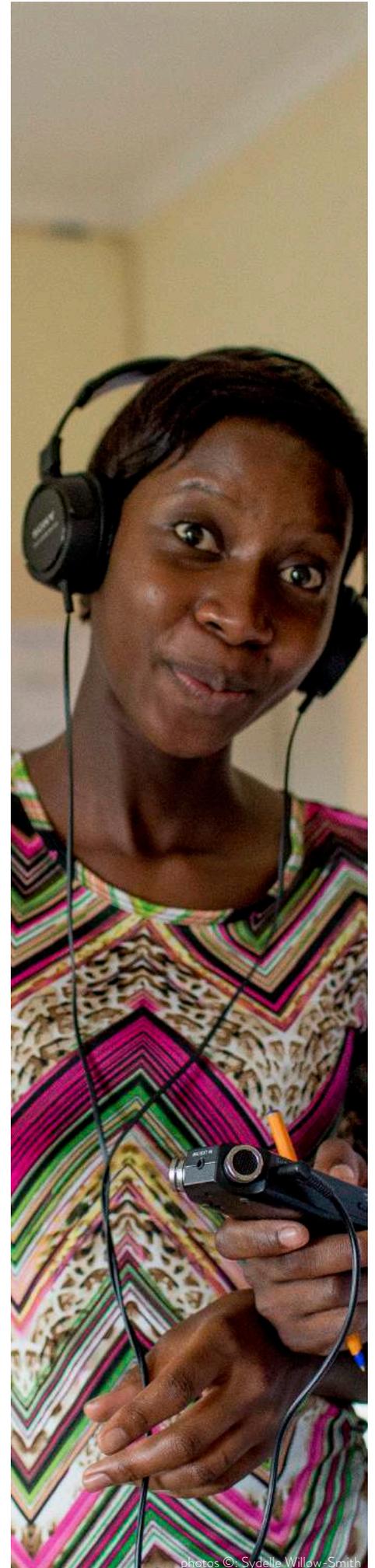
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