Editorial

Sexual and Reproductive Health and Rights and HIV Programming Among Young People Most Affected by HIV: Lessons From the Link Up Project in Five Countries

The current cohort of adolescents and young adults (10–24 years) is the largest the world has ever seen, representing an enormous challenge for health systems and health services, particularly in low- and middle-income countries [1]. Unmet need for both sexual and reproductive health and rights (SRHR) and HIV services is substantial in the developing world [2]; unmet need is often highest among older adolescent girls and young women (15–24 years), who tend to have high rates of unintended pregnancy and sexually transmitted infections [3]. For example, in Africa, and especially in eastern and southern Africa, HIV-related mortality is the major cause of mortality among adolescent girls and a substantial cause among adolescent boys [4]. Adolescents and young adults are at risk for poor SRHR outcomes because of social and structural factors and partner-related risk factors. Particularly vulnerable sub-populations include young people who are poor, are living with HIV, are living on the streets, are engaged in transactional sex, are sexual minorities, and are without educational and employment opportunities. Thus, empowering young people—in addition to providing SRHR and HIV services—is essential.

The three commentaries and five articles in this supplement report on the Link Up consortium project (2013–2016), which aimed to improve the SRHR of young people (10–24 years old) most affected by HIV in five countries; three in Africa (Burundi, Ethiopia, and Uganda), and two in Asia (Bangladesh and Myanmar). The primary groups of young people engaged in the research were young men and women who sell or transact sex or are living with HIV, men who have sex with men, and young transgender people. The project was a consortium effort led by the International HIV/AIDS Alliance and funded by the Dutch Ministry of Foreign Affairs.

The lead commentary, by Stackpool-Moore et al. [5], gives a description of the Link Up project and summarizes aspects of the key lessons from it. The authors stress that program developers must remember that there is considerable diversity, both between the specific subgroups of young people most affected by HIV, but also within them, e.g., by location, age, and sex. The project also explored the potential of integrating—or at least improving connections between—SRHR and HIV services.

Many of the specific interventions that were introduced during the Link Up project were led by young people. This is illustrated in the second commentary, by Nininahazwe et al. [6], which describes the Réseau National de Jeunes Vivant avec le VIH, a national network of young people living with HIV in Burundi. It gives examples of the energy and insights that can be generated by such networks for both peer support and advocacy and describes some of the challenges faced by such organizations. These include the continuous requirement for training and mentorship of future leaders and the need to find roles for older young adult members as they “age out” of the target age range.

The Link Up project endeavored to make a rights-based approach to SRHR and HIV programming for young people a cornerstone of its research interest and interventions. The third commentary, by Orza et al. [7], stresses how rarely such programs actually do put the “second R” (rights) into SRHR programs for young persons. It provides a five-point framework for advancing programming and advocacy to improve health outcomes by better protecting, respecting, and fulfilling the sexual health and reproductive rights of young people living with, and most vulnerable to, HIV.

Very important structural drivers of both adolescent SRHR and HIV are inequitable gender norms [8]. The measurement of gender norms is essential both to quantify and unpack the scale of the problem initially, but also to measure changes over time, especially in the context of an intervention. The GEM scale is a tool that aims to do this. It was developed and initially tested among young men in Brazil [9]. The first article, by Vu et al. [10], evaluates the performance of the GEM scale in young adolescents (10–14 years) and in youth (15–24 years) in Uganda. The authors concluded that the GEM scale appeared to be a valid tool in both age groups and in both sexes in this context. There were high levels of support for inequitable gender norms in all four age-sex groups. Interestingly, young adolescents displayed less equitable norms than youth.

Also in Uganda, in the second article, Vu et al. [11] present the results of a before-after evaluation of the impact of a peer-led intervention that provided a package of HIV and SRHR services through community-based peer support groups for young people living with HIV. The intervention was associated...
with an increase in the uptake of a wide range of HIV, sexually transmitted infection, and family planning services and a reduction in self-reported sexual risk behaviors. Despite the lack of a contemporaneous comparison group, the consistency of the improvements was encouraging.

Programs have tended to assume that most of the transactional sex that young people living on the streets engage in will be where the young person sells sex for money or gifts. However, in the third article in the supplement, an insightful study by McClair et al. [12] demonstrates that many young men living on the streets of Dhaka City, Bangladesh, also purchased sex. The study has important implications for intervention design for this highly vulnerable group of young men.

A second study from Bangladesh evaluated changes in health care providers’ self-reported attitudes toward marginalized young people before and after a 2-day HIV and SRHR training workshop that included a 90-minute session on stigma and was followed 6 months later by a whole-day’s training on stigma [13]. The study documented improvements in the health care providers’ attitudes. But importantly, their young clients also reported greater satisfaction with the consultations after the health care providers had received training, especially after the whole-day training workshop.

The final article, by Aung et al. [14], evaluated the acceptability and effectiveness of a combined community-based and clinic-based intervention to reduce HIV risk among young men (15–24 years) who have sex with men (YMSM) in Myanmar. Using respondent-driven sampling in purposively selected intervention and control communities, cross-sectional surveys were conducted among YMSM before and 6 months after the start of the intervention. Disappointingly, there were no significant differences in any of the variables used to assess HIV knowledge, self-reported sexual risk behavior, or health seeking behaviors. Although the lack of any statistically significant differences by study arm means that the intervention itself may truly have been ineffective, these findings may have been due to other reasons: only a small proportion of the YMSM in intervention communities had heard of the intervention at the follow-up survey; the numbers involved in the surveys were relatively small; and the duration of the intervention was relatively short at 6 months.

While much remains to be learned about how best to program with, by, and for young people who are most affected by HIV (and even more remains to be done), this supplement will give heart to many involved in SRHR and HIV programming for such young people in low- and middle-income countries. Critical insights from the Link Up project include the importance of never forgetting that young people are individuals with unique needs and unique capacities to support both themselves and others. This is as true for those who share a vulnerability—such as being a young man who has sex with other men or a young woman who is living with HIV—as it is for other young people. Working with and empowering such young people can release untapped resources and translate many of the principles of rights, stigma reduction, and equity into concrete action.

When taken as a whole, the studies reported here illustrate the importance of taking an integrated and comprehensive approach to programming, including integration across the components of SRHR and HIV services, integration of services provided within health care facilities and in the community, and coordination of interventions at the structural, community, and individual level.

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References