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LINKUP



LESSONS FROM LINK UP! WHAT'S SO DIFFERENT ABOUT ADOLESCENTS?

UNIQUE CHALLENGES AND OPPORTUNITIES IN ENGAGING 10-19 YEAR OLDS IN INTEGRATED HIV AND SRHR SERVICES

Adolescents are unique in their development, their health and their social needs; therefore, their service requirements are different. The developmental changes experienced during adolescence make it one of the most rapidly changing stages of life.[1] These changes impact on adolescents' health, not only during adolescence but also across their lifetime. The effect of barriers and poor quality health services are intensified by their ongoing development, impacting the way that adolescents engage with services and, ultimately, affecting their health and wellbeing.[2]

Despite growing recognition of adolescence as a distinct time of life with specific needs that requires targeted programmes and services, adolescents continue to be left out of national responses including sexual and reproductive health and HIV.[1] Policies, strategies, programmes and monitoring systems have failed to include specific considerations for adolescents. The lack of targeted interventions for adolescents and key gate keeper, inappropriate use of service delivery platforms, slow responses to changing legal and policy barriers and the inability to report disaggregated data has meant that adolescents are not receiving the services they require. This also means that they are caught in a persistent cycle of gaps in understanding and expertise in programming for adolescents.

Launched in 2013 by a consortium of partners led by the International HIV/AIDS Alliance, Link Up sought to improve the sexual and reproductive health and rights (SRHR) of 10–24 year olds most affected by HIV through the delivery of integrated HIV and SRHR programmes.[3] Over the course of three and a half years, Link Up helped reach 939,045, or almost

Link Up has brought SRHR interventions to existing community-based HIV programmes and created links between public and private SRH and HIV service providers.[3] It has succeeded in:

- Linking up HIV and SRHR training and information, education and communications materials to enable peer educators and service providers to engage young people and refer them to services
- Linking up services within health facilities and between health facilities to properly address the diverse HIV and SRH needs of young people
- Linking up HIV and SRH services between community-based organisations and clinical health facilities
- Linking up young advocates with policy and decision-makers working on HIV and SRHR.

1 million young people, in five countries across Africa and Asia: Bangladesh, Burundi, Ethiopia, Myanmar and Uganda. In putting young people at the centre of programming, Link Up provided a framework of interventions that was adapted by the target countries, each having a different focus depending on their epidemiological and country context.

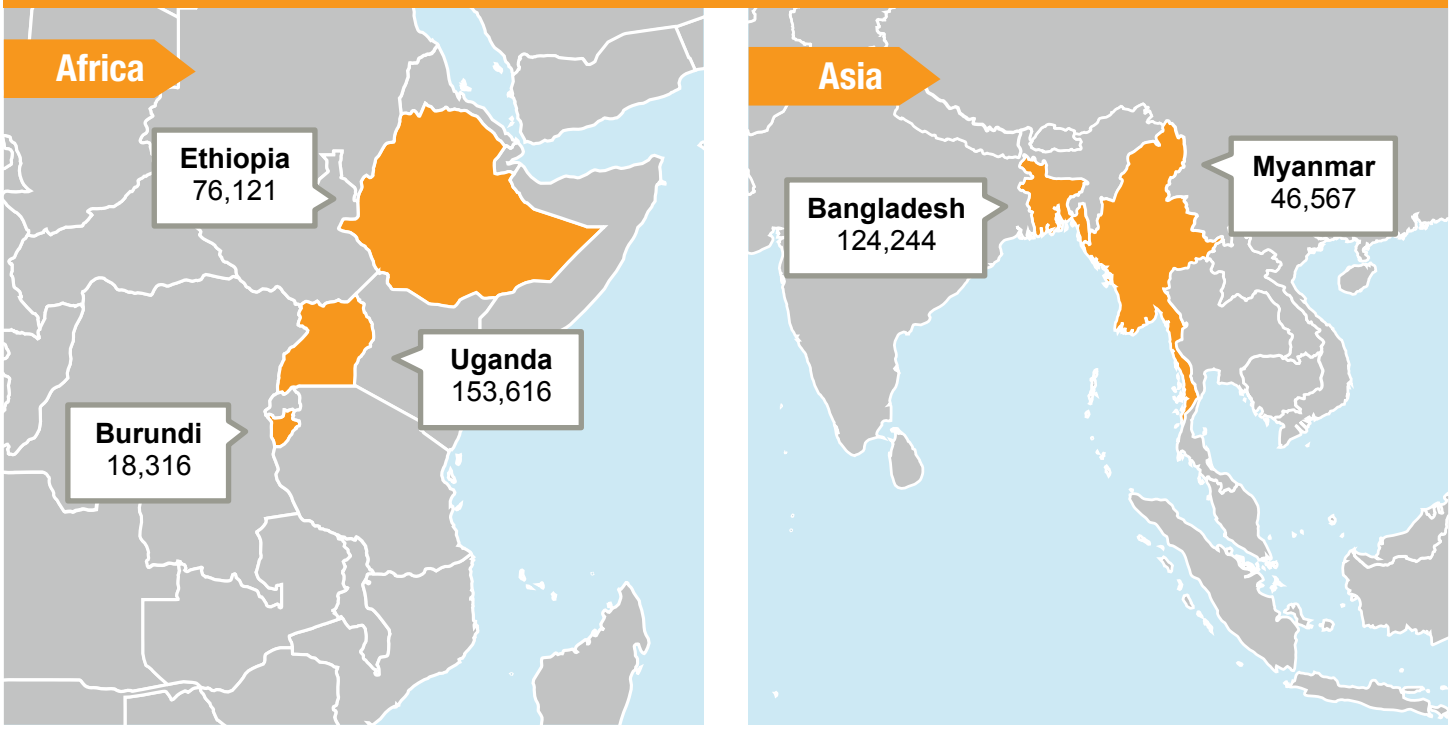
The broad programming emphasis meant that initially interventions included adolescents but were not specifically designed for or delivered differently to them. However, as Link Up progressed, its success in engaging large numbers of adolescents was evident. Link Up reached 418,864 adolescents, accounting for 45% of all young people reached. Of the adolescents reached, 27% (112,584) were 10–14 years and 73% (306,280) were aged 15-19.

Those at most risk or from key population (i.e adolescents selling sex, using drugs and identifying as sexual minorities) accounted for 43% of 10–14 year olds and 48% of 15–19 year olds. Across the five Link Up countries, Uganda and Bangladesh engaged the largest numbers of adolescents and over 50% of those reached through Link Up in Ethiopia and Bangladesh were 10–19 years old. The number of adolescents reached increased particularly in the second year of Link Up. For community based services, adolescents reached in the second year increased 50 times those reached the first and for facility based services 16 times.

With increased exposure to adolescents, Link Up organisations implementing the project (Alliance Linking Organisations (LOs), their implementing partners (IPs) and other consortium partners) became increasingly aware of the developmental differences and unique needs of adolescents and the challenges they confront in accessing SRHR and HIV services. Consequently, programmers and service providers became better informed and equipped to adapt their services in order to more adequately address adolescents' evolving needs. Given the limited global experience of programmes to comprehensively address the SRHR and HIV needs of adolescents, it is vital that we take this opportunity to learn from Link Up in order to ensure that future programmes targeting this population maximise resources and efforts.

This brief explores some of the key lessons learned from Link Up in terms of engaging and providing services to adolescents. Specifically, this brief aims to:

Link Up adolescent reach by country (2013-2016)



a) gain a better understanding of how adolescents were reached and engaged; b) outline the key challenges encountered as well as critical success factors (from providers', programmers' and adolescents' perspectives) in relation to reaching adolescents with services; and c) identify gaps and make recommendations for future adolescent programming. Data from the Link Up monitoring system, findings from research studies and outcomes of community dialogues were all examined for adolescent aspects. In order to complement these data, interviews with LOs and IPs explored the perspectives of those involved in managing and providing services.

Adolescence: unique opportunities and challenges

Adolescents are sexually active: In contrast to the prevailing view in many settings, providers in all five Link Up countries highlighted that many adolescents initiate sexual activity at an early age. Participants taking part in research conducted in Uganda as part of Link Up reported sexual debut at age 15, while young MSM taking part in a study in Myanmar reported average sexual debut at age 16.[4,5] 'Age at first sex' is an important indicator of sexual risk as it marks the onset of exposure to infection with HIV and other STIs. Research conducted as part of Link Up in Bangladesh with young pavement dwelling males found that early sexual debut was significantly associated with an STI; this finding highlights the vital need to design interventions that target adolescents before sexual debut, and to ensure access to SRH information and services from a younger age.[6]

Adolescents often do not seek out SRH services: Community mobilisation activities implemented prior to Link Up targeted young people more generally and not adolescents specifically. LOs and IPs described how they found it challenging to adequately engage with adolescents at the outset of Link Up. Adolescents are often faced with many competing priorities and interests and may not prioritise their health or proactively engage in health-seeking behaviours. Many adolescents are not aware of their need for services,

The BEZA Anti-AIDS youth group get messages about HIV prevention across to the wider public, and in particular to their peers, Ethiopia. © 2016 International HIV/AIDS Alliance

Panna a beneficiary of the Link Up project. Poverty drove her into sex work when she was 18. © 2016 Syed Latif Hossain/International HIV/AIDS Alliance

Ritah Nabukala (18) and a friend burst into laughter during a sex education talk, Uganda. © 2016 International HIV/AIDS Alliance

where services are or how to access them. Additionally, taboos and stigma related to adolescents' sexuality often discouraged them from seeking services.

Evolving nature of adolescence: Adolescence is a developmental period characterised by rapid physical, psychological and emotional changes. Adolescents' evolving capacities often means they are less empowered to make decisions and have autonomy over how and when they engage with SRH services. Identity formation is a key aspects of adolescence. Adolescents might not necessarily define themselves by a particular risk group or key population; they may have multiple overlapping risks which change over time. This includes the formation of sexual identity and sexual exploration, as these develop, confusion and weak self-identification of different sexual identities or risk-taking behaviours may mean that some adolescents remain hidden from and without services. It is necessary for programmes be dynamic and responsive to the ever-changing needs of adolescents in order to ensure that the information, services and support being offered/provided to adolescents remains relevant and appropriate.

Lack of confidence, developing coping mechanisms, and limited support structures: Such factors meant that adolescents required more support to seek out and engage with the services they needed. Adolescents were noted to be susceptible to exploitation and abuse. In particular, those from key populations faced ongoing harassment, even from those who are supposed to protect them. Adolescents are still-developing internal resilience, together with often-limited support structures, greatly affects their ability to cope with and overcome the consequences of this. Within Link Up, the diversity of adolescents was noted, with those selling sex or transgender adolescents tending to have greater agency and capacity to make decisions, look after themselves and live independently, compared with those adolescents born with HIV, who, for example were living at home or had support from caregivers.

Adolescents are open to new experiences and show a willingness to learn: Adolescents typically have less-established behavioural patterns and are therefore more easily influenced in positive or beneficial ways. Those engaged by the Link Up project were eager to learn, open to new ideas, and receptive and responsive to information and activities related to their SRH needs.

Adolescents are particularly receptive to peer influence: Adolescents were more likely to engage in activities that included

Members of The BEZA Anti-AIDS youth group use their combined talents for music and dance to get messages about HIV prevention across to the wider public, and in particular to their peers, Ethiopia.

their peers, and were more likely to attend a service if supported by a peer. Having peers in clinical settings supported them to be more open about their needs and to discuss them without fear. Peers provided a vital link between adolescents and facilities, and between facilities. Once engaged, adolescents often mobilised and encouraged the engagement of their friends; this may be an effective and cost-effective way of extending the reach to ever greater numbers of adolescents.

Adolescents rely on gatekeepers: Engaging with gatekeepers in all settings was also viewed as key to facilitating access to SRH services for adolescents. In many cases, even those adolescents without parents/guardians were inclined to seek the permission of gatekeepers around them before accessing SRH services. For example, young people selling sex may seek the permission of older sex workers or from pimps before accessing services. Schools and teachers were also viewed as critical gatekeepers to ensure access for 10–19 year olds but school policies and regulations, combined with societal norms, proved to be barriers to engaging with schools.

Adolescents are influenced by cultural and societal expectations: In particular, views and norms around what is deemed socially "acceptable" in relation to SRH often overrode an adolescent's still-developing risk perception or understanding of their need for services. Research conducted as part of Link Up in Uganda looking at gender norms among 10–14 year olds highlighted that those aged 10–14 had already internalised inequitable gender norms and demonstrated greater acceptance of such norms than their older counterparts.[7]

Myanmar outreach workers in Yangon. © 2016 International HIV/AIDS Alliance in Myanmar

Adolescents belonging to key populations remain hidden: Many adolescents from key populations in particular remain hidden from services. Other important priorities such as shelter and food were seen to compete or distract them from accessing SRH and HIV services, with LOs and IPs both having limited capacity or options of partner organisations to link them to support these needs. Adolescents from key populations were also noted to be the least likely to re-engage in services; their often chaotic lifestyle meant that they were less likely to follow up on services provided, requiring additional investment from service providers. Fear of harassment and legal redress also greatly impedes access to essential services for these populations. In Link Up, this impacted the ability of LOs and IPs to actively reach out to and engage adolescents from key populations. In some cases, providers are forced to deny any involvement with these populations for fear of legal consequences.

Parental/guardian consent requirements are a key barrier to adolescents accessing services: Difficulties in reaching adolescents with SRH services were compounded by age of consent laws, particularly for those aged 10–14 years. Providers acknowledged feeling conflicted, torn between the need to adhere to consent requirements on the one hand while maintaining adolescents' best interests on the other. Many reported having to work in the absence of parental consent, particularly to treat STI's or in the provision of contraception

when sexual activity was reported. Providers in settings where the age of consent for services were lower, i.e. 15 years old, recognised this as an enabling factor in allowing adolescents greater access.

Adolescents have limited knowledge of SRHR due to poor access to information: Compared to those over 19, adolescents—especially younger adolescents—had limited SRHR and HIV knowledge, even in relation to pubertal changes. Low levels of understanding were mainly attributed to a lack of accessible information. Programmes found that any form of SRHR and HIV information to adolescents was often blocked; adolescents were rarely exposed to the information they needed. Social media as a platform for information sharing was seen to be less effective with adolescents—especially younger ones—as they had limited access.

Many service providers and family members lack the skills and experience necessary for effectively communicating with adolescents: Communicating with adolescents was noted to be particularly challenging. Service providers found it difficult to know how to communicate with adolescents and how to approach sensitive topics. Expertise in 'knowing what to say and how to say it', especially with those aged 10–14 years and those from key populations, was consequently developed by providers over time. Conversations within the home were minimal, with many parents unsure of how to approach discussions around SRHR. In some Link Up countries, programmes found that SRHR and HIV information was not delivered in schools. In countries where comprehensive sexuality education (CSE) was provided, it was often weakened by conservative school authorities. In the absence of the provision of accurate SRHR information, adolescents relied instead on their peers as sources of knowledge; this often resulted in the promotion of misinformation, myths and uncertainty among adolescents regarding their right to access services.

Poor quality of services: Limited experience and expertise on the part of service providers in managing adolescents, especially those aged 10–14 years and those from key populations, created significant challenges in providing appropriate and acceptable services for adolescents. This lack of training or mentorship, combined with limited adolescent-specific guidance, tools and materials, negatively impacts the quality of services.

Providers who lack training are unable to meet the expectations of adolescents for non-judgmental and confidential services that are appropriate to their needs. Most guidance available to providers did not include adolescents or specific considerations on how to deal with more complicated and sensitive issues. Limited access to adolescent-specific IEC materials and guidance meant that providers had to learn how to adjust the content verbally to suit the development of the adolescent. This led to some IPs having to adjust different resources and guidance with the assistance of adolescents, to ensure they were developmentally appropriate.

Common myths about SRHR and HIV among adolescents:

- **Having sex reduces menstrual pains**
- **You can't get HIV if you have sex with a virgin**
- **If you shower immediately after sex, you won't get pregnant**
- **If you put insects on your breasts then they will grow bigger**
- **Having sex with a condom is like eating a wrapped sweet**

Link Up IEC materials covering a range of subjects for adolescents; developed by Organisation for Social Support, Health and Development (OSSHD), formerly OSSA, in Ethiopia.

Effective Link Up strategies and approaches for adolescents

Peer-based interventions were central to the success of Link Up: Services in Link Up provided by peers proved highly acceptable among adolescents. Peers were critical in facilitating access to SRH services: adolescents were more likely to engage in activities that included their peers and were more likely to attend a service if supported/accompanied by a peer. Even through word of mouth, stories of quality service from peers encouraged access. For the facilitation of information-sharing activities peer educators were central. Using their personal stories, peers provided basic SRH/HIV facts and focused on life skills such as decision making, friendships and staying safe. Within facilities, younger providers and peers were based in waiting areas, youth-friendly corners and regular services. Although many peer providers were slightly older than the adolescents, their proactive and friendly approach helped adolescents to feel more comfortable and welcomed in a setting that is perceived to be very intimidating.

Interactive fun activities such drama, music, sports events and tea ceremonies were central to capturing the attention of adolescents: Interactive activities were not only successful in engaging adolescents, they conveyed key messages and information. Drama and film were useful in engaging adolescents' attention while exploring important and sensitive issues such as sexuality and stigma. With additional roles plays, they were able to 'break the ice' and facilitate conversations. Art, drawings and other visual activities were also very popular amongst adolescents as they facilitated expression and allowed for a different way of communicating. For younger adolescents and those of lower educational status, sharing information with pictures was extremely useful in overcoming communication barriers. Through play and fun, these activities encouraged discussion around SRH and HIV in a non-threatening and entertaining way. Youth camps were also noted as successful strategy to engage adolescents. Their less formal structure, away from authority figures, facilitated a fun and free learning environment where adolescents felt comfortable to express themselves.

The role of community health workers and nurse counsellors in supporting peer approaches:

LOs and IPs acknowledged the success of peer approaches and the critical need for ongoing collaboration and support through mentorship and supervision. Community health workers (CHW) and nurse counsellors are key to providing support to peer providers. In particular, for younger adolescents and those from key populations, peer interventions were more closely supervised with the CHWs and nurse counsellors taking on more active roles. Not only did they provide the necessary support and supervision for adolescent peer educators, they reinforced and expanded on key messages, dealt with more serious and sensitive topics, provided one-to-one counselling and facilitated urgent follow-up and support.

Group-based activities facilitated the sharing of information: The majority of information-sharing activities for adolescents were conducted in groups. They were often less formal and less structured than sessions with their older counterparts. They were more spontaneous and driven by adolescents, shaped by their priority topics and the information they wanted. Facilitators took these opportunities to listen, understand the gaps or misinformation in their knowledge and provide the appropriate information accordingly. These discussion groups were frequently divided into age groups of younger and older adolescents to take into account their evolving needs. They took place in spaces that were deemed safe, confidential and acceptable to the adolescents. Although this was often away from the facility, these group discussions led to adolescents receiving the services they needed.

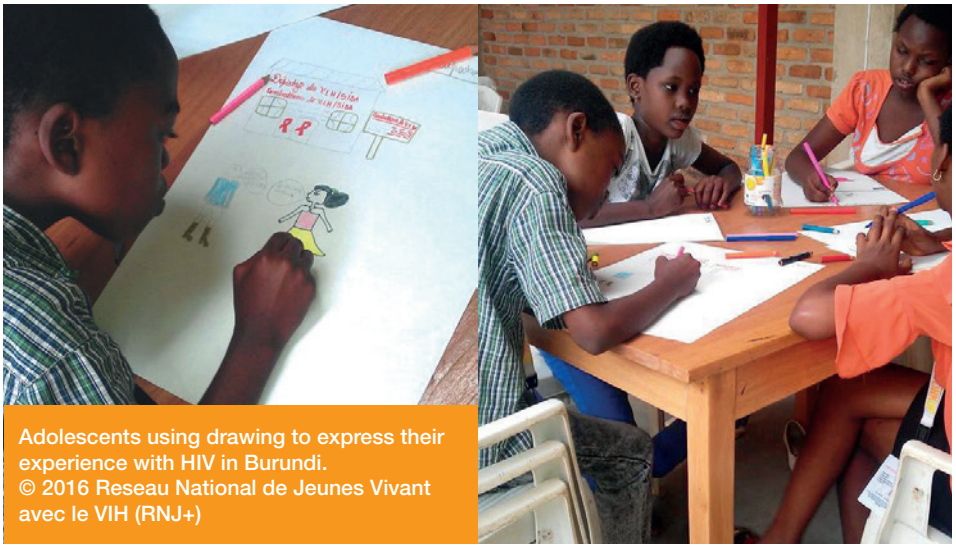
Adolescents favoured community-based over facility-based services: Link Up engaged with adolescents in their own environments; providing services in the places they typically socialise and meet with others. This was key to ensuring access. Analysis of Link Up data monitoring systems indicated that adolescents were more likely to use community-based services than facility-based services. This was particularly evident for those 10–14, with over 85% of interaction in the age group being through community-based services.

Provision of integrated services, in one place or linked through referral systems, supported adolescents to navigate often-complex health systems: Vouchers and referral slips used in Link Up were particularly effective in ensuring completed referrals.[8] Having something tangible to hold that was linked to a task supported them to access services. The most common referral for adolescents was for STI diagnosis and treatment (46%) followed by voluntary counselling and testing (VCT). Among those 10–14 years, VCT accounted for 28% of adolescent referrals which was higher compared to those 15–19 years at 16%.

Service Delivery points - What service delivery points did adolescents use?

Overall in Link Up, community-based services received four times more clients than facility-based ones. Outreach services were the most common service delivery entry point for adolescents. iv Seventy-three percent of 10-14 year olds and 64% of 15-19 year olds first accessed services through outreach compared to 57% of 20 -24 year olds.iv Outreach services and drop-in centres were particularly popular with adolescents from key populations especially amongst those who sell sex.

When accessing facility-based services, adolescents were more inclined to attend private services offered by non-governmental organisations (NGOs) compared to those 20–24, who were more willing to go anywhere. These services were favoured over public facilities as they were more orientated towards adolescents' needs. NGO services are generally located within the community and easy to find, they are confidential, faster, provide dedicated adolescent spaces and have adolescent-trained providers who are younger.



Adolescents using drawing to express their experience with HIV in Burundi.
© 2016 Reseau National de Jeunes Vivant avec le VIH (RNJ+)

In providing a range of integrated interventions, Link Up services were able to be flexible and respond to individual needs, delivering responsive packages of care. Experience gained from Link Up highlighted that adolescents' needs are diverse and constantly evolving, and the requirements for services, interventions and support differ across age groups and key population groups. Analysis of routine data indicated, for instance, that 47% of adolescents aged

10–14 years were mostly accessing a combination of basic/safer sex counselling and gender and sexuality counselling. In comparison, for those aged 15–19 and 20–24 years, the services accessed most frequently were basic/safer sex counselling and family planning services (47% and 48%, respectively). Service providers noted that that younger adolescents were less inclined to attend clinical services but rather preferred to access information and counselling through peer and group activities. For older adolescents, services focused on information on condoms with an introduction to contraception methods, while those 20–24 had full access to services without questioning. Information provided to 10–14 year olds concentrated on growing up, body development (i.e. menstruation, wet dreams and hygiene), for those aged 15–19 sessions further explored relationships and sexual activity, and for those from key populations, discussion focused in more detail on 'hot issues' such as sexuality and risk-taking behaviour.

Building providers' capacity: Within Link Up, greater emphasis was made regarding provider attitudes towards adolescents. The importance of providers who are knowledgeable, supportive and non-judgmental, and who respect confidentiality was expressed in numerous community dialogues as being essential for the success of this programme. Training delivered through Link Up in all countries built the capacity of both private and NGO services and public facilities. NGO facilities that were known to have trained competent providers were popular amongst adolescents. Great improvements were observed after training especially in relation to those from key populations. Research conducted to examine the effectiveness of stigma reduction training, in Bangladesh, showed that across all age groups, there was greater client satisfaction with provider interactions after training interventions and providers had greater exposure to young marginalised groups.[9]

Engaging with key gatekeepers helped to facilitate open discussions around the SRHR of adolescents and challenge cultural barriers to access: Community dialogues with key gatekeepers, such as parents, facilitated open discussion and were seen as a step towards addressing cultural norms that hinder access. In Burundi, dialogues with parents and adolescents were piloted. Parents discussed together SRHR issues that they found difficult to address with their children. Adolescents likewise, had time together to discuss the issues that they found difficult to address with their parents. Through sensitively-facilitated discussion between gatekeepers and adolescents, the various challenges were explored and dealt with.

The importance of effective communication

The biggest difference noted in communicating with adolescents was how the information is provided, with the provider's approach of particular importance. In order to effectively communicate with adolescents, providers noted the essential requirement to build trust for adolescents to feel 'safe' and at ease. This was achieved through ensuring a confidential environment free from prejudice, where information provided is based on facts rather than subjective judgements. Additionally, active listening allows adolescents to voice their concerns and raise questions, and displaying neutral body language cultivates open dialogue that guarantees that adolescents receive the appropriate package of care. As IEC materials in general were generic across all age groups, the difference for adolescents was in the way the information was verbally communicated. Going through information contained in the materials with the adolescent was key to ensuring their understanding.

Recommendations for future adolescent programming

Utilise, strengthen, and invest more in already successful adolescent approaches and interventions used in Link Up:

Continue to take services and information to adolescents

- Increase outreach to adolescents from key populations
- Find more innovative ways to connect and engage with adolescents through music, sports and games.
- Collaborate with schools, primary and secondary, to promote and improve access
- Increase communication platforms to include media that is accessible for adolescents

Strengthen the quality of services provided

- Invest in youth-friendly spaces/ corners, drop-in centres, waiting areas—that ensure continued engagement of adolescents at health facilities
- Improve referral system with clearer pathways, closer collaborations and more dedicated peer navigators
- Increase number of younger providers, including peers, within services
- Develop collaborations between health facilities and youth organisations to facilitate regular ongoing feedback and opportunities for creative collaborative activities

Provide ongoing training and mentorship to service providers on adolescent development, assisting providers to improve their communication and respond to adolescent needs

- Involve adolescents in trainings as co-facilitators or facilitate their inclusion and bring them in in creative and exciting ways

Explore different new interventions and approaches for adolescent programmes and services:

Greater focus on empowerment

- Build capacity and self-esteem of adolescents from key populations
- Support exploration of gender related activities and sexual identities
- Support adolescents from key populations to recognise and stand up for their rights
- Increase provision of peer support to ensure safe space for adolescents from key populations

Ensure adolescents, not just young people, are involved and given roles of responsibility

- Provide guidance on how to do this safely and effectively
- Provide necessary support and mentorship to develop capacity including pairing with older and experienced young people
- Facilitate opportunities and provide space for participation
- Ensure involvement from the beginning of all programming processes

Provide adolescent-specific guidance at facility and national level

- Ensure guidance on consent, best interest principles, counselling, service packages and special considerations for adolescents from key populations.
- Advocate for policy change or 'exceptions' at national level regarding consent

Provide adolescent-specific materials and tools to deliver services differently

- Improve 'how to' content focused on communication and counseling, especially regarding consent

Engage and provide interventions for gate keepers of adolescents, i.e parents, families, teachers, older key populations

- Explore different interventions that support and provide gatekeepers with skills especially regarding communication
- Empower gatekeepers to understand their important role in supporting adolescents' health and wellbeing

Place a greater emphasis on addressing stigma around sex, contraception, safe abortion, HIV and key populations through broader community interventions

- Explore community interventions to increase awareness about adolescent health needs and that create a supportive environment for adolescent health-seeking behaviours
- Engage more with community and religious leaders
- Continue engagement of communities through community dialogues with greater emphasis on gender norms and sexuality

Seek out collaboration to provide interventions to reduce economic vulnerabilities of adolescents, especially those from key populations

- Explore interventions that address the broad situation of adolescents including their families
- Increase availability of livelihood and vocational training opportunities

Ensure provision of SRHR and HIV information from a younger age

- Support providers to improve communication and assessment skills to limit negative assumptions regarding sexual activity or identity
- Provide information prior to sexual activity so that adolescents can make informed decisions
- Build capacity and motivation (to counteract conservative views) of schools to provide appropriate and accurate CSE

Address gender, sexuality and violence

- Increase knowledge on sexual identities
- Include adolescents in gender programmes to promote equitable gender roles and responsibilities
- Support providers to develop expertise in discussing more sensitive issues like sexuality and gender
- Provider information on violence prevention and referral for counselling and support for violence and harassment, including gender-based and against for those from key populations

Link Up peer educator talks to young people, Uganda. © 2016 International HIV/AIDS Alliance

Endnotes

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Front cover photos:

Left: Addis Beza youth dance troupe, ages 15-20, raise awareness about HIV prevention.

Middle: Esther (18), dances a traditional folk dance from UYDEL. UYDEL Masooli is a home for all ages between 9-25, supported by Community Health Alliance Uganda and other partners.

Right: Girls play netball at Masooli, Uganda.

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Link Up improved the sexual and reproductive health and rights of nearly 940,000 young people affected by HIV across five countries in Africa and Asia. The project was implemented by a consortium of partners led by the International HIV/AIDS Alliance.

For more information, visit www.link-up.org

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Government of the Netherlands

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Contact details:
International HIV/AIDS Alliance,
91-101 Davigdor Road,
Hove, East Sussex,
BN3 1RE
United Kingdom
Tel: +44 1273 718 900
Fax: +44 1273 718 901
Email: mail@aidsalliance.org
Registered charity number 1038860
www.aidsalliance.org