MEETING THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF YOUNG PEOPLE WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITY/EXPRESSION

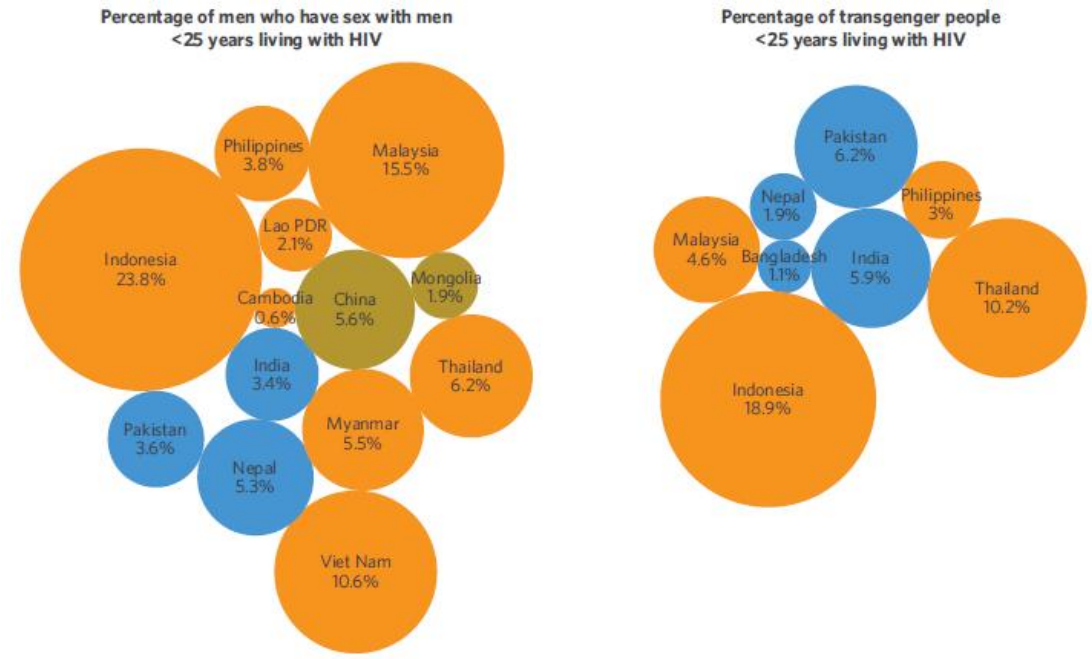
YOUNG PEOPLE WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITY/EXPRESSION EXPERIENCE A DISPROPORTIONATELY HIGH BURDEN OF POOR SRH

Throughout the region, young people with diverse sexual orientation and gender identity/expression (SOGI/E) experience an excess, and preventable burden of poor SRH. Much of the data and evidence of SRH needs among this population are limited to young men who have sex with men, and young transgender women, with very little information available about the SRH needs of young lesbian and bisexual women, transgender men, intersex young people, or young people with other non-cis/non-binary gender identity/ expression. Additionally, much of the focus of available data and studies is on HIV and related risk factors, with less documented about other SRH needs.

Young men who have sex with men, and young transgender people, experience a disproportionate burden of HIV

The vast majority of new HIV infections among young people in Asia and the Pacific occur among key populations, including young people with diverse SOGI/E. HIV prevalence is considerably higher among young men who have sex with men and transgender young people than the overall prevalence for 15-24 year olds: 2020 UNAIDS estimates of HIV prevalence for young men who have sex with men range from 0.6% in Cambodia, to 23.8% in Indonesia, and for young transgender people 1.1% in Bangladesh to 18.9% in Indonesia (figure 29).

FIGURE 29. HIV PREVALENCE AMONG YOUNG MEN WHO HAVE SEX WITH MEN AND YOUNG TRANSGENDER PEOPLE



Source: AIDSInfo

Available data indicate that rates of new HIV infection among young people in Asia and the Pacific have declined 23% between 2010 and 2019, and increased in some countries such as Afghanistan, Fiji§§, Malaysia, Pakistan, Papua New Guinea, Philippines, and Timor-Leste. The fastest growing epidemics in the region are among young men who have sex with men, particularly those living in urban areas. Low levels of HIV knowledge, low risk perception, substance use, marginalization from education, exposure to high risk settings, and transactional sex contribute to risky sexual behaviour and HIV infection in this region.

There are very limited national-level data about STIs among this population. However, smaller studies have indicated that young transgender women and young men who have sex with men have low condom use and high rates of curable STIs, such as syphilis.

Rates of physical intimate partner violence, sexual violence and coercion are high among young people with diverse SOGI/E

Recent studies from the Philippines, Myanmar, Thailand and Mongolia reported that between 15% and 50% of men who have sex with men and transgender women have experienced forced sex. In Thailand, 18% of all men who have sex with men reported ever experiencing forced sex, and for more than 55%, sexual violence had first occurred during adolescence. In Pakistan, young transgender women described significant violence and sexual abuse, often starting in early adolescence. Around 30% of young men who have sex with men, and bisexual men in China reported intimate partner violence, and coerced sex was strongly associated with inconsistent condom use. Severe stigma and victim-blaming contribute to low care seeking among young people who have experienced physical and/or sexual violence.

Substantial stigma and discrimination create significant barriers that prevent access to SRH information and services, contribute to exclusion and marginalisation, and increase young people's risk of violence and exposure to SRH risks.

A significant proportion of young men who have sex with men report risk behaviours such as multiple partners, non-use and inconsistent use of condoms and transactional sex in some settings. In China, a study of young men who have sex with men found that 43% had sex with a partner more than 10 years older, which was associated with non-use of condoms. High rates of substance use (including alcohol and amphetamines), and transactional sex are also associated with risk behaviour and HIV acquisition in this population.

> "I was bullied by ninth grade boys when I was in fifth grade. They teased me and dragged me to a room and tried to take my clothes off. I fought my way out."
>
> (Young transgender person, Thailand)

In addition to poor SRH, young people with diverse SOGI/E report high rates of psychological distress

In a study in India, two thirds of men who have sex with men, and 91% of transgender women reported psychological distress, which was associated with increased sexual risk behaviour. Studies in China and Thailand demonstrated that suicidal behaviour and self-harm were more common among young people with diverse SOGI/E than their heterosexual and cisgender peers. Victimization, bullying, lack of social support, stigma and discrimination are key drivers of psychological distress and poor mental health, and are commonly experienced by young people with diverse SOGI/E. These factors also contribute to risky behaviour such as substance use and sexual risk-taking.

YOUNG PEOPLE WITH DIVERSE SOGI/E HAVE A HIGH UNMET NEED FOR NON-JUDGMENTAL, CONFIDENTIAL SRH INFORMATION AND SERVICES

Many young people lack access to comprehensive sexuality education either because they are not engaged with formal education, and/or programmes are predominantly heteronormative and do not adequately address the needs of young people with diverse SOGI/E. Subsequently, low levels of comprehensive HIV knowledge contribute to higher risk sexual behaviour, low risk perception, and poor awareness of SRH services. To fill knowledge gaps and the need for relevant information that can be accessed anonymously, many rely on informal information sources, such as online sources, social media, or peers

> “The material in the [school sexuality education] module shouldn’t be biased towards just one sexual orientation. So far the material is still very cisgender-biased and there’s no room for conversations about transgender.”
>
> (23-year-old man, Indonesia)

The coverage of HIV prevention interventions among young men who have sex with men, and transgender people under the age of 25 years is low (table 9). With the exception of Cambodia, less than half were reached with combination prevention interventions in countries with available data, and fewer than 10% in Bangladesh, Pakistan, and Lao PDR. In all countries where data are available, fewer young people than adults over 25 years have been reached by these programmes.

TABLE 9. CONDOM USE, HIV PREVENTION, AND KNOWLEDGE OF HIV STATUS

Region	Country	% young men who have sex with men who report condom use at last sex	% young men who have sex with men who report receiving HIV prevention interventions	% of young men who have sex with men who know their HIV status	% young transgender people who report condom use at last sex	% of young transgender people who report receiving HIV prevention interventions	% young transgender people who know their HIV status
South Asia	Afghanistan	17.0					
	Bangladesh	46.3	3.5	10.0	43.2	28.8	36.4
	India	84.0			81.4		
	Nepal	95.1		90.6	96.2		82.7
	Pakistan	83.3	1.8	44.7	26.9	0.8	24.2
	Sri Lanka	47.0					
East Asia	China	85.4		53.6			
	Mongolia	78.7	23.8	76.5			
Southeast Asia	Cambodia	75.4	19.7	72.9	85.0	87.9	71.8
	Indonesia	88.0					
	Lao PDR	25.2	8.0	8.3			
	Malaysia	66.2	35.6	42.1	68.2	45.7	31.1
	Myanmar	55.0	26.0	30.6			
	The Philippines	38.0	12.2	23.0	37.8	16.2	33.7
	Thailand	84.0	52.8	45.1	80.0	46.8	34.9
	Viet Nam	64.9	28.4	72.7			
Pacific	Papua New Guinea	59.9		58.8			
	Samoa	2.2	100.0	100.0	46.7	100.0	100.0
	Tonga	66.7			77.8		

Source: AIDSInfo

Young people with diverse SOGI/E experience considerable barriers to accessing quality health services. Concerns about confidentiality, discrimination experienced within the health system, lack of health provider competency, young people's low health literacy, and financial constraints are commonly reported as reasons for not accessing public health services. In Lao PDR, 75% of young men who have sex with men have avoided seeking health care because of stigma and discrimination. These barriers contribute to low levels of HIV testing (table 9), as well as low retention in care and poor treatment adherence for those living with HIV.

> **We hope SRH services could be completely confidential and the service providers will not overestimate the personal life of the patient, and treat young people equally.**
>
> (Young person, China)

Additionally, the lack of comprehensive services and weak linkages with other clinical and social supports are important contributors to poor health outcomes. Young people with diverse SOGI/E can experience multiple needs and vulnerabilities, including substance use, mental health, social isolation, and violence that increase the risk of poor SRH behaviours and outcomes, in addition to being substantial causes of morbidity and mortality in their own right. There is also some evidence that some young men who have sex with men and transgender women are not always included in services and interventions that are tailored to the gay community. Young people in Myanmar, Vietnam and Thailand who did not openly disclose their sexual orientation or gender identity (that is, did not identify publicly as gay or transgender) were reluctant to access such services due to concerns about their own SOGI/E being disclosed, or because they did not feel these services were designed to meet their needs, highlighting the need for a diversification of responses that are inclusive and acceptable.

National policy and legislation are also critical determinants. **Young people with diverse SOGI/E are largely neglected by existing adolescent health, SRH, and HIV policies and strategies in the region,** which often fail to recognize or address the specific needs and barriers faced by young people. Fifteen countries currently criminalize consensual same-sex sexual acts between men, 10 criminalize same sex acts between women, and three have punitive laws that punish transgender people and related behaviour (figure 30). Many countries that do not criminalize consensual same-sex relations still lack legislation prohibiting discrimination on the basis of sexual orientation or gender identity. In addition to contributing to substantial stigma, such laws are additional barriers to young people accessing services for fear of discrimination or arrest.

Fifteen countries currently criminalise consensual same-sex sexual acts between men; 10 criminalise same sex acts between women

Legislation that requires mandatory parental consent is also a major barrier to accessing services, including HIV testing.

Underpinning all these barriers are the substantial and entrenched individual, community and structural stigma and discrimination that young people with diverse

SOGI/E experience. Non- conformity with rigid, conservative gender and sexual norms, as well as cultural and religious beliefs and taboos, mean that these young people are faced with the double stigma associated with both premarital sexual activity and engaging in behaviours that may be highly taboo or criminalized. Across the region, the experience of stigma is associated with higher prevalence of risks for HIV and low use of SRH services, and contributes to social isolation and exclusion, including from formal education. The major determinants of poor SRH risks and outcomes are summarised in figure 31.

FIGURE 30. CRIMINALISATION OF SAME-SEX SEXUAL ACTS AND TRANSGENDER PEOPLE

Source: ILGA 2019

FIGURE 31. COMMON DETERMINANTS OF POOR SRH AMONG YOUNG PEOPLE WITH DIVERSE SOGI/E

RESPONDING TO THE NEEDS OF YOUNG PEOPLE WITH DIVERSE SEXUAL ORIENTATION AND GENDER IDENTITY/EXPRESSION

Much of the evidence for addressing SRH needs of young people with diverse SOGI/E comes from HIV research, with very little published research from this region addressing other SRH needs and outcomes. A summary of key WHO strategies, regional initiatives, and global evidence of effective approaches to address HIV is provided in box 8.

Several recent studies from this region have suggested that peer-led approaches to provide education and counselling have the potential to increase knowledge, improve condom use, and increase uptake of HIV testing among young men who have sex with men and transgender women, particularly when these approaches are linked with health services. There is also the significant potential of digital media to provide accurate, tailored and anonymous sexuality information, education and counselling, particularly for those young people with very poor access to comprehensive sexuality education. However, some studies have identified the need to combine other approaches (such as face-to-face counselling) with online platforms to promote life-skills. There is also potential of using mobile phone apps to enable young people with diverse SOGI/E to identify health services that provide non-judgmental care.

Other studies have highlighted the need for comprehensive ‘one-stop’ services that address multiple health needs and risks, and also link to community-based organisations to improve access to social and other supports. Lay / peer provider testing for HIV, or self-testing, has also been reported to be preferred by some young people due to convenience, confidentiality and less stigma. Vouchers for targeted HIV prevention, testing and care may improve linkages to SRH and HIV services in some settings. Pre-exposure prophylaxis for HIV (PrEP) has been demonstrated to be

highly effective at reducing HIV transmission, across age groups. While there is currently limited evidence of its use in adolescents, in 2014 WHO recommended PrEP for all men who have sex with men, with recent technical guidance provided on the implementation of PrEP for adolescents and young adults. Low adherence has been reported among some adolescent populations most vulnerable to HIV, suggesting that young people may require additional support and monitoring to ensure adherence. Careful consideration of policies and procedures in relation to consent and confidentiality are also required. Limited studies from this region have reported low awareness and willingness to use PrEP among young men who have sex with men and transgender women, and 2015 regional guidelines for Asia and the Pacific have emphasized the need to develop clear communication strategies to support PrEP implementation.

While the current evidence base in this region has some limitations, what is evident is that a multi- component, multisectoral approach that fully engages young people with diverse SOGI/E in design, implementation and evaluation is required to address the complex determinants and multiple vulnerabilities that contribute to poor health outcomes.

BOX 9. KEY STRATEGIES TO ADDRESS SRH OF YOUNG PEOPLE WITH DIVERSE SOGI/E

- **Create an enabling environment:**
  - Inclusion of young people with diverse SOGI/E in national policy and strategic plans related to adolescent health, SRH, and HIV
  - Remove regulatory and legislative barriers that limit access to SRH services, including HIV testing (such as requirements for parental consent)
  - Remove discriminatory laws that criminalise consensual same-sex sexual acts and transgender behaviour
  - Introduce legislation that protects young people with diverse SOGI/E from discrimination
  - Introduce and enforce legislation to protect young people from violence and sexual exploitation
  - Improve linkages with community-based organisation and other social supports to address multiple risk factors
  - Mass media and other community-engagement strategies to address stigma and discrimination
- **Scale-up high-impact, effective interventions:**
  - Consistent condom use (including community-distribution of free condoms and lubricant through peer-led and outreach approaches)
  - Access to testing and counselling for HIV and STIs (improved point-of-care and rapid testing)
  - Improve continuity of care and adolescent-friendly delivery of HIV care and treatment
  - PrEP to prevent HIV infection (develop communication strategies, screening tools, delivery approaches, support and monitoring)
- **Empower and engage young people with diverse SOGI/E**
  - Engage young people with diverse SOGI/E in policy, programme design, delivery and evaluation to ensure approaches are responsive, inclusive and acceptable
  - Advocacy with youth networks to address social norms and include young people in decision-making
  - Peer support and peer empowerment
- **Improve engagement with formal education and access to comprehensive sexuality education**
  - Address stigma and safety in schools
  - Improve access to and quality of school-based sexuality education to better address SOGI/E, diversity, stigma
  - Improve school-based and out-of-school sexuality education to better address the needs and realities of young people with diverse SOGI/E (self-stigma, life-skills, risk perception)
  - Multiple channels to reach young people (peer-led, outreach, digital media)
- **Increase access to and quality of SRH services, including HIV testing**
  - Improve health provider training and supportive supervision
  - Ensure confidentiality and remove requirements for parental consent
  - Mobile outreach services
  - 'One-stop' health centres to provide comprehensive, non-judgmental services that extend beyond HIV testing to address other SRH needs and risks
  - Linkages with other clinical services and supports (violence, substance use, mental health)
  - Remove financial barriers
- **Strengthen data and research to inform policies and programmes**