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LOOKING OUT FOR ADOLESCENTS AND YOUTH FROM KEY POPULATIONS

Formative assessment on the needs of adolescents and youth at risk of HIV: Case studies from Indonesia, the Philippines, Thailand and Viet Nam

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Contents

Preface

Significant progress has been made in the response to the HIV epidemic over the last three decades. UNAIDS and its cosponsors, UNICEF, UNFPA, UNDP, UNESCO, UN Women, UNODC, WHO, ILO, UNHCR, WFP and the World Bank have joined forces with governments, bilateral and multi-lateral agencies, academia, the private sector and civil society and have made huge strides towards strengthening and sustaining political commitment towards 2020 Fast-Track targets and ending AIDS by 2030.

While the Asia Pacific region has witnessed some of the earliest successes in responding to the HIV epidemic, the pace of progress in reducing new HIV infections is slowing down. We are seeing an upward trend in new HIV infections – a second wave epidemic – in the region. This re-emerging epidemic is disproportionately affecting young people especially those from key populations.

This formative assessment presents the experiences of adolescents and young people including those from key populations and the perspectives of experts working with young people in the four domains: education, parental and peer support, communication and mental health – in relation to HIV risk and prevention, and broader sexual reproductive health rights, including perceived needs, access to and use of services, and barriers and opportunities for young people.

The assessment highlights some promising practices and includes policy and programme recommendations on what we can do to give the support that our adolescents and young people desperately need.

Now more than ever, a multi-sectoral response is required to address the multiple vulnerabilities relating to HIV. We are committed to working tirelessly and cooperatively across sectors to protect the rights of every adolescent and young person in the region and leaving no one behind.

We count on you to address the urgent needs and to ensure that every adolescent and young person has access to quality education, sexual and reproductive health care including mental health and social services where, when and how they need them.

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Executive summary

The global community has committed to ending the AIDS epidemic as a public health threat by 2030. The number of new HIV infections and AIDS-related deaths each must decrease by 90 per cent between 2010 and 2030 in order to realize this commitment.[1] This goal will not be achieved, however, unless greater resources and attention are focused on preventing HIV infection among adolescents and young people, especially those at greatest risk.[2,3]

A recent analysis of global and regional trends in the HIV epidemic among adolescents and young people reveals that if current trends continue, the number of new infections will not decline fast enough to end AIDS as a health threat in this age group by 2030.[4] While new HIV infections decreased globally by 20 per cent among adolescents and young people between 2010 and 2017, they presently account for 36 per cent of new HIV infections among adults aged 15 and older.[5] Every day an estimated 1,400 adolescents and young people become infected with HIV.[6]

The Asia-Pacific region is credited with some of the earliest successes in responding to the HIV epidemic, however the pace of progress in reducing new HIV infections is slowing down.[7] Young people aged 15 to 24 years in the region accounted for one out of four new HIV infections (26 per cent) in 2018, with East Asia and the Pacific region comprising 64 per cent of the new HIV infections in this age group.[8] Notably, this includes an "alarming rate of increase" in new HIV infections among adolescents and young people aged 15 to 24 years in the Philippines, which nearly doubled between 2010 and 2018, with the majority among men who have sex with men (MSM); and increases in HIV prevalence are reported among young MSM in Indonesia and Thailand.[9] In Indonesia, HIV prevalence among MSM nearly quadrupled between 2011 and 2015 (from 3.8 to 15.6 per cent).[10] In Thailand, HIV prevalence nearly doubled (from 5.9 to 11 per cent) among young MSM, and more than tripled (from 3.4 to 12.0 per cent) among young transgender people between 2010 and 2014.[11,12]

Primary challenges for young people in the Asia-Pacific region, especially adolescent and young key populations (AYKP) and young people living with HIV, have been identified in the context of increases in stigma and discrimination – by healthcare workers, law enforcement officers, teachers, employers, parents, religious leaders and community members – and punitive laws, that prevent them from accessing HIV prevention (including condoms), HIV testing, HIV and sexually transmitted infection (STI) treatment, and broader sexual and reproductive health (SRH) services.[13] While the HIV response for adolescents and young people has traditionally targeted individual behaviour change, often with a narrow focus on disease prevention, powerful social and structural factors impact on their vulnerability to HIV infection. Among these, the large-scale absence of adolescent and youth-friendly HIV and broader health care programmes and policies means that young people are further disadvantaged in having to navigate health care systems and regulations designed for adults.[14]

Given the need for reinvigorated HIV-prevention efforts for adolescents and youth in the Asia-Pacific region, the goal of this assessment is to identify the needs of young people especially AYKP, gaps in programmes and services, and model programmes and policies in four countries: Indonesia, the Philippines, Thailand and Viet Nam, in order to support strategic planning to strengthen local and national responses to the epidemic. The primary aims of the assessment are to explore and understand experiences and key contexts of HIV risk and prevention, and broader sexual and reproductive health and rights (SRHR) for young people, including AYKP at greatest risk. This report presents the experiences and reports of young people, including AYKP, and the perspectives of experts working with young people in the region.

A central tenet of this report is that HIV and AIDS do not occur in a vacuum. Although it is important to document HIV statistics and individual-level determinants of risk (knowledge, attitudes, sexual practices, etc.), the HIV epidemic among young people is most meaningfully understood – and effectively addressed – through addressing the broader social ecologies in which they live and interact. Accordingly, a combination approach to HIV prevention[15] for young people is crucial, that is, one that includes behavioural (e.g., condom use), biomedical (e.g., pre-exposure prophylaxis [PrEP] and immediate initiation of antiretroviral therapy [ART]), and structural approaches (e.g., changes to policies and laws to improve access to SRH information, HIV testing and treatment for young people, and stigma reduction programmes). These factors are even more influential in the lives of young people than among adults.

A vital principle guiding this assessment is that adolescents and youth are experts on their own experiences; young people must be meaningfully involved in identifying and assessing their own needs, and in developing and implementing solutions to promote their health and well-being.
In accordance with these guidelines, in March 2018, an initial brainstorming meeting was held with adolescents and youth (aged 15 to 24 years) from civil society networks in nine countries in the Asia-Pacific region by the United Nations Asia Pacific Inter-Agency Task Team (IATT) on Young Key Populations. Young people identified four priority domains for addressing HIV and broader sexual and reproductive health and rights (SRHR): **education, parental and peer support, communications and mental health**.

METHODS

Qualitative data were collected from 139 young people and 37 key informants. A total of 16 focus group discussions (FGDs) (four in each country), were conducted with adolescents and youth, including AYKP. Key informant interviews were conducted with experts from governments, non-governmental organizations (NGOs), and youth networks. FGDs solicited primary data on youths' experiences that focused on the four domains – education, parental and peer support, communication (online and offline), and mental health – in relation to HIV risk and prevention, and broader SRHR, including perceived needs, access to and use of services, and barriers and opportunities for young people. The purpose of key informant interviews was to identify and understand risk environments, resources, and social support systems, programmes, policies and strategies used as well as obstacles to reaching young people, including AYKP, and strategic directions moving forward.

STRENGTHS AND LIMITATIONS

As a formative assessment, the purpose of this report is to explore in depth the perspectives and lived experiences of young people, and adult key informant experts, in each of the four countries (Indonesia, the Philippines, Thailand and Viet Nam). The country reports successfully engaged input from diverse young people, including YKP and general population youth, by age and gender; however, resources were limited to conducting primary data collection in major urban areas.

Key informant experts were purposively selected to represent multiple sectors engaged in practice and policy with adolescents and youth, including HIV, SRHR, mental health and social development. Notably, data were successfully collected in several settings despite formidable social and political constraints. As a result, the report purposely does not provide detailed socio-demographic information on the source of each quotation that could be used to identify any individual.

Given the limited resources available for this formative assessment, it was decided that the assessment would first be conducted in Indonesia, the Philippines, Thailand and Viet Nam. Based on lessons learned and availability of funding, similar assessments will be conducted in other countries in the Asia-Pacific region. Notably, three of the four countries, the Philippines,

Indonesia and Thailand, have among the highest proportions of young people among total estimated new HIV infections in the region – well above the regional average of 26 per cent.[19]

Importantly, pilot programmes in each of the four countries show the positive, proactive and on-going activities around SRHR education and awareness raising, and HIV prevention, among adolescents and youth. Further research is needed to assess reach and engagement of AYKP, coverage, factors affecting attendance/usage, and the acceptability, effectiveness and sustainability of these programmes. To that end, future investment in age-, sex- and AYKP-disaggregated data collection is pivotal to strategic planning and evidence-informed programmes and evaluation.

Finally, the aim of this assessment was not to compare countries on their strengths and weaknesses, which

may have impeded data collection and diminished the willingness of participants to provide the rich and unvarnished accounts revealed in the four case studies. Rather, this report aimed to provide meaningful and detailed insights and experiences, from young people and adult key informant experts, to inform strategic planning and programme implementation within national and sub-national levels. However, the key recommendations to strengthen responses to the HIV epidemic among young people benefit from crosscutting challenges and opportunities that emerged across four countries in the Asia-Pacific region.

KEY FINDINGS

Findings revealed shared dimensions of experiences and needs among adolescents and youth, including AYKP, across countries in the four focal domains.

Education	Comprehensive sexuality education (CSE) is largely absent in schools — including in countries where policy directives require it.
	CSE implementation is limited to a small proportion of progressive and well-resourced (often urban) schools, provided intermittently (biannually) by external actors at the discretion of individual schools and administrators. It is largely not integrated into existing curricula.
	Teachers are largely unprepared and under-resourced to offer CSE, including lack of SRHR and HIV information and curricula, and lack of training in skill-based learning and active pedagogy beyond lectures.
	SRHR education is limited to facts in biology textbooks, often out-dated HIV/AIDS information, and solely focuses on heterosexuality, with virtually no attention to sexual and gender diversity, gender and power relations, and development of communication and negotiation skills.
Parental and peer support	Parents are largely unprepared, lacking in information and skills, to discuss SRHR with adolescents, and most have never experienced CSE themselves nor discussion with their own parents.
	Young people often view their parents as a last resort for discussions of SRHR or HIV, preferring peers and social media.
	AYKP, including lesbian, gay, bisexual, transgender, intersex or queer/questioning (LGBTIQ) youth, experience disproportionate familial rejection, stigma, marginalization, violence and homelessness. Most LGBTIQ youth hide their sexual orientation or gender identity due to these pervasive risks. A few report passive parental tolerance ("don't ask, don't tell") with evolving acceptance of their identities from parents as adolescents and youth get older.
	Some AYKP seek out peer support in school; many others fear stigma and rejection if their identity is disclosed to peers. AYKP find support through peer educators, generally under-resourced community-based organizations (CBOs) serving LGBTIQ youth, and school clubs (predominantly in college).
	Peer support programmes are crucial sources of SRHR information and referrals for young people; and peer navigators are a key resource in bridging online information and offline action, such as accessing HIV testing sites and treatment services.
	Laws and regulations that require parental consent for HIV testing and HIV care and treatment for adolescents under 18 years old create substantial barriers in access to a broad array of HIV prevention and treatment services – the antithesis of a human rights-based public health approach to HIV prevention.

Executive summary

Communication	Social media platforms, including YouTube, Facebook and various apps, emerged across countries as primary sources of SRHR information, including information on sexuality, gender identity, HIV/STIs and menstrual health. However, some information is out-dated or outright 'fake news'/myths, while other information is unreliable or not designed with young people in mind.
	Online communications and social media platforms provide a relatively safe space for AYKP, including LGBTIQ youth, which help to disrupt cognitive and social isolation, and promote self-acceptance, peer support and social networking; but online platforms are also sites of discrimination and bullying for some AYKP/LGBTIQ, as well as venues for sexual 'hook-ups' that can enable sexual risk behaviours.
	Online apps designed with and for youth can promote broadly accessible and acceptable HIV/STI information, education, social support and linkages to appropriate HIV testing, prevention, care and treatment services for young people, many of whom might not otherwise access information and services in schools, clinics and other offline venues.
	Developing apps is expensive and requires technical skills and collaborations; many young people want to engage in designing youth-friendly apps with SRHR and HIV information but require accessible training and capacity building in computer skills, programming and communications, along with technical support from professionals and funding from government, non-governmental and private sectors.
Mental health	All adolescents are at elevated risk for mental health challenges due to significant biological, psychological and behavioural developments in the transition from puberty to adulthood. AYKP and LGBTIQ youth experience heightened vulnerability due to environments permeated by stigma, rejection, bullying, violence and religious condemnation, and amidst lack of access to competent youth-friendly and LGBTIQ-affirmative services.
	Mental health issues are broadly stigmatized among youth; even talking about 'mental health' is taboo, equated with 'crazy', with some limited discussion enabled by addressing 'wellness', happiness or life skills.
	Mental health programmes and services tailored for adolescents and youth are extremely limited across the four countries. The overall lack of competent mental health services, more so for young people, is even more pronounced in rural and outlying areas.
	Baseline data on adolescent mental health, inclusive of AYKP, is sorely lacking, amidst reported increases in youth depression and suicide.
	Youth-friendly services tailored for adolescents and young people living with HIV, including AYKP, are extremely scarce, and urgently needed. Existing services tend not to respect the human rights of adolescents and youth, and, in the absence of informed consent and confidentiality, and focus on criminal liabilities of 'perpetrators' and 'victims' rather than on young peoples' needs.

Alignment of recommendations with the Sustainable Development Goals for 2030

Key recommendations from this report are designed to promote adolescents' and youths' sexual and reproductive health and rights, and youth-friendly combination HIV prevention and treatment. These recommendations directly address six of the Sustainable Development Goals (SDGs) for 2030:[16]

SDG 3. Good health and well-being: Adolescents and youth, including those living with HIV and at higher risk of HIV exposure (AYKP), should have access to HIV prevention, testing, care and treatment that is affordable, youth friendly and tailored to their needs.

SDG 4. Quality education: Improve the quality and relevance of curricula through learning and skills that incorporate and monitor CSE, and that increase school safety and gender-responsive approaches, and reduce gender-based and sexuality-based violence, along with strategies for reaching out-of-school adolescents who are often at heightened risk.

SDG 5. Gender equality: Practice and promote gender equitable attitudes and norms and work to end all forms of gender-based and sexual violence.

SDG 10. Reduced inequalities: Promote access to affordable and youth-friendly combination HIV prevention, treatment and mental health services, with tailored and competent services for AYKP.

SDG 16. Peace, justice and strong institutions: End punitive and repressive laws, policies and practices, and stigma and discrimination, which block effective responses to HIV and SRHR among adolescents and youth. This should be done in conjunction with empowering AYKP to play a catalytic role in the change-making processes in their societies and communities. Stigma and discrimination produce risk environments for AYKP, and LGBTIQ youth in particular, and are antithetical to health and well-being.

SDG 17. Partnerships for the goals: Integrate approaches to promote and monitor SRHR and HIV prevention, and to improve the collection of age-and gender-disaggregated data and the use of strategic information, within and across government sectors to support adolescents and youth. This should be done through multi-sectoral cooperation with NGOs, youth organizations, the private sector and international donors.

KEY RECOMMENDATIONS TO STRENGTHEN RESPONSES TO THE HIV EPIDEMIC AMONG YOUNG PEOPLE

In addition to broad policy recommendations aligned with the United Nations SDGs, the following reflect crosscutting action agendas and strategies for advancing SRHR, HIV prevention, and broader health and well-being for adolescents and youth, including AYKP, which emerged across the four countries. Each country report includes specific and targeted recommendations to strengthen local and national responses to the epidemic.

A key issue that arose across countries was the need to invest in data to monitor the HIV epidemic, and broader health and mental health, among young people. Often, national level data mask sub-population and sub-national disparities in HIV incidence and prevalence, and in achieving targets for HIV prevention, diagnosis, treatment and care for young people.[17] The collection of data disaggregated by sex, age and key populations supports strategic planning and effective programme design, implementation and resource allocation that are essential to meeting global commitments to ending the HIV epidemic as a public health threat by 2030.

Education

- **Capacitate teachers and schools** to provide fact-based, fun and non-stigmatizing CSE and HIV prevention education, and engage youth and youth-friendly experts external to schools, including CBOs, to enhance CSE curricula and activities.
- **Ensure CSE and HIV prevention education is age-appropriate, gender-responsive and inclusive of AYKP and LGBTIQ people** to contribute to improving knowledge and enabling the young people to exercise their choices in ways that do not harm their wellbeing.
- **Integrate pedagogies based on active learning** to develop skills (in addition to knowledge) in critical thinking about gender and power, sexual and gender diversity, and communication and negotiation, to more effectively promote SRHR.
- **Promote integration of schools with youth-friendly health and social services** to enable young people to act on information and perceived risks

by accessing acceptable and affordable HIV/STI counselling and testing, SRH services, menstrual services for girls, mental health and social services, through greater cooperation between health, education, social welfare and other sectors.

- **Collect data to monitor and evaluate CSE implementation in schools** at national and sub-national levels. Given widespread gaps between CSE policy mandates and their implementation, in addition to self-reports from school and ministry staff and authorities, it is crucial to systematically elicit input and responses from young people, the intended audience for these initiatives.

Parental and peer support

- **Expand and intensify parenting interventions,** including CSE workshops designed for parents and families in the workplace and the community, parenting support groups, family workshops and family therapy, to provide basic and up-to-date lay-language information on sexuality, gender, sex and HIV; to respectfully dispel misinformation and myths, and counteract stigma; and to build and practice skills in communicating about CSE, HIV, mental health and well-being with their children and adolescents.

- **Capacitate and resource peer-outreach and support programmes** through initial and on-going training, monitoring and evaluation, and emotional support for peer educators/outreach workers, and through linking peer educators with counsellors in school and health facilities for referrals. Peer outreach workers are the preferred frontline source of information and support for many adolescents and AYKP; however, they are not a substitute for trained professionals.

- **Design and promote whole-school anti-bullying programmes and policies** to encourage respect for all young people, including sexually and gender diverse youth, and to create safe spaces for AKYP, including LGBTIQ youth, in schools, universities and broader communities.

- **Implement evidence-based drug-use prevention programmes,** including parenting skills programmes for families, and teaching social skills for children in primary/elementary schools. In addition to direct benefits in reductions in substance use, these programmes yield positive outcomes in reducing sexual risk behaviours, delinquency and violence, and improve school performance.

Communications

- **Leverage the extensive social media penetration in the Asia-Pacific region** (55 per cent), which exceeds the global average (42 per cent) – and widespread mobile phone ownership or usage by early adolescents – by developing and providing fun and engaging trainings for young people, within and outside of school settings, to support digital literacy, enable critical evaluation of information received online and its sources, and promote safety. Indonesia, the Philippines, Thailand and Viet Nam are among the 10 countries worldwide with the greatest number of Facebook users.[18]

- **Promote and resource multi-sectoral partnerships** between youth and CBOs, and with ministries of health, social welfare, education, including vocational education, sports, and broadcasting/telecommunications, and the private sector, to design, develop and sustain youth-friendly and engaging online websites and apps to support the overall well-being of adolescents and youth. Online resources should address the need for accurate SRHR and HIV-prevention education, linkages to HIV testing, care and treatment, and gender-responsive SRH and mental health services, inclusive of AYKP.

- **Establish government hotlines and web-based apps** to enable young people to seek counselling and report online abuse, while ensuring their safety, privacy and confidentiality.

- **Collect age-, sex- and AYKP-disaggregated data among young people** to monitor coverage, acceptability, usage and linkages to services achieved through online resources and social media, and integrate quality improvement data from young people to promote positive change.

Mental health

- **Conduct national and regional research to establish baseline data on adolescent and youth mental health** that is gender responsive and inclusive of AYKP and LGBTIQ youth.

- **Introduce and integrate curricula on gender-responsive youth-friendly mental health** into the training of healthcare providers, and regular on-the-job training and job aids to support competencies in providing youth-friendly mental health consultations, diagnosis, treatment, and referrals for all adolescents and youth, inclusive of AYKP.

- **Promote training of health providers on the impact of gender norms** on adolescent and young people's mental health and well-being, as well as gender differences in girls' and boys' reactions to stress, and coping mechanisms.

- **Urgently develop and expand accessible and affordable comprehensive physical and mental health care and treatment services for adolescents and youth living with HIV** that fundamentally respect their human rights — including privacy, confidentiality, and the right to engage in decision-making about their own health and well-being; that provide counselling about potential risks and benefits of disclosure of their HIV status; and that meaningfully involve

adolescents and youth, particularly those living with HIV and AYKP, in developing and delivering effective, gender-responsive, and acceptable HIV testing and counselling, and HIV treatment and care services for young people. This is essential to ensuring access, adherence and retention in care to support the health and well-being among adolescents and youth living with HIV, as well as a vital, evidence-based intervention to prevent onward HIV transmission.

- **Implement health-promotion initiatives to reduce stigma associated with mental health,** and that specifically address traditional masculinity norms that discourage seeking help.
- **Integrate mental health and psychosocial well-being in life-skills education in schools,** to ensure improved learning outcomes and skills acquisition
- **Invest in the collection of quality data to assess baseline mental health indicators and trends among adolescents and youth** at national and sub-national levels, including sex- and age-disaggregated data, to inform strategic planning, resource allocation and effective programmes.

THE WAY FORWARD

Adolescents and youth have high HIV prevalence relative to other age groups, even more so among young key populations. In the absence of interventions specifically tailored to address the experiences, needs and social ecologies of young people, they will remain at a disadvantage, marginalized from information about sexual and reproductive health, and HIV prevention and treatment services designed for adults.[20] The four country case studies reveal gaps in HIV and sexual and reproductive health and rights information, education, prevention, care and treatment services designed to meet the needs of adolescents

and young people, more so for AYKP and LGBTIQ youth, amidst extensive risk environments in each country. Model programmes, policies and partnerships in each country should be evaluated, replicated and scaled up as indicated to support combination HIV-prevention initiatives, including those tailored for AYKP – those most vulnerable to HIV infection – and broader sexual and reproductive health and rights moving forward. **However, it is imperative that prevention initiatives address root social and structural drivers of HIV and sexual and reproductive health risks among young people, including those that specifically disadvantage AYKP, at macro-social, community and national levels** in each context, in addition to integrating an array of youth-focused behavioural and biomedical approaches.

In responding to broader adolescent needs, stronger advocacy is needed for investments in adolescents' and young people's skills that are required to 'succeed' in today's world – termed '21st-century skills'. In addition to health and wellness literacy, these include skills and knowledge relating to critical thinking, creativity, communication, collaboration, and technological, scientific and media literacy. These are not only necessary for improving overall adolescent health and well-being, but also to contribute to a stronger work force, better social cohesion and ultimately improved human-capital outcomes for their countries. **To that end, strategies that meaningfully engage adolescents, youth and AYKP in partnering to advance understanding and assessment of their own needs, and in designing and delivering effective, gender-responsive programmes with respect for sexual and gender diversity serve dual but complementary aims:** they increase 21st-century skills, and promote increased acceptability, access and uptake of measures to support SRHR, HIV prevention and well-being. These initiatives must be supported and sustained by young people and adults working together across sectors to effectively control the burgeoning HIV epidemic among adolescents and youth.

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Acknowledgements

Acronyms

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
AYKP	adolescent and young key populations
CBO	community-based organization
CRC	Convention on the Rights of the Child
CSE	comprehensive sexuality education
CSO	civil society organization
DM	direct message
DOH	Department of Health
FGD	focus group discussion
FGM	female genital mutilation
GEN	general population
HIV	human immunodeficiency virus
HTC	HIV testing and counselling
IATT	Inter-Agency Task Team (IATT) on Young Key Populations
IMS	infeksi menular seksual (sexually transmitted infection)
IPD	initial professional development
LGBT	lesbian, gay, bisexual or transgender
LGBTIQ	lesbian, gay, bisexual, transgender, intersex, or queer
mHealth	mobile health
MOE	Ministry of Education
MOH	Ministry of Health
MSM	men who have sex with men

NGO	non-governmental organization
PEP	post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PrEP	pre-exposure prophylaxis
SDGs	sustainable development goals
SDQ	strengths and difficulties questionnaire
SOGIE	sexual orientation, gender identity and expression
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TasP	treatment as prevention
ToT	training of trainers
U = U	undetectable equals untransmittable
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
USD	United States dollar
WHO	World Health Organization
WPF	World Population Foundation
YKP	young key populations

Definitions of key terms

Adolescents: People aged 10–19 years.

Children: People aged 0–17 years.

Youth: People aged 15–24 years.

Young people: People aged 10–24 years.

Harm reduction: A comprehensive package of evidence-informed services for people who use drugs, consisting of the following: needle and syringe programmes; drug dependence treatment including opioid substitution therapy; HIV testing and counselling; antiretroviral therapy (ART); prevention and treatment of sexually transmitted infections; condom programmes for people who use drugs and their sexual partners; targeted information, education and communication for people who use drugs and their sexual partners; diagnosis and treatment of, and vaccination for, viral hepatitis; prevention, diagnosis and treatment of tuberculosis; and overdose prevention and access to naloxone.

HIV prevalence: Number of people with a characteristic or behaviour – in this case those who are HIV positive – at a given time divided by the number of people who could possibly have this characteristic, attribute or behaviour. Prevalence is normally measured in a sample. For example, the number of people who are HIV positive over the total number of people in the sample.

Men who have sex with men (MSM): Refers to all men who engage in sexual and/or romantic relations with other men regardless of their sexual orientation or personal or social gay or bisexual identity. The term 'young MSM' includes adolescents.

People who inject drugs: Refers to people who inject psychotropic (or psychoactive) substances for non-medical purposes. These drugs include, but are not limited to, opioids, amphetamine-type stimulants, cocaine, hypno-sedatives and hallucinogens. Injection may be through intravenous, intramuscular, subcutaneous or other injectable routes. The term 'young people who inject drugs' includes adolescents. This definition of injecting drug use does not include people who self-inject medicines for medical purposes,

referred to as 'therapeutic injection', nor individuals who self-inject non-psychotropic substances, such as steroids or other hormones, for body shaping or for improving athletic performance.

Pre-exposure prophylaxis (PrEP): Refers to antiretroviral medicines prescribed before exposure (or possible exposure) to HIV to prevent the acquisition of HIV infection by uninfected persons. Several studies have demonstrated that a daily oral dose of appropriate antiretroviral medicines is effective in both men and women for reducing the risk of acquiring HIV infection through sexual or injection transmission.

Sex workers: Refers to female, male and transgender adults (18 years of age and above) who receive money or goods in exchange for sexual services, either regularly or occasionally. Sex work is consensual sex between adults, can take many forms, and varies between and within countries and communities. Sex work may vary in the degree to which it is 'formal' or organized.[1]

Treatment as prevention (TasP): Refers to HIV prevention methods that use ART in persons living with HIV to decrease or eliminate the chance of HIV transmission.[2] (See Undetectable = untransmissible.)

Transgender: An umbrella term for all people whose internal sense of their gender (their gender identity) is different from the sex they were assigned at birth. A transgender woman is someone born male who identifies as female, and a transgender male is someone born female who identifies as male. Recognition as transgender is not based on sex reassignment surgery. Most countries in Asia and the Pacific have their own terms to refer to culturally specific subpopulations of transgender people, which also include identities that are neither male nor female. The term 'young transgender people' includes adolescents.

Undetectable = untransmittable (U = U): Building on 20 years of evidence demonstrating that HIV treatment is highly effective in reducing the transmission of HIV (TasP), the evidence is now clear that people living with HIV with an undetectable viral load cannot transmit HIV sexually. Three large studies of sexual HIV transmission

among thousands of couples, one partner of which was living with HIV and the other was not, were undertaken between 2007 and 2016. In those studies, there was not a single case of sexual transmission of HIV from a virally suppressed person living with HIV to their HIV-negative partner. A person can only know whether he or she is virally suppressed by taking a viral load test. The awareness that they can no longer transmit HIV sexually can provide people living with HIV with a strong sense of being agents of prevention in their approach to new or existing relationships, as well as reducing stigma.[3] (See undetectable viral load.)

Undetectable viral load: Refers to when the amount of HIV in the blood is too low to be detected with a viral load (HIV RNA) test. A person's viral load is considered "durably undetectable" when it remains undetectable for at least 6 months after a first undetectable test result. Antiretroviral (ARV) medicine may reduce a person's viral load to an undetectable level; however, that does not mean the person is cured. Some HIV, in the form of latent HIV reservoirs, remains inside cells and in body tissues.[4] (See undetectable = untransmittable.)

Young key populations (YKP): People between the ages of 10 and 24 years who are most likely to be exposed to HIV or to transmit it. Central to this formative assessment are adolescents belonging to young key populations of men who have sex with men and transgender people, as well as adolescents living with HIV. Adolescents who are vulnerable to HIV also include those who are sexually exploited by (under 18) or engaged in (18 and over) sex work, people who inject drugs, those in detention centres and other closed settings, orphans, street children, migrants, mobile workers, and people with disabilities. Many adolescents will relate to more than one key population, which increases their vulnerability.

Young people selling sex: Refers to people aged 10–24 years, therefore including both adolescents aged 10–17 years defined as sexually exploited under the United Nations Convention on the Rights of the Child (CRC) and young people aged 18–24 years. This report uses age categories currently employed by the United Nations and the World Health Organization (WHO). It is

acknowledged that the rate of physical and emotional maturation of young people varies widely within each category. The United Nations Convention on the Rights of the Child (CRC) recognizes the concept of the evolving capacities of the child, stating in Article 5 that direction and guidance, provided by parents or others with responsibility for the child, must take into account the capacities of the child to exercise rights on his or her own behalf.[5]

The United Nations Convention on the Rights of the Child. The United Nations Convention on the Rights of the Child (1989) (CRC) is the global treaty guiding the protection of human rights for people under 18 years of age.[6] One of its key principles is that the best interests of the child should guide all actions concerning children (Article 3). The CRC also recognizes the concept of the evolving capacities of the child (Article 5). The CRC guarantees the rights to non-discrimination (Article 2), life, survival and development (Article 6), social security (Article 26) and an adequate standard of living (Article 27), among other rights. Article 24 stresses "the right of the child to the enjoyment of the highest attainable standard of health and to facilities for treatment of illness and rehabilitation of health."[7]

Sexual exploitation of children. All forms of involvement of those under the age of 18 years in selling sex, and other forms of sexual exploitation or abuse, contravene Articles 12, 19 and 34 of the CRC and international human rights law, and governments have a legal obligation to protect those under 18 from such exploitation. Under the CRC people under 18 also have rights to life and health, which are contravened when they are excluded from effective HIV prevention and life-saving treatment, care and support services.

The Committee on the Convention of the Rights of the Child has highlighted that young people who sell sex need services that address their risk of HIV and other sexually transmitted infections (STIs), unwanted pregnancies, unsafe abortions, violence and psychological distress. The Committee also emphasizes their right to physical and psychological recovery and social reintegration in an environment that fosters health, self-respect and dignity.[8]

Introduction

The Asia-Pacific region is home to nearly 60 per cent of the world's population[1] and second only to sub-Saharan Africa in the number of people living with HIV.[2] An estimated 5.9 million people are living with HIV in the region.[3] Modest strides have been made against HIV and AIDS among the adult population in the Asia-Pacific region, with an overall 9 per cent reduction in new infections since 2010; however, this is far below UNAIDS global targets to reduce new HIV infections by 75 per cent between 2010 and 2020.[4] Between 2010 (270,000) and 2018 (200,000) there was a 26 per cent decline in AIDS-related deaths in the Asia-Pacific region, though in some countries – including Indonesia and the Philippines – AIDS-related deaths have increased.[5]

Notably, while the Asia-Pacific region was credited with some of the earliest successes in responding to the epidemic, it is falling behind the global trend in reaching Fast-Track targets (or 90-90-90 targets). UNAIDS data in 2019[6] indicate that 69 per cent of people living with HIV in the Asia-Pacific region were aware of their HIV status as compared to 79 per cent of people living with HIV aware of their status globally. In terms of treatment coverage, only 54 per cent of all people living with HIV in the Asia-Pacific region were on antiretroviral therapy (ART) in contrast to 62 per cent of people living with HIV on ART globally.[7] This indicates the need for reinvigorated efforts in local, national and regional responses to the epidemic, and the critical importance of better targeting marginalized communities at greatest risk.

Young people are at increased risk for HIV

Young people aged 15 to 24 years accounted for one of four new HIV infections (26 per cent) in the Asia-Pacific region in 2018. The Philippines (69 per cent), Myanmar (54 per cent), Indonesia (50 per cent) and Thailand (47 per cent) had the highest proportions of young people among new HIV infections in the region, well above the regional average.[8] Of total new HIV infections among young people, a 63 per cent higher proportion of new infections occurred among boys and young men (52,000) than girls and young women (31,000).[9] In 2018, 120,000 adolescents between 10 and 19 years of age were living with HIV in the Asia-Pacific region; estimated AIDS-related deaths decreased by 48 per cent among this population, from 2,500 in the year 2010, to 1,300 in 2018.[10]

Proportion of young people among total estimated new HIV infections, Asia and the Pacific, 2018

Philippines — 69%
Myanmar
Indonesia — 50%
Thailand — 47%
Lao People's Democratic Republic
Malaysia
ASIA AND THE PACIFIC — 26%
Papua New Guinea
Nepal
Cambodia
Pakistan
Sri Lanka
Bhutan
Mongolia
Afghanistan
Viet Nam — 17%
Bangladesh — 13%

Per cent
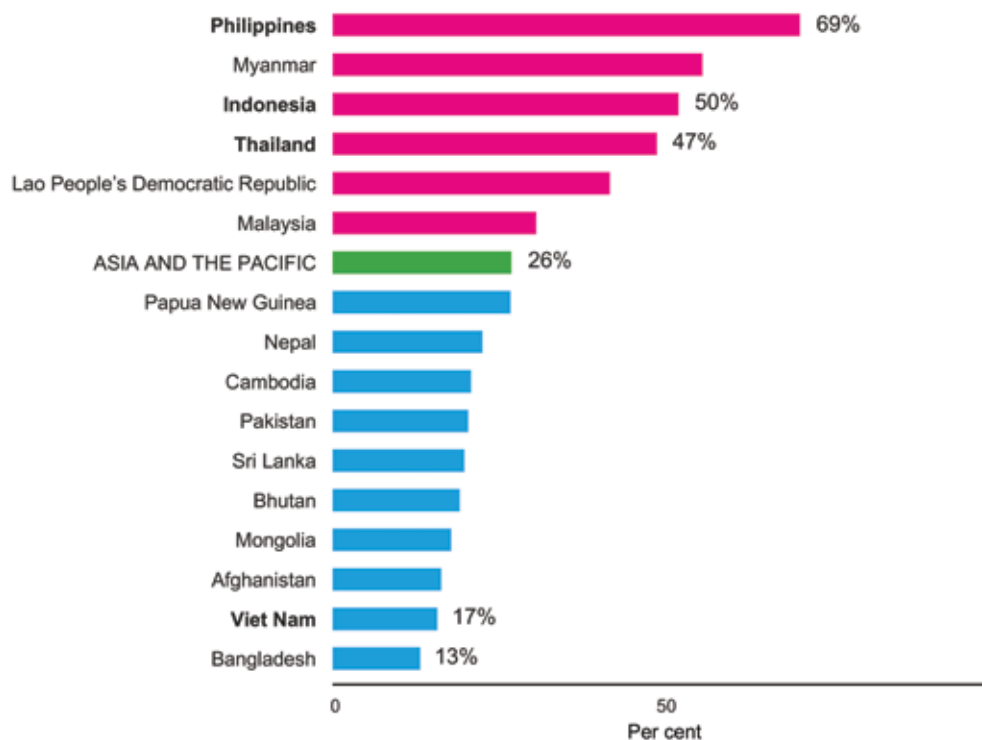
Source: www.aidsdatahub.org; UNAIDS Global AIDS Update 2019

HIV rates among key populations are far higher than among the general population

While the Asia-Pacific region is generally marked by low HIV prevalence on a national level, this masks concentrated and growing epidemics among key populations in many countries. Overall, the "vast majority" (78 per cent) of new HIV infections in the region are among key populations and their partners, including expanding epidemics among gay, bisexual and other men who have sex with men (MSM) –particularly among the younger cohort in many countries.[11] **Notably, 30 per cent of all new infections in Asia are estimated to occur among MSM**, with UNAIDS reporting that "unless the course of the HIV epidemic among MSM is changed, new infection rates among this population will surpass those among every other high-risk group in the region."[12] In large urban areas, including Bangkok, Hanoi, Jakarta and Kuala Lumpur, high HIV prevalence among MSM has been reported between 15 per cent and 43 per cent (UNAIDS, 2019).[13]

Young key populations are especially vulnerable to HIV

HIV risk among young people within key populations is a critical concern. Young key populations are people between the ages of 10 and 24 years who are most likely to contract HIV. Several studies indicate that adolescent key populations, including MSM and transgender people, are increasingly becoming infected by HIV at a young age.[14,15] In the Asia-Pacific region, an "alarming rate of increase" in new HIV infections has been documented among adolescents and youth aged 15 to 24 years in the Philippines, up 195 per cent from 2010 to 2018, with the vast majority of new infections among MSM.[16] Increases in HIV prevalence have been reported among young MSM in Indonesia and Malaysia,[17-19] and higher rates of new infections documented among MSM aged 21 years or younger than MSM older than 21 years of age in Thailand.[20]

Young MSM[21-25] and young transgender people[26-28] face particular vulnerabilities due to stigma, discrimination, criminalization, familial rejection, homelessness, bullying, social isolation and violence that increase their HIV risk and produce systematic barriers in access to services.

Introduction

Young people who sell sex, including those under 18 who are sexually exploited, are at heightened vulnerability to HIV in comparison to their older counterparts due to greater susceptibility to violence, less power to negotiate safer sex, more often working in illegal venues, higher drug use and lack of HIV prevention outreach.[29-31] Men and transgender women who engage in sex work are at even higher risk for HIV than women who engage in sex work.[32]

Young people who inject drugs face multiple vulnerabilities and risks for HIV due to social marginalization, family alienation and extreme poverty that may precede drug use, lack of knowledge about safer injecting practices, behaviours such as sharing unsterilized injecting equipment and exchanging sex for drugs by young women and young men, police harassment and violence amidst criminalization of drug use, and added restrictions in access to harm reduction services for adolescents.[33,34] LGBTIQ young people and young people selling sex who also use drugs face additional vulnerability to police harassment, misconduct and violence, and stigma and discrimination in health-care settings.[35]

Young key populations are less likely to be reached by HIV prevention and SRH services

Amidst the escalating epidemic among adolescents and young people, a UNAIDS Prevention Gap Report[36] indicates that two thirds of young people do not have correct and comprehensive knowledge about HIV and its prevention. Globally, despite their high rates of new HIV infections and HIV prevalence, young people among key populations are less likely to be reached by HIV prevention, testing, care and treatment services, and are less likely to use condoms than their older counterparts.[37] In the context of inadequate capacity and resource allocation for youth-friendly sexual and reproductive health (SRH) and HIV prevention services, existing resources tend to be focused on lower-risk young people rather than adolescent and young key populations (AYKP). This is despite their increased vulnerability due to stigma, discrimination, violence and criminalization.[38] As a result, suboptimal access to and uptake of HIV testing and counselling, late HIV diagnosis, and late initiation of ART and challenges in adherence contribute to lower numbers of AYKP who are virally suppressed, even more so in low-and middle-income countries, thereby increasing the risk of onward HIV transmission.[39,40] The potential of pre-exposure prophylaxis (PrEP), a highly efficacious new biomedical prevention technology, also remains unrealized as part of broader combination HIV prevention for AYKP amidst a lack of national guidelines and tailored strategies for implementing PrEP among young people.[41-46]

Formative Assessment

In the context of an expanding HIV epidemic among adolescents and young people in the Asia-Pacific region, the need for a formative assessment was identified following a two-day brainstorming consultation in March 2018. The consultation included adolescents and youth at risk from nine countries in the Asia-Pacific region, with a focus on sexual and gender identities, socialization, and vulnerabilities to HIV. A post-meeting reflection and synthesis from the core team of organizers and facilitators described key gaps in four main areas: education, peer and family support, communications (online and offline) and mental health. In a follow-up meeting of the United Nations (UN) Asia Pacific Inter-Agency Task Team (IATT) in August 2018, each of the four main areas and action points were discussed in regard to conducting the case studies for this formative assessment in four countries in the region.

This assessment included both adolescents and youth from key populations, and the general population of adolescents and youth. AYKP included young MSM, transgender people, people who inject drugs and those who are sexually exploited (under 18) by or engaged (18 and over) in sex work. All key populations include young people living with HIV. Adolescents and youth who are vulnerable to HIV also include those in detention centres and other closed settings, orphans, children who live in the streets, migrants, mobile workers and people with disabilities. Many young people relate to more than one key population.

The four main domains of this formative assessment arose from the youth consultation, the IATT and expert input, which described them as follows:

Education: school programmes were generally thought to lack comprehensive sexuality education (CSE) including information on gender identity and sexual orientation in many countries. While CSE in schools is important, the need to reach out-of-school youth with CSE was also discussed.

Parental and peer support: parents were identified as influential but least likely to provide support. It was noted that strategies were needed to target parents, neighbours, and other older family members to encourage understanding and acceptance. The development of tailored interventions for parents on sexual and gender diversity, including processes of identity development and inclusive parenting strategies for adolescents, might be useful, but more research evidence is required. Peers and friends were identified as being highly influential, with the need to strengthen peer-education approaches to address misinformation, promote inclusion and provide support.

Communications: the widespread use of social media, including dating or 'hook-up' apps, was repeatedly mentioned. Discussions focused on how the apps contributed to sexual and gender identities, and stigmatization, of adolescents, including racism and gender discrimination expressed via some of the apps. Social media and dating apps were also identified as potential channels for accurate information, support and referrals given their broad uptake and reach among adolescents, perhaps even more so among adolescent and young key populations.

Mental health: the core team agreed that more attention to mental health among MSM and transgender adolescents and young people is needed to address issues including trauma, depression, anxiety and suicidality. Mental health issues and normative developmental challenges are often exacerbated for these at-risk populations due to lack of appropriate support and multiple contexts of stigmatization, bullying and social exclusion. Exploration of the services available to adolescents, and their competencies in working with gender and sexually diverse youth, is an important component of mental health, as well as the language and approach to discussing mental health issues.

Based on these insights and as a follow up to the consultation, the assessment was designed to focus on understanding the perspectives and experiences of adolescents and youth most vulnerable to HIV. This included differences among sexually and gender diverse adolescents and youth, as well as commonalities and differences with general population girls/young women and boys/young men. The assessment also examined how certain socio-cultural norms and expectations, and socio-political frameworks and other structural factors may constrain healthy development for these adolescents and young people (including MSM and transgender people) who are at a higher risk for HIV.

Objectives of the formative assessment:

1. Identify the most critical issues in the areas related to education, parental and peer support, communications and mental health for adolescents and youth at risk for HIV;
2. Identify the most critical health support needs in the areas related to education, parental and peer support, communications and mental health for adolescents and youth at risk;
3. Explore effective, contextualized and preferred means of facilitating access to education, parental and peer support, communications and mental health support for adolescents and youths at risk.

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Country case studies

Each country case study is divided into four sections based on the key domains identified from young people and expert consultation meetings: Education, Parental and peer support, Communications and Mental health.

In the four country case studies (Indonesia, the Philippines, Thailand and Viet Nam), the quantitative data on HIV are presented first. The key informants and focal organizations consulted in each country are provided; however, there is intentionally no identification of any of the individual sources or their specific roles in the organization that might identify them. This is in the interest of respecting the privacy and confidentiality of all key informants. Further, contentious legal and political environments in several of the countries may present varying degrees of risk. Each key informant provided individual informed consent and agreed to have their interview digitally recorded and transcribed, with select quotations presented in the report.

Four focus group discussions (FGDs) were conducted with adolescents and youth in each country. The composition of the groups was similar in each country, with some differences based on differences in local epidemics as well as logistics and access to various populations. Overall, in each country, two FGDs were conducted with adolescents, aged 16–18 years, and two with youth aged 19–24 years. All participants under the age of 18 received parental consent to participate and provided individual assent. Youth 18 years of age and older provided informed consent. Consent was obtained for digital recording of all groups. Each FGD was transcribed and then translated into English. No names or other personally identifying information were collected.

The case studies are presented separately for each of the four countries in order to accurately represent and highlight the different socio-cultural and structural (including policy and legal) contexts, to reflect the HIV and AIDS scenario for adolescents and youth at risk in that country, and to support differentiated responses to guide country and programme prioritization in each setting. The country case studies are each subdivided into the four focal themes identified for this formative assessment. Within each of these domains, data are presented and identified as from key informant interviews or from adolescents and youth in FGDs to illustrate and support the findings reported.

In addition, within each case study, boxes are presented describing programmes and initiatives identified by key informants, adolescents and youth, or expert reviewers that have had, or demonstrate the potential to have significant influence on HIV prevention, sexual and reproductive health and rights (SRHR), and broader youth engagement, empowerment and support. These programmes and initiatives are sometimes enacted under serious socio-cultural, political and legal constraints, with the aim of demonstrating opportunities for strategic action and advocacy within real-world contexts.

At the end of each of the case studies, recommendations in each of the four focal domains are presented for strategies to advance SRHR and HIV prevention for adolescents and youth, especially adolescents and young key populations (AYKP), and to work towards achieving the United Nations Sustainable Development Goals (SDGs).

INDONESIA

Indonesia, the world's fourth most populous country, reported 46,000 new infections in 2018 compared to 63,000 new infections in 2010.[1] Overall, 59 per cent of new infections in 2018 were among boys and men. According to UNAIDS, in 2018 only half (51 per cent) of people living with HIV were aware of their status; moreover, only 17 per cent of the 640,000 people living with HIV/AIDS in Indonesia were receiving antiretroviral therapy (ART).[2] AIDS-related deaths increased by 58 per cent from 24,000 in 2010 to 38,000 in 2018.[3] Among key populations, HIV prevalence was estimated at 26 per cent among men who have sex with men (MSM), 25 per cent among transgender people, 29 per cent among people who inject drugs, and 5 per cent among sex workers. Notably, young people aged 15–24 years accounted for half (23,000) of all new HIV infections in 2018. Among those, 61 per cent (14,000) were boys and young men.[4] Amidst overall decreases in annual new HIV infections among adults, new infections among young people – young MSM in particular – continue to increase.

Key facts on HIV in Indonesia

NEW INFECTIONS
46000

PEOPLE LIVING WITH HIV
640000

PEOPLE ON ART
108479
(**17%** ART COVERAGE)

AIDS-RELATED DEATHS
38000

New infections	People living with HIV	Deaths
▼	▲	▲
Declining	Increasing	Increasing
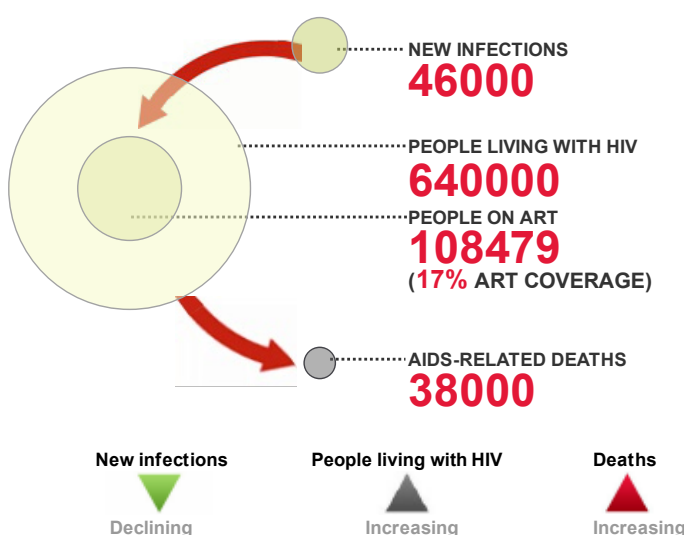
HIV prevalence among young men who have sex with men (<25 years)

4x
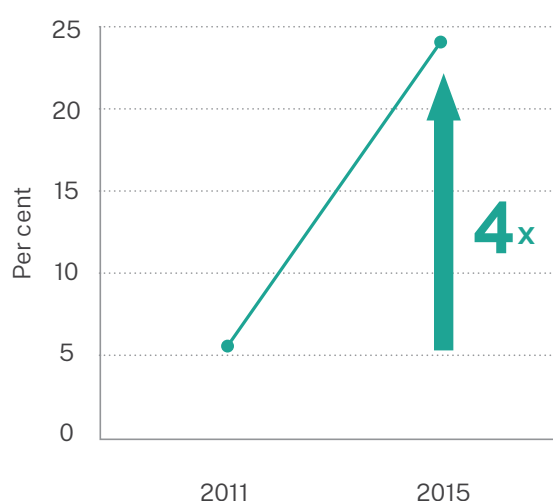
Source: UNAIDS data, 2019; www.aidsdatahub.org

Indonesia

Ten key informant interviews with six women and four men were conducted with representatives from national and international organizations working with adolescents and youth, and youth organizations in Indonesia. Organizations included the Ministry of Health (MOH), UNAIDS, UNFPA, Fokus Muda (National Network of Young Key Affected Populations) and Aliansi Remaja Independen (ARI) (Independence Young People Alliance).

Four focus group discussions (FGDs) were held with a total of 40 adolescents and youth (21 girls, 17 boys, and 2 transgender persons) from the general population and young key populations:

- FGD 1: general population youth (aged 16–18 years);
- FGD 2: general population youth (aged 19–24 years);
- FGD 3: high risk and young key populations (aged 16–18 years); and,
- FGD 4: high risk and young key populations (aged 19–24 years).

While the focus groups were all conducted in Jakarta, with most young people coming from urban areas, community organizations working with young people purposively engaged some youth to represent rural areas.

EDUCATION

Representatives from various governmental and non-governmental organizations (NGOs) discussed detailed guidelines for teaching about 'reproductive health' tailored to different stages of youth development. These guidelines started for children as young as 6–7 years old and included separate junior high school and high school curricula. However, informants also revealed serious gaps between these well-stated guidelines and the implementation of comprehensive sexuality education (CSE) due to the 'sensitivity' involved in broaching topics about sex, sexuality and HIV in schools, and government monitoring and restrictions on allowable content. Sexuality was described as completely absent from educational materials in schools.

Informants explained that generic information about 'reproductive health' is introduced in basic school, often only in biology classes. HIV is first introduced in junior high school, with some additional details provided in senior high school.

"We believe that the idea of a comprehensive framework for young people is first education – comprehensive sexuality education – second is youth-adult partnership and also involvement of youth meaningfully, and the last one is about youth-friendly services."

"Reproductive health education is starting from basic school, from 6 or 7 years old. But it sequentially differentiates between basic school, junior high school and also senior high school. So, the HIV would be specifically explored in junior high school."

Key informants from government ministries and international NGOs discussed the ages at which basic HIV education is begun – generally not until age 17 in senior high school – and constraints on the official curriculum. Information about HIV and AIDS is strictly limited to broad discussion of 'high-risk behaviours', with no specific mention of any young key populations. Material about sexual orientation and gender identity is in effect prohibited. Key informants further described having to compromise evidence-based sexual and reproductive health rights (SRHR) curricula and HIV-prevention education in schools in order to be allowed to engage in the educational system at all, and they are hoping to provide more comprehensive education outside of school settings.

"About 14 or 15, but would be specifically explored in the level of senior high school, around 16–17–18 [years old]."

"It is Grades 11–12; so, the curriculum is plotted into subjects like biology."

"Because it's for the school setting, anything related with the government, [the solution to any sex-related problem] is abstinence. So, we try to be in school and out of school to accommodate those needs. In school, we have to be quite flexible with this because, if not, it will not go on at all."

"Honestly the gap is so huge that even a menstrual problem, if it can be discussed at all in school, is already a huge leap forward because people don't discuss 'private organs'. I think that's a worthwhile compromise in the school setting while targeting all the extra information in the out-of-school setting."

Key informants explained the absence of any discussion or even naming of adolescent and young key populations (AYKP), such as LGBTIQ youth or youth engaged in sex work, in any health materials or official programming or in the educational system.

"It is not specifically mentioned, but we focus on higher risk behaviours. Because the situation in Indonesia in regard to HIV/AIDS is sensitive enough, so we have to pay attention and be careful on how to write materials. But because we believe that HIV should be given attention, we focus on risk behaviour."

Youth across all FGDs, including general population youth and AYKP groups, corroborated key informants' perspectives. Young people described the absence of information on sexual and reproductive health (SRH), condoms and HIV in school; some described very limited presentation of materials that were often indirect and unclear to them.

"I know about sex from the Titanic film. I go to school in the area where sexuality is taboo."

"There is no information about SRHR in my city; the information is not provided because sexuality is still taboo."

"I know about SRHR from my father, who is a nurse, and from meetings in the church. At school I got nothing."

"My experience when I went to school during biology subjects and talked about sexual relations was that there was some strange information, usually only explaining about the consequences of having sex [pregnancy], and did not discuss people who have HIV; so not all teachers know."

"In junior high school there can be a little; in vocational high school it can be presented by the class leader, but the information is unclear."

In terms of discussion of sexual diversity and LGBTIQ issues, FGD participants reported

"Talking about LGBT at school ... you should not discuss it. It is strange, and if a kid talks about LGBT, I feel like my friends are shunned. Nobody even discusses this."

"When I was in high school, I never talked about sexual orientation, gender identity and expression (SOGIE) because it was taboo. I had permission to attend activities at Erasmus [European Union programme for education, training, youth and sport], but it was not allowed by the teacher because it was feminism; and HIV was also rarely discussed."

Key informants and AYKP described persistent myths and misconceptions among adolescents and youth about how HIV can and cannot be transmitted. These myths and misconceptions are due the absence of direct education about HIV in schools, including HIV transmission, prevention and condom use.

"There are still misconceptions dealing with basic transmission, just like mosquito bites; and also using the same toilet, sharing food, etc."

"My friend once told me that she made love and never used condoms, and asked if kissing people with HIV is contagious."

"I know a number of things, but it's not enough. I need to know more about HIV transmission and how to act with someone; for example, being gay is also considered contagious, but, in fact, it isn't."

Indonesia

Key informants and young people, particularly AYKP, described pervasive bullying in schools and especially victimization of those perceived to be sexual and gender minorities. This response was attributed not only to a widespread lack of action by teachers to intervene, but also collusion of teachers in promoting bullying.

Beyond acts of harassment in schools, AYKP in FGD 3 and FGD 4 described toxic ideologies promoted by some teachers and administrators, and being remanded to undergo dangerous practices of 'conversion therapy', including exorcism. These practices have also been reported in international media.

> "Yeah, I think it [bullying] is a big problem. You know, especially for LGBTIQ persons – the boy who expresses femininity. Actually, two years ago one of the teachers in junior and high school...even the teacher bullies like this: 'Why do you walk like this?'"
>
> "So, students are not just bullied by students, but also by teachers. 'Why do you walk like that; why are you feminine in your body language?'"

> "When I was in high school, there is someone who spread the word that I was a lesbian. I was called to the office and directed to a psychologist, he said I was in trouble, and I was expelled from school. While I was brought to a psychologist by my mother, who is a teacher [and well-educated], I was also brought to a dukun [shaman] who did ruqyah [exorcism]."
>
> "My experience in high school, discussing with the sociology teacher ... and I was referred to the pastor, and read the mantra and told, 'the demon came out of your body.'"

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Key informants described an escalating hostile environment towards AYKP, and particularly LGBTIQ people. This created further challenges in their work to support AYKP, to offer CSE, and provide even basic HIV prevention information.

"The key populations – sex workers, MSM, people who inject drugs, clients of sex workers – are now under this kind of moral debate in this political year. So many who were allies before are turning to be critics and saying we mustn't teach young people about sex because it will make them have sex. We need to make sure that our young people are 'good' and this should simply not exist. That doesn't help when you take this approach and then, I don't know, I mean every ministry has turned ultra-conservative. So, the solution is to close the brothels, so 'there won't be any more sex workers', 'cure' LGBT. They don't even understand what LGBT is, they don't even break the acronym down. They all think this is contagious as well, liking same-sex or whatever can 'transmit' easily. And then, all these other programmes that we need to reach these YKP because of their risk behaviour is under threat, because we cannot openly promote this prevention information. So, that has been for the last two years, we've been heading to this problem."

Despite the pervasive challenges in a constrained environment, adult and youth key informants described successes in iterative development of some curriculum content, even as it was subject to many redactions and revisions based on opposition from other government ministries and the schools. They further described barriers to piloting the implementation of limited curricula in even a small fraction of the vast geography of Indonesia's 34 provinces and 500 districts. Despite this, they described on-going efforts to try to ensure basic coverage is achieved and its implementation evaluated:

"It is good news, because last month we helped the Ministry of Education to make the modules in the schools. The content is from the Ministry of Health, so content starting from prevention until treatment is already in that module."

"During the programme it has been like three times of revision of the book. Also we found from our midline research there are some teachers, you know, even they are assigned to teach about the material from the book, but they did not really deliver the content of the book, because they have their personal values, and etcetera."

"So, we saw that in specific schools we needed more monitoring and evaluation systems; and also, for the facilitators, especially for the teachers. When we give only education, there's no monitoring and evaluation."

Indonesia

On a broader institutional level, key informants described earlier agreements among government ministries, which might be an effective means to bridging and integrating Ministry of Health and Ministry of Education agendas, and gaps between provincial offices and schools. However, these agreements were reported to have expired in 2014 with no officially sanctioned updates. While the earlier agreement is still referred to, the gaps among ministries, and between provincial level administrations and schools continue.

"The Ministry of Health also gives intervention to schools, which is in collaboration with the Family Health Directorate, not the HIV/AIDS-STI Sub-Directorate, because they have specific sub-directorates for adolescents in school settings. So, we ensure the content, we ensure the materials dealing with HIV and AIDS. It becomes one package with the health package delivered to students. We also have a reference that we call the 'Five minister agreement letter', which is already expired, actually, from 2012 until 2014."

"Between the educational office at the provincial level and the schools, the perspective has not changed here, because the education is not comprehensive yet."

One intervention was described as engaging doctors from clinics to come to schools to discuss issues that would not be broached by teachers. These were described as sporadic at best, and at each school's discretion, such that many schools did not sponsor these activities.

"Ideally, it is once in six months...the doctors from the health facilities can go to the schools. Because in the first school year, we have health screening from health facilities in the schools. So, health clinics can integrate into the education system."

Peer initiatives emerged as among the most plausible and potentially effective inroads into sharing SRHR information in the formal educational system. Key informants from the government, NGOs and youth organizations alike described various peer initiatives and the importance of meaningfully engaging adolescents in programme development and content.

"We educate students by also involving peer educators and peer counsellors in schools. We have a programme also about how to have life skills for adolescents and young people, so the life skills will be a way to help prevent and to avoid HIV infection."

"We should engage the adolescents more meaningfully in school settings; but it also depends on different situations. Because we cannot guarantee all facilitators in schools have the same skills and potential. Sometimes there's more engagement; sometimes there's no involvement."

"I think there are more challenges for SRHR, CSE in formal schools than out of schools. Because it all has social values."

A youth key informant described the 'Yes, I Do' programme, sponsored by the Rutgers WPF (formerly World Population Foundation), as well as their working through challenges in designing and implementing the curriculum content:

"In the 'Yes, I Do' programme, one of our interventions that is led by Rutgers WPF, is the comprehensive sexuality education in schools, so we developed a module on reproductive health and sexuality. It has just been implemented in our intervention areas and it's only in 10 schools in one area. We are still working how to mainstream that. Also, in the school that works with us, they give many inputs regarding the content, which is related to the 'decency' of the contents that we are providing."

'YES, I DO'

In 2016, Rutgers WPF (formerly World Population Foundation) Indonesia, Plan International Indonesia and the Independent Youth Alliance launched the 'Yes, I Do' alliance. The alliance is committed to preventing child marriage, teen pregnancy and harmful practices for women's reproductive organs. 'Yes, I Do' implements community-based prevention programmes in Rembang, Sukabumi and West Lombok Districts where these cases are high.

https://www.rutgers.id/program/yes-i-do

Youth key informants further described many revisions and, in their perspective, sometimes outlandish pushback they had to endure in order to implement reproductive health materials. They further described selective implementation in schools, even in the same locality.

"For example, for the first of our implementations, first we distributed the module. They had a problem with the module called 'Setara' – the 't' looks like a cross? So, it became a problem as they think it is a part of missionary agenda of the christening, something like that. We have to change it after that. Regarding the content, the pictures [of sexual organs] were the issue; when they saw the picture they said, 'No, we cannot.'"

"There's a subject about the whole body, the illustration of a body with, you know, complete with sexual and reproductive organs. In all of the areas they wanted it to be gone and then of course, about SOGIE, they don't mention lesbian, gay, everything, take everything out. There is also something about power relations, violence in relationships; it is also considered vulgar."

"When I joined the monitoring team in Lombok and I talked with two different schools, one of them has good implementation of the Setara module and the second one says we don't have time to give the materials in the modules. I asked the girls – the students: 'No, we cannot talk about this kind of stuff in here because the teacher will say no.'"

Community and NGO representatives from YKP groups further described challenges and delays in their interactions with the educational system around curriculum development:

"They already developed a reproductive health module, and two days ago I asked them if the NGO can see the module and give feedback to ensure that it is youth friendly, without stigmatizing the community. They said yes, we can do that; but sometimes, you know, they say yes, but there's no follow up. At least they are open to input, but they mention reproductive health, because they won't go through sexual and reproductive health and rights, even though they actually have adolescent programmes – 'Adolescent generation', 'Ambassador', 'the pigeon for young people'."

International NGOs described the long process of developing SRH education for teachers, adapted for the Indonesian context, and the necessity of constraining and delaying content about condoms, contraception and sexuality. They described the paradox of needing to be invited by schools in order to engage with adolescents – an invitation that typically only followed a spate of unwanted pregnancies – but then being rebuffed when they actually tried to address content relevant to teen pregnancy.

"We worked together with the Ministry of Health, Ministry of Education and Ministry of Religious Affairs to develop the module on adolescent reproductive health education for teachers. It is a long process that started in 2014. There is a back and forth on the content, but we developed it based on the International technical guidance on sexual and reproductive health education; that was a global effort by UNICEF, UNESCO, UNFPA, UNAIDS and WHO. Again, it is adapted within the Indonesian context; except sexual orientation and contraception, which is only for senior high school."

"The thing is we work by invites from school groups. So, when a school has six or seven unwanted pregnancies, most people invite us and say, 'Oh, can you help us? It's not nice for teachers to talk about this.' But if you start talking about these issues, immediately we will not get that engagement from these stakeholders or partnerships."

Out-of-school SRHR programmes were described by all stakeholders – government ministries, international NGOs, United Nations agencies and youth groups – as facing fewer obstacles in their implementation than those within schools. Most programmes outside of school operate through peer educators and capacitate them to provide information, support and referrals for adolescents and youth. Nevertheless, limitations were reported, such as peer educators not being allowed to provide information about, discuss or suggest condom use. In the case of any issues or questions about condoms, they must make referrals to the healthcare system. In practice, this means that most adolescents and youth do not receive information about condoms from peers or healthcare providers due to anticipated stigma and discrimination if they broach the topic with healthcare providers, and challenges in access to the healthcare system. Generally, it was reported that more information could be shared outside of schools than within school settings. The out-of-school milieu was also described as being more conducive to young people openly discussing and absorbing this information.

"We have a health gathering; the youth gather, and their knowledge is improved. Some of the youth organizations are coordinated by our health office, youth scout organizations, also organizations in health faculties in some universities. We believe that in the youth environment the information will be absorbed better."

"Actually, we capacitated more community youth rather than in schools. We have one organization that uses an intervention called 'Forum Anak Desa' that is a youth forum. Another forum is called 'Karangtaruna'. There's a difference in that the Rutgers WPF programme is focusing on formal schools and we are working with youth in the community."

"First, we capacitate youth on leadership, because that's one of our key interests and expertise: leadership and meaningful youth participation. So, we encourage them first to be able to communicate and talk about this and other social issues that they have concerns about in the community. Then we proceed with other capacity that is more scientific, like SRHR, and about our three main topics: FGM (female genital mutilation), teenage pregnancy and early marriages. From partners who do monitoring, they say that there's no protocol that prevents us from doing this, but of course we consider the situation in the area, and safe spaces are always considered."

"No, I am not allowed [to discuss condoms], but I do referral."

"So, what we are doing now is we are trying to look at the model and all the knowledge products we have. We identify the possibilities to integrate young people's issues in the curriculum. At least we are able to provide skills to the peer leaders and the outreach workers to be able to reach the young people to equip themselves in some of the issues, such as those surrounding young sex workers."

In alignment with findings from key informants and FGDs, several reports have documented widespread bullying and violence in schools. A 2015 report from the NGOs Plan International and the International Center for Research on Women (ICRW) (March 2015) found that 84 per cent of children in Indonesia experienced various forms of violence in schools, including bullying. Yet, most schools, teachers, parents and government officials were characterized as trivializing the problem. A 2015 UNESCO report (January 2015), From Insult to Inclusion: Asia-Pacific Report on School Bullying, Violence, and Discrimination on the Basis of Sexual Orientation and Gender Identity, indicates reduced ability to learn, school dropout, and suicidal ideation and attempts among LGBTIQ youth in schools in Indonesia; 17 per cent of respondents reported attempting suicide – this is four times higher than the 3.7 per cent reported in the 2015 WHO Global School-based Student Survey among all students in Indonesia aged 13 to 17 years.

Widespread bullying in schools is often exacerbated for youth who are, or are perceived to be LGBTIQ. The #PurpleMySchool campaign in 2015 was one effort to address such bullying. More recent campaigns are less visible or not being undertaken in the context of increasing political hostility towards sexual and gender minorities.

#PURPLEMYSCHOOL

#PurpleMySchool campaign, Stop Bullying, Hargai Perbedaan (Respect Diversity) was being run through social media such as Facebook, Twitter and Instagram. For the campaign, UNDP and UNESCO were collaborating with local civil society groups such as Sudah Dong (Enough is Enough), Into the Light, and the Independent Youth Alliance. Students were invited to upload photos of themselves wearing purple shirts, or creating anything in purple, and to share them through campaign.com/PurpleMySchool or upload them on social media with the hashtag #PurpleMySchool. The aim is to create safe spaces for LGBTIQ youth in educational settings in Indonesia and the Asia-Pacific region.

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Finally, legislative and policy challenges and successes were described as impacting the effectiveness of HIV prevention programmes within and outside of schools. While discussion of condoms remains taboo, the structural barriers preventing condom distribution also remain in place. Stigma was described as a pervasive barrier to engaging with HIV counselling and testing.

"There are condoms because the National AIDS Commission was procuring condoms. So, there are millions, I mean 10 million condoms are sitting in the warehouse, no longer distributed. And our homework is, you know, we are working on this from Australia to reconfigure the condom distribution system."

"With the stigma, many people don't go to get tested. It is not about remote area or not remote area; it is about simple denial of the fact and just imagining that you will give your family a bad reputation if you are found to be HIV positive. You will be ostracized from the community; you will be fired from your job and your kids kicked out of school. So, that feeling is real. It is prevalent among average people. When we talk about HIV and those people who are engaging in risk activities, they know they are at risk; they see their friends dying, getting sick and dying. But still that fear is so high that they just say, you know, many friends say that they would rather just die and get sick than go find out about their status. So, that is really something that we are then trying to address."

Youth and adult key informants described a major countrywide structural obstacle in the form of the regulation that requires adolescents below age 18 to secure parental consent for HIV testing. This introduces a disconnect between HIV awareness and education, on the one hand, and health seeking behaviours, on the other. Adolescents are required to be referred by healthcare providers in schools to health facilities for HIV testing, with supervision by parents. As adolescents fear alienating their parents, and anticipate negative reactions, in even raising the issue of their being tested for HIV, this effectively renders HIV testing inaccessible.

"When the doctors find risk behaviour, they refer directly to the health facility, not HIV testing in school, due to the consent policy. It means adolescents below 18 years old should be accompanied by parents."

"Besides the parents, also guardians from the local NGO, which is acknowledged by the health facility. The process of producing new regulations of the Ministry of Health is around once in two years. We are hopeful that it will be changed in 2019."

New regulations are pending that would allow HIV testing of adolescents with the consent of a guardian from an NGO, thereby obviating the requirement for parental consent. This would be a substantial step towards mitigating pervasive structural barriers to HIV counselling and testing in the context of pervasive stigma and discrimination.

PARENTAL AND PEER SUPPORT

Youth generally engaged in some discussion about sex and sexual health information with their peers, but not with their parents. Even peers, however, were not considered uniformly 'safe.' Both general population and LGBTIQ youth described concerns about being labelled or 'outed' as LGBTIQ for merely asking about or discussing sexuality, and as 'promiscuous' or living with HIV if they introduced the topic of HIV or AIDS. Trained peer educators were considered the mainstay of peer support and education.

"Usually about sexual experiences, for example, on Monday they are in hurry to come to their friends to talk about their experiences on Saturday and Sunday; and they talk about they felt attraction from their partners, and they will talk so openly with their friends. But they don't talk about these issues with teachers, even with school counsellors."

"It depends on the kids, but mostly they don't want to talk about sexual orientation with friends."

Youth across FGDs similarly described some discussions and interactions with peers on SRH, but these avoided more sensitive topics around sexuality or HIV for fear of unwanted disclosures or rumours, and being stigmatized or bullied.

> "I know about romantic relationships from friends; but health problems are usually through seminars."
>
> "I have never had a conversation about sexual problems."
>
> "When I started talking [about SOGIE], he thought I was against LGBT; and then I was instead considered to be LGBT myself."
>
> "I'll talk to my friends. If there is no support, usually I'll talk to myself; just forget it, let it be my business between God and me."

Adolescents and youth described engaging in discussions with friends about HIV as a courageous as well as a risky act, with some revealing experiences of stigma and isolation. Several college youths reported that talking about HIV and sexuality was more acceptable than when they were in high school, with some recounting discussions with their older college peers.

> "Talking about HIV every day, I usually am thought of as a 'garbage can' [receptive partner] for gadun-gadun ['sugar daddies'] or kucing sarinah [a 'cat' or male sex worker, in a high-end shopping mall] for discussing this."
>
> "I have difficulty believing in friends, so when I became a sex worker, I took my own steps, testing for HIV also before even getting to know NGOs or friends."
>
> "I talk routinely about HIV and SRHR with my friends, so they want HIV and STI tests. When talking about sexuality, my friends are fine, but just they ridicule lesbians."
>
> "Now when I am in my college, my alumni taught me about SOGIE, about LGBT. Sharing with seniors how to not get HIV, we have to use condoms."

Most youth described not engaging in conversations about SRH or romantic relationships in their families, oftentimes due to parents' conservative religious beliefs. In some instances, YKP described reaching out to their parents and experiencing criticism and alienation, and being remanded to boarding school.

> "My family's background is the pesantren [Islamic boarding school]. When talking about SOGIE, sexuality and SRHR, they argued that it was haram [forbidden]. Except about menstruation. My sister was caught masturbating and sent directly to boarding school. My parents knew I was a lesbian, and they thought I was lost. I was left [in boarding school] for 2 years, because they are conservative."
>
> "[Sharing with my family], it does not seem possible. For me, mostly I share with my friends."
>
> "In the family environment, I never discussed LGBT because it was a sin; especially in the church environment."
>
> "My parents trust other people more than then their own children. I gave information, but mom doesn't believe me. Even my dad didn't want to have a discussion with me."

A few adolescents described experiencing support and acceptance from their parents, as long as they maintained certain boundaries. This included generally not discussing sex, sexuality/gender identity and relationships with their parents.

> "I am grateful to have parents like my parents. My parents accept me as a transgender person; they are always bothered with other people's talk. The important thing is I'm not harming others."
>
> "I have never had conversations about sexual problems; mostly talked with friends who have sexual diversity, or during their first menstruation period. If I'm dating with a guy, my parents have no problem, they said, as long as I maintain my virginity."

Indonesia

Peer educators were described as serving key roles for information and support for many adolescents, who generally do not discuss sex or risk behaviour with their parents for fear of stigma and negative repercussions –and for some who do not live with their parents. Key informants also described parents as generally having minimal knowledge about HIV and SRH.

"We need to talk about peer education, because it is one of our interventions. We have peer educators in schools, and of course they talk about HIV, IMS (infeksi menular seksual; STIs)."

"When we find risk behaviour in adolescents, they don't want to talk with parents. Or some live without their parents; the parents are far away from adolescents. And young people don't want to talk with parents because of fear of stigma."

"Dealing with the data from 2017 about the demographics and health in Indonesia, the graph of parents' knowledge is low about HIV and about reproductive health. This includes both education and the perspective of the parents."

Peer counsellors and peer educators are located in many schools, as well as working with NGOs. Some are trained by doctors and healthcare workers to provide information and education about SRHR, sexuality, HIV and STIs. Some peer educators in schools act as guardians in taking adolescents who want to be tested to HIV testing centres without seeking the consent of parents or being required to report to parents – though the laws are under evaluation. The need to seek parental consent otherwise poses barriers that prevent many youth from accessing HIV testing. Peer educators are still limited in not being able to broach the topic of contraception.

"We have adolescent health facilities and the doctors can go to schools to give training and education and empower them [students] to become peer educators and peer counsellors."

"Peer educators are acting as guardians in such cases and take school students to testing centres."

"One of the challenges for young people is to go to the test services, not just because they are afraid to get tested, but they are afraid of a new place, an unfamiliar place for them, where to go first. So, having someone with them, it really helps."

"In one of the workshops of Saya Berani counsellors, I participated too. There's a discussion among counsellors and outreach workers on the ground on how to find the cases and provide additional support, like adolescents underage."

"Under the new draft of the new law, which will be finalized early next year, there's a section that mentions specifically under-18 YKP, that they can go and they can have the test without parental consent, as long as there's a guardian. This could be a person from the NGO or another health service provider as the witness."

Peer educators described challenges they face in navigating proscriptive government policies while serving in their roles as providers of education and support for adolescents and youth, including providing information on HIV prevention. Peer leaders demonstrated independent and critical thinking, and thoughtful approaches in training and educating other young people as peer educators. They also demonstrated their role as advocates for youth and youth empowerment. In one instance, a peer trainer described the constraints of existing regulations. Peer leaders shared their experiences in confronting other junior peer educators about how to provide a space for discussion, but to be non-judgmental and enable youth to make decisions for themselves. They described speaking up in meetings with government and NGO representatives to advocate for resources and services for HIV prevention, and they had an awareness of sometimes being 'used' as an excuse for official (adult) inaction.

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"As long as you don't give out condoms, and just say, 'don't have premarital sex, you can get HIV', something like that. So, schools support that and schools don't want the students to have premarital sex. From our last monitoring, our peer educators do not promote contraceptive use; they are afraid that they will encourage their friends to be 'wild'. They only encourage that if your girlfriend or boyfriend keeps insisting that you have intercourse, and then you need to break up. I asked them again, 'Is it your duty as peer educators to decide for somebody else?' They said, 'Well, we just want it to be good.' I confronted them: 'No you cannot make sure they can be good in everything. You should just inform them and the decision is theirs.' From our midline research, peer education is sometimes not really that effective."

COMMUNICATION

Key informants from government ministries, international NGOs and youth community-based organizations (CBOs) all acknowledged the importance of the Internet and social media in raising awareness among adolescents about SRHR and HIV. Social media outlets and campaigns typically addressed broad health concerns among youth, with some programming about sexual health and HIV. A few were more specific to SRHR and HIV. Some social media campaigns went beyond awareness to targeting engagement with services, such as health clinics and HIV testing. A few health facilities were described as using social media, such as Facebook and Instagram, to spread awareness of their programmes, with the occasional options to consult via online messaging, such as WhatsApp. Youth organizations and NGOs described online apps and interactive campaigns via messaging services, such as WhatsApp and Line, that were specifically targeted to HIV information and testing. Finally, youth spoke about YouTube and talk show formats that they sought to learn about topics around SRHR, including sexuality and HIV – information they noted they did not receive from their school or their parents.

Indonesia

Key informants described the use of the Internet and social media by healthcare facilities and for broader awareness campaigns:

"Some health facilities use the Internet and social media. One example, in Bandung, Garuda Health Primary care has Facebook and Instagram accounts. Some of them have a hotline you can directly consult through WhatsApp. In Jakarta, if there's an emergency, you can consult or directly communicate through WhatsApp also."

"In Jakarta province, there's an unwritten policy from the health office saying that all of the primary health care [facilities] should have a social media account. It would be easier for the patient who would like to consult."

In describing the information covered through social media regarding SRHR and HIV:

"Only at particular times, because there are a lot of issues in dealing with health. For example, on 1 December - World AIDS Day – there is much HIV information; because we have hundreds of health days, like drug day, etc."

"They pick a day: for example, Monday is for HIV, this day about diabetes; different topic every day."

Key informants from United Nations agencies spoke of the importance of launching online platforms to reach young people, more so in the context of pervasive stigma and structural constraints. The lack of an organized online directory of HIV testing services inspired them to fill this gap by creating a chatbot called 'Ask Marlo' on the Line messaging application (with an estimated 90 million users overall in Indonesia, 50 per cent of whom are youth) so that young people can access information from a non-intimidating source. The programme intentionally does not include 'AIDS' or 'HIV' in the name, but the chatbot provides information about HIV, dispels myths, provides access to online counselling and directs the user to testing services.

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"When we Googled HIV in Indonesia, we found out that there's no organized information source for people to find out where to go and get tested. There's no online directory of services, and so forth. So, this year we have expanded our website, like Saya Berani, and we have just created a chatbot in the Line messaging application. So your average young person that wants to find out about HIV, they can just talk to the chatbot that is very friendly and cute. This not intimidating and also gives information in a very relaxed, friendly way; but is also giving very critical information that provides facts and myths about HIV, quizzes, and where to go to get tested."

"This is Line, and this is 'Ask Marlo'. I have added him and now I am one of Marlo's friends and you can get basic information about HIV, you can get to counsellors also."

"You can find out where to go to get an HIV test. I have just asked where to go and get the test, and the answer is immediate. You need to answer which city, and if I say Jakarta, it gives me a list. Asks me which areas? Selatan. Then it tells you immediately these are two you can go to. And then you click one (Name of clinic), and then you go here to see more. It tells you, if you want to go to the (Name of the clinic), if you have BPJS, which is the health insurance programme, it is free. If you don't have BPJS, it will cost you 5,000 rupiah. If you click 'Get Tested,' you can make an appointment, so I have just clicked get tested, it goes to the linkages appointment making system."

Beyond information and awareness, the programme aims to engage online users in offline action, including counselling and HIV testing:

'ASK MARLO'

"A new online chat platform is the latest innovation that tries to raise public awareness about the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). The platform, called Tanya Marlo (Ask Marlo), features a character named Marlo who constantly reminds and informs users about HIV/AIDS.

'Let's take an HIV test!' Marlo says through the platform, which is integrated with the LINE messaging application. Wearing a yellow shirt under a blue sweater, the bespectacled man encourages anyone, especially those who are sexually active, to take an HIV test at least once a year to maintain a healthy sex life. HIV is preventable, Marlo reminds users via the platform."

https://www.thejakartapost.com/life/2019/01/22/curious-about-hivaids-just-ask-marlo.html

Another example of successful use of social media – and successful collaboration – can be seen in the campaign 'Saya Berani' ('I am Brave') initiated in 2016 by UNAIDS in collaboration with several local NGOs. The name reflects courage in seeking information, getting tested for HIV, and talking to friends about these issues. It is accessible via Instagram, Facebook and a website. The content is youth-friendly, developed by young people, and has 3,000 followers. Key informants described how the name of the programme was formerly something related specifically to MSM, which generated opposition. Collaboration between United Nations agencies and community organizations led to a more acceptable platform for users.

"Actually, this is why it became Saya Berani. It used to be called something else, because it was developed by an MSM group. That then came under attack, because it was too visible and risky, so we changed it to be more inclusive and it is not as visible as that. We have these little stickers, campaigns, you know, getting very famous movie stars, celebrities. It has 3,000 followers; it is not millions, but it's not bad. I have only 200 followers."

"That is, in Indonesian, 'I am Brave' — brave to seek information, brave to test, brave to tell your friends and talk about it. We work with all NGOs to do this. We funded a consultant to develop the platform, but then there's a guy in an NGO that is good at making websites, so he did it. And content, they created their own content."

SAYA BERANI

Saya Berani ('I am Brave') is one of the first major campaigns to use the power of social media to promote HIV testing in Indonesia. UNAIDS, community groups representing people living with HIV and key populations, the National AIDS Commission, the Atma Jaya AIDS Research Center and the media organization Rappler launched the campaign in November 2016.

"The #SayaBerani Campaign is a community independent movement that aims to promote HIV testing and treatment in the community, as well as reduce stigma and discrimination against people living with HIV."

https://sayaberani.org/

Key informants described the great potential of NGO-government collaborations in using social media to communicate with young people. The government was described as recognizing the potential of social media and sometimes seeking out the capabilities of United Nations agencies. When these efforts are handled internally by the government, they are often imbued with stigma and stymied by internal politics. But when international NGOs are engaged in collaboration, they can bring expertise in social media to effectively navigate these challenges.

Key informants also spoke about some young people using social media to disclose their sexuality or HIV status, and to disseminate helpful information, such as the importance of knowing one's HIV status. However, serious reality-based concerns around safety and confidentiality were also described, and an atmosphere that has become more dangerous for LGBTIQ communities.

> "And you would not believe, so we have some young people from Fokus Muda, actually, who post their status about being gay or whatever on social media, on Instagram and try to talk about positive living and knowing your status. And there are a lot of positive comments of support, and there are some comments that are saying you can get HIV via social media!"

> "Actually, we work mostly online and put our voices online as it is easy to reach young people online. But we are aware that it can be someone from the other side attacking us on the Internet, and we have safety and security training for us."

In the FGDs and key informant interviews, youth from YKP networks described difficult experiences of being harassed and bullied online and threatened with violence, as well as the dangers of in-person gatherings. NGO key informants corroborated an increasingly hostile political climate for LGBTIQ populations and for HIV prevention. In this context, it is imperative that efforts to engage with and reach out to YKP, particularly those from marginalized and at-risk populations such as LGBTIQ youth, include measures to protect their safety and security in both online and offline contexts.

> "Based on my FGD, lots of young people got bullied from social media. If they expressed their sexual orientation, they got bullied. Even a friend got bad messages every morning, got messages on DM [direct messaging]. It makes them insecure, lowers self-esteem, etc."

YKP and NGO key informants described a recent hostile act by a religious extremist group, largely unprecedented in the relatively more liberal enclave of Bali, which targeted transgender people:

DEFACING AND THREATS AGAINST ONLINE GAY/TRANSGENDER PAGEANT ANNOUNCEMENT

"In Bali, there's usually no problem with LGBTIQ and people are open about it. Until last month, I believed that anything with transgenders, as long as we link it with pageants – because Indonesian people love pageants and karaoke – is fine. It is widely accepted. But starting a month ago, one local organization working with MSM in Bali on transgender issues, they conducted a pageant for MSM and transgender women. For the first time in history, the final night for awarding the crown needed to be cancelled and closed, because there were a lot of reports to the police. There were a lot of attacks from social media, not just from Bali, but across Indonesia. The host of the venue said, 'Sorry, we need to close this.' And this happened in Bali! The pressure is difficult."

Indonesia

An AYKP representative described the struggles of their organization to have an impact offline. Public discussions are often met with a low turnout due to concerns around confidentiality, harassment and security issues.

Young people were described as being more receptive to online platforms, such as YouTube and to the use of infographics, as they are less inclined to read these days. Most of the work of YKP organizations is therefore conducted online.

> "For the first time, we were forced to go inside the building. Then the march organized by faith-based organizations wanted to come inside [to attack us] and chanted, 'Kill them'."
>
> "We feel sometimes we want to have public discussions, but recently there are few people who are willing to come to talk. Even if we tell them we secured the venue and have security staff; and if they want to register, we get their contact numbers and search for them on social media. We are very careful about our participants, but for now they [in-person gatherings] are not feasible."

> "I think in Indonesia, most youth are using YouTube platforms nowadays, because they are too lazy to read. [Among] the most popular Instagram accounts used by youth is Tirto.id."
>
> "Tirto.id is an Indonesian online platform account – news. They rely on youth preferences and again it is developed by young people."
>
> "In FGDs, they mentioned that they used YouTube at night and some looked for SRH information. There's a YouTube series of talk shows that's developed by millennials, so they interviewed me and they do research to provide some information. This group is called Kompass media – Pijaru. Many people access that; we can see from the viewers."

YKP described constraints on meeting other youth in person, including adolescents and youth living with HIV. Participants revealed experiences of being harassed and bullied online, mostly under the guise of religious conservatism.

"Kamil Project is a YouTube account run by young people. They produced a video on World AIDS Day about HIV and they got a lot of responses."

"In Indonesia, for young people, they don't want articles. They wake up and watch and read all the information on Instagram."

Youth described turning to the Internet and social media for information about SRH and HIV, in part due to fears of negative repercussions if they sought information from teachers, parents, healthcare providers, or peers.

"I don't want to talk or ask the teacher. Usually I find the information through the Internet. I fear that the teacher can spread our story and [that] scares us."

"In my friends and family environment, I have never discussed it. Usually I get that information from social media, about sexual education."

"Searching on Google ... participating in socializing about HIV in the community is scarce, because it is still taboo."

"My friends are afraid of health services, and browse to buy medicine independently, such as antibiotics, with doses that are not of course on a doctor's prescription."

Given the predominant use of the Internet and social media, youth key informants described the need for further capacity and resources to support their work on developing youth-oriented apps and social media presence, as well as plans moving forward. The even limited, sporadic funding is generally dedicated to initial development of an app, not to processes of working with youth feedback and revising it to better meet the needs of young people. Resources are also needed for paid advertising on mainstream online services like Facebook, with great potential to reach many young people.

"We use Blued to reach YKP through programmes of our partners and link them with our social media to search for further information. We are officially planning to work with Blued to be on their main page to reach more YKP."

"We developed an app for one year that responded to the needs of young MSM, transgenders and drug users. We worked in five provinces, but sadly preparation is only two months and implementation four months. It was good, but they [the funder/developer] didn't want to continue. The main challenge is how to maintain it and how to sell it to the government. The developers... are not eager to change the application based on youth feedback."

"A local NGO used ads on Facebook, and reached a big group of young key populations, especially MSM and sex workers. They were advised by my friend who told them to allocate a small amount of money for advertisement [on Facebook], and more than 2,000 YKP were reached. Some of the people were asking general questions, some for testing, and some who are HIV positive were referred to ART."

Some online platforms were described as being subject to restrictions, such as a family planning organization that was forced to change the information on their webpage at risk of expulsion from Indonesia.

Staff from an NGO described a project that uses social media to engage youth to attend clinics:

"Our project is really aimed at a general audience. So, we ask people we meet in cafes to engage in social media and so on. We find social media as a really good way to engage people who we already meeting continuously. We go to the cafe and say, 'Oh we have this photo booth. You go to Instagram and there we give info.' So there is that continuity. That's how we use social media in the Yogya project."

"There are young-people-based social media like taboo.id where we have 16k followers. And we share sexual health information so there is a lot of [that]. But our key [aim] is to get them to the clinics. That's how we use social media to connect to the clinics."

The success of online methods of outreach was described as varying depending on the key population in question. However further migration to online platforms was described in the wake of increasing conservatism.

> "For sex workers, it's not really a young sex worker-specific approach using online social media outreach. But we have to now; from the field, [there are] stories from the outreach workers who are using Facebook, Instagram, Line and Twitter to reach sex workers because most of them now are going online. Because, as you know, Indonesia is actually set back in terms of conservatism. It applies not only for sex workers, LGBT, but also for young people in general. They are not really open to speak about sex, about their life in social media, because their parents who used to be neutral are also now influenced by the conservative groups. And it connects to mental health issues."

MENTAL HEALTH

Key informants described a general lack of mental health infrastructure in Indonesia, with some availability of trained psychologists through primary health care centres in urban areas. In response to reported increases in depression and suicide across adolescents and youth, there are several initiatives to provide mental health care and referrals through the educational system. However, several informants described serious constraints to mental health care due to the influence of religious ideology and its impact throughout the government, which operates in opposition to both international evidence on mental health and broadly accepted professional guidelines. Increasing mental health challenges were identified among AYKP due to stressors that are produced and exacerbated by homophobic and religious ideologies and practices that fuel pervasive bullying, harassment and outright violence against AYKP. There is a complete lack of mental health care focused on youth living with HIV.

"We have psychologists in primary health care. The doctors can call the psychologist in primary health care when there's an issue about mental health, especially for youth living with HIV and AIDS. But the Mental Health Sub-Directorate is new and the priority is mental health in schools first. They don't have mental health programmes for youth living with HIV. But there's potential to work on this issue."

"Until now, there's not [a psychologist] at all in primary public health centres. But they have a schedule, maybe twice a week for a psychologist to come to primary care centres."

"It is a problem, because reflecting on our survey on demographics and health, the number of youths who potentially want to [commit] suicide is increasing, with depression and feeling lonely; and because school assignments are also very heavy. Now, it is a first step, our programmes on mental health in schools; and in the future, we will collaborate with the Mental Health Sub-Directorate and also the Family Directorate."

"We were just speaking to a researcher and parliamentarian who did research in schools. She found 18 per cent [of students] in high schools had suicidal thoughts; 30 per cent had depression and needed referrals."

The availability and accessibility of mental health services was reported to vary greatly by region, with particular challenges outside of major urban areas.

General lack of awareness and taboos around the topic of mental health and suicide were described as characteristic of Indonesia. Broad and systematic problems exist in the lack of mental health services tailored for people living with HIV.

"In Jakarta it is ok, no problem. But if you come to another province, it is very difficult to find a psychologist."

"The small islands and the rural areas [lack mental health services] … but in the capital, it's more accessible."

Informants described challenges of suicidal ideation, depression and loneliness among youth, as well as particularly acute challenges for YKP, including young MSM and youth living with HIV. Broad lack of awareness and understanding about mental health was discussed among the general public in Indonesia, as well as within the healthcare system, including HIV services.

Increasing mental health challenges were identified among youth, along with beginning efforts to conduct mental health screening and referrals in the school system.

"When you talk about mental health in Indonesia, everyone thinks psychosis. It's really hard to mainstream depression and common mental disorders. Currently, it's part of the healthy school systems in which we are involved. They have SDQ [strengths and difficulties questionnaire] screening, which is a screening tool to see who needs referrals; and it is indeed a part of the school-based mental health programme."

"But outside that, especially for youth with HIV, HIV counselling is totally delinked from the mental health system; but when you look at the people who come to our clinics, almost everybody comes just to talk. To speak. And that's something."

"Indonesia is still developing a suicide risk assessment although every district now has to report suicide. But people are not sensitized to what suicide is."

Indonesia

Across general youth organizations, YKP groups, and national and international NGOs, key informants described escalating religious extremism in Indonesia and a broad 'crackdown on LGBTIQ' populations. This was reported to be widely known in the country. The increasingly hostile atmosphere was described as causing mounting stress for all AYKP, including LGBTIQ populations and youth living with HIV, sometimes leading to fatalism, discontinuation of HIV medications and outright suicide.

> "It is a big issue, especially because of bullying online and offline, some news online stigmatizing LGBTIQ. They internalize homophobia and transphobia, so they feel unfit with themselves and of course they get depressed. I think every YKP always feel depression in their life."

> "Just being a young person as YKP they are struggling."

> "I mean for HIV programmes we are far away from mental health integration, even though we are aware that now with the crackdown of LGBT, most of the MSM in the field, they live in fear. I mean all the nationals are aware of what they are feeling now. The pressure is like increasing every day significantly and impacts them psychologically."

> "This is an example of a dear friend who just committed suicide, six to seven days back. He was very young, 21 years old, MSM, HIV positive, and he just jumped off a bridge into a river and nobody reported it as suicide. Everybody was like, 'Oh, it was an accident. He jumped off the bridge.' So that's the kind of sensitivity, it's still very, very far off."

Adolescents and youth described grappling with the limited information they were given, in the context of myths and stigma about contagion from HIV due to casual contact, and even from being gay. A gay adolescent described acute awareness of the pain and depression some of his gay friends endure due to family pressure and rejection. An adolescent who is a lesbian spoke of being forced to endure counselling she found "traumatizing."

> "If a kiss automatically transmits infection, if there is a friend who has HIV, how do you keep your distance without hurting his heart?"

> "Never had hetero friends, but people always thought he was homosexual, even though he wasn't."

> "There are many gay friends who are depressed, but sometimes they are happy, too. Usually they have family problems. It can be seen from the way they cry. Sometimes they look like a happy person, but we can see that actually they are feeling stressed and depressed because of the pressures that they face."

> "I had to go when my mother forced me, and I became a bit traumatized by a psychiatrist. But once I went to a counsellor independently, but it was expensive."

Some young people described receiving and giving support among friends when they feel sad or 'down'.

> "Being supported there is a community of students growing together. If we have a problem or our hearts are sad, we usually tell stories, and they provide solutions."

> "I don't go to counselling services; it's better with friends."

> "When I see a friend who is having a problem, I like to ask questions and try to help and give suggestions regarding the problem, such as suggesting aid or a psychologist. I sharpen myself to be sensitive and caring."

Other young people reported wishing they had access to youth-friendly mental health and HIV counselling services, with challenges due to the costs as well as religiously based ideological barriers.

"I am confused at the puskesmas [government-sponsored community health clinics] because there is counselling from a psychologist or psychiatrist, but it certainly costs a lot. I want it free."

"Services for adolescents should be subsidized or free, so that it is easier to access, such as HIV services. If I am silent, it does not mean that I am fine."

"Bipolar and depression; the stigma says if we are depressed, we are not close to God, and will be asked to undergo ruqyah [exorcism]. I want to eliminate the stigma that depression is a spiritual problem. I want to get service from the Ministry of Health."

A particular mental health challenge was described in regard to suicidality among YKP living with HIV. The culmination of hopelessness, depression and a hostile social environment leads to what is termed 'Bosan ARV', literally meaning 'I am bored of ARVs', which was described as the practice of ceasing to take one's HIV medications. Notably, there are also sporadic stock-outs of ARV medications across hospitals in Indonesia, reported again in early 2019, which is an additional source of anxiety for persons living with HIV who might otherwise adhere to treatment.

"Suicide is a problem, and from anecdotal experience, I worked with homeless young MSMs before and it's really a huge problem. No one is sensitized, including the HIV outreach system, so no one knows that it is actually suicide, including from stopping taking ARVs. That's a form of suicide which a lot of people do and it's called 'Bosan ARV' – so that's, 'I am bored of ARVs' – a very colloquial term people use to describe committing suicide. No one is sensitized to that issue as of yet."

On a broader societal level, several informants described how the conservative climate, which holds sway over many institutions, contributes to a hostile social environment for AYKP, including on-going harassment and violence. They reported documentation of escalating incidents of arrests and harassment of LGBTIQ persons, and obstacles to HIV prevention and adolescent's sexual and reproductive health more broadly. They also reported the hope that once the (now completed) election is held, the level of vitriol will abate, as some of the rhetoric was described as political in nature to support electoral success.

"It is just really obvious that, not only in Jakarta, in other areas of the country, all of a sudden, some issues that never had been an issue before are just beginning. I mean Human Rights Watch and a legal aid organization are monitoring the number of arrests and harassment incidents by the authorities towards these vulnerable groups. It had been more than 700 separate incidents last year alone. There have been many local regulations that have been issued. These are all under the Sharia law and things like that, and not only about LGBT, but also about religion and about any of these issues. And just in one city, the fine issue – a local law to fine someone 1 million rupiah for displaying any LGBT traits or behaviour. Whereas in the Philippines you hear they issued in one city a protective law for LGBT people. So, you know, at the same time, the same week, we found these things out."

"At least it will stop, the campaigning and positioning; and you know, using these issues will stop."

Religious extremism also was described as contributing to the spread of myths and misconceptions that undermine the evidence-based practice of psychology and psychiatry. Persons who lack any credentials or training as mental health professionals promote various forms of 'spiritual psychiatry'. This is enabled by the scarcity of professional training in mental health as well as the lack of official regulations and enforcement. The unfortunate culmination of this confluence of extremist ideologies, lack of evidence-based practices, and the absence of regulations is that

practices that have been long discredited by every major international mental health organization, such as so-called 'conversion therapy,' are promoted, even as they have been documented to cause harm. In opposition to broad international evidence, the Indonesia Psychiatric Association still classifies homosexuality, bisexuality and transgenderism as mental disorders.

In this less than optimal context, key informants described the imperative of strategically moving forward through efforts in education, training and advocacy to support the development of professional mental health providers to repair the existing system. Examples included identifying qualified psychiatrists and engaging them to mentor mental health counsellors who provide direct services to youth and AYKP, and advocating for integration of professionals in the mental health system along with the development of regulations for mental health practice.

"It also means that to integrate programmes, you need to know experts who can mentor; but it's very rare. There are one or two friendly psychiatrists in Yogya that I used in that model to mentor. I do really think that IPD [initial professional development], core skills, and training according to that can work, but it is very rare. I don't know how to do it without the psychiatrists' support at least. You can outsource the psychotherapy and screening to counsellors and so on; but without psychiatrists' mentorship and referral and support, I don't know how you can integrate the programmes."

"Four years of bachelor of psychology, plus two-year professional degree in clinical psychology, but that just started. They [psychologists] are just starting to get regulated."

"They don't have common standard guidelines. So, when we ask IPD [initial professional development], CPD [continuing professional development] guidelines for every psychotherapist, they don't have it, …even counselling guidelines, like the skills for counselling, they don't have it."

"Like there is no backbone to build the mental health system on."

In a context of pervasive stigma, threats and acts of violence against AYKP including LGBTIQ populations, people living with HIV, people who use drugs and sex workers, NGOs described reframing their approaches to HIV surveillance and reporting. Previous HIV reporting by 'risk groups' was being exploited to further stigmatize and discriminate against these groups, rather than to promote HIV prevention.

"New infections continue to increase. It is at 50,000 a year, which is the third highest in the Asia-Pacific region after India and China. So, you don't want that. But we don't want to propagate this discrimination. Starting last year, we heard people saying, 'How do we stop HIV in our city? We have to get rid of the gays, of the LGBTs, just get rid of them and then we will be safe from HIV. We don't talk about KP (key populations) anymore. We don't say, oh the prevalence among MSM is 'x', among sex workers is 'y', you know."

Finally, in the broader context of SRHR and HIV prevention amidst formidable structural constraints, key informants described strategic approaches to support success and move forward, such as disseminating advances in biomedical HIV prevention.

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"Exactly to your question, I mean, 'Can we do this?' We are doing it! We say that we are not implementing, you know, identity campaigns. We are implementing support programmes to key populations to be protected and ensure they access the health services and Global Fund programme. So, that somehow manages to let us get away with it and we are just, you know, very firmly saying that it is all about access to health care, which is we want to ensure access to for all our population."

"We are also talking PrEP, there was at first some resistance from the Ministry of Health, because they understood that to be only for MSM. So, we talked to them over a number of meetings and we said it is not for MSM. In all countries that have implemented this, it is a public health intervention for all people who are at higher risk and it is the only way – since you (MOH) are not doing condoms – the only way you are going to see any hope of bringing down the number of new [HIV] infections. So, 'you have to look at this, because every other country in the region is doing it, apart from you and Pakistan. You don't want to be the only one left not doing this.' So, they said, 'Yes, but we are not ready'. 'That's ok; you don't have to do it tomorrow. You can get information on whatever questions and concerns you have. We will do a review of the literature and answer all your concerns, and then we can do modelling.' WHO brought in a team from the University of New South Wales to do modelling on the impact and cost-effectiveness analysis; and so they have just agreed to do the modelling [on PrEP]. And they are planning that by the end of 2019, they can start a pilot in two cities. So, we are very happy about that. That was a big breakthrough."

RECOMMENDATIONS

Education

1. Integrate CSE from junior high school level and above to provide coherent information about sexuality, gender, HIV prevention and risk behaviour, and to counter myths about HIV transmission.
2. Develop and implement teacher trainings on CSE incorporating components on tolerance, discrimination and anti-bullying initiatives for teachers.
3. Prioritize meaningful adolescent and youth involvement in the design and development of SRHR curricula and content.
4. Address distinct barriers to CSE curricula in different geographical locations, with a focus on rural and remote areas, in order to ensure a basic level of CSE is broadly implemented.
5. Strengthen and support peer-to-peer SRHR and HIV prevention initiatives that provide information, support, and referrals to adolescents and youth in out-of-school settings who are often more difficult to reach due to geographical dispersion and poverty.
6. Update and enact policies to bridge and integrate Ministry of Health and Ministry of Education agendas to promote CSE and HIV education and services.
7. Marshall joint United Nations efforts to promote policy development to support implementation of CSE and adolescent health; each United Nations agency should strengthen their ministry partners to move this agenda forward.
8. Systematically reduce legislative and policy barriers and practices that constrain effective HIV prevention programmes for adolescents and youth, including barriers in access, availability, and even talking about condoms, and restrictions in access to HIV testing, through strategic partnerships and advocacy based on widespread scientific evidence.

Parental and peer support

1. Promote education, awareness and interventions to protect the safety and security of security of AYKP and other LGBTIQ.
2. Increase resources and support for peer-to-peer approaches to promote outlets for discussions around sensitive topics such as SRHR, HIV, sexuality and bullying among youth.
3. Design tailored interventions for parents to provide and discuss basic information about SRHR, sexuality and HIV, and adolescent health, through parenting courses in parents' clubs at schools and through social media, including supporting parents as mentors and role models in their communities.
4. Expand and scale-up the use of peer mobilizers to support adolescents and youth at risk in accessing HIV testing to bridge gaps between online information and offline behaviour.
5. Expand existing training and support of peer counsellors and peer educators, including by doctors and healthcare providers with competencies in working with youth and AYKP, and with peer counsellor access to on-going emotional and practical support amidst sometimes stressful encounters in trying to support other young people in precarious situations.
6. Advocate and enforce legislation to lower the age at which adolescents can access HIV testing without parental consent with support from trained peers or CBO representatives.
7. Promote and implement institutional and policy reforms to ensure protection from discrimination for all populations, including young MSM and transgender people, who are at disproportionately high risk for HIV infection, and people living with HIV.

Communication

1. Capitalize on the pervasive use of online social media by young people by developing and distributing up-to-date content that addresses knowledge gaps in existing online (and off-line) sources, promotes accurate information about SRHR, and counters widespread myths and stereotypes.

2. Utilize the growing power of social media and online apps to promote self-awareness, acceptance, and to break isolation among AYKP through online spaces where they can meet, exchange information, and experience a sense of belonging and community.
3. Adopt and follow explicit guidelines to protect youths' privacy, confidentiality and safety in online forums that promote education and support for AYKP and youth in general.
4. Develop, evaluate, and scale-up interventions (such as availability of trained peer navigators) to bridge online information (about HIV/STI risk, HIV testing) and offline action (accessing HIV/STI testing services) in order to realize the health promoting potential of social media and online initiatives.

Mental health

1. Design and integrate basic mental health information, screening, and referrals in the school system.
2. Support inclusion of mental health services in existing youth-friendly clinics.
3. Develop and launch pilot programmes to address the near complete lack of mental health and counselling services for youth living with HIV, including AKYP.
4. Promote multilevel interventions (in schools, online, etc.) to combat stigma and counter myths to reduce the hostile social and institutional climate for AYKP including youth living with HIV.
5. National and local governments should prioritize training, credentialing, and monitoring of psychologists through primary healthcare centres to provide competent mental health services as a response to increased depression and suicide rates among adolescents and youth, including AYKP.
6. Promote education and social advocacy to bring the Indonesia Psychiatric Association in line with accepted global classifications of mental illness, including the removal of homosexuality, bisexuality and transgenderism from identified disorders, and the banning of so-called 'conversion therapy'.

Philippines

In the Philippines, new HIV diagnoses were reported to be 195 per cent higher in 2018 (13,000) than in 2010 (4,400), an alarming rate of increase.[1] The majority of new infections (71 per cent) in 2018 were among young people, particularly young men who have sex with men (MSM). The overall number of people living with HIV in the Philippines increased from 15,000 in 2010 to 77,000 in 2018, a fivefold increase. Less than half (44 per cent) of people living with HIV in 2018 were receiving antiretroviral therapy (ART), with even lower rates of ART coverage (22 per cent) among women. Among key populations, HIV prevalence was estimated at 4.9 per cent among MSM, 1.7 per cent among transgender people, 29 per cent among people who inject drugs, and 0.6 per cent among sex workers.[2]

Key facts on HIV in the Philippines

NEW INFECTIONS
13000

PEOPLE LIVING WITH HIV
77000

PEOPLE ON ART
33593
(44% ART COVERAGE)

AIDS-RELATED DEATHS
1200

New infections	People living with HIV	Deaths
▲	▲	▲
Increasing	Increasing	Increasing

Source: UNAIDS data, 2019; www.aidsdatahub.org

Philippines
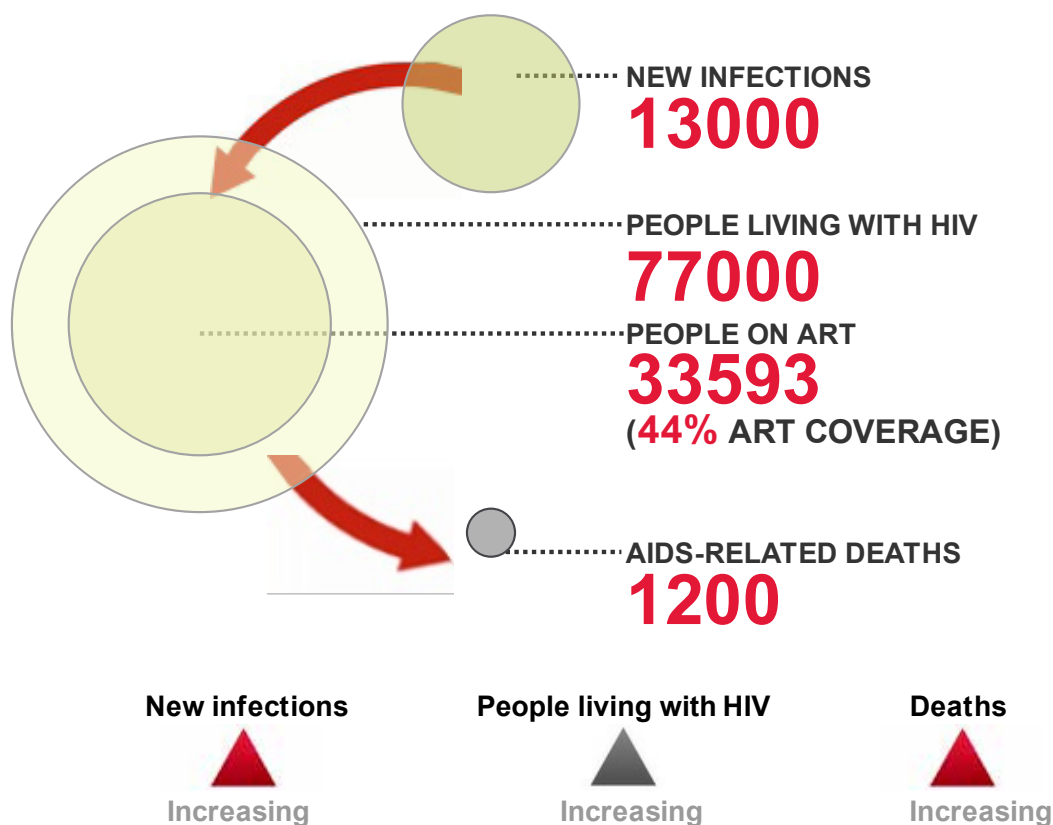
New HIV infections among young people (15–24) – by sex
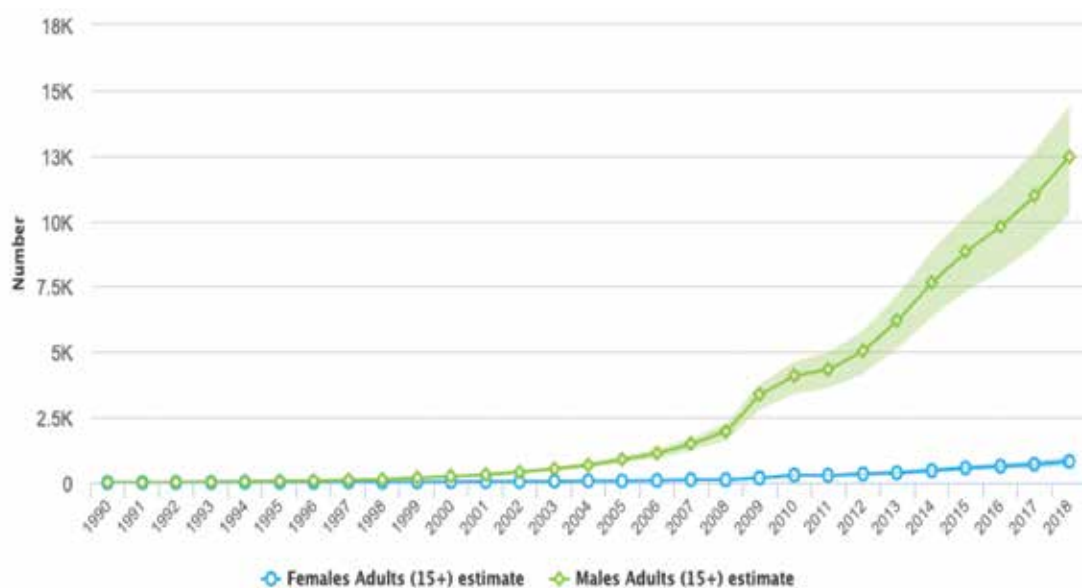
Source: UNAIDS data, 2019; www.aidsdatahub.org

Among young people aged 15–24 years, new HIV infections increased by 197 per cent from 2010 to 2018.[3] Notably, young men accounted for 96 per cent of new HIV infections among young people in 2018. Philippines Department of Health data among a sample of young people indicate almost all (97 per cent) were infected through sexual contact, with the majority (63 per cent) of infections among MSM, and 24 per cent among men who had sex with both men and women.[4]

Eleven key informants (four women, six men, and one transgender person) comprised experts in the fields of HIV prevention, adolescent health, child welfare, and mental health from government departments, United Nations agencies and private industry. Key informants were from the Department of Health, the Council for the Welfare of Children, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the World Health Organization (WHO) and Unilab Foundation. The Council for the Welfare of Children is the focal inter-agency body of the Philippine Government for children. Unilab, the largest pharmaceutical company in the Philippines, provides funding for public health initiatives.

Four focus group discussions (FGDs) were conducted with a total of 27 adolescents and young adults (12 girls/young women, 14 boys/young men, and one transgender person) from the following populations:

- FGD 1: MSM and transgender young key populations (YKP) (aged 16–18 years);
- FGD 2: young people living with disabilities, young people living with HIV and young women from urban poor communities (aged 19–24 years);
- FGD 3: YKP in schools and organized groups (aged 16–18 years); and
- FGD 4: teen mothers, teen fathers and youth in the labour sector (aged 19–24 years).

A draft report was circulated to all key informants and to youth networks for feedback and suggestions – known as member checking, which supports rigor in qualitative research – which were then incorporated in the final report. The report was then presented and discussed in the National Dissemination Forum on the Formative Assessment on the Needs of Adolescent and Youth At-Risk, held in May 2019 at Community and Family Services International, an international non-governmental organization (NGO) in Metro Manila. The Forum included 25 adolescent and youth outreach staff and peer educators, and representatives from local government, United Nations agencies and private industry. Suggestions and recommendations from the Forum were incorporated in this final report.

EDUCATION

In the face of widespread misinformation and societal myths about sexuality, sex and HIV, efforts are underway in the Philippines to launch comprehensive sexuality education (CSE) programmes in schools. Informants described specific initiatives both to develop content and to focus on the process of introducing CSE programmes aimed at facilitating their acceptability and implementation.

CSE programmes were first piloted in 2016 in more progressive locales (such as Quezon City, the most populous city in the Philippines) with local government support. They were then revised with rollout to broader areas of Quezon City, and included an evaluation component to estimate their effectiveness. Specific obstacles in implementation were identified and addressed, with broader efforts underway to disseminate CSE programmes throughout the educational system with age-appropriate material from kindergarten through Grade 12. Additional and more in-depth programmes were also piloted at the college level. Informants identified challenges that remain in terms of content and programme implementation for the Philippines.

"Quezon City is a very progressive city. It is one of the cities with the largest budgets for HIV. This has a lot to do with its local programmes."

"The first one with four schools was a post-test (only) and the second with 46 schools was a pre- and post-test. And it showed promising results in terms of knowledge. The jump in knowledge was 20 per cent...which is interestingly the same as the four schools, the year before. So, it seems like teaching that [CSE curriculum] increases the knowledge by about 20 per cent. So, the question is the retention...I don't know if it will be at 20 per cent after a year or more."

Informants also described the need to directly address the many misconceptions about HIV and sexuality, as well as to make training fun and engaging for both students and teachers. Specific attention was paid to not single out and shame individuals for their mistaken views, but at the same time to point out the degree of misconceptions held.

"So, what we did was revise the training material and we put all the misconceptions in the training material. And we made it a game where it is fun. It is like question and answer, so it would be like "who thinks this?" and they sort of vote and make it fun, and then the result would come out. We also did a lot of polling. So, you wouldn't be singled out per person, but it would show the disparities in the answers."

A specific misconception was described around who can contract HIV and perceived protection by virtue of one's gender or sexual identity. One key informant explained:

"I think the other thing that is starting to become something we are thinking about is the female partners of young MSM, because they are still experimenting and so they still have female partners. So, we have two issues, teen pregnancy, and HIV and STIs. So, because we have an MSM epidemic, females think they will not get HIV or STIs, so they are shocked when they do. And that's something that we have to not forget. Because they can get both pregnant and have STIs."

Similarly discussed were the myths and misinformation about HIV and its transmission, and the limited availability of accurate information through schools. For example, some youth in the FGDs recalled a rumour spread through Facebook that Coca-Cola was mixed with blood from someone having HIV and avoided drinking the soda as they might get sick or die.

In FGD 4 of young parents, participants reported knowing about condoms, but described their use of 'withdrawal' and 'rhythm methods', as well as being able to identify who has HIV, which are all ineffective in preventing HIV transmission: "I am aware of the risks and I am always reminded by my parents to be careful with the women I had sex with, that I should choose 'safe' and 'clean' women to avoid getting viruses or other illness." They discussed learning about HIV and its transmission from their friends, as well as in seminars provided by local government units.

Philippines

Teacher training and the lack of appropriate CSE materials were identified as among the most problematic links in implementing even basic sexual and reproductive health education. Challenges arose due to lack of information among teachers themselves; lack of appropriate information and materials for teaching about sexual and reproductive health; the teachers' own prejudices and value judgments about sex, sexuality and HIV; and pervasive social stigma around sexuality and HIV. As a key informant explained, "in some instances teachers may have the knowledge but because of their own stigma they don't even want to talk about that."

"Teaching the teachers is the big challenge, actually. How can you teach something you're not comfortable or competent with? Just mentioning the word 'sex' is a taboo for teachers. So, you really need to desensitize teachers and really capacitate them to be more comfortable in teaching this."

"One of the things that we found out during the workshop was that there was no material to teach about HIV in schools. So, all of the teachers would Google materials for HIV. There was material in their handbook, but it was super out-dated and did not even talk about ARV and said that HIV was among overseas Pilipino workers only. It was written before 2009, when the epidemic was very different. And so that needed to be updated. And that was the clamour because teachers did not feel comfortable teaching HIV because knowledge was so low. Like our National Health Demographic Survey said 20 per cent of Philippine girls ages 15–24 had correct knowledge about HIV, and for MSM it was 40 per cent. Teachers were lower. So, you can imagine what they are teaching? They are the cause of stigma. A lot of them don't even want to teach about HIV...they skip the topic altogether."

Youths' experiences in schools corroborated teachers' uneasiness in talking about sex and HIV transmission. Youth reported being told to go home and discuss it with their parents or family members. A young woman from the adolescent YKP group (FGD 3) explained: "Young people find it more comfortable to open up to friends and peers than parents. Talking with an adult is often awkward for teenagers."

Interestingly, youth also described how their parents largely did not talk with them about sex or HIV, reasoning that sexual and reproductive health would be taught in schools. An adolescent (FGD 3) explained that she was more likely to provide her parents with sexual and reproductive health (SRH) information than receive it from them: "I feel that I have more information to share with my parents. It came to a point that I understand why they are like that because they did not have access to correct information when they were young."

This reveals gaps in resources available for youth who seek out information about SRH.

In response to the challenges for teachers, the Department of Health developed and tested teaching materials designed for educators. Key informants described their intervention with teachers and school curricula, as well as initial evaluations of their effectiveness:

"Actually, we've changed the curriculum now to have more time for discussion of myths and misconceptions. It used to be shorter; we really stretched it and actually put it in the PowerPoint material for teaching because we already prevented so many myths from rolling it out that we realized that if we can achieve one thing, it is to make sure these teachers know what they are talking about and at least remove all the myths."

"One of our issues was that the teachers had values that they were laying down on HIV, which can go either way depending on those values. And we were telling them it is a scientific sub-topic and you can remove your values first, and teach it without any myths and use facts. You can still be a teacher or mentor, but don't confuse facts with your own opinion."

"One of the things that we assessed during the first and second roll out is the comfort level of the teachers to teach HIV, and that significantly increased. It was at first [comfort level] 3 or not at all, and it actually went up to 8, 9 or 10 when they were actually teaching. A lot of them said using the material was more comfortable because it was scientific."

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Specific examples of good educational practices were described around antiretroviral therapy (ART) for HIV and around condom use, which employed cartoons and games. The information about ART, in particular, was described as instilling realistic hope even for youth who might contract HIV, and simultaneously reducing the stigma around HIV as equivalent with death. These false beliefs deter discussion about HIV and drive it (and people living with HIV) further underground; and they fuel fatalism among YKP, which disincentivizes HIV testing and treatment. HIV stigma nevertheless remains an on-going concern.

In addition to honing the content of CSE programmes, the developmental process of trying out and testing the intervention, and willingness to revise the delivery methods as well as the content, emerged as keys to success. Among the chief obstacles that remain is widespread stigma about HIV, with any future direction described as interventions aimed at reducing stigma.

"One of the things that I saw changed was the understanding of the effects of ARV (antiretroviral drugs). That was not in the awareness of people and that was causing the sense of HIV as a death sentence once you have it — and it was fuelling so much stigma. But because we made a cartoon about ARV, the teachers had an easy time teaching it. So, they made skits. So, this was basically HIV and then ARV is here. All of a sudden, students understood that, 'I have HIV, but it's ok as long as I take ARV'. So that change, when I was observing the teachers and students, that was something they remembered because it was a cartoon."

"This is our third round. So, the first round was good, the second was more comprehensive, but still produced a lot of misconceptions and stigma. And in this last round, the past few months, I think it's been a little better. But I think it would still take a while to reduce the stigma."

"The Department of Education has been developing the curriculum guide as well as the teaching materials, and that's integrating CSE from kindergarten all the way up to Grade 12; so that's really aimed at reaching young people. There is going to be a lot of work that needs to be done in developing the materials and training the teachers to become comfortable in teaching CSE. That's one partnership that is a very concrete partnership that UNFPA has with Department of Education."

Philippines

Significant systemic issues arose beyond the schools and school systems regarding strategies for packaging CSE to increase its acceptance in schools, while still retaining key information to support its effectiveness. Merely gutting CSE materials of all content deemed 'sensitive' often has the perverse result of emboldening (rather than challenging) myths and misconceptions, and may contribute to increased risk (for example, if 'sex' is exclusively taught as between a man and a women, gay and bisexual youth, who are most at risk for HIV, may believe themselves to be not at risk and thereby unwittingly increase their risk for contracting HIV infection). Key informants described the importance of local governments in sponsoring and supporting sexuality education, including exerting leverage on schools to implement these initiatives – and the great potential when that support was granted. Importantly, in initial rollout of CSE, a growing awareness emerged around disconnects between the educational and healthcare systems, and the resulting missed opportunities for linking adolescents and youth to sexually transmitted infection (STI) and HIV testing and treatment.

Informants described the educational system as an essential link, due to the intransigence of beliefs and values in society that permeate family systems and render it very difficult for parents to serve as effective conduits for sexual health information.

"That's why, because of that, it's hard to break that culture; so, we're engaging the second level, which is the school. We see the teachers because kids are spending more time, more hours in schools, we see the opportunity for kids to learn this in their schools."

However, teachers reflect broader social attitudes and prejudices. They must answer to local communities and may be held accountable for information they share. Key informants described strategies to adapt to different levels of acceptance of discussing HIV, and sexual and reproductive health and rights (SRHR):

"You could introduce it as adolescent health, a broader framework of health, just being sure to incorporate HIV and SRHR; I think if they seem to be open to [discussion of] HIV, we can go straight to HIV. If not, then you could package it in the context of adolescent health."

"Another way of doing it is like packaging adolescent health and reproductive health in a more general theme like providing life skills. You know, some are kind of religious about this, but if you attack it in a way that you are just providing, empowering them, [with] leadership, life skills, there are many ways to kill a cow."

"The Catholic Church in the Philippines has an HIV network. Of course, they're not going to endorse condoms; in terms of education, they will of course emphasize abstinence. But still, for a certain age abstinence messages are okay. I think they've stopped spreading misinformation about condoms. I haven't heard lately. Because in the past I used to hear it that condoms had holes but of late I haven't heard."

This means that while the Catholic Church had not assumed a hoped-for large-scale role in intervening in the escalating rates of HIV infection among young people, key informants described as a positive development the church's refraining from spreading misinformation; and they accepted and integrated those messages from the church that were conducive to HIV prevention.

Among the important lessons learned was that initial SRH programmes had a catalytic effect in creating demand in other locales in the Philippines. Challenges arose in the quality of the rollout, its evaluation, and the lack of funding allocations by other local governments to support the programme. However, the demand itself for CSE programmes is an important step forward in scaling up.

"The nice thing about this was that [it inspired other] local governments to actually push for this and recognize the potential; because soon after, there was a clamour across the Philippines which actually entails an ad-hoc programme wherein the trained teachers of Quezon City were asked to train teachers of other cities with help from our team. But as things haven't been institutionalized yet, the local governments did not have money and relied on us for sources of funds and to produce the materials. And there was no evaluation on how they did it. So, we just did the training. Parallel with everything that I talked about, there was the Department of Education at a national level. There was push from other stakeholders. Not just from the HIV circles."

Youth, too, described demand for more detailed information about SRHR in schools. They discussed the importance of not only addressing sex and sexuality in terms of factual information and HIV, but also in the context of strong sociocultural pressures that they experienced. Participants in FGD 2 and FGD 4 emphasized how societal and familial pressures affect adolescents, such as the importance of marriage, and childbearing in marriage. These contribute to marriage at a relatively earlier age, and the pressure to bear children often results in little time between marriage and childbirth. The 2017 Philippines National Demographic and Health Survey[5] indicates that among the group of women who are presently age 25 to 49 years, their median age upon first marriage was 22.5 years; 15 per cent of these women were married by age 18, and one third by age 20. Comparable data are not provided for men, but Philippines Statistics Authority (PSA)[6] reports first marriage for men occurs on average two years older than for women. Women's median age of first birth was within one year of marriage, at 23.5 years old. Notably, these statistics differ among women in urban and rural areas, in which marriage and childbearing occur 1.5 years earlier. Many social and cultural factors combine to shape Filipino adolescents' sexual and reproductive health.

Important structural challenges were described by key informants, who reported how the implementation of pilot programmes brought to their attention disconnects between the educational system and the healthcare system. From the perspective of the healthcare system, schools hold great potential in serving as a conduit for engaging adolescents and youth in healthcare. Nevertheless, the accessibility and availability of healthcare services remains a concern.

"A few of the students approached…because they had a sexually transmitted infection (STI), or thought they had HIV, or had unprotected sex. Or they were scared they had an STI or HIV. One of the things we realize more and more is that there has to be a referral between school and health. And that's one of the things that we are still trying to establish; it's not certain yet because each city has a different concern. One operational concern is if the health facilities are few and there are so many schools, or the distances are very far."

"The thing we realized is that a lot of the cities did not make their programmes known because the teachers had no idea that HIV programmes existed in their cities. There is really a disconnect between the health services and the education sectors. So, one of the things we told the cities is please make your services more known and be specific about it."

Several projects were described that were sponsored by NGOs or by private industry, which operated in the context of the educational system.

"There are a lot of projects. For example, 'Gongbokhao' involving HIV in Iloilo; they [have been] running it for about two years now and they are expanding. They screen, they educate students of universities to do voluntary HIV screening. They are very successful."

HIV STIR UP: HIV STRATEGIC INFORMATION AND RESPONSE PLANNING, QUEZON CITY

The National Epidemiology Center (NEC) of the Department of Health (DOH) in collaboration with the National AIDS and STI Prevention and Control Programme (NASPCP) implemented HIV STIR-UP Workshops from 2009. The workshop includes participants from 17 regional teams and partners from local government and United Nations agencies.

"One of the key things emphasized in this year's STIR UP was testing and access to treatment among 15–24-year olds. Because what we were seeing from the data was testing was high for those above 25, but there was no clear strategy on how to provide testing for 15–19 and 20–24. Quezon City, from their own initiative, made something similar for college students. Through the help of the Filipino Shell Foundation, they are creating materials for college students lodged in the National Service Training Programme. So, all college students must go through a one-year module and they are wanting HIV [education] to be a part of that. That's for the schools."

KLINIKA NOVALICHES SUNDOWN CLINIC
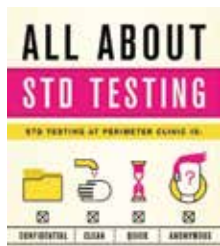
Quezon City's HIV programme continues to serve as a model for other Philippine cities, having established the first clinic providing services for MSM and transgender people, and with three "Sundown Clinics" (operating from 3pm to 11pm), which reportedly carry out 40 per cent of the city's HIV testing (UNAIDS, 2017). Their success is attributed to reducing the stigma that presents barriers to seeking out HIV testing in traditional health services, particularly among MSM.

https://www.facebook.com/klinikanovalichessocialhygieneclinic/

Finally, several informants described challenges in launching CSE with regard to the sheer vastness of the country: "because of the archipelagic nature of the country, a one-size programme won't actually work; so, we have to consider the uniqueness of each region as well."

The geographic challenges and logistical implications, with broad cultural differences, renders reaching out to all the islands with differentiated educational outreach approaches, including for rural and urban areas, a monumental task.

Youth themselves also raised the challenge of tremendous geographic variation and cultural diversity in the Philippines, recognizing different sociocultural expectations in different locales – some of which they shared in their own stories. In one example, girls and young women described the gender norms that they feel pressure them to get married and bear a child. They also spoke of relationships in which their male partners have more power to make decisions; and this is regardless of young women's sexual orientation. These pressures create additional vulnerability to HIV infection among young women. A young man (FGD 4) recounted, "I know of someone who got pregnant by her friend and was abandoned." A young woman (FGD 4) reported:

"I got pregnant when I was devirginized [sic] by my first boyfriend. He abandoned me, and I planned to commit suicide by slashing my wrist. However, my scar formed into a keloid. It was very painful."

Key informants explained how cultural gender norms present barriers to their work on sexual and reproductive health, and HIV-prevention education; and that norms, which render girls and young women more vulnerable, are even more pronounced in areas of rural poverty. These are described in more detail in the following section, with a focus on families.

An understanding of the geographical and cultural diversity of the Philippines, and the centrality of family, emerged as shared perspectives from youth and key informants alike. These represent important touchstones for SRHR and HIV-prevention programming.

PARENTAL AND PEER SUPPORT

Key informants described a general disconnect between adolescents and their parents in addressing issues around dating, sex, sexuality, relationships and HIV. Adolescents were described as hesitant to even mention the subject of dating with their parents or other adults in the community; in that context, more sensitive discussions about HIV, and its transmission and prevention, were described as highly unlikely. This also rendered the need for parental consent to have an HIV test a substantial barrier for even the minority of adolescents who seek out HIV testing. Parental stigma around lesbian gay, bisexual, transgender, intersex or queer (LGBTIQ) issues further compounded the challenges for sexual minority youth, and for any youth who found out they were HIV positive.

Parents were described as generally lacking in basic knowledge and skills to enable them to discuss sexual health and sexuality with their children. In the absence of relevant knowledge and experience, parents were more easily influenced by negative societal attitudes and myths about same-sex sexuality, gender nonconformity and HIV transmission sometimes promoted in the media. In response to questions around what information about sexual health and HIV young people get from or share with their parents, one key informant indicated, "I doubt if they get it." Other key informants explained further:

> "If the kids, the adolescents, are shy enough or afraid enough that they don't ask permission for a date, how much more difficult it is to ask about HIV and ask permission to have HIV testing; can you imagine that? So, HIV, I think is the last thing they talk about inside the home."
>
> "Most of Asian cultures share the same issue. It's like a taboo between the kids and the parents to talk about sex."

A transgender youth described working through her own gender and sexual identity, and the pain of feeling discriminated against by her parents:

> "For now, I am okay about my sexuality because I am already educated and aware. Unlike before, I didn't know what was a transwoman. All I know was I am a gay. That is why my father kept on telling me, 'Why are acting like gay? Are you gay? You should act like a man! It won't help you as a gay.' I felt discriminated against by my own family, and it was very painful!"

Parents were further described as lacking the knowledge and skills to impart sexual and reproductive health education to their adolescent children:

> "Parents were asked 'are you confident to teach your children how to use contraception?' Well the thing is some of the parents are not using the contraceptives themselves. So, it is difficult – how would you tell your kids about it if you are not using…?"

Parents' lack of valid information about sexual health and HIV resulted in their transmitting societal prejudices to their own children, who in turn were even more reticent to engage in any discussions around sexuality or HIV in the context of the family. This in turn also left those youth who were diagnosed as HIV-positive largely unable to share this information with their parents, or to seek parental care and support. It also prevents youth who want to get tested for HIV from raising the issue with their parents.

Philippines

"I've worked with HIV-positive people, including young people, and sometimes they say that the challenge of disclosing your HIV status to your parents is that you'll also have to disclose your sexual orientation and gender identity when in fact they are not open about that to their parents. You are disclosing at two levels, your sexual identity and HIV status. So even if there is one for which you want to get tested, it would also bring in discussions on sexual orientation. That's one of the challenges as well."

Many youths described how families provide a backbone for their social support systems, including tight-knit, extended family support networks, strong clan loyalty, and deference to and dependence upon parents and elders. However, socialization from within these systems provides space for the frequent propagation of misinformation that fosters high-risk sexual behaviour; gender norms that foster differences in acceptable sexual behaviour for boys and girls; and tremendous geographic variation and cultural diversity.

One key informant described even greater challenges in smaller municipalities outside of Manila:

"One major issue which is a bit different in urban areas like Manila, [is that] since everyone knows everyone, it's kind of difficult for that person to access or go for testing because of the fear that he might be seen by any friends or family, neighbours, who are actually working in the hospital or that facility. So those things are very particular to rural areas and I think that's one of the challenges that we have in terms of getting more people tested – because of that fear that, someone, you know, family friends might see them."

Poverty emerged as a multilevel challenge. Several key informants described how poverty intersected with rurality and the vastness of the geography of the Philippines to produce multiple vulnerabilities for children and youth. Poverty exerts multilevel stress on the family system, placing children and adolescents at greater risk for HIV and other sexual and reproductive health challenges. These challenges include lack of parental monitoring of their children; lack of parent education and even lower awareness about sexuality and HIV than in more cosmopolitan urban settings; adult and youth involvement in the drug trade to earn money, and substance use; and adolescents' involvement in casual sex work to earn money for survival.

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"The children living in poverty, some of them are in slum areas still and I think they are the ones who are at risk. They are not properly supervised or taught acceptable behaviour."

"There are also indicators during our knowledge, attitudes, and practices test that indicate that some parents, when we asked them to answer this test, are not usually informed where their children are."

"When I went down and talked to some of the young boys who are HIV-positive, when we talk about what is happening inside the family, the absentee father, the mother is out, it's a dysfunctional family. The values and information should be among the adults around them. It's not just the family but also the extended family around them."

"We are also talking about their average family size, which would be like six kids belonging to a family whose income is 5,000 pesos (US$ 100) a month. So, it is tough. And since they belong to an economically depressed area, a lot of the services don't reach them…in terms of streetlights at night; the water facilities are not good. There are also a lot of people, adults who have a lot of vices; some of the groups are also involved in prostitution, drugs and all those things. It's creative ways of having money. The other common thing is that if you talk about the risks they always point back to the dysfunctional family: 'My mom and dad are not here.' The parents don't know where their children are. Some of them are in denial. Some of the girls would say, 'They know I am a student. They know I don't have a job but then they ask me for money to buy rice. So, why are they not thinking where I am getting the money?' Some of the girls in prostitution, that's how they will reason."

SUBSTANCE-USE TRENDS IN THE PHILIPPINES

The United Nations Office on Drugs and Crime (UNODC) Global Smart Programme report (March 2019) indicates escalating drug use and drug treatment admissions in the Philippines. From 2015 to 2018, crystal methamphetamine was reported to be the cause of over 90 per cent of all drug treatment admissions, with vastly disproportionate use among males. Young people below 20 years of age accounted for 11 per cent of drug treatment admissions, with ages 20 to 39 years accounting for two thirds of drug treatment admissions. Globally, "chemsex" – the use of recreational drugs before and/or during sex by some MSM – is associated with higher levels of HIV-risk behaviours; and the primary drug used is methamphetamine (Maxwell et al., 2019). Chemsex is also associated with negative psychosocial outcomes, such as various mental health issues; and it may be more likely in contexts in which MSM face greater stigma, with the use of drugs for coping. Although chemsex is reported by a minority of MSM, its association with HIV risk due to unprotected sex as well as injection drug use is a cause for concern. Very limited research has been reported on chemsex in the Philippines, but anecdotal reports suggest the need for tailored interventions for MSM, including for younger MSM, as a component of broader HIV prevention initiatives.[i] Nevertheless, evidence-based interventions to address drug use and HIV risk may be rendered vastly more challenging in the context of on-going human rights violations and approaches that treat drug users as criminals; these are counterproductive to public health and HIV prevention.[ii, iii]

Proportions of crystalline methamphetamine related treatment admissions among all treatment admissions, 2013–2017
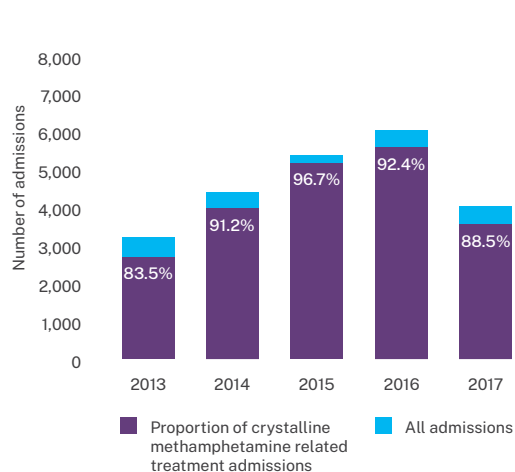
Methamphetamine related treatment admissions by gender, 2013–2017
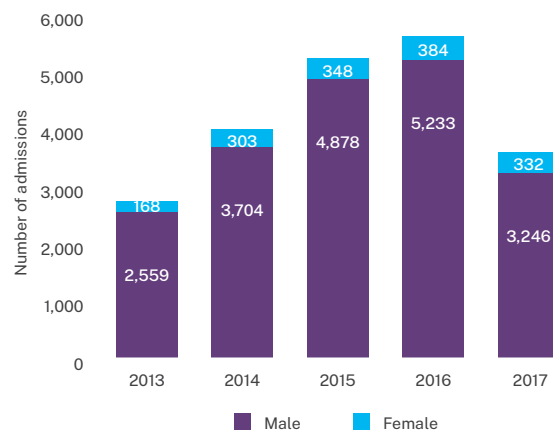
Note: Some of the crystalline methamphetamine related admissions include admissions for polydrug use.

Source(s): DAINAP; DDB and PDEA, "Latest situation on synthetic drugs and reponses to the threats in Philippines", presented at the Regional SMART workshop, Chiang Rai, Thailand, August 2018.

[i] Mendoza, D. G., 'Sex, drugs and disease: The deadly mix (Part 2)', Philstar Global, 15 December 2017, accessible at https://www.philstar.com/headlines/2017/12/15/1768679/sex-drugs-and-disease-deadly-mix-part-2

[ii] Simbulan, N., et al., 'The Manila Declaration on the drug problem in the Philippines', Annals of Global Health, vol. 85, no. 1, 2019, p. 26.

[iii] United Nations Secretary-General. Secretary-General's message on International Day Against Drug Abuse and Illicit Trafficking; 26 June, 2015, accessible at https://www.un.org/sg/en/content/sg/statement/2015-06-26/secretary-generals-message-international-day-against-drug-abuse-and. Accessed November 11, 2019.

Specific challenges around HIV testing and the role of families in the case of minors arose from several sources. Proxy consent is allowed in the case of absent parents, through social workers or physicians. But, some physicians were described as hesitant to intervene in providing HIV testing in the absence of parental consent for perceived fear of retribution – regardless of whether such consequences actually occur or not. Another informant suggested this argument was merely raised by physicians who simply did not want to intervene in SRH and HIV issues. Several key informants described a recently enacted legal statute that allows 15 to 18-year

olds to access HIV testing without parental consent as a major step forward in identifying youth with HIV. The new Philippine HIV and AIDS Policy Act lapsed into law in December 2018, having not been signed or vetoed by the President after 30 days. However, informants also explained that this is just the beginning in that even if an adolescent is tested and identified as HIV positive, family support is often essential to their actually initiating and adhering to ARV treatment. HIV testing is therefore a highly important gateway to services; but it requires programmes and policies to competently work with young people after they test positive.

"That's why we have a problem in terms of detecting their status, since minors cannot really access testing and services. Fortunately, they recently passed a law; we have the mature minor doctrine [allowing youths from 15 to 18 years old to access testing without parental consent]. This is where CWC (Council for the Welfare of Children) will get into the picture…at least with the practice of proxy consent…in terms of preparing them for whatever results they would get. And family support is still there."

"If you talk to the different physicians who tried to give them access to testing and services, the problem was when they were having their treatment, they could not handle it. So, we lost them to treatment. Still we are emphasizing to different non-governmental organizations. Yes, they can access [HIV testing and services] but we cannot do away [with efforts to engage the family] because we are trying to protect them also and ensure that there is family support. Because the state can only come in if there is really no family that will support them. But as long as a family exists, then they should be supported by their family. So that is where our service providers should be focusing on to convince the families on how they should be supporting their children. A lot of help we get from the NGOs is for reaching out to the parents."

"Legally the physician may be facing a legal battle if you give consent. Not all doctors are willing to take that risk."

"The local arrangement is that when the parents come in and they are angry at the doctors or the health workers, the [doctor] will pass it [the parents] to the social worker. You talk to them [the social worker] because that's why you are angry."

"The Department of Education really wants the parents to be a part of it. The Adolescent Health Programme of the DOH wants parents to be a part of it. They know to have parents involved is a little tricky, so there is no clear effort except from the parent-teacher association and the mothers' classes in the community. Those are the two identified entry points, but there is no clear effort to actually implement the programme between those two."

"So, one of our activities is focused lately on involving the parents and caregivers of these children so they are supported well; because we have admitted the fact that we as an organization cannot change their behaviour just by attending or having them attend our sessions. It has to be supported and it has to be sustained during their stay at home."

"Apparently, it is something that kids and parents don't talk about; teens usually talk about this with their friends, with their peers, rather than talking about it with their parents. The communication part is where we come in. And there are sessions where we encourage them, we teach them how to openly communicate with one another. At the culmination of our sessions, we have a family day where we have activities where they will start, at least, even if they are really awkward conversing with one another; they are really not that close and especially about the discussion of sex and use of contraception."

"Somehow during these little activities, we hope to break the cycle of these behaviours that are putting the children at risk. Because you know with the parents, we cannot teach them new tricks. But at least we can teach them how to become better parents for their children."

In the face of these challenges, **key informants from various sectors described the value they place on trying to engage parents in their children's sexual and reproductive health,** and challenges as well as successes in implementing interventions to engage parents in discussions with their children and in supporting their adolescents' sexual health. Such programmes need to be extended to HIV-positive adolescents and their parents as well.

From the perspectives of both key informants and youth, peers emerged as a primary source of information and support around SRHR, dating and relationships, and HIV. Both key informants and youth described the large-scale absence of parents in providing information, education or support around sexuality, sex, relationships and HIV. Importantly, youth largely did not fault their parents for this; even as parents were seen as primary and respected sources of emotional support in their lives, they saw parents as an inappropriate vehicle for discussions about sex and sexuality.

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Accordingly, youth themselves were described by several key informants as a key element in their SRHR efforts, and a major element of effective outreach to YKP and general youth.

"Since it is the young people that are being affected, they are really the catalyst for change. I mean if they are given the right knowledge and they can spread it among themselves, then we feel they would be better protected. Since, as we said, we seldom would be talking about this to their parents."

"Yes, and even the Global Fund focus has been supporting peer educators because it's very hard to reach young people with older people."

Peer involvement was described on multiple levels, from programmes to train and engage YKP as peer educators, to general activities to engage youth with their peers that include HIV-prevention education, activities specifically geared for young LGBT populations, CSO-led efforts, and youth councils that exist throughout the Philippines as part of government structures.

"These groups can be school based, community based, or activity based. Like theatre groups, sports groups, and different types of groups…but [which] happen to include HIV advocates."

"They create peer-to-peer support programmes and safe spaces for LGBTs in Cebu, so they also have modules for other organizations. They promote self-awareness and how to combat bullying."

A number of efforts were described in the growing involvement of youth councils in promoting HIV prevention, sometimes as an effective mechanism for introducing CSE and HIV programming into communities that are more politically resistant.

"I think also that CSOs [civil society organizations] play an important role, whether they're youth led, or youth oriented. There are a number of civil society organizations that are doing work on adolescent and sexual reproductive health; the largest network I think would be Y-Peer, the youth peer education network. So, there are other youth organizations, and I think they also play an important role, and I guess eventually they would go, if they were strong youth leaders, into the youth councils; but again I think it's very important that we have to acknowledge that there are youth organizations that can be tapped. They're usually the ones that would use social media, of course, being young. So now we have a complete picture of government, UN, civil society and youth organizations."

"What has happened is that in the local planning, the youth representatives from these villages have started to be very visible. So, the coordinators now invite local youth representatives from the community. And they are the ones who say, 'we actually have funds, we have projects, help us.' At least for the higher prevalence cities like Cebu, even Quezon City, these youth representatives are actually moving very actively, and the desire is to have more of them in the planning."

©Y-PEER/2019/Ralph Ivan Samson

Importantly, informants raised the issue of not overwhelming peer educators and making sure that they have adequate and on-going support. Many effective peer educators are from YKP themselves, and deal with many of the same challenges faced by the peers to whom they are offering support and guidance. This may make them effective supports and advocates, but it also makes on-going support and care for these peer educators essential.

> "And other regular programming is on peer education, but the aim is preventing peer educators from becoming overwhelmed and overburdened, so they could continue providing information and services to their peers."

COMMUNICATIONS

Key informants described a general absence of reliable sources of information designed for adolescents and youth about SRHR and HIV in the Philippines. Social media and the Internet were described as the predominant resources for information, but informants feared that these platforms also include a mix of misinformation and myths as well as accurate, scientifically based knowledge. Adolescents are already using social media and other online sources to access information about sex and sexuality, therefore one of the important roles of education is enabling adolescents to critically assess the information that spreads via social media and to teach them to ascertain the truthfulness of the material they access.

> "We believe since all these kids are able to access social media, we might as well give them variety of knowledge, so they can discuss amongst themselves. They know what the right thing is to do, to discuss. Because you know it is so easy to Google things and not realize what is fake and what is really good for yourself."

> "Unlike Western countries, here, the parents are not comfortable [discussing SRHR and HIV], so kids are getting this information from their friends and the Internet. Most of the time, it's getting out of proportion, they don't get the correct information."

Philippines

While FGDs present some limitations in discussion of topics deemed sensitive, they also provide highly relevant information beyond the content, to demonstrate some of the dynamics of youth interaction. Not surprisingly, some youth were not able to articulate words directly relating to sex or sexuality, revealing the lack of communication and shame around these topics. Instead, they have adopted symbols or substitute words (euphemisms). This corroborates concerns raised by key informants and other youth in terms of the challenges around communications involving SRHR, sexuality and HIV.

However, some of the youth in the FGDs, including older youth aged 19–24 years old who were living with HIV, and YKP who were already engaged in school-based and community-based youth organizations, demonstrated greater knowledge and ability to articulate issues around SRHR. These youth described the importance of political movements in the Philippines to gain legal recognition for lesbian and gay people and relationships, and broader laws around SRHR, and HIV. These youth indicated hope that a Sexual Orientation, Gender Identity and Expression ("SOGIE") bill would be passed by Congress in 2019/2020. Youth also described their negative perceptions of the on-going campaign against drugs as both ineffective and violating their human rights (FGD 4):

> "I hope the Tokhang [Drug Raid Campaign] will be stopped. Just arrest them instead of killing. In some cases, those who are killed are not actual addicts and those who are addicts remain alive."

Youth described the primacy of social media in their lives – that it was a preferred and more prevalent means of communicating with their friends than in-person (or phone) contact. However, they described rarely seeing online information about HIV/AIDS, teenage pregnancy, mental health, condom promotion, sexuality, reproduction, gender orientation, etc. As the 'experts'–the intended end users for such educational media–young people appeared quite savvy in suggesting the importance of graphic presentations, videos, photos, and blogging as well as posts with brief captions. Youth described that the webpages and websites need to be very aggressive with their campaigns and highly responsive when inquiries were received. Recognizing the highly competitive nature of online space in terms of grabbing youths' attention, they explained the need to get the highest number of 'likes' and shares, and suggested that any presentation must be brief, varied, colourful, and exciting to read. Another element was to involve known personalities from media and entertainment industries, such as TV and movie actors, as these would be received as pleasing and convincing sources of information.

Key informants similarly described the importance of social media and apps in reaching and connecting with young people, including YKP and youth in general. Interestingly, informants also expressed awareness of the challenges they face in developing and launching such apps:

> "It is quite slow to load, but it does work…but not up to its potential. Even the prevention messages posted by young people's organizations, it doesn't sound like it is from someone who is young. So, it doesn't seem to connect. It doesn't have enough memes or viral things. It's actually hard to push for these messages, even with our experiences with online messaging in December (2018). It was a struggle tapping onto Twitter personalities to post a link to the survey. They are there. I think it's just a question of teaching the existing culture here of peer educators, frontline workers, to actually engage those young people to actually broaden your base. But at this point I think we were fairly bleak."

One example of a successful effort in its early stages is Red Whistle, an online forum that was described as effective in encouraging people to get tested for HIV, and in helping to reduce the stigma associated with HIV testing.

> "There's some work that has been done on that, such as the Red Whistle. It's an organization that uses social media for HIV education and it's really more [a way] of letting the general population know. They produce videos and do onsite events, and everybody that wants to get tested just lines up. It's like bringing down the stigma because it's not just MSM, but its friends getting tested together and it's more open. So there's work that's been done there but needs to be expanded even further. The Love Yourself (LY) project also has social media campaigns, I think, and even through the Global Fund."

RED WHISTLE #MOVETOGETHERPH

"The Red Whistle is a collaborative online platform for people to come together and show their support to those living with HIV and AIDS. It is also an agent and partner for brands to show their support to HIV and AIDS advocacy. The Red Whistle aims to empower and inspire people to come together and help each other in the battle against HIV and AIDS. Using pop culture as a way to change mindsets, we hope to start discussions among the youth so that they will sound the alarm and spread the word that HIV is here — and that it must be stopped."

"Move Together is a dance performance video on ending HIV together."

https://theredwhistle.com/about-us/; https://theredwhistle.com/movetogetherph/

BATTLE IN THE BLOOD

We have an app. It's a game. We didn't do it but the Uni of Philippines created that app and it's called "Battle in the Blood". They held a gaming competition in different cities and the prize was an iPad. I don't know how popular this is or how many downloads they have but it's a good game."

Battle in the Blood (#BitB) is a puzzle and turn-based combat mobile game. Players journey across 90 levels battling the HIV virus and its army of co-infections. Along the way, they encounter eight short stories. Each story follows the events leading up to characters decision to take an HIV test and concludes with a glimpse into their life after a positive diagnosis. A twist in the eighth story allows the player to choose how the story will end.

The game was launched on the Google Play and App Store on 1 December 2017 to coincide with World AIDS Day. The game is free to download with no in-app purchases required.

https://etch.lstmed.ac.uk/games/battle-in-the-blood-bitb; https://play.google.com/store/apps/details?id=com.emstudios.get&hl=en_US

Philippines

Several key informants described social media efforts funded by the Global Fund, called Safe Spaces, which focuses on connecting people to HIV testing. The site was noted as having some success, and the potential to be disseminated more broadly, but is presently limited to Metro Manila.

> "The Global Fund has a Facebook page and app called Safe Spaces. Safe Spaces provides condoms and HIV testing. You just state where you are, and someone will come to you or you can go to them. But that's only in Metro Manila right now. I think they are expanding to different cities by next year...Safe Spaces is also about condom access points. It's a map."

SAFE SPACES Facebook page and app, supported by the Global Fund

Safe Spaces provides a sustainable model where everyone can get access to FREE condoms without fear or judgment.

Ashamed to buy condoms? Are they too expensive? Accessibility and availability of condoms remain two of the biggest challenges in the country.

"In case of 'emergencies', you need not worry about where you can get condoms. Just open the mobile app or the website to see the Safe Spaces near you. We've designed an application with inventory and supply management capabilities, so Safe Spaces never run out of stock."

https://safespaces.ph

Finally, **key informants described the need for prevention education and programmes to keep pace with the dynamics of the HIV epidemic in the Philippines.** The Department of Health's HIV Surveillance Report (2018) identified HIV infections among MSM as being among the most rapidly escalating MSM epidemics in the world, including young MSM. In light of this, an informant explained:

> "I think all of the things we had foreseen for 2018 are MSM programmes that have significantly scaled up since 2008. However, it has not changed with the times. There is a need for shift as the MSM dynamics shift. So, we kind of got stuck. In scaling up, the change in messaging in platforms and in strategies needs to shift with the changing dynamics."

MENTAL HEALTH

Mental health challenges associated with child and adolescent development, including general youth and YKP, comprise an under-researched and under-served domain. In particular, the psychosocial challenges of youth adjusting to and living with HIV emerged as a substantial and unmet need, both in large cities and, particularly, rural areas. Key informants concurred on the lack of programmes in the Philippines that address youth mental health and a lack of professionally trained mental health professionals. Informants described that many adolescents experience depression upon HIV diagnosis; and suicide among school and college students is common and on the rise.

In response, WHO's Mental Health Gap Action Programme (mhGAP) has been rolled out by the Department of Health, and the age of consent to engage in the programme was recently reduced from age 18 to 15 years old. This has enabled some organizations working with adolescent mental health to begin to develop and test programmes. But challenges persist in that government mental health initiatives often do not include young people's perspectives in assessing young people's needs. Amidst a general lack of trained mental health providers, most examples of mental health initiatives focused on one-time post-disaster programmes, such as private foundation funded peer-to-peer counselling to LGBT youth and other victims of conflict in Marawi, Mindanao. Many of these programmes were described as arising due to pressing needs as a result of increasing stigma and youth suicide, cases of abuse in LGBT communities, and responses to natural disasters.

Important progress was described in changes in the law, which now allows youth aged 15-years and older to access services without explicit parental consent. A key informant described the two-plus decades of effort to revise laws that prohibited service provision to youth under 18 years of age as a major victory. These consent laws posed particular challenges for youth living with HIV, for whom initial fears of revealing their diagnosis to parents created a major obstacle to seeking help, and for sexual and gender minority youth, and general youth, seeking counselling on SRH, who would not do so if required to disclose information to their parents.

"I remember entering [the government ministry] in 1996, my first assignment was with children with HIV and AIDS. The challenge was, before 1996, when you talked of HIV/AIDS, it was more of a medical issue. None on the psychosocial side, none on the development issues for children. So that is what we had to bring to the national government. And it took us time before finally, in 2009, they included young people, 15-year-olds, in the IHPS [Integrated Health Planning System]. That was the first time. We love it for that. NDOH [National Department of Health] finally granted us to have 15-year-olds. It is very difficult for us to see the real picture of children. What really is their status? Because speaking to parents, due to discrimination, they won't tell us when their children are [HIV] affected or infected."

Other obstacles were described in service provision to youth, for example, requiring that all youth newly diagnosed with STIs or HIV go through psychological screening focused on potential abuse. Such broadly applied, mandated services were described as repelling youths' help-seeking behaviours and as an additional burden to already emotionally distraught youth who have been newly diagnosed. Key informants recognized that some of the challenges in moving toward youth-friendly services required youth involvement in assessment of their own needs as a population.

"I have to jump into the mental health issue. Part of the things that were floated during the discussion by implementers was that one of the recommendations is they won't tell the minors to go through the psych (sic) evaluation when they are diagnosing. Because a lot of them really go through depression upon diagnosis. Even those who are at risk, they were finding out if the decision-making of the child was being influenced by others, as that would be grounds for abuse...."

"We passed the MH (mental health) law, the Mental Health Gap Act in the Philippines, last year. The government is currently developing the implementing rules and regulations... however, we noticed that there's a lot of gaps in these procedures. Specifically, the lack of focus on young people. They want to address the increasing mental health rates affecting young people, but the procedures do not include youth participation."
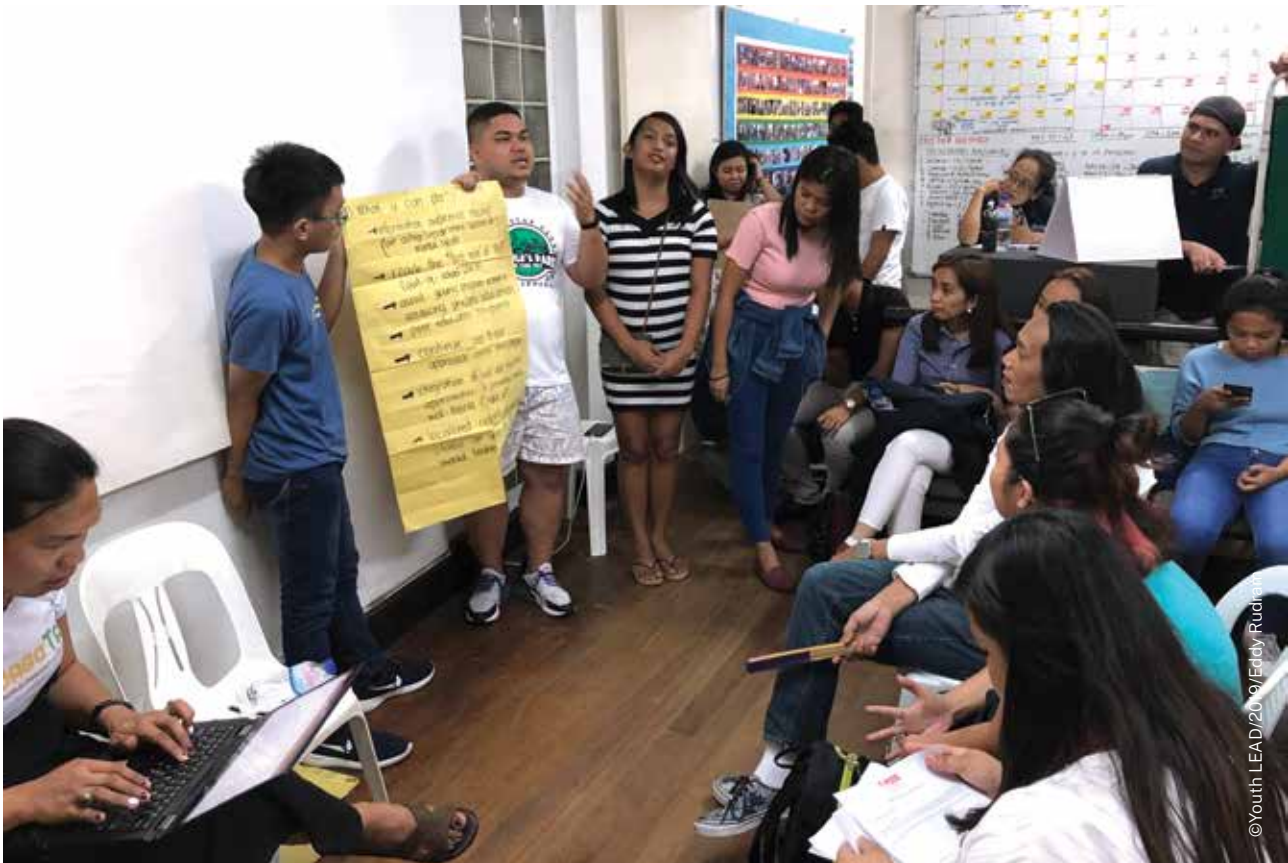
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An innovative programmatic approach was described by a privately funded initiative:

> "For this year the programme that we identified is for mental health. So, part of the process is that we do consultations with the peers. The young people conduct their own survey and consultations with them on what the major problems are that young people are facing nowadays. And in the survey, youth mental health is the number-one issue being faced by the young people. Specifically, in the areas where we operate, Quezon City has recorded a huge number of young people attempting or committing suicide due to school requirements and family."

> "We use the word 'well-being'. Because when you say 'mental' that will directly correlate with mental hospital."

> "If you want to examine the education curriculum for primary and secondary schools in the Philippines, they don't really give a premium for mental health issues.... And unlike, for example, in physical health they have clinical check-ups and well-being check-ups. But if you want to examine the forms, they don't have this, if you want to check for happiness, for example, of a student and the level of stress they are experiencing. Unlike in other countries where I have seen the medical sheets that have a mental health aspect in the questionnaire."

Key informants described pervasive stigma around mental health issues, and barriers to even broaching the topic, as well as challenges due to HIV stigma and taboos around discussing sex that compounded barriers to discussion and access to help for youth at risk or for youth living with HIV. Widespread lack of inclusion of mental health information or curricula in schools was also identified, both a cause and effect of stigma.

More broadly, informants identified the lack of mental health professionals in the country. "There's a scarcity in the whole country for psychologists and the certified ones will do the counselling."

Several informants described school-based initiatives to promote youth mental health:

"I think there's currently just over 500 psychiatrists in the Philippines and also few psychologists."

"How can 500 actually cater for 100 million population? That's only for psychiatrists. We have issues with social workers to provide protection. But there are very few social workers and decreasing numbers of [social work] students each year."

"The standard according to WHO is 10 to a 100,000, but here in the Philippines we have .52 to 100,000 and that is very alarming. Even though the government now is getting towards training of non-mental health professionals that would include health workers or even teachers, they don't have concrete modules or training materials which we can give to local government units. In short, there's a lot of interventions moving on,… but I am not sure how to determine the success for these interventions."

Several initiatives were described that aim to address the myriad challenges around mental health, including the lack of trained and certified providers, gaps in school curricula and school-based mental health assessments and services, and pervasive stigma around mental health and HIV more broadly.

"So, basically there's not many specialists; so the aim of WHO is the Mental Health Gap Action Programme to fill in that gap in services. We try to capacitate or provide scale-up services for mental health, like capacitating mental health officers and private health care physicians to have that capacity to screen, provide brief intervention…and referral to treatment to higher specialists, if they cannot manage it on their own."

"There's a tool from WHO that we will roll out in partnership with the Department of Health next year that has an e-training component for broader reach out and face-to-face training. Another initiative launched by the Department of Health is 'mHealth'–mobile health. So, it is a big umbrella for mobile health where one arm is already functioning and focused on a tobacco-free initiative called 'I am ready to quit'."

"At school, actually promoting mental health and well-being is a big piece, along with strengthening community-based programmes for mental health and then the special populations, also."

"We improve the curriculum; we train teachers to become first-aiders. We train them to identify early signs and call them 'red flag' students. For example, to identify the signs of anxiety and depression. Then after identifying, we train them [teachers] to follow specific protocols, such as immediate referral to the guidance counsellor, who must call and notify parents. For worst case scenarios, they can go and ask help from the Department of Social Welfare."

"Mental health, actually, is part of the agenda under the Department of Education; it is not solely on substance abuse, which is the priority of the President. So, substance abuse and mental health became one and include sexual and reproductive health. Just last April, the Department of Education hosted the third series on learning and focus on adolescent health with the focus on sexual and reproductive health, mental health and gender-based violence. Mental health is still crucial, and teachers are considered to be the first targeted ones, as they are overburdened."

Efforts to address pervasive mental health stigma were also described, including through the legal system, community activism and events, building the capacity of adolescents and youth, as well as through attempts to integrate HIV and mental health assessments and services.

Philippines

"It is a concern just having...stigma attached to it...as if you have your positive HIV test there. We are trying to move away from that component of stigma there. So, it is in the process of advocating with the policymakers, our partners in UNODC, as well our local government, and asking for lowering the consent age."

"When you go to a psychiatrist the stigma is still there, but I have seen in the Philippines many mental health activists coming out. There's a Youth for Mental Health Coalition in the Philippines. It is a big group and works with other advocates as well. There is a medical student's group that launched a film festival for health by asking professionals to submit short films about mental health issues. A total of 73 shorts films were submitted and 9 films were selected to be included in the facilitators' guide to address myths and facts of different conditions around the mental health. It was an approach to address the stigma around mental health."

"In adolescent health programmes, when we integrated mental health, it was about building the capacities of adolescent health coordinators in the HEADSS assessment. This is an acronym for assessing Home, Education Activities, Drugs, Sexuality and Suicide/depression. In Region 6, where we are working together, we do mapping of those who attempted suicide. So, regional adolescent health coordinators were able to document around 800 adolescents who attempted suicide. It is very important. This is the same region where we had programmes on integrating HIV and sexual reproductive health services delivery. While looking at HIV and addressing access to family planning commodities and mental health, psychologists and psychiatrists need to be included in the process; these issues also have to be addressed."

Many of these initiatives, both regional government funded and privately funded, share promise as new approaches for the Philippines; but they face major challenges in implementation, in moving beyond one-off or isolated local efforts. Primary challenges are reported to be the overall lack of baseline data on mental health, including adolescent and youth mental health, across the Philippines, and the need for much larger and sustained funding and buy-in from local, regional and national governments, and private-public partnerships. Key informants shared that the massive scale and great diversity of the Philippines likely

requires not just one approach, but many different approaches tailored to diverse geographical settings and social and cultural contexts. Nevertheless, baseline data across selected settings would provide a highly important next step for mental health initiatives.

"That's the biggest challenge now. [We need] data telling [about] regions and specific groups, male or females, the LGBT community in urban or rural areas. In the Philippines it is very different and we cannot generalize because the level of stress here in Manila is different from the level of stress in the provinces, and there are differences in the South, for example."

"Now our problem is the lack of a national data, lack of indicators. Yes, we have a Mental Health Gap Action Programme from WHO, but it is highly technical; youth organizations and even NGOs cannot really interpret this...document."

Several key informants described stressors among the many youth who migrate to Manila in search of work and face new life challenges, frequently absent family support. Key informants also explained the burden of intersecting challenges and vulnerabilities, such as among displaced young people who are LGBT, even as these are often conceptualized as separate populations.

"So, the needs vary based on the population groups. For example, in Mindanao it is worse because of the conflict...and the areas involving the LGBT community in Luzon. We identified that the major cost of stress is number one – displacement, for example, of those from the provinces who go here in Manila, so the stress of displacement."

Finally, privately funded initiatives were described, including through the Unilab Foundation, supported by the largest pharmaceutical company in the Philippines. These included student submissions to the foundation based on innovative approaches to health, from which the foundation selects some each year for pilot funding. Unilab has previously supported "Project Inclusion", focused on greater engagement of persons with disabilities in society.

UNILAB FOUNDATION
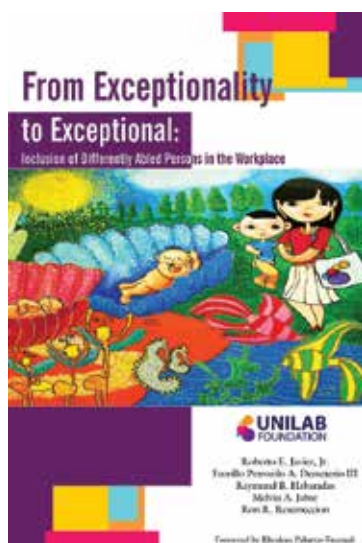
"The DLSU Publishing House, in partnership with the Unilab Foundation Inc., launched the book From Exceptionality to Exceptional: Inclusion of Differently Abled Persons in the Workplace. The book was developed from research about autism and other persons with intellectual disabilities and their inclusion in the workplace, conducted by a team of researchers from the DLSU-Social Development Research Center."

"In terms of mental health, Unilab Foundation, the current progress is that we are partnering with universities to develop modules to improve social-emotional skills of children at the ages of 8 to 12 years old, starting in the secondary schools. Because it's where a lot of suicide incidents, depression and anxiety [occur], especially in schools that are highly competitive."

https://www.dlsu.edu.ph/dlsuph-and-unilab-foundation-launch-javier-et-als-from-exceptionality-to-exceptional/

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RECOMMENDATIONS

The following recommendations include suggestions voiced by key informants and youth in the formative assessment, and recommendations that emerged from gaps identified in each of the four focal domains along with further recommendations from the National Dissemination Forum held at Community and Family Services International (CFSI).

Education

1. Promote culturally sensitive, gender-responsive CSE tailored for youth based on facts and science to address the many myths about HIV transmission that continue to circulate. These myths undermine efforts to reduce HIV and STI risk, and do not promote sexual and reproductive health and rights (SRHR).
2. Integrate CSE initiatives that focus on addressing sexual violence, and promote understanding and acceptance of diversity in sexual orientation, gender identity and expression, which are foundational to SRHR and HIV prevention.
3. Provide clear and up-to-date information about life-long antiretroviral therapy (ART), an essential element in combatting fatalism, denial and stigma, which are counterproductive to HIV/STI prevention and SRHR.
4. Ensure CSE curricula includes fact-based content and experiential training for teachers, who are often ill-prepared in terms of both knowledge and skills to lead trainings about SRHR.

5. Include easy-to-administer evaluation components in CSE and teacher training curricula in order to determine effective programme elements and to make revisions based on evidence.
6. Develop CSE curricula to acknowledge the tremendous geographical and cultural diversity in the Philippines. Programmes that are appropriate and effective in metropolitan areas (e.g., Quezon City) may not 'translate' to or be acceptable in rural areas.
7. Involve activities deemed fun and entertaining in CSE curricula and strictly avoid shaming individuals, including students, teachers and other adults, for their misconceptions, to make activities more acceptable and more likely to be engaging.
8. Begin HIV/AIDS education at an early age, as early as Grade 2, using a gradual and developmentally appropriate approach, as effective primary prevention must begin before young people are sexually active (3,100 new infections were reported among 10–19 year-olds in 2018).
9. Focus condom promotion programmes on early use, which is a predictor of future correct and consistent condom use.
10. Strengthen existing networks of youth-led and youth-serving organizations in partnership with Local Government Units (LGUs), CSOs and other youth networks.
11. Bridge the gap between the educational and health sectors, which is an essential component of effective HIV/STI prevention and SRHR programming. Youth who become aware of HIV/STIs and possible risks through schools frequently experience challenges in accessing youth-friendly services for HIV testing and other SRH needs.

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Parental and peer support

1. Design and implement programmes and interventions to:
   a. raise parents' awareness about SRH and HIV/STI prevention;
   b. counteract myths about HIV;
   c. address cultural gender norms that render girls and LGBTQI youth particularly vulnerable; and
   d. increase parents' skills in discussing HIV/STI and SRH with their children (including through workplace trainings).
2. Promote facilitated family and group interventions and workshops, including adolescents and parents, to promote communication and support within families, including training, modelling, and practicing communication skills.
3. Peers already provide the majority of information on SRHR to their friends. Peers should be trained to provide accurate information, education, support and referrals to improve SRH and promote HIV/STI prevention among other youth, including local, regional and national programmes.
4. Strengthen and support youth-led and youth-serving organizations to build capacities of community-based organizations to enable them to meaningfully engage with government, local partners, and other stakeholders.
5. Strengthen capacity of Sangguniang Kabataan (SKs), also known as Youth Councils, a unique governance mechanism in the Philippines present in every 'Barangay' – the smallest unit of government – to address HIV, gender-based violence and adolescent pregnancy, and their socioeconomic and cultural determinants, through the Philippine Youth Leadership and Governance Program (YLGP).
6. Ensure that Barangays allocate at least 10 per cent of their funds intended for SK to be used for youth-related activities, programmes and projects, as mandated by the Republic Act 10742 (SK Reform Act of 2015).
7. Promote structural interventions that are needed to reduce poverty, including in geographically isolated and disadvantaged areas, which places multiple stressors on children and family systems (e.g., low parental monitoring of children, young children needing to work, and children engaging in sex to provide money for food), which are unlikely to be addressed through education and awareness alone.
8. Advocate for the revision of decades-old policy in order to increase the age of consent from 12-years old, the lowest in Asia, which should be supported as a cornerstone of SRHR and HIV/STI prevention.

Communications

1. Capitalize on social media, which is broadly considered to be one of the most promising means for connecting with young people, including adolescents and young key populations (AYKP) who may be 'hidden' populations, such as gay and transgender youth. Social media and online apps should be used to disseminate accurate information about SRHR, including HIV/STIs, condom promotion, sexuality and teenage pregnancy.
2. Capacitate young people, including YKP, to meaningfully engage in the design and development of social media and online apps to promote SRHR (including graphic arts, web development, etc.); this is essential to ensuring that information (often emerging from well-meaning adults) is acceptable and accessible to young people.
3. Capacitate governmental agencies to develop effective communication plans in consultation with youth, and to regularly post relevant materials on social media from a centralized platform that is verified and reliable.
4. Design and develop social media and apps to promote SRHR that use graphics, photos, videos and brief postings to capitalize on the potential of this medium to reach young people.
5. Develop and implement trainings for adolescents and youth (and adults) to develop skills in critically assessing information and debunking myths shared over the Internet/social media.

Mental health

1. Basic epidemiological data on youth and AYKP mental health are needed in order to establish the local/regional and national prevalence of depression, suicide, and other mental health issues; these are reported to be on the rise among young people, especially AYKP. However, lack of baseline data makes it difficult to assess prevalence, identify gaps and measure changes in rates of mental health problems over time.
2. Conduct local, community-based research on mental health among adolescents and youth, including AYKP, to develop evidence to support local youth development plans for SKs (Youth Councils).
3. Increase the number of trained and certified mental health providers, including in geographically isolated and disadvantaged areas, with competencies in working with marginalized and at-risk youth.

4. Train mental health providers starting at the current level of competency of frontline service providers, including social workers and paraprofessionals, most of whom are not trained psychologists or psychiatrists.

5. Address gaps in school curricula and school-based mental health assessments and services (including guidance offices) to expand the limited access of young people to youth-friendly, gender-responsive mental health services and to reduce the extensive stigma around mental health issues.

6. Increase multifocal awareness and educational efforts, including in the healthcare system and media campaigns, in addition to schools, to combat rampant stigma and myths about mental health.

7. Strengthen peer-to-peer education by providing orientations and seminars on appropriate measures when encountering youth, including YKP, with mental health needs.

8. Expand existing youth-friendly health services to include basic mental health assessments and referrals, and competent services for AYKP, including youth living with HIV, as a means of increasing access to care and utilization by young people.

9. Strengthen confidentiality commitments and procedures among service providers to avoid stigma and discrimination, and increase the number of young people who access services.
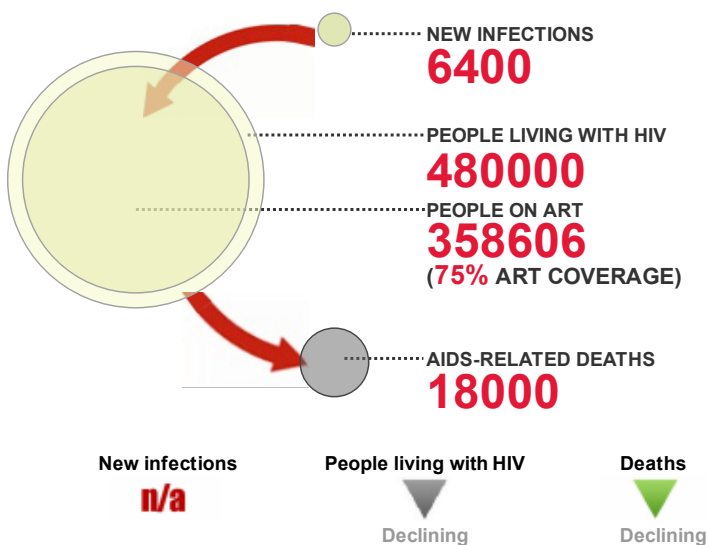

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Thailand

In Thailand, 480,000 people were living with HIV in 2018, compared with 580,000 in 2010. From 2010 to 2018, there was a 60 per cent decrease in annual new HIV infections.[1] Overall, 75 per cent of people living with HIV are receiving antiretroviral therapy (ART), although more than half (53 per cent) are diagnosed late (with an initial CD4 count below 200, which means a person is diagnosed with AIDS).[2] Among key populations, HIV prevalence is estimated at 20.5 per cent among people who inject drugs, 11.9 per cent among men who have sex with men (MSM), 11.0 per cent among transgender people, and 1.7 per cent among sex workers.[3] Even higher HIV prevalence (28 per cent) is estimated among MSM in Bangkok.[4]

Young people aged 15–24 years accounted for nearly half (47 per cent) of the 6,400 new HIV infections in Thailand in 2018; of these, three-quarters (73 per cent) of new HIV infections were among boys and young men.[5] The annual rate of new HIV infections among young MSM is much higher than that reported in other key populations in Thailand, and higher than similar populations in Western countries. Many MSM are at risk for HIV well before age 18,[6] and less than half of young people (46 per cent) had accurate knowledge about HIV prevention.[7]

Key facts on HIV in Thailand

NEW INFECTIONS
6400

PEOPLE LIVING WITH HIV
480000

PEOPLE ON ART
358606
(**75%** ART COVERAGE)

AIDS-RELATED DEATHS
18000

New infections
n/a

People living with HIV
Declining

Deaths
Declining

Source: UNAIDS Data 2019

Bangkok Men Who have Sex with Men Cohort Study (BMCS), 2006-2014

HIV incidence per 100 person yesrs

7.7 — 18-21 years
7.2 — 22-24 years
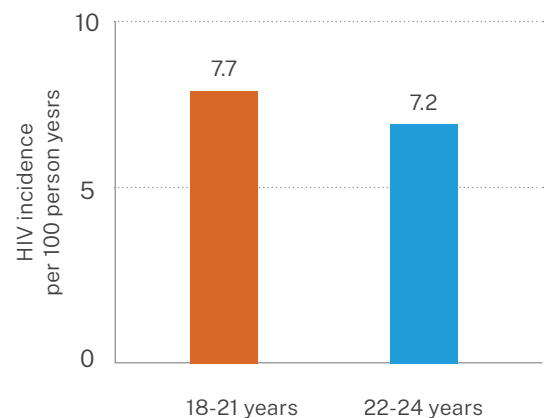
Source: Thienkrua, 2018; UNAIDS Region Profiles 2019, p. 38

Ten key informant interviews, which included two women, seven men and one transgender person, were conducted. The key informants were experts in HIV prevention; adolescent health; lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) youth; sex workers; mental health and youth empowerment. Organizational affiliations spanned government and civil society, and education and health sectors. The key informants were from the Youth Friendly Clinic, Burapha University Hospital; the Thai Red Cross; Baankhai Hospital, Rayong; Thammasat University, Bangkok; Youth-Lead, Thailand; Rainbow Sky Association of Thailand; Service Workers in Group (SWING); Transgender Student Council, Burapha University; and TAKE CARE!! Pattaya.

Four focus group discussions (FGDs) were conducted with 25 participants:
- FGD 1: heterosexual males, heterosexual females, lesbian females and gay males (aged 16–22 years) in Chiang Mai;
- FGD 2: gay, bisexual and transgender adolescents (aged 16–18 years) in Chiang Mai;
- FGD 3: gay, bisexual and transgender adolescents (aged 16–18 years) in Chantaburi; and
- FGD 4: gay, bisexual and transgender youth (aged 19–24 years) in Chonburi.

Findings were shared with members of the Interagency Task Team on Young Key Populations, with experts from UNICEF, UNAIDS, UNFPA, UN Women, and civil society organizations (CSOs), and at an interagency forum held in Bangkok in June 2019 to review and validate findings. All feedback is incorporated to enrich this report.

EDUCATION

Key informants described the general lack of implementation of comprehensive sexuality education in schools. Young people discussed learning about sex largely through trial-and-error. Despite mandates to provide CSE in schools, such as the Adolescents Pregnancy Prevention Act of 2016, the Thai educational system was described as still largely reflecting a traditional culture in which open discussion of sex and sexual practices is considered shameful, particularly between youth and adults, including teachers. In effect, there are substantial gaps between official directives on CSE and its implementation in practice.

"Generally speaking, talking about sex or sex education in schools would be seen as something quite extreme. Some schools do not really want or support us in us going in to teach their students. In Thai society, parents don't really feel comfortable discussing sex in detail with their children. So, it creates problems and challenges in receiving proper information and knowledge for children. Parents in many other countries would sit down with their children discussing sex even before they become a teenager. Do we do that? Yes, we do, but only the basics...not enough. Parents, teachers, and other adults feel shy, ashamed, or too uncomfortable. These are the main challenges."

"The conservative Thai culture still teaches us to be reserved about sex and that sex is a shameful thing. A question for the university entrance exam asks what you would do if you're horny. And the answer is to go play soccer."

Key informants indicated that sex education should be more specific, especially including a focus on skills. Basic information was deemed insufficient when it comes to real-world encounters.

"Knowledge is important...how much you know. People know of prevention, like condoms. But do they really know about condom use and skills? High school students and even university students know of condom use, but do they really know how to use it correctly or how to put it on correctly? Some people know but do not know well enough or have no skills. When it comes to using it, they do it incorrectly and that leads to incidents [of HIV-risk behaviour]."

"Talking about providing knowledge, there will always be some health theory against it, saying that knowledge doesn't help with behaviours. We can see that some healthcare providers smoke cigarettes. But we still need to provide knowledge as a background. I think teaching and training specifically on skills is the best. Before gaining skills, one should have some background knowledge, yes. Then they need skills to refuse/ say no and to use prevention tools correctly."

A key informant reported that in some localities, community-based organizations are occasionally invited to provide basic information about HIV prevention in schools:

"There is now a network of people who provide HIV/AIDS information in schools in our city. We collaborate with schools, factories, municipal offices, vocational schools and colleges."

Participants from adolescent and young key populations (AYKP) explained that the preponderance of information they received was generic to sex between men and women in heterosexual relationships. This left some AYKP with little useful information for themselves or with the impression that sex education (and perhaps sexual risk) didn't apply to them.

However, AYKP reported that they receive only limited and circumscribed information about health education in school that is inclusive of gender, sexual orientation, and HIV and AIDS. Often the opportunities were described as one-off, with a special in-school lecture or a field trip, such as visiting a social centre for people/ children living with HIV/AIDS.

"There is a training/session at school that teaches students about condom use, but it is for [sex between] a man and a woman."

"We went to XX social centre in Rayong to learn about HIV infections and that HIV as a virus is different from AIDS."

Heteronormative educational practices, including textbooks that omit discussion of sexual and gender diversity, and material on LGBTIQ persons, are laden with negative stereotypes and limited to discussion of HIV. These resources contribute to sexual stigma and the feeling that one is not 'normal' and not invited to participate if they are not heterosexual. An adult key informant described:

A few AYKP described participating in helpful campaigns organized by NGOs outside of the school system, and, to a limited extent, older adolescents described college education curricula as a source of sex education.

"But what they don't get is any sort of acceptable information from school. There's virtually no standard sexual education material that is, let's say, acknowledging or affirming the existence of gay people as anything other than potential victims of diseases. So, if there's information about sexual development in teenage life, it oftentimes is stilted towards stigmatizing gay life."

"I used to have training about HIV prevention and was involved in a campaign for teen sex education organized by an NGO."

"I used to be a part of sex education for teenagers through a course from college."

Youth across FGDs described 'self-study' – seeking information about sexuality and sex through the Internet and social media, including information about how to use a condom for anal sex and use of lubricants.

"Self-study. I went through YouTube videos for entertainment and came across HIV prevention, so I took a look…. I used Facebook to see how to use a condom to prevent from infection."

A gay adolescent shared his seeking information around sexual activities and HIV prevention in the context of sex with other males as a family friend who was older and more experienced.

"I always asked my older friend at my mom's work. He has sex every night. He says we must use a condom every time with lubricant. If it is too dry, a condom can break and anal tissue can also break. It is dangerous and risky."

Overall, schools were reported to provide only very basic and time-limited education about sex and HIV/STI risk, virtually no information about sexuality or LGBTIQ youth. The most often mentioned source of information about sex and sexuality was online, including YouTube and social media, and to some extent NGOs. Online sources were deemed singularly important given that the limited information from schools was presented based on sex between men and women in the context of heterosexual relationships.

Key informants also reported different institutional cultures and environments, as well as different students, between high schools, and technical or vocational schools. The level of acceptance and support for sex education and HIV prevention is higher among technical and vocational schools than among high schools.

"Also, it is different between schools regarding sexuality. High schools are different than technical schools. High schools are somehow not totally supportive of free condoms, while technical schools are quite open and supportive about it."

"Thai culture and traditions did not really support these things. If we had been taught since a younger age, we would have had better understanding and preparation for situations, and also how to prevent HIV when we grew up."

"When there is a condom machine set up in schools, society blames it for encouraging kids to have sex. This happens a lot. The government got refused from many high schools. Thai culture and society are still a big barrier to access prevention tools."

A key informant representing AYKP described concerns about the need to educate AYKP on their sexual orientation and gender identity as foundational for their leading healthy lives and to avert later regrets and health challenges:

"I think we need to best prepare to handle and educate young populations on their gender versatility and uncertainty. They are this (gender) at 16 or 17, then they decide to change to that (another gender expression) at 18. I think we should not only focus on their sexual behaviours. Like for transgender boys, why do they want to take hormones? Do they really want to become a woman? Or is this just a phase they are going through to fit in with their friends? Other girly friends take hormones to look pretty, so 'I want to, too'. And deep down they don't really want to have a vagina in the future. This is important and definitely affects their future. They need to be educated and to consult professionally to make such a decision."

REVIEW OF COMPREHENSIVE SEXUALITY EDUCATION IN THAILAND

"The Ministry of Education has policies mandating the provision of comprehensive sexuality education (CSE) in basic education… Although diverse topics are covered in the CSE curriculum, many institutions teach about sexuality from a point of view that emphasizes the negative consequences of sex and does not cover positive aspects or promote students' analytic and critical-thinking skills related to sexuality.

Topics related to the prevention of teenage pregnancy, STIs and HIV, as well as sexual anatomy and development are emphasized most, while topics related to gender, sexual rights and citizenship; sexual and gender diversity; gender inequality; safe abortion; safe sex for same-sex couples; and bullying are less often taught. Many students still lack a correct understanding of a range of sexuality-related issues… Only half of general secondary teachers and less than half of vocational teachers have received training for providing CSE."

https://www.unicef.org/thailand/sites/unicef.org.thailand/files/2018-08/comprehensive_sexuality_education%20EN.pdf

Key informants expressed specific concerns that lack of appropriate knowledge and skills related to sex and one's sexual orientation can lead to HIV risk.

"Some freshly graduated high school students are still not 'out' or truly don't know about their sexual orientation. Once they go to college, they get to know others, get to make [LGBT] friends… They hang out or do more… and what puts them at risk is that they still lack knowledge and skills about safe sex. Knowledge can be easily researched these days but not skills. From our prevention research data, we found that the majority of first-time experiences did not involve condom use."

"In Thailand, it is not common to see sex education in schools, or even education about gender. So, for young populations to truly understand themselves and know what they really like and want leads to situations where they have to naively try out by themselves to find out…being forced to, or physical or sexual abuse situations in schools or with friends…."

A key informant from a youth clinic shared an example in which a gay adolescent had misconceptions about HIV transmission, as being impossible for a 'top', and engaged in condomless sex based on such misunderstanding:

"One case for example of a young gay boy…he had some knowledge about HIV transmission, but rather incorrect. He said he was a top (insertive role) so he should be fine. He said anal sex was fine because men (anus) did not have fluid like females did. It would only be from himself, so he should be fine. So, I was concerned that there could be serious issues with knowledge, skills and experience."

One key informant who worked with male sex workers further expressed the importance of providing information about pre-exposure prophylaxis (PrEP) as an ethical imperative (given its proven effectiveness) in the context of supporting informed decision-making among AYKP.
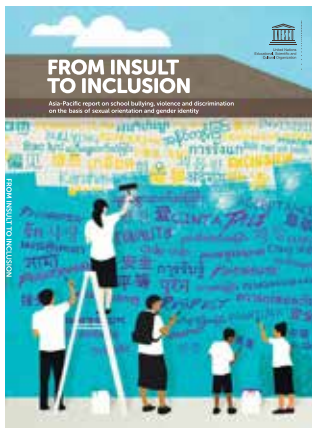
"I think knowledge around PrEP is very important these days. The key of PrEP is a choice. Teenagers should be educated about PrEP, at least the basics of PrEP and what is it for, and how to use it. They don't have to study about its combination of two drugs. Ethically, they should be educated about what prevention is. They can then tell their friends and help educate others."

Thailand

BULLYING OF LGBTIQ YOUTH STILL PERVASIVE IN THAI SCHOOLS

Bullying in schools, including victimization of LGBTIQ youth, was described as a pervasive challenge. This often takes the form of social exclusion, verbal abuse and harassment, and sometimes physical harassment. Bullying victimization of LGBTIQ youth is also woven into the curriculum, which reflects negative stereotypes of LGBTIQ populations. Contrary to a previous claim from the Basic Education Commission that there were no cases of bullying of LGBTIQ youth in schools, key informants described a 2015 UNESCO report that identified pervasive school violence perpetrated on the basis of sexual orientation and gender identity.

http://www.khaosodenglish.com/featured/2018/06/22/bullying-of-lgbt-youth-still-pervasive-in-thai-schools/

UNESCO REPORT

From Insult to Inclusion: Asia-Pacific report on school bullying, violence and discrimination on the basis of sexual orientation and gender identity "The report finds that the majority of LGBTI youth in Asia-Pacific, including Thailand, say they have been subjected to some form of violence or bullying in school...." Thailand, as most countries in the region, lack evidence-based and whole school responses and policies that provide protection for LGBTI persons.

https://unesdoc.unesco.org/ark:/48223/pf0000235414

Gay and transgender adolescents described experiences of social exclusion, and verbal and physical harassment in school settings, as well as inability to tell teachers.

"In kindergarten, both boys and girls refused to play with me. I didn't have friends. I wasn't brave enough to tell the teacher."

"I was bullied by ninth grade boys when I was in fifth grade. They teased and dragged me to a room and tried to take my clothes off. I fought my way out. They sometimes teased me like shouting that one of their friends liked me. I knew they were just teasing and playing. I didn't care."

Raising awareness of bullying victimization of children and youth based on perceived sexual orientation or gender identity, and promoting respect for sexual and gender diversity are important aspects of CSE. Recent efforts to increase awareness of bullying and to address some of the underlying causes include engagement between academic researchers and the Office of the Basic Education Commission, Ministry of Education to correct and revise textbooks and school curricula that negatively portray sexual and gender diversity, and to correct frequent misconceptions and antiquated information. More recently, in response to the low implementation of CSE in Thailand, UNESCO Bangkok, in collaboration with the Embassy of Sweden in Thailand, released a Thai language version of the International Technical Guidance on Sexuality Education (ITGSE).

INTERNATIONAL TECHNICAL GUIDANCE ON SEXUALITY EDUCATION

"To enable Thailand to strengthen CSE programmes and curricula in line with evidence-based 'best practices' in the language spoken and understood by students, teachers and education policy-makers."

https://bangkok.unesco.org/content/press-advisory-lets-talk-about-sex-thai-language-technical-guidance-sexuality-education

Finally, despite the suboptimal implementations of CSE in schools, several programmes were described that provide youth-friendly services in college and university settings. These include staff from NGOs who make monthly visits to university dormitories to provide basic screening and HIV testing for youth and AYKP; and adolescent health clinics nearby or in universities that are designed to comprehensively address sexual, mental and physical health needs.

"We also provide in-house services. We go to university dormitories every semester, on Mondays and Tuesdays. We will visit each dorm about four times in one semester. We provide basic check-ups and also HIV testing."

"Our clinic covers all issues of teenage health within the university area."

PARENTAL AND PEER SUPPORT

Parents were generally described as very limited sources of support and education regarding sex, sexuality, and relationships. Socially conservative traditions in Thailand in regard to open discussion about sex were described as a barrier to adolescents and young people's seeking and receiving support from their family. In a few cases, older YKP described their parents as evolving towards being supportive of their sexual orientation, though not engaging with youth in direct discussions about sex or sexuality. For younger AYKP, parents were generally not supportive of their sexual orientation. For some AYKP, parents did not emerge as being detrimental to their sense of self and their psychosocial development; but parents did not serve as sources of information or support beyond a stance of passive tolerance or in some cases acceptance.

One key informant described challenges in regard to the impact of Thai society on constraining parental support and understanding of their children's sexual orientation-related issues and questions about sexual behaviour.

"In Thai society, parents don't really feel comfortable discussing sex in detail with their children. So, it creates problems and challenges in receiving proper information and knowledge for children. Parents in many other countries would sit down with their children discussing sex even before they become a teenager. Do we do that? Yes, we do, but only the basics...not enough. Parents, teachers, or adults feel shy, ashamed, or too uncomfortable. These are the main challenges."

"It is nearly impossible in Thai society to see parents sitting down with their kids discussing sex. If something happens to the kids, they are more likely to ask their friends for help and to accompany them to see a doctor...or even self-research before going to see a doctor alone."

Another key informant described that it is not necessarily a reflection of social conservatism around sexual behaviour in Thai society – today's parents were not that conservative themselves when they were growing up – but that parents were not exposed to sex education as children and were rather taught 'shame around sex'; and they have not since been taught how to communicate with their children about sexual and reproductive health or HIV prevention.

"It is quite obvious that older generations (parents and older) did not receive sex education and gender [education].... They are not really in a position to discuss these things. Young people now also do not get educated about sex and gender either. So, they cannot discuss with their parents. Parents might want to but do not know how...because they were not taught how. This is the main problem. I don't think it has to do with culture. Parents in this generation did not really grow up in a culture where they had to be so conservative or reserved (no sex before marriage, no holding hands in public). The parents did not follow the culture/tradition either and also did not know how to protect themselves...so it results in the same for younger generations."

Some key informants shared stories about parents' disapproval of their child's sexual orientation and their possessing condoms. This often resulted in lack of communication, stigma, and adolescents' disengagement from HIV preventive measures — including condoms and PrEP— that they feared might alienate their parents.

"Some gay and transgender people have to act manly when they go back home. This can raise the risk that parents do not know or accept their children's sexual orientation...they then do not know the best way to communicate and to support their children, or even to correctly educate them."

"Actually, they are still afraid to use any preventive tools. I was once in an [group] interview and someone was asked, "What would you do if you found a condom in your child's bag?" And the answer was, "I won't accept it." I was very surprised. You should instead be realizing that your child was using protection. It is hard for people in Thai society to think that far. Many people would jump to negativity. Grown-ups like to think like this. It affects their children; they would then have to hide it, or be so afraid to carry it around...not wanting people to find out or see. Just like PrEP...it is quite similar to ARV... people might think you had HIV. Or a partner might suspect something...so young people these days decided not to deal with these issues, by not using it. They then get infected."

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Another key informant explained that lack of foundational support and guidance from parents to their gay and transgender adolescents as a result of their sexual/gender diversity may contribute to sexual risk behaviours. In the absence of parental support, adolescents may satisfy their strong need for affirmation and support by blindly trusting people they meet who show them acceptance; in turn, they may be more likely dispense with condoms.

> "Young gay boys and transgender people may not be comfortable enough to be themselves. To reveal their identity could make them feel like a freak. I am not sure. They may have their own perception that without acceptance or support from parents means they have to keep their feelings to themselves. Once they meet someone they really like or someone who understands them, they can just trust that person 100 per cent. With that kind of trust, it can lead to unprotected sex."

Adolescents in FGDs, particularly males with feminine gender expression, corroborated their experiences of lack of acceptance and lack of support from parents. However, they also described differences between younger adolescents and slightly older youth, with the latter feeling their sexual orientation or gender identity was more accepted or 'tolerated'. Several youths

described learning to navigate their self-presentation by acting differently with their families – suppressing ostensible signs of their sexual orientation or gender identity – than with their peers and others outside of their home community.

> "My parents do not accept who I am. We had a fight before. They said no one in their families was ever like this. They scold me for plucking my brows. I kind of get used to it. I think and hope they will get over it one day."

A slightly older transgender youth described that while she did not feel supported by her parents, she also did not feel pressured to adopt more typical masculine gender expression; and that she found a space in which she could navigate her identity and her parents' reactions.

> "My parents were not very supportive of me dressing up like a woman, but they didn't encourage me to be a man either. I feel like we can be who we are as long as we know how to behave."

Thailand

Gay youth similarly described experiencing greater difficulties with their parents at a younger age, with emergence of a neutral stance ('don't ask, don't tell') or acceptance of their sexual orientation.

> "When I was younger, they were not very okay with me being like this. I had to behave when I was at home. Once I finished high school, started doing part-time job and providing for them financially, they started to be more accepting. They said they were worried about how I would stand in the society and how the society would treat me if I were gay."

> "My parents know. I know that they know. They have known about me for a long time, but they just don't talk about it. They are not that supportive but at the same time not against it."

One gay youth described what may be understood as indirectly 'coming out' to his parents; but this entailed a kind of passive acceptance, with no discussion or support around navigating sex, sexuality and relationships.

> "I'm open. They accept me. When I have a boyfriend, I usually take him to my house. They seem to be okay with it."

In addition to adolescents' lack of information and preparation around sex, key informants shared other elements of youths' HIV risk. In one example, an informant described a gay youth who felt very suppressed while living with his parents – "in a box" – who then became "wild" when he went away to college, though he was completely unprepared to navigate sex and relationships.

> "I had a friend who was in the same class. He has always been 'in a box' when he was in high school, as he stayed at home. His parents kept telling him to follow a certain path that they wanted. Now he lives alone (dormitory) for college, far away from his hometown, and he has become quite wild (sexually). I think parents should be more open with their children and let them experience and learn...otherwise they will lose it when they first try, without any knowledge."

Some of the youth in all FGDs described receiving peer support around sexual orientation and romantic relationships. Participants described this in contrast to the discomfort and awkwardness around sharing personal issues around sex and sexuality with parents. Thai adolescents and youth are relatively more open to expressing themselves and sharing with their close friends, including those at school. Supportive relationships also were not limited to same gender or sexual orientation peers, with a few young gay men and trans youth describing young female friends as close confidantes and sources of support.

> "I would only be open with my friends, not to my family, because I am afraid they would not accept it."

> "I am very open with my friends. They are very open with me, too. We talk about and share everything. We even share our sexual stories."

> "Some of my friends and I are comfortably open when we are together, among our group of friends. However, we are different people at home. We behave and try to be in the closet. Things get a little better when we go to college."

Beyond challenges in navigating sexuality and gender identity, concerns arose around HIV stigma and the cost of HIV testing. A key informant described that youth who go for an HIV test risk having this disclosed to their parents when they use their parents' insurance coverage, particularly if the parents work for the government. This is a systemic barrier to youths' access to HIV testing.

> "Our concern is a case of those at a younger age whose parents work for the government. Their health insurance is covered by their parents' jobs. So even though they could go and get tested by themselves, their parents will be informed. I am so worried for this case. I won't know what to do."

In the context of challenges in access to healthcare, a Thai regulation that allows minors aged 15 years and older to access HIV testing without parental consent is a significant achievement; however, implementation of HIV testing among adolescents, including AYKP who are most at risk, remains suboptimal. Although it has been few years since the implementation of this regulation, it is still commonly referred to as a "new policy", and characterized by noncompliance and resistance by healthcare providers. Key informants described the Thai Red Cross in Bangkok as one organization that is in full compliance with this policy, and sporadic and unpredictable compliance among many other health providers and institutions. Some key informants described seeking out assistance from the Thai Red Cross to compel providers at other hospitals and clinics to allow adolescents and youth to access HIV testing.

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> "It really depends on doctors too. I heard so often from our care support team. Each hospital will have about one to three doctors for this, and their mind will be the same pattern. Our care support team takes kids to get tested at a hospital, its name I'd rather not mention, and we get refused because they say kids have to bring their parents...and they are over 20! The doctor said, "they have to come with a parent or guardian or relative; if something happens, we can then contact their family, not you!" The Red Cross doesn't even need parents to come with adolescents. We always have to contact the Red Cross for help. The Red Cross has to then contact that hospital to inform them about the new policy."

Of course, having support from one's parents for HIV testing would be ideal; but the pervasive lack of support reported from parents around sexual orientation, gender identity and HIV prevention have the perverse effect of creating further barriers to HIV testing for AYKP. Health care providers were reported to enact their own rigid guidelines and not offer HIV testing to young people who present alone, with a friend, or with a community-based organization representative.

Several programmes that successfully engage peers to provide HIV education and prevention have trained YKP as 'peer mobilizers' to conduct outreach with other AYKP, with documented increases in HIV testing – such as the USAID-PEPFAR funded LINKAGES Thailand programme. However, it was reported that these peers, even as they are over age 18, are often prevented from accompanying youth under 18, sometimes under 20 years of age, to access HIV testing.

LINKAGES THAILAND: USING PEER MOBILIZERS TO INCREASE UPTAKE OF HIV TESTING AND COUNSELLING

"LINKAGES has members from key populations (known as 'peer mobilisers') reach out to their peers in order to link them to HTC (HIV testing and counselling) services. Those who test positive for HIV are then supported by their peers to access treatment and care. First year results found HTC had significantly increased among key populations in areas where LINKAGES is being implemented."

COMMUNICATION

Online resources and social media were described as playing central roles in the information-seeking activities and 'self-research' done by young people.
Given the absence of relevant information from schools and parents, youth, including AYKP, described seeking information about sexuality, gender, sex and HIV on the Internet. In acknowledging this scenario, key informants described the need for youth to receive information and training to enable them to critically assess the information they receive online, along with its sources, given the prevalence of out-dated information and persistent myths about HIV transmission. Key informants further described the divide between information and behaviour, with the need for linkages to in-person training and skill building, as well as HIV testing.

Key informants expressed concerns about the accuracy of sources from which youth seek information and the gap between knowledge and practice.

"They [young populations] also need to be more careful about doing research. Like, HIV information from 10 years ago may not be completely true today, as things keep changing. New information and new technology keep coming. They need to check the post date. There is also false information, like HIV can be cured. They need to know how to do self-research…when it is posted, compare with other sources. The best way is to get information from specific organizations just like our SWING. We are happy to help. We have a website, we have a hotline number to call about HIV, about sexual health…even health in general. We always keep our information up-to-date."

"I am in my 40's. I, myself, did not know about gay/same-sex prevention stuff until graduating from college and beginning to work for this NGO. From what I see, teenagers these days, especially during workshops, they seem to know what they are doing. They seem to have background knowledge about these things. They can really do self-study/research, also through social media too. Information now is pretty direct. However, having knowledge doesn't mean they can realize how they can actually deal with it when it comes to the real situation."

Youth key informants described how social media and online sites exert a powerful influence on young peoples' sexual behaviours, through both influencing social norms and providing mechanisms to meet others on online apps, which sometimes leads to impulsive sex. Social media is also a powerful vehicle for providing accurate information, positive social norms and HIV prevention.

> "There is so much temptation and persuasion in society now, which make us want to try and experience. I think this leads to HIV risk, too."
>
> "Social factors are also influential for sexual risk. I saw on social media that guys can just decide to have sex from only walking past each other. I was quite surprised about this statement. But then again, there are so many online applications supporting that statement these days. It is really easy to have sex nowadays. There really are so many online channels supporting free sex and casual sex…and also making it seem so normal. This leads to more sexual activities for MSM and TG [transgender people]."
>
> "I think teenagers, such as gay boys or transgender or actually all genders, don't usually think about consequences of their actions and behaviours when it comes to meeting someone they like. With their impulsiveness and their hormones, they don't like waiting…they don't like plans or rules…they do whatever they feel like."

Mobile dating applications and online websites emerged as playing an important if not central role in young people's lives. Apart from self-learning about sexual orientation and sexual health, virtual spaces also serve as venues for meeting other youth–sometimes providing social and emotional support, but sometimes leading to sexual risk behaviour. Interestingly, one youth recounted the privacy risks inherent in social media, like Facebook, an important issue to maintain awareness of in terms of balancing opportunities and limitations of using social media for education and support.

Youth in FGDs described online apps as serving as comfortable venues for open discussion about sex and sexual issues with other youth:

> "I think people who use the same dating application or an application that is mostly for sharing sexual issues can really get along and feel more comfortable sharing secrets."

AYKP's narratives revealed such dating apps as opportunities for sexual encounters and HIV risk behaviour. For example, while the following encounter was described as consensual, the youth's limited knowledge around HIV prevention, and lack of sexual experience and skills, enabled sex without condoms:

> "I met one guy through a gay app. I was curious. He then picked me up and took me to his house. We kind of did it and I was so shaky and nervous as it was my first. I didn't know what to say or what to prepare. We didn't even use a condom."

Key informants reported that HIV stigma and fear have been historically promoted in the Thai media, including some online HIV-prevention campaigns, which they described as a barrier to HIV prevention. More recent attention to the importance of destigmatizing HIV was indicated as a positive element in youths' greater ability to engage with accurate HIV information. However, another key informant described some youths' concerns and seeking out information as surfacing too late – after they had contracted an STI or experienced worry over not having used a condom for sex. This dynamic supports the need to engage young people earlier in their lives, such as through schools, in learning about sexual and reproductive health and rights.

"I think it is like a two-sided coin when it comes to campaigns and media. I feel like young people would only choose to see what they want to see. They would ignore consequences. If they do care, it would just be for the short term. They do not think about long-term consequences. The issue is that they only look at nearby influences. Also, in the past, media around HIV/AIDS had been very scary with upsetting images. It could be effective in making people scared and concerned; however, at the same time, it put stigma on HIV/AIDS. It has been changed now. Groups of people working against HIV/AIDS stigma tried to change that."

"I actually do not want to blame our conservative culture. Of course, there are people who are very conservative and old-fashioned around this stuff [sexuality and sexual health]. But if you are interested in studying, you can just search online. You just sit in your room and receive a lot of information. You don't even have to leave your house. So, it depends how much people care about health. People usually care about it when it is about to get to them or when it is almost too late. I don't think culture is a barrier these days."

"I think it is important to integrate those people [older people/parents] to work and plan with us. We know that young populations usually do not want to discuss gender, sex, drug use, etc., with their parents. They'd rather talk to their friends. The fact that they need their parents to consent with them during processes for health services is the main barrier. They would only think, 'Why bother, why go through such hassle?' We also need to see whether health service centres are too strict. They should think more about young people's needs. Friends also play an important role. If service providers can be as friendly as a friend or they can bring friends, it would really encourage young people to go."

"We cannot stop them or prevent them from doing it [sex]. The more we try to stop it, the more they want to do it. It is probably better and easier to focus on how to make them capable of doing it safely and correctly."

Adult and youth key informants indicated that promoting communication between families and healthcare providers may help to reduce barriers to healthcare seeking among youth. They pointed to the paradox that conversations about sexual and reproductive health are much more likely to occur between adolescents and their peers than with their parents; however, engagement with the healthcare system is often encumbered by requirements to involve parents, which frequently results in youth not pursuing healthcare services. Key informants described the importance of youth-friendly clinics and harm reduction approaches as components of health promotion for adolescents and youth.

In the context of extensive use of online sources and social media for seeking out information about sexuality and sexual health, as revealed by key informants and youth, several social media campaigns have promoted HIV testing among MSM in Bangkok. These positive and gay-affirmative campaigns are largely designed for adults rather than adolescents, although they may reach some young MSM. Many young people are unlikely to access HIV testing sites themselves and may be reluctant to engage with overtly gay-identified services for adults.

WHAT IS TESTBKK?

"TestBKK is an initiative of APCOM [Asia Pacific Coalition on Male Sexual Health] to encourage men who have sex with men to get tested for HIV. We also provide sexual health information to protect you and the people you play with. Whether you're single, in a new relationship, part of a couple or enjoying the company of many, whether you're a top or bottom, we all need to take care of our sexual well-being. Do you know that an estimated one out of three MSM in Bangkok are HIV-positive? If you're sexually active, apart from using condoms and water-based lubricant, getting tested regularly for HIV should be an important part of your routine."

https://www.testbkk.org/en

Lovecarestation.com is an innovative, Internet-based health promotion and counselling platform initiated by the Path2Health Foundation (P2H), a Thai NGO, and supported by and in partnership with UNICEF Thailand since 2015. Originally focused mainly on HIV, LoveCare Station now has adopted a broad focus on sexual and reproductive health, including HIV and STIs, and programming for MSM. A mental health component was recently added, with a vision to offer comprehensive services on health issues important to young people aged 10–24 years.

LOVECARE STATION

"LoveCare Station is an online platform that provides relevant information about sexual health for teenagers, counselling, knowledge and articles about sex education in a safe and accurate manner." Online services include a chat room and online consulting including HIV/STIs, contraceptives, bullying, and mental health; a web board for posting questions; reliable information; and youth-friendly services and referrals.

https://www.lovecarestation.com/

MENTAL HEALTH

Mental health challenges were described as a function of stigma and rejection of AYKP, including LGBTIQ youth, that occurs across school, family and health care settings. It is not necessarily any one event, or one sector, that emerges as primary; rather, it is the pervasiveness of stigma across multiple key domains of youth's social ecology, further exacerbated by Thai media, that creates stressors resulting in internalized stigma and shame for some LGBTIQ youth. Compounded with HIV stigma, the combination of internalized and societally enacted sexual stigma creates barriers in access to HIV-prevention and treatment services, including HIV testing, and to mental health services.

Key informants described some LGBTIQ youths' alienation from family and being ejected from or feeling forced to leave their homes. This distancing from family was reported as a function of the family's standing in the community, and their wanting to avoid being 'tainted' by having an LGBTIQ child, in conjunction with lack of information, education and services to support parents in interacting with their LGBTIQ children/adolescents.

Thailand

"There are those, regardless of their gender, who are forced to leave their houses. It doesn't always mean they are bad kids. There are many factors. What do we do to help these kids? And if they are LGBT, what do we do? Society likes to ignore this group. We need to find a way to reach out and offer help. We need to accept them."

"Kids whose parents have been maintaining a good image and social respect would want to find a way to escape from it. I think society now is very chaotic and it is still searching for a space for these kids…a space that meets both sides' situations."

Another key informant recounted multiple sources of alienation among some AYKP that drive them to leave schools, families and their local communities as adolescents. Absence of the social and economic support usually associated with positive youth development – from family, school, peers and the local community – was described as fostering some male adolescents to take up sex work with its many associated challenges for health and safety.

"The other piece that is needed to be said is that many of these guys [male sex workers] don't function comfortably in the school system. So, they are early leavers – many of them, they don't fit in on a number of dimensions. They don't fit in because of their feelings about their sexual identity, and they don't fit in in terms of expectations and the demands for performance that school imposes on them. So, those factors all contribute to their desire to get out of their home communities."

A combination of anti-LGBTIQ stigma in healthcare services, HIV stigma and internalized sexual stigma were described as posing barriers to engaging with healthcare services, and to buying and using condoms. Stigma about sexual health and condom use was also described among heterosexual youth, particularly girls and young women.

"Stigma is important — stigma around HIV and stigma around gender. Stigma issues around being LGBT have become much better than before, but it doesn't mean it is gone. Self-stigma on being LGBT is much less now, as they are pretty much 'proud to be gay' these days. However, stigma around HIV still exists. Especially if a gay guy has HIV, he would be doubly stigmatized by the society. So, I think stigmatization is one of the barriers for people to access health services."

"I think people are not that open about it [sexuality]. I think it is also shame. Like you are already like this [gay] and still do those things [HIV risk behaviours]. I think most people still think HIV is something shameful. People did not grow up knowing or learning about it. Society put walls around us. So, if we choose to learn about it, it could be seen as obsession. Like obsession with porn. Unlike other countries where this is more open."

"Culture is one thing. Like when we are to have sex…culture will put walls around us. Let's say young people want to buy condoms and then realize our culture…they then feel bad. Not many people feel comfortable buying condoms in a convenience store; except those who have sex often, they feel comfortable buying condoms. Some people have to pretend to shop for so many items and then slip a pack of condoms into a basket to hide it from others during payment. Stigmatization towards buying condoms still exists. You buy condoms means you will have sex. You are stigmatized. It is worse for younger people. Sex is not appropriate. Girls are scared to buy emergency birth control. MSM are shy to buy condoms."

Participants' reports of HIV and sexual stigma are largely corroborated by the Thai Ministry of Public Health data (October 2018; see figure following). The data shows reductions in certain measures of stigma from 2014 to 2017 in response to targeted interventions

for healthcare providers. Notably, reports of experiencing breaches of confidentiality in a healthcare facility were markedly reduced, from 24.5 per cent in 2014–2015 to 10.3 per cent in 2017, as were reports of avoiding or delaying healthcare because of fear of stigma and discrimination (from 13.0 per cent in 2014–2015 to 5.2 per cent in 2017). However, little change occurred in experiencing stigma and discrimination in a healthcare setting (still over 10 per cent in 2014–2015 and 2017), and a 10 per cent increase between 2014–2015 and 2017 was reported in deciding not to access a health facility due to "internalized stigma" (over one third of participants in 2017).

Stigma and discrimination in healthcare settings experienced by people living with HIV in the past 12 months, Thailand, 2014–2015 and 2017
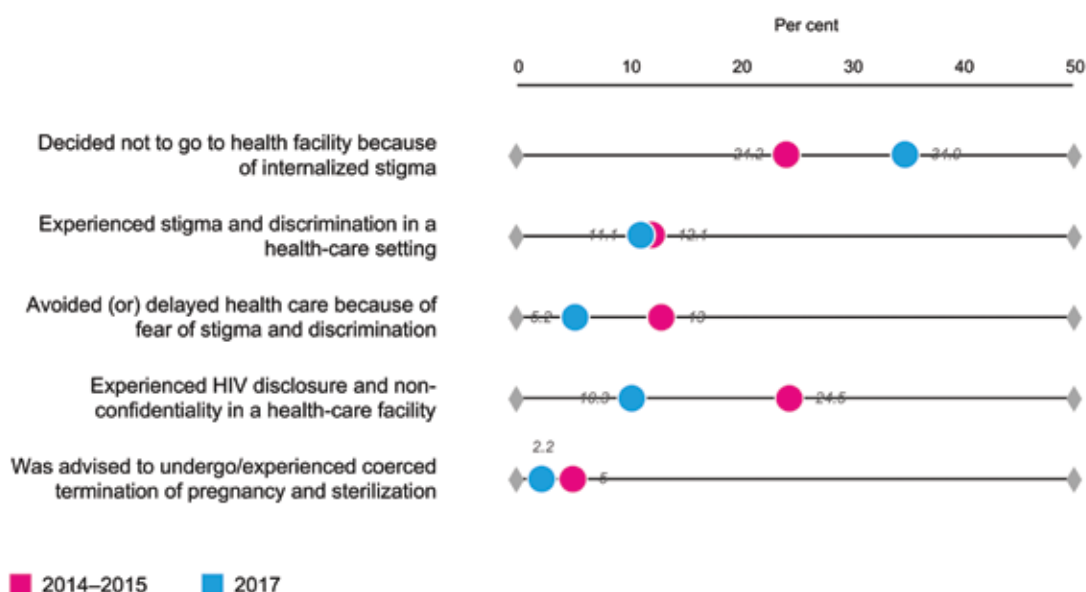
Source: Stigma and discrimination among health care providers and people living with HIV in health care settings in Thailand: comparison of findings from 2014–2015 and 2017. Bangkok: Ministry of Public Health [Thailand]; Oct 2018. Presented in UNAIDS Region Profiles 2019, p. 54.

AYKP in FGDs largely did not engage in discussion of general mental health or feeling depressed, anxious, etc. This is not surprising given the broad stigmatization of mental health among the general population in Thailand and the overall low availability of trained mental health providers. Mental health is often approached as a binary, with the two options being healthy versus 'crazy'. However, some participant narratives addressed specific challenges and stressors for AYKP that affected their mental health, several based on stories participants had heard about their peers. The use of such narratives may be a helpful means to engage youth in discussion around mental health, that is, without having to reveal personal details or experiences – which is perhaps a greater taboo than discussing one's sexuality. In the discussions that did transpire, peer pressure/support, familial pressure/harmony and societal conformity/judgment emerged as stressors for all youth, with added pressures and concerns for AYKP.

In the following narrative, a transgender youth describes some of the challenges for AYKP in navigating their evolving sexuality and gender in the context of peers and a desire for peer acceptance.

The participant recounts the importance of youth-friendly resources that promote early engagement with information and support in the context of youth's evolving sense of gender and sexuality, and given later consequences of youth's decisions, such as use of hormones.

> "I think what is also important is sexual orientation/identity versatility. Let's say a very young gay boy decides to take hormones, as he wants to become pretty like his friends. After a few years, he feels that he doesn't want to be or look so feminine anymore. He then has to deal with his body change. He is not comfortable wearing a shirt as his breasts will show. He wants to grow some beard but what about his breasts. This is quite a serious matter for someone like this. We need information and fundamental preparation to help them make a good decision."

Thailand

A few programmes were described as providing youth-friendly services, including for mental health, that are inclusive of or focused on AYKP. Even as many youth-friendly clinics were reported to be in existence in Thailand, the vast majority were described as focusing strictly on reproductive health and as lacking knowledge and competence in working with sexual and gender minority youth. This often results in stigma and discrimination that repel AYKP from using these services. In this context, some youth-friendly services were described as playing a strategic role in accompanying youth to hospital clinic visits.

"It is challenging for gay people. Some hospitals do not have a staff/nurse who specializes in services for sexually diverse populations. Some places don't even have someone who can provide basic oral, anal, or penile tests."

"We cover mental health, sexual health and general health for teens. They can contact us via Facebook, LINE chat, and phone calls. They can talk about anything to us. We also assist in accompanying them to the hospital, if needed."

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One model programme for mental health services is sponsored by Chulalongkorn University in Bangkok, including a Wellness Center for University students and a Psychological Wellness Center for the general public, including youth.

CHULA STUDENT WELLNESS CENTER

Chulalongkorn University, a prestigious state university in Bangkok, operates two counselling centres: the Chula Student Wellness Center for university students and staff, and the Center for Psychological Wellness for the general public (www.chulawellness.com). Both centres use a client-centred and holistic approach that affirms LGBTIQ identities. The student clinic offers mental health services, as well as other programmes and activities, such as a small LGBTIQ-themed film festival. Given the stigma around mental health issues in Thailand, these other activities aim to familiarize students with clinic staff, build trust, and increase comfort in accessing counselling or mental health treatment.

www.sa.chula.ac.th/wellness

The Thai Red Cross operates a clinic that specializes in transgender-specific health, including for young people, the first of its kind in Asia.

TANGERINE COMMUNITY HEALTH CENTER

The Thai Red Cross Tangerine Community Health Center is the first transgender-specific health centre in Asia, operated by gender-sensitive medical professionals, including transgender staff. Its focus areas include safer use of hormones, HIV and STI prevention, and addressing the stigma and discrimination faced by transgender people. The clinic aims to serve as a model for the region in expanding transgender people's access to competent health care and promoting their rights.

www.facebook.com/TangerineCenter

RECOMMENDATIONS

Education

1. Increase multifaceted support mechanisms and resources to promote and evaluate the implementation of Ministry of Education policies (Adolescent Pregnancy Prevention Act, 2016) mandating the provision of CSE in basic education, given sporadic and suboptimal introduction of CSE in schools and school curricula despite policy mandates.
2. Provide teacher training and resources to challenge teachers' own discriminatory attitudes about sexuality, gender, HIV and AYKP; promote understanding of rights-based and gender-responsive approaches; develop skills to support students' critical thinking; promote students' skill-building through activity-based learning; and expand coaching systems and rewards to support teachers' performance and motivation.
3. Introduce age-appropriate CSE in schools from a younger age, including basic information about sex, sexuality, sexual and gender diversity, and HIV, and skills in sexual negotiation and refusal. Many adolescents engage in first sexual encounters completely unprepared to understand and negotiate HIV and STI risk – and many young MSM are at risk for HIV well below 18 years of age.
4. Revise out-dated and heteronormative material in school textbooks and school curricula – which contribute to sexual stigma, HIV stigma, and bullying victimization of AYKP – based on International Technical Guidance on Sexuality Education guidelines.
5. Implement whole-school anti-bullying initiatives and zero-tolerance policies that are specifically inclusive of sexually and gender diverse youth, non-threatening reporting mechanisms for youth who are victimized, and transparent monitoring and evaluation of progress at the school, district, and national levels.

6. Introduce and support peer education programmes in schools alongside teacher training, modelled on successful programmes such as TeenGen (for adolescent key populations and young people living with HIV) and NewGen (for YKP and young people living with HIV).
7. Address widespread gaps in condom promotion and distribution programmes in many provinces, which have resulted from decentralization of national efforts and funding streams, in order to increase young people's access to condoms and condom use, to prevent HIV and STI transmission, and teen pregnancy. Barriers in access to condoms are counterproductive to CSE and HIV-prevention programme effectiveness.
8. In accordance with UNESCO recommendations, promote mechanisms to coordinate CSE-related work among the Ministry of Education, the Ministry of Public Health, and the Ministry of Social Development and Human Security, and among the various bodies within the Ministry of Education to improve the efficiency of CSE in educational institutions and other contexts.

Parental and peer support

1. Design and launch non-threatening initiatives with and for parents to increase understanding of sexual and reproductive health and rights (SRHR), including sexual orientation and gender identity, build skills to promote communication with their children about SRH and HIV prevention, and support parent role models who have navigated challenges around their own children's sexuality, gender identity and sexual behaviours.
2. Develop and resource systematic initiatives to train and capacitate peer educators to promote communication, support and referrals for adolescents and youth, including AYKP, to youth-friendly health and mental health service providers.

3. Build on and replicate successful peer-mobilization initiatives in which youth conduct outreach to other AYKP around SRHR and HIV prevention, and accompany their peers to HIV counselling and testing facilities.

4. Enact multi-sectoral initiatives targeting physicians, nurses, clinics and hospitals to promote awareness, understanding and monitoring in regard to public health regulations (Medical Conduct on HIV, 2014) stipulating that adolescents under age 18 can access HIV testing without parental consent. This is routinely subverted across the health care system despite a sustained and explosive HIV epidemic among young MSM in Thailand.

5. Develop and disseminate routine guidelines and training to ensure protection of adolescents' confidentiality when they access HIV and STI testing and services. Frequently this is usurped when adolescents are forced to register under their parents' government health insurance to pay for HIV testing; fear of unwanted disclosure (of sexuality, sexual behaviour and HIV) to parents and others is a powerful obstacle to HIV testing, PrEP and HIV treatment access.

Communication

1. Develop and launch fun, engaging and youth-friendly trainings to promote adolescents' ability to critically assess information provided online, along with its sources, and to discriminate between myths and rumours ('fake news' about HIV transmission), and science.

2. Design online and offline resources and trainings, in collaboration with adolescents and youth, including AYKP, to capacitate youth to evaluate and anticipate potential risks of online dating apps, in addition to their potential benefits for reducing social isolation and building peer networks.

3. Capitalize on adolescents' widespread use of social media and online apps to develop youth-friendly and engaging materials to disseminate accurate information about SRH, including HIV/STIs, condom promotion, sexuality, HIV testing and teenage pregnancy.

4. Adopt youth-friendly, LGBTIQ-affirmative, harm reduction approaches to address HIV risk and prevention among adolescents and youth. Scare tactics and condemnation are highly unlikely to be effective, and are counterproductive to health and well-being.

Mental health

1. Incorporate information and skills in CSE initiatives to promote self-acceptance by LGBTIQ adolescents and young people, to help them to understand their own evolving sexuality and gender in the context of peers and a desire for peer acceptance.

2. Provide basic education for all adolescents and youth about different types of stressors and common mental health conditions among young people, and how to discuss them and seek assistance.

3. Integrate competent mental health services inclusive of AYKP in existing youth-friendly health services.

4. Train, capacitate and expand existing youth-friendly SRH programmes and clinics to provide competent, gender-responsive services to AYKP in addition to heterosexual youth. Pregnancy prevention programmes, while important, do not address the full spectrum of concerns among AYKP or the sustained HIV epidemic in Thailand.

5. Utilize social media to combat sexual (anti-LGBTIQ) and HIV stigma, and general stigma around mental health, through online campaigns developed in collaboration with youth and AYKP.

6. Resource, replicate, and expand model programmes that provide LGBTIQ-affirmative and competent health care for youth, using integrated approaches to incorporate physical and mental health, and HIV prevention and treatment (such as The Thai Red Cross Tangerine Community Health Center, and Chulalongkorn University Health Center), both within Bangkok and throughout Thailand.
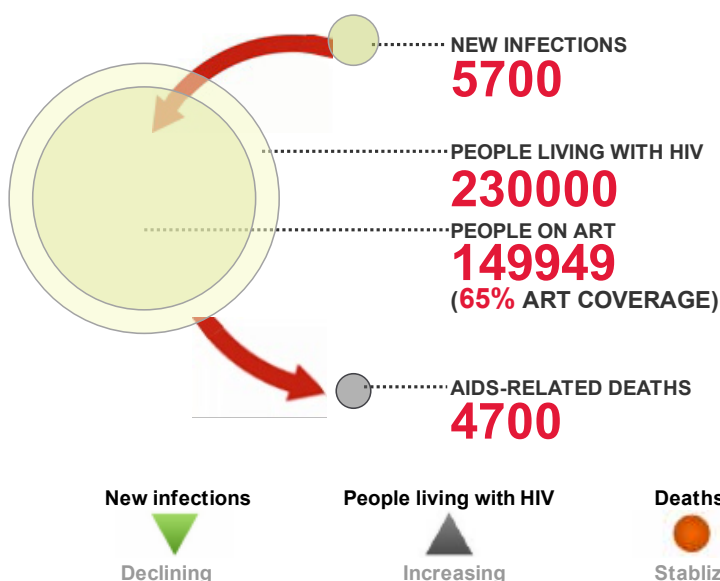
Viet Nam

In Viet Nam, the estimated number of people living with HIV has increased from 220,000 in 2010 to 230,000 in 2018; among these, two thirds are men.[1] There was a reported 64 per cent decrease in new infections between 2010 and 2018, from an estimated 16,000 to 5,700.[2] Overall, about 65 per cent of people living with HIV are on treatment; however, this overlooks egregious disparities in treatment coverage among key populations. An estimated 12.2 per cent of men who have sex with men (MSM) are living with HIV, with only 23.3 per cent of them receiving antiretroviral therapy (ART) in the past 12 months; 3.6 per cent of female sex workers (FSW) are living with HIV, with 21.3 per cent of them receiving ART in the last 12 months; and 14.0 per cent of people who inject drugs are HIV positive, with 53.4 per cent of them on ARV treatment in the last 12 months.[3]

UNAIDS 2019 estimates of new HIV infections among young people aged 15 to 24 years in Viet Nam indicate a reduction from 1,400 girls/young women and 1,600 boys/young men newly diagnosed in 2010, to 500 girls/young women and 500 boys/young men newly diagnosed with HIV in 2018.[4] However, despite the concentrated HIV epidemic among adult key populations and disparities in treatment coverage, available data on HIV and AIDS among young people are not disaggregated by key populations. Notably, the 2016 National Survey on Sexual and Reproductive Health among Vietnamese Adolescents and Young Adults aged 10 to 24 years indicated that only 26.8 per cent of respondents demonstrated comprehensive correct knowledge about HIV.

Key facts on HIV in Viet Nam

NEW INFECTIONS
5700

PEOPLE LIVING WITH HIV
230000

PEOPLE ON ART
149949
(65% ART COVERAGE)

AIDS-RELATED DEATHS
4700

New infections — Declining

People living with HIV — Increasing

Deaths — Stablizing

Source: UNAIDS data, 2019; www.aidsdatahub.org

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Nine key informants (four women, three men, and two transgender persons) were interviewed for this Formative Assessment, representing national and international stakeholders, and institutions working on health promotion and HIV prevention programmes in Viet Nam: UNICEF; UNAIDS; Vietnam Union of Science and Technology Association (VUSTA); Vietnam Network of Young Key Populations; Vietnam Network of Men who have Sex with Men; and Vietnam Network of Transgender People.

Four focus group discussions were conducted with 40 adolescents and youth (17 girls, 20 boys, and 3 transgender persons) from the following populations:
- FGD 1: young people from schools and organized groups (aged 16–18 years)
- FGD 2: young people from universities and organized groups (aged 19–24 years)
- FGD 3: young MSM, people living with HIV and transgender people (aged 16–18 years)
- FGD 4: young people who use drugs, MSM, and people living with HIV (aged 19–24 years)

EDUCATION

Sexual and reproductive health education is reported to be limited due to societal values that ostensibly seek to 'protect' children and general taboos on discussing sex and sexuality, particularly with young people. Schools generally lack any but the most basic sexual health information and teachers generally do not want to engage in sex education with their students, more so regarding sexuality, which generally reflects their own limited knowledge and prejudices. As key informants explained:

"Sexual education in Viet Nam is very limited because adults often avoid such matters since they have prejudices against this. They think that children should not have too much knowledge of sexuality. Recently, organizations have better connections to youth unions in high schools. Through the curriculum, they would like to spread the knowledge and awareness of sexual education. They will have two stages. The first is done in classes of 30 students."

"These meetings on sexual health and rights often take place in international schools; they have a better approach than the rest of the city and their mindset is more open. The meetings are usually held monthly. But the international schools are only a very small percentage of students. The rest are public schools and we don't have sexuality lessons in public schools. The Secretary of the Youth Union in the school will discuss with the organizations. Then they will gain the approval from the schoolmaster... sometimes, but not always."

"And the situation is much better in private schools and big schools in Hanoi and Ho Chi Minh City, but in rural areas you cannot expect it to happen very soon."

Key informants described that teachers were generally not part of initiatives in which sexuality education was offered. Rather, limited education on sexual and reproductive health is introduced through sporadic and ad-hoc efforts, sometimes organized by parents, and mostly offered by organizations outside of schools when they can garner the necessary approvals:

"And the right to tell always depends on the teacher, if teachers are confident to talk about this."

"It's not the teachers that teach on sexuality. It's the organizations. So, the educational system here, the local teachers don't really like to talk about sexuality. They will only talk about the difference between men and women but not digging into sexuality or LGBT. In our classes, they will have lessons to teach you about sexual organs but will go through that lesson very quickly because they are shy. Nothing about HIV. The teachers have a stigmatized behaviour on HIV. In the network, they also have LGBT in high school. Some parents belong to the LGBT, so they will contact the master of the school and one day come to the first ceremony of the school and talk a little bit of LGBT. It's more like individual contact to discuss this."

Young people's accounts echoed those of key informants, reporting scant information offered about sexual and reproductive health in schools – "once every semester during biology class" – and a general aversion on the part of teachers to broaching any topics related to sex and sexuality.

A young participant representing young key populations (YKP) from FGD 4, detailed the lack of information on sexuality and safer sex from schools:

"Back to secondary/high school, teachers apparently skipped lessons relating to the male/female body and genital organs. The same thing would happen for topics on safe sex, they are completely left out. In Grade 9, girls had a private sharing on sexual and reproductive health. Other than that, the school provided no other information. Thus, I wasn't clearly aware of sexuality and sexual identity, so I just shared with my peers or those with the same interest."

Similarly, youth from FGD 1 and FGD 2 reported receiving very scant information on sexual and reproductive health:

"Teachers in our secondary and high school only scratch the surface when it comes to the knowledge about these areas."

"I was told that I was not old enough to talk about these kinds of matters. I barely got any information from my teachers."

Beyond secondary schools, some college students detailed receiving more comprehensive information. However, sometimes this information was offered only by sources that had commercial interests, thereby leaving out important material, including in the case detailed below regarding sexual and reproductive health information for young men:

"When I got into university, I gained a substantial amount of knowledge through lecturers' exercises and self-research. Take my first assignment as an example, which was about the approval and disapproval opinions of same-sex marriage. That's how I came over a book that explained the terms of LGBTQI. In addition, the second assignment was about law implementation on recognition of sex workers."

"During the first year of college, a great number of companies brought their products to our place for advertising purposes (mostly deodorants) and gave female students some basic knowledge. However, they mentioned the female aspects only and the male counterpart had little to no access to these kinds of marketing information. Thus, a large proportion of the students have resorted to different entertainment websites for the information (from the pop-up advertisement to online clips and videos)."

Youth, and particularly YKP, described being stigmatized and victimized by bullying, oftentimes with collusion of teachers and administrators, and the policing of their behaviours and relationships:

"None of the friends at school was willing to talk about these subjects. Back in my school, there were two lesbians having relationships. Then, it started to have discrimination and stigmas from teachers and students at the school. Teachers didn't even care about those jokes."

"When I was in secondary school, teachers abhorred students having relationships. So, they usually captured pictures of students going hand in hand with each other, and then sent them to their parents for notification so that they (the students) would not be able to be together anymore. In my case, I had an early relationship. My boyfriend's family came to my house and talked, because of the teachers."

"My secondary school's principal was a person always discriminating against me, attacking me with offending words such as 'ái', 'pê đê' (pronounced as peh deh) – [derogatory terms for gay and pedarest]. I feared her. Though I had several close female friends, I didn't tell them my personal stories until I had graduated."

"In high school, I knew I was an advocator supporting sexual acts among men (Fujoshi – 腐女子 – a self-mockingly pejorative Japanese term for females that approve of romantic relationships between men). One day, my friends borrowed my phone and saw I had clips containing intimate acts between men. Since then, people looked at me with stigma and misunderstood that I was a lesbian. My teachers were unaware of this."

Key informants as well as youth connected the lack of comprehensive sexuality education (CSE) in what is a stigmatizing environment to the high HIV and abortion rates among youth and young key populations. Key informants explained:

"Because we don't bring such matters into our education, the HIV and abortion rate is very high in young key populations. In recent years, they are more concerned about drug use among teenagers. The risks for HIV infection are increasing."

"To my observation, in terms of education, most is propaganda activity; but there are some programmes in place."

Similarly, a young woman described her education and the outcomes:

"They briefly introduced us to various forms of contraception, as both the teachers and the pupils were too shy to discuss these 'sensitive subjects'. This has led to the avoidance, unawareness, ignorance and numerous cases of unintended pregnancy of female pupils."

More broadly, key informants described increases in rates of sexually transmitted infection (STI) diagnoses among young people, including MSM in particular, amidst a general lack of accurate information on STIs and HIV prevention, lack of awareness about the risks of substance use, and misinformation around pre-exposure prophylaxis (PrEP):

"I think beyond HIV, we also see that there's a very high rate of sexually transmitted infections: syphilis, chlamydia – the rates are really, really high. So, obviously there's a need in terms of information ... services, testing and treatment; there's a big gap and not a clear agenda. And even a limited number of people protect themselves from HIV with PrEP which is available in few locations now, but that, you know, doesn't prevent STIs, so there's obviously a need."

"There's also an issue of substance use, methamphetamine use, on the rise. So, that's including young key populations. It is very cheap and available in the market and there's peer pressure to use it at parties and for people who are engaged in sex work, if there's a pressure from the client, for example; but then young people don't know the risk associated with it. So, then it opens doors for other risks. So, the knowledge of young people about what puts them at risk and how to protect themselves in all different areas will be very much welcomed."

Key informants also described the particularly high risk for HIV and increasing rates of new infections for young MSM in Viet Nam, and the need for increased and accurate information among MSM communities:

"If we are talking about the MSM community. It is small and it is not like they are not diagnosed and treated, but it is like, they lack … correct understanding. For example, with people when they heard about PrEP, I heard some young people argued that if we have PrEP, why do we still we have to use condoms? When we are talking about the MSM community in Hanoi, they can have rather easy access to user friendly clinics, but they don't have correct understanding."

Amidst the lack of sexual and reproductive health information offered in the vast majority of schools, which were often described as stigmatizing environments by YKP (even more so outside of major urban areas), **key informants focused on supporting and expanding existing initiatives that had shown some success.** These include support for community-based organizations (CBOs) that fill in major gaps left by the educational system and building on their successes in engaging, even if sporadically, inside schools.

Rather than relying solely on changing the educational system and overcoming significant barriers in teachers' willingness to transmit CSE, they suggested a multi-pronged strategy: resources and capacity-building for CBOs promoting affirmative support and information for YKP both inside and outside of schools. The more evolutionary but nonetheless important route of slowly changing the official sexual and reproductive health education.

"I think it will be helpful on a larger scale, because it can reach every school in every corner in the country. That's an official channel and I think it is like you are trying to change the teacher first and then the teacher will help to carry the knowledge to the student, right? That channel through MOE (Ministry of Education) is important to do but for the key populations and children on the street, I think it's better to work through CBOs."

"No change can take place overnight, right? You take it step-by-step. I think about 10 years ago, that was the very first time where the United Nations agencies managed to get agreement by the MOE leaders to include [addressing] HIV, drugs, sexuality, SRHR [sexual and reproductive health and rights], in extracurricular activities. So, that's the first step and now I think it takes time. I think my children do not get the sexuality education, however, I wish they could. But there's the fact and the reality: we do not have to select this or that, we try to do both things."

Amidst the widespread lack of youth-friendly services and of health services with competencies in serving AYKP including LGBTIQ populations, the USAID and PATH Healthy Markets Project has supported innovative private/non-profit partnerships to reach key populations with HIV prevention and broader health services. However, these programmes don't supplant the need for more widespread programmes and scale-up of government-sponsored youth-friendly services, including adolescent and young key populations (AYKP), across Viet Nam–including rural areas and mountainous regions outside of major cities. They demonstrate the possibilities for multipronged efforts and private-public partnerships.

USAID-PATH partnered with Glink, a local social enterprise, to provide MSM-led HIV prevention, care and treatment services for the MSM community. Glink has clinics in Ho Chi Minh City and more recently in Hanoi, with five clinics in total in Viet Nam. Recent initiatives have included community-based HIV testing and PrEP pilot projects.

LOVE, RESPECT, AND COURAGE PREVENTS THE SPREAD OF HIV IN VIET NAM

"Between June 2017 and May 2019, 12,420 injecting drug users and sexual partners of people living with HIV have been invited to test for HIV. Of those, 12,070 (97.2 per cent) then accessed community-based HIV testing services, and 1,038 (8.6 per cent of those tested and 8.4 per cent of those contacted) were subsequently diagnosed with HIV and linked to treatment."

The social enterprise Glink provides friendly and confidential HIV testing services to men who have sex with men in Ho Chi Minh City.

Key informants raised the potential of UNICEF to advocate for sexual and reproductive health information within the Ministry of Education, given its respected international status in promoting health and well-being for young people. Through UNICEF, approaches that may be seen by some as too progressive or subversive can be transformed into a less politicized and more acceptable agenda with a focus on promoting children's health:

"Yes, sexual health, exactly; so, turn that into a positive healthy behaviour. That's UNICEF's power as an agency and can be useful for healthy behaviour."

PARENTAL AND PEER SUPPORT

Young people generally do not discuss issues around sex, HIV or sexuality with their parents. In those few cases described in which youth did disclose challenges to their parents, they reported interactions that were less than supportive and led to bearing the brunt of their parents' prejudices. In a few cases, however, supportive siblings were specifically identified, who played a crucial role in YKP's feeling accepted and validated, including in their health-promoting decisions about HIV prevention and HIV testing.

A key informant representing YKP explained:

"They figure it out by themselves, like through the Internet or asking organizations; but they don't talk to parents, as parents have prejudices."

Students across FGDs, including male, female and transgender students, shared their perspectives and experiences in the huge gap between generations, and if they did reach out to their parents, they often did not feel supported when they disclosed information. They further recounted siblings who contracted HIV, and were then discriminated against by their families:

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"Due to the differences between the two generations, sharing was difficult. The gap between parents and children is still substantial for both sides and hard to take initiative and raise their voices."

"I have talked to them, and they told me to get married when they heard that I was pregnant. Many families demand their daughters not to have sex before marriage. They can love but they cannot have sex."

"Never discussed with parents because they have a negative attitude toward intercourse/sex. When the teachers reported me to my parents for smoking, they [my parents] only asked if I was addicted and demanded me to quit."

"One of my siblings is a sex worker. When she contracted HIV, people in my family forbid every interaction with her and said that we must use all sorts of 'protective gear' like gloves to avoid direct contact."

A young gay man described the challenges he experienced growing up in his family, including not being accepted and even being taken to a doctor to 'change' his sexual orientation. He explains now feeling accepted by his family, though still experiencing stigma from the local community:

"When growing up until being a teenager, I had no one to share with. My parents blamed my 'bad' attitude and expression on my uncle's faults. They thought he had affected me and made me imitate his conduct. To be honest, my uncle has a strong love passion, and he is still sad for his past relationship. My parents even took me to the doctor. They cannot accept that I am gay. However, they fully understand my sexual identity now. Still, in my neighbourhood, people keep talking impolitely about me in front of my house, which my grandmother hears and tells me."

Another YKP participant recounted constantly being joked about by peers and struggling to find social and emotional support. While finding some self-expression in dressing up, he tried to share this with his mother, but reported a lack of communication and understanding:

"I don't share with anyone since people have already known, and I have been familiar with receiving jokes. Sometimes, when I went to showcase and put on makeup, I usually brought photos home for my mother. But I don't think my mother truly understands that I am emotionally attracted by men."

In FGD 4, a few YKP participants described key support from older siblings:

"My uncles often teased me about my relationships with others. I am an introvert, so I don't usually talk to my parents, except my elder brother. When he knew my sexual identity, he supported me to come out. I feel my life is completely normal and comfortable."

"When I brought home a demonstration of HIV testing, my older brother absolutely approved of HIV prevention."

"My sister is a tomboy, who dresses and lives like a boy and has a girlfriend. For me, it's completely normal, but my parents find it very unusual and abnormal. And they told me to persuade my sister to change but I didn't."

Even as key informants and youth described a greater degree of openness with their peers, they generally described peer support as being very limited. This was reported to be due to a combination of AYKP's caution in anticipation of negative reactions or rejection if they were to disclose being LGBT, and the lack of accurate information about sex, HIV and sexuality among peers. Discussions about HIV and prevention measures, as well as sexuality, are often shared as a joke among adolescents, with HIV seeming unrelated or relatively unimportant in the context of the broader challenges they face:

"The talk about HIV and how to prevent it often comes out as a joke, because they don't really have any knowledge of this. So, they tend to avoid this discussion because of their parents. And this may not be a concern to them in comparison to other problems."

"The situation depends on the intimacy of the teenager with his or her peers. First thing, they will go to the community of people like them to ask for help, to ask for advice, to ask for who they really are. After they figure out who they really are, they will consider if they should tell their parents or friends since there is still discrimination. Because social media is spreading, they will use that to connect to community-based organizations."

Youth from both YKP FGDs similarly described lack of communication with peers around sex, HIV and sexuality more broadly:

"There are absolutely no straightforward discussions among friends in class on the above matters, only jokes surrounding them."

"My current class has a girl who has short hair and loves a girl. Many times, I wanted to ask her but I was afraid that she would be shy, especially because she does not have much interaction with other classmates."

YKP also described the need to hide their sexual orientation due to stigma within their peer groups:

"My friends who see me going with gay, lesbian, and transgender people usually ask me whether I am gay or not. I answer that I am not gay, and that going with them does not mean I am gay."

Peers who were generally outside of youths' immediate social circle were described as playing a very constructive role through peer support and community-based HIV prevention initiatives. Youth 'champions' were described as effective role models for health and well-being, and HIV prevention. Peer-led interventions also emerged as effective in reaching communities of youth through peer networks that are not always adequately covered by social media. Peers were also described as effective in helping to bridge the challenging online-offline gap – between information and action:

"What we have seen worked well in some of the communities for testing and PrEP is peer support. So, champions who can relay those messages are found in the community. That's the snowball approach, I think it seems to be the most productive."

"What we have seen from the programmes on community-based testing and PrEP was that it was the most successful when it was peer driven … when people talk in public with other people. That's where you can see that more people are coming forward to information and services. That's obviously the most powerful."

However key informants also cautioned about the importance of investing in, training and paying peer workers, rather than solely relying on them as volunteers. They noted challenges due to emotional overload and the high rotation among peers as many move on to better jobs after a short time:

"The challenge is the resources. You know that you need to invest in the peer, train them and then sustain that pool and pay for what they do, and not just to rely on voluntary services, which is not fair. And that's often the high rotation of peer educators, because they find a better job. [Being a peer educator] is not well paid and it is just a few incentives. It is also not easy work, because most of it should be done in the evenings or the weekends because people are working or only available at night or during the day on weekends. So, services and peer outreach needs to be, too, but it's an investment in people. Of course that also requires the sustained investment. I found that's a challenge to do it on a sufficient scale and organize it in a way that's efficient."

"What I like to think with new technologies is that you keep going … in other areas where UNICEF is working you could have a virtual network, but with face-to-face meetings and events, to empower groups of young people. So, there could be different ways to do this nowadays. There is an out-dated model of training of trainers (ToT) and [we could] retrain them in a few years … but young people should be asked for more effective approaches."

"There's a need for awareness raising initiatives and we need to reach out to young people [in a] more systematic way. For example, in Ho Chi Minh City there are a lot young people on the move, many universities and many people come from different cities where they found many new infections."

Informants further described hybrid approaches that could engage technology along with peer leaders or peer educators and suggested that new ideas may best come from youth themselves. They also described challenges for HIV prevention in urban areas in Viet Nam, such as Ho Chi Minh City, with a lot of migration from other parts of the country and young populations on the move. A related challenge was that of the provincial nature of the healthcare system, such that youth who move to new areas are often not covered by public health insurance, with various rules and requirements that they transfer registrations. These often become barriers to receiving services, as they are not able to afford easier to use private providers or clinics:

COMMUNICATION

The Internet and social media were described as broadly used by young people and YKP. Activities included information-seeking and social media as well as sexual networking. Key informants and youth described opportunities as well as limitations of social media as a source of information regarding sexual and reproductive health and HIV prevention. In the absence of 'official' information from schools, these online sources filled a gap; however, it was sometimes difficult for adolescents and youth to distinguish accurate information from pervasive myths and stereotypes. Several initiatives were described in attempts to harness social media and apps to bring relevant sexual and reproductive health and HIV prevention information to young people, with varied levels of success.

Viet Nam

Typically, regular use of apps was described as beginning around age 16 in high school, or even earlier:

> "They are often in high school, when they are 16 and over; but there are cases of being 14."

However, in the absence of comprehensive information from trusted sources offline, youth described challenges in navigating the huge volume of material available online:

> "Considering the truthfulness of the information on the Internet, it is complicated to distinguish between a genuine and an unreliable source, not to mention the troubles of tracking down the original sources of information. This has resulted in many misunderstandings."
>
> "I know about these issues, but my friends don't, and after looking up on the Internet, the information given is contradictory with the information given by the office."

YKP and key informants described online apps as important avenues for young MSM and transgender persons to find others with the same gender identity or sexual orientation, and in turn to help them to realize they are not alone. Many other YKP described the apps as largely used for finding sexual partners.

Key informants described widespread use of apps and social media, as well as the role of social media in breaking isolation among YKP:

> "Apps are very common in Viet Nam. MSM or transgender persons are at least connected to one social media or app."
>
> "Transgender youth not only figure out they are different when in high school but also even earlier. Like primary school. They feel they are different from others. I remember cases of transgender youths, and that their parents were hopeful that the boys would have a bright future as a male. But the transgender youth eventually realizes they don't like to mix with other male friends. So years later, when they find out they want to be female, they are frightened to share this with their parents and family, and many think of committing suicide. But they search on the Internet to find very small groups/networks who have the same gender identity as them and it helps them realize they are not the only people in the world."

Across FGDs, youth including AYKP described their varied uses of social media apps for making friends and sometimes leading to sexual encounters.

In one case, a young college student described his experience of being bullied online, and his reaction not to disclose this to anyone due to a combination of embarrassment and fearing disclosure or rumours about his sexuality:

> "Got flirted and then threatened to be beaten up; after that, I locked my Facebook account and made another one. I did not share this with anyone else because it was personal."

Key informants representing YKP described the **different purposes and strengths of social media and online apps,** and strategic use of both to reach YKP more broadly, while also needing to be cautious in preserving users' confidentiality in broader online forums:

"These apps are mostly used for a one-night stand or sex partner. We can advocate through the apps about prevention. But the most advocacy we do is through Facebook, not those apps like Grindr. We can advocate and provide knowledge, but we have to pay for the app. The thing about Facebook, though, is that it is too inclusive – for everyone – so promoting there may not be the best way. So, we may also promote through apps, such as Jack'd. We provide information in closed groups on Facebook."

"Three to five years earlier we had many websites like 'Green Apple'. But with the increase of Facebook users, and that it is so accessible, most people prefer to go to Facebook for information instead of these websites."

Key informants also reported that even with these apps, sometimes YKP were not reached early enough, nor with sufficient uptake of information:

"We researched at Hanoi University among young MSM and the average age of MSM was 23 years old. Maybe you are looking for younger age, but the young people infected at that age didn't receive prevention awareness."

Youth also described the impact of broader media, like television, in helping to dispel stigma and promote alliances across sexual and gender minorities and heterosexual youth:

"I have heard LGBT terms since 2011, from a programme on VTV6 channel shared by ... the Web Tao Xanh project. The information from the programme has altered my early perspectives of LGBT communities. After that, I joined Thanh Hoa Province LGBT community. Since 2012, I have supported friends and people of Thanh Hoa province LGBT community and helped them go to colleges in Hanoi."

Key informants and youth described several initiatives using social media and apps to address sexual health and HIV prevention, including successes as well as challenges. These included the cost of hosting information on online apps amidst under-resourced CBOs, the fact that not all youth access these apps – particularly outside urban areas – and the broader challenge of bridging online use and offline behaviours, such as HIV testing:

"I know some groups are trying to develop social media tools that are more attractive for young people. I remember one of the CBOs here in Hanoi was doing some – I think it was a social app – game with information, I think it was for MSM. I think it doesn't cost too much money actually, and might be useful to invest some resources in."

"Social media is used widely by NGOs and CBOs in cities, but not all people are on social media. There were some studies done on social media by Hanoi Medical University recently, I think around MSM, trying to encourage people to come to testing. So, they reached a lot of people and a lot of people showed interest, but when people have to start to register, you know and then at the end they contacted us and hundreds of people replied, it looked promising; but then two registered. Social media is good to spread the message but it does not necessarily lead to behaviour change or changes in how to access services. So, I think it is a useful avenue of course, but it is not sufficient."

Along these lines, a college student shared:

> "I would use the information because I prefer [to be] anonymous, I only want to reveal my identity when I go to the hospital."

One effort that appears to help bridge the online-offline gap is supported by VUSTA. Through the app, young people can contact the VUSTA Project to learn about HIV testing onsite, with another option to have an HIV test kit delivered to their home. VUSTA also hosts a live streaming introduction on how to use HIV tests and where to find HIV testing in the community:

> "Even now we have a delivery option to send an HIV test to the person's home if they contact us. We will provide two means of advising service. First is online, where we host live stream introduction on how to use the test and where to find the tests. And if someone is shy and doesn't want to show themselves, the organizations will go to their homes and help them."

VUSTA ONLINE TESTING INFO/OFFLINE SUPPORT

Vietnam Union of Science and Technology Associations
"The Vietnam Union of Science and Technology Associations (VUSTA) is a socio-political organization of the Vietnamese science and technology intellectuals. VUSTA is organized and operates under the principle of voluntarism and democracy. VUSTA is the biggest network of non-governmental science and technology organizations in Vietnam (http://www.vusta.vn/en/about/introduction.html).

"HIV services including HIV community testing, differentiated care, PrEP and PEP (post-exposure prophylaxis) using both fee-based and non-free based models are provided by private clinics and key population-led CSOs (civil society organizations) under PEPFAR (President's Emergency Plan for AIDS Relief) and Global Fund/VUSTA support." (Country Operational Plan, Viet Nam, March 2018, p. 80)

Key informants discussed more broadly the availability of national and international resources to support HIV treatment, and the lack of resources and support for HIV prevention initiatives in Viet Nam.

They detailed some enthusiastic pilot initiatives that are celebrated with much fanfare, but also detailed the serious challenges in scaling up such pilot programmes without resources and sustained support. Overall, PrEP was described as an important new prevention technology, but one that must be resourced and integrated as part of combination prevention, including substantial scaling up of presently available HIV treatment:

"Yeah, no not for prevention. Of course, treatment support is there, but for prevention."

"PrEP availability is expanding in some cities, but slowly; and it is still new in Viet Nam. It is currently free or subsidized (funded by donors) and it is not yet clear how it can be further scaled up and become sustainable – and, if not free, how many people will be able to access it. It is great for individuals to protect themselves from HIV, but to have an impact at the population level, we need a combination approach with other prevention methods – condoms, behaviour change – and scaling up of HIV and STI treatments."

MENTAL HEALTH

Youth and key informants described broad challenges for mental health among adolescents and young people, particularly YKP. Informants described some focus in Viet Nam on children's mental health issues, including developmental challenges and difficulties within families, but the wholesale absence of youth-friendly mental health services for adolescents and young adults.

Some YKP described challenges and information was presented about high rates of suicide attempts among transgender youth, however, cultural norms were described as eschewing professional or even volunteer mental health services. Mental health professionals were described as rare, such that locating a mental health provider with competence in working with LGBTIQ youth was largely not possible. Rather, care was often left to unlicensed community volunteers, many of whom had little if any training and lacked competence in addressing issues around sexuality and gender. Similarly, there appeared to be an absence of mental health initiatives for people living with HIV:

"According to the latest survey of 2018 about transgender people in the provinces in Viet Nam, with 232 interviews, 60 per cent have talked about suicide and 30 per cent had attempted suicide from one to five times."

"Their willingness to share their stories, or their unwillingness, because they always hide them, because Vietnamese society still has discrimination toward the LGBT community."

"It's rare in Viet Nam to find licensed psychologists because that service is not common, even for general populations. So in other cases, therapists or psychologists don't really have much knowledge on the [LGBT] community. Therefore, it leads to consequences like speaking with that community might be taken as inappropriate. It is more severe in key populations."

"The medical people working in the field [psychology] are very limited, and culturally, depression is not taken seriously. If you are sad you are told to be brave and you will get through this. So, if a child has depression, the parents won't take them to the clinics."

Local community efforts to address mental health (and general health) challenges were described, including the National HIV Programme and YKP peer-led initiatives. "In the regional area they have 38 provinces and if they want to get the support they can go to the local provider. They cannot provide licensed psychiatrists but the ones providing support are volunteers."

"That is one of the limitations that is recognized by the national programme. I am speaking about the approach used by the National HIV Programme. For urban areas, they rely more on CBOs and community networks; but for the mountainous areas … they rely more on primary health care workers' networks. Those are not healthcare workers but more of collaborators of the healthcare system. So, those people are based in each of the villages and know the population of that village."

Viet Nam

Key informants representing YKP organizations described their efforts to reach out:

> "Our group, although they are not licensed, will try to help or observe someone who is depressed to keep the person from committing suicide. But if they do not wish to accept help, our group won't force it."

Moving forward, key informants described the importance of collecting data and developing evidence about adolescent health more broadly in Viet Nam, and the important role that UNICEF and other United Nations agencies could play in promoting that effort. They further discussed the need for developing and initiating programmes to address mental health issues faced by people living with HIV, including adolescents and youth. Finally, they described the need to broaden international funding for HIV prevention programming in Viet Nam overall, and the challenges in coordinating such efforts to make sure that AYKP are adequately resourced and reached:

> "Generating general information about adolescents, which may include health, nutrition, HIV and AIDS. That way we could understand better the situation and then we can position where and what we are going to support. So, first evidence on adolescent health; that's something that we have to work on."
>
> "For my understanding, it focuses on children's mental health issues, not HIV/AIDS."
>
> "I think it is also relating to how the services are organized because I think CBOs are 99 per cent funded through VUSTA/The Global Fund. But how we ensure that the coverage is optimized and the frequency of services reaching the right people who need the services the most is not clear and is sensitive. There is also a bit of competition among CBOs to get funding."

RECOMMENDATIONS

Education

1. Broadly target public schools with SRHR information sessions and programmes; these can build on existing models at some international schools in which student/youth unions in school settings partner with youth services or YKP organizations outside of schools to hold monthly meetings and educational programmes.
2. Institutionalize quality CSE as part of the regular school curricula and monitor its implementation.
3. Promote full and meaningful participation and feedback of adolescents and young people, including AYKP, on CSE in both in-school and out-of-school settings.
4. Engage teachers in CSE initiatives, including those organized in collaboration with outside organizations, in order to promote and provide education to adolescents on SRH, including sexual development, puberty and HIV/STI prevention.
5. Promote and expand trainings and capacity building for teachers, a crucial component of effective CSE implementation in schools, to address and overcome significant barriers in teachers' willingness to offer CSE to students. This requires a national commitment to allocate funding for training of teachers.
6. Closely monitor and provide technical support to teachers in using interactive, youth-participatory methods in teaching CSE.
7. Address stigmatization and bullying of AYKP and LGBTIQ youth, as well as harassment and violence from those present in the academic environment, including peers and teachers.
8. Promote gender-responsive education and youths' capacity for informed decision-making through CSE programmes delivered in schools that address reproductive health, sexuality, healthy relationships, and respecting sexual and gender diversity, including LGBTIQ youth.
9. Provide accurate and reliable information to young MSM and other AYKP in existing and expanded youth-friendly clinics in order to counteract myths and misconceptions about STI transmission and condom use, and to promote awareness of oral PrEP.
10. Allocate greater resources and expand capacity building for existing CBOs through a multi-pronged strategy to more effectively promote affirmative support and information for AYKP, and scale up sexual and reproductive health education.

Parental and peer support

1. Develop and promote interventions targeting parents to raise their awareness about SRHR and sexuality, so parents can become sources of information and support rather than transmitters of prejudice and discrimination towards AYKP, including in their own families.
2. Expand existing peer education programmes to include and capacitate siblings to serve as sources of support for family members, including their siblings who are LGBTIQ and/or living with HIV.
3. Strengthen and expand existing peer education programmes to cover broader geographical areas (in rural and mountainous areas outside major cities) as well as to include new communication technologies to provide accurate SRHR information, support, and HIV/STI prevention inclusive of AYKP.
4. Support and expand peer-led (youth-to-youth) interventions, including AYKP-led initiatives, as an effective method for reaching adolescents, youth and AYKP, and for helping to bridge online-offline gaps between SRHR information and action.
5. Design and tailor gender-responsive HIV/STI education and prevention programmes for adolescents, youth and AYKP, to address differential needs and social and healthcare contexts of urban and rural youth.

Communication

1. Promote educational resources and public health interventions for adolescents and youth that capitalize on widespread use of online platforms and social media as sources of information on SRHR, gender, sexuality, and HIV prevention.
2. Incorporate visual contents – videos, infographics, memes – in online media to promote SRHR and HIV prevention for general youth, and tailored for AYKP, that are less reliant on the written word.
3. Develop gender-responsive, interactive websites using professional help in collaboration with young people to share youth sexual and reproductive health problems, and mental health challenges.
4. Pilot and implement programmes that effectively bridge online information (HIV/STI risk) and offline action (getting tested), including measures to protect user confidentiality.

5. Capacitate youth organizations to develop and evaluate youth-oriented SRHR and HIV prevention apps to foster their social media presence and to better meet the needs of young people via online activities.
6. Promote training of trainers (ToT) in student councils to provide cascade training to students to expand peer support mechanisms, as well as trainings to youth outside of schools.
7. Train school counsellors to provide information and support about SRHR and HIV.
8. Develop and advocate policies and laws that combat cyberbullying and online harassment of youth.

Mental health

1. Advance professional training and increase competencies among programme employees and volunteers – including the Ministry of Education and Training (MOET), Ministry of Health (MOH), and Ministry of Labour, Invalids and Social Affairs (MOLISA) programmes – to address broader needs for adolescent mental health and to enable them to work effectively with LGBT youth, including urban, rural and less accessible mountainous areas.
2. Provide resources and capacity building for YKP peer-led mental health initiatives, including outreach and peer support, to AYKP, including LGBTIQ youth.
3. Train and sensitize healthcare providers to develop supportive attitudes and competencies in providing services to AYKP.
4. Allocate resources and professional staff, both in-country and through United Nations and other agencies, to initiate and support data collection in order to develop baseline evidence about adolescents' (including AYKPs') mental health and priority needs across Viet Nam.
5. Develop and implement urgently needed programmes to address mental health issues faced by people living with HIV, including adolescents and youth.
6. Expand and better coordinate funding streams for HIV prevention programming in Viet Nam, including from international donors, to ensure adequately resourced, broad and integrated coverage of AYKP.

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