Advancing Inclusion of Sexual and Gender Minority Youth in Family Planning and Sexual and Reproductive Health Programs

Insights to Action Brief

USAID
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Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

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Acronyms

AFAB	Assigned female at birth
FP	Family planning
CBO	Community-based organization
CSO	Civil society organization
CSE	Comprehensive sexuality education
HCD	Human-centered design
HIC	High-income country
HIPs	High Impact Practices in Family Planning
LARC	Long-acting reversible contraception
LGBTQIA+	Lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and more
LMIC	Lower- and middle-income country
MAAYGO	Men Against AIDS Youth Group
NGO	Nongovernmental organization
PYD	Positive Youth Development
SBC	Social and behavior change
SEM	Socio-Ecological Model
SGBV	Sexual and gender-based violence
SGM	Sexual and gender minority
SOGIESC	Sexual orientation, gender identity, gender expression, and sex characteristics
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
USAID	United States Agency for International Development

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Background

The global health and development community increasingly recognizes the health experiences, priorities, and needs of sexual and gender minority (SGM) youth and other youth with diverse sexual orientation, gender identity, gender expression, and sex characteristics (SOGIESC) **(Box 1)**.[1] Compared to their cisgender and heterosexual peers, SGM youth experience far reaching health disparities, including elevated rates of poor immune and cardiovascular function, substance use and misuse, sexually transmitted infections (STIs), violent victimization (e.g., bullying, forced sex), and adverse mental health outcomes (e.g., anxiety, depression, self-harm).[1–3] Although most evidence comes from high-income countries (HICs),[4] emerging evidence from lower- and middle-income countries (LMICs) reveals similar health disparities among SGM youth.[1,5]

Contextualizing these health disparities within the context of a region or country can further clarify why SGM people experience such health issues and outcomes **(Box 2)**.[6,7] Growing global evidence supports a strong association across all country contexts between stigma, prejudice, discrimination, and violence based on SOGIESC and negative health issues and outcomes among SGM people.[1,5] The restrictive sanctions on SOGIESC diversity, as evidenced by discriminatory laws and policies that disadvantage and criminalize SGM people,[8,9] some of which condone imprisonment and death,[10] bolster stigma, prejudice, discrimination, and violence based on SOGIESC and worsen health disparities.[1,11]

Box 1. Defining Sexual and Gender Minority Youth

SGM youth are people aged 10–29* years who do not identify as cisgender, heterosexual, and/or with the categories upheld by the sex/gender binary (i.e., male/female, man/woman). Given this brief's global audience, it uses the acronym "SGM" to be inclusive of the full spectrum of people with diverse SOGIESC and moves away from the acronym LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual, and more), which originated in HICs. While SGM people have diverse SOGIESC, not all people with diverse SOGIESC identify as SGM people. Consulting with SGM and SOGIESC-diverse people and SGM-serving organizations about appropriate terminology is a good practice in implementation contexts.

Definitions of key terms used throughout this brief are included in **Appendix 1**.

* USAID defines youth as people between the ages of 10 and 29 in the USAID Youth in Development Policy.[19]

With youth representing more than 60% of the population in LMICs and SGM youth more likely to conceal their SOGIESC due to safety and security concerns,[1,12,13] family planning (FP) and sexual and reproductive health (SRH) programs implemented in LMICs have a critical role to play in reducing FP/SRH and related health disparities among these youth. Programs that are more inclusive of SGM youth can support them in navigating complex and conflicting social and gender norms regarding SOGIESC, and are better equipped to respond to their health experiences, priorities, and needs, and also improve their FP/SRH access and outcomes.[1,14] However, global evidence shows that SGM youth remain largely excluded and underserved by FP/SRH programs implemented in LMICs,[15–18] which primarily focus on their cisgender and heterosexual peers **(Box 3)**. This technical brief considers what can advance the inclusion of SOGIESC diversity and SGM youth in FP/SRH programs implemented in these country contexts.

Box 2. Contextualization of Health Disparities Among SGM People

Gender as a core social determinant of health functions differently for men, women, and people with other genders.[20] Gendered pathways to health include (1) gender-related differences in exposures; (2) gendered health behaviors (such as hazardous masculinities and toxic femininities); (3) gender impacts on accessing health care; (4) gender-biased health systems; and (5) gender-biased health research, institutions, and data collection. All of the pathways have implications for health issues and outcomes.[21] For SGM people, the stigma, prejudice, discrimination, and violence they experience based on SOGIESC profoundly impacts their health issues and outcomes.[6]

To learn more about context and how it impacts overall health issues and outcomes among SGM people, consult these resources:

- LGBTQI+ Inclusive Development Policy (USAID)
- The Sustainable Development Goals: Sexual and Gender Minorities (United Nations Development Programme)
- State-Sponsored Homophobia 2020: Global Legislation Overview Update (ILGA World)
- Social Acceptance of LGBTI People in 175 Countries and Locations 1981-2020 (The Williams Institute)
- Migration Experiences of People with Diverse SOGIESC (United Nations Women)
- Global LGBTQ Health: Research, Policy, Practice, and Pathways (Springer)
- A Primer on LGBTQ+ Health Disparities (Eidos LGBTQ+ Health Initiative)

Box 3. Inclusive and Equitable Youth Engagement in FP/SRH Programs

The High Impact Practices in Family Planning (HIPs) briefs build global consensus and describe practices that are scalable, sustainable, and serviceable across diverse implementation contexts. Several of these briefs focus on youth engagement in FP/SRH and underscore the value of inclusion and equity in partnering with youth in all their diversity, meaning across their intersecting identities.* To date, there is little mention of SGM youth in the HIPs briefs, which reinforces the prioritization of cisgender and heterosexual youth.

- Meaningful Adolescent and Youth Engagement and Partnership in Sexual and Reproductive Health Programming: A Strategic Planning Guide (HIP Partnership)
- Adolescents: Improving Sexual and Reproductive Health of Young People: A Strategic Planning Guide (HIP Partnership)
- Adolescent-Responsive Contraceptive Services: Institutionalizing Adolescent-Responsive Elements to Expand Access and Choice (HIP Partnership)
- Discussion Paper on Equity for the High Impact Practices Partnership (HIP Partnership)

* Intersectionality is a framework that recognizes and examines the interconnected nature of social identities—such as race, gender, class, disability, age, sexuality, among others—and systems of oppression. Intersectionality acknowledges individuals simultaneously hold multiple social identities and therefore can simultaneously experience multiple forms of oppression like racism, sexism, classism, ableism, ageism, homophobia, and transphobia.

Purpose

This technical brief contributes thinking and guides action for advancing the inclusion of SOGIESC diversity and SGM youth* in FP/SRH programs implemented in LMICs.† This brief summarizes insights from learning and assessment activities conducted by the Breakthrough ACTION project and recommends priority actions to design and implement FP/SRH programs in LMICs that are more inclusive and equitable **(Box 4)**.

The brief is intended for program implementers working at the intersection of FP/SRH, positive youth development (PYD), and social and behavior change (SBC), or otherwise working to improve FP/SRH access and outcomes among youth. The insights and actions in this brief most directly apply to program design and implementation by health nongovernmental organizations (NGOs) working with multi-level partners and stakeholders, including funders, governments, and communities. Health NGOs include civil society organizations (CSOs), community-based organizations (CBOs), and other locally led organizations, working across implementation settings (e.g., schools, health facilities, communities, online platforms) to improve health access and outcomes according to what is most appropriate for the implementation context. Program implementers can apply these insights and actions to advance the inclusion of SOGIESC diversity and SGM youth in FP/SRH programs and improve FP/SRH access and outcomes among youth in all their diversity.

To learn more about the guiding conceptual frameworks and the development process for this brief, refer to **Appendices 3** and **4**.

* In line with learning and assessment activities, this brief focuses on SGM youth and does not address other SOGIESC-diverse youth. Though the content of this brief can also apply to other SOGIESC-diverse youth, relevant programs should conduct additional learning and assessment activities to understand their unique lived experiences.

† In line with learning and assessment activities, this brief focuses on youth-focused FP/SRH programs. Though the content of this brief can also apply to age-expansive FP/SRH programs that engage youth, such programs should conduct additional learning and assessment activities to understand similarities and differences in programmatic responses.

Box 4. Priority Actions for Advancing Inclusion in FP/SRH Programs

1. Partner with SGM-led and SGM-serving organizations and SGM youth throughout program design, implementation, and evaluation.
2. Prioritize well-being, safety, and security in partnership with SGM-led and SGM-serving organizations and SGM youth.
3. Promote representation and inclusion of SGM youth across the full spectrum of SOGIESC diversity.
4. Conduct SGM-inclusive situational assessments to define program strategy and approach for the implementation context.
5. Integrate SOGIESC diversity and SGM-specific FP/SRH experiences into program activities and materials.
6. Partner with influential groups to promote inclusion and reduce stigma, prejudice, discrimination, and violence towards SGM youth.
7. Create opportunities for meaningful engagement and leadership among SGM youth.
8. Document and disseminate evidence to build the global evidence base on SGM youth's FP/SRH experiences and programmatic responses.

Insights: Key Findings and Considerations

The learning and assessment activities revealed critical information about SGM youth's FP/SRH experiences, priorities, and needs in LMICs. The key findings and considerations are summarized here. Because these findings and considerations reflect information gathered during the learning and assessment activities, they are by no means exhaustive; however, they are a useful starting point for further inquiry and research.

Box 5. Evidence Spotlight: Barriers to Health Care-Seeking Among Men Who Have Sex with Men in Malawi

In Malawi—where the government criminalizes consensual same-sex sexual acts—a staff member with an SGM-serving organization recounted a young client who disclosed they were gay and had sex with men to a health provider during a health facility visit. In direct violation of client-provider confidentiality, the provider reported the client to the police. This incident spread across social networks of men who have sex with men in country, reinforcing the risk of disclosing one's non-normative SOGIESC and/or same-sex or same-gender relationships to providers.[17] As such, SGM youth who anticipate stigma, prejudice, discrimination, or violence at health facilities have lower health care-seeking behavior and/or conceal their non-normative SOGIESC from health staff and providers.[11,39]

Stigma, prejudice, discrimination, and violence profoundly impact SGM youth's FP/SRH access and outcomes. Compared to their cisgender and heterosexual peers, SGM youth experience elevated rates of sexual and gender-based violence (SGBV), including psychological, emotional, physical, sexual, and economic violence, perpetrated by partners and non-partners (e.g., family members, schoolmates, teachers, police officers, strangers),[22–26] which can put them at higher risk for STI transmission and unintended pregnancy.[2,27–29]

Specific examples of SGBV based on SOGIESC include so-called "conversion therapy" and "corrective rape," both of which aim to coerce people into changing or suppressing any aspect of their SOGIESC that communities may not consider the norm in a particular context.[30,31] Beyond the stigma, prejudice, discrimination, and violence that youth already experience in accessing FP/SRH care in LMICs,[15,16] SGM youth have a compounded experience based on SOGIESC.[17,18] Regarding FP/SRH access, existing laws and policies that disadvantage and criminalize SGM people also hinder and deter SGM youth from seeking health services.[10] Regardless of whether laws criminalize SOGIESC diversity, health systems, facilities, services, staff, and providers largely reflect the same social and gender norms, values, and beliefs that reinforce cisnormativity and heteronormativity in broader society.[21,32,33] As a result, they primarily recognize and cater to cisgender and heterosexual people, which also hinders and deters SGM youth from seeking services.[11] SGM youth who seek services at health facilities risk facing stigma, prejudice, discrimination, and violence from staff and providers.[34,35] For example,

health staff and providers may assume they are cisgender and misgender them, even after being corrected; this and other assumptions by staff and providers not only result in inaccurate data collection when taking client health histories—which can harm the client—but also represent a lack of respectful, affirming, and competent care.[1] Additionally, the lack of health staff and providers sensitized and trained in SGM-inclusive care limits their awareness and responsiveness to their FP/SRH experiences, priorities, and needs.[17,36] Instances of disclosure, misgendering, and lack of respectful, affirming, and competent care have been documented in FP/SRH services in LMICs such as China, India, Iran, Malawi, South Africa, Turkey, and Uganda **(Box 5)**.[1,17,26,37,38]

Limited access to respectful, affirming, and competent FP/SRH education and care profoundly impacts SGM youth's body and health literacy and bodily and reproductive autonomy. SGM youth have limited financial resources for accessing FP/SRH care[39] and limited opportunities to learn about themselves, their bodies, and their right to health from trained educational and health professionals.[40] SGM-serving organizations struggle to address this gap, since they often operate with scarce resources and in restrictive contexts where laws, policies, and norms make it difficult to work publicly with SGM youth.[41]

Box 6. Evidence Spotlight: FP/SRH Experiences and Outcomes Among SGM Women and People Assigned Female at Birth

Globally, lesbians, bisexual women, women who have sex with women, and people assigned female at birth face individual and interpersonal barriers to FP method uptake and use, which are mediated by the vulnerabilities they experience based on SOGIESC—such as being socialized and/or perceived as women and identifying as SGM individuals—and other intersecting identities. Individually, they may believe that long-acting reversible contraception methods and barrier methods (such as condoms) may not be necessary for them. Interpersonally, they may experience SGBV, intimate partner violence, and/or reduced ability to negotiate method use.[2,43,44] Underuse of these methods, whether voluntary or involuntary, can heighten their risk of STI transmission and/or unintended pregnancy, depending on sexual partners.[44]

Limited opportunities for learning in safe, supportive environments hinder development of body and health literacy[‡] and bodily and reproductive autonomy among SGM youth.[16] Lower body and health literacy makes youth less knowledgeable about their FP/SRH experiences, priorities, and needs, while lower bodily and reproductive autonomy[§] renders youth even more vulnerable to coercion and violence, with serious implications for STI transmission and

[‡] Body literacy refers to being educated and familiar with one's body through observing, learning, and understanding. Health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.

[§] Bodily autonomy is having the power to decide and control what does and does not happen to one's body. Reproductive autonomy means having the power to decide and control contraceptive use, pregnancy, and childbearing. For example, people with reproductive autonomy can control whether and when to become pregnant, whether and when to use contraception, which method to use, and whether and when to continue a pregnancy.

unintended pregnancy **(Box 6)**.[22] Comprehensive sexuality education (CSE) which is age appropriate and context specific supports youth to advocate for their health and well-being by equipping them with necessary knowledge, skills, and abilities. However, its implementation is often limited and not SGM-inclusive in LMICs, particularly those within more restrictive contexts (e.g., discriminatory laws and policies).[16,40–42]

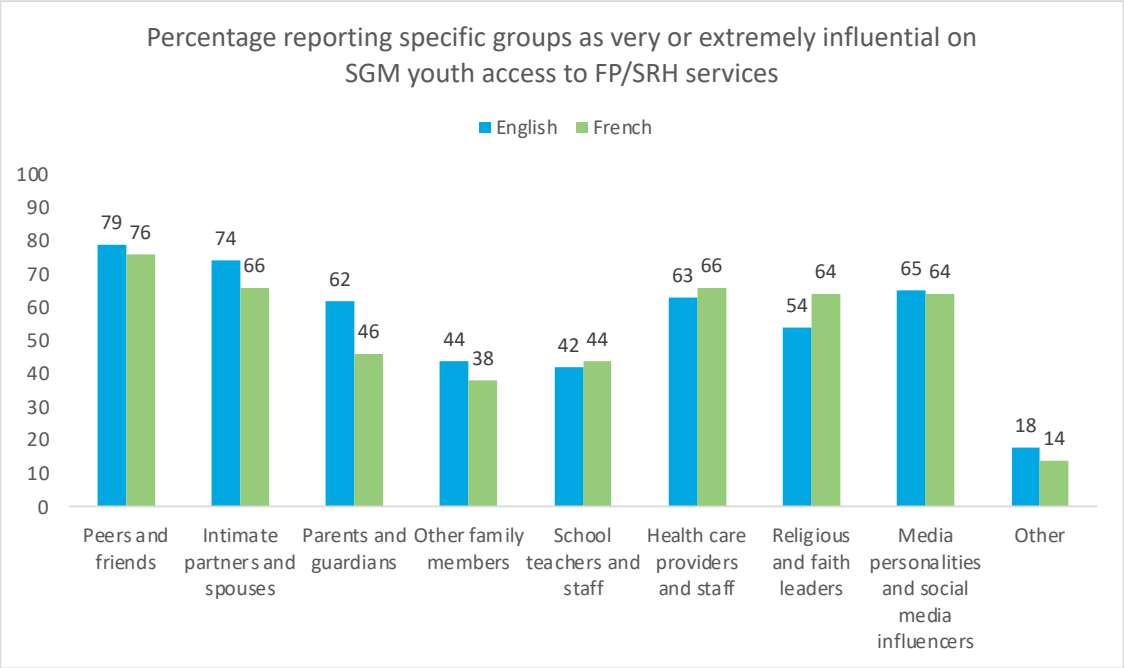

Figure 1. Groups influential upon SGM youth access to FP/SRH services: English and French Survey Results.[41] Of those surveyed, 150 responded in English and 60 in French. Percentages have been rounded to the nearest whole number.

Peers and friends, intimate partners, health staff and providers, religious and faith leaders, and the media significantly influence SGM youth's FP/SRH access and outcomes. Breakthrough ACTION survey respondents listed these individuals and groups as most influential **(Figure 1)**. Similarly, desk review findings and workshop/learning series participants identified these groups as facilitators and/or barriers to FP/SRH access, depending on whether they accept or reject SGM youth.[41] Knowing that SGM youth risk being disowned by their families and experience SGBV at home and school, programs that support these youth necessitate working with and reducing stigma among parents, guardians, and other family members, as well as school staff and teachers.[16,45] The buy-in and support of these influential adults can lead to scaling up and sustaining CSE implementation in schools—as well as other formal and informal education settings—and making it more SGM-inclusive.[16,46] Given the prevalence of discriminatory laws and policies towards SGM people, police officers emerged as another influential group in the desk review and among workshop/learning series participants due to their role in law enforcement.[16,41,47,48]

FP/SRH programs and services in LMICs largely exclude and underserve SGM youth, and such programs that are SGM-inclusive are limited and not well documented. Examples of SGM-inclusive FP/SRH programs and services were scarce in the literature, and survey results echoed

this,[1,49] with the exception of HIV/AIDS programs that work with and support men who have sex with men and transgender women.[2,6] Of these, few programs focused on reducing stigma, prejudice, discrimination, and violence toward SGM youth, despite their profound impact.[16] Workshop/learning series participants confirmed this critical gap in programmatic approach.[41] Survey respondents reported that the FP/SRH information and services most available to youth in their communities are comprehensive SRH education, FP/RH counseling and care, and violence prevention and response. Survey respondents working for SGM-serving organizations (125 English survey; 55 French survey) reported the services most offered to youth are comprehensive SRH education, FP/RH counseling and care, STI counseling, diagnosis, and treatment, and violence prevention and response. More than half of these respondents also reported offering mental health and psychosocial support. The least common services included social support services and gender-affirming treatments and procedures. These findings were confirmed by learning series participants; however, respondents also reported that these information and services are largely not SGM-inclusive.[41] When information and services are SGM-inclusive, they mostly cater to gay, lesbian, and homosexual people, trailed distantly by bisexual and transgender people, with little to no attention to people with other diverse SOGIESC (such as intersex, nonbinary, asexual, and pansexual).** Importantly, discriminatory laws and policies also impact whether FP/SRH and related information and services are accessible, available and/or legal, especially in the case of transgender people seeking gender-affirming treatments and procedures.[10,35,39] As previously discussed, the lack of health staff and providers sensitized and trained in respectful, affirming, competent, youth-friendly, and SGM-inclusive care significantly contributes to SGM youth being excluded and underserved.[6,39]

SOGIESC terminology varies according to audience, purpose, and context. In the Breakthrough ACTION survey, when presented with a list of SOGIESC terms,†† most respondents reported not knowing whether youth with whom they work self-identify using these terms, with the exception of male, female, heterosexual, and homosexual.[41] Some respondents reported other terms they encounter in their work, including fluid, genderqueer, queer, demiboy, anyone on the LGBTIQ+ spectrum, gender non-conforming, male and female persons that don't want to be labeled, agender, and sapiosexual.[41] This finding reveals the need for program implementers to be more intentional in surveying youth about how they self-identify and what SOGIESC terms they use across implementation settings and contexts. During the learning series, participants discussed how SOGIESC terminology varies according to audience, purpose, and context. Umbrella terms like gender minorities, sexual minorities, and key populations are used in lieu of LGBTQIA+ and its derivatives to avoid unwanted attention, especially in contexts where diverse SOGIESC is highly stigmatized and/or criminalized.[41] Results from the learning and assessment activities reinforced the need for consulting SGM-led and SGM-serving organizations and SGM youth about which SOGIESC terms to use, according to audience, purpose, and context.[50]

** The terminology used here reflects that used in the survey.

†† Terms included: female, male, intersex, heterosexual, homosexual, bisexual, pansexual, asexual, cisgender (either woman/girl or man/boy), transgender woman/girl, transgender man/boy, and non-binary.

International donors and funders, international NGOs, and local CSOs are most likely to champion inclusion of SOGIESC diversity and SGM youth in FP/SRH programs. Survey respondents reported these groups to be most likely to champion inclusion efforts, and also reported national donors and funders and national and local governments to be least likely to do so **(Figure 2)**.[50] Learning series participants shared that national and local governments in LMICs can erect significant barriers to SGM inclusion, especially when introducing and passing discriminatory laws and policies.[41,47] Discriminatory laws and policies negatively impact SGM youth and SGM-led and SGM-serving organizations, whose employees can face direct threats or registration revocation.[41,47]

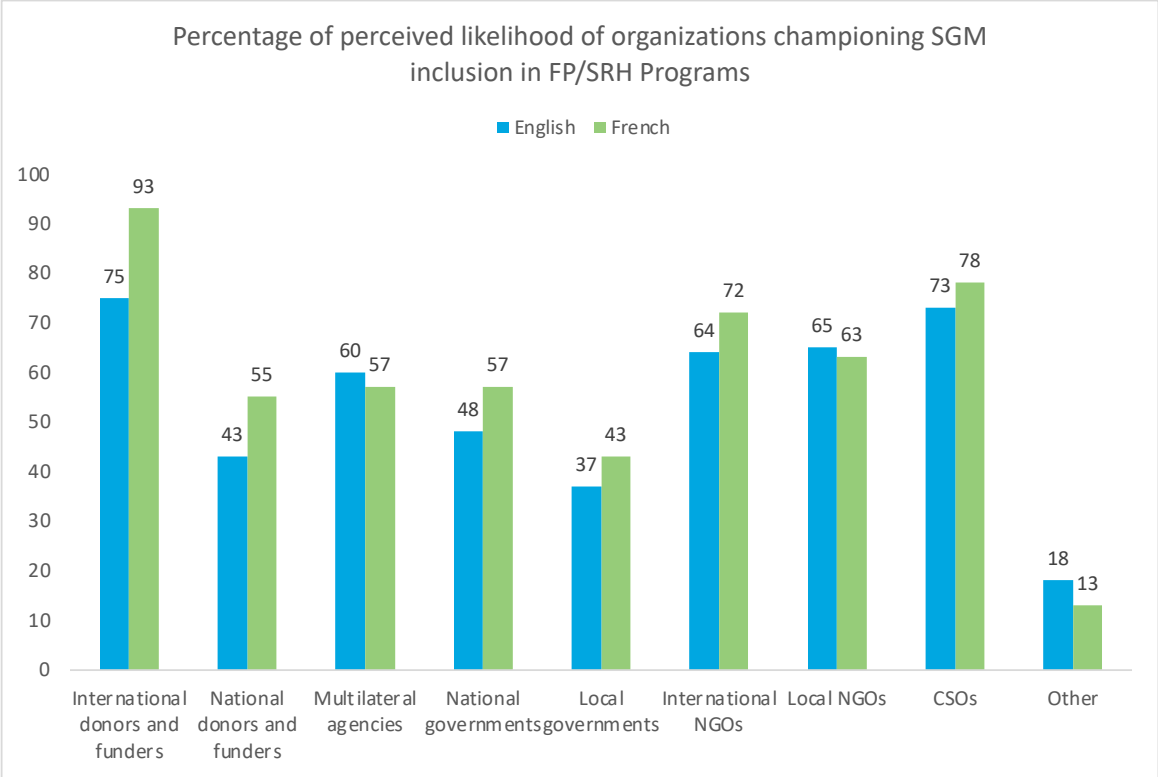

Figure 2. Perceived likelihood of organizations championing SGM inclusion in FP/SRH programs: English and French Survey Results.[41] Of those surveyed, 150 responded in English and 60 in French. Percentages have been rounded to the nearest whole number.

Limited evidence is a significant barrier in designing high-quality, evidence-based FP/SRH programs that are SGM-inclusive. The desk review revealed limited evidence of FP/SRH experiences, priorities, and needs among SGM youth, as well as SGM-inclusive FP/SRH programs in LMICs.[1] During the learning series, participants confirmed the limited evidence and lack of high-quality, evidence-based programs.[41] Challenges to conducting research and building the evidence base include the following:

- Discriminatory laws and policies that hinder obtaining ethical approval from government-run institutions for research with SGM youth on their FP/SRH experiences.[41]
- High levels of stigma, prejudice, discrimination, and violence that drive SGM-led and SGM-serving organizations and SGM youth to be protective and private for their safety and security.[41,51]

- Limited research methodology for collecting data about SOGIESC diversity, especially among youth and related to FP/SRH, that is contextually specific and globally aggregable.[5,50–53]
- Lack of strength-based approaches in research with SGM people that acknowledge positive supports and strengths and protective factors.[51,54,55]
- Lack of political will, capacity, and financing for SGM-inclusive, equity-centered research.[47]

Although the evidence base is growing steadily, the field needs more research on the FP/SRH experiences, needs, and priorities of SGM youth in LMICs so it can better determine how to develop effective and appropriate programs that are inclusive and equitable.[5,24]

Priority Actions: Advancing Inclusion in FP/SRH Programs

Based on the insights outlined in the previous section, Breakthrough ACTION identified the following priority actions to advance the inclusion of SOGIESC diversity and SGM youth in FP/SRH programs implemented in LMICs. These actions supplement existing guidance for youth engagement in FP/SRH programs in LMICs—such as the PYD approach and framework[19,56,57] and HIPS[58–60]—and focus on what programs need more of to include SGM youth. Those who are less familiar with existing guidance are encouraged to review it and then return to this brief.

To consider how to apply priority actions throughout SBC program design, implementation, and evaluation, refer to **Appendix 4**.

ACTION 1: Partner with SGM-led and SGM-serving organizations and SGM youth throughout program design, implementation, and evaluation.

Program implementers must prioritize local leadership and ownership when designing, implementing, and evaluating FP/SRH programs to be more inclusive of SOGIESC diversity and SGM youth.[61] As the actors and entities that are mostly directly affected, SGM-led and SGM-serving organizations and SGM youth—both formal and informal networks—should lead and guide program design, implementation, and evaluation. Because many communities and institutions overlook and disempower SGM youth, meaningful youth engagement[tt] can positively influence their personal and professional development.[19] Program implementers should carry out all of the actions that follow in this section in partnership with these organizations and youth. Additionally, programs should schedule regular opportunities to plan

[tt] Youth engagement is "an inclusive, intentional, mutually respectful partnership between youth and adults whereby power is shared and respective contributions, including young people's ideas, leadership, perspectives, skills, and strengths, are valued."[19]

and prepare for program closeout and sustainability. Thoughtful planning and preparation can support the work's transition as safely and securely as possible, while also empowering organizations and youth to continue the work independently.

ACTION 2: Prioritize well-being, safety, and security in partnership with SGM-led and SGM-serving organizations and SGM youth.

To contend with prevalence of stigma, prejudice, discrimination, and violence towards SGM people, programs must prioritize well-being, safety, and security and apply trauma-informed approaches.[10,16] This includes conducting risk assessments and developing safety and security management plans; program implementers should perform these actions in partnership with SGM-led and SGM-serving organizations as well as with SGM youth.[10] Risk assessments can identify real and perceived threats affecting organizations and youth such as discriminatory laws and policies and local actors that perpetuate stigma, prejudice, discrimination, and violence.[62] These assessments can also identify real and perceived protections, including nondiscrimination laws and policies and local champions and allies for SGM inclusion. Safety and security management plans allow the program to monitor, track, and respond to changes in the implementation context that not only influence program design, implementation, and evaluation, but also affect SGM youth themselves.[63] These plans need to integrate child protection elements and account for how and when to refer SGM youth to health, legal, and social support services that are youth-friendly and SGM-inclusive as available.[62] Program staff and participants must receive training on the safety and security management plan and receive periodic updates as the plan is revised in response to changes in the implementation context. Existing resources like the Safety and Security Toolkit: Strengthening the Implementation of HIV Programs for and with Key Populations (LINKAGES Project) can be adapted to FP/SRH programs in consultation with partnering organizations and youth. In addition to conducting assessments and developing plans to prevent and reduce the impact of potential threats, programs should apply conflict-sensitive and trauma-informed approaches and the "do no harm" principle **(Box 7)**.[10,64,65] Recognizing that SGM youth may have a history of adverse childhood experiences, regardless of whether related to their SOGIESC, programs should apply these approaches and the "do no harm" principles to support SGM youth and create safer and supportive spaces for their personal and professional development.

Box 7. Defining Trauma-Informed Approaches

A trauma-informed approach is an active, continuous, and intentional process that requires awareness and commitment to understanding adverse childhood experiences and related experiences among SGM youth. The guiding principles for this approach are: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) cultural, historical, and gender issues.[64] Programs can apply tools like the Trauma-Informed Youth-Centered Health Design framework to supplement other health, safety, and security considerations.[65] This framework integrates principles from the trauma-informed approach, PYD, and human-centered design (HCD) to ensure inclusive, intentional, mutually respectful partnership with youth throughout program design and implementation.

ACTION 3: Promote representation and inclusion of SGM youth across the full spectrum of SOGIESC diversity.

Programs need to account for the full spectrum of SOGIESC diversity throughout program design, implementation, and evaluation.[10,62] In practice, this means working with SGM-led and SGM-serving organizations to consider the full spectrum of SOGIESC diversity and then safely and securely identifying and learning about SGM youth and their FP/SRH experiences in the implementation context.

In addition to SOGIESC diversity, programs need to consider other intersecting identities (e.g., race, class, disability, age) held by SGM youth.[10] SGM youth will have different FP/SRH experiences based on their SOGIESC and other intersecting identities, as well as the extent to which different actors and entities know or perceive their non-normative SOGIESC. Recommended practices to ensure SOGIESC-diverse representation among partners and participants include:

- Creating a youth advisory board representing as much SOGIESC diversity as possible, as well as other intersecting identities, both to inform program design, implementation, and evaluation and to guide safe, inclusive, and equitable decision making and execution.[16,62,66]
- Developing participant selection criteria that ensures representation and participation of SGM youth in all their diversity in the program.
- Employing purposeful recruitment and retention strategies to reach and engage SGM youth in all their diversity throughout the program.[62]
- Creating opportunities for SGM youth to report any changes in their SOGIESC and other intersecting identities over time and shifting programmatic response accordingly.[51]

ACTION 4: Conduct SGM-inclusive situational assessments to define program strategy and approach for the implementation context.

SGM-inclusive situational assessments prioritize learning about (1) the enabling environment for the inclusion of SOGIESC diversity and SGM youth in FP/SRH programs and services across the Socio-Ecological Model (SEM) in a specific region and country—both barriers and facilitators (e.g., laws and policies, influential groups, social and gender norms)—and (2) the full spectrum of SOGIESC diversity among SGM youth and their FP/SRH experiences, priorities, and needs in the implementation context. Findings from risk assessments should be integrated with those from situational assessments to comprehensively inform program design, implementation, and evaluation. Situational assessments should also adopt a strengths-based approach, rather than a deficit-based approach, to identify positive supports and strengths and protective factors, such as resilience.[51,54,55] For example, a strengths-based approach can identify sources of resilience among SGM youth that support their well-being, safety, and security, in the face of stigma, harassment, discrimination, and violence.[54] Applying an intersectional lens to these assessments can deepen understanding of context-specific barriers and facilitators (e.g., laws and policies, influential groups, social and gender norms) to FP/SRH access and outcomes among SGM youth in all their diversity.[10,51] Existing tools and resources can be applied or adapted to conduct these assessments in partnership with SGM-led and SGM-serving organizations and SGM youth **(Box 8)**.

Box 8. Conducting SGM-Inclusive Situational Assessments

These tools and resources can be applied or adapted to conduct situational assessments. These assessments can and should be updated throughout the program in response to changes in the implementation context.

- ILGA World Database
- Gender Data Portals (Monitoring and Action for Gender Equity Project)
- Rapid Gender Analysis Toolkit (CARE)
- Diverse SOGIESC Rapid Assessment Tool to Assess Diverse SOGIESC Inclusion Results in Humanitarian Contexts (United Nations Women)
- Intersectional Rapid Gender and Protection Analysis Workbook and Toolkit (Youth Excel)
- Is Your Health System Adolescent- and Gender-Responsive? A Participatory Tool for Analysis and Action Planning (MOMENTUM)
- Social Norms Exploration Tool (Passages Project)
- Resources for Measuring Social Norms: A Practical Guide for Programme Implementers (Social Norms Learning Collaborative)

ACTION 5: Integrate SOGIESC diversity and SGM-specific FP/SRH experiences into program activities and materials.

Program implementers can use findings from risk assessments, situational assessments, and other sources, to inform the design and implementation of program activities and materials. Conducting stakeholder workshops with SGM-led and SGM-serving organizations, SGM youth, and other key stakeholders, can further inform program activities and materials. Program implementers may need to conduct stakeholder workshops separately with different groups (e.g., SGM youth, parents and guardians, health staff and providers, teachers) to protect the well-being, safety, and security of SGM youth and other partners. These workshops will support idea generation and integration that is context-specific and culturally responsive. Prior to integrating ideas into program activities and materials, programs should determine whether they pose any risk to well-being, safety, and security in the implementation setting and context and adhere to the safety and security management plan in executing the work. Examples of ideas that can be integrated into programs across diverse implementation settings and contexts are included in the following list and in **(Box 9)**:

- Promoting use of gender-inclusive language across all activities and materials.
- Developing materials with inclusive graphics and visuals that respect and represent SGM youth in all their diversity (e.g., race, class, disability, age).

- Reviewing, selecting, and adapting CSE curricula and materials to include information on the full spectrum of SOGIESC diversity and examples of FP/SRH experiences, needs, and priorities among SGM youth in all their diversity.[40]
- Developing SGM-inclusive FP/SRH training curricula and materials and FP counseling guides for health providers.[39]
- Refurbishing spaces in health facilities to be more SGM-inclusive and youth-friendly or creating spaces in SGM-led and SGM-serving organizations to provide FP/SRH care.

Box 9. Program Spotlight: SGM-Led Culturally Competent HIV Prevention, Treatment, and Care in Kenya

Advocates for Youth and Men Against AIDS Youth Group (MAAYGO) applied a community-based participatory approach to equip SGM youth to sensitize and train over 100 health providers in SGM-inclusive and youth-friendly services. They also partnered with SGM youth to develop radio broadcasts about SGM-specific health information and experiences across Kenya, reaching four million people.[48] Additionally, MAAYGO engaged in advocacy efforts with decision makers like Kisumu County's Gender Technical Working Group and trained SGM youth to directly lead discussions with the technical working group, Ministry of Health officials, law enforcement representatives, media representatives, and other CSOs. As a result of these advocacy efforts, MAAYGO was allotted space at a major health facility to provide culturally competent care to SGM youth and became an official member of the technical working group. These and other program activities increased awareness and understanding of the health experiences, priorities, and needs of SGM youth among decision makers and community members and resulted in improved health access and outcomes among SGM youth.

Existing tools and resources can be applied or adapted to integrate SOGIESC diversity and SGM-specific experiences into FP/SRH programs and services **(Box 10)**.

Box 10. SGM Inclusion in FP/SRH Programs and Services

Program implementers can apply or adapt these tools and resources to integrate SOGIESC diversity and SGM-specific experiences into FP/SRH programs and services. Efforts to integrate SOGIESC diversity and SGM-specific experiences can and should be revisited throughout program implementation in response to changes in the implementation context and feedback from partnering organizations and youth.

- Gender Integration Continuum (Interagency Gender Working Group)
- Diverse SOGIESC Continuum (Edge Effect)
- Gender Equality Check-in Tool (Breakthrough ACTION)
- Consider Gender and Social Inclusion in Your SBC Programs Checklist (FHI360)
- CSE Curriculum Review, Selection and Adaptation (UNESCO)
- Transgender and Gender-Diverse Inclusion in USAID-Supported Family Planning and Sexual and Reproductive Health Service Delivery (Agency for All)
- Taking a Transgender-Inclusive Sexual Health History (Bedsider Providers)
- A Provider Self-Assessment Tool to Measure Gender Competency for Family Planning Services (Data for Impact)

ACTION 6: Partner with influential groups to promote inclusion and reduce stigma, prejudice, discrimination, and violence towards SGM youth.

Program implementers identify influential groups for FP/SRH access and outcomes among SGM youth through risk assessments, situational assessments, and other sources. To inform program strategy and approach, programs should work with SGM-led and SGM-serving organizations and SGM youth to prioritize influential groups across the SEM. When selecting influential groups for outreach and engagement, the well-being, safety, and security of SGM youth and other partners must remain a priority at all times. For example, in a more restrictive context with discriminatory laws and policies that criminalize SGM people, working with police officers may not be safe, despite their essential role in law enforcement and their potential ability to remove barriers to FP/SRH access and use among SGM youth. Programs must adhere to the principle of "do no harm" in outreach and engagement with influential groups.[10] During the Breakthrough ACTION learning series, a participant reported that challenges with shifting discriminatory laws and policies to be more inclusive of SGM people led them to embrace more local solutions.[41] Instead, they partnered with SGM youth to increase resilience and strengthen capacity for FP/SRH self-care, and also worked with supportive family members

and social networks to bolster social support for SGM youth.[41] As such, program implementers must avoid making assumptions about which influential groups are supportive or unsupportive of SOGIESC diversity and SGM youth and should monitor and track any changes in support levels across influential groups.[67] Religious and faith leaders have emerged as "unlikely allies" with the power to raise awareness and influence attitudes, beliefs, and norms known to impact FP/SRH access and outcomes among SGM youth **(Box 11)**.[16,68–70]

Box 11. Engaging Religious and Faith Leaders in SGM Inclusion in Kenya and South Africa

Church World Service's Safe Space Program engages religious leaders in Kenya and South Africa to promote respectful inclusion of people in their communities.[71–73] The program engages religious leaders in discussions about HIV, SGBV, and other health issues and experiences that are relevant to SGM people and then gradually introduces discussions on SGM rights.[71] The Safe Space Program also conducts educational outreach and engagement with the families of SGM people to reduce stigma and create a safer home environment.[71] To date, most engagement with religious and faith leaders focuses on sensitization and training; however, countries like Kenya are providing models of how to engage them in supporting the safety and protection of SGM people.[74]

To learn more about how to engage religious and faith leaders in SGM inclusion, consult these resources:

- Building Bridges in Development: USAID's Strategic Religious Engagement Policy
- Faith-Based Efforts in East Africa to Combat Discrimination Based on Sexual Orientation and Gender Identity

ACTION 7: Create opportunities for meaningful engagement and leadership among SGM youth.

Programs can create opportunities for SGM youth to experience meaningful engagement and leadership in support of their personal and professional development.[60] These opportunities must prioritize well-being, safety, and security at all times and offer channels for SGM youth to provide feedback and make complaints.[10] Channels to provide feedback and make complaints safely and securely can positively influence SGM youth's self-confidence, self-efficacy, and willingness and ability to meaningfully contribute to programmatic efforts.[56,57] Examples of opportunities include co-design workshops, co-led activities, and fellowships. Co-design workshops engage SGM youth as thought partners in program design, generating ideas and providing input on activities and materials. In particular, the HCD process can be applied to co-design workshops and to further bolster youth engagement and leadership. Existing resources like the Gender Equity Today for Youth Pilot Package, which uses an HCD process,

can be adapted to FP/SRH programs that are inclusive of SOGIESC diversity and SGM youth in consultation with partnering organizations and youth. Co-led activities ensure SGM youth are directly engaged in activity implementation and leading decision-making processes **(Box 12)**. SGM youth engagement and leadership is particularly empowering when implementing program activities and materials aimed at influential groups and intended to promote inclusion and reduce stigma, prejudice, discrimination, and violence towards SGM youth.[67] Lastly, fellowships are funded, short-term opportunities for SGM youth to gather and learn with peers in a safe and supportive environment, and also participate in personal and professional networking.

These and other opportunities value SGM youth as lived experience experts and support them in developing knowledge, skills, abilities relevant to improving their FP/SRH access and outcomes. They can be more or less publicly visible depending on the implementation setting and context and related safety and security concerns. In settings and contexts where SGM youth may be more publicly visible, they can further benefit from networking and advocating with actors and organizations at local, state, national, and global levels. As an example, an SGM-inclusive fellowship program in East Africa[§§] equipped youth with the essential knowledge, skills, and abilities to become effective FP/SRH advocates in their respective countries.[41] Fellowship participants reported increased awareness and understanding of the FP/SRH experiences, priorities, and needs among SGM youth. Additionally, SGM youth participants reported improved capacity to lead and advocate for SGM inclusion in FP/SRH in their countries and continue to serve as youth FP/SRH champions in their countries and in international fora.[41]

Box 12. Program Spotlight: Youth Leading SGM-Inclusive CSE Implementation in India

The YP Foundation's[75] Know Your Body, Know Your Rights Program builds and strengthens youth's leadership on promotion and implementation of the SGM-inclusive CSE curricula of the same name in underserved communities, as well as advocacy on youth's access to FP/SRH information and services at local, state, and national levels.[76] Youth advocates generate bottom-up demand for CSE implementation in formal and informal education settings through outreach and engagement with communities, youth-led and youth-serving organizations, schools, and government. The program works with these two age groups: (1) adolescents aged nine to 13 years and (2) adolescents aged 14 years and older.[76] An external evaluation revealed that program participants, including SGM youth, increased body and health literacy relevant to their SOGIESC, increased self-confidence, and improved negotiation skills for effective advocacy.

[§§] Due to safety and security concerns, the organization's name is not mentioned to protect its identity.

ACTION 8: Document and disseminate evidence to build the global evidence base on SGM youth's FP/SRH experiences and programmatic responses.

Program design, implementation, and evaluation generate evidence that can be further documented and disseminated to build the global evidence base. Accounting for the full spectrum of SOGIESC diversity in formative research and data collection is necessary to produce accurate and meaningful data.[51,77] Engaging SGM-led and SGM-serving organizations and SGM youth in all aspects of research design and implementation supports local capacity building and strengthening as well as sustainability and scale-up. In addition to training them in research design and implementation, programs can partner with them in conducting research priority setting exercises, analyzing and interpreting data, and disseminating findings to decision makers and community members. Most existing research guidance on SGM-inclusive research focuses on adults and not youth, which presents an opportunity for programs to develop, test, and refine data collection tools to be youth-friendly.[53,77] Programs can also adopt youth-friendly research methodologies to facilitate SGM youth participation in research.[78–80] For example, narrative methods like storytelling can generate rich data, especially around social and gender norms, that can be applied to programmatic and advocacy efforts.[80] Examples of youth-driven storytelling include African Queer Love is Love, Courage to Share, and Global Dialogues. Existing tools and resources can be applied or adapted to integrate SOGIESC diversity and SGM-specific experiences into FP/SRH research **(Box 13)**.

Box 13. SGM Inclusion in FP/SRH Research

Program implementers can apply or adapt these tools and resources to integrate SOGIESC diversity and SGM-specific experiences into FP/SRH research. Efforts to integrate SOGIESC diversity and SGM-specific experiences can and should be revisited throughout research implementation in response to changes in the implementation context and feedback from partnering organizations and youth.

- To Whom It May Affirm: Considerations for Advancing LGBTQIA+ Equity in Research (RTI International)
- Inclusive Survey Design: Collecting Data on Gender and Sexual Minorities (DHS Program)
- Sexual Orientation and Gender Identity Measures for Global Survey Research: A Primer for Improving Data Quality (MEASURE Evaluation)
- Transgender and Gender-Diverse Inclusion in USAID-Supported Family Planning and Sexual and Reproductive Health Research Activities (Agency for All)
- Explore: Toolkit for Involving Young People as Researchers in Sexual and Reproductive Health Programmes (Rutgers)
- Gender Responsive Monitoring and Evaluation for Health Programs, Interventions, and Reforms (MAGE)

Conclusion: The Way Forward

This brief summarizes insights and recommends actions to design and implement FP/SRH programs in LMICs that are more inclusive of SGM youth and their experiences, needs, and priorities. Insights underscored the profound impact of stigma, prejudice, discrimination, and violence on health issues and outcomes among these youth on a global scale, and also a lack of evidence and documentation to support the design and implementation of high-quality, evidence-based programs that are more inclusive and equitable. Most FP/SRH programs in LMICs continue to exclude and underserve these youth and primarily focus on their cisgender and heterosexual peers. Positively, recent programmatic efforts are proving effective in leveraging and building on positive supports and strengths and protective factors to improve FP/SRH access and outcomes among SGM youth in countries like India and Kenya.[48,76]

Health NGOs at the global, regional, national, and local levels have an essential role to play in advancing the inclusion of SOGIESC diversity and SGM youth in FP/SRH programs in LMICs. By partnering with multi-level partners and stakeholders, including funders, governments, and communities, these organizations can implement and scale up more inclusive and equitable

programs. They can raise awareness, support advocacy, and take actions to be more responsive to the experiences, priorities, and needs of SGM youth in the implementation context. Program implementers who apply these insights and actions will advance the inclusion of SOGIESC diversity and SGM youth in FP/SRH programs and improve FP/SRH access and outcomes among youth in all their diversity.

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Appendix 1: Key Terms and Definitions

This list is by no means comprehensive. There are many more terms in use that represent the full spectrum of identities among SGM individuals and individuals with diverse SOGIESC. Language is constantly evolving and changing over time.

KEY TERMS	WORKING DEFINITIONS
Agender	An individual who has an internal sense of being neither male nor female nor some combination of male and female. An individual whose gender identity is genderless or neutral.
Asexual	An individual who experiences little or no sexual attraction towards people of any gender.
Cisgender	Individuals whose gender identity corresponds to the sex and gender they were assigned at birth, commonly based on the appearance of external anatomy. For example, an individual who identifies as a woman and was assigned woman at birth based on sex characteristics that are categorized as female.
Cisnormativity	The assumption that everyone's gender identity is the same as the sex and gender they were assigned at birth and that those for whom this is not the case are considered "abnormal." The assumption that all people are or should be cisgender.
Demiboy	An individual whose gender identity aligns partly with a masculine identity but doesn't conform entirely to the binary concept, irrespective of their assigned gender.
Demigirl	An individual whose gender identity aligns partly with a feminine identity but doesn't conform entirely to the binary concept, irrespective of their assigned gender.
Gender affirming	Relating to actions, practices, or interventions that validate, respect, and support an individual's self-identified gender and/or gender identity.
Gender-affirming services	Gender-affirming services consist of an array of services that may include medical, surgical, mental health, and non-medical services for individuals to feel supported and affirmed in their gender identity. Avoid using the following terms: "sex reassignment surgery" and "gender reassignment surgery." Examples of such services include hormone therapy, puberty suppression, hair removal, speech therapy, and surgeries (e.g., chest reconstruction surgery).

KEY TERMS	WORKING DEFINITIONS
Gender diverse	A term used to describe individuals whose gender identity and/or gender expression are not the same as the sex and gender they were assigned at birth. This may include people who identify as transgender, nonbinary, gender expansive, gender fluid, gender nonconforming, and others who do not identify as cisgender.
Gender dysphoria	Gender dysphoria is the feeling of significant discomfort or distress related to one's sex and gender assigned at birth. Gender euphoria is the feeling of significant rightness or comfort with one's sex assigned a birth, gender identity, or gender expression.
Gender expression	The external manifestations of gender, expressed through such things as names, pronouns, clothing, haircuts, behavior, voice, body characteristics, and more.
Gender fluid	An individual whose gender identity and/or gender expression evolves and changes over time.
Gender identity	An individual's internal, deeply held sense of their own gender.
Gender expansive, Genderqueer, Gender nonconforming	An individual whose gender identity and/or gender expression expands beyond, actively resists, and/or does not conform to the gender binary.
Gender minority	Individuals whose gender identity (man, woman, other) or expression (masculine, feminine, other) is different from the sex and gender they were assigned at birth.
Heteronormativity	The assumption that everyone's sexual orientation is towards individuals of the opposite sex/gender per the binary, and those for whom this is not the case are considered "abnormal." The assumption that all people are or should be heterosexual.
Heterosexual	An individual who is emotionally, romantically, or sexually attracted primarily to people of the opposite sex/gender per the binary. For example, a man is primarily attracted to women and a woman is primarily attracted to men.
Homophobia	Prejudice or hatred toward gay, lesbian, bisexual, and/or queer people, expressed in speech or actions. Intolerance, bias, or prejudice is usually a more accurate description. Homophobia can manifest structurally (e.g., discriminatory policies and practices), socially (e.g., harassment and violence), and/or internally (e.g., internalized prejudice).

KEY TERMS	WORKING DEFINITIONS
Intersectionality	A framework that recognizes and examines the interconnected nature of social identities—such as race, gender, class, disability, age, sexuality, among others—and systems of oppression. Intersectionality acknowledges that individuals simultaneously hold multiple social identities and therefore can simultaneously experience multiple forms of oppression like racism, sexism, classism, ableism, ageism, homophobia, and transphobia.
Intersex	Someone who, due to a variety of factors, has reproductive or sexual anatomy that do not seem to fit the binary categories for the female or male sex. Some people who are intersex may identify with the gender assigned to them at birth, while many others do not.
LGBTQIA+	An acronym for lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual, and other identities that do not fit within the binary categories upheld by the sex/gender binary (male/female, man/woman). There are many other variations of this acronym that are used in different contexts, including LGB, LGBT, and LGBTQA.
Misgender	To refer to someone using a word, pronoun, or name that does not correctly reflect their gender identity. This is offensive and harmful. To accidentally misgender someone can be understandable but should be corrected quickly and can be avoided with practice.
Nonbinary	An individual whose gender identity does not conform to the gender binary. "Nonbinary" can be used as an adjective or as an umbrella term encompassing several different gender identities.
Pansexual	An individual who is attracted to people independent of sex and/or gender.
Queer	An umbrella term that refers to an individual who is not cisgender and/or not heterosexual.
Questioning	For some, the process of exploring and discovering one's own sexual orientation, gender identity, and/or gender expression.
Sapiosexual	Of, relating to, or characterized by sexual or romantic attraction to intelligence.
Sex/gender binary	A system that classifies sex and gender into opposing binary categories and assumes that sex determines gender (male/man, female/woman).

KEY TERMS	WORKING DEFINITIONS
Sex assigned at birth	At birth, infants are routinely assigned a sex category (male/female). This is usually based on the appearance of their external anatomy and then erroneously linked to gender. Increasingly, there is recognition of individuals whose anatomy does not fit the typical definitions for the female or male sex. The term "sex assigned at birth" is more accurate than "sex" or "biological sex," as it recognizes that sex categories are socially constructed, rather than biologically mandated, and that the gender and sex assigned at birth do not automatically determine one's gender identity. AFAB is an abbreviation for "assigned female at birth," while AMAB is an abbreviation for "assigned male at birth."
Sex characteristics	Refers to the chromosomal, gonadal, and anatomical features of a person, which include primary characteristics such as reproductive organs and genitalia and, or in chromosomal structures and hormones; and secondary characteristics such as muscle mass, hair distribution, breasts, and/or structure.
Sexual minority	Individuals who identify as gay, lesbian, bisexual, pansexual, asexual, or who are otherwise attracted to or have sexual contact with people who are not a different sex or gender.
Sexual orientation	The desire one has for enduring emotional, romantic, and/or sexual relationships with others based on their gender expression, gender identity, and/or sex. Terms to describe sexual orientation include gay, lesbian, heterosexual, bisexual, pansexual, asexual, among others. Many people choose to label their sexual orientation, while others do not. Sexual orientation can be fluid and vary over time.
Transfeminine	A transfeminine person is a transgender person whose gender identity falls on the feminine spectrum (especially people whose gender and sex assigned at birth are man/male). Transfeminine people may or may not self-identify as women. The term transfeminine is broader than transgender woman or "transwoman" as it is inclusive of individuals whose gender identity falls along the feminine spectrum (e.g., nonbinary or genderfluid people) while not identifying as women (whether cisgender or transgender).
Transgender	Individuals whose current gender identity is not the same as sex and gender they were assigned at birth, commonly based on the appearance of external anatomy. For example, an individual who identifies as a man and was assigned woman at birth based on sex characteristics that are categorized as female. Transgender should be used as an adjective as in "transgender woman" or "transgender person." "Trans" is used as a shortened version of transgender. Avoid using the following terms: "transgenders," "a transgender," "transgendered."

KEY TERMS	WORKING DEFINITIONS
Transition	The process by which individuals, especially transgender and nonbinary individuals, support and affirm their gender and gender identity. Individuals may transition socially by, for example, changing their name, pronouns, clothing, haircut, and behavior. Transitioning may or may not involve undergoing gender-affirming services to alter body characteristics and voice. Individuals may transition multiple times in their lifetime.
Transmasculine	A transmasculine person is a transgender person whose gender identity falls on the masculine spectrum (especially people whose sex assigned at birth is female). Transmasculine people may or may not identify as men. The term "transmasculine person" is broader than the terms "transgender man" or "transman" as it is inclusive of individuals whose gender identity falls along the masculine spectrum (e.g., nonbinary or genderfluid people) while not identifying as men (whether cisgender or transgender).
Transphobia	Prejudice or hatred toward transgender, nonbinary, or other gender-diverse people, expressed in speech or actions. Intolerance, bias, or prejudice is usually a more accurate description. Transphobia can manifest structurally (e.g., discriminatory policies and practices), socially (e.g., harassment, discrimination, and violence), and/or internally (e.g., internalized stigma).

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Appendix 2: Guiding Conceptual Frameworks

Given critical linkages between the surrounding context and health issues and outcomes among SGM youth, Breakthrough ACTION used these frameworks to ensure a comprehensive, integrated approach to learning about their FP/SRH experiences, priorities, and needs and how to meaningfully account for them in program design and implementation.

Socio-Ecological Model

The SEM **(Figure A1)**[a] depicts the dynamic overlap and interactions between multiple levels of influence and factors (individual, interpersonal, community, institutional, and societal) that can shape an individual's norms, values, beliefs, and more.[b,c,d]

Figure A1. The Socio-Ecological Model

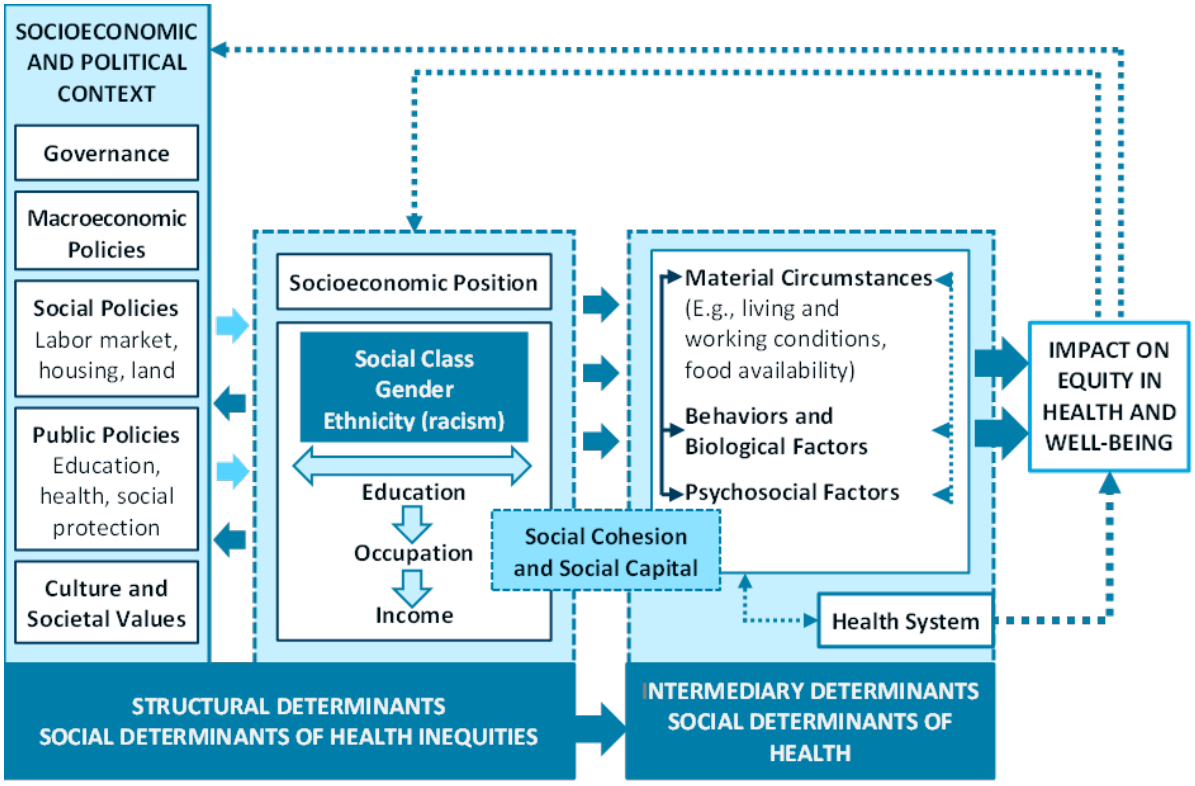

Figure A2. The Commission on Social Determinants of Health Framework. Adapted from the World Health Organization in accordance with CC BY-NC-SA 3.0 IGO.

Commission on Social Determinants of Health Framework

This framework **(Figure A2)**[e] visualizes how the context into which a person is born and lives dictates their socioeconomic position which then conditions their access to and control over assets and resources and the likelihood of exposure to health-compromising conditions.[e] It is divided into structural and intermediary determinants that are bridged by social cohesion and capital.

Gender System and Health Framework

This framework,[f] published in the *Lancet*, illustrates the "complex relationship between gender and health, including how the gender system interacts with other axes of power and privilege to determine an individual's social position and thus their health throughout life."[f]

Health Stigma and Discrimination Framework

This framework **(Figure A3)**[g] outlines the stigmatization process as it unfolds across the SEM in the context of health, which can vary across HICs and LMICs.[g] The model breaks elements down into a series of domains, including drivers and facilitators, stigma "marking," and stigma manifestations (experiences and practices), which influence wide-ranging outcomes among affected populations, organizations, and institutions and ultimately impact health and society.

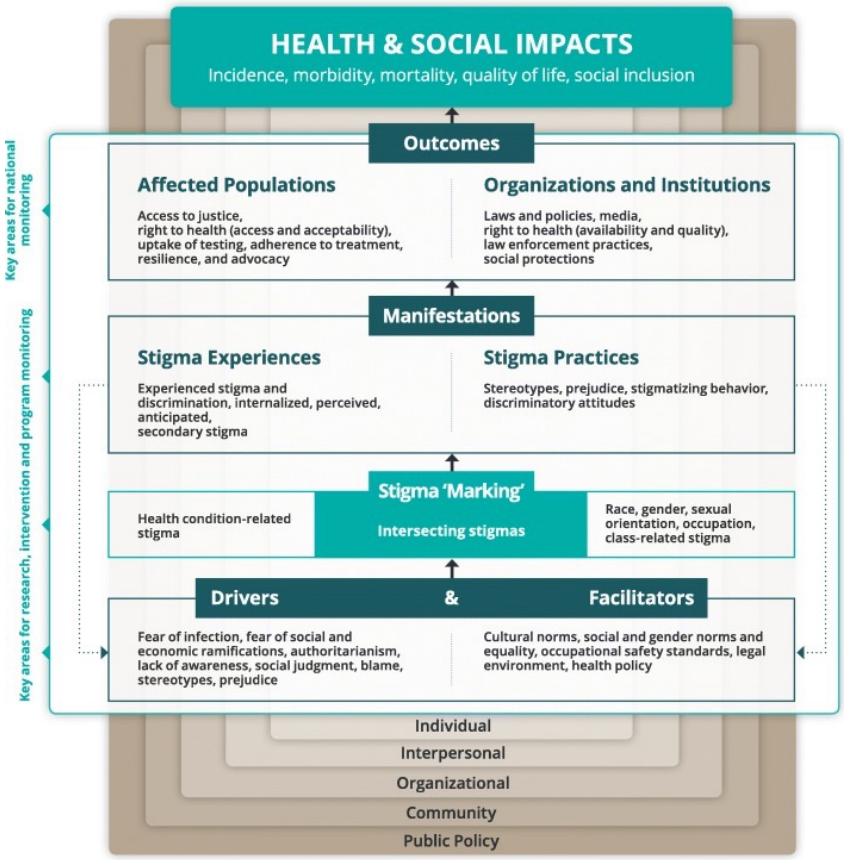

Figure A3. Health Stigma and Discrimination Framework. Reprinted from BMC Medicine in accordance with the Creative Commons Attribution (CC-BY) license.

Positive Youth Development Framework

The PYD framework (available at the YouthPower website)[h] conceptualizes how to engage youth along with their families, communities, and/or governments so that youth are empowered to reach their full potential of health and well-being. PYD approaches build skills, assets, and competencies; foster healthy relationships; strengthen the environment; and transform systems.[h,i,j] Program implementers can apply these approaches to all youth or tailor them to specific groups, such as SGM youth.

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Appendix 3: Development Process

Breakthrough ACTION conducted learning and assessment activities to better understand the FP/SRH experiences, priorities, and needs of SGM youth living in LMICs and what programs have done and can do to include them and respond to their experiences, priorities, and needs across implementation settings (e.g., schools, health facilities, communities, online platforms) and contexts. These activities included: (1) a desk review, (2) an online survey, (3) a skills-building workshop at the Women Deliver 2023 Conference, and (4) a virtual learning series. **Box A1** contains the guiding research questions for the desk review and subsequent activities.

Across all activities, Breakthrough ACTION prioritized partnering with or otherwise engaging SGM people, SGM-led and SGM-serving organizations, and youth-led and youth-serving organizations. It is worth noting the overlap in the intended audience across both types of organizations, often working with SGM youth. The project made every effort to ensure the safety and security of participants and implemented measures to protect privacy and confidentiality when collecting data and convening participants. As part of safety and security protocols, Breakthrough ACTION limited participation in these activities to individuals aged 18 and above. The perspectives and lived experiences of youth aged 18-29 years were gathered directly from participants in the same age range. As a proxy for learning about the perspectives

and lived experiences of youth aged 10–17 years, Breakthrough ACTION relied on the inputs of participants that work directly with SGM youth in this age range and/or possess lived experience from earlier in their own lives as SGM people.

Box A1. Learning and Assessment: Research Questions for Desk Review

- What are key issues in FP/SRH facing SGM youth in LMICs? And why do they exist? (Note: Includes access to and use of FP/SRH information, services, and products)
- To what extent have SGM youth been served so far by FP/SRH programs at different levels (global, regional, national, local)? And why?
- What are key considerations, lessons learned, and promising practices for supporting SGM youth and integrating their experiences, needs, and priorities into FP/SRH programs LMICs?

Breakthrough ACTION conducted the desk review in late 2022 and consulted more than 100 peer-reviewed articles and gray literature in English and French. Although the desk review intended to focus on LMICs, Breakthrough ACTION incorporated select literature from work conducted in HICs to fill in gaps in the available evidence from LMICs and identify programmatic approaches that can be adapted or applied to LMIC contexts. Following the desk review, Breakthrough ACTION conducted an online survey, in English and French, to enrich desk review findings and address remaining gaps. A total of 307 respondents (223 English survey, 84 French survey) participated in the survey across 20 countries. Respondents included local NGOs (34.9% and 50% in the English and French surveys, respectively), international NGOs (28% and 33%), government agencies (9.6% and 6%), independent consultants (6.6% and 4%), multilateral agencies (2.6% and 5%), and others (8.3% and 2%), including research organizations, CBOs, and SGM-serving organizations).

Across both surveys, most respondents worked with local or international NGOs. Most respondents reported working in a single country (78.9% English survey, 94% French survey) and within Africa. For the English survey, the most represented countries were Niger (16.1%), Nigeria (15.7%), Ghana (9.4%) and Kenya (9.0%). For the French survey, the most represented countries were Senegal (16.9%), Burkina Faso (15.7%), Benin (14.5%), and Côte d'Ivoire (9.6%).

In July 2023, Breakthrough ACTION compiled and explored the desk review and online survey findings during a skills-building workshop jointly hosted with the Agency for All project and Health Development Initiative Rwanda at the Women Deliver Conference in Kigali, Rwanda. The workshop hosted about 70 participants, including activists, advocates, program implementers, researchers, government officials, and funder representatives working in FP/SRH, HIV, violence prevention and response, PYD, SGM advocacy and inclusion, and/or SBC. Importantly, SGM youth aged 18-29 years were among participants.

As a final activity, Breakthrough ACTION co-designed and co-hosted a virtual learning series in August 2023 with an East Africa-based, youth-led health NGO focused on SRH.*** The

invitation-only learning series brought together over 35 individuals working in over 25 countries across Africa, Asia, Latin America and the Caribbean, North America, and Europe. Similar to the skills-building workshop, participants included activists, advocates, program implementers, researchers, government officials, and funder representatives working in FP/SRH, HIV, violence prevention and response, PYD, SGM advocacy and inclusion, and/or SBC. Participants included SGM individuals and youth aged 18-29 years. During the learning series, participants reviewed and discussed findings from the desk review, online survey, and skills-building workshop, and ultimately validated findings and filled in gaps where possible.

The information gathered during these activities informs the content for this brief. Importantly, these activities did have some limitations. The desk review was not systematic and primarily focused on English-language literature, including only a few documents in French. The online survey and virtual learning series were only conducted in English and French, and the skills-building workshop was only conducted in English, French, and Spanish. Survey respondents and workshop/learning series participants included cisgender and heterosexual people who do not possess relevant lived experience. Survey respondents and learning series participants tended towards those with greater access to technology and internet, while workshop participants tended towards those with greater access to travel funds through their sponsoring organizations or the Women Deliver scholarship program. Additionally, Breakthrough ACTION focused on SGM youth and did not consider other SOGIESC-diverse youth. As such, the information gathered and shared in this brief is not globally representative nor solely representative of the lived experiences of SGM youth. These limitations present opportunities for others to conduct similar learning and assessment activities to build the evidence base on SGM youth and their FP/SRH experiences, needs, and priorities, and the range of programmatic responses across implementation settings and contexts.

*** Due to safety and security concerns, the organization's name is not mentioned to protect their identity.

Apendix 4: SBC Flow Chart and Corresponding Actions

Developed by Breakthrough ACTION, the SBC Flow Chart outlines a participatory process for SBC program design, implementation, and evaluation, involving partners and stakeholders from start to finish **(Figure A4)**. Here is the mapping of the priority actions highlighted in this brief to the phases of the SBC Flow Chart: Define, Design & Test, and Apply. To learn more about each phase, consult this resource: SBC Flow Chart Introduction.

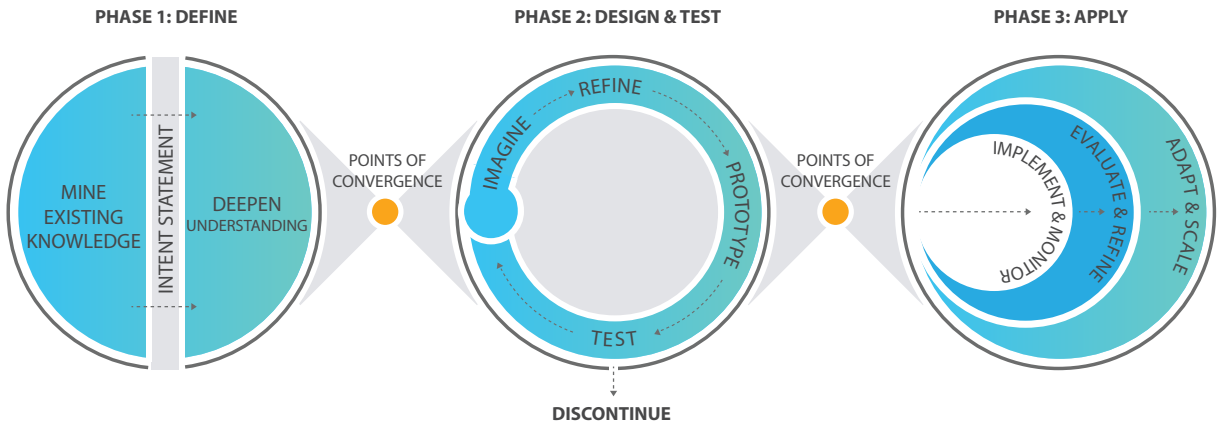

Figure A4. The SBC Flow Chart

PRIORITY ACTION	SBC FLOW CHART PHASE
Action 1: Partner with SGM-led and SGM-serving organizations and SGM youth throughout program design, implementation, and evaluation.	**Define** and understand the (SBC) problem **Design & Test** potential solution concepts **Apply** successful prototypes as activities or interventions
Action 2: Prioritize well-being, safety, and security in partnership with SGM-led and SGM-serving organizations and SGM youth.	**Define** and understand the problem **Design & Test** potential solution concepts **Apply** successful prototypes as activities or interventions
Action 3: Promote representation and inclusion of SGM youth across the full spectrum of SOGIESC diversity.	**Define** and understand the problem **Design & Test** potential solution concepts **Apply** successful prototypes as activities or interventions

PRIORITY ACTION	SBC FLOW CHART PHASE
Action 4: Conduct SGM-inclusive situational assessments to define program strategy and approach for the implementation context.	**Define** and understand the problem
Action 5: Integrate SOGIESC diversity and SGM-specific FP/SRH experiences into program activities and materials.	**Define** and understand the problem **Design & Test** potential solution concepts **Apply** successful prototypes as activities or interventions
Action 6: Partner with influential groups to promote inclusion and reduce stigma, prejudice, discrimination, and violence towards SGM youth.	**Define** and understand the problem **Design & Test** potential solution concepts Apply successful prototypes as activities or interventions
Action 7: Create opportunities for meaningful engagement and leadership among SGM youth.	**Define** and understand the problem **Design & Test** potential solution concepts **Apply** successful prototypes as activities or interventions
Action 8: Document and disseminate evidence to build the global evidence base on SGM youth's FP/SRH experiences and programmatic responses.	**Define** and understand the problem **Design & Test** potential solution concepts **Apply** successful prototypes as activities or interventions