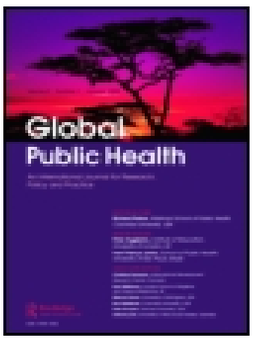

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HIV and mental health among young people in low-resource contexts in Southeast Asia: A qualitative investigation

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ABSTRACT

Young people aged 15–24 years comprise one-fourth of incident HIV infections in Southeast Asia. Given the high prevalence and impact of mental health issues among young people, we explored intersections of HIV and mental health, with a focus on adolescent and young key populations (AYKP) in Indonesia, the Philippines, Thailand, and Vietnam. Sixteen focus group discussions (4/country) with young people ($n = 132$; 16–24 years) and 41 key informant interviews with multisectoral HIV experts explored young people's lived experiences and unmet needs, existing programmes, and strategic directions for local and regional HIV responses. Cross-cutting challenges emerged in healthcare, family, school, and peer domains amid fragmented and under-resourced HIV and mental health services in socio-politically fraught environments. We identified strategic opportunities and initiatives in development and integration of youth-friendly HIV and mental health services; programmes to promote parent–adolescent communication about sex and HIV; and teacher training and resources to advance HIV and mental health awareness, serve as first-responders, and provide community referrals. Youth-led peer education programmes and LGBT-networks were central to the HIV response—promoting HIV prevention, sexual health, and mental health awareness for young people, and resilience and socioeconomic empowerment of peer educators themselves—thereby transforming sociocultural and political contexts of vulnerability.

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HIV prevention; mental wellness; LGBT youth; young people living with HIV; structural interventions

Introduction

Young people aged 15–24 years accounted for over one-fourth of incident HIV infections in the Asia-Pacific region in 2018 (UNAIDS, 2019a), home to 60% of the world's youth population (UN ESCAP, 2014). The epidemic among young people across the region, particularly in low – and middle-income countries (LMIC), is concentrated in adolescent and young key populations (AYKP): young men who have sex with men (YMSM), transgender youth, and young people who use drugs or sell sex. In the past decade, available data indicate nearly 2- to 3-fold increases in HIV prevalence among YMSM in Indonesia (from 3.8%–15.6%) (Ministry of Health, Indonesia, 2015) and Thailand (from 5.9%–11.0%) (UNAIDS, 2019b), and young transgender people in

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Thailand (from 3.4%–12.0%) (Ministry of Public Health, Thailand, 2011). HIV prevalence is estimated at 5.0% among MSM in the Philippines with a 2-fold overall increase in annual incident HIV infections (UNAIDS, 2020), and an estimated 12.2% prevalence among MSM in Vietnam (UNAIDS, 2019b). Escalating HIV prevalence among AYKP in LMIC presents substantial challenges across HIV prevention and care, more so in the context of resource-constrained mental health systems. Global estimates indicate that about 20% of adolescents and youth are affected each year by mental health issues, such as depression and anxiety; 85%–90% of these live in LMIC, and their needs are generally neglected (de Jong et al., 2015; Patel et al., 2008; UN ESCAP, 2014).

HIV and mental health are significantly and bidirectionally associated. Depression, anxiety, and post-traumatic stress disorder are correlated with HIV acquisition risk, including among young people; and young people living with HIV (YPLHIV) are at increased risk for mental health and neuropsychiatric conditions (Chibanda et al., 2016; Koegler & Kennedy, 2018; Sikkema et al., 2015). Young people in LMIC have increased vulnerability to mental illness and associated mortality owing to higher rates of HIV and adverse social determinants of health, such as poverty, food insecurity, community violence, and low access to mental health care (Lund et al., 2018; Patel et al., 2008)—challenges compounded for AYKP (Sturke et al., 2020). Positive associations between syndemic (co-occurring) psychosocial factors—such as depression, suicidality, and substance use—and HIV risk, incidence, and prevalence have been identified among young MSM in Thailand (Guadamuz et al., 2014) and Vietnam (Biello et al., 2014).

Amid expanding HIV epidemics among young people in Southeast Asia, and with mental health issues among the leading contributors to disease burden among young people globally (Mokdad et al., 2016), we explored lived experiences, unmet needs, and priorities among young people and multisectoral HIV experts in Indonesia, the Philippines, Thailand, and Vietnam, with a focus on intersections of HIV and mental health. We aimed to identify challenges and strategic opportunities for strengthening local and regional responses to the HIV epidemic among young people.

Methods

Study settings

The four countries were selected based on their being lower- (the Philippines, Vietnam) and upper-middle-income countries (Indonesia, Thailand) with disproportionate HIV incidence and prevalence among AYKP, and their existing collaborations with UNICEF's East Asia and Pacific Regional Office, other United Nations (UN) agencies, and youth-led network affiliates. Indonesia, the Philippines, and Thailand report escalating HIV transmission among young people, with a levelling off in Vietnam. The study was conducted with UNICEF and youth network involvement across all phases of the research.

Participants and recruitment

Young people in each country were recruited by staff from local community-based organisations (CBOs) and youth networks to participate in one-time focus group discussions (FGDs). Purposive sampling was used to identify adolescents and youth age 16–24 years from key populations and the broader general population. Key informants (KIs) were selected based on having expertise on AYKP and HIV within each country, and representing diverse sectors (i.e. health/mental health, education, child welfare, youth networks) and organisational types (i.e. CBOs, nongovernmental [NGOs] and intergovernmental organisations [IGOs], and government ministries).

We conducted 16 FGDs (70–90 min), four per country ($n = 132$; 71 boys/young men, 50 girls/young women, 11 transgender youth), and 41 KI interviews (60–120 min; 9–11/country) with 20 men, 17 women, and 4 transgender people (see Table 1).

Table 1. Focus group demographics and key informant sector and gender by country ($N = 173$).

	INDONESIA			PHILIPPINES			THAILAND			VIETNAM		
	Population	Age Range	Gender	Population	Age Range	Gender	Population	Age Range	Gender	Population	Age Range	Gender
FGD 1	General population	16–18	3 F 7 M	AYKP	16–18	6 M 1 TGP	AYKP	18–20	5 M 1 TGP	General population	16–18	7 F 3 M
FGD 2	General population	19–24	7 F 3 M	AYKP	19–24	4 F 3 M	AYKP	16–17	4 M 2 TGP	General population	19–24	6 F 4 M
FGD 3	AYKP	16–18	6 F 3 M 1 TGP	AYKP	16–18	4 F 1 M	AYKP	16–17	5 M 1 TGP	AYKP	16–18	2 F 5 M 3 TGP
FGD 4	AYKP	19–24	5 F 4 M 1 TGP	General population	19–24	4 F 4 M	AYKP	18–20	6 M 1 TGP	AYKP	19–24	2 F 8 M
	Subtotal FGDs		***40***			***27***			***25***			***40***
KIs	AYKP & Youth Networks; Government/ Public Health; UN		6 F 4 M	Government/ Public Health; Private Industry; UN		4 F 6 M 1 TGP	AYKP & Youth Networks; Government/ Public Health; NGO; UN		3 F 7 M 1 TGP	AYKP & Youth Networks; NGO; UN		4 F 3 M 2 TGP
	Subtotal KIs		***10***			***11***			***11***			***9***

AYKP, adolescent and young key populations; FGD, focus group discussion; KI, key informant; TGP, transgender person.

Data collection

We developed semi-structured topic guides informed by a literature review, and UN agency and youth network input. The FGD guide included open-ended questions and probes that addressed young people's HIV- and mental health-related awareness, experiences and needs, stigma, and services availability and access. For example, all FGD participants were asked, 'Sometimes young people look for information about things like romantic/intimate relationships, and gender or sexual orientation, including health and HIV prevention. Where and from whom do you or your friends usually get this information? (School? Friends? Family? Online? …).' A subsequent question indicated, 'Next, I want to ask you about you and your friends' feelings and what makes you happy. Who do you trust to get information and support from when you feel unhappy or need to cope? (Friends? Family? Teachers? Counsellors? Online? Community? …).' FGD questions were translated from English into local languages, back translated in English, and revised in local languages. FGDs were segmented by age (16–18, 19–24 years) and co-led by youth network staff with training from the lead investigator (PAN). FGD participants received ~$5–$10 compensation.

The semi-structured KI interview guide paralleled the FGD topic guide, with questions posed in reference to young people and tailored to KIs' areas of expertise. Interviews were based on a dialogic and critically reflexive approach, in which the interviewer aims toward an egalitarian relationship, flexibility, shared responsibility for meaning-making, with acknowledgment of power relations—both how these influence KIs' knowledge and practices (i.e. those working in government ministries) and between interviewer and interviewee (Farias et al., 2019; Tufford & Newman, 2012). In-depth key informant individual and small-group (2–3 person) interviews were conducted by the lead researcher (PAN) in English. KIs received no compensation.

Data analysis

FGDs and KI interviews were digitally recorded and transcribed. FGDs were then translated into English and redacted by youth network staff in each country. Transcripts were manually coded by two independent researchers and examined using framework analysis, which is particularly pertinent for applied and policy-relevant research. We used ecological systems theory (EST) (Bronfenbrenner, 1979) as a sensitising framework to examine proximal (e.g. direct contact with young people) and distal influences (i.e. social-structural conditions, such as policies, institutional practices, and resource allocation) (Auerbach et al., 2011) in healthcare, family, school, and peer domains; these correspond to WHO-identified priority research areas for adolescent health in LMIC (Nagata et al., 2016). In accordance with framework analysis, we undertook five steps: 1) familiarised ourselves with the transcripts through immersion in the data, reading and re-reading transcripts and writing memos; 2) generated a thematic framework in successive team meetings, based on both a priori themes guided by EST and participant narratives; 3) indexed the data to the themes through deductive and inductive coding of transcripts; 4) charted the data by organising coded text in accordance with the themes; and 5) mapped and interpreted the data, involving analysis of key characteristics with the aim of generating strategies and recommendations that reflected the experiences, thoughts, and priorities of participants (Ritchie & Spencer, 1994; Srivastava & Thomson, 2009). We implemented extensive member checking through a consultative, knowledge exchange process (Madill & Sullivan, 2018): draft findings and interpretations were shared with young people, KIs, NGO/IGO staff, and experts in each country through in-person forums and written reports, and their feedback integrated into data analysis and interpretation. The overall goal was to identify common as well as context-specific themes and challenges for young people in the four countries, along with local and regional programmatic and policy responses that reflected multiple stakeholder input, rather than to rank or compare countries to one another.

Ethical considerations

The study received approval from the University of Toronto Research Ethics Board, and administrative approval from UNICEF in each site. All minors provided parental consent, and all young people provided written informed consent/assent. Verbal consent was recorded for KIs. Specific details that could identify KIs or young people have been redacted to protect confidentiality.

Results

We present findings in healthcare, family, school, and peer domains focused on challenges and opportunities for HIV prevention and mental health, and their intersections. Illustrative quotations in each domain are identified as from FGDs with young people (AYKP) or key informants (KI), and by country (IN, Indonesia; PH, the Philippines; TH, Thailand; or VN, Vietnam).

Healthcare: 'HIV counselling is totally delinked from the mental health system'

A lack of competent and accessible youth-friendly HIV and mental health services was identified by young people and KIs, especially for sexual and gender minority young people, and for YPLHIV. AYKP reported no or low access to appropriate mental health support and reluctance to communicate their experiences to providers in the context of systems that were not designed for them: 'If I am silent, it does not mean that I am fine. Services for adolescents should be subsidised or free, so that it is easier to access, such as HIV services' (AYKP, IN). KIs explained, 'It is challenging for gay people; some hospitals do not have a staff-person or nurse who specialises in services for sexually diverse populations' (KI, TH); and, 'There's also an issue of … methamphetamine use on the rise; but young people don't know the risk associated with it' (KI, VN). Another KI detailed poignant challenges at the intersections of HIV and mental health:

> Suicide is a problem and, from anecdotal experience, I worked with homeless young MSM before and it's really a huge problem. No one is sensitised, 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'—that's 'I am bored of ARVs'—a very colloquial term people use to describe committing suicide. No one is sensitised to that issue as of yet. (KI, IN)

KIs also identified a lack of gender-affirmative healthcare for young people, which can negatively impact sexual/gender identity, self-esteem, and sexual behaviours.

> 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 … we need information and fundamental preparation to help them make a good decision. (KI, TH)

Disconnects between limited HIV and mental health services resulted in lost opportunities for engaging YPLHIV in mental health assessment and counselling, with negative impacts on medication adherence and retention in care. KIs reported, 'They don't have mental health programs for youth living with HIV' (KI, IN); ' … 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 (HIV) clinics, almost everybody comes just to talk' (KI, IN). As a result, ' … when they were having their treatment, they couldn't handle it; so, we lost them to treatment' (KI, PH).

Lost opportunities were also described due to fragmentation between education and healthcare systems. Some youth who receive sexual and reproductive health (SRH) education in schools become newly aware of their HIV risk, and motivated to seek HIV counselling and testing; but they are left to navigate adult healthcare systems on their own:

> The thing we realised is that a lot of the cities did not make their programs known because the teachers had no idea that HIV programs 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. (KI, PH)

Intersectional stigma permeated HIV, sexuality, and mental health issues across countries, presenting barriers to service availability, access, and utilisation. KIs explained, 'Especially if a gay guy has HIV, he would be doubly stigmatised by society' (KI, TH); and, 'Their willingness to share their stories, or their unwillingness, because they always hide them—Vietnamese society still has discrimination toward the LGBT community' (KI, VN). A KI in Indonesia described a public/government forum: ' … we heard people saying, 'How do we stop HIV in our city? We have to get rid of the gays, of the LGBTs … and then we will be safe from HIV' (KI, IN). A KI in the Philippines indicated the need to deftly broach mental health in FGDs in order to elicit any discussion among young people: 'When you say 'mental' that will directly correlate with mental hospital' (KI, PH).

Lack of mental health awareness on a societal level in conjunction with conservative religious beliefs, inadequate professional training and certification, insufficient mental health resource allocation, and stigma *within* the mental health profession presented obstacles to care in each setting.

> 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. (AYKP, IN)

> 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 a clinic. (KI, VN)

KIs explained that 'They don't have common standard [training] guidelines … even counselling guidelines, the skills for counselling' (KI, IN); relatedly, 'When you go to a psychiatrist, the stigma is still there' (KI, PH).

With the dearth of trained mental health professionals, achieving service coordination and targeting programme initiatives for AYKP was deemed exceptionally challenging: ' … to integrate programs, you need experts who can mentor; but it's very rare' (KI, IN). Similarly, 'It's rare to find licensed psychologists because that service is not common, even for general populations; … therapists or psychologists don't have much knowledge on the [LGBT] community' (KI, VN).

Limited advocacy initiatives generally focused on HIV, not mental health, with a notable exception reported in the Philippines:

> I have seen in the Philippines many mental health activists 'coming out'. There's a Youth for Mental Health Coalition … it's a big group and works with other advocates. And there's a medical students' group that launched a film festival for mental health. (KI, PH)

Overall, sparse, under-resourced, and fragmented HIV and mental health services for young people, negative sociocultural beliefs and stigma around mental health, HIV, and sexuality, and lack of professional mental health training and certification fuelled pervasive unmet needs and service gaps for young people, especially sexual and gender minorities, and YPLHIV.

Families: 'It can be seen from the way they cry'

HIV-related mental health stressors in the family domain centred on fear of disclosure—of sexual orientation, gender identity, and/or HIV status—creating barriers to family involvement and support, as reported by AYKP in each country:

> Many gay friends are depressed; 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 they face. (AYKP, IN)

> Before, I didn't know what a transwoman was. All I know was I am gay. My father kept telling me, 'Why are you acting like gay? Are you gay? You should act like a man!' I felt discriminated against by my own family, and it was very painful! (AYKP, PH)

> 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 got used to it. I think and hope they will get over it one day. (AYKP, TH)

Moreover, the risks of broaching discussion of HIV risk behaviours or HIV testing, or of being diagnosed as HIV-positive, were attributed to intersectional stigma. HIV is understood to be a signifier of sexual and gender minority status, sex work, and other stigmatised identities:

> HIV-positive young people … sometimes say the challenge of disclosing your HIV status to your parents is that you'll also have to disclose your sexual orientation and gender identity. (KI, PH)

> 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. (KI, IN)

> 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. (AYKP, IN)

For some young people, particularly LGBT youth, parental non-acceptance and conflicts led to being remanded to 'reparative therapy' (or exorcism in some cases): 'I had to go when my mother forced me, and I became a bit traumatised by a psychiatrist' (AYKP, IN). KIs also reported LGBT youths' experiencing indirect and direct pressure to leave their homes:

> There are those, regardless of their gender, who are forced to leave their homes. 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. (KI, TH)

Occasional narratives detailed support or guidance from a sibling or extended family member: 'I don't usually talk to my parents, except my elder brother. When he knew my sexual identity, he supported me to come out' (AYKP, VN). Others reported passive (or tacit) acceptance from parents, absent direct communication: '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' (AYKP, TH). To a limited extent, familial support included HIV education: 'I always asked my older friend at my mom's work. He has sex every night. He says I must use a condom every time with lubricant' (AYKP, TH).

Finally, despite evolving policies in each country that allow minors to be tested for HIV without parental consent, reality-based concerns about confidentiality and stigma emerged as barriers to access. KIs described programmes that aim to engage families in a supportive role to facilitate HIV testing and care:

> Our concern is the those at younger ages whose parents work for government. Their health insurance is covered by their parents' jobs. Even though they could get tested by themselves, their parents will be informed. I am so worried about this. (KI, TH)

> 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. (KI, PH)

Young people's experiences and fears around disclosure of sexuality, gender identity, or drug use to their parents posed barriers to family communication and support, instead exacerbating stress and foreclosing discussions about HIV, as well as presenting potent barriers in access to HIV testing and care.

Schools: 'LGBT at school … you should not discuss it'

In each country, schools were characterised by verbal and physical harassment, social exclusion, and dropouts, especially among LGBT youth, largely absent intervention by teachers or administrators. A youth network leader explained, 'It is seen as strange if a kid talks about LGBT … they are

shunned' (KI, IN). In the context of sexual and HIV stigma, a YMSM reported: 'None of the friends at school was willing to talk about these subjects' (AYKP, VN). A gay youth recounted being bullied by older boys and his ostensible method of coping by minimising the impact:

> 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. (AYKP, TH)

Beyond harassment and victimisation by peers, AYKP described teachers as often complicit or even perpetrators themselves, along with the absence of institutional support: 'Back in my school, there were two lesbians having a relationship. Then they started to experience discrimination and stigma from teachers and students at the school. Teachers didn't even care about those jokes' (AYKP, VN). Other AYKP reported, 'I fear that the teacher can spread our story and [that] scares us' (AYKP, IN); and, 'I don't want to talk or ask the teacher. Usually, I find the information through the Internet' (AYKP, IN). A KI explained a trajectory for some gay or transgender youth who leave school, later engaging in sex work for survival:

> The other piece that needs 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 don't fit in on a number of dimensions … because of their feelings about their sexual identity, and … expectations and demands for performance that school imposes on them. So, those factors all contribute to their desire to get out of their home communities. (KI, TH)

Nevertheless, KIs described schools as having great potential for strengthening education and support around HIV, SRH, and mental health through curriculum development, teacher training, and linkages to behavioural health professionals; however, sociocultural and political constraints to implementing school-based programmes were described in each country:

> These meetings on sexual health and rights often take place in international schools; but they are only a very small percentage of students … we don't have sexuality lessons in public schools. The Secretary of the Youth Union in the school will discuss with organisations; they gain approval from the schoolmaster—sometimes, not always. (KI, VN)

> Some schools don't really want or support us in going to teach their students. (KI, TH)

> 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 correct answer is to go play soccer. (KI, TH)

Specific challenges were also described in regard to mental health curricula:

> … primary and secondary schools in the Philippines, they don't really give a premium for mental health issues. We improve the curriculum … train teachers to become first-aiders … to identify early signs, and call them 'red flag' students—for … signs of anxiety and depression … and immediate referral to the guidance counsellor. (KI, PH)

> 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. (KI, PH)

> It's really hard to mainstream depression and common mental disorders. Currently, it's part of the 'healthy school systems'; they have … a screening tool to see who needs referrals … part of the school-based mental health program. (KI, IN)

Schools were characterised as environments rife with harassment and social exclusion of AYKP, at times with complicity from teachers and most often absent adult intervention. However, schools were also sites of inchoate programmes to integrate HIV, SRH, and mental health education, reduce stigma, and train teachers as 'first-responders' to identify and refer youth to health and mental health professionals.

Peer networks: 'Peer outreach needs to be an investment in people—a sustained investment'

Peer networks, both informal and formal, emerged as vital sources of information and support for navigating HIV, sexual and gender identity, and mental health stressors. Informal peer networks afforded intermittent support, however imminent risk of betrayal through unwanted disclosure of one's identity or HIV risk concerns presented constraints to AYKP's reaching out. Although some AYKP indicated, 'It's better with friends; I don't go to counselling services' (AYKP, IN), others reported that, 'There are absolutely no straightforward discussions among friends in class on the above matters, only jokes surrounding them' (AYKP, VN). As a result, many AYKP feared discussing or revealing information that might be disclosed and used against them.

Formalised youth networks and LGBT peer networks in each country were described as primary resources for accurate information and support for AYKP in understanding their experiences around sexual orientation and gender identity, HIV, SRH, and substance use; this included advice on navigating stressors among family and friends, and referrals to competent professionals with whom they could openly discuss their concerns.

> First thing, they will go to the community of people like them (LGBT) to ask for help … advice … . After they figure out who they really are, they will consider if they should tell their parents or friends, since there is still discrimination. (KI, VN)

> We do consultations with peers. The young people conducted their own survey … mental health was the number-one issue faced by young people … attempting or committing suicide due to school requirements and family. (KI, PH)

> … it is not the priority focus, but we are well aware about mental health issues … that they can't talk about with their friends and family … but need some doctor or professional care, and we provide a referral mechanism to a university that has this kind of support. (KI, IN)

> There's also an issue of methamphetamine use on the rise … . It's very cheap and available … there's peer pressure to use it at parties and for people engaged in sex work … . But young people don't know the risk … , so it opens doors for other risks. This knowledge … and how to protect themselves … will be very much welcomed. (KI, VN)

Youth and adult KIs discussed the extensive frontline outreach and support provided by youth networks, often a primary mechanism for reaching young people with information about HIV and SRH. Youth KIs described and advocated for socioeconomic empowerment and educational support for peer outreach workers: 'Peer outreach needs to be an investment in people, a sustained investment' (KI, VN).

> You need to invest in the peer, train them, and sustain that pool, and pay for what they do—not just rely on voluntary services, which is unfair. Often there's a high turnover of peer educators because they find a better job; they are not well paid and have few incentives. (KI, IN)

Adult KIs echoed the centrality of peer networks for HIV, SRH, and broader mental health outreach: 'Yes, and even the Global Fund focus has been supporting peer educators because it's very hard to reach young people with old people' (KI, PH). KIs further expressed concerns about the need to support peer educators and avoid burnout: 'The aim is preventing peer educators from becoming overwhelmed, overburdened, so they can continue providing information and services to their peers' (KI, PH); ' … doctors can go to schools to give training and education and empower them [students] to become peer educators and peer counsellors' (KI, IN).

Peer networks emerged as crucial resources for youth-friendly outreach, education, support, and referrals around HIV, sexuality and gender identity, and mental health issues; however, youth and adult KIs articulated concerns about burnout and exploitation of unpaid peer educators, and the need for scale-up of government programmes and resource allocation in renewed commitments to young people's health and wellbeing.

Discussion

This qualitative exploration with young people in Indonesia, the Philippines, Thailand, and Vietnam reveals pervasive social-structural challenges and unmet needs around HIV and mental health in the context of under-resourced and fragmented health and mental health systems, and multiple and intersecting forms of stigma and discrimination. We identified gaps in youth-friendly HIV and SRH services, and a lack of trained health and mental health professionals, as described in other LMIC settings; these coalesce in scarce implementation of evidence-informed programmes, which leaves large numbers of young people without access to quality care for HIV or mental health issues (Saxena et al., 2007; Sturke et al., 2020). Intersectional stigma based on sexuality, gender identity, HIV, and mental health creates barriers to HIV, SRH, and mental health awareness, service access, and utilisation (Huang et al., 2020; Logie et al., 2016; Pantelic et al., 2020), which further disrupt HIV prevention and care continua for AYKP and YPLHIV. Nevertheless, emergent programme and policy initiatives were described in each country, in healthcare, family, school, and peer domains; these present strategic opportunities for mobilisation of multilevel (i.e. at two or more levels of young peoples' social ecology) and multicomponent interventions (i.e. multiple actions at the same level) (Auerbach et al., 2011; Riedel et al., 2020) to advance local and regional responses to HIV among young people.

Social and environmental risk factors in LMICs, including poverty, community violence, and substance use (Lund et al., 2018; Pedersen et al., 2019), impact children and youth via the family environment. Risk factors for HIV and poor mental health, such as aggressive family environments, family violence (Repetti et al., 2002) and parental rejection, are overrepresented among AYKP (Newman et al., 2018; Newman & Fantus, 2015; Sturke et al., 2020). Strategic interventions were reported in limited programmes that aimed to promote protective factors by engaging family support for adolescent HIV testing, counselling, and retention in care; these were sponsored by NGOs and, to a limited extent, government ministries in each country. A model government-sponsored programme by the Council for the Welfare of Children in the Philippines hosted weekend family-skills training retreats to strengthen parent–child communication and family cohesion, which have been identified as having positive effects on a number of youth mental health and HIV outcomes in LMICs (Pedersen et al., 2019); however, the programme was constrained by lack of resources amid the country's vast and dispersed geography, and lack of trained mental health professionals and locally available services post-intervention.

School-based initiatives that address HIV, SRH, and sexual diversity in implementation of comprehensive sexuality education, along with integrating basic mental health in educational curricula, afford opportunities to reach many young people, thereby supporting HIV prevention and sexual health, mental wellness, and reducing pervasive stigma (Fonner et al., 2014). The present study identified training and support for teachers as crucial—to increase teachers' knowledge of HIV, SRH, and mental health, reduce their own stigma around HIV and sexuality, and provide school resources and administrative support—as similarly indicated in other contexts (Domitrovich et al., 2008; Iyer et al., 2014; Sarma & Oliveras, 2013). Inchoate collaborations between Ministries of Education and Health reported in each country provided opportunities for intervention packages in schools that integrate early recognition and care for HIV, and mental and neuropsychiatric issues, for adolescents, then mainstreaming them through primary healthcare and community-level services. Establishing referral pathways from schools to bridge segmented health, child protection, and community systems, increasing awareness of locally available programmes and services for young people, and promoting government involvement (Kasedde et al., 2014) and resource allocation for young people's health and education (Sturke et al., 2020) are strategic responses to increase the effectiveness of the educational sector in early intervention for HIV, SRH, and mental health issues.

Peer education has been identified as an effective intervention for HIV prevention, particularly in LMIC (Medley et al., 2009). To that end, the integration of adolescent and youth social networks

in HIV interventions for young people is a key element of their success (Kasedde et al., 2014; Sturke et al., 2020). Youth networks in each country trained and supported peer educators and outreach workers to recognise HIV risk practices, signs and symptoms of mental health issues, and to some extent challenges faced by LGBT youth. Peers offer basic education, validation, support, and referrals. This reflects a task-sharing model of care whereby non-specialists are trained to deliver interventions with specialist supervision (Patel, 2012). Task-sharing offers a lower-cost mechanism for addressing HIV, SRH, and mental health issues in low-resource contexts, with demonstrated feasibility and effectiveness in increasing health and mental health services coverage (Patel, 2012). However, youth leaders articulated feeling overburdened by the demands of providing services to large populations of young people—often absent adequate referral options—and the need for salary to compensate their work. Along with adult KIs, youth leaders described the need for greater training and ongoing professional supervision to support peer educators' wellbeing and avoid burnout.

Beyond the effectiveness of peer networks in promoting HIV prevention and SRH among young people, these networks exert salutogenic effects through fostering empowerment and resilience of peer educators themselves (McDaid et al., 2020; Sturke et al., 2020). Socioeconomic support of peer educators is a strategic intervention that acknowledges the importance and value of young peoples' work; it also reduces their need to hold multiple jobs to support themselves, thereby enhancing peer retention, and promotes broader twenty-first century skills (e.g. creativity and innovation, critical thinking, problem-solving, collaboration, computer literacy) (Global Partnership for Education, 2020), while increasing programme coverage and sustainability. Training peers to capitalise on the vast mobile phone penetration and social media use among young people in the Asia-Pacific region—ranking among the highest usage of Internet-powered devices and services in the world—has great potential to expand coverage and reach (Schunter et al., 2014; UNICEF, 2019), particularly amid the COVID-19 pandemic.

Online initiatives to reach young people can operate at relatively low cost and circumvent some of the pervasive barriers—due to intersectional stigma and discrimination, and logistical challenges—to HIV and mental health service utilisation. Emerging programmes in the region include #SayaBerani (2018) ('I am brave!'), among the first major social media campaigns in Indonesia to promote HIV testing and treatment, which engages pop-culture icons and celebrities to combat stigma and discrimination against PLHIV. More recently, 'Tanya Marlo' (Ask Marlo), an initiative of UNAIDS (2019c), Indonesia, features a youth-friendly chatbot through the ubiquitous LINE messaging application to destigmatize and provide basic information about HIV; Marlo invites users, 'Let's take an HIV test!', providing maps of local HIV testing sites and online appointment booking. The Thai website, 'Love Care Station', provides targeted SRH and HIV information and referrals for adolescent MSM and sex workers, including youth-friendly message boards, and online mental health counselling and referrals (UNICEF, 2019). In the Philippines, 'The Red Whistle' is an online HIV awareness platform that operates in collaboration with civil society organisations to bridge PLHIV displaced by the COVID-19 pandemic with HIV treatment hubs; volunteers are mobilised to provide home delivery of 30–90-day antiretroviral medication refills (UNAIDS, 2020).

Next-stage challenges are bridging online information and referrals with offline implementation (i.e. online-to-offline [O2O]) (Anand et al., 2017) that is tailored for young people—for example, providing trained peer navigators (Shah et al., 2018) who accompany young people reached online to youth-friendly HIV testing sites. Additionally, online provision of differentiated HIV self-testing (Johnson et al., 2017; WHO, 2018) and HIV pre-exposure prophylaxis (PrEP) (Newman & Guta, 2020; Touger & Wood, 2019) designed for AYKP can mitigate barriers due to stigma and discrimination, and improve access.

Finally, sporadic HIV surveillance data and wholesale lack of baseline data on mental health for young people in each country impedes assessment, evaluation, and advocacy efforts, and evidence-informed, tailored interventions. Investment in the sustained collection of age-, sex-, and sexual- and gender-identity disaggregated data is fundamental to documenting unmet needs, assessing

the availability and reach of programmes for young people, and evaluating programme effectiveness (Schunter et al., 2014; UNICEF, 2016).

Strengths of this investigation include meaningful youth involvement throughout research design, implementation, and interpretation of results, and triangulation of data from AYKP, and youth and adult experts across multiple sectors in four middle-income countries. Further research should build on the present identification of young people's experiences and needs in regard to HIV prevention, SRH, and mental health with representative samples of adolescents and youth. Due to resource limitations, we conducted FGDs in urban areas, though young people were provided with transportation and financial support from CBOs and youth networks to attend youth forums to discuss initial findings and share their perspectives. Further investigations should include remote areas, such as islands and/or mountainous regions in each country that are even less served by existing programmes. Finally, given the political sensitivities around HIV, SRH, and sexual and gender minority populations, we strictly redacted information that would have provided greater details about the breadth of expert engagement and specific programmatic challenges; however, this enabled participants to speak openly as evidenced in the frank assessments presented, despite political constraints.

Conclusions

This qualitative investigation reveals HIV and mental health issues, challenges, and their convergences among young people in four resource-constrained contexts in the Asia-Pacific region. Multilevel and multicomponent interventions are needed to develop integrated, youth-friendly healthcare systems and organisations, as well as to address risk environments and service gaps in education, family, and peer domains. Importantly, social and structural interventions must function in the context of formidable political and sociocultural restrictions on sexual health and rights for AYKP and young people, which limit the effectiveness of HIV prevention and care (Anderson & Kanters, 2015; Medland et al., 2020; Riedel et al., 2020). Targeted research conducted with meaningful involvement of young people, and programme implementers and policymakers, can advance socioculturally acceptable interventions through 'evidence-making' approaches (Rhodes & Lancaster, 2019); these promote resilience and socioeconomic empowerment of young people in the research process, as well as its outcomes, thereby simultaneously generating evidence and transforming social and structural contexts of vulnerability.

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