POLICY RESPONSES TO THE SEXUAL AND REPRODUCTIVE HEALTH OF QUEER YOUTH IN THE GLOBAL SOUTH: A SYSTEMATIC REVIEW

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ABSTRACT

Concerns surrounding youth sexual and reproduction health (SRH) are deeply embedded within systems of heteronormativity and ciscentrism. Resultantly, youth SRH is filtered through a lens of heterosexual and cisgender experience, rendering invisible the SRH needs of queer youth. Importantly, a failure to recognise queer experiences of SRH has implications for normative subject positions, which enjoy stronger institutional support and constitute legitimate ways of being. As such, the failure to recognise queer youth as health care subjects within policy has far reaching consequences for their sexual and reproductive health.

Within this research, a sexual and reproductive justice (SRJ) framework is adopted as a backdrop for exploring policy documents related to youth SRH within selected global South countries in Africa, Asia, and the Caribbean. The final data set comprises of 1035 policy excerpts extracted from 152 policies across these three regions. Research takes the form of a systematic review utilising a deductive framing and positioning thematic analysis. Analysis identifies framings of youth SRH and explores the subject positions assigned to queer youth in relation to these identified framings, with the understanding that the manner in which youth SRH concerns are framed and queer youth are positioned within policies provides an important foundation for the implementation of SRH-related policy.

Findings demonstrate that policy responses to youth SRH are most often framed in terms of a public health approach. As a result, dominant understandings of youth SRH serve to reduce youth sexuality to notions of infections and impact, which may speak to an overreliance on biomedical and population-level health models. Themes emerging within human rights framings demonstrate a presumption that rights are equally afforded to, and freely exercised by, all individuals once legally secured, failing to engage with the creation of enabling conditions to realise these rights. Although context and culture framings were by no means exhaustive examples of SRJ, they provide an interesting insight into how such SRJ concerns might be integrated into policy.

Importantly, policy responses demonstrate a general pattern hypervisibility of men who have sex with men (MSM) standing in marked contrast to the invisibility of queer youth and other adult queer populations. Within policy extracts, both youth and ‘MSM’ are positioned as

particularly prone to poor SRH outcomes. By virtue of their inclusion within both populations, queer youth may be considered as especially at risk for, or vulnerable to, such outcomes. Relatedly, these populations (and by extension queer youth) are positioned as in need of correction, containment, and/or protection by those occupying 'gatekeeping' positions (e.g. health care providers). The positioning of 'MSM' solely within the context of HIV/AIDS serves to link same-sex sexualities (and at times gender non-conformity) with harmful consequences, suggesting that the positioning of queer youth could similarly serve to conflate their SRH needs with concerns around HIV/AIDS. Many of the subject positions deployed in policies serve to deny the potential for youth and 'MSM' agency, strength, and resilience. Thus, queer youth subjects are unlikely to be positioned as empowered, autonomous, and agentic.

Across both framing and positioning themes, a number of key shortcomings were observed. For the most part, policy responses fail to acknowledge the influence of social, economic, political, and cultural forces that may serve to hinder SRH outcomes according to particular contexts and the intersection of multiple and varied social identities. By obscuring these broader contextual factors and power relations, policy responses may serve to hold individual youth responsible for poor SRH outcomes. In failing to engage with the potential for diversity within youth populations, these populations are largely homogenised. Finally, the need for the creation of an enabling environment in order to secure sexual and reproductive health is largely unacknowledged within policy responses.

Keywords: sexual and reproductive health; SRH; youth; queer youth; LGBT youth; systematic review; framing; positioning; global South

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NOTES ON TERMS USED

BISEXUAL: A term used to refer to persons who are attracted to, and may form sexual and romantic relationships with, two sexes (usually male and female) or two genders (usually men and women), but not necessarily at the same time or equally (Meer, 2014; Qmunity, 2013).

CISCENTRISM: A term used to describe a system of attitudes, bias, and discrimination that favours cisgender gender identity and/or gender expression (Qmunity, 2013).

CISGENDER: A term used to describe persons whose gender identity and/or gender expression fits with the sex and/or gender they were assigned at birth (Meer, 2014; Qmunity, 2013).

GAY: A self-chosen label or identity for men who are attracted to other men. It is possible for men to have sexual and romantic feelings for other men but not identify as gay. Moreover, some men may identify as gay without acting on their feelings for other men. This term can also be used as an umbrella term to refer to all lesbian, gay, bisexual, transgender, intersex, and queer people (Meer, 2014; Qmunity, 2013).

GENDER EXPRESSION: A term used to describe the way one presents oneself to the world, as either masculine or feminine, or both or neither. This can include dress, posture, hairstyle, tone of voice, gestures and other behaviours (Meer, 2014).

GENDER IDENTITY: A term used to describe a person's internal and psychological sense of oneself as male, female, both, in between, or neither, which may or may not match the person's sex assigned at birth. This can include refusing to label oneself with a gender birth (Meer, 2014; Qmunity, 2013).

GENDER MINORITIES: A term used to describe persons who do not identify as mainstream interpretations of male or female, and whose gender expression and/or gender identity does not match traditional societal norms. Often used to refer to transgender and intersex persons (Meer, 2014).

GENDER NON-CONFORMING: This term refers to those who do not conform to dominant gender norms for their biological sex in terms of their gender identity and/or gender

expression. Some people prefer the terms ‘gender variant’, ‘gender fluid’, or ‘gender queer’ (Meer, 2014; Qmunity, 2013).

GLOBAL SOUTH: This term is used to refer to low and middle-income countries (as determined by World Bank classification) within the regions of Africa, Asia, Latin America, and the Caribbean. The term emerged to differentiate less wealthy countries from those in the overdeveloped, wealthier global North. Although the term is used for the sake of brevity, it is important to acknowledge that such a conceptual distinction does often serve to gloss over pockets of economic equality and inequality in global South and global North regions (Chant & McIlwaine, 2009).

HETERONORMATIVITY: A term used to refer to social roles, structures, and systems that reinforce the idea that heterosexuality is the presumed norm and is superior to other forms of sexual identity (Meer, 2014; Qmunity, 2013).

HETEROSEXISM: A term used to describe a system of attitudes, bias, and discrimination that favours opposite-sex sexuality and relationships, which serves to marginalise those who do not identify as heterosexual (Meer, 2014; Qmunity, 2013).

HETEROSEXUALITY: A term used to describe sexual, emotional, and/or romantic attraction to people of the ‘opposite’ sex or gender; also sometimes referred to as being ‘straight’ (Meer, 2014; Qmunity, 2013).

HOMOPHOBIA: A term used to describe fear or hatred of, aversion to, and discrimination against sexual minorities. There are many levels and forms of homophobia, including cultural/institutional homophobia, interpersonal homophobia, and internalized homophobia. Homophobia results in a number of adverse consequences for sexual minorities including exclusion from social spaces, stigma, discrimination, abuse, and violence (Meer, 2014; Qmunity, 2013).

HOMOSEXUALITY: A term used to describe sexual, emotional, and/or romantic attraction to people of the ‘same’ sex or gender; also sometimes referred to as being ‘straight’ Given that this term is used as a pejorative epithet, some queer persons are uncomfortable with its use (Meer, 2014; Qmunity, 2013).

LESBIAN: A self-chosen label or identity for women who are attracted to other women. It is possible for women to have sexual and romantic feelings for other women but not identify as

lesbian. Moreover, some women may identify as lesbian without acting on their feelings for other women. Sometimes the term 'gay women' is used instead of lesbian (Meer, 2014; Qmunity, 2013).

LGBT: An acronym used to refer to lesbian, gay, bisexual, and transgender persons. There are a number of variants of this acronym, for example LGBTQI, which is also inclusive of questioning and intersex persons. Like the term queer, most variants of this acronym are intended to be inclusive of all persons, excepting those who identify as heterosexual and/or cisgender (Meer, 2014; Qmunity, 2013).

MEN WHO HAVE SEX WITH MEN (MSM): This is a term commonly used in public health discourse to describe men who engage in sexual relationships with other men. It is important to note that this term, along with the term women who have sex with women (WSW), have been problematised on the basis that they obscure social dimensions of sexuality, undermine queer persons' self-identification, fail to sufficiently describe variations in sexual behaviour (Young & Meyer, 2005). Given that the use of this term is pervasive within policy documents, a decision was taken to replicate this usage within discussion of findings. However, within discussion of the findings the term is operationalised as 'MSM' in an attempt to acknowledge the problematic nature of its usage.

QUEER: In the context of this research, the term queer is used to refer to both *orientation* queer persons (individuals attracted to people of the same gender) and *gender* queer persons (individuals - irrespective of sexual orientation - who do not identify with the gender they were assigned at birth) (Stryker, 2008).. The term is intended to be inclusive of all persons, excepting those who identify as heterosexual and/or cisgender. However, it is important to note that queer is a reclaimed term that is also used as a pejorative epithet, and as such some people feel uncomfortable with its use. This term is often used instead of the LGBT acronym (Meer, 2014; Qmunity, 2013).

SEXUAL MINORITIES: A term used to describe persons whose sexual orientations or sexual activities do not adhere to mainstream notions of heterosexuality – i.e. lesbian, gay, bisexual, and queer persons (Meer, 2014).

SEXUAL ORIENTATION: A term used to refer to a person's physical, romantic, emotional, and/or spiritual attraction to another person, which they may label as lesbian, gay, heterosexual, bisexual, queer, asexual etc. Many people experience sexual orientation

fluidly, and feel attraction or degrees of attraction to different genders at different points in their lives. Sexual orientation is defined by feelings of attraction rather than behaviour (Meer, 2014; Qmunity, 2013).

TRANSGENDER: A term used to refer to a wide range of people whose gender identity and/or expression differs from conventional expectations based on their assigned biological birth sex. This term may be inclusive of, for example, persons on the male-to-female or female-to-male spectrums, persons whose gender identity and/or expression falls outside of the male/female binary, and persons whose gender identity and/or expression is fluid. Importantly, identification is not dependent on criteria such as surgery or hormone treatment status (Meer, 2014; Qmunity, 2013).

LIST OF ACRONYMS

CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRC	Committee on the Rights of the Child
CSWs	commercial sex workers
FSWs	female sex workers
HIV/AIDS	human immunodeficiency virus, acquired immunodeficiency syndrome
HRC	Human Rights Committee
ICCPR	International Covenant on Civil and Political Rights
IDUs	injecting drugs users
LGB	lesbian, gay, and bisexual
LGBT	lesbian, gay, bisexual, and transgender
LGBTI	lesbian, gay, bisexual, transgender, and intersex
MARPS	most-at-risk populations
MSM	men who have sex with men
NGOs	non-governmental organisations
PLHIV	people living with HIV
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
SRJ	sexual and reproductive justice
STIs	sexually transmitted infections
TMBs	treaty-monitoring bodies
ToP	termination of pregnancy
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNEP	United Nations Environment Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation

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CHAPTER 1: BACKGROUND TO THE RESEARCH

Introduction

The majority of the world's population resides in global South countries that are predominantly constituted of children and adolescents (Hindin, & Fatusi, 2009; Rigg, 2007; UNICEF, 2013; Woog, Singh, Browne, & Philbin, 2015). Initially, the recognition of the importance of youth sexual and reproductive health (SRH) within the global South emerged in the context of concerns over HIV prevalence in these regions (Klepp, Flisher, & Kaaya, 2008). However, it is now widely acknowledged that the SRH of youth is one of the most important individual, social, and economic challenges facing global South regions. As a result, youth sexual and reproductive health (SRH) has emerged as an important public health priority at both a regional and international level (Judhistari, Kayastha, & Jahanath, 2012; Klepp et al., 2008; Woog et al., 2015).

Importantly, the link between SRH and a number of interrelated and broad-reaching areas of concern (including the broader health agenda, economic and social transformation, education, gender equity, and environmental sustainability) has become increasingly acknowledged (Barroso, 2014). Much of the literature on youth SRH argues that the risks related to sexual activity and early childbearing jeopardise not only young people's physical and emotional health, but also their economic and social wellbeing. Some of the research concerned with youth SRH notes a number of risks that young people typically face including: sexually transmitted infections (STIs) and HIV, early sexual debut, early and/or forced marriage, sexual violence and coercion, and complications related to early pregnancy and unsafe abortions. In light of concerns surrounding youth SRH, states have increasingly utilised policy measures in an attempt to address poor SRH outcomes.

Subsequent discussion will provide a brief overview of the context within which this research is undertaken. Discussion will explore the status of youth SRH in the global South, followed by an examination of the international legal systems that operate in relation to SRH concerns. The key theoretical and methodological concepts informing the research will then be discussed, followed by a discussion on the rationale that informed the decision to undertaken

this particular area of investigation. Finally, discussion will conclude with an overview of the forthcoming chapters, providing a brief summary of each.

Status of Youth Sexual and Reproductive Health in the Global South

Research on the SRH of youth within the global South is largely concerned with the risks associated with the sexual behaviour of youth. This research tends to highlight risks related to the contraction of sexually transmitted infections (STIs) and HIV (which is often linked to a failure to use barrier contraception), early sexual debut, early and/or forced marriage, experiences of sexual violence and coercion, and complications related to early pregnancy and unsafe abortions. The impact of SRH outcomes on youth education (particularly in terms of school completion and educational attainment) has also been identified as an important area of concern (Unterhalter, 2005). Overall, research concerning outcomes for youth SRH paints a somewhat dire picture of the status of youth SRH within the global South.

According to such research, adolescents and young adults carry a disproportionate burden of STIs and HIV (Musacchio & Forcier, 2008; WHO, 2014). Nearly half of all new HIV infections in the global South are represented by young people, with the WHO (2004) estimating that 2 million young people are infected with HIV each year. Of the 40 million people infected with HIV worldwide, nearly one-third are between the ages of 15 and 24 (WHO, 2014). Additionally, youth who are incarcerated, homeless, or engaging in sex work have the highest risk for acquiring STIs and HIV (Musacchio & Forcier, 2008). According to Musacchio and Forcier (2008), high levels of STI and HIV infections among adolescents in the global South are linked to a consistent failure to use barrier contraception. Although contextual factors that hinder use of contraception (such as cost, poor access, lack of proper health education, and lack of empowerment in seeking out health care) are acknowledged, unprotected sexual activity among adolescents is also linked to having multiple sexual partners and engagement in other 'risk-taking' behaviours (such as alcohol or drug use).

Adolescent sexual activity is also believed to lead to negative reproductive health outcomes for youth populations, particularly for young women (Dixon-Mueller, 2008). Within global South regions, early sexual debut for young women (before or within the context of marriage) is an area of particular concern (Santhya & Jejeebhoy, 2015). In particular, early sexual debut is often linked with unprotected sexual activity that results in a number of issues including:

increased risks of unintended pregnancy, unwanted childbearing, abortion, and HIV and other STIs for young women (Hindin, & Fatusi, 2009; Musacchio & Forcier, 2008). Moreover, early sexual debut is often associated with coercion and abuse, and other risk behaviours such as substance use (Musacchio & Forcier, 2008).

Although most countries have declared their commitment to the elimination of early marriage, research has demonstrated that the practice endures in many regions of the world (Santhya & Jejeebhoy, 2015). During the period of 1986 – 2004, 36% of women globally (between the ages of 20-24) were married or in a union before they reached the age of 18 (UNICEF, 2006). Based on data obtained from 33 global South countries, Santhya and Jejeebhoy (2015) argue that there has been limited change in the rates of early marriage. Interestingly, the practice of early marriage appears to be particularly gendered – with fewer than 5% of men globally (between the ages of 15-19) reporting being married – even in regions known for high levels of early marriage among young women (Santhya, & Jejeebhoy, 2015). Such research seems to point to the operation of age and power disparities within relationships. Early marriage, particularly for women, is often linked to a number of possible adverse outcomes including: early sexual debut, early pregnancy resulting in health risks (e.g. obstetric fistulae) (Zheng & Anderson, 2009), increased risk of HIV infection (Clark, 2004; Hindin & Fatusi, 2009; Musacchio & Forcier, 2008), and failure to complete schooling (Grant, & Hallman, 2008; Musacchio & Forcier, 2008).

Research is often concerned with rates of physical and sexual violence in global South regions and the consequences for youth SRH. The WHO (2013) estimates that 29% of adolescent women (aged 15–19) have experienced physical or sexual violence perpetrated by an intimate partner. According to Santhya and Jejeebhoy (2015) 28.8% of married women (aged 15-19) in Sub-Saharan Africa have experienced physical or sexual violence within marriage or cohabitation, with similar rates identified in Asia (the highest being 32.6% reported in South Asia) and Latin American and the Caribbean (30.4%). However, reliable data concerning the rates of physical and sexual violence among adolescents are often difficult to ascertain given that many cases go unreported. Moreover, in many regions laws against sexual violence do not exist or are not enforced (Musacchio & Forcier, 2008). In addition to being a human rights concern, high levels of physical and sexual violence are associated with adverse reproductive health outcomes, such as increased risk for contracting

STIs and HIV (Koenig et al., 2004; Maharaj, & Munthree, 2007; Williams, McCloskey, & Larsen, 2008; Zablotska et al., 2009; Polis et al., 2009).

With particular reference to young women, the risks associated with pregnancy and abortion is frequently cited in relation to youth SRH in the global South. Of the more than 14 million births to adolescents each year, the vast majority occur in global South regions (Musacchio & Forcier, 2008). Complications related to pregnancy and/or unsafe abortion are stipulated as the leading cause of death for young women (aged 15-19) in research concerning low- and middle-income countries (Levine, Lloyd, Greene, & Grown, 2009). Adolescent pregnancy in global South regions is often associated with several risk behaviours including: multiple sexual partners, STIs, failure to use contraception, and alcohol use. Moreover, early pregnancy is often linked to poor economic and educational opportunities (Musaccchio & Forcier, 2008). Adolescent pregnancy may lead to school dropout or expulsion (where school policy is unsympathetic to adolescent pregnancy) (Hindin, & Fatusi, 2009), further exacerbating economic and educational disadvantage for many young women. It is important to note that rates of pregnancy- and unsafe abortion-related complications within global South regions are disproportionate to higher income countries. However, these complications and related maternal mortality can be linked to weak health systems that are common in resource constrained contexts in the global South.

Importantly, the advancement of youth SRH in the global South occurs amid various constraints including poverty, relative deprivation, and vast social asymmetries (WHO, 2014), which may significantly contribute to poor SHR outcomes. Research has shown that some young people are particularly susceptible to poor SRH outcomes. Such vulnerability stems from a range of individual and contextual factors, including marginalisation, social asymmetries, and exploitation that are related to educational status, sociocultural and economic status, geographic location, disability status, caste, ethnicity, citizenship status, and gender or sexual identity (WHO, 2014; Woog et al., 2015). Further, poor SHR outcomes may contribute to increased marginalisation, criminalisation, and added vulnerability of adolescents and youth (Judhistari et al., 2012) and serve to entrench existing social inequalities.

As illustrated in the above discussions, it is important to note that research surrounding youth SRH is often primarily linked to heterosexual, cisgendered women's access to various SRH

programmes and services (Miller, & Vance, 2004). Importantly, research that seeks to consider youth SRH (particularly the SRH of queer youth) outside of such a heteronormative and ciscentric framework remains sparse. While the importance of SRH in these terms should not be negated, failure to recognise the intersection of other social hierarchies and inequalities in terms of sexual orientation, gender identity, race, and class serves as a form of material and symbolic deprivation for already marginalised and stigmatised populations, such as queer youth (Miller, & Vance, 2004). As such, subsequent chapters will serve to review those studies that have sought to address SRH concerns for both queer youth and queer adult populations.

In addition to research interests, international, regional, and national commitments to youth SRH also fail to reflect the specific needs of queer persons (Miller, & Vance, 2004; Saiz, 2004), as will be discussed in greater detail in the subsequent section. Notably, representation of queer persons occurs not only through active inclusion, but also when such representations are rendered invisible. The focus on youth SRH concerns in terms of heterosexual and cisgender experience serves to render invisible the SRH needs of queer youth. Moreover, these representations have implications for normative subject positions (and by extension non-normative subject positions), which enjoy stronger institutional support and as such, constitute more legitimate ways of being, validating the power of certain groups and excluding others. As such, the failure to include concerns surrounding queer youth has far reaching consequences for their sexual and reproductive health.

Situating Sexual and Reproductive Health for Queer Youth in the Global Arena

Youth SRH issues tend to be driven by several international commitments, dating back to the International Youth Year (1985), which served to recognise adolescents' rights to reproductive health care. Despite an initial increase in international attention towards youth SRH, vast inequalities exist between and within global South countries in terms of the development and implementation of youth SRH policies. Such differences are observable in differing government expenditure and youth access to SRH education and services (Aine, & Bloem, 2004; Berer, 2004; Dennis, & Zuckerman, 2008). However, given that no reviews of country-level policies in the global South currently exist, it is difficult to ascertain the status of SRH policies in these regions.

Although some of the literature points to the value of both international and regional commitments in the advancement of SRH, many of these instruments fail to directly address SRH concerns for sexual and gender minorities (Saiz, 2004). Moreover, discriminatory laws and policies (and the lack of forthcoming guarantees of equal rights regardless of sexual orientation and/or gender identity) at a national level serve to hinder the attainment of SRH for queer persons (Campbell, 2013; de Graaf, Bakker, & Wijsen, 2015; Saiz, 2004). For example, the presence of criminalising laws (and absence of legal protections) within states can impede access to health information and services, adversely affecting the health status of queer persons. Notably, the presence and operation of a sexual hierarchy (Rubin, 1984) in international and national policy making and indeed in the literature surrounding SRH serves as another form of censure and erasure for queer populations (Miller, & Vance, 2004).

The following discussion provides a comprehensive overview of the global arena in which SRH is situated in order to provide an overriding context for the implementation of state policies concerning youth SRH. Discussion will commence with an exploration of international legal systems, detailing how such systems operate in relation to the regulation of global health standards and the creation of global norms that influence state action. Discussion will then move to examining SRH concerns as they relate to individual states - outlining the ways in which state action and accountability operate in relation to these international systems, with particular reference to SRH. Finally, a brief history of the progress that has been made in securing rights in terms of diversity in sexual orientation and gender identity within international legal systems will be outlined. Given the influence of international legal systems in setting the agenda for responses to youth SRH, it is important to provide an overview of these systems. In seeking to explore the policy responses to the SRH of queer youth, it is important to ensure that national policies are located within this international context, in order to facilitate a broad understanding of policy responses to queer youth SRH.

Understanding international legal systems in relation to SRH

Although public health law is predominately a domestic concern, globalisation has resulted in a decline in the practical capacity of individual states for unilateral national action. According to Taylor (2008), there is a need for structures that transcend traditional national approaches and allow for multilateral negotiation and cooperation between member states if public health

challenges are to be effectively addressed. In theory, international law allows for the regulation of global health standards and the creation of global norms that influence state action. Further, international structures are intended to serve as relatively stable and on-going negotiating forums, facilitating treaty-making efforts. However, the ability of international systems to operate effectively in this capacity is often contested.

International health law is largely treaty-based and is conducted under the guidance of international organisations. In recent years there has been a significant increase in the number of international organisations active in the area of health. In addition to the United Nations (UN), the World Health Organisation (WHO), United Nations Children's Fund (UNICEF), United Nations Environment Programme (UNEP), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), and the World Bank (WB) are significantly involved in health-related concerns. Although many of these organisations (for example, the World Bank) do not have law-making authority or the legal mandate to serve as a platform for international health negotiations, they still operate as highly influential forces within the field of health (Taylor, 2008).

Most international public health law is outlined in international treaties (Taylor, 2008). International treaties (also called conventions, covenants, protocols, and pacts) are legally binding agreements between states with formal enforcement mechanisms (Kossen, 2012). Treaties only become binding on states after signature and ratification, which is the formal process whereby treaties are incorporated into the domestic law of a country (Kismödi, Cottingham, Gruskin, & Miller, 2015). In some countries, this automatically happens upon signature of a treaty, while in other countries, the enactment of national legislation is required to ratify a treaty. However, once almost all the nations of the world have adopted a particular treaty, it is considered part of customary international law and its provisions are recognized as the common standard of achievement for all nations regardless of signature and ratification. In such cases, even non-signatories can be bound by treaties (Kossen, 2012).

Further, each international treaty has a monitoring body, or committee, that monitors state compliance with the provisions of the treaty (Gruskin & Ferguson, 2009). Governments are

required to report to UN treaty-monitoring bodies (TMBs) on a regular established basis[1] (Gruskin & Ferguson, 2009; Gruskin, Roseman, & Ferguson, 2007; Merali, 2000). TMBs also issue Concluding Observations which report on the country's status, including recommendations that seek to enable governments to better understand the nature and scope of their obligations under the treaty (Gruskin & Ferguson, 2009; Gruskin et al., 2007; Merali, 2000; Nowicka, 2011). In doing so, TMBs can draw attention to areas of concern, suggest strategies to remedy violations, request implementation steps to be taken, and call for improved performance prior to the next reporting session (Merali, 2000).

TMBs are comprised of independent experts who have been nominated and elected by national governments in consultation with a wide range of specialised agencies, non-governmental organisation (NGOs), academics, and other human rights experts (Gruskin & Ferguson, 2009; Gruskin et al., 2007). Although these experts may represent differing political and legal ideologies, such bodies are often able to reach consensus relatively quickly in comparison to national governments (Gruskin & Ferguson, 2009). In theory, such experts are believed to be less influenced by political controversies than national governments and as a result have been able to make important gains in the area of SRH where national governments have failed (Nowicka, 2011). Additionally, such bodies are largely unencumbered by the complexities of effecting legal reform at a national level and are in a position to challenge the reluctance of certain states to enact changes that oppose their political ideologies or 'popular' opinions of citizens (Gruskin & Ferguson, 2009).

In some cases, treaties are accompanied by Optional Protocols, which outline procedures for undertaking complaints and inquiries (Kossen, 2012; Merali, 2000). Given that treaty obligations fall to governments rather than citizens, states must bring actions against other states in cases of violations. However, many states are unwilling or reluctant to take such an action. Nevertheless, the Optional Protocol is an important mechanism in so far as it allows an individual to bring a complaint against the state. Although determinations following a complaint are not binding, they do provide persuasive precedent for future complaints heard by TMBs (Kossen, 2012). For example, the Optional Protocol to the Women's Convention allows for an inquiry procedure, which may include a visit to a territory, if reliable

[1] UN Member states must also submit a comprehensive review to the Human Rights Council every four years, providing an analysis of the entire human rights record of the relevant country (Kossen, 2012).

information is received by a state party indicating grave or systematic violations of rights under the Convention (Merali, 2000).

TMBs are in a position to examine state laws, legal and enforcement procedures, health services, health funding and accessibility, and health needs as part of monitoring states' obligations (Merali, 2000). Moreover, they have increasingly begun to play a visible role in monitoring state obligations in terms of a wide range of health-related issues, including sexual and reproductive health (Merali, 2000; Nowicka, 2011). The findings and recommendations issued by TMBs have constituted important tools for the protection of human rights related to sexuality and sexual health (Kismödi et al., 2015). For example, the Committee on Economic, Social and Cultural Rights (CESCR) and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) have repeatedly and consistently called for the repeal of laws criminalizing homosexuality in countries around the world (CESCR, 1998; CEDAW, 1999).

The effectiveness of reporting procedures is often dependent upon full and timely submission of reports, prompt consideration of reports by TMBs, access to independent sources of information, the ability to follow up on recommendations to state parties, and publicity for the proceedings (O'Hare, 1999). These bodies often depend on the power of moral condemnation, political embarrassment, and national pride to induce change. The public announcement of governmental failure within an international forum can sometimes be a powerful tool to induce change at a domestic level. Moreover, recommendations and criticisms issued by TMBs can be a useful tool for advocacy and lobbying action by NGOs (Merali, 2000).

Finally, other consensus documents (including resolutions, declarations, and codes of conduct, guidelines, or standards) can also play an important role in guiding state action. These documents are most often intended to be nonbinding instruments which express the common interest of several states in specific areas of international cooperation (Kossen, 2012; Taylor, 2008). However, these instruments can serve as effective mechanisms for the advancement of international consensus in important areas of concern and can be utilised to promote consistent state action (Taylor, 2008). Further, these instruments often include provisions (such as prohibitions against torture, slavery, and genocide) that amount to

customary international law and are therefore prohibited no matter which treaties a state has signed (Kossen, 2012).

In the absence of an effective overarching framework to manage and co-ordinate law-making efforts among different international organisations, there exists a significant overlapping of legal authority and institutional objectives, which has resulted in the risk of institutional overload and inconsistent standard setting (Taylor, 2004). Outside the UN system, national governments and individual citizens have utilised international law to push for legal and policy reforms within their national legislative and judicial systems. Many states have taken important and proactive steps to domesticate many of the standards set out in international treaties and other nonbinding consensus documents (e.g. declaration, resolutions etc.) (Kossen, 2012). International law has also been cited by individuals in domestic lawsuits brought against governments and has sometimes resulted in positive changes in the application of international law within the domestic sphere (Gruskin, Mills, & Tarantola, 2007).

Considering state accountability within international legal systems

Although treaties do not establish human rights because those are inherent to all human beings, they do guarantee those rights and place obligations on state parties to respect, protect, and fulfil them (Kossen, 2012). Respecting rights means that parties must refrain from making laws or policies that either directly or indirectly results in the infringement of citizens' enjoyment of their rights (e.g. restrictions on voting rights for women). Meanwhile, states must also protect rights by taking proactive steps to prevent rights violations by state actors (unlawful detention by law enforcement officials, for example). Finally, states are obligated to fulfil rights by putting in place mechanisms that will ensure the full realization of human rights. Fulfilling rights can take many forms, including enacting laws and policies that support human rights, fully funding health care services, enhancing and training the judiciary to ensure that citizens have appropriate redress for rights violations, and establishing other accountability mechanisms for violations (Kossen, 2012).

In theory, states can be held accountable for failure to comply with their obligations to bring their laws, policies, and practices in line with international, regional, and national human rights standards – either by demonstrating state action or inaction (Kismödi et al., 2015;

Merali, 2000; Tarantola & Gruskin, 2008). State accountability is seemingly monitored through international and regional monitoring mechanisms (such as the UN treaty monitoring bodies) and other mechanisms such as the UN Special Rapporteur on the right to health and the Special Rapporteur on torture (Kismödi et al., 2015; Tarantola & Gruskin, 2008). These review processes seek to identify laws that have harmful effects and/or that contradict human rights. Social and political movements can also play an important role in upholding or reforming laws to guarantee legal protection and fulfilment of sexual health and related rights (Kismödi et al., 2015).

However, accountability mechanisms generally focus on the existence of laws and policies rather than the specificity of their content and implementation. Most often, little attention is paid to the co-existence of legislation and policy that may refer to relevant populations in inconsistent and contradictory ways (Gruskin & Ferguson, 2009). According to Gruskin and Ferguson (2009), many countries have reported the co-existence of laws that specify protections for particular populations whilst others present obstacles to their ability to deliver effective health care services for these same populations. For example, in Vietnam some legislation encourages the provision of condoms to vulnerable groups, but under other legislation carrying condoms can be regarded as evidence of sex work, which is illegal (Gruskin & Ferguson, 2009).

Moreover, in practice, it is not always clear how accountability might be ensured – particularly since much of public health policy implementation is dependent upon resources (Merali, 2000; Yamin, 2008). Accountability is informed by the principle of progressive realisation, which takes into account the inability of governments to meet their obligations immediately and completely (Tarantola & Gruskin, 2008; Taylor, 2008). However, this principle does create an obligation for governments to set their own benchmarks in line with the resources available to them and to demonstrate that progress towards the health goals to which they have agreed in international and regional forums is being achieved (Tarantola & Gruskin, 2008). Many states, particularly ‘developing’ countries, face acute problems of limited resources and capacity. In response, expanded mechanisms have been incorporated into relevant conventions in the form of international technical and financial assistance programs such as the UNDP, UNICEF, and UNFPA (Taylor, 2008).

However, at times, failure of states to implement international commitments is more related to lack of political will, rather than lack of resources. In fact, many conservative governments rarely comply with the recommendations of the human rights bodies regarding sexual and reproductive rights (Nowicka, 2011). One of the innate weaknesses of international law stems in large part from the core principle of state sovereignty – meaning that states are still afforded a wide margin of discretion within the UN human rights system when it comes to implementing international commitments (Saiz, 2004; Taylor, 2008). Appeals to cultural and national sovereignty are frequently used as justification for denying rights on the basis of sexual and/or gender diversity (alongside other sexual rights) (Saiz, 2004). Some governments in Asia, Africa, and the Middle East have drawn on fixed and selective notions of culture by asserting that homosexuality is a foreign imposition and manifestation of Western decadence (Long, 2003; Saiz, 2004). Such appeals are not limited to governments of the South – the US has been at the forefront of recent fundamentalist attempts to impede (and even reverse) sexual and reproductive rights in the name of defending traditional family values (Girard, 2014; Petchesky, 2000).

Exploring the international legal system in relation to queer rights

For the most part, women's sexual and reproductive health has been consistently recognised as a human right by most UN political bodies (through instruments such as the Vienna Declaration and Programme of Action, Cairo Programme of Action, Beijing Declaration and Platform of Action and so on) (Barroso, 2014; Bianco, 1997; Gruskin et al., 2007; Merali, 2000; Nowicka, 2011; Seims, 2011). Although there is an argument to be made that progress in strengthening sexual and reproductive health and rights standards for women has been slow (Bianco, 1997; Girard, 2014; Nowicka, 2011), even less progress has been made in securing rights in terms of diversity in sexual orientation and gender identity. To date, sexual orientation is still not mentioned in any binding UN human rights treaty, or in any final political commitment document resulting from a UN conference. In fact, instruments such as the Beijing Declaration and Platform for Action contain extensive reservations by states on the provisions relating to sexuality (Saiz, 2004).

The Cairo Programme of Action (resulting from the 1994 International Conference on Population and Development) serves as the strongest international instrument pertaining to sexual and reproductive health. The Programme of Action recognised that global

sustainability could only be achieved by securing women's reproductive rights, calling for provision of a full range of sexual and reproductive health services (Barroso, 2014; Gruskin et al., 2007; Merali, 2000; Nowicka, 2011; Saiz, 2004; Seims, 2011). The Cairo Programme of Action also recognised the particular vulnerabilities of adolescents to sexual and reproductive health risks (Barroso, 2014; Kismödi et al., 2015). It called upon governments to meet the educational and service needs of adolescents, highlighting the importance of developing reproductive health information, counselling and services specifically designed to meet adolescents' needs (Barroso, 2014). However, despite these positive steps, the Programme of Action failed to elaborate on the various dimensions of sexuality, sexual health, and sexual rights (Kismödi et al., 2015).

Since the ICPD in 1994, several attempts to include references to sexual orientation in draft declarations have been met with staunch opposition, with the words remaining bracketed before being dropped in the interest of "consensus". At the 1995 Fourth World Conference on Women in Beijing, four references to the persecution of women based on sexual orientation in the draft Platform for Action were removed following opposition from the Holy See, some Islamic states, and organizations representing the Christian right (Girard, 2007; Saiz, 2004). In 1999, the Holy See and other theocratic governments successfully resisted the inclusion of any language that could be interpreted as addressing either abortion or homosexuality in the ICPD+5 Key Actions Document (Center for Reproductive Rights, 2000).

At the UN General Assembly Special Session in 2000, a proposal to add reference to measures taken to prohibit discrimination on the basis of sexual orientation was opposed by delegates from Senegal, Syria, Nicaragua, and Kuwait on the grounds that they could not accept sexual orientation (more specifically same-sex sexualities) as a human right. At the UN World Conference against Racism in 2001 a proposal by Brazil to recognize sexual orientation as a related form of discrimination remained bracketed in the Conference's draft Program of Action until the last day and was eventually deleted (Saiz, 2004).

At the 60th session of the UN Commission on Human Rights in 2004, a resolution expressing concern about human rights violations occurring on the grounds of sexual orientation was met with concerted opposition from the Organization of Islamic Conference (OIC) and the Holy See (Center for Reproductive Rights, 2000). It was argued that sexual orientation was not a proper subject for consideration by a human rights body. Five member states of the OIC

proposed deleting all reference to sexual orientation in the draft (rendering it meaningless), with Pakistan describing the draft resolution as an “insult” to the world's 1.2 billion Muslims (Saiz, 2004).

Arguments made by certain conservative states against the inclusion of sexual orientation within binding legal instruments consistently assert that the principle of non-discrimination on the grounds of sexual orientation cannot be considered as universally recognized as it does not appear in any UN treaty. Accordingly, it is argued that discrimination on the basis of sexual orientation is not a human rights issue, but rather a social and cultural one that should be left to each state to address within its own sovereign systems. Moreover, it has been argued that sexual orientation (an "undefined term") may be a legitimate basis for discrimination to protect children and the family and any inclusion within a binding legal instrument serves as a major threat to fundamental religious and cultural values. As such, it is asserted that sexual orientation as a source of universal rights is culturally divisive and therefore threatening to the UN consensus. Certain governments have intensified their efforts to impede or reverse any recognition of such rights, using "cultural sovereignty" as a justification. As preceding discussion has demonstrated, such arguments have a long and successful history at many UN forums made up of government representatives (O’Flaherty & Fisher, 2008; Saiz, 2004).

More recently, the inclusion of provisions pertaining to sexual orientation and gender identity have enjoyed greater success at regional meetings of governments. In 2013, at the Economic Commission for Latin America and the Caribbean, governments agreed to design policies and programmes to eradicate discrimination and violence based on sexual orientation and gender identity. These governments also agreed to ensure effective and universal access to fundamental services for all victims and survivors of gender-based violence, with special attention paid to women in high-risk situations. The list of women considered vulnerable to violence was extensive and included older women, pregnant women, women with disabilities, culturally diverse groups, sex workers, women living with HIV/AIDS, lesbians, bisexuals, ‘transsexuals’, Afro-descendant, indigenous and migrant women, women living in border areas, asylum-seekers and victims of trafficking. It was also unprecedented – representing the first time “lesbians, bisexuals and transsexuals” were mentioned in any inter-governmental agreement (Girard, 2014).

At the Sixth Asia-Pacific Population Conference in 2013, governments expressed concern over violence and discrimination committed against individuals on the grounds of their sexual orientation and gender identity and called for the elimination of vulnerability and discrimination on the basis of sex, gender, age, race, caste, class, migrant status, disability, HIV status, sexual orientation, and gender identity. These governments agreed to address the barriers that impede access to HIV prevention, treatment, care and support, particularly among what is identified as 'key affected populations', including sex workers, persons who inject drugs and men who have sex with men (MSM), transgender and mobile populations. Such provisions were included despite pressure exerted by Russia and Iran throughout the negotiations. The final text was adopted by 38 votes in favour and only three against (Russia, Iran and Azerbaijan) and one abstention (Afghanistan). Importantly, countries such as Malaysia and Bangladesh, which had expressed difficulties with mentions of sexual orientation and gender identity, chose to vote in favour and issue an explanation of position instead (Girard, 2014).

However, at the African Regional Conference on Population and Development in the same year, provisions concerning sexual orientation and gender identity were not included in the final Declaration. Although the initial draft contained a reference to non-discrimination on the basis of sexuality, the lack of support by several African states caused all references to be removed from the text before adoption. There was significant opposition to the inclusion of any language that, even covertly, could be seen to address sexual orientation and gender identity – to this end a number of governments called for the removal of language that called for protecting human rights 'without distinction of any kind' or 'without discrimination'. Even more regrettably, a few civil society organisations present at the conference actively promoted homophobic positions. Similarly, at the Economic Commission for Europe in 2013 provisions concerning discrimination and violence on the basis of sexual orientation and gender identity were not reflected in the final document, despite the fact that an overwhelming number of governments spoke about the need to combat these particular issues (Girard, 2014).

A number of decisions and interpretations made by treaty monitoring bodies have sought to address concerns surrounding discrimination on the basis of sexual orientation. In 1994 the Human Rights Committee (HRC) issued a ground-breaking decision in the case of Toonen v. Australia. The HRC found that Tasmanian laws criminalizing sexual relations between men

were in breach of the International Covenant on Civil and Political Rights (ICCPR), whose non-discrimination provisions were interpreted as including sexual orientation (Gruskin & Ferguson, 2009; Saiz, 2004). Moreover, the Committee on the Rights of the Child (CRC) has highlighted the adverse effects of discrimination on the basis of sexual orientation for adolescent health. Further, it has called on states to ensure that young gay and transgender people have adequate access to appropriate information, support, and necessary protection (CRC, 2002). Two General Comments by the CRC have reaffirmed the need to address sexual orientation discrimination in the context of promoting adolescent health and preventing HIV/AIDS (CRC, 2003a; CRC, 2003b). The Special Rapporteur on the Right to Health has highlighted how discrimination and violence against lesbian, gay, bisexual, and transgender people impede their enjoyment of sexual and reproductive health and rights. More recently, the Committee on Economic, Social, and Cultural Rights has broadened proscriptions of discrimination on the grounds of sexual orientation to include gender identity, including concerns related to the availability of health information and services (Gruskin & Ferguson, 2009). However, although these decisions and interpretations are authoritative, most states hold that they are not legally binding (Saiz, 2004).

In theory, international human rights systems might provide recourse against laws and practices that have criminalised and pathologised sexual and/or gender minorities. In practice, however, rights related to sexual orientation and gender identity remain politically contested. Nevertheless, progress in terms of international legal bodies cannot be measured solely in terms of textual references to sexual orientation. Where such references are absent, sexuality more broadly has had an increasingly tangible presence. The lack of explicit reference to sexual orientation has meant a reliance on progressive interpretations of existing human rights provisions, typically in terms of the right to privacy, rights to physical integrity (freedom from torture and the right to life), and freedom from discrimination on the grounds of sex. For the most part, the principle of non-discrimination on the grounds of sexual orientation has become established in some international standards (particularly the decisions and interpretations of TMBs discussed in the previous paragraph), requiring not only the repeal of discriminatory criminal laws but also the adoption of proactive anti-discrimination measures (Girard, 2007; Saiz, 2004).

Although rights claims based on these approaches have achieved important victories, each has its limitations and has proven insufficient on its own. In particular, non-discrimination

allows considerable scope for subjective interpretation regarding what circumstances may justify differential treatment. If the criteria for differentiation are deemed "reasonable and objective" and/or the aim is to achieve a purpose deemed "legitimate" under international standards, differential treatment is not considered discrimination. Moreover, the basic concepts underpinning human rights law (such as marriage, the family, and state sovereignty) continue to be interpreted in heterosexist ways (Saiz, 2004). Further, the binary categories inherent to non-discrimination norms (such as men/women, homosexual/heterosexual etc.) can also serve to subtly reinforce the prioritisation of one over the other (Heinze, 2000). Concepts such as “lesbian and gay” and “sexual minorities” are often fluid and culturally-specific and as such impede the kind of categorisation that is necessary for codification in anti-discrimination instruments. As such, non-discrimination arguments will only have limited success without addressing the structural biases of international human rights law (Saiz, 2004).

International legal systems are intended to serve as a means to regulate global health standards and create global norms that guide state action. In theory, states can be held accountable for failure to comply with international human rights standards. However, in practice, it is not always clear how accountability of states might be ensured. In theory, these systems might provide recourse against laws and practices that have criminalised sexual and/or gender minorities. In practice, however, rights related to sexual orientation and gender identity remain politically contested. In fact, many conservative governments fail to comply with recommendations calling for the provision of equal rights for sexual and gender minorities, by drawing on claims to cultural and national sovereignty. Moreover, sexual orientation is not mentioned in any binding UN human rights treaty, or final political commitment document resulting from a UN conference. Since the ICPD in 1994, several attempts have been made to include references to sexual orientation in draft declarations. These have been have been met with staunch opposition, with the words remaining bracketed before being dropped in the interest of “consensus”. In seeking to explore the policy responses to the SRH of queer youth within selected global South countries, it is important to be mindful that recognition of sexual and gender minorities remains contested at international and regional levels of policy-making. As such, the location of national policies within such a challenging international context must be acknowledged, especially in cases where national policy is deemed inadequate in addressing the SRH concerns of queer youth.

Key Theoretical and Methodological Concepts

Within this research, a sexual and reproductive justice (SRJ) framework was adopted as a backdrop for exploring policy documents related to youth sexual and reproductive health (SRH) within selected global South countries in Africa, Asia, and the Caribbean. This research took the form of a systematic review utilising a deductive framing and positioning thematic analysis. Analysis drew on Chong and Druckman's (2007a; 2007b) notion of communication frames and Davies and Harré's (1990) concept of positioning to analyse the framing of policies and the subject positions deployed in these policies. Although framing and positioning do not share the same epistemological foundations, they can be understood as distinct, yet compatible, theoretical frameworks (Gordon, 2015). Additionally, a basic content analysis was also conducted. Frequency counts were conducted for each identified framing and for each framing broken down according to region. This allowed the researcher to ascertain the frequency of use for each framing – both generally and according to region.

Analysis sought to explore three distinct, yet related, avenues of inquiry including: identification and examination of the framings of youth SRH within policy extracts; and the utilisation of identified framings to explore the deployment of clearly delimited subject positions for queer youth. Finally, the research sought to draw out any trends (or themes) within and across countries, and regions in relation to the framing of youth SRH and the positioning of queer youth in particular. The final data set comprised of 1035 policy excerpts extracted from 152 policies across Africa, Asia, and the Caribbean (with Latin America being excluded from review during preliminary stages of data collection). This research was connected to a broader team project which took the form of a systematic review of policy responses to the SRH of young women and other marginalised youth in the global South. As such, a number of the initial methodological processes were undertaken in conjunction with a co-researcher (Dr Malvern Chiweshe). Further details of this collaboration will be explored in Chapter 4.

Finally, it is necessary to note that this research is located within the field of political psychology, which serves to apply what is known about human psychology to the study of politics. Political psychology draws from a broad range of theoretical frameworks including those related to the fields of intergroup relations, personality psychology, psychopathology, development psychology, cognitive psychology, and social psychology. Utilising these varied

theoretical frameworks, political psychology addresses a number of political phenomena such as mass political behaviour, mass communication effects, political socialisation and civic education, political movements, political mobilisation, policy decision-making, and intergroup conflicts involving race, gender, sexual orientation etc. (Sears, Huddy, & Jarvis, 2013).

According to Elcheroth, Doise, and Reicher (2011) political psychology gains particular relevance in the exploration of social representations (such as framings and positionings) as examined within the current research. In particular, they argue that social representations serve as a form of shared knowledge, and that this knowledge is critical in understanding human action. Moreover, these representations are meta-knowledge, meaning that collective behaviour can often be influenced more successfully at the level of meta-representations than of personal beliefs. Social representations are also enacted in communication. As such, social influences are utilised by both constraining social practices, and the discourses that interpret these same practices. Finally, Elcheroth and colleagues (2011) argue that social representations do not simply reflect social reality but they also serve to constitute (and sometimes change) that social reality. In this sense, the theoretical underpinnings and key methodological assumptions of the research undertaken here align closely with the field of political psychology.

Rationale for the Research

Despite the far-reaching implications of youth SRH, there are few policies that focus specifically on youth SRH. Instead, these issues are more commonly addressed in general terms across different policies, and in some cases are neglected entirely. This is especially true of the global South (which comprises largely of low- and middle-income countries) where youth SRH issues are subsumed within school health policies (e.g. South Africa, Kenya, and Rwanda), national youth health policies (e.g. India, Nepal, and Malaysia), national youth policies (e.g. Bangladesh, Kazakhstan, and Uruguay), and national health policies (e.g. Botswana and Lesotho) (Pillay, & Flisher, 2008). Additionally, such policies often adopt a narrow definition of young people, fail to recognise the diversity of needs within youth populations, and overlook the range of individual and contextual factors that play an important role in SRH outcomes (Department of Health, 2011; Hindin, & Fatusi, 2009; Judhistari et al., 2012).

Given the way that youth SRH have tended to be addressed in policy-making, it is difficult to gain an overall perspective of policy responses in the global South. Thus, significant difficulties arise in ascertaining the current status of youth SRH policies in these regions. To date, no comprehensive or systematic review has been conducted to assess policy responses to youth SRH in general (and queer youth SRH specifically) in the global South. A key advantage of systematic reviews of policy is that it assists in presenting oftentimes conflicting and complicated data in more useable and accessible ways, in line with the growing emphasis placed on 'evidence-based' decisions and interventions in public health policy and practice (see Boaz, Ashby, & Young, 2002; Davies, Nutley, & Smith, 2000; Klein, 2000; and Solesbury, 2002).

Moreover, a framing and positioning thematic analysis is able to provide valuable recommendations for the improvement of policy responses to the SRH of queer youth. In particular, the manner in which youth SRH concerns are framed and how queer youth are positioned within policies provide a foundation for the implementation of health care and similar social services (such as education and welfare). Although there is no direct correspondence between policy and practice, policy is nevertheless an important factor to be carefully considered in relation to efforts to address concerns surrounding the sexual and reproductive health of queer youth. The systematic review undertaken here will provide insight into the themes evidenced in policy responses to youth SRH (particularly in relation to framings and positioning), and as such can be utilised to informed the development of innovative interventions to advance SRH of queer youth, and support further development of enabling policy drawing on the principles and sexual and reproductive justice.

Overview of Chapters

The subsequent chapters will outline a number of key areas related to the undertaken research. Discussion in Chapter 2 explores previous research in the field of youth SRH – particularly in relation to policy implementation and the effects on punitive and protective legal environments for queer SRH. This chapter will also explore research on youth SRH in the context of two key institutions particularly relevant to the sexual and reproductive lives of queer youth – the health care and education systems. Chapter 3 explores the theoretical frameworks underpinning the research. Discussion will explore the value of a SRJ framework as a theoretical tool for developing nuanced approaches to addressing SRH concerns before

detailing the concepts of framing and positioning as operationalised during the analysis process. Chapter 4 will outline the various methodological processes undertaken including those related to conducting a systematic review, and the various steps undertaken to conduct a thematic analysis. Chapters 5 and 6 will outline the findings that emerged during analysis. Chapter 5 outlines the identified framings of youth SRH (including public health, human rights, and context and culture framings); highlighting the basic assumptions underpinning reference to youth SRH in selected global South policies. Chapter 6 explores the positioning of queer youth within these policies, whilst also exploring how identified framings allow for the deployment of certain subject positions for queer youth. The final chapter will review the findings of the analysis, making note of the strengths and limitations of the research. Suggestions for improving policy responses to queer youth SRH will be made, along with avenues for future research.

CHAPTER 2: THE SEXUAL AND REPRODUCTIVE HEALTH OF QUEER PERSONS WITHIN LEGAL, POLICY, AND HEATH CARE DOMAINS

A growing body of evidence has illustrated that queer persons face significant levels of social marginalisation and discrimination in many areas including employment, education, income, housing, and health care (Corliss, Belzer, Forbes, & Wilson, 2007; Holman & Goldberg, 2006; Lombardi, 2001; Morison & Lynch, 2016). Of particular interest to the current research are concerns around equitable access to health care and SRH for sexual and gender minorities. Findings from a broad range of research suggest that the main areas for concern are: pervasive systems of heteronormativity and heterosexism, high instances of discrimination, untrained and culturally insensitive health care providers (HCPs), failure to accommodate queer-specific health care needs within current systems, and structural barriers that limit sexual and gender minorities' decision-making and access to health care services (Corliss et al., 2007; De Santis, 2009; Gapka & Raj, 2003; Morison & Lynch, 2016; Müller & Hughes, 2016; Skinner, 2015).

The subsequent discussion will explore each of these main areas of concern, in an attempt to explore the social determinants of health. In doing so, links will be created between stigma, marginalisation, discrimination, and health outcomes in order to engage with a nuanced understanding of queer SRH. In order to foreground discussion of queer experiences of health care, discussion will first address the implications of criminalising laws (and absence of legal protections) in terms of the enactment of policy, and the inclusion of queer populations within SRH policy concerns. Discussion will then explore dominant discourses within policy responses to the SRH of heterosexual and queer youth, before concluding with an overview of key research findings (across global North and South regions) of queer experiences of health care systems.

The Effects of Punitive Legal Environments

Members of queer populations may be subject to social exclusion, stigma, discrimination, violence, and other human rights violations, particularly within the context of punitive legal environments (such as those that criminalise same-sex sexualities and gender non-conformity) (Cáceres, Aggleton, & Galea, 2008; Ehlers, Zuyderduin, & Oosthuizen, 2001; Hatzenbuehler et al., 2014; Hatzenbuehler, Phelan, & Link, 2013; Johnson, Carrico, Chesney,

& Morin, 2008; Meyer, 2003; Ross, Rosser, Neumaier, & the Positive Connections Teams, 2008). According to the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA) (2017) there are 72 states[2] classified as 'criminalising' states, including Egypt where same-sex sexual relations are de facto severely outlawed. In 45 of these states the law is applied to both women and men (Carroll & Mendos, 2017). Penalties for such 'offences' are highly varied - ranging from 1 month to life in prison, with some countries continuing to apply the death penalty[3] (Carroll & Mendos, 2017). Moreover, 19 states in North Africa and the Middle East (and Tanzania) utilise 'morality' laws or 'promotion' laws that actively target public promotion or expression of same-sex and transgender realities (Carroll & Mendos, 2017). For example, Nigeria's Same-sex Marriage (Prohibition) Act (2013) provides that a person who "directly or indirectly makes public show of same-sex amorous relationship[s]" may receive a sentence of up to ten years in prison. Appendix A provides a full outline of the legal status in terms of criminalisation including the legality or illegality of 'homosexuality', equal or unequal ages of consent, prison sentences, and laws concerning gender expression in global South regions.

Importantly, there are 124 states (122 UN member states as well as Taiwan and Kosovo) where there are no legal penalties levied for consenting same-sex sexual activity between adults in private (Carroll & Mendos, 2017). However, while many states may be officially tolerant of sexual and gender minorities, the pervasiveness of heterosexism (and hetero-patriarchal cultures) demands secrecy and erasure around such identities, and thus significantly impedes access to an array of constitutionally guaranteed rights, including health rights (Epprecht, 2012; Rispel, Metcalf, Cloete, Moorman & Reddy, 2011; Rispel & Metcalf, 2009; Stacey & Meadow, 2016). The number of states which actively seek to shield sexual and gender minorities through legal protections is growing, but they still remain in the

[2] Given that the focus of this research lies in the global South it is worth noting that states that criminalise 'homosexuality' in Africa, Asia, Latin American and the Caribbean include: Angola and Cameroon (Central Africa); Burundi, Comoros, Eritrea, Ethiopia, Kenya, Malawi, Mauritius, Somalia, South Sudan, Tanzania, Uganda, Zambia, and Zimbabwe (Eastern Africa); Algeria, Egypt, Libya, Morocco, Sudan, and Tunisia (Northern Africa); Botswana, Namibia, and Swaziland (Southern Africa); Gambia, Ghana, Guinea, Liberia, Mauritania, Nigeria, Senegal, Sierra Leone, and Togo (Western Africa); Turkmenistan and Uzbekistan (Central Asia); Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Pakistan, and Sri Lanka (Southern Asia); Brunei Darussalam, Malaysia, Myanmar, and Singapore (South-eastern Asia); Gaza, Iraq, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, United Arab Emirates, and Yemen (Western Asia); Antigua and Barbuda, Barbados, Dominica, Grenada, Jamaica, St Kitts and Nevis, St Lucia, St Vincent and the Grenadines, and Trinidad and Tobago (Caribbean) Belize (Central America); and Guyana (South America) (Carroll & Mendos, 2017).

[3] As of May 2017, only four sovereign states apply the death penalty, while regions of two other states apply it under Shari'a, and non-state actors apply it across two more states (Carroll & Mendos, 2017).

minority within the global context (Carroll & Mendos, 2017). Appendix A provides a full outline of the issues relating to protection measures including whether an existing national human rights institution recognises sexual orientation and laws relating to discrimination protections in global South regions.

The presence of criminalising laws (and absence of legal protections) can have important implications for the enactment of policy and access to health information and services, which may adversely affect the health status of queer populations. Given that the majority of research pertaining to queer health (most often in relation to 'MSM') has focused on HIV, the findings of such research provide a useful lens to explore the potential harm to health and wellbeing within punitive legal environments (Gruskin & Ferguson, 2009). The overarching argument of most of this research is that the criminalisation of same-sex sexual activity significantly hampers HIV/ AIDS prevention (Anderson & Kanters, 2015; Gruskin & Ferguson, 2009; Itaborahy & Zhu, 2013; Saiz, 2004).

Specifically, countries where same-sex sexual behaviour is criminalized tend to have little or no data on the HIV epidemic among their 'MSM' population (Anderson & Kanters, 2015). Moreover, criminalisation can result in proscription of condom distribution within prisons, lack of HIV prevention information targeting men who have sex with men, reduced service utilisation and/or failure to disclose risk factors due to fear of the potential social and legal repercussions of seeking HIV testing or treatment services (Gruskin & Ferguson, 2009; Itaborahy & Zhu, 2013). In contrast, protective legal environments: have been found to help promote access to HIV-related information and services for 'MSM' (Cáceres, Pecheny, Frasca, Rios, & Pocahy, 2008); tend to have more government funding allocated to HIV prevention (Saavedra, Izazola-Licea, & Beyrer, 2008); and can help reduce the risk to HIV through mobilizing civil society's response to the HIV epidemic (Piot, Bartos, Larson, Zewdie, & Mane, 2008; Wright, 2005). As such, the existing legal environment within individual states serves to inform the inclusion of certain populations within policy enactments related to SRH (whilst also influencing the quality of this inclusion) and will also have important implications for the experience of sexual and reproductive health care for queer persons.

Representations of Youth and Queer Youth in Policy and Research

The consideration of policy responses to the sexual and reproductive health of queer youth offers a vital insight into dominant notions of youth sexuality. In this sense, policy represents "a site where various issues and 'truths' about sexuality are contested, challenged, reformed and transformed" (Carabine, 1996a, p. 55). In examining policies, the key assumptions of policy makers in relation to youth SRH can be explored. Often, policies present different and conflicting standpoints on youth and adolescence that serve to create (and in turn are created by) the social, cultural, and institutional conditions that determine responses to youth SRH. As such, policy is the link through which institutional and discursive practices are produced and reproduced (Moore & Prescott, 2013). In general, public adolescent sexual and reproductive health policy has the following purposes, to: (1) change behaviour at the individual and collective levels, (2) facilitate a higher priority being assigned to adolescent SRH, (3) establish a set of goals to be achieved, upon which future action can be based, (4) improve procedures for developing and prioritising adolescent sexual and reproductive services and activities (5) identify principal stakeholders in the field of adolescent SRH and to designate clear roles and responsibilities, and (6) achieve consensus of action among the different stakeholders (Pillay, & Flisher, 2008).

Within policy responses to youth SRH, Thomson (2004) argues that it is possible to identify two key perspectives - to protect youth from sexuality and to address the consequences of the youth sexuality. In terms of youth sexuality, the authority to determine what is legitimate (or appropriate) sexual behaviour has often been located within the Judeo-Christian church (particularly within Western contexts), the medical and scientific professions, and the state and its various agents (Crossley 2005; Moore & Prescott, 2013). The domination of a protectionist, heteronormative, familial welfare discourse is apparent within policy (Moore & Prescott, 2013). Within contemporary youth policy, protectionist and heteronormative discourses of youth sexuality are dominant. As a result, heterosexuality and cisgender gender identity are the dominant discursive positions for youth, serving to problematise and marginalise sexual orientations and gender identities that exist outside of the heterosexual and cisgendered 'norm' (Carabine, 1996a; Carabine, 1996b; Carabine, 2004; Moore & Prescott, 2013; Mulé et al., 2009; Russel & Bohan, 1999; Young & Meyer, 2005).

Understandings of appropriate and deviant sexual behaviour

In examining policy responses to youth sexual and reproductive health, a number of researchers have noted persistent and conflicting positions on youth sexuality. On the one hand, youth are positioned as asexual and presexual beings. On the other, youth who possess sexual knowledge and engage in sexual behaviour are positioned as problematic (Aggleton, Ball, & Mane, 2000; Egan & Hawkes 2008; Hawkes & Egan 2008; Moore & Prescott, 2013; Yoshida, 2013). As such, ideas of the sexual innocence of certain youth and sexual deviance of others are often perpetuated within policy (Warwick & Aggleton, 1990). In the UK, Aggleton and colleagues (2000) argue that this dichotomy serves to impede nuanced understandings of the sexual and reproductive health needs of youth, whilst also obscuring diversity within youth populations.

Research emerging from the US has also noted worrying trends in the perpetuation of dichotomous understandings of youth sexuality. For example, social identities such as race, ethnicity, gender and socioeconomic status are deployed to position particular youth as risky sexual subjects. For instance, young women who engage in sexual behaviour are often positioned as permissive and deviant, while those who abstain from sexual activity are considered pure and innocent (Buckingham & Bragg, 2004). Both Field (2008) and Jackson (2008) have argued that in some cases middle- and upper-class youth are deemed innocent, while their poorer counterparts are positioned as hypersexual. Similarly, youth of colour are positioned as lacking restraint and self-control with regards to their sexual behaviour, in contrast to their more 'restrained' white counterparts. Consequently, 'innocent' youth are positioned as in need of protection, whereas 'deviant' are in need of external control (Kirby, 1994). In Japan, the need to protect youth that maintain the asexual subject position and the need for corrective measures for those that deviate from this position has also been noted (Yoshida, 2013).

Similarly, the sexuality of queer youth is often positioned as abnormal, deviant, and shameful (McDermott, Roen, & Scourfield, 2008). Such homophobic views of queer youth sexuality are often linked to issues of religion, with same-sex sexualities and gender non-conformity positioned as a sin (DePalma & Francis, 2014). Although Christianity has been largely implicated in perpetuating such views, the reality is more complex, with many religious denominations playing varied and shifting roles in perpetuating (and sometimes even

disrupting) homophobic beliefs (Van Klinken & Gunda, 2012). In many cases, religious views conceptualise homosexuality as an unfortunate condition or disorder requiring tolerance (drawing on Christian teachings that good Christians should not judge their fellow man) (DePalma & Francis, 2014). Oftentimes views on homosexuality as a sin are linked to beliefs that it can be cured through religious intervention (DePalma & Francis, 2014).

Relatedly, understandings of the sexuality of queer youth (and queer persons more generally) often draws on notions of 'homosexuality' as a scientific aberration and/or mental disorder. Until 1986 it was listed in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) as a mental disorder. Although understandings of homosexuality (and gender non-conformity) as a scientific aberration and/or mental disorder have largely fallen out of favour within modern scientific and medical communities they remain pervasive within the popular imagination (DePalma & Francis, 2014). Popular understandings of homosexuality often combine out dated understandings of 'homosexuality' as a disorder with more recent scientific views (e.g. those linking homosexuality to hormonal and genetic malfunctions), resulting in vague, incomplete and often discriminatory 'explanations' for queer sexuality (DePalma & Francis, 2014).

As a result, policy responses situated within the 'appropriate' vs. deviant discursive framework seek to ensure that young people (including both heterosexual and queer youth) adopt 'appropriate' sexual behaviour (Yoshida, 2013). Within this framework, youth are constructed, targeted, and educated with the intent of producing 'responsible' adults Importantly, however, responsible sexual behaviour is determined by developmental assumptions enforced by institutional powers (such as governments) about what 'appropriate' youth sexual behaviour should entail, serving to deny youth a sense of autonomy (Egan & Hawkes, 2008, Hawkes & Egan, 2008; Yoshida, 2013).

Developmental assumptions of youth: Adolescence as transition

One of the key developmental assumptions informing notions of 'appropriate' youth sexual behaviour is the understanding of adolescence as a period of transition (Waites, 2005). Current research on adolescence tends to position it as a critical time of transition and upheaval, with the potential for progress or degeneration (Lesko, 2000; Patton, 1996). As such, it is understood as a period of development that must be carefully monitored (Lesko,

2000). Ayman-Nolley and Taira (2000) argue that much of the research in this area demonstrates a significant preoccupation with adolescence as a period of 'storm and stress'. Adolescence is thus depicted as a time of risk, turmoil, instability, and abnormality – both behaviourally and emotionally. As such, it is understood as inherently necessitating some form of intervention (Talburt, 2004).

Importantly, understandings of youth as a period of 'transition' serve to perpetuate colonialist assumptions which characterise adolescence as a distinct period of transition to adulthood. Such understandings of adolescence emerged within Western contexts, filtering into Africa and other parts of the world through a process of direct colonisation and (neo)colonialism (Caldwell, Caldwell, Caldwell, & Pieris, 1998). According to this understanding, adolescence involved a transition characterised by conflict between the primitive urges characteristic of childhood and the requirements of civilised behaviour characteristic of adulthood (Kett, 2003). This conflict inherently involved the danger of degeneration. In colonial times anxieties around degeneration centred on masturbation. More recently, these anxieties have shifted to early reproduction, abortion and the spread of disease (Macleod, 2009).

Within the realm of policy responses, Moore and Prescott (2013) argue, for example, that notions of 'transition' serve as the major framework for understanding youth behaviour in current youth policy in England and Wales. Relatedly, youth is understood as a period of 'storm and stress' that requires careful management by adults in order to ensure that adolescents grow to be responsible adults (Moore & Prescott, 2013). Within the discursive framework of transition, youth policies often fail to specifically address youth sexuality (Carabine 1996b; Moore & Prescott, 2013). Carabine (1996b) argues that in most cases youth sexuality is discussed in general terms, and is frequently conflated with sexual health and wellbeing.

Moreover, Carabine (1996b) and Moore and Prescott (2013) note that notions of transition are predicated on the assumption that 'normal' youth development is linear, progressive, and orientated towards heteronormative standards of adulthood. As such, policy responses often serve to implicitly normalise and naturalise heterosexuality (Richardson, 1996). Discourses of transition fail to account for diversity of youth experience of the basis of race, ethnicity, gender, sexual orientation, gender identity and so forth. In particular, these discourses position queer and heterosexual (and cisgender) youth differently. For heterosexual youth this

period is characterised as "normally abnormal" (Patton, 1996, p. 43), coming to an end when these youth reach adulthood (Talburt, 2004). However, queer youth are positioned as belonging to a very particular subculture with differing relationships to heterosexual peers and queer adults. Membership within this subgroup means that queer youth require additional resources (such as information and community) if they are to successfully form coherent, unified identities (Uribe & Harbeck, 1991). As such, their transition to adulthood takes on additional problems that place them at further 'risk' (Talburt, 2004). As a result, youth who are unable or unwilling to conform to compulsory heterosexuality (and the prescribed asexuality of adolescence) are pathologised, marginalised, or rendered invisible within the dominant discourses of transition that permeate contemporary youth policy.

Considering the 'consequences' of youth sexuality

In line with the conflation of youth sexuality and sexual health and wellbeing, youth policy is often concerned with the risky sexual behaviour of youth populations resulting in, for example, STIs, unwanted pregnancies, and abortions (Moore & Prescott, 2013; Yoshida, 2013). Similarly, risky sexual behaviour is frequently linked with other 'risk taking' behaviour, such as alcohol and drug use. Within the context of concerns of the HIV epidemic, policy has increasing focused on disease prevention models as it relates to youth SRH (Yoshida, 2013). However, it is important to note that understandings of 'risky' sexual behaviour is frequently conceptualised outside of the context of current political, economic, and social conditions (such as poverty, economic deprivation, health care deficiencies, racism, police harassment, stigma and discrimination, educational demise) (Ginwright, Cammarota, & Noguera, 2005). As Ginwright and colleagues (2005) argue, youth behaviour cannot be understood in isolation from such factors.

DePalma and Francis (2014) outline some of the ways that pathologising discourses emerge in the context of discussions around SRH in relation to same-sex sexualities. Their research demonstrates the ways in which teachers engage in discussions around sexuality education in South Africa by drawing on views that closely link understandings of sexual orientation with notions of risk and danger. For example, discussions around sexual orientation often emerged in the context of HIV/AIDS and other STIs – serving to link same-sex sexualities with harmful consequences. In a sense this has adverse effects for heterosexual and queer youth alike – in so far as it perpetuates popular understandings that HIV/AIDS is an illness that only

affects ‘gay people’ (Gowen & Winges-Yanez, 2014). Relatedly, mentioning sexual orientation only in the context of HIV/AIDS limits discussion about women, given that ‘women who have sex with women’ are often omitted from conversations about HIV/AIDS (Blake et al., 2001; Fethers, Marks, Mindel, & Estcourt, 2000). DePalma and Francis (2014) also note that sexuality education often tends to focus on hetero-vaginal intercourse at the expense of other sexual behaviours, sometime going as far as labelling sexual activity outside of vaginal intercourse as ‘dangerous’.

In addition to positioning youth as at risk, policy responses also frequently position youth sexuality as potentially dangerous (Holzer & Oetomo, 2004; Moore & Prescott, 2013). Within such discourses, youth sexuality is positioned as both problematic and potentially threatening to society-at-large (Ginwright et al., 2005; Griffin, 1993, Roche, Tucke, Thomson, & Flynn, 2004). Some researchers have noted that youth sexuality has also been linked to concerns around maintaining social order and preventing moral decay. For example, Yoshida (2013) notes that in Japan youth are often held responsible for neglecting traditional morality and manners, and creating social disorder by engaging in sexual behaviour that is considered delinquent. Similarly, Holzner and Oetomo (2004) argue that sexual behaviour that poses a threat to, for example, religious norms (such as sex outside of marriage) is subject to strict regulation in Indonesia. Resultantly, policy initiatives are often introduced in an attempt to “strengthen the moral, political and social character of young people” (Wood, 2010, p. 50).

Subsequently, these ‘risks’ must be managed, limited and contained by adults (Moore & Prescott, 2013). As such, youth are deemed in need of protection (to prevent risky behaviour) and control (to prevent dangerous behaviour) ensuring that youth agency is largely denied or undermined. For example, Mitchell, Welsh, and Larkin (2004) argue that youth in South Africa are “often publicly referred to and visually constructed as children in need of protection, rather than as youth who have the right to relevant information about their own bodies and their sexuality” (p. 36). Similarly, Yoshida (2013) notes that within parliamentary discussions on sex education in Japan children and young people are systematically portrayed as in need of protection from potential harm. Notable absent from such discussions is the notion of youth making informed decisions about their own health. Likewise, Jackson and Scott (2010) note that within policy in the UK youth are rarely granted the authority to make their own assessment of risk, this authority lies firmly in the hands of adults. As a

consequence, youth become the objects of policies rather than the protagonists of policy making (Yoshida, 2013).

With specific reference to queer youth, discourses of protection (and control) draw heavily on understandings of queer youth as victims of abuse, discrimination, and varied disadvantages as a result of their sexual orientation and/or gender identity (Marshall, 2010; Talburt, 2004; Talburt, Rofes, & Rasmussen, 2004; Warner, 1999). Drawing on understandings of the victimisation of queer youth has featured prominently in anti-homophobic politics for some time (Marshall, 2010). The centrality of such views is evident in the emergence of suffering, isolation, suicide, and HIV/AIDS prevention as the dominant frames for understanding the experiences of queer youth (Marshall, 2010; Talburt, 2004). Without negating the experiences of queer youth that may serve to validate such discourses, it is important to note the problems associated with presenting the victim trope as the *only* frame for understanding queer youth experience (Blackburn, 2007). Recent literature in the field of queer studies presents a strong argument that overreliance on the victim trope has undermined and de-emphasized the potential for queer youth agency and resilience (Blackburn, 2007; Bruhm & Hurley 2004; Curran, 2002; Rasmussen, Rofes, & Talburt, 2004; Rofes, 2004). As such, there is a need for these discourses to transcend universalizing understandings of queer youth as subjects in need of saving by external forces (such as institutional and adult agents) (Rasmussen et al., 2004).

Embracing notions of youth agency and multiple subject positions for youth

As the previous discussion has demonstrated, dominant understandings of heterosexual and queer youth sexuality create little room for the possibility of youth agency. According to Moore and Prescott (2013) youth policy in the UK denies youth agency by perpetuating the symbolic order between adults and youth, despite the current trend of citing participation, engagement and inclusion as key policy priorities. Ginwright and colleagues (2005) argue that a failure to promote youth agency in US policy making renders them second-class citizens who are prevented from full democratic participation. Many researchers have argued for a shift in focus towards empowering youth and seeking to facilitate youth agency by, for example, recognising their own knowledge and experiences about sexuality, and their ability to exercise choice around their sexual decision-making (Francis, 2010; Holzner & Oetomo, 2004; Moore & Prescott, 2013; Yoshida, 2013). Some research has begun to recognise the

ways in which queer youth speak back to homophobic discourses and refute negative subject positions. For example, Hillier and Harrison (2004) argue that queer youth are able to successfully identify the contradictions and inconsistencies running through homophobic beliefs, and reframe homophobia as a societal problem rather than an individual deficiency. Willis (2012) contends that despite predominately negative first encounters with their sexual identity, queer youth are subsequently able to construct these identities as core dimension of their sexual selves and as an inner source of pride, strength, and affirmation (Willis, 2012). Similarly, McDermott and colleagues (2008) have highlighted how queer youth have constructed pride identities in response to homophobic discourses.

Similarly, many researchers have argued for the importance of embracing multiple and intersecting subject positions for queer youth within both research and policy. For example, Blackburn (2004; 2007) argues that research which presents 'queer youth as victims' or 'queer youth as agents' presents a false dichotomy. Instead, she argues that they are both victim and agent, among other aspects of their identities. Blackburn (2007) draws on the notion of multiple subject positions in order to recognise that queer youth inhabit various identities (such as gender, sexuality, race, class etc.), and that these identifications vary across contexts. Similarly, research conducted by Hillier and colleagues (2010) and Willis (2012) highlights the importance of engaging with multiple subject positions. In Hillier et al.'s (2010) recent survey of same-sex attracted youth, respondents identified lesbian and gay categories as restrictive and ill-fitting. Likewise, participants in Willis' (2012) research conveyed a reflexive awareness of the constraints of gay and lesbian identity frames. Such findings demonstrate the limitations of fixed sexual categories for framing individual lives, sexual attractions, and relationships (Sedgwick, 1990). More broadly, such findings also speak to the need to incorporate understandings of intersectional concerns when seeking to understand the lived experiences of queer youth. Importantly, Talburt (2004) notes that youth who are not recognisable within the victim/agent discourse may be excluded from interventions designed for them, which can have real world implications in terms of, for example, their sexual and reproductive health.

Issues Surrounding Sexual and Reproductive Health Care for Queer Persons

The majority of research concerning adult queer populations and health care has emerged from global North regions, including the United States, the United Kingdom, Europe, Australia, and Canada. By and far, the United States represents the highest output of research in this area. However, a growing body of research is emerging in relation to the health concerns of queer populations in global South regions – particularly in relation to Asia and Africa (especially South Africa). Research emanating from Latin America and the Caribbean is minimal. Similarly, research concerning the health concerns of queer youth is largely deployed in Western contexts. The United States is again the leader here, followed by the United Kingdom, Canada, Europe, and Australia. Importantly, however, research concerning queer youth in global South regions is particularly scarce. The following discussion will explore research findings in relation to both adult and youth queer populations, touching on issues related to: heteronormativity[4], heterosexism[5], and discrimination in health care settings; misinformation and ignorance of queer health needs; the need to embrace principles of culturally competent care for queer persons; issues of limited services for queer populations; the focus on HIV/AIDS and 'MSM' in program efforts and research concerns; failures to recognise health disparities within queer populations, and the homogenisation of queer populations in relation to SRH concerns.

Heteronormativity and heterosexism within health care settings

Morison and Lynch (2016) argue that within contexts of pervasive heteronormativity and heterosexism queer persons are not constructed as legitimate citizen subjects, and as such responses to their SRH needs are restricted. Many barriers to health care (with particular reference to SRH services) are constructed and maintained by systems of heteronormativity and heterosexism (Morison & Lynch, 2016). These systems operate to mark queer persons as different, whilst also rendering invisible any sexual and gender identity that falls outside of the heterosexual and cisgender experience (Lind, 2009; Logie & Gibson, 2013).

Such systems validate and perpetuate a number of processes and practices, ranging from certain pervasive biases, unjust social privilege, social exclusion, and heterosexual and

[4] A term used to refer to social roles, structures, and systems that reinforce the idea that heterosexuality is the presumed norm and is superior to other forms of sexual identity (Meer, 2014; Qmunity, 2013).

[5] A term used to describe a system of attitudes, bias, and discrimination that favours opposite-sex sexuality and relationships, which serves to marginalise those who do not identify as heterosexual (Meer, 2014; Qmunity, 2013).

cisgender bigotry (Callahan, Mann & Ruddick, 2007). In many cases, these processes operate within individual interactions – serving to hinder the health of queer persons, their ability to access health care, and the quality of care they receive (Irwin, 2007). Such processes and practices are also often observable at an institutional level where, for example, policies fail to accommodate in-patient placement consistent with a patient's expressed gender at institutions with separate male and female wards (Bauer et al., 2009; Namaste, 2000) or official paperwork does not allow for transgender patients the option to express themselves accurately in terms of their gender identity (Tschurtz et al., 2011). As such, the influence of heteronormativity and heterosexism within medical institutions often serves to make queer persons feel invisible or unwelcome, which in turn has negative consequences for their health (Bowers, Plummer, McCann, McConaghy, & Irwin, 2006).

The analysis presented by Morison and Lynch (2016) also outlines many of the ways that sexual minorities are made both invisible and hyper visible in relation to public health SRH services. Their analysis demonstrates the various ways that the institutionalisation of heterosexism in health systems serves to establish certain persons as inferior, excluded, wholly other or invisible (Morison & Lynch, 2016). Relatedly, certain persons are positioned as hyper visible (due to their divergence from heterogendered norms), yet at the same time they remain unintelligible within the public health system. Similarly, Hiestand, Horne, and Levitt (2007) note that butch-identified lesbian women face significant challenges related to poor treatment and access to health care as a result of their gender atypicality.

Discrimination in health care settings

Evidence from the global North suggests that discrimination on the basis of sexual and/or gender identity constitutes a significant access barrier to health care, in terms of both general primary care (Bockting, Robinson, Benner, & Scheltema, 2009; Melendez & Pinto, 2009; Rachlin, Green, & Lombardi, 2008; Sayles, Wong, Kinsler, Martins, & Cunningham, 2009), and in specialised areas such as mental health (Avery, Hellman, & Sudderth, 2001), substance abuse treatment (Lombardi, 2007), and HIV (De Santis, 2009; Kenagy, 2005). As a consequence of discrimination, the needs of sexual and gender minorities are often rendered invisible in health systems both indirectly, due to a heterosexual bias, and through direct discrimination (Logie, 2015). Moreover, access barriers are further intensified when it comes

to issues of sexual and reproductive health, which tend to be infused with moral, and value judgements often associated with sex, reproduction, and intimacy (WHO, 2010).

In a survey conducted by Lamba Legal (2010) in the United States 70% of transgender respondents and 56% of LGB respondents reported experiencing some form of health care discrimination. According to Meyer (2001) stigma and discrimination can affect the health of queer persons both directly and indirectly. Direct avenues of discrimination include exposure to violence and discrimination and poor clinical care. In contrast, indirect avenues of discrimination are often hidden or invisible and can include inadequate attention to health concerns of queer persons, lack of attention to queer health issues because they affect only a relatively small number of people, and lack of knowledge and insensitivity regarding the cultural concerns of queer persons (Meyer, 2001). In the context of Australian health care services, Bowers et al. (2006) noted various forms of discrimination including derogatory comments about queer patients made by HCPs, the disregarding of same-sex partners of patients by HCPs, failure to keep partners informed of the patient's condition, and exclusion of partners from decision making processes concerning patient care.

Similar depictions of discrimination emerge in the context of research conducted in Africa. In South Africa and Botswana, noted experiences of discrimination range from less obvious behaviours such as gossip, rudeness and humiliation committed by health care workers, to more overt acts such as refusing treatment, providing expired medication and abusive behaviour (Ehlers et al., 2001; Lane, Mogale, Struthers, McIntyre, & Kegeles, 2008; Morison, Moolman, & Reddy, 2015; Rispel et al., 2011). Lane and colleagues (2008) reported that South African men who have sex with men believed their options for non-stigmatising sexual health care services were limited by homophobic verbal harassment by HCPs. In many cases, non-gay-identified 'MSM' presented masculine, heterosexual identities when presenting for sexual health problems in order to avoid anticipated discrimination. In Swaziland, Kennedy et al. (2013) found that perceived and experienced discrimination within health care settings resulted in selective disclosure or lack of disclosure of sexual identity, delayed care-seeking, decisions to access distant clinics and missed opportunities for appropriate services.

According to research emerging from the US and Canada, many queer persons may postpone necessary medical treatment (or avoid it entirely) and fail to disclose sexual or gender identity

when receiving medical care as a result of negative experiences within the health care sector, with potentially dire consequences (Bockting, Robinson, & Rosser, 1998; De Santis, 2009; Gapka & Raj, 2003; Mayer et al., 2008). Queer youth have also been found to avoid medical services, and fail to disclose their sexual orientation or gender identity to HCPs as a result of experienced or anticipated discrimination (Corliss et al., 2007; Rossman, Salamanca, & Macapagal, 2017). Similar findings have been noted in South Africa (see for example Padmanabhanunni & Edwards, 2013) and within Southern Africa more generally (see for example Müller & Hughes, 2016). In contexts where same-sex relationships and/or gender non-conformity is criminalised, queer persons may withhold information from health workers and others, for fear of being stigmatised, arrested and prosecuted. In such contexts, queer persons may be forced to avoid health services entirely (Day & Ward, 2007; Global Commission on HIV and the Law, 2012; Reckart, 2005; UN, 2011; Joint United Nations Programme on HIV/AIDS [UNAIDS], 2013). A US study conducted by Smalley, Warren, and Barefoot (2016) found that nearly one third of transgender women reported routine avoidance of necessary medical care. Similar results were found amongst transgender men and gender queer participants. Interestingly, nearly one quarter of bisexual participants reported that they routinely avoid medical care, significantly more than their lesbian or gay counterparts. Moreover, mistrust of the health care system also leads many queer persons to seek care outside of the formal sector (Bradford, Reisner, Honnold, & Xavier, 2013).

Misinformation and ignorance of queer health needs

Much of the research emerging from the global North has centred on health care providers' ignorance or misunderstanding of queer health needs, resulting in a poor standard of care. Although there is growing recognition of the health needs of queer persons within medical communities, this recognition has also drawn attention to a number of troubling approaches to queer health care (Davy & Siriwardena, 2012). Most medical professionals and health care providers receive minimal (if any) education and training regarding queer health care (Campbell, 2013; Davy & Siriwardena, 2012; Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012), meaning that they are ill-equipped to deal with many of the unique health needs of queer communities (Mayer et al., 2008; Shukla, Asp, Dwyer, Georgescu, & Duggan, 2014). For example, some sexually transmitted infections might present differently in transgender patients who have had genital surgery or are taking hormones. However, current

education and training does not prepare health care workers to recognise signs of this in transgender patients (Müller, 2013).

In the United States, Carabez and colleagues (2015) found that nearly 80% of practicing nurses had no training about queer health care at all, with nearly 30% reporting some level of discomfort in treating queer persons (which was often linked to their lack of education on queer health issues). Similar findings were noted by Cornelius and Carrick (2015) (in the US) and Neville and Henrickson (2006) (in New Zealand) resulting in recommendations such as the revision of nursing curricula to specifically address issues of heteronormativity, homophobia, and the provision of culturally competent health care for queer persons. According to a UK study conducted by Hinchliff, Gott, and Galena (2005) same-sex sexualities present a significant barrier to the discussion of sexual health matters amongst General Practitioners. These barriers were seemingly linked to ignorance of queer 'lifestyles' and sexual practices, and concerns about the appropriate language to use. Again, revision of medical curriculum was suggested as a potential remedy to mitigate such barriers.

Similar findings were reported by van der Elst (2013) in which Kenyan HCPs reported limited knowledge of 'MSM' sexual health needs. Prior to participating in training, HCPs reported secondary stigma, lack of professional education about 'MSM', and personal and social prejudices as barriers to serving 'MSM' clients. After completion of the programme, HCPs expressed greater acknowledgement of 'MSM' patients and the need to treat these patients with high professional standards, and demonstrated increased awareness of the social and behavioural risks for HIV among 'MSM'.

However, despite additional training of HCPs and the increasing public profile of queer persons, many of the recommended changes in health care of queer persons are still often not implemented consistently. For example, Neville and Henrickson (2006) note that despite an increase in training, health care workers in New Zealand still largely assume that clients are heterosexual until proven otherwise. Therefore, it is important to note that changes in policy, training, and curriculum do not automatically translate into changes in practice. As such lack of knowledge and understanding, and continued prejudice surrounding queer health continue to be major obstacles for queer health (Davy & Siriwardena, 2012).

Similar findings concerning HCP competency were also noted in relation to queer youth experiences of health care. Greifinger, Batchelor, and Fair (2013) argue that the current health care system in the United States is not equipped to meet the needs of queer youth, particularly given the multitude of psychosocial and structural barriers they experience due to their sexual orientation or gender identity. In Canada, Knight, Shoveller, Carson, and Contreras-Whitney (2014) found that many HCPs are unprepared to provide culturally competent sexual health services for queer youth. This lack of competency was demonstrated both implicitly (e.g. by describing heteronormative practices) or explicitly (e.g. by expressing frustration that they had not been provided with appropriate training related to queer youth sexual health). Moreover, institutional norms and values were clearly identified as the dominant barriers in the effective provision of queer-tailored services. Likewise, in the US Kitts (2010) found that the majority of the physicians surveyed did not believe they had the skills necessary to address issues of sexual orientation with queer youth.

Participants from the recent study conducted by Morison and Lynch (2016) in South Africa found that instances of rudeness, suspicion, ridicule, privacy violations, and refusals of care were commonly directed towards sexual minorities. As such, culturally insensitive care must be considered a central component underlying the lack of access and utilisation of health care often reported in relation to queer persons (Müller & Hughes, 2016; Shukla et al., 2014). In fact, there is a growing body of literature to suggest that some potential health disparities within queer communities may be the result of a fundamental disconnect between the medical community and the needs of gender and sexual minorities, and as such concerns around misinformation and ignorance of queer health needs have far reaching consequences (Kismödi et al., 2015; Smalley et al., 2016).

Ensuring culturally competent care

Research from the United States recommends a number of measures for ensuring culturally competent care for queer persons. For example, Wilkerson, Rybicki, Barber, and Smolenski, (2011) suggest several key measures including: structural components such as decor (e.g. queer-affirming images on posters); systemic components such as mission statements, policies, and forms; interpersonal environmental changes (e.g. ensuring that all personnel that patients will come into contact with are sensitised to issues of cultural competency), and annual diversity training for staff about interacting with queer persons and their particular

health needs. They argue that implementing such changes can create an environment that reduces fear of discrimination, increases queer patients' willingness to access care, and improves provider-patient communication about health concerns related to sexual orientation and/or gender identity.

Similarly, Redfem and Sinclair (2014) state that health care providers can take a variety of practical steps in order to improve the experiences of transgender patients including: office environment, registration forms, initial interview and assessment, confidentiality, personnel training, awareness of and compliance with applicable anti-discrimination legislation, health insurance-related issues, and outreach and transgender health promotion. Hoffman, Freeman, and Swann (2009) found that queer youth in the US and UK place equal importance on health care providers' qualities, interpersonal skills, provider knowledge and experience in assessing their experiences of treatment. Moreover, youth indicated the need for greater sensitivity on the part of HCPs to both the cultural and developmental differences among LGBT youth. According to Ginsburg and colleagues (2002) queer youth in the US value privacy, cleanliness, honesty, respect, competency, and a non-judgmental stance when being treated by a HCP. Moreover, it was determined that clinicians need to achieve and convey a higher comfort level in addressing the special needs of sexual minority youth.

Limited range of services for queer populations

Previous research emerging from the US has demonstrated that although most health issues affecting queer persons parallel those of the general population, queer persons may have unique health and informational needs and could benefit from access to queer-specific health care resources (Fikar, 2004; Johnson, Mimiaga, & Bradford, 2008; Makadon, 2011). In many cases, existing services are not able to adequately meet differing needs of diverse populations (including, for example, gender and sexual minorities, people with disabilities, people living with HIV, adolescents and young people, and sex workers) (Klugman, Treger, Conco & Moorman, 2011). Importantly, in the United States and Canada, it has been reported that even in cases where medical services are directed specifically at LGBT communities, oftentimes the needs of transgender patients remain marginalised (De Santis, 2009; Melendez & Pinto, 2009; Bauer et al., 2009). As such, the expansion of SRH service packages to reach a wider range of beneficiaries is a key issue for health sector reform (Braam, 2005; Lind, 2009).

However, it is important to remain cognisant that specialised services should not overly rely on an understanding of queer populations as an 'exceptional subgroup', but rather they should also be understood as a primary care population with a set of care needs that are not limited solely to their sexual and/or gender identity (Snelgrove et al., 2012). In fact, most health needs of sexual and gender minorities are not directly linked to their gender identity. As such, it is important that all primary health workers are knowledgeable about sexual and gender diversity within patient populations, and the health needs that are relevant for primary health care (Müller, 2013).

Focus on HIV/AIDS and 'MSM' in program efforts and research concerns

In general, research on queer populations is not particularly widespread. Research that does engage with sexual and gender minorities is often disproportionately focused on issues surrounding HIV/AIDS and other STIs, is heavily skewed toward (cisgender) men who have sex with men, and tends to be conducted in urban, higher resourced locations (Logie, 2015; Müller & Hughes, 2016; Skinner, 2015). In several countries, recognition of queer persons first emerged in the context of HIV prevalence studies among 'MSM' (Beyrer, 2012). Moreover, HIV program efforts are generally larger in scale and in scope than queer rights programs, and as such the HIV agenda has often been the focus of many organisations working with sexual minorities (Beyrer, 2012).

Much of the research in this area tends to focus on the prevalence of HIV/AIDS amongst 'MSM' (see for example Beyrer et al., 2010; Campbell, 2013; Godwin, 2010; Johnson et al., 2009; van Griensven, 2007). This is particularly true of research emerging within Africa (see for example, Baral et al., 2013; Dramé, Crawford, Diouf, Beyrer, & Baral, 2013; Lane et al., 2011; Wirtz et al., 2013). Many of the studies conducted in African countries (e.g. Cameroon, Malawi, Senegal, Swaziland) argue that 'MSM' are at high risk for HIV infection, and as such should be considered a priority population for targeted HIV prevention, treatment, and care services (Baral et al., 2011; Baral et al., 2013; Dramé et al., 2013; Fay et al., 2013; Park et al., 2013; Wirtz et al., 2013). For example, Wirtz and colleagues (2013) argue for ensuring access to regular confidential HIV testing and counselling, and risk reduction counselling related to anal intercourse targeted specifically at 'MSM' in Malawi. They also argue for the provision of condoms and compatible lubricants, HIV prevention information, and HIV and STI treatment and adherence support. Baral and colleagues (2011; 2013) argue that without a

scale-up in targeted HIV services, it is likely that the HIV epidemic among 'MSM' may expand in the context of slowing epidemics in the general population. In addition to scaling up services, Wirtz et al. (2013) and Park et al. (2013) also note the need to address structural factors that increase risk amongst 'MSM' and evaluate the feasibility of biomedical interventions (e.g. antiretroviral pre-exposure prophylaxis and early antiretroviral therapy).

Although limited, a focus on 'MSM' and HIV was also evidenced in Asia and Latin America. For example, Magidson et al. (2015) argue that HIV/AIDS in Latin America is concentrated among 'MSM', calling for targeted HIV interventions within this population. Similarly, Wirtz and colleagues (2013) argue that limited knowledge of HIV among 'MSM' speaks to urgency for improvements in HIV research, prevention, and care in Central Asia. Although scarce, there is also evidence on HIV prevalence amongst transgender women. In Vietnam, Bao and colleagues (2016) found that HIV prevalence among transgender women is estimated at 18%. In line with research on 'MSM', this study also advocated for targeted services for these populations. Similarly, Khan and colleagues (2009) noted that among *hijra*[6] population in Bangladesh condom use remains low. Consequently, *hijra* were found to suffer from higher rates of active syphilis, putting them under threat of HIV transmission. Importantly, this study argued that the effectiveness of current condom interventions is undermined by a failure to acknowledge the socio-cultural and socio-economic scripts of sexual relationships and eroticism of *hijra*-sexuality.

However, as Arora and Streed (2015) note, it is important to exercise caution when generalising 'MSM' population as uniformly high-risk rather than accounting for individual risk and various sub-profiles similar to those applied to heterosexual populations. Moreover, it is a matter of concern that whilst 'MSM' (and queer populations in general) are considered as a high risk group for HIV/STI, funding and programming efforts directed to this population are consistently low (Commission on AIDS in Asia, 2008; Health Policy Initiative, 2006; Izazola-Licea & Valladares, 2002; Mprah, 2016). According to an annual analysis of national responses conducted by UNAIDS country offices, only 54 of 90 responding countries had included men who have sex with men as a target population within their national HIV/AIDS action framework; these countries were mainly in the Asia Pacific, Eastern Europe, Latin America, and the Caribbean (UNAIDS, 2007). Moreover, public health

[6] A South Asian term used to refer to a transgender individual who was assigned male at birth.

efforts in HIV prevention have been criticised for perpetuating sex-phobic discourses concerning anal sex for 'MSM' that fail to account for the importance of sexual expression (Meyer, 2001). Finally, the specific focus on 'MSM' has meant that limited attention has been paid to women who have sex with women in both the areas of research and data collected and the resulting policy discussions (Gruskin & Ferguson, 2009).

Significantly, the marginalisation of sexual and gender minorities is shaped by other structural drivers of inequality (such as race, ethnicity, socioeconomic status, language etc.), which create multiple, complex lines of advantage and disadvantage (Logie, 2015). Thus, it is important to remain mindful that sexual minorities experience health care settings in unique ways, and have differing health concerns and needs (Müller & Hughes, 2016). In fact, research conducted by Smalley and colleagues (2016) found pervasive and highly variable levels of high risk behaviours across sexual orientations and gender identities. For example, differences in health risk behaviours between transgender, gender queer, and nonbinary participants were significant – suggesting that these frequently combined subgroups have distinct health risk profiles (Smalley et al., 2016). Nevertheless, these intersecting identities and experiences consistently place queer persons in positions of vulnerability when negotiating health systems (Smith, 2015).

Failure to recognise health disparities within queer populations

According to research emerging from the United States, a number of health disparities exist between adult queer and heterosexual persons (see for example Dean et al., 2000; Institutes of Medicine, 2011). Much of this research points to a higher prevalence of certain conditions among queer populations such as tobacco use (e.g. Rath, Villanti, Rubenstein, & Vallone, 2013), obesity (e.g. Bowen, Balsam, & Ender, 2008), physical health issues ranging from poor general health status to increased risk for cancer and heightened diagnoses of cardiovascular disease, asthma, diabetes, and other chronic conditions) (e.g. Lick, Durso, & Johnson, 2013), enhanced cardiovascular risks among transgender persons due to exogenous hormone use (Futterweit, 1998), and mental health issues (King et al., 2008). Although some research points to the absence of evidence concerning the cause of such health disparities, many studies argue that many of these disparities are the result of experiences of minority stress (i.e. stress caused by stigma, discrimination, and prejudice directed towards sexual and gender minorities) (Frost, 2017; Lick et al., 2013; Meyer, 2003; Williams & Mann, 2017).

Similarly, some research also suggests that queer youth experience additional health concerns (in comparison to their heterosexual peers) due to the stress associated with coming out, and discrimination against sexual and gender minorities (Reitman et al., 2013; Rew, Whittaker, Taylor-Seehafer, & Smith, 2005).

In particular, research concerning the mental health of queer persons is particularly prevalent. According to much of this research, queer persons have a higher prevalence of mental health disorders (such as depression, anxiety, and risk of suicide) in comparison to their heterosexual counterparts (see for example, Bagley & Tremblay, 1997, Cochran, 2001; Cochran & Mays, 1994; Cochran & Mays, 2000a; Cochran & Mays, 2000b; Cochran, Sullivan, & Mays, 2003; D'Augelli & Grossman, 2001; Mays & Cochran, 2001; McCabe, Hughes, Bostwick, West, & Boyd, 2009; McDaniel, Purcell, & d'Augelli, 2001). However, some of this research also argues that mental health disorders are not inherent to sexual and gender minorities but can manifest as a result of stigma, prejudice, and discrimination that create a hostile and stressful social environment that cause mental health problems (Meyer, 2003; Meyer, 2013; Mills et al., 2004). Meyer (2003; 2013) attributes mental health problems among queer populations to a number of 'stress processes' including the experience of prejudice events, expectations of rejection, hiding and concealing sexual orientation for the purposes of protection (e.g. to avoid physical assaults), and internalised homophobia.

Similarly, research concerning queer youth is often concerned with mental health issues. In the United Kingdom, Scourfield, Roen, and McDermott (2008) found a disproportionate risk of suicidal thoughts and suicide attempts among queer young people. Likewise, Silenzio, Pena, Duberstein, Cerel, and Knox (2007) found that LGBT youths in the United States are still at greater risk for suicide attempts than non-LGBT youths. Much of this research draws on the assumption that queer youth are subjected to the typical challenges associated with adolescence, but also experience additional challenges due to the stigma surrounding their sexual orientation and/or gender identity. For example, Coker, Austin, and Schuster (2010) and Wright and Perry (2006) argue that queer youth experience psychosocial stress, increased health risks, and poor health outcomes as a result of the stigma around their sexual orientation and/or gender identity in the US. As such, concerns around increased incidence of substance abuse (e.g. Jordan, 2000), eating disorders (e.g. Austin et al., 2009), suicidality (e.g. Savin-Williams, 2001), risky sexual behaviour (e.g. Robin et al., 2002), exposure to violence and

victimisation (e.g. Bontempo & d'Augelli, 2002), and homelessness (Keuroghlian, Shtasel, & Bassuk, 2014) are frequently referenced in relation to queer youth.

Homogenisation of queer populations

In many cases, research on queer health tends to minimise the heterogeneity of queer populations and their respective health issues, and overlook the potential existence of diverse health care needs. Although such research may serve to highlight health care issues relevant to some queer persons, they may also serve to homogenise, pathologise and stereotype queer populations as a whole by inadvertently perpetuating a narrow framing of queer health (Davy & Siriwardena, 2012). For example, research conducted by Smalley and colleagues (2016) in the United States found pervasive and highly variable levels of high risk behaviours across sexual orientations and gender identities. Differences emerged with regard to sexual risk-taking behaviour with gay participants reporting the lowest rates of unprotected sex (37.8%) in comparison to 60% of lesbian participants. The differences in health risk behaviours between transgender, gender queer, and nonbinary participants were often substantial – suggesting that these frequently combined subgroups may have distinct health risk profiles (Smalley et al., 2016). Similarly, Hiestand and colleagues (2007) found that butch lesbian women may be more at risk for physical health concerns than femme lesbian women, in particular those illnesses that can be prevented or treated with regular gynaecological care. Moreover, the marginalisation of sexual and gender minorities is shaped by other structural drivers of inequality beyond sexual orientation and gender identity. As noted earlier, within queer populations there exists diversity across multiple social identities related to, for example, culture, ethnicity, race, age, socioeconomic status etc. which create complex lines of advantage and disadvantage (Logie, 2015; Meyer, 2001).

While it is important to remain cognisant of the ways in which intersecting identities and experiences may consistently place queer persons in positions of vulnerability when negotiating health systems (Smith, 2015), it is also important to remain mindful that sexual minorities experience health care settings in unique ways, and have differing health concerns and needs (Müller & Hughes, 2016). As such, queer persons should not be treated as a homogenous group, especially for the purposes of health behaviour research (de Graaf et al., 2015; Fredriksen-Goldsen et al., 2014; Institute of Medicine, 2011). It is vital that research studies begin to engage with the potential effects of cumulative risks and resources across

multiple social identities that can be simultaneously occupied by queer persons in order to facilitate a better understanding of the full range of health outcomes, resources, and risks that may influence the development of culturally responsive interventions (Fredriksen-Goldsen et al., 2014).

Given the emerging research on levels of stigma, marginalisation, and discrimination experienced by queer persons within a number of contexts, it is important for the current research to explore the experiences of queer persons within the context of health care systems. As the previous discussion has demonstrated, queer persons often experience various forms of inequitable access to health care. For example, the operation heteronormative and heterosexist health care systems, high instances of discrimination, and untrained and culturally insensitive health care providers all contribute to poor SRH outcomes. As such, in order to engage with a nuanced understanding of queer SRH these social determinants of health must be acknowledged and addressed. Moreover, the presence of criminalising laws and problematic discourses within policy serve to further entrench existing inequalities and marginalisation for many queer persons, to the detriment of their sexual and reproductive health. The subsequent chapter will explore the theoretical framework that was adopted as part of this research, which will build on discussion concerning the need to developed nuanced understandings of the SRH of queer persons.

CHAPTER 3: THEORETICAL FRAMEWORK

In this research, a sexual and reproductive justice (SRJ) framework was adopted as a backdrop for analysing the framing of policies, as well as the subject positions deployed in these policies as they relate to certain framings. While a SRJ framework does not eschew public health or human rights arguments, it does seek to extend these to highlight systemic inequities that contribute to poor SRH outcomes. To this end, the SRJ framework draws heavily on the concept of reproductive justice in order to engage with the histories, circumstances, and contexts that hinder the exercising of reproductive rights (Morison, 2013). Understandings of reproductive justice are also infused with an acknowledgement of the existence of sexual hierarchies that serve to hinder the enjoyment of SRH for queer persons specifically. As such, the SRJ framework foregrounds the operation of sexual hierarchies and the intersection of these with other social hierarchies in line with reproductive justice concerns.

The subsequent discussion will commence with a brief overview of the emergence of reproductive justice as a framework for understanding SRH concerns. This discussion highlights some of the limitations of understandings of SRH that are firmly entrenched in notions of reproductive rights and choice. Discussion will then explore the value of a SRJ framework as a theoretical tool for developing nuanced approaches to addressing SRH concerns. Finally, the concepts of communication frames and subject positions will be examined in some detail in order to foreground how these concepts were operationalised within and through a SRJ framework during analysis.

The Emergence of Reproductive Justice as a Framework for Understanding Sexual and Reproductive Health

Reproductive justice arose as a concept in response to some of the shortcomings surrounding efforts to secure reproductive rights, particularly the emphasis placed on reproductive choice. Typically, mainstream Western feminist advocacy has relied on a liberal rights-based approach in their efforts to secure reproductive rights for women (Cook & Dickens, 2003; Ferree, 2003), a strategy which has also largely been taken up by advocacy groups in the global South (Hessini, 2005). Within this approach, efforts to secure reproductive rights for women are centred on concepts of self-determination, choice, and equality (Cook & Dickens,

2003; Ferree, 2003). This liberal framing of reproductive rights rests on an assumption of unfettered agency in terms of individual choice and decision-making (Morison, 2013; Petchesky, 1986). Resultantly rights are viewed as equally afforded to and freely exercised by all individuals once legally secured (Morison, 2013). However, such an approach fails to consider the gendered, raced, and classed social conditions that structure women's ability to exercise the right to 'choose' (Fried, 2006), meaning that the possession of reproductive rights does not necessarily translate into the ability to exercise them.

The language of choice has also largely disregarded the reality that race inevitably limits one's choice and access to reproductive options (Fried, 2006). Largely, the rhetoric of reproductive choice has privileged predominantly Western, white, middle-class women from individualistic cultures who have access to reproductive options that are unavailable to poor, low-income women, especially women of colour and those residing in global South regions (Chrisler, 2013; Roberts, 2015). Furthermore, the rhetoric of reproductive choice has consistently failed to acknowledge the manner in which population control, sterilization abuse, high-risk contraception, poverty, and the effects of environmental pollution on fertility and maternal health has shaped, and continues to shape, the reproductive lives of women of colour and those women residing in 'developing' nations (Bailey, 2011).

Liberal rights-based approaches to SRH often fail to adequately account for the role that socio-economic status plays in facilitating or hindering women's enjoyment of reproductive rights. As such, socio-economic factors (e.g. inadequate information, poverty, inaccessibility of medical care, and so on) are frequently overlooked within discussions of reproductive choice (Fried, 2006; Morison, 2013; Silliman & Bhattacharjee, 2002). The rhetoric of choice causes blame to be assigned to those women held responsible for making 'bad' choices, without taking into account access to sufficient resources (Roberts, 2015; Morison, 2013). Importantly, the language of choice has become increasingly aligned with a neoliberal agenda, meaning that access is dependent on financial resources and as such reproductive choice becomes a luxury for those who can afford it (Fried, 2006; Morison, 2013; Silliman & Bhattacharjee, 2002). Resultantly, reproductive choice has undermined arguments for the provision of public resources, which most women rely on in order to access sexual and reproductive health care (Fried, 2006; Roberts, 2015).

In response to such concerns around the rhetoric of rights and choice, a caucus of black American feminists coined the term "reproductive justice", seeking to reposition reproductive rights within an agenda that accounts for the importance of context and intersectional concerns. Reproductive justice sought to acknowledge and address the historical, social, cultural, and economic factors that serve to enhance and/or undermine SRH outcomes and decision-making at personal, familial, and community levels, and the associated health implications for women (Bailey, 2011; Chrisler, 2013; Gilliam, Neustadt, & Gordon 2009; Morison, 2013; Roberts, 2015). As such, reproductive justice conceived of, for example, not only the right to decide not to have children, but also the right to have children in safe, healthy, and supportive environments (Roberts, 2015). Resultantly, issues of social justice were effectively linked with reproductive health – expanding understandings of reproductive freedom and creating a platform for multi-issue agendas for action (Chrisler, 2013; Fried, 2006; Gillam, Neustadt, & Gordon, 2009; Katz, 2017; Roberts 2015).

Beyond Reproductive Choice: The Value of a Sexual and Reproductive Justice Framework for Understanding Sexual and Reproductive Health

SRJ advocates argues that, as a theoretical tool, a SRJ framework is able to develop more nuanced approaches to addressing SRH concerns than those offered by the rhetoric of reproductive choice (Fried, 2006; Morison, 2013). By drawing heavily on understandings of reproductive justice, and infusing these understandings with notions of sexual hierarchies (including those related to sexual orientation and gender identity), a SRJ framework is able to engage with the histories, circumstances, and contexts that hinder the exercising of reproductive rights and the enjoyment of SRH – particularly as these relate to the SRH of queer persons (Morison, 2013). As such, this framework is able to provide a holistic formulation of SRH issues, seek to address the social reality of inequality, and create room for intersectional concerns in order to facilitate nuanced understandings of the SRH needs of queer persons (Fried, 2006; Gilliam et al., 2009).

In line with the principles of reproductive justice, a SRJ framework foregrounds the connections between SRH and other areas of concern, particularly those related to issues of social justice (Morison, 2013). As such, this framework provides a systemic or holistic formulation of SRH concerns that focuses on achieving a broad set of conditions necessary for securing SRH (Fried, 2006; Gilliam et al., 2009). In doing so, issues relating to poverty,

access to care and insurance, lack of community resources, gender-based violence, and stigma and discrimination based on race, sexual orientation, and gender identity are incorporated into the SRH agenda (Gillam, Neustadt, & Gordon, 2009; Morison, 2013; Ross, 2006). Importantly, sexual and reproductive health issues are seen as intertwined with economic issues, welfare reform, housing, prisoners' rights, environmental justice, immigration policy, drug policies, violence, work and family (Bailey, 2011). Moreover, such an approach foregrounds how state policies may construct particular bodies as unfit to have sex or to reproduce (for example, eugenicist policies) (Ross, 2006), or in the case of queer persons, mark certain bodies as different or even invisible – further highlighting inequalities at an institutional level (Lind, 2009; Logie & Gibson, 2013).

Sexual and reproductive justice seeks to address the social reality of inequality – with particular focus on the inequality of opportunities in the context of SRH (Bailey, 2011; Ross, 2006). As such, it embraces not only the establishment of reproductive rights, but also the creation of enabling conditions to realise these rights (Ross, 2006). Importantly, it asserts that the ability of any person to determine their own reproductive destiny is linked directly to the conditions in their community and these conditions are not only a matter of individual choice and access (Ross, 2006). It highlights the ways in which political, cultural, and socio-economic inequalities shape particular (and myriad) communities (Fried, 2006; Ross, 2006). Moreover, it acknowledges that certain communities do not enjoy equal opportunity to influence institutional framings (such as those within public policy), and are also subject to disproportionate rates of poverty, lack of access to health care services and information, high incidences of violence, and poorer health outcomes (Fried, 2006; Ross, 2006). As such, sexual and reproductive justice seeks to give context and perspective to the underlying (and often unacknowledged) social injustices that hinder the fulfilment of sexual and reproductive health (Gillam, Neustadt, & Gordon, 2009).

One of the fundamental strengths of a SRJ framework is its ability to create room for intersectional concerns. As previously discussed, a reproductive justice lens allows for the intersection of race, gender, socioeconomic status, sexual orientation, and gender identity (amongst other factors) to be acknowledged and brought to bear on understandings of the varied issues faced by queer persons according to their particular context (Morison, 2013). Within such an understanding, inequities are understood as being mediated through manifold social identities (e.g. race, gender, socioeconomic status, sexual orientation, gender identity,

age, religion, culture, immigrant status, and so on) that converge to create distinct experiences of both oppression (e.g. stigma) and opportunity (e.g. solidarity) (Gillam, Neustadt, & Gordon, 2009; Logie, 2015; Morison, 2013). Resultantly, a SRJ framework also works to include those who are often alienated by the mainstream agenda, including queer youth (Gillam, Neustadt, & Gordon, 2009; Roberts, 2015).

With such intersectional concerns in mind, the SRJ framework adopted here also seeks to foreground concerns around the operation of sexual hierarchies, both in terms of sexual orientation and gender identity. According to Rubin (1998), sexual hierarchies operate to privilege sexuality that is heterosexual, cisgendered, marital, monogamous, reproductive, and non-commercial. In this way, the SRH concerns of queer persons are linked to those of, for example, young unmarried women and sex workers. Such hierarchies are often rooted in conservative religious values, and medical and psychiatric prejudices. Resultantly, other forms of sexual and/or gender identity and expression are often subjected to religious condemnation, presumptions of mental illness, disreputability, criminality, restricted social and physical mobility, loss of institutional support, and/or economic sanctions. Moreover, sexual and gender minorities are frequently subjected to varying levels of stigma, discrimination, harassment, and even violence. Any understanding of queer youth SRH must consider and account for the existence of such sexual hierarchies and the intersection of these hierarchies with other social hierarchies (in terms of age, race, cultural belief, and socio-economic status) within multiple and varied contexts (Miller & Vance, 2004).

In practice, sexual and reproductive justice seeks to ensure universal access to information, resources, and services. Such an approach advocates for policies and practices that enable marginalised populations to access SRH care, including the reduction of linguistic and cultural barriers, and the implementation of policies and practices that address family support, housing stability and transportation needs. It seeks to promote increased investment in comprehensive SRH education (eschewing abstinence-only education) that includes HIV and STI prevention, contraception, pregnancy planning, fertility, termination of pregnancy (ToP), and gender-based violence. Such an approach also seeks to address the role of stigma and shame in accessing ToP services and establish compassionate and culturally competent abortion counselling. Moreover, a sexual and reproductive justice approach seeks to ensure that the intersection of violence and SRH is addressed. It also advocates for the removal of barriers that limit contraceptive and reproductive care/access to women with disabilities and

seeks to implement policies that expand coverage to people without medical aid (Chrisler, 2014; Gillam, Neustadt, & Gordon, 2009; Morison, 2013). In this research, such understandings of sexual and reproductive justice were brought to bear on the researcher's own conceptualisations of comprehensive sexual and reproductive health and rights throughout the analysis phase of the research process, particularly in connection to the operationalization of framing and positioning during the analysis process.

Utilising Framing and Positioning to Explore Policy Responses to Queer Youth SRH

Against the backdrop of a SRJ framework, theoretical understandings of framing and positioning were utilised by the researcher to explore policy responses to queer youth SRH. Analysis drew on Chong and Druckman's (2007a; 2007b) notion of communication frames and Davies and Harré's (1990) concept of positioning to analyse the framing of policies and the subject positions deployed in these policies in relation to certain framings. Although framing and positioning do not share the same epistemological foundation, they can be understood as "kindred theories" (Gordon, 2015, p. 325). Gordon (2015) argues that framing and positioning can be understood as distinct, yet compatible, theoretical frameworks. According to Gordon (2015) both framing and positioning provide insight into the layered and flexible nature of social interactions; the discursive construction of subjects and selves as multifaceted, complex, and ambiguous; and the complexity of language use. Further, both incorporate the general notion of intertextuality.

Several researchers have successfully integrated aspects of these two frameworks to explore, for example, workplace relationships (Tannen, 1999), narratives of professional experience (Baynham, 2011), talk about painful experiences (Matsumoto, 2011; Schiffrin, 2002), functions of slang (Bucholtz, 2009), and gendered identity construction in naturally occurring family conversations (Kendall, 2007; 2008). In line with Gordon's (2015) understanding of kindred theories, the analysis undertaken as part of this research sought to explore the possibility that the manner in which texts (in this case policy extracts) are framed may allow for the deployment of certain subject positions for queer youth, and that such subject positions may diverge, shift, and/or remain constant across different framings. In this sense, framing and positioning are treated as distinct, yet potentially related, theoretical frameworks.

Drawing on Chong and Druckman's notion of communication frames

In this research the notion of communication frames (sometimes referred to as frames in communication) is drawn on to highlight the basic assumptions underpinning reference to queer youth SRH in policies. In this sense, framing refers to the use of particular words, images, phrases, and presentation styles that a 'speaker' or author(s) (in this case those tasked with drafting policy) use when relaying information about an issue or event to an 'audience' (those tasked with implementing policy) (Gamson & Modigliani, 1987). As such, the chosen frame reveals the underlying premises of what the author(s) sees as relevant to the topic at hand (Chong & Druckman, 2007a).

Understandings of communication frames are premised on an assumption that an issue can be viewed from a multitude of perspectives (Chong & Druckman, 2007b). As such, it is possible for a variety of frames to exist which represent alternate (or even opposing) positions on the same issue (Chong & Druckman, 2007a). Communication frames are often conceptualised as a means to develop particular understandings of an issue for the purpose of reorienting the public's thinking around that same issue (Chong & Druckman, 2007b). Often this is achieved by promoting "particular definitions and interpretations of political issues" (Shah, Watts, Domke, & Fan, 2002, p. 343).

According to Chong and Druckman (2007b), framing can operate on several levels by: (i) making new beliefs about an issue available to the audience, (ii) making certain beliefs accessible to the audience, and (iii) increasing the 'strength' of certain beliefs in people's evaluations. The importance of communication frames lies in their ability to affect the attitudes and behaviour of their audience (Chong & Druckman, 2007b). This process is referred to as a framing effect (Chong & Druckman, 2007b). In other words, framing effects occur when changes in the presentation of an issue successfully produce changes in opinions (Chong & Druckman, 2007b).

Framing effects depend on a number of factors including the strength and repetition of the frame, the competitive environment (i.e. the number of frames operating in competition with each other), and individual motivations (Chong & Druckman, 2007b). However, there are competing understandings of which frames will have the greatest influence in changing

individual opinion. These tend to centre around two central competing arguments related to the frequency of a frame versus the relative strength of a frame.

On one side, it is argued that those frames which are repeated most frequently will have the greatest influence on individual opinion (Chong & Druckman, 2007a). This argument assumes that individuals embrace the frame that they hear most often, without consciously evaluating the relative strength of the frame. Conversely, it is argued that the strongest frame will exert the greatest influence on individual opinion, regardless of frequency of use (Chong & Druckman, 2007a). The relative strength of a frame has been linked to issues of credibility (i.e. frames delivered by credible sources are more likely to shift opinions) (Druckman, 2001), consensus values (i.e. frames that invoke longstanding cultural values are more likely to shift opinions) (Chong, 2000), and the presence or absence of strong predispositions (i.e. frames that do not contradict strongly held prior beliefs are more likely to shift opinions) (Brewer, 2001; Druckman & Nelson, 2003; Haider-Markel & Joslyn, 2001; Shah, Domke, & Wackman, 1996).

Common framings of youth sexual and reproductive health concerns

Concerns surrounding youth SRH are most often framed in terms of the public health approach and the human rights approach, although these are by no means exhaustive framings. The public health approach views youth SRH within a framework of health and is often characterised by the use of 'neutral' medical language (Epprecht, 2012; Young & Meyer, 2005). Such a framing emphasises population wide patterns, including the prevalence and incidence of, and morbidity and mortality associated with, sexual and reproductive health problems. In cases where political issues and power relations are referenced, they are often cited as explanatory factors.

Such a framing also retains a narrow focus on risk and 'key populations', rendering only certain persons visible and recognisable as subjects requiring health care. Of particular concern is the concentrated focus on HIV risk related to queer men that is often evidenced in such framings (with particular reference to issues of sexual and reproductive health) (Logie & Gibson, 2013; Logie, 2015; Müller & Macgregor, 2014; SANAC, 2011). While such a focus ensures that health concerns faced by queer men are made visible, it also excludes other sexual and gender minorities, such as queer women (Logie, 2015; Morison & Lynch, 2016;

Müller & Macgregor, 2014). Therefore, drawing on this framing may be effective in securing health care for certain sexual minorities whilst failing to bring broader awareness of and responsiveness to sexual and gender diversity (Morison & Lynch, 2016). Finally, and as alluded to in the previous chapter, the public health framing's focus on risk and 'key populations' potentially limits the attention paid to other pertinent risks, such as structural disparities that diminish SRH outcomes for queer persons (e.g. heterosexism, poverty, racial inequality, rurality and violence) (Ham & Gerard, 2014; Logie, 2015; Matthews, Smith, Brown & Malebranche, 2016; Siconolfi, Halkitis, Moeller, 2015).

In contrast, the human rights approach highlights sexual and reproductive rights, including: the rights of choice (most often in terms of abortion, contraception, and sexual debut), the rights of access to services and information, and the rights of recognition (e.g. the universal right to marry). However, as a reproductive justice approach highlights, the human rights approach has been critiqued for resting on the assumption of unfettered agency on the part of young people, and for a failure to foreground the gendered, raced, and classed social conditions that structure recognition, access, and choice (Fried, 2006). Moreover, a rights-based framing is intricately linked with individualism and neo-liberal conceptions of personal responsibility and freedoms, which misalign with efforts to advance social solidarity (Siconolfi et al., 2015).

In many contexts a rights framing is drawn upon to position queer persons as deserving of equal treatment (Morison & Lynch, 2016). Although many consider such a framing a powerful tool for enacting social change (Ellis & Kitzinger, 2002), it is politically limited. As Morison and Lynch (2016) note, such a framing can be negated in contexts where enjoyment of rights is contingent on recognition of queer subjects as full citizens (Morison & Lynch, 2016). Perversely, such a framing can also be effectively utilised to counter claims for equal treatment by drawing on another set of competing rights (often linked to religion and/or culture) which may be regarded as superseding sexual and reproductive rights (Richardson & Munro, 2012). Despite these limitations, rights-based framings should not be wholly abandoned as they do offer some utility. For example, a rights-based framing can be utilised to repair the invisibility of sexual and gender minorities by positioning them as equal citizens deserving of equal treatment. Therefore, these framings should be employed in conjunction with additional rhetorical and/or framing resources tailored to the nuances of local contexts in order to effectively respond to counter-positions (Jowett, 2014).

Given the concerns surrounding these two framings, a third potential framing was conceptualised by the researcher and co-researcher – a sexual and reproductive justice framing – drawing on the central tenets of sexual and reproductive justice. A SRJ frame would need to highlight the interconnectedness of SRH with other areas of concern (e.g. welfare reform, housing etc.) and foreground the need to secure a broad set of conditions necessary for securing SRH (e.g. reduction in poverty levels, equal access to care and insurance etc.). Moreover, such a framing would need to give context and perspective to the underlying social injustices that hinder the fulfilment of SRH – highlighting the ways in which political, cultural, and socio-economic inequalities shape particular communities. As such, this frame would need to embrace both the establishment of sexual and reproductive rights, *and* the creation of enabling conditions to realise these rights. Importantly, such a frame would need to be informed by an intersectional understanding that inequities are mediated through manifold social identities (e.g. race, sexual orientation, gender identity etc.) that converge to create distinct experiences of both oppression and opportunity. In relation to the SRH of queer youth in particular, such a framing would need to be cognisant of the existence of sexual hierarchies and the intersection of these with other social hierarchies (in terms of age, race, socio-economic status etc.) within multiple and varied contexts. Broadly, such a framing would need to promote more nuanced understandings of the SRH needs of queer persons informed by the principles of social justice and the recognition of individual, community, and institutional inequalities.

Incorporating Davies and Harré's understanding of positioning

As stated previously, the analysis undertaken as part of this research sought to explore the possibility that the manner in which policy extracts are framed may allow for the deployment of certain subject positions for queer youth. According to Davies and Harré (1990) positioning is a discursive process that allows for the production of certain understandings of identities through the deployment of socially- and culturally-available discourses. The way people 'talk' (particularly language usage) serves to position people (both the self and others) in certain ways (van Langenhove & Harré, 1999). Discourses make certain subject positions available, which may serve to enable and/or limit possibilities for action within a particular discourse (Arribas-Ayllon & Walkerdine, 2008; Davies & Harré, 1990). As such, subject positions allow the analysis to highlight connections between wider notions of discourses,

dominant cultural narratives, and the social construction of identities (Reynolds, Wetherell, & Taylor, 2007).

Central to the positioning framework is an understanding of the role of language in constructing reality and the manner in which certain discourses and discursive practices provide space for particular subject positions – both in terms of how subjects are positioned by others (interactive positioning) and by themselves (reflexive positioning) (Davies & Harré, 1990). Such a framework recognises both the constitutive force of discursive practices, and the ability to exercise choice in relation to these practices (Benwell & Stokoe, 2006; Davies & Harré, 1990; Wetherell, 2001a; 2001b). As such, subject positions must be understood as both 'conferred from above' by available discursive resources, and also agentively taken up or resisted by individuals (Bamberg, 2004; Davies & Harré, 1990; Taylor & Littleton, 2006; Wetherell, 1998). For the purposes of this research, analysis sought to identify the subject positions of queer youth named in policy extracts. As such, analysis focused exclusively on interactive positioning (i.e. how subjects are positioned), while reflexive positioning (i.e. how subjects position themselves) was excluded from the field of inquiry.

According to Davies and Harré (1990), subject positions incorporate both a conceptual repertoire and a "location for persons within the structure of rights for those that use that repertoire" (p. 66). The notion of conceptual repertoires incorporates particular images, metaphors, storylines, and concepts that gain relevancy in the context of certain framing practices (Davies & Harré, 1990). In other words, certain discourses provide certain conceptual repertoires that people draw on as a way of representing themselves and others (Burr, 1995).

Importantly, subject positions are constructed within certain discursive practices and as such are not permanent, fixed, or static (Davies & Harré, 1990; Edley, 2001; Magnusson & Marecek, 2010; Wetherell, 1998; 2001a; 2001b; 2003; Wetherell & Edley, 1999). Instead, subject positions are context-dependent and constantly shift and change depending on a particular context. As such, subject positions may be in conflict with each other (e.g. the agentic youth subject position versus the victim subject position) and may change over time or across different sites (i.e. they are multifaceted and dynamic).

By being positioned, subjects (e.g. health service providers and youth) are immediately placed in certain relations with one another, which has implications for what is and is not possible in particular interactive spaces (Davies & Gannon, 2004). Moreover, different subject positions are associated with different levels of power and prestige (Magnusson & Marecek, 2010; Wetherell, 1998; 200la; 2001b; 2003). In particular, interactive positioning highlights the role of power relations in discourses, discursive practices, and available subject positions (Davies & Harré, 1990). The process of interactive positioning can be understood as a process of continual struggle to set the tone of the 'interaction' and define the parameters of a particular situation (Moodley, 2015).

Certain discourses (and by extension certain subject positions) enjoy greater ideological power and institutional support (Willig, 2008; Wooffitt, 2005). The representation of queer youth (or lack thereof) in policy has implications for what is regarded as the normative subject and by extension, what is regarded as non-normative. An analysis informed by positioning theory is able to avoid simplistic analyses that reduce subjects to single, homogenous identity groupings by recognising the intersection of multiple and contingent subjectivities within a variety of contexts (Taylor & Littleton, 2006). As such, positioning coheres strongly with the SRJ framework that serves as an overarching backdrop for the undertaken research.

Against the backdrop of a SRJ framework, theoretical understandings of framing and positioning were utilised by the researcher to explore policy responses to queer youth SRH. Drawing on Gordon's (2015) understanding of kindred theories, the analysis undertaken as part of this research sought to explore the possibility that the manner in which policy extracts are framed may position queer youth in certain ways. Moreover, analysis sought to explore whether such subject positions may diverge, shift, and/or remain constant across different identified framings. In this sense, framing and positioning were treated as distinct, yet potentially related, theoretical frameworks. The preceding discussion outlined the emergence of the term reproductive justice, highlighting the limitations of understandings of SRH that are firmly entrenched in notions of reproductive rights and choice. Discussion then explored the value of a SRJ framework as a theoretical tool for developing nuanced approaches to addressing SRH concerns. Discussion concluded by detailing the concepts of framing and positioning in order to foreground how these concepts were applied during analysis. Building

on this, the subsequent chapter will explore the methodological processes undertaken as part of the deductive framing and positioning thematic analysis conducted by the researcher.

CHAPTER 4: METHODOLOGY

The methodology used in this systematic review was a deductive framing and positioning thematic analysis. The research explored three distinct, yet related avenues of inquiry. Firstly, the research sought to identify and explore the framings of youth SRH (with particular reference to queer youth) within policy extracts related to youth SRH in selected global South countries in Asia, Africa, and the Caribbean. Next, the research sought to examine how identified framings allowed for the deployment of clearly delimited subject positions for queer youth. Finally, the research sought to draw out any trends within and across countries, and regions in relation to the framing of youth SRH and the positioning of queer youth in particular.

Subsequent discussion will outline the various methodological processes undertaken in order to explore these specific research questions. Discussion will commence with a general overview of systematic reviews and thematic analysis respectively, highlighting how these were deployed in the research. Next, the unit of analysis will be outlined, detailing both the preliminary and final data set. Procedures for data collection undertaken in accordance with Bambra (2011) will then be explored, including the formulation of a review question, development of a systematic review protocol, performance of a literature search, and screening of the preliminary data set. Discussion will then move to the procedures undertaken to capture and finalise the data set. Finally, discussion will outline the various steps undertaken to conduct a thematic analysis in accordance with those advocated by Braun and Clark (2006; 2012).

The Deployment of Systematic Review Procedures – General Overview

Systematic reviews are broadly understood as a method involving the identification, selection, appraisal, and synthesis of data (Bambra, 2011; Dickson, Cherry, & Boland, 2014). The expectation is that the methods involved in such a review will be systematic, explicit, transparent, and accountable (Dickson et al., 2014; Gough, Oliver, & Thomas, 2012). The systematic nature of such reviews stems from the attempt to follow a predetermined and clearly stated procedure to locate data, often both published and unpublished. Further, such data are critically evaluated on the basis of relevance to the review question(s) and a set of predetermined methodological inclusion criteria. Only data fulfilling both these requirements

are included in the final analysis. As such, the analysis facilitates production of a summary of the 'best available evidence' on a particular area of interest (Higgins & Green, 2008, Tacconelli, 2010).

The current research made use of systematic review measures to conceptualise procedures for the collection of data. The advantages of the relationship between systematic reviews and SRH policy have been increasingly emphasised by a number of authors in light of the growing emphasis placed on 'evidence-based' decisions and interventions in public health policy and practice (see Boaz et al., 2002; Davies et al., 2000; Klein, 2000; and Solesbury, 2002). As such, systematic reviews are widely considered a valuable method of choice to present oftentimes conflicting and complicated data in more useable and accessible ways within policy domains. However, guidelines on conducting systematic reviews are largely produced within the fields of health care and evidence-based medical literature (Bambra, 2011). Consequently, advice on systematic reviews (for example, the emphasis placed on meta-analysis of results) cannot always be universally applied to certain areas of research (Egger, Davey Smith, & Altman, 2001). In light of such considerations, the present research methodology has reconceptualised certain systematic review measures in order to ensure that the epistemological framework and research aims remain intact – particularly in relation to the thematic analysis undertaken according to the steps outlined by Braun and Clark (2006; 2012).

The Deployment of Thematic Analysis Procedures – General Overview

In the current research, thematic analysis was utilised to identify, analyse, and report on patterns (themes) observed within the data. This method of analysis allowed for the organisation and description of the data set in order to facilitate interpretation of the data in line with the key research questions pertaining to: (i) the framing of youth, and (ii) the subject positions assigned to youth. According to Braun and Clark (2006; 2012) a theme should capture an important aspect of the data in relation to the research question(s), whilst also representing some level of patterned meaning within the data set as a whole. Ideally, themes should be observable across the entire data set. However, the prevalence of themes across the data set does not necessarily mean that the theme itself is crucial to the analysis. According to Braun and Clark (2006; 2012), the importance of a theme is not necessarily dependent on quantifiable measures. Rather, importance is determined by the theme's relationship to the

overall research question(s). Analysis aimed to provide a rich thematic overview of the predominant themes observed in the data set in relation to two key concerns - framing and positioning. As such, prevalence was counted in terms of the number of different policies (or policy extracts) that articulated a theme across the entire data set. Themes were identified, coded, and analysed with the intent of providing an accurate reflection of the content of the data set in terms of certain framings and subject positions specifically.

Resultantly, themes were identified in a theoretical or deductive manner. Unlike an inductive thematic analysis (which is largely data-driven), a deductive thematic analysis is largely driven by theoretical understandings of the area of interest. The coding process was focused on particular features of the data, resulting in a number of themes around framing and positioning respectively (with a sexual and reproductive justice approach serving as a backdrop for analysis). Moreover, engagement with the literature was undertaken prior to analysis in order to sensitise the researcher to the subtle features of the data, thereby enhancing the analysis (Tuckett, 2005). Furthermore, analysis was focused on the latent or interpretive level of data. As such, analysis attempted to go beyond the semantic content of the data in order to identify and examine the underlying assumptions, conceptualisations, and ideologies (linked to the theoretical understandings of framings, subject positions, and sexual and reproductive justice) informing the semantic content of the data. In other words, the analysis attempted to engage with broader assumptions, structures and/or meanings that are theorised as underpinning what is actually articulated in the data.

Unit of Analysis

The preliminary data set comprised of existing policy documents related to youth SRH in selected global South countries, from the period of 2010 to 2015, in order to ensure a contemporary focus. Given that youth SRH issues tend to be addressed in general terms across policies, the review focused on Ministries of Health, Youth, Education, and Development, of identified countries within the general areas of national health policies, national youth policies, national education policies, and national sexual and reproductive health policies. While an attempt was made to ensure inclusivity in terms of the countries surveyed, feasibility dictated that some countries were excluded from the preliminary data set. Nevertheless, an attempt was made to ensure that there was a good distribution of countries across the global South on the basis of geographical location, socio-political

history, and current economic standing as a low- or middle-income country (with the latter determined by World Bank categorisation). Upon finalisation of data collection procedures, the final data set comprised of 1035 policy excerpts extracted from 152 policies across Africa (see Appendix B for a full list), Asia (see Appendix C for a full list), and the Caribbean (see Appendix D for a full list) (with Latin America being excluded from the final review as discussed in later sections).

Procedures for Data Collection

A systematic review generally involves three key processes: (1) identification and description of the relevant research (i.e. 'mapping' the research), (2) critical appraisal of material in a systematic manner, and (3) synthesis of the findings. Bambra (2011) outlines eight key stages involved in a systematic review including: (1) formulation of review question(s) (2) development of a protocol (outlining inclusion and exclusion criteria, search strategy, and sources that will be consulted); (3) performance of a rigorous literature search (possibly combining electronic database searches with hand, citation, and website searches); (4) selection of material based on inclusion and/or exclusion criteria; (5) data extraction utilising standardised methods and critical appraisal of included material; (6) synthesis of material; (7) interpretation of synthesised results and reflection on research, policy, and practice implications, and (8) writing up and publication of the review (with methods clearly described and limitations acknowledged). Although the undertaken research was able to adhere to the initial stages (i.e. stages 1-4) suggested by Bambra (2011), it was necessary to adapt subsequent stages (stage 5-8) in order to successfully align the requirements of a systematic review with those of thematic analysis. The initial stages outlined by Bambra (2011) that were undertaken as part of the analysis process will be explored below. It is important to note that these stages were undertaken in collaboration with a co-researcher. Subsequent stages (as adapted and undertaken by the researcher) will be noted in the ensuing discussions pertaining to data capturing, coding, and analysis.

Stage 1: Formulating the review questions

Guidance related to systematic reviews advocates that the review question should provide a definition of the area of interest, the research population, and the outcome(s) of interest (Higgins & Green, 2008). Given that this question dictates the remit of the review it is an undoubtedly an important area for consideration (Bambra, 2011). In this instance, the review

question was related to, but differed from, the three research questions serving as the primary avenues of inquiry informing analysis. The research questions are primarily concerned with the framings of youth SRH and the subject positions assigned to queer youth within policies across global South countries. As such, the review question was concerned with the identification and location of relevant policy documents that might address youth SRH in global South regions. In contrast to traditional guidance that advocates for narrow and concise review questions (Bambra, 2005), the particular area of interest of this research necessitated a review question that is fairly broad in scope. In an attempt to mitigate the potential difficulties that accompany a broader review question, the researcher and co-researcher ensured that a pilot scoping study was undertaken to 'map' the potential area of interest (and generate the 'best available' evidence).

This scoping study involved the consultation of government websites of global South countries to explore policy enactments related to youth SRH. Moreover, reports on youth SRH compiled by a number of organisations (such as the UN, Advocates for Youth, Sexual Rights Initiative etc.) were consulted. This pilot search demonstrated that within global South regions there are few SRH policies that focus specifically on youth SRH. As expected, youth SRH was more commonly addressed across different national policies. This appears to be especially true of the global South (which comprises of low- and middle-income countries) where adolescent and youth SRH issues tend to be driven by international commitments and are subsumed within various national policies (Pillay, & Flisher, 2008). As such, the pilot search was able to successfully produce a preliminary impression of the availability and location of data (i.e. to 'map out' the potential evidence base).

Stage 2: Development of systematic review protocol

Once initial parameters had been established during the pilot search, a systematic review protocol was developed. This protocol sought to outline: which sources would be consulted, a well-defined search strategy, and inclusion and/or exclusion criteria. This systematic review protocol was adapted from the protocol developed for the larger team project, to which the current research was attached. It is important to note that dependent territories in Eastern Africa[7], Western Africa[8], South America[9], and the Caribbean[10] were disqualified from

[7] Disqualified countries In Eastern Africa included the British Indian Ocean Territory, French Southern Territories, Mayotte, and Réunion.
[8] Disqualified countries in Western Africa included Saint Helena.

inclusion at this stage of the data collection process given their relationship to global North countries. This finalised systematic review protocol can be found on the next page (see Table 1). In most cases, a systematic review protocol addresses additional issues including: information regarding the context and rationale for the review, primary outcomes of interest, a strategy for data synthesis, and any additional aspects relevant to the research plan (Eden, Levit, Berg, & Morton, 2011). However, given that these concerns had been largely addressed within the research proposal and would be addressed in subsequent stages of the research process, the researcher determined that inclusion of these aspects would add little value to the protocol. Nevertheless, the protocol was able to serve as an adequate description of the objectives and methods undertaken as part of the review (Eden et al., 2011), and served as a useful management tool in the data collection process (Higgins & Green, 2008; Tacconelli, 2010).

Stage 3: Performance of literature search

Given the parameters established in the pilot search, the researcher and co-researcher decided that data collection would combine first-line searches with specialist database searches. Importantly, some evidence suggests that this particular search strategy may be the most fruitful and efficient approach for undertaking a systematic review (Ogilvie, Egan, Hamilton, & Pettigrew, 2005; Ogilvie, Hamilton, Egan, & Pettigrew, 2005). However, it is also important to note that this particular approach stands in opposition to more 'purist' approaches to formulating search parameters which advocate searches to be conducted in every available and potentially relevant electronic database (or data source). A more focused search strategy ensures that unnecessary time is not spent on the collection of data that do not constitute the best available evidence (e.g. lower level studies). Although a decision not to limit the search strategy will greatly broaden the remit of the review and ensure that potential to overlook relevant sources is limited, this process is likely to be very costly in terms of time (at the both the searching stage and document screening stage). On balance, it was decided that a comprehensive search strategy was unnecessary given that potential data sources had already been identified during the pilot search, meaning that only the better quality material would be subjected to the lengthy data analysis process (Bambra, 2011).

[9] Disqualified countries in South American included the Falkland Islands and French Guiana.
[10] Disqualified countries in the Caribbean included Anguilla, Aruba, Bonaire, British Virgin Islands, CaymanIslands, Curaçao, Guadeloupe, Martinique, Montserrat, Puerto Rico, Saba, Saint Maarten, Saint Martin, Saint-Barthélemy, Sint Eustatius, Turks and Caicos Islands, and the United States Virgin Islands.

Table 1. Finalised systematic review protocol.

Title of the review	Policy responses to the sexual and reproductive health of queer youth in the global South: A systematic review
First reviewer	Ms Sarah-Ann Moore
Team of reviewers	Dr Malvern Chiweshe
Supervisor(s)	Dr Ingrid Lynch Prof Catriona Macleod

1. Sources to be Consulted	
Primary sources of data include all policies related to youth SRH, not inclusive of legislation. However, academic sources (e.g. journal articles) will also be consulted.	

2. Search Strategy	
First-line searches will be conducted, followed by specialist database searches in order to produce the best available data.	
a. First-line searches	These searches should be conducted by accessing ministry websites (Ministries of Health, Youth, Education, and Development), country-specific parliamentary monitoring sites, and in cases where this is unsuccessful, contacting representatives of the relevant ministries directly.
b. Specialist database searches	These searches should include relevant academic databases (including Pubmed, EBSCO, JSTOR, Popline, World Cat, Mendeley) and search engines (including Google and Google Scholar).

3. Criteria for Exclusion from the Review	
a. Region	Only regions classified as 'global South' regions (low to middle income countries) should be included. Dependent territories in Eastern Africa, Western Africa, South America, and the Caribbean that are aligned with countries in the 'global North' (e.g. US, UK, France etc.) should be excluded.
b. Period of Coverage	Only policies covering the period of 2010-2015 should be included in the final data set. *Amendment: Policies that cover this period, but were effected prior to 2010, must also be included.*
c. Language	Policies available in English, French, Spanish, and Portuguese should be included in the final data set. *Amendment: Only policies available in English should be included.*
d. Type of Policy	Only policies falling into the following categories should be included: national youth policy, programme, or strategy; national health policy, programme, and strategy; national health development policy; national development policy; national education policy; national HIV/AIDS policy; and national gender policy.
e. Key Words in Documents	Only policy documents that contain the following key words should be included in the final data set: youth, young people, adolescents, adolescence, sexual and reproductive health (and rights), sexual health, reproductive health, sexual rights, reproductive rights, SRH, SRHR, sexuality, sexual orientation, reproduction, lesbian, gay, bisexual, transgender (and transsexual), intersex, LGB, LGBT, and LGBTI. *Amendment: men who have sex with men, MSM, and third gender.*

Moreover, the inclusion of secondary specialist database searches and supplemental searches (including citation searches) were deemed sufficient to negate the need for a broad search strategy.

Accordingly, first-line searches were conducted to identify relevant policy documents. Searches for Asia, Latin America, and the Caribbean were conducted by the researcher, while searches for Africa were conducted by the co-researcher. These searches focused on documents produced by the Ministries of Health, Youth, Education, and Development of identified countries in the global South. This was done by accessing the websites of the respective ministries, country-specific parliamentary monitoring sites, and in cases where this was unsuccessful, contacting representatives of the relevant ministries directly. Searches focused on the general areas of national health policies, national youth policies, national education policies, and national sexual and reproductive health policies. Legislation pertaining to the legal status of same-sex relationships and gender non-conforming practices were also located. Subsequently, specialist database searches were conducted. Databases including Pubmed, EBSCO, JSTOR, Popline, World Cat, and Mendeley were searched, as well as search engines including Google and Google Scholar. These searches were conducted in order to locate any outstanding documents and additional relevant literature pertaining to youth SRH. Supplemental citation searches were also conducted to ensure that the best available evidence had been located. At this stage, it became necessary to revisit governmental websites in order to locate additional policy documents suggested by the literature.

Stage 4: Screening of preliminary data set

Once these searches were finalised and all potentially relevant policies had been located, the policy documents were screened by the researcher and co-researcher according to the exclusion criteria outlined in the review protocol (see Table 1). However, before this screening process was undertaken, it was deemed necessary to revise exclusion criteria following an initial reading of the literature. These revised screening criteria were cultivated on the basis of an inductive reading of the policies (i.e. screening criteria were data-driven). A number of amendments were made to the exclusion criteria following discussion between the researcher and co-researcher. The period of coverage was refined to ensure that policies that cover the period of 2010 to 2015, but were introduced prior to 2010, should be included. Moreover, a number of additional terms were added to exclusion criteria relating to key words including, ‘men who have sex with men’, ‘MSM’, and ‘third gender’.

Finally, although the research had initially intended to be inclusive in terms of language (intending to potentially include documents available in English, French, Spanish, and Portuguese); the skills of the review team and budgetary limitations meant that the exclusion criteria required amendment. The decision was taken to include only those documents available in English. The inclusion of policies located for Africa, Asia, and the Caribbean was largely unaffected by this amendment. Importantly, identified policy documents from French-, Spanish-, and Portuguese-speaking countries (particularly in Africa) were not excluded based on this amendment as most policies were available in English. However, of the identified policies located for Latin American, none were available in English. This meant that the 36 policies located for Central America and 34 for South America were excluded from the final data set. As such, Latin America was no longer included as a region of interest in the subsequent analysis.

At the end of the screening process, 22 of 55 African countries were included in the preliminary data set. By sub region, this included: 12 of 18 Eastern African countries, all Southern African countries, and 5 of 16 Western African countries. No Middle or Northern African countries were included in the preliminary data set, either because no policies could be located or because policies were not available in English. Appendix E includes a full list of African countries included in the preliminary data set. For Asia, 31 of 47 countries were included in the preliminary data set. By sub region, this included: 4 of 5 Central Asian countries, 1 of 4 Eastern Asian countries, 8 of 9 Southern Asian countries, 8 of 11 South-eastern Asian countries, and 10 of 18 Western Asian countries. Appendix F includes a full list of Asian countries included in the preliminary data set. For the Caribbean, 9 of 13 countries were included in the preliminary data set. Appendix G includes a full list of Caribbean countries included in the preliminary data set. The complete preliminary data set comprised of 76 policy documents from African countries (see Appendix B for a full list), 62 from Asian countries (see Appendix C for a full list), and 14 from Caribbean countries (see Appendix D for a full list) – totalling 152 policy documents across all regions. These 152 policy documents included: 60 health policies, 35 youth policies, 28 development policies, 15 SRH policies, and 14 education policies.

Procedures for Data Capturing and Finalisation of Data Set

According to Bambra (2011), completion of preliminary data screening is followed by data extraction using standardised forms and critical appraisal of included material (stage 5) and synthesis of the material using meta-analysis (a statistical strategy for pooling the results of several studies into a single effect estimate) or narrative synthesis (data synthesis and exploration of heterogeneity using description) (stage 6). However, given that these particular stages were largely conceptualised for the purposes of quantitative analysis they were not undertaken by the researcher and co-researcher. Rather, data were extracted by means of a simplified procedure aimed at identifying extracts relevant to youth SRH within the preliminary data set (i.e. policy documents that were retained following the earlier screening process). Each policy document was searched for the following key words: youth, young people, adolescents, adolescence, sexual and reproductive health (and rights), sexual health, reproductive health, sexual rights, reproductive rights, SRH, SRHR, sexuality, sexual orientation, reproduction, lesbian, gay, bisexual, transgender (and transsexual), intersex, LGB, LGBT, LGBTI, men who have sex with men, 'MSM', and third gender. All excerpts that referenced these terms (with particular reference to youth and queer populations) were extracted and copied into an Excel spread sheet. As such, the final data set comprised of 1 035 excerpts (extracted from a total of 152 policies).

However, prior to commencing with the 'formal' thematic analysis process all extracts were read and re-read in an attempt to identify the various communication frames operating within the policy documents in relation to youth SRH. This identification process would serve to inform subsequent analysis concerning emergent themes relating to the framings of youth SRH. The process was informed by the method for identifying communication frames as outlined by Chong and Druckman (2007b). Firstly, according to this method a communication frame can only be identified in relation to a specific issue or event, and as such the identification process can only commence following the identification of such an issue or event (Chong & Druckman, 2007b; Entman, 2004). The underlying assumption here is that communication frames are often issue-specific, i.e. the communication frames invoked in relation to youth SRH may differ from those invoked in relation to other public health concerns. Following this, an initial set of frames for youth SRH were identified inductively by the researcher and co-researcher (Chong & Duckman, 2007b).

Consistent with the literature in this area, this reading process demonstrated that concerns around youth SRH are most often framed in terms of the public health approach and the human rights approach. Although less ubiquitous, a third framing was also identified by the researcher and co-researcher and was subsequently included in order to ensure that the identification process was inclusive of "culturally available frames" in elite discourse (Gamson & Modigliani, 1987, p. 144). This framing sought to highlight relevant contextual issues that serve to hinder SRH, particularly in reference to social and cultural practices. Although this framing was the most closely aligned with a SRJ approach, it did not represent an enactment of the full spectrum of principles advocated by a SRJ approach. As such, a decision was made to name this framing a 'context and culture' framing rather than a SRJ framing.

Following the identification of the three key framings, all extracts comprising the final data set were categorised as belonging to a public health framing, human rights framing, or context and culture framing respectively. Policy extracts for Asia and the Caribbean were categorised by the researcher, with extracts from African policies categorised by the co-researcher. Once this process was complete inter-rater reliability was calculated using percentage agreement. Initially correspondence in the two sets of coding was 71.05%. After re-examination of the data and discussion between the researcher and co-researcher, 100% consensus was reached. Following this, a basic content analysis was conducted to enable the transformation of verbal documents into quantitative data (Neuendorf, 2002) and to reveal patterns of framings across policies in Africa, Asia, and the Caribbean. Statistical analysis of these patterns consisted of frequency counts converted to percentages. Frequency counts were conducted for each framing (i.e. public health, human rights, and context and culture) and for each framing broken down according to region (i.e. Africa, Asia, and the Caribbean). This process allowed the researcher to ascertain the frequency of use for each framing – both generally and according to region. Once this process was complete, the formal thematic analysis process was undertaken solely by the researcher.

Procedures for Thematic Analysis

Analysis was undertaken according to the six phases of analysis outlined by Braun and Clark (2006; 2012). However, it is important to note that the process of analysis essentially begins

during data collection. At this stage in the research process, the researcher began to take note of patterns of meaning and issues of potential interest in the data which would later inform the 'formal' analysis process. Moreover, analysis was not a linear process where the researcher was able to move effortlessly from one phase to the next. Rather, the analysis served more as a recursive process – where the researcher moved back and forth between phases as and when needed. Nevertheless, for the purposes of clarity, the following discussion of analysis phases is presently in a largely linear manner.

Phase 1: Familiarisation with the data

Analysis commenced with immersion in the data. The primary focus during this stage of analysis was repeated reading of the data, with the aim of establishing researcher familiarity with the depth and breadth of the content. Reading of the data was informed by broader concerns regarding the type of analysis being conducted (i.e. overall analysis), the focus on latent (rather than semantic) themes, and with the understanding that analysis would be theoretically-driven. Moreover, reading was undertaken with the intent to begin to identify meanings, patterns, and trends within the data. Throughout this process, the researcher took notes concerning potential codes that might be utilised during the coding phase(s) of analysis. The entire data set was read twice before coding was undertaken. While this process proved time consuming, the reading and re-reading of data at this stage provided an important foundation for later phases of analysis (Braun & Clark, 2006; 2012).

Phase 2: Generation of initial codes

The second phase of analysis focused on the production of initial codes across the entire data set and collating data relevant to each code. In this sense, codes serve to identify a specific feature of the data that is of interest to the researcher. Full and equal attention was given to each data item in order to identify aspects in the data items that could form the basis of themes across the data set (Braun & Clark, 2006; 2012). As such, the coding process allowed the researcher to organise the data into meaningful groups (Tuckett, 2005). In many cases data items were allocated a number of codes in order to reflect any tensions and inconsistencies that were present within and across the data items. As such, the coding process was able to provide an overall conceptualisation of the data patterns, and relationships between them, whilst also retaining codes which departed from the dominant trends in the analysis. The coding process was undertaken manually, and was theoretically-

driven in so far as the researcher coded the data with specific questions in mind (Braun & Clark, 2006; 2012).

During this stage of analysis, two separate (yet related) coding processes were undertaken.
In the first coding process, all extracts were coded by drawing on the notion of communication frames. Throughout the process, codes were assigned by reviewing and highlighting the underlying premises of what the authors of the extracts prioritised as relevant to the topic of youth SRH. Once this process was complete all extracts were sorted according to the three framings (i.e. public health, human rights, and context and culture) assigned in previous stages of analysis. This sorting process was undertaken in order to facilitate the next stage of analysis: identification of themes within each framing 'category' respectively.

In the second coding process, all extracts were coded by drawing on understandings of positioning. Throughout the process, codes were assigned by seeking to identify the ways in which youth, queer youth, and queer populations were positioned within the extracts. Of vital importance here was the role of language and the manner in which certain framings provide space for particular subject positions concerning the various 'actors' named in the text. As such, this second coding process often served to build upon the first, and there was often a great deal of parity with codes generated during the first coding process.

Phase 3: Identification of themes

The next phase of analysis involved the collation of different codes *into* potential themes, and the collation of all data extracts *within* the identified themes. This process was undertaken separately for both 'framing' codes and 'positioning' codes (Braun & Clark, 2006; 2012). Although the process of coding forms part of the analysis process (Miles & Huberman, 1994), it was during this stage of analysis that interpretation of the data occurred. During this phase of analysis, the researcher began to analyse the codes and consider how different codes might be combined to form an overarching theme. As such, relationships between codes, between themes, and between overarching themes and sub-themes were all considered. Following this process a number of main overarching candidate themes were successfully identified for both 'framing' codes and 'positioning' codes. However, a number of codes could not easily be assigned to these candidate themes, and were temporarily assigned to a

'miscellaneous' theme category. At this stage of the analysis, the significance of identified themes began to emerge (Braun & Clark, 2006; 2012).

Phase 4: Review and revision of themes

The fourth phase on analysis was concerned with refinement of candidate themes by ascertaining whether themes work in relation to (i) the coded extracts, and (ii) the entire data set. Again, this process was undertaken separately for both 'framing' themes and 'positioning' themes (Braun & Clark, 2006; 2012).

First, coded data extracts were reviewed. Extracts for each candidate theme were read to ascertain whether they formed a coherent pattern (Braun & Clark, 2006; 2012). To this end, Patton's (1990) dual criteria for judging categories were utilised. According to these criteria themes should meet the requirements of internal homogeneity and external heterogeneity (i.e. each theme should cohere together meaningfully, but distinctions between themes should also be clear and identifiable). During this process, the majority of identified themes met the requirement of coherency. However, a number of themes were somewhat inconsistent and required revision. Most cases of theme inconsistency were resolved by breaking down one theme into two separate themes (in cases were the original theme was too diverse) or collapsing two themes into each other. In one case, a previously identified candidate theme was discarded as there was not enough data to support it. A number of extracts were also reallocated to other themes to improve theme consistency. Once this was completed, codes that had been previously assigned to a 'miscellaneous' theme category were reallocated to candidate themes with minimal reworking of candidate themes. Once the researcher was satisfied that all candidate themes adequately captured the contours of the coded data (i.e. whether the candidate thematic map(s) were adequately inclusive), analysis proceeded to the next stage of theme refinement (Braun & Clark, 2006; 2012).

During the second refinement process the researcher sought to: (i) review the validity of identified themes in relation to the data set, and (ii) ensure that the candidate thematic maps (for both framing and positioning themes) served as an accurate reflection of the data set as a whole. To this end, the researcher re-read the entire data set in order to ascertain that candidate themes 'worked' in relation to the data set. This process was essentially undertaken twice, once for framing themes and again for positioning themes. Moreover, the process of

re-reading the data set allowed the researcher to code any additional data within the themes that had been missed in earlier coding stages. No additional codes were allocated in terms of framing themes. However, a number of codes were allocated in terms of positioning themes. Following this process, the researcher was satisfied that the thematic map(s) adequately fit the data set, and analysis was able to progress to the next phase (Braun & Clark, 2006; 2012).

Phase 5: Definition and naming of themes

During this phase of analysis the researcher undertook to refine the specifics of each theme, and generate clear definitions and names for each of the identified candidate themes. During this phase it was necessary to identify the 'essence' of each theme (as well as the themes overall), and determine what aspect of the data each theme was able to capture. In order to achieve this, the researcher returned to the collated data extracts for each theme and organised them into a coherent and internally consistent account, with an accompanying narrative. Rather than paraphrasing the content of data extracts, it was important to identify and explore interesting aspects within the extracts and explore the reasons behind this (Braun & Clark, 2006; 2012).

As such, a detailed analysis of each theme was conducted. This analysis focused on identifying the 'narrative' within each theme, whilst also considering how it fits into the broader overall 'narrative' of the data as a whole. As such, it was necessary to consider the themes themselves, and explore how each theme operates in relation to the others. Importantly, each detailed analysis was informed by the theoretical understandings informing the undertaken research. This process was undertaken separately for both framing and positioning themes. In other words, a detailed analysis of framing themes was conducted (informed by the theory of communications frames), which explored each theme in turn, whilst also exploring how each theme operated in relation to the others. Similarly, a detailed analysis of positioning themes was conducted (informed by the theory of positionings), which explored individual themes and their relationships to one another (Braun & Clark, 2006; 2012).

It was also important to ensure that there was minimal overlap between themes. Although there was little overlap in terms of positioning themes, this undertaking was somewhat more complicated in relation to the framing themes, as many of the themes were often concerned

with the same issue (or 'narrative'). As such, on the surface, there might appear to be significant overlap between themes across public health, human rights, and context and culture framings. However, the manner in which these issues were presented (or framed) was varied, and as such each represents a distinct theme. For example, each framing category contains a theme related to the singling out of certain population groups as requiring special attention in terms of addressing their SRH needs. However, these population groups are conceptualised in distinct and varied ways – as high risk groups (public health framings), vulnerable groups (human rights framings), and marginalised groups (context and culture framings) – meaning that these themes are both similar and distinct. Therefore, it was necessary for the researcher to identify these relationships between themes, and explore them within the analysis (Braun & Clark, 2006; 2012).

Once this process was complete, the researcher then turned to exploring the relationship between framing themes and positioning themes. Given that the research was informed by an understanding that certain framings allow for the creation of certain subject positions, it was important to identify and explore any relationships between framing and positioning themes. Therefore, at the end of this phase the researcher had clearly defined each theme, had identified potential relationships between framing themes, and had identified potential relationships between framing themes and positioning themes. Finally, 'working titles' for each theme were revised and amended to ensure that each theme name was concise and able to give an immediate understanding of what the theme was about (Braun & Clark, 2006; 2012).

Phase 6: Finalisation of analysis

During the final stage of analysis, the researcher sought to provide an expansive 'telling' of the data with the intent of demonstrating the merit and validity of the analysis. The analysis write-up was separated into two key analysis chapters – the first focusing on themes around communication frames and the second focusing on positioning themes. In order to generate a comprehensive write-up of the key themes, the researcher selected a number of extracts that were able to provide sufficient evidence of each identified theme within the data set. For each theme, the researcher initially selected a number of extracts that might serve to capture the essence of the theme, without unnecessary complexity. These extracts were then reviewed to ascertain which were the most compelling, and which served as those most identifiable

examples of the issues explored within each theme. Those extracts that did not meet these criteria were discarded. Once these extracts were selected, the write-up process began in earnest. Final written analysis of selected extracts was undertaken. Extracts were embedded within an analytic narrative that sought to identify, explore, and draw out certain arguments in relation to the research questions. The final analysis attempted to provide a concise, coherent, logical, non-repetitive, and interesting account of the data – within and across themes – in order to provide a rich overview of the patterns and trends within the data in reference to communication frames and subject positions (Braun & Clark, 2006; 2012).

Preceding discussion has outlined the methodological processes conducted as part of the deductive framing and positioning thematic analysis that was undertaken. Discussion provided a general overview of systematic reviews and thematic analysis, followed by details of the unit of analysis. Procedures for data collection, data capturing, and finalisation of the data set were then explored. Finally, discussion concluded with an outline of the various steps undertaken to conduct a thematic analysis. In particular, discussion sought to outline the procedures undertaken in order to explore three central avenues of inquiry including identification and exploration of: (1) the framings of youth SRH within policy extracts; (2) the subject positions assigned to queer youth within these same policies, and (3) trends within and across countries, and regions in relation to the framing of youth SRH and the positioning of queer youth in particular. In the subsequent chapters, findings related to the framing of youth SRH within policy extracts will be discussed.

CHAPTER 5: FRAMINGS OF YOUTH SEXUAL AND REPRODUCTIVE HEALTH

Within the following discussion, identified framings of youth SRH will be examined, highlighting the basic assumptions underpinning reference to queer youth SRH in selected global South policies. In particular, identified themes within each framing (i.e. the public health framing, human rights framing, and context and culture framing) will be examined in an attempt to provide a nuanced understanding of the particular perspective each framing brings to bare on the issue of youth SRH. Understandings of communication frames are premised on an assumption that an issue can be viewed from a multitude of perspectives. As such, the forthcoming discussion will identify and examine each of these perspectives in turn, and critically engage with the value of each in furthering sexual and reproductive health and justice for young persons.

Discussion will explore identified themes within the public health framing, namely a narrow definition of sexual and reproductive health interventions and outcomes, and a targeted focus on certain populations as the 'key' to resolving sexual and reproductive health concerns. Next human rights framing themes will be examined, including a narrow focus on securing rights of access, and understandings of vulnerability, discrimination, and equality. Finally, themes that emerged within the context and culture framing will be discussed, including: a focus on marginalised population groups; concerns around the consequences of stigma and discrimination; addressing taboos around the discussion of SRH; addressing problematic cultural practices; acknowledging societal pressures and family expectations as barriers to SRH; and acknowledging invisibility and secrecy as barriers to SRH. First, however, it is necessary to provide an overview of the relative 'strength' of each of these framings within the examined policies.

Overarching Framing Trends across the Data Set

Across all three regions public health framings of youth SRH were the most prominent. Of the extracts included in the final analysis 62% (Africa), 59.7% (Asia), and 61.3% (Caribbean) conceptualised youth SRH within this framework. Although less prevalent than public health framings, references to youth SRH also consistently drew on a human rights approach – with 26.5% (Africa), 31.7% (Asia), and 29.4% (Caribbean) of extracts conceptualising youth SRH

as a human rights issue. Significantly, context and culture framings were the least utilised framings. Less than 10% of the extracts (i.e. 11.5% for Africa, 8.6% for Asia, and 9.2% for the Caribbean) conceptualised youth SRH within a framework of context and culture (drawing on and referring to contextual issues that contribute to poor SRH and cultural practices that might adversely affect SRH outcomes) across all regions.

The dominance of certain framings has an important impact on the potential framing effect (i.e. the ability of a communication frame to affect the attitudes and behaviour of the audience) of each communication frame. As indicated earlier, some argue that those frames which are repeated most frequently will have the greatest influence on individual opinion irrespective of the relative strength of the frame (Chong & Druckman, 2007a). If one aligns with this school of thought, it is clear that within the context of policy concerning youth SRH, public health framings are likely to produce the strongest framing effect. Conversely, context and culture framings are likely to have little effect on the attitudes and behaviour of the audience, in this case those tasked with implementing policies.

Alternatively, it is argued that the strongest frame will exert the greatest influence on individual opinion, regardless of frequency (Chong & Druckman, 2007a). As indicated earlier, the relative strength of a frame has been linked to issues of credibility, consensus values, and the presence or absence of strong predispositions. The issue of credibility is premised on an understanding that frames delivered by credible sources are more likely to shift opinions. Given that the framings under review here are linked to similar sources (i.e. ministry branches of government), credibility does not serve as a valuable measure of framing effect. However, consensus values (i.e. frames that invoke longstanding cultural values), and the presence or absence of strong predispositions (i.e. frames that do not contradict strongly held prior beliefs are more likely to shift opinions) might offer insights into potential framing effects. While a more detailed exploration is beyond the reach of this research, it seems plausible that public health framings could potentially be viewed as the strongest frame given the pervasiveness of public health understandings of SRH, and the lack of 'contestation' of problematic predispositions around youth SRH that is often exemplified by public health approaches. At any rate, a deeper examination of the key themes within each identified framing should provide some insight into the potential influence(s) and shortcomings of each framing.

Themes Emerging within Public Health Framings

Within the public health framing, two central themes emerged including: (1) a narrow definition of sexual and reproductive health interventions and outcomes, and (2) a targeted focus on certain populations as the 'key' to resolving sexual and reproductive health concerns. Each of these themes contained a number of notable sub-themes which were present across the entire data set. Theme 1 was largely concerned with (a) understandings of health in terms of prevalence, morbidity, and mortality, (b) the prioritisation of reduction and prevention of disease; and (c) a specific focus on certain types of SRH intervention. Theme 2 tended to centre around (a) a specific focus on high risk and/or most-at-risk populations; and (b) the prioritisation of targeted interventions, programmes, and services.

Importantly, all themes represent a key failing of public health framings – a failure to position SRH within a context of intersecting social, economic, cultural and health care possibilities and challenges that serve to either enhance or hinder youth enjoyment of sexual and reproductive health and rights. Moreover, these framings tended to align with narrow understandings of health as the absence of disease, effectively limiting the ways in which intervention was conceived and implemented. In addition, these framings failed to engage with the potential for diversity within youth populations. By obscuring youth diversity, these framings served to homogenise youth populations and call into question the effectiveness of interventions that fail to consider the context in which they become necessary.

Theme 1: Narrow definition of sexual and reproductive health interventions and outcomes

Overwhelmingly, understandings of youth SRH within public health framings failed to provide systemic or holistic formulations of SRH, opting to retain a narrow focus on specific SRH outcomes. Understandings of youth SRH within public health framings were intrinsically linked to the prevalence, and incidence of, morbidity and mortality associated with sexual and reproductive health issues. Concerns around the prevalence of HIV, STIs, pregnancy, low levels of contraception use, and early sexual debut appeared frequently within these framings.

Public health framings typically served to reduce youth SRH to a series of statistical data concerning prevalence, stating for example: "HIV infection rates are highest in the age

groups 15-29. The average age at first intercourse is 17.5 years and first birth is 18.6 years. Teenage pregnancy rate is 16% while contraceptive use is only 29% among this age group" (Botswana Policy Guidelines and Service Standards - National Sexual and Reproductive Health Programme, 2015, p. 1). Similarly, extracts pertaining to the incidence of morbidity and mortality were largely reductionist, serving to diminish arguably complex health concerns to a series of numbers and figures devoid of context. For example, Jamaica's HIV and AIDS National Strategic Plan (2007-2012) states "Between 1982 and … December 2006, there were 11,739 persons reported with AIDS in Jamaica. AIDS and sexually transmitted infections (STI) … are the second leading cause of death for both male and female 15 to 24 years old" (p. 2).

While such understandings of youth SRH may be necessary for providing a general overview of the 'status' of youth SRH within individual countries, they are limited. By placing a specific emphasis on prevalence and incidence, such extracts tend to align with narrow understandings of health as the absence of disease and thus perpetuate a narrow understanding of SRH. Importantly, such framings often fail to acknowledge the context(s) in which these outcomes occur. As such, these framings promote a specific (and limited) understanding of SRH, which has implications for the ways in which intervention is conceived of and implemented. Although the inclusion of such statistical data is not inherently problematic, the dominance of such a framing within policy documents could speak to an overreliance on biomedical and population-level health models, serving to overshadow nuanced understandings of youth SRH concerns.

In line with the dominance of concerns around prevalence and incidence, public health framings often detailed concern around the reduction and prevention of HIV and STI transmissions. These extracts ranged from 'specific' targets such as to "reduce the incidence of STI/HIV among young people by 30% by 2015" (Timor-Leste National Reproductive Health Strategy, 2004-2015, p. 15), to more general targets seeking to "contribute to the reduction in the spread of STIs and HIV among the youth and mitigate their impact on the individual and society" (Zimbabwe National Youth Policy, 2000-2010, p. 11). Additionally, many extracts prioritised the reduction of early marriage, adolescent pregnancy, and unsafe abortion. The prevention of new HIV infections was highlighted throughout most policy documents, with particular reference to youth and other 'high risk' groups. For example Afghanistan's National Strategic Framework for HIV/AIDS (2006-2010) argues that

"preventing HIV infections among young people is vital" and that "young people [must] be at the center of prevention actions … [in order to] ultimately halt the pandemic" (p. 31).

Although reduction and prevention outcomes might be deemed a necessary aspect of policy scope, such framings serve to further perpetuate a narrow understanding of SRH. The emphasis placed on reduction and prevention serves as a valuable illustration of the kind of intervention that is likely to arise from a framing of SRH that is overly reliant on concerns around prevalence and incidence. A widespread focus on reduction and prevention suggests that 'improvement' in the area of SRH should be judged against a singular benchmark, i.e. the complete absence of disease. Moreover, such a framing serves to reduce understandings of youth sexuality to notions of infections and impacts. Even if the necessity of such outcomes is accepted, the failure of such framings to account for, or even engage with, relevant contextual factors that might facilitate or hinder their realisation are likely to limit the efficacy of such targets.

Similar to concerns around reduction and prevention, extracts detailing the need for information and education to effect behavioural change in youth populations were widespread within public health framings. Many policies prioritised the need to "provide the information, education, skills, and services that young people need to make choices that keep them healthy and able to pursue their potential in life" (Barbados National HIV Prevention Plan, 2010, p. 36). In short, these extracts sought to highlight the need for increased SRH knowledge in order to ensure the practise of 'appropriate' sexual behaviour among youth. As such, these extracts operate on the assumption that information on SRH "contributes to the reduction of the incidence of abortions and STIs, including HIV among young people. In addition it promotes avoidance of risks and negative consequences associated with the early marriages, early pregnancy and related maternal and child health risks" (Georgia Youth Policy, 2014, p. 13).

While the importance of access to SRH-related information should not be negated, it is necessary to situate such interventions within a broader context. By operating on the assumption that the provision of information will undoubtedly result in desired behaviour change, such framings run the risk of overlooking additional factors (beyond lack of information) that may hinder or prevent behavioural changes. Moreover, many of these extracts seemingly fail to consider the broader context within which 'undesirable' sexual and

reproductive behaviour occurs. By obscuring these broader contextual factors, such framings may serve to hold individual youth responsible for poor SRH outcomes in cases where their behaviour is deemed unsafe and/or unchanged despite access to information.

In addition to concerns surrounding access to information, public health framings made reference to additional interventions for improving youth SRH. By and large, these extracts focused on the implementation of comprehensive SRH programmes, ensuring access to services, and the provision of SRH-related products (e.g. contraception). For example, Mauritius' National Youth Policy (2010) lists the following objective: (1) "To institute comprehensive programmes to prevent the transmission of sexually transmitted infections and HIV by providing education, information, communication and awareness creation as well as making protective measures and reproductive health services available and accessible" (p. 24). Interventions around the provision of "contraceptives, condoms and voluntary [HIV] counselling and testing" (Grenada National HIV/AIDS Strategic Plan, 2012-2016, p. 16) were also frequently cited. Outcome objectives concerned with increased levels of condom and contraception use often accompanied discussion of such interventions. For example, Mauritius' National Sexual & Reproductive Health Strategy and Plan of Action (2009-2015) outlines aims to increase contraceptive use "among young people aged 15 to 19 years from 4 percent to 7 percent" (p. 49).

Once more, while the implementation of such interventions should not be overlooked, it is important to situate them within a broader context. Many of these extracts seemingly fail to consider the broader context within which such interventions are made 'necessary' and as such are unable to fully engage with factors that may serve to facilitate or hinder their effectiveness. Moreover, and functioning in a similar manner to the previous sub-theme, by obscuring these broader contextual factors such framings may serve to hold individual youth responsible for poor SRH outcomes in cases where they fail to, for example, access available services or make use of contraceptives and/or condoms.

The prioritisation of issues related to prevalence and incidence, and reduction and prevention represented in public health framings sets the foundation for interventions that are largely narrow in focus. In repeatedly overlooking issues beyond prevalence and incidence, for example, such framings create little room for interventions that might seek to address issues beyond access to information and services. Within such a framing intervention outcomes are

limited to a narrow focus on achieving reduced levels of illness and/or unsafe sexual behaviour. Relatedly, failure to significantly engage with broader contextual factors (e.g. poverty, lack of community resources, stigma, and discrimination) calls into question the potential efficacy of such interventions and the capability to achieve stipulated intervention outcomes. By failing to account for context, public health framings may serve to obscure the relationship between SRH issues and related areas of concern such as economic disparity, welfare reform, housing shortages, and so on. Sexual and reproductive health concerns do not exist in isolation and as such understandings of interventions and outcomes must seek to acknowledge and address the broader set of conditions necessary for securing youth SRH.

Theme 2: Targeted focus on certain populations as the 'key' to resolving SRH concerns

Public health framings tended to focus on risk and 'key populations', with a related prioritisation of targeted interventions, programmes, and services for identified key populations. Largely, targeted interventions, programmes, and services are considered the most cost-effective means to address SRH concerns. However, not only do notions of key populations serve to homogenise arguably diverse populations groups, but they may also contribute to 'othering' (and further marginalising) these same groups. A narrow focus on key populations also serves to render certain populations as visible and recognisable health care subjects, while potentially overlooking other population groups (Morison & Lynch, 2016). Oftentimes, this visibility serves to isolate specific population groups as potentially 'dangerous' to the general public, particularly in relation the spread of HIV. Additionally, by conflating risk with certain 'unsafe' sexual practices attributed to particular groups, the public health framing often overlooks other pertinent risks (such as structural disparities) that diminish SRH outcomes for youth and queer persons alike (e.g. heterosexism, poverty, racial inequality, rurality and violence).

Youth populations were routinely categorised as high risk and/or most-at-risk, both in terms of general health concerns and more specifically in reference to sexual and reproductive health. Many policies outlined the need to improve youth health by "addressing all risk factors" associated with this period of life (Bhutan Adolescent Health Programme, 2013-2018, p. 1). Often these risk factors were linked to understandings of youth as a period of transition and development. Given the manner in which this period of transition was framed, youth were subsequently understood as particularly susceptible to many 'dangerous' or

'risky' sexual practices and "more prone to certain health risks, such as those related to reproductive health and sexually transmitted diseases" (Lebanon National Youth Policy, 2012, p. 19). Often, youth behaviour was linked to attempts to gain peer acceptance by engaging in 'high risk' behaviours such as early sexual initiation, unsafe sexual practices, and drug and alcohol use. For example Oman's 8th Five Year Plan for Health Development (2011-2015, p. 224) states that:

> Adolescence is considered a transition stage in human being lives, as he/she gets physical, biological, psychological and social changes which substantially shape his/her personality and attitudes. However during this delicate phase of a lifetime, many sources can influence the attitudes and behaviors of adolescent and youth such as peer pressure, media and communication technology…etc. Adolescents and youth may be exposed to risky behaviors such as sexual behaviors, … which may negatively affect their attitudes and practices.

Such framings draw on an understanding of youth populations as universally at risk by virtue of the inescapable 'period of life' in which they find themselves. As such, these framings often overlook the potential diversity within youth populations. Thus, these framings may fail to acknowledge that diverse contexts and varied social identities may serve to reduce or heighten the potential for risk among youth. Moreover, the inevitable risk associated with the period of adolescence may serve to deny the potential for youth agency and resilience. Importantly, such framings also serve to position youth peer groups (and the peer pressure associated with such groups) as significantly contributing to poor SRH outcomes. As such, both individual youth and youth peer groups are constituted as inherently risky. Such a framing may serve to discourage reliance on peers in engaging with concerns around sexual and reproductive health, serving to position certain adults (e.g. teachers, health care providers etc.) as the only reliable source for SRH information. However, such framings need to be mindful that relationships between youth and adults are often informed by unequal power relations, and social and cultural practices that might impede free engagement on issues around sexual and reproductive health.

Importantly, by drawing on understandings of youth as a period of 'transition' such framings also serve to perpetuate colonialist assumptions which characterise adolescence as a distinct period of transition to adulthood. Such understandings of adolescence emerged within

Western contexts, filtering into Africa and other parts of the world through a process of direct colonisation and (neo)colonialism (Caldwell et al., 1998). According to this understanding, adolescence involved a transition characterised by conflict between the primitive urges characteristic of childhood and the requirements of civilised behaviour characteristic of adulthood (Kett, 2003). This conflict inherently involved the danger of degeneration. As noted in the earlier review of literature, in colonial times anxieties around degeneration centred on masturbation. More recently, these anxieties have shifted to early reproduction, abortion and the spread of disease (Macleod, 2009). Such anxieties are clearly illustrated in the pervasiveness of concerns around youth susceptibility to 'risky' sexual practices and predisposition to sexual and reproductive health risks evidenced in public health framings.

In many of the policies, youth were included in broader groupings of high risk populations – frequently referred to as most-at-risk populations (MARPs). Largely, these 'MARPs' included: commercial sex workers (CSWs) and/or female sex workers (FSWs) (and their clients), injecting drugs users (IDUs), people living with HIV (PLHIV), people living with disabilities, women, prison inmates, long distance truck drivers, migrant or mobile populations (e.g. refugees), men who have sex with men, "bisexual men and beach boys[11]", *hijra*[12], *waria*[13], *kathoy*[14], third gender persons, and transgender persons. The rationale for linking these diverse and varied populations appears to be based on their actual and/or presumed engagement in high risk behaviours, which was closely linked to concerns surrounding the spread and transmission of HIV/AIDS and other STIs.

The HIV epidemic was often described as a concentrated epidemic among MARPs. For example, Sri Lanka's National HIV AIDS/Strategic Plan (2007-2011) states that "it is unlikely that Sri Lanka will develop a generalized HIV epidemic, but concentrated HIV epidemics among FSWs, MSM, and their sex partners cannot be ruled out" (p. v). These populations were frequently described as the "present drivers of the [HIV] epidemic" (The Philippine Strategic Plan on HIV and AIDS, 2011-2016, p. 10). In particular, queer populations (including MSM, "bisexual men [and] beach boys", *hijra*, *waria*, *kathoy*, "third

[11] A term that appears in policy documents originating in the Caribbean; it appears to refer to young male sex workers who operate within the sex tourism industry.
[12] A South Asian term used to refer to a transgender individual who was assigned male at birth.
[13] A traditional Indonesian term for 'third gender' persons.
[14] A term used to describe a 'third gender' person, most often used in Thailand and Laos People's Democratic Republic.

gender" and transgender persons) were frequently referred to as engaging in high risk behaviour and at high risk of HIV infection. In some cases sexual behaviour practised by 'MSM' was described as "dangerous" (see for example Tajikistan Programme on the Response to the Epidemic of HIV in the Republic of Tajikistan, 2007-2010, p. 22) and even predatory, with certain extracts asserting that male-to-male sex often involves adolescents and children (see for example Afghanistan National Strategic Framework on HIV/AIDS for Afghanistan, 2011-2015, p. 12). Many policies detail concerns that the HIV epidemic may "break out from the highly at risk groups into the general population" (Nepal Health Sector Programme - Implementation Plan II (NHSP-IP 2), 2010-2015, p. 33) and assert the need to "control HIV/AIDS transmission from high-risk groups to the [general] population" (Vietnam National Strategy on HIV AIDS, 2010-2020, p. 3).

Such framings position 'MARPS' as at risk *of* HIV infection, but also serve to distinguish them as a risk *to* the general population thus creating a kind of 'hypervisibility'. It is also important to note that concerns around the SRH of queer populations were solely mentioned in the context of HIV/AIDS focused policies, seeming to suggest that queer SRH concerns are only made relevant in the context of HIV/AIDS. Moreover, while a focus on MARPs may 'visibilise' certain population groups (sometime problematically so as is the case with the 'hypervisible' linking of 'MSM' with HIV concerns), this visibility also serves to potentially exclude other minority groups, such as queer women. Therefore, drawing on this framing may be effective in securing health care for certain sexual minorities whilst failing to bring broader awareness of and responsiveness to more diverse concerns. By conflating risk with certain 'unsafe' sexual practices attributed to particular groups, the public health framing also serves to homogenise these populations and overlook other pertinent risks (such as structural disparities) that diminish SRH outcomes for youth and queer persons alike (e.g. heterosexism, poverty, racial inequality, rurality and violence).

Linked to the focus on youth as a key population, public health framings tended to prioritise interventions, programmes, and services targeted specifically at youth. Many extracts detailed concern over inadequate access to youth-friendly health services, or stipulated the need to establish youth friendly services. For example, Bangladesh's 3rd National Strategic Plan for HIV and AIDS Responses (2011-2015) states that "youth health strategies [will be used] to establish youth friendly health services. The availability and location of youth friendly health services will be promoted … and integrated into more targeted interventions likely to be

accessed by young people" (p. 35). Similarly, targeted interventions were often prioritised for other 'MARPs', particularly men who have sex with men. For example, Nepal's National HIV/AIDS Strategy (2011-2016) stipulates the need to provide comprehensive priority interventions for "MSM and Third Gender to prevent sexual transmission of HIV and other STIs including promoting condom use, water-based lubricants, detecting and managing STIs, information, education and communication through peer outreach; enabling people to know their HIV status and receive counselling" (p. 35).

While it could be argued that targeted interventions are necessary for particular population groups on the assumption that their experiences of marginalisation hinder access to 'general' interventions, it is important to situate such interventions within the broader context within which such interventions are made 'necessary'. For example, discussions of targeted interventions for 'MSM' often overlook experiences of stigma and discrimination in health care settings that may discourage access and thus contribute to increased risk. As such, these extracts are unable to fully engage with factors that may serve to facilitate or hinder the effectiveness of interventions. Additionally, by obscuring broader contextual factors, such framings may serve to hold individual youth and queer persons responsible for poor SRH outcomes in cases where they fail to, for example, utilise targeted interventions. A narrow focus on 'MARPs' also serves to render certain populations (or sub-populations) as visible and recognisable health care subjects (for example, men who have sex with men), while potentially overlooking other population groups (for example, queer youth, queer women etc.). However, visibility itself (or hypervisibility) is not unproblematic and often serves to isolate specific population groups (predominantly 'MSM') as potentially 'dangerous' to the general public, particularly in relation the spread of HIV.

Themes Emerging within Human Rights Framings

Within the human rights framing, two central themes emerged including: (1) a narrow focus on securing rights of access, and (2) understandings of vulnerability, discrimination, and equality. Each of these themes contained a number of notable sub-themes which were present across the entire data set. Theme 1 was largely concerned with (a) understandings of SRH as a human right; (b) ensuring rights of access to vulnerable populations; and (c) conceptualising access to information as a human right. Theme 2 tended to centre around (a)

vulnerable population groups; (b) conceptualising freedom from discrimination as a human right; and (c) concerns over issues of equality.

Importantly, all themes represent a key failing often observed in human rights framings – a failure to critically engage with the assumption of agency in terms of individual choice and decision-making. Each theme largely served to further entrench the belief that rights are equally afforded to and freely exercised by all individuals once legally secured. Moreover, these framings tend to operate on the assumption that available resources are equally accessible irrespective of the operation of power relations within particular contexts. While some extracts did demonstrate an emerging understanding of the role of contexts in determining youth ability to exercise their rights in relation to sexual and reproductive health, this type of recognition was notably infrequent and largely undeveloped.

Theme 1: Narrow focus on securing rights of access

Perhaps unsurprisingly, the "promotion of health as a right" (Nepal Health Sector Programme - Implementation Plan II (NHSP-IP 2), 2010-2015, p. 37) was a pervasive trend within human rights framings, with many extracts declaring a recognition of the "intimate link between HIV/AIDS [and similar SRH concerns] and human rights" (Sri Lanka National HIV AIDS/Strategic Plan, 2007-2011, p. 5). In particular, extracts pertaining to rights of access (with particular emphasis placed on access to services and treatment, and access to information) appeared most frequently in these framings.

Human rights principles were commonly drawn on to assert that no person should be denied access to services or treatment on the "basis of their real or perceived HIV status, sexual orientation, gender, age, disability, religious or other beliefs, socio-economic status, geographic location, level of literacy, capacity to understand the nature of HIV/AIDS and how it is prevented and treated" (Jamaica HIV and AIDS National Strategic Plan, 2007-2012, p. 25). Unlike public health framings, these framings went beyond the mere fact of access, and attempted to specify the kind of access that should be guaranteed to address youth SRH. For example, Timor-Leste's National Reproductive Health Strategy (2004-2015) asserts that in addition to being accessible, youth friendly health services should also be "equitable, acceptable, appropriate, comprehensive, confidential, effective and efficient and available in both public and private sectors" (p. 18).

Although barriers to access experienced by youth were acknowledged, such acknowledgements were rare and often superficial. In addition, very few extracts made mention of the rights of queer populations to access services. However, the rights of queer populations were referenced in some policy extracts. For example, the Philippine Strategic Plan on HIV and AIDS (2011-2016) asserts that services must be "conscious of, and sensitive to the different needs of the various MSM and Transgender (TG) populations and the factors that may compound the risks experienced by these subgroups" (p. 75). Nevertheless, recognition of manifold social identities and acknowledgement of barriers required deeper engagement – these extracts failed to significantly explore the ways in which certain social identities might converge to create distant and disparate experiences of SRH services. For example, the ability of an affluent, white, transgender youth to access health care is likely to be considerably different from that of a cisgender youth of colour who identifies as gay and lives within an impoverished context – despite the inclusion of both within a queer population. As such, these framings fail to meaningfully contribute to understandings of the various difficulties faced (and privileges enjoyed) by youth according to their particular contexts and social identities.

Often linked to the right of access to services, human rights framings also made frequent mention of the right to information. Again, unlike the public health framings, these framings moved beyond the issue of access to attempt to ensure certain standards of information provision. For example, many policies asserted that SRH information should be accurate, gender-sensitive, and relevant to the daily lives of youth (see for example St Vincent & Grenadines HIV and AIDS National Strategic Plan, 2010-2014, p. 27). Access to information was often linked to the issue of empowerment – arguing that youth should have access to information that "empowers them to make informed choices about matters affecting their … health and well-being" (Mongolia Health Sector Strategic Master Plan, 2006-2015, p. 9). In this sense, public health and human rights framings were closely aligned in so far as both framings sought to emphasise the need for information to effect behavioural change. Although some human rights framings acknowledged that certain populations "have little control over their behavioural choices", informational empowerment was positioned as the remedy for "increase[ing] their control over behaviour" (Cambodia Revised National Strategic Plan II for a Comprehensive & Multi-Sectoral Response to HIV/AIDS, 2008-2010, p. 11).

These extracts appear to operate on the assumption that the provision of information (and the resulting empowerment of youth) will undoubtedly result in desired behaviour change. However, such an assumption may serve to overlook additional factors (beyond ensuring access to information that is accurate, gender-sensitive, and relevant to the daily lives of youth) that may hinder or prevent behavioural changes. Moreover, many of these extracts seemingly fail to consider the broader context within which 'undesirable' sexual and reproductive behaviour occurs, and may continue to occur, despite the securement of certain legal rights. For example, these extracts often fail to consider the operation of power relations within certain contexts that may serve to create barriers to information access. By obscuring these broader contextual factors and power relations, such framings may serve to hold individual youth responsible for poor SRH outcomes in cases where rights of access have been 'secured'.

Theme 2: Understandings of vulnerability, discrimination, and inequality

Where public health framings made reference to high risk populations, human rights framings tended to refer to vulnerable populations. Understandings of these vulnerable populations were often linked to notions of discrimination and inequality. Overall, these populations were positioned as in need of protection, support, and 'special attention' and should be "accorded all their due rights" (Botswana Policy Guidelines and Service Standards - National Sexual and Reproductive Health Programme, 2015, p. 5). These framings attempted to embrace nuanced understandings of risk and/or vulnerability by recognising the distinction between the general youth population and those groups which may be particularly vulnerable to poor SRH outcomes. For example, India's National AIDS Control Programme Phase III (2007-2012) stipulated that "youth are another vulnerable and heterogeneous group with differing risk levels" (p. 14).

These extracts often sought to identify the varied circumstances that might result in increased vulnerability. For example, India's National Youth Policy (2014) makes reference to a number of categories of vulnerable youth including: socially and economically disadvantaged youth; out-of-school youth; youth living in conflict affected districts; youth living with disability or suffering from chronic diseases; youth at risk (including youth suffering from substance abuse, at risk of human trafficking, working in hazardous occupations, and those working in the sex industry); youth that suffer from social or moral stigma (including LGBT

youth and those infected with or affected by HIV/AIDS) and youth in institutional care, orphanages, correctional homes and prisons.

Consequently, these framings were able to embrace an emergent recognition of the diversity of youth experiences in the context of varied economic, political, social, and cultural environments and begin to recognise that "underlying factors influence behaviour" (Jamaica HIV and AIDS National Strategic Plan, 2007-2012, p. 31). While the recognition of youth diversity was present in some policy extracts, it was also frequently omitted. In such cases, the framing of youth 'vulnerability' operates in much the same way as understanding of youth risk (as evidenced in public health framings) – serving to conflate vulnerability and adolescence, homogenise youth populations and overlook other pertinent risks (such as structural disparities) that diminish SRH outcomes. Similarly, while notions of vulnerability might seem to treat youth more sympathetically than those of risk, both serve to deny the potential for youth agency and resilience. The depiction of youth as particularly vulnerable to poor SRH inevitably locates others (e.g. teachers, health care providers etc.) in the role of 'protector'. As such, these framings fail to engage with the potential of youth self-reliance and often appear to overlook that relationships between youth and certain 'protectors' are often informed by unequal power relations, and social and cultural practices that might impede free engagement on issues around sexual and reproductive health.

Freedom from discrimination was featured as a key concern within extracts informed by a human rights perspective. These framings were informed by an understanding that in addition to violating universally recognised principles of human rights, discrimination also "reduces access to health and social services, and reduces quality of life" (St Kitts & Nevis National Strategic Plan for HIV/AIDS, 2009-2013, p. 8). These extracts asserted that, for example, "the rights of adolescents [should be] respected, protected and fulfilled within an environment free of discrimination based on sex, HIV-status, sexuality, sexual orientation or gender identity" (South Africa National Adolescent Sexual and Reproductive Health and Rights Framework Strategy, 2014-2019, p. 7). A broad range of 'identity categories' were referenced throughout these extracts including: age, race, ethnicity, cultures, traditions, religion, language, political affiliations, socio-economic status, disease status, ability status, gender, gender identity, sexual orientation, and sexual identity. In short, these extracts attempted to assert that youth have the right "to live with dignity in an environment that is

free from fear and discrimination" on the grounds of these 'identity categories' (Nepal National Youth Policy, 2010, p. 9).

These extracts demonstrate an emergent and valuable recognition of the adverse effect of discrimination for youth SRH. However, many of these extracts seem to suggest that recognition of the right to freedom from discrimination should directly translate into the ability to exercise and enjoy such a right. Although an admirable attempt is made to acknowledge a broad range of identity categories that might contribute to experiences of discrimination, such extracts do little to engage with the lived realities within which such discrimination might be mitigated or enhanced. By failing to explore the need for additional measures beyond mere recognition and legal guarantees of freedom from discrimination such framings do little to encourage thinking around measures that will work towards the creation of enabling conditions to realise these rights.

Concerns around the issues of inequality were frequently mentioned within human rights framings. Notably however, discussion of issues related to inequality was limited almost exclusively to the experiences of (presumably heterosexual, cisgendered) women and young girls. Broadly speaking these extracts were concerned with the need to "promote gender equality and empower women" (Yemen National Youth Strategy, 2006-2015, p. 68). Many of these extracts asserted that "unequal gender relationships … contribute to the continued spread of HIV and limit access to services" (St Vincent & Grenadines HIV and AIDS National Strategic Plan, 2010-2014, p. 23), whilst also violating the basic human rights of girls and young women. In many cases, these extracts outlined the consequences of gender inequality and violation of human rights including "violence, abuse, genital mutilation, rape, sexual abuse and exploitation, trafficking, prostitution, and pornography" (Zimbabwe National Youth Policy, 2000-2010, p. 20).

While the importance of recognising experiences of inequality for women and young girls should not be negated, many of these extracts seemingly fail to consider the social and cultural conditions that contribute to the perpetuation of such inequality. Again, many of these extracts seem to suggest that mere recognition of inequality may, in some sense, serve as a form of intervention. It would be valuable for such framings to move beyond cursory recognition of the adverse effects of unequal gender relations, in order to situate issues of inequality within a broader agenda. In other words, in order to effectively address issues of

inequality, the connection between SRH-related issues and other areas of concern (particularly those related to issues of social justice) must be foregrounded. Much like human rights framings of inequality, this framing *may* be effective in securing recognition for certain women and young girls. However, they also render invisible other experiences of inequality that are unrelated to the very specific (and perhaps narrow) gender related concerns outlined in these policies.

However, it must be noted that concerns around vulnerability, discrimination, and inequality were sometimes referenced in relation to queer populations. In these instances, a human rights framing was often drawn upon to position queer populations as deserving of equal treatment in accordance with their basic human rights. For example, Nepal's National HIV/AIDS Strategy (2011-2016) asserts the need to: "advocate [for] MSMs' right and needs with local law enforcement, health service providers, and other stakeholders to encourage them to respect, protect, and fulfil the rights of men who have sex with men/TG and meet the needs of men who have sex with men and TG and their female partners for services" (p. 35).

Although such a framing might be considered a powerful tool for enacting social change, it is easily negated within certain contexts where enjoyment of rights is contingent on recognition of queer subjects as full citizens. For example, the inclusion of the above mentioned extract is likely made possible by the recognition of queer citizenship in Nepal – a country in which 'homosexuality' is not criminalised, where age of consent is equal for both heterosexual and same-sex attracted persons, and discrimination protections are enshrined in the constitution (see Appendix A). In contrast, such a framing is politically limited in contexts where 'homosexuality' is criminalised. Perversely, such a framing can also be effectively utilised to counter claims for equal treatment by drawing on another set of competing rights (often linked to religion and/or culture) which may be regarded as superseding sexual and reproductive rights.

Themes Emerging within Context and Culture Framings

Within the context and culture framing, six themes emerged including: (1) focus on marginalised population groups; (2) concerns around the consequences of stigma and discrimination; (3) addressing taboos around the discussion of SRH; (4) addressing problematic cultural practices; (5) acknowledging societal pressures and family expectations

as barriers to SRH; and (6) acknowledging invisibility and secrecy as barriers to SRH. While context and culture framings were far less prevalent than other framings, it is interesting to note that they were the most thematically diverse. Unlike public health and human rights framings, these extracts were able to engage more meaningfully with, and account for, fundamental societal inequalities that undermine SRH outcomes and decision making at personal, familial, and community levels, and the associated health implications for youth. Although these extracts should not be considered faultless enactments of sexual and reproductive justice principles, they were able to delve more deeply in considering the histories, circumstances, and contexts that hinder the attainment of sexual and reproductive health for youth.

Theme 1: Focus on marginalised populations groups

A significant theme that emerged within context and culture framings was the structural determinants that lead to marginalisation of certain populations, and the need for interventions that seek to re-integrate marginalised populations into mainstream society. These extracts attempted to engage with the factors that contribute to marginalisation, arguing that "conducting HIV awareness campaigns to improve HIV knowledge alone is not sufficient when it overlooks the harsh realities in many children and young people's lives" (Philippines The Philippine Strategic Plan on HIV and AIDS, 2011-2016, p. 85). To this end, these extracts attempted to examine the prevailing social, political, legal, economic, cultural, religious, and demographic contexts that inform the sexual and reproductive health of adolescents, including implications for and consequences to their health. For example, Kenya's National Adolescent Sexual and Reproductive Health Policy (2015) states that:

> There is need to address other aspects that have a bearing on the health of young people. Income and social status are linked to living conditions (physical environment) that include aspects such as safe water and clean air among others. Other factors are social support systems, individual make up and gender related factors … Though many of these factors are beyond their control and often lead to poor health outcomes, they are more critical than access and use of health care (p. 4-5)

Unlike framings of risk and vulnerable populations, framings of marginalised populations were able to move beyond notions of individual responsibilisation by acknowledging that youth SRH is frequently influenced by factors beyond their control. Consequently, these framings are able to recognise the possibility of single and multiple intersections of marginalisation that have a significant impact on health outcomes for youth. Furthermore, many extracts were able to conceptualise the need for responses to sexual and reproductive health that are "varied, deep-rooted and inter-connected" (Barbados National Youth Policy, 2011, p. 25). As such, these extracts were able to consider that social, material, and interactional effects may be more critical to address poor SRH outcomes than can be addressed through a narrow health approach.

However, it is worth noting that many of these extracts paid particular concern to structural and social determinants of marginalisation as they pertain to girls and young women, to the exclusion of other marginalised groups. For example, Botswana's Policy Guidelines and Service Standards - National Sexual and Reproductive Health Programme (2015) states that societal expectations exert "pressure on young women to engage in early sex and early marriages" and that "social and cultural expectations in our society exert pressure on females to engage in high-risk behaviour to accomplish their motherhood role" (p. 48). While the importance of recognising experiences of marginalisation for women and young girls should not be negated, many of these extracts seemingly fail to move beyond recognition of marginalisation, in order to situate issues of inequality within a broader agenda. In order for issues of marginalisation to be effectively addressed the connection between SRH-related issues and other areas of concern (particularly those related to issues of social justice) must be foregrounded. Moreover, while such framings *may* be effective in securing recognition for certain women and young girls, they also render invisible other experiences of marginalisation that are unrelated to the very specific (and perhaps narrow) gender related concerns outlined in these extracts.

Theme 2: Concerns around the consequences of stigma and discrimination

While issues relating to stigma and discrimination are featured in public health and human rights framings, they appear most prominently in context and culture framings. These framings often spoke to a number of barriers serving to hinder the attainment of SRH for youth populations, of which stigma and discrimination were frequently included. For

example, Pakistan's National HIV and AIDS Strategic Framework (2007-2012) asserts that "SRH services are not easily accessible by young people, due to constraints on their mobility, denial by caregivers that such services are needed, and/or the stigma attached to care seeking for issues related to sexual and reproductive health" (p. 38). Many of these extracts went beyond the mere acknowledgement of stigma and discrimination, seeking to engage with the potential consequences of these. For example, the National Strategic Plan for HIV/AIDS (2009-2013) of St Kitts and Nevis states:

> Saint Kitts and Nevis are relatively small and close-knit island communities, resulting in stigma and discrimination. Some people are reluctant to admit (and seek support to change) risky behaviours; young people are reluctant to buy condoms; few people access VCT or STI treatment, for fear of breach of confidentiality. Some AIDS patients don't want to get their ARV from the pharmacy, or even seek care abroad. (p. 4)

By seeking to engage with the consequences of a commonly acknowledged barrier to SRH (i.e. stigma and discrimination) these framings are able to move beyond notions of individual responsibilisation by acknowledging that youth SRH is frequently influenced by powerful social, cultural, and institutional forces. Consequently, these framings are able to link youth SRH with broader contextual issues – thus moving towards an understanding of youth SRH that takes into consideration the social, material, and interactional effects that may be more critical to addressing poor SRH outcomes than can be attained through a narrow health approach. Nevertheless, the connection between SRH-related issues and other areas of concerns, particularly those related to issues of social justice, may need deeper engagement than that evidenced in many of these extracts.

Issues of stigma and discrimination were most often referenced in relation to queer populations and their ability to access SRH services. The following issues were frequently cited in these framings: poor treatment by health service providers; failure to seek treatment due to fear of being identified as gay; involuntary HIV testing; low societal acceptance; homophobia; criminalising laws; and arbitrary detentions, interrogations, and even violence (see for example St Kitts & Nevis National Strategic Plan for HIV/AIDS, 2009-2013, p. 3).

Again, these extracts are able to effectively move beyond notions of individual responsibilisation by acknowledging that queer SRH is frequently influenced by powerful

social, cultural, and institutional forces. Consequently, these framings are able to effectively locate health concerns within broader contexts, facilitating an understanding of queer SRH that takes into consideration the social, material, and interactional effects that are critical to addressing poor SRH outcomes. Nevertheless, deeper exploration of the ways in which certain social identities might converge to create distant and disparate experiences of SRH services *within* queer populations could provide a more nuanced understanding of queer experiences of stigma and discrimination than evidenced in many of these extracts. It is worth noting that many of these extracts utilised very strong language (for example, the idea that there is not escape from the circumstances in which transgender youth find themselves) in describing the experiences of queer persons. While such framings may accurately reflect the experiences of certain queer persons, it is important to ensure that such experiences are not universally applied to queer populations.

Theme 3: Addressing taboos around the discussion of sexual and reproductive health

Taboos around the discussion of sex were frequently referenced in context and culture framings. According to these framings "cultural, social and religious taboos concerning the discussion of sexual behaviours have inhibited the public discussion of reproductive health and sexual behaviours" (Pakistan National HIV and AIDS Strategic Framework, 2007-2012, p. 21). In particular, it was noted that "parents and teachers are often uncomfortable or are otherwise unprepared to talk with young people about issues related to sexual and reproductive health" (Pakistan National HIV and AIDS Strategic Framework, 2007-2012, p. 38), leaving youth to rely on information from their peers which was often deemed inaccurate (see for example, Gambia Gender and Women Empowerment Policy, 2010-2020, p. 16). Moving forward, many of these extracts asserted that "social and cultural habits that stay silent on the subject [of youth SRH] need to change" (Qatar Youth Development Report, 2012, p. 85).

Similar to other themes that emerged within context and culture framings, framings around SRH-related taboos were able to acknowledge the consequences of social, cultural and religious forces for SRH outcomes. By linking youth SRH with broader contextual concerns, these framings were able to move beyond notions of individual responsibilisation. Nevertheless, such taboos are likely to have far reaching consequences that operate within spheres beyond youth SRH. Many of these extracts failed to link the issue of taboos around

the discussion of SRH (and its consequences) with other areas of concern. Moreover, if such extracts attempt to outline ways in which these 'problematic' practices might be addressed, it is necessary to engage with the ways in which certain social identities might converge to create distant and disparate experiences of such taboos *within* youth populations. For instance, taboos around the discussion of sex may be compounded in instances of same-sex sexual behaviour. Interestingly, these extracts often made particular mention of the role that parents and teachers play in reinforcing taboos around SRH. Although this is a valuable contribution to understandings of barriers to youth SRH, it may be necessary for such extracts to engage with the potential power relations that operate within youth-adult relationships.

Theme 4: Acknowledging problematic cultural practices

Similarly, many context and culture framings identified 'problematic' cultural practices that may have an adverse effect on youth SRH. Focus was primarily given to the practice of early and forced marriages. For example, Pakistan's Punjab Youth Policy (2012) asserts that "young people especially the female youth are faced with many deviations over the issue of marriage. There still exist marriage practices that involve criminal activities i.e. forced and early marriages, etc." (p. 12). Likewise Ethiopia's National Reproductive Health Strategy (2005-2015) asserted that practices including "polygamy, wife inheritance, marriage by abduction, exchange and other forms of forced marriage … bring with them important RH [reproductive health] risks, including the increased likelihood of contracting HIV/AIDS and other STIs" (p. 8). Although limited, some extracts were able to identify these practices and engage with possible remedies such as "develop[ing] positive attitude among them towards delayed marriage" (Bangladesh Health, Population and Nutrition Sector Development Program, 2011-2016, p. 212).

Again, these extracts are able to effectively move beyond notions of individual responsibilisation by acknowledging that youth SRH is frequently influenced by powerful cultural forces. Consequently, these framings are able to link youth SRH to broader contextual issues. As such, these framings demonstrate an emergent awareness that consideration of social, material, and interactional effects is critical to effectively addressing poor SRH outcomes. Nevertheless, the connection between SRH-related issues and other areas of concerns, particularly those related to issues of social justice, may need deeper engagement than that evidenced in many of these extracts. Moreover, discussion of

problematic cultural practices tended to focus on those specific to the experiences of young women. While the importance of recognising these experiences should not be negated, many of these extracts seemingly fail to consider practices that may affect other youth populations (e.g. transgender youth). While such framings *may* be effective in securing recognition of, for example, the adverse consequences of early and/or forced marriage for young women, they also render invisible other experiences of problematic cultural practices that are unrelated to the very specific (and perhaps narrow) gender related concerns outlined in these extracts. As such, these extracts echo similarly narrow understandings of gender related concerns evidenced in human rights framings.

Theme 5: Acknowledging societal pressure and family expectations as barriers to SRH

The primacy of expectations of marriage alluded to in the preceding section during discussion of early and/or forced marriage, is also evidenced in context and culture framings. Although both framings are able to acknowledge that expectations of marriage serve as an impediment to SRH, these impediments are placed within a particular context in relation to queer populations. For example, Mongolia's National Strategic Plan on HIV, AIDS and STIs (2010-2015) states that "as a result of societal pressure and family expectations, many MSM eventually marry and live 'double' lives – engaging in sex with multiple male sexual partners, while at the same time having sexual relationships with women" (p. 19). These extracts contain worrying references to the presumed number of sexual partners of 'MSM' (no doubt drawing on prejudices concerning the promiscuity of queer men) and often identify 'MSM' as a "potential bridge population for spreading HIV into the general population" (Mongolia National Strategic Plan on HIV, AIDS and STIs, 2010-2015, p. 19).

While it is important to acknowledge barriers that may specifically relate to queer populations, the underlying assumptions that seem to inform many of these extracts are troubling. Although many of these extracts are able to move beyond individual responsibilisation by acknowledging that queer populations are often subjected to certain societal pressures, they also serve to perpetuate prejudiced views of queer populations (specifically men who have sex with men). For example, these extracts appear to operate under the assumption that queer men routinely engage in sexual relationships with multiple male partners. Although these extracts are able to acknowledge that certain behaviours may arise within a particular context, they frequently seem more concerned with the potential

consequences for female partners of ‘MSM’ and spread of HIV into the general population. Moreover, these extracts almost entirely omit the inclusion of queer persons other than ‘MSM’, effectively rendering them invisible and failing to acknowledge the barriers that might impede their realisation of SRH.

Theme 6: Acknowledging invisibility and secrecy as barriers to SRH

Prominently featured in context and culture framings was the recognition that certain contexts necessitate invisibility and secrecy for queer populations. For example, Mongolia’s National Strategic Plan on HIV, AIDS and STIs (2010-2015) acknowledges that “Very high levels of stigma and discrimination, including violence, and very low societal acceptance of MSM – even within their own families – drive most MSM underground, which makes it particularly difficult to reach them with specific HIV prevention interventions” (p. 19). Although less frequent some extracts did attempt to explore how these circumstances might lead to increased risk, such as: “many MSM, especially young men, are exploring their sexuality in semi-hidden MSM settings, such as public MSM cruising areas, MSM-friendly hotels or MSM websites, that are often not conducive to safer sex” (Mongolia National Strategic Plan on HIV, AIDS and STIs, 2010-2015, p. 19).

These extracts are able to effectively move beyond notions of individual responsibilisation by acknowledging that queer SRH is frequently influenced by powerful social forces. Consequently, these framings are able to effectively locate health concerns within broader contexts. Nevertheless, deeper exploration of the ways in which certain social identities might converge to create distant and disparate experiences of barriers to SRH *within* queer populations could provide a better understanding of how such barriers might be reduced or eradicated. For the most part, these extracts focus specifically on the experiences of queer men, and as such render invisible the experiences of other sexual and gender minorities. In doing so, these extracts overlook potential barriers that might impede realisation of SRH for queer populations outside of the ‘MSM’ experience.

A Multitude of Perspectives: Summarising Understandings of Youth SRH within Varied Framings

Overwhelmingly, references to youth SRH were most often framed in terms of a public health approach. Importantly, all themes emerging within public health framings fail to position SRH within a context of intersecting social, economic, cultural, and health care possibilities and challenges. These framings tend to align with narrow understandings of health as the absence of disease through an emphasis on prevalence and incidence. Consequently, public health framings perpetuate a narrowing understanding of SRH, reducing understandings of youth sexuality to notions of infections and impacts. In addition, these framings failed to engage with the potential for diversity within youth populations, thus homogenising youth SRH concerns.

The emphasis placed on reduction and prevention serves as a valuable illustration of the kind of intervention that is likely to arise from a framing of SRH that is overly reliant on concerns around prevalence and incidence. In repeatedly overlooking issues beyond prevalence and incidence such framings create little room for interventions that might seek to, for example, address issues beyond access to information and services. By failing to locate youth SRH concerns within a broader context, these framings may serve to hold individual youth responsible for poor SRH outcomes in cases where their behaviour is deemed unsafe and/or unchanged despite access to information and services. The failure of such framings to account for, or even engage with, relevant contextual factors also calls into question the potential efficacy of interventions. Importantly, the dominance of such a framing within policy documents could speak to an overreliance on biomedical and population-level health models, serving to overshadow nuanced understandings of youth SRH concerns.

Although less prevalent than public health framings, references to youth SRH also consistently drew on a human rights approach. These framings often rested on the assumption of agency in terms of individual choice and decision-making. While some extracts did demonstrate an emergent understanding of the role of contexts in determining youth ability to exercise their rights in relation to SRH, this type of recognition was notably infrequent and largely undeveloped. Although some extracts were able to embrace an emergent recognition of the diversity of youth experiences in the context of varied economic, political, social, and

cultural environments (particularly in relation to barriers to access), such recognition was rare and often superficial.

Moreover, these framings tend to operate on the assumption that available resources are equally accessible irrespective of the operation of power relations within particular contexts. For example, extracts often fail to consider the operation of power relations within certain contexts that may serve to create barriers to information access. By obscuring these broader contextual factors and power relations, such framings may serve to hold individual youth responsible for poor SRH outcomes in cases where rights of access have been 'secured'. While the recognition of youth diversity was present in some policy extracts, it was also frequently omitted. In such cases, the framing of youth 'vulnerability' operates in much the same way as understandings of youth risk (as evidenced in public health framings) – serving to conflate vulnerability and adolescence, homogenise youth populations and overlook other pertinent risks (such as structural disparities) that diminish SRH outcomes.

While the human rights framings was able to demonstrate an emergent and valuable recognition of the adverse effect of discrimination and inequality for youth SRH, many of these extracts seem to suggest that recognition of the right to freedom from discrimination and issues of inequality should directly translate into the ability to exercise and enjoy such rights. By failing to explore the need for additional measures beyond mere recognition and legal guarantees of freedom from discrimination such framings do little to encourage thinking around measures that will work towards the creation of enabling conditions to realise these rights. In other words, in order to be effectively addressed issues of discrimination and inequality the connection between SRH-related issues and other areas of concern (particularly those related to issues of social justice) must be foregrounded.

In contrast to public health and human rights approaches, one of the fundamental strengths of the SRJ framework is its ability to create room for intersectional concerns. Although policy extracts framed in terms of a context and culture agenda were by no means exhaustive examples of engagement with intersectional concerns, they provide an interesting insight into how such concerns might be integrated into policy. A sexual and reproductive justice lens allows for the intersection of race, gender, socioeconomic status, sexual orientation, and gender identity (amongst other factors) to be actively acknowledged and brought to bear on understandings of the varied issues faced by youth according to their particular context. The

above-mentioned context and culture themes serve as a valuable (albeit imperfect) example of the ways in which inequities need to be understood as being mediated through manifold social identities that converge to create distinct experiences of both oppression and opportunity. Although the need for deeper engagement was often evident, these context and culture framings were able to build upon, and where necessary, distance themselves from understandings of youth SRH which overly rely on biomedical and population-level understandings of health, and notions of individual choice and rights. In the next chapter, discussion will provide an examination of positioning themes identified across policies, seeking to explore how the manner in which policy extracts are framed may serve to position queer youth in certain ways and how these subject positions may enable and/or limit possibilities for action among queer youth populations.

CHAPTER 6: POSITIONING OF QUEER YOUTH IN SEXUAL AND REPRODUCTIVE HEALTH POLICIES

Building on the framing themes discussed in the previous chapter, the subsequent discussion will explore the positioning themes identified within policy extracts across selected global South countries. Drawing on theoretical understandings outlined by Davies and Harré (1990), the analysis was informed by an understanding that positioning is a process that allows for the production of certain understandings of identities through the deployment of socially- and culturally-available discourses. In general, analysis sought to identify and explore the subject positions assigned to queer youth within policy extracts. However, extracts referencing queer youth specifically were scarce. As such, analysis included an examination of positioning themes in relation to youth populations and queer adult populations, in order to explore the convergence of these two positionings as a means to provide insight into how queer youth might be implicitly (and explicitly) positioned within policy extracts. Moreover, analysis explored the possibility that the manner in which policy extracts are framed may serve to position queer youth in certain ways. Additionally, the ways in which subject positions might diverge, shift, and/or remain constant across different identified framings was also explored.

Discussion will commence with an exploration of the noted invisibility of queer youth in policy extracts. This invisibility will be discussed in relation to the hypervisibility of 'MSM' evidenced in the data. Following this, the subject position themes identified in relation to youth, adult queer populations, and queer youth will be examined. First, subject positions related to an understanding of key and/or priority populations will be discussed. These include: the risky subject, the dangerous subject, the vulnerable subject, and the marginalised subject. Although these represent distinct positionings with each being aligned with a particular framing (namely the public health framing, human rights framing, and context and culture framing), they all draw on understandings of certain populations as particularly prone to poor SRH outcomes. Next, two key positioning themes operating across public health and human rights framings will be explored, namely the unresponsive and unknowing subject, and the valid service user subject. Following this, discussion will explore the rights bearer subject evidenced solely in human rights framings. Each subject position will be discussed first in relation to youth populations, followed by adult queer populations. Where relevant, the discussion of identified subject positions will examine the ways in which certain framings and positionings create and/or limit possibilities for action among queer youth populations.

Finally, possibilities for the queer youth subject position will be summarised by drawing on discussion of the various positioning themes, and where relevant, bridging these subject positions with available extracts concerning queer youth.

The Invisibility of Queer Youth across SRH Policies

A central avenue of inquiry for the present research was the exploration of queer youth subject positions within policies in selected global South countries. However very few of these policies made explicit reference to queer youth - of the 152 policies included in the final data set, 1036 relevant extracts were identified. Of these, only 8 extracts refer to queer youth. Most of these extracts refer to 'LGBT youth', with another specifically referring to transgender youth. One extract refers to "young people exploring same-sex relationships, who do not identify as gay or bi-sexual" (Barbados National HIV Prevention Plan, 2010, p. 35), while another refers to "youth with different sexual orientations" (Sri Lanka National Youth Policy, 2014, p. 12). Extracts inclusive of queer youth were located in policies from Barbados, India (2 extracts), Lesotho (2 extracts), Pakistan (2 extracts), and Sri Lanka. More than half of these extracts (i.e. 5 extracts) were located in national youth policies. The remaining extracts were located in a national development policy (2 extracts) and a national HIV prevention policy (1 extract).

Although the absence of references to queer youth is notable, it becomes particularly relevant in comparison to the references to queer adult populations located in the policy extracts. In contrast to the 8 references to queer youth, 168 extracts refer to adult queer populations. It is important to note that rather than referring to adult queer populations in general, these extracts consistently focus specifically on 'MSM' (with sporadic mention of transgender and third gender persons). Notably, of the 168 extracts that refer to adult queer populations, only one extract makes mention of an adult queer population besides 'MSM' (and transgender and third gender persons). The Philippine Strategic Plan on HIV and AIDS (2011-2016) recognises three subgroups according to gender and sexual orientation including "(a) MSM or men having sex with men, (b) straight/heterosexual and lesbian females, and (c) straight/heterosexual males" (p. 92).

As such, there appears to be a general pattern of hypervisibility of 'MSM' (although 'MSM' are by no means the most frequently referred to populations within policy extracts) standing

in marked contrast to the invisibility of queer youth and other adult queer population groups, such as queer women. Moreover, it is also important to note that references to 'MSM' appear exclusively in policies dealing with HIV/AIDS, seeming to suggest that queer SRH is only considered relevant within the context of HIV/AIDS. A deeper exploration of the subject positions deployed in relation to queer youth and 'MSM' will be explored in later discussion concerning the various positioning themes identified in the policies extracts.

Subject Positions Operating across Public Health, Human Rights, and Context and Culture Framings

Across all three framings, certain population groups were identified as particularly prone to poor SRH outcomes. Youth and queer adult populations were frequently included in these groupings. As discussed in the previous chapter, each framing tended to refer to these populations in a particular manner such as 'at risk' populations (public health framings), vulnerable populations (human rights framings), and marginalised populations (context and culture framings). In line with this, specific subject positions emerged within each framing including: the risky subject, the dangerous subject (both evidenced in the public health framing), the vulnerable subject (aligned with the human rights framing), and the marginalised subject (context and culture framing). Although these represent distinct positionings, each draws on an understanding of certain populations as in need of special attention in relation to their sexual and reproductive health.

The risky subject position

Within public health framings the positioning of youth as a "generation at risk" (Barbados National HIV Prevention Plan, 2010, p. 35) was pervasive across all three regions. In many cases, youth were positioned as "more prone to certain health risks, such as those related to reproductive health and sexually transmitted diseases (STDs)" (Lebanon, National Youth Policy, 2012, p. 19). For example, according to Botswana's Policy Guidelines and Service Standards for the National Sexual and Reproductive Health Programme (2015):

> youth form 25% of the population [and] are at the highest risk of both STI/HIV/AIDS infection, unwanted pregnancy and abortion. HIV infection rates are highest in the age groups 15-29. The average age at first intercourse is 17.5 years and first birth is 18.6

> years. Teenage pregnancy rate is 16% while contraceptive use is only 29% among this age group. (p. 1)

Relatedly, adolescence was often described as a period of transition during which youth are highly susceptible to various risks. According to such extracts it is during these years that youth experience "physical, emotional, social and personal changes and developments" (Turkey National Youth Policy, 2013). Adolescence was often understood as a "period of rapid personal development, when young people acquire new capacities and are faced with many new situations that create not only opportunities for progress, but also risks to health and wellbeing" (Timor-Leste National Reproductive Health Strategy, 2004-2015).

While the positive aspects of adolescence were sometimes cited (e.g. the acquisition of new capabilities), the majority of extracts examining youth as a period of transition tended to focus on the potential for negative outcomes. For example, Yemen's National Youth Strategy (2006-2015) emphasises the "*critical risks* [emphasis added] of this life period relate[d] to the lack of access to… secondary education, limited employment opportunities, [and] opportunities for risky behaviors (e.g. early pregnancy, HIV/AIDS, violence and crime, substance abuse)" (p. 9-10). Overall, adolescence was understood as a precarious and "delicate" phase of life with innumerable opportunities for exposure to "risky behaviors such as sexual behaviors, tobacco and drugs addiction, [and] exposure to psychological diseases which may negatively affect their attitudes and practices" (Oman 8th Five Year Plan for Health Development, 2011-2015, p. 224). Importantly, adolescence was also conceptualised as kind of 'point of no return' during which "boys and girls learn attitudes and behaviours that become more fixed in later years" (Malawi National Youth Friendly Health Services Strategy, 2015-2020, p. 28).

Such extracts position youth as risky subjects. In operating to position youth within a discourse of risk, these extracts draw on narrow understandings of youth sexuality. Within the risky subject position, youth sexuality is reduced to notions of infections and impacts. Rather than allowing for an understanding of youth sexuality that is inclusive of pleasure and desire, the risky subject position limits youth sexuality to concerns over danger and disease. In this sense, the sexual behaviour of youth is understood to be *inherently* risky. As such, the risky subject position serves to homogenise youth populations, overlooking how diverse contexts and varied social identities may serve to reduce or heighten the potential for risk

among youth. In failing to create space for considerations of the broader context within which sexual behaviour occurs, the risky subject position may serve to hold individual youth responsible for poor SRH outcomes. As such, this subject position perpetuates notions of youth irresponsibility. Moreover, the inevitable risk and turmoil connected to adolescence within such a positioning may serve to deny the potential for youth agency, strength, and resilience.

By depicting adolescence as a period of transition and turmoil (and youth sexual behaviour as risky and irresponsible), youth are positioned as in need of careful monitoring in order to safely and successfully progress through this period of development. As such, adolescence is understood as inherently necessitating some form of intervention, ensuring that youth are positioned as inherently in need of assistance, and even containment. Relatedly, certain adults such as teachers, health care providers etc. (although not always explicitly mentioned) are positioned as the 'gatekeepers' of youth sexuality, tasked with ensuring that youth sexual behaviour is conducted safely and responsibly. Importantly, however, these positionings fail to account for power relations that operate within relationships between youth and adults, whilst also obscuring social and cultural practices that might impede free engagement on issues around sexual and reproductive health.

Similarly, adult queer populations (or more specifically men who have sex with men) were consistently positioned as a high risk group or at a "dangerously elevated risk of contracting HIV" (Barbados, National HIV Prevention Plan, 2010, p. 18). For example, Mongolia's National Strategic Plan on HIV, AIDS and STIs (2010-2015) states that "reported HIV cases indicate that MSM and female SWs are the two key groups of the population at greatest HIV risk, with 88% of male cases among MSM, and 60% of female cases among SWs" (p. 16). Similarly, the Philippine Strategic Plan on HIV and AIDS (2011-2016) states that "more males are infected [with HIV]. The mode of transmission is principally through male-to-male sex and bisexual contact" (p. 20).

In many cases, 'MSM' were linked with other identified 'most-at-risk' populations groups such as CSWs and/or FSWs (and their clients), IDUs, PLHIV, people living with disabilities, women, prison inmates, long distance truck drivers, and migrant or mobile populations (e.g. refugees). Similarly, discussion of MARPs also made mention of other queer populations in addition to 'MSM' including: 'bisexual men and beach boys', *hijra*, *waria*, *kathoy*, third

gender persons, and transgender persons. For example, Malaysia's National Strategic Plan on HIV and AIDS (2011-2015) states that "population groups where these [high risk] behaviours are concentrated include: injecting drug users (IDUs); female sex workers (FSWs), clients of FSWs; men who have sex with men (MSM); and transgender persons (TG)" (p. 9). The rationale for linking these diverse and varied populations appears to be based on their actual and/or presumed engagement in high risk behaviours, which was closely linked to concerns surrounding the spread and transmission of HIV/AIDS and other STIs

In many cases, references to 'MSM' as a high risk group drew on an understanding that their "practices or behaviours put them at greater risk of HIV infection" (Malaysia National Strategic Plan on HIV and AIDS, 2011-2015, p. 9). Many policies cited the practice of anal sex (both protected and unprotected) and the possession of multiple sexual partners as key to greater risk of HIV infection associated with 'MSM' (see for example, St Kitts & Nevis National Strategic Plan for HIV/AIDS, 2009-2013, p. 3).

As such, adult queer populations (specifically 'MSM' and transgender persons) are also positioned as risky subjects. In positioning adult queer populations within this same discourse of risk, these extracts draw on narrow (and largely problematic) understandings of queer sexuality. Much like the risky youth subject, queer sexuality is positioned as interconnected with concerns of danger and disease. In particular, the sexual behaviour of 'MSM' is understood as inherently risky, even in cases where 'MSM' practice protected sex. Such positionings homogenise queer populations by obscuring the diverse contexts and varied social identities (beyond sexual and gender identity) that may serve to reduce or heighten the potential for risk. As such, this positioning serves to hold queer persons responsible for poor SRH outcomes simply by virtue of their sexual and/or gender identity.

Moreover, given that the SRH of queer populations is situated specifically in the context of HIV/AIDS, an additional layer to the risky subject position not evidenced in youth positionings may be created. Specifically, the focus on 'queer sex' as a particularly dangerous form of sexual behaviour (in contrast to heterosexual sexual behaviour) seems to draw on problematic (and potentially homophobic) discourses. The positioning of queer subjects solely within this context serves to inextricably link same-sex sexualities (and at times gender non-conformity) with harmful consequences. Moreover, such positionings may even

perpetuate longstanding, popular understandings that HIV/AIDS is an illness that only affects 'gay people' (Gowen & Winges-Yanez, 2014).

The particular focus given to "the practice of anal sex" with "multiple sexual partners" amongst 'MSM' (St Kitts & Nevis National Strategic Plan for HIV/AIDS, 2009-2013, p. 3) not only serves to position sexual behaviours outside of vaginal intercourse as problematic (whilst also seemingly overlooking the practice of anal sex within, for example, heterosexual sexual behaviours), but may also perpetuate harmful stereotypes of the 'promiscuity' of queer men. Relatedly, the specific focus on the sexual behaviours of 'MSM' means that other adult queer persons (such as queer women, transgender men etc.) are often overlooked. Although inclusion within a discourse of risk is not necessarily desirable, it is worth noting that exclusion results in certain persons being rendered unrecognisable as health care subjects.

The dangerous subject position

As previously discussed, many of the extracts within the public health framing depict the current state of youth SRH as a cause for concern. However, many extracts move beyond this understanding – asserting that youth behaviour, in particular, is the greatest cause for concern in relation to SRH. These framings position youth behaviour as particularly dangerous, often citing extreme consequences for this behaviour. Namibia's National Health Policy Framework (2010-2020) states, for example, youth sexual behaviour often results in unplanned pregnancies with "baby dumping" noted as an "extreme consequence of this phenomenon" (p. 9). Some policy extracts went as far as to describe youth as, for example, "delinquents [that] engage [in] negative acts that affect both elders and young people. As users, they consume illegal narcotics (drugs) and excessively drink and smoke. Further, young people also act carelessly by getting pregnant" (Trinidad & Tobago National Youth Policy, 2012-2017).

These kinds of framings serve to position youth as not only risky and irresponsible subjects, but also as prone to indulging in dangerous behaviours that requires urgent correction. This dangerous subject position not only serves to present young people as a kind of threat, but also fails to make allowance for the influence of social, economic, and cultural forces that impact youth behaviour. For example, concerns around the occurrence of unplanned pregnancies and 'baby dumping' fail to consider issues such as lack of access to

contraception and safe abortion services, stigma around ToP and so on, that can limit opportunities for action for young women. In failing to create space for considerations of the broader context within which such behaviour might occur, the dangerous subject position serves to assign blame entirely on youth populations. Moreover, within the dangerous subject position youth behaviour is seen as causing detrimental consequences not only for themselves, but also others (e.g. elders) and arguably society at large. As such, youth behaviour is positioned as in need of urgent containment. In positioning youth in this way, the 'invisible' state actor (and by extension those individuals who interact with youth in relation to SRH concerns) is positioned as a kind of 'authority figure' tasked with intervening to correct and/or contain youth behaviour.

Within extracts concerning 'men who have sex with men', the dangerous subject position was particularly condemning. Many extracts referred to the sexual behaviour practised by 'MSM' as "dangerous" (see for example Tajikistan Programme on the Response to the Epidemic of HIV in the Republic of Tajikistan, 2007-2010, p. 22). In some cases, the sexual behaviour of 'MSM' was described as predatory and exploitative. For example, Afghanistan's National Strategic Framework on HIV/AIDS for Afghanistan (2011-2015) states that within Afghanistan there is a tradition of "sexual relationships of adult men with younger men and boys on one hand, including sexual exploitation of the latter" (p. 11). This same policy also goes on to state that male-to-male sex sometimes occurs with adolescents and children.

Concerns that the HIV epidemic "may break out from the highly at risk groups into the general population" were frequently cited in policy extracts (Nepal Health Sector Programme - Implementation Plan II (NHSP-IP 2), 2010-2015, p. 33). Particular concern was directed towards women who are "potentially prone to infection as they are in direct contact with … MSM … and thus are potentially on the 'receiving end' of the HIV virus" (Afghanistan National Strategic Framework on HIV/AIDS for Afghanistan, 2011-2015, p. 13). Similar extracts noted that "some MSM who engage in unsafe sex are married or have regular female partners and these women are thus exposed to the risk of HIV" (Sri Lanka National Policy on HIV and AIDS in the World of Work in Sri Lanka, 2010, p. 9). Although some extracts acknowledged issues such a homophobia and stigma necessitating secrecy around same-sex sexual behaviour, the overriding emphasis is that women are placed at risk by 'MSM'. For example, St Kitts and Nevis' National Strategic Plan for HIV/AIDS (2009-2013) states that

"the stigma associated with male-to-male sex leads some homosexuals to have a female partner as an alibi, thus putting her at risk" (p. 3).

Much like the risky/precarious subject position, the dangerous subject position draws on problematic understandings of queer sexuality as an inherently risky and dangerous form of sexual behaviour. Moreover, this positioning obscures the context(s) that may serve to reduce or heighten the potential for risk, thus homogenising queer populations as universally dangerous. Most notably, the dangerous subject position serves to position 'MSM' as a danger *to* the general population. By referring to the sexual behaviour of 'MSM' as predatory and exploitative, the dangerous subject position serves to identify 'MSM' as a potential threat to adolescents and children. Similarly, by emphasising the risk of HIV spreading from 'MSM' populations, 'MSM' are again positioned as dangerous to the general population. Moreover, references to the need for, for example, an "alibi" may serve to embed notions of criminality into discourses surrounding same-sex sexuality for 'MSM'. In this sense, the dangerous subject position draws on homophobic discourses which conflate homosexuality and paedophilia, and discourses that view homosexuality as a kind of contaminant that can, quite literally in this instance, spread to the general population.

The vulnerable subject position

Within human rights framings, youth were often described as particularly vulnerable to poor SRH outcomes. This vulnerability was linked to a number of outcomes (some of which were particularly dire) including "STI/HIV/AIDS, pre-marital sex, sexual abuse, unwanted pregnancy, violence, coercion, delinquency, drug addiction, exploitation, deprivation, repression, abduction and trafficking" (Bangladesh Health, Population and Nutrition Sector Development Program, 2011-2016, p. 40). Largely, this vulnerability was seen as arising in a context where young people "have not yet acquired the information and the skills to effectively address the threat of HIV/AIDS [and other SRH concerns]" (Jamaica HIV and AIDS National Strategic Plan, 2007-2012, p. 37). In most cases, youth vulnerability was presented as universal. However, human rights framings did demonstrate an emerging understanding of youth diversity. For example, Bhutan's National Youth Policy (2011) noted a number of youth that might be particular vulnerable to poor SRH outcomes including out of school youth, unemployed youth, youth engaging in risky sexual behaviour, youth using drugs and alcohol, youth with disabilities and so on.

Unlike public health framings of youth as risky subjects, human rights framings serve to position youth as vulnerable subjects in need of protection and support. However, similar to youth as risky subjects, vulnerable subjects are also in need of some form of assistance. Importantly, concerns around vulnerability were linked to an understanding that youth are largely unaware of "their rights to lead a healthy reproductive health" (Bangladesh Health, Population and Nutrition Sector Development Program, 2011-2016, p. 40). According to such framings youth must be safeguarded against their own ignorance until they have been armed with the necessary information and skills to "effectively protect themselves" (Jamaica HIV and AIDS National Strategic Plan, 2007-2012, p. 37).

Such extracts position youth as vulnerable subjects. Although the vulnerable subject position did, at times, demonstrate an emergent recognition of the diversity of youth experience in the context of varied environments, the positioning of youth 'vulnerability' generally drew on similar discourses as those evidenced in the risky subject position. As such, the vulnerable subject position tended to conflate vulnerability and adolescence, serving to homogenise youth populations and overlook other factors (such as structural disparities) that diminish SRH outcomes. Similarly, while the vulnerable subject position might seem more sympathetic to youth than the risky subject position, both serve to deny the potential for youth agency, strength, and resilience. By positioning youth as inherently vulnerable, and as in need of protection and support, the vulnerable subject position also serves to locate others (e.g. teachers, health care providers etc.) in the role of 'protector', potentially overlooking the operation of unequal power relations that often characterise relationships between young people and adults (particularly those in positions of power).

Similarly, 'MSM' were frequently positioned as a vulnerable population in terms of HIV infection. For example, Jamaica's HIV and AIDS National Strategic Plan (2007-2012) states that populations "most at risk of HIV infection are vulnerable populations such as commercial sex workers (SWs) and their clients, men who have sex with men (MSM), those with a history of a sexually transmitted infection (STI), and adolescents, particularly adolescent girls" (p. 2). In many cases vulnerability was determined on the basis of "lifestyles, social or professional context and behaviour [that] make [these populations] most vulnerable to HIV/AIDS" (Lao People's Democratic Republic National Strategy and Action Plan on HIV/AIDS/STI, 2006-2010, p. 10). Unlike the risk subject position, the vulnerable subject position often created room to consider the contexts within which vulnerability might

emerge (rather than a focus on individual choice and responsibility). For example, Jamaica's HIV and AIDS National Strategic Plan (2007-2012) states that increased vulnerability may be due to lack of education, poverty and gender inequities. As such, the policy advocates for shifting focus "from improving knowledge to examining how underlying factors influence behaviour" (p. 31).

Such extracts pertaining to 'MSM' within a human rights framing situate these populations within a discourse of vulnerability. 'MSM' (and at times transgender persons) are understood as inherently vulnerable. Similar to the risky subject position, this vulnerability is understood to stem from the practice of sexual behaviour outside of the heterosexual 'norm'. However, the vulnerable 'MSM' subject position did demonstrate a more consistent recognition of the underlying factors that may contribute to increased vulnerability within 'MSM' populations. As such, it was often able to move away from understandings of vulnerability which hold queer persons responsible for poor SRH outcomes simply by virtue of their sexual and/or gender identity. In this sense, the vulnerable subject position of 'MSM' is largely more sympathetic to these populations than the risky and dangerous subject positions evidence in public health framings. However, it is worth noting that by drawing on a discourse of vulnerability (similar to the deployment of discourses of risk and danger evidenced in public health framings) 'MSM' are also positioned as in need of protection and support. Consequently, the vulnerable subject position locates others in the role of 'protector', which may serve to patronise 'MSM' populations and deny them any sense of agency, strength, and resilience.

The marginalised subject position

In relation to context and culture framings, several themes were identified that informed one key youth subject position - the marginalised subject. Many of the extracts sought to "implement programmes that will see marginalized young people being re-integrated into the mainstream of society" (Barbados National Strategic Plan, 2005-2025, p. 58). Unlike positionings related to risk and vulnerability, understandings of marginalisation were located within particular contexts. For example, Nepal's National Youth Policy (2010) classifies marginalised youth as "youths who are deprived of state and non-state services and facilities, … and other youths who remain out of the mainstreaming of national development, because

of geographical remoteness and on grounds of ethnicity, language, culture, region, class and gender" (p. 4).

As such, these framings were able to recognise that "increasing numbers of youth people were becoming marginalized … from force of circumstances" (Barbados National Youth Policy, 2011, p. 3). In many cases, these framings were able to acknowledge and address specific concerns related to particular marginalised populations, rather than treating marginalised youth as a homogenous group. For example, Kenya's Adolescent Reproductive Health and Development Policy Plan of Action (2005-2015) made specific reference to sexual and reproductive health concerns as they pertain to young people with disabilities, stating:

> The major issue here is that even young people with disabilities have needs in terms of reproductive health information and services, but many are not reached by the limited existing services, which, in any case are rarely tailored to meet their needs. They are, in short, marginalized, not just in terms of access to social services and amenities, but also in the availability of reproductive health information and life skills training. (p. 4)

Unlike the risk and vulnerable subject positions, the marginalised subject was often able to acknowledge and engage with the social, cultural, political, and religious forces which contribute to poor SRH outcomes for youth. By acknowledging that youth SRH is frequently influenced by factors beyond their control, the marginalised subject position is able to move beyond notions of individual responsibilisation that were frequently embedded within public health and human rights framings. As such the marginalised subject position is the most sympathetic discursive construction of youth across all three framings. By linking youth SRH to broader contextual concerns (such as stigma and discrimination, cultural taboos, and problematic cultural practices), the marginalised subject position also represents a clearer enactment of how subject positions informed by a SRJ might operate. Nevertheless, the marginal subject position did not demonstrate a broader understanding that certain social identities might converge to create distant and disparate experiences of poor SRH outcomes *within* youth populations. Moreover, the marginal subject position is often presented without reference to how poor SRH outcomes are linked with other areas of concern (such as issues of poverty, lack of community resource etc.).

The marginalised subject position was also evidenced in relation to 'MSM'. In many cases, extracts pertaining to 'MSM' made reference to "strong societal stigma and discrimination [that drives] many individuals from most-at-risk populations, such as MSM, SWs, and IDUs underground, making it harder to reach them during surveillance and other research, as well as for prevention, care and treatment" (Mongolia National Strategic Plan on HIV, AIDS and STIs, 2010-2015, p. 41). Similarly, some extracts noted "reports of arbitrary detentions, interrogations and even violence against the MSM community by police and intelligence, and of involuntary testing without pre- and post-test counselling" (Afghanistan National Strategic Framework on HIV/AIDS for Afghanistan, 2011-2015, p. 17). Most of these extracts were concerned with the ways in which such stigma, discrimination, and violence often results in 'MSM' failing to access treatment (or creating conditions in which it is difficult to reach them with specific HIV prevention interventions), which "further [exacerbates] their HIV risk and the risk of bridging to other groups" (Mongolia National Strategic Plan on HIV, AIDS and STIs, 2010-2015, p. 19). Some extracts did make note of the need for "an enabling environment that does not stigmatise and discriminate against those affected and most at risk (i.e. PLHIV, ESWs, MSM and IDU)" if prevention programmes are to prove effective (Cambodia Revised National Strategic Plan II for a Comprehensive & Multi-Sectoral Response to HIV/AIDS, 2008-2010, p. 18).

These extracts are able to effectively move beyond notions of individual responsibilisation by acknowledging that queer SRH is frequently influenced by powerful social forces, such as stigma and discrimination. Consequently, the marginal 'MSM' subject is effectively located within broader contexts. Although the marginal subject position is able to acknowledge that certain behaviours may arise within a particular context, it is frequently presented alongside concerns that 'MSM' sexual behaviour will result in the spread of HIV into the general population. Much like the dangerous subject position evidenced in public health framings, the marginal 'MSM' subject position also draws on a discourse of threat. As such, this positioning may serve to perpetuate the same stigma and discrimination it proposes to diminish. Moreover, this subject position fails to consider distant and disparate experiences of barriers to SRH *within* 'MSM' populations. The marginal 'MSM' subject position also fails to include queer persons other than 'MSM', effectively rendering them invisible and failing to acknowledge the barriers that might impede their realisation of SRH.

Subject Positions Operating across Public Health and Human Rights Framings

Across public health and human rights framings two key positioning themes were identified: the unknowing and unresponsive subject position, and the valid service user subject position. While these subject positions were evidenced across framings, it is important to note that within each framing, positioning often drew on distinct discourses. For example, public health framings often drew on epidemiological and risk reduction discourses. As such, the unknowing and unresponsive subject position and the valid service user subject position arose in the context of concerns over the reduction and prevention of poor SRH outcomes. In the positioning of youth and queer subjects, human rights framings drew on a rights discourse in order to frame demands to, for example, equal access to services. Where public health framings sought to ensure access to services for youth and queer populations in order to reduce poor SRH outcomes within 'at risk' populations, the human rights discourse argues for access to health care as an inalienable human right that all are entitled to enjoy (which ultimately served to improve SRH outcomes). As such, despite drawing on distant discourses, these framings ultimately serve to position youth and queer populations in much the same way, as will be evidence in the subsequent discussion.

The unknowing and unresponsive subject position

Across both public health and human rights framings, lack of knowledge and a failure engage in safe sexual and reproductive behaviour were frequently mentioned in relation to youth. As such, youth were consistently positioned as unknowing subjects. A lack of knowledge and information was frequently cited as an area for concern in addressing youth SRH outcomes. For example, according to Bangladesh's Health, Population and Nutrition Sector Development Program (2011-2016) "young people are at risk of contracting STIs and HIV because of their lack of knowledge and awareness regarding HIV" (p. 70). While some policies were able to acknowledge that some young people "may possess limited knowledge about reproductive/sexual health and HIV and AIDS", most asserted that "the majority does not have even the most basic information" (Pakistan National HIV and AIDS Strategic Framework, 2007-2012, p. 38). In addition, youth were often positioned as falling victim to myths and misconceptions about sexual and reproductive health. Resultantly, these extracts argued that youth "ignorance" is a serious impediment to the attainment of sexual and reproductive health.

Improving the knowledge of youth about preventive health care was conceptualised as a key undertaking in order to assist youth in "avoid[ing] practices such as engaging in early and irresponsible sexual activities and exposing themselves to STDS such as HIV/AIDS" (Ghana National Youth Policy of Ghana, 2010, p. 14). In cases where knowledge concerning SRH was acknowledged, most extracts called into question young people's ability to "act in accordance with their knowledge" (Namibia National Gender Policy, 2010-2020, p. 29). For example, Barbados' National Strategic Plan for the Prevention and Control of HIV (2008-2013) states that "the lack of significant demonstrable change in attitudes and behaviour among [youth] … has resulted from an insufficient translation of knowledge into sustained behaviour change" (p. 25). As such, youth are positioned as an unresponsive subject.

In some cases 'MSM' were also positioned as the unknowing subject. However, such instances were notably less frequent than those pertaining to youth populations. For example, Lao People's Democratic Republic's National Strategy and Action Plan on HIV/AIDS/STI (2006-2010) states that "many men who engage in casual sex with other men neither have knowledge of, nor practice safe sexual behaviour when having sex with their male partners (p. 17). In contrast to the positioning of youth, adult queer populations were largely excluded from the unresponsive subject position. Resultantly, adult queer populations are not made particularly relevant within the unknowing and unresponsive subject position.

The unknowing and unresponsive subject position serves to cast youth as responsible for poor SRH outcomes in cases where their behaviour is deemed unsafe and/or unchanged despite, for example, access to information. As such, it largely serves to obscure other factors (beyond lack of information) that may hinder or prevent behavioural changes. Such a positioning seemingly fails to consider the broader context within which 'undesirable' sexual and reproductive behaviour occurs. Resultantly, this subject position is not able to meaningfully contribute to understandings of the various difficulties faced (and privileges enjoyed) by youth according to their particular contexts and social identities. The unknowing and unresponsive subject position largely reduces potential for youth agency and serves to completely deny the possibility of youth as knowledgeable sexual beings. Similar to other subject positions within public health and human rights framings (i.e. the risky and vulnerable subject positions), the unknowing and unresponsive subject position serves to cast certain adults as the 'gatekeepers' of youth sexuality, responsible for ensuring that they have access to appropriate information and services to ensure responsible sexual behaviour.

Importantly, however, such a positioning fails to account for power relations that operate within relationships between youth and adults.

The valid service user subject position

Also prevalent within both public health and human rights framings was the positioning of youth as in need of interventions, programmes, and services tailored to meet their specific needs. Many policies prioritised the need to, for example, "develop and implement a national adolescent and youth reproductive health strategy establishing youth friendly centers to educate adolescents and youth on life skills and premarital testing" (Swaziland National Health Sector Strategic Plan, 2008-2013, p. 94). As such, these extracts largely positioned youth as deserving of recognition as valid service users. Moreover, many extracts were able to engage with emerging understandings of personal sovereignty of youth as valid service users by arguing for, for example, the enactment of laws which enable young people below the age 18 years to access health service points unaccompanied by adults (see Mauritius National Sexual & Reproductive Health Strategy and Plan of Action, 2009-2015, p. 16).

In contrast to many of the other positions assigned to youth across framings, a valid service user position does offer room for youth agency. In this sense, youth are positioned as able to utilise services that meet their specific needs, suggesting that youth are able to make their own determinations as to what these needs might be. Importantly, by including provisions that youth should be able to access services such a position render youth recognisable as health care subjects and allocates them the autonomy to make their own decisions in terms of their sexual and reproductive future. However, it is unclear how this autonomy might be ensured within the lived realities of youth experience. The valid service user subject position fails to account for the intersection of race, gender, socioeconomic status, sexual orientation, and gender identity (amongst other factors). Moreover, this positioning fails to account for the unequal power relations that operate within contexts such as health care services between, for example, youth and HCPs. As such, the valid service user position is aligned with other subject positions evidenced in public health and human rights framings in so far as it fails to account for forces that may server to hinder youth access to services within particular contexts.

Similarly, men who have sex with men were also positioned as in need of targeted interventions, programmes, and services. For example, Grenada's National HIV/AIDS Strategic Plan (2012-2016) promises that "prevention efforts will be intensified utilizing structured and targeted interventions focusing on the population groups with the highest prevalence – youth, MSM and CSW" (p. 11). Such targeted interventions were often conceptualised as 'comprehensive' and inclusive of "promoting condom use, water-based lubricants for them, detecting and managing STIs, information, education and communication through peer outreach; enabling people to know their HIV status and psychosocial and emotional counselling" (Nepal National HIV/AIDS Strategy, 2011-2016, p. 35). However, very few extracts were able to meaningfully acknowledge potential barriers of access beyond statements such as "[MSM] find it difficult to access health services, (including sexual health, prevention services including the diagnosis and treatment of STIs) in settings where there is provider stigma and discrimination" (Barbados National Strategic Plan for the Prevention and Control of HIV, 2008-2013, p. 14).

Similar to the valid youth service user position, 'MSM' are also recognised as valid service users within public health and human rights framings. 'MSM' are positioned as entitled to services that meet their specific needs. As such, 'MSM' are rendered recognisable as health care subjects with some sense of agency to address their SRH needs. However, this subject position also serves to obscure the diverse contexts and varied social identities (beyond sexual and gender identity) that may serve to enable or hinder access to services. As such, this positioning may serve to hold 'MSM' responsible for poor SRH outcomes in cases where they fail to access available services. Moreover, this positioning fails to include queer persons other than 'MSM', effectively rendering them invisible and failing to acknowledge the barriers that might impede their realisation of SRH. Finally, it is important to reemphasise that references to 'MSM' appear exclusively in policies dealing with HIV/AIDS, seeming to suggest that the 'validity' of their status as service users is only relevant within the context of HIV/AIDS. This serves to deny the possibility that queer populations may have SRH needs beyond the treatment and prevention of HIV/AIDS.

Subject Positions Operating across Single Framings

Within human rights framings, youth were consistently positioned as in possession of certain inalienable rights, particularly in reference to sexual and reproductive health. For example, South Africa's National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2014-2019) affirmed the need to improve the standards of health care provisions in order to ensure that "the rights of adolescents are respected, protected and fulfilled within an environment free of discrimination based on sex, HIV-status, sexuality, sexual orientation or gender identity" (p. 7). Additionally, an emphasis was placed on the imperative to ensure that youth are "empowered [through the provision of knowledge] and are able to exercise their rights with responsibility" (South Africa National Adolescent Sexual and Reproductive Health and Rights Framework Strategy, 2014-2019, p. 27).

The rights bearing subject is a valuable, albeit limited, positioning for youth with respect to their sexual and reproductive health. Much like the valid service user subject position, the rights bearing position creates room for youth agency and autonomy in so far as youth are positioned as recognisable health subjects entitled to certain rights with regards to their SRH. As rights bearing subjects, youth as subsequently positioned as having the power to make their own determinations in terms of their sexual and reproductive choices. As such, this subject position does offer the potential for an empowered youth subject. However, this positioning also suggests a current lack of empowerment within youth populations with minimal engagement around the potential contexts that might serve to disempower youth (beyond a cursory acknowledgement of discrimination on the basis of gender, HIV-status etc.). Within its current framing, the rights bearing subject fails to recognise that the possession of certain rights does not necessarily translate into the ability to exercise them. Thus, while the rights bearing subject offers a valuable contribution in recognising youth sexual and reproductive rights, recognition of the need to create an enabling environment to realise these rights needs further engagement.

'MSM' were also frequently positioned as rights bearing subjects. For example Jamaica's HIV and AIDS National Strategic Plan (2007-2012) asserts that "no person shall be denied access to prevention knowledge, skills and services or treatment, care and support services on the basis of their real or perceived HIV status, sexual orientation, gender, age, disability, religious beliefs, socio-economic status, geographic location …", going on to specify that this

is inclusive of "orphans, wards of the state, MSM, SWs, street and working children, persons living with disabilities, and prisoners" (p. 25). Some extracts went on to acknowledge that that the rights of 'MSM' are often compromised. For example, Mongolia's National Strategic Plan on HIV, AIDS and STIs (2010-2015) states that "protection of these human rights is particularly important in the context of HIV and AIDS, which disproportionately affects marginalized population groups such as … MSM … who often face stigma, discrimination, social exclusion and denial of their human rights" (p. 36). Some extracts even go as far as to outline the need to engage with "local law enforcement, health service providers, and other stakeholders to encourage them to respect, protect, and fulfil the rights of men who have sex with men/TG and meet the needs of men who have sex with men and TG" (Nepal National HIV/AIDS Strategy, 2011-2016, p. 35).

Similarly, the rights bearing subject position deployed in relation to 'MSM' does offer some value. By positioning 'MSM' as rights bearing subjects they are rendered recognisable as valid health subjects entitled to certain rights with regards to their SRH. However, this recognition only extends to 'MSM', overlooking other queer populations. These populations are thus rendered invisible, with little recognition given their own claims to sexual and reproductive rights. Although human rights framings did attempt to engage with the factors that might underlie vulnerability within certain groups (such as 'MSM'), this engagement frequently failed to move beyond a cursory recognition of discrimination on the basis of, for example, sexual orientation, gender, age, disability, socio-economic status, and so on. As such, this subject position is also limited in so far as deeper engagement with the ways in which diverse contexts and varied social identities may serve to enable or hinder the enjoyment of sexual and reproductive rights is largely superficially addressed. In seeking address to concerns around SRH it is necessary to establish both the recognition of rights and the creation of enabling environments to realise these rights. Finally, the recognition of 'MSM' as rights bearing subjects is largely referenced in the context of HIV/AIDS, serving to obscure the claims of queer populations beyond treatment and prevention of HIV/AIDS.

The Queer Youth Subject Position: Possibilities across Positioning Themes

As indicated previously, queer youth were largely absent within policy documents. However, an examination of the subject positions deployed in relation to youth and queer adult populations does offer some insight into how queer youth might be positioned within the

context of sexual and reproductive health concerns. In essence, queer youth are linked to each of these groupings by virtue of their age and sexual/and or gender identity. As such, positioning themes explored in the previous discussion serve as a valuable tool for providing insight into how policy responses may serve to hinder and/or enhance the SRH of queer youth. Moreover, while extracts pertaining to queer youth were largely absent, available extracts align closely with the identified themes. The subsequent discussion will summarise key arguments from the preceding discussion in order to highlight the ways in which positionings of youth and queer adult populations converge to produce particular understandings of the queer youth subject.

Across framings, both youth and 'MSM' were positioned as particularly prone to poor SRH outcomes. The risky, dangerous, and vulnerable subject positions all draw on narrow understandings of youth and queer sexuality, equating these with concerns of disease and danger. Within these positionings, the sexual behaviour of youth and 'MSM' is understood to be inherently risky, dangerous, or contributing to increased vulnerability. For youth, this risk/danger/vulnerability stems from the turmoil associated with the period of adolescence. For queer adults, the practice of sexual behaviour outside of the heterosexual 'norm' is central to understandings of risk/danger/vulnerability. By virtue of their inclusion within both populations, queer youth may be considered as especially at risk for, or vulnerable to, poor SRH outcomes. Extracts pertaining to queer youth seem to support this by arguing, for example, youth at high risk for HIV infection include "young people exploring same-sex relationships, who do not identify as gay or bi-sexual, drug and alcohol users, out-of-school youth, juvenile offenders, and other young people living on the margins of society" (Barbados' National HIV Prevention Plan, 2010, p. 35).

Linked to the positioning of youth and 'MSM' as risky/dangerous/vulnerable subjects, these populations were also positioned as in need of correction/containment/protection. By extension, queer youth might be considered especially in need of correction/containment/protection. Consequently, the 'invisible' state actor (and by extension those individuals who interact with youth and 'MSM' in relation to SRH concerns such as teachers, HCPs etc.) is positioned as a kind of 'gatekeeper' tasked with intervening to correct/contain/protect youth and 'MSM'. However, as noted in previous discussions, this positioning fails to account for the unequal power relations that operate within contexts such as health care services between, for example, youth and HCPs. These subject positions fail to

account for forces that may serve to hinder youth and 'MSM' access to services within particular contexts. In failing to acknowledge the influence of social, economic, political, and cultural forces, these subject positions may serve to hold individual youth and 'MSM' (and by extension queer youth) responsible for poor SRH outcomes. Many of the subject positions deployed in policies serve to deny the potential for youth and 'MSM' agency, strength, and resilience. Notably, the valid service user and rights bearing subject positions did create room for potential agency within these populations. However, for the most part youth and 'MSM' were not positioned as agentic subjects capable of making their own determinations as to their sexual and reproductive needs and choices. Thus, queer youth subjects are unlikely to be positioned as empowered, autonomous, and agentic.

Across all identified subject positions, the need for the creation of an enabling environment in order to secure sexual and reproductive health was largely unacknowledged. For example, the rights bearing subject position fails to recognise *both* the recognition of rights *and* the creation of enabling environments to realise these rights. Although subject positions informed by human rights and context and culture framings did attempt to engage with the factors that might underlie vulnerability within certain groups, this engagement frequently failed to move beyond a cursory recognition of, for example, stigma and discrimination. This was also evidenced in extracts pertaining to queer youth. For example, Sri Lanka's National Youth Policy (2014) makes passing reference to how "youth with different sexual orientations or facing personal crises often have no support" (p. 12). India's National Youth Policy (2014) made two references to queer youth in the context of issues relating to stigma and discrimination including: asserting the need for "monitoring and media attention to prevent illegal social practices such as dowry, child marriage, honour killings, castebased discrimination and stigmatisation of LGBT youth" (p. 72), and stipulating that a number of youth at risk and marginalised youth require special attention in order to ensure that they can access and benefit from the government programmes, including "Youth that suffer from social or moral stigma including but not limited to Lesbian, Gay, Bisexual and Transgender (LGBT) youth" (p. 66-7). The most extensive extract relating to discrimination faced by queer youth was outlined in Pakistan Sindh Youth Policy (2012) which stated that:

> Transgender youth faces severe discrimination in all walks of life. One of the main issues faced by them is mental depression due to the attitude and behavior of the society. Certain life style is imposed on them and they find no way to escape from it.

> Most of them have to live as beggars or sex workers and are at high risk of sexually transmitted diseases. The Supreme Court of Pakistan has ruled on transgender people's right to health and inheritance and recently judged that transgender be added as a third gender category on national identity cards. But still the government needs to ensure that transgender youth enjoy equal citizen rights. (p. 20)

Positionings of youth and queer populations also suggest that queer youth populations are likely to be homogenised within policy responses. With the possible exception of the vulnerable 'MSM' subject position and marginal (youth and 'MSM') subject position, most subject positions deployed within policies failed to significantly engage with distant and disparate experiences of barriers to SRH *within* youth and 'MSM' populations. By and large, subject positions served to overlook how diverse contexts and varied social identities might serve to enhance or diminish SRH outcomes. Nevertheless, some extracts did demonstrate an emerging, albeit superficial, recognition of diversity within youth populations. This is evidenced in the following extract inclusive of queer youth which refers to the "rights of minority, differently-abled youth and other vulnerable youth groups would portray social issues due the identity or status of certain youth groups. Such groups may include religious minorities, differently abled persons, transgender [youth], youth in workshops and youth in jails" (Pakistan's Sindh Youth Policy, 2012, p. 20).

The positioning of queer subjects solely within the context of HIV/AIDS serves to inextricably link same-sex sexualities (and at times gender non-conformity) with harmful consequences. Moreover, this serves to deny the possibility that queer populations may have SRH needs beyond the treatment and prevention of HIV/AIDS. The positioning of queer youth could similarly serve to conflate their SRH needs with concerns around HIV/AIDS. This is evidenced in two policy extracts concerning queer youth. Lesotho's National Human Development Report (2015) asserts the need to "facilitate access to community-based providers who have experience counselling and providing health services to LGBT youth, including on HIV/STI testing" (p. 149). The same policy also notes the need to implement a "comprehensive and integrated HIV and AIDS youth strategy. This strategy is to follow best practice, be highly efficient and correctly target the different youth groups, especially adolescents, the LGBT community and those with disabilities" (p. 45). The conflation of 'queerness' with HIV/AIDS can have important implications for queer youth in so far as it can result in, for example, a denial of queer sexuality outside a discourse of disease within

sexuality education as evidenced in previous research (e.g. DePalma & Francis, 2014). Potentially, the hypervisibility of 'MSM' evidenced in policies could mean that positionings of queer youth might adopt a narrow focus on queer (cisgender) male youth. In doing so, such positionings would also serve to render other queer youth (such as queer cisgender female youth, transgender youth etc.) invisible and unrecognisable as health care subjects, and thus fail to acknowledge the barriers that might impede their realisation of SRH.

CHAPTER 7: CONCLUSION

Rationale for the Research

Within global South regions it is difficult to gain an overall perspective of policy responses to SRH. Across these regions, very few policies focus specifically on youth SRH. Instead, SRH issues are more commonly addressed in general terms across different policies (Pillay, & Flisher, 2008). Given the growing emphasise placed on 'evidence-based' policy-making in the field of public health, systematic reviews are widely considered to serve as a valuable means to present oftentimes conflicting and complicated data in more useable and accessible ways within policy domains (Boaz et al., 2002; Davies et al., 2000; Klein, 2000; and Solesbury, 2002). However, at present no comprehensive review has been conducted to assess policy responses to youth SRH in general (and queer youth SRH specifically) in these regions.

Moreover, the consideration of policy responses to the SRH of queer youth offers a vital insight into dominant notions of youth sexuality. In this sense, policy represents "a site where various issues and 'truths' about sexuality are contested, challenged, reformed and transformed" (Carabine, 1996a, p. 55). In examining policies, the key assumptions of policy makers can be explored. Often, policies present different and conflicting standpoints on youth (such as the innocent vs. risky positioning noted in previous research) that serve to create (and in turn are created by) the social, cultural, and institutional conditions that determine responses to youth SRH. As such, policy is the link through which institutional and discursive practices are produced and reproduced (Moore & Prescott, 2013).

Previous research has demonstrated that policies often adopt a narrow definition of young people, fail to recognise the diversity of needs within youth populations, and overlook a range of individual and contextual factors that play an important role in influencing SHR outcomes (Department of Health, 2011; Hindin, & Fatusi, 2009; Judhistari et al., 2012). Given the growing body of evidence concerning the difficulties faced by queer persons with the realm of health care, an examination of policy responses can be utilised to provide insights into the contexts in which these difficulties might arise and inform efforts to address these concerns.

In particular, the framing and positioning thematic analysis undertaken as part of this research is able to provide valuable recommendations for the improvement of policy responses to the SRH of queer youth. In particular, the manner in which youth SRH concerns are framed and how queer youth are positioned within policies provides a foundation for the implementation of health care and similar social services. Findings from this research provide insight into the themes evidenced in policy responses to youth SRH (particularly in relation to framings and positioning), and as such can be utilised to informed the development of innovative and nuanced interventions to advance the SRH of queer youth, and support further development of enabling policy drawing on the principles and sexual and reproductive justice.

Overview of the Research Process

Within this research, a sexual and reproductive justice (SRJ) framework was adopted as a backdrop for exploring policy documents related to youth sexual and reproductive health (SRH) within selected global South countries in Africa, Asia, and the Caribbean. This research took the form of a systematic review utilising a deductive framing and positioning thematic analysis. Analysis drew on Chong and Druckman's (2007a; 2007b) notion of communication frames and Davies and Harré's (1990) concept of positioning to analyse the framing of policies and the subject positions deployed in these policies. Additionally, a basic content analysis was also conducted. Frequency counts were conducted for each identified framing and for each framing broken down according to region.

Analysis explored three distinct, yet related, avenues of inquiry including: (i) identification and examination of the framings of youth SRH within policy extracts, (ii) identification and examination of the subject positions assigned to queer youth within policy extracts, and (iii) identification of trends (or themes) within and across countries. The preliminary data set comprised of existing policy documents related to youth SRH in selected global South countries, from the period of 2010 to 2015. Given that youth SRH issues tend to be addressed in general terms across policies, the review focused on Ministries of Health, Youth, Education, and Development, of identified countries within the general areas of national health policies, national youth policies, national education policies, and national sexual and reproductive health policies. The final data set comprised of 1035 policy excerpts extracted from 152 policies across Africa, Asia, and the Caribbean (with Latin America being excluded from review during preliminary stages of data collection).

By drawing heavily on understandings of reproductive justice, and infusing these understandings with notions of sexual hierarchies (including those related to sexual orientation and gender identity), the SRJ framework served as a valuable backdrop for engaging with the histories, circumstances, and contexts that enable and/or hinder the exercising of sexual and reproductive rights and the enjoyment of SRH – particularly as these relate to the SRH of queer youth. As such, this framework was utilised to draw on holistic formulations of SRH issues, examine issues related to the social reality of inequality, and create room for intersectional concerns in order facilitate nuanced understandings of the SRH needs of queer youth.

Review of Findings

Across both framing and positioning themes, a number of key shortcomings were observed. Findings demonstrated that policy responses to youth SRH are most often framed in terms of a public health approach. As a result, dominant understandings of youth SRH serve to reduce youth sexuality to notions of infections and impact, which may speak to an overreliance on biomedical and population-level health models. Themes emerging within human rights framings demonstrate a presumption that rights are equally afforded to, and freely exercised by, all individuals once legally secured, failing to engage with the creation of enabling conditions to realise these rights. Although context and culture framings were by no means exhaustive examples of SRJ, they did provide insight into how SRJ concerns might be integrated into policy through a sustained recognition of the influence of context in determining SRH outcomes. Figure 1 provides an overview of all identified framings themes evident in the data.

Importantly, identified positioning themes within policy responses demonstrated a general pattern of hypervisibility of 'MSM' standing in marked contrast to the invisibility of queer youth and other adult queer population. Notably, youth and queer adult populations were consistently positioned as at risk/vulnerable/marginalised, particularly in terms of poor SRH outcomes. By virtue of their inclusion within both populations, queer youth may be considered as especially at risk for, or vulnerable to, poor SRH. The positioning of 'MSM' solely within the context of HIV/AIDS also serves to link same-sex sexualities (and at times gender non-conformity) with harmful consequences, suggesting that the positioning of queer youth could similarly serve to conflate their SRH needs with concerns around HIV/AIDS.

Many of the subject positions deployed in policies also serve to deny the potential for youth and 'MSM' agency, strength, and resilience. Figure 2 provides an overview of all identified positioning themes evident in the data.

Figure 1. Framing themes across selected global South policies

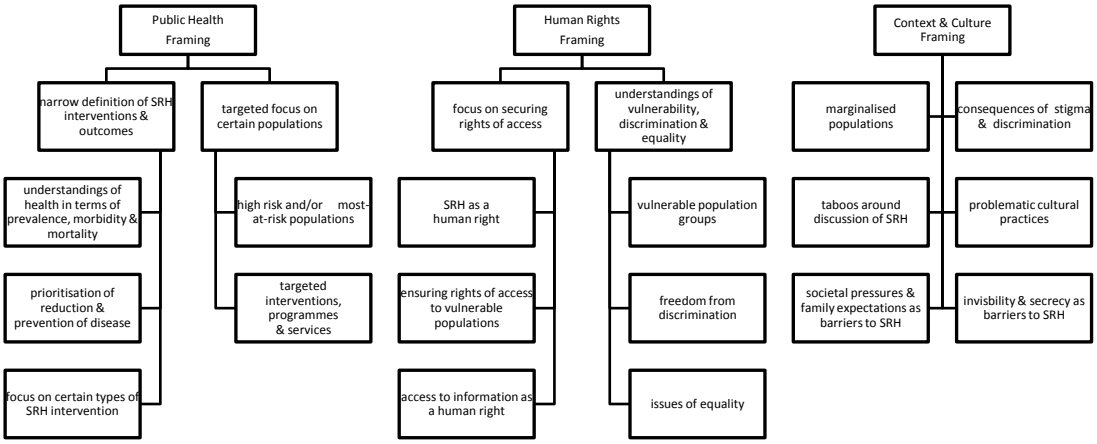
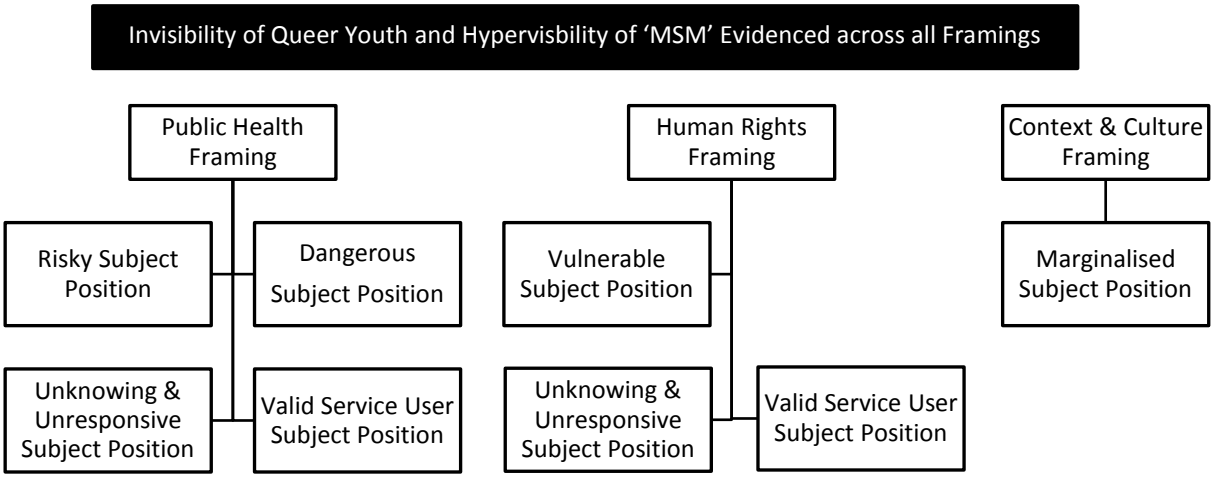


Figure 2. Positioning themes across selected global South policies



The subsequent discussion will provide an overview of findings, in order to highlight shortcomings and review in greater detail key aspects that emerged within and across the data in relation to framing and positioning themes evidenced in policy responses. Where relevant, discussion will draw linkages between the findings arising out of the current research, and similar findings noted by other researchers. First, however, it is important to reiterate that the

consideration of policy responses to the SRH of queer youth offers a vital insight into dominant notions of youth sexuality. In this sense, policy serves as a link through which institutional and discursive practices are produced and reproduced. In examining policies, the key assumptions of policy makers in relation to youth SRH can be explored (Moore & Prescott, 2013).

Given the prevalence of public health framings policy responses tended to align with narrow understandings of health as the absence of disease through an emphasis on prevalence and incidence. Consequently, policy responses serve to perpetuate narrow understanding of SRH and reduce youth sexuality to notions of infections and impacts. Moreover, across the various framings and subject positions identified in the data, a failure to consider youth SRH within a context of intersecting social, economic, cultural, and health care possibilities and challenges was widespread. By failing to locate youth SRH concerns within a broader context, these framings may serve to hold individual youth and 'MSM' responsible for poor SRH outcomes in cases where their behaviour is deemed unsafe and/or unchanged despite access to information and services. The failure of such framings to account for, or even engage with, relevant contextual factors also calls into question the potential efficacy of interventions. Although some extracts informed by the human rights approach were able to embrace an emergent recognition of the diversity of youth experiences in the context of varied economic, political, social, and cultural environments (particularly in relation to barriers to access), such recognition was rare and often superficial.

In contrast to public health and human rights approaches, one of the fundamental strengths of the SRJ framework is its ability to create room for intersectional concerns. Although policy extracts framed in terms of a context and culture agenda were by no means exhaustive examples of engagement with intersectional concerns, they provide an interesting insight into how such concerns might be integrated into policy. A sexual and reproductive justice lens allows for the intersection of race, gender, socioeconomic status, sexual orientation, and gender identity (amongst other factors) to be actively acknowledged and brought to bear on understandings of the varied issues faced by youth according to their particular context. As such context and culture themes serve as a valuable (albeit imperfect) example of the ways in which inequities need to be understood as being mediated through manifold social identities that converge to create distinct experiences of both oppression and opportunity. Although the need for deeper engagement was often evident, these context and culture framings were able

to build upon, and where necessary, distance themselves from narrow understandings of youth SRH.

Previous research has noted that within contemporary youth policy, protectionist and heteronormative discourses of youth sexuality are dominant. Resultantly, sexual orientations and gender identities that exist outside of the heterosexual and cisgendered 'norm' are problematised (see for example Carabine, 1996a; Carabine, 1996b; Carabine, 2004; Moore & Prescott, 2013; Mulé et al., 2009; Russel & Bohan, 1999; Young & Meyer, 2005). Given the absence of representations of queer youth within the data, findings from this research align closely with such arguments. However, in addition to protectionist and heteronormative discourses, policy responses analysed here also draw on rights discourses and, to a limited extent, sexual and reproductive justice discourses – although the effectiveness of these discourses was often limited despite a demonstrated intent to embrace and enhance youth empowerment. Moreover, by examining the intersection between youth and queer adult populations (and exploring what this may mean for the framing of queer SRH, and the positioning of queer youth in policy), findings from the current research suggest additional correlations with existing research that are important to note.

Some researchers have argued that within policy, youth are frequently constructed, targeted, and educated with the intent of producing 'responsible' adults. However, the standards for responsible sexual behaviour are determined by developmental assumptions (such a notions of adolescence as a period of transition) that are enforced by institutional powers (such as governments) about what 'appropriate' youth sexual behaviour should entail, serving to deny youth any sense of autonomy (Egan & Hawkes 2008, Hawkes & Egan 2008; Yoshida, 2013). As such, adolescence is depicted as a time of risk, turmoil, instability, and abnormality – both behaviourally and emotionally - that inherently necessitates intervention (Ayman-Nolley & Taira, 2000; Lesko, 2000; Moore & Prescott, 2013; Patton, 1996; Talburt, 2004; Waites, 2005).

Similarly, findings from the present research demonstrate that both youth and 'MSM' are consistently positioned as particularly prone to poor SRH outcomes. The risky, dangerous, vulnerable, and marginalised subject positions all draw on generally narrow understandings of youth and queer sexuality, equating these with concerns over disease and danger. Within these positionings, the sexual behaviour of youth and 'MSM' is understood to be inherently

risky, dangerous, or contributing to increased vulnerability and marginalisation. For youth, this risk/danger/vulnerability/marginalisation stems from the turmoil associated with the period of adolescence. For queer adults, the practice of sexual behaviour outside of the heterosexual 'norm' is central to understandings of risk/danger/vulnerability/marginalisation.

By virtue of their inclusion within both populations, queer youth may be considered as especially at risk for, or vulnerable to, poor SRH outcomes. Such findings echo arguments made by several researchers which stipulate that notions of 'youth as transition' are predicated on the assumption that 'normal' youth development is linear, progressive, and orientated towards heteronormative standards of adulthood. Resultantly, policy responses often serve to implicitly normalise and naturalise heterosexuality (Carabine, 1996b; Moore & Prescott, 2013; Patton, 1996; Richardson, 1996, Talburt, 2004). In this sense, the transition to adulthood for queer youth, takes on additional problems that place them at further 'risk' (Uribe & Harbeck, 1991; Talburt, 2004).

Linked to the positioning of youth and 'MSM' as risky/dangerous/vulnerable subjects, current findings also suggest that these populations are positioned as in need of correction/containment/protection. By extension, queer youth might be considered especially in need of correction/containment/protection. Correspondingly, previous research has noted that youth are frequently deemed as in need of protection (to prevent risky behaviour) and control (to prevent dangerous behaviour), ensuring that youth agency is largely denied or undermined in policy responses (Mitchell et al., 2004; Moore & Prescott, 2013; Yoshida, 2013). Further, it has also been noted that youth are rarely granted the authority to make their own assessment of risk; this authority lies firmly in the hands of adults (Jackson & Scott, 2010). As a consequence, youth become the objects of policies rather than the protagonists of policy-making (Yoshida, 2013), as clearly evidenced in the present research.

In line with such findings, the current research illustrates how policy extracts often fail to consider the operation of power relations within certain contexts that may serve to create barriers to the realisation of SRH. By positioning youth and adult peer populations as in need of correction/containment/protection, the 'invisible' state actor (and by extension those individuals who interact with youth and 'MSM' in relation to SRH concerns such as teachers, HCPs etc.) are in turn positioned as a kind of 'gatekeeper' tasked with intervening to correct/contain/protect youth and 'MSM'. However, this positioning fails to account for the

unequal power relations that operate within contexts such as health care services between, for example, youth and HCPs. In doing so, these policy extracts deny youth agency by perpetuating the symbolic order between adults and youth (Moore & Prescott, 2013).

Current findings also demonstrated the positioning of queer subjects solely within the context of HIV/AIDS serves to inextricably link same-sex sexualities (and at times gender non-conformity) with harmful consequences. Such findings are echoed in previous research which has noted the conflation of sexual orientation with notions of risk and danger, evidenced in, for example, failures to mention queer sexuality outside the context of HIV/AIDS and other STIs (De Palma & Francis, 2014; Gowen & Winges-Yanez, 2014). Similarly, the sexuality of queer youth is often positioned as abnormal, deviant, shameful, and even sinful (see for example DePalma & Francis, 2012; McDermott et al., 2008; Van Klinken & Gunda, 2012).

Moreover, as evidenced in the current data, this limited focus serves to deny the possibility that queer populations may have SRH needs beyond the treatment and prevention of HIV/AIDS. The positioning of queer youth could similarly serve to conflate their SRH needs with concerns around HIV/AIDS. Potentially, the hypervisibility of 'MSM' evidenced in policies – and within similar research (see for example Blake et al., 2001; Fethers et al., 2000) - could mean that positionings of queer youth might adopt a narrow focus on queer (cisgender) male youth. In doing so, such positionings would also serve to render other queer youth (such as queer cisgender female youth, transgender youth etc.) invisible and unrecognisable as health care subjects, and thus fail to acknowledge the barriers that might impede their realisation of SRH.

Across the current data set most of the subject positions deployed in policies serve to deny the potential for youth and 'MSM' agency, strength, and resilience. Notably, the valid service user and rights bearing subject positions did create room for potential agency within these populations. However, for the most part youth and 'MSM' were not positioned as agentic subjects capable of making their own determinations as to their sexual and reproductive needs and choices. Thus, queer youth subjects are unlikely to be positioned as empowered, autonomous, and agentic. Relatedly, a number of studies have noted that an overreliance on the victim trope within policy has undermined and de-emphasized the potential for queer youth agency and resilience (Blackburn, 2007; Bruhm and Hurley 2004; Curran 2002; Rasmussen et al., 2004; Rofes 2004). As such, there is a need for policy responses to

transcend universalizing understandings of queer youth as subjects in need of saving by external forces (such as institutional and adult agents) (Rasmussen et al., 2004). Many researchers have argued for a shift in focus towards empowering youth and seeking to facilitate youth agency by, for example, recognising their own knowledge and experiences about sexuality, and their ability to exercise choice around their sexual decision-making (Francis, 2010; Holzner & Oetomo, 2004; Moore & Prescott, 2013; Yoshida, 2013).

Similarly, many researchers have argued for the importance of embracing multiple and intersecting subject positions for queer youth within both research and policy (see for example Blackburn, 2004; 2007; Hillier et al., 2010; Sedgwick, 1990; Talburt, 2004; Willis, 2012). Previous research has noted that dichotomous (or narrow) understandings of youth sexuality serve to impede nuanced understandings of the sexual and reproductive health needs of youth, whilst also obscuring diversity within youth populations (see for example Aggleton et al., 2000; Buckingham & Bragg, 2004; Field, 2008; Jackson, 2008; Kirby, 1994; Warwick & Aggleton, 1990). Within the current research similar findings were noted. With the possible exception of the vulnerable 'MSM' subject position and marginal (youth and 'MSM') subject position, most subject positions deployed within policies failed to significantly engage with distant and disparate experiences of barriers to SRH *within* youth and 'MSM' populations. By and large, subject positions served to overlook how diverse contexts and varied social identities might serve to enhance or diminish SRH outcomes. Nevertheless, some extracts did demonstrate an emerging, albeit superficial, recognition of diversity within youth populations.

Across all identified framings and subject positions in the present research, the need for the creation of an enabling environment in order to secure sexual and reproductive health was largely unacknowledged. For example, the rights bearing subject position fails to recognise *both* the recognition of rights *and* the creation of enabling environments to realise these rights. Although subject positions informed by human rights and context and culture framings did attempt to engage with the factors that might underlie vulnerability within certain groups, this engagement frequently failed to move beyond a cursory recognition of, for example, stigma and discrimination.

While certain framings were sometimes able to demonstrate an emergent and valuable recognition of the adverse effect of discrimination and inequality for youth SRH, many of

these extracts seem to suggest that recognition of the right to freedom from discrimination and issues of inequality should directly translate into the ability to exercise and enjoy such rights. By failing to explore the need for additional measures beyond mere recognition and legal guarantees of freedom from discrimination such framings do little to encourage thinking around measures that will work towards the creation of enabling conditions to realise these rights. In other words, in order to be effectively addressed issues of discrimination and inequality the connection between SRH-related issues and other areas of concern (particularly those related to issues of social justice) must be foregrounded.

Moreover, discourses of protection (and control) that draw heavily on understandings of queer youth as victims of abuse, discrimination, and varied disadvantages as a result of their sexual orientation and/or gender identity, often serve to homogenise queer youth (Marshall, 2010; Talburt, 2004; Talburt et al., 2004; Warner, 1999). Without negating the experiences of queer youth that may serve to validate such discourses, it is important to note the problems associated with presenting the victim trope as the *only* frame for understanding queer youth experience (Blackburn, 2007).

Strengths, Limitations, and Suggestions for Future Research

By and large, findings of the research were able to effectively address the key research questions informing the analysis. In this sense, findings were able to highlight interesting aspects of the dominant framings and positioning identified within policy responses in selected global South regions. While many of these findings strongly aligned with previous research concerned youth representations of youth in policy, the use of a SRJ framework as a backdrop served to contribute additional theoretical concerns to this body of work, thus facilitating a move towards a more nuanced approach to addressing the sexual and reproductive health of queer youth (and youth more broadly). Given that the thematic analysis was undertaken deductively, it must be noted that findings tended to provide less of a rich description of the data overall. Instead, findings provide more of a detailed analysis around specific aspects of the data (i.e. framing and positioning). This loss is somewhat mitigated in so far as the research is concerned with a previously under-researched area of concern. However, a number of additional limitations of the research should also be noted.

Particularly, analysis was unable to include policy documents not available in English. As a result, a number of countries (most notably the entire region of Latin America) were excluded from the study. Although this limitation was largely the result of resource constraints, it does speak to some potential limitations of the research. Firstly, the exclusion of policy documents not available in English does serve to involuntarily (and perhaps implicitly) privilege the use of certain languages over others – especially in cases where English is prioritised over local languages – and where the failure to provide documents available in English means exclusion from the research concerns. Additionally, this exclusion meant the loss of a number of potentially rich sources of data, particularly in relation to Latin American countries. The inclusion of policies without such a limited restriction in terms of language could mean the emergence of additional themes, or further nuances within themes to emerge. As such, future research might seek to explore similar analysis within regions and countries excluded from this particular systematic review.

Moreover, although policy documents themselves did prove a valuable source of data they are (in a sense) also limited. Future research could look towards incorporating additional data sources to augment the study of public policy. Framing theory has been used to great success in exploring, for example, the framing of certain issues by politicians and within the media (see for example Gamson & & Modigliani, 1987; Shah et al., 1996; Shah et al., 2002). Similar sources could be utilised in addition to policy documents in further research concerning representations of the SRH of queer youth. In addition, the use of policy documents meant that only certain aspects of positioning theory, namely interactive positioning, was explored. Thus, future research could seek to integrate aspects of reflexive positioning through the incorporation of additional data sources in order to explore the ways in which queer youth (and youth more generally) 'speak back' to how they are positioned in relation to their sexual and reproductive health (see for example Dwyer, 2014; Francis & Reygan, 2016; Hillier & Harrison, 2004; McDermott et al., 2008; Willis, 2012)

Recommendations for Policy Responses to Queer Youth SRH

In seeking to incorporate the principles of sexual and reproductive justice into policy responses to the SRH of queer youth, the current research findings suggest a number of recommendations. Firstly, it is vital that policy responses serve to *foreground* (rather than simply acknowledge) the connection between SRH and other areas of concern, particularly

those related to issues of social justice (Morison, 2013). If measures to improve poor SRH outcomes are to enjoy any success, the context within which these outcomes persist must not only be acknowledged but also brought to bear on how SRH interventions, services, and programmes are planned, operationalised, and monitored. As such, policy responses need to focus on a achieving a broad set of conditions (such as necessary for securing SRH – beyond access to information, services etc. as currently evidence in policy) (Fried, 2006; Gilliam et al., 2009).

As evidenced in research findings, there is some value in certain positionings offered by a human rights (and even public health) framings. Whilst, sexual and reproductive rights should continue to be reflected in policy, it is important to move beyond inclusion to incorporate understandings of the need to create enabling conditions that allow for the rights to be realised (Ross, 2006). In this sense, political, cultural, and socio-economic inequalities must be acknowledged but also actively addressed, and incorporated into, policy responses to youth SRH (Fried, 2006; Morison, 2013; Silliman & Bhattacharjee, 2002). By obscuring these broader contextual factors, policy responses may serve to hold individual youth responsible for poor SRH outcomes (Roberts, 2015; Morison, 2013)..

While findings suggest an emerging recognition that inequities are understood as being mediated through manifold social identities (e.g. race, gender, socioeconomic status, sexual orientation, gender identity, age, religion, culture, immigrant status, and so on) that converge to create distinct experiences of both oppression and opportunity, this recognition is often superficial and largely unexplored. In failing to engage with the potential for diversity within youth populations, these populations are also largely homogenised. Such intersections of identity need recognition, but they must also be *brought to bear* on understandings of the varied issues faced by queer persons according to their particular context. In line with recommendations from other research (e.g. Francis, 2010; Holzner & Oetomo, 2004; Moore & Prescott, 2013; Rasmussen et al., 2004; Yoshida, 2013), there is a need for policy responses to transcend universalizing understandings of queer youth as subjects, and shift policy focus towards empowering youth and seeking to facilitate youth agency. Similarly, many researchers have argued for the importance of embracing multiple and intersecting subject positions for queer youth within both research and policy (see for example Blackburn, 2004; 2007; Hillier et al., 2010; Sedgwick, 1990; Talburt, 2004; Willis, 2012).

Finally, policy makers need to demonstrate a deeper understanding of the ways in which policy responses can serve to mark certain bodies as different, risky, dangerous, vulnerable, marginalised, or even invisible – both through inclusion and exclusion within policies. As current findings demonstrate, inclusion within policies can serve to further marginalise certain groups. For example, the positioning of 'MSM' solely within the context of HIV/AIDS serves to link same-sex sexualities (and at times gender non-conformity) with harmful consequences. Relatedly, the exclusion of queer youth and queer adult persons (beyond 'MSM') from policy responses served to disregard their status as valid health subjects. As such, policy responses need to embrace a holistic formulation of SRH issues that seeks to address the social reality of inequality, and create room for intersectional concerns in order to facilitate nuanced understandings of the SRH needs of queer youth.

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APPENDIX A

		CRIMINALISATION											PROTECTION								
		Legal	Age of Consent		Illegal		Max Sentences				Expression		NRHI Inclusive of Sexual Orientation				Discrimination Protection				
		All Genders	Equal	Unequal	Male	Female	1 month - 2 years	3 - 7 years	8 - 14 years	15 years - life	Death Penalty	Promotion Law	Morality Code	Yes	No	Unclear	None	Employment	Constitution	Hate Crime	Incitement	Other
Central Africa	Angola																					
	Cameroon																					
	Central African Republic																					
	Chad																					
	Democratic Republic of Congo																					
	Equatorial Guinea																					
	Gabon																					
	Republic of the Congo																					
	São Tomé and Principe																					
Eastern Africa	Burundi																					
	Comoros																					
	Djibouti																					
	Eritrea																					
	Ethiopia																					
	Kenya																					
	Madagascar																					
	Malawi																					
	Mauritius																					
	Mozambique																					
	Rwanda																					
	Seychelles																					
	Somalia										B											
	South Sudan																					
	Tanzania																					
	Uganda																					
	Zambia																					
	Zimbabwe																					
Northern Africa	Algeria																					
	Egypt																					
	Libya																					
	Morocco																					
	Sudan										A											
	Tunisia																					
Southern Africa	Botswana																					
	Lesotho																					
	Namibia																					
	South Africa																					
	Swaziland																					
Western Africa	Benin																					
	Burkina Faso																					
	Cape Verde																					
	Côte d'Ivoire																					
	Gambia																					
	Ghana																					
	Guinea																					
	Guinea-Bissau																					
	Liberia																					
	Mali																					
	Mauritania										D											
	Niger																					
	Nigeria										B											
	Senegal																					
	Sierra Leone																					
	Togo																					

A Codified under Sharia and implemented countrywide

B Codified under Sharia and implemented provincially

C Implemented by local courts / vigilantes / non-state actors

D Codified in the law, but not implemented for same-sex behaviour specifically

		CRIMINALISATION												PROTECTION								
		Legal	Age of Consent		Illegal		Max Sentences					Expression		NRHI Inclusive of Sexual Orientation				Discrimination Protection				
		All Genders	Equal	Unequal	Male	Female	1 month - 2 years	3 - 7 years	8 - 14 years	15 years - life	Death Penalty	Promotion Law	Morality Code	Yes	No	Unclear	None	Employment	Constitution	Hate Crime	Incitement	Other
Central Asia	Kazakhstan																					
	Kyrgyzstan																					
	Tajikistan																					
	Turkmenistan																					
	Uzbekistan																					
Eastern Asia	China																					
	DPR Korea																					
	Mongolia																					
	Republic of Korea																					
Southern Asia	Afghanistan										D											
	Bangladesh																					
	Bhutan																					
	India																					
	Iran										A											
	Maldives																					
	Nepal																					
	Pakistan										D											
	Sri Lanka																					
South-Eastern Asia	Brunei Darussalam																					
	Cambodia																					
	Indonesia	most																				
	Lao People's DR																					
	Malaysia																					
	Myanmar																					
	Philippines																					
	Singapore																					
	Timor-Leste																					
	Vietnam																					
Western Asia	Armenia																					
	Azerbaijan																					
	Bahrain																					
	Cyprus																					
	Georgia																					
	Gaza																					
	Iraq										C											
	Israel																					
	Jordan																					
	Kuwait																					
	Lebanon																					
	Oman																					
	Qatar										D											
	Saudi Arabia										A											
	Syrian Arab Republic										C											
	Thailand																					
	Turkey																					
	United Arab Emirates										D											
	West Bank																					
	Yemen										A											

A Codified under Sharia and implemented countrywide

B Codified under Sharia and implemented provincially

C Implemented by local courts / vigilantes / non-state actors

D Codified in the law, but not implemented for same-sex behaviour specifically

		CRIMINALISATION												PROTECTION								
		Legal	Age of Consent		Illegal		Max Sentences					Expression		NRHI Inclusive of Sexual Orientation				Discrimination Protection				
		All Genders	Equal	Unequal	Male	Female	1 month - 2 years	3 - 7 years	8 - 14 years	15 years - life	Death Penalty	Promotion Law	Morality Code	Yes	No	Unclear	None	Employment	Constitution	Hate Crime	Incitement	Other
Caribbean	Antigua and Barbuda																					
	Bahamas																					
	Barbados																					
	Cuba																					
	Dominica																					
	Dominican Republic																					
	Grenada																					
	Haiti																					
	Jamaica																					
	St Kitts and Nevis																					
	St Lucia																					
	St Vincent and the Grenadines																					
	Trinidad and Tobago																					
Central America	Belize																					
	Costa Rica																					
	El Salvador																					
	Guatemala																					
	Honduras																					
	Mexico																					
	Nicaragua																					
	Panama																					
South America	Argentina																					
	Bolivia																					
	Brazil																					
	Chile																					
	Colombia																					
	Ecuador																					
	Guyana																					
	Paraguay																					
	Peru																					
	Suriname																					
	Uruguay																					
	Venezuela																					

A Codified under Sharia and implemented countrywide

B Codified under Sharia and implemented provincially

C Implemented by local courts / vigilantes / non-state actors

D Codified in the law, but not implemented for same-sex behaviour specifically

APPENDIX B

Region	Country	Name of Policy	Policy Focus
Eastern Africa	Comoros	National Health Development Plan (2010-2014)	Development
Eastern Africa	Eritrea	National Health Policy (2010)	Health
Eastern Africa	Ethiopia	National Girls' Education Strategy (2010)	Education
Eastern Africa	Ethiopia	National Reproductive Health Strategy (2005-2015)	SRH
Eastern Africa	Kenya	Population Policy for National Development (2012)	Development
Eastern Africa	Kenya	National Education Sector Plan (2013-2018)	Education
Eastern Africa	Kenya	National School Health Strategy Implementation Plan (2011-2015)	Education
Eastern Africa	Kenya	National Health Policy (2012-2030)	Health
Eastern Africa	Kenya	Adolescent Reproductive Health and Development Policy Plan of Action (2005-2015)	SRH
Eastern Africa	Kenya	National Adolescent Sexual and Reproductive Health Policy (2015)	SRH
Eastern Africa	Malawi	Health Sector Strategic Plan (2011-2016)	Health
Eastern Africa	Malawi	National Population Policy (2012)	Health
Eastern Africa	Malawi	National Plan of Action for Scaling up SRH and HIV Prevention Initiatives for Young People (2008-2012)	SRH
Eastern Africa	Malawi	National Youth Friendly Health Services Strategy (2015-2020)	Youth
Eastern Africa	Malawi	National Youth Policy (2013)	Youth
Eastern Africa	Mauritius	National Youth Policy (2010)	Youth
Eastern Africa	Mauritius	National Sexual & Reproductive Health Strategy and Plan Of Action (2009 - 2015)	SRH
Eastern Africa	Mozambique	Education Strategic Plan (2012-2016)	Education
Eastern Africa	Seychelles	National Action Plan (2001-2015)	Education
Eastern Africa	Seychelles	Reproductive Health Policy (2012)	SRH
Eastern Africa	Seychelles	National Youth Policy (2013)	Youth
Eastern Africa	Tanzania	Health Sector Strategic Plan III (2009-2015)	Health
Eastern Africa	Uganda	Health Sector Development Plan (2015/19-2019/20)	Development
Eastern Africa	Uganda	Second National Development Plan (2015/16-2019/20)	Development
Eastern Africa	Uganda	National Population Policy Action Plan (2011-2015)	Health
Eastern Africa	Uganda	National Strategy for Girls' Education (NSGE) (2015-2019)	Education
Eastern Africa	Zambia	Human Development Report (2016)	Development
Eastern Africa	Zambia	National Health Strategic Plan (2011-2015)	Health
Eastern Africa	Zambia	National Youth Policy (2015)	Youth
Eastern Africa	Zimbabwe	National Gender Policy (2013-2017)	SRH
Eastern Africa	Zimbabwe	National Youth Policy (2000-2010)	Youth
Southern Africa	Botswana	National Development Plan 10 (2009-2016)	Development
Southern Africa	Botswana	Revised National Population Policy (2010)	Development
Southern Africa	Botswana	Integrated Health Service Plan (2010-2020)	Health
Southern Africa	Botswana	National Health Policy (2011)	Health
Southern Africa	Botswana	Policy Guidelines and Service Standards - National Sexual and Reproductive Health Programme (2015)	SRH
Southern Africa	Botswana	SRHR and HIV & AIDS Linkages Integration Strategy and Implementation Plan (2012)	SRH
Southern Africa	Botswana	National Youth Action Plan (2010-2016)	Youth
Southern Africa	Botswana	Revised National Youth Policy (2010)	Youth
Southern Africa	Lesotho	National Human Development Report (2015)	Development
Southern Africa	Lesotho	National Strategic Development Plan (2012/13-2016/17)	Development
Southern Africa	Lesotho	Education Sector Strategic Plan (2005-2015)	Education
Southern Africa	Lesotho	Health Sector Strategic Plan (2012/13-2016/17)	Health
Southern Africa	Lesotho	National Health Policy (2011)	Health
Southern Africa	Namibia	Third National Development Plan (2007/08-2011/12)	Development
Southern Africa	Namibia	Vision 2030 (2004-2030)	Development
Southern Africa	Namibia	Education and Training Sector Improvement Programme (ETSIP) (2006-2011)	Education
Southern Africa	Namibia	Ministry of Education Strategic Plan (2012-2017)	Education
Southern Africa	Namibia	Ministry of Health and Social Services Strategic Plan (2009-2013)	Health
Southern Africa	Namibia	National Health Policy Framework (2010-2020)	Health
Southern Africa	Namibia	National Gender Policy (2010-2020)	SRH
Southern Africa	South Africa	National Development Plan 2030 (2011)	Development
Southern Africa	South Africa	Action Plan to 2014 (2011-2014)	Education
Southern Africa	South Africa	Intergrated School Health Policy (2012)	Education
Southern Africa	South Africa	School Health Policy and Implementation Guidelines (2011)	Education
Southern Africa	South Africa	Strategic Health Plan (2010/11-2012/13)	Health
Southern Africa	South Africa	National Adolescent Sexual and Reproductive Health and Rights Framework Strategy (2014-2019)	SRH
Southern Africa	South Africa	Adolescent and Youth Health Policy (2012)	Youth
Southern Africa	South Africa	National Youth Policy (2015-2020)	Youth
Southern Africa	Swaziland	National Development Strategy (1997-2022)	Development
Southern Africa	Swaziland	National Gender Policy (2010)	SRH
Southern Africa	Swaziland	National Policy on Sexual and Reproductive Health (2013)	SRH
Southern Africa	Swaziland	National Health Sector Strategic Plan (2008-2013)	Health
Western Africa	Benin	National Health Development Plan (2009-2018)	Development
Western Africa	Gambia	Gender and Women Empowerment Policy (2010-2020)	Development
Western Africa	Gambia	National Development Strategy (2017-2020)	Development
Western Africa	Gambia	National Gender Policy (2010-2020)	Development
Western Africa	Gambia	Education Policy (2004-2015)	Education
Western Africa	Gambia	National Health Policy (2012-2020)	Health
Western Africa	Gambia	National Health Strategic Plan (2014-2020)	Health
Western Africa	Gambia	National Population Policy (2007-2011)	Health
Western Africa	Gambia	National Youth Policy (2009-2018)	Youth
Western Africa	Ghana	Education Strategic Plan (2003-2015)	Education
Western Africa	Ghana	National Youth Policy of Ghana (2010)	Youth
Western Africa	Liberia	National Health and Social Welfare Policy (2011)	Health
Western Africa	Nigeria	National Strategic Health Development Plan (2010-2015)	Youth

APPENDIX C

Region	Country	Name of Policy	Policy Focus
Central Asia	Kazakhstan	Strategic Plan for Development of the Republic of Kazakstan (2010-2020)	Development
Central Asia	Kyrgyzstan	Den Sooluk National Health Reform Program in the Kyrgyz Republic (2012-2016)	Health
Central Asia	Tajikistan	Programme on the Response to the Epidemic of HIV in the Republic of Tajikistan (2007-2010)	Health
Central Asia	Uzbekistan	Welfare Improvement Strategy (2013-2015)	Development
Central Asia	Uzbekistan	Public Health Strategy (2010-2020)	Health
Eastern Asia	Mongolia	Health Sector Strategic Master Plan (2006-2015)	Development
Eastern Asia	Mongolia	National Strategic Plan on HIV, AIDS and STIs (2010-2015)	Health
Southern Asia	Afghanistan	National Development Strategy (2008-2013)	Development
Southern Asia	Afghanistan	Health & Nutrition Sector Strategy (2007-2012)	Health
Southern Asia	Afghanistan	National Public Nutrition Policy & Strategy 1388-1392 (2009-2013)	Health
Southern Asia	Afghanistan	National Strategic Framework for HIV / AIDS (2006-2010)	Health
Southern Asia	Afghanistan	National Strategic Framework on HIV/AIDS for Afghanistan (2011-2015)	Health
Southern Asia	Afghanistan	Strategic Plan for the Ministry of Public Health (2011-2015)	Health
Southern Asia	Afghanistan	National Reproductive Health Policy (2012-2016)	SRH
Southern Asia	Afghanistan	National Child and Adolescent Health Policy (2009-2013)	Youth
Southern Asia	Afghanistan	National Youth Policy (2014)	Youth
Southern Asia	Bangladesh	Health, Population and Nutrition Sector Development Program (2011-2016)	Development
Southern Asia	Bangladesh	3rd National Strategic Plan for HIV and AIDS Responses (2011-2015)	Health
Southern Asia	Bhutan	Eleventh Five Year Plan (2013-2018)	Development
Southern Asia	Bhutan	National Health Policy (2011)	Health
Southern Asia	Bhutan	Adolescent Health Programme (2013-2018)	Youth
Southern Asia	Bhutan	National Youth Policy (2011)	Youth
Southern Asia	India	Twelfth Five Year Plan (2012-2017)	Development
Southern Asia	India	The National AIDS Control Programme Phase III (2007-2012)	Health
Southern Asia	India	National Youth Policy (2014)	Youth
Southern Asia	Maldives	Health Master Plan (2006-2015)	Health
Southern Asia	Nepal	Health Sector Programme - Implementation Plan II (NHSP-IP 2) (2010-2015)	Health
Southern Asia	Nepal	National AIDS/STI Policy (2011)	Health
Southern Asia	Nepal	National HIV/AIDS Strategy (2011-2016)	Health
Southern Asia	Nepal	National Youth Policy (2010)	Youth
Southern Asia	Pakistan	National HIV and AIDS Strategic Framework (2007-2012)	Health
Southern Asia	Pakistan	Punjab Youth Policy (2012)	Youth
Southern Asia	Pakistan	Sindh Youth Policy (2012)	Youth
Southern Asia	Sri Lanka	Health Master Plan (2007-2016)	Health
Southern Asia	Sri Lanka	National HIV AIDS/Strategic Plan (2007-2011)	Health
Southern Asia	Sri Lanka	National Policy on HIV and AIDS in the World of Work in Sri Lanka (2010)	Health
Southern Asia	Sri Lanka	National Youth Policy (2014)	Youth
South-eastern Asia	Cambodia	Health Strategic Plan (2008-2015)	Development
South-eastern Asia	Cambodia	Revised National Strategic Plan II for a Comprehensive & Multi-Sectoral Response to HIV/AIDS (2008-2010)	Health
South-eastern Asia	Cambodia	National Policy on Youth Development (2011)	Youth
South-eastern Asia	Indonesia	National HIV and AIDS Strategy and Action Plan (2010-2014)	Health
South-eastern Asia	Lao People's DR	Five-Year Health Sector Development Plan (2011-2015)	Health
South-eastern Asia	Lao People's DR	National Strategy and Action Plan on HIV/AIDS/STI (2006-2010)	Health
South-eastern Asia	Malaysia	National Strategic Plan on HIV and AIDS (2011-2015)	Health
South-eastern Asia	Philippines	Strategic Plan on HIV and AIDS (2011-2016)	Health
South-eastern Asia	Thailand	HIV AIDS Strategy (2012-2016)	Health
South-eastern Asia	Thailand	National Child and Youth Development Plan (2012-2016)	Youth
South-eastern Asia	Timor-Leste	National Reproductive Health Strategy (2004-2015)	SRH
South-eastern Asia	Vietnam	Five-Year Health Sector Development Plan (2011-2015)	Health
South-eastern Asia	Vietnam	National Strategy on HIV AIDS (2010-2020)	Health
South-eastern Asia	Vietnam	Vietnamese Youth Development Strategy (2011-2020)	Youth
Western Asia	Armenia	Strategy on Maternal and Child Health Care (2003-2015)	Health
Western Asia	Azerbaijan	The State Program on Youth (2011)	Youth
Western Asia	Cyprus	Youth Strategy (2010-2012)	Youth
Western Asia	Georgia	Youth Policy (2014)	Youth
Western Asia	Lebanon	National Youth Policy (2012)	Youth
Western Asia	Oman	The 8th Five Year Plan for Health Development (2011-2015)	Development
Western Asia	Qatar	Youth Development Report (2012)	Youth
Western Asia	Saudi Arabia	The Ninth Development Plan (2010-2014)	Development
Western Asia	Turkey	Strategic Plan (2013-2017)	Health
Western Asia	Turkey	National Youth Policy (2013)	Youth
Western Asia	Yemen	National Youth Strategy (2006-2015)	Youth

APPENDIX D

Region	Country	Name of Policy	Policy Focus
Caribbean	Antigua & Barbuda	National Business Plan for Health (2008-2010)	Health
Caribbean	Antigua & Barbuda	National Strategic Plan for HIV/AIDS (2012-2016)	Health
Caribbean	Bahamas	National Health System Strategic Plan (2010-2020)	Health
Caribbean	Barbados	National HIV Prevention Plan (2010)	Health
Caribbean	Barbados	National Strategic Plan (2005-2025)	Health
Caribbean	Barbados	National Strategic Plan for the Prevention and Control of HIV (2008-2013)	Health
Caribbean	Barbados	National Youth Policy (2011)	Youth
Caribbean	Dominica	Fourth Medium-Term Growth and Social Protection Strategy (2014-2018)	Development
Caribbean	Grenada	National HIV/AIDS Strategic Plan (2012-2016)	Health
Caribbean	Jamaica	HIV and AIDS National Strategic Plan (2007-2012)	Health
Caribbean	St Kitts & Nevis	National Strategic Plan for HIV/AIDS (2009-2013)	Health
Caribbean	St Kitts & Nevis	National Youth Policy - Draft (2010)	Youth
Caribbean	St Vincent & Grenadines	HIV and AIDS National Strategic Plan (2010-2014)	Health
Caribbean	Trinidad & Tobago	National Youth Policy (2012-2017)	Youth

APPENDIX E

Region	Country	Included in Final Data Set
Eastern Africa	British Indian Ocean Territory	Dependent Territory
Eastern Africa	Burundi	
Eastern Africa	Comoros	
Eastern Africa	Djibouti	
Eastern Africa	Eritrea	
Eastern Africa	Ethiopia	
Eastern Africa	French Southern Territories	Dependent Territory
Eastern Africa	Kenya	
Eastern Africa	Madagascar	
Eastern Africa	Malawi	
Eastern Africa	Mauritius	
Eastern Africa	Mayotte	Dependent Territory
Eastern Africa	Mozambique	
Eastern Africa	Réunion	Dependent Territory
Eastern Africa	Rwanda	
Eastern Africa	Seychelles	
Eastern Africa	Somalia	
Eastern Africa	South Sudan	
Eastern Africa	Tanzania	
Eastern Africa	Uganda	
Eastern Africa	Zambia	
Eastern Africa	Zimbabwe	
Middle Africa	Angola	
Middle Africa	Cameroon	
Middle Africa	Central African Republic	
Middle Africa	Chad	
Middle Africa	Congo	
Middle Africa	Democratic Republic of the Congo	
Middle Africa	Equatorial Guinea	
Middle Africa	Gabon	
Middle Africa	São Tomé and Principe	
Northern Africa	Algeria	
Northern Africa	Egypt	
Northern Africa	Libya	
Northern Africa	Morocco	
Northern Africa	Sudan	
Northern Africa	Tunisia	
Northern Africa	Western Sahara	

APPENDIX E CONT.

Region	Country	Included in Final Data Set
Southern Africa	Botswana	
Southern Africa	Lesotho	
Southern Africa	Namibia	
Southern Africa	South Africa	
Southern Africa	Swaziland	
Western Africa	Benin	
Western Africa	Burkina Faso	
Western Africa	Cabo Verde	
Western Africa	Côte d'Ivoire	
Western Africa	Gambia	
Western Africa	Ghana	
Western Africa	Guinea	
Western Africa	Guinea-Bissau	
Western Africa	Liberia	
Western Africa	Mali	
Western Africa	Mauritania	
Western Africa	Niger	
Western Africa	Nigeria	
Western Africa	Saint Helena	Dependent Territory
Western Africa	Senegal	
Western Africa	Sierra Leone	
Western Africa	Togo	

APPENDIX F

Region	Country	Included in Final Data Set
Central Asia	Kazakhstan	
Central Asia	Kyrgyzstan	
Central Asia	Tajikistan	
Central Asia	Turkmenistan	
Central Asia	Uzbekistan	
Eastern Asia	Democratic People's Republic of Korea (North Korea)	
Eastern Asia	Mongolia	
Eastern Asia	People's Republic of China	
Eastern Asia	Republic of Korea (South Korea)	
Southern Asia	Afghanistan	
Southern Asia	Bangladesh	
Southern Asia	Bhutan	
Southern Asia	India	
Southern Asia	Iran	
Southern Asia	Maldives	
Southern Asia	Nepal	
Southern Asia	Pakistan	
Southern Asia	Sri Lanka	
South-eastern Asia	Brunei Darussalam	
South-eastern Asia	Cambodia	
South-eastern Asia	Indonesia	
South-eastern Asia	Lao People's Democratic Republic	
South-eastern Asia	Malaysia	
South-eastern Asia	Myanmar	
South-eastern Asia	Philippines	
South-eastern Asia	Singapore	
South-eastern Asia	Thailand	
South-eastern Asia	Timor-Leste (East Timor)	
South-eastern Asia	Vietnam	

APPENDIX F CONT.

Region	Country	Included in Final Data Set
Western Asia	Armenia	
Western Asia	Azerbaijan	
Western Asia	Bahrain	
Western Asia	Cyprus	
Western Asia	Georgia	
Western Asia	Iraq	
Western Asia	Israel	
Western Asia	Jordan	
Western Asia	Kuwait	
Western Asia	Lebanon	
Western Asia	Oman	
Western Asia	Qatar	
Western Asia	Saudi Arabia	
Western Asia	State of Palestine	
Western Asia	Syrian Arab Republic	
Western Asia	Turkey	
Western Asia	United Arab Emirates	
Western Asia	Yemen	

APPENDIX G

Region	Country	Included in Final Data Set
Caribbean	Anguilla	Dependent Territory
Caribbean	Antigua and Barbuda	
Caribbean	Aruba	Dependent Territory
Caribbean	Bahamas	
Caribbean	Barbados	
Caribbean	Bonaire, Sint Eustatius and Saba	Dependent Territory
Caribbean	British Virgin Islands	Dependent Territory
Caribbean	Cayman Islands	Dependent Territory
Caribbean	Cuba	
Caribbean	Curaçao	Dependent Territory
Caribbean	Dominica	
Caribbean	Dominican Republic	
Caribbean	Grenada	
Caribbean	Guadeloupe	Dependent Territory
Caribbean	Haiti	
Caribbean	Jamaica	
Caribbean	Martinique	Dependent Territory
Caribbean	Montserrat	Dependent Territory
Caribbean	Puerto Rico	Dependent Territory
Caribbean	Saint Kitts and Nevis	
Caribbean	Saint Lucia	
Caribbean	Saint Maarten	Dependent Territory
Caribbean	Saint Martin	Dependent Territory
Caribbean	Saint Vincent and the Grenadines	
Caribbean	Saint-Barthélemy	Dependent Territory
Caribbean	Trinidad and Tobago	
Caribbean	Turks and Caicos Islands	Dependent Territory
Caribbean	United States Virgin Islands	Dependent Territory