

Introduction

North American studies demonstrate that sexual minority youth (SMY) have poorer sexual health across various outcomes than their heterosexual counterparts. This was observed in SMY's more frequent early sexual initiation, sexually transmitted diseases, unprotected sexual intercourse, pregnancy involvement, non-consensual sex, sexual abuse and dating violence victimisation (e.g. Goodenow et al., 2008; Saewyc et al., 2008). However, evidence for such disparities in other cultures is largely missing, and cross-cultural comparisons are practically non-existent. The available evidence suggests that both-gender attracted or bisexually identifying youth face even more burden than exclusively same-gender attracted youth, or youth identifying as lesbian or gay.

In this study, we compared rates of sexual initiation, early first sex (under the age of 14), and lack of condom and contraceptive pill use at last sexual intercourse, in SMY and non-minority youth in eight European countries.

Based on earlier findings in the international literature on SMY, we predicted that sexual minority youth, especially those attracted to both-gender partners, will be more likely to report sexual initiation and early sexual debut, while they will be less likely to report condom or pill use compared to their non-minority peers. We anticipated that gender and social class, to some extent, would influence these associations.

Method and sample

Nationally representative subsamples of adolescents participating in the 2018 Health Behaviour in School-aged Children (HBSC) study (Inchley et al., 2018) in France, Hungary, Ireland, Moldova, Netherlands, Spain, North Macedonia and England, were analysed ($N = 11,548$; mean age: 15.48 ± 0.36 years; 51.8% girls).

Statistical analyses were carried out in SPSS 25. Sexual health outcomes, highlighted in bold in **Figure 1**, were compared across five groups: (1) attracted to opposite-gender, (2) same-gender, (3) both-gender partners, (4) not attracted, (5) no response to the question on attraction (Költő et al, 2018). Binary logistic regression models were built, first to compare romantic attraction groups (univariate models), then adjusted for gender, family affluence and country (multivariate models).

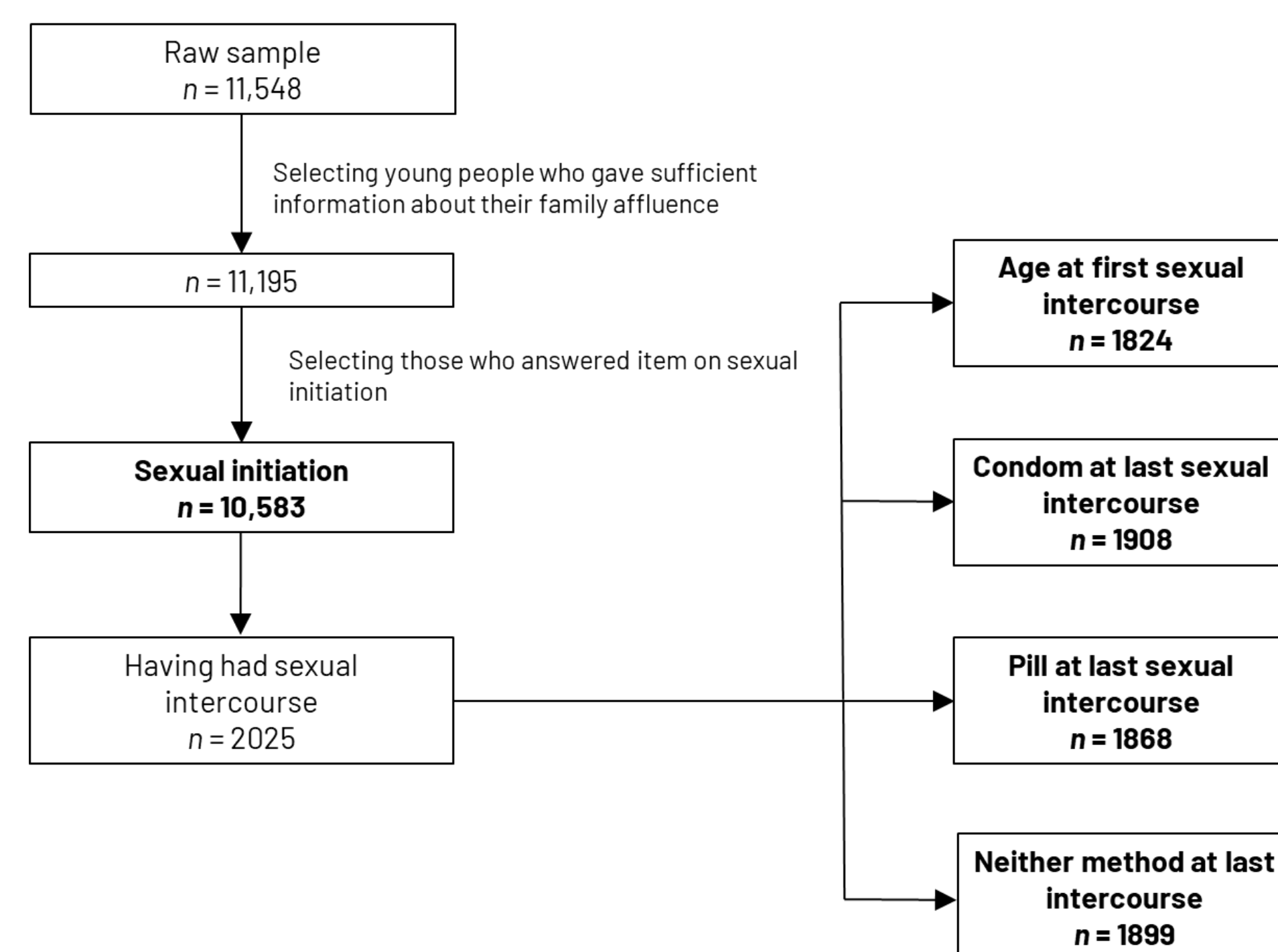


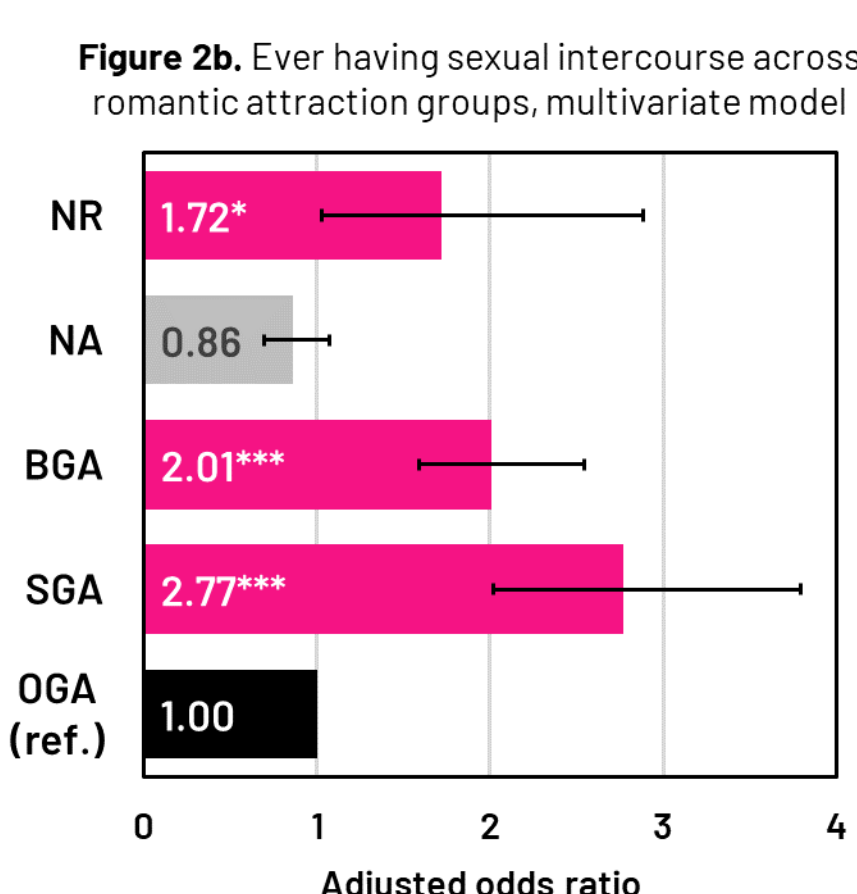
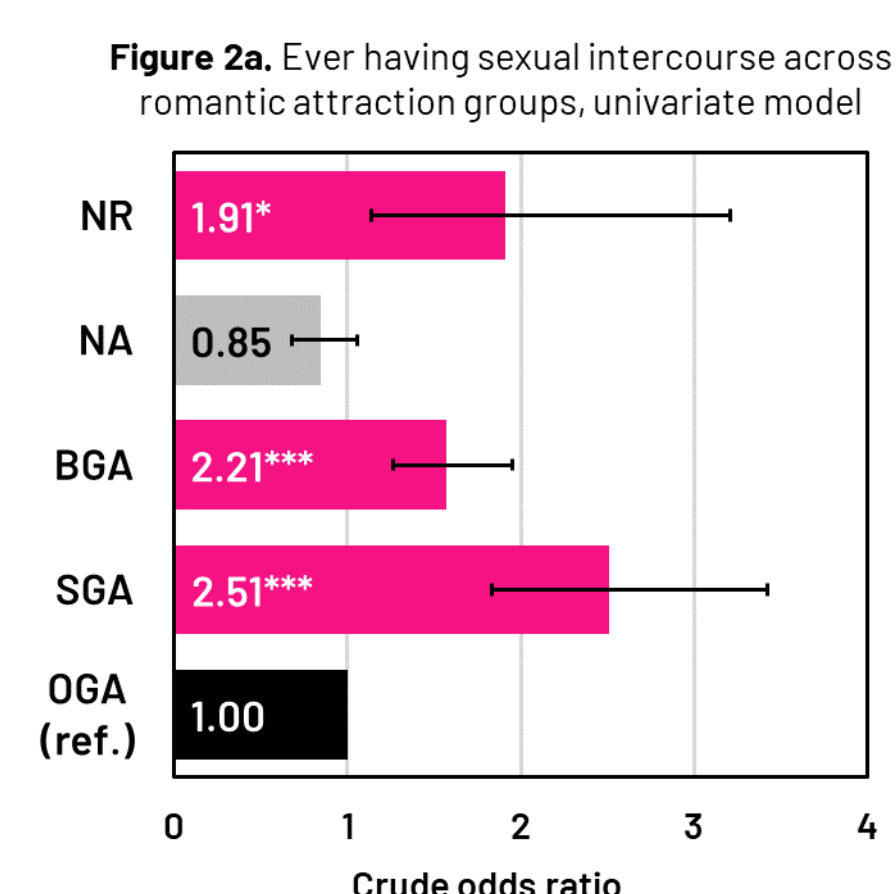
Figure 1. Sample selection flowchart. Bolded text indicates mark the five sexual health outcomes analysed in the study.

Sexual behaviour in sexual minority and non-minority young people in eight European countries

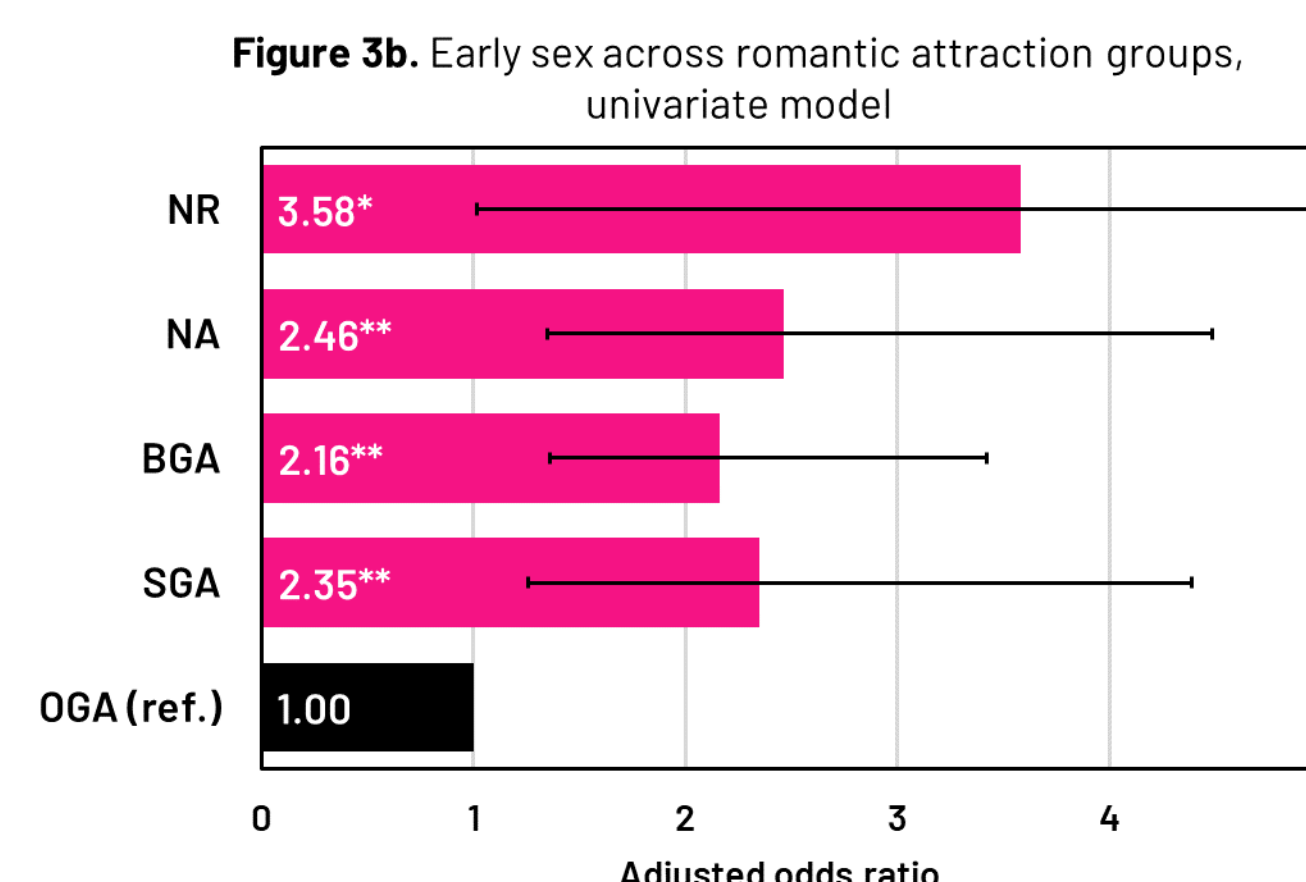
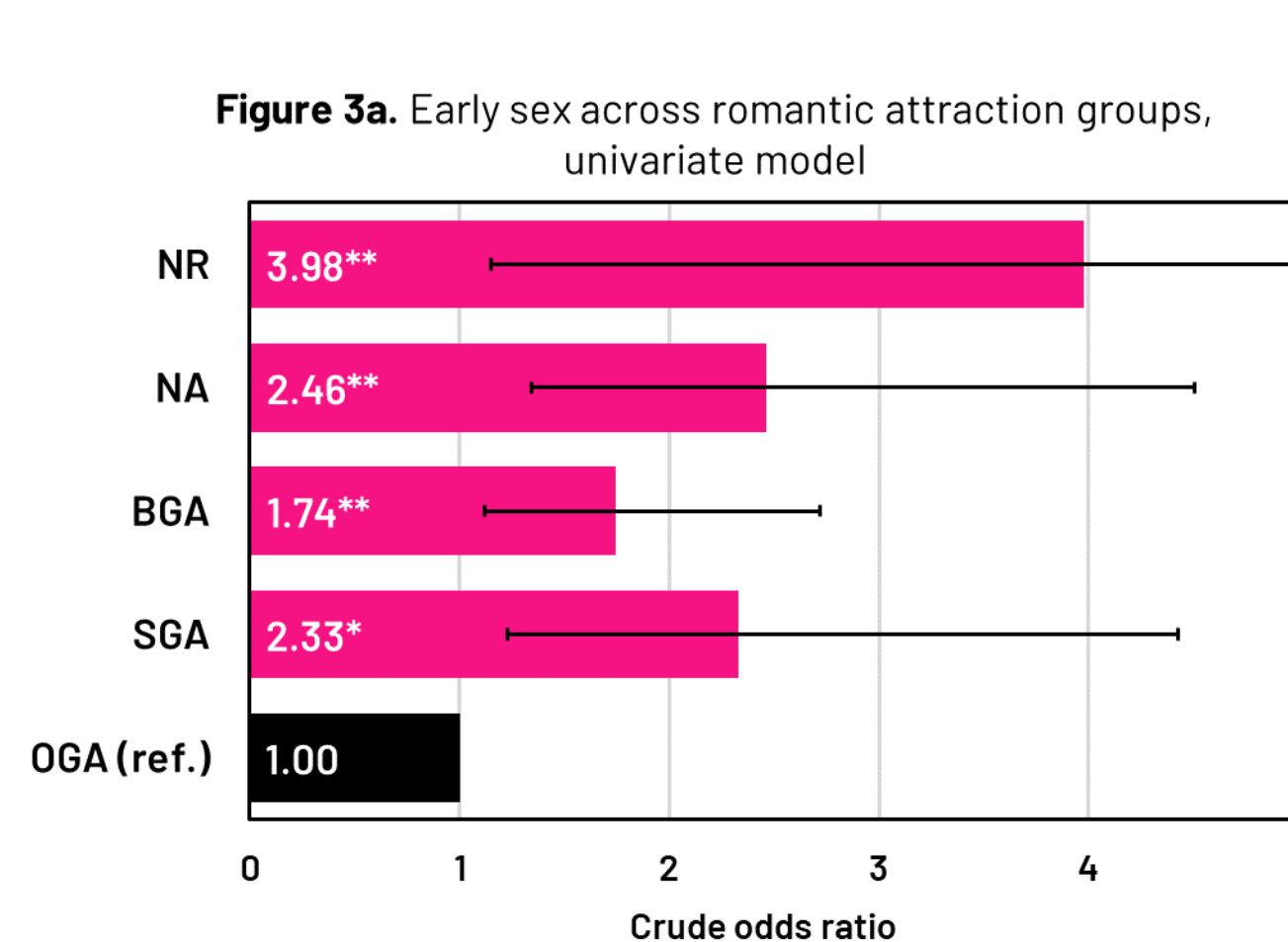
András Költő^{1*}, Honor Young², Emmanuelle Godeau³, Elizabeth M. Saewyc⁴ and Saoirse Nic Gabhainn¹

¹Health Promotion Research Centre, National University of Ireland Galway, Galway, Ireland. ²School of Social Sciences, Cardiff University, Cardiff, Wales. ³EHESP School of Public Health, Rennes, France. ⁴Stigma and Resilience Among Vulnerable Youth Centre, University of British Columbia, Vancouver, Canada. *Correspondence: andras.kolto@nuigalway.ie

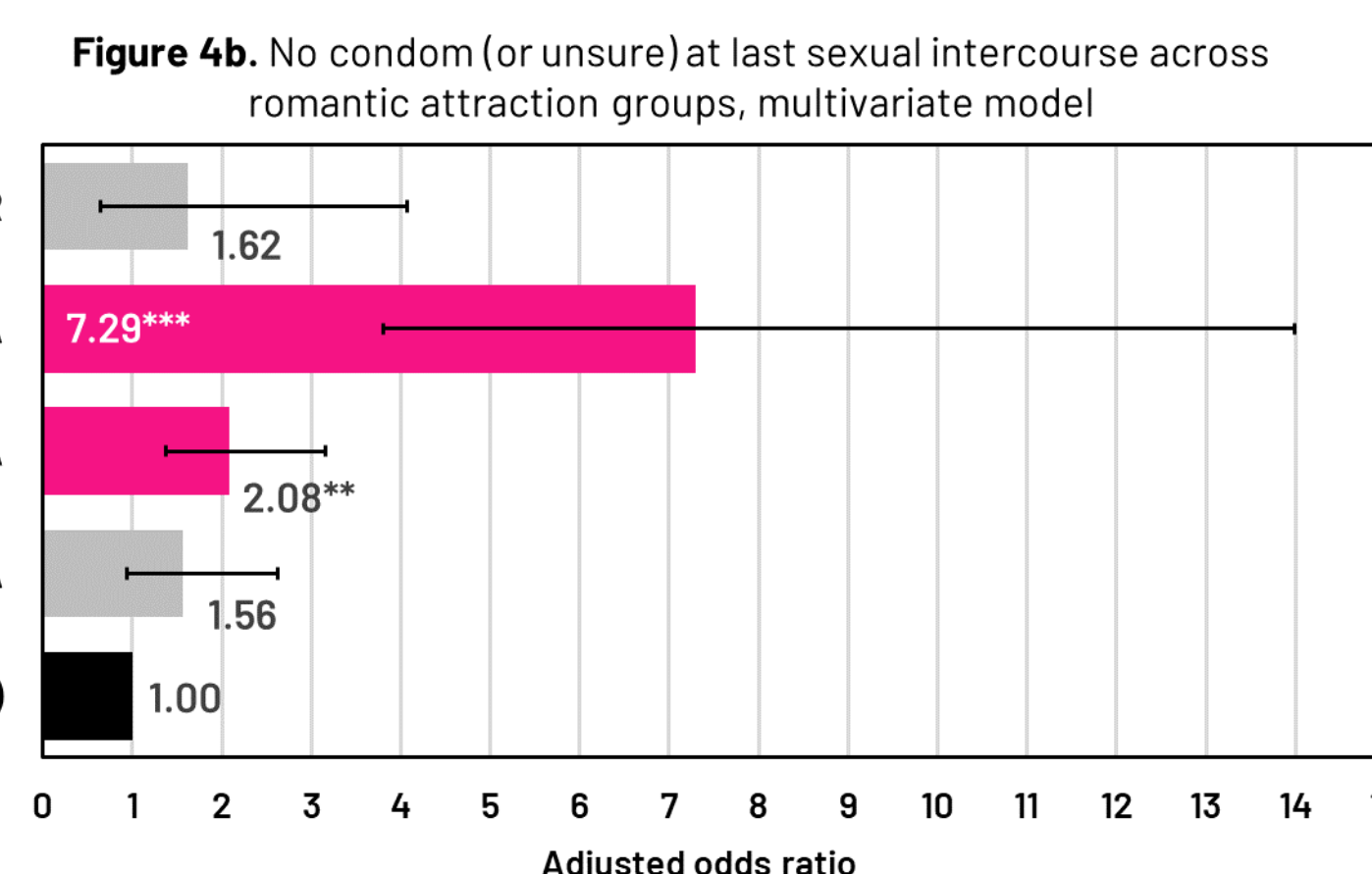
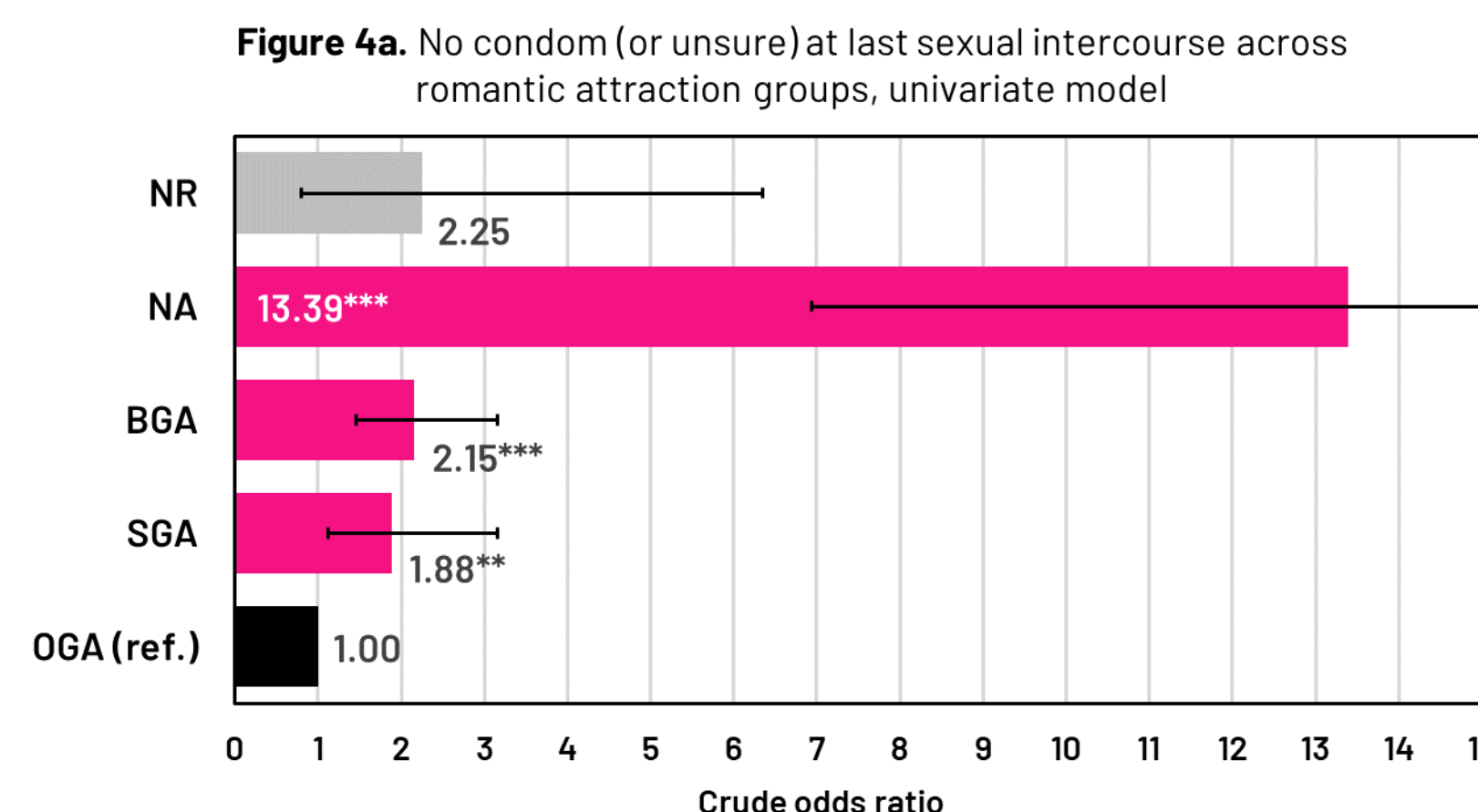
Results



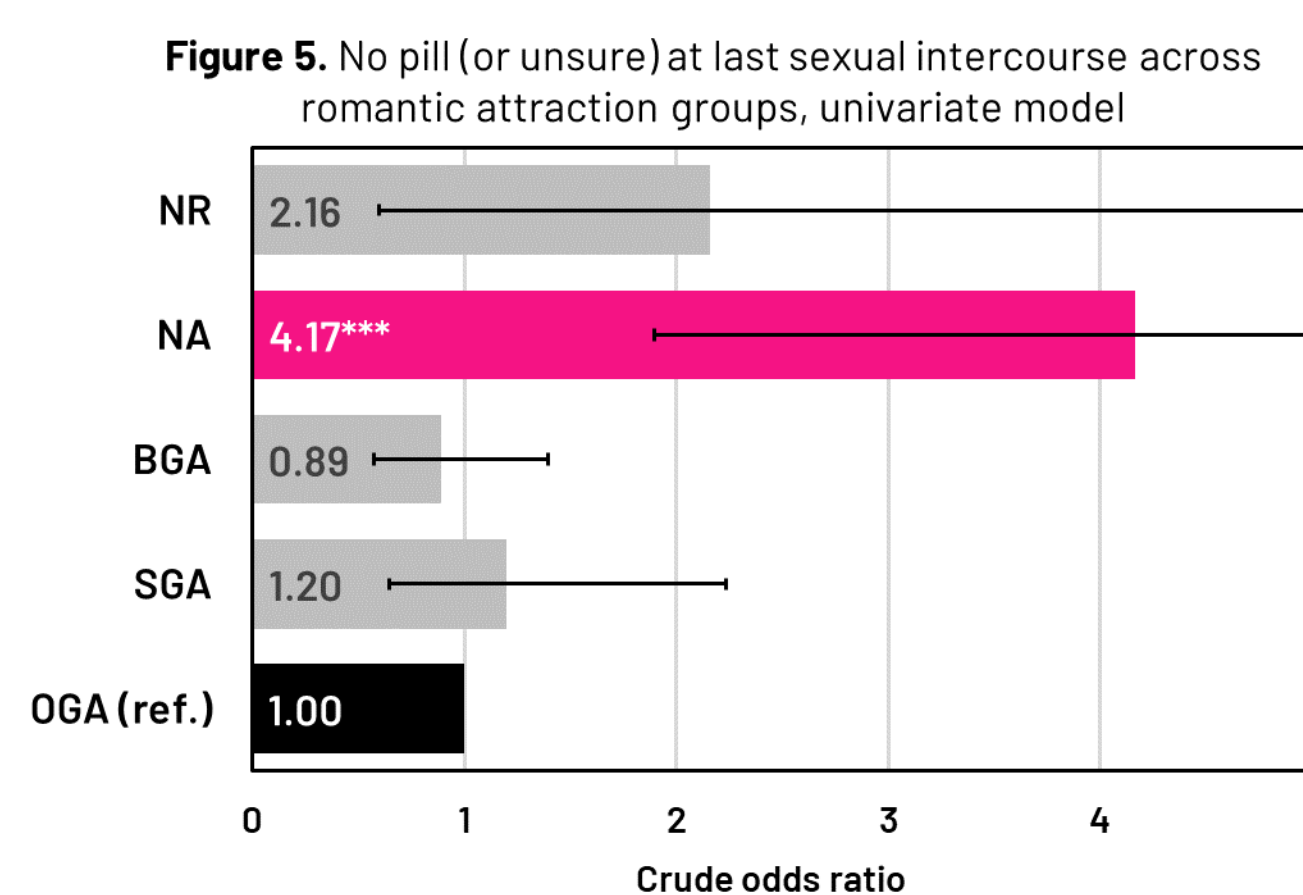
Binary logistic models revealed that compared to their opposite-gender attracted (OGA) peers, adolescents reporting same-gender attraction (SGA) or both-gender attraction (BGA), and non-responders (NR) had two times or higher odds of having had sexual intercourse. Those who had not been attracted to anyone (NA) had statistically similar odds of sexual intercourse (**Figure 2a**). Adjusting the model for sociodemographic variables did not result in substantial changes in the odds ratios (**Figure 2b**).



Compared to their opposite-gender attracted peers, adolescents in all other groups had 2-4 times higher odds for early sexual intercourse (**Figure 3a**). Adjusting the model for sociodemographic variables did not result in substantial changes in the odds ratios (**Figure 3b**). Country did not have a significant contribution in the multivariate model.



Compared to their opposite-gender attracted peers, adolescents without attractions had 13 times higher odds, and both sexual minority groups around two times higher odds for not using a condom at last sexual intercourse or not being sure (**Figure 4a**). Adjusting the model for sociodemographic variables remarkably reduced the odds for not attracted adolescents, and rendered the odds for same-gender attracted adolescents insignificant (**Figure 4b**).



Compared to their opposite-gender attracted peers, adolescents without attractions had four times higher odds of not using contraceptive pill at last sexual intercourse or not being sure (**Figure 5**). Since none of the sociodemographic variables had a significant contribution to this effect, the multivariate model is not reported.

Note for figures 2a-5. * $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$. NR = No response. NA = Not attracted. BGA = Attracted to both-gender partners. SGA = Attracted to same-gender partners. OGA (ref.) = Attracted to opposite-gender partners (reference group). Error bars mark 95% confidence interval.



Discussion

The results indicate that SMY in Europe are more likely to report having had sexual intercourse and early sex. Same- and especially both-gender attracted youth are also disproportionately exposed to sexual health risk (lack of using condom at last sexual intercourse) compared to their non-minority peers. While from our data we cannot infer young people's motives for sexual risk-taking, we believe this disparity can be explained by stigma management processes (Saewyc et al., 2008).

Not being attracted to anyone was found to be the strongest risk factor for early and unprotected sex. This finding echoes those of Manning et al. (2005), who found that around 60% of sexually active teenagers have had sex in *both* romantic and non-romantic contexts, and their normative beliefs had a strong impact on non-romantic sexual activity.

These findings flag an urgent need to revisit sexuality and relationships education in multiple European countries, to make it more inclusive of sexual and gender minorities. We also need to explore in depth how attraction, or its lack, is related to the sexual experiences of adolescents.

References

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