FACULTY OF MEDICINE

Factors associated with male youth's utilization of youth clinics

–A cross-sectional study in southern Sweden

Master's thesis in Public Health

June 2022

Student: Stella Hedlund

Supervisor: Jesper Sundewall, Associate Professor

Division of Social Medicine and Global Health, Department of Clinical Sciences, Malmö

Innehållsförteckning

Abstract

Background: Sweden has a long-standing tradition of youth-friendly services focusing on sexual, reproductive and mental health. Currently, they are mainly targeting and being used by girls and young women. Little is known about what motivates and prevents boys and young men from seeking out and utilising health services, including the youth clinics. This study therefore aimed to investigate factors associated with male youth's utilization of youth clinics.

Methods: This cross-sectional study used survey data collected in March-April of 2022, including 175 male youths living in Skåne, Sweden. Data analysis was conducted using binary and multivariate logistic regressions, with experience of visiting a youth clinic as the outcome measure.

Results: Being or having been sexually active were the strongest predictors of youth clinic experience. Only recent sexual activity remained significant when adjusted for other individual characteristics. Talking to others about one's health, valuing access to mental health services, feeling one has access to sexual health services, and age were marginally correlated to the outcome. Apart from these correlations, no clear patterns were revealed. There were little or no associations between youth clinic experience and perceived service needs, perceived access to services, and knowledge of where to access services. When adjusted for each other, some factors encouraging or discouraging the use of health services could significantly predict the experience of visiting a youth clinic ($p<0.001$). These included; having previously refrained from seeking out health services; ability to talk to others about one's health; being sexually active; and having relationship experience.

Conclusion: Being sexually active strongly predicts experience of vising a youth clinic. However, overall few significant associations were revealed. Further research is needed to gain deeper insight into the factors underlying the observed associations, their causal directions, and the lack of associations found.

1. Introduction

The years of adolescence are critical for the individual's biological, psychological, and social development. They lay the foundation of an individual's future physical, emotional, psychological and sexual health and wellbeing. The development and growth of young people have implications that will resonate across generations (1–3). However, young people are vulnerable to certain health problems, in particular related to sexual and reproductive health. Easy access to quality health services is therefore key to providing young people with the tools to gain the highest attainable standard of health and recognise and protect their human rights (2,3).

Ill mental health is a leading cause of morbidity and mortality among youths, sometimes creating long-term morbidity and a substantial burden on individuals and society (4). Other youth health risks include interpersonal violence; substance use; lifestyle factors such as inactivity and poor diet, leading to obesity and overweight as well as undernutrition; sexual and reproductive health issues, including sexual development - identity and expression, sexually transmitted infections (STI), including HIV/AIDS, contraception, pregnancies and abortion (5). Young people's health and health-seeking-behaviour will be largely affected by social factors and conditions (6). The adverse health outcomes that they are predominantly affected by will therefore vary with age, gender and socioeconomic status (3). Although at large the health of youths in Sweden is improving, structural differences in unequal subjection to risk factors and experiences of adverse health outcomes are still seen across different genders, socioeconomic backgrounds, sexualities and gender identities (7,8).

Despite increasing efforts to improve young people's health through research, policy, and programme development, globally, many efforts and interventions have failed to include or address male youth's health and support needs. Therefore, their sexual and reproductive health and rights (SRHR)-and mental health needs often remain unaddressed and unfulfilled, and their experiences and realities are to a large extent missing in public health efforts. This is due to a combination of factors.

Firstly, health-seeking behaviour among boys and men is generally poor. They seek preventive health services and healthcare to a much lower degree than girls and women, especially primary

health care (9,10). On a global scale, primary health clinics that are perceived as mainly serving girls and women have shown to increase the risk that boys and men avoid them (11). It means that even if there are youth-friendly services available, they might not be considered male-friendly and will not be utilised by boys and men if they are not perceived as acceptable and appropriate to male youths specifically (9,12). Estimates from the Swedish youth clinics show that as much as 85-90 per cent of their visits are made by girls and young women (1,13). To a considerable extent, they are also staffed only by female professionals (14). These two factors enforce a common perception of the youth clinics as 'women and girls clinics' (15–17).

Secondly, in many countries health policies and programmes are lacking sufficient effort to proactively engage boys and men in sexual and reproductive health services (11). Existing sexual and reproductive health (SRH) services have largely failed to address the specific health needs of boys and men, and many health services are primarily designed according to girls' and womens' needs (18–20). This pattern has been observed in the Swedish YC, where most targeted interventions are tailored and directed toward female youths and their needs (21).

Furthermore, health care services and professionals have continuously shown to be gendered in SRH matters. Health care professionals are, for example, more prone to enquire about female patients' sexual health and wellbeing compared to male patients (20,22,23). An extensive report from Sweden describes that many boys and men seeking sexual and reproductive healthcare do not receive the care or support they were hoping for (8). Statistics also suggest that boys and men are strikingly underserved in mental health care compared to their needs (10,24). One reason for this might be low awareness and preparedness within the healthcare system on discovering and understanding signs of ill mental health amongst boys and men (10,25).

Third, research literature that focuses specifically on boys and young men is limited, and therefore comparatively little is known about the SRH and mental health needs and vulnerabilities of boys and young men (26,27). The research literature is scarce looking at a Swedish context as well. A limited amount of studies have been done investigating the perspective of male youths, their experiences of the youth clinics and the issues of low boys and men visiting rates at youth clinics (28,29). A few have focused on the perspective of professionals possessing experience in the population. Investigating their perspective on the low numbers of boys and men at the youth clinics, and counsellors' experiences of boys and men seeking mental health support at the youth clinics (30,31). One study has been conducted,

interviewing both professionals and young men about boys' and men's difficulties with seeking mental health support at the youth clinic (32).

The Swedish Public Health Agency's report from 2017 gives a valuable overview of some of the current service-seeking patterns and behaviours amongst young people, including boys and men aged 16-29 in Sweden. It, for example, tells us something about who and where young people generally turn for information and support and how this somewhat differs between boys/young men and girls/young women (13). Furthermore, through an extensive report, the Swedish Association of Local Authorities and Regions (*Swe* SKR) has mapped recommendations on how to strengthen the role and work of the youth clinics. Their report emphasises the importance of systematically strengthening the accessibility and acceptability of services among all groups of youths, especially among those not easily reached today, such as male youths (1).

However, the low visibility of male youths in sexual and reproductive health research means that we miss out on critical information about this population's needs and realities. Consequently, we also miss to include them in health care services and standards, health promotion efforts and health policies. Furthermore, it affects the extent to which health care services and programmes are evidence-based and meet this population's needs and expectations (26). Therefore, there is arguably a need for increased research on male youths' needs and health-seeking behaviours related to their mental, sexual and reproductive health.

While we know that male youths seek out health services to a much lower extent than their female counterparts, including services provided by youth clinics - we lack knowledge about what factors that are associated with their utilization of youth clinics.

1.2 Aim and research questions

This study aims to investigate factors associated with male youths' utilization of youth clinics. More specifically I am seeking to answer the following two research questions:

1. To what extent do male youths utilize the youth clinics?
2. What factors are associated with male youth's utilization of youth health services?

2. Background

The following section provides further background information, introducing the concept of youth or youth-friendly services, and an overview of Sweden's answer to this concept —the youth clinics. A brief account is also provided of a gender perspective on boys' and men's sexual and reproductive health, and why the failure to adequately address and meet the healthcare and support needs of this population continues to implicate a risk for the extent to which boys and young men are aware of, and take responsibility for, issues related to their health. Bearing consequences for their own health as well as that of their partners and families.

2.1 Youth-friendly services

As the WHO has continuously emphasised the health of adolescents and youths, the awareness and understanding of these population's vulnerability and health needs have increased on a global scale. In 1995 the Common Agenda on Action for Adolescent Health pointed toward the importance of addressing young people's health and development needs globally. The Agenda's goals being to promote healthy development in young people, and prevent and respond to health problems if and when they arise (33). Furthermore, in 2016 adolescent health and development were specially recognised together with that of women and children in the Global Strategy for Women's, Children's and Adolescents' Health, developed as part of the UN's Agenda 2030 (34).

It has become increasingly recognised that low threshold services for adolescents and youths are essential for ensuring that they obtain the health services they need to improve and protect their health and well-being (3,35). It includes sexual and reproductive health services in particular (3,35). Not all barriers to obtaining health services will be limited to affecting adolescents and youths only, but some are. To improve the delivery of health services for these populations, the WHO developed a quality framework —stating that services should be

accessible, acceptable, equitable, appropriate, and effective to be considered 'adolescent or youth-friendly' (35).

2.1.1 Youth Clinics —youth-friendly services in Sweden

Since the 1970s, youth clinics (*Swe* Ungdomsmottagningar) has been a key provider of youth-friendly health services nationally in Sweden. They aim to offer young people medical and psychosocial support and care, with a holistic and salutogenic focus on their mental, sexual and reproductive health (36). The youth clinics commonly welcome young people aged 12-25, although the age limits will vary between regions, clinics and services.

Most youth clinics are organised under, and members of, a national nonprofit association (Swedish Society for Youth Clinics, *Swe* FSUM), whose purpose is to stimulate and support the individual youth clinics. FSUM has developed a handbook to guide the member clinics and provide guidelines and recommendations on competency and objectives. The guidelines have, however, no official status and are not legally binding. There is still no clear definition of what a youth clinic is, although FSUM states that a clinic should have at least a midwife, doctor, psychologist, or counsellor to be considered a youth centre. The type of services and resources they provide therefore vary between clinics. There are currently 250 youth clinics, of which 220 are part of FSUM, spread over 290 Swedish municipalities (37). It has so far meant that the distribution of clinics varies significantly between different parts of the country, especially between larger cities and rural areas (1). Making inequitable access to services for young people a much-debated issue (38). Apart from the physical clinics, information and support are offered through a virtual clinic (www.umo.se) accessible everywhere. An immigrant-friendly version of this platform (www.youmo.se) is also available in six different languages, including Swedish.

2.2 Gender perspective on boys' and men's sexual and reproductive health

Women and girls have continuously carried the larger burden of responsibility for their own as well as their partner's and family's sexual and reproductive health, and are also disproportionally affected by the global burden of sexual and reproductive ill health (11,17,39). Particularly in relation to maternal morbidity and mortality, family-planning, menstrual-

hygiene, and sexual violance. Sexual and reproductive health have therefore since long been viewed as a matter primarily concerning women and girls (11,17,39). However, awareness has increased globally on the importance to recognize that there are sexual and reproductive health needs and vulnerabilities specific to boys and men that impact their mental, emotional and physical health and wellbeing. There is a growing global realisation that boys and men have substantial needs for information, skills, and access to services to reduce adverse health outcomes and increase quality of life. Both for themselves and their partners (24,26,40).

The 1994 Cairo International Conference on Population and Development (ICPD) Programme of Action states the importance of increased efforts to "encourage and enable men to take responsibility for their sexual and reproductive behaviour" and to "share responsibility with women in matters of sexuality and reproduction"(41). Especially if starting from a young age, it can help redefine gender roles, combat violence, and promote healthier and more equitable behaviours (42). The Swedish National Board of Health and Welfare also recognised the issue in their 2014 Basis for a National SRHR Strategy, stating that areas for future improvement include developing methods to better reach boys and men with preventative measures and support in SRHR matters (43). While women's autonomy in sexual and reproductive decision making must be protected, investing in boys' and men's SRHR is vital, and does not necessarily need to be done at the expense of girls' and women's SRHR (11).

Without undermining the rights of women and girls, appropriate and sufficient recognition and addressing of the right to health, including sexual and reproductive health, is a human right that includes boys and men in their own right. WHO states that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (44). This has since come to include the right to sexual and reproductive health as well (42,45).

Goals for boys' and men's SRH, must include, but also go beyond, the prevention and treatment of sexually transmitted infections (STIs), including HIV, and the prevention of unwanted pregnancies. It should also include access to information, support, and services for sexual and reproductive dysfunctions, sexual development and identity, and promotion of healthy relationships and behaviours (19). It also includes targeted support and services addressing young males' support needs related to their mental health (9).

It has become increasingly evident that engaging boys and men in SRHR is essential for developing and progressing in gender equality. A growing amount of evidence suggests that involving boys and men in SRHR can effectively improve equity, as well as, health outcomes across genders. Programmes working with a gender transformative approach have been especially successful in this (40,46). Gender norms and attitudes contribute to shaping boys' and mens' behaviours in ways that directly impact their family's and partner's health, as well as their own. Inequitable gender dynamics and harmful masculinities continue to sustain negative SRH outcomes for boys and men as well as girls and women (40). They have for example shown to be associated with boys and mens greater rate of perpetration of intimate partner violence and the controll over women's sexual-and reproductive decision making and access to SRH services (27). In turn, gender norms create power hierarchies that make many boys and men vulnerable. It can contribute to higher risk-behaviours and discourage help-and health seeking behaviours, which negatively impacts their mental, emotional, sexual and reproductive health (40,47).

Engaging boys and men as full partners in sexual and reproductive health (accompanied by a maintained focus on women's health and rights), and encouraging responsibility for and investment in their own health and health-seeking behaviour, is therefore imperative to successfully achieve the UN's sustainable development goals of health and well-being for all, as well as gender equality (40).

3. Method

3.1 Study setting and participants

No global consensus exists on the definition of adolescence and youth, although the United Nations and the WHO understand adolescence to include those aged 10-19 and youths aged 15-24, and young people aged 10-24 (48). Other international reports on young people's health have defined adolescence as the ages 10-24 (3). The terms are therefore sometimes interchangeable and the age ranges do overlap. In Sweden, no legal definitions of adolescence or youth exist, although the equivalent Swedish term may be defined as including individuals aged 13-25 (49,50). For this study, the age range 13-25 will be referred to as youths or young

people. Adolescence is however still used when describing WHO reports or documents, as this is the term predominantly used by them.

The study was conducted in Skåne, Sweden's southernmost regional county. Skåne has approximately 1.39 million inhabitants, of which 61 200 are between the ages 15-22 and 31 800 of these are male (51). The youth clinics in Skåne are part of the primary health care system and they cater to young people aged 12-22. There are currently 11 physical clinics spread out over five major cities in Skåne, and they also offer video and chat consultations via the online platform 'umo.se' (52). About 13% of visits made at the youth clinics in 2017 were by male visitors (53).

Youths aged 15-22, who identify as male, are Swedish speaking, and live in Skåne were invited to participate in the study. This age group was selected based on ethical considerations and the regional youth clinics' official age limits. A convenience and voluntary response sampling strategy was applied. Participants were recruited at a public upper secondary school, two non-profit organisations for children and youth, and a military regiment. In addition, posters and information sheets were put up in public places and shared on various social media channels like Facebook and Instagram (see appendix). The information materials included a short description of the study and a link to the survey including written information stating the purpose of the study and the rights of the participant – such as the ability to withdraw from the study at any point, and its anonymous nature. Participants were included based on their willingness to participate and fulfilment of the inclusion criteria. The inclusion criteria were that they identify as male, are within the stated age range, and currently reside in Skåne. Participants were asked to confirm that they fulfilled the criteria before starting the survey. Individuals failing to give their informed consent were excluded from the study at the sampling stage.

3.2 Data source and study design

This cross-sectional study was based on data collected in Skåne, Sweden from March to April 2022. The data was collected using a self-administered questionnaire, containing 22 questions of which 15 were included in the study. These belonged to four main areas: (1)

sociodemographics; (2) perceived service needs and access to support and care; (3) previous experiences of health-seeking; (4) sexual activity and relationship status.

The survey (see appendix) was adapted from the WHO's 'illustrative questionnaire for interview surveys with young people (54). Since the WHO questionnaire is an interview guide rather than a survey, the questions had to be modified for this survey. Questions on relationship and sexual activity experience were adapted to fit the intended survey format. As were the questions on religiosity. The question on subjective socioeconomic status was adopted from surveys used by The Public Health Agency of Sweden. The remaining parts of the survey were developed following a literature search to identify relevant content specific to the aim and objectives and have not been validated. All questions were subjected to quality testing by individuals from the study population- giving feedback on the content and nature of the questions and the structure and time of completing the survey.

First, a draft for the survey was developed, which was pilot tested on a group of male youths. They were asked to go through the survey individually and answer the questions, although no answers were collected or reviewed. Afterwards, participants were interviewed about their thoughts, feelings and opinions of the questions and overall survey. Adjustments to the survey draft were made according to the given feedback. The questionnaire was kept as brief as possible to increase the chance of participants being willing to participate and completing the questionnaire. This is important for reducing the risk of selection bias and information bias.

3.4 Conceptualization of variables

As mentioned above, some of the questions in the survey were adapted from WHO and the Public Health Agency of Sweden, whereas other questions were constructed for this survey based on the literature. This section describes how the main outcome variable and other covariates were conceptualized.

3.4.1 Main outcome variable

Utilization of the youth clinics was assessed through the question ' Have you ever visited a youth clinic'. The response alternatives for this question were 'Yes', 'No' and 'Do not

know/Unsure'. They were then dichotomized as 'Yes' for everyone that answered 'Yes', and 'No' for everyone that answered 'No' or 'Do not know/Unsure'.

3.4.2 Sociodemographic covariates

The factors controlled for in this study were considered after reviewing previous public health research on youths and youths' SRH. The included variables age, subjective socioeconomic status, birth country for participants and their parents, and religiosity have previously been associated with lower SRH health-seeking or youth clinic utilization.

3.4.2.1 Age

For the question age, respondents were asked to fill in their current age in years, ranging from 15-22. This variable was not further dichotomised.

3.4.2.2 Birth country

Previous research has suggested that youths born outside Sweden, or with parents born outside Sweden, generally seek out the youth clinics' services to a lower extent than other Swedish youths (1,16,72). For this reason it would be of interest to control for birth country of both participants and their parents. Participants' birth country was assessed with the question 'What country are you born in', with the response alternatives 'In Sweden', 'In Norway, Denmark, Finland or Iceland', 'Other country in Europe', 'Other country outside Europe'. Answers were dichotomized as 'Sweden' for those that answered 'In Sweden', and 'Other', for all the other response alternatives. Birth country of the parents were assessed the same way, with one response given per parent. These measures were then combined and dichotomized as 'Both parents born in Sweden', 'One parent born outside Sweden' and 'Both parents born outside Sweden'.

3.4.2.3 Subjective SES

Socioeconomic status (SES) is in adults normally measured through a combination of variables, such as income, education and occupation. There is less consensus on how to measure SES in students and young people. One option is using the same objective measures of parental SES, reported through the youth. However, the reliability of this method can be questioned, since youths' knowledge and awareness of such information might vary by a lot, increasing the risk of information bias. An alternative method that has gained increasing evidential support and

usage is subjective SES in studies exploring associations between SES and health outcomes (55–60). Subjective SES measures the individual's perception of theirs or their family's socioeconomic, financial, or social status. For this study subjective SES was measured using the likert scale question 'How would you describe the economic situation in your family', with response options being 'Very good', 'Fairly good', 'Not very good', 'Not good at all' and 'Do not know/unsure'. 'Very good' and 'Fairly good' were then dichotomised as 'Good', and the remaining responses as 'Poor'

3.4.2.4 Religiosity and spirituality

Religiosity or spirituality has in previous studies been shown to be associated with health service utilization. In particular those focusing on sexual and reproductive health (1,16,61–63). It is also included in the WHO's questionnaire on young people's sexuality. It was assessed using the single item question 'How religious or spiritual would you say that you are'. The response alternatives were, 'Very religious or spiritual', 'Partly religious or spiritual', 'Not very religious or spiritual', 'Not at all religious or spiritual' and 'Do not know/unsure'. This variable was dichotomized as 'Religious or Spiritual' for the answers very or partly religious and 'Not religious or spiritual' for all other answers.

3.5 Independent exposure variables

3.5.1 What health services are valued

The likelihood of youths utilizing health services might be impacted by how appropriate they are (35). In order for health services to be appropriate to the target population, they have to provide services that the population feel they have a need for. These variables aimed to assess what type of services male youths feel is important for them to have access to.

This was assessed using the multiple choice question 'In which of these areas does it feel important to you to have access to support / information / care', with the options being 'Your sexual health', 'Your physical health', 'Your mental health', 'Sexual relations', 'Love relations', 'Friend relations', 'Family relations', 'Other areas', 'None of these areas'. Each answer was turned into individual variables dichotomised as 'Yes' or 'No'.

3.5.2 Knowledge of, and perceived access to, available health service

Another factor that might impact utilization of health services is accessibility. Although health services are officially accessible to all youths, services might not be perceived as such. Youth might be hindered by a lack of knowledge on where, and how to access services. Participant's knowledge of, and perceived access to, available health service was assessed using two multiple choice questions; 'In which of these areas do you feel that you have access to support / information / care' and 'Do you know where to turn to access support / information /care in the following areas'. Answer options for both questions were 'Your sexual health', 'Your physical health', 'Your mental health', 'Sexual relations', 'Love relations', 'Friend relations', 'Family relations', 'Other areas', 'None of these areas'. Answer options for both questions were turned into individual variables dichotomised as 'Yes' or 'No'.

3.5.3 Factors encouraging or discouraging the use of health services.

Individual factors could also have an indirect encouraging or discouraging effect on weather male youths utilize youth clinics. This was assessed through six different questions. The first two being meant to assess whether subjects have previously been discouraged from visiting the youth clinics, from fear of others finding out, or difficulty in talking to a professional about their health. This was done through the questions 'Have you ever refrained from seeking support/information/care related to your health because you thought it was embarrassing or difficult to talk to someone in the healthcare or at school', and 'Have you ever refrained from seeking support/information/care related to your health because of fear that friends, family or outsiders would find out'. Answer options for both questions were ' Yes, once', 'Yes, more than once', 'No' and 'Do not know/unsure'. Both were dichotomized as 'Yes' and 'No'.

One of the questions was a multiple choice question, meant to assess whether the ability to talk to others has encouraging or discouraging effects on health seeking. The question used was as follows; 'If I need to, I can talk relatively openly about my sexual, physical or mental health with…'. With the answers options being 'One of my parents', 'Two of my parents', 'Friend(s)', ' Other adult(s)', 'None of the above'. All answer options were turned into individual variables dichotomised as 'Yes' or 'No'. Answer options 'One of my parents' and 'Two of my parents' were combined into a new variable named ' If I need to, I can talk relatively openly about my sexual, physical or mental health with at least one parent', dischoctomised as 'Yes' Or 'No'.

The fourth included measure was intended to measure sexual activity, which might encourage use of especially sexual health services. It was measured using the question 'Have you ever had sex? Base your answer on what you yourself would define as sex', which had answer options 'Yes', 'No', 'Do not know/unsure'. The two last options were both dischoctomised as 'No'. If Answering yes to this question, participants were asked to also answer the question 'Have you had sex at some point in the last 3 months'. As a means of measuring current sexual activity. Answer options were also 'Yes', 'No', 'Do not know/unsure' and were dichotomised as 'Yes' and 'No' similarly. The last included variable was relationship history, measured through the question 'Are you in, or have you been in a relationship in the last 12 months'. Answer options were 'I am in a relationship now', ' I have been in a relationship', 'No' and 'Do not know/unsure'. The first two options were dichotomized as 'Yes' and the other as 'No'.

4. Construction of multivariate regression models

Three multivariate logistic regression models were built. Model one and two were both built around seven areas of health and relations that included; mental health, sexual health, physical health, love relations, sexual relations, friend relations and family relations. Model one describing in which of these areas participants personally value access to health services, and how this is associated with utilization of the youth clinics. Model two describing in which areas participants know where to access health services, where they feel they currently have access to health services, and how this is associated with utilization of the youth clinics. Model three includes variables that might indirectly encourage or discourage use of health services. These include; whether participants have previously refrained from seeking out health services; Participants ability to talk to others about their health; participants experience of sexual activity; and participants' relationship experience. All three multivariate regression models included adjustment for the sociodemographic factors age, subjective SES, birth country, birth country of parents, and religiosity.

5. Statistical analysis

Statistical analyses were performed using RStudio (RStudio, PBC, Boston, MA, United States). Bivariate logistic regression analyses were performed to examine the associations between the independent variables and the dependent variable - experience of visiting a youth clinic. The

association between dependent and independent variables are presented in tables as crude odds ratios (OR) and 95% confidence intervals (CI) to indicate the level of statistical uncertainty.
A log likelihood ratio X^2 test was performed to test how well the individual models could predict the outcome. The X^2 associated p-value was reported to indicate the level of statistical significance, which was set at $p < 0.05$. Individuals with missing values for the outcome variable were excluded from the analysis. The level of statistical significance was indicated through p-value at three different levels, $p<0.05$, $p<0.01$, and $p<0.001$, in the evaluation of whether the predictors significantly contributed to the models or not. The sample size was calculated based on a 0.5 standard deviation, a confidence interval of +/- 5%, and a confidence level of 95%. This calculation showed that a sample size of 365 was needed to capture large and medium-sized effects in the population.

6. Ethical considerations

One of the international research community's most important guiding documents for medical research is the Declaration of Helsinki (3). It provides guiding principles on how to ethically conduct research with human subjects or material. To ensure that these are upholded, the declaration further states that all medical research protocols must be independently reviewed and approved by the concerned ethics committee (3). In Sweden this befalls the Swedish Ethical Review Authority (61), in accordance with the Swedish Ethical Review Act (SFS 2003:460). Stating that all research conducted on human subjects, with human materials or sensitive personal data, as described in the EU data protection directive, must receive ethical permit (62). Considering this, ethical approval was for this study sought and obtained from the concerned authority (Dnr 2022-00295-01).

Research may only be approved if its scientific value is not outweighed by any risks it may entail for the study participants' health, safety and personal integrity (62,63). Therefore, a risk and benefit analysis was carried out before the study was initiated. No foreseeable risks were identified in relation to participants as well as researchers. The expected benefits identified are that the study participants will perceive it as a positive experience to share their perspective on an issue where boys and men often are overlooked. However, a majority of the expected benefits of the study will befall the population of boys and young men as a whole. An increased understanding of their perceived needs for support and services in mental, sexual and reproductive health hopes to lead to future changes in the services offered by the youth clinics

as well as other care providers, to better reach and benefit boys and young men.

The law and ethical principles also contain clear demands for providing research participants with the right facts and information, in a way that they can understand, so that participation is truly voluntary and based on an informed consent. Information provided to the participants included information on the research principal, handling of their personal data, the purpose, and methods of the study, and the ability to refuse participation or withdraw previously given consent. Although consent may be withdrawn at any point, data collected up til that point may still be included in the study, if this has been clearly stated to the participant beforehand (62). In this study, participants were informed they could cancel their participation up until the point that their answers had been sent in. Another core ethical principle is the protection of participants' privacy and confidentiality, which means that all data obtained, including any other information on the study participants, should be kept strictly confidential to the appropriate individuals (13). Data for this study was collected using self-administered questionnaires, ensuring anonymity to the researcher as well and therefore complete anonymity of the participant (14). This is advantageous if collecting what might be perceived as sensitive information, such as in this study.

If individuals belonging to vulnerable populations are included in the study, special considerations and procedures to protect these individuals must be taken. This generally applies to, for example, individuals under the age of 18. However, the Ethical Review Act states that individuals over the age of 15, that are able to understand and consider what participation entails for him or her, may leave informed consent without that of his or her legal guardian(s) (62). In this study, children and young adults between 15-22 were included, and informed consent was therefore only obtained from the participants themselves.

7. Result

7.1 Description of participants

175 youths responded to the survey. The applied sampling strategy does not allow for response rate calculations since the survey was advertised on social media platforms, local institutions

and public places. Since there is no way to know exactly how many people took part of the study information the response rate cannot be calculated.

7.2 Distribution of baseline characteristics

The main outcome variable was whether subjects had utilized the youth clinics. Out of the 175 respondents, 78 (45%) reported that they had visited a youth clinic at some point. The age range of the respondents was 15-22 years, with the majority (62%) of the respondents being between 16-18. 89% of the respondents were born in Sweden, and most had two parents from Sweden (66%). Only a few (13%) had two parents born outside Sweden. Most respondents considered their subjective socioeconomic status to be good (88%), and most (79%) viewed themselves as non-religious or non-spiritual. About half of the respondents (47%?) have refrained from seeking healthcare due to fear of others learning about it, or (58%) due to perceived difficulties in talking with a professional (**Table 1**).

As seen in Table 2, most respondents reported that they are able to talk to others about their sexual, mental and physical health if they need to. Although, some of the respondents (14%) reported they could not talk to either parents, friends or other adults about their sexual, mental and physical health. Generally the number of respondents that felt they had access to support, care and advice in matters concerning their health and relations, were equal to those that felt they did not (Table 2). Only a small number (4%) reported to have no access to any support, care or advice. A majority of the respondents reported that they felt it was personally important with support, care and advice in matters concerning their health. Numbers were more evenly divided in wanting support and care in matters concerning their relations (Table 2). Most respondents knew where to turn in matters concerning their health issues. Less of them knew where to turn for care and support for their relations. Only a few (5%) respondents reported not knowing where to turn in matters regarding either their health or relations (Table 2).

39 % percent of the respondents who had been to a youth clinic (n=78) reported that they completely received the help they were hoping for. Another 51 % said they only partly received the help they were hoping for. Of those who had not visited a youth clinic (n=96), 62 % said that they had not felt the need to go, and 39% reported being unsure of whether they needed health care or support. In general respondents were aware of what services youth clinics provide and where the clinic(s) are located. Very few reported that other reasons (6%), or none of the reasons (1%) listed had been their reasons for not visiting a youth clinic (**Table 3**).

7.3 Bivariate and multivariate regression models

Four logistic regression models were created. One simple, unadjusted, regression model described in **Table 4**, and three adjusted multivariate logistic regression models (Tables 6, 7. 8).

7.3.1 Sociodemographics

The unadjusted simple logistic regression model (**Table 3)** indicates that youth clinic experience is positively correlated with age. The odds of having youth clinic experience, therefore, increase by about 17% per year of age (OR 1.17, 95% CI 1.01 to 1.38). However, there was no significant association between youth clinic experience and subjective SES (OR 1.14, 95% CI 0.45 to 2.85), religiosity (OR 0.60, 95% CI 0.28 to 1.26), and birthplace for study participants (OR 0.53, 95% CI 0.18 to 1.42) or birthplace of the study participants parents (OR 1.00, 95% 0.48 to 2.09; OR 0.42, 95% CI 0.14 to 1.09).

7.3.2 Perceived importance of access to support and health services

Not feeling it is important to have access to mental health services was the only factor significantly associated with youth clinic experience (OR 0.29, 95% CI 0.08 to 0.85) in the unadjusted model (**Table 3**). This association did not remain significant in the population after adjustment for other independent variables and sociodemographic factors (adjustedOR 0.31, 95% CI 0.06 to 1.30), as seen in **Table 4**. Not feeling it is important to have access to support in friend relations was, when adjusted, the only factor significantly associated with youth clinic experience (adjustedOR 3.81, 95% CI 1.38 to 11.5). The tests did not reveal any clear patterns for these factors, generally suggesting little or no associations with the outcome (**Table 3**). In **Table 4**, X2 tests for the model's predictability of the outcome revealed no significance ($p>0.05$).

7.3.3 Knowledge of and perceived access to health services

Youth clinic experience was, as seen in **Table 3**, significantly associated with not feeling one has access to sexual health services or support (OR 0.45, 95% CI 0.24 to 0.83). This association of marginally statistical significance did not persist in the adjusted model (**Table 5)**. However, in the adjusted model, knowing where to turn for support in physical health matters was somewhat statistically associated with youth clinic experience. Overall, few significant

associations were found, and the overall model's predictability of the outcome was not significant (p>0.05) (**Table 5**).

7.3.4 Factors encouraging or discouraging the use of health services

Table 3 (unadjusted model) indicates that youth clinic experience was significantly associated with previous sexual activity (OR 0.43, 95% CI 0.23 to 0.79) and more recent sexual activity (sex in the last three months) (OR 0.23, 95% CI 0.12 to 0.45). Youth clinic experience was also significantly associated with having been in a relationship in the past year (OR 0.45, 95% CI 0.24 to 0.82), and inability to talk to parents, friends or other adults about one's health (OR 0.36, 95% CI 0.13 to 0.91). After adjustment (**Table 6)**, only recent sexual activity remained a significant predictor of youth clinic experience (adjOR 0.21, 95% CI 0.06 to 0.60). On the other hand, having previously refrained from utilising health services due to difficulty talking to someone in the healthcare or at school, was when adjusted, significantly associated with youth clinic experience (adjOR 2.57, 95% CI 1.12 to 6.18). When adjusted for each other, sexual activity, relationship experience, previous avoidance of health services, and ability to talk to others about their health showed highly significant predictability of youth clinic experience (<0.0001) in the X2 test (**Table 6**).

8. Discussion

8.1 Results discussion

This study aimed to investigate male youths' health service-needs and health-seeking behaviour, related to their experience of visiting a youth clinic. Having been sexually active, expecially in the last three months, was strongly positively associated with youth clinic experience. Younger age, no perceived need for mental health services, no perceived access to sexual health services, no ability to talk to someone about their health, and no relationship history in the last year had a mild negative association with youth clinic experience. However, it must be noted that no adjustment for multiple comparisons was made, presenting some risk of type 1 errors – especially in cases of only mild statistical significance. When, as in the present study, multiple independent associations are tested for statistical significance, the probability

that at least one will be significant increases with every examined association (64). Therefore, some caution is warranted when interpreting this study's results, and further research is needed to confirm any associations. The only regression model significantly predicting the experience of visiting a youth clinic was the model for factors encouraging or discouraging the use of health services (**Table 6**). However, the results do not tell us how these factors interact or in what might encourage or discourage the use of health services. Further research is needed to understand this relationship better.

Although the results at large did not reveal any strong patterns of association, the purpose of the study was achieved and presented some noteworthy discoveries. First of all, the results showed that 44 % of the respondents had visited a youth clinic. It is not easy to know exactly how this compares to a population average. Previous studies have shown that between 10 and 15 percent of the youth clinics' visits are made by boys and men (1,53,65). However, no statistics are currently available on how many percent of the general population, men or women, have visited a youth clinic. Still, assuming that in Skåne, only 13% of the youth clinics' visits are made by men (53), it seems unlikely that 44 % should represent the number of men in the general population that has ever been to a youth clinic. This study's high reported visiting numbers could be due to biases introduced in the data collection method. It is also possible that the numbers observed in this study represent the population average in the areas where data has been collected. However, it might not be generalisable to a broader population of boys and men. Still, it is of interest to gain a further understanding of youth clinics-service seeking behaviour in the male population in general, not only in the context of the youth clinics.

Other interesting observations were the lack of correlation between the perceived need for care, support and advice and having visited a youth centre. It could mean that individuals primarily receive care somewhere else or intend to visit the youth centre in the future. It might also be that need does not define the actual use of services. It means that people in need of care, for some reason, have not sought it. It is interesting in its own way and confirms a pattern of boys and men seeking health care to a lower degree, regardless of actual need (9,10). A relatively large number of the respondents reported that they at least once refrained from seeking health care due to fear of others finding out about it. It somewhat confirms results seen in previous studies of the youth clinics, where fear of discovery discourages the use of health services. For example, one study has concluded that many young people do not dare enter youth clinics if they are located so that surrounding people can easily tell what kind of building they are

entering (17). Many also seem to find it important that others, including family, friends and outsiders, do not find out about their visit to the youth clinic (65). The results also suggested that many find it embarrassing or difficult to talk to health care or school professionals. To what extent this explains the gap between the need for care and seeking care remains uncertain. The results do not indicate that this would significantly explain why some refrain from seeking care. Further research is needed to investigate barriers to seeking care in this population.

Further surprising observations were the unclear correlation between perceived access to care, support and advice and having visited a youth centre. One might have expected people visiting youth clinics to feel like they have access to support. However, only perceived access to support in sexual health matters showed some level of significant correlation to the experience of the youth clinics. Meaning that higher odds of having been to a youth clinic were observed among those feeling they have access to sexual health services. It indicates that this is the area where the youth clinics somewhat meet the needs of this population and is backed by the fact that the odds of having been to a youth clinic were higher among sexually active subjects. It suggests that the youth clinics are used for services related to sexual health and that this is where the need for services seems to affect the decision to seek out their services. It can, however, not be sure if sexual activity preceded visits to the youth clinic or if the visit took place before an individual decided to become sexually active. However, some level of disparity seems to exist between visiting youth clinics and feeling that one has access to, and knows where to turn, for health care and support in several areas related to health and relations. It suggests there are improvements to be made in offering services that boys can relate to and find acceptable to their needs.

A perhaps worrying result was that less than half of those who had visited a youth clinic felt that they had received the support they hoped to get. A majority felt that they had only partly received the support they had hoped to get. In contrast, previous studies indicate a positive perception of the youth clinics, including amongst boys and young men (65–67). However, participants in these studies were recruited at various youth clinics, which could result in a bias toward positive attitudes. It is unclear why participants in the present study felt they only partly received the services they hoped to get or what their expectations looked like. It is also unclear what the motive behind their visits to the youth clinics has been – if it was per initiation of the participant or someone else. For example, it is common to go at least once with one's school class or with other groups on a study visit (66,68). In these instances, the visit is not initiated

by the boys or young men themselves, which might also affect the extent to which they feel they have had their expectations met. Future research could provide further insight into how the reasons behind boys' and men's visits to the youth clinic correspond with their support satisfaction levels. Furthermore, what the expectations are in this population, and what part of their visit they feel could have better fulfilled these expectations.

Another interesting discovery was that the experience of visiting a youth clinic and neither country of birth, including for parents, nor subjective socioeconomic status were significantly correlated. Previous reports have suggested that young people from socioeconomically disadvantaged backgrounds seek out healthcare services, including the youth clinics, to a lesser extent (1,65). Furthermore, reports from both Sweden and Europe have suggested that young immigrants, or those with immigrant parents, utilise the youth clinics' services and other preventative health care services to a much lower degree than non-immigrants. Especially services related to SRH (17,67). However, some reports have also suggested that socioeconomic status and country of birth perhaps have a more noticeable effect on youth clinic-health-seeking among girls and women and not so much among boys and men (1,16). This study confirms this pattern, even if some correlation was still expected.
Similarly, religiosity was not associated with the experience of visiting a youth clinic. Although religion and culture have been reported to affect how young people seek out and utilise health care services, particularly those related to SRH, this is also reportedly affecting girls and women more than boys and men (1,16,69,70). Therefore, it might explain the lack of association found in this study.

8.2 Methodological considerations

8.2.1 Data collection tool

Although the survey used in the study was not a very extensive one, not all variables ended up being used in the final analysis. Some had to be excluded for varying reasons. The original study idea was, for example, to include an outcome variable on the future intention of visiting a youth clinic and data was collected for this purpose. Similarly, data for a variable on the experience of the virtual youth clinic was also collected. However, this proved to be challenging for the project's comprehensibility and was therefore excluded. The idea was also to include a

variable on knowledge of the youth clinic to compare how this might influence participants' willingness to go there. However, due to skewed response levels between the response alternatives, they could not be analysed in the intended way, and it was no longer meaningful to include them. A larger sample size might have avoided this issue.

Surveys are resource-efficient and relatively easy to obtain quick data from larger masses of people. It is also the primary tool for collecting self-reported data on beliefs, knowledge, attitudes, opinions or satisfaction. However, there is an inherent uncertainty in how truthfully participants have responded to the questions. One strength of this study method was that answers were given anonymously, including to the researchers. Anonymity is especially recommended when investigating information that might be perceived as sensitive. It creates a higher chance of participants answering questions truthfully and reduces the risk of information bias (64,71). However, although the questions were thought not to be of a very high level of sensitivity, there is always a risk that individuals have not answered truthfully (64). It could be because they still perceive some questions as value-laden. Such as, 'have you ever had sex'. It could also be that participants try to answer in a way that they think would be favourable to the researcher.

The survey was subjected to pre-testing by participants from the intended research population to strengthen its overall quality and reduce the risk of information bias. It was done to ensure that all information and instructions were easy to understand and that questions felt easy to understand and answer. It was also essential to ensure that the overall survey was kept as brief as possible and that the time to complete the survey was short. As a result, the chances that people will complete the survey, even if they do not hold a specific interest in the matter, will be higher (72). An essential strength of this study was the overall high data completeness, with only one missing value. It indicates high data quality and limits the risk of information bias (73).

8.2.2 Data collection method and study design

This study was based on cross-sectional data, and as such, it cannot capture any changes in behaviour over time or new incidences of, for example, visits to the youth clinic. Furthermore, because data on outcome and exposure variables are collected simultaneously, no causal inferences can be made (64,74). For example, it is not possible to conclude that utilisation of the youth clinics' services leads to higher perceived access to sexual health services, even if

these two factors seem to be correlated (Table 3). Instead, it could be that those who are very aware of the youth clinics' services and know that they can access particular services are more prone to visit them. Similarly, we cannot know if being sexually active precedes a visit to the youth clinic or if the visit takes place before an individual decides to become sexually active.

Obtaining a representable sample for the population of interest is important but not easy. Ideally, this would require a probability, or random sampling process, which ensures a sample that is more likely to match the studied population in its characteristics. It reduces the risk of bias and generates higher generalizability of results (1). However, this requires a correct sampling frame of all the possible participants and is generally a rather costly and time-consuming process. It is, therefore, not always a feasible option, and many studies go for a non-probability sampling (75). This study adopted a non-probability convenience and voluntary response sampling strategy. It means that very particular slices of the population of interest are asked to participate or can self-select (76). Participants were recruited by sending out information to students at a large upper secondary school in Lund, to members of two large youth organisations in Malmö, to recruits at a military regiment, by public information put up in Lund and Malmö and by social media platforms and word of mouth. A sample collected by these methods cannot be assumed to be representative of the wider population. Results can, therefore, generally not be generalised to the same extent as a probability sample (77). However, despite the inherent risks of selection bias and low generalizability of results, this method has some advantages. The applied method is time and resource-efficient and is considered an important tool when seeking to establish the existence of a problem or explore research areas where previously little has been done (64,77), as was the situation with this study.

One common type of bias in cross-sectional studies is the non-response bias, where those opting out of joining the study differ systematically from those choosing to join (64). This risk increases in studies where participants self-select their participation (76). There is, for example, a present risk that individuals who are more aware of their health service needs or have been more in contact with health care services have a greater interest and motivation in joining the study (76). Conversely, it could mean that those who have never been to a youth clinic, or have no interest in them or the subject, to a more considerable extent, choose not to join the study. This type of bias may have contributed to the somewhat surprisingly high rates of participants reporting to have visited a youth clinic. However, since the applied sampling strategy does not

allow for response rate calculations, evaluating the actual effects of self-selection bias is challenging.

Another way of reducing recall bias, a form of information bias, is not relying too much on retrospective data (64,73). In some instances, this was unavoidable, for example, in questions related to the experience of having visited or not visited a youth clinic. In some cases, this might have happened a long time ago, and the feelings or motives they had at that time could be challenging to remember correctly. An overall strength of the study was that it mainly relied on information either close in time or not reliant on time at all.

The overall lack of associations observed also ha to be considered in light of the study's sample size. Despite the turnout of 175 responses to the survey, the study possibly had too little power to detect any associations, if there were any (78). The estimated effect size was set to a medium level to uncover associations with both large and medium-sized practical significance. Original calculations, therefore, suggested that a sample size of 365 participants would be needed. A smaller sample of at least 170 respondents would allow the detection of only large effects. This means that there is a high risk of type II errors, meaning that even if there are present associations in the population, this study might not have been able to detect these due to the small sample size.

9. Conclusion

This study is the first study in Sweden investigating male youths' health service needs and health-seeking behaviour in relation to their youth clinic experience. It carries important implications for future research and efforts to address and meet male youths' health and support needs. The results provided insights into the population's perceived service needs, perceived access to services, and knowledge of where to access them. Little or no associations were seen between these measures and the experience of youth clinics. When adjusted for other individual characteristics, being recently sexually active was the strongest individual predictor for youth clinic experience. One model containing four variable types: (1) having previously refrained from seeking out health services; (2) ability to talk to others about one's health; (3) being sexually active; and (4) relationship experience, could significantly predict youth clinic experience. Surprisingly, neither subjective socioeconomic status, religiosity or immigration

status, including for the parents, was associated with youth clinic experience. These results must be considered in light of the study's low power to detect present associations. Further research is needed to gain deeper insight into factors underlying the observed results and the causal directions of any associations.

9. References

1. SKR. Ungdomsmottagningar och ungas sexuella hälsa - Nuläge och vägar framåt. Sveriges Kommuner och Regioner; 2020.
2. Committee of the rights of the child. Convention on the Rights of the Child. In: General comment No 4 (2003). United Nations; 2003.
3. Patton GC, Sawyer SM, Santelli JS, Ross DA, Afifi R, Allen NB, et al. Our future: a Lancet commission on adolescent health and wellbeing. Lancet. 2016 Jun 11;387(10036):2423–78.
4. Blakemore SJ. Adolescence and mental health. Lancet. 2019 May 18;393(10185):2030–1.
5. World Health Organization. Key facts [Internet]. Adolescent and young adult health. 2021 [cited 2022 Feb 6]. Available from: https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions.
6. Viner RM, Ozer EM, Denny S, Marmot M, Resnick M, Fatusi A, et al. Adolescence and the social determinants of health. Lancet. 2012 Apr 28;379(9826):1641–52.
7. Folkhälsomyndigheten. Skolbarns hälsovanor i Sverige 2017/18: Grundrapport. Folkhälsomyndigheten; 2018.
8. Folkhälsomyndigheten. Sexuell och reproduktiv hälsa och rättigheter (SRHR) i Sverige 2017: Resultat från befolkningsundersökningen SRHR2017. 2019 Sep.
9. IPPF, UNFP. Global Sexual and Reproductive Health Service Package for Men and Adolescent Boys. 2017.
10. Nordenmark L, Hyllander K. Maskulinitet och psykisk hälsa: strategier för förbättringsarbete i vård och omsorg. [Stockholm]: Sveriges kommuner och landsting; 2018.
11. Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet. 2018 Jun 30;391(10140):2642–92.
12. Osika Friberg I, Krantz G, Määttä S, Järbrink K. Sex differences in health care consumption in Sweden: A register-based cross-sectional study. Scand J Public Health. 2016 May;44(3):264–73.
13. Folkhälsomyndigheten. Sexualitet och hälsa bland unga i Sverige UngKAB15 – en studie om kunskap, attityder och beteende bland unga 16–29 år. 2017.
14. Socialstyrelsen. Ungdomsmottagningarnas kontakter med pojkar. 2000.
15. Sollesnes R. Exploring Issues That Motivate Contact with Adolescent Health Clinics. Vård i Norden. 2010 Jun 1;30(2):4–7.
16. C. Björk, J. Rangmar, R. Fornazar och J. Malmborg Heiling. Varför kommer de inte? en undersökning om ungdomsmottagningens besökare. Göteborgsregionen; 2019.

17. Thomée S, Malm D, Christianson M, Hurtig AK, Wiklund M, Waenerlund AK, et al. Challenges and strategies for sustaining youth-friendly health services - a qualitative study from the perspective of professionals at youth clinics in northern Sweden. Reprod Health. 2016 Dec 21;13(1):147.

18. Grubb LK, Powers M, Committee on adolescence. Emerging Issues in Male Adolescent Sexual and Reproductive Health Care. Pediatrics [Internet]. 2020 May;145(5). Available from: http://dx.doi.org/10.1542/peds.2020-0627.

19. Marcell AV, Wibbelsman C, Seigel WM, Committee on Adolescence. Male adolescent sexual and reproductive health care. Pediatrics. 2011 Dec;128(6):e1658–76.

20. Baroudi M, Stoor JP, Blåhed H, Edin K, Hurtig AK. Men and sexual and reproductive healthcare in the Nordic countries: a scoping review. BMJ Open. 2021 Sep 30;11(9):e052600.

21. Socialstyrelsen & Folkhälsomyndigheten. Underlag till nationell strategi för sexuell och reproduktiv hälsa och rättigheter. 2014 Oct.

22. Marcell AV, Gibbs SE, Pilgrim NA, Page KR, Arrington-Sanders R, Jennings JM, et al. Sexual and Reproductive Health Care Receipt Among Young Males Aged 15-24. J Adolesc Health. 2018 Apr;62(4):382–9.

23. Adams SH, Husting S, Zahnd E, Ozer EM. Adolescent preventive services: rates and disparities in preventive health topics covered during routine medical care in a California sample. J Adolesc Health. 2009 Jun;44(6):536–45.

24. Rice SM, Purcell R, McGorry PD. Adolescent and Young Adult Male Mental Health: Transforming System Failures Into Proactive Models of Engagement. J Adolesc Health. 2018 Mar;62(3S):S9–17.

25. Wicks S, Kosidou K, Dalman C. Väsentligt fler kvinnor än män vårdas för psykisk ohälsa i Stockholms läns landsting. Stockholm: Centrum för epidemiologi och samhällsmedicin. 2017;

26. Saewyc EM. What about the boys? The importance of including boys and young men in sexual and reproductive health research. J Adolesc Health. 2012 Jul;51(1):1–2.

27. Levtov RG, Barker G, Contreras-Urbina M, Heilman B, Verma R. Pathways to Gender-equitable Men: Findings from the International Men and Gender Equality Survey in Eight Countries. Men Masc. 2014 Dec 1;17(5):467–501.

28. Persson Fork C, Carlsson E. Vad tycker unga män om ungdomsmottagningen. Master's thesis. 2014 Jan 27;

29. Abrahamsson K, Sundin C. Where have all the young men gone? En problematisering av den låga andelen unga män bland ungdomsmottagningens besökare [Bachelor's]. Stenqvist K, editor. Göteborgs universitet; 2008.

30. Pettersson R. En mottagning med bara ett kön i kön? : En intervjustudie av kuratorer om den låga andelen unga män på ungdomsmottagningen. 2018;

31. Gustafsson T, Grune E. "Vart tar alla killar vägen?" : En kvalitativ studie om kuratorers erfarenheter av killars inställning till att söka samtalsstöd på ungdomsmottagningar. 2015.

32. Knutsson J, Medina A. Killars svårigheter att söka samtalsstöd på ungdomsmottagningen [Bachelor's]. Hadodo R, editor. Göteborgs Universitet; 2011.

33. World Health Organization. Action for adolescent health: towards a common agenda: recommendations from a joint study group (WHO, UNFPA, UNICEF). 1997;

34. Every Woman Every Child. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030). World Health Organization; 2015.

35. World Health Organization. Making Health Services Adolescent Friendly: Developing National Quality Standards for Adolescent Friendly Health Services. Department of Maternal, Newborn, Child and Adolescent Health; 2013 Sep.

36. Nationell strategi mot hiv/aids och vissa andra smittsamma sjukdomar. 2005/06:60 Dec 15, 2005.

37. FSUM. Ungdomsmottagningen i första linjen för psykisk (o)hälsa. Föreningen för Sveriges ungdomsmottagningar, FSUM; 2018.

38. Socialutskottet. Ungdomsmottagningar [Internet]. Motion 2019/20:2326 Oct 3, 2019. Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/motion/ungdomsmottagningar_H7022326

39. United Nations. Beijing Declaration and Platform for Action Fourth World Conference on Women. Vol. 112. 1995.

40. Hook C, Miller A, Shand T, Stiefvater E. Getting to equal: Engaging men and boys in sexual and reproductive health and rights and gender equality. Washington, DC: Promundo-US. 2018;

41. UNFPA. Programme of Action Adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994. United Nations Population Fund; 1995.

42. United Nations. Programme of Action of the International Conference on Population Development: Twentieth Anniversary Edition. In: ICPD Programme of Action. UNFPA; 2014.

43. Folkhälsomyndigheten & Socialstyrelsen. Underlag till nationell strategi för sexuell och reproduktiv hälsa och rättigheter. Socialstyrelsen Stockholm; 2014 Oct.

44. World Health Organization. Constitution of the World Health Organization: Signed at the International Health Conference, New York, 22 July 1946. WHO. World Health Organization, Interim Commission; 1948.

45. World Health Organization. Sexual health and its linkages to reproductive health: an operational approach. Geneva, Switzerland: World Health Organization; 2017.

46. Ruane-McAteer E, Amin A, Hanratty J, Lynn F, van Willenswaard KC, Reid E, et al. Interventions addressing men, masculinities and gender equality in sexual and reproductive health and rights: an evidence and gap map and systematic review of reviews. BMJ Global Health. 2019;4(5):e001634.

47. Barker G, Greene M, Goldstein Siegel E, Nascimento M, Segundo M, Ricardo C, et al. What men have to do with it: public policies to promote gender equality. 2010;

48. United Nations. What does the UN mean by "youth" and how does this definition differ from that given to children? [Internet]. Frequently asked questions. 2021 [cited 2022 Feb]. Available from: http://dx.doi.org/10.1016/j.jflm.2020.102106

49. Hälsa SU om U. Ungdomar, stress och psykisk ohälsa : analyser och förslag till åtgärder : slutbetänkande. Norstedts Juridik AB; 2006. 375 p.

50. Västra Götalandsregionen. Ungas erfarenhet av hälsoinformation via internet. SBU; 2019.

51. Region Skåne. Befolkning [Internet]. Hur har det gått i skåne? 2021 [cited 2022 Feb 10]. Available from: https://utveckling.skane.se/digitala-rapporter/huga/befolkning/

52. Primärvården Skåne. Ungdomsmottagningar [Internet]. Primärvården Skåne. [cited 2022 Feb 10]. Available from: https://vard.skane.se/primarvarden/vara-verksamheter/ungdomsmottagningar/

53. Lenefors L, Svensson A. Analys av Ungdomsmottagningarnas uppdrag Region Skåne. Professional Management; 2018 Sep.

54. Cleland J. Illustrative questionnaire for interview-surveys with young people. Asking Young People About Sexual and Reproductive Behaviors Illustrative Core Instruments, Geneva: World Health Organization. 2001;

55. Moor I, Richter M, Ravens-Sieberer U, Ottová-Jordan V, Elgar FJ, Pförtner TK. Trends in social inequalities in adolescent health complaints from 1994 to 2010 in Europe, North America and Israel: The HBSC study. Eur J Public Health. 2015 Apr;25 Suppl 2:57–60.

56. Ahlborg M, Svedberg P, Nyholm M, Morgan A, Nygren JM. Socioeconomic inequalities in health among Swedish adolescents - adding the subjective perspective. BMC Public Health. 2017 Oct 23;17(1):838.

57. Joffer J, Flacking R, Bergström E, Randell E, Jerdén L. Self-rated health, subjective social status in school and socioeconomic status in adolescents: a cross-sectional study. BMC Public Health. 2019 Jun 20;19(1):785.

58. Präg P, Mills MC, Wittek R. Subjective socioeconomic status and health in cross-national comparison. Soc Sci Med. 2016 Jan;149:84–92.

59. Wu S, Wang R, Zhao Y, Ma X, Wu M, Yan X, et al. The relationship between self-rated health and objective health status: a population-based study. BMC Public Health. 2013 Apr 9;13:320.

60. Quon EC, McGrath JJ. Subjective socioeconomic status and adolescent health: a meta-analysis. Health Psychol. 2014 May;33(5):433–47.

61. Arousell J, Carlbom A. Culture and religious beliefs in relation to reproductive health. Best Pract Res Clin Obstet Gynaecol. 2016 Apr;32:77–87.

62. Forsberg M. Brunetter och blondiner: om ungdom och sexualitet i det mångkulturella Sverige. Göteborgs universitet, Institutionen för socialt arbete; 2005. 321 p.

63. Figueroa LR, Davis B, Baker S, Bunch JB. The influence of spirituality on health care-seeking behaviors among African Americans. ABNF J. 2006 Spring;17(2):82–8.

64. Etikprövningsmyndigheten. Värnar människan i forskning [Internet]. Etikprövningsmyndigheten. 2014 [cited 2022 Apr 14]. Available from: https://etikprovningsmyndigheten.se/

65. Riksdagsförvaltningen. Lag (2003:460) om etikprövning av forskning som avser människor [Internet]. Sveriges Riksdag. 2022 [cited 2022 Apr 14]. Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2003460-om-etikprovning-av-forskning-som_sfs-2003-460

66. 64th WMA General Assembly, Fortaleza, Brazil, October 2013. WMA declaration of Helsinki – ethical principles for medical research involving human subjects. Vol. 10, {World Medical Association}. 2013.

67. Aschengrau A, Seage GR. Essentials of Epidemiology in Public Health. Jones & Bartlett Publishers; 2013. 532 p.

68. SWECO. Barnkonsekvensanalys Omorganisering av ungdomsmottagningarna i Stockholms län. 2021 Apr.

69. Swedish Society for Youth Centres (FSUM). “Ni är grymma”(“Keep up the good work”). 2015.

70. Baroudi M, San Sebastian M, Hurtig AK, Goicolea I. The perception of youth health centres’ friendliness: does it differ between immigrant and Swedish-Scandinavian youths? Eur J Public Health. 2020 Aug 1;30(4):780–5.

71. Uppdrag Psykisk Hälsa. Psykisk hälsa på ungdomsmottagningen-en kartläggning av Sveriges ungdomsmottagningar [Mental health in youth clinics--a mapping of Swedish youth clinics]. Stockholm: Uppdrag Psykisk Hälsa. 2017;

72. Ekholm A, Englund E, Lönnfjord V. Kuratorns roll på ungdomsmottagningen [Degree of Bachelor of Science in Social Work]. Lönnfjord V, Östman C, editors. Karlstad Universitet; 2022.

73. Gaur PS, Zimba O, Agarwal V, Gupta L. Reporting Survey Based Studies - a Primer for Authors. J Korean Med Sci. 2020 Nov 23;35(45):e398.

74. De Leeuw ED, Hox JJ, Huisman M. Prevention and treatment of item nonresponse. J Off Stat. 2003;19:153–76.

75. Bankhead CR, Spencer EA, Nunan D. Information bias [Internet]. Catalog of Bias. 2019 [cited 2022 Apr 24]. Available from: https://catalogofbias.org/biases/information-bias/

76. Wang X, Cheng Z. Cross-Sectional Studies: Strengths, Weaknesses, and Recommendations. Chest. 2020 Jul;158(1S):S65–71.

77. Galloway A. Non-Probability Sampling. In: Kempf-Leonard K, editor. Encyclopedia of Social Measurement. New York: Elsevier; 2005. p. 859–64.

78. Albert B, Tullis T, Tedesco D. Chapter 2 - Planning the Study. In: Albert B, Tullis T, Tedesco D, editors. Beyond the Usability Lab. Boston: Morgan Kaufmann; 2010. p. 17–47.

79. Hedt BL, Pagano M. Health indicators: eliminating bias from convenience sampling estimators. Stat Med. 2011 Feb 28;30(5):560–8.

80. Sullivan GM, Feinn R. Using Effect Size-or Why the P Value Is Not Enough. J Grad Med Educ. 2012 Sep;4(3):279–82.

Tables and figures

Table 1.

Distribution of sociodemographic factors, utilization of the youth clinics, relationship experience, sexual activity, previously refrained from health seeking and ability to talk to others among male youths in Skåne

Characteristic	N = 175
Age	
15	3 (1.7%)
16	34 (19%)
17	42 (24%)
18	34 (19%)
19	20 (11%)
20	13 (7.4%)
21	10 (5.7%)
22	19 (11%)
Country of birth	
Sweden	156 (89%)
Other	19 (11%)
Country of birth parents	
Both parents born in Sweden	115 (66%)
One parent born outside Sweden	38 (22%)
Both parents born outside Sweden	22 (13%)
Subjective socioeconomic status	
Good	154 (88%)
Poor	21 (12%)
Religious and/or Spiritual	
No	138 (79%)
Yes	37 (21%)
Have visited a youth clinic before	
No	96 (55%)
Yes	78 (45%)
Missing	1
Have previously refrained from seeking health care/information/support because of worry that friends, family or outsiders would find out	
Yes	82 (47%)
No	93 (53%)
Have previously refrained from seeking care/information/support because it felt embarrassing/difficult to talk to someone in the health care or at school	
Yes	101 (58%)
No	74 (42%)
Have ever been sexually active	
Yes	95 (54%)
No	80 (46%)
Have been sexually active in the last 3 months	
Yes	60 (34%)
No	115 (66%)
Have been in a relationship in the last 12 months	
Yes	78 (45%)
No	97 (55%)
People that participants can talk to about their sexual, mental and physical health	
Parent(s)	101 (58 %)
Other adult(s)	57 (33 %)
Friend(s)	125 (71 %)
Neither parents, other adults or friends	24 (14%)

Data from March-April 2022 on male youths residing in Skåne, Sweden

Table 2.

Prevalence of need, access, and knowledge of health services among male youths in Skåne

Areas where partcipants value access to healthcare, support and information	N (%)
Mental health	156 (89 %)
Sexual health	114 (65 %)
Physical health	135 (77 %)
Love relations	100 (57 %)
Sexual relations	91 (52 %)
Friend relations	105 (60 %)
Family relations	116 (66 %)
None of these	7 (4 %)
Other than these	3 (2 %)

Areas where participants' knows where to turn for healthcare, support and information	N (%)
Mental health	139 (79 %)
Sexual health	109 (62 %)
Physical health	153 (87 %)
Love relations	60 (34 %)
Sexual relations	64 (37 %)
Friend relations	76 (43 %)
Family relations	95 (54 %)
None of these	9 (5 %)
Other than these	4 (2 %)

Areas where participants' feel they have access to healthcare, support and information	N (%)
Mental health	138 (79 %)
Sexual health	94 (54 %)
Physical health	153 (87 %)
Love relations	78 (45 %)
Sexual relations	61 (35 %)
Friend relations	102 (58 %)
Family relations	106 (61 %)
None of these	7 (4 %)
Other than these	4 (2 %)

Data from March-April 2022 on male youths residing in Skåne, Sweden

Table 3.

Characteristics specific to experience of visiting a youth clinic among male youths in Skåne

	Support satisfaction among those that have visite a youth clinic	Reasons for having never visited a youth clinic
Characteristic	N = 78 (100 %)	N = 96 (100 %)
Received the support/care/advised they were hoping for		
Yes, completely	30 (38%)	
Yes, partly	40 (51%)	
No, not at all	8 (10%)	
Do not know/unsure	0 (0%)	
Do not know the location or how to get there		11 (11%)
Do not know what to do there		16 (17%)
Have not had the time to go		10 (10%)
Have not felt the need to go		60 (62%)
Have received help somewehere else (school nurse, primary hc etc)		15 (16%)
Unsure of need for care/support		37 (39%)
None of the above reasons		1 (1.0%)
Other reasons than the above		6 (6.2%)

Data from March-April 2022 on male youths residing in Skåne, Sweden

Table 4.

Association between study variables and youth clinic utilization among male youths in Skåne. Presented for non-reference values as crude ORs and 95% CIs.

Variable	OR(95 % CI)
Age	1.17(1.01 to 1.38)*
Country of birth (Other)	0.53(0.18 to 1.42)
Country of birth parents	
One parent born outside Sweden	1.00(0.48 to 2.09)
Both parents born outside Sweden	0.42(0.14 to 1.09)
Subjective socioeconomic status (poor)	1.14(0.45 to 2.85)
Religious and/or Spiritual (Yes)	0.60(0.28 to 1.26)
Have parent(s) to talk to about their fysical, mental and sexual health (No)	0.55(0.30 to 1.02)
Have friend(s) to talk to about their fysical, mental and sexual health (No)	0.60(0.30 to 1.17)
Have other adult(s) to talk to about their fysical, mental and sexual health (No)	0.74(0.39 to 1.39)
Can talk with neither parent(s), other adult(s) or friend(s) about their fysical, mental and sexual health (Yes)	0.36(0.13 to 0.91)*
Have previusly refrained from seeking care/information/support because it felt embarrassing/difficult to talk to someone in the health care or at school (Yes)	1.49(0.81 to 2.76)
Have previously refrained from seeking care/information/support because of worry that friends, family or outsiders would find out (Yes)	0.85(0.46 to 1.54)
Have access to care/support/information for sexual health (No)	0.45(0.24 to 0.83)*
Have access to care/support/information for mental health (No)	0.60(0.28 to 1.26)
Have access to care/support/information for physical health (No)	0.83(0.33 to 2.05)
Have access to care/support/information in romantic relations (No)	0.60(0.32 to 1.09)
Have access to care/support/information in sexual relations (No)	0.53(0.28 to 1.00)
Have access to care/support/information in friend relations (No)	0.58(0.31 to 1.06)
Have access to care/support/information in family relations (No)	0.56(0.30 to 1.03)
Have no access to care/support/information in either of the above areas (Yes)	0.92(0.18 to 4.30)
Have access to care/support/information in other areas than the above (No)	0.26(0.01 to 2.10)
Values access to care/support/information for mental health (No)	0.29(0.08 to 0.85)*
Values access to care/support/information for sexual health (No)	0.60(0.31 to 1.13)
Values access to care/support/information for physical health (No)	0.77(0.37 to 1.58)
Values access to care/support/information in romantic relations (No)	0.89(0.49 to 1.64)
Values access to care/support/information in sexual relations (No)	0.81(0.45 to 1.48)
Values access to care/support/information in friend relations (No)	1.42(0.77 to 2.62)
Values with access to care/support/information in family relations (No)	0.81(0.43 to 1.53)
Not important with access to care/support/information in either of the above areas (No)	2.09(0.44 to 14.9)
Knows where to turn for care/support/information for mental health (No)	0.85(0.40 to 1.78)
Knows where to turn for care/support/information for sexual health (No)	0.63(0.34 to 1.18)
Knows where to turn for care/support/information for physical health (No)	1.27(0.51 to 3.14)
Knows where to turn for care/support/information in romantic relations (No)	0.69(0.37 to 1.30)
Knows where to turn for care/support/information in sexual relations (No)	0.69(0.37 to 1.28)
Knows where to turn for care/support/information in friend relations (No)	0.80(0.44 to 1.46)
Knows where to turn for care/support/information in family relations (No)	0.92(0.51 to 1.68)
Do not know where to turn for care/support/information in either of the above areas (No)	1.67(0.42 to 8.11)
Knows where to turn for care/support/information in other areas than the above (No)	0.26(0.01 to 2.10)
Have ever been sexually active (No)	0.43(0.23 to 0.79)**
Have been sexually active in the last 3 months (No)	0.23(0.12 to 0.45)***
Have been in a relationship in the last 12 months (No)	0.45(0.24 to 0.82)*

*P<0.05, **P<0.01, ***P<0.001

Data from March-April 2022 on male youths residing in Skåne, Sweden

Table 5.

Multiple logistic regression analyses (OR, 95% CIs) for the association between value of access to health services and youth clinic utilization among male youths in Skåne.

Values access to services and support in mental health		Overall model significance[1]	
Yes	(reference)	*Null deviance*	239.35
No	0.31(0.06 to 1.30)	*Recidual deviance*	218.67
Values access to services and support in sexual health		*Degrees of freedome*	14
Yes	(reference)	*P-value*	0.1101
No	0.59(0.21 to 1.55)		
Values with access to services and support in physical health			
Yes	(reference)		
No	1.38(0.50 to 3.87)		
Values with access to services and support in romantic relations			
Yes	(reference)		
No	0.70(0.24 to 1.92)		
Values access to services and support in sexual relations			
Yes	(reference)		
No	1.06(0.39 to 2.96)		
Values access to services and support in friend relations			
Yes	(reference)		
No	3.81(1.38 to 11.5)*		
Values access to services and support in family relations			
Yes	(reference)		
No	0.61(0.23 to 1.52)		
Age	0.85(0.37 to 1.91)		
Country of birth			
Sweden	(reference)		
Other	0.97(0.19, 4.99)		
Country of birth parents			
Both parents born in Sweden	(reference)		
One parent born outside Sweden	0.72(0.29 to 1.75)		
Both parents born outside Sweden	0.37(0.07 to 1.68)		
Subjective socioeconomic status			
Good	(reference)		
Poor	1.55(0.52 to 4.90)		
Religious and/or Spiritual			
No	(reference)		
Yes	0.73(0.29 to 1.77)		

[1] Results from the log likelihood ratio X^2 test

**P<0.05, **P<0.01, ***P<0.001*

Data from March-April 2022 on adolescent boys and young men residing in Skåne, Sweden

Table 6.

Multiple logistic regression analyses (OR, 95% CIs) for association between knowledge of, and perceived access to health services and youth clinic utilization among male youths in Skåne.

Knows where to access services and support in mental health		Overall model significance[1]	
Yes	(reference)	*Null deviance*	239.35
No	0.85(0.32 to 2.26)	*Recidual deviance*	214.53
Knows where to access services and support in sexual health		*Degrees of freedome*	22
Yes	(reference)	*P-value*	0.3058
No	0.60(0.24 to 1.46)		
Knows where to access services and support in physical health			
Yes	(reference)		
No	5.68(1.21 to 33.9)*		
Knows where to access services and support in romantic relations			
Yes	(reference)		
No	0.95(0.31 to 2.96)		
Knows where to access services and support in sexual relations			
Yes	(reference)		
No	0.96(0.35 to 2.69)		
Knows where to access services and support in friend relations			
Yes	(reference)		
No	0.84(0.28 to 2.46)		
Knows where to access services and support in family relations			
Yes	(reference)		
No	1.93(0.73 to 5.23)		
Feel they have access to services and support in mental health			
Yes	(reference)		
No	0.30(0.05 to 1.46)		
Feel they have access to services and support in sexual health			
Yes	(reference)		
No	0.77(0.28 to 2.13)		
Feel they have access to services and support in physical health			
Yes	(reference)		
No	1.04(0.40 to 2.71)		
Feel they have access to services and support in romantic relations			
Yes	(reference)		
No	0.72(0.26 to 2.02)		
Feel they have access to services and support in sexual relations			
Yes	(reference)		
No	0.59(0.22 to 1.55)		
Feel they have access to services and support in friend relations			
Yes	(reference)		
No	0.59(0.22 to 1.55)		
Feel they have access to services and support in family relations			
Yes	(reference)		
No	0.14(0.00 to 1.65)		
Country of birth			
Sweden	(reference)		
Other	0.81(0.18 to 3.51)		
Country of birth parents			
One parent born outside Sweden	1.13(0.48 to 2.69)		
Both parents born outside Sweden	0.40(0.08 to 1.81)		
Subjective socioeconomic status			
Good	(reference)		
Poor	2.34(0.71 to 8.17)		

[1] Results from the log likelihood ratio X^2 test

**P<0.05, **P<0.01, ***P<0.001*

Data from March-April 2022 on adolescent boys and young men residing in Skåne, Sweden

Table 7.

Multiple logistic regression analyses (OR, 95% CIs) for association between youth clinics utilization and factors encouraging or discouraging the use of health services among male youths in Skåne

Have previously refrained from health seeking because of worry that friends, family or outsiders would find out		Overall model significance[1]	
No	(reference)	*Null deviance*	239.35
Yes	0.70(0.29 to 1.66)	*Recidual deviance*	207.34
Have previously refrained from health seeking due to difficulty in talking to someone in the health care or at school		*Degrees of freedome*	15
No	(reference)	*P-value*	<0.0001
Yes	2.57(1.12 to 6.18)*		
Have been in a relationship in the last 12 months			
Yes	(reference)		
No	1.13(0.41 to 3.30)		
Have been sexually active			
No	(reference)		
Yes	1.26(0.46 to 3.58)		
Have been secually active in the last 3 months			
Yes	(reference)		
No	0.21(0.06 to 0.60)**		
Can talk to parent(s) about their fysical, mental and sexual health			
Yes	(reference)		
No	0.72(0.33 to 1.57)		
Can talk to friend(s) about their fysical, mental and sexual health			
Yes	(referene)		
No	0.88(0.34 to 2.28)		
Can talk to other adult(s) about their fysical, mental and sexual health			
Yes	(reference)		
No	0.88(0.41 to 1.86)		
Can talk With neither parent(s), other adult(s) or friend(s) about their fysical, mental and sexual health			
No	(reference)		
Yes	0.58(0.12 to 2.48)		
Age	1.06(0.87 to 1.28)		
Country of birth			
Sweden	(reference)		
Other	1.59(0.31 to 8.65)		
Country of birth parents			
One parent born outside Sweden	0.83(0.36 to 1.90)		
Both parents born outside Sweden	0.40(0.07 to 1.83)		
Subjective socioeconomic status			
Good	(reference)		
Poor	1.64(0.52 to 5.33)		
Religious and/or Spiritual			
No	(reference)		
Yes	0.60(0.24 to 1.43)		

[1]Results from the log likelihood ratio X^2 test

*P<0.05, **P<0.01, ***P<0.001

Data from March-April 2022 on adolescent boys and young men residing in Skåne, Sweden

Popular science summary

Sweden has a long-standing tradition of providing young people with youth-friendly health services through the youth clinics. However, they have so far been mainly targeted towards and utilised by girls and young women, and it has proven difficult to break the trend. One reason for this is that we still know very little about what motivates and prevents boys and young men from seeking out and utilising healthcare services and supports, including those provided by the youth clinics. This study was based on survey data collected in southern Sweden from March to April 2022 and investigated health service needs and health-seeking behaviour related to the experience of visiting a youth clinic among male youths aged 15 to 22.

Results showed that being sexually active, especially recently, is a strong predictor of youth clinic experience. A few other factors showed a limited significant association with the outcome. These included not being able to talk to parents, friends or other adults about one's health, not valuing access to mental health services, and not feeling one has access to sexual health services. Age showed a small positive association with the outcome, where the odds of having been to a youth clinic increased with age. Overall no clear patterns were revealed, suggesting little or no associations. When adjusted for each other, some factors encouraging or discouraging the use of health services could predict the experience of visiting a youth clinic significantly. Neither subjective socioeconomic status, religiosity, nor immigration status was able to significantly predict whether participants' had experience of the youth clinics.

As the first study of its kind, this study carries important implications for future research and public health efforts to address and meet young males' health and support needs.

Appendix


LUNDS UNIVERSITET
Identifierar du dig som kille, är mellan 15-22 år och bosatt i Skåne?
I så fall är vi intresserade av ditt perspektiv på killars och unga mäns kunskaper och behov av stöd och tjänster kopplat till sexuell, psykisk och fysisk hälsa!
Projektet genomförs av Lunds Universitet och undersökningen består av en enkät som tar ca 10 min att fylla i. Ditt deltagande sker anonymt.
Länk och QR-kod för att komma till enkäten
bit.ly/killar

Tack för ditt intresse för att delta i den här studien,

Den här enkäten handlar om killars och unga mäns kunskaper och behov av stöd eller tjänster som rör deras till fysiska, mentala och sexuella hälsa.

Att delta i studien är helt frivilligt. Om du börjar svara på enkäten och sedan inte vill göra klart den är det helt ok. Du kan avbryta ditt deltagande ända fram tills att du skickat in ditt svar, utan att det får några konsekvenser eller att någon information registreras. Studien är godkänd av Etikprövningsmyndigheten (Dnr 2022-00295-01).

Dina svar är anonyma och enkäten kommer sammanställas på gruppnivå. Det betyder att dina svar inte kan kopplas till dig som individ. Dina svar kommer att behandlas och förvaras så att obehöriga inte kan ta del av dem. Resultaten kommer ligga till grund för en masteruppsats och eventuellt även presenteras i vetenskapliga tidskrifter.

Den organisation som är ansvarig för projektet och de uppgifter som samlas in är Lunds Universitet. Inga personuppgifter kommer samlas in som i enlighet med EU:s dataskyddsförordning kräver särskilt skydd vid hantering. Dataskyddsombudet vid Lunds universitet kan kontaktas på 046-2220000 eller dataskyddsombud@lu.se.

Kontaktperson och ansvarig för projektet är Jesper Sundewall. Har du frågor om studien eller ditt deltagande får du gärna mejla till jesper.sundewall@med.lu.se.

Med vänliga hälsningar

Jesper Sundewall
Projektledare, biträdande forskare, Socialmedicin och global hälsa
Inst. för kliniska vet., Lunds universitet
Epost: jesper.sundewall@med.lu.se

Stella Hedlund
Masterstudent i folkhälsovetenskap, Lunds Universitet
Leg. Sjuksköterska

Frågor om dig och din bakgrund

Jag identifierar mig som kille och bor i Skåne

☐ Ja

Hur gammal är du?

☐ 15
☐ 16
☐ 17
☐ 18
☐ 19
☐ 20
☐ 21
☐ 22

Vad är din huvudsakliga sysselsättning?

☐ Går i grundskolan
☐ Går i gymnasiet
☐ Går en eftergymnasial utbildning (högskola/universitet/folkhögskola/yrkesutbildning)
☐ Arbetar
☐ Är arbetssökande
☐ Annat

☐

Vilket land är du född i?

☐ I Sverige
☐ I Norge, Finland, Danmark eller på Island
☐ I annat land i Europa
☐ I annat land utanför Europa
☐ Vet inte

Vilket land är dina föräldrar födda i?

	I Sverige	I Norge, Finland, Danmark eller på Island	Annat land i Europa	Annat land utanför Europa	Vet inte
Förälder 1	☐	☐	☐	☐	☐
Förälder 2	☐	☐	☐	☐	☐

Hur skulle du beskriva din/ditt hushålls ekonomi?

- [ ] Mycket god
- [ ] Ganska god
- [ ] Inte särskilt god
- [ ] Inte alls god
- [ ] Vet inte/osäker

Hur religiös eller spirituell skulle du säga att du är?

- [ ] Väldigt religiös eller spirituell
- [ ] Delvis religiös eller spirituell
- [ ] Inte särskilt religiös eller spirituell
- [ ] Inte alls religiös eller spirituell
- [ ] Vet inte/osäker

Några frågor om hur du upplever behovet och tillgången till stöd, information och vård

Om jag behöver kan jag prata relativt öppet om min sexuella, fysiska eller psykiska hälsa med… Klicka i alla som stämmer

- [ ] ...en av mina föräldrar
- [ ] ...två av mina föräldrar
- [ ] ...annan vuxen
- [ ] ...kompis(ar)
- [ ] ...ingen av ovanstående

Inom vilka av dessa områden upplever du att du har tillgång till stöd/information/vård? Klicka i alla som stämmer

- [ ] Din psykiska hälsa
- [ ] Din sexuella hälsa
- [ ] Din fysiska hälsa
- [ ] Kärleksrelationer
- [ ] Sexuella relationer
- [ ] Vänskapsrelationer
- [ ] Familjerelationer
- [ ] Inget av ovanstående
- [ ] Annat

[ ]

Inom vilka av dessa områden känns det för dig viktigt att ha tillgång till stöd/information/vård? Klicka i alla som stämmer

- [ ] Din psykiska hälsa
- [ ] Din sexuella hälsa
- [ ] Din fysiska hälsa
- [ ] Kärleksrelationer
- [ ] Sexuella relationer
- [ ] Vänskapsrelationer
- [ ] Familjerelationer
- [ ] Inget av ovanstående
- [ ] Annat

Vet du vart du kan vända dig för att få stöd/information/vård inom följande områden? Klicka i alla som stämmer

- [ ] Din psykiska hälsa
- [ ] Din sexuella hälsa
- [ ] Din fysiska hälsa
- [ ] Kärleksrelationer
- [ ] Sexuella relationer
- [ ] Vänskapsrelationer
- [ ] Familjerelationer
- [ ] Inget av ovanstående
- [ ] Annat

Några frågor om dina erfarenheter av stöd, information och vård

Har du besökt en ungdomsmottagning någon gång?

- [ ] Ja
- [ ] Nej
- [ ] Vet inte/osäker

Upplevde du att du fick det stöd/information/vård du hade hoppats på?

- [ ] Ja, helt
- [ ] Ja, delvis
- [ ] Nej, inte alls
- [ ] Vet inte/osäker

Vilka anledningar finns det till att du inte varit på en ungdomsmottagning? Klicka i alla svar som stämmer

- [ ] Vet inte vart de ligger eller hur jag tar mig dit
- [ ] Har inte haft tid
- [ ] Vet inte vad man gör där
- [ ] Jag har inte känt något behov
- [ ] Har fått hjälp någon annanstans, tex skolsköterska, vårdcentral, BUP
- [ ] Varit osäker på om jag behövt hjälp/vård
- [ ] Inget av ovanstående
- [ ] Annat

Har du någon gång låtit bli att söka stöd/information/vård relaterat till din hälsa för att du varit orolig för att kompisar, familj eller utomstående skulle få veta?

- [ ] Ja nån gång
- [ ] Ja fler än en gång
- [ ] Nej
- [ ] Vet inte/osäker

Har du någon gång låtit bli att söka stöd/information/vård relaterat till din hälsa för att du upplevt det som pinsamt/jobbigt att prata med någon i vården eller på skolan?

- [ ] Ja nån gång
- [ ] Ja fler än en gång
- [ ] Nej
- [ ] Vet inte/osäker

Här är ett par frågor om sex och relationer

Är du eller har du varit i ett förhållande de senaste 12 månaderna?

- [ ] Ja, jag är i ett förhållande just nu
- [ ] Ja, jag har varit i ett förhållande tidigare
- [ ] Nej
- [ ] Osäker

Har du någon gång haft sex? Utgå från vad du själv skulle definiera som sex.

- [ ] Ja
- [ ] Nej
- [ ] Vet inte/osäker

Har du haft sex någon gång de senaste 3 månaderna?

- [ ] Ja
- [ ] Nej
- [ ] Vet inte/osäker

Frågor om din kunskap och uppfattning om ungdomsmottagningarna

Har pass väl känner du till ungdomsmottagningarna?

- [ ] Jag har aldrig hört namnet förens nu
- [ ] Har hört namnet men vet inte mer än så
- [ ] Jag skulle kunna ge exempel på något man kan få hjälp med på ungdomsmottagningarna
- [ ] Jag känner till flera saker man kan få hjälp med på ungdomsmottagningarna

Känner du till hemsidan www.UMO.se?

- [ ] Hört talas om men aldrig besökt
- [ ] Besökt nån gång kanske
- [ ] Besökt fler än en gång
- [ ] Nej, inte alls

På vilka ställen har du någon gång hört talas om ungdomsmottagningarna? Klicka i alla svar som stämmer

- [ ] Av skolan
- [ ] Av kompis
- [ ] Av partner
- [ ] Hemma
- [ ] Internet
- [ ] Sett reklam
- [ ] Annat

Tror du att du kommer besöka en ungdomsmottagning kommande året?

- [ ] Ja, men bara fysisk mottagning
- [ ] Ja, men bara hemsidan
- [ ] Ja, både mottagning och hemsida
- [ ] Kanske/vet inte
- [ ] Nej det tror jag inte

Grattis och tack! Du har nu nått slutet på enkäten! Bara ett klick kvar, välj 'skicka in ditt svar'

Popular Science Summary

Sweden has a long-standing tradition of providing young people with youth-friendly health services. However, they have so far been mainly targeted towards and utilised by girls and women, and it has proven difficult to break the trend. One reason for this is that we still know very little about what motivates and prevents boys and men from seeking out and utilising healthcare services and supports, including those provided by the youth clinics. This study was based on survey data collected in southern Sweden from March to April 2022 and investigated health service needs and health-seeking behaviour related to the experience of visiting a youth clinic among male youths aged 15 to 22.

Results showed that being sexually active, especially recently, is a strong predictor of youth clinic experience. A few other factors showed a limited significant association with the outcome. These included not being able to talk to parents, friends or other adults about one's health, not valuing access to mental health services, and not feeling one has access to sexual health services. Age showed a small positive association with the outcome, where the odds of having been to a youth clinic increased with age. Overall no clear patterns were revealed, suggesting little or no associations. One model containing four variable types: (1) having previously refrained from seeking out health services; (2) ability to talk to others about one's health; (3) being sexually active; and (4) relationship experience, could significantly predict youth clinic experience. Neither subjective socioeconomic status, religiosity, nor immigration status was able to significantly predict whether participants' had experience of the youth clinics.

As the first study of its kind, this study carries important implications for future research and public health efforts to address and meet young males' health and support needs.